

**THE IMPACT OF OPERATION IRAQI FREEDOM/
OPERATION ENDURING FREEDOM ON THE
U.S. DEPARTMENT OF VETERANS AFFAIRS
CLAIMS PROCESS**

HEARING

BEFORE THE

SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS

OF THE

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

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CONTENTS

March 13, 2007

	Page	
The Impact of Operation Iraqi Freedom/Operation Enduring Freedom on the U.S. Department of Veterans Affairs Claims Process	1	
OPENING STATEMENTS		
Chairman John J. Hall	1	
Prepared statement of Chairman Hall	39	
Hon. Doug Lamborn, Ranking Republican Member	2	
Prepared statement of Congressman Lamborn	40	
WITNESSES		
U.S. Government Accountability Office, Daniel Bertoni, Acting Director, Education, Workforce, and Income Security Issues	5	
Prepared statement of Mr. Bertoni	41	
U.S. Department of Veterans Affairs, Ronald R. Aument, Deputy Under Secretary for Benefits, Veterans Benefits Administration	32	
Prepared statement of Mr. Aument	61	
Bilmes, Linda, Professor, John F. Kennedy School of Government, Harvard University, Cambridge, MA		6
Prepared statement of Ms. Bilmes	48	
Iraq and Afghanistan Veterans of America, Patrick Campbell, Legislative Director	23	
Prepared statement of Mr. Campbell	58	
National Association of County Veterans Service Officers, Ann G. Knowles, President	17	
Prepared statement of Ms. Knowles	51	
Veterans for America:		
Stephen L. Robinson, Director of Veterans Affairs	19	
Prepared statement of Mr. Robinson	53	
Brady Van Engelen, Associate Director	21	
Prepared statement of Mr. Van Engelen	57	
VoteVets.org, Jon Soltz, Co-Founder and Chairman	25	
Prepared statement of Mr. Soltz	59	
MATERIAL SUBMITTED FOR THE RECORD		
“How the U.S. Is Failing Its War Veterans,” Newsweek Magazine, March 05, 2007, by Dan Ephron and Sarah Childress	66	
“Pomona Veteran Shares Story of Fighting for Health Benefits,” The Journal News, (Original Publication: March 13, 2007), by Hema Easley	80	
“Vietnam Vet Fights for Fellow Soldiers,” Times Herald-Record, March 13, 2007, by Greg Bruno	81	
“Veterans Face Vast Inequities Over Disability,” New York Times, March 09, 2007, by Ian Urbina and Ron Nixon	82	
“The Economic Costs of the Iraq War: An Appraisal Three Years after the Beginning of the Conflict,” January 2006, by Linda Bilmes, Kennedy School, Harvard University, and Joseph E. Stiglitz, University Professor, Columbia University	85	
“Soldiers Returning From Iraq and Afghanistan: The Long-Term Costs of Providing Veterans Medical Care and Disability Benefits,” January 2007, by Linda Bilmes, Professor, Kennedy School of Government, Harvard University	108	

**THE IMPACT OF OPERATION IRAQI FREEDOM/
OPERATION ENDURING FREEDOM (OIF/OEF)
ON THE U.S. DEPARTMENT OF VETERANS
AFFAIRS CLAIMS PROCESS**

TUESDAY, MARCH 13, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:17 a.m., in Room 334, Cannon House Office Building, Hon. John J. Hall (Chairman of the Subcommittee) presiding.

Present: Representatives Hall, Hare, Rodriguez, and Lamborn.

OPENING STATEMENT OF CHAIRMAN HALL

Mr. HALL. Okay. Now we are going to move to our hearing on the Impact of Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) Returning Veterans on the VA Claims Process.

And if our first two panelists would like to come to the table in front, Dan Bertoni from the U.S. Government Accountability Office and Linda Bilmes from the John F. Kennedy School of Government.

And I think I have asked Congressman Lamborn, if it is okay with my colleagues on this side of the aisle, we will make a brief statement each and then we will hear from you because that is where the hearing is. And then we can each make statements as part of our 5 minutes. We can have as many 5 minutes as we want.

Thank you again for coming here today, and I am honored and at the same time troubled to be sitting here with our topic today and the news that has been heard and seen recently and what I am hearing from veterans in my district.

Regardless of whether or not you agree or disagree with a particular policy or a particular war, all Members of Congress I have spoken to, and I think all Americans, believe that our young men and women who serve in OIF/OEF deserve the best medical care and all the help we can give them in transitioning from military to civilian life.

Nothing bothers me more than hearing people say they support the troops, but seeing a cold shoulder being turned when those troops return home, or seeing veterans have to fight their way

through layers of bureaucracy, or wait for months or years while their claims are processed.

The purpose of today's hearing is to ensure that the problems discovered at Walter Reed Army Medical Center are not the tip of the iceberg with respect to how prepared we are for our returning servicemembers.

Since the jurisdiction of this Subcommittee is not veterans' healthcare but veterans' benefits, we are going to focus on the VA's claims process and how it has been impacted by OIF and OEF, and more importantly, how it will be impacted, I think, as the wave—I think we are only beginning to see the front end of the wave of returning veterans who are affected physically or psychologically.

As an aside, I would like to say that I am sponsoring a bill to allow active-duty servicemembers the option of receiving medical treatment at their local VA hospital if they so desire without changing their status as active-duty Members of the military.

In addition to looking at whether the VA is equipped to handle the claims of returning servicemembers, this hearing will also examine reports of discrepancies among active and reserve veterans. Some media reports state that Reserve and National Guard servicemembers had a greater risk of their claims being denied or lowered than their active-duty counterparts.

I am going to skip over the rest of my statement for now. I just want to refer you all to, if you have not seen it already, to the March 5th edition of Newsweek, which I will introduce into the record, to see how some returning OIF and OEF veterans are falling through the cracks.

[The article referenced by Chairman Hall, "How the U.S. Is Failing Its War Veterans," Newsweek Magazine, March 5, 2007, by Dan Ephron and Sarah Childress, appears on page 66.]

Mr. HALL. There is a story on page 33 of that magazine about Patrick Feges, who was wounded in October of 2004 and had to wait 17 months until his first VA disability check arrived. His mother, an elementary schoolteacher, took a second job at McDonald's to help support him.

Mr. Feges' claim was only approved after Newsweek and the Veterans for America began looking into his case. I thank them both for their work.

And this hearing today is to see if the 17-month delay is an anomaly or evidence of a systemic problem for returning OIF and OEF veterans. If it is the latter, I would be interested in hearing any and all recommendations from our witnesses on how we can fix the problem.

And now I would like to recognize our Ranking Member, Congressman Lamborn, for his opening statement.

[The prepared statement of Chairman Hall appears on page 39.]

OPENING STATEMENT OF HON. DOUG LAMBORN

Mr. LAMBORN. Thank you, Mr. Chairman, for recognizing me. And I want to thank you for holding this hearing on the claims backlog and how it will affect the returning servicemembers from the Global War on Terror.

As I said earlier, I congratulate you on your being appointed as the Chairman of this Subcommittee, and I look forward to working with you in a bipartisan manner to solve these problems.

Today we are here to talk about the effect of OIF and OEF veterans on the VA claims process. I am more concerned about the effect of the VA claims process on our great veterans. And since the beginning of Operation Enduring Freedom, more than 150,000 claims have been filed by OIF and OEF veterans.

In part, this is a positive response to VA's increased outreach, but now we have a responsibility to process these claims and to care for these veterans in a responsible manner.

I believe the first step toward improvement for these veterans is to improve the overall VA claims processing system. The backlog of compensation and pension claims is over 632,000 claims, about 15,000 more than a month ago according to the VA's weekly report.

The VA has set a goal to decide a given claim in an average of 125 days. While more than 4 months does strain the meaning of the word prompt, it is not unreasonable given the complexity and the demands of the "Veterans Claims Assistance Act" and other administrative requirements, but now we need the VA to go out and just do it.

I know that we in Congress bear some responsibility for all of the complexity. I look forward to asking Mr. Aument what we can do to help improve the bureaucratic process while safeguarding it for veterans.

Mr. Chairman, both the budget views and estimates from the Committee's Majority and the Minority recommend 1,000 new hires for the VBA over and above the President's request for 457 new staff for compensation and pension.

In two years when they are all hired and trained, they will indeed make a difference. The conventional approach of increased hiring is entirely appropriate. VBA has over the past several years experienced personnel shortages.

We must also explore some innovative ways to tackle the challenge that may have even faster payoffs than the new hires. That is why Committee Republicans this year have recommended funding for innovative pilot programs to address the backlog as well.

We recommended funding for a pilot program to explore the feasibility of inter-governmental and VSO partnerships with VA in the development of compensation and pension claims. This pilot program would build on positive findings from a 2002 project conducted between the VA's Buffalo, New York regional office and the New York State Division of Veterans Affairs.

Within six months of their collaboration, the State Veterans Division was developing claims in partnership with VA. Decisions for the region's veterans came faster and accuracy improved. This kind of innovation holds great promise.

Access to VBA regional offices can be difficult for many veterans. That is why we also recommended funding a pilot program for mobile claims offices.

VBA staff Members in mobile offices would provide outreach, help veterans file their claims, and gather ombudsman feedback and resolution for veterans.

Mobile offices helping veterans with their claims could speed up the claims process by improving communication and access for veterans.

To take advantage of the potential offered by technology, we recommend funding to explore a rules-based adjudication system. Software could potentially decide simple claims accurately, quickly, and consistently so that developers can focus on the complex cases.

For our newest veterans returning from Afghanistan, Iraq, and elsewhere in the Global War, we must achieve a seamless transition from the military into the VA system. It is apparent to me that a seamless transition will help erase that backlog because it does increase the system's overall efficiency.

We need full inter-operable electronic health records between VA and Department of Defense, an electronic DD Form 214, military separation physicals that can also function as VA disability physicals, and a disability rating process that provides consistent ratings.

What good is a separation exam and health records from DoD if the veteran has to repeat the whole process all over again with the VA?

Mr. Chairman, I am sure you agree no veteran should have to wait 6 months to a year for their claim to be decided and then endure an appeal possibly that adds another year or two. For some veterans, this is not merely inconvenient, it is financial and potentially emotional disaster.

Every one of these claims is an American veteran and his or her family awaiting a decision. Every veteran deserves to have their claim adjudicated quickly and accurately.

One thing is certain. If we do not fix this problem now, our legacy will be an intolerable backlog regrettably endured by this generation of veterans and inexcusably bequeathed to a future generation. I firmly believe no one in this room wants such an outcome.

I want to thank the witnesses for their service and for their testimony. I look forward to hearing it and I look forward to our continued discussion today.

Mr. Chairman, I yield back.

[The prepared statement of Congressman Lamborn appears on page 40.]

Mr. HALL. Thank you, Mr. Lamborn. Some good ideas there, and we will be taking close looks at them as we go forward.

If our other Members would be content to submit opening statements to the record, then we will move straight to the testimony.

And if we could start with you, Mr. Bertoni. Daniel Bertoni, the Acting Director of Education, Workforce, Income Security Issues for the GAO.

Welcome, Mr. Bertoni.

STATEMENTS OF DANIEL BERTONI, ACTING DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; AND LINDA J. BILMES, PROFESSOR, JOHN F. KENNEDY SCHOOL OF GOVERNMENT, HARVARD UNIVERSITY, CAMBRIDGE, MA

STATEMENT OF DANIEL BERTONI

Mr. BERTONI. Mr. Chairman, Members of the Subcommittee, good morning. I am pleased to be here to discuss the Department of Veterans Affairs disability claims process in the context of the wars in Iraq and Afghanistan.

Last year, VA provided nearly \$35 billion in benefits to 3.5 million veterans and survivors. For years, the claims process has been the subject of attention by VA, the Congress, and others due to untimely decisions, large backlogs, and other weaknesses.

In 2003, we designated VA and other Federal disability programs high risk because these programs were based on outmoded concepts and continue to experience management and operational problems. And since that time, we have issued numerous reports with recommendations for change.

My testimony today is based on our prior work and focuses on three areas, service delivery challenges facing VA, actions taken to better serve applicants, and areas where fundamental reform may be needed to further improve performance in the future.

In summary, several factors have created service delivery challenges for VA. In general, the growth in disability claims has strained operations. Since 2000, the number of annual claims, including those filed by veterans of Iraq and Afghanistan, have risen steadily from about 579,000 to over 800,000 last year.

While VA has had success in the past reducing its claims inventory, it is now losing ground. Since 2003, pending claims have increased almost 50 percent to nearly 400,000. Those pending over 6 months also increased more than 75 percent to over 80,000.

And the time required to resolve appeals also remains problematic. The current average processing time of 657 days is far from VA's stated goal of 1 year.

Other factors affecting performance include court decisions requiring VA to assist veterans in developing claims, laws and regulations which have expanded benefit entitlement, increasing caseload complexity as more veterans claim multiple disabilities, difficulties obtaining key evidence in a timely manner, and VA's increased outreach to veterans and servicemembers.

VA is also receiving more claims for new and complex disabilities related to combat overseas, including traumatic brain injuries, as well as posttraumatic stress disorder cases as well, which are generally hard to evaluate.

In light of these considerable challenges, we have noted that continuing to devise new ways to work smarter and more efficiently will be essential to VA's productivity. VA has taken steps to improve claims process. Its 2008 budget requests over 450 additional claims processing staff, a 6 percent increase over last year.

Other productive initiatives include increasing overtime, using retired staff as trainers, and piloting a paperless benefits delivery

and discharge process where servicemembers' disability claim and medical records are captured electronically prior to separation.

VA has also enhanced internal training and information sharing to reduce the number of cases sent back by the Board of Appeals due to errors or incomplete evidence.

VA also recently announced a new initiative to provide priority processing of all OIF and OEF disability claims.

It is imperative that VA continue to address weaknesses and bottlenecks in its system to expedite case processing, increase decisional accuracy, as well as consistency.

Through our ongoing work, we will continue to monitor and assess VA's near-term initiatives to ensure that VA balances the need for improved case processing, that they need to protect the veterans' due process rights.

Going forward, there also may be opportunities for more fundamental reform that could dramatically improve the program in the longer term.

In designating VA's disability program high risk, we noted that its processes did not reflect the current state of science, medicine, technology, and the national economy which has moved away from manual labor to service and knowledge-based employment.

We recommended that VA reassess its disability criteria to better align with changes in the national economy and that it place a greater emphasis on early intervention and rehabilitation services.

We have also reported that VA's field structure may impede efficient operations. Despite limited efforts to consolidate some processes and workloads, VA has not changed its basic field structure for processing claims at 57 regional offices which have experienced large variations in productivity, accuracy, and consistency.

While reexamining claim processing challenges can be daunting, key efforts are underway. In 2003, the Congress established the Veterans Disability Benefits Commission to study many of the issues discussed today, including VA claims processing operations and the location and number of processing centers.

The Commission is scheduled to report to Congress by October of 2007. And like you, we look forward to the findings and recommendations.

Mr. Chairman, this concludes my remarks. I am happy to answer any questions that you or the Members of the Subcommittee may have. Thank you.

Mr. HALL. Thank you, Mr. Bertoni. And your written testimony as submitted will be added to the record.

[The prepared statement of Mr. Bertoni appears on page 41.]

Mr. HALL. And before we go to questions, we would like to hear the statement of Professor Linda J. Bilmes from the Kennedy School of Government at Harvard University.

Professor Bilmes.

STATEMENT OF LINDA J. BILMES

Ms. BILMES. Thank you, Mr. Chairman, Mr. Lamborn, Members of the Subcommittee. Thank you for inviting me to speak to you today on this important topic.

I am Professor Linda Bilmes, a faculty member of the Kennedy School of Government where I teach budgeting and public finance.

Just by way of background, last year, I co-authored with Nobel Laureate Professor Joe Stiglitz a paper that analyzed the economic cost of the Iraq War. One of the long-term costs we identified is the cost of providing lifetime disability benefits and medical care for veterans.

[The paper referenced above, "The Economic Costs of the Iraq War: An Appraisal Three Years after the Beginning of the Conflict," appears on page 85.]

Today I would like to focus on the projected number of veterans' claims, the capacity of the Department of Veterans Affairs to process those claims, and the cost of providing benefits to returning OIF/OEF soldiers.

This was the subject of my second paper written this year which specifically looked at the cost of providing care and disability benefits to veterans in Operation Iraqi Freedom and Enduring Freedom. The paper has been entered into the record.

[The second paper referenced above, "Soldiers Returning From Iraq and Afghanistan: The Long-Term Costs of Providing Veterans Medical Care and Disability Benefits," appears on page 108.]

I would like to discuss five key areas of concern and then to recommend five changes that I believe would significantly streamline the process.

First, the areas of concern. First, the VBA is currently overwhelmed with the volume of claims it is receiving, leading to a huge backlog. In 2006, the VBA received over 800,000 claims.

Secretary Nicholson testified last month that he expects to receive 1.6 million additional claims in the next 2 years. My own projections show that between 250,000 and 400,000 of these claims will be new, unique applications from soldiers currently serving in Iraq and Afghanistan. The number of pending claims and paperwork has risen from 69,000 in 2001 to more than 600,000 as of today.

Second, the claims process itself is extremely long, cumbersome, and paperwork intensive. As noted, the VBA takes an average of about 6 months to process an initial claim and an average of about 2 years to process an appeal. By contrast, the private sector medical insurance settles 30 million insurance claims, including the appeals, within an average of 89.5 days.

The process for ascertaining whether a veteran is suffering from a disability and rating the percentage level of a veteran's disability is far too complex. After a veteran applies to one of the 57 regional offices, a claims adjudicator evaluates the veteran's service-connected impairments and assigns a rating for the degree to which the veteran is disabled.

Claims specialists determine the percentage of disability for each condition in increments of ten. However, you would think that would be complicated enough, but conditions are not scaled monotonically from zero to a hundred.

Mental conditions, for example, are rated zero, ten, thirty, fifty, seventy, or a hundred. Coronary artery disease ratings are ten, thirty, sixty, and one hundred. Spinal conditions are rated ten, twenty, thirty, forty, fifty, one hundred. A huge amount of time and effort is devoted to making these determinations and then on the veteran's side, to appealing the decision.

There is wide disparity in efficiency between individual VBA offices. Regional offices are inconsistent in how they rate disabilities. GAO found that the days needed to process a claim range from 99 days in the Salt Lake City VA to 237 in Honolulu. Currently some of the States providing the most soldiers for the war are suffering the longest delays in claims adjudication.

In addition, the claims themselves are more complicated than in previous conflicts. Vietnam-era claims cited on average three disability conditions. Gulf War veterans filed four. For GWOT veterans, the average claim includes five separate disability issues. One-quarter of the new claims filed this year cited eight or more disabilities. And then since each item within a claim is treated separately, there is a great deal of opportunity for duplication and delay.

The VBA has more than 9,000 claims specialists. Many of them are themselves veterans, and they generally do a good job and they try very hard to help veterans. But they are under an enormous strain. They are required to assist the claimant in obtaining evidence in accordance with hundreds of arcane VBA regulations, policies, procedures, and guidelines. They have to rate the claims, establish files, authorize payments, conduct in-person and telephone interviews, process appeals, and generate various notification documents through the process. New employees require about 18 months to become trained.

For all these reasons, I believe that the agency as currently structured is simply not capable of settling the current and projected volume of claims in a timely manner.

My third point is that the projected number of claims from the wars in Iraq and Afghanistan will rapidly turn this disability claims problem into a crisis. The current conflict has the highest incidence of nonmortal casualties in U.S. military history, a ratio of 16 woundings or injuries per fatality.

To date, of the more than 1.4 million U.S. soldiers who have been deployed, about 631,000 have been discharged and one-third have already been treated and diagnosed at VHA hospitals and clinics. About 180,000 have applied for disability benefits.

If returning GWOT soldiers claim benefits at the same rate as veterans from the first Gulf War, we can expect anywhere from 638,000 to 869,000 unique, new first-time claims from the GWOT in the next 5 years. If all the troops return home sooner, if they all return home by 2008, there are likely to be more than 400,000 new claims by the end of 2009 alone.

Fourth, the cost of providing disability benefits to GWOT veterans is projected to be between 70 billion and 150 billion in 2007 dollars. The cost is not the only issue here, but it is yet another major cost of war that has not been anticipated by the Administration.

The eventual cost will depend on several factors, including the total number of troops deployed and the length of time they are deployed, the rate of claims and utilization of benefit programs by returning troops, and the cost of living adjustments in their benefits.

Fifth, it is important to understand that the disability process and the health process are inter-related. The growing number of disability claims is creating additional demand for veterans' med-

ical examinations. This is adding to pressure on the veterans health facilities.

The current system, as Mr. Lamborn pointed out, does not guarantee that all soldiers receive complete physicals in the military upon discharge and even if they do, they cannot automatically transfer that information from DoD to VA.

Consequently newly discharged veterans who intend to file a disability claim are seeking medical examinations from VHA health facilities in order to document their disabilities. Some of the backlog at the veterans health facilities is from veterans who are seeking appointments not necessarily because they require immediate treatment but they have to verify a disabling condition, even in cases where it was already documented upon discharge from the military.

Recommendations. To address the immediate backlog, the proposal from Secretary Nicholson is to hire 457 additional claims specialists, to increase the claims processed per specialist from 98 to 101, and to make training manuals more readily available.

He projects that this will cut the length of time it takes to process a veteran's claim by 32 days by 2008. I am not at all optimistic that a few hundred inexperienced new staffers, even assuming that they can be hired quickly, will produce a 22 percent improvement in claims processing time during a period in which the agency faces a huge influx of complex claims.

Indeed, it is conceivable that the task of training and integrating a large number of inexperienced new hires will in the short term actually lengthen claims processing times and increase the number of appeals. And this problem is compounded by the fact that like many Federal agencies, many experienced VBA personnel will be retiring over the next 2 to 5 years.

Therefore, I believe that finding an answer to the claims problem requires us to think outside the box, and I would like to offer several proposals that do this.

First, for the next 2 years, the VBA should accept and pay all disability claims by returning GWOT soldiers at face value and then audit a sample of them. In other words, what we should do is essentially what the IRS does with taxes, accept the claims and then audit them.

I would not see this as being a long-term solution, but as a short-term solution. This would ensure that new returning veterans do not fall through the cracks and it would shift the focus while the VBA reforms its process.

Second, the VBA should replace the cumbersome zero to one hundred scale for disabilities with a simple four-level ranking, zero disabled, low disability, medium disability, and high disability. This would immediately streamline the process, reduce discrepancies between regions, and likely cut the number of appeals.

The VBA should create a short form for returning veterans using this four-level ranking and set a goal of processing all claims within 60 days of receipt. This new system should be up and running within 2 years, including retraining the workforce and developing necessary guidelines and appeals procedures.

Third, all soldiers serving in the GWOT should receive a mandatory full medical examination at discharge from DoD with all

records from this examination made available electronically to the VBA immediately, and then the VBA should be able to use these records to grant disability, to spot check and audit claims, and to assist veterans and to relieve some of the pressure on VBA.

Moreover, if veterans are discharged without full medical examinations, they should be reimbursed to receive such an examination from any fully accredited physician within 90 days of discharge, and this record should be used by VBA for making claims.

Fourth, VBA should shift some of its focus away from claims processing onto more rehabilitation and reintegration of veterans. In other words, the VBA staff should be used more as a strategic asset. More of them should be placed in neighborhood veteran centers, health centers, and assisting in benefits at discharge systems.

Fifth and finally, Congress should enact what is a bill now in the Senate, Senate Bill 117, the Lane Evans "Veterans Healthcare and Benefits Improvement Act," co-sponsored by Senators Obama and Snowe. This is an excellent piece of legislation that would improve data collection, improve monitoring of claims, improve access to mental healthcare, and improve the benefits and level the playing field for Guards and Reservists.

Thank you very much for your time and attention, and I would be pleased to answer any questions you have.

[The prepared statement of Ms. Bilmes appears on page 48.]

Mr. HALL. Thank you, Professor Bilmes.

Excellent presentations from both of our witnesses.

I will keep my questions short for now, and say there have been a number of instances you both have brought up and Congressman Lamborn has also mentioned the redundancy of having a discharge physical from DoD and then an evaluation physical from the Department of Veterans Affairs.

I had a visit yesterday in my district with a soldier, a Vietnam veteran, who had repeated physicals for a prostate diagnosis when, in fact, he had prostate cancer. He already had scans showing that it was in his bones already and he went 5 years before getting his claims recognized and the bills paid.

And I will submit a couple stories about that into the record, but he was complaining not just that he was going back for redundant physicals, but the time the doctor was taking on his could have been used for somebody who actually needed a physical who had not been diagnosed already with a more high-tech means.

[The articles referenced by Chairman Hall, "Pomona Veteran Shares Story of Fighting for Health Benefits," *The Journal News*, (Original Publication: March 13, 2007), by Hema Easley, "Vietnam Vet Fights for Fellow Soldiers," *Times Herald-Record*, March 13, 2007, by Greg Bruno, appear on pages 80 and 81.]

And it seems that obviously there are some procedural guidelines, the simplification that you speak of in terms of categories, but also in terms of certain conditions, what the doctors and the staff are required to do, maybe to cover their own backs so that they can show a paper trail and not be questioned later.

Which would you suggest, and this can be for both of our witnesses, that we accept the DoD's separation physical, we make that mandatory? And you were saying it did not always occur, but that

we make that mandatory and make that the equivalent of a VA evaluation entry physical or vice versa.

And a more radical thought, what would you think of—it has been suggested recently to me—what would you think of the Department of Veterans Affairs being folded into the Department of Defense so that the true cost of war and of the use of our soldiers is evaluated in the long term and seen as part of the same budget?

Ms. BILMES. Shall I comment first? First of all, in terms of the discharge issue, I think there are three parts to it. First, all soldiers should have a mandatory physical on discharge from the military, you know, while they are there in the military.

And if you think about the private sector analogy, you cannot imagine most employers dumping the entire cost and responsibility on to their insurers, which is sort of the VA, for the care of their employees.

So, I would recommend that they should have a mandatory examination, and it is very important that the information be then useable, that the files be electronically immediately available to people in the VA and that they not be sort of at the mercy of the fax machine to be trying to locate documents from the DoD, and finally that this examination be allowable within the VA for benefits.

You know, those are three different things that need to be accomplished at the same time. But I strongly feel it would be very helpful.

Secondly, regarding the more radical idea of folding the VA into DoD, I would not be in favor of that at this time. I think that generally the culture in the VA is very much an empathetic culture that favors the veteran, that cares about the veteran.

Certainly when you speak to people who run the polytrauma units and some of these units, they are wonderful people. They really, care about the veterans and there is sort of an inherent conflict in putting some of those people into a military fighting machine.

However, there has to be a much better transition between the DoD and the VA, and GAO has certainly documented many cases of a lack of sharing of information between DoD and VA.

So what typically happens now is a veteran has to scramble around, having already fought for his country, to get hold of a blood test or something like that was already taken in DoD. It takes a huge amount of time and effort just to get the most basic information that DoD already has.

So this kind of lack of sharing of DoD medical records and medical information with VA simply has got to be stopped.

Mr. HALL. Thank you, Professor.

My time has expired, and I will turn to Ranking Member Lamborn.

Mr. Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman.

Mr. Bertoni, what do you think about the feasibility of the VA using a rules-based computer system to automate some of the claims decisions that do not require complex interpretations?

Mr. BERTONI. I think for some straightforward maladies, disabilities, that is a possibility. There can be deviations even for those

and perhaps a rules-based system would not work. There would have to be, I think, an escape hatch where you would go to another process if it did not apply.

But certainly the concept for applying that technology or that approach to more straightforward—I do not want to say simple—but more straightforward conditions, there is a potential.

But we have not looked at that. We would be happy to explore that further in the future though. But conceptually it is possible to use.

Mr. LAMBORN. Thank you.

And, Professor Bilmes, in your study, you propose a change in the disability rating system to four levels that you just described to us.

What would be the compensation levels for each of those four categories?

Ms. BILMES. Sir, you know, I have not studied what would be the compensation levels for those four levels, but I have discussed this proposal with a number of veterans organizations as well as Cynthia Bascetta at GAO. And I believe that it is something that should be studied. I mean, I think it could be designed to be a better and fairer system.

Mr. LAMBORN. Okay. Thank you.

And which VSOs were you just referring to?

Ms. BILMES. I have been in contact over the course of the last 6 months on all of the research I have done with the American Legion, the Veterans of Foreign War, the Paralyzed Veterans of America, the Vietnam Veterans of America, the Veterans for America, the Disabled Veterans of America, the Iraq and Afghanistan Veterans, as well as other groups of veterans, the university veterans organizations, you know, with basically a full range of the veterans organizations.

Mr. LAMBORN. Thank you, Professor.

Ms. BILMES. Indeed, I want to point out the reason I wrote this paper is that veterans from the Legion, the VFW, and Veterans for America approached me and asked if I would look at this.

Mr. LAMBORN. Okay. Thank you.

Mr. BERTONI. Mr. Chairman, could I respond to your first question—

Mr. HALL. Yes. Certainly.

Mr. BERTONI [continuing]. With regard to the exit physical? I believe an exit physical, regardless of whether it is at DoD or VA, makes good sense in terms of establishing a baseline whether that person ultimately never even enters the disability system or whether they do shortly thereafter.

But I think it is a good idea to have. We think it is a good idea to have that baseline. And certainly when you look at the VA's Benefits Delivery at Discharge Program, that is an avenue where you are getting pretty comprehensive medical information, historical information up front where you can use that in the event of a claim. And to the extent that that is electronic, it can be transferred electronically, that is even better.

Mr. HALL. Okay. Thank you, Mr. Bertoni, Professor Bilmes.

I will now recognize for his questions Congressman Rodriguez for 5 minutes.

Mr. RODRIGUEZ. Thank you very much, and thank you for your testimony.

And let me just make a couple of comments and ask you for your comments. First of all, you know, the recommendations that you have made with the exception of the first one, are good.

And I think the idea of the Ranking Minority Member about trying to get an assessment on some of the individuals who are almost assured through a computer process, that they will receive the correct rating that they deserve. It might be something that we ought to look at.

But let me make some general comments. It is my understanding, and it is based on maybe just stereotypes and feedback, because there were some people that, I thought it was a no-brainer, they should have received something the first time around. The general rule is, and I tell them, hey, you are going to get turned down the first time no matter what, so you just apply the second time and keep going at it.

And is there a feeling within the system that they automatically—because that is the feeling that we have back home—that they automatically, no matter how genuine their request is, they are going to get denied the first time and that there is an attitude by the administration, by the VA to do that.

I am wondering if from region to region, how that varies in terms of how veterans get treated in one region versus another, and if there have been any assessments from that perspective? I would assume that in some areas where there is a no-brainer, that we just go ahead and recognize the fact that these individuals might deserve those benefits. Just do that, and that in itself would reduce the number of claims in the future because they have a feeling, like I do, that they are going to get turned down the first time anyway.

Ms. BILMES. I think that may be a perception that some people have, but my research showed that 88 percent of claims are accepted, at least at some level. That means at least part of the claim is granted.

So, you know, my sense is that the real problem here is that when you have a system where almost 90 percent of the claims are eventually granted, the process of getting to that final point is unbelievably complex and bureaucratic. And so it is really a process problem compounded by a huge volume of incoming claims problem.

Mr. RODRIGUEZ. You just indicated that 88 percent get granted and then at the end 90 percent. That means all this fighting is over 2 percent?

Ms. BILMES. No. Eighty-eight—

Mr. RODRIGUEZ. Or did I misunderstand?

Ms. BILMES. If I submit a claim, 88 percent of the total claims do get granted, but sometimes claims have multiple parts. The claim might have four parts and not all of the parts might be granted.

And what we see in this war is much greater complexity of claims. And so we do not have the data yet on how many, at least I do not have the data on what percentage of, say, an eight-condition claim, you know, is granted.

Mr. RODRIGUEZ. And do any of you have any data on the regions, if one region is harsher than the other regions?

Mr. BERTONI. Yeah, I can speak to that. I would reiterate what the witness just said that there is a continuum. Someone can apply, be denied, and ultimately get to appeal and their case will be approved. And ultimately as they go through that process, we end up with the 80 percent approval rate.

As far as consistency across regions, we have reported on numerous occasions that there is considerable inconsistency across the 57 regional offices. And veterans with like conditions are not always treated consistently in terms of the actual determination of disability, the compensation amount, and/or the rating percentage.

So there has been numerous reports that we put out where we have been concerned about consistency. We have recommended that VA look at all levels of their decisionmaking process, identify specific disabilities that are most problematic or areas that are most problematic and take actions to address them. And we are aware of some movement on their part to do that.

But, yes, consistency has been a long-standing issue and your benefit amount or decision should not be contingent upon where you filed.

Mr. RODRIGUEZ. My last comment. I know that we had situations where we would submit a case on behalf of a veteran, and I think most of the Members of Congress, I think, are doing a lot of the casework for VA, and we would submit it and then 30 days later, we would call up and they would say, sorry, you know, we have not gotten it yet. So we would submit it again, and this was a game that was played.

Have we made any end roads in that area?

Mr. BERTONI. In terms of hand-offs and lost documents, I mean, I think that is part of the paper process that we are in. You know, we have real concerns about the hand-offs, the movement of case files across country, the brokering of claims, how that can result in just lost records and materials.

So certainly, yes, that is an issue of concern. I cannot talk to specific circumstances, but, yes, it is an issue.

Mr. RODRIGUEZ. Thank you. My time has expired.

Thank you, sir.

Mr. HALL. I thank the gentleman from Texas.

I now recognize the gentleman from Illinois, Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

Thank you both for coming this morning.

It seems like every time we take one step forward here on disability, we are taking two or three steps backward. And, you know, we really, from my perspective, have got to get this under control and we have got to do it sooner rather than later.

And, Professor, let me just say I like what you had in your testimony in terms of your recommendations. I think that would go a long way toward helping solve some of the problems that we have encountered here because I have a lot of veterans in my congressional district and I hear this over and over again, "It takes so long and, you know, I fought and defended this country and, you know, what is the holdup here."

And for that veteran, they do not understand the process. They need the help. And they said you guys have got to figure it out. So, that is why we are here today.

I just want to ask you, if I could, Mr. Bertoni. You said in your written testimony that due to the increased number of compensation claims for posttraumatic stress disorders, it adds to the amount of time required to process the claim because the claims are more difficult to evaluate and provide evidence for.

Can you talk about why these claims are more difficult to evaluate and what actions the VA can take to improve the process to evaluating medical or mental health?

Mr. BERTONI. Sure. And in the case of PTSD claims, one of the key variables is to document the stressor event. And if a veteran comes into a regional office and claims PTSD, if in the record they can corroborate combat experience or POW status, that individual's allegation of a stressor event is sufficient for them to process the claim.

If they cannot substantiate combat or a POW status and this individual alleges a stressor event, you have to go to the record. And if it is not immediately available, the regional office submits a claim.

The National Personnel Records Center is a VBA unit that has to do the search to find that specific event that is claimed. And you are talking about historical record, you know, the person's unit, whatever, to dig through this information.

If, in fact, the individual is a Marine Corps veteran, it is easier. There is an electronic historical database where the analyst can go and do the research. And I believe we were told that that turnaround time could be as little as one day. Any of the other services, we are in a more difficult situation, basically slog through manual paper documents, a needle in a haystack. And that can take up to in excess of a year.

So, you know, we are back to this automated electronic environment versus paper manual environment, and you can see how the deficiencies occur when you have two environments.

We did find that VA has been trying to sort of offset, at least in a couple regional offices. They have cobbled together or put together an unclassified historical database of records that they are able to use prior to making that referral to the Records Center. And we are told that they can close the loop on that in about 3 weeks. And they have farmed that out to other regions, and we have recommended that they consider a similar system nationally.

Mr. HARE. Okay. In both the testimonies, you state that the VBA needs to seriously reexamine the structure and program design for the benefits system.

I wonder if you could describe what specific structural problems you have encountered and what recommendations you would have to improve the VBA system to meet the demands.

Ms. BILMES. I favor, as I have testified, a complete revamp of the system basically in every way. I mean, first of all, I think that the claims disability rating system needs to be vastly simplified. I think there needs to be a short form where people can apply quickly.

I think that the benefit of the doubt should go to the veteran right away up front so that claims should be essentially granted for returning first-time unique claims at least to some extent, so a veteran has a small stipend at least coming in while the rest of the claim is processed.

And I think that the VA needs to kind of shift its culture in the benefits process, shifting the culture away from trying to make sure that not one penny is given out that is not deserving to a process of trying to use the people more strategically, deploying them more in the field at benefits of discharge, deploying them more in theatre which is not done at the moment, and deploying claims adjudicators in the vet centers which are very popular neighborhood walk-in clinics for veterans to help them fill in these simplified forms.

And so I think that the whole way that it is structured in terms of what people do, what the process is, the records, the medical records for granting disabilities, and the culture needs to be reformed.

Mr. HARE. Thank you.

Mr. BERTONI. Our position is that as VA considers how it may want to modernize its disability process and think more about more timely intervention support services, with that, you might want to look at how you are organized structurally.

We do know that they have at times consolidated workloads and processes to ring out efficiencies, and these were mainly tactical efforts to try to go after problem areas or backlogs.

But we also know that in doing that in those isolated or specific instances, they were able to again ring out additional efficiencies, productivity increases, accuracy, consistency, building staff expertise are particular issues and even administrative overhead savings.

We also know where they have not done that in their current existing 57 regional office structure, we have a situation with massive productivity variance. We have timeliness, accuracy, consistency issues.

So we believe that they really need to look at this more strategically as they move into the 21st century, as we move forward, and think about this more strategically and how they want to reorganize and they have the right people, processes, and technologies in the right place going forward.

We do not have the answers, but somebody has to take a hard look at this.

Mr. HARE. Thank you.

Mr. HALL. Thank you very much, Mr. Bertoni and Professor Bilmes.

The idea of giving veterans the benefit of the doubt sounds good to me. When you said that in the end 88 percent of claims are approved, that would seem to indicate that maybe only 12 percent of them are an excessively ambitious task.

And so we may actually save money as well as serve our veterans benefit if we tried your idea of a temporary plan of accepting all claims and then auditing them later so that our returning soldiers get, as you said, at least a baseline of assistance.

So thank you very much, both of you, and the first panel is now excused.

Mr. BERTONI. Thank you.

Ms. BILMES. Thank you.

Mr. HALL. And we are going to try to keep moving along because we all have busy days of solving such serious problems and others.

Panel two, Stephen Robinson from Veterans for America, Brady Van Engelen from Veterans for America, Patrick Campbell from Iraq and Afghanistan Veterans for America, and Ann Knowles of the National Association of County Veterans Service Officers, please come up and take your seats. Oh, I am sorry. Jon Soltz from VoteVets.org. Thank you, Mr. Soltz.

Thank you all. You do not need to hear a speech from me. We will start with Mrs. Knowles.

And we have your written testimony and it will be included in the record, so feel free to deviate from your statement.

STATEMENTS OF ANN G. KNOWLES, PRESIDENT, NATIONAL ASSOCIATION OF COUNTY VETERANS SERVICE OFFICERS; STEPHEN L. ROBINSON, DIRECTOR OF VETERANS AFFAIRS, VETERANS FOR AMERICA; BRADY VAN ENGELEN, ASSOCIATED DIRECTOR, VETERANS FOR AMERICA; PATRICK CAMPBELL, LEGISLATIVE DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; AND JON SOLTZ, CHAIRMAN, VOTEVETS.ORG

STATEMENT OF ANN G. KNOWLES

Ms. KNOWLES. Thank you, sir.

Mr. Chairman and Members of the Committee, it is truly my honor to be able to present this testimony before you. As President of the National Association of County Veterans Service Officers, I am going to talk about the issues affecting the veterans of the OIF and OEF.

Returning veterans from these two theaters of action have been receiving priority care from the Veterans Administration. There are valid reasons, but it has resulted in many other claims being placed on the back burner, claims that have equal and valid reasons for priority action.

VA officials have stated the number of claims filed since 2000 has risen nearly 40 percent, and this has caused the number of cases pending to balloon to over 800,000. Yet, only about 4 percent of the new claims are from Iraq and Afghanistan. This is according to the St. Louis Post dispatch February the 26th, 2007.

To stay on target with the subject at hand, let us look at the number and nature of injuries of OIF and OEF veterans. It has been reported by the DoD that over 19,000 Purple Heart Medals have been awarded since the beginning of OIF and OEF. Each of these is a potential claim for benefits with the DVA. Add to this another 25,000 wounded and ever-escalating KIA numbers as additional troops are assigned to Iraq.

Secretary Nicholson in his interview with Bob Woodard of ABC News showed statistics of treatment within VA facilities of over 200,000 OIF/OEF veterans, and not every treatment is a claim, but

even a small percentage of these filing a claim for benefits will escalate the numbers in the pipeline waiting processing.

PTSD is recognized in returning veterans from Iraq and Afghanistan. Their treatment has been given priority. A United States Army study places those suffering from PTSD at approximately one in eight soldiers who have served in either Iraq or Afghanistan.

A survey of deployed troops indicates that twelve percent of those serving in Iraq and up to 6 percent who served in Afghanistan have reported symptoms of major depression, anxiety, or PTSD.

The most frightening statistic is that only 38 percent were interested in getting help and as low as 28 percent actually have even looked at help. They cited concerns for how they would be viewed by their peers if they sought assistance.

This, Mr. Chairman, is a ticking timebomb that will eventually blow up in our faces, not necessarily in the face of the military, but in the local communities where the veterans are returning to their homes.

CVSOs and the VA would be forced to deal with these issues because local officials and families concerned about the mental health of these young men and women will demand it. And it is a sad state of affairs indeed.

Another issue is the number of veterans who are returning with missing limbs and prosthetic devices. Battlefield treatment and speed of evacuation of wounded service men and women have advanced substantially over the years. Many of the veterans returning from the Gulf region needing specialty care for missing limbs may well have died in previous battles.

This has placed a tremendous and vital responsibility on the Veterans Administration that they are ill equipped to deal with in health and medical care, but also to provide adequate and timely and fair compensation decisions for the veterans, their families who are desperately trying to survive.

Other issues that must be addressed is that of placing one group of veterans in a higher priority or class than other veterans. When the VA decides to give top priority to a select group of claims, the other claims, the veterans suffer. Some claims that have been pending for a year or more suddenly become less likely to be rated or receive appropriate attention because of a change of a policy.

This is because personnel in the regional office have been instructed to focus on OIF and OEF veterans' claims, the deterrent of other claims that have been working their way through this backlog or inventory or whatever we want to call it now. We feel this is tragic and extremely inappropriate. Veterans continue to die while waiting for VA benefits.

