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BENEFITS AND MEDICAL CARE FOR FEDERAL AND U.S. CONTRACTOR EMPLOYEES DEPLOYED TO IRAQ AND AFGHANISTAN

HEARING

BEFORE THE

OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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BENEFITS AND MEDICAL CARE FOR FEDERAL AND U.S. CONTRACTOR EMPLOYEES DEPLOYED TO IRAQ AND AFGHANISTAN

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE,
Washington, DC, Tuesday, September 18, 2007.

The subcommittee met, pursuant to call, at 10:07 a.m., in room 2212, Rayburn House Office Building, Hon. Vic Snyder (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. VIC SNYDER, A REPRESENTATIVE FROM ARKANSAS, CHAIRMAN, OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE

Dr. SNYDER. The hearing will come to order.

Good morning, and welcome to the Subcommittee on Oversight and Investigations' hearing on benefits and medical care for Federal civilian and U.S. contract employees deployed to Iraq and Afghanistan.

Recently, the subcommittee has begun to investigate a variety of interagency issues raised by the ongoing wars in Iraq and Afghanistan. Military means alone are clearly not enough to bring about success in either country. Civilians from across the Federal Government are increasingly being called upon to help us achieve our goals in these dangerous environments through the use of Provincial Reconstruction Teams (PRT) and other civilian-oriented programs.

An unfortunate but inevitable consequence of deploying civilians to combat zones is that some of them may be injured or killed. The purpose of today's hearing is to consider issues related to the hazardous nature of this duty, and we have grouped those into three basic questions.

First, given the critical need for U.S. Government Federal civilian employees deployed to Iraq and Afghanistan, what kind of incentives and benefits are provided to encourage those with the right skills and experience to do so?

Second, what practices and policies are in place within the military health-care system to provide medical care for deployed Federal civilian employees, both while overseas and upon returning home?

Of course, most of the civilians overseas in Iraq and Afghanistan are not Federal employees, but are instead working for U.S. Government contractors. Thus, a third purpose of today's hearing is to examine the practices employed and policies in place for providing medical care and medical support to wounded contract employees.

So we have what are the incentives for our Federal civilian employees, how do we take care of them—our Federal civilian employees—and then the third, what about the contract employees of U.S. Government contractors.

There have been approximately 6,000 Department of Defense (DOD) civilians deployed to Iraq and 1,500 to Afghanistan since 2001. More than 1,400 Department of State employees have served in Iraq since 2003. U.S. Government employees from DOD, State and other Federal agencies, including Justice, Agriculture and Labor, volunteer to serve in these positions.

To date, 118 DOD civilians have been wounded, and seven have been killed. Three State Department employees have been killed in Iraq and Afghanistan. Overall, the Department of Labor Office of Workers' compensation Programs, which handles claims for medical benefits by government civilians, reports 166 claims submitted for injuries sustained by U.S. Federal civilians in Iraq and Afghanistan.

With respect to contractors, estimates range as high as 180,000 in Iraq as of July 2007. The bulk of these, of course, are Iraqi citizens and Third Country nationals, but approximately 21,000 are U.S. citizens. Accurate casualty numbers are not available, but as many as 1,000 contractors, both U.S. and non-U.S. citizens, have reportedly been killed, and about 13,000 have been wounded.

We have assembled a panel of witnesses to help us examine and sort out these issues this morning—we appreciate you all being here—Ms. Brenda Farrell, Director of the Defense Capabilities and Management Team from the U.S. Government Accountability Office (GAO); Secretary Patricia Bradshaw, Deputy Under Secretary for Civilian Personnel Policy of the Department of Defense; and Mr. Shelby Hallmark, Director of the Office of Workers' Compensation Programs at the Department of Labor.

I had hoped to have a State Department person, a fourth panelist, sitting there this morning, and I am very disappointed that we do not, and I, frankly, do not understand that because this is an opportunity for some of you to make cases about any changes we might need to make in personnel policies as a Congress in order to get the job done, and, as you know, there has been dissatisfaction on the ability of the State Department to complete the staffing of the Provincial Reconstruction Teams.

We had a report here, Ginger Cruz from the Special Inspector General for Iraq Reconstruction (SIGIR) report that the State Department has identified 68 percent of their employees on PRTs as of the coming December. So that means, after several years, as of this December, we will have only identified two-thirds of the civilian State Department staff members for PRTs.

Well, maybe part of it is these issues that we are going to be discussing this morning, but the State Department did not provide us with a witness this morning, and my own sarcastic comment is no wonder we are having problems getting State Department employees to Iraq if we cannot get them to the Rayburn Building. [Laughter.]

But we appreciate——

Dr. GINGREY. It is a southern trick.

Dr. SNYDER. Sorry?

Dr. GINGREY. It is a southern trick.

Dr. SNYDER. Gingrey, you like that line, don't you? Thank you.

Dr. GINGREY. That is pretty sharp. [Laughter.]

Dr. SNYDER. But, I mean, this committee is being supportive to the State Department. We really value the work they do, and this committee is in the spirit of trying to help them get their work done, and if there is something that the Congress needs to do with incentives, then we want to look at it.

I defer to Mr. Akin for any opening statement he wants to make.

[The prepared statement of Dr. Snyder can be found in the Appendix on page 37.]

STATEMENT OF HON. W. TODD AKIN, A REPRESENTATIVE FROM MISSOURI, RANKING MEMBER, OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE

Mr. AKIN. Thank you, Mr. Chairman.

And good morning to our witnesses. Thank you for being here today.

In dealing with the benefits and the medical care for Federal civilian U.S. contract employees deployed in Iraq and Afghanistan, that has a direct impact on how the U.S. Government can incentivize U.S. citizens across the Federal agencies to deploy to combat zones.

We have taken a look a little bit at PRTs, we will probably be looking at them even more in the future, and, certainly, this topic bears on that. I would not be surprised if the chairman maybe did not choose this hearing partly along those lines.

While the challenge of getting personnel other than military deployed in the theater is multifaceted, the issue of pay and health care for civilians operating in theater is a major factor affecting the government's ability to recruit qualified personnel, whether it be filling civilian positions on Provincial Reconstruction Teams or manning a transition team to build the capacity of Iraq's or Afghanistan's ministry, this subcommittee has firsthand knowledge of how getting the right civilians into theater improves the ground operations.

Today's hearing should give us a sense of the pay and healthcare benefits civilian Federal employees and contractors receive in theater as well as when they return home. This information will help the subcommittee assess whether the benefits package we offer civilians in Iraq and Afghanistan includes the right set of incentives so that the best and most capable civilians sign up for these critical posts.

Finally, I want to state for the record my deep respect and appreciation for all the civilians who risk their lives in carrying out the critical missions in what is often a very dangerous environment. When we discuss Operation Iraqi Freedom and Operation Enduring Freedom, the role and work of civilians is often overlooked in favor of the warfighter. But if you listen to our military, they will tell you that we need to turn our attention to the civilian side. I am glad we are listening.

Thank you, Mr. Chairman, for holding this hearing.

And, again, thank you for the witnesses for coming here today. I look forward to your testimony.

[The prepared statement of Mr. Akin can be found in the Appendix on page 39.]

Dr. SNYDER. Thank you, Mr. Akin.

Your written statements will without objection be made a part of the record. We will now want to hear from you. We will start with Ms. Farrell and go down the line.

Ms. Farrell.

STATEMENT OF BRENDA S. FARRELL, DIRECTOR, DEFENSE CAPABILITIES AND MANAGEMENT, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. FARRELL. Thank you, Mr. Chairman, Mr. Akin, members of the subcommittee. Thank you for the opportunity to discuss our 2006 report on DOD's policies for Federal civilians who deployed to Afghanistan and Iraq.

To begin, let me emphasize that as DOD has expanded its involvement in overseas military operations, it has grown increasingly reliant on its Federal civilian workforce to provide support in times of war or national emergency. Since fiscal year 2005, DOD has been converting thousands of military positions to civilian positions, and additional conversions are planned for the future. Therefore, the need for attention to policies and benefits that affect the health and welfare of these individuals becomes increasingly significant.

Now let me summarize my written statement in three parts.

First, in 2006, we reported that DOD had established policies to assess the medical condition of civilians both before and after deployment, but it lacked a quality assurance mechanism to ensure implementation of health requirements.

Our review of over 3,400 deployment records found that DOD lacked documentation that some Federal civilians who deployed to Afghanistan and Iraq had received, among other things, required before and after deployment health assessments and immunizations. As a larger issue, DOD lacked centralized data to readily identify its deployed civilians, track their movement in theater and monitor their health status.

Today, I wish to note that DOD has taken action to track deployed Federal civilians. DOD issued policy effective in December 2006, which requires the components within three years to report locations for all deployed DOD personnel, including civilians. Further, in February 2007, DOD issued a new instruction that, if properly implemented, would ensure that medical requirements are being met.

Second, we found DOD had established medical treatment policies for its deployed Federal civilians. We reviewed a sample of seven workers' compensation claims, out of an identified universe of 83, filed with the Department of Labor under the Federal Employees Compensation Act (FECA) by DOD Federal civilians who had deployed to Iraq. We found that the care provided was consistent with DOD policies.

There were three cases where initial care was provided in theater and seven cases where DOD civilians, who requested care after returning to the United States, had received initial medical examinations and/or treatment for their deployment-related injuries.

The Department of Labor could not identify claims from civilians deployed to Afghanistan, so our review was limited to claims for civilians who had deployed to Iraq.

Finally, Mr. Chairman, the myriad of pays and benefits for DOD personnel is a very complex area. Our work has found that changes are made to military personnel compensation in a piecemeal fashion with an imprecise understanding of how the changes will affect the total cost of compensation or what the return on investment decision makers should expect.

Further, DOD Federal civilians and military personnel are governed by a distinctly different system. Thus, caution should be exercised in making any direct comparisons between civilian military pay. Our work in 2006 found that both DOD civilians and military personnel are eligible to receive special pays to compensate them for deployment. However, the types and the amounts differ.

For example, unlike DOD Federal civilians, military personnel receive combat zone tax exclusion while deployed to Afghanistan and Iraq. In contrast, DOD Federal civilians are eligible for a variety of premium pays, such as overtime and night differential, that are not available to military personnel.

Also, as with special pays, the types and amounts of benefits vary between military personnel and Federal civilians for those who sustain an injury while deployed.

Mr. Chairman, in summary, DOD has a number of policies in place for medical care and compensation for those deployed, but effective implementation is paramount.

That concludes my opening statement. I will be happy to take questions at your convenience.

[The prepared statement of Ms. Farrell can be found in the Appendix on page 42.]

Dr. SNYDER. Thank you, Ms. Farrell.

Secretary Bradshaw.

STATEMENT OF HON. PATRICIA S. BRADSHAW, DEPUTY UNDER SECRETARY OF DEFENSE (CIVILIAN PERSONNEL POLICY), DEPARTMENT OF DEFENSE

Secretary BRADSHAW. Good morning.

Mr. Chairman and subcommittee members, thank you for this invitation today. I appreciate the opportunity to discuss the Department of Defense's view on medical-care coverage for our deployed civilians and highlight the various benefits and incentives that we have in place.

DOD civilian employees have had a long and proud history of serving along with and supporting our military members, and today, more than ever, we see our civilian workforce transforming into one that is more global and expeditionary to meet the department's 21st century mission requirements.

