

Current and Projected Future Costs of Caring for Veterans of the Iraq and Afghanistan Wars

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Summary:

As of December 2010, 1.25 million service men and women had returned home from Iraq and Afghanistan. Many have been wounded or injured in some way — over 90,000 seriously enough to require medical evacuation from the conflict. A much larger number suffer from other injuries, ranging from brain injuries to hearing loss. To date, 650,000 Iraq and Afghanistan veterans have been treated in Department of Veterans Affairs (VA) medical facilities for a wide range of medical conditions. Nearly 500,000 of these veterans are receiving compensation from the VA for injuries sustained or worsened during their military service. The US has already spent \$31.3 billion since 2001 in providing medical care and disability benefits to these veterans.

But our commitment to veterans continues after the war ends. The service members who have been deployed to the Afghanistan and Iraq conflicts are entitled to receive free or subsidized medical treatment for the rest of their lives. In addition, a significant percentage of them are eligible to receive permanent disability compensation and other benefits for physical and/or mental disabilities stemming from their wartime service. Veterans of the current wars will also be entitled to receive a certain educational, housing, training and other benefits funded by government agencies outside of VA.

The history of previous wars shows that the cost of caring for war veterans rises for several decades and peaks in 30-40 years or more after a conflict. This will be especially true for veterans of the current wars. Veterans from Iraq and Afghanistan are utilizing VA medical services and applying for disability benefits at much higher rates than in previous wars. Based on current patterns of benefit claims and medical usage, it is estimated that the total present value of such costs for Iraq and Afghanistan veterans over the next 40 years is in the range of \$600 billion to \$1 trillion.

In addition, there are significant social-economic costs that will be borne by these veterans and their families, including factors such as family members who give up paid employment to become unpaid caregivers, loss of income for self-employed service members, and diminished quality of life.

Finally, although Veterans care comprises the fourth largest category of government spending, the magnitude of Iraq and Afghanistan veterans' costs is grossly understated in government projections. There is no provision set aside to cover these future obligations. Given that our pledge to care for veterans is a form of "deferred compensation", we should appropriate funds for these inevitable long-term costs at the time we budget for the wars in which they will fight.

Veterans Cost Estimates

This paper estimates the costs for veterans in four categories:

1. Budgetary costs already incurred and paid by the federal government from 2001 to 2011
2. Long-term budgetary costs incurred (but not yet paid) by the federal government for troops who have served in the Iraq and Afghanistan conflicts, and who have already been discharged and entered veteran status from 2001 to 2010
3. Total long-term budgetary costs for veterans estimated for the federal government (including payments already made, obligations incurred for veterans to date, and estimated obligations for active service members currently deployed to Iraq and Afghanistan operations when they become veterans).
4. Economic costs for veterans (covering some aspects of social and economic costs)

1. What has the U.S. Already Spent on Veteran's Care to Date?

How much has the federal government spent on veterans' medical care and disability benefits since 2001? To date, \$13.2 billion has been spent directly on veterans' medical care and \$18.1 billion has been paid out in disability compensation and other benefits, for a total of \$31.3 billion (see exhibit 1 below). However, these figures significantly understate the total costs for the following reasons:

- The \$13.2 billion number is for *veterans only* – not for medical costs to those who are still serving. A service member who is wounded on the battlefield is first treated within the military medical system, for example in battlefield medical centers and then transferred to Army or Naval Hospitals, such as Walter Reed. It is not until *after the service member has been discharged* that he or she is eligible to use the veterans' medical system. Therefore there is a lag between when the injury takes place and the initial treatment is conducted (paid for by DoD) and the later period in which that troop receives medical care from the VA and shows up as a direct cost to the VA medical system.
- For disability benefits, the service member again becomes eligible to apply for benefits after discharge. However, this is the beginning of the process, and there is a 6-12 month backlog of pending claims from veterans who have applied for disability compensation and benefits. Therefore, once again there is a lag between the time when veterans are discharged and when the benefits paid out are shown as expenditures for the VA.