We are concerned with the VA's centralization of OIF and OEF claims. We are not convinced that the practice can be justified. When the regional office claims are brokered out, the focus becomes quantity and not quality. Issuing flawed rating decisions just increases the inventory or backlog of an already inflated and bloated backlog of appellate litigation, but we have some suggested solutions for you.

One solution would be to reemphasize the BDD. That is the program, a pre-separation program. Claims and medical course could be submitted prior to separation allowing local VA teams to adju-

dicating the claims and to dramatically shorten the time that the veteran has to wait for a decision after separation.

Second, streamlining single issue disability claims at the regional office level while multi-face claims that have a combination of disabilities that require extensive research are passed to a tiger team. This would speed the process.

Another suggestion, solution is to increase outreach efforts. Outreach efforts must be expanded in order to reach those veterans and dependents that are unaware of their benefits and to bring them into the system.

The National Association of County Veterans Service Officers believes that we must do better. Approximately 88 percent of the veterans not being compensated is more likely than not an issue of lack of access or knowledge of available services rather than lack of need or some other issue.

NACVSO supports House Resolution 67 introduced by Congressman Mike McIntyre of North Carolina that would allow Secretary Nicholson to provide Federal, State, and local grants for assistance to State and county veterans service officers to enhance outreach to veterans and their dependents.

We also support House Resolution 1435 introduced by Congressman Baca of California which would have a significant impact upon existing claims backlog.

We stand ready to partner with the Veterans Administration to bring about a reduction in the backlog and increase the outreach efforts to the veterans of our community.

In conclusion, the bottom line is that the Veterans Administration is going to have to rise to the occasion, place more personnel to handle the expected large influx of new claims and resulting larger inventory or backlog of claims and they need a much improved IT.

Thank you.

[The prepared statement of Ms. Knowles appears on page 51.]

Mr. HALL. Thank you very much for your testimony, Ms. Knowles.

And we are going to jump to the middle of the table now to Mr. Robinson.

Welcome.

STATEMENT OF STEPHEN L. ROBINSON

Mr. ROBINSON. Thank you.

I am going to deviate from my written testimony. It is very extensive and well worth the read if you get the opportunity.

Mr. HALL. Thank you. We were going to try to keep this to five minutes approximately. We do have your written testimony for the record.

Mr. ROBINSON. Thank you.

Benefits delivery at discharge is the gold standard to reduce claims backlog in the Department of Veterans Affairs.

In 1998, I served in the Office of the Secretary of Defense and I used to go around and do briefings about the great things that we were doing to make sure we did not repeat the mistakes of the first Gulf War.

One of the things that was recommended at that time was a thing called the personal information carrier, a dog-tag sized device that you could carry the whole entire medical record on. And we went around and briefed that for about three or 4 years while I was in the Department of Defense. Never implemented. And one of the big problems that we have today is data, data from DoD to the VA.

Now, the discharge process in DoD is broken. That has been widely publicized with the stories from Walter Reed. And that puts the Department of Veterans Affairs at a disadvantage because when the soldier does not get a proper discharge from the DoD or does not have the proper medical record or has to go out and find witness statements from commanders on the battlefield, it creates a situation where the gap from getting out and getting care gets wider and wider and wider.

I am Steve Robinson. I am the Director of Veterans Affairs with Veterans for America. And in my position, I meet with Iraqi Freedom, Enduring Freedom veterans on a regular basis and happen to know pretty much everybody at the table too.

There is a systematic failure in the DoD and the VA programs designed to address their medical needs, to track them, and to share information across platforms. As a result, we do not have an adequate understanding of what this generation needs, what are their unique needs as it involves the kinds of battles they are fighting, improved body armor, higher survivability, more soldiers that are married leaving families behind, 16,000 single mothers. These are all unique needs that will have to be identified and programs developed around, but currently we do not know because no one has looked at what is unique about this war.

The face of the American soldier has changed since Vietnam, but, yet, we are still using a system designed for them. The VA needs to come up to the 21st century model, and they are making incredible improvements. But, again, I stress that they do not know what this generation looks like and what their unique needs are.

More than 155,000 women have served in Iraq and Afghanistan. We are creating new female combat veterans in a system that was designed for men that came home after World War II and trauma nurses. Combat female veterans are a unique entity that will need programs and services. Sixteen thousand single mothers, as I said.

Three out of every five deployed servicemembers have family responsibilities, spouse, and children. That is an incredibly different scenario than when people served in Vietnam. But, yet, we are treating them with the exact same system.

What is happening today is a new chapter in the rule book. We have yet to begin to recognize the true needs of the current generation and create programs and services for their war-related problems.

What do multiple deployments mean? Less than a percent of this population is serving the war over and over and over and over again. If you can imagine an NFL football player playing the Super Bowl every day for 365 days and the kinds of injuries that they would sustain, they would not have a long career. And it is the same thing with these soldiers that are fighting the war over and

over. Multiple deployments create unique situations, break down the bodies. That needs to be identified.

We are especially concerned that servicemembers are not provided the mental healthcare they need. There is a dramatic rise in less than honorable discharges and a subsequent loss of VA benefits. That is a DoD problem, but it also impacts the Department of Veterans Affairs in their vet centers and in people seeking mental healthcare services, trying to get those services even though they may have lost them forever.

There is also an over-use of personality disorders, again a DoD problem, but it prevents people from receiving the benefits of the VA and it needs strong investigation.

The Veterans Benefits Administration disability compensation claims process can be characterized as either completely broken or partially broken depending on how you want to look at it. It is completely broken when you are a soldier who has honorably served and you have been denied your VA benefit. It is completely broken. It is partially broken for those who are able to get into the system and then go through the wait process, and if they are fortunate enough, survive.

I see my time is getting close, so I am going to come to summary.

We want to address the problems. We urge the Members of the House to consider co-sponsoring House Resolution 1354, the Lane Evans "Health Improvement Act." This bill has key components in it which collect data which will allow us to know what is happening to this generation. It also tracks and trends what is happening in this war and it provides mental healthcare in a way that we currently do not offer it.

We owe this generation, Mr. Chairman. We thank you for your leadership on taking up these hard issues. They have earned what we want to give them. Now let us make sure that we give them what they are owed.

Thank you, sir.

[The prepared statement of Mr. Robinson appears on page 53.]

Mr. HALL. Thank you very much, Mr. Robinson. Thank you for your service on active duty and thank you for your service since and today.

We will now hear the testimony of Mr. Van Engelen. And, once again, we have your written statement for the record, so 5 minutes, please.

STATEMENT OF BRADY VAN ENGELEN

Mr. VAN ENGELEN. Chairman Hall, Representative Lamborn, Members of the Subcommittee, thank you for the opportunity to testify.

On April 6th, 2004, I sustained a gunshot wound to the head in Baghdad while positioned at an observation post. After being shot, first aid was immediately administered. I was fortunate to survive long enough to make it to the 28th Combat Support Hospital.

The primary repairs and closures for my head were conducted while in theater at the 28th CSH. From there, I was medically evacuated to a military hospital in Landstuhl, Germany, where I stayed for recovery until I had regained enough strength to travel

back to Walter Reed Army Medical Center to complete the recovery process.

I arrived at Walter Reed Army Medical Center on April 14th, 2004. I was immediately asked if I wanted to be treated as an inpatient or an outpatient. Wanting to spend time with my family and loved ones, I chose to be an outpatient.

At this point, I was given the building number of the Malone House and told to go check in. With no clue as to where the building was, I hopped onto the facility shuttle and asked if I could get a ride to the Malone House to check in.

The first 2 weeks of appointments, I was fortunate enough to have my family and loved ones at my side to assist me through the bureaucratic maze that is outpatient care at Walter Reed.

In one month's time, my rehabilitative care was completed and I was told the Physical Evaluation Board process would begin shortly thereafter. That was May 30, 2004. I did not hear back about my case until December of 2004.

Other than the research that I conducted on my own time, I was completely unaware of what my possibilities were and what to do next. Throughout the entire process, I was the one who always initiated contact with the case managers in the hospital. If it were not for my persistence, I would have gone unnoticed for months. There were just too many patients and not enough case managers to oversee the process.

The systemic problems exposed at Walter Reed also exist in the Department of Veterans Affairs. The VA is overwhelmed by the numbers of claims filed and patients needing attendance. We did not prepare for this and it is painfully evident. My generation is going to have to pay for this and we will be paying for years and years.

While at Walter Reed as an outpatient, there was no outreach on behalf of the VA to inform me of my benefits for myself and my family.

When troops were returning from World War II, there were VA claims specialists on the boats with the servicemen informing them of their benefits that they were eligible for. We have lost that aggressive approach with today's servicemembers and veterans.

Today we are being asked to navigate the bureaucratic maze of DoD and VA on our own. I can assure you that this is no small feat. Shifting the burden from our government to those who serve has created a system where servicemembers and veterans are unaware of the benefits and programs promised to them upon enlistment.

I understand the VA has begun to more aggressively address the inpatients while they are recovering at medical facilities. But as the case at Walter Reed, only a small number of injured soldiers are benefiting. This is not acceptable.

Many wounded servicemembers at other medical outpatient facilities throughout the country remain as uninformed as I was upon leaving the military. Servicemembers from my generation are becoming increasingly disenfranchised with the system that our government promised would help us to heal and rehabilitate.

Claims backlogs are currently at 180 days. A few years ago, claims were half that. The families of servicemembers are suffering

from the lack of preparation by our VA. They cannot call the bank and say they are waiting for a response on a claim and ask for payments to be delayed for another 180 days.

The passive nature of the VA regarding health and claims dispensation will only tarnish their perception amongst the military and their families. We may end up with an entire generation of veterans who have no faith in our VA because those running it as well as those overseeing it were unable to uphold their end of the bargain. This saddens me deeply.

I urge the Members of this Subcommittee to keep one question in mind as they work to repair this broken system. What is owed to those who serve?

While I do not claim to have all the answers to this question, I am confident that you will conclude that the answer is more than servicemembers and veterans are receiving now.

Thank you.

[The prepared statement of Mr. Van Engelen appears on page 57.]

Mr. HALL. Thank you, Mr. Van Engelen, and thank you for your service and for your testimony. And I think we would agree with your last statement there at the very least.

And, Mr. Campbell, would you like to go next?

STATEMENT OF PATRICK CAMPBELL

Mr. CAMPBELL. Thank you so much for allowing me to be here and actually thank you for allowing me to sit at a table with such fine representatives.

I, too, want to deviate a little bit. On the Metro ride over here, I noticed a guy in a wheelchair kind of laughing how late he was to a meeting with a Congressman. I asked him why he was going down there, and he said, "I am a traumatic brain injury sufferer." Actually, he said, "I am a traumatic brain injury survivor."

And I remember thinking that, you know, this whole day we are talking about these statistics hundreds of thousands of people. And as I am sitting here watching this one person so excited to go talk about, you know, some programs on how to find soldiers who are suffering from traumatic brain injury, he could not even get out, you know, the little gates because he could not figure out how to use the system.

You know, this is a person who used to come here once a month, could not even figure out how to put the ticket in the machine. And he was yelled at twice by the Metro employees for not having enough money on his card when he just honestly did not know what was going on.

So I am sitting here in front of you as one of the 54,000 OIF and OEF veterans that the VA is guesstimating will use the system in 2007.

Earlier in January when the Department of Veterans Affairs presented their budget, they said that 263,000 of their current users of their system are OEF and OIF veterans.

In looking at their budget, there is a general principle that a department's proposed budget is a clear signal to the outside world of both their priorities and their assumptions.

When you look at the assumptions the Department of Veterans Affairs are making for the next 5 years, it is clear that they honestly believe that there will be a drop in VA claims over the next 5 years. That is why in 2009, the budget for VA is supposed to drop and then it is supposed to stay the same for the next 2 years.

Now, I am not an accountant. I am actually in law school, so I am definitely not good with numbers. And I do not want to argue with the VA's accountants and actuarial tables. But when the numbers seem to defy common sense, our alarms must go off.

If you remember any one thing from this testimony today from me, remember that the VA has grossly underestimated the demand for their services once again. The soldiers coming home and they will be asking for care. The question we must be asking ourselves is, will we be ready for them.

If anything, the recent Walter Reed exposé has taught us is that trying to treat and care for soldiers on a limited budget and limited oversight only has one logical conclusion: poor care.

In the context of this specific hearing, soldiers are languishing while they wait for their claims to be processed and woe to the veteran who does not file his or her paperwork correctly and gets denied. They will be stuck in bureaucratic limbo for years.

If you think that only 54,000 people, veterans are going to ask for help this year and even less in the next years, all you are doing is setting yourself up for failure. Soldiers fight for their country and they should not be made to fight for their benefits when they get home.

We are all here, you know, all these organizations here and Linda, are offering you great statistics and great suggestions. And the Iraq and Afghanistan Veterans of America stands behind their recommendations.

My purpose here is just to remind you as clear as I can in a single message, that if you start with faulty assumptions, you will end up with poor results.

This Committee must work with the Department of Veterans Affairs and us, the Veterans Service Organizations, to formulate a realistic number of incoming veterans, not the OMB approved number that fits nicely into their balanced budget for the next 10 years. Only then will we be able to hire the correct number of claim processors and medical staff to provide the quality healthcare that these veterans deserve.

Thank you for allowing me to testify.

[The prepared statement of Mr. Campbell appears on page 58.]

Mr. HALL. Thank you Mr. Campbell for your testimony and for your service. And we are here to work with you.

That is why we are holding these hearings and everybody on this Subcommittee, including the members who could not be here now because they are in the middle of other work, other Committee hearings that are scheduled at the same time, I know all agree with our wish to collaborate in coming up with a realistic picture and solving the problems in terms of funding.

We will now hear the testimony of Jon Soltz.

Mr. Soltz.

STATEMENT OF JON SOLTZ

Mr. SOLTZ. Sir, I just want to thank everyone here first for having us here as well and for you inviting us. And to Mr. Lamborn, Congressman Lamborn, thank you. Thank you as well.

Everyone here was listening. I am obviously an Iraq War veteran, served in Iraq in 2003, served in Kosovo in 2000. I am still an officer of the United States Army today. I am about to hit my 8-year mark.

You know, obviously my greatest honor is leading soldiers in war. I wanted to go to Iraq. The hardest part was coming back. I have gone to the VA and sought VA services when I returned. I have still got my card right here. I, like many others when I left active duty, lost healthcare, so it was the place I went.

I think there has been a lot of great statistics, so I am going to deviate from my testimony about obviously some personal stories. There are a lot of people that are going to use the VA, specifically the Guard and Reserve. When they come off active duty, they lose healthcare benefits.

When I went to the VA, it took me a long time, so I do not want you to think that, you know, if the DoD is giving them a little questionnaire when they get off their airplane, they are going to pay attention to it. It is going to take them 6 to 8 months, 10 months, sometimes years before they walk in the doors of the VA and get help.

Specifically if they do not have a wound that is identifiable immediately for disability like they got their arm shot or so forth, that you are going to see more and more stress with the disorders that we do not see. Obviously the mental disorders.

My experience was one similar. I heard the professor talk about the culture climate. When I went to the VA, it was one of the hardest things I ever did. My nurse, she looked at me and she said, you know, you came to the right place and she asked me why I came. And I came because I was not sleeping right after eight months and, you know, it took me less than 20 hours to get into combat. And it was something that did not affect me when I was there, but affected me when I got back.

So I went to the VA. You know, I went through the process and I took a couple tests and it took me several weeks to get in to see a doctor. And, you know, ultimately the VA told me that I was just, you know, not adjusting properly.

And I do not want us to focus so much on the backlog specifically. I think there are two broader issues that you all should be aware about before we look at systematically fixing the backlog. And one is the diagnosis process. And I do not think that it is quantifiable and I do not think it is consistent with when you talked about why some issues are harder than others, it is hard to quantify posttraumatic stress disorder.

And what you are seeing is a lot of soldiers and Marines that are going to go through the system and they are going to be given adjustment disorder. You know, we know one in three are having these kind of issues, but only 12 percent get diagnosed with PTSD.

So the quantification moving from DoD to VA is very difficult, and I think that for the first time in this country, we have an opportunity to have a real conversation over an extended period of

time, that we all need to sort of understand what I call the yellow brick road. And I think we saw a piece of that with the Walter Reed.

But when a soldier gets wounded like Brady did, he entered the system on one side and I entered it on another, but they are really going to go through five or six different institutions before they settle at the VA or they are going to answer at their home duty station and what that process is.

And if we only look at it from the Veterans Administration's side and fixing that piece of it, then we are still going to have a tremendous amount of problems watching the soldier through the entire system.

And it is sort of like a school system and right now the way we are set up is K through six is one school system and six through twelve is another. And if you just look at it that way, I am not quite sure we are going to get the answer we need.

And until we fix the diagnosis inconsistencies, look, there is a big reason why people are giving adjustment disorder. How do you quantify what PTSD is? What is the quantification recommendations that we are making between what the DoD is and VA?

If I brought ten Iraq War veterans in here, and I am more than willing to do it, if I brought a psychiatrist from the VA, a psychiatrist from DoD, and a private psychiatrist, you are going to get three different answers.

And this is part of why we are getting this backlog, and I think we have to look at it from both sides, DoD and VA, and then I think you need to look at how we quantify where we are going to see the most amount of stress which is the TBI and the PTSD because they are not entering the system like Brady did. Brady enters the system because he got shot.

A lot of soldiers, especially Guard and Reservists, one in three who served in Iraq are from that component. Because of the way we redesignated the force, we cannot deploy without them. They are going to enter the system at their home VA centers when they return home because they fall out of the DoD system.

So I think that this has to be very broad-based and I think that we have to look specifically at how we quantify what these illnesses are.

I do support the recommendation, however, of treating, if anyone, we give them the benefit of the doubt to provide them support immediately like the IRS. I think that is why we have a lot of homeless vets. And at least we are guaranteeing we are protecting everybody.

With that said, my time is up. And thank you guys for having me.

[The prepared statement of Mr. Soltz appears on page 59.]

Mr. HALL. Thank you, Mr. Soltz. You win the prize for stopping before your time was actually up.

Mr. SOLTZ. Usually I go over my time, so I wanted to make sure I behaved today.

Mr. HALL. It will not happen often today, I am sure.

Anyway, I just have a couple of questions. Mr. Robinson, you made mention of the number of women who have served in OIF/OEF. I think it was 155,000.

Are you aware of any particular instances in which women veterans have had a more difficult time with the claims process and how might that be approached differently?

Mr. ROBINSON. I have not broken out in terms of women veterans and the claims process, but one stunning example is that Reserve and National Guard soldiers are twice as likely to be denied if they file a claim than active-duty soldiers. And I do not understand why that is happening.

Mr. SOLTZ. Can I say one thing. I think Steve is right on that, sir, but I think the point here is that National Guard and Reserve soldiers that get wounded in Iraq, they enter the system with a prior sort of wound. And if you go home to your home duty station and you fall out of the active component force, you then become dependent on going to the VA.

So the National Guard and Reserve soldiers that are entering directly through the VA are obviously entering with something like PTSD, which is harder to quantify. You cannot give them a blood test. You cannot quantify that. And that is the systematic issue that Steve is talking about.

Mr. ROBINSON. Some of the other issues that we have noticed—I do not know if the Committee saw the New York Times article on disparities—the cities and towns that send the most people to war are the cities and towns where the backlog is the greatest. And there was a great New York Times article that was written on that just several days ago.

[The article referenced by Mr. Robinson, “Veterans Face Vast Inequities Over Disability,” New York Times, March 09, 2007, by Ian Urbina and Ron Nixon, appears on page 82.]

Mr. SOLTZ. May I say one more thing about women—

Mr. HALL. Yes, please.

Mr. ROBINSON [continuing]. To try to answer the question you asked? There are no unique programs. They are starting to develop unique programs, but there are no unique programs for female combat veterans.

Imagine a female combat veteran in a group therapy session trying to discuss sexual intimacy. Imagine her talking about not wanting to hold her baby. It is not going to happen in front of a bunch of other men.

So we need to create specialized care programs for the new female combat veterans. And there may be unique claims issues surrounding that.

Mr. HALL. Thank you very much.

I want to ask Ms. Knowles what has been the impact of prioritizing OIF/OEF claims on the other claimants waiting to be adjudicated?

Ms. KNOWLES. Whenever you prioritize and you bring in putting new claims over the older claims, we have veterans that literally have had claims in there a year, and this is not an appeal. This is a regular claim. And they are pushed to the back burner. No way saying that the OIF and OEF is not important. It is. A veteran is important be it Vietnam, World War II, Korea, or our current veteran of Iraq and Afghanistan. They are all veterans and they should all be treated the same.

The impact that we see, and I think it is due to regional offices, I think when your regional office has that priority that they are following the guidelines and do not take the common sense approach and look at those that are already a year old, that is how we see the impact.

And about the numbers earlier, when they were saying that the 1,000 new employees, it will take 2,000 new employees because the 400 the President is talking about are retiring, people that are going to retire. It will take 2,000 new employees to put in the regional offices to handle the claims that they have now and will have in the very near future.

Mr. HALL. Thank you.

And one last question. This could go to anybody. There have been in previous wars extended illnesses, for example, that came up due to exposure to Agent Orange from Vietnam. I have a close family member of mine who just underwent prostate surgery for—well, we do not know for sure, but it is one of the things that has been known to be caused by Agent Orange, and a gentleman from my district, the veteran I spoke about before who is dealing with prostate cancer also.

Gulf War syndrome, I am not sure if the verdict really is in on it. Is it depleted uranium? You know, there can be exposures that show up 20, 30 years later due to these things.

Are any of you expecting or seeing already a similar kind of long-term problem that may crop up in the distant future?

Mr. ROBINSON. I would like to start because I just came off of the VA Research Advisory Committee on Gulf War veterans' illnesses, so I am pretty familiar with it.

There are things that are occurring on the battlefield that are things we are doing to ourselves. There are things that need serious investigation and have not yet been fully investigated that servicemembers on this battlefield are facing that veterans from the first Gulf War faced.

The drug Mefloquine Lariam, DoD stood up a task force to investigate whether or not that drug was a neurotoxin and harming people. The Armed Forces Epidemiological Board never completed its work. The Anthrax vaccine, depleted uranium screening. What we have learned from the mistakes of the first Gulf War are that a lot of times we do things to ourselves that were unintentional or perhaps not really scientifically validated before we did it.

But we do not see any, at this point, any strange or unique thing happening except people coming home with exposures to, you know, the things that happen on the battlefield that make people sick.

As you mentioned, Agent Orange is now a presumptive service connection for the disease that you are speaking about and it came about because people did scientific work and initially it was poo-pooed. People did scientific work and they discovered the connection.

There are going to be connections to things that soldiers used on the battlefield in the future or that science is now looking at that are going to be presumptively connected to their service in this war. But right now we see no giant epidemiological trend like we did in the first Gulf War, primarily because in the first Gulf War,

we blew up the majority of all chemical warfare agents on the battlefield in the pre-war, during-war, and post-war bombing phase.

Mr. SOLTZ. Sir, we have a lady, a woman who I work with very closely. Her son, he committed suicide. He blew his brains out with his weapon. And she to this day, you know, talks about her own personal studies in regards to Lariam. He was a Marine Corps officer and, you know, it is her specific interest.

And I would agree with Steve. We have not seen a large trend like Gulf War syndrome or Agent Orange in effect, but there are individual cases out there. You know, in Iraq, there is a mystery ammonia, lice meiosis, some very different things, but—

Mr. ROBINSON. There is a huge cancer, rapid onset cancer. We are seeing it at Fort Carson, Colorado, sir. There are a couple of people that have died. There is rapid onset cancer that kills them. We do not know what it is, but it needs to be investigated.

Mr. SOLTZ. Yeah. Just like in theater, we had this ammonia where soldiers were dying immediately in theater. But the Lariam is something I would take specific attention of considering there are people that claim that it causes psychological problems and can be the cause of suicide. We see a lot of suicide in theater.

Mr. CAMPBELL. If I could just add one more thing. This is not nearly as dramatic, but I think we are going to be seeing a lot of people with back injuries from all this body armor that we are putting on people.

You cannot wear 60, 70 pounds of armor every day for 365 days, you know, two or three tours without 10 years, 15 years down line, people's backs and knees and shoulders and everything. You know, it is not as dramatic, but I am telling you all my soldiers are already starting to suffer their problems, and they are only in their twenties. You know, 20 years down the line, they are going to be coming to the VA.

Mr. HALL. Thank you very much.

I am going to remind our Members that we have a first vote expected at 12:20, so we will try to move the questions along.

Ranking Member Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman. And I just have one question.

But first I want to thank all of you for coming here today and helping put a personal face on these issues that we are looking at. So thank you.

Mr. Robinson, a question for you in particular. You had some really good suggestions on clearing up the backlog. Of those suggestions, if you could just implement one of them right off the bat, if we cannot do all, which one would you single out?

Mr. ROBINSON. Fix the DoD discharge process because it is going to make the VA backlog disappear. Benefits Delivery at Discharge is the gold standard along with other recommendations. You are inheriting a problem because they are not doing their job.

Mr. LAMBORN. Okay. Thank you.

Mr. HALL. Thank you for yielding back. I assume you do.

Mr. LAMBORN. I do.

Mr. HALL. Mr. Hare.

Mr. HARE. Well, first of all, thank you all for your service and thanks for taking the time to come here today. And, again, it never

ceases to amaze me how we are quick to put people in harm's way and very slow to help them when they need help the most.

I know, if I could, Mr. Campbell, I know you were speculating we were going to have some people testify. But in your opinion, why do you think the VA is anticipating a drop in claims that you were talking about, and I think you said they were grossly underestimating? What are they using for criteria, do you think? I mean, I know we will ask later, but I am just wondering from your end.

Mr. CAMPBELL. Well, I think it has to do with budget numbers. I mean, you have—we want to balance the budget. You know, this whole debate is about paying for the full cost of the war. And when you are trying to balance a budget without raising taxes and fighting two wars at the same time, you know, you have to kind of cross your fingers and hope and pray that certain things are going to happen.

And, you know, the administration wanted a budget that is going to look balanced in 2 years, 3 years, 4 years down the line and, you know, that is one of the ways to do it. And it is just not going to happen. You cannot have a VA budget that stagnates or decreases when you are just starting to see the claims begin. I mean, there is no way to get around it.

The budget needs to increase with the increased demand. And unless you are planning on cutting services or hoping a whole bunch of World War II veterans are going to die in the next couple years, you know, it is not going to happen.

So the assumption has to be that there are not going to be any more claims. Like I said, I am not a statistician, but it does not pass the test.

Mr. HARE. I do not think you have to, Mr. Campbell. I think being realistic, I think we clearly know that there is going to be an increase and not a decrease.

Mr. Van Engelen, I just had a question for you. When you were in Walter Reed and experiencing this transition between the DoD healthcare to the VA, from your experience, what recommendations would you give to us to improve the transition from the whole VA disability claims process? I mean, as I understand it, you said it was 7 months that you were—

Mr. VAN ENGELEN. That was the discharge process from the DoD aspect of it. On addressing the issue of them informing, keeping me informed of what I should know, I was at Walter Reed, so, you know, there were some people there that were in a similar situation that could brief me on this stuff.

Mr. HARE. But you said you initiated the contact with the case managers.

Mr. VAN ENGELEN. That is correct.

Mr. HARE. And basically you were working for yourself in this process. And I guess what I am asking you is, for those people who may not be able to do that or do not do that, what do we need to do better? I mean, clearly this has got to get fixed.

Mr. VAN ENGELEN. I agree. It does need to get fixed. I think that they need to be much more aggressive. I think they need to have people on the field literally out there pounding pavement at Walter Reed and all the medical installations, talking with family Members.

I know that General Waitman, when he was in command at Walter Reed, he had town halls. That would be a great place to send the VA representative and just have them sit there and say, look, I want everyone that is within timeframe of being discharged to come talk to me. I am going to give you a general spiel and then we will work some stuff out from there. But this is not an outpatient facility more or less.

I have a friend who is at Fort Richardson in Alaska. He has no idea of what the VA has to offer and what benefits he can get. And he is 6 days from ETS.

Mr. HARE. And he has no idea?

Mr. VAN ENGELEN. No idea. He is a college educated individual, sir. It is just part of the process. There is no one up there to help these guys. They just came back from Iraq and they are all getting ready to ETS and there is no one there to inform them of what there is out there for them to get.

Mr. HARE. Amazing. Sad, but amazing.

Ms. Knowles, just one quick question. You said of those 400 and some people that they are talking about adding 1,000 and I think you said you would need like 2,000, do you see if we can up those numbers significantly that this is going to help in the processing of the claims and help our vets out?

I know that the Professor testified that training these new people is going to be a problem because you have got to train them and get them up to speed and that could take up to a year, I think she was talking about, or longer.

So if we do get the new people, which, by the way, I think we should do more than we are going to do or thinking of doing what is the fix here from your perspective for us?

Ms. KNOWLES. From a person who sits across the desk and files a claim daily, that is my job, I sit across the desk every day and file the claims, when we submit it to the regional office, it stagnates. They do not have adjudicators, enough adjudicators, and the ones they have, she is absolutely right, they are brand new on the job. The decisions they make are wrong decisions and we have to go back with a reconsideration.

We know there are going to be people retiring. We have to start somewhere. That is the reason we need to go ahead and put employees there to start training them. We still have another bad 5 years before we are going to see the backlog really come down because we have got to have people there to do the job.

Now, County Service Officers, the State Service Officers are doing the legwork on the outside. We are gathering the information and presenting it. That is why we have tried to work with the VA for years. Give us your check list of what you need. We will make sure you get it so that even a brand new adjudicator can do their job, a new rater can do their job.

Mr. HARE. Thank you all very much.

Mr. HALL. Thank you, Mr. Hare.

Thank you, our panel. Thank you for your service continuing and in the past, and you have been a great enlightenment to us.

I am going to ask Mr. Hare if you would sit in the Chair for a moment.

Mr. HARE. I would.

Mr. HALL. Thank you.

Mr. HARE [presiding]. If we can call our last panel, I think Mr. Ronald Aument.

Thank you, Mr. Secretary, for coming to visit with us this afternoon, and we will go ahead and start with your testimony.

STATEMENT OF RONALD R. AUMENT, DEPUTY UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MICHAEL WALCOFF, ASSOCIATE DEPUTY UNDER SECRETARY FOR FIELD OPERATIONS, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. AUMENT. Thank you, Mr. Chairman.

Mr. HARE. You are welcome.

Mr. AUMENT. Mr. Chairman and Members of the Subcommittee, it is my pleasure to be here to discuss the Disability Compensation Program and our efforts to meet the needs of servicemembers and veterans of Operations Iraqi and Enduring Freedom.

I am accompanied today by Mr. Michael Walcoff, VBA's Associate Deputy Under Secretary for Field Operations.

The Veterans Benefits Administration is responsible for administering a wide range of benefits and services for veterans, their families, and their survivors.

At the heart of our mission is the Disability Compensation Program. Last year, we provided veterans with decisions on over 774,000 disability claims and performed more than 1.3 million other award actions and benefits adjustments for beneficiaries already on our rolls.

Additionally, we handled over 6.6 million phone calls, conducted over a million interviews, briefed more than 390,000 service persons, and conducted nearly 65,000 hours of outreach.

Today I will discuss the challenges we face in providing timely, accurate, and consistent determinations on veterans' claims for disability compensation. I will also discuss some of the actions we are taking to improve claims processing and expedite the process of the claims from Operations Iraqi and Enduring Freedom of veterans.

VBA is engaged in numerous initiatives aimed at better managing the disability claims workload and providing benefits processing. The efforts include changes to the organization and structure of the veterans service center, delivery of training, consolidation of specialized operations, and redistribution of workload.

The implementation of the claims processing improvement initiative, CPI model established a consistent organizational structure across all of our regional offices. Work processes were reengineered and specialized teams established to reduce the number of tasks performed by individual decisionmakers, establish consistency in work flow and process, and incorporate a triage approach to incoming claims. Implementation of this model provided a strong foundation for improving both the accuracy and consistency of our claims processing.

We also established an aggressive and comprehensive program of quality assurance and oversight to assess compliance of VBA claims processing, policy, and procedures, and assure consistent ap-

plication. As a result of these efforts, our quality has risen over the last 4 years from 81 percent to 89 percent.

VBA has deployed new training tools and centralized training programs that support accurate and consistent decisionmaking. New hires receive comprehensive training and a consistent foundation in claims processing principles through a national centralized training program, and local training is provided utilizing a standard curriculum.

Standardized computer-based tools have been developed and training letters and satellite broadcasts are provided to the field on the proper approach to rating complex issues.

In addition, the mandatory cycle of training for all veterans service center employees has been developed consisting of an 80-hour annual curriculum.

The consolidation of specialized processing operations for certain types of claims has been implemented to provide better and more consistent decisions, and we continue to look for ways to achieve additional organizational efficiencies through further consolidation.

Some of our efforts include the establishment of pension maintenance centers, the tiger team, the appeals management center, and the casualty assistance unit. We are exploring the centralization of all pension adjudications in these centers.

VBA also established two development centers in Phoenix and Roanoke and centralized the processing of all radiation claims to the Jackson regional office.

The Benefits Delivery at Discharge Program provides servicemembers with briefings on VA benefits, assistance with completing applications, and a disability examination before leaving service. Through the BDD Program, a servicemember can file a pre-discharge claim while on active duty.

These claims are received at one of our designated BDD intake sites and processed through the BDD Program. In order for a claim to be processed as a BDD claim, servicemembers must have 60 to 180 days remaining on active duty and must be available for all required examinations at the local intake site. The goal of this program is to deliver benefits within 60 days following discharge.

VBA has consolidated the rating aspects of our BDD Program which will bring greater consistency of decisions on claims filed by newly separated veterans.

VBA is aggressively pursuing measures to decrease the volume of pending disability claims and shorten the time veterans must wait for decisions on their claims.

We began aggressively hiring additional staff in fiscal year 2006, increasing our on-board strength by over 580 employees between January 2006 and January 2007.

We will continue to accelerate hiring and fund additional training programs this fiscal year and then maintain staffing at maximum levels based upon funding received in 2008 and following.

We are recruiting now to increase our on-board strength by an additional 400 employees by the end of June. We have also increased overtime funding this year and recruited retired claims processors to return to work as reemployed in order to increase decision output.

VBA implemented the brokering strategy in which rating cases are sent from stations of high inventories to other stations with the capacity to process additional rating work. Brokering allows the organization to address simultaneously the local and national backlog issues by maximizing the use of available resources.

Since the onset of combat operations in Iraq and Afghanistan, VA has provided expedited and case managed services for all seriously injured Operations Iraqi and Enduring Freedom veterans and their families.

VA assigns special benefits counselors, social workers, and case managers to work with these servicemembers and their families throughout the transition to VA care and benefit systems and to ensure expedited delivery of all benefits.

Last month, the Secretary of Veterans Affairs announced a new initiative to provide priority processing of all OIF/OEF veterans' disability claims. This initiative covers all active duty, National Guard, and Reserve veterans who were deployed to or in support of the OIF/OEF combat operations as identified by the Department of Defense.

This initiative will assist these veterans to enter the VA system and begin receiving disability benefits as soon as possible after separation. We have designated our two development centers in Roanoke and Phoenix and three of our resource centers as special tiger team resources for processing OIF/OEF claims.

The development centers will obtain the evidence needed to properly develop the OIF/OEF claims and the resource centers will rate OIF/OEF claims for regional offices with the heaviest workloads. Medical examinations needed to support these claims are also being expedited.

We are expanding our outreach programs for National Guard and Reserve components and our participation in OIF/OEF community events and other information dissemination activities.

An OIF/OEF team is being established at VBA headquarters to address all operational and outreach issues at the national level to include the coordination of a national memorandum of understanding with each of the Reserve components.

The MOUs will ensure that VA is provided service medical records and notified of when and where Reserve Members are available to be briefed during the demobilization process and at later times.

We will work with DoD to discuss the possibility of expanding VA's role and VA's military pre-separation process. Specifically we will assess the feasibility of providing a new claims workshop where groups of servicemembers would be instructed on how to complete the general portions of the VA application forms. Personal interviews would be conducted at the end of the workshop with those applying for benefits.

Mr. Chairman, this concludes my testimony. I appreciate being here today and look forward to answering your questions.

[The prepared statement of Mr. Aument appears on page 61.]

Mr. HALL. Thank you very much for your testimony, Mr. Aument, is it?

Mr. AUMENT. That is correct.

Mr. HALL. What percentage of the current claims backlog would you say is made up of OIF/OEF veterans?

Mr. AUMENT. Of the currently pending claims workload? Around 10 percent.

Mr. HALL. And what are your projected casualties for OIF/OEF and also how many of those veterans do you anticipate will file a claim with VBA?

Mr. AUMENT. We do not project casualties. What we do is project claims workload based upon prior experience. Our projection models, we use one both for projecting the mandatory account spending as well as for the claims workload, have been in use for some time now and they rely primarily upon prior years' experience being adjusted based on the most recent experience.

Mr. HALL. I was wondering if you had the opportunity to read Professor Bilmes' paper and, if so, what your thoughts are on her conclusions.

Mr. AUMENT. Yes, I have. I have read her earlier work together with Professor Stiglitz's that was published earlier. I found it very interesting. They obviously involved a lot of research. There are many points I certainly could agree with. Others, I am not so certain I agree with.

I certainly agree with some of her over-arching observations in listening to her testimony today. One is that the disability compensation system is extremely complex. I believe that is probably one of the most confounding hurdles that we all face, those of us who are charged with administering the program, as well as those who come to us for support.

Of her recommendations, I do not know that she touched upon it today so much, but in her most recent paper, one of the recommendations I was very intrigued by, and wholeheartedly endorse, was the idea of modernizing many of our systems to include the use of more electronic information within our systems to include imaging and systems that much like that, parallel those that are used in private industry.

Mr. HALL. I think she is writing her third paper right now.

Mr. AUMENT. I see.

Mr. HALL. I was wondering how you might explain the 10 percent discrepancy between ratings approved for active-duty servicemembers as opposed to those in the Guard and Reserves.

Mr. AUMENT. I certainly do not have a full explanation. I can put forth a couple of theories on this.

We are about to release, I expect later this month or early next month, a study that was performed by the Institute for Defense Analyses that we contracted with about a year ago following some of the controversy over consistency and interest in the fact that we had inconsistencies from office to office.

They have a number of very interesting findings. One that I find most compelling for this issue is that a military retiree is four times more likely to be receiving disability compensation than a non-retiree. Many of the Guardsmen and Reservists, quite frankly, unless they have been injured in the past while they are on active duty for training, typically were not eligible for VA benefits. So they are only becoming more eligible because of the mobilization periods that they have gone through.

They spend considerably less time on active duty than an active-duty servicemember does. We believe that there is some rationale that would connect those two facts.

One of the things that we are discussing is going back to the Institute for Defense Analyses and having them examine this very issue to try to give us greater insight as to what might be driving some of those discrepancies.

Mr. HALL. Back to Professor Bilmes, she was invited by a VA health economist, Dr. Todd Wagner, to present her studies to all the VA health economists. This was scheduled, but the VA headquarters canceled it the day before it was to take place.

I am just curious if you were aware of that or maybe we could find out why and whether it could be rescheduled.

Mr. AUMENT. I will certainly take that back. I was not aware of this at all, but I will certainly take that back.

Mr. HALL. That would be good.

And of the 57 regional offices of VBA, 54 of them received an outstanding rating. I was wondering how that could happen with a backlog of 600,000 cases. I mean, I understand there is a lot of good work going on in the VA. Nobody says that there is not. I know plenty of people who have been treated and are happy with their treatment. It is the numbers that are adding up to accentuate the negative at this point. And so I am just curious how we get 54 of 57 regional offices being judged outstanding.

Mr. AUMENT. We typically do not really judge the regional office. Are you speaking about the Directors of the regional offices, their performance evaluation?

Mr. HALL. Yes. That is correct.

Mr. AUMENT. I am not sure we agree with that number. I will ask Mr. Walcoff to address that.

Mr. WALCOFF. I am the rating official for all of our regional office directors, and I do not have the exact number, but I will tell you that the number rated outstanding was probably somewhere around 15. It was nowhere near 54.

Mr. HALL. Okay. Well, glad to hear my information was wrong. I have exhausted my time. Mr. Lamborn, you are next.

Mr. LAMBORN. Thank you, Mr. Chairman.

Mr. Aument, in shortening the time for a claim to be decided, there are certain administrative challenges that you face. What are some of these and how do you think we could streamline these administrative issues so that we can get the adjudications done faster?

Mr. AUMENT. There truly are, Congressman Lamborn. Probably the very first one that we encounter is assuring that we have the background records necessary to perform an accurate review of the claim.

Typically that means that we need to have, more often than not, the veteran's service medical records in hand before we can actually fairly evaluate the claim. Often cases come to us without those service medical records.

That is one of the reasons why the Benefits Delivery at Discharge Program is a good model to follow, because we are able to overcome that initial bureaucratic hurdle while the servicemember is still on active duty.

Secondly, most cases that come to us require some form of physical evaluation. That typically is going to add anywhere from 35 to 50 days on the front end of the evaluation process, particularly if specialty examinations are required.

General medical examinations are difficult enough to arrange, but when you need specialist examinations, orthopedic specialists, audiologists, those types of examinations, that can lengthen the delays.

Then also there are some built-in due process considerations that are there for the protection of the veterans that were enacted, I think, certainly in the best interest of the veteran, through the "Veterans Claims Assistance Act." But they clearly do add to the cycle time for the processing of a typical claim.

Today when we believe that we have all the evidence finally gathered that is needed to rate a claim, we have to inform the veterans that we are preparing to rate their claims and we have to give them 60 days to tell us whether or not they have any additional evidence they want us to consider in that rating.

If we do not hear back from that veteran, we have to wait for that 60 days to expire before we can proceed to rate the claim, which is often the case.

So there are some built-in wait states to today's claims process that, if left unchanged, we believe, under the best of circumstances, will compel us to take around 125 days on average to rate a claim.

Mr. LAMBORN. Mr. Aument, you referred to that 60-day waiting period. I believe that that is waivable. But how good of a job are you doing to let the claimant know that that is waivable and the claim could be expedited if they have no reason to ask for it and they want to waive it?

Mr. AUMENT. Absolutely, it is waivable. We do inform the veteran that it can be waived. We are working with the Veterans Service Organizations. When a service organization is representing a veteran, quite often they can be helpful in obtaining that waiver from them.

In other cases, and unfortunately some of our offices are more challenged than others by their pending workload, they are less able to do this, but we do encourage attempts by our claims processors to reach the veteran by telephone because we can obtain waivers by telephone. That is legally acceptable as long as we document the record.

So we do that wherever we can. But we operate normally during normal business hours and, quite frankly, most veterans are working during that period of time. So sometimes contacting them can be challenging.