As you noted, since 2001, we have had approximately 1,500 Department of Defense civilian employees deployed to Afghanistan and over 6,000 deployed to Iraq. Currently, we have approximately 300 civilians serving in Afghanistan and about 1,750 in Iraq.

These brave civilians are working side by side with our military members to support our national security mission. And they fill a variety of positions, from accounting and budget to logistics, equip-

ment maintenance and repair, information technology and, as you noted, most recently, working with the State Department. We developed and led an initiative to use a capabilities-based approach to meeting Provincial Reconstruction Team needs and helping to fill those requirements.

Civilian employees with the Department of Defense volunteer for assignments to serve on these PRTs, based upon their personal skills and capabilities not inherent in their current positions. Typically, civilians are deployed based upon their position of record.

The department had well over 1,000 resumes from DOD civilians who were willing and able to help in the rebuilding of Iraq. We were able to fill 40 of those. That was our allocation from State.

Under the department's current authority, however, the department can deploy DOD civilian employees to hostile or combat areas based upon their position responsibilities. These positions are coded as what we call emergency essential, or EE, positions. These positions are announced with an EE requirement and employees sign statements agreeing to the terms of these position requirements before they are hired.

In circumstances where a position is identified afterwards, the incumbent is provided with a notice and an opportunity to decline that, and we then will find a reassignment opportunity for that individual.

Although the department has the authority to forward deploy DOD civilians based upon these position responsibilities, the majority of our jobs are volunteer. These employees contribute their talent to the joint integrated national security mission.

So why would they do that? We have held a number of focus groups with our employees and asked them that question, and they give us a variety of reasons, from their desire to serve their country, witness the results on the ground, and engage in this very specific mission-focused work. They state that it is an honor and a privilege to serve our country and to serve our warfighters in such deployments. They also come back with a greater appreciation and a broadened perspective of what the Department of Defense's role is in time of war.

Thanks to you, the Congress, we have also been able to offer additional financial incentives to our Federal civilians serving in Iraq and Afghanistan. Currently, deployed civilians assigned to Iraq and Afghanistan as part of their compensation package receive a 35 percent danger pay allowance, a 35 percent foreign post differential, and they have the opportunity for increased premium pay limit of $212,000. This particular benefit must be renewed annually.

Additionally, thanks to you, the Congress, last year, Public Law 109–234 authorized all Federal agencies through fiscal year 2008 who have civilians deployed to be provided with the same allowances, benefits and gratuities comparable to those provided to members of the Foreign Service. These included such benefits as enhanced death gratuity level, home leave and rest and recuperation breaks.

Additionally, employees serving in Iraq and Afghanistan for specific periods of time are eligible for the Secretary of Defense's Global War on Terror Medal. This medal recognizes their service and

is much like an expeditionary medal that we award to our military members.

In addition, those who pay the ultimate sacrifice and are injured or killed in theater may also be eligible for the department's Defense of Freedom Medal, which is equivalent to the military Purple Heart.

As the department civilian support expanded in the theater of operations, policies have been implemented to provide DOD deployed civilians both pre- and post-deployment assessments, health assessments and a prescription for professional medical treatment both in theater and upon their return to the States.

As noted by my GAO colleague, we have updated our instruction on deployment health. This instruction specifically requires that each of the defense components execute a comprehensive deployment health program. The regulation requires essential pre- and post-deployment health assessments which include a mental health component.

Prior to deploying, DOD civilians are required to obtain a physical examination. Of course, the purpose of this exam is to determine a number of things: first of all, the existence of any non-deployable medical conditions, which are identified by the combatant commanders working with the medical community and identify the required immunizations. These records become part of the lifecycle maintenance of the employee, as long as they are deployed, and serve as the base line for medical screening upon their return from their deployment.

Regrettably, our employees are not immune to the dangers associated with these global assignments. To date, in Iraq, as noted, we have 118 employee injuries and seven deaths. Currently, we understand, we have four claims for post-traumatic stress disorder (PTSD) and two claims for traumatic brain injury that have been accepted by the Department of Labor.

Any civilian employee injured in theater receives immediate medical attention equivalent to our military members. Deployed civilians who were treated in theater continue to be eligible for treatment in a medical treatment facility, a military medical treatment facility or a private-sector medical facility upon their return to the U.S. for any of their compensable injuries or diseases. This care is provided at no cost to the employee.

Additionally, deployed civilians who later identify compensable illnesses or injuries are also eligible for treatment at our military medical treatment facilities or a private sector medical facility at no cost to them for coverage under the workers' compensation plan.

Furthermore, DOD policy mandates that Federal civilian employees returning from deployment must be scheduled for a face-to-face health assessment with a trained health-care provider within 30 days after returning. The assessment must include a discussion of mental health and psychosocial issues commonly associated with deployment. Additionally, after 90 to 100 days, they must have another follow-on assessment.

While you have already heard the GAO concluded we did a good job on the seven cases that we reviewed, in terms of following our policy, there is always one that falls through the crack, and I think you are well aware of that one. And so we did have one case of a

Department of Army employee who was one of the early injuries in Iraq, and the department acknowledges that there were a number of unfortunate mistakes that were made. The treatment was not consistent with the department policy.

However, we learned a lot from that particular event. We learned that these policies are sometimes well documented, but not well known and not well understood. Since our knowledge of this particular case, I personally have been working with the Department of Army and its components and my staff to resolve the issues and concerns of this particular employee.

As a result of these early errors, we have been working on improving the policies for our deployed civilians and, more importantly, on the communication of these policies.

In summary, our civilian employees play an integral role in supporting our military members around the globe. We are proud of our brave men and women who volunteer for these types of assignments, and we are committed to ensuring that they have the appropriate compensation, benefits and that their health care is first and foremost in our mind.

Thank you for this opportunity. I look forward to your questions.

[The prepared statement of Ms. Bradshaw can be found in the Appendix on page 74.]

Dr. SNYDER. Thank you, Madam Secretary.

Mr. Hallmark.

STATEMENT OF SHELBY HALLMARK, DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, EMPLOYMENT STANDARDS ADMINISTRATION, U.S. DEPARTMENT OF LABOR

Mr. HALLMARK. Good morning, Mr. Chairman and members of the committee. Thank you for the opportunity to come and talk about the OWCP role—that is the Office of Workers' Compensation Programs—in delivering benefits to both of the groups at issue here today, civilian Federal workers and civilian contractor employees who are injured or killed while working in the Middle East.

OWCP directly administers the Federal Employees Compensation Act, or FECA, for feds, and we oversee the delivery of insurance benefits under the Defense Base Act for contractors.

FECA, which we affectionately call it, provides workers' compensation for three million Federal employees and postal workers around the world. It is a generous program.

All injuries and all occupational diseases are payable. Disabled workers receive two-thirds of their date of injury salary or three-fourths if they have a dependent, and it is tax free. There is essentially no cap on weekly benefits, as there are in almost all other workers' comp programs, and there is no limit to the duration of time that an individual can receive benefits.

One hundred percent of medical costs related to the injury are reimbursed. There is no co-pay. And vocational rehabilitation services are provided as well, and anything we pay is charged back to the employment agency.

We work very hard to ensure that Federal workers' cases are handled promptly and properly, especially for war zone claims. Injured workers file their claims through their employing agency and

the latter, as Ms. Bradshaw has indicated, makes special efforts to expedite the processing of overseas claims and providing medical services, in come cases, in remote locations.

If the worker cannot return to work quickly, OWCP will assign a vocational rehabilitation nurse to help in the medical recovery and to return to work.

Since 2004, we have identified 194 FECA claims from Iraq. Most were routine accidents or exposures, but about a quarter of those derived from combat injuries. Ten were death claims, 11 were emotional conditions, and four for traumatic brain injury. To date, more than $1.7 million has been paid in FECA benefits to this group of workers and their families.

Of course, not all claims are meritorious. Some lack medical evidence or simply do not meet the criteria established in law. But claimants have multiple chances to ask for a reconsideration of any decision or for an oral hearing or they can file a formal appeal with the employees' compensation appeals court.

Your invitation, Mr. Chairman, addressed questions about one particular FECA claim which was mentioned. We will provide a full accounting of that case in a letter to the committee. In summary, I can say that I believe it was handled properly, but because of the sensitive circumstances involved in that case, I would prefer not to describe it in detail in this open forum.

As I said, OWCP also administers the Defense Base Act (DBA). The DBA is an extension of the Longshore and Harbor Workers Compensation Act covering employees of overseas contractors working for Federal agencies. While OWCP actually determines and pays FECA benefits, in DBA, we are an oversight entity and the program is private insurance driven, like most state workers compensation systems.

OWCP authorize insurers. We offer technical assistance. We track claims. We work to resolve disputes between the insurer and the employee, and the Department of Labor offers administrative appeals from either of those two parties, if there are disputes, and makes formal decisions.

DBA benefits are generally similar to FECA, except that in DBA we pay two-thirds of the pre-injury salary, subject to a maximum weekly benefit amount of $1,114 as of this year. Again, it is a tax-free benefit.

As expected during times of war, the number of claims under the DBA has risen from about 800 in 2003 to more than 5,700 last year, and we expect 14,000 DBA claims to be filed in 2007, primarily from Iraq and Afghanistan, but DBA, of course, covers people all over the world.

As with FECA, however, the majority of those claims are for routine industrial accidents as opposed to combat injuries. Some are combat related, but most are not.

The DBA covers both American civilian workers and foreign nationals who work overseas for U.S. contractors. In the Middle East, the delivery of benefits has been challenging due especially to cultural differences and other barriers that we find with respect to foreign nationals and having to do with problems of maintaining continuity of service for injured American workers when they return home.

OWCP has no enforcement authority under DBA, but we have worked hard to provide effective compliance assistance to contracting agencies, contractors and insurance companies. We believe those efforts have been helpful and that the industry has, in fact, improved its handling of these challenging claims. We monitor DBA insurers' activities closely at the case level in our district offices and through periodic meetings with the insurance industry leaders.

And we understand the subcommittee is concerned particularly about individuals who incur war-related head wounds and psychological impacts, such as post-traumatic stress disorder. Both of our two programs fully address these conditions. Under FECA, as I said, any medical condition can be accepted—that is not true in all workers' comp systems, by the way—as long as medical evidence establishes that the condition relates to the job.

We do not use a separate diagnosis code for combat injuries because the same kinds of conditions that can arise in a combat situation, such as traumatic injury of the brain, amputation, PTSD, can also be sustained in non-combat situations, and we know how to handle those cases. Medical conditions are categorized in relation to the individual's medical diagnosis using the International Classification of Diseases (ICD) system, regardless of the cause or source of the injury.

The injured worker has the initial choice of physician. They can, obviously, in many cases go to a DOD facility in Iraq, but then when they are home, they can choose a private physician of their choice, or they can use military facilities. We will refer individuals to other specialists if their condition requires that and it is connected to the accepted injury.

As indicated, our FECA record showed that 11 cases from Iraq had been filed involving emotional or stress conditions, four involving traumatic brain injuries, and all but two of those cases have been approved.

All conditions likewise are compensable under DBA. The Defense Base Act, however, ensuring efforts to determine whether conditions are, in fact, work related can require time consuming collection of evidence and expert medical evaluations. The DBA, like most workers' comp systems, is an adversarial system. The employer can provide evidence, the employee can provide evidence, and then there can be disputes.