Table 1: Costs of Afghanistan and Iraq War Veterans Care to December 2010

| | FY01/02 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011E | Total |
|---------------|---------|------|------|------|------|------|------|------|------|-------|-------|
| VA Medical | 0.1 | 0.2 | 0.2 | 0.4 | 0.8 | 1.1 | 1.9 | 2.1 | 2.9 | 3.5 | 13.2 |
| VA Disability | 0.1 | 0.3 | 0.5 | 1.2 | 1.6 | 1.9 | 2.3 | 2.7 | 3.4 | 4 | 18.1 |
| Total | | | | | | | | | | | 31.3 |

2. Veterans Costs Accrued To Date but Not Yet Paid

What are the total *accrued* liabilities by the federal government for veterans' medical care and disability benefits that have been *already incurred* during the period from 2001 to 2011 for those serving in the Iraq and Afghanistan conflicts? In other words, what is the total projected amount that the VA will be obligated to pay out to the 1.25 million veterans who have served through December 2010, over the course of the veterans' lifetimes?

- The present value of medical liabilities for veterans who have served in these conflicts through December 2010 will be between \$118 billion and \$168 billion, (depending on assumptions for the rate of health care inflation, health benefits adjustments, and rate of deterioration in medical conditions of some veterans) through 2055. This does not include the costs of these veterans beyond the age of 67, which will be additional costs to the US taxpayers through the Medicare and TRICARE for LIFE systems.
- The present value of disability benefits payable to veterans who have served in these conflicts through December 2010 is between \$228 billion to \$301 billion (depending on rate of cost-of-living adjustments) through 2055. This does not include payments beyond age 67 for these veterans.

3. Total Projected Costs for Veterans of the Iraq and Afghanistan Conflicts

These projections cover the more than 2.2 million service members who have served in OIF and OEF, including those who have become veterans from 2001 to the present, as well as estimates for those currently still deployed to the conflict (and expected replacements). The model for projecting long-term budgetary costs is based entirely on government data. Projections for future troop levels are based on estimates by the CBO and CRS, and we used rates of average disability compensation, social security disability benefits and medical costs on information from the VBA, VHA, Social Security Administration and government economic indicators.

In 2008, Stiglitz and Bilmes estimated that the long-term cost of providing medical care and paying disability compensation for veterans of the Iraq and Afghanistan wars would be between \$400 billion and \$700 billion, depending on the length and intensity of the conflict and future deployment levels¹. It is now expected that the cost range will be between \$589 billion and \$934 billion, depending on these factors. (Three quarters of this increase is due to higher claims activity and higher medical utilization of Iraq and Afghanistan veterans. 18% is due to a higher number of troops deployed and 6% is due to the difference in the projected number of future troops deployed).

Disability Cost Projections

In 2008 Stiglitz and Bilmes projected that between 366,000 and 398,000 returning Iraq and Afghanistan veterans would have filed disability benefit claims by this point. In fact, more than 552,215 veterans had *already* applied for VA disability compensation by February 2011. By this date, there were already 482,364 veterans awarded service-connection and 435,854 receiving compensation². (The remaining veterans were awaiting processing of their claims). In our earlier projections, the VA would not have received this many claims until 2013 at the very earliest. We had also underestimated the complexity of these claims, the number of disabling conditions being demonstrated, and the likely increases in disability ratings over time for veterans who have been diagnosed with PTSD. We now estimate that the present value of these claims, over the next 40 years, will be from \$355 billion to \$534 depending on the duration and intensity of US military deployment to the region.

In addition, veterans who can no longer work may apply for Social Security disability benefits. We estimate that the present value of the lifetime benefits for these veterans will range from \$33 to \$52 billion.

Medical Cost Projections

In our earlier analysis, we had estimated that 30-33% (which would be fewer than 400,000) of returning veterans would be treated in the VA health system by 2010. The actual number is running at more than 654,348 veterans, which is about 51 % of discharged troops³. In the earlier work, we projected that the VA would not reach this level until 2016 or later.

We had also underestimated the long-term costs of treating and caring for these veterans. We had projected that at worst 20% of veterans would be diagnosed with mental health issues, whereas recent data shows that 331,514 unique returning veterans have been diagnosed with a possible mental disorder, including 177,149 diagnosed with PTSD.⁴ This increases both immediate and long-term costs, given the relationship between mental illness and other conditions. We also did not account for the cost to VA of adding personnel and increasing the mental health infrastructure.

Accordingly, we can project how disability claims, and medical costs of the Iraq and Afghanistan veterans are likely to continue to increase with age. In this respect, they are likely to follow the pattern of Vietnam veterans, where it is estimated that 30% suffered from PTSD. For example, the disability compensation paid to Vietnam veterans is 60% higher than the amount paid to veterans who served in peacetime.