Mr. LAMBORN. Thank you.

And I yield back my time.

Mr. HALL. I want to thank you, Mr. Aument, Mr. Walcoff. I thank all Members of all the three panels.

It has been a very educational day. We seem to be learning a lot about our system and how we can better serve those who defend our country and fight on our behalf when they come home.

And we will follow-up with more questions as they occur to us and hope that together we can find the solutions to reduce this

waiting time and provide the same shock and awe in terms of treatment that we do in terms of initiating combat.

I think that, you know, if we are capable of being prompt and accurate in the way that we deploy and utilize our Armed Forces, that we should attempt to be and get closer to being that prompt and that accurate and that immediate, especially when the injuries or diseases that they face are so immediate to them and their families.

And I appreciate your contributing to our understanding of this. Thank you, Mr. Lamborn. Thank you, Counsel and staff, for the Members who were here. And the hearing is now adjourned.

[Whereupon, at 12:20 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Opening Statement of the Honorable John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs

Thank you all for coming today. I am pleased that so many folks could attend this oversight hearing on the "Impact of OIF/OEF on the VA Claims Process."

Regardless of whether or not you agree or disagree with the war in Iraq, I think most—if not all—Members of Congress believe that our young men and women who served in OIF/OEF deserve the best medical care and all the help we can give them in transitioning from military to civilian life. Nothing bothers me more than those who say they support the troops, but turn a cold shoulder when those same troops return home and become veterans.

The purpose of today's hearing is to ensure that the problems discovered at Walter Reed Army Medical Center are not the tip of the iceberg with respect to how prepared we are for our returning servicemembers. Since the jurisdiction of this Subcommittee is not veterans' healthcare, but veterans' benefits, we are going to focus on the VA's claims process and how it has been impacted by OIF/OEF. However, as an aside, I would like to say that I am sponsoring a bill to allow Active Duty servicemembers the option of receiving medical treatment at their local VA hospital if they so desire.

In addition to looking at whether the VA is equipped to handle the claims of returning servicemembers, this hearing will also examine reports of rating discrepancies among Active and Reserve veterans. Recently, media reports stated that Reserve and National Guard servicemembers had a greater risk of their claims being denied or lowered than their Active Duty counterparts. I don't think there should be a Reserve/Active Duty distinction with respect to a veteran who suffers an injury.

In determining whether the VA claims' system can handle the influx of returning OIF/OEF servicemembers, we will hear from GAO who will discuss the current claims backlog and possible solutions to fix the problem. As most know, the VA has had a claims backlog for many years now and it only continues to grow.

At last count, the average wait to have a VA claim processed, had grown from 2 months to 6 months, and even much longer in some areas of the country. From December 2000 to March 2007, the backlog of compensation claims grew from 363,412 to 632,140.

Next, we will hear from Professor Linda Bilmes who has written a widely acclaimed paper entitled, "The Long Term Costs of Providing Veterans Medical Care and Disability Benefits." I will be most interested to learn whether or not Professor Bilmes expects the rate of OIF/OEF claims to grow significantly. Furthermore, I want to hear her thoughts about how the DoD and VA define the term "casualty."

After Professor Bilmes, we will hear from three veterans' organizations: (1) Veterans for America; (2) Iraq and Afghanistan; and (3) VoteVets. I want to hear their assessment of how the VA is handling the claims of returning OIF/OEF veterans. Finally, we will hear from the Veteran Benefits Administration, which has the Herculean task of ensuring that our veterans receive the benefits they deserve. I am specifically interested in learning more about the VA's new priority processing for OIF/OEF veterans which was recently instituted. Also, I want to know about the VA's projection for future OIF/OEF claims. Specifically, I want to understand how they can predict an actual decrease in the number of claims in 2007 and 2008 in light of the President's escalation of the Iraq War.

As I stated earlier, I am concerned about an overall lack of preparedness by this Administration with respect to the War in Iraq, whether it be insufficient body armor or inadequate housing at Walter Reed. The cost for caring for our veterans must be understood by Congress and the Administration as an ongoing cost of war—veterans shouldn't suffer because of poor planning.

One only has to read the March 5, 2007 edition of *Newsweek*, which I will be introducing into the record, to see how some returning OIF/OEF veterans are falling through the cracks. On page 33, there is a story about Patrick Fejes who was

wounded in October 2004 and had to wait 17 months until his first VA disability check arrived. His mother, an elementary schoolteacher, took a second job at McDonalds to help support him. Mr. Feiges' claim was only approved after *Newsweek* and the Veterans for America began looking into his case. I thank both for their work.

I am holding this hearing today to see if Mr. Feiges 17 month delay is an anomaly or evidence of a systemic problem for returning OIF/OEF veterans. If it is the latter, I would be interested in hearing any and all recommendations from the speakers today on how we can fix the problem. 6 months, not to mention 17 months, can be devastating to a person who is rated unemployable and is without any other means of support.

Opening Statement of the Honorable Doug Lamborn, Ranking Republican Member, Subcommittee on Disability Assistance and Memorial Affairs

Thank you Mr. Chairman for recognizing me. I thank you for holding this hearing on the claims backlog and how it will affect the returning servicemembers from the global war on terror.

Before I begin, I would like to offer my congratulations to you Mr. Hall, for your appointment as chairman of this Subcommittee. I look forward to working with you in a bipartisan fashion as we fulfill our number-one priority—doing what is right for our veterans *and* our Nation.

Today we are here to talk about the effect of OIF and OEF veterans on the VA claims process.

I am more concerned about the effect of the VA claims process on these wonderful veterans.

Since the beginning of Operation Enduring Freedom, more than 150,000 claims have been filed by OIF and OEF veterans. In part, this is a positive response to VA's increased outreach, but now we have a responsibility to process those claims and care for these veterans.

I believe the first step toward improvement for these veterans is to improve the overall VA claims processing system. The backlog of compensation and pension claims is over 632,000—about 15,000 more than a month ago, according to VA's own weekly report.

VA has set a goal to decide a given claim in an average of 125 days. While more than 4 months strains the meaning of the word "prompt," it is not unreasonable, given the complexity and demands of the Veterans Claims Assistance Act and other administrative requirements.

Now we need VA to "just do it."

I know that we in Congress bear some responsibility for all this complexity. I look forward to asking Mr. Aument what we could do to help improve the bureaucratic process, while safeguarding it for veterans.

Mr. Chairman, both the budget views and estimates from the Committee's majority and the minority recommend 1,000 new hires for VBA *over* the President's request for 457 new compensation and pension staff. In 2 years, when they are all hired and trained, they will indeed make a difference.

The conventional approach of increased hiring is entirely appropriate; VBA has over the past several years experienced personnel shortages.

We must also explore some innovative ways to tackle this challenge that may even have faster payoffs than new hires.

That is why Committee Republicans this year have recommended funding for innovative pilot programs to address the backlog.

We have recommended funding for a pilot program to explore the feasibility of intergovernmental and VSO partnerships with VA in the development of compensation and pension claims.

This pilot would build on positive findings from a 2002 project conducted between VA's Buffalo, New York, regional office and the New York State Division of Veterans Affairs.

Within 6 months of their collaboration, the state veterans' division was developing claims in partnership with VA. Decisions for the region's veterans came faster and accuracy improved. This sort of innovation holds great promise.

Access to Veterans Benefits Administration regional offices can be difficult for many veterans. That is why we also recommended funding a pilot program for mobile claims offices.

VBA staff members in mobile offices would provide outreach, help veterans file their claims, and gather "ombudsman" feedback and resolution for veterans.

Mobile offices helping veterans with their claims could speed up the claims process by improving communication and access for veterans.

To take advantage of the potential offered by technology, we recommend funding to explore a rules-based adjudication system. Software could potentially decide simple claims accurately, quickly, and consistently, so that developers can focus on the complex ones.

For our newest veterans returning from Afghanistan, Iraq, and elsewhere in this global war, we must achieve a *seamless* transition from the military into the VA system. It is apparent to me that a seamless transition will help erase that backlog, because it increases the system's overall efficiency.

We need fully interoperable electronic health records between VA and DoD, an electronic DD Form 214, military separation physicals that can also function as VA disability physicals, and a disability rating process that provides consistent ratings.

What good is a separation exam and health records from DoD if the veteran has to repeat the whole process over again with VA?

Mr. Chairman, I am sure you agree, no veteran should have to wait 6 months or a year for their claim to be decided—and then endure an appeal that adds another year or two. For some veterans, this is not mere inconvenience; it is financial and potentially emotional disaster.

Every one of these claims is an American veteran and his or her family awaiting a decision. Every veteran deserves to have their claim adjudicated quickly and accurately!

One thing is certain. If we do not fix this problem now, our legacy will be an intolerable backlog regrettably endured by this generation of veterans, and inexcusably bequeathed to a future generation.

I firmly believe no one in this room wants such an outcome.

I want to thank the witnesses for their service and their testimony, and I look forward to our discussion today.

Mr. Chairman, I yield back.

Statement of Daniel Bertoni, Acting Director, Education, Workforce, and Income Security Issues, U.S. Government Accountability Office

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to comment on the claims processing challenges and opportunities facing the Department of Veterans Affairs' (VA) disability compensation and pension programs. Through these programs, VA provided about \$34.5 billion in cash disability benefits to more than 3.5 million veterans and their survivors in fiscal year 2006. For years, the claims process has been the subject of concern and attention by VA, the Congress, and veterans service organizations, due in large part because of long waits for decisions and large claims backlogs. Veterans of the conflicts in Iraq and Afghanistan, and survivors of servicemembers who have died in those conflicts, are facing these same issues as they seek VA disability benefits. In January 2003, we designated modernizing VA and other Federal disability programs as a high-risk area, because of these service delivery challenges, and because our work over the past decade has found that these programs are based on outmoded concepts from the past.

You asked us to discuss VA's disability claims process, in light of the ongoing conflicts in Iraq and Afghanistan. My statement draws on a number of prior GAO reports and testimonies, (see related GAO products), and information we have updated to reflect the current status of VA claims processing and initiatives.

In summary, VA continues to face challenges in improving service delivery to veterans. Between fiscal years 2003 and 2006, the inventory of rating-related claims grew by almost half to a total of about 378,000, in part because of increased filing of claims, including those filed by veterans of the Iraq and Afghanistan conflicts.¹ During the same period, the average number of days these claims were pending increased by 16 days, to an average of 127 days. Meanwhile, appeals resolution remains a lengthy process. In fiscal year 2006, it took an average of 657 days to resolve appeals. Several factors may be affecting VA's claims processing performance. These include the potential impacts of laws and court decisions, continued increases in the number and complexity of claims being filed, and difficulties in obtaining the evidence needed to adjudicate claims in a timely manner, such as military service

¹ Rating-related claims are primarily original claims for disability compensation and pension benefits, and reopened claims. For example, veterans may file reopened claims if they believe their service-connected conditions have worsened.

records. To help improve claims processing performance, VA has taken a number of steps, including requesting funding for additional staff and undertaking initiatives to reduce appeal remands. The President's fiscal year 2008 budget requests an increase of over 450 full-time equivalent employees to process compensation claims. Through training and information sharing, VA is also working to reduce appeals processing times by decreasing the number of cases sent back from the appeals level for further development.

Despite the steps VA is taking, opportunities for significant performance improvement may lie in more fundamental reform of VA's disability compensation program. This would include reexamining program design as well as the structure and division of labor among field offices. For example, we found that VA's and other Federal disability programs have not been updated to reflect the current state of science, medicine, technology, and labor market conditions. For example, the criteria for disability decisions are based primarily on estimates made in 1945 about the effect of service-connected impairments on the average individual's ability to perform jobs requiring manual labor. In addition, VA and other organizations have identified potential changes to field operations that could enhance productivity in processing disability claims. While major reexamination may be daunting, there are mechanisms for undertaking such an effort. For example, the congressionally chartered commission on veterans' disability benefits has been studying a number of program design issues and will report to the Congress later this year.

Background

VA pays monthly disability compensation benefits to veterans with service-connected disabilities (injuries or diseases incurred or aggravated while on active military duty) according to the severity of the disability. VA also pays compensation to some spouses, children, and parents of deceased veterans and servicemembers. VA's pension program pays monthly benefits based on financial need to certain wartime veterans or their survivors.²

When a veteran submits a claim to any of the Veterans Benefits Administration's (VBA) 57 regional offices, a veterans service representative is responsible for obtaining the relevant evidence to evaluate the claim. Such evidence includes veterans' military service records, medical examinations, and treatment records from VA medical facilities and private medical service providers. Once a claim has all the necessary evidence, a rating specialist evaluates the claim and determines whether the claimant is eligible for benefits. If the veteran is eligible for disability compensation, the rating specialist assigns a percentage rating based on degree of disability. A veteran who disagrees with the regional office's decision can appeal to VA's Board of Veterans' Appeals, and then to U.S. Federal courts. If the Board finds that a case needs additional work, such as obtaining additional evidence or contains procedural errors, it is sent back to the Veterans Benefits Administration, which is responsible for initial decisions on disability claims.

In November 2003, the Congress established the Veterans' Disability Benefits Commission to study the appropriateness of VA disability benefits, including disability criteria and benefit levels. The commission is scheduled to report the results of its study to the Congress in October 2007.

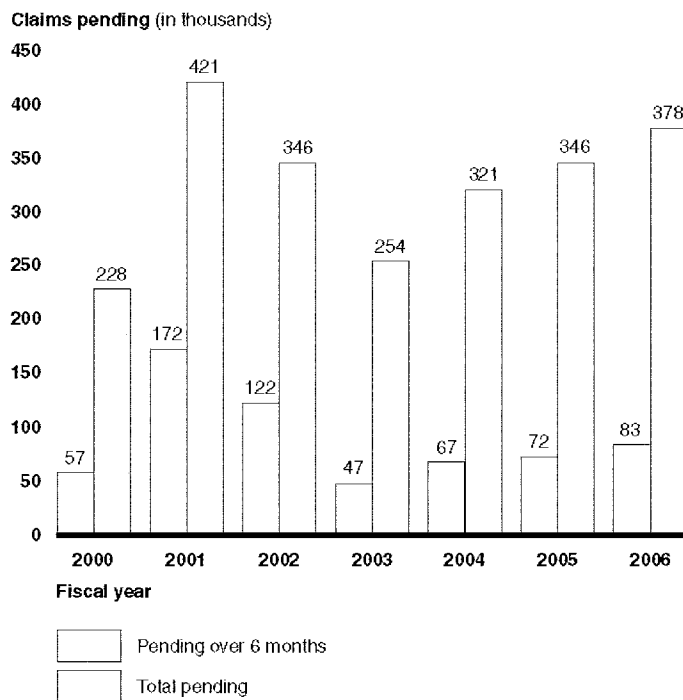
VA Continues to Face Challenges in Improving Its Claims Processing

Several factors are continuing to create challenges for VA's claims processing, despite its steps to improve performance. While VA made progress in fiscal years 2002 and 2003 reducing the size and age of its pending claims inventory, it has lost ground since then. This is due in part to increased filing of claims, including those filed by veterans of the Iraq and Afghanistan conflicts. Other factors include increases in claims complexity, the effects of recent laws and court decisions, and challenges in acquiring needed evidence in a timely manner. VA's steps to improve performance include requesting funding for additional staff and undertaking initiatives to reduce appeal remands.

VA's inventory of pending claims and their average time pending has increased significantly in the last 3 years, in part because of an increase in the number of claims. The number of pending claims increased by almost one-half from the end of fiscal year 2003 to the end of fiscal year 2006, from about 254,000 to about 378,000. During the same period, the number of claims pending longer than 6 months increased by more than three-fourths, from about 47,000 to about 83,000 (see fig. 1).

²Veterans qualify for pensions if they have low income, served in a period of war, and are permanently and totally disabled for reasons not service-connected (or are age 65 or older).

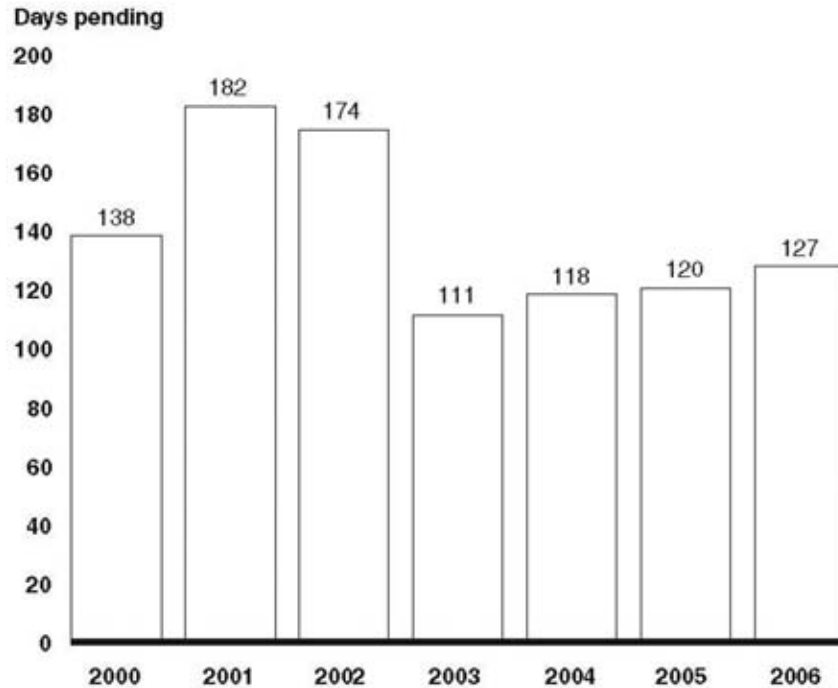
Figure 1: Rating Related Claims Pending at End of Period, Fiscal Year 2000–2006



Source: VA

Similarly, as shown in figure 2, VA reduced the average age of its pending claims from 182 days at the end of fiscal year 2001 to 111 days at the end of fiscal year 2003. However, by the end of fiscal year 2006, average days pending had increased to 127 days. Meanwhile, the time required to resolve appeals remains too long. The average time to resolve an appeal rose from 529 days in fiscal year 2004 to 657 days in fiscal year 2006.

Figure 2: Average Days Pending for VA Compensation and Pension Rating-Related Claims, Fiscal Years 2000–2006



Source: VA Data.

The increase in VA's inventory of pending claims, and their average time pending is due in part to an increase in claims receipts. Rating-related claims, including those filed by veterans of the Iraq and Afghanistan conflicts, increased steadily from about 579,000 in fiscal year 2000 to about 806,000 in fiscal year 2006, an increase of about 39 percent. While VA projects relatively flat claim receipts in fiscal years 2007 and 2008, it cautions that ongoing hostilities in Iraq and Afghanistan, and the Global War on Terrorism in general, may increase the workload beyond current levels. VA also attributes increased claims to its efforts to increase outreach to veterans and servicemembers. For example, VA reports that in fiscal year 2006, it provided benefits briefings to about 393,000 separating servicemembers, up from about 210,000 in fiscal year 2003, leading to the filing of more original compensation claims. VA has also noted that claims have increased in part because older veterans are filing disability claims for the first time.

Moreover, according to VA, the complexity of claims is also increasing. For example, some veterans are citing more disabilities in their claims than in the past. Because each disability needs to be evaluated separately, these claims can take longer to complete. Additionally, VA notes that it is receiving claims for new and complex disabilities related to combat and deployments overseas, including those based on environmental and infectious disease risks and traumatic brain injuries. Further, VA is receiving increasing numbers of claims for compensation for post-traumatic stress disorder, which are generally harder to evaluate, in part because of the evidentiary requirements to substantiate the event causing the stress disorder.

Since 1999, several court decisions and laws related to VA's responsibilities to assist veterans in developing their benefit claims have significantly affected VA's ability to process claims in a timely manner. VA attributes some of the increase in the number of claims pending and the average days pending to a September 2003 court decision that required over 62,000 claims to be deferred, many for 90 days or longer. Also, VA notes that legislation and VA regulations have expanded benefit entitlement and added to the volume of claims. For example, in recent years, laws and regulations have created new presumptions of service-connected disabilities for

many Vietnam veterans and former prisoners of war. Also, VA expects additional claims receipts based on the enactment of legislation allowing certain military retirees to receive both military retirement pay and VA disability compensation.

Additionally, claims processing timeliness can be hampered if VA cannot obtain the evidence it needs in a timely manner. For example, to obtain information needed to fully develop some post-traumatic stress disorder claims, VBA must obtain records from the U.S. Army and Joint Services Records Research Center (JSRRC), whose average response time to VBA regional office requests is about 1 year. This can significantly increase the time it takes to decide a claim. In December 2006, we recommended that VBA assess whether it could systematically utilize an electronic library of historical military records rather than submitting all research requests to JSRRC. VBA agreed to determine the feasibility of regional offices using an alternative resource prior to sending some requests to JSRRC.

VA has recently taken several steps to improve claims processing. In its fiscal year 2008 budget justification, VA identified an increase in claims processing staff as essential to reducing the pending claims inventory and improving timeliness. According to VA, with a workforce that is sufficiently large and correctly balanced, it can successfully meet the veterans' needs while ensuring good stewardship of taxpayer funds. The fiscal year 2008 request would fund 8,320 full-time equivalent employees working on compensation and pension, which would represent an increase of about 6 percent over fiscal year 2006. In addition, the budget justification cites near-term initiatives to increase the number of claims completed, such as using retired VA employees to provide training and the increased use of overtime.

Even as staffing levels increase, however, VA acknowledges that it still must take other actions to improve productivity.³ VA's budget justification provides information on actual and planned productivity, in terms of claims decided per full-time equivalent employee. While VA expects a temporary decline in productivity as new staff are trained and become more experienced, it expects productivity to increase in the longer term. Also, VA has identified additional initiatives to help improve productivity. For example, VA plans to pilot paperless Benefits Delivery at Discharge, where servicemembers' disability claim applications, service medical records, and other evidence would be captured electronically prior to discharge. VA expects that this new process will reduce the time needed to obtain the evidence needed to decide claims.

To resolve appeals faster, VA has been working to reduce the number of appeals sent back by the Board of Veterans' Appeals for further work such as obtaining additional evidence and correcting procedural errors. To do so, VA has established joint training and information sharing between field staff and the Board. VA reports that it has reduced the percentage of decisions remanded from about 57 percent in fiscal year 2004 to about 32 percent in fiscal year 2006, and expects its efforts to lead to further reductions. Also, VA reports that it has improved the productivity of the Board's judges from an average of 604 appeals decided in fiscal year 2003 to 698 in fiscal year 2006. The Board attributes this improvement to training and mentoring programs and expects productivity to improve to 752 decisions in fiscal year 2008.

Opportunities for Improvement May Lie in More Fundamental Reform

While VA is taking actions to address its claims processing challenges, there are opportunities for more fundamental reform that could dramatically improve decisionmaking and processing. These include reexamining program design, as well as the structure and division of labor among field offices.

After more than a decade of research, we have determined that Federal disability programs are in urgent need of attention and transformation, and we placed modernizing Federal disability programs on our high-risk list in January 2003. Specifically, our research showed that the disability programs administered by VA and the Social Security Administration (SSA) lagged behind the scientific advances and economic and social changes that have redefined the relationship between impairments and work. For example, advances in medicine and technology have reduced the severity of some medical conditions and have allowed individuals to live with greater independence and function in work settings. Moreover, the nature of work has changed in recent decades as the national economy has moved away from manufacturing-based jobs to service- and knowledge-based employment. Yet VA's and SSA's disability programs remain mired in concepts from the past, particularly the concept that impairment equates to an inability to work. Because of this, and because of continuing program administration problems, such as lengthy claims processing

³ See GAO, *Veterans' Benefits: More Transparency Needed to Improve Oversight of VBA's Compensation and Pension Staffing Levels*, GAO-05-47 (Washington, D.C.: Nov. 15, 2004).

times, we found that these programs are poorly positioned to provide meaningful and timely support for Americans with disabilities.

In August 2002, we recommended that VA use its annual performance plan to delineate strategies for and progress in periodically updating labor market data used in its disability determination process. We also recommended that VA study and report to the Congress on the effects that a comprehensive consideration of medical treatment and assistive technologies would have on its disability programs' eligibility criteria and benefits package. This study would include estimates of the effects on the size, cost, and management of VA's disability programs and other relevant VA programs and would identify any legislative actions needed to initiate and fund such changes.

In addition to program design, VA's regional office claims processing structure may be disadvantageous to efficient operations. VBA and others who have studied claims processing have suggested that consolidating claims processing into fewer regional offices could help improve claims-processing efficiency and save overhead costs. We noted in December 2005 that VA had made piecemeal changes to its claims-processing field structure. VA consolidated decisionmaking on Benefits Delivery at Discharge claims, which are generally original claims for disability compensation, at the Salt Lake City and Winston-Salem regional offices. VA also consolidated in-service dependency and indemnity compensation claims at the Philadelphia regional office. These claims are filed by survivors of servicemembers who die while in military service.⁴ VA consolidated these claims as part of its efforts to provide expedited service to these survivors, including servicemembers who died in Operations Iraqi Freedom and Enduring Freedom. However, VA has not changed its basic field structure for processing compensation and pension claims at 57 regional offices, which experience large performance variations. Unless more comprehensive and strategic changes are made to its field structure, VBA is likely to miss opportunities to substantially improve productivity, especially in the face of future workload increases. We have recommended that VA undertake a comprehensive review of its field structure for processing disability compensation and pension claims.

While reexamining claims-processing challenges may be daunting, there are mechanisms for undertaking such an effort, including the congressionally chartered commission currently studying veterans' disability benefits. In November 2003, the Congress established the Veterans' Disability Benefits Commission to study the appropriateness of VA disability benefits, including disability criteria and benefit levels. The commission is to examine and provide recommendations on (1) the appropriateness of the benefits, (2) the appropriateness of the benefit amounts, and (3) the appropriate standard or standards for determining whether a disability or death of a veteran should be compensated. The commission held its first public hearing in May 2005, and in October 2005, the commission established 31 research questions for study. These questions address such issues as how well disability benefits meet the congressional intent of replacing average impairment in earnings capacity, and how VA's claims-processing operation compares to other disability programs, including the location and number of processing centers. These issues and others have been raised by previous studies of VBA's disability claims process. The commission is scheduled to report to the Congress by October 1, 2007.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions that you or other Members of the Subcommittee may have.

Contact and Acknowledgments

For further information, please contact Daniel Bertoni at (202) 512-7215. Also contributing to this statement were Shelia Drake, Martin Scire, Greg Whitney, and Charles Willson.

Related GAO Products

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High-Risk Series: An Update. GAO-07-310. Washington, D.C.: January 31, 2007.

Veterans' Disability Benefits: VA Can Improve Its Procedures for Obtaining Military Service Records. GAO-07-98. Washington, D.C.: December 12, 2006.

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Veterans' Disability Benefits: Claims Processing Challenges and Opportunities for Improvements. GAO-06-283T. Washington, D.C.: December 7, 2005.

⁴VBA also provides dependency and indemnity compensation to survivors of certain deceased disability compensation beneficiaries.

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VA Disability Benefits: Board of Veterans' Appeals Has Made Improvements in Quality Assurance, but Challenges Remain for VA in Assuring Consistency. GAO-05-655T. Washington, D.C.: May 5, 2005.

Veterans Benefits: VA Needs Plan for Assessing Consistency of Decisions. GAO-05-99. Washington, D.C.: November 19, 2004.

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GAO Highlights

VETERANS' DISABILITY BENEFITS

Processing of Claims Continues to Present Challenges

Why GAO Did This Study

The Subcommittee on Disability Assistance and Memorial Affairs, House Veterans' Affairs Committee, asked GAO to discuss its recent work related to the Department of Veterans Affairs' (VA) disability claims and appeals processing.

GAO has reported and testified on this subject on numerous occasions. GAO's work has addressed VA's efforts to improve the timeliness of decisions on claims and appeals and VA's efforts to reduce backlogs.

What GAO Found

VA continues to face challenges in improving service delivery to veterans, specifically speeding up the process of adjudication and appeal, and reducing the existing backlog of claims. For example, as of the end of fiscal year 2006, rating-related compensation claims were pending an average of 127 days, 16 days more than at the end of fiscal year 2003. During the same period, the inventory of rating-related claims grew by almost half, in part because of increased filing of claims, including those filed by veterans of the Iraq and Afghanistan conflicts. Meanwhile, appeals resolution remains a lengthy process, taking an average of 657 days in fiscal year 2006. However, several factors may limit VA's ability to make and sustain significant improvements in its claims-processing performance, including the potential impacts of laws and court decisions, continued increases in the number and complexity of claims being filed, and difficulties in obtaining the evidence needed to decide claims in a timely manner, such as military service records. VA is taking steps to address these problems. For example, the President's fiscal year 2008 budget requests an increase of over 450 full-time equivalent employees to process compensation claims. VA is also working to improve appeals timeliness by reducing appeals remanded for further work.

See Figure 1. Rating-Related Claims Pending at End of Period, Fiscal Years 2000–2006 above.

While VA is taking actions to address its claims-processing challenges, opportunities for significant performance improvement may lie in more fundamental reform of VA's disability compensation program. This could include reexamining program design such as updating the disability criteria to reflect the current state of science, medicine, technology, and labor market conditions. It could also include examining the structure and division of labor among field offices.

Statement of Linda J. Bilmes, Professor, John F. Kennedy School of Government, Harvard University, Cambridge, MA

Thank you for inviting me to speak to you today on this important topic.

By way of background, last year I co-authored, with Nobel laureate Professor Joseph Stiglitz, a paper that analyzed the economic costs of the Iraq War. One of the long-term costs we identified is the cost of providing lifetime disability benefits and medical care for veterans. After we published the paper, a number of prominent veterans' organizations approached us. They argued that we had underestimated the cost of providing veterans care, primarily because we had not included all the soldiers who would potentially become eligible to claim benefits. They urged me to do additional research into this topic. As a result I wrote a second paper this year, specifically looking at the cost of providing medical care and disability benefits to veterans deployed in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF). [The paper, *Soldiers Returning from Iraq and Afghanistan: The Long-term Costs of Providing Veterans Medical Care and Disability Benefits*, KSG Research Working Paper RWP07–001 has been submitted for the record.]

To date, over 1.4 million US servicemen have been deployed to operations in and around Iraq and Afghanistan.¹ The servicemen who have been officially wounded in combat are a small percentage of the veterans who will be using the veteran's administration system. Hundreds of thousands of these men and women will be seeking medical care and claiming disability compensation for a wide variety of disabilities incurred during their tours of duty. Disability compensation is thus a significant long-term entitlement cost that will continue for at least the next forty years.

Today I would like to focus on the projected number of veterans' claims, the capacity of the Department of Veterans Affairs to process those claims, and the cost of providing benefits to returning OIF/OEF soldiers. I would like to discuss five key areas of concern and then to recommend five changes that I believe would streamline the claims process.

- First, the Veterans Benefits Administration (VBA) is overwhelmed with the volume of claims it is receiving, leading to a huge backlog;
- Second, the claims process is unnecessarily long, cumbersome, and paperwork-intensive;
- Third, the wars in Iraq and Afghanistan are rapidly turning the disability claims problem into a crisis;
- Fourth, the long-term cost of providing disability benefits to GWOT veterans is projected to be \$70 to \$150 billion, in today's dollars; and
- Fifth, the growing number of disability claims has increased demand for veteran's medical examinations, which is adding to the pressure on veteran's health facilities.

I will review these points first, and then I will offer my recommendations.

First, the VBA is currently overwhelmed with the volume of claims it is receiving, leading to a huge backlog. In 2006, the VBA received over 800,000 claims. Secretary Nicholson testified last month that he expects to receive 1.6 million additional claims in the next 2 years. These include both new claims from returning OIF/OEF veterans as well as claims from veterans who are already service-connected, mostly for conditions that have worsened since their initial claim. My own projections show that between 250,000 and 400,000 of these claims will be new applications from soldiers currently serving in Iraq and Afghanistan.

¹As of September 30, 2006, 1,406,281 unique servicemembers have been deployed to the wars in Iraq and Afghanistan, according to the Department of Defense, Defense Manpower Data Center, and "Contingency Tracking System." The Veterans Health Administration (VHA) Office of Public Health and Environmental Hazards, November 2006 uses the number 1.4 million (as of November 2006). The Veterans Benefits Administration (VBA) lists 1,324,419 unique servicemen deployed to GWOT as of May 2006 (prepared by VBA/OPA&I, 7/20/06).

The number of pending claims has risen from 69,000 in 2001 to more than 400,000 as of December 2006. Including the back-and-forth of paperwork related to claims, the VBA currently has a backlog of more than 600,000.

Second, the claims process itself is long, cumbersome and paperwork-intensive. The VBA takes an average of 177 days (about 6 months) to process an initial claim, and an average of 657 days (about 2 years) to process an appeal. This is 22% below the agency's own target goal of 145 days. It is also far below the standards of the private sector medical insurance industry, which settles 30 million insurance claims—including appeals—within an average of 89.5 days.

Back in 2000, before the current war, the GAO identified longstanding problems in the claims process. These included large backlogs of pending claims, lengthy processing times for initial claims, high error rates in claims processing, and inconsistency across regional offices.

The process for ascertaining whether a veteran is suffering from a disability, and rating the percentage level of a veteran's disability, is too complex. A veteran must apply to one of the 57 VBA regional offices, where a claims adjudicator evaluates the veteran's service-connected impairments and assigns a rating for the degree to which the veteran is disabled. Claims specialists must determine the percentage disability for each condition, in increments of ten. However, conditions are not scaled monotonically from 0 to 100. Mental conditions, for example, are rated: 0, 10, 30, 50, 70, or 100. Coronary artery disease ratings are: 10, 30, 60, and 100. Spinal conditions are rated: 10, 20, 30, 40, 50, and 100. A huge amount of time is devoted to making these determinations.

If a veteran disagrees with any part of the regional office's decision, he or she can file a notice of disagreement with the local office. If this is rejected, the veteran may file a formal appeal and the claim will be physically transferred to the Board of Veterans Appeals based in Washington, DC, which is not part of VBA. The Board may then grant, deny, or remand the claim, in whole or in part. If the veteran still disagrees with the board, the veteran may appeal to the courts. This process often takes years during which the veteran is left in limbo.

Moreover there is a wide disparity in efficiency between individual VBA offices. Regional offices are inconsistent in how they rate disabilities. GAO found that the days needed to process a claim ranged from 99 in Salt Lake City to 237 in Honolulu. Some of the states providing the most soldiers for the war are suffering the longest delays in claims adjudication.

In addition, the claims themselves are more complicated than in previous conflicts. Vietnam era claims cited on average three disability conditions. Gulf War veterans filed on average for four conditions. In the current conflict the average claim includes five separate disability issues. One-quarter of the new claims filed in 2006 cited 8 or more disabilities. Often these involve complex battle related injuries, as well as traumatic brain injury, PTSD, or complications from chronic diseases. Since each item within a claim is treated separately, there is a great deal of duplication and delay.

The VBA has more than 9,000 claims specialists. Many are themselves veterans, and they generally do a wonderful job in assisting veterans obtain the maximum amount of benefits to which they are entitled. But they are under enormous strain. They are required to assist the claimant in obtaining evidence, in accordance with hundreds of arcane VBA regulations, policies, procedures and guidelines. They must also rate the claims, establish claims files, authorize payments, conduct in-person and telephone interviews, process appeals and generate various notification documents through the process. New employees require about 18 months to become fully trained. The VBA has antiquated IT systems that make it difficult for the claims specialists to do their job efficiently. For example, many staffers are dependent on unreliable old fax machines to obtain vital documentation from veterans and medical providers.

For all these reasons I believe that the agency, as currently structured, is simply not capable of settling the current and projected volume of claims in a timely manner.

My third point is that the projected number of claims from the wars in Iraq and Afghanistan will rapidly turn the disability claims problem into a crisis. The current conflict has the highest incidence of non-mortal casualties in U.S. military history: a ratio of 16 woundings or injuries per fatality. To date, of the more than 1.4 million U.S. soldiers who have been deployed, about 631,000 have been discharged. One-third of these men and women—about 205,000—have already been treated and diagnosed at VHA hospitals and clinics, and 180,000 have applied for disability benefits. If returning GWOT soldiers claim benefits at the same rate as veterans from the first Gulf War, we can expect 638,000 unique new first-time

claims in the next five years. If all troops return home by 2008, there are likely to be more than 400,000 new claims by the end of 2009 alone.

Fourth, the cost of providing disability benefits to GWOT veterans is projected to be between \$70 billion and \$150 billion in 2007 dollars.² The cost is not the only issue here, but it is yet another major cost of war that has not been anticipated by the administration. The eventual cost will depend on several factors, including the number of troops stationed in Iraq and Afghanistan and the length of time they are deployed. It will also depend on the rate of claims and utilization of benefit programs by returning troops and the rate of increase in disability payments (including cost-of-living adjustments). My study did not take into account the additional costs of nursing home care, concurrent receipt pay, or the social and economic cost to society of these disabilities.

In order to project the number of claims for the current conflict, I looked at the claims history of veterans from the first Gulf War. We currently pay over \$4 billion per year in disability claims for that war, even though it was short and had relatively few casualties. The cost of providing benefits to GWOT veterans will be higher by an order of magnitude.

The “best case” low scenario cost of \$71 billion (present value discounted at 4.75% over 40 years) assumes the total number of soldiers deployed does not exceed 1.4 million, that all troops come home by 2010, and that GWOT veteran’s disability claims show a similar profile to Gulf War veterans—that is, 44% claim some level of disability and 87% of those claims are at least partially granted. This scenario assumes that 643,000 GWOT veterans eventually claim benefits, that the average payment to a veteran is the same as the average to a Gulf War veteran (\$504 per month) and that the veteran receives an average annual cost-of-living adjustment of only 2.8%

The moderate scenario—which is looking increasingly likely—assumes that the conflict involves a total of 1.7 million servicemen, including keeping a small U.S. presence in the region through 2015, and that 747,000 GWOT soldiers file claims. The present value cost of this scenario, assuming that cost-of-living adjustments are 4.1% (the amount given this year) and average payment is in line with Gulf War veterans, is \$109 billion.

The “high” scenario assumes that two million servicemen are deployed to GWOT through 2015, that 50% of veterans file disability claims, and that benefits increase at a compound annual growth rate of 6.1%, which is the actual rate of increase over the past 10 years. Here I have estimated the monthly benefit at \$716, which is the average benefit to all veterans today. Under this scenario I project 869,000 successful claimants and a total present value cost of \$125 billion. If the amount of the GWOT veterans claims were to equal the level of Vietnam veterans, the cost would rise beyond \$150 billion.

Fifth, the growing number of disability claims is creating additional demand for veterans’ medical examinations. This is adding to the pressure on veterans’ health facilities. The current system does not guarantee that all soldiers receive complete physicals in the military upon discharge. Even if the soldier does obtain a complete physical exam prior to discharge, he or she cannot automatically transfer that information to the VBA for use in certifying disabilities. Consequently, newly discharged veterans who intend to file any kind of disability claim are seeking medical examinations from VBA health facilities primarily in order to document their disabilities. The VBA health facilities already face a major challenge to provide first rate care for the large volume of soldiers returning from Iraq and Afghanistan. My point is that the complexity of the claims process itself is diverting valuable medical resources away from providing treatment into supporting the claims process itself. Veterans are seeking appointments with doctors in the VBA, not because they require immediate treatment, but rather to verify a disabling condition—even in cases where it was already documented upon discharge from the military.

RECOMMENDATIONS

The veterans returning from Iraq are suffering from the same problem that has plagued many other aspects of the war, namely a failure to plan ahead. The VBA has many initiatives underway to streamline the benefits process. But these efforts are unlikely to be fully implemented in time to help the returning Iraq and Afghanistan war veterans.

To address the immediate backlog, Secretary Nicholson proposes to hire 457 additional claims specialists, to increase the claims processed per specialist from 98 to 101, and to make training manuals more readily available. He projects this will cut the length of time it takes to process a veteran’s claim by 32 days in 2008. I am

²The discount rate used for this analysis was 4.75%.

not optimistic that a few hundred inexperienced new staffers (even assuming they can all be hired quickly) will produce a 22% improvement in claims processing time, during a period in which the agency faces a huge influx of complex claims. Indeed it is conceivable that the task of training and integrating a large number of inexperienced hires will in the short term actually lengthen claims processing times and increase the level of appeals. The problem is compounded by the fact that many experienced VBA personnel will be retiring over the next 5 years.

I believe that finding an answer to the claims problem requires us to think outside the box. I would like to offer several proposals that do this.

1. First, for the next two years, the VBA should accept and pay all disability claims by returning GWOT soldiers at face value—and then audit a sample of them. This is essentially the same system that is used elsewhere in government, for example, the IRS for taxes and the SEC for filings. This idea would involve retraining some of the claims specialists as auditors, freeing up the remaining specialists to focus on assisting non GWOT veterans claims, which should reduce the backlog of old claims. At the same time, this bold step would ensure that new claimants do not fall through the cracks or endure months of bureaucratic delay.

2. Second, the VBA should replace the cumbersome 0–100 scale for disabilities with a simple four-level ranking: zero disabled, low disability, medium disability, and high disability. This would immediately streamline the process, reduce discrepancies between regions, and likely cut the number of appeals. The VBA should create a “short form” for returning veterans, using this four-level ranking and set a goal of processing all claims within 60 days of receipt. This new system should be up and running within two years, including retraining of the workforce and developing necessary guidelines and appeals procedures.

3. Third, all soldiers serving in the GWOT should receive a mandatory full medical examination at discharge, with all records from this examination made available electronically to the VBA immediately. The VBA should then be able to use these records to spot check and audit claims and to assist veterans, and to relieve some of the pressure on VBA. If veterans are discharged without full medical examinations, they should be reimbursed to receive such an examination from any fully accredited physician within 30 days of discharge, and this record should be used by VBA for making claims awards.

4. Fourth, VBA should shift its focus away from claims processing and onto rehabilitating and reintegration of veterans. The VBA has a dedicated staff who wants to help veterans. Instead of using them to process papers, we should use this workforce as a strategic asset. The VBA staff should be given much greater discretion in helping veterans. Claims specialists should be placed in all neighborhood veterans’ centers, help centers, and special centers to assist reservists and Guardsmen.

5. Fifth and finally, Congress should enact Senate Bill 117, the Lane Evans Veterans Healthcare and Benefits Improvement Act of 2007, sponsored by Senators Obama and Snowe. This legislation would improve data collection and monitoring of disability claims, improve access to mental healthcare and create a more level playingfield for Guards and Reservists.

Thank you very much for your time and attention today. I would be pleased to answer any questions you may have.