So we have met with the insurance industry leadership specifically to address the handling of PTSD cases arising from the war zone, and we think we have noted improvements in their efforts in that regard.

OWCP is sensitive to the hardships endured by Federal and contractor employees in the war zone. We continue to work closely with our FECA partner agencies and with Defense Base Act stakeholders to provide the best possible claims services and outcomes.

I will be pleased to answer your questions. Thank you.

[The prepared statement of Mr. Hallmark can be found in the Appendix on page 83.]

Dr. SNYDER. Thank you all for your testimony. Mr. Akin and I will put ourselves on our five-minute clock, and then we will go to members, priority given to those who were here at the time of the

beginning of the hearing and then the order in which people came in after that.

At the conclusion either of our first or second round, depending on how we are doing with time, Mr. Akin, I think I will give the staff an opportunity to ask any questions they may have for five minutes, because some of this is pretty technical stuff, and they help sort it out.

Mr. Hallmark, I recently met with a State Department employee from back home. I assume that under your Administration of the statutes that you outlined, you are talking about all Federal civilian employees—is that correct—or all contractors?

Mr. HALLMARK. The numbers I quoted were all Federal employees.

Dr. SNYDER. My point is you are not here to say, "I am the person that oversees DOD civilian claims."

Mr. HALLMARK. No.

Dr. SNYDER. It does not matter to you.

Mr. HALLMARK. We cover all three million Federal workers.

Dr. SNYDER. Right. And he had not worked in Iraq, though he worked overseas, but, as you know, there is a great communication between employees all over the world now and their old friends.

He was under the impression from an experience a friend of his had, who was wounded in Iraq by a mortar round, that the man was having difficulty making his case for a workers' comp claim because he was playing basketball or something after hours, and it was not an on-duty experience. Is that an accurate reflection?

I am going to make the cases as dramatic as I can. There was a beer festival in honor of his birthday at midnight, and he had three days off in country and was hit by a mortar. Would he be covered under the statutes that you outlined in a war zone?

Mr. HALLMARK. Well, I cannot say that I am a claims examiner who is fully equipped to make those kinds of adjudicatory judgments sitting at the table here. Clearly, the example that you have given gets to some of the boundary lines that are established in our regulations and case law.

One of the key elements in accepting a case has to do with performance of duty. When the injury occurred, was the individual in performance of duty? There is a tremendous and complex amount of case law defining how that works, not just in this kind of circumstance, but when a person is on temporary duty (TDY), and they are engaged in some kind of activity that is or isn't part of the intended purpose for their travel.

I cannot say with regard to that particular case whether our examination of the claim would find that the injury was covered. On the other hand, it may very well be covered, because there are certain circumstances, such as doctrine of the special zone of danger, where coverage is not limited to just the eight hours that you are in the office, but to a larger period of time, maybe 24/7, because of the circumstances that you are in.

So, off the top of my head, it sounds like a coverable injury, but it also sounds like one that we would probably need to develop and ask questions about.

Dr. SNYDER. Well, that is a pretty basic question for what we are talking about. When Secretary Bradshaw is trying to entice a thou-

sand people to step forward, I think most of them are going to assume, "If I am hit by a mortar or my car blows up when I am driving to the beer festival, because it is an act of war, that I will be covered."

As a civilian employee, if you are saying they are not going to be covered, that has big ramifications for them and their employee, if there is even a possibility. I think that is something that this committee needs to have clarified fairly rapidly.

I think most of them would just assume that any kind of a war wound would clearly be covered. Otherwise, you know, are we saying like 15 hours a day they are on their own in terms of——

Mr. HALLMARK. I would assume——

Dr. SNYDER. I think we need to clarify——

Mr. HALLMARK [continuing]. That condition would be covered. I just am not able to provide you a——

Dr. SNYDER. Why don't you get——

Mr. HALLMARK [continuing]. Certain decision——

Dr. SNYDER [continuing]. Back to us fairly quickly on that?

Mr. HALLMARK. Sure.

[The information referred to can be found in the Appendix beginning on page 95.]

Dr. SNYDER. I think that is a pretty basic——

Mr. HALLMARK. The circumstances are important, and each claim that we adjudicate is based on the full state of evidence with respect to that case, and, unfortunately, we are obligated to be consistent with our case law. So there may be circumstances where we are obliged to say, "Under our statute, that falls outside the realm."

The example you give probably does not. I would assume that under the circumstances of a war situation, an event that involved a hostile action like that would clearly be covered. But——

Dr. SNYDER. Do you have any comment, Secretary Bradshaw, on that specific scenario?

Secretary BRADSHAW. I certainly hope it is covered since I am getting ready to travel there——

Dr. SNYDER. Haven't you——

Secretary BRADSHAW [continuing]. Thursday evening.

Dr. SNYDER. Otherwise, you are going to have to work 24 hours a day so you can make your case to Mr. Hallmark. [Laughter.]

Secretary BRADSHAW. But I do appreciate his situation that there are circumstances, but I would look forward to the clarification as well.

Dr. SNYDER. But, clearly, until this very moment, you would have assumed——

Secretary BRADSHAW. Yes, sir.

Dr. SNYDER [continuing]. That any kind of war wound, all your people would be covered, correct?

Secretary BRADSHAW. Yes, sir.

Dr. SNYDER. Yes.

Mr. Akin.

Mr. AKIN. Thank you, Mr. Chairman.

Part of the reason for getting together here this morning was our interest particularly in the PRTs and making sure that the coverage and benefits is appropriate. Would any of you want to comment on the question of PRTs, or do you have any personal experi-

ence with that for getting people, and what is the relation between benefits and people volunteering to work on the PRTs?

Secretary BRADSHAW. Well, I certainly can speak to that from the DOD experience. Our employees are detailed to the State Department for this purpose, but they are the same whether they are performing on the PRTs or whether they are performing Department of Defense missions being assigned as an emergency essential person or having applied for a vacancy announcement. So the benefits are the same.

Mr. AKIN. When I was over here at the Army Engineer school, they had some civilians that taught classes or taught us about how the maintenance procedure was done. These were civilians that came in that were, sort of, professional teachers in a way for us. Those would be covered. They would have certain benefits while they are civilians who are attached to the military. Is that what you are saying?

Secretary BRADSHAW. Yes. If they are deployed into the specific area that the benefit describes, whether it is specifically Iraq and Afghanistan, which the differentials that I described are——

Mr. AKIN. Would they have benefits in Washington, D.C., or anywhere in this country?

Secretary BRADSHAW. No, no.

Mr. AKIN. So the——

Secretary BRADSHAW. The ones that I described would not be available to them here.

Mr. AKIN. Well, these are benefits for people who are deployed.

Secretary BRADSHAW. Correct.

Mr. AKIN. But they are civilians.

Secretary BRADSHAW. Correct.

Mr. AKIN. Now, are they attached to the Army, or are they attached to State?

Secretary BRADSHAW. The PRT members are attached to State Department, and then they are——

Mr. AKIN. Are they paid by the Army?

Secretary BRADSHAW. They are paid by their home component. We have people who volunteered from the Army, the Navy, the Air Force, our defense agencies, and they continue to be paid at this point by the Defense Department and their home component.

Mr. AKIN. How about if you are State and you volunteer? Are you paid by State?

Secretary BRADSHAW. To my knowledge, the State Department has, as their primary mission, the PRTs. So those State Department employees that are on the PRTs are paid by State Department.

Mr. AKIN. So pretty much you are a volunteer, but you are spun out of whatever the organization that you normally work for.

Secretary BRADSHAW. Yes.

Mr. AKIN. It is a temporary kind of assignment.

Secretary BRADSHAW. Absolutely.

Mr. AKIN. But they are getting the coverage. The coverage for all of them is uniform, and it should be good coverage.

Secretary BRADSHAW. Yes. Yes, sir. And that was why, as I noted in my testimony, the benefits that you gave us last year ended up being aligned with the State Department. Because it is not just

State Department and Defense Department, but, as I think Chairman Snyder acknowledged, we have Justice Department and Agriculture and others, in many instances, very interagency. So we are trying to ensure that the civilian Federal employees are receiving comparable benefits.

Mr. AKIN. Yes.

Ms. FARRELL. I know very little about the PRTs, but, as you noted, the Special Inspector General for Iraq has noted the human capital challenges from the beginning in terms of recruiting and retaining staff for those Provincial Reconstruction Teams, and DOD graciously provided the resources to allow the State Department to identify staff that were willing to go.

But what you are raising could be an emerging issue. We are in the third phase, the staffing the PRTs, and what is starting to emerge is that in addition to the DOD personnel that Ms. Bradshaw has noted, we are growing in numbers from the personnel from the State Department, as well as from Agriculture, Commerce and Treasury. So the interagency coordination is going to be challenging, I believe, in Iraq, as well as making sure that the equity of benefits is understood.

As you know, some of DOD's benefits have been administered differently among the services—the Air Force, the Army, the Navy, in Continental United States (CONUS)—and it becomes more challenging for them when they are overseas. So what you are going to have now in Iraq is a Treasury employee and a State Department employee and a Defense employee comparing notes about the pay and benefits, and I think it is important to look at those and see what is available.

We have seen other issues emerge, such as deployment cycles. Te rotations are different among the services, and they are different amongst the military personnel as well as the civilian personnel.

It is a good question you raise.

Mr. AKIN. Thank you.

Thank you, Mr. Chairman.

Dr. SNYDER. Mr. Jones.

Mr. JONES. Thank you, Mr. Chairman.

Mr. Hallmark, if families of workers killed overseas are receiving DBA benefits from the Department of Labor, can the families also sue the contractor for damages in court?

Mr. HALLMARK. Well, first of all, the Department of Labor does not pay benefits under DBA. The benefits come from the employer and the employer's insurer.

The question you are asking is with respect to the exclusivity of workers' compensation benefits, and DBA, like most workers' comp systems, is an exclusive benefit. And there is in effect a bar on litigation—tort suits—where eligibility under Longshore or DBA is shown.

There happens to be a case in North Carolina right now where that issue is being tried, and, obviously, those are legal matters where there is a lot of nuance and opportunity for both sides of the case to be argued. But, in general, workers' comp systems are an exclusive remedy, in effect, a no-fault insurance system, wherein the worker gives up the right to file a tort case, and the employer

agrees to provide these relatively consistent and promptly paid benefits under the workers' comp scheme.

Mr. JONES. In the world we live in now—and, of course, that is one reason you are here—the issue of the contractors—you made reference to the one in North Carolina, which definitely is in my district, by the way. Where is the line? Is there a relationship there quasi, I guess, representing America and the employees? If they are being paid——

I should ask Ms. Farrell. In this case, we are talking about those who provide security, okay. How is the relationship with the government? Obviously, they have to be authorized by the Federal Government to go there to provide services. Then are there employees who still have the right to some benefits from the government, whether it be health benefits, or are they just solely under the umbrella of the company that has been authorized to go into the country?

Ms. FARRELL. These are contractors and subcontractors. My understanding, as Mr. Hallmark has noted, they are covered under Defense Base Act, and contracts vary. It is whatever you write into the contract.

Take medical treatment. Generally, it is provided for contractors and subcontractors at that Level III care, which is at military health hospitals within theater, not the basic care, you know, emergency, first aid or the second level of care at an aid station. It usually begins at Level III.

They could write in the contract to have more care, but routine dental, routine medical is usually not covered. It depends upon the contract in terms of the scope of benefits that the personnel might receive.