We now estimate that the present value of medical care provided by the VA to veterans from Iraq and Afghanistan over the next 40 years will be between \$201 billion and \$348 billion, depending on the duration and intensity of military operations in the region.

Table 2: Estimated PV of Iraq and Afghanistan Veterans Disability and Medical Costs

| (US\$ Billions) | Moderate-Realistic | Best Case |
|------------------------------|--------------------|------------|
| Medical | 348 | 201 |
| Disability (VA) | 534 | 355 |
| Disability (SSA) | 52 | 33 |
| Total Cost \$ billion | 934 | 589 |

Some critics have pointed out that the costs associated with injuries may be overstated because young males would have experienced high injury (or even death) rates even if they were not in military service. This argument may be correct in estimating economic cost, but for a budgetary estimate, the government bears the costs of such injuries whether or not they might have been sustained in civilian life. It is certainly important to know the incremental impact of *conflict* on injury, death, and disease rates. To ascertain this, we analyzed death rates among peacetime military and compared it with the numbers emerging subsequent to the beginning of the Iraq conflict.⁵ These can therefore be attributed as incremental costs of war in addition to hostile injuries.

Background: Understanding the Cost Projections

There are two cost streams associated with the wounded and injured: (a) the medical costs of caring for veterans over their life spans, and (b) the cash compensation and other benefits (such as housing loans and home and physical rehabilitation) that are awarded to eligible veterans and their survivors. Some of these benefits are payable to all veterans regardless of their disability status, including five years of free medical care in the veterans health care system upon their discharge from active duty. Veterans can qualify for a range of compensatory benefits and stipends on approval from the medical and administrative apparatus of the veterans department. Additionally, veterans may be eligible to receive assistance from other government agencies, such as supplementary disability compensation from the Social Security Administration if they can no longer work.

The number of veterans who will be entitled to receive lifetime medical care and disability compensation is significant, and is currently is close to 50% of returning servicemen. The costs described here include the cost of all those who were wounded in combat, and those who were injured in non-combat situations (e.g., transportation, vehicle crashes, construction, rare diseases) over and above the rate of such injuries during peacetime. The costs include the ongoing costs of medical care and disability benefits to the larger number of veterans who qualify for these services. The evidence from previous wars shows that the cost of caring for war veterans rises for several decades and peaks in 30-40 years or more after a conflict. The costs rise dramatically over time as veterans get older and their medical needs grow. The likely costs of providing medical care and disability benefits to Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans, based on a study of these historical patterns, were estimated by Stiglitz and Bilmes in 2008.

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The *actual* records of several hundred thousand recent veterans have now been analyzed and the revised estimates are based on this new information.

The most striking finding is that veterans from Iraq and Afghanistan are utilizing VA medical services and applying for disability benefits at much higher rates than in previous wars. The higher medical use is the result of several factors, including: a) higher survival rates for seriously wounded troops; b) higher incidence of PTSD and other mental health ailments; c) more veterans who are willing to seek treatment and apply for benefits for mental health problems; d) more generous medical benefits, more presumptive conditions, and higher benefits in some categories.

The high incidence of PTSD is likely to increase the long-term medical cost beyond the level of previous conflicts. Recent medical studies have documented that PTSD sufferers are at higher risk for heart disease, rheumatoid arthritis, heart failure, bronchitis, and asthma, liver and peripheral arterial disease. One recent study found that PTSD sufferers are 200% more likely to be diagnosed with a disease within 5 years of returning from deployment than the control group. Another new study found that that veterans with PTSD utilized non-mental health care services such as primary care, ancillary services, diagnostic tests and procedures, emergency services and hospitalizations 71-170% higher than those without PTSD. In addition, recent studies have shown that traumatic brain injury, which is estimated to affect some 20% of Iraq and Afghanistan veterans (often in conjunction with PTSD) places sufferers at higher risk for lifelong medical problems, such as seizures, decline in neurocognitive functioning, dementia and chronic diseases⁶.