Statement of Ann G. Knowles, President, National Association of County Veterans Service Officers

Introduction

Mr. Chairman, members of the Committee, it is truly my honor to be able to present this testimony before your Committee. As President of the National Association of County Veterans Service Officers, I am commenting on:

- The impact of Operation Iraqi Freedom and Operation Enduring Freedom on the Veterans Administration Claims Process

The National Association of County Veterans Service Officers is an organization made up of local government employees. Our Members are tasked with assisting veterans in developing and processing their claims. We exist to serve veterans and partner with the National Service Organizations and the Department of Veterans

Affairs to serve veterans. Our Association focuses on outreach, standardized quality training, and claims processing. We are an extension or arm of government, not unlike the VA itself in service to the nation's veterans and their dependents.

The Relationship Between CVSOs and the VA

The relationship between the Department of Veterans Affairs (DVA) and the County Veterans Service Officers (CVSO) throughout our great nation has traditionally been professional and mutually advantageous. The DVA has assisted CVSOs in providing limited training and access to information the DVA holds on the CVSO's clients. The CVSO serves as the entry point for a large majority of disability and pension claims nationwide for the local veteran to access the services offered by the DVA. Most veterans view the local CVSO as "The VA" and do not realize that the DVA and the CVSO are not one and the same.

NACVSO sees the role of county veteran's service officers as one of advocacy and claims development in concert with the veteran or dependent at the grassroots level.

Our Members sit across the desk from our veterans everyday. Because of this direct access to our veterans, we believe we are in the position to assist the DVA in claims development in an unprecedented way. Developing complete and ready to rate claims eases the burden on the DVA's backlog or inventory of claims.

The process begins with a face to face, in depth interview between the veteran and the CVSO. This initial interview accomplishes many things. It builds a trust between the veteran and the CVSO and provides the veteran with a basic understanding of how the DVA system works. The CVSO honestly explains the process with the veteran while building realistic expectations for the veteran. This results in lessening the impact of frivolous claims or unrealistic appeals that the DVA is mandated to process and develop.

Once complete, the application package is passed on to a state or national service office for review and presentation to the VA regional office of jurisdiction. Any hearings or additional records required can be obtained by the CVSO of record if needed.

Once the rating decision is made and received by the veteran, the veteran nearly always returns to the CVSO for an explanation. The CVSO then interprets the decision for the veteran and explains what the decision means. The CVSO reviews the rating decision for accuracy and explains the veteran's benefits. If an appeal is warranted, the CVSO can explain a notice of disagreement and assist the veteran with the preparation of the appeal. The CVSO can also limit frivolous claims through proper guidance and counsel to the veteran without further bogging down the system. We believe this division of responsibility, between two arms of government, benefits the veteran, the CVSO and the DVA and has the potential to provide a clearer understanding for the veteran of the process of claims development and how the DVA system works.

Issues Affecting Veterans of OIF/OEF

The returning veterans from these two theaters of action have been receiving priority care from the Veterans Administration. There are valid reasons but it has resulted in many other claims being placed on the back burner, claims that have equally valid reasons for priority action. VA officials have stated the number of claims filed since 2000 has risen nearly 40% and this has caused the number of cases pending to balloon to over 800,000. Yet, only about 4% of the new claims are from Iraq and Afghanistan (St Louis Post Dispatch, February 26, 2007). To stay on target with the subject at hand, let us look at the numbers and nature of injuries of OIF and OEF veterans. It has been reported by the DOD that over 19,000 Purple Heart Medals have been awarded since the beginning of OIF/OEF. Each of these is a potential claim for benefits with the DVA. Add to this another 25,000 wounded and ever escalating KIA numbers as additional troops are assigned to Iraq. Secretary Nicholson, in his interview with Bob Woodward of ABC News, showed statistics of treatment within VA facilities of over 200,000 OIF-OEF veterans. Not every treatment is a claim, but even a small percentage of these filing a claim for benefits will escalate the numbers in the pipeline waiting processing.

Post-Traumatic Stress Disorder is recognized in the returning veterans from Iraq and Afghanistan; their treatment has been given priority. A United States Army study places those suffering from PTSD at approximately one in eight soldiers who have served in either Iraq or Afghanistan. A survey of deployed troops indicates that 12% of those serving in Iraq and up to 6% who served in Afghanistan have reported symptoms of major depression, anxiety or PTSD. The most frightening statistic is that only 38% of those were interested in getting help and as low as only 23%. They cited concerns for how they would be viewed by their peers if they sought assistance. This, Mr. Chairman, is a ticking time bomb that will eventually blow up in our faces. Not necessarily in the face of the military but in local communities

where the veterans are returning to their homes. CVSOs and VA will be forced to deal with these issues because local officials and families concerned about the mental health of these young men and women will demand it. And it is . . . a sad state of affairs indeed.

Another issue is the number of veterans who are returning with missing limbs and prosthetic devices. Battlefield treatment, and speed of evacuation of wounded servicemen and women, has advanced substantially over the years. Many of the veterans returning from the Gulf Region needing specialty care for missing limbs may well have died in previous conflicts. This has placed a tremendous and vital responsibility on the Veterans Administration that they are ill equipped to deal with, in health and medical care but also to provide adequate, timely and fair compensation decisions for the veterans and their families who are desperately trying to survive.

Other Issues

An issue that must be addressed is that of placing one group of veterans in a higher priority or "Class" than other veterans. When the VA decides to give "Top Priority" to a select group of claims, the other claims, veterans, suffer. Some claims that have languished for a year or more suddenly become less likely to be rated or receive appropriate attention because of a change of policy. This is because personnel in the Regional Office have been instructed to focus on OIF/OEF veterans claims to the detriment of other claims that have been working their way through the backlog or inventory of claims. We feel this is tragic and extremely inappropriate. Veterans continue to "die while waiting for VA benefits".

We are concerned with the VA's centralization of OIF/OEF claims. We are not convinced that the practice can be justified. When Regional Office claims are "brokered out", the focus becomes quantity and not quality. Issuing flawed rating decisions just exacerbates the inventory or backlog of and further inflates the bloated backlog of appellate litigation.

Suggested Solutions

One solution would be to re-emphasize the Benefits Delivery at Discharge (BDD) program as a "Pre-separation Program". Claims and medical reports could be submitted prior to separation allowing local VA teams to adjudicate the claims and dramatically shorten the time that the veteran has to wait for a decision after separation.

Secondly, streamlining single-issue disability claims at the Regional Office level while multi-faced claims that have a combination of disabilities that require extensive research are passed to Tiger Teams would speed the process.

Another suggested solution is to increase outreach efforts. Outreach efforts must be expanded in order to reach those veterans and dependents that are unaware of their benefits and to bring them into the system. The National Association of County Veterans Service Officers believes that we must do better. Approximately 88 plus % of veterans not being compensated is more likely than not an issue of lack of access or knowledge of available services rather than lack of need or some other issue.

NACVSO supports HR 67 introduced by Congressman Mike McIntyre, of North Carolina that would have allowed Secretary Nicholson to provide Federal—state—local grants for assistance to state and county veterans service officers to enhance outreach to veterans and their dependents. We also support the Bill introduced by Congressman Baca of California which would have a significant impact upon the existing claims backlog.

NACVSO stands ready to partner with the Veterans Administration to bring about a reduction in the backlog and increase the outreach efforts to the veterans of our communities.

Conclusion

The bottom line is that the Veterans Administration is going to have to rise to the occasion and place more personnel to handle the expected large influx of new claims and the resulting larger inventory or backlog of claims.

Statement of Stephen L. Robinson, Director of Veterans Affairs, Veterans for America

Chairman Hall, Representative Lamborn, Members of the Subcommittee:

Thank you for the opportunity to testify.

I am Steve Robinson, and I am the Director of Veterans Affairs for Veterans for America, formerly known as the Vietnam Veterans of America Foundation.

VFA unites a new generation of veterans with those from past wars to address the causes, conduct and consequences of war. In my position, I constantly meet with Iraq and Afghanistan war veterans about their needs and concerns.

The recent uproar over the treatment of returning servicemembers at Walter Reed is not simply an issue of dilapidated physical facilities, mice and mold, or inadequacies with one hospital. The issue is much larger. Specifically, there is a systematic failure in both Department of Defense (DoD) and Department of Veterans Affairs (VA) programs designed to address the medical and overall readjustment needs of war veterans. As one example, there appears to be no plan to gather robust consistent data and then closely monitor the 1.5 million deployed Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) servicemembers as they return to duty or reintegrate into civilian society. As a result, we do not have an adequate understanding of the unique needs specific to our newest generation of veterans.

The controversy around Walter Reed reminds Veterans for America of the squalid conditions of the hospitals and the inadequacy of care for the returning servicemembers more than 36 years ago. This topic was on the cover of the May 22, 1970 issue of *Life* magazine, which was the second-highest selling issue in the magazine's history.

Today, the same story is being repeated for a new generation of war veterans. The recent scandals were noticed by many when the *Washington Post* gave the issue national attention, but the alarm bell first rang in a 2003 series by Mark Benjamin, then with United Press International, for which I helped to provide key information.

With Benjamin's reporting, along with that of others, providing ample evidence of a broken, failing system, I am surprised that the nation has not expressed its outrage before now. That said, I am pleased that Congress has begun to execute its oversight authority on this critical issue.

On March 5, 2007, the *Washington Post* reporters who published the series on the Walter Reed situation stated that they were flooded with e-mails, calls, and faxes from servicemembers and veterans recounting similar experiences in military and veterans' hospitals across the country. It was clear to these reporters that the system has failed.

Veterans for America has also been dealing with tremendous numbers of servicemembers, veterans, and their families reaching out to our organization for help. Too often we have encountered unresponsive agencies. We have been painfully aware of the distress that exists amongst servicemembers and the need to address it. The situation requires immediate remedies, and the effort required will need commitment and leadership from the upper echelons of our government—starting with you, our elected representatives.

The face of the American soldier has changed since Vietnam. The average age of the servicemembers then was just over 19 years old. Today's military is much older. The average age of an active-duty soldier is 27 years. The Reserve and Guard soldier is even older: averaging 33 years.

More than 155,000 women have served in Iraq and Afghanistan. Among their ranks are more than 16,000 single mothers. More than half of those deployed are married, and three out of every five deployed servicemembers have family responsibilities (i.e., a spouse and/or children).

Recently the American Psychological Association released an excellent report stating that no serious study has yet been undertaken to define what these new factors mean in terms of the needs of returning servicemembers and their families.

We are all too familiar with the failure to recognize the unique needs of each generation of veterans. For instance, it was not until a decade after the height of the Vietnam War that the Veterans Administration undertook the first study of Vietnam veterans. Years later the National Vietnam Veterans' Readjustment Study was commissioned. Post-traumatic stress disorder was not recognized as a mental health problem until 1980. We can only guess at the number of veterans whose lives were destroyed because no one understood their needs. In short, we failed an entire generation of veterans.

What's happening today is new chapter in an old book. We have yet to begin to recognize the true needs of the current generation and create programs and services appropriate to their war-related problems.

- What have multiple deployments meant?
- What are the implications of traumatic brain injury being the signature injury of this war?
- What are the effects of so many being constantly exposed to a high degree of violence?
- What does it mean to have the unprecedented survival rates of casualties?

These questions—and many more—need answering.

VFA is especially concerned that servicemembers and veterans are not being provided the mental healthcare they need. There are a number of pressing issues:

- A dramatic rise in less than honorable discharges, and subsequent loss of VA healthcare and benefits,
- Overuse of “personality disorders” to discharge veterans (e.g., use of chapters 5–13, 5–17, 14–12),
- Rise in disciplinary problems related to alcohol and drug use, domestic violence, risk-taking behavior, motor vehicle violations, and other war-related reintegration issues,
- Inadequate staffing in mental health, Medical Evaluation Board–Physical Evaluation Board (MEB–PEB) case work, social work, family care and “seamless transition” programs into the VA network,
- Absence of consistently prompt mental health referrals as part of the Post-Deployment Health Assessment process, and
- Absence of Alcohol and Substance Abuse Programs (ASAP) at all military bases.

VFA also believes the VA’s Veterans Benefits Administration (VBA) disability compensation claims process is completely broken.

Many veterans do not receive their benefits in a timely and accurate manner. VBA’s problems are linked strongly to the DoD’s failure to manage their disability discharges, as was epitomized by the fiasco at Walter Reed. Just as America saw that active duty servicemembers were denied prompt evaluations and disability benefits, America demands that Congress and VA take immediate action so that no disabled veteran waits endlessly.

Our nation was prepared for the return of troops after World War II. The quality and timelines of veterans’ claims are not negotiable.

If both DoD and VA are not overhauled soon, we will see the situation worsen when all of our 1.5 million deployed servicemembers eventually return home from the wars in Iraq and Afghanistan.

Here are the facts:

- As of October 2006, more than 176,000 OEF/OIF veterans filed claims against VBA.
- More than 200 OEF/OIF veterans become disabled every day.
- The rise in the backlog of more than 100,000 claims in 2 years is directly related to the flood of new Iraq and Afghanistan war claims.
- VBA can expect between 700,000 and 1,000,000 claims in the next 10 years.
- VBA can expect to pay between \$67 and \$127 billion in the next ten years.
- As the war escalates and casualties climb, VBA can expect even more claims.
- VBA has not presented a written plan of action so that every VBA employee knows how to produce fast and accurate results.

These problems are especially severe for Members of the National Guard and Reserve.

Here are some facts:

- 37 percent of active duty veterans have filed for disability compensation.
- Only 20 percent of those who served with National Guard or Reserve units have filed such claims.
- 8 percent of claims filed by active duty troops are denied.
- 18 percent of claims filed by Guard and Reserve soldiers are denied.

In short, while about half as many members of the Guard and Reserve file disability claims as compared to active duty veterans, these claims are rejected at twice the rate. These statistics beg the question: are our Members of the Guard and Reserve again being short-changed compared to their active-duty brothers and sisters? VBA is broken in a variety of areas.

- It takes 6 months to decide original claims. VA’s stated goal is for this to be accomplished in 90 days.
- It takes 24 months to decide appealed claims; the goal is 12 months.
- As of February 17, 2007, the total backlog of claims was 558,000—402,000 are original claims and 156,000 are appealed claims.
- This backlog is a disgrace. The message being sent is that VBA doesn’t care about disabled veterans.

VBA’s failures hurt veterans many ways:

- Lack of prompt and adequate VA healthcare,
- Inability to pay bills for food, utilities, etc.,

- Increase in credit problems,
- Rise in evictions and foreclosures, and
- Mounting homelessness.

Here are some “band-aid” approaches that might be utilized to take care of some of the most pressing problems:

First, the signal needs to be sent from the top that the VBA backlog will be reduced soon.

After the tone is set, a number of steps should be taken, including:

1. Insist that VA and DoD better coordinate efforts and become more proactive.
2. Hire additional VBA claims adjudication staff.
3. End the Post-Traumatic Stress Disorder (PTSD) “second signature” policy.
4. Stop reviewing 72,000 PTSD cases.
5. End VA’s efforts to narrow the definition of PTSD via contract with the National Academy of Sciences.
6. Grant the presumption of a stressor for deployment to a war zone.
7. Immediately produce quarterly reports on the number of claims by OEF/OIF servicemembers (as required by S. 117). This will allow VBA to conduct trend analysis and determine staffing and budget needs specific for this cohort.
8. Provide sufficient VBA staff for all military treatment facilities and bases so that the Benefits Delivery at Discharge Program (BDD) is fully implemented.
9. Appoint an ombudsman with responsibility and authority to fix transition problems between DoD and VA.
10. Define the war zone (also included in S. 117) so that VBA knows which veterans are eligible for war-related benefits, for data collection and for accurate reports and projections.
11. Hold executives accountable by eliminating bonuses and terminating those who fail to perform.
12. Adopt mandatory electronic records at discharge given to veteran and VA within 1 year.
13. Shift military ratings of disabled servicemembers from DoD to VA and the BDD program.
14. Review and consider Professor Linda Bilmes’s proposal to streamline claims.
15. Allow all servicemembers a “second look” for PTSD, TBI, VA healthcare, and VA claims assistance.

We don’t need more excuses. A claim delayed is a claim denied.

To address these problems, VFA urges Members of the Senate to consider cosponsoring a House version of S. 117, the Lane Evans Veterans Health and Benefits Improvement Act of 2007 which:

- **Requires face-to-face medical exams.** DoD currently requires servicemembers to answer a limited questionnaire to determine if they need to be referred for treatment. Soldiers are typically rushing to return home after a deployment and do not necessarily give these questions sufficient attention. DoD should, instead, conduct mandatory in-person physical and mental health exams with every service Member 30 to 90 days after deployment.
- **Extends VA Mental Health Care.** Currently, the VA holds a 2-year window to allow newly returning veterans to obtain free healthcare. Unfortunately, it can take many years for symptoms of PTSD and other mental health problems to manifest themselves. S. 117 provides a 5-year window for veterans to receive a free assessment of mental health medical needs by the VA.
- **Defines the Global War On Terror (GWOT).** To accurately determine healthcare and benefit eligibility for returning servicemembers, the GWOT needs to be explicitly defined in statute. Currently, the Secretary of Defense is not allowing some soldiers serving in GWOT territories to receive combat-related medical benefits.
- **Establishes a GWOT registry to track healthcare data.** Collect aggregate data on GWOT servicemembers and veterans to monitor their healthcare and benefit use. The data will help lead to better budget forecasting and avoid shortfalls. A similar effort was undertaken after the Gulf War.
- **Requires equal transition services for Guardsmen and Reservists.** A 2005 GAO report found that demobilization for guardsmen and reservists is accelerated and these units receive insufficient transition assistance.
- **Requires Secure Electronic Records.** DoD should provide a full, secure electronic copy of all medical records at the time of discharge.

Again, Veterans for America appreciates the opportunity to submit a statement for this hearing. We reaffirm our desire to work with Congress and the relevant agencies in trying to address these critical needs, but it is important that I reiterate that we will not stop failing our servicemembers and veterans across-the-board until we take a step back, evaluate their unique needs. We must stop trying to squeeze our new military into a system designed for a previous generation.

Thank you.

Statement of Brady Van Engelen, Associate Director, Veterans for America

Chairman Hall, Representative Lamborn, Members of the Subcommittee:

Thank you for the opportunity to testify.

On April 6th of 2004 I sustained a gunshot wound to the head in Baghdad while positioned at an observation post. First aid was immediately administered, and I was fortunate to have survived long enough to make it to the 28th Combat Support Hospital (CSH). The primary repairs and closures for my head were conducted while in theater at the 28th CSH. From there, I was medically evacuated to a military hospital in Landstuhl, Germany, where I was staged for recovery until I had regained enough strength to travel back to Walter Reed Army Medical Center to complete the recovery process.

I arrived at Walter Reed Army Medical Center on April 14, 2004, where I was immediately asked if I wanted to be treated as an inpatient or outpatient. Wanting to spend time with family and loved ones, I chose to be an outpatient, at which point I was given the building number of the Mologne House and told to check in there. With no clue as to where the building was, I hopped onto a facility shuttle and asked if I could get a ride to the Mologne House to check in.

The first 2 weeks of appointments I was fortunate enough to have my family and loved ones at my side to assist me through the bureaucratic maze that is outpatient care at Walter Reed. In one month's time, my rehabilitative care was completed, and I was told the Physical Evaluation Board (PEB) process would begin shortly thereafter.

That was May 30, 2004.

I didn't hear back about my case until December of 2004.

Other than the research that I conducted on my own time, I was completely unaware of what my possibilities were and what to do next. Throughout the entire process I was the one who always initiated contact with the case managers and the hospital. If it weren't for my persistence, I could have gone unnoticed for months. There were just too many patients, and not enough case managers to oversee the process.

The systemic problems that have highlighted Walter Reed in recent weeks have unfortunately trickled over to the Department of Veterans Affairs (VA). The VA is overwhelmed by the number of claims filed and patients needing attendance. We didn't prepare for this, and it's painfully evident. My generation is going to have to pay for this, and we will be paying for years and years.

While at Walter Reed as an outpatient there was no outreach on behalf of the VA to inform me of benefits for myself and for my family. When troops were returning from WWII, there were VA claims specialists on the boats with the servicemen informing them of benefits that they were eligible for. We have lost that aggressive approach with today's servicemembers and veterans. Today, we are being asked to navigate the bureaucratic maze of DoD and VA on our own. I can assure you that this is no small feat. Shifting the burden from our government to those who serve has created a system where servicemembers and veterans are unaware of the benefits and programs promised to them upon enlistment.

I understand that the VA has begun to more aggressively address the **inpatients** while they are recovering at medical facilities, but, as was the case at Walter Reed, only a small number of injured soldiers are benefiting. This is not acceptable.

Many wounded servicemembers at other medical outpatient facilities throughout the country remain as uninformed as I was upon leaving the military. Servicemembers from my generation are becoming increasingly disenfranchised with a system that our government promised would help us heal and rehabilitate.

Claims backlogs are currently at 180 days. A few years ago claims were half that. The families of servicemembers are suffering from this lack of preparation by our VA. They cannot call the bank, say they are waiting for a response on a claim, and ask for payments to be delayed for another 180 days. The passive nature of the VA regarding health and claims dispensation will only tarnish their perception amongst the military and their families. We may end up with an entire generation of vet-

erans who have no faith in our VA because those running it—as well as those overseeing it—were unable to hold up their end of the bargain. This saddens me deeply.

In closing, I'd sum up the problems with the VA claims process like this:

I entered the VA system on January 29, 2005.

That was 774 days ago.

No one from the VA has contacted me yet to tell me how the system works.

I urge the Members of this subcommittee to keep one question in mind as they consider how to repair this broken system:

What is owed those who serve?

While I do not claim to have all the answers to that question, I am confident that you will conclude that the answer is: *More than servicemembers and veterans are receiving now.*

Thank you.

Statement of Patrick Campbell, Legislative Director, Iraq and Afghanistan Veterans of America

Mr. Chairman and Members of the House Subcommittee on Disability Assistance & Memorial Affairs, on behalf of the Iraq and Afghanistan Veterans of America (IAVA), thank you for this opportunity to address the issue of “The Impact of OIF/OEF on the VA Claims Process.”

My name is SGT Patrick Campbell and I am a combat medic for the DC National guard, an OIF vet and the Legislative Director for the Iraq & Afghanistan Veterans of America. IAVA is the nation's first and largest organization for Veterans of the wars in Iraq and Afghanistan. IAVA believes that the troops and veterans who were on the frontlines are uniquely qualified to speak about and educate the public about the realities of war, its implications on the health of our military, and its impact on the strength of our country.

According to the Department of Veterans Affairs I am one of the 54,000 OIF/OEF veterans they are guesstimating will seek care from the VA in 2007. In a briefing with Veteran Service Organizations the Department of Veterans Affairs stated that, “263,000 of their current users” are from the Global War on Terror and they expect an increase of 54,000 in FY 2007.

In general a department's proposed budget is the clearest signal to the outside world of their priorities and their assumptions. Although IAVA sincerely applauds the Department of Veterans Affairs for removing certain onerous proposals from their FY08 budget proposal and requesting healthy increases, we believe that the VA's assumptions about future usage of the VA system from the soldiers fighting in the Global War on Terror are severely flawed.

The administration's budget projections show a decrease in VA spending over the next 3 years. One can only assume that the VA is wishing/hoping/expecting the number of veterans demanding services to decrease or maintain their current levels. It is hard to argue with VA's accountants and their actuarial tables because they will cloak their assumptions in mounds of numbers, but when these numbers seem to defy common sense that is when the alarms must go off.

If you remember one thing from this testimony today, remember that the VA has grossly *underestimated* the demand for their services once again. The soldiers are coming home and they will be asking for care. The question we must be asking ourselves, will it be ready for them?

If anything the recent Walter Reed expose has taught us is that trying to treat and care for soldiers and veterans on a limited budget and limited oversight only has one logical conclusion, poor care. In the context of this specific hearing, soldiers are languishing while they wait for their claims to be processed. And woe to the veteran who does not file his/her paperwork correctly and gets denied, because they will be stuck in bureaucratic limbo for years.

We also believe that the VA's current standard for evaluating the speed a veteran gets seen by a medical professional should not be a whopping 45 days or even 30 days. For veterans coming home, especially with mental health issues, a month is like an eternity. The standard should be 2 weeks or at least broken down into categories.

Soldiers fight for their country, they should not be made to fight against their country.

Many of the other organizations today who are testifying will be providing excellent statistics and solutions. IAVA stands firmly behind their recommendations. Our purpose here today is to convey a single message, that if you start with faulty assumptions you will end with poor results.

This Committee must work with the Department of Veterans Affairs and the various veterans service organizations to formulate a realistic number of incoming veterans into the VA system over the next 5 years. Only then will we be able to hire to the correct number claims processors and medical staff to provide the quality of care these veterans deserve.

Statement of Jon Soltz, Co-Founder and Chairman, VoteVets.org

Thank you, Mr. Chairman, Congressman Lamborn, and Members of the Committee for inviting me here today to discuss this critically important issue.

I am Jon Soltz, and I am the Co-Founder and Chairman of VoteVets.org, which is a leading organization of Iraq and Afghanistan Veterans. VoteVets.org was established to give voice to the 21st century patriots who have fought in these wars, and to raise concerns about the state of today's military preparedness as well as the resources and support available to servicemen and women when they return home.

I myself am an Iraq war veteran. From May to September 2003, I served as a Captain during Operation Iraqi Freedom, deploying logistics convoys with the 1st Armored Division. During 2005, I was mobilized for 365 days at Fort Dix, New Jersey, training soldiers for combat in Afghanistan and Iraq. I also served with distinction in the Kosovo Campaign as a Tank Platoon Leader between June and December 2000. Let me make clear, however, that today I am speaking for my organization and the troops and veterans we represent, not for the U.S. Army.

I've also experienced, first-hand, many of the issues we'll be talking about today. After I returned from Iraq, I knew that I was mentally affected from the war. Eight months later, I went to the VA and asked for help. The nurse, who I'm close with to this day, told me I came to the right place. After a few tests, though, I was told that I just had something called "Adjustment Disorder," and that I should come back in for counseling once a month, for 4 months. Maybe that was the right diagnosis, and maybe it wasn't. All I know is that I didn't feel that the diagnosis was based on any in-depth testing, and I'm not sure that my treatment was enough.

Even worse, just a short time later, it was announced that the VA center I had been going to, in Pennsylvania, would be closed. I tried to attend the press conference to announce the closure, so I could learn more about what was going on, and was told that I could either leave on my own, or police would be called to escort me out. I hadn't even said a peep, or protested at the event. I simply wasn't allowed to watch.

That's when I held my own first press conference, across the street, where I questioned to the media, why I was good enough to go and fight and risk my life for this country, but not good enough to deserve an explanation as to why my VA hospital was closing. That is when I made the decision that I would talk about these issues, until I was blue in the face, so that not only would veterans get answers, but we could see real fixes to the issues we face.

The recent report in the Washington Post regarding Walter Reed's Building 18 set off a media and political firestorm here on Capitol Hill. Many in the media dramatically shook their heads in sorrow on television. Many Members of Congress started to call press conferences to express their dismay. Even the President expressed surprise and anger.

I have to admit, as someone who has dealt with our veterans' care system, and talks on a daily basis to many others who have, I found it somewhat amusing that everyone seemed so surprised that the quality of care didn't meet the quality of service these troops and veterans gave. Those of us who have served have known for a long time about bureaucratic and capacity problems, especially at the VA. I want to make clear that I do not impugn the fine service those who work at the VA centers have given. They are all great people, and do heroic work. But, it is an overburdened and woefully underfunded system that has all too often tied their hands, and hurt America's veterans.

Nonetheless, veterans care in this nation has not been up to snuff for a long time. Many veterans' organizations much older than VoteVets.org have been trying to get the media and politicians to pay attention for a long time. No one wanted to listen. In the end, what I find so sadly funny is that a few rats did in one day what we veterans haven't been able to do for years—get America's attention.

It's important that we as a nation look at the larger issue here, though, and not get too bogged down in just the problems at Building 18. That larger issue goes way past the Pentagon's hospitals, like Walter Reed, into the VA system.

Are our current military obligations affecting the capacity of the VA to deal with an influx of vets? Absolutely. Last year, VoteVets.org did a poll of about 450 vet-

erans of the wars in Iraq and Afghanistan, focusing both on the issues they faced in the field, and issues they faced at home. Here is some of what we found:

Troops returned home, and many encountered emotional and physical health problems as well as economic hardship resulting from their service.

- One in four veterans has experienced nightmares since returning, including 33 percent of Army and Marine veterans and 36 percent of combat veterans.
- A fifth of all veterans (21 percent) and a quarter of Army and Marines (26 percent) and ground combat veterans (27 percent) say they have felt more stress now than before they left for war.
- Among National Guard or Reserve veterans, 32 percent said their families experienced economic hardship; 25 percent feel more stress now than before the war; 32 percent experienced more extreme highs and lows; and 30 percent experienced nightmares.
- Twenty-six percent of all veterans have sought some service from the VA or a VA hospital, including 33 percent of Reservists and National Guard respondents.

These numbers were compiled just last fall, so we believe those numbers have held, if not gotten worse, as the violence and chaos our troops have to deal with gets more intense. Nearly 1.5 million troops have now been deployed to Iraq or Afghanistan. So, to put our poll in real numbers, about 390,000 troops and veterans have or will seek care from the VA, if no more troops are deployed to the wars. Frankly, I think the numbers will be higher, for two reasons. First, the nature of this war lends itself to more mental trauma, because you are in a 360 degree battlefield, where you truly feel hunted. This stress becomes worse as you are extended multiple times, which many troops have been. Second, we are using our National Guard and Reserve at a much greater level than we have ever, in any war. Those Guardsmen and Reservists are still not guaranteed healthcare, and many of them will not be working when they return home, so they'll have no insurance at all. Thus, the only option available to them will be VA services, meaning we'll surely see a huge spike in the levels of demand from Guardsmen and Reservists.

If you talked to any veteran of Vietnam or the Gulf War, they'll tell you there were serious capacity issues with the VA before Iraq and Afghanistan. Since the start of the wars, the Bush administration has failed to adequately increase resources for the VA to meet the need. That's why Secretary Nicholson had to come back to Congress a while back and admit the agency was billions short. Though Congress acted fast to appropriate emergency funds for the VA, the agency doesn't get close to what it needs. According to the nation's top veterans groups, which put together The Independent Budget each year, the agency is still being shortchanged by about ten billion dollars in the latest budget proposal.

If the President has his way, the agency's budget will be cut in 2009 and 2010. God willing, we will have started to redeploy from Iraq by then. That will be precisely the time when hundreds of thousands of new veterans will flood the VA system. Will there be capacity problems? You can't possibly imagine.

What does this mean in real terms? It means more frequent tales that I've heard since beginning VoteVets.org. I know one veteran, Josh Lansdale of Missouri. Josh served as an EMT in Iraq and came back with post-traumatic stress disorder and a busted ankle. He faced a 6 month wait to get the care he needed.

Another young patriot, Tomas Young, is now wheelchair bound, paralyzed from the chest down, because he was shot in the spine while riding in a truck without the right armor. Every day, he takes a cocktail of pills just to get through the day. He's lucky enough to have a wife that brings him to his VA center on a regular basis, but Tomas tells me that the quality of care is never as consistent. Sometimes he has a good experience, and sometimes the VA just doesn't have the ability to deal with him. In short, Tomas can't depend on the system.

I know of veterans who have to hold their prosthetics together with duct tape, because their VA center doesn't have anything that fits right. Veterans in rural areas I know of have to travel for hours to get the care they need. Veterans like Tyson Johnson from Alabama, who lost a kidney and had shrapnel in his lungs from a mortar attack, often couldn't stand the long drive to the VA hospital, followed by the long wait for care, so he didn't go at all, a lot of the time.

Again, the people employed by the VA are not the problem. The problem is two-fold: Budgetary and systemic. But, the problem right now is a walk in the park compared to what the situation will be like in a year or two, if nothing substantial is done.

I'm hopeful that Congress and the Bush administration will finally address these issues. I hope this Committee works with your colleagues on the Committee on

Armed Services, to examine the serious transition problems there when a troop leaves the Pentagon system and enters the VA system.

Those of us who served have kept our end of the bargain. We've risked our bodies and lives in service. Now it is time for you to do your jobs, and keep the government's end of the deal by ensuring that the Department of Veterans Affairs is fully funded, and that bureaucratic SNAFUs are eliminated. No more excuses. No more delays. We veterans deserve nothing less.

Thank you again for allowing me to testify here today. I sincerely hope that this marks a new day in how we address the issues facing veterans care in this nation. And though much of what I said today I've said before, for the first time, I feel that the American people are listening. Most importantly, I hope you will commit to keeping this process moving, and not end your concern with today's hearing. It will be important that all of us—those of us on this panel, those of you in Congress, and the administration all work together to really make a difference and give America's veterans the level of care they deserve.

**Statement of Ronald R. Aument, Deputy Under Secretary for Benefits,
Veterans Benefits Administration, U.S. Department of Veterans Affairs**

Mr. Chairman and Members of the Subcommittee, it is my pleasure to be here today to discuss the Disability Compensation Program and our efforts to meet the needs of servicemembers and veterans of Operations Iraqi and Enduring Freedom. I am pleased to be accompanied by Mr. Michael Walcoff, VBA's Associate Deputy Under Secretary for Field Operations.

The Veterans Benefits Administration (VBA) is responsible for administering a wide range of benefits and services for veterans, their families, and their survivors. We manage a life insurance program that consistently ranks among the best in the nation. We promote homeownership through the loan guaranty program and help veterans and their dependents seek greater education and economic opportunities through the highly successful Montgomery GI Bill program and other educational programs. We assist low-income disabled and elderly wartime veterans and their survivors through our pension programs. For qualifying veterans with disabilities related to their military service, our Vocational Rehabilitation and Employment Program provides both rehabilitation and training and assists them in reentering the civilian workforce. We are proud of our achievements in all these vital areas.

At the heart of our mission is the Disability Compensation Program, which provides monthly benefits to veterans who are disabled as a result of injuries or illness incurred or aggravated during their military service. Over 2.7 million veterans of all periods of service currently receive VA compensation benefits. Last year, we provided veterans with decisions on over 774,000 disability claims. We also performed more than 1.3 million other award actions and benefits adjustments of all types (e.g., dependency adjustments, death pension awards, income adjustments, burial awards, and so forth.) to maintain the accounts of the beneficiaries already on the rolls. Additionally, we handled over 6.6 million phone calls; conducted over a million interviews; briefed more than 390,000 service persons; and conducted nearly 65,000 hours of outreach to military members, former prisoners of war, homeless, minorities, women, and other targeted groups.

Today I will discuss the challenges we face in providing timely, accurate, and consistent determinations on veterans' claims for disability compensation. These challenges include the growth of the disability claims workload, the increasingly complex nature of that workload, the rise in appellate processing, and the absolute need to produce accurate benefit decisions. I will also discuss some of the actions we are taking to improve claims processing and our efforts to expedite the processing of claims from Operations Iraqi and Enduring Freedom veterans.

Growth of Disability Claims Workload

The number of veterans filing initial disability compensation claims and claims for increased benefits has increased every year since FY 2000. Disability claims from returning Afghanistan and Iraq war veterans as well as from veterans of earlier periods of war increased from 578,773 in FY 2000 to 806,382 in FY 2006. For FY 2006 alone, this represents an increase of nearly 228,000 claims or 38 percent over the 2000 base year. It is expected that this high level of claims activity will continue.

The primary factors leading to the sustained high levels of claims activity are: more beneficiaries on the rolls with resulting additional claims for increased benefits; Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF); im-

proved and expanded outreach to active-duty servicemembers, guard and reserve personnel, survivors, and veterans of earlier conflicts; and implementation of Combat Related Special Compensation (CRSC) and Concurrent Disability and Retired Pay (CDRP) programs by the Department of Defense (DoD).

Ongoing hostilities in Afghanistan and Iraq are expected to continue to increase the VA compensation workload. Earlier studies by VA indicate that the most significant indicator of new claims activity is the size of the active force. Nearly 1.46 million active-duty servicemembers, members of the National Guard, and reservists have thus far been deployed in the Global War on Terrorism. Over 689,000 have returned and been discharged.

Whether deployed to foreign-duty stations or maintaining security in the United States, the authorized size of the active force and the mobilization of thousands of citizen soldiers means that the size of the total force on active duty has significantly increased. The claims rate for veterans of the Gulf War Era, which began in 1991 and includes veterans who are currently serving in Operations Iraqi Freedom and Enduring Freedom, is significant. Veterans and survivors of the Gulf War Era currently comprise the second largest population of veterans receiving benefits after Vietnam Era veterans.

The number of veterans receiving compensation has increased by almost 400,000 since 2000—from just over 2.3 million veterans to nearly 2.7 million in 2006. This increased number of compensation recipients, many of whom suffer from chronic progressive disabilities such as diabetes, mental illness, and cardiovascular disabilities, will continue to stimulate more claims for increased benefits in the coming years as these veterans age and their conditions worsen. Reopened disability compensation claims currently comprise 54 percent of VBA's disability claims receipts.

VA is committed to increased outreach efforts to active-duty personnel. These outreach efforts result in significantly higher claims rates. Original claim receipts rose from 111,672 in FY 2000 to 217,343 in FY 2006—a 95-percent increase. We believe this increase is directly related to our aggressive outreach programs; we believe this increasing trend will continue.

Combat-Related Special Compensation (CRSC) and Concurrent Retired and Disability Pay (CRDP) further contribute to increased claims activity for VBA. It is now potentially advantageous for the majority of our military retirees, even those with relatively minor disabilities, to file claims with VA and to receive VA disability compensation, since their waived retired pay may be restored and not be subject to waiver in the future under these new DoD programs. Today more than 54,000 military retirees receive CRSC and approximately 194,000 retirees receive CRDP. The number of military retirees receiving VA compensation has increased since the advent of these programs to over 840,000. The total number of retirees as of the end of FY 2006 was approximately two million, meaning that over 40 percent of all U.S. military retirees now receive VA benefits.

Complexity of Claims Processing Workload

The increase in claims receipts is not the only change affecting the claims processing environment. The greater number of disabilities veterans now claim, the increasing complexity of the disabilities being claimed, and changes in law and Court decisions affecting the decision process pose additional challenges to timely processing the claims workload. The trend toward increasingly complex and difficult-to-rate claims is expected to continue for the foreseeable future.

A claim becomes more complex as the number of directly claimed conditions increases because of the larger number of variables that must be considered and addressed. Multiple regulations, multiple sources of evidence, and multiple potential effective dates and presumptive periods must be considered. The effect of these factors increases proportionately and sometimes exponentially as the number of claimed conditions increases. Additionally, as the number of claimed conditions increases, the potential for additional unclaimed but secondary, aggravated, and inferred conditions increases as well, further complicating the preparation of adequate and comprehensive Veterans Claims Assistance Act of 2000 (VCAA) notice and rating decisions. Since veterans are able to appeal decisions on specific disabilities to the Board of Veterans' Appeals (Board) and the United States Court of Appeals for Veterans Claims (CAVC), the increasing number of claimed conditions significantly increases the potential for appeal.

VA's experience since 2000 demonstrates that the trend of increasing numbers of conditions claimed is system-wide, not just at special intake locations such as Benefits Delivery at Discharge (BDD) sites. The number of cases with eight or more disabilities claimed increased from 21,814 in FY 2000 to 51,260 in FY 2006, representing a 135-percent increase over the 2000 base year and a 15-percent increase over FY 2005.

The VCAA has significantly increased both the length of time and the specific requirements of claims development. VA's notification and development duties increased as a result of VCAA, adding more steps to the claims process and lengthening the time it takes to develop and decide a claim. Since enactment, we are required to review the claims at additional points in the decision process.

Appellate and Non-Rating Workload

As VBA renders more disability decisions, a natural outcome of that process is more appeals filed by veterans and survivors who disagree with some part of the decision made on their case. Appeals of regional office decisions and remands by the Board and the CAVC following appeal are some of the most challenging types of cases because of their complexity and the growing body of evidence necessary to process these claims. In recent years, the appeal rate on disability determinations has climbed from a historical rate prior to 2000 of approximately 7 percent of all disability decisions to the current rate of 11 percent. There are more than 130,000 appeals now pending in the regional offices and the Appeals Management Center. This number includes cases requiring processing prior to transfer of the appeal to the Board and cases remanded by the Board and the CAVC following an appeal. There are over 30,000 additional appeals pending at the Board.

Claims Processing Accuracy and Consistency

In 2001, then Secretary of Veterans Affairs Anthony J. Principi, established the VA Claims Processing Task Force to examine a wide range of issues affecting the processing of claims. A product of the Task Force Report was the Claims Processing Improvement (CPI) model. Implementation of the CPI model established a consistent organizational structure across all regional offices. Work processes were re-engineered and specialized teams established to reduce the number of tasks performed by individual decisionmakers, establish consistency in workflow and process, and incorporate a triage approach to incoming claims.

Implementation of this model provided a strong foundation for improving both the accuracy and consistency of our claims decisions. We also established an aggressive and comprehensive program of quality assurance and oversight to assess compliance with VBA claims processing policy and procedures and assure consistent application. As a result of these efforts, our accuracy has risen over the last 4 years from 81 percent to 89 percent.

We are also identifying unusual patterns of variance in claims adjudication by diagnostic code, and then reviewing selected disabilities to assess the level of decision consistency among and between regional offices. These studies are used to identify where additional guidance and training are needed to improve consistency and accuracy, as well as to drive procedural or regulatory changes. Site surveys of regional offices also address compliance with procedures.

Training

Critical to improving claims accuracy and consistency is ensuring that our employees receive the essential guidance, materials, and tools to meet the ever-changing and increasingly complex demands of their decisionmaking responsibilities. To that end, VBA has deployed new training tools and centralized training programs that support accurate and consistent decisionmaking.

New hires receive comprehensive training and a consistent foundation in claims processing principles through a national centralized training program called "Challenge." After the initial centralized training, employees follow a national standardized training curriculum (full lesson plans, handouts, student guides, instructor guides, and slides for classroom instruction) available to all regional offices. Standardized computer-based tools have been developed for training decisionmakers (69 modules completed and an additional 8 in development). Training letters and satellite broadcasts on the proper approach to rating complex issues are provided to the field stations. In addition, a mandatory cycle of training for all Veterans Service Center employees has been developed consisting of an 80-hour annual curriculum.

Consolidation of Specialized Operations

The consolidation of specialized processing operations for certain types of claims has been implemented to provide better and more consistent decisions, and we continue to look for ways to achieve additional organizational efficiencies through further consolidation. Three Pension Maintenance Centers were established to consolidate the complex and labor-intensive work involved in ensuring the continued eligibility and appropriateness of benefit amounts for pension recipients. We are exploring the centralization of all pension adjudications in these Centers.