We have done very little work looking at contractors in theater and their benefits. We did look back in 2005 at the Defense Base Act trying to look at the cost and the challenges that the agencies had in determining the insurer. DOD, I believe, goes with a single insurance. Some of the other agencies have multiple insurance companies that cover it.

We had difficulty reviewing the program because of the data reliability issues just determining the number of contractors and the different levels of subcontractors. So we were limited. I am not sure if that helps or answers your question.

Mr. JONES. Well, it does help. It is quite a complex arrangement that the government has, and, obviously, many of us are trying to better understand the contractual agreements so that anything you say is helpful. I appreciate that.

Do you have anything else, Mr. Hallmark?

Mr. HALLMARK. Only that the Defense Base Act has been particularly difficult, I think, to administer in the war zone in the Middle East. It has been around for a long time.

It was passed in 1942, but the situations are particularly difficult in the Middle East, and the Department of Labor has done its best to try to coordinate with the players, with the contracting agencies, with the contractors themselves, insurance companies, attorneys, the whole group of people who all have to work together to make those claims work properly.

So it is something that we have worked hard at, and I think we are making some headway, but it is a challenge.

Mr. JONES. Thank you.

Thank you, Mr. Chairman.

Dr. SNYDER. Dr. Gingrey.

Dr. GINGREY. Mr. Chairman, thank you.

And I thank our witnesses for being here.

I want to go back to the situation that the chairman was walking about in regard to a defense civilian employee getting injured in their off-duty time by a combat event, if you will. I think that was a real good point he brought up, and I do also, as I am sure all committee members, look forward to a response, and I would guess that the answer would be clearly they should be covered.

On the other hand, if that particular scenario that the chairman presented was out playing basketball, celebrating at a beer festival, and in the course of playing basketball fell on the court and sustained a head injury, I do not think that individual would be eligible for a claim against the government for traumatic brain injury, as an example, and I would think that you would agree with that.

So, you know, you just have to balance very carefully and make sure we get it right, and I think from all three witnesses, I would assume, we are getting it right.

I wanted to ask maybe Honorable Bradshaw, in regard to that EE situation, the emergency situation, Department of Defense civilians, of course, you are talking about?

Secretary BRADSHAW. That is correct.

Dr. GINGREY. In certain job descriptions, that is part of their contract.

I want to make sure I understand. They could actually be deployed. There would be a need, and they could be deployed just as anybody else who is actually serving in the military, either actively, reserve or even a guard component, but they could be assigned.

Now I think you said that they would have the opportunity to decline if there was somebody else that would step forward and volunteer to fill that position. But suppose there was not and they still declined. What are the recourses of the Department of Defense, their employer, in regard to that?

And then as another follow-on in regard to getting—this is a different question but somewhat related—our Federal civilian employees to take these positions, whether it is PRTs through the State Department or maybe the Department of Defense to assign someone to a PRT under the auspices of the State Department. We know that we are not getting enough. I do not know what the percentage is—I think it was mentioned—maybe 60 percent. Are we providing them enough incentive to fill these volunteer roles?

And finally, does this enhance their career opportunities if they serve in these capacities, either voluntarily or if they are actually made to serve?

Secretary BRADSHAW. The first question about the emergency essential designation because these employees know upfront, and basically sign a contract acknowledging that they understand if they serve in an emergency essential position, that they are expected to deploy, if they decline to go, very technically, we have the right to

remove them from that job and take whatever, you know, the worst possible action could be, you know, separating someone.

I would tell you that would not be something we would do, but the technical letter of the law allows us to do that, because they have signed up to that and that is their job and that is the expectation.

In all reality, as you have already noted, if we have had a circumstance where, because of whatever the individual situation is, that they are not able to go at that point, we work with them to move them to another job and to get another volunteer.

But, at the end of the day, we can force them to go and deploy because they have signed an agreement that says they know that up front, just like any other contract.

Dr. GINGREY. And real quickly, the last part of my question—I know I am running out of time—but in regard to the incentives in place to get people to volunteer to take these positions, whether it is on a PRT team or otherwise, does it enhance their career opportunity if they do this?

Secretary BRADSHAW. We see the enhanced opportunity for these experiences, at least within the Department of Defense, because forward deployment and being expeditionary has not always been an inherent part of a civilian employee's opportunity, and as part of where we believe the department is going, particularly as we look for our leadership for the future, we want people who have had these kind of experiences, who have actually served with our members and understand what it means to be forward deployed.

So I would tell you we are building those kind of experiences into our career progression systems as extra credit, or at least making one absolutely more competitive for advancement.

In terms of incentives, I can only speak to DOD. I cannot speak to the State Department situation. But, as I noted, we had over a thousand resumes of individuals who just really wanted to go and serve because they believed in what we are doing there. So I believe that at least what we are offering today seems to be working.

Dr. SNYDER. Mr. Conaway.

Mr. CONAWAY. Thank you. Well, thank you, Mr. Chairman.

Appreciate everybody being here.

Ms. Bradshaw, you said there were 118 injuries. As a result of *The Washington Post* article, have you gone back and looked at all 118? I mean, that does not seem to be a very daunting number of cases to go back and look at and make sure you have dotted the i's and crossed the t's with respect to that. But you guys looked at all 118 to make sure everything is all right?

Secretary BRADSHAW. No, sir. I did not go back and look at all 118. We relied on working with the worker compensation office, with Department of Labor, and——

Mr. CONAWAY. Okay. Was the subject of The Post article in that 118, or was he someone who came back and later decided he was injured?

Secretary BRADSHAW. No. He was clearly one of the 118. He was one of the earliest in that number.

Mr. CONAWAY. Okay. And as a result of that publicity, no one else has stepped up to say that they have been mistreated at this stage that you are aware of?

Secretary BRADSHAW. No, sir. No, sir.

Mr. CONAWAY. Okay. Now, Mr. Hallmark, now you mentioned that there are hard caps under DBA for disability. You said two-thirds, up to $1,100 a month.

Mr. HALLMARK. Right. A week. $1,100 a week.

Mr. CONAWAY. A week, yes. How does that compare to the civilian similar circumstance? Usually, there is no cap on that. Is the dollar differential about the same?

Mr. HALLMARK. As I said, FECA is one of the more generous workers' comp systems in the world. Almost every other system has a cap based on the average weekly wage of people covered. The cap in FECA is for GS–15, step 10, so only Senior Executive Service (SES) individuals would receive less than either two-thirds or three-fourths of their date of injury salary. Whereas in a program like DBA, a person who is making more than the average weekly wage would not get the full two-thirds.

Mr. CONAWAY. What would be the GS–15, step 10?

Mr. HALLMARK. It is in the $140,000 range, I believe.

Mr. CONAWAY. Okay.

Mr. HALLMARK. So most of our recipients receive 75 percent, so it is substantially more. That would be in the range of $100,000 something per year. So you can do the math.

Mr. CONAWAY. Ms. Farrell, I did not see any recommendations in your report. Did I just miss those, or did you guys make recommendations?

Ms. FARRELL. There were recommendations regarding the quality assurance mechanism needed to be put in place to make sure that civilians receive those before and after health requirements.

DOD, as I mentioned, has an instruction that was issued in February of this year that would make such a mechanism happen, but that is the reason it is so important that they move forward and implement that instruction.

Mr. CONAWAY. And, Ms. Bradshaw, I heard you say you have done that.

Secretary BRADSHAW. Absolutely. And we took those recommendations to heart, sir, and we have implemented the instruction which calls for and basically audits the components accountable for ensuring both the pre- and the post-deployment assessments.

We have conducted one audit since the instruction was implemented, and we have those on the schedule now to go out and do that and make sure that that happens, in addition to finally integrating our tracking systems so that we actually know what is happening.

So we took those to heart.

Mr. CONAWAY. Mr. Hallmark, just one final thing, you made an interesting turn of a phrase when you were talking about DBA insurance companies making improvements in their progress. Your phrase was "We think we have noted progress." First is, you have actually noted progress. I am not sure I understood

Mr. HALLMARK. Well, I was not trying to be——

Mr. CONAWAY. You have noted progress or——

Mr. HALLMARK. I was not trying to be equivocal, but, again, the cases are actually handled by the insurance companies. We only have an oversight role. So, in the context of——

Mr. CONAWAY. You have noted progress?

Mr. HALLMARK. I am sorry?

Mr. CONAWAY. You have noted progress?

Mr. HALLMARK. We have been advised by the insurance companies. There are three major companies that do most of the work in the Middle East in the DBA area. We have been advised by them about procedures. For example, they have hired, in many cases, local Arabic-speaking representatives to help foreign nationals file claims. They have brought on specialists to deal with PTSD cases more rapidly and effectively.

So we have been advised that those things have happened. I was only saying that I cannot speak to the fact of what the outcomes of those initiatives are, but they appear to us to be positive initiatives and progress.

Mr. CONAWAY. All right.

Mr. HALLMARK. If I could take one moment for a point of order here?

Mr. CONAWAY. Sure.

Mr. HALLMARK. The question that Congressman Gingrey raised about the scenario of an individual who was injured in a basketball event similar to the other one, but it is not a mortar but simply a fall, and he hits his head, I cannot speak to whether we would approve that or not. We might very well approve that claim as well.

Again, it gets to the whole set of issues that we would have to look at in terms of the evidence of any given case. And I would point also to the fact that, in some cases, the scenario that the chairman raised might bring into question whether the person had violated safety rules or other kinds of instructions that the employee was bound by. And so even if it were, in fact, a hostile action, there may be a complexity.

So we will give you an answer on the scenario, but, in fact, the workers' comp world is a complex world, and it is not one that is particularly amenable to across-the-board judgments.

Dr. SNYDER. Mrs. Davis.

We will have time for both Mrs. Davis and Mr. Andrews to have their five minutes.

Mrs. Davis for five minutes.

Ms. DAVIS OF CALIFORNIA. Okay. Thank you, Mr. Chairman.

Thank you all for being here.

I wanted to look at the issue of PTSD, and I think, Secretary Bradshaw, you mentioned that only, I think, four cases out of 6,000 civilian employees presented themselves as cases of PTSD, and yet some of the surveys would indicate that even among diplomatic personnel stationed in Iraq and Afghanistan, about 15 percent are coming in with that diagnosis. Can you explain then? Is it partly the differences of jobs, or what is it that you would see such low numbers among the civilian employees?

Secretary BRADSHAW. My suspicion at this time is that perhaps we have not had enough aware of this, and perhaps they have not reported it. It also may be the jobs. It may be the location of the

jobs. I think it is something we will explore. We are learning so much more about it, as you know, from our military side, and I think as we become more informed and smarter about this, it might help us understand the low numbers specifically in——

Ms. DAVIS OF CALIFORNIA. Well, I was especially interested because you mentioned the face-to-face interviews, and that is one task that certainly the military is using to try and bring people in and bring people in after an extended period of time. And we still do not, obviously, have this right on the military side, but I am just wondering whether something about the communication with personnel or the openness of discussing these issues is something that really has not reached them at all.

Secretary BRADSHAW. It may very well be, and I really do not know. Again, we were surprised at the low number. But, again, as we have learned from our military counterparts, as we have become smarter about that as a condition that we need to pay attention to and that it may not show up for some period of time, it may well be that we see an increase as we really implement the instruction for the pre- and the post-deployment assessments in a very deliberate way. We have just begun that process, so it may be that that number goes up. We will——

Ms. DAVIS OF CALIFORNIA. Yes. Are you doing particular screening before people are deploying that would help them understand the perils or the reaction to being in theater? Is that something that did not happen and is happening now?