The high claims activity is related to better outreach and capacity at the VA; greater availability of information on the Internet and through veteran's service organizations; and other factors. VA has expanded the Benefits Delivery at Discharge (BDD) program and Quick Start, increased the number of conditions that are presumptive in favor of the veteran, liberalized the PTSD stressor definition, increased some categories of benefits and outreach, provided five years of free health care instead of two, and is in the process of restoring medical care to 500,000 moderate income "Category 8" veterans. VA has also hired more medical and claims personnel, invested heavily in IT upgrades to the claims process.

All of these factors contribute to the high cost estimates.

4. Other Budgetary Costs

These estimates do not include a range of additional costs that will be paid by departments across government; including veterans' home loan guarantees, veterans' job training, concurrent receipt of pensions, and higher costs to Medicare and TRICARE for Life for veterans who are not enrolled in the VA system. For example, Pentagon spending on health care for active-duty military has increased by 167% since 2001⁷. These estimates also do not include costs paid by state and local governments, or billions of dollars in VA capital investments, such as the construction of mental health clinics and construction of new facilities, that will serve all veterans but are primarily targeted toward those returning from Iraq and Afghanistan.

In addition, Congress and the Administration finally enacted a new GI bill in 2008 – an important measure that will grant Iraq and Afghanistan veterans full education benefits, on a par with those provided to World War II veterans in the GI Bill. This bill was enacted largely through the sustained advocacy by the Iraq and Afghanistan Veterans of America (IAVA) organization and also as a measure to aid recruiting to the all-volunteer force (which fell below targets in 2005 -2007). This is an investment that will yield significant economic benefits. However it will also add to the budgetary cost of the war.

Taking all these costs into account, the total budgetary costs associated with providing for America's war veterans from Iraq and Afghanistan is likely to approach \$1 trillion.

Economic Costs of Veterans and Contractors

The true cost of war goes beyond the budgetary costs; there are much larger social and economic costs. While this is true for the country, it is especially true for veterans and their families.

The Iraq and Afghanistan conflicts have presented the military with its biggest challenge since conscription ended in 1973. In many respects, the “All-Volunteer Force” has come under enormous strain. Suicide among veterans is at record levels. Women troops (who make up 11% of the force) have been especially hard-hit: divorce rates are three times higher for female than for male troops, and more than 30,000 single mothers have deployed to the war zone. These social costs are far-reaching. They include the loss of productive capacity of young Americans who have been killed or seriously wounded in Iraq and Afghanistan, lost productivity due to mental illness, the burden on caregivers who frequently have to sacrifice paid employment in order to take care of a veteran with a disability, as well as increases in divorce, domestic violence, substance abuse, and other social problems. Additionally, a substantial number of those who were deployed, particularly among Reservists and Guards, were self-employed and have lost their livelihood as a result of deployment. For many veterans there is simply a diminished quality of life, the costs of which are borne by the individuals and families.

The military has also been forced to employ a workforce of several hundred thousand contractors, who have proven to be indispensable to the war effort. These contractors have also suffered from high rates of casualties, injuries and mental health problems. These impose both direct budgetary costs (through federal subsidies to worker compensation and insurance companies, and projected higher costs to Medicare as they age) and social costs in all the areas mentioned for troops. These costs are significant. For instance, during the 18-month period from fiscal year 2007 through the first half of 2008, the US spent \$34 billion on almost 57,000 contingency contracts for construction, capacity building, security and a range of support services for US forces in Iraq and Afghanistan⁸¹. There were in the order of 200,000 contractor personnel working on these activities; and during this period there were at least 455 contractors killed and 15,787 injured⁹.

The use of contractors has been costly in many respects. In previous wars, military commanders had been able to relieve the heavy strain of conflict for their troops by temporarily assigning them to lighter support tasks (such as kitchen duty -- the traditional “peeling potatoes”, or deliveries, construction, vehicle repairs or custodial duties). This flexibility provided commanders with a tool to help soldiers dealing with stress or who had experienced unusually heavy combat for a long period. But in the Iraq and Afghanistan conflicts, virtually all of these support tasks were carried out by private contractors. This may have contributed to the epidemic of post-traumatic stress disorder which has been observed among returning veterans.

These substantial “social” costs are not captured in the federal government budget but nevertheless represent a real burden on society. In a number of countries, this is actually recognized with quality of life impairment lump sum payments. Many of these costs cannot be quantified; however it is possible to monetize some aspects of the costs. Based on the casualty levels prior to 2008, we estimated that the social costs would reach between \$295 and \$400 billion, in excess of the budgetary costs. Given the higher incidence of illnesses, especially mental illness that has become apparent during the past two years it is certain that the true cost will be even higher.