In November 2001, a Tiger Team was established at the Cleveland Regional Office to adjudicate the claims of veterans age 70 and older. VBA also established an Ap-

peals Management Center to consolidate expertise in processing remands from the Board of Veterans' Appeals. In a similar manner, a centralized Casualty Assistance Unit was established to process all in-service death claims. VBA also established two Development Centers in Phoenix and Roanoke to assist regional offices in obtaining the required evidence and preparing cases for decision, and centralized the processing of all radiation claims to the Jackson Regional Office.

The Benefits Delivery at Discharge (BDD) Program provides servicemembers with briefings on VA benefits, assistance with completing applications, and a disability examination before leaving service. The goal of this program is to deliver benefits within 60 days following discharge. VBA has consolidated the rating aspects of our BDD program, which will bring greater consistency of decisions on claims filed by newly separated veterans.

Inventory Reduction

VBA is aggressively pursuing measures to decrease the pending inventory of disability claims and shorten the time veterans must wait for decisions on their claims. Our pending inventory of rating related claims is currently about 400,000 claims, and average processing time is 177 days. However, all 400,000 claims in our inventory should not be considered as "backlog;" this number includes all claims, whether pending only a few days or a number of months. Under the very best of circumstances, it takes about four months to fully develop a claim (obtain military and private medical records, schedule necessary medical examinations and receive results, evaluate evidence, etc.). Based on our projected receipts of 800,000 claims and our timeliness performance target of 145 days, our expected level of pending inventory with no backlog would be approximately 318,000 claims.

To balance the inventory of disability claims across regional offices, VBA implemented a "brokering" strategy in which rating cases are sent from stations with high inventories to other stations with the capacity to process additional rating work. Brokering allows the organization to address simultaneously the local and national inventory by maximizing use of available resources.

We are increasing staffing levels to reduce the pending inventory and provide the level of service expected by the American people. We began aggressively hiring additional staff in FY 2006, increasing our on-board strength by over 580 employees between January 2006 and January 2007. With a workforce that is sufficiently large and correctly balanced, VBA can successfully meet the needs of our veterans.

Our plan is to continue to accelerate hiring and fund additional training programs for new staff this fiscal year. We are recruiting now and will increase our on-board strength by an additional 400 employees by the end of June. However, because it requires an average of two to three years for our decisionmakers to become fully productive, increased staffing levels do not produce immediate production improvements. Performance improvements from increased staffing are more evident in the second and third years. We have therefore also increased overtime funding this year and recruited retired claims processors to return to work as reemployed annuitants in order to increase decision output.

Priority Processing for OIF/OEF Veterans

Since the onset of the combat operations in Iraq and Afghanistan, VA has provided expedited and case-managed services for all seriously injured Operations Iraqi and Enduring Freedom (OIF/OEF) veterans and their families. This individualized service begins at the military medical facilities where the injured servicemembers return for treatment, and continues as these servicemembers are medically separated and enter the VA medical care and benefits systems. VA assigns special benefits counselors, social workers, and case-managers to work with these servicemembers and their families throughout the transition to VA care and benefits systems, and to ensure expedited delivery of all benefits.

Last month the Secretary of Veterans Affairs announced a new initiative to provide priority processing of all OIF/OEF veterans' disability claims. This initiative covers all active duty, National Guard, and Reserve veterans who were deployed in the OIF/OEF theatres or in support of these combat operations, as identified by the Department of Defense (DoD). This will allow all the brave men and women returning from the OIF/OEF theatres who were not seriously injured in combat, but who nevertheless have a disability incurred or aggravated during their military service, to enter the VA system and begin receiving disability benefits as soon as possible after separation.

We have designated our two Development Centers in Roanoke and Phoenix and three of our Resource Centers as a special "Tiger Team" for processing OIF/OEF claims. The two Development Centers will obtain the evidence needed to properly develop the OIF/OEF claims. The three Resource Centers, located in Muskogee, San


Diego, and Huntington, will rate OIF/OEF claims for regional offices with the heaviest workloads. Medical examinations needed to support OIF/OEF veterans' claims are also being expedited.

We are expanding our outreach programs for National Guard and Reserve components and our participation in OIF/OEF community events and other information dissemination activities. An OIF/OEF Team is being established at VBA Headquarters to address all OIF/OEF operational and outreach issues at the national level and to support and assist newly designated OIF/OEF Managers at each regional office. The VBA OIF/OEF Team will also direct and coordinate national Memoranda of Understanding (MOU) with each of the Reserve Components to formalize relationships with them, mirroring the agreement between VA and the National Guard Bureau signed in 2005. Having an MOU with each Reserve Component will ensure that VA is provided service medical records and notified of "when and where" reserve Members are available to be briefed during the demobilization process and at later times.

In order to ensure that VA benefits information is provided to all separating Guard and Reserve servicemembers, we will work with DoD to discuss the possibility of expanding VA's role in DoD's military pre-separation process. Specifically, we will assess the feasibility of providing a new "Claims Workshop" in conjunction with VA benefits briefings and Disabled Transition Assistance (DTAP) briefings. At such workshops, groups of servicemembers would be instructed on how to complete the general portions of the VA application forms. Following the general instruction segment, personal interviews would be conducted with those applying for individual VA benefits.

Expediting the claims process is critical to assisting OIF/OEF veterans in their transition from combat operations back to civilian life. VA is also continuing to focus on reducing the pending workload and improving the overall timeliness of processing for all veterans.

Mr. Chairman, this concludes my testimony. I greatly appreciate being here today and look forward to answering your questions.



MATERIAL SUBMITTED FOR THE RECORD

How the U.S. Is Failing Its War Veterans

By Dan Ephron and Sarah Childress

Newsweek Magazine, March 5, 2007, Issue

After returning from Iraq in late 2005, Jonathan Schulze spent every day struggling not to fall apart. When a Department of Veterans Affairs clinic turned him away last month, he lost the battle. The 25-year-old Marine from Stewart, Minn., had told his parents that 16 men in his unit had died in 2 days of battle in Ramadi. At home, he was drinking hard to stave off the nightmares. Though he managed to get a job as a roofer, he was suffering flashbacks and panic attacks so intense that he couldn't concentrate on his work. Sometimes, he heard in his mind the haunting chants of the muezzin—the Muslim call to prayer that he'd heard many times in Iraq. Again and again, he'd relive the moments he was in a Humvee, manning the machine gun, but helpless to save his fellow Marines. "He'd be seeing them in his own mind, standing in front of him," says his stepmother, Marianne.

Schulze, who earned two Purple Hearts for wounds sustained in Iraq, was initially reluctant to turn to the VA. Raised among fighters—Schulze's father served in Vietnam and over the years his older brother and six stepbrothers all enlisted in the military—Jonathan might have felt asking for help didn't befit a Marine.

But when the panic attacks got to be too much, he started showing up at the VA emergency room, where doctors recommended he try group therapy. He resisted; he didn't think hearing other veterans' depressing problems would help solve his own. Then, early last month, after more than a year of anxiety, he finally decided to admit himself to an inpatient program. Schulze packed a bag on Jan. 11 and drove with his family to the VA center in St. Cloud, about 70 miles away. The Schulzes were ushered into the mental-health-care unit and an intake worker sat down at a computer across from them. "She started typing," Marianne says. "She asked, 'Do you feel suicidal?' and Jonathan said, 'Yes, I feel suicidal.'" The woman kept typing, seemingly unconcerned. Marianne was livid. "He's an Iraqi veteran!" she snapped. "Listen to him!" The woman made a phone call, then told him no one was available that day to screen him for hospitalization. Jonathan could come back tomorrow or call the counselor for a screening on the phone.

When he did call the following day, the response from the clinic was even more disheartening: the center was full. Schulze would be No. 26 on the waiting list. He was encouraged to call back periodically over the next 2 weeks in case there was a cancellation. Marianne was listening in on the conversation from the dining room. She watched Jonathan, slumped on the couch, as he talked to the doctor. "I heard him say the same thing: I'm suicidal, I feel lost, I feel hopelessness," she says. Four days later Schulze got drunk, wrapped an electrical cord around a basement beam in his home and hanged himself. A friend he telephoned while tying the noose called the police, but by the time officers broke down the door, Schulze was dead.

How well do we care for our wounded and impaired when they come home? For a country amid what President Bush calls a "long war," the question has profound moral implications. We send young Americans to the world's most unruly places to execute our National policies. About 50,000 servicemembers so far have been banged up or burned, suffered disease, lost limbs or sacrificed something less tangible inside them. Schulze is an extreme example but not an isolated one, and such stories are raising concerns that the country is failing to meet its most basic obligations to those who fight our wars.

The question of after-action care also has strategic consequences. Iraq marks the first drawn-out campaign we've fought with an all-volunteer military. In practice, that means far fewer Americans are taking part in this war (12 percent of the total population participated in World War II, 2 percent in Vietnam and less than half of 1 percent in Iraq and Afghanistan). Already, the war has made it harder for the military to recruit new soldiers and more expensive to retain the ones it has. If we fall down in the attention we provide them, who's to say volunteers will continue coming forward?

The issue of veterans' care jumped into the headlines last week when The Washington Post published a series about Walter Reed Army Medical Center in Washington, D.C. The stories revealed decay and mismanagement at the hospital, and provoked shock and concern among politicians in both parties. "The doctors were fantastic," a Walter Reed patient, 21-year-old Marissa Stroock, tells NEWSWEEK. "But some of the nurses and other staffers here have been a nightmare." Stroock suf-

ferred multiple injuries, including broken bones, a lacerated liver and severely bruised lungs, when her Humvee rolled over an improvised explosive device on Nov. 24, 2005. She later had both her legs amputated. "I think a big part of [Walter Reed's problems] is they just don't have enough people to adequately handle all the wounded troops coming in here every day," she says. (Walter Reed did not respond to requests for comment about Strock's case.) The Pentagon responded swiftly to the Post series. It vowed to investigate what went wrong and immediately sent a repair crew to repaint and fix the damage to the aging buildings.

The revelations were especially shocking because Walter Reed is one of the country's most prestigious military hospitals, often visited by prominent politicians, including the president. But it is just one part of a vast network of hospitals and clinics that serve wounded soldiers and veterans throughout the country. A NEWSWEEK investigation focused not on one facility but on the services of the Department of Veterans Affairs, a 235,000-person bureaucracy that provides medical care to a much larger number of servicemen and women from the time they're released from the military, and doles out their disability payments. Our reporting paints a grim portrait of an overloaded bureaucracy cluttered with red tape; veterans having to wait weeks or months for mental-health care and other appointments; families sliding into debt as VA case managers study disability claims over many months, and the seriously wounded requiring help from outside experts just to understand the VA's arcane system of rights and benefits. "In no way do I diminish the fact that there are veterans out there who are coming in who require treatment and maybe are not getting the treatment they need," White House Deputy Press Secretary Tony Fratto tells NEWSWEEK. "It's real and it exists."

The system's shortcomings are certainly not deliberate; no organization is perfect. Some of the VA's hospitals have been cited as among the best in the country, and even in extreme cases, the picture is seldom black-and-white. Before he killed himself, Schulze was seen by the VA 46 times, VA Secretary James Nicholson told Congress this month. (He did not elaborate on what care Schulze received.)

Yet, as the number of veterans continues to grow, critics worry the VA is in a state of denial. In a broad sense, the situation at the VA seems to mirror the overall lack of planning for the war. "We know the VA doesn't have the capacity to process a large number of disability claims at the same time," says Linda Bilmes, a Harvard public-finance professor and former Clinton administration Commerce Department official. Last month Bilmes released a 34-page study on the long-term cost of caring for veterans from Iraq and Afghanistan. She projects that at least 700,000 veterans from the global war on terror (GWOT) will flood the system in the coming years.

As it is, for some veterans the wait can be agonizing. Patrick Feges was on hold for 17 months until his first disability check from the VA came through. An Eagle Scout from Sugar Land, Texas, Feges enlisted in 2003 and found himself in Ramadi a year later. In October 2004, a mortar exploded on his base about 50 yards from him, spraying him with shrapnel, slicing his intestines and severing a major artery. Feges lost consciousness and was flown to Walter Reed, where he underwent surgery. Long scars trail down his legs and midsection. At the hospital a fellow Texan came to visit: President Bush stood by his bed and chatted with him.

Feges is a polite 22-year-old with a military manner. He addresses strangers by last name and an honorific, even when prodded to drop the formality. "I was brought up right, sir," he explains. But his voice rises slightly when he describes his ordeal with the VA. A case officer in Houston processed Feges's request for disability in September 2005, then lost his application. Feges was summoned to repeated medical evaluations at the Houston center, but a year later he was still waiting for a check. By then, Feges had been accepted to culinary school in Austin and did not want to put off his studies. His mother, an elementary-schoolteacher, took a second job at a local McDonald's to help support him.

For discharged servicemembers, the VA serves two functions: it provides medical care for service-related conditions at its clinics and hospitals across the country, and it reviews claims for disability benefits—chiefly, the monthly payments wounded veterans get for the rest of their lives. The review process can be complicated. It requires veterans to prove, through documents and sometimes through the testimony of fellow soldiers, that their afflictions are a result of their time in the military. Feges listed on his application all the ways he'd been affected by the wounds: he'd lost mobility in his ankles and knees, he suffered regular stomach cramps from the intestinal wound, he lost sensation in his hands and legs, he had trouble standing for long periods. NEWSWEEK presented the VA with the names and details of the veterans whose stories are told here, but a spokesman for the agency declined to comment on individual cases, citing doctor-patient confidentiality. Speaking generally, Dr. Michael Kussman, the VA's acting under secretary for health, tells NEWSWEEK that the department is trying to reach veterans earlier, as they ap-

proach their date of discharge, and that he does not believe Iraq and Afghanistan are straining resources severely. “The impact on the VA so far has been relatively small,” Kussman says. “It has not kicked the system over in our budget and in our ability to absorb it.”

Still, a jump in disability claims in recent years has created a bottleneck. Daniel Cooper, the VA’s under secretary for benefits, confirmed his department was coping with a backlog of 400,000 applications and appeals; 75 percent of them were still within a “reasonable” reviewing timeframe, he says. Yet, most of those claims were filed by veterans of previous wars (a veteran can file or appeal a claim even decades after discharge). As more servicemen and women return from Iraq, the backlog is likely to increase. Cooper says the average waiting time for a benefits claim is about 6 months. NEWSWEEK turned up a number of veterans who’d waited longer. Keri Christensen, a National Guard veteran and a mother of two, says the VA in Chicago took 10 months to process her application. Rory Dunn, who nearly died in an IED attack outside Fallujah, says his application was delayed because, among other things, the VA mixed up his file with that of a Korean war veteran.

Feges’s claim was finally approved last month: after NEWSWEEK and the advocacy group Veterans for America began looking into his case, he got a call from a VA official in Waco, Texas, with the news that his money would come through. Last week he received back pay to the date of his application.

The compensation is not huge. A veteran with a disability rating of 100 percent gets about \$2,400 a month—more if he or she has children. A 50 percent rating brings in around \$700 a month. But for many returning servicemen burdened with wounds, it is, initially at least, their sole income. “When I started school, that’s when it became really hard not to have that money,” says Feges.

One reason to worry about a crush of new vets at the VA has to do with the proportion of wounded to dead Americans in Iraq. Though we tend to mark the grim timeline of the war by counting fatalities, what really distinguishes this conflict is how many soldiers *don’t* die, but suffer appalling injuries. In Vietnam and Korea, about three Americans were wounded for every one who died. The ratio in WWII was nearly 2–1. In Iraq, 16 soldiers are wounded or get sick for every one who dies. The yawning ratio marks progress: better body armor and helmets are shielding more soldiers from fatal wounds. And advanced emergency care is keeping more of the wounded alive. The VA’s Kussman says that soldiers who survive the first few minutes after an explosion have a 98 percent chance of surviving altogether. But that means an increased burden on the VA’s health-care system.

Two such survivors are Albert and Connie Ross. Albert lost a leg when a rocket-propelled grenade landed close to him in August 2004 while he was on patrol in Baghdad. Connie lived through a 2004 suicide bombing in Mosul but suffered multiple fractures and burns. When the two met in a hallway at Brooke Army Medical Center in San Antonio, Texas, Connie thought she noticed a certain swagger in Albert’s walk. “He had this weird dip in his walk, so I asked him, ‘Why are you pimp-walking in a hospital?’ And he said: ‘I’m not pimp-walking, I’m an amputee.’ I was so embarrassed.” The two married earlier this year and are expecting a child.

Though he’s been in the VA system for more than 2 years now, Albert still doesn’t have a primary-care doctor. Without one, getting appointments with specialists can be difficult. “You’re supposed to be assigned one right away,” says Albert, who now lives in San Antonio. “I’m not frustrated so much as worried—worried if and when something does go wrong, something will happen with one of my legs. . . . They [primary-care doctors] are the ones who have to fill out a work-order form; it’s impossible to do anything without them.”

One thing Albert desperately wants to do: get a new prosthetic. He’s one of the early African-American amputees of the war. But the fake limb he’s been given matches the skin tone of a Caucasian. It so embarrasses Albert that he always wears a sock over it—even if he’s in sandals. “He’s very self-conscious about it,” says Connie. “It really bothers him.”

Albert’s situation is probably atypical. The VA says a huge majority of veterans get primary-care doctors within 30 days. But people inside the system do concede there’s a shortage of mental-health workers at many of the VA’s hospitals and clinics across the country. And Schulze is not the only veteran to commit suicide after being turned away. In a similar case in 2004, the VA twice neglected to treat Iraq veteran Jeffrey Lucey for posttraumatic stress disorder (the second time because he was told alcoholics must dry out before being accepted to an inpatient program). By the time a VA counselor tracked down a bed in a New York facility with a built-in detox program, Lucey had already hanged himself. “The system doesn’t treat mental health with the same urgency it treats general healthcare,” says a senior VA manager who did not want to be named talking about shortcomings in the agency.

Even when veterans get to the right doctors, understanding how to leverage what they need from the system can be mind-bending. Tonia Sargent, whose husband, Kenneth, nearly died in a sniper attack in Najaf in 2004, says no one ever sat her down and explained the benefits and how to access them. Her husband's brain injury made him often incapable of understanding his own care. Key decisions fell to her alone. It's a "don't ask, don't tell system," she says.

Kenneth is a Marine master sergeant who'd been in the Corps for nearly 18 years. He was on his second tour in Iraq when a sniper bullet ricocheted off the metal hatch on his vehicle and hit him directly below the right eye, grazing the front of his brain and exiting near his left ear. Among other things, he was diagnosed with traumatic brain injury, which has become the signature wound of the Iraq war. Tonia had to fight the Marine Corps to keep him from being discharged, figuring he'd get better medical care if he remained in active service. But some of his treatment has been outsourced to the VA.

One of the tricks she learned early on was to demand photocopies of her husband's records—every exam, every X-ray, every diagnosis—and personally carry the file from appointment to appointment. "I don't know if there is a more formal protocol for transferring documents, but I know that what I brought . . . was definitely put to use." When Sargent was transferred to the VA's lauded Polytrauma Center in Palo Alto, Calif., doctors there encouraged her to go home to Camp Pendleton near San Diego and treat his stay at the hospital as if it was a deployment. "After 2 weeks, they asked me how long I was planning to stay with my husband," she says. "They said it was his rehab, not mine. But I needed to learn how to care for him, and he suffered from extreme anxiety without me." She pushed back, staying in Palo Alto until he completed his care.

How can the system improve? Bilmes, who authored the Harvard study, proposes at least one drastic change—automatically accepting all disability claims and auditing them after payments have begun. (The VA says that would be an irresponsible use of taxpayer money.) Other critics have focused on raising the VA's budget, which has been proposed at \$87 billion for 2008. More money could go toward hiring more claims officers and more doctors, easing the burden now and preparing the VA for the end of the Iraq war, when soldiers return home en masse.

But veterans' support groups and even some former and current VA insiders believe there's a reluctance in the Bush administration to deal openly with the long-term costs of the war. (All told, Bilmes projects it could cost as much as \$600 billion to care for GWOT veterans over the course of their lifetimes.) That reluctance, they say, trickles down to the VA, where top managers are politically appointed. Secretary Jim Nicholson, a decorated Vietnam War veteran who was chosen by Bush in 2005, tends to be the focus of this criticism.

The senior VA manager who did not want to be named criticizing superiors told NEWSWEEK: "He's a political appointee and he needs to respond to the White House's direction." Steve Robinson of Veterans for America levels the accusation more directly. "Why doesn't the VA have a projection of casualties for the wars? Because it would be a political bombshell for Nicholson to estimate so many casualties." The VA denies political considerations are involved in its budgeting or planning. Nicholson declined to be interviewed but Matt Burns, a spokesman for the VA, called Robinson's comments "nonsensical and inflammatory," adding: "The VA, in its budgeting process, carefully prepares for future costs so that we can continue to deliver the quality healthcare and myriad benefits veterans have earned."

Fratto, the White House deputy press secretary, says money is not the problem. He points out the VA has had a hard time filling positions in some remote parts of the country. "You need to find people who are trained in PTSD and other disorders that are affecting veterans and find those who are willing to go to places where they are needed."

As is often the case in America when government institutions falter, however, community groups are already stepping into the void. Veterans of Foreign Wars has advocates helping vets negotiate the VA bureaucracy, much the way health facilitators in the private sector help consumers get the most from their health insurance. Robinson, of Veterans for America, has pulled together teams of volunteers—physicians, psychologists, lawyers—who give vets free services when the local VA branch falls down. At his office recently, he was coordinating a traumatic-brain-injury screening with a private doctor for a veteran who'd been denied access to VA care. The fact that Americans are coming forward doesn't absolve the VA of its obligation to provide first-rate care for veterans. Most of the wounded's problems just can't be solved by private citizens and groups, no matter how well meaning. But it does serve to remind us that we should take better care of veterans wounded in the line of duty as they make their way home, and try to remake their lives.

With Jamie Reno, Eve Conant, John Barry, Richard Wolffe, Karen Springen, Jonathan Mummolo and Ty Brickhouse

Still Hurting Photographs
Pictures by Ethan Hill

How well does the United States care for its wounded and impaired when they come home? For a country engaged in what President Bush calls a 'long war,' the question has profound moral implications. About 50,000 servicemembers so far have been banged up or burned, suffered disease, lost limbs or sacrificed their mental well-being while implementing American policies in dangerous places. The stories of these soldiers raise concerns that the country is failing to meet its most basic obligations to those who fight its wars.

'THE SECRET' EXPOSED: WHAT YOU WON'T SEE ON 'OPRAH'

Newsweek

March 8, 2007

Shattered in body and mind, too many veterans are facing poor care and red tape. Why we're

Failing Our Wounded

A SPECIAL INVESTIGATION



PHOTOGRAPH BY LINDA BELL

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Specialist Marissa Strook, 21

Albert Ross: He was on foot patrol in Baghdad when a rocket-propelled grenade exploded near him. That was over 2 years ago, and Ross still doesn't have a primary care doctor.



Connie Ross: During her rehab, she was sitting in her wheelchair in the hallway of the hospital, when she met the man she'd eventually marry. Now she and Albert Ross, pictured in the previous slide, are expecting their first child.



Eric Edmundson: A bomb blast ruptured this 26-year-old father's spleen. Military doctors inserted a catheter that accidentally tickled his heart, enough trauma to stop it—and deprive his brain of oxygen—for 30 minutes. The resulting damage—near-total lack of muscle control—was bad enough to require therapy outside the VA system.



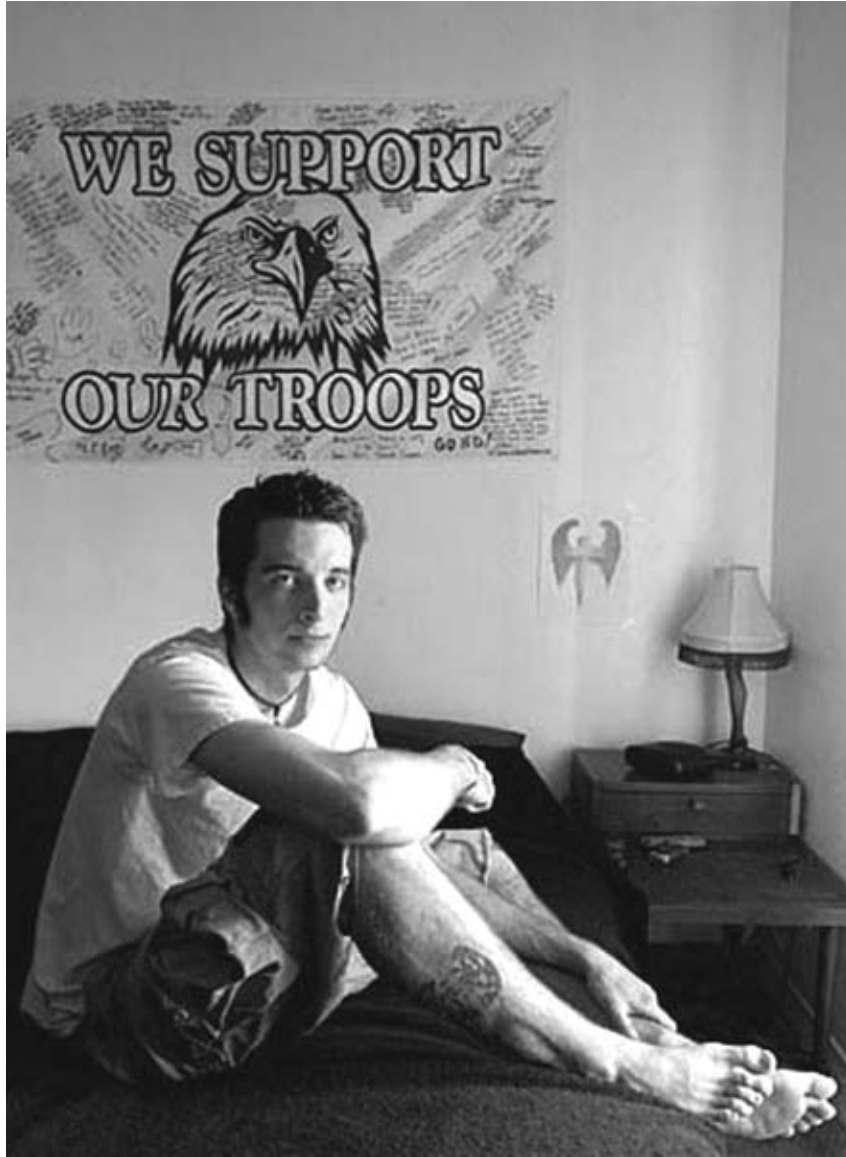
Keri Christensen: Since coming home from Iraq, the mother of two has struggled with emotional issues. She's haunted by nightmares, has imaginary conversations with her husband and rarely leaves the house.



Rory Dunn: Shrapnel ripped through Dunn's unarmored Humvee, causing traumatic brain injury, the signature wound of the Iraq war. He was so severely hurt that the triage doctor initially set the 24-year-old aside to die.



Patrick Feges: Shrapnel tore into his intestines and cut a major artery. While the 22-year-old waited 17 months for his disability check to come, his mother took a second job at McDonald's to help support him.



Marissa Strock: The 21-year-old lost both of her legs after her Humvee rolled over an IED in Iraq. The others on board, whose names she tattooed on her back, died. The trauma didn't end once she got to the hospital.



John Newport: The discs in his back became compressed when he manned a truck-mounted machine gun—now he walks with a cane and wears a nerve stimulator to moderate pain. These injuries have still not been verified by the VA, more than 2 years later. He also suffers from PTSD, and has had flashbacks of an Iraqi girl he saw run over by an American vehicle—she reminded him of his daughter.



Pomona Veteran Shares Story of Fighting for Health Benefits

By Hema Easley

The Journal News, (Original Publication: March 13, 2007)

GOSHEN, N.Y.—Vietnam War veteran Ted Wolf tells a saga of government apathy in providing him treatment for cancer, which he likely developed because of exposure to chemicals during the war.

His saga ended because of Rep. John Hall, D–Dover Plains, who intervened with the Department of Veterans Affairs to get Wolf his due benefits.

In the wake of revelations of substandard treatment for veterans at the Walter Reed Army Medical Center, Wolf's case is not alone. In fact, the backlog of veterans' benefit claims has grown to more than 630,000, said Hall, who is the chair of the Subcommittee on Disability Assistance and Memorial Affairs.

"You get the feeling that the VA doesn't care," said Wolf, 62, a Pomona resident, speaking at a news conference yesterday in Hall's office.

His comments came a day before Hall holds a House Veterans Affairs subcommittee hearing on the healthcare needs of veterans of the Iraq and Afghanistan wars, and their impact on the ability of the VA to process disability claims.

The hearing will also examine reports of claims rating discrepancies between active duty and Reserve veterans.

Wolf and Hall blamed the VA bureaucracy, inadequate staffing and lack of information sharing between the Department of Defense and the VA for the backlog.

In addition, Hall said, the ratio of wounded-to-killed in the Iraq war is 15–1, several times the ratio in previous wars. More military men and women are surviving injuries because of better medical care on the battlefield, thereby putting pressure on the system.

"It's only fair that we pick up the bill," said Hall, who estimated that the cost of taking care of veterans would rise to \$1 trillion.

"When our soldiers and military personnel return home and need help, they should get the assistance they have earned, without delay," Hall said.

Wolf shared his story yesterday at Hall's office to illustrate how many veterans have to struggle to get benefits, and how he was helped by the congressman's office.

After being diagnosed with prostate cancer in September 2002, Wolf initially didn't think to apply to the VA for help. He didn't think he was eligible, and on his doctor's advice he went to Memorial Sloan Kettering Cancer Center in New York City.

But browsing on the Internet one day, he read about the suspected link between prostate cancer and Agent Orange, a chemical that he and many other servicemembers had been exposed to during the Vietnam War. His wife, Harriet, had suffered seven miscarriages before their only daughter was born, and Wolf thought that that might also have been linked to the chemical.

But when Wolf approached the VA, he was put on a 6-month waiting list for a physical based upon which VA would decide if he was eligible.

"There is a bureaucracy doing needless physicals," said Wolf, a former realtor. "The cancer is in my bones. It will not come up in a physical."

After an initial physical, Wolf was recalled for another physical in six months. While Wolf waited, the VA reduced his pension from \$2,300 a month to \$600, saying that his cancer was in remission.

There are an estimated 18,000 veterans in Rockland County. About 6,000 are enrolled in the VA's health clinic.

"The backlog of cases is phenomenal," said Jerry Donnellan, director of the county's Veterans Service Agency. "We've had people literally die waiting to have their cases adjudicated."

Help finally came to Wolf when he approached Hall's office, and it intervened to expedite his case.

Earlier this year, Wolf's pension was raised to \$2,900. He was also reimbursed for all medical expenses since June, which totaled \$19,000.

"I was extremely pleased with the care and rapid response," said Wolf.

But, he said, "We shouldn't need to contact a congressman. The process should be easier."



Vietnam Vet Fights for Fellow Soldiers

By Greg Bruno

Times Herald-Record, March 13, 2007

GOSHEN—Three and a half decades after dodging bullets in the jungles of Vietnam, Ted Wolf is still fighting for fellow soldiers.

But now his enemies are cancer, politics and a foundering veterans' health-care system.

"My concern is for the young guys coming back from war today," said Wolf, 62, as he detailed his 5-year odyssey through the Department of Veterans Affairs. "They shouldn't have to wait (for care)," he said, choking back tears. "There's enough stress. They shouldn't have to wait."

As the wars in Iraq and Afghanistan chew up American soldiers, creating the largest pool of wounded veterans since the Vietnam era, the backlog of disability claims is skyrocketing, lawmakers and veterans' advocates say.

There are more than 630,000 claims waiting to be processed by the VA, according to congressional estimates. That number will only increase as servicemembers return from America's latest war.

"I'm here, my staff, we're here to fight for veterans to get their due. But it absolutely shouldn't be necessary," said Rep. John Hall, D-Dover Plains, who joined Wolf during a news conference yesterday in Goshen.

"It's easy to say you support the troops, but the way you do it is by putting up the money and getting it done," the congressman said.

Problems with veterans' medical care reached a boil last month when The Washington Post detailed the unsanitary and decrepit living conditions at Walter Reed Army Medical Center.

But woes within the Department of Defense and VA health-care systems run deeper than one Army hospital in Washington.

In testimony last week, Cynthia A. Bascetta, director of healthcare for the Government Accountability Office, told a House Subcommittee that veterans returning from Iraq and Afghanistan often fall through the medical cracks.

Many veterans are not screened for mental health problems, leading to undiagnosed conditions, the GAO said. Other oversights include poor military recordkeeping and payment issues that force financial burdens on veterans.

Fixing the system won't come cheap. As of March 1, more than 24,000 servicemembers had been injured during fighting in Iraq and Afghanistan, according to the Defense Department. Hall said long-term care estimates for the nation's veterans top \$1 trillion.

"Disability benefits is a hot topic, and the quality of care our active soldiers and veterans are getting has been revealed "to have some serious difficulties," Hall said.

Wolf knows firsthand how broken the system is: His run-in with a bumbling VA began in 2002, when he was diagnosed with prostate cancer. Wolf was eligible for coverage within the VA system because prostate cancer is one of four cancers linked to exposure to Agent Orange, a defoliant used by the U.S. military during the Vietnam War.

But when the VA wrongly declared Wolf to be in remission, his disability benefits were slashed by 60 percent, to about \$600 a month, he said. Even though his cancer never stopped eating at his bones and skull, it took congressional intervention from Hall to get benefits restored.

"We should not need to have a congressperson to make the process easier," he said. Returning soldiers "should be processed immediately."

What's Next?

Rep. John Hall and Members of a Veterans' Affairs subcommittee will hear testimony in Washington today on how to reduce the backlog of veterans' claims. The hearing will also examine reports of care discrepancies between active and reserve duty veterans.

Vietnam veteran Ted H. Wolf, left, speaks yesterday at a news conference about problems with veterans' healthcare and benefits alongside Rep. John Hall at the Orange County Government Center in Goshen.



Times Herald-Record/TOM BUSHEY

Veterans Face Vast Inequities Over Disability

By Ian Urbina and Ron Nixon

New York Times, March 9, 2007

WASHINGTON, March 8—Staff Sgt. Gregory L. Wilson, from the Texas National Guard, waited nearly 2 years for his veterans' disability check after he was injured in Iraq. If he had been an active-duty soldier, he would have gotten more help in cutting through the red tape.

Allen Curry of Chicago has fallen behind on his mortgage while waiting nearly two years for his disability check. If he had filed his claim in a state deploying fewer troops than Illinois, Mr. Curry, who was injured by a bomb blast when he was a staff sergeant in the Army Reserve in Iraq, would most likely have been paid sooner and gotten more in benefits.

Veterans face serious inequities in compensation for disabilities depending on where they live and whether they were on active duty or were members of the National Guard or the Reserve, an analysis by The New York Times has found.

Those factors determine whether some soldiers wait nearly twice as long to get benefits from the Department of Veterans Affairs as others, and collect less money, according to agency figures.

"The V.A. is supposed to provide uniform and fair treatment to all," said Steve Robinson, the director of veteran affairs for Veterans for America. "Instead, the places and services giving the most are getting the least."

The agency said it was trying to ease the backlog and address disparities by hiring more claims workers, authorizing more overtime and adding claims development centers.

The problems partly stem from the agency's inability to prepare for predictable surges in demand from certain states or certain categories of servicemembers, say advocates and former department officials. Numerous government reports have highlighted the agency's backlog of disability claims and called for improvements in shifting resources.

“It’s Actuary Science 101,” said Paul Sullivan, who until last March monitored data on returning veterans for the V.A. “When 5,000 new troops get deployed from California, you can logically expect a percent of them will show up at the V.A. in California in a year with predictable types of problems.”

“It makes no sense to wait until the troop is already back home to start preparing for them,” Mr. Sullivan said. “But that’s what the V.A. does.”

Veterans’ advocates say the types of bureaucratic obstacles recently disclosed at Walter Reed Army Medical Center are eclipsed by those at the Veterans Affairs division that is supposed to pay soldiers for service-related ills. The influx of veterans from the Iraq war has nearly overwhelmed an agency already struggling to meet the healthcare, disability payment and pension needs of more than three million veterans.

Stephen Meskin, who retired last year as the V.A.’s chief actuary, said he had repeatedly urged agency managers to track data so they could better meet the needs of former soldiers. “Where are the new vets showing up?” Mr. Meskin said he kept asking. “They just shrugged.”

Agency officials say they have begun an aggressive oversight effort to determine if all disability claims are being properly processed and contracted for a study that will examine state-by-state differences in average disability compensation payments.

“V.A.’s focus is to assure consistent application of the regulations governing V.A. disability determinations in all states,” the department said in a written statement.

Many new veterans say they are often left waiting for months or years, wondering if they will be taken care of.

Unable to work because of post-traumatic stress disorder and back injuries from a bomb blast in Iraq in 2004, Specialist James Webb of the Army ran out of savings while waiting 11 months for his claim. In the fall of 2005, Mr. Webb said, he began living on the streets in Decatur, Ga., a state that has the 10th-largest backlog of claims in the country.

“I should have just gone home to be with family instead of trying to do it on my own,” said Mr. Webb, who received a Bronze Star for his service in Iraq. “But with the post-traumatic stress disorder, I just didn’t want any relationships.”

After waiting 11 months, he began receiving his \$869 monthly disability check and he moved into a house in Newnan, Ga. About 3 weeks ago, Mr. Webb moved back home to live with his parents in Kingsport, Tenn.

The backlogs are worst in some states sending the most troops, and discrepancies exist in pay levels.

Illinois, which has deployed the sixth-highest number of soldiers of any state, has the second-largest backlog. The average disability payment for Illinois veterans—\$7,803 a year—is among the lowest in the nation, according to 2005 V.A. data.

In Pennsylvania, which has sent the fourth-highest number of troops, the claims office in Pittsburgh is tied for second for longest backlogs, where 4 out of 10 claims have been pending for more than 6 months. Veterans from this state on average receive relatively low payments, \$8,268 per year, according to 2005 V.A. data. Comparable 2006 data were not available.

The agency’s inspector general in 2005 examined geographic variations in how much veterans are paid for disabilities, finding that demographic factors, like the average age of each state’s veteran population, played roles. But the report also pointed to the subjective way that claims processors in each state determined level of disability.

Staffing levels at the veterans agency vary widely and have not kept pace with the increased demand. The current inventory of disability claims rose to 378,296 by the end of the 2006 fiscal year. The claims from returning war veterans plus those from previous periods increased by 39 percent from 2000 to 2006. During the same period, the staff for handling claims has remained relatively flat, a problem the department highlighted in its 2008 proposed budget. The department expects to receive about 800,000 new claims in 2007 and 2008 each.

“It’s clear to everyone here that the system overall is struggling and some veterans are waiting far too long for decisions,” Senator Larry E. Craig, Republican of Idaho, said Wednesday at a hearing before the Senate Veterans’ Affairs Committee.

The growing strains on the veterans agency have affected some soldiers more than others.

While the Reserve and National Guard have sent a disproportionate number of soldiers to the war, the average annual disability payment for those troops is \$3,603, based on 2006 V.A. data for unmarried veterans with no dependents. Active-duty soldiers on average receive \$4,962.

Though the V.A. acknowledged that there were discrepancies, officials also said they believed that a significant factor might be length of service. Active-duty soldiers generally serve longer, and therefore more suffer from chronic diseases or dis-

abilities that develop over time. Many who served in the Guard think they are losing the battle against the bureaucracy.

"We take a harder toll," said Mr. Wilson, the Texan, referring to the fate of reservists and Guard troops compared with active duty soldiers.

He said that last month he received his disability check for his back injuries but only after a 21-month wait and the intervention of a congressman and a colonel.

When active-duty soldiers near discharge, they have access to far more programs offering assistance with benefits than do reserve and National Guard soldiers, according to veterans' advocates.

"The active-duty guys, they get those resources," Mr. Wilson said. "We don't."

He said that while active-duty soldiers often received medical disability evaluations in about 30 days, many reservists he knew waited 2 years or more to get an initial appointment. Active-duty personnel also routinely received legal advice about appeals and other issues from military lawyers, while reservists had to request those hearings, he said.

For years, the V.A.'s inspector general, the Government Accountability Office, Members of Congress and veterans' advocates have pointed out the need to improve how the V.A. tracks data on soldiers as they are deployed and when they are injured. That would help prepare for their future needs and ease delays in processing health and benefit claims.

In 2004, a system was designed to track soldiers better, prepare for surges in demand and avoid backlogs. But the system was shelved by program officials under Secretary Jim Nicholson for financial and logistical reasons, V.A. officials said Thursday at a hearing before the House Veterans' Affairs Committee.

The V.A., which has said it has an alternate tracking system nearly operational, depends on paper files and lacks the ability to download Department of Defense records into its computers.

President Bush has appointed a commission to investigate problems at military and veterans hospitals.

For Mr. Curry, the reservist from Chicago who has fallen behind on his mortgage payments, his previous life as a \$60,000-a-year postal worker is a fading memory. "It's just disheartening," he said. "You feel like giving up sometimes."

Richard G. Jones contributed reporting from Trenton, Bob Driehaus from Cincinnati, and Sean D. Hamill from Pittsburgh.



James Webb waited 11 months for benefits and began living on the streets. Now he lives at his parents' house with his son, Christian.

**THE ECONOMIC COSTS OF THE IRAQ WAR: An Appraisal
Three Years after the Beginning of the Conflict¹**

Linda Bilmes, Kennedy School of Government, Harvard University,
and Joseph E. Stiglitz, University Professor, Columbia University,
January 2006

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Three years ago, as America was preparing to go to war in Iraq, there were few discussions of the likely costs. When Larry Lindsey, President Bush's economic adviser, suggested that they might reach \$200 billion, there was a quick response from the White House: That number was a gross overestimation.² Deputy Defense Secretary Paul Wolfowitz claimed that Iraq could "really finance its own reconstruction," apparently both underestimating what was required and the debt burden facing the country. Lindsey went on to say that "The successful prosecution of the war would be good for the economy."³

Many aspects of the Iraq venture have turned out differently from what was purported before the war: There were no weapons of mass destruction, no clear link between Al Qaeda and Iraq, no imminent danger that would warrant a pre-emptive war. Whether Americans were greeted as liberators or not, there is evidence that that they are now viewed as occupiers. Stability has not been established. Clearly, the benefits of the War have been markedly different from those claimed.