Secretary BRADSHAW. Yes. We were doing some of that before, but I would tell you our experience with the PRTs really helped us improve the training, both the sort of psychological and social issues that one will encounter, because particularly being in a PRT, these folks are actually embedded so they are actually deployed out there with our battalions, unlike many of our civilians actually serve in the green zone, so they are in an office environment. So, as you suggest, that may very well be part of why there are fewer claims. They are not out seeing the day-to-day conditions.

Ms. DAVIS OF CALIFORNIA. And just the issue of career advancement as well, I mean, how does it affect one's career to either be a volunteer or to be told to go and to agree to that? How is it affecting career advancement and, in fact, is the PTSD diagnosis one that people would perceive would hurt advancement?

Secretary BRADSHAW. I am sure there are all those perceptions and concerns out there, as we have also learned from the military and why many of our soldiers and sailors and airmen have not come forward. So I think that is certainly a concern.

Ms. DAVIS OF CALIFORNIA. What are you doing then to get a handle on this so that you can look a year from now and say, "Yes, in fact, this was a factor." Or is there any way that we, you know, if we come back a year from now, can say, "Okay, what"——

Secretary BRADSHAW. In terms of the career advancement of individuals?

Ms. DAVIS OF CALIFORNIA. Career advancement. Also, identification of PTSD. And education. How can we evaluate that a year from now?

Secretary BRADSHAW. And that is a very good question, and we are maturing in our understanding of that. I would submit that we

have a couple of systems in place now. I think the pre- and the post-deployment assessment with the mandatory mental health component of that.

Again, we have just really implemented this in a way that we are going back and doing, as the GAO chastised us for, really holding people accountable. So we are going back and looking, ensuring that that data are in the system and that somebody is looking at that.

So my hope would be a year from now, we can look at that and we can say, yes, so-and-so was followed up, and we know exactly where there were indications where someone should have had attention, and they had it.

In terms of career advancement, I would submit to you the specific case with which you are familiar. That individual has actually been promoted twice, and part of his condition has to do with PTSD. So I think we have a case of one, at last, where we have become very sensitive to this issue, and ensuring that we work with the individual, that it does not become a career detractor. And I think that is really the goal here, and working with them under a lot of the flexibilities that the Office of Personnel Management (OPM) gives us under what they call their career patterns, alternative work schedules, flexible working arrangements, that there are ways in which we can work with individuals with these conditions to accommodate them.

Dr. SNYDER. Mr. Andrews for five minutes.

Mr. ANDREWS. Thank you.

I thank the panel for your testimony this morning.

If my office received a call this morning from a constituent that said that their mom and wife was a DOD civilian employee wounded in Iraq and she is in a military hospital in Germany about to come home and they said, "We want her to go to Walter Reed for her follow-up care," does she have the right to do that?

Secretary BRADSHAW. Yes, sir. She does.

Mr. ANDREWS. And if the physicians at Walter Reed, the therapists, say, "We think you should continue on an outpatient basis here with us over time until your conditions are dealt with," does she have the right to do that?

Secretary BRADSHAW. Yes, sir. She does.

Mr. ANDREWS. Is there an ombudsman or advocate for her that my office would call to work through all that?

The reason I ask this question is the legislation this committee adopted, and the DOD has largely started to implement since the Walter Reed problem, has set up a sort of case manager and ombudsman for wounded soldiers. Is there an equivalent person for a wounded civilian person?

Secretary BRADSHAW. We are advocating that that apply to the civilian workforce. And, once again, with the unfortunate experience of the case to which I keep referring, the Army in this case would absolutely say, yes, they would assign a case manager.

Mr. ANDREWS. Is there statutory ambiguity as to whether the act that we passed covers the civilian employee? Do we have to make that explicit in the act that we passed?

Secretary BRADSHAW. That would be appreciated.

Mr. ANDREWS. It is probably something we should take a look at doing.

The second question I have for you is in the compensation side, Mr. Hallmark. Let's assume that this civilian employee made $80,000 a year, and she is wounded to the point where continuing her prior duties is not doable. She is badly wounded. What is the maximum she is entitled to as compensation for her injuries?

Mr. HALLMARK. Well, if she is unable to work at all—in your example, she had children—she would be entitled to 75 percent of her date of injury salary, tax free, for as long as she is unable to work.

Mr. ANDREWS. And this would be handled under the same rules of adjudication as any other Federal employee? In other words, the burden of proof would be on her to show that the injury was job related?

Mr. HALLMARK. There is always a burden on the claimant as a matter of law, but in the examples that you give, if the individual is involved in a combat situation and she just came forward——

Mr. ANDREWS. What would your—and not necessarily speaking for your whole agency—opinion be of a statutory change that would say that the burden of proof would shift in the case of a civilian employee in a war zone, that the government would have to prove that their injury was not job related, rather than the other way around?

The premise of my question is that, boy, it seems to me when you are in the green zone and the mortar shells are flying in, and every moment you are in country, as you know personally, you are at risk. What would you think about a change in the burden of proof where if someone were in the war zone and sustained an injury, the burden would be on the government to show the injury was not job related, rather than on the plaintiff to show that it was?

Mr. HALLMARK. I obviously cannot speak to an Administration position on something like that.

Mr. ANDREWS. Sure.

Mr. HALLMARK. I would only say that in my long experience with workers' compensation, every case is different, every case is subject to complexities, and there is a down side associated with the notion of the government being required to prove that benefits are not payable.

Mr. ANDREWS. There is no question. My own sense is, though, the down side is outweighed by the extraordinary sacrifices these civilian employees are making, and I am not suggesting there are not slips and falls in the green zone, but I am suggesting that perhaps the right way to differentiate between the slip and fall and the traumatic brain injury because of a mortar shell is for the burden of proof to fall on the government rather than the claimant.

I mean, we put these folks in extraordinary conditions. I realize that is an extraordinary position of law. The workers' comp law I know says the burden is almost never on the employer, but, of course, very few employers are assigning people to a war zone where they are subjected to the risks that these men and women are subjected.

Let me just close by saying please convey to the people with whom you work our thanks that they have taken on this very difficult job. We are very, very grateful. They are unsung heroes, but

they are heroes nevertheless, and please convey, Madam Secretary, our appreciation to them.

Secretary BRADSHAW. Yes, sir.

Dr. SNYDER. We will stand in recess. We hope you can stay with us. We will have a few questions after. We have a series of three votes which should not take us a terribly long time. The staff will be glad to help you find privacy, phones, restrooms, whatever you need during your time here.

Thank you. We will be right back.

[Recess.]

Dr. SNYDER. The hearing will come back to order.

And I had a series of questions if you want to start the five-minute clock. Then we will go to Dr. Gingrey and see if we have other members come in. We will do that and then go to the staff for any questions they might have.

Mr. Akin may or may not be able to get back.

Secretary Bradshaw, I wanted to say I appreciate your opening statement, your knowledge of whether there were some previous problems. What is your formal plan for oversight of this? How do you monitor the situation with regard to this, you know, reasonably well defined universe of civilians?

Secretary BRADSHAW. I think we have a couple of things in place, Mr. Chairman. First of all, we have had a robust effort over this last year to have each of the components go through and make sure that their EE positions are designated. Let me back up there. There are two things that I see that we have, as pointed out by the GAO, to focus on, tracking the civilians in theater and following up with them when they return.

So, in terms of getting our arms around those that are serving in theater, designating the EE positions, making sure that we can pull data from a central file to identify those, we have that in place, and we have done a complete scrub, and we are expecting a report momentarily from the components on that.

In terms of tracking the civilians once they go into theater, we have had, again, another robust effort over the last year to integrate the various systems that are in place by the components. And the Joint Staff, who really has overall responsibility for tracking military and civilian in and out of the war zone, are experimenting right now with a defense accountability tracking system that basically will take our Common Access Card (CAC) card—and I will find out Friday when I show up in theater how well this works—swiping your CAC card and being able to track you while you are in theater and track your movement. So that is one thing we are looking at, and we are working very diligently to get that tracking system in place.

In terms of the follow-on, getting civilians deployed, again, it has been a matter of taking these independent systems that have been in place with the components, now integrating them into a Department of Defense-wide system for health-care surveillance, and we now have such a system in place that now feeds data from each of the components that have deployed civilians, and it feeds into a centralized system, and you can see and track whether the pre-employment health-care assessment was completed as well as the

post-deployment health-care assessment was completed and whether all of the items that were required were followed.

As the GAO noted, we had all these great policies in place, but they were not necessarily widely known, and we did not have an accountability system in place to follow. We have done two things in that regard.

One, I manage a human capital accountability system that looks at a number of human resources programs. This is one of the specific items that my staff will be looking at on regular audits of our systems and compliance. The second one is the health affairs part of our personnel and readiness domain has responsibility for ensuring that the pre- and post-deployment and all the follow-up assessments are completed, and, as noted, that instruction went out.

We have actually conducted one audit to ensure we are going to the places where the deployments are being processed and actually looking at the data, looking at the processes, ensuring that those are done.

So we have done one, and we are scheduling the rest of those audits for this year.

Dr. SNYDER. Ms. Farrell, to your knowledge, has there been any GAO look at why the State Department has had difficulty filling the PRTs?

Ms. FARRELL. Not to my knowledge. If I could elaborate on that?

Dr. SNYDER. Sure.

Ms. FARRELL. As you know, we have done a wealth of work looking at medical tracking and the shortcomings that DOD has to track their personnel in theater since the mid–1990's, and you were asking what do they need to do now, and this is an area that, although the instructions are definitely a step in the right direction, it is a time for increased management attention to make sure that that oversight takes place.

It was in 1997 that Congress mandated that DOD have a tracking system and that that tracking system have the elements that we have been talking about today, the pre- and the post-health assessment. GAO came along a few years later and looked at that and noted that the quality assurance mechanism was not effective to ensure that that compliance was happening. We were looking at servicemembers in the Army and Air Force that served in Bosnia.

Then a few years later, we came along and looked at servicemembers who were serving in Enduring Freedom and Iraqi Freedom, and we noted that there were the same compliance problems. There was missing data—the documentation issues that we have been talking about today—that the records were not being sent to the central database location at Walter Reed to help monitor the trends and the oversight of those who had been deployed.

We followed up with another report looking at reserve and guard members, found the same issues that we had with the actives, followed up in 2005 looking at pre-existing conditions before members were deployed, saw that DOD did not have tracking systems in theater to monitor those who were being deployed with pre-existing conditions that were treatable in theater. But still you needed to closely monitor them.

Then we issued the report last September looking at civilians deployed. The same issues that we have seen with the civilians, we

have seen and reported on with the reserve and guard and with the active duty. DOD has taken steps. They move toward the right direction, but definitely close monitoring needs to be attended to in this area, and it takes senior management oversight and attention.

Dr. SNYDER. Mr. Akin for five minutes.

Mr. AKIN. Thank you, Mr. Chairman.

Just a question on that very area, because a couple of years ago I had a sense that DOD was very weak in that area.