Government Estimates of Veterans Costs

Veterans’ costs comprise the fourth largest category of budgetary expenditure in the United States. The scale of the current outgoings can be seen in the U.S. financial statements on the *Statement of Net Cost*, which lists the gross cost of US expenditures minus revenues. It shows, for example, that the net cost of providing for veterans in 2008 equaled some 12% of the total cost of running the country.

In terms of accrued long-term liability, the Balance Sheet of the United States lists \$1.3 trillion in veterans' compensation and burial benefits, and a liability for \$220 billion in veterans housing loan guarantees¹⁰. However, this significantly understates the true liability because it does not take into account the funding needed for providing medical care, or for veterans pensions, or education benefits, or for many of the other benefits we have committed to pay.

In fact, the magnitude of Iraq and Afghanistan veterans' costs is grossly understated in government projections. This is in part due to poor government accounting which fails to account for accrued liabilities. The peak funding years for conflicts are typically so far into the future that they are not included in official estimates. (It is a sobering fact that the peak year for paying veterans disability compensation to World War I veterans was 1969 – more than 50 years after Armistice. The largest expenditures for World War II veterans came in 1982. Payments to Vietnam and first Gulf War veterans are still climbing).

The CBO typically projects forward on a rolling ten-year basis, with most focus on the extreme near-term. The actuarial capability of the VA is weak, and has been the focus of criticism by the GAO and the Institute of Medicine. VA does not have the capacity to fully estimate its obligations, and ran short of funds in 2005 and 2006 due to budget planning that was based on 2001 numbers, (before the conflict began). As recently as January 2009, GAO found that VA's assumptions of the cost of long-term care were "unreliable" because the assumed cost increases were lower than VA's recent actual spending experience¹¹.

The 2008 Stiglitz and Bilmes estimates were derived by looking at the costs for early returning veterans, and by extrapolating costs on the basis of the pattern observed in previous wars. These estimates were considerably higher than the estimate by the Congressional Budget Office (CBO); in large part because CBO used early data for returning Iraqi veterans which suggested that the cost of care for these veterans would be less than the average costs for veterans. We projected that these costs would become more apparent, and grow larger over the lifetime of the veteran, whereas CBO projected out for only a decade.

Unlike the initial CBO estimates, the Stiglitz and Bilmes analysis expected that veterans costs would rise for four reasons: (a) The early costs were disproportionately associated with diagnosing and initial check-ups, rather than the more expensive long term care; (b) those returning early were less likely to have had multiple deployments, whereas the costs especially from PTSD and other psychological problems associated with multiple deployments would increase disproportionately as those who had served multiple tours were eventually discharged; (c) the evidence from previous wars shows that the costs of caring for veterans extend well into the future.; and (d) many of the costs are manifested as they interact with the aging process. (For example, a number of conditions that can occur in later life such as prostate cancer are automatically presumed to be related to a veteran's service, and therefore entitling the veteran to financial compensation). Additionally, the Iraq and Afghanistan wars were producing a higher number of severe casualties than in previous conflicts— and that the majority of veterans filing for disability compensation were submitting claims for a higher number of separate disabling conditions. All of these factors suggested that the long run costs for these veterans would be even higher than the historical average costs.

By 2010, the actual data collected on the veterans from Iraq and Afghanistan, including their physical medical needs, incidence of mental health conditions, and disability claims, has already far exceeded the 2008 Stiglitz and Bilmes estimates and certainly superseded the initial CBO projections. In October 2010, CBO issued a new report which substantially increased its projections for the medical cost of veterans care¹². The new CBO analysis is consistent with the medical cost estimates outlined in this paper. However, CBO does not include the cost of paying disability benefits, Social Security compensation, or other compensation that will also be paid throughout the veterans' lifetimes.

Conclusions

Veterans medical and disability costs are generally not included in discussion of the costs of war. The consequence of essentially ignoring the cost of caring for veterans is threefold.

First, it understates the true cost of going to war. We know that every war will have a long “tail” of costs, including the inevitable cost of providing for those who fight in the war, and their families and survivors. If this cost is overlooked, it simply hides the real cost of war.

Second it is poor financial management. The United States is financing a 40+ -year long pension and benefit obligation from annual budget revenues, without making any provision for it.