So too for the costs. It now appears that Lindsey was indeed wrong—by grossly underestimating the costs. Congress has already appropriated approximately \$357 billion for military operations, reconstruction, embassy costs, enhanced security at U.S. bases and foreign aid programs in Iraq and Afghanistan. This total, which covers costs through the end of November 2005, includes \$251 bn for military operations in Iraq, \$82 bn for Afghanistan and \$24 bn for related foreign operations, such as reconstruction, embassy safety and base security.⁴ These costs have been rising throughout the war. Since FY 2003, the monthly average cost of operations has risen from \$4.4 bn to \$7.1 bn—the costs of operations in Iraq have grown by nearly 20% since last year (whereas Afghanistan was 8% lower than last year).⁵ The Congressional Budget Office has now estimated that in their central, mid-range scenario, the Iraq war will cost over \$266 billion more in the next decade, putting the direct costs of the war in the range of \$500 billion⁶

These estimates, however, underestimate the War's true costs to America by a wide margin. In this paper, we attempt to provide a range of estimates for what those costs have been, and are likely to be. Even taking a conservative approach, we have been surprised at how large they are. We can state, with some degree of confidence, that they exceed a trillion dollars.

Providing even rough order of magnitude estimates of the costs turns out to be very difficult, for a number of reasons. There are standard problems in cost allocation; there are future costs associated with the Iraq war that are not included in the current calculations; there are marked differences between social costs and prices paid by the government (and it is only the latter which traditionally get re-

¹ Paper prepared for presentation at the ASSA meetings, Boston, January 2006. The views expressed here are solely those of the authors, and do not represent those of any institution with which they are currently affiliated, or with which they have been affiliated in the past.

² OMB Director Mitch Daniels is reported to have said that Lindsey's estimates were "very, very high." Both he and Secretary of Defense Rumsfeld estimated the costs in the range of \$50–60 bn, some of which they believed would be financed by other countries.

³ *Wall Street Journal*, September 15, 2002.

⁴ Congressional Research Service Report for Congress, "The Cost of Iraq, Afghanistan and Enhanced Base Security Since 9/11", Amy Belasco, Defense Specialist, October 7, 2005. This covers funding in P.L. 107–117, 107–206, 1207–115, 108–7, 108–11, 108–106, 108–199, 108–287, 109–13, 108–447, and the recent FY 2006 Continuing Resolution (109–77) which provides \$45 bn for the 6-week period starting 9/30/05. DOD will need additional funds to cover the rest of the year.

⁵ *Ibid.*

⁶ The CBO estimated costs for the period of 2005–2014 under three scenarios. The estimates were \$179 bn, \$266 bn, and \$392 bn, respectively. We have conservatively used their middle scenario. CBO 2005.

flected in the cost estimates); and there are macro-economic costs, associated both with the increase in the price of oil and the Iraq war expenditures.

Consider, as an example, accounting for the value of the more than two thousand American soldiers who have died since the beginning of the war, and the more than sixteen thousand who have been wounded. The military may quantify the value of a life lost as the amount it pays in death benefits and life insurance to survivors—which has recently been increased from \$12,240 to \$100,000 (death benefit) and from \$250,000 to \$500,000 (life insurance). But in other areas, such as safety and environmental regulation, the government values a life of a prime age male at around \$6 million, so that the cost of the American soldiers who have already lost their lives adds up to around \$12 billion⁷

The standard estimates of the death costs also omit the cost of the nearly one hundred American civilian contractors⁸ and the four American journalists that have been killed in Iraq, as well as the cost of coalition soldiers, and non-American contractors working for U.S. firms.

The military values the cost of those injured by what their medical treatment costs and disability pay; and current accounting only reflects current payments in disability, not the present discounted value of (expected) future payments; a full cost analysis includes both the present discounted value of all future payments, as well as the difference between the disability pay and what the individual might have earned—and even this ignores the enormous compensation that would have been paid for pain and suffering had this been a private injury.

Costs of recruiting have increased enormously—and even after the war ends, there is reason to believe that compensation will have to be increased, including for Reserves and National Guard. Many Reservists, particularly those who are older, supporting families and established in their careers, underestimated the risks of being called to fight a war abroad and the ability of the government to force them to extend their tours of duty and even to serve second and third tours. The majority of these Reservists have suffered a significant loss in wages due to serving in Iraq. By the same token, wages currently paid the military almost surely represent an underestimation of a fair market wage, given what individuals would have needed to make them willingly undertake the job in Iraq. In fact, we know from the wages being paid by contractors performing similar work what the free market wage for such services are, and they are a multiple of what the American military get paid.⁹

Even determining the current “direct” expenditures turns out to be a difficult task.¹⁰ The Administration has provided a number, based on the current costs of operations in Iraq. We are interested here in finding the *total economic cost*, the value of the resources used, and it is not always clear that standard accounting and budgetary figures reflect that. For instance, the faster depreciation or destruction of equipment already owned by the government is clearly part of the cost of the war. Standard cost allocation procedures would attribute a substantial fraction of the overhead in the Pentagon to the War; by devoting its attention to Iraq, it has less time to work on other issues, to prepare for other problems.

A true costing of the war would focus, of course, on the incremental cost; to the extent that the actual War substitutes for expensive “war games,” the incremental cost is less than the actual money spent. In our analysis we have subtracted the direct savings, such as policing the “no-fly” zone in Iraq, from the cost of the war.

This paper attempts to provide a more complete reckoning of the costs of the Iraq War than have previously been provided, using standard economic and accounting/budgetary frameworks. Of course, a final tally will have to wait until the end, and even the President has made it clear that there is no clear end in sight. And even then, it will be years before we can be sure about whether our estimates of future

⁷ Government agencies have estimated the value of a life at \$6.1m (Environmental Protection Agency), and \$5.5m (Department of Transportation). The value of a life for victims of 9/11 were estimated in a range from \$2–\$11million.

⁸ Although the actuarial value of those lives should, presumably, have been included in the contractors’ bid price when undertaking the contract.

⁹ For example, experienced security guards working for Blackwater Security, who guarded senior officials in the Coalition Provisional Authority, were earning up to \$1,000 per day. The majority of such guards were former members of the military.

¹⁰ A recent report by the Government Accountability Office (GAO–05–767) states that the Defense Department has “lost visibility” on over \$7 bn of funding and reports several cases where obligations exceeded appropriations in 2004, including \$4.3 bn in Army operation and maintenance. A recent report by the Congressional Research Service cites the difficulty of tracking Pentagon expenditures in Iraq, because (unlike the State Department and other agencies), DOD does not allocate funds by operation or mission until after the fact. “Defense Department witnesses periodically give average monthly costs or ‘burn rates’ for Iraq and Afghanistan but DOD has not provided Congress with a complete or consistent record showing those rates over time or total amounts for each operation each year.” CRS, 10/7/05.

costs—increased costs of recruiting or payments for disability or the healthcare costs of the injured veterans—were accurate.

Of necessity, the numbers, especially of future expenditures, are estimates, and we have tried to avoid a false sense of accuracy by rounding our numbers from the more precise estimates provided by econometric and statistical studies, when those are employed. We provide several sets of numbers. A “conservative” estimate that we think is *excessively* conservative. We realize that the numbers provided here may be controversial. They provide a picture of costs that is much larger than that which has been provided by the administration, especially before the War. We also provide a second estimate, which, while still conservative, is more reasonable. We refer to this as our “moderate” estimate.

Our estimates, for instance, assume that we have 136,000 troops stationed in Iraq in 2006. The Administration has recently announced a troop reduction, from 160,000 due to the pre-election buildup, to 140,000, a number which is still larger than the numbers employed in our analysis.

We have not been able to quantify many of what may turn out to be the most important costs of the Iraq venture. There is a value in military preparedness, and it is the reason for investing so heavily in defense. By most accounts, America’s ability to engage in a second front at the current time is greatly diminished. At the beginning of the War, there was a great deal of talk about winning the hearts and minds of those in the Middle East. Recent opinion polls reflecting public opinion in the Arab world show that exactly the opposite has happened. Some American businesses have even claimed that anti-Americanism spawned by the Iraq War has had an effect on their sales and profits. America’s credibility has been diminished: If some time in the future another American President were to claim that he had solid evidence based on intelligence that there was a threat, that evidence is more likely to be treated with skepticism. America has always prided itself in fighting for human rights; but America’s credentials have been tarnished by Abu Ghraib and Guantanamo. These are among the many costs of the Iraq War that we do not attempt to quantify, but which should clearly be counted in any assessment of the Iraq War.

Nor have we included in this paper any of the costs borne directly by other countries, either directly (as a result of military expenditures) or indirectly (as a result of the increase in the price of oil.) Most importantly, we have not included the costs of the war to Iraq, either in terms of destruction of property (infrastructure, housing) or the loss of lives.¹¹ Clearly, including these would increase the cost of the war substantially—perhaps by an order of magnitude.

The paper is divided into two parts. In the first, we provide an estimate of the “direct” expenditures, and provide adjustments to reflect the true social costs of the resources deployed. The second provides an estimate of the macro-economic costs; the effects of the War on the overall performance of the economy, taking into account both the effects of the expenditures themselves and of the increased price of oil, some of which at least should be attributed to the War.

I. Budgetary Costs to the U.S. Government

The budgetary costs of the war reflect the huge scale of operations that are being undertaken. For the first half of 2005, there were over 200,000 U.S. military personnel stationed in Iraq and Kuwait (which serves as a staging ground for Iraq). To date, over 550,000 troops have served in Iraq in a combined total of approximately one million tours of duty.¹²

The costs of the war in Iraq that have been reported in the media have almost exclusively focused on one type of cost—the \$251 bn in cash that the government has spent on combat operations since the invasion of Iraq in March 2003. This is an important element of the financial cost but it is only the tip of a very deep iceberg.

Currently the U.S. is spending about \$6 bn per month on operations in Iraq. However, there are additional costs to the government—over and above this number. These include disability payments to veterans over the course of their lifetimes, the cost of replacing military equipment and munitions which are being consumed at a faster-than-normal rate, the cost of medical treatment for returning Iraqi war veterans, particularly the more than 7,000 servicemen with brain, spinal, amputation

¹¹ We have not included the cost of the deaths of coalition soldiers and contractors, nor of the Iraqis themselves. Even the most conservative estimates put the loss of life at a multiple of that of the United States, with some estimates putting the numbers in excess of 30,000, or even 100,000. Of those, over 3,000 Iraqi deaths have been among Iraqi military and police who are supporting coalition forces.

¹² Many troops have served two or three tours of duty.

and other serious injuries, and the cost of transporting returning troops back to their home bases. The Defense Department, for which expenditures not directly appropriated for Iraq have grown by more than 5% (CAGR) since the war began, has also spent a portion of this increase on support for the war in Iraq, including significantly higher recruitment costs, such as nearly doubling the number of recruiters, paying recruitment bonuses of up to \$40,000 for new enlistees and paying special bonuses and other benefits, up to \$150,000 for current troops that re-enlist. Another cost to the government is the interest on the money that it has borrowed to finance the war.

Although it is difficult to estimate these costs precisely, we can use current and expected troop deployment to make a reasonable projection of the likely costs. Looking purely at direct budgetary costs to the taxpayer, we estimate that the total cost of the Iraq war is in the range of \$750 billion to \$1.2 trillion, assuming that the U.S. begins to withdraw troops in 2006 and maintains a diminishing presence in Iraq for the next 5 years. We have looked at the budgetary cost both including and excluding the cost of interest on the debt. We have also adjusted this cost for economic factors, as outlined in section two. Under any reasonable set of assumptions, the cost of the war *even without* considering the macroeconomic costs—is more than double the current number provided by the administration.

We have estimated the budgetary costs using two scenarios. Both scenarios are based on the troop deployment projected by the Congressional Budget Office.¹³ Our “Conservative” scenario assumes that all troops will be withdrawn from Iraq by 2010, and that all interest on the debt borrowed to finance the war will be repaid within 5 years. Under this scenario we count the long-term costs of disability pay and healthcare for veterans over a twenty-year period, even though most of the troops in Iraq are between ages 21–28 and are likely to live far longer. We have taken the present value of all cash flows at a 4% discount rate. Even under this conservative scenario, the direct costs to the government are likely to exceed \$700 bn. (See figure 1).

Under a second, “Moderate” scenario, we have used CBO’s assumption that a small but continuous U.S. presence in Iraq continues through 2015. This has implications for the projected number of casualties and the length of involvement by the Defense Department. This scenario also assumes that the U.S. budget will remain in deficit for the next 20 years. This would raise the cost of the war to over \$1.2 trillion. Both scenarios exclude the cost of operations in Afghanistan—estimated to be approximately \$82 bn to date and consuming \$1 bn per month.

Figure 1: Budgetary Cost of the Iraq War (\$BN)

	Conservative	Moderate
1 Spent to date	251	251
2 Future spending on operations	200	271
3 VA costs	40	57
4 Cost for Brain injuries	14	35
5 Veterans disability payments	37	122
6 Demobilization costs	6	8
7 Increased defense spending	104	139
8 Interest on debt	98	386
Total	750	1,269

Assumptions for Figure 1 “Total Cost of War in Iraq to the U.S. Government”.

1. Spending to Date on Combat and Support Operations

The total spending to date, as of December 30, 2005 is \$251 billion. This includes funds appropriated specifically for Iraq in Emergency supplemental appropriations in April 2002, November 2003, August 2004, April 2005, and the Continuing Resolution of September 2005, which covers the first 6 weeks of FY 2006. This money includes funding for combat operations, basic troop deployments and logistics, deployment of National Guard and Reserves,¹⁴ food and supplies, training of Iraqi forces,

¹³U.S. Congressional Budget Office, *Estimate of War Spending FY 2005–FY2015*, Feb 1, 2005.

¹⁴Approximately 40% of the U.S. troops serving in Iraq have been drawn from the National Guard and the Reserves, particularly the Army Reserves. Currently some 56,000 National Guardsmen and Reservists serve in Iraq. Additionally, over 60,000 people have been recruited to “backfill” domestic positions in the Guard and Reserves that are vacant because the others

weapons, munitions, supplementary combat pay, reconstruction,¹⁵ and payments to countries such as Jordan, Pakistan and Turkey. This also includes the payment of \$500,000 in “death gratuity payment” and life insurance to the survivors of the 2,156 fatalities in Iraq during this period. We have not included the costs to the Defense Department for planning the invasion in the months prior to the invasion, which the Congressional Research Service has estimated at \$2.5 bn.¹⁶

2. Future Spending on Combat and Support Operations

We have estimated the cost of future operations to be proportional to the number of troops scheduled to be deployed in Iraq from 2006–2010. We have estimated the current number of troops *stationed* in Iraq as 160,000, using the number cited by the Pentagon. Future troop deployment figures are based on recent forecasts by the Congressional Budget Office, which predicts that troop levels in 2006 will be reduced to 136,000. The CBO has forecast troop levels through 2015, but in the conservative scenario we are assuming that all troops are out of Iraq by 2010. However, this approach almost certainly underestimates the actual cost of military operations, because the Pentagon will hire contractors to replace some portion of the activities performed by troops who are withdrawn.¹⁷ In our moderate scenario, we have assumed that the U.S. maintains a small troop presence until 2015, that we increase the number of contractors as troops decline, and that casualties continue, proportional to troop deployment. . . .

3. Additional Veterans Administration Medical Care Costs for Returning Veterans

As of December 2005, over 16,000 military personnel have been wounded in Iraq since March 2003, of whom 96% were injured after the official combat operations ceased (since May 1st, 2003). Due to improvements in body armor that protect the core body, there has been an unusually high number of soldiers who have survived with major injuries, such as brain damage, spinal injuries, and amputations. According to the Pentagon and other sources,¹⁸ about 20% of those injured have suffered major head or spinal injury and an additional 6% are amputees. Another 21% suffered serious wounds that prevented them from returning to the military, including blindness, deafness, partial vision and hearing impairments, nerve damage and burns. In addition, more than half of the 550,000 U.S. troops who have served in Iraq have served two or three tours of continuous duty under stressful, grueling conditions. Some 20,000 soldiers have been prevented from leaving the service by the government’s “stop-loss” policy, which requires troops to extend their tours in case of emergency. It is perhaps not surprising that the surgeon general of the Army reported, in July 2005, that 30% of U.S. troops have developed mental health problems within 3–4 months of returning from Iraq. To date, more than one-third of returning veterans have used the VA system for health ailments.

The number we include here represents a conservative estimate of the additional costs to the Veterans Administration due to providing medical care and other benefits (such as rehabilitation, retraining, purchase, fitting and replacement of prosthetic devices, and counseling—but not including disability, housing, educational or loan payments) to returning Iraqi War veterans (other than those with brain injuries). The costs of treatment could be substantial. The VA had originally projected that 23,553 veterans returning from Iraq would seek medical care last year, but in June 2005, the VA revised this number to 103,000. The VA also is now responsible for providing care to an estimated 90,000 National Guards, who previously were not eligible for VA services. To meet these unforeseen demands, the VA appealed to

are in Iraq. The direct additional cost of mobilizing these individuals is \$3 billion per year. We have assumed that participation of the Guards and Reserves remains constant at 40%.

¹⁵Congress appropriated \$18.4 bn—an unprecedented sum—for Iraqi reconstruction in September 2003. This funding was specified for purposes including school construction, sewerage, sanitation, repair of the electrical grid and other civilian projects. To date, most of the money spent has been diverted to military projects, including training bomb squads, training Iraqi security forces, constructing prisons, purchasing armored cars, and of the 3,600 projects completed, some 25% of funds were spent on security. Money has also been diverted to pay for the elections (source: Special Inspector General for Iraqi reconstruction). The Administration has recently announced that it will rescind its request for remaining reconstruction money.

¹⁶CRS, 10/7/05, *Ibid.*

¹⁷Currently there are 20,000–25,000 private military contractors operating in Iraq, representing some 60 contracting firms. Experienced U.S. soldiers can earn up to several times their military salary working for high-end contractors, in some cases up to \$1,000/day. (IPS, 2004).

¹⁸Wallsten and Kosec, AEI-Brookings Working Paper 05–19, September 2005, estimates 20% with serious brain injuries and 6% amputees. They estimate 24% with other serious injuries. (We use 21% with other serious injuries based on the latest Pentagon numbers.)

Congress for an emergency \$1.5 bn in funding for FY 2005. The VA is likely to face a shortfall of \$2.6 billion in 2006.¹⁹ While not all the additional healthcare expenditures may in fact be directly linked to the Iraq war, it will be difficult not to provide the requested medical care. We assume that this need will continue and increase to \$3 bn as the veterans return home, and that the VA will require this additional level of funding added to its base budget.²⁰ (We expect that this figure is significantly understated, considering that The Veterans Administration is already facing a shortfall in funding to meet its existing obligations.²¹)

The additional cost of providing benefits to Iraqi war veterans will become a major challenge for the VA. In our conservative scenario we have estimated that all troops are withdrawn by 2010 and these costs are for 20 years; in the moderate scenario we have assumed that troops continue to be deployed through 2015 and these costs continue throughout the lifetime of the veterans (40 years).

4. Medical Treatment for Brain Injuries

There is a special category of healthcare expenditures that goes beyond those included in the above calculation—for those with brain injuries. To date, 3,213 people—20% of those injured in Iraq—have suffered head/brain injuries that require lifetime continual care at a cost range of \$600,000 to \$5 million.²² The government will be required to commit resources through intensive care facilities, round-the-clock home or institutional care, rehabilitation and assisted living for these veterans.

For the conservative estimate, we have used a midpoint estimate of a net present value of \$2.7 million over a 20 year expected survival rate for this group, which is about \$135,000 per year, yielding a cost of \$14 billion. This amount seems low for brain-injured individuals who will require round-the-clock care in feeding, dressing and daily functioning. For the moderate estimate, we use a higher cost estimate (\$4m) and assume longer life duration for a total cost of \$35 billion. In both cases we assume that the number injured will rise in a manner consistent with the duration of the conflict.

5. Disability Pay for Veterans

Veterans of the Iraq war are eligible to claim disability pay and benefits, ranging up to a maximum of about \$44,000 per year, under a complex formula administered by the Veterans Administration. It is important to note that that Congressional intent for disability payments is to “compensate for a reduction in quality of life due to service-connected disability payment of this disability”. The benefit is intended to “provide compensation for average impairment in earnings capacity”—but it does not require the veteran to actively seek employment nor is it offset against post-military civilian earning. The principle dates back to the Bible at Exodus 21:25, which authorizes financial compensation for pain inflicted by another.²³

Veterans are awarded claims based on the percentage of disability they can demonstrate; in gradations (0–100%) though it is possible to have a 0% disability percentage across multiple conditions and still qualify a veteran for some disability pay. The presumption for disability compensation is tied to symptoms that appear within a period of time after service. There are numerous programs that provide benefits depending on the situation, including disability compensation, specially adapted housing grants, medical benefits with higher priorities, vocational rehabilitation, service-disabled veterans life insurance, dependency and indemnity compensation (paid to surviving spouse and children if a veteran dies of an illness or injury contracted while on active duty, or dies of such after retirement).²⁴

We have estimated the amount of claims that the government will need to pay based on a projection of the rate of claims based on the Persian Gulf War. The government currently pays \$2 billion annually in support of 169,000 claims, or an average of \$11,834 per claimant. (Hartung, 2004) The total number of claims for that war exceeded 200,000, or more than one-third of the troops deployed, despite the

¹⁹ Institute for Policy Studies, 2005.

²⁰ See the discussion in the next section for an alternative methodology, which focuses on the *direct* costs of the Iraq injured.

²¹ Former VA Secretary Anthony Principi said that the VA will need \$600 bn over the next 30 years to meet its existing obligations for healthcare, education, pensions and housing loans—but this figure did not include the Iraqi war veterans. It also does not include additional funding for capital needs, including construction and repairs of VA facilities.

²² Wallsten and Kosec, AEI, *The Economic Cost of the War*, 2005 and Department of Defense estimates for number of wounded.

²³ VA Disability Compensation Program, *Legislative History*, VA Office of Policy, Planning and Preparedness, December 2004

²⁴ This principle is cited in numerous legal cases in which juries award compensation for injury.

fact that the war lasted 4 weeks with 148 dead and 467 wounded. Many of those claims were related to the exposure to depleted uranium during the Persian Gulf conflict, and included ailments such as memory loss, sleep problems, Lou Gehrig's disease, poor concentration, and joint problems. Congress has established a "presumption of service-connection" for any health problems linked to "exposure to possible nerve agents and other toxins present in the Persian Gulf conflict and vaccinations against biological war hazards in preparation for the Persian Gulf."²⁵

In the Iraq conflict, more depleted uranium was used in the bombing of Baghdad than in the Persian Gulf conflict;²⁶ therefore the Iraq war veterans will be easily eligible for disability claims for any health problems that they can link to exposure. As we noted earlier, more than one-third of returning veterans have used the VA system for health ailments. We have estimated that those with serious injuries would receive the maximum disability benefits from the VA, those with medium-serious injuries would receive half those benefits (\$22,000), and one-third of the remaining forces would receive the average benefit awarded to the Gulf War veterans, or \$11,834. This sums to an annual payment of \$2.3 billion. In the conservative scenario we have estimated this payment over 20 years; in the moderate scenario we have assumed that these payments continue over the lifetime of the veteran, so until 2045.

6. Cost of Demobilization

The Pentagon has announced plans to reduce troop levels from their current force of over 160,000 to around 140,000 in the next year, and we have assumed that this withdrawal will continue gradually as outlined by the CBO. This will in itself require direct payments of \$6–10 bn for the transportation and demobilization of troops, returning them to their home bases, or civilian roles (in the case of Reserves).

7. Increased Defense Spending

Since 2002, the total appropriations for the Defense Department have increased from \$310 bn to \$420 bn, representing a total cumulative increase of \$325 bn. Portions of the FY 2002, 2003, 2004 and 2005 appropriations bills, as well as FY 2003 and FY 2004 transfers, have been appropriated for Iraq. In total we estimate that 30% of the \$325 increase has been devoted to Iraq. This figure covers increased military pay, research and development, recruitment, operations and maintenance and replacement of equipment. According to Pentagon estimates, the military is wearing out equipment at a rate that is 4–5 times the rate of usage in non-combat situations.²⁷ Additionally, CBO has estimated that the military will require some \$100 bn in replacements over the next five to 10 years. (Much of this funding has not yet been requested)²⁸ and GAO has referred to the shortfall in funding for repairs, replacements and procurements²⁹ and the confusion between determining emergency supplemental and ordinary funding needs. . . .

In our estimates, we have attributed one-third of the increase in Defense spending to Iraq, minus the savings from no longer policing the no-fly zone to the Pentagon. Savings from the no-fly zone have been estimated to be from \$11 to \$15 bn per year.³⁰ Given that the Department is highly focused on the outcome of the war in

²⁵In 1994 Congress passed the Gulf War Veterans Benefit Act, which legislated a presumption of service connection for an undiagnosed illness that occurred within an unexpired time frame, taking into account the Gulf War Syndrome. This time frame period was extended in 2001 to include any disabilities associated with the Persian Gulf War service that may appear through Dec. 31, 2011. (VA Disability Compensation Program, *Ibid*).

²⁶William Hartung, "The Cost of War" 2004, Taxpayers for Common Sense.

²⁷Secretary Donald Rumsfeld said at a briefing on March 10, 2005 that U.S. military equipment such as tanks, Bradley fighting vehicles and helicopters are being worn out at up to 6 times the peacetime rate. (Washington Post, 3/11/05)

²⁸Scott Lilly, staff director of the House Appropriations Committee, said the Army would need more than \$17.5 bn to replace or repair worn or damaged equipment in the first year of the war. But the Army's request for depot maintenance and procurement was only about \$2.2 bn in the supplemental. "Pentagon's Request for Iraq includes money for troops and rewards", New York Times, 10/03/03. Additionally, Rep. Duncan Hunter, Chairman of the House Appropriations Committee, has cited figures that the Defense Department needs \$90 bn per year in annual modernizations and at present levels, is still \$30 bn short, based on CBO estimates. (Wall Street Journal, 5/03)

²⁹The GAO has also referred to the shortfall in funding requests for military replacements. (GAO, "Global War on Terrorism: DOD Should Consider All Funds Requested for the War When Determining Needs and Covering Expenses."

³⁰Wallsten and Kosec estimate savings from the no-fly zone at \$32 bn in the nearly 3 years since March 2003. John Amidon of the Air War College estimates the cost of policing the no-fly zone at \$15 bn per year.

Iraq, we estimate that up to one-half of the increase in the defense spending may be related to Iraq, but we have used only 30% of the spending in our conservative and moderate scenarios.

In addition, this increase reflects the military's increasing difficulty in recruiting troops and officers at all levels since the beginning of the Iraq conflict. During 2005, the Army was below target for most of the year, and actually lowered its targets in order to achieve them.³¹ There were shortfalls in the Army National Guard, Army Reserves, and Marine Reserves. Applications to West Point and the U.S. Naval Academy also fell between 10–25% from previous years. The military has responded to this challenge by hiring thousands of additional recruiters, increasing its national advertising campaigns, offering sign-up bonuses of up to \$40,000 for new recruits, offering higher retirement and disability benefits, increasing the “death gratuity” to \$100,000, and providing re-enlistment bonuses of up to \$150,000 for experienced troops (who might otherwise leave the military to join private contractors who would pay even higher amounts). In further efforts to boost recruitment, the Pentagon increased the maximum enlistment age from 35 to 42 and relaxed standards for appearance and behavior, making it more difficult to be fired. The cost to the military per recruit has increased from \$14,500 in 2003 to \$17,500 in 2005. (Pentagon). Hardship pay has been increased from \$300 to \$750 per month. We assume that the military will need to make these changes permanent, adding at least \$1 bn–\$2 bn per year into the permanent budget base. Additional increases include military pay raises, and the purchase of more expensive body armor for combat.

8. Interest Payments on Debt

Given that at the onset of the War, the country was already running a deficit, and no new taxes have been levied, it is not unreasonable to assume, for purposes of budgeting,³² that all of the funding for the war to date has been borrowed, adding to the already existing Federal budget deficit. In the conservative scenario we assume that these funds are borrowed at 4% and repaid in full within five years. The moderate scenario assumes that the country continues to have a deficit over the next 20 years and therefore interest continues to accrue.

II. Costs of the War to the U.S. Economy: Adjustments to the Budgetary Estimates

A second way to measure the cost of the war is to examine its *economic* cost. Economic costs differ from budgetary costs in three ways: (a) costs are borne by others (than the Federal government and those fighting in the war), and these are obviously excluded from the budgetary costs *to the Federal government*; (b) the prices paid by the government do not reflect full market value; and (c) economic costs do not include interest payments (which can be viewed just as transfer payments), but do include long run impacts on the growth of the economy. For instance, in the days of the draft, pay provided soldiers were a vast underestimate of their opportunity costs. Healthcare costs borne by soldiers and their families are examples of costs borne by others.

Here, we focus on the loss of productive capacity of the young Americans who have been killed or seriously wounded in Iraq, and the loss of civilian wages that would have been earned by those called back to duty in the Reserve forces.

There are some “problematic” items within the budgetary costs, most notably expenditures on veterans *not* linked with the Iraq war. The best way to think of this is as part of deferred compensation, and therefore, while the “categorization”—repairing human damage as a result of the war—is incorrect, it is still part of the cost of the war.

Once again we have estimated the costs under two scenarios. In the conservative case, the adjustments add \$187 bn onto the budgetary cost—raising the cost to \$839 bn, even when subtracting the entire cost of interest payments. In the moderate case, the economic adjustments increase costs by \$305 bn. Even if we deduct the cost of interest, the cost of the war under this scenario exceeds \$1 trillion. But these calculations ignore the fact that some of the resources deployed in the war could have been used to promote economic growth, and that there are a broad range of macro-economic costs, the effect of which, as we shall show in the next section, is to increase the economic costs of the war by a significant amount.

³¹For example, the May recruiting target was originally 8050, but was lowered to 6706. Similar adjustments were made throughout the year.

³²An *economic analysis* is somewhat more complicated, as the discussion in section IV will make clear.

Figure 2: Adjustments to Budgetary Numbers to Account for Economic Costs (\$BN)

	Conservative	Moderate
1 Spent to Date	3	8
2 Economic Cost of Reserves	3	9
3 Economic Cost of Fatalities	23	29
4 Loss due to Brain Injuries	34	48
5 Loss due to Other Serious Injuries	30	64
6 Loss due to Other Injuries	18	26
7 Less veterans disability payments	(12)	(28)
8 Increased depreciation of military hardware	89	149
Net Adjustment	187	305

The cost of the war to the United States, *before* taking macroeconomic factors into account, can therefore be estimated under a variety of assumptions to fall between \$700 bn and \$1 trillion dollars, as shown in Figure 3.

Figure 3: Projected Cost of the Iraq War (\$US bn) without macroeconomic costs

Scenario	Budgetary cost (without interest)	Budgetary Cost (inc. interest)	Cost with Economic Adjustments ³³
Conservative	652	750	839
Moderate	884	1269	1189

Differences between assumptions for economic and budgetary models.

1. Economic Cost³³ of Reserves

As we noted earlier, the U.S. force in Iraq is composed of 40% the National Guard and Reserve forces. Many of these men and women normally work in critical “first responder” jobs in their local communities, such as firemen, policemen and emergency medical personnel. More than 210,000 of the National Guard’s 330,000 soldiers have served in Iraq or Afghanistan, and the average length of Guard mobilization is 480 days.³⁴ It is difficult to measure the cost of this deployment in purely economic terms because there is a large unquantifiable cost in terms of the loss of these “first responders” to emergencies, including the value of the “insurance” of having these people ready to respond to emergencies. This was clearly seen in the Hurricane Katrina debacle, where 3000 Louisiana National Guardsmen and 4000 Mississippi Guardsmen were stationed in Iraq when the hurricane hit. According to the Institute for Policy Studies, some 44% of U.S. police forces have some of their ranks deployed in Iraq. The loss of these services in Katrina and elsewhere clearly has had large budgetary and economic costs. We do not directly measure either the economic costs of the loss of “insurance” or the economic and budgetary costs arising from reduction in first responder capabilities (which may have been considerable.)

Still, there are some quantifiable economic costs that go beyond those noted earlier in our budgetary analysis. In the budgetary model, we included (as part of operating costs) the additional cost to the government of hiring replacements for those sent to Iraq, which is around \$3 bn per year. In this model, we have subtracted that sum from the total cost of operations but added in the economic cost of the difference between the civilian wages that these individuals would earn in their regular occupations and the lower wages they typically earn in the Reserves. Scott Wallsten and Katrina Kosec (AEI/Brookings, 2005) have calculated that Reserve soldiers earn about \$33,000 per year as civilians. They estimate that the opportunity cost of using Reserve troops at current levels is \$3.9 billion to date. We have adopted that figure into our conservative assumptions. In our moderate model, we have increased the pay per Reservist slightly to \$46,000, taking into account the fully

³³ Budgetary cost without interest + economic adjustments.

³⁴ IPS, *Ibid.*

loaded cost of benefits, particularly for those reservists who are in police and fire departments and receiving 60–100% benefits.³⁵

2. Economic Cost of Military Fatalities

The budgetary model only incorporates the payments made to individuals as a result of death. Had these individuals been killed in a car accident or a work related accident (other than military) there would have been much larger payments, reflecting the economic costs of the losses.

Although it is impossible to translate the value of a life into purely monetary terms, the government commonly uses this approach and determines the “Value of statistical life” or “VSL”, based to some extent on the value of foregone earnings and contributions to the economy. This method is also widely used by insurance companies and other private sector concerns. In this study, we have estimated the VSL of each U.S. military and contractor fatality as of December 2005. According to the Pentagon casualty reports, this is 2156 military fatalities and approximately 100 contractors.³⁶ We have projected these forward according to the two different scenarios described earlier.

We have not taken into account the number of Iraqis who have been killed in the conflict, estimates of which range from 30,000 (the number estimated by President Bush in December 2005), to a 100,000 estimated by the British *Lancet*. We have also not counted the several hundred casualties among coalition countries, of which about 100 were British soldiers.

There are a wide range of VSL values in use. In our conservative scenario, we have adopted the standard set by the U.S. Environmental Protection Agency, \$6.1 million per life. However this is only an approximation. The value of a young life may be determined to be higher than average, based on an estimate of foregone earnings (Viscusi and Aldy, 2005³⁷.) Juries frequently award much higher amounts in wrongful death lawsuits, and some have reached as high as \$269 million.³⁸ We have used the number \$6.5 million in our moderate scenario. In projecting the number of fatalities and casualties forward, we have assumed that these would be proportional to the number of troops deployed in Iraq, based on the average number of casualties per month to date. However, even this is a conservative estimate, since the number of casualties has been increasing.

3. Economic Cost of Contractor Fatalities

There have been about 100 U.S. contractors killed in Iraq since March 2003 (as well as some non-U.S. contractors, mostly working for western companies.) In this model we have only included the U.S. contractors, and extrapolated the numbers according to the two different war scenarios. We have used the VSL of 6.1 million and 6.5 million, respectively, for the conservative and moderate models. However it should be noted that in many cases, the contractors were highly skilled, highly paid specialists, working on reconstruction projects such as fixing the electricity grid and oil facilities. We have not counted their true loss to the success of the project in Iraq, or the fact that their high casualty rate has made it more difficult and more expensive for western contractors to higher replacements to perform these jobs.

³⁵It is apparent (evidenced by increased difficulties in recruiting) that individuals did not fully appreciate the risks they faced when joining the reserves, so that the wage received does not reflect adequate compensation for those risks. This is particularly true because of the stop-loss policy which requires troops to extend their tours, with some 20,000 having in fact been prevented from leaving their service at their scheduled dates. A full adjustment of the economic costs would include appropriate compensation for the risks taken. See below.

³⁶In the case of the contractors, one might argue that their wages (already included in the analysis) includes compensation for the risk of the loss of life, so that the value of the loss of these 100 contractor lives should be subtracted (reducing the overall cost of the War by some \$600 million.)

³⁷The “peak” age for VSL may be 29, in terms of lost earnings potential, with a VSL between \$5.9 and \$7.5 (Viscusi, and Aldy, NBER Working Paper 10199, 2003)

³⁸There have been hundreds of large jury awards (ranging from \$2 m–\$269 m) in wrongful death suits over the past 5 years. These include the awards of \$112 to Elizabeth and John Reden of New York for a malpractice case in which their daughter suffered brain damage (2004) and \$43 in Louisiana in 2001 for Seth Becker, a 24-year old who needed both legs amputated after an injury he sustained while working for Baker Oil Tools. In both of these and many other cases the amount awarded was determined primarily on the basis of the cost of round-the-clock medical care for life that the injured person would require. The \$269 m award was for Rachel Martin, a 15-year old Texas girl who died in 1998. In most cases the plaintiffs receive less than the total award, typically about 10%.

4. Economic Cost of the Seriously Injured³⁹

Earlier, we described the budgetary costs of healthcare and disability for the seriously injured. The wounded contribute significantly to the cost of the war—both in a budgetary sense (in the form of lifetime disability payments, housing assistance, living assistance and other benefits from the Veterans Administration), and in an economic sense. The budgetary expenditures discussed earlier underestimate the true economic costs for three reasons: (a) They do not include adequate compensation for “pain and suffering,” of the kind that would have been provided, for instance, had those suffering injuries been hurt in an automobile accident; (b) they do not include additional healthcare expenditures by the parties themselves, their families, or other government agencies; and (c) perhaps most importantly, they do not include the loss of economic services. On the other hand, they do include healthcare expenditures that may not be directly a consequence of the war. However, as we noted earlier, we are treating this as part of the deferred compensation, and therefore it *is* both a budgetary and an economic cost.

In their recent study of the economic costs of the war, Wallsten and Kosec used a “value of statistical injury” to estimate the cost of the wounded. This value represents what people are willing to pay in order to avoid being injured. They applied this value to the number of injured personnel, according to the severity of their injuries and the average cost of treatment over its lifetime. They calculated total net present value of injuries at \$18.2 bn to date, and \$48 bn through 2015, using a 5% discount rate.⁴⁰

The Wallsten and Kosec study is quite thorough and we have used their estimates of the number and type of wounds, and lifetime treatment costs. However, they probably underestimated the total cost of the wounded because they only assigned an amount to the 26% with brain injuries and/or amputations. We have included additionally the cost of the 21% of personnel (5545 people, as of December 2005) with other serious wounds. Such injuries would include wounds from shells, explosions, gunfire, mortar, landmines, grenades, firearms and infections, resulting in conditions such as blindness, partial blindness, deafness, partial deafness, cardiac injury, facial deformation, burns, multiple broken bones, nerve damage and mental breakdown. We have deducted the veterans’ disability payments from all these individuals.

We have estimated that personnel with serious injuries (including brain injuries) receiving full disability payments will essentially be lost to the economy and therefore we should assign them a VSL similar to the deceased, of \$6.1 m. In the Conservative case, we have estimated that those who were wounded during the conflict, but returned to the military will suffer some impairment beyond the small amount of disability pay they may receive. We have very conservatively estimated that 20% of the total VSL would be an approximation of this impairment. Taken together, this adds approximately \$70 bn.

Under our moderate scenario, we have used a similar formula, but using an estimate of \$6.5 m for the VSL and assuming that there are more casualties, due to the longer duration of the conflict. Less disability payments this adds another approximately \$110 bn.

There is another significant cost that we have not included, simply because we did not have the data to prepare a robust estimate. This is the degree of impairment that will be suffered by the other veterans—numbering some 160,000, or approximately one-third of the 550,000 veterans from the Iraq war—who will be eligible to claim some disability benefits. We believe that a significant number of these individuals will suffer substantial mental and physical ailments that will significantly reduce their earning potential and quality of life. If even 15% of these veterans fall into this category, this alone would add another \$30–35 bn to the economic cost of the war.⁴¹

A conservative estimate of the risk premium individuals would require to be compensated for the injuries (beyond the loss of economic functionality and healthcare

³⁹One might argue that for those joining the army and reserves *after* the beginning of the War, the increased compensation already incorporates the (present discounted value of) loss in welfare from the increased injuries (deaths), and so including both item 10 from table 1 and items 2 and 4 from table 2 represents “double counting.” Therefore, it may be argued, we should subtract \$5.3 (conservative; \$8.76 in moderate case) from the total. However, there is no reason to believe that those enlisting have a good sense of the actual risks (there is no evidence that the armed forces provides accurate information to the enlistees) and the increased compensation reflects no just increased probability of injury and death, but also the stop loss provisions which did not allow individuals to leave the services at the scheduled time. In any case, the basic pattern of results is unaltered.

⁴⁰This is based on their “midpoint” scenario. Their high estimate is \$74 bn.

⁴¹Assuming 20% of the VSL for 24,000 individuals.

costs) could (with reasonable estimates of risk premia) double the total.⁴² We have, however, omitted those numbers from the analysis.

5. Accelerated Depreciation of Military Hardware

There is only a slight difference in the estimate of the budgetary and economic costs associated with military hardware. The budgetary costs focus on replacement expenditures, the economic costs on the more rapid depreciation of hardware (than otherwise would have been the case.) In our conservative scenario, we have simply estimated straight-line 5-year depreciation for the \$100 m in military replacements estimated by the House Armed Services Committee and CBO, over the next 5 years. This is in line with the DOD's assessment that equipment is being used up at 5 times the normal rate of utilization in peacetime. We are assuming that the Pentagon will incur at least an additional \$25 bn in replacements through 2015, in the moderate scenario.

III. The Macro-economic Effects of the War in Iraq

As large as the direct costs—current and future—are, the macro-economic consequences may even be several times larger.⁴³ There are at least three major sources of macro-economic consequences: (a) the increase in the price of oil; (b) the increase in defense expenditures; and (c) the increased insecurity that has followed from the way that the war has been pursued.

In ascertaining the magnitude of these macro-economic effects, there is a standard problem: the counterfactual, what would the world have looked like, but for the war in Iraq.

Security

Consider the issue of security. The bombings in Madrid and London have only exacerbated a growing sense of insecurity. Would matters have been even worse had there been no war? One of the stated objectives of the war was to enhance the sense of security (to make sure that the war on terrorism was fought *there*, not here.) It is conceivable that the Middle East would have been even more unstable than it is today. But especially on the basis of what we know today—Iraq did not have weapons of mass destruction, and it did not have the capacities to develop them quickly—this seems unlikely. Contrary to the assertions before the War by the administration, Iraq (with its highly secular regime) was not working with Al Qaeda, and was not a training ground for insurgency. Unfortunately, the disorder that has followed the war has provided a place where such training is going on today.

The costs of this insecurity are potentially huge.

- a. Individuals are risk averse, and there is thus a direct quantifiable cost associated with the increase in risk.
- b. The response to security threats has been to create significant barriers to the free flow of people, goods, and services. The Administration champions the virtues of free trade and the benefits from lowering trade barriers, even when those barriers are already low. But increased border security (including airport security, the reporting and registration requirements of the bioterrorism act, and so forth) are trade barriers; not only are there direct costs associated with administering these security measures, there can be significant macro-economic effects of the reduced flow of goods and services. A special category of costs is associated with the significantly reduced flow of students to the U.S., especially in areas of science and technology, where we have become very dependent on these "imports." (Many have stayed and made large contributions to the economy.)
- c. Increased risk is bad for business; it lowers investment, and over the long run thus has supply side as well as demand side effects.