We had come up with the idea that maybe our office, as a congressional office, could come up with a letter that we sent home to wives—not wives—at least try to get politically correct here—spouses, okay, something to the effect that. "I just wrote you today to let you know how proud we are of your wife or your husband that is in theater and the great work that they are doing. We want you to know that those of us in Congress appreciate that," a very personalized kind of thing with a little eagle on the top, you know, and hand signed, and then send a bunch of those to people, particularly when they have had somebody deployed for some period of time. We thought that would be at least a nice step toward building family relations and letting the family know that we are thinking about them.

I have asked my staff to work on it a number of different times and gotten nowhere, and finally came to the conclusion that the Army did not have, or the military did not have, a personnel database that they could basically go in on Congressional District 2 and pull out who we had to crank those letters out. And it gave me the sense, I wonder, if we really know where our people are. Is that along the same lines as what you are talking about?

Ms. FARRELL. Yes, it is. DOD has had difficulties tracking servicemembers in theater. Past reports where we have looked at medical records going back to the beginning of Enduring Freedom, we have had to omit data because——

Mr. AKIN. Well, I think medical records are even more complicated. I was just asking where the people are, you know.

I mean, I used to work for IBM, and I understand the massive programming effort that would be to put that kind of system together. Is that the sort of thing that could be farmed out to a private company like IBM or something to build that personnel system, or is that something that we as a government or as a military are equipped to do very well?

Anybody who wants to answer, it is fine. I am not trying to be critical. I am just saying that is not easy. It is easy to talk about or conceive it. It is not very easy to do it. I know that.

Ms. FARRELL. Well, it is not easy because there is something like over 550,000 servicemembers that have been deployed. We do not know the number exactly, but it is in that neighborhood.

Mr. AKIN. Which is the point.

Ms. FARRELL. Yes. And for civilians, it is even shorter.

DOD does have a system called Defense Integrated Military Human Resources System (DIMHRS) that they have been working on for some time that would provide some of the answers for tracking and other medical records issues, but that has not been implemented.

Perhaps Ms. Bradshaw could speak more to the other partnerships that they might have with outside agencies on it.

Secretary BRADSHAW. Well, DIMHRS is expected to be the ultimate tool, and we would certainly never undertake the actual programming of such a vast system within the department. So there are contractors that are working on that with us, and it is envisioned that that will be the military system that will track and house a lot of this data, as Ms. Farrell noted.

Mr. AKIN. Are you familiar with the status of where that project is? It must be behind from what we are hearing, or maybe it is not behind. But what do you know about it?

Secretary BRADSHAW. Well, I guess that it has been——

Mr. AKIN. One thing I will tell you ahead of time and brag on our chairman. Our interest is solving problems. We are not trying to find people to blame. That is our whole tone here. We want to be helpful. Is there something we can be helpful in that area?

Secretary BRADSHAW. Well, I would be pleased with the opportunity to give you a written status on DIMHRS. It has been around and underway for some time, and, actually, I retired in 1999 and they were working on it then. So it was interesting to learn that we are still working on it.

But my sense is in the last number of years, the components have actually come together in a collaborative way and have actually defined the requirements and are actually leveraging the work that has been done previously, and we have a very robust oversight council under my boss, Dr. Chu, that is overseeing the development of this.

But we will take for the record to get back to you with specifics on it.

[The information referred to can be found in the Appendix beginning on page 99.]

Mr. AKIN. Mr. Chairman, I did not mean to take too much time here.

Is this really the Personnel Subcommittee's turf more than our own, because you used to be chairman of that? Are you familiar with it?

Dr. SNYDER. Our turf is all of human activity and knowledge.

Mr. AKIN. Okay. Good. [Laughter.]

Dr. SNYDER. Having said that, we will work on conjunction with our subcommittees so that we are all pulling on the same harness, but there are clearly issues. I mean, in this subcommittee, we can explore a lot of different things, but we want to do it in cooperation with our other subcommittees.

Mr. AKIN. Is that something——

Dr. SNYDER. As you know, Mrs. Davis is one of our committee members, and she is the chairperson of the Military Personnel Subcommittee.

Mr. AKIN. Yes. Is that something that you have dealt with before, that personnel records thing, when you were chairman of the personnel thing? Did you run into that problem?

Dr. SNYDER. The——

Mr. AKIN. Military records and where the different military people are, knowing where they are, where——

Dr. SNYDER. Yes, that certainly came up.

Mr. AKIN. Okay.

Dr. SNYDER. And then it became an issue, too, in the situation we are talking about. When somebody got hurt, both their personal effects and their records may not follow along with them as they were moving rapidly through the health-care system.

Mr. AKIN. Could I ask that we could get a written report of the status of that, with at least a reasonable historic background of when Congress——

Ms. FARRELL. Sure.

[The information referred to can be found in the Appendix beginning on page 99.]

Mr. AKIN [continuing]. Where we are in those different steps?

Ms. FARRELL. We also have ongoing work looking at the status of DIMHRS that we would be happy to brief the committee or members at any time.

I want to say, in reference to Ms. Bradshaw talking about the components coming together, the Marine Corps wanted to establish its own system, and the Navy has been supportive of that, having the Marine Corps branch away and have a different personnel system and then later go to the DIMHRS.

So it is an area they are in various stages depending upon which component you want to talk about, but we could provide you information.

Mr. AKIN. Thank you very much. Thank you.

Thank you, Mr. Chairman.

Dr. SNYDER. Dr. Gingrey.

Dr. GINGREY. Mr. Chairman, thank you. This has been a great hearing. As I said before we had to leave to go vote, it always seems like the best hearings are the ones that get interrupted the most times.

But we appreciate, again, all of you being here.

Before we did take the break, I had asked a question—and I am going to direct this mainly to Secretary Bradshaw and Mr. Hallmark—in regard to incentivizing Federal civilian employees to take these assignments. And I think, Secretary Bradshaw, you indicated that, yes, it was a good thing for them to do, whether it was mandatory under the EE program, certainly if it is voluntary, that it probably puts them in a little bit better position when they come back home.

I am going to suggest that maybe some formal promise for serving and serving well and completion of assignment could lead to an increased pay grade or whatever. Now I am showing my ignorance of the Federal civilian employment system by maybe suggesting that.

I also wanted to pursue a little bit more this idea of the pre-deployment physical that the civilian employees undergo and particularly in regard to screening for mental health. Now, you know, I am a physician. The chairman is a physician. We have a lot of interest in that, and concerns, because I would say in particular the condition post-traumatic stress syndrome—or post-traumatic stress disease maybe it is called today—is a very difficult thing to measure. And while the civilian employees are not nearly as likely to come back having sustained traumatic brain injury, I would hope, they certainly could be just as likely to come back from a deploy-

ment in an area like the Middle East suffering from post-traumatic stress disorder, and so you have to be very careful in evaluating.

While I am talking about wanting to incentivize people to go, there are certain ones that you absolutely would not want to go, and maybe Mr. Hallmark could discuss this a little more, too, because that is a pretty expensive lifetime of disability payments when you get into something PTSD, which is awfully hard to say whether a person really has it or whether they do not. You know, the same thing to some extent applies to traumatic brain injury.

And wouldn't it be great if there were a blood test that could be done pre-deployment and post-deployment for a person particularly who has been injured and is concerned about traumatic brain injury, if there were some mark or some blood marker that could measure not only if it had occurred, but how severe and then help our health-care personnel follow the progress of the treatment?

I do not know if I put that in the form of any question or not. Maybe you could come up with an answer even though it was not phrased in the form of a question.

Secretary BRADSHAW. Well, we certainly concur with your observation and, certainly, from a very practical standpoint as a doctor, a physician, the difficulty of making those pre-deployment assessments, and then you say, "Okay." So, if you are doing this, what is the threshold at which you say, "You are not deployable," if it is a mental health condition?"

I can only tell you I know of one situation where we actually had a PRT member volunteer who got to the training that we provided, and through the observation of some very alert leaders on the ground and the psychologists and doctors assigned there, we actually made that type of assessment and did not allow that person to deploy.

So is there a checklist by which you can just follow the checklist and then, at the end of the day, hope you get to the right answer? Probably not. But there are some general guidelines and principles. Our leaders also have to be leaders. They need to be able to look for those types of behaviors and things.

And I would submit that those are the types of people that we put into these training centers where individuals are processed before they are deployed, so we have experienced leadership on the ground that observe and watch the civilians—and, I presume, the military members as they come through as well—for exactly those types of things. So it is not just resigned to a checklist of "Did you answer this question well?" but what is the general observation.

Dr. GINGREY. Madam Secretary, thank you.

Mr. Chairman, I know I have run out of time, but if Mr. Hallmark can comment, would that be all right?

Mr. HALLMARK. Well, I would, I guess, simply say that typically in the workers' comp world, it is very difficult to do much in the way of prescreening that is satisfactory and helpful. I mean, the only example where it is pretty straightforward—and you were talking about if we had a blood test—but hearing loss you can do prescreening for to some extent and identify, you know, existing loss, and then look at how that plays out in the later employment.

But, as you point out, PTSD and similar psychological conditions are very ambiguous in the first place, and finding markers for peo-

ple who might be susceptible to them is probably even more difficult. I think this is just one of those areas where defense and whoever is sending people over, as the Honorable Ms. Bradshaw has indicated, just have to use common sense and identify people who look like they may be problematic.

But, for the most part, in workers' comp, you take the worker as they come. People get over there, are going to get injured, and some of them are going to have bad experiences, and then it is our job to try to address the issue, and not only pay them benefits and take care of them medically, but also work with individuals to get them back to work. And that is something that the FECA program truly emphasizes and that is very important for the health and benefit of the worker and their family and for the taxpayer in terms of the cost of the program.

Dr. GINGREY. Thank you. Thank you both.

Dr. SNYDER. Thank you, Dr. Gingrey.

Tom, come have a seat up here with us.

We will give our two staff members here an opportunity to ask questions.

Now you are self-timing yourself here, Steve. I do not know.

First will be Steve DeTeresa and then Tom Hawley.

Steve, go ahead and put yourself in——

Dr. DETERESA. Okay.

Dr. SNYDER. See, you did not start the clock. See. [Laughter.]

Dr. DETERESA. I have not started my question yet. Thank you, Mr. Chairman.

Actually, I have a two-part question, so I better start the clock on myself, and I think both of these would go to Mr. Hallmark.

First is, GAO found in the report that they could not examine claims from DOD civilians who were wounded in Afghanistan, and that is because there was not any way to track them. So the question is, what has been done to remedy that?

And then the second one, a little more detailed, a little more involved, is with Defense Base Act insurance. Who, if anyone, is responsible for making sure that all of our contractors—U.S. citizens, non-U.S. citizens—have this coverage as required by law, and then who, if anyone, is responsible for making sure that they actually get the benefits they are entitled to under DBA insurance.

Mr. HALLMARK. Well, I will take the easier one first. As GAO pointed out, we have not had in place an ability to track Afghan cases. The FECA system does not actually give us the ability to identify the location of injury in an automated fashion. We do get 130,000-plus cases per year. So the manual approach is not an effective one.

However, for Iraq, we set up a special numbering system so that we could track and report on those cases. I had actually thought that it covered Afghanistan injuries as well, but, you know, that was not clarified. So we have now gone back and created a separate numbering system for Afghanistan. Unfortunately, it starts in the summer of 2007, but we will have it for going forward.

On the Defense Base Act questions, the Department of Labor's responsibility is to try to oversee that the program is being administered properly, so one of the things we have done is hold a num-

ber of seminars and compliance assistance programs to help the people who are responsible for making it happen do their part.