Third, it leads to the possibility that veterans’ needs will not be funded adequately. Veterans’ benefits are different from entitlements -- they are more akin to “deferred compensation.” These benefits are part of the implicit contract between our country and those that serve our country by fighting for and defending it. By concealing such costs, we face the very real risk that men and women who are injured in the wars today will not be well cared for in the future.

While this analysis can only capture a fraction of the burden on veterans, it may contribute to a new way of thinking about long-term veterans’ costs, a way of thinking that would require us to budget for the lifetime needs of war veterans at the same time that we appropriate funds for the wars they will fight.

¹ Joseph E. Stiglitz and Linda J. Bilmes, *The Three Trillion Dollar War: The True Cost of the Iraq Conflict* (Norton, 2008)

² As of December 2010, 2.2 million US troops had served in the GWOT in Iraq and Afghanistan and there were 1.25 million veterans who were discharged. The number who had filed claims for compensation in connection with their service disabilities was 552,215 (Veterans Benefits Administration Office of Performance Analysis and Integrity, 2/14/11). The number of GWOT veterans who had been treated at VA Hospitals and medical facilities was 654,348 (Veterans Health Administration, April 2011).

³“Analysis of VA Health Care Utilization among Operation Enduring Freedom, Operating Iraqi Freedom, and Operation New Dawn”, Office of Public Health and Environmental Hazards, DVA, April 2011.

⁴ Ibid.

⁵See Horton (2007). This paper shows that the Iraq and Afghanistan conflicts caused approximately 190 additional accidental fatalities compared with what would have occurred during peacetime deployments – comparing the rate of accidental casualties in the five years prior to the invasion of Iraq and five years after. Extrapolating this to accidental injuries suggests that the rate of non-hostile injuries during the current conflict is 50% higher than during peacetime.

⁶ See Hoge, C.W. *et al.*, “Mental disorders among US military personnel in the 1990s: Association with high levels of health care utilization and early military attrition,” *American Journal of Psychiatry*, 159(9):1576-1583; see also work from the Veterans Health Research Institute. See also: Daniel Bertenthal, Beth Cohen, Charles Marmar, Li Ren and Karen Seal, 2009, “Association of cardiovascular risk factors with mental health diagnoses in Iraq and Afghanistan war veterans using VA health care,” *JAMA* 302 (5):489-492.; and Boscarino JA, 2008, “A prospective study of PTSD and early-age heart disease mortality among Vietnam veterans: implications for surveillance and prevention,” *Psychosomatic Medicine*, July, 70(6):668-7; Boscarino, JA, CW Forsberg and J Goldberg, 2010, “A twin study of the association between PTSD symptoms and rheumatoid arthritis,” *Psychosomatic Medicine*, June 72(5):481-6 . In the latter, a study of twin pairs showed that the highest PTSD sufferers were 3.8 times likely to have rheumatoid arthritis compared with the lowest sufferers). Spitzer has also shown increased incidence of angina, heart

failure, bronchitis, asthma, liver and peripheral arterial diseases among PTSD sufferers). See also Judith Andersen, *et al.*, 2010, "Association Between Posttraumatic Stress Disorder and Primary Care Provider-Diagnosed Disease Among Iraq and Afghanistan Veterans," *Psychosomatic Medicine* 72.

⁷ Statement by Rear Adm. Christine Hunter, Deputy Director of TRICARE, that Pentagon spending has increased from \$19 billion in 2001 to projected \$50.7 billion in 2011. (USA Today 4/25/10)

⁸ The military uses "system" contractors and "contingency" contractors. System contractors typically provide support to specific weapon systems, regardless of war or peace. Contingency contractors typically provide support services primarily during wartime operations. The majority of contracts awarded in Iraq and Afghanistan are contingency contracts, including the huge LOGCAP service contracts awarded to Halliburton subsidiary KBR. For data, see GAO (2008).

⁹ See GAO reports (2008 and 2010). Note: the US government does not keep track of the number of contractors killed and wounded, so these numbers are based on reports to the Department of Labor (which provides insurance) and is likely to be an underestimate.

¹⁰ "Financial United States Government Notes to the Financial Statements for the Years Ended September 30, 2008, and September 30, 2007," Notes to the Financial Statements.

¹¹ GAO-09-664T.

¹² CBO. "Potential Costs of Veterans Health Care," October 2010.