Calculating these costs—and particular, the *incremental* costs associated with the Iraq War (beyond the costs which would otherwise be associated with the War on Terrorism)—is sufficiently difficult and problematic that we do not provide any estimates here. But it means that the numbers reported below almost surely underestimate the total macro-economic effects.

⁴² Individuals are willing to pay insurance premia that are typically 60% to 120% of the value of the loss. In the case of the loss of limbs and other major bodily injuries, the risk premia are likely to be considerably higher.

⁴³ We provide here preliminary estimates of the costs so far, and what those costs might be expected to be under various scenarios. We do not provide what would have been a reasonable estimate of the costs at the time that the United States went to war. Given the administration's attempt to minimize the expected costs, it is not surprising that they did not take into account all of the costs discussed in this section.

Oil

The price of oil is significantly higher today than it was before the War in Iraq. Even as the country went to war, it was recognized that it might have effects on the global oil market. Some of the remarks of those in the administration seem to suggest that it may have even been a factor driving the country to war. Larry Lindsey is reported to have said, “the best way to keep oil prices in check is a short, successful war on Iraq . . .”⁴⁴

The higher price of oil brings costs and benefits. Profits of the oil companies have increased enormously.⁴⁵ It is the one group (besides certain defense contractors) that has clearly benefited from the war. (Though popular discussions of the still not-clear motives for going to war often focused on oil, there is so far no reason to suppose that these benefits to one of the President’s “constituencies” played an important motivation.) Here, we are concerned with the costs to the overall economy of these high oil prices.

First, however, we have to ascertain to what extent has the increased price (from \$25 a barrel **before** the War to around \$50 today—ignoring the spike associated with Katrina when prices rose to \$60) been a result of the war itself.⁴⁶ Again, the question is, what is the counterfactual? What would the price have been had there been no war? To what extent is the rise in price due to the war, and to what extent is it due to other factors?

Future markets provide some insight. Before the war, they were forecasting that oil prices remain in the range that they had been, \$20 to \$30. Futures markets take into account growth in demands in China and elsewhere as well as changes in supply. They do so on the basis of “business as usual,” that is, on the basis that nothing out of the ordinary happens. The war in Iraq was the most notable event, and it is hard to identify any other which can be given as much credit for significant change in demand or supply (apart from Katrina). Some might blame the high demand for oil from China. But China has had two decades of robust growth, and its growth in 2004 was stronger than many market analysts had anticipated earlier; but global growth in 2005 (of around 4%) is clearly not particularly unusual. Markets are supposed to anticipate and respond to changes in demand by increasing supply. Errors in one year are quickly corrected in the next.

What is striking is that present prices are significantly higher than what most analysts believe is the long run price, and futures markets expect that such prices will persist for at least another 2 years.⁴⁷ That is, costs of extraction in Iraq (apart from the security concerns), Saudi Arabia, and elsewhere in the Middle East are much lower than \$40, and at \$40 there are many alternative sources (shale, tar sands) with a large supply elasticity. The question is, why has there not been this normal supply response. We suggest that the War in Iraq provides the critical explanation.

Had there been no war, and had price increased, the international community could have allowed Iraq to expand production, and this would have brought down the price. But it is more likely that production elsewhere, including and especially elsewhere in the Middle East, would have increased. The instability in the Middle East which has been brought about by the Iraq War has increased the risk of investing in that region; but because costs of extraction are so much lower than elsewhere, it has not provided a commensurate supply response elsewhere. If stability is restored, then prices will fall, and these investments elsewhere would turn a loss.⁴⁸

⁴⁴ *Wall Street Journal*, September 15, 2002.

⁴⁵ In 2005, four of the ten most profitable corporations in the world are oil and gas companies—Exxon-Mobil, Shell, BP and Chevron Texaco. In 2002, only one of the top 10 most profitable corporations was from the oil and gas industry. Source: The Forbes Global 2000, <http://www.forbes.com/2005/03/30/052000land.html>, <http://www.forbes.com/2002/03/27/forbes500.html>.

⁴⁶ Oil price averaged \$23.71/barrel during 2002. In run up to the war, price rose to \$32.23 by February 2003 (war began on March 20, 2003). One has to interpret a significant part of the run up of costs prior to the war to the war itself—an increase in stockpiling in response to worries about supply interruptions. The price averaged \$27.71 in 2003, \$35.90 in 2004 and rose to \$49.28 by June 2005. After Katrina, prices have stayed relatively high. As we argue, part of the cost of the War is the reduction in the capability of responding quickly to these supply shocks.

⁴⁷ Futures market predicts the price to remain mid \$60 range during 2006 and 2007 and then fall in 2008.

⁴⁸ The increase in the price immediately after the war can be partially directly attributed to Iraq, as what it had been supplying to the world markets under the oil-for-food program was

Continued

In addition, there is the fact that oil production in Iraq has plummeted since the war. Even though Iraq is not an oil producer on the scale of Saudi Arabia and Russia, Iraq did produce around 2.6m barrels per day (a similar level to Kuwait, Nigeria and the UK) on the eve of the war. Now production has dropped to 1.1 million barrels per day. The insurgency has sabotaged refining capacity and truck drivers have refused to transport oil from the north, due to the threat of insurgents.⁴⁹

Though we believe, accordingly, that the best estimate of the cost of Iraq on oil prices is a very large proportion of the \$25 a barrel or more increase in the price of oil (and looking forward, we can extrapolate this cost for the next two years), we provide a conservative calculation based on the assumption that only 20% of that amount—\$5—is due to Iraq. In our moderate estimate, we assume \$10 is due to Iraq.

Figure 4: Impact of Oil Prices

Year	Total Crude Oil Import (Thousand Barrels Per Day)	Total Import Per Year (Billion Barrels)	Refiner Acquisition Cost of Crude Oil, Imported (\$/Barrel)	Total Cost of Oil Import (Billion US\$)
2000	11459.3	4.19	27.7	116.2
2001	11871.3	4.34	22.0	95.3
2002	11530.2	4.22	23.7	99.8
2003	12264.4	4.49	27.7	124.0
2004	13145.1	4.81	35.9	172.7
2005*	13415.5	4.91	47.9	234.7
2006**	13952.1	5.11	57.4	292.3
2007**	14510.2	5.31	65.0	344.3

* Average for the first 9 months of 2005. The total import cost is for the 12-month period using the 9-month average.

** Assuming 4% growth in 2006 and 2007.⁵⁰

Given U.S. imports of roughly 4.75 to 5.0 billion barrels a year, a \$5 per barrel increase translates into an extra expenditure of approximately \$25 billion (\$10 would be \$50 billion). Americans are, in a sense, poorer by that amount.

In a neoclassical model that assumes full employment of all resources, this would be the principle effect on national income. If the economy continues to use all of its resources fully, gross output remains unchanged; only what is paid for inputs of oil has increased, so that value added (GDP) is reduced commensurately.⁵¹

Assuming that a \$5 price increase persists for 5 years, this generates a conservative estimate of \$125 billion. For our moderate estimate, we use a \$10 price increase, but more plausibly, assume it extends (as future markets believe) for at least 6 years. That generates a cost of \$300 billion.

This supply side approach assumes that if the price increase is reversed, the damage is over. To put it another way, this simple model implies that if first the price goes up by \$10 for 1 year, and then down by \$10 by 1 year (from its baseline), and

greatly diminished (by almost 1 mbd). Oil prices had, of course, increased even before the war, in anticipation of these effects, so that the costs of the war began even before the war itself.

⁴⁹ Iraqi Oil production statistics from Pearson Education. Iraq produced 3.5 million barrels per day in 1990, prior to the Gulf War, and is said to have one of the world's greatest oil reserves.

⁵⁰ Data compiled from Energy Information Administration, Department of Energy, U.S. Government, <http://www.eia.doe.gov/emeu/international/petroleum.html#IntlProduction>

⁵¹ That is, simplifying, if we write $GDP = vL + \pi$, where π is profits, v is real wages, and L is employment, then $\partial GDP/\partial p = M + v\partial L/\partial p$, where p is the price of oil and M is imports. The last term is the effect of the price of oil on the amount of labor individuals wish to supply, which we assume is negligible. Note that when there is a large change in price, the effect is measured by $\Delta p M^*$, where M^* is some number between the level of the actual imports and what the imports would have been, had the price of oil not increased. Given the low short run elasticity of the demand for oil, the difference may be small.

then is restored to its previous level, there is no cost. This is wrong. There is a cost to this volatility. The technology, for instance, that is best adapted to one set of prices will not be that appropriate for another. And the costs can be significant. This is consistent with macro economic studies that show large asymmetries between the impacts of increases and decreases in oil prices.⁵² Thus this analysis of a 5-year period of high prices, which assumes that the only cost is the increased transfer abroad, provides a significant underestimate of the true economic costs. We have not, however, provided an estimate of this additional cost.

Global Income and Price Effects

The value of national income is affected by the prices of other goods the country imports or exports, and these too can *indirectly* be affected by the increase in the price of oil. If, for instance, a global increase in the price of oil leads to a decrease in the price of other commodities (because of a global slowdown), then America is thereby better off. These effects are complex and likely in any case to be small.

There may be some commodities that the United States exports in which it has market power. In that case, we take firms as setting the price of exports to maximize profits. An oil price shock lowers income of buyers of American products, shifting the demand curve over to the left. The income effect (at least for a small perturbation) is just the change in profits at the old price. If markets are fairly competitive, the effect is small, but especially in areas of the New Economy where mark-ups are large, the losses in income can be significant. We have not, however, directly tried to estimate the magnitude of these effects.

Most macro-economic analyses, however, assume that there are more than just these (neoclassical or) supply side effects. This is especially important when the economy is operating below full employment. We noted that with the increase in oil prices, Americans are poorer; they have that much less to spend on other goods—including goods made in the United States. There will be a reduction in aggregate demand, and the reduction in aggregate demand caused by an increase in oil prices is likely to result in a lower level equilibrium output.

The Macro-economic Counterfactuals

The net effect depends on the macro-economic state of the world and how policy makers respond. If the economy is already in a world in which there is excess supply (demand constrained), then we need to focus on how monetary and fiscal authorities respond to stimulate demand. If the economy were in a state of excess demand, then the dampening of demand would lower inflationary pressure, but would leave output largely unaffected. Unfortunately, the post Iraq War world is one in which there has been excess supply (demand constrained output) in all of the major economies.

Monetary policy response is determined by two offsetting factors. The oil price increase generates some inflationary pressures, and especially among central banks focusing on inflation, this leads to higher interest rates, exacerbating the slowdown of the economy. On the other hand, *if* central banks focus on aggregate demand and unemployment, it is conceivable that monetary policy could offset the adverse effects of oil price increases. If they fully offset the effect, then the *only* effect would be the transfer effect described earlier.

Fiscal policy typically does not adjust quickly enough to stabilize the economy (and the effect of built-in automatic stabilizers is reflected in the multipliers discussed below). Again, there are two effects. For countries with fixed expenditures, then the increase in the oil price means that there is less to be spent on domestic goods, and that exerts a downward effect on the economy. On the other hand, for countries running active countercyclical fiscal policies, the slowdown in the economy could be offset by such policies.

With Europe's Central Bank focusing on inflation, the higher inflation resulting from higher energy prices most likely contributed to higher interest rates *than they otherwise would have been*, and thus a further weakening of the economy. Fiscal constraints (the growth and stability pact) has also meant that fiscal policy could not respond; on the contrary, increased government expenditures on energy meant there was less to spend on domestically produced goods and services, again contributing to the weakening of aggregate demand. In short, for Europe, the contractionary effects including policy responses are greater than without them.

In Japan, with interest rates close to zero in any case and fiscal policy stretched to its limits, probably little policy response can be attributed to the oil price increase.

⁵² See, e.g., Rodriguez, 2005.

The United States is the most problematic. It appears that fiscal policy has not been closely related to the short run cyclical state of the economy. (The worsening of the fiscal position of the United States may have contributed to the resolve by some moderate Republicans not to cut taxes or expand expenditures as much as they otherwise would have done.⁵³ In this sense, the oil price increase has probably had a negative effect on cyclical fiscal policy, i.e. the multipliers are larger than they would be if fiscal authorities took a “neutral” stance.) So too for monetary policy: the increased inflationary pressure from the high oil prices would, if anything, led to a tightening of monetary policy in response to the high oil price, leading to a larger multiplier.

We have not carried out a full global general equilibrium analysis, but rely instead on results of standard macro-economic models. These suggest an “oil multiplier” of around 1.5 (achieved over 2 years).^{54 55} Thus, assuming that the economy remains below its potential over the period of analysis, and focusing on the total impact (not the timing), our conservative estimate is increased to \$187 billion, and our more reasonable estimate to \$450 billion. These models too have no feedback from exports.⁵⁶

Global Effects

There are some studies, however, which obtain much larger results. The IMF’s models yield results with longer lags, but with full effects that are almost 4 times as large.⁵⁷

One of the standard studies, that of Hamilton, estimates that *in the past* a 10% increase in the price of oil has been associated with a 1.4% decrease in GDP. A \$5 increase in the price of oil thus implies a lowering of GDP by 2.8%, or approximately (\$300 billion) *per year that oil prices remain at that level*. A 5-year price rise would generate costs of \$1.5 trillion. Hamilton’s analysis is consistent with an oil price multiplier that is much larger than the earlier studies.

There are two possible explanations of the large discrepancies in results. The first has to do with the analysis of global general equilibrium results, and can be seen most sharply in the context of a “counterfactual” which has governments maintaining a fixed level (or percentage of GDP) deficit. In the standard model, what limits the multiplier are leakages, income which is not spent “domestically,” but is taken out of the system, and spent abroad, or by government. In both cases, the feedback of income into further expenditures stops. But if we take a global equilibrium approach, then the money spent abroad is part of the system. If we include government endogenous expenditures as part of the system, then as taxes are taken out of disposable income, government spends the increased revenues, just as if the individual himself had spent them. (There can be even “negative” leakages; if the government maintains a fixed deficit to GDP ratio, a stimulus—such as a fall in oil prices—leads to a higher GDP, and so an increase in government expenditures. Thus, for a global closed economy, the multiplier increases from $1/s(1-t) + t$, in which taxation reduces the multiplier, to $1/(s(1-t)-d)$, where taxation increases the multiplier (where s is the savings rate, t the tax rate on income, and d the allowable

⁵³The tax cut of 2003 occurred roughly contemporaneously with the War in Iraq. It does not appear that the War played any significant effect either in support or opposition to its passage; though it is likely that had the magnitude of the expenditures been identified, it might have weighed against the tax cut.

⁵⁴One-year multipliers are typically smaller, but our concern is with the total impact, not the timing of the impact (the focus of most short run GDP forecasting models.) See Blinder and Wescott, 2004, based on model simulations from Global Insight, Inc. simulation results supplied August 9, 2004 (results with a monetary policy reaction function engaged and disengaged were essentially the same); and Macroeconomic Advisers, LLC simulation results supplied August 2, 2004.

⁵⁵Increased expenditures on oil can adversely affect consumption (as households have less to spend on other goods), investment (as firms, other than producers of oil, see profits decrease from what they otherwise would have been), and government expenditures on domestically produced goods (as with budget constraints, there is less to spend on these). Impacts on households are, for instance, marked. Median household expenditures on gasoline and home heating have increased about 5% of household income. Given the low (zero) level of savings, this can be expected to translate into an equivalent reduction in expenditures on other goods.

⁵⁶While these models predict the effects are not fully felt for two periods, they also predict that the effects are felt even after the prices come down. Our calculations ignore the timing of the impacts. Oil price shocks have effects that are different (and presumably greater) than many other shocks, since they adversely affect all of the advanced industrial countries simultaneously.

⁵⁷See International Monetary Fund, “The Impact of Higher Oil Prices on the Global Economy,” Dec. 8, 2000, prepared by Research Department staff under the direction of Michael Mussa; cited in Blinder and Wescott.

deficit to GDP ratio). Thus, if $d = 0$, $s = .2$ $t = .25$, the multiplier increases from 1/4 to 1/15, i.e. it increases by a factor of almost 3.⁵⁸

(Of course, we need to model the oil exporting countries as separate from the oil importing countries, and spending a substantially smaller fraction of the income on American goods than Americans would. If Saudi expenditure and savings patterns were identical to those of Americans, then the change in the price of oil would simply be a change in the distribution of income, but have no effect on aggregates, besides the supply side effects originating from the higher price of oil. We have slightly overestimated the negative effects on American GDP by assuming that there is no feedback from increased Saudi income back to the United States.)

If we further include future consumption generated by extra savings, then even savings does not constitute a leakage, so long as over the prevailing time horizon, the economy remains in a demand constrained situation. In short, leakages are much, much smaller, when multiyear aggregate incomes are calculated. These dynamic feedbacks are even present in first year income. Thus, increased savings this year leads to increased wealth next year, and that increased wealth leads to increased output (if output is sensitive to demand). But rational consumers will realize this;⁵⁹ their lifetime income has gone up, and so too will their current consumption. In calculating the cost of the War, we are concerned not just with the impact today, but the impact in all future years. Calculating the total multipliers requires assessing the fraction of future periods in which it is reasonable to assume that demand constraints will be binding.^{60, 61}

In the periods at hand, Europe, the United States, and Japan were all demand constrained throughout the relevant time, and government expenditures were very much constrained by the level of revenues (especially in Europe). In the very short run, it was clear that such constraints were not perfectly binding in the U.S., but government expenditures were tempered from what they otherwise would have been by the looming deficit. This is clearly true for the states and localities (which make up a third of total expenditure) but even true at the Federal level. Accordingly, we believe a multiple period multiplier that is substantially in excess of that generated by the partial equilibrium American models (generating, as we have noted multipliers around 1.5) is warranted. Numbers of the order of magnitude generated by the IMF model are totally reasonable, but to stay on the conservative side, we use a much smaller multiplier of 2 as our (conservative) “moderate” estimate. (We even believe the very large multipliers implicit in Hamilton’s study are not implausible.)

However, we do believe that great care must be used in employing studies based on the impact of earlier oil price shocks. Changes in the structure of the economy, the nature of the policy responses, and the state of the economy (the extent to which it was at or near full employment) can have large effects on the full response of an oil price increase. Earlier increases occurred at a time when the global economy was already facing inflationary pressures (the U.S. from trying to ignore the fiscal costs of the Vietnam War.) Under doctrines of monetarism, there were large responses—excessive—to the inflation resulting from the oil price shock. Globalization has put greater downward pressure on prices, so today, inflation is much more benign. Monetarism has been discredited, and even if de jure or de facto inflation targeting has meant that some countries put excessive focus on inflation, including the inflation generated by high oil prices—and thus monetary policy exacerbates the contractionary pressures of oil—it does so less than it did in the earlier oil price shocks.

Thus, while we believe that these global general equilibrium effects are significant, and should raise the multiplier considerably about 1.5 or 2, given the uncertainties associated with these global general equilibrium effects, we do not include them in our conservative estimate. For our “moderate” estimate, we use a 6-year

⁵⁸ $Y = (1-t)(1-s)Y + tY + dY + I + X - mY$, since $G - tY = dY$, so $Y = I + X / (s(1-t) + m - d$

⁵⁹ See Neary and Stiglitz, 1983.

⁶⁰ When supply constraints are binding, individuals may displace consumption to other periods, so the net effect may be not much different from that which would prevail if demand constraints were always prevailing.

⁶¹ Consider a simple two period model in which there is not the second feedback, but in which increased savings this period does lead to increased consumption next period. Then the two-period ($Y_1 + Y_2$) multiplier associated with increased investment the first period is, instead of $1/m$ (where $m = s(1-t)$), $(1 + \alpha(1+r))/m$, where α is the marginal propensity to consume out of wealth. In a simple life cycle model with no bequests, where the only reason to save is for consumption in “the” future period(s), $t = 1$, so the multiplier has more than doubled.

impact and a multiplier of 2. We believe, however, that a substantially larger multiplier might be justified.⁶²

Budgetary Costs

The most difficult to estimate macro-economic costs are those associated with the increased expenditure. If we were not spending the money on the war, would we be spending it on something else? Would we have cut back spending, and had a smaller deficit? Would we have had the same deficit, but just more tax cuts?

But this is only part of the counterfactual analysis. How would the Federal Reserve have responded to the different macro-economic situation? Would it have dampened or exacerbated these effects?

These are standard questions in *incidence analysis*, in which public sector economists attempt to ascertain the consequence of one policy or another. One standard methodology focuses on *expenditure switching*: it is assumed that the government simply substitutes Iraq expenditures for other expenditures (some defense, some non-defense). This is the methodology upon which we focus here.

Another methodology focused on *marginally balanced budgets*, where taxes are assumed to increase in tandem (from what they otherwise would have been; there may still be tax cuts, but they are somewhat smaller than they otherwise would have been.) The Bush administration seems undeterred in its commitment to make its tax cuts permanent, unaffected by the War, but Congress is showing some sensitivity to the size of the deficit.

A third methodology assumes that the increased expenditure leads to higher deficits. We comment on the implications of this at the end of this section.

The expenditure switching methodology focuses on two critical differences between expenditures on the war in Iraq and other public expenditures, such as investments in research, infrastructure, or education. The first is that the *domestic content and leakages* differ. Consider, for instance, a \$1000 spent to hire Nepalese workers to perform services in Iraq. There is no “first round” effect on domestic GDP, and little impact on subsequent rounds (only to the extent that the Nepalese contractors buy goods made in the United States). By contrast, a \$1000 spent on university research in the United States has a full \$1000 first round impact, and high impacts in subsequent rounds. While “multipliers” associated with different kinds of expenditures are known to differ, there may be few expenditures with a lower multiplier than those in Iraq.

There are no data on the basis of which to provide accurate estimates of the differences in multipliers and leakages. Assume, however, that in the case of normal investment expenditures (like university based research) the first round and subsequent rounds of expenditure have a leakage of .67, generating an overall multiplier of 1.5. (The numbers are chosen to be deliberately very conservative.) By contrast, if the first round expenditure for Iraq is three-fourths that amount (again a conservative number, since it may well be much less) and leakages are the same thereafter, then the overall multiplier is 1.1. Switching \$500 bn (over the years of the war) to domestic investment would have resulted in increased GDP by \$200 bn.

(For some of the long run costs referred to in the first section of this paper, there are not likely to be large differences in multipliers. The increased disability and healthcare costs of Iraq War veterans are likely to have multipliers similar to that for investment expenditures. That is why we have conservatively focused on the impact of switching only \$500 bn.)

The second major difference is impacts on long run output. Investments in the public sector yield high returns, and so output would have been higher in the future. Expenditures on the Iraq war have no benefits of this kind. As a result, output in the future will be smaller. Assume, for instance, that of the direct costs of the war estimated in the previous section \$500 billion⁶³ were put into investments yielding conservatively a 6% real return on the investment, and using a (conservative) 4% discount rate, the present discounted value of the lost income is \$750 billion.⁶⁴

⁶²For instance, the IMF study cited earlier with much larger multi-year multipliers, near 4, would be associated with a total impact of \$1.2 billion over 6 years.

⁶³Obviously, it is conceivable that far more than \$500 billion out of the nearly \$1 trillion in Iraq expenditures switch to investment.

⁶⁴6% is the certainty equivalent return. Investments in government research have been shown to have much higher rates of return. The natural discount rate to use (for discounting certainty equivalents) is the real T-bill rate, which in recent years has been close to zero or negative. Historically, it has been around 1.5%. The present discounted value of lost income of an investment I yielding a return of g at a discount rate of r is Ig/r , i.e. a “multiplier” of g/r . We have been conservative in choosing a low g and a high r , generating a multiplier of 1.5. The standard cut-off for government projects is 7%, and research yields are even higher. Using a

If the government had, instead, simply let the deficit grow, one would have to calculate the additional growth costs of that deficit. The additional deficit could, for instance, crowd out private investment, and calculations similar to those just performed would provide an estimate of the cost, somewhat larger than the costs estimated above.⁶⁵

Other Macroeconomic Costs (Stock Market, Housing)

Higher oil prices and higher interest rates to which the oil prices give rise also have effects on asset values. To the extent that these effects are greater than just the current year effects on profits, they suggest a persistence of the consequences that our previous analysis did not fully take into account, and the existence of large nonlinearities. This is evident in the industries that are particularly sensitive to oil prices, like the airline industry, where many firms face the prospect of bankruptcy.

The surge in corporate profits in the last couple of years has not been accompanied by an increase in stock prices of the magnitude that would have been expected. Robert Wescott⁶⁶ estimates that the value of the stock market is some \$4 trillion less than would have been predicted on the basis of past performance. Assuming that the major factor contributing to that is the increase in oil prices, and that 20% of that increase in oil prices is due to Iraq leads to a cost of some \$800 billion. This is several times the increase in the direct energy costs over the next few years. This may reflect the fact that we have grossly underestimated the effects by limiting our analysis to 6 years; or to the fact that there are large nonlinearities.⁶⁷ But this decrease in corporate wealth does imply that consumption was lower than it otherwise would have been, with the attendant multiplier effects.⁶⁸

Uncertainty about future oil prices also has a dampening effect on investment. Firms do not know what technology is appropriate for the economic environment that will prevail, and respond to that uncertainty by postponing investment. This has both an effect on aggregate demand and aggregate supply in the short run. Again, we have not estimated the magnitude of these effects.

Summary

The macro-economic costs are potentially very large; possibly even a multiple of the direct costs. Clearly, though ensuring supply of oil was one of the sometimes stated or inferred goals, the risks of Middle East instability that might result was often noted as one of the main risks of the venture. What has happened is certainly within the range of predicted consequences to the price of oil;⁶⁹ and experiences in the seventies should have made us aware of how large the macro economic consequences could be. In short, while large, when adjusted for the larger size of the economy today, they are, we believe, totally plausible.⁷⁰

value of $g = .07$ and $r = .015$ yields a multiplier of 4.67, which is substantially higher. In the case at hand, with forgone investment of \$500 billion, the PDV of future lost income is \$2.3 trillion.

Note that it would be double counting to both count the value of the investment (the opportunity cost) and the value of the benefits that would have been generated by the investment. In a world with perfect markets and no costs to raising taxes, presumably there would be no difference between the discount rate and the marginal return to investment, in which case, the value of the investment would be equal to the present discounted value of the benefits generated by it. In the public sector, however, it is clear that there are often large discrepancies. A relatively modest investment in levees in New Orleans would have saved hundreds of billions of dollars.

⁶⁵If the private investment yields a return of 8%, and we discount at the rate of 4%, then the \$500 billion of displaced investment has a PDV costs of \$1 trillion, or \$500 billion in excess of the direct costs. If the United States borrows the full amount abroad, and there are no effects on the interest rates at which the U.S. can borrow, then there is no displacement effect, and the only costs are the direct costs already estimated. At the same time, the deficit-financed expenditures will give rise to a positive aggregate demand effect. \$500 billion of expenditures, in the assumptions given earlier, would have an additional multiplier effect of \$50 billion. Note that in the case of full deficit financing, in the moderate scenario, the total budgetary impact is \$1.185 trillion; if just 25% of this displaces private investment, the estimated macro-economic costs would be greater than under the expenditure switching analysis.

⁶⁶Personal correspondence

⁶⁷For example, bankruptcy exerts a strong nonlinearity. Some key American industries (automobile, airlines) have been pushed near bankruptcy as a result of oil prices.

⁶⁸Similar issues arise in the case of housing. Though there has been a boom in housing, presumably if the costs of operations were lower, the demand for housing services would have been higher, and prices would have been still higher. We have not estimated the value of the implied reduction in the value of housing *from what it otherwise would have been*.

⁶⁹See, in particular, Nordhaus [2002].

⁷⁰For most of the analysis, we have assumed that there has been excess capacity in the economy, i.e. the economy during the period of concern has been operating below its potential. This

Continued

Figure 5: Macro-economic Effects (\$ billion)

Impact	Conservative	Moderate
Oil price increase		
Transfer (supply side) effect	125 ⁷¹	300
Aggregate demand ⁷²	62	150
Global General Equilibrium		150
Budgetary impacts		
Expenditure switching		200
Growth impacts (PDV)		250
Total	187	1050

We therefore estimate that the total economic costs of the war, including direct costs and macroeconomic costs, lie between \$1 and \$2 trillion, as shown in Figure 6.

Figure 6: Total Economic Costs of the Iraq War (\$BN)

Scenario	Conservative	Moderate
Direct costs	839	1189
Macroeconomic	187	1050
	1026	2239

List of Omitted Costs**Defense and destruction costs**

- Costs of planning war ⁷³
- All costs borne by other countries, including Iraq
 - Military costs
 - Destruction of property
 - Loss of life
- All costs of increased insecurity ⁷⁴

is evidenced not only by figures on capacity utilization and by the fact that the employment ratio (fraction of working age population working) is significantly below the level of the nineties. Even the unemployment rate is significantly higher than the 3.8% reached in the 90s (and there appeared to be no significant inflationary pressures even at that unemployment rate.) The factors that have led to a decrease in the NAIRU, including the competitive supply of goods from abroad, have continued to operate, so that there is every reason to believe that the NAIRU remains far lower than current unemployment rates. (See Stiglitz, 2000). Stagnation and declines in real wages, higher than normal levels of “disability,” and large numbers of individuals claiming to be working part time involuntarily are consistent with this view of significant weaknesses in the labor market, i.e. significant potential for increasing incomes without generating increases in inflation. Our analysis assumes that potential output will exceed actual output for (in the conservative scenario) the next 2 years. This is consistent with most forecasts which see a slowing of growth to between 3.25% and 3.5% in the period 2006–2008, particularly as consumption growth is dampened from its unsustainable levels fueled by rising real estate prices and low interest rates. Even if productivity growth slows from the 3% that marked the nineties, these rates are not sufficient to overcome the “jobs deficit” created in 2001–2003. In any case, even our “moderate” estimate projects that had oil prices not been as high, output would have been higher by amounts that are a fraction of the estimated gap between potential and actual output.

⁷¹ Conservative: \$5 barrel for 5 years; moderate: \$10 barrel for 6 years.

⁷² Conservative: (multi-year) multiplier of 1.5; moderate: (multi-year) multiplier of 2.

⁷³ Estimated at \$2.5 billion.

⁷⁴ Other than the indirect impact of increased insecurity in impeding oil supply response.

- Increased costs of cross border flows
- Reduced investment
- Consequences of Loss of credibility
- Value of reduced capability of responding to national security threats elsewhere in the world

Value of reduced capability of responding to domestic situations in which the National Guard or the Reserves might have been called upon (as in New Orleans).

Macroeconomic costs

- All costs of increased insecurity⁷⁵
 - Increased costs of cross border flows
 - Reduced investment
- Indirect aggregate demand effects (as a result of reduced incomes in trading partners)⁷⁶
- Costs of oil price volatility
 - Including on investment
 - Costs of bankruptcy⁷⁷
- Reduced demands as a result of anti-American sentiment
- Consequences of losses of asset values (arising from increase in oil prices or otherwise)
 - Equity markets
 - Housing
- Consequences of tighter monetary policy as a result of increased inflation⁷⁸
- Consequences of worsening fiscal position
 - As a result of increased government expenditures on oil⁷⁹
 - As a result of increased expenditures on the war⁸⁰

Other Costs

- Costs of risks borne by individuals⁸¹ (including compensation that would be required to make them willingly bear risks)
- Economic Cost of impairment to earnings potential and quality of life for veterans who claim partial disability (est. 160,000) but were not wounded during the conflict
- Healthcare costs not borne by the government

IV. Concluding Remarks

The most important things in life—like life itself—are priceless. But that doesn't mean that topics like defense, involving the preservation of our way of life and the protection of life itself, should not be subject to cool, hard analysis of the kind for which economics has long earned a reputation.

Take the decision of when to go to war. Here, economic analysis employs the concept of *option value*. Even if one thinks war is inevitable or highly likely, there is a question of timing because there are costs and benefits to postponement. The enemy may be better prepared, but so may we. Normally, one goes into such a war under the presumption that one is going to win, and therefore a critical issue is managing the post-war occupation. Without adequate preparation, weapons may easily fall in the hands of insurgents—as in fact they did—enormously increasing the occupation costs. With adequate armor, fewer American troops are likely to be injured or killed. As even the Secretary of Defense has admitted, in the rush to war, there was not time to provide adequate protection for the troops, protection that clearly the richest country in the world could have afforded and that its citizens would have expected.

⁷⁵Other than the indirect impact of increased insecurity in impeding oil supply response.

⁷⁶Other than as reflected in higher multiplier in “conservative” case.

⁷⁷Other than as reflected in the multiplier analysis. The multiplier analysis focuses on demand side effects; bankruptcy costs are more correctly viewed as supply side effects (not included in the standard neoclassical model.)

⁷⁸Other than as reflected in multiplier analysis.

⁷⁹Other than as reflected in multiplier analysis.

⁸⁰In the “Conservative” scenario. In the “moderate” scenario, we perform an expenditure switching incidence analysis, which provides a number that may partially reflect these costs.

⁸¹Other than as reflected in increased recruitment costs.

Economists also think about the *value of information*. In this situation, postponing war might have allowed us to gather better information with which to judge whether Iraq posed a real threat. This is not, as Americans say, Monday morning quarterbacking: there were already strong suspicions regarding our sources of intelligence on Iraq's alleged weapons of mass destruction. More time would have enabled the verification of this evidence. The value of this information would have been enormous. The possibility of war later on would have still been an option. Tens of thousands of lives would have been spared, and hundreds of billions of dollars saved.

All of this leads to economists' constant urging that politicians undertake a *cost benefit analysis* before undertaking any project—especially one with as significant consequences as war. This can and should be done even if certain elements of the costs and benefits are hard to value.

If Congress had been informed of the range of costs, perhaps if they had been told that the costs might exceed a half trillion, or a trillion dollars, perhaps, in the end, they would have made the same decision. But perhaps they would have been a bit more cautious in making that decision, looked a little harder at the evidence, thought differently about how best to conduct the war.

We have not attempted in this paper an overall assessment of whether the war was conducted in the most cost efficient manner, i.e. whether, given what has been achieved (however that is defined), those objectives could have been achieved at lower costs. We have taken the expenditures, as they have occurred, not as they might have been. The Administration has explicitly tried to fight the war on the cheap, that is limit direct commitments of American troops, even shortchanging body and personnel armor. In violating the Powell doctrine, this may be one of those instances of “penny wise-pound foolish”. Certainly, the long run costs to the individuals and to society of the individuals who died or were badly maimed (not to mention the additional costs of recruitment) far exceed the savings from not purchasing better body protection. Many observers believe that the manner in which the War was conducted led to the extended insurgency, which too has greatly increased cost.

Though we have suggested that many of the costs were within the range of what could have been anticipated, we have not sought in this paper to ascertain whether on the basis of the information available, the Administration could have made more reliable estimates. We do not address the question of whether the disparity between the predicted numbers and the actual numbers is a result of a deliberate attempt of the Administration to mislead the American people on the cost of the war, or of incompetence, going to War with information of low reliability and with best estimates that were far from the mark. In response to accusations about the existence of weapons of mass destruction and the connection with Al Qaeda, the Administration has been adamant that it did not intentionally deceive the American people; it prefers charges of incompetence to those of malevolence. We have not attempted to ascertain the relative role of each in the failure to provide the American people with an accurate cost of the venture. At the very least, though, honesty would have required laying out the various scenarios, even if it attached low probabilities to those that in fact turned out to be the case.⁸²

Americans could, and should have asked, are there ways of spending that money that would have enhanced our long run well-being—and perhaps even our security—more. Take the conservative estimate of a trillion dollars. Half that sum would have put Social Security on a firm grounding for the next seventy-5 years. If we spent even a small fraction of the remainder on education and research, it is likely our economy would be in a far stronger position. If some of the money spent on research were devoted to alternative energy technologies, or to providing further incentives for conservation, we would be less dependent on oil, and thereby more secure; and the lower prices of oil that would result would have obvious implications for the financing of some of the current threats to America's security. While we may not know what causes terrorism, clearly the desperation and despair that comes from the poverty that is rife in so much of the Third World has the potential of providing a fertile feeding ground. For sums less than the direct expenditures on the war, we could have fulfilled our commitment to provide 7% of our GDP to help developing countries—money that could have made an enormous difference, for the better, to the well-being of billions today living in poverty. We could have had a Marshall Plan for the Middle East, or the developing countries, that might actually have succeeded in winning the hearts and minds of those in the Middle East.

⁸²An excellent example of the kind of analysis that could and should have been provided is that of Nordhaus (2002), who lays out various scenarios. The CBO and the House Budget Committee provided some estimates. Nordhaus points out, however, that they did not include scenarios involving extended engagement, occupation, and reconstruction.

What is clear is that the Administration's original estimates were strikingly low.⁸³ Would the American people have had a different attitude toward going to war had they known the total cost? Would they have thought that there might be better ways of advancing the cause of democracy or even protecting themselves against an attack, that would cost but a fraction of these amounts? In the end, we may have decided that a trillion dollars spent on the War in Iraq was better than all of these alternatives. But at least it would have been a more informed decision than the one that was made. And recognizing the risks, we might have conducted the War in a manner different from the way we did.

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⁸³It is of interest that our "moderate" estimate is not dissimilar to Nordhaus' "high" (protracted and unfavorable) case, \$1.9 trillion. His estimate of direct military spending, occupation, and reconstruction was \$745. However, he did not include a number of the long run costs (such as health costs and disability benefits and increased recruiting costs), nor the adjustments between economic and budgetary costs noted in section III. His estimate of the direct impact on oil markets (the transfer effect) was \$778 billion, which we believe to be more accurate than estimate of \$300 million (in the moderate case), which was deliberately chosen to be conservative. He uses a "macro-economic oil" multiplier that is similar to ours, but because he (realistically) assumes a large oil price effect, he obtains a larger macro-economic effect. He does not include any "growth investment/displacement" or "expenditure switching" effects in his analysis. Nordhaus' historical analysis puts some perspective on the magnitude of the expenditures: the projected direct expenditures in Table 1 are comparable to those of the Vietnam War (\$494 billion), somewhat greater than the Korean war (\$336 billion) and more than twice as large as World War I (\$190 billion).

**SOLDIERS RETURNING FROM IRAQ AND AFGHANISTAN:
The Long-term Costs of Providing Veterans Medical Care
and Disability Benefits**

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January 2007

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EXECUTIVE SUMMARY:

This paper analyzes the long-term needs of veterans returning from the Iraq and Afghanistan conflicts, and the budgetary and structural consequences of these needs. The paper uses data from government sources, such as the Veterans Benefit Administration Annual Report. The main conclusions of the analysis are that:

(a) the Veterans Health Administration (VHA) is already overwhelmed by the volume of returning veterans and the seriousness of their healthcare needs, and it will not be able to provide a high quality of care in a timely fashion to the large wave of returning war veterans without greater funding and increased capacity in areas such as psychiatric care;

(b) the Veterans Benefits Administration (VBA) is in need of structural reforms in order to deal with the high volume of pending claims; the current claims process is unable to handle even the current volume and completely inadequate to cope with the high demand of returning war veterans; and

(c) the budgetary costs of providing disability compensation benefits and medical care to the veterans from Iraq and Afghanistan over the course of their lives will be from \$350–\$700 billion, depending on the length of deployment of U.S. soldiers, the speed with which they claim disability benefits and the growth rate of benefits and healthcare inflation.

Key recommendations include: increase staffing and funding for veterans medical care particularly for mental health treatment; expand staffing and funding for the “Vet Centers,” and restructure the benefits claim process at the Veterans Benefit Administration.

This paper was prepared for the Allied Social Sciences Association Meetings in Chicago, January, 2007. The views expressed here are solely those of the author and do not represent any of the institutions with which she is affiliated, now or in the past.

Introduction

The New Year has brought with it the grim fact that 3000 American soldiers have been killed so far in Iraq. A statistic that merits equal attention is the unprecedented number of U.S. soldiers who have been injured. As of September 30, 2006, more than 50,500 U.S. soldiers have suffered non-mortal wounds in Iraq, Afghanistan and nearby staging locations—a ratio of 16 wounded servicemen for every fatality¹ This is by far the highest killed-to-wounded ratio in U.S. history. For example,

¹Department of Veterans Affairs, Office of Public Affairs, “America’s Wars”, September 30, 2006. This document shows that the number of non-mortal woundings in the Global War on Terror (combining Iraq, Afghanistan and surrounding duty stations) as of 9/30/06 was 50,508 compared with 2333 deaths in battle plus 707 other deaths in theater. The comparison numbers for previous conflicts are as follows: Desert Storm/Desert Shield: 1.2 wounded per fatality; Vietnam: 2.6 wounded per fatality; Korea: 2.8 wounded per fatality; World War II: 1.6 wounded per fatality; World War I: 1.8 wounded per fatality; Civil War (union): .7 wounded per fatality; War of 1812: 2.5 wounded per fatality; American Revolution: .7 wounded per fatality. Note: the VA defines non-mortal wounded as those who are “medically evacuated from theatre”. The Pentagon

in the Vietnam and Korean wars there were 2.6 and 2.8 injuries per fatality, respectively. World Wars I and II had fewer than 2 wounded servicemen per death.²

While it is welcome news and a credit to military medicine that more soldiers are surviving grievous wounds, the existence of so many veterans, with such a high level of injuries, is yet another aspect of this war for which the Pentagon and the administration failed to plan, prepare and budget. There are significant costs and requirements in caring for our wounded veterans, including medical treatment and long-term healthcare, the payment of disability compensation, pensions and other benefits, reintegration assistance and counseling, and providing the statistical documentation necessary to move veterans seamlessly from the Department of Defense payroll into Department of Veterans Affairs medical care, and to process VA disability claims easily.

To date, 1.4 million U.S. servicemen have been deployed to the Global War on Terror (GWOT), the Pentagon's name for operations in and around Iraq and Afghanistan.³ The servicemen who have been officially wounded are a small percentage of the veterans who will be using the veteran's administration medical system. Hundreds of thousands of these men and women will be seeking medical care and claiming disability compensation for a wide variety of disabilities that they incurred during their tours of duty.⁴ The cost of providing such care and paying disability compensation is a significant long-term entitlement cost that the U.S. will be paying for the next forty years.⁵

The objective of this paper is to examine the structural and budgetary requirements for caring for the returning war veterans from Iraq and Afghanistan, in terms of U.S. capacity to pay disability compensation, provide high quality medical care, and provide other essential benefits. The paper grew out of a previous paper that was co-authored in January 2005 with Columbia University professor Joseph Stiglitz, in which the overall costs of the war in Iraq were estimated to exceed \$2 trillion. One of the long-term costs cited in that paper was the cost associated with providing healthcare and disability benefits to veterans⁶ This paper expands on that topic.