The contracting agencies—DOD, State, Agency for International Development (AID)—primarily are responsible for ensuring that the contracts they let that have likely coverage under DBA contain provisions that require the contractors to obtain Defense Base Act insurance. And so one of the things we have done is work with those agencies contracting folks, make sure that those kinds of boilerplate provisions are in there.

Obviously, as time has gone on, that is become more and more clear cut. There have been discussions about the cost of DBA premiums and trying to procure coverage in more efficient and effective ways, and DOD has been in the forefront of that.

The second part of that question goes to the question of once there is, in fact, an injury and we have insurance in place, what do we do to make sure that people receive the services they are supposed to get? And the answer is the job of the insurer, in that circumstance, is to identify cases that are applicable and covered under the statute and then provide the services.

That has been, in the case of a war zone, a difficulty, and, as I mentioned in my testimony, we have worked with the insurers and the contractors themselves to try to work on that issue and to make it happen better in the war zone.

As I believe I mentioned, some of the insurers have taken steps such as acquiring resources in Arabic-speaking folks in the Middle East who can go and actually be on site and help especially foreign nationals file their claims and obtain the services that they should receive. That has been an evolving practice, but I think there has been, in fact, improvement in that regard.

But it is very difficult, and there are real challenges associated with getting services, medical services, especially, for foreign nationals, for Iraqis in a country which has a very, very weak infrastructure, and where medical services are hard to come by for anybody, much less for injured workers in this circumstance.

Dr. DETERESA. Thank you.

Dr. SNYDER. Go ahead, Tom.

Mr. HAWLEY. Just one question. You all testified that the incentives across the government are the same statutorily. They could be applied by all agencies. They are equal for all agencies for civilian pay. And. Ms. Farrell, in your report, you stated that the civilian employee deployed to Iraq and Afghanistan with the 35 percent danger pay and the post differential and with premium pay essentially can more than double their salary. DOD has been successful in getting people to go, but DOD is on a war footing.

The State Department is, of course, very interested in success in Iraq, but Ginger Cruz testified in exchange with the chairman a few weeks ago that State Department culture is not there. Is it so much of an incentive question that we cannot get other agencies to fill, or is it more of a cultural and leadership question, or what needs to be done?

Is it something Congress needs to do, something the agencies need to do? Do they need to change their mentality in the Agriculture Department, Justice Department that service in Iraq is im-

portant, or do they need more money? What is your opinion on what needs to be done?

Ms. Farrell and Secretary Bradshaw.

Ms. FARRELL. Well, again, a word of caution about approaching this from a piecemeal fashion. You have to first determine the purpose. Is the purpose to provide compensation for those who are deployed and an additional benefit is worthy? Is the purpose for equity? That is the key. Whenever you look at a special pay or a bonus or an incentive, what are we trying to accomplish? As far as the incentive to be——

Mr. HAWLEY. Well, the purpose would be to get skilled staff to accomplish the national mission. So what do we need to do to do that?

Ms. FARRELL. And then you have align your human capital policies, including any recruiting or retention pay, to meet that particular mission and build it into that human capital system all the way down.

Mr. HAWLEY. So why is DOD successful in doing that and the other agencies are not?

Ms. FARRELL. Well, I would ask DOD to look carefully at those thousand volunteers and make sure that the thousand were specialists that would meet the needs of what you are getting to, the mission, or was the population somewhat smaller. I think part of it has been reported that the State Department has had the culture problem of wanting a more secure Iraq before they send their specialists to help build the departments, to oversee finance and maintenance and road building, et cetera.

Mr. HAWLEY. Ms. Bradshaw.

Secretary BRADSHAW. I think your question leads to some very exciting initiatives that are actually underway right now, and that is the definition about national security and whose mission is it. And I would tell you we have a number of things going that are trying to break this barrier with other agencies, that every Federal employee's job is national security, that this blending between and this line between homeland domestic and national, it is really starting to blur, and that we are really all about national security.

And so to your question about is this sometimes a cultural component of the agency, I would submit, probably so. You work for the Department of Defense because you know that there is a specific kind of mission there. You work for the Department of Agriculture, you see yourself more domestic, and there is a Foreign Service component of that.

But we do have, as I suggested, some initiatives underway right now that are really focusing on this interagency blending and the commitment and the need for every Federal employee to see themselves as involved in national security.

Mr. HAWLEY. And who should the committee follow up with to learn more about these missions?

Secretary BRADSHAW. I would be happy to come chat with you about them.

Dr. SNYDER. Who is the "we" when you say "we have initiatives"? Is the we the Department of Defense, or is the we an agency——

Secretary BRADSHAW. They are coming out of the National Security Council, so the——

Yes, exactly. There was an executive order on the definition of a national security professional looking at education that needs to be provided and defining what that community looks like, the whole interagency NSPD–44 about interagency management. So there is recognition at the highest levels in the government right now that the interagency coordination needs some work, and we are moving toward it, and it is a very exciting opportunity.

Mr. HAWLEY. Thank you.

Dr. SNYDER. Thank you, gentlemen.

We appreciate you all being here today. We apologize for the votes, but some of you have been through that before.

And the hearing is adjourned.

[Whereupon, at 12:17 p.m., the subcommittee was adjourned.]

A P P E N D I X

SEPTEMBER 18, 2007

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

SEPTEMBER 18, 2007

Opening Statement of
Chairman Dr. Vic Snyder
Subcommittee on Oversight and Investigations

Hearing on "Benefits and Medical Care for Federal Civilian and U.S. Contract Employees Deployed to Iraq and Afghanistan"

September 18, 2007

The hearing will come to order.

Good morning, and welcome to the Subcommittee on Oversight and Investigations' hearing on benefits and medical care for federal civilian and U.S. contract employees deployed to Iraq and Afghanistan.

Recently, the Subcommittee has begun to investigate a variety of interagency issues raised by the ongoing wars in Iraq and Afghanistan. Military means alone are clearly not enough to bring about success in either country. Civilians from across the federal government are increasingly being called upon to help us achieve our goals in these dangerous environments, through the use of Provincial Reconstruction Teams and other civilian-oriented programs.

An unfortunate but inevitable consequence of deploying civilians to combat zones is that some of them may be injured or killed. The purpose of today's hearing is to consider issues related to the hazardous nature of this duty.

First, given the critical need for U.S. government federal civilian employees to deploy to Iraq and Afghanistan, what kind of incentives and benefits are provided to encourage those with the right skills and experience to do so?

Second, what practices and policies are in place within the military healthcare system to provide medical care for deployed federal civilian employees, both while overseas and upon returning home?

Of course, most of the civilians overseas in Iraq and Afghanistan are not federal employees, but are instead working for U.S. government contractors. Thus, a third purpose of today's hearing is to examine the practices and policies in place for providing medical support to wounded contract employees.

By way of background, there have been approximately 6,000 Department of Defense civilians deployed to Iraq and 1,500 to Afghanistan since 2001. More than 1,400 Department of State employees have served in Iraq since 2003. U.S. government employees from DOD, State, and other federal agencies including Justice, Agriculture, and Labor volunteer to serve in these positions. To date, 118 DOD civilians have been wounded and 7 have been killed. 3 State employees have been killed in Iraq and Afghanistan. Overall, the Department of Labor Office of Workers' Compensation

Programs, which handles claims for medical benefits by government civilians, reports 166 claims submitted for injuries sustained by U.S. federal civilians in Iraq and Afghanistan.

With respect to contractors, estimates range as high as 180,000 in Iraq as of July 2007. The bulk of these are Iraqi citizens and third country nationals, but approximately 21,000 are U.S. citizens. Accurate casualty numbers are not available, but as many as 1000 contractors, both U.S. and non-U.S. citizens, have reportedly been killed, and about 13,000 have been wounded.

Some published accounts indicate that civilians, particularly contractor employees, have encountered difficulties in obtaining medical care for injuries sustained while deployed to Iraq upon returning to the United States. It is not clear, however, whether these issues are symptomatic of underlying issues with healthcare for civilians or merely isolated incidents. One area of particular interest is whether civilians receive adequate diagnoses and treatment for mental health disorders that commonly occur in combat zones, such as Post-Traumatic Stress Disorder.

We have assembled a panel of witnesses to help us examine these issues:

- Ms. Brenda Farrell, Director of the Defense Capabilities and Management Team, from the U.S. Government Accountability Office
- Secretary Patricia Bradshaw, Deputy Under Secretary for Civilian Personnel Policy of the Department of Defense.
- Mr. Shelby Hallmark, Director of the Office of Workers' Compensation Programs at the Department of Labor.

We expected to have a State Department representative here today as well, but were informed that pressing commitments prevented them from attending. We hope to reschedule a session with them at a later date.

Welcome to all of you and thank you for being here. After Mr. Akin's opening remarks, I'll turn to each of you for a brief opening statement. Your prepared statements will be made part of the record.

On an administrative note, we will use our customary five-minute rule today for questioning, proceeding by seniority and arrival time.

With that, let me turn it over to our ranking member, Mr. Akin, for any statement he would like to make.

Statement of Ranking Member Todd Akin
Subcommittee on Oversight and Investigations
House Armed Services Committee

Benefits and Medical Care for Federal Civilian and U.S. Contract Employees Deployed to Iraq and Afghanistan

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September 18, 2007

Thank you, Mr. Chairman.

Good morning to our witnesses; thank you for being here today. Today's hearing begins a new inquiry for this subcommittee: the benefits and medical care for federal civilian and U.S. contract employees deployed to Iraq and Afghanistan. This subject, in many ways, goes to the heart of an issue that this subcommittee keeps returning to – how can the U.S. government incentivize U.S. civilians across the federal agencies to deploy to combat zones.

While the challenge of getting personnel other than the military to deploy into theatre is multi-faceted, the issue of pay and healthcare for civilians operating in theatre is a major factor affecting the Government's ability to recruit qualified personnel. Whether it be filling civilian positions

on Provincial Reconstruction Teams or manning a transition team to build the capacity of an Iraqi or Afghan ministry, this subcommittee has first hand knowledge of how getting the right civilians into theatre improves on the ground operations.

Today's hearing should give us a sense of the pay and health care benefits civilian federal employees and contractors receive in theater, as well as when they return home. This information will help the subcommittee assess whether the benefits package we offer civilians in Iraq and Afghanistan includes the right set of incentives so that the best and most capable civilians sign up for these critical posts.

Finally, I want to state for the record my deep respect and appreciation for all of the civilians who risk their lives carrying out critical missions in what is often a dangerous environment. When we discuss Operation Iraqi Freedom and Operation Enduring Freedom, the role and work of civilians is often overlooked in favor of the warfighter. But if you listen to our military, they will tell you that we need to turn our attention to the civilian side. I'm glad we're listening - thank you Mr. Chairman for holding this hearing.

Again, thank you to the witnesses for being here today. I look forward to hearing your testimony.

[Yield Back to Chairman Snyder]

United States Government Accountability Office

GAO

Testimony

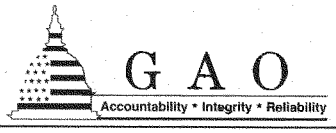
Before the Subcommittee on Oversight and Investigations, Committee on Armed Services, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Tuesday, September 18, 2007

DOD CIVILIAN PERSONNEL

Medical Policies for Deployed DOD Federal Civilians and Associated Compensation for Those Deployed

Statement of Brenda S. Farrell, Director
Defense Capabilities and Management



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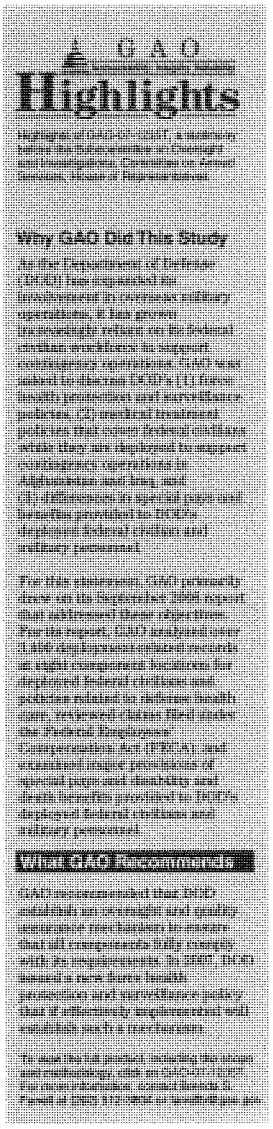

GAO

Highlights

Why GAO Did This Study

What GAO Recommends

September 18, 2007

DOD CIVILIAN PERSONNEL

Medical Policies for Deployed DOD Federal Civilians and Associated Compensation for Those Deployed

What GAO Found

In 2006, GAO reported that DOD had established force health protection and surveillance policies to assess and reduce or prevent health risks for its deployed federal civilians, but it lacked procedures to ensure implementation. GAO's review of over 3,400 deployment records found that components lacked documentation that some federal civilians who deployed to Afghanistan and Iraq had received, among other things, required pre- and post-deployment health assessments and immunizations. Also, DOD lacked centralized data to readily identify its deployed civilians and their movement in theater, thus hindering its efforts to assess the overall effectiveness of its force health protection and surveillance capabilities. GAO noted that until DOD establishes a mechanism to strengthen its oversight of this area, it would not be effectively positioned to ensure compliance with its policies, or the health care of deployed federal civilians.

GAO also reported that DOD had established medical treatment policies for its deployed federal civilians, which provide those who require treatment for injuries or diseases sustained during overseas hostilities with care under the DOD military health system. GAO reviewed a sample of seven workers' compensation claims (out of a universe of 83) filed under FECA by DOD federal civilians who deployed to Iraq. GAO found in three cases where care was initiated in theater that the affected civilians had received treatment in accordance with DOD's policies. In all seven cases, DOD civilians who requested care after returning to the United States had, in accordance with DOD's policies, received medical examinations and/or treatment for their deployment-related injuries or diseases.

GAO reported that DOD provides certain special pays and benefits to its deployed federal civilians, which generally differ in type and/or amount from those provided to deployed military personnel. For example, in cases where injuries are sustained while deployed, both DOD federal civilian and military personnel are eligible to receive government-provided disability benefits; however, the type and amount of the benefits vary, and some are unique to each group. Importantly, continuing challenges with modernizing federal disability programs have been the basis for GAO's designation of this as a high-risk area since 2003. In addition, while the survivors of deceased DOD federal civilian and military personnel generally receive similar types of cash survivor benefits for Social Security, burial expenses, and death gratuity, the comparative amounts of these benefits differ. However, survivors of DOD federal civilians almost always receive lower noncash benefits than military personnel. GAO does not take a position on the adequacy or appropriateness of the special pays and benefits provided to DOD federal civilian and military personnel. Any deliberations on this topic should include an examination of how such changes would affect ensuring adequate and appropriate benefits for those who serve their country, as well as the long-term fiscal well-being of the nation.

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to be here today to discuss the Department of Defense's (DOD) policies for its federal civilians[1] who deploy in support of contingency operations in Afghanistan and Iraq. First, let me emphasize that as DOD has expanded its involvement in overseas military operations, it has grown increasingly reliant on its federal civilian workforce to provide support in times of war or national emergency. Further, in recent years, DOD has undertaken efforts to expand the use of its civilian workforce to perform combat support functions traditionally performed by military personnel. Therefore, the need for attention to the policies and benefits that affect the health and welfare of these individuals becomes increasingly significant. Today's hearing is particularly timely considering the continuing role of the United States in Afghanistan and Iraq as discussed during last week's hearings.

The structure of the armed forces is based on the Total Force concept, which recognizes that all elements of the structure—active duty military personnel, reservists, defense contractors, host nation military and civilian personnel, and DOD federal civilian employees—contribute to national defense. In recent years, federal civilian personnel have deployed along with military personnel to participate in Operations Joint Endeavor, conducted in the countries of Bosnia-Herzegovina, Croatia, and Hungary; Joint Guardian, in Kosovo; and Desert Storm, in Southwest Asia. Further, since the beginning of the Global War on Terrorism, the role of DOD's federal civilian personnel has expanded to include participation in combat support functions in Operations Enduring Freedom and Iraqi Freedom.[2]

DOD relies on the federal civilian personnel it deploys to support a range of essential missions, including intelligence collection, criminal investigations, and weapon systems acquisition and maintenance. To ensure that its federal civilian employees will deploy to combat zones and perform critical combat support functions in theater, DOD established the emergency-essential program in 1985. Under this program, DOD designates as "emergency-essential" those civilian employees whose

[1]DOD's civilian workforce includes federal government employees, foreign nationals hired directly or indirectly to work for DOD, and contractor personnel. This statement focuses on DOD's federal government employees, who we refer to as DOD's federal civilians.

[2]Operation Enduring Freedom includes ongoing operations in Afghanistan and in certain other countries; Operation Iraqi Freedom includes ongoing operations in Iraq.

positions are required to ensure the success of combat operations or the availability of combat-essential systems. DOD can deploy federal civilian employees either on a voluntary or involuntary basis to accomplish the DOD mission.

DOD's use of its civilian personnel to support military operations has long raised questions about its policies relating to the deployment of civilians in support of contingency operations. In 1994, we reported on the adequacy of DOD's planning for the future use of civilian personnel to support military operations in combat areas and noted a number of problems in deploying civilians to the Gulf War and caring for them in theater.[3] For example, we noted that many civilians had not been screened to ensure that they were medically fit to serve in desert conditions. Thus, some had arrived in the desert with medical and physical limitations, such as severe heart problems and kidney disorders, that precluded them from effectively performing their duties. Other problems, while not as grave, indicated a lack of preparation for civilians in theater. For example, clear procedures did not exist to ensure that civilians received medical care comparable to that received by military personnel. In addition, procedures were not in place to provide for overtime or danger pay that the deployed civilians were eligible to receive.

My testimony today will focus on (1) the extent to which DOD has established and implemented force health protection and surveillance policies, (2) medical treatment policies and procedures for its deployed DOD federal civilians who require treatment for injuries and diseases, and (3) the differences in special pays and benefits provided to DOD's deployed federal civilians and military personnel. My remarks today are primarily based on our September 2006 report on DOD's policies concerning its federal civilians who have deployed in support of operations in Afghanistan and Iraq.[4] For the 2006 report, we reviewed DOD deployment health requirements for contingency operations in Afghanistan and Iraq. To assess the implementation of these requirements,

[3]GAO, *DOD Force Mix Issues: Greater Reliance on Civilians in Support Roles Could Provide Significant Benefits*, GAO/NSIAD-95-5 (Washington, D.C.: Oct. 19, 1994).

[4]GAO, *DOD Civilian Personnel: Greater Oversight and Quality Assurance Needed to Ensure Force Health Protection and Surveillance for Those Deployed*, GAO-06-1085 (Washington, D.C.: Sept. 29, 2006). For this report, we examined the Departments of the Army, Navy, and Air Force and the Defense Contract Management Agency (DCMA). We selected DCMA because it deployed the largest numbers of federal civilian personnel compared to other defense agencies.

we analyzed over 3,400 deployment-related records for deployed federal civilians. We also analyzed DOD policies and guidance related to defense health care and discussed these with senior DOD and service surgeon general officials. To assess the implementation of these policies, we requested all workers' compensation claims that had been filed under the Federal Employees' Compensation Act[5] (FECA) by DOD federal civilians who had deployed to Afghanistan and Iraq. We selected and reviewed a non-probability sample of workers' compensation claims to reflect a range of casualties, including injuries, physical and mental illnesses, and diseases. The scope of our review did not extend to the Department of Labor's claims review process, which covers the workers' compensation claims process. We also examined the major provisions for special pays and disability and death benefits for civilian and military personnel, relying primarily on statutes, Department of State regulations, and DOD guidance. We performed our review in accordance with generally accepted government auditing standards.

In summary, we found DOD had established force health protection and surveillance policies aimed at assessing and reducing or preventing health risks for its deployed federal civilian personnel, but lacked a quality assurance mechanism to ensure the components' full compliance with its policies, or the health care and protection of its deployed federal civilians. DOD has taken steps in the right direction by issuing a new policy in February 2007 toward that end. DOD has also established medical treatment policies that cover its federal civilians while they are deployed in support of contingency operations in Afghanistan and Iraq, and selected workers' compensation claims that we reviewed confirmed that those deployed federal civilians received care that was consistent with the policies. Further, DOD provides certain special pays and benefits to its deployed federal civilians, which generally differ in type and/or amount from those provided to deployed military personnel. We are not taking a position on the adequacy or appropriateness of the special pays and benefits provided to DOD federal civilian and military personnel. We believe that any deliberations on this topic should include an examination of how such changes would affect ensuring adequate and appropriate benefits for those who serve their country, as well as the long-term fiscal well-being of the nation.

[5]The Federal Employees' Compensation Act is a comprehensive workers' compensation law for federal employees that calls for medical coverage and compensation for federal employees with injuries and occupational illnesses incurred in the performance of their duties.

DOD Has Established Force Health Protection and Surveillance Policies for Deployed Federal Civilians, but Should Do More to Ensure That Components Comply with Its Requirements

We reported in 2006 that DOD had established force health protection and surveillance policies aimed at assessing and reducing or preventing health risks for its deployed federal civilian personnel; however, at the time of our review, the department lacked a quality assurance mechanism to ensure the components' full implementation of its policies. In reviewing DOD federal civilian deployment records and other electronic documentation[6] at selected component locations, we found that these components lacked documentation to show that they had fully complied with DOD's force health protection and surveillance policy requirements for some federal civilian personnel who deployed to Afghanistan and Iraq. As a larger issue, DOD's policies did not require the centralized collection of data on the identity of its deployed civilians, their movements in theater, or their health status, further hindering its efforts to assess the overall effectiveness of its force health protection and surveillance capabilities. In August 2006, DOD issued a revised policy that became effective in December 2006, outlining procedures to address its lack of centralized deployment and health-related data. However, at the time of our review, the procedures were not comprehensive enough to ensure that DOD would be sufficiently informed of the extent to which its components fully comply with its requirements to monitor the health of deployed federal civilians.

DOD Components Did Not Always Implement All Force Health Protection and Surveillance Requirements

Our 2006 report noted that DOD components included in our review lacked documentation to show that they always implemented force health protection and surveillance requirements for deployed federal civilians. These requirements included completing (1) pre-deployment health assessments to ensure that only medically fit personnel deploy outside of the United States as part of a contingency or combat operation; (2) pre-deployment immunizations to address possible health threats in deployment locations; (3) pre-deployment medical screenings for tuberculosis and human immunodeficiency virus (HIV); and (4) post-deployment health assessments to