Unlike the previous paper,⁷ this study does not differentiate between veterans returning from Iraq, or Afghanistan or adjacent locations (such as Kuwait, an important staging post for Iraq) in the GWOT, for three reasons. First, nearly one-third of the servicemen involved in the war have been deployed two or more times and

has several definitions, but the daily casualty reports on its website use a narrower definition referring to those wounded by shrapnel, bullets, and so forth. Using this narrow definition, the Iraq conflict has a ratio of 8 wounded per fatality—still much higher than any previous war in U.S. history.

²Ibid.

³As of September 30, 2006, 1,406,281 unique servicemembers have been deployed to the wars in Iraq and Afghanistan, according to the Department of Defense, Defense Manpower Data Center, and "Contingency Tracking System." The Veterans Health Administration (VHA) Office of Public Health and Environmental Hazards, November 2006 uses the number 1.4 million (as of November 2006). The Veterans Benefits Administration (VBA) lists 1,324,419 unique servicemen deployed to GWOT as of May 2006 (prepared by VBA/OPA&I, 7/20/06).

⁴Based on an analysis of the first Gulf War in 1991, using the Gulf War Veterans Information System (GWVIS August 2006, chart on "Gulf War Veteran Outpatient Stays", there were 297,125 veterans from that conflict who used VA medical care, or 48.4%. If the same percentages of Iraq/Afghan veterans use VA medical care then VA should expect approximately 700,000 new patients from the 1.4 million existing servicemen. Increasing the number of unique servicemen deployed will increase medical and disability usage.

⁵Veterans' disability pay is an entitlement program, like Medicare and Social Security. Once a veteran has been approved to receive disability pay, he or she is entitled to receive an annual payment and cost-of-living adjustments. The average age of a servicemen is about 25 years of age, therefore given current life expectancy rates, 40 years is a reasonable amount of years to project payment of benefits, even assuming the veteran does not claim for some years following the period of service.

⁶Bilmes, Linda and Stiglitz, Joseph, *The Economic Costs of the Iraq War: An Appraisal Three Years After the Beginning of the Conflict*, NBER Working Paper 12054 (<http://www.nber.org/papers/w12054>), February 2006. The long-term budgetary costs associated with veterans health and disability cited in that paper ranged from \$77 bn to \$179 bn (depending on the length of the war), based on a population of 550,000 unique Iraqi war veterans. After we published this paper, a number of veteran's organizations including the American Legion and Veterans for America, contacted us in appreciation of our highlighting the needs of veterans. Veterans for America has particularly encouraged further research to understand the needs of the returning GWOT veteran's community.

⁷The Bilmes/Stiglitz cost of war paper did not include the costs of Afghanistan or other areas outside of Iraq in the GWOT. Had we included those costs, the total cost of war would have increased by 15–20%.

many of them have served both in Iraq and Afghanistan, and/or other locations.⁸ Second, the data available from the VA does not distinguish between the wars in Iraq and Afghanistan. Third, for the purposes of estimating the long-term costs of taking care of the returning veterans it does not matter where they served. However it is worth noting that the overwhelming majority of the deaths and injuries incurred in the GWOT have been in Iraq. Among those listed as wounded on the Pentagon's casualty reports, more than 95% have been injured in Iraq.⁹

This paper will analyze the following aspects of the returning veterans' needs.

1. Disability compensation
 - Projected Cost
 - Backlog of Pending Claims
2. Medical care
 - Capacity issues
 - Projected Cost
 - Veterans Centers
 - Transitioning from the Department of Defense to VA care
3. Overall assessment of U.S. readiness to meet its obligations to veterans
4. Recommendations

Methodology

All statistics used in this paper are from government sources, including publications of the Veterans Benefit Administration (VBA), Veterans Health Administration (VHA), and other VA offices, as well as from the Congressional Budget Office, the Government Accountability Office, the Department of Defense, and Congressional testimony. The numbers are based on the servicemen involved in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF, Afghanistan) unless otherwise noted.

The cost and structural requirements for returning veterans will depend on several factors, including the number of U.S. troops stationed in the region and how long they are deployed; the rate of claims and utilization of health resources by returning troops, and the rate of increase in disability payment and healthcare costs over time. The model developed allows the user to vary these assumptions and may be obtained with permission from the author's website. The current analysis has been performed under three "base" scenarios that reflect, broadly the three options now under consideration for the war.

- **Low Scenario:** The low scenario assumes that the U.S. begins withdrawing troops in 2007 and that all U.S. servicemen are home by 2010. This pattern is roughly in parallel with the recommendations of the bipartisan Baker Commission that reported to President Bush in November 2006. This scenario assumes that *we will not deploy any new troops beyond the 1.4 million already participating in the war*. It assumes that 44% of U.S. troops will claim for disability payment over a period of years, with 87% of claims granted, following the same claims pattern as the first Gulf War in 1991.¹⁰ The low scenario assumes that soldiers will initially receive the VA's 2005 average recurring benefit and that the annual rate of increase will be 2.8% to reflect a cost-of-living adjustment only. (As opposed to the actual growth rate over the past 10 years which is 6.1%). The medical usage in this scenario is based on the lowest possible uptake of medical care and a rate of increase that is below the historical rate of healthcare inflation. In short, this scenario shows the absolute basement level—the lowest possible cost of providing medical care and disability benefits to soldiers returning from Iraq and Afghanistan under the most optimistic assumptions.

⁸As of 9/30/06, some 421,206 (30%) of 1,406,281 unique servicemembers had been deployed twice or more to the wars in Iraq and Afghanistan. Army Times, December 11, 2006, page 14, from the Department of Defense, Defense Manpower Data Center, "Contingency Tracking System."

⁹As of 12/28/06, the DOD website listed 22,565 wounded in Operation Iraqi Freedom and 1084 wounded in Operating Enduring Freedom (Afghanistan). As noted previously, this is a narrower definition of injuries than the one used by the Veterans administration, which lists 50,508 non-mortal woundings as of 9/30/06.

¹⁰Using the claims patterns from Gulf War I is almost certainly too conservative because that war was much shorter and relied primarily on aerial bombardment, whereas the current wars involve long deployments and ground warfare. However it provides a baseline for the current Iraq/Afghan wars.

- **Moderate Scenario:** The moderate scenario is based on the current course of the war. This scenario uses the Congressional Budget Office's expected deployment figures, which would involve a gradual drawdown of troops but maintain a small U.S. force in the region through 2015. Under this scenario, the total unique servicemen involved in the conflict will be 1.7 million, that is, 300,000 additional troops rotated in over the period of years. Nearly 20,000 new troops are regularly deployed into the two war zones each month, before any "surge" or escalation of the conflict is considered.¹¹ This scenario uses the first Gulf War as the basis for predicting the level of troops who will claim disability benefits, the rate of approval of the claims, and the utilization of medical resources. However a growth rate of 4.4% is projected for claims benefits, half way between the base cost-of-living adjustment and the actual growth rate of 6.1%.
- **High "Surge" Scenario:** This scenario assumes that troop levels with surge in 2007 and that the total participation in the war over time will eventually reach 2 million unique servicemen by 2016. It also models the potential that half the veterans claim disability payments, which is a reasonable possibility given the ferocity of the conflict and the number of second and third deployments. This model also looks at the impact of growth in claims benefit payments and healthcare costs based on the actual growth rates over the past 10 years. If the U.S. decides to increase troops and all trends on disability and healthcare continue as they have in the past, this model presents the resulting cost consequences.

The costs estimated in this study are budgetary costs to the U.S. government directly associated with the payment of disability benefits and medical treatment for returning OIF/OEF war veterans. The costs do not include the interest payments on the debt that is being incurred in borrowing money to finance the war. Future cash flows were discounted at a rate of 4.75% reflecting current long-term U.S. borrowing rates.

1. Disability Compensation

There are 24 million living veterans, of whom roughly 11% receive disability benefits. Overall, in 2005 the U.S. currently paid \$23.4 billion in annual disability entitlement pay to veterans from previous wars, including 611,729 from the first Gulf War, 916,220 from Vietnam, 161,512 Korean war veterans, 356,190 World War II veterans and 3 veterans of World War I.¹²

All 1.4 million servicemen deployed in the current war effort are potentially eligible to claim some level of disability compensation from the Veterans Benefits Administration. Disability compensation is a monetary benefit paid to veterans with "service-connected disabilities"—meaning that the disability was the result of an illness, disease or injury incurred or aggravated while the soldier was on active military service. Veterans are not required to seek employment nor are there any other conditions attached to the program. The explicit congressional intent in providing this benefit is "to compensate for a reduction in quality of life due to service-connected disability" and to "provide compensation for average impairment in earnings capacity." The principle dates back to the Bible at Exodus 21:25, which authorizes financial compensation for pain inflicted by another¹³

Disability compensation is graduated according to the degree of the veteran's disability, on a scale from 0 percent to 100 percent, in increments of 10%. Annual benefits range from a low of \$1304 per year for a veteran with a 10% disability rating to about \$44,000 in annual benefits for those who are completely disabled.¹⁴ The average benefit is \$8890 although this varies considerably; Vietnam veterans average about \$11,670.¹⁵ Additional benefits and pensions are payable to veterans with severe disabilities. Once deemed eligible, the veteran receives the compensation payment as a mandatory entitlement for the remainder of their lives, like Medicare and Social Security.

¹¹Footnote: Analysis of DMDC's Contingency Tracking System shows 57,462 new first-time deployments between June 2006 and September 2006, an average 19,154 per month

¹²Ibid, page 33, "Benefits delivery network", RCS 20-0221

¹³See Veterans Benefits Administration "Annual Benefits Report" (ABR), 2005, page 17 for definition of disability compensation and see VA Disability Compensation Program, *Legislative History*, VA Office of Policy, Planning and Preparedness 2004 for principles behind the program.

¹⁴Ibid, page 24, lists \$1304 for 10% and \$31,611 for 100%, but those with 100% disability also receive additional payments that combined result in an annual payment of approximately \$44,000.

¹⁵Ibid, page 33.

There is no statute of limitations on the amount of time a veteran can claim for most disability benefits. The majority of veteran's claims are within the first few years after returning, but some disabilities do not surface until years later. The VA is still handling hundreds of thousands of new claims from Vietnam era veterans for post-traumatic stress disorder and cancers linked to Agent Orange exposure.

The process for ascertaining whether a veteran is suffering from a disability, and determining the percentage level of a veteran's disability, is complicated and lengthy. A veteran must apply to one of the 57 regional offices of the Veterans Benefits Administration (VBA), where a claims adjudicator evaluates the veteran's service-connected impairments and assigns a rating for the degree to which the veteran is disabled. For veterans with multiple disabilities, the regional office combines the ratings into a single composite rating. If a veteran disagrees with the regional office's decision he or she can file an appeal to the VA's Board of Veterans Appeals. The Board makes a final decision and can grant or deny benefits or send the case back to the regional office for further evaluation. Typically a veteran applies for disability in more than one category, for example, a mental health condition as well as a skin disorder. In such cases, VBA can decide to approve only part of the claim—which often results in the veteran appealing the decision. If the veteran is still dissatisfied with the Board's decision to grant service connection or the percentage rating, he or she can further appeal it to two even higher levels of decision-makers.¹⁶

Most employees at VA are themselves veterans, and are predisposed to assisting veterans obtain the maximum amount of benefits to which they are entitled. However, the process itself is long, cumbersome, inefficient and paperwork-intensive. The process for approving claims has been the subject of numerous GAO studies and investigations over the years. Even in 2000, before the current war, GAO identified longstanding problems in the claims processing area. These included large backlogs of pending claims, lengthy processing times for initial claims, high error rates in claims processing, and inconsistency across regional offices.¹⁷ In a 2005 study, GAO found that the time to complete a veteran's claim varied from 99 days at the Salt Lake City regional office to 237 days at the Honolulu, Hawaii office.¹⁸

The backlog of pending claims has been growing since 1996. In 2000, VBA had a backlog of 69,000 pending initial compensation claims, of which one-third had been pending for more than 6 months.¹⁹ Today, due in part to the surge in claims from the Iraq/Afghan wars, VBA has a backlog of 400,000 claims.²⁰ VBA now takes an average of 177 days (6 months) to process an original claim, and an average of 657 days (nearly 2 years) to process an appeal.²¹ This compares unfavorably with the private sector healthcare/financial services industry, which processes an annual 30 billion claims in an average of 89.5 days per claim, *including* the time required for claims that are disputed.²²

Projected Demand for Benefits among OIF/OEF Veterans

It is difficult to predict with certainty the number of veterans from the two current wars who will claim for some amount of disability. The first Gulf War provides a baseline number although the Iraq and Afghanistan war has been longer and has involved more ground warfare than the Desert Storm conflict, which relied largely on aerial bombardment and 4 days of intense ground combat. However, in both conflicts, a number of veterans were exposed to depleted uranium that was used in anti-tank rounds fired by U.S. M1 tanks and U.S. A10 attack aircraft. Many disability claims from the first Gulf War stem from exposure to depleted uranium, which has been implicated in raising the risk of cancers and birth defects. Gulf War veterans also filed disability claims related to exposures to oil well fire pollution, low-levels of chemical warfare agents, experimental anthrax vaccines, and experimental anti-chemical warfare agent pills called pyridostigmine bromide, the anti-malaria pill Lariam, skin diseases, and disorders from living in the hot climate,²³

¹⁶ GAO, "Veterans Benefits Administration: problems and Challenges Facing Disability Claims Processing", GAO Testimony before the Subcommittee on Oversight and Investigations, House Committee on Veterans Affairs, May 18, 2000

¹⁷ Ibid.

¹⁸ "Veterans Benefits: Further Changes in VBA's Field Office Structure could help improve disability claims processing", GAO-06-149, December 2005

¹⁹ Ibid.

²⁰ The VBA's backlog of pending claims was 399,751 as of December 9, 2006 (VBA Monday Morning Workload Report).

²¹ The average time to process a claim is 177 days as of 9/06 and average time to process an appeal is 657 days (VA Performance and Accountability Report FY 2006).

²² Bearing Point, Health Care/Financial Services industry report, September 14, 2006.

²³ Veterans for America, interview with Paul Sullivan, program director, 11/06.

which are likely to be cited in the current conflict. However, the number of disability claims in the Iraq/Afghan wars is likely to be higher due to the significantly longer length of soldier's deployments, repeat deployments, and heavier exposure to urban combat.

Following the Gulf War the criteria for receiving benefits were widened by Congress based on evidence of widespread toxic exposures.²⁴ The same criteria for healthcare and benefits eligibility still apply to veterans of the Iraq and Afghanistan wars²⁵ Forty-4 percent of those veterans filed disability claims for a variety of conditions and 87% were approved.²⁶ The U.S. currently pays about \$4 billion annually in disability payments to veterans of Desert Storm/Desert Shield.²⁷

Of the 1.4 million U.S. servicemen who have so far been deployed in the Iraq/Afghan conflicts, 631,174 have been discharged as of September 30, 2006. Of those 46% are in the full-time military and 54% are reservists and National Guardsmen.²⁸ Therefore the total population that is potentially eligible for disability benefits is this number (631,174). To date 152, 669 servicemen have applied for disability benefits and of those, 104,819 have been granted, 34,405 are pending and 13,445 have been rejected. This implies an approval rate of 88% to date.²⁹

We have estimated the cost of providing disability benefits to veterans under three scenarios. Under the low scenario, we expect that as in the first Gulf War, 44% of the current veterans will eventually claim disability, with an approval rate of 87%. We estimate that the remaining 900,000 troops will be discharged in equal installments over the next 4 years bringing all U.S. troops home by 2010. We expect the same percentage of these troops to claim for disabilities, with the same approval rate, within a further 5 years. We have assumed that on average, claims are lower than average rate, at the lower rate of new claimants from the first Gulf War of \$6506.³⁰ This is probably an excessively conservative assumption because it projects the same rate of serious injuries as occurred in Gulf War I, when in fact we already know that more than the actual rate of serious injuries is much higher.³¹

The moderate scenario assumes that the war continues through 2014 with a total deployment of 1.7 million over the course of the war, and with gradually reduced deployment. It assumes that a slightly higher percentage of eligible veterans (50%) make claims, which is more realistic given deployment lengths. This scenario uses the actual average VA benefit payment of \$8890. It assumes the rate of increase in benefits is 4.4%, midway between the mandatory Cost of Living Adjustment and the actual 10-year growth rate of 6.1%. The high scenario models the impact of a surge in forces bringing the total unique deployments to 2 million. It assumes 50% of eligible forces claim benefits and a rate of 6.1% increase, which is the actual rate over the past 10 years. It further assumes a higher rate of medical inflation (10% vs. 8% in the low and moderate scenarios).

Table 1: Long-term Cost of Veterans Disability Benefits³²

Scenario	Low	Moderate	High
Disability Benefits (\$bn)	67.63	109.98	126.76

²⁴“Veterans Benefits Improvement Act 1994” (Public Law 103-446) and “Persian Gulf War Veterans Act 1998” (PL 105-277).

²⁵In fact, the VA does not distinguish, for the purpose of claims processing, between the end of the first Gulf War and the present conflict (38 USC section 101(33) defines the Gulf War as starting on August 2, 1990, and continuing until either the President or the Congress declares an end to it and 38 CFR 3.317 defines the locations of the conflict).

²⁶For Gulf War, the total claims filed to date are 271,192, of which 205,911 have been approved, 20,382 were denied and 34,899 are still pending (GWVIS, August 2006, p.7: Granted Service Connection +Denied Service Connection +Claims Pending)

²⁷Gulf War total annual payment \$4.3 billion (Ibid., VBA, ABR 2005 pp. 33)

²⁸VHA, Office of Public Health and Environmental Hazards, November 2006

²⁹VBA “Compensation and Benefit Activity among veterans deployed to the GWOT”, July 20, 2006, obtained under Freedom of Information Act by the National Security Archive at George Washington University.

³⁰Ibid, ABR 2005, p33

³¹Of the 50,508 non-mortally wounded soldiers in OIF/OEF there are at least 10,000 serious injuries such as brain injuries, spinal and amputations, according to DOD sources. See also Wallsten and Kosec, AEI-Brookings Working Paper 05-19, September 2005, estimate of 20% serious brain injuries, 6% amputees and 24% other serious injuries.

Backlog of Pending Disability Claims

The issue is not simply cost but also efficiency in providing disabled veterans with their benefits. In addition to all the problems detailed above, the Iraq and Afghan war veterans are filing claims of unusually high complexity (see table 3). To date, the backlog of pending claims from these recent war veterans is 34,000, but the vast majority of servicemen from this conflict have not yet filed their claims. Even without the projected wave of claims, the VA has an overall backlog of 400,000, including thousands of Vietnam era claims. Including all pending claims and other paperwork, the VA's backlog has increased from 465,623 in 2004 to 525,270 in 2005 to 604,380 in 2006.³³

The fact that the VBA is largely sympathetic to the plight of disabled veterans should not obscure the fact that this system is already under tremendous strain. If only one fifth of the returning veterans who are eligible claim in a given year, and the total claims reaches a high of 38% effective rate (44%* 88% approval rate), the number of likely claims at the VBA over the next 10 years can be expected to rise from 104,819 to more than 600,000.³⁴ (See table 2).

Table 2: Projected Increase in Disability Claims (moderate scenario)

Disability Benefits	2006	2007	2008	2009	2010	2011	2012
Discharged		118,758	118,758	118,758	118,758	118,758	118,758
<i>cum</i>		118,758	237,517	356,275	475,034	593,792	712,551
Eligible claimants							
Existing discharged							
non-claimants	526,355	526,355	526,355	526,355	526,355	526,355	526,355
Newly discharged	—	118,758	237,517	356,275	475,034	593,792	712,551
Total potential claimants	645,113	645,113	763,872	882,630	1,001,389	1,120,147	1,238,906
Claim rate	22%	22%	27%	33%	38%	44%	44%
New claims	—	140,312	207,678	287,958	381,154	487,264	538,924
Current beneficiaries	104,819	104,819	104,819	104,819	104,819	104,819	104,819
Total claims (number)	104,819	245,131	312,497	392,777	485,973	592,083	643,743
Total claims (\$bn)	0.93	2.27	2.89	3.63	4.49	5.47	5.95

If nothing is done to address the problem, the claims backlog will continue to grow throughout the period of the war, along with growing inequity between different regional offices. A key question is: what is a reasonable amount of time for the U.S. to make a disabled veteran wait for a disability check? This paper proposes several actions that could reduce the length of time for processing from zero to 90 days. (Described in more detail in section 4: Recommendations). These include: (a) greater use of the "Vet Centers" to provide assistance for veterans to file their claims, (b) automatically granting all or some of the claims, with subsequent audits to deter fraud, and (c) streamlining and technologically upgrading the claims system into a "fast track" where veterans receive a quick decision on most claims.

2. Veterans Medical Care Shortfall

The VA's Veterans Health Administration provides medical care to more than 5 million veterans each year. This care includes primary and secondary care, as well as dental, eye and mental healthcare, hospital inpatient and outpatient services. The care is free to all returning veterans for the first 2 years after they return from active duty; thereafter the VA imposes copayments for various services, with the amounts related to the level of disability of the veteran.³⁵

The VA has long prided itself on the excellence of care that it provides to veterans. In particular, VA hospitals and clinics are known to perform a heroic job in areas such as rehabilitation. Medical staff is experienced in working with veterans and provides a sympathetic and supportive environment for those who are disabled. It is therefore of utmost important that the quality of care be maintained as the demand for it goes up.

However, the demand for VA medical treatment is far exceeding what the VA had anticipated. This has produced long waiting lists and in some cases simply the absence of care. To date, 205,097, or 32% of the 631,174 eligible discharged OEF/OIF

³²The figures in Table 1 represent the present value of disability benefits over 40 years for eligible veterans projected under the three scenarios described.

³³VBA's "Monday Morning Report" of pending claims and other work performed at regional offices, cites: 11/25/06: 604,380; 11/26/05: 525,270; 11/27/04: 465,623.

³⁴This projection based on the moderate scenario described previously, based on 1.7 million unique servicemen and CBO troop deployment figures through 2014.

³⁵38 USC section 1710

veterans have sought treatment at VA health facilities. These include 35% of the eligible active duty servicemen (101,260) and 31% of the eligible Reservists/Guards (103,837). To date, this number represents only 4% of the total patient visits at VA facilities—but it will grow. According to the VA, “As in other cohorts of military veterans, the percentage of OIF/OEF veterans receiving medical care from the VA and the percentage of veterans with any type of diagnosis will tend to increase over time as these veterans continue to enroll for VA healthcare and to develop new health problems.”³⁶

The war in Iraq has been noteworthy for the types of injuries sustained by the soldiers. Some 20% have suffered brain trauma, spinal injuries or amputations; another 20% have suffered other major injuries such as amputations, blindness, partial blindness or deafness, and serious burns.

However, the largest unmet need is in the area of mental healthcare. The strain of extended deployments, the stop-loss policy, stressful ground warfare and uncertainty regarding discharge and leave has taken an especially high toll on soldiers. Thirty-six percent of the veterans treated so far—an unprecedented number—have been diagnosed with a mental health condition. These include PTSD, acute depression, substance abuse and other conditions. According to Paul Sullivan, a leading veterans advocate, “The signature wounds from the wars will be (1) traumatic brain injury, (2) post-traumatic stress disorder, (3) amputations and (4) spinal chord injuries, and PTSD will be the most controversial and most expensive”³⁷ (see Table 3).

Table 3: VHA Office of Public Health, November 2006

<i>Frequency of Possible Diagnoses Among Recent Iraq and Afghan Veterans</i>		
Diagnosis (Broad ICD-9 Categories)	(n = 205,097)	
	Frequency*	%
Infectious and Parasitic Diseases (001–139)	21,362	10.4
Malignant Neoplasms (140–208)	1,584	0.8
Benign Neoplasms (210–239)	6,571	3.2
Diseases of Endocrine/Nutritional/Metabolic Systems (240–279)	36,409	17.8
Diseases of Blood and Blood Forming Organs (280–289)	3,591	1.8
Mental Disorders (290–319)	73,157	35.7
Diseases of Nervous System/Sense Organs (320–389)	61,524	30.0
Diseases of Circulatory System (390–459)	29,249	14.3
Disease of Respiratory System (460–519)	36,190	17.6
Disease of Digestive System (520–579)	63,002	30.7
Diseases of Genitourinary System (580–629)	18,888	9.2
Diseases of Skin (680–709)	29,010	14.1
Diseases of Musculoskeletal System/Connective System (710–739)	87,590	42.7
Symptoms, Signs and Ill Defined Conditions (780–799)	67,743	33.0
Injury/Poisonings (800–999)	35,765	17.4

* Hospitalizations and outpatient visits as of 9/30/2006; veterans can have multiple diagnoses with each healthcare encounter.

A veteran is counted only once in any single diagnostic category but can be counted in multiple categories, so the above numbers add up to greater than 205,097.

Additionally, far more returning Iraqi war veterans (than those in previous conflicts) are likely to seek such help, in part due to awareness campaigns run by veteran’s organizations through the press. There is no reliable data on the length of waiting lists for returning veterans, but even the VA concedes that they are so long as to effectively deny treatment to a number of veterans. In the May 2006 edition of *Psychiatric News*, Frances Murphy M.D., the Under Secretary for Health Policy Coordination at VA, said that mental health and substance abuse care are simply not accessible at some VA facilities. When the services are available, Dr. Murphy asserted that, “waiting lists render that care virtually inaccessible.”³⁸

The VA curiously maintains that it can cope with the surge in demand, despite much evidence to the contrary. For the past 2 years, the VA ran out of money to provide healthcare. In FY 2006, the VA was obliged to submit an emergency supplemental budget request for \$2 billion, which included \$677 million to cover an unexpected 2% increase in the number of patients (half of which were OIF/OEF patients), \$600 million to correct its inaccurate estimate of long-term care costs, and \$400 million to cover an unexpected 1.2% increase in the costs per patient due to

³⁶ VHA, Office of Public Health and Environmental Hazards, November 2006, *Ibid*, p. 14

³⁷ Paul Sullivan, Program Director of Veterans for America, 12/23/06 interview

³⁸ Frances Murphy, May 2006, *Psychiatric News*

medical inflation. The previous year, (FY 2005), VA requested an additional \$1 billion, of which one-quarter was for unexpected OIF/OEF needs and remainder was related to overall under-estimation of patient costs, workload, waiting lists, and dependent care. The GAO analysis of these shortfalls concluded that they were due to the fact that VA was modeling its projections based on 2002 data, before the war in Iraq began.³⁹

The budget shortfalls and the statement by Dr. Murphy suggest that the volume of veterans returning from Iraq and Afghanistan will not be able to obtain the healthcare they need, particularly for mental health conditions. Such veterans are at high risk for unemployment, homelessness, family violence, crime, alcoholism, and drug abuse, all of which impose an additional human and financial burden on the nation. In addition, many of these social services are provided by state and local governments which are already under tremendous strain.

Projected Medical Costs

The number of veterans who will eventually require treatment can be estimated using a baseline of the utilization during the first Gulf War, in which the VA is providing medical care to 48% of veterans. The average annual cost of treating veterans in the system is now \$5000,⁴⁰ although it is difficult to know whether the more grievous injuries and disabilities of the current conflict will drive up costs per patient.

The costs of providing medical care have been calculated under the three scenarios. Under the low scenario, under which the U.S. will deploy no new troops, the ceiling for medical care is 48% of OIF/OEF veterans. If half of all veterans eventually seek medical treatment from the VA that will produce a demand of some 700,000 veterans. However, due to the fact that veterans are eligible for free care during the first 2 years after discharge, we can expect a wave of returning war veterans within 2 years of their discharge date. Additionally, since active duty veterans claim medical care at a higher rate (than Guards/Reservists) and have been deployed in more of the most hazardous front-line task come home, we can expect that the average cost of treating such veterans increases as well as a high level of demand.⁴¹

If the demand for medical care increases as projected to some 700,000 or more veterans, there is a serious risk that the VA, which is already overwhelmed, will be unable to meet the medical needs of returning OIF/OEF veterans. Additional staff is needed in important areas such as brain trauma units and mental health. The VA also needs to expand systems such as triage nursing, to help leverage scarce medical resources.

Even assuming that no more troops are deployed, the long-term cost of treating returning veterans will reach \$208 billion. This however assumes that the supply of healthcare exists to treat them. If the number of troops continues to grow as in the moderate then cost of providing lifetime care rises to \$315 billion. The annual budget payment under this scenario will reach \$3 bn by 2010 and more than double by 2014. (See Table 4)

Table 4: Projected Cost of Providing VA Medical Care (moderate scenario)⁴²

MEDICAL COSTS	2006	2007	2008	2009	2010	2011	2012	2013	2014
Total Discharged	631,174	749,932	868,691	987,449	1,106,208	1,224,966	1,343,725	1,462,483	1,581,242
% OIF/OEF veterans seeking care	32.50%	33.96%	35.49%	37.09%	38.76%	40.50%	42.32%	44.23%	46.22%
Total OIF/OEF veterans seeking care	205,132	254,696	308,305	366,224	428,731	496,123	568,711	646,827	730,822
Cost/medical claim	\$ 5,000	\$ 5,400	\$ 5,832	\$ 6,299	\$ 6,802	\$ 7,347	\$ 7,934	\$ 8,569	\$ 9,255
Total cost (\$bn)	1.0	1.4	1.8	2.3	2.9	3.6	4.5	5.5	6.8
NPV	\$315.23								

Table 4: Projected Cost of for Providing VA Medical Care (moderate scenario)⁴²

However, these scenarios are conservative in assuming that only half of the returning veterans will eventually seek medical treatment from the VA and that the

³⁹ GAO-06-430R, "VA Health Care Budget Formulation", pp 18-20.

⁴⁰ This amount is calculated by estimating the budget 2006 supplemental budget request for OIF/OEF veterans per additional patient, using the GAO analysis in GAO-06-430R

⁴¹ VHA, Office of Public Health and Environmental Hazards, Ibid.

level of healthcare inflation will remain constant at 8%. Under a worst-case scenario, if troops levels rise to 2 million and if health inflation rises to the double-digit levels experienced during the nineties, we can expect the total cost of providing lifetime medical care to veterans to reach \$600 bn.⁴³

Veterans Centers

How can the VA possibly handle the number of returning troops who require care, as well as their families, especially for mental health conditions? Perhaps the most creative and successful innovation in the VA in past two decades has been the introduction of the “Vet Centers”—207 walk-in storefront centers where veterans or their families can obtain counseling and reintegration assistance. The centers, operated by VA’s “Readjustment Counseling Service” are popular with veterans and their families and—at a total cost of some \$100m per year—provide a highly cost-effective option for veterans who are not in need of acute medical care. The Vet Centers are particularly helpful for families, for example they provide a venue for a soldier’s spouse to seek guidance of the veteran is showing mental distress but will not seek help. They also supply bereavement counseling to surviving families of those killed during military service. And they offer a friendlier environment often staffed with recent OEF/OIF combat veterans and other war veterans—unlike VA regional offices which tend to be stuffy, bureaucratic offices located in downtown locations.⁴⁴

To date, 144,000 veterans have sought assistance at these centers.⁴⁵ However the demand for their services is threatening their ability to provide care. Vet Center managers recently surveyed by Congress said that in 50% of the Centers, the increasing workload is affecting their ability to treat veterans. Some 40% of the Vet Centers have directed veterans for whom individualized therapy would be appropriate into group therapy, and more than one-quarter of the Centers have limited or plan to limit family therapy. Nearly 17% have established waiting lists (or are in the process of setting them up).⁴⁶

Currently the centers do not assist veterans in filing disability claims, but provided that the facility had sufficient secure storage space to handle such documents, there is no reason why they could not. The VA has recommended hiring an additional 1000 claims adjudicators—who could be placed in the Vet Centers (an average of 5 each) to help veterans figure out how to claim. The cost of expanding the number of centers, hiring additional staff and placing more claims adjudicators in the centers is minimal.

Transition from DOD Payroll to VA Care

One of the chief bottlenecks in the current system is the soldier’s transition from the DOD payroll into the VA benefit system. There are three primary ways that a soldier makes this transition.

A veteran who is discharged regularly, and has some level of disability will typically have to wait 6 months before receiving his or her disability check from the VA. This is a period during which the veterans, particularly those in a state of mental distress, are most at risk for serious problems, including suicide, falling into substance abuse, divorce, losing their job, or becoming homeless.

A second route is to exit via the “Benefits Delivery at Discharge” (BDD) program. This successful program allows soldiers to process their claims up to 6 months prior to discharge, so they can begin receiving benefits as soon as they leave the military. However, the use of this route has become much more difficult due to the extended deployments, the use of “stop-loss” orders, and the resulting unpredictability about when a soldier will be discharged. Additionally, this program is not available to Reservists and Guardsmen, who comprise 40% of the forces in Iraq and Afghanistan. The VBA claim denial rate is twice as high for Reserve and Guard veterans, pos-

⁴²The NPV is calculated over 40 years, at a discount rate of 4.75%, with a peak rate of 50% veterans claiming care by 2016.

⁴³High scenario assuming 10% medical inflation rate.

⁴⁴Opinion based on conversations with veterans organizations.

⁴⁵Vet Center costs document, page 3B-11

⁴⁶October 2006 report issued by the House Veterans Affairs Committee, testimony by Vet Center managers.

sibly due in part to their lack of access to BDD.⁴⁷ Consequently the usage of this apparently better route has not been increasing as would have been expected.⁴⁸

For veterans who are more seriously wounded, the process is more complicated as they transition from medical facilities run by DOD into medical facilities run by the VA. For example a wounded veteran may be treated initially at Walter Reed Army Hospital and then transferred to a VA facility. Veterans experience some difficulties in securing the maximum amount of disability benefits at discharge during such transitions, due to a lack of compatibility between the DOD and VA paperwork and tracking systems. The VA complains that the records they receive from DOD are delayed or contain errors, in many cases it is the situation where the data that is tracked is not compatible. This not only creates unnecessary problems in moving veterans through the system but it also makes it more difficult for the data to be analyzed in medical and other studies.

Additionally there are the problems caused by the Pentagon's poor accounting system. GAO investigators have found that DOD pursued hundreds of battle-injured soldiers for payment of non-existent military debts—because DOD financial systems erroneously reported that they were indebted. For example, one Army Reserve Staff Sergeant, who lost his right leg below the knee, was forced to spend 18 months disputing an erroneously recorded debt of \$2231 which prevented him from obtaining a mortgage to purchase a home. Another staff sergeant who suffered massive brain damage and PTSD had his pay stopped and utilities turned off because the military erroneously recorded a debt of \$12,000. Hundreds of injured soldiers may be in this situation.⁴⁹

Overall Assessment and Cost

Overall the U.S. is not adequately prepared for the influx of returning servicemen from Iraq and Afghanistan. There are three major areas in which it is not prepared: claims processing capacity for disability benefits; medical treatment capacity, in terms of the number of healthcare personnel available at clinics throughout the country, particularly in mental health; and third, there is no preparation for paying the cost of another major entitlement program.

As discussed earlier, the backlog in claims benefit is already somewhere between 400,000 and 600,000. Unless major changes are made to this process, the number of claims pending and requiring attention will reach some 750,000 within the next 2 years and the pendency period will increase proportionately, resulting in more veterans falling through the cracks that could have been avoided. In addition, veterans whose claims reach different centers in different parts of the country will have widely different experiences, proving highly unfair to those who just happen to be located in areas of greater backlog.

The quality of medical care is likely to continue to be high for veterans with serious injuries treated in VA's new polytrauma centers. However, the current supply of care makes it unlikely that all facilities can offer veterans a high quality of care in a timely fashion. Veterans with mental health conditions are most likely to be at risk because of the lack of manpower and the inability of those scheduling appointments to distinguish between higher and lower risk conditions. If the current trends continue, the VA is likely to see demand for healthcare rising to 750,000 veterans in the next few years, which will overwhelm the system in terms of scheduling, diagnostic testing, and visiting specialists, especially in some regions.⁵⁰

The cost of providing disability benefits and medical care, even under the most optimistic scenario that no additional troops are deployed and the claims pattern is only that of the previous Gulf War, would suggest that at a minimum the cost of providing lifetime disability benefits and medical care is \$350 billion. If the number of unique troops increases by another 200,000 to 500,000 over a period of years, this number may rise to as high as nearly \$700 bn. (See Table 5) The funding needs for veterans' benefits thus comprise an additional major entitlement program along with Medicare and Social Security that will need to be financed through borrowing if the U.S. remains in deficit. This will in turn place further pressure on all discretionary spending including that for additional veterans' medical care.

⁴⁷ Active Duty denial rate is 7.6 percent compared with National Guard and Reserve denial rate of 17.8 percent, See Footnote 28

⁴⁸ Congressional testimony of Jack McCoy, VBA, March 16, 2006, <http://www.va.gov/OCA/testimony/hvac/sdama/060316JM.asp> and a VA fact sheet indicate 26,000 BDD claims in 2003, 39,000 in 2004, and 46,000 in 2005. <http://www1.va.gov/opa/fact/transasst.asp>.

⁴⁹ GAO-06-494, "Hundred of Battle-Injured GWOT Soldiers Have Struggled to Resolve Military Debts"

⁵⁰ However, the availability of medical care may vary significantly by region.

Table 5: Total Veterans Disability and Medical Costs⁵¹

	LOW	MODERATE	HIGH
Disability	67.6	109.5	126.8
Medical	282.2	315.2	536.0
TOTAL (\$Bn)	349.8	424.7	662.8

In the context of the overall costs of the War

Veteran's disability benefits and medical care are two of the most significant long-term costs of the War. As shown in our previous analysis of the costs of the war, the war has both budgetary and economic costs. This paper focuses only on the budgetary costs of caring for veterans. It does not take into account the value of lives lost, or effectively lost due to grievous injury. Not does it take into account the economic impact of the large number of veterans living with disabilities who cannot engage in full economic activities.⁵²

Recommendations

a) Medical Care

The Veterans Health Administration will not be able sustain its high quality of care without greater funding and increased capacity in areas such as psychiatric care and brain trauma units. In addition, more funding should be provided for readjustment counseling services by social workers at the Vet Centers. Even doubling the amount of funding for counseling at the Vet Centers is a small amount compared to the funds now being requested for additional recruiting of new soldiers.

(b) Disability Claims Backlog

There are at least three potential methods of reducing the number of pending claims. Perhaps the easiest would be to "fast track" returning Iraq and Afghan war veteran's claims in a single center staffed with highly experienced group of adjudicators who could provide most veterans with a decision within 90 days. At a minimum, all simple claims could be dispatched in this manner. During the past decade, private sector health insurance companies have reengineered their processes and adopted technologies, such as new automated data capture and document processing systems that have dramatically improved their ability to handle large volumes of information. This has allowed the industry to bring the average claim processing time down to 89.5 days. For example, the firm Noridian used technology to enable operators to process four to five times more claims in the same amount of time as under their old system, and to speed the form retrieval process for better customer service.⁵³

The VA has proposed a more typically governmental solution of adding 1,000 more claims adjudicators. Even apart from the cost of \$80 m or so of adding these personnel, the question is whether adding additional personnel to a cumbersome system is the best possible way to speed up transactions and improve service. A better idea would be to expand the Vet Centers to offer some assistance in helping veterans figure out their disability claims. The 1,000 claims experts could be placed inside the Vet Centers (5 per center), thus enabling veterans and their families to obtain quick assistance for many routine claims. Vet Centers would only require minor modifications (secure storage space, additional computers and offices) to fill this role.

The best solution might be to simplify the process—by adopting something closer to the way the IRS deals with tax returns. The VBA could simply approve all veterans' claims as they are filed—at least to a certain minimum level—and then audit a sample of them to weed out and deter fraudulent claims. At present, nearly 90 percent of claims are approved. VBA claims specialists could then be redeployed to assist veterans in making claims, especially at VA's "Vet Centers." This startlingly

⁵¹Total lifetime costs over 40 years, discounted at 4.75% under scenarios described.

⁵²This paper considers only the budgetary costs of veterans care. Standard economic theory would treat disability benefits as a transfer payment and deduct these from the economic and social loss associated with veteran's reduced economic lives. This was the methodology used in (stiglitz paper).

⁵³KM World, June 1999.

easy switch would ensure that the U.S. no longer leaves disabled veterans to fend for themselves.

The cost of any solution that reduced the backlog of claims is likely to be an increased number of claims, and a quicker pay-out. If 88% of claims were paid within 90 days instead of the 6 months to 2 years currently required, the additional budgetary cost is likely to be in the range of \$500m in 2007.

Conclusions

President Bush is now asking for more money to spend on recruiting in order to boost the size of the Army and deploy more troops to Iraq. But what about taking care of those same soldiers when they return home as veterans? The number of veterans who are returning home with injuries or disabilities is large and growing. We have not paid careful enough attention, or devoted sufficient resources, to planning for how to take care of these men and women who have served the nation.

There has been a tendency in the media to focus on the number of U.S. deaths in Iraq, rather than the volume of wounded, injured, or sick. This may have led the public to underestimate the deadliness and long-term impact of the war on civilian society and the government's pocketbook. Were it not for modern medical advances and better body armor, we would have suffered even more loss of life.

One of the first votes facing the new Democratic-controlled Congress will be yet another "supplemental" budget request for \$100+ billion to keep the war going. The last Congress approved a dozen such requests with barely a peep, afraid of "not supporting our troops". If the new Congress really wants to support our troops, it should start by spending a few more pennies on the ones who have already fought and come home.

Limitations of Data

This paper has been prepared based on the best available data from VA sources, CBO, GAO, and veterans organizations. Reconciling this data has therefore been done to try to generate realistic estimates, but is not precise. It is also difficult to predict with certainty the uptake in the military of benefits and medical care. In all cases this study has been done conservatively, for example it is entirely possible that after the length and grueling nature of this war, that a much higher number—perhaps $\frac{2}{3}$ of returning veterans—would seek disability benefits and/or healthcare and the estimates in this paper prove too low.

Issues not addressed

This paper has not attempted to address the cost of taking care of wounded and disabled Iraqi soldiers in Iraq. A number of studies have estimated the fatalities in Iraq, but there are few studies of the number of injuries among the Iraqi military. As the U.S. continues to place an emphasis on developing the Iraqi military to replace it, it is worth asking what the cost to that country will be of providing medical care and any kind of long-term benefits to those who are fighting. This study excludes VBA benefits such as education, insurance, vocational rehabilitation, and home loan guaranty programs. This study also excludes private, state, and local healthcare, disability, and employment benefits for returning veterans.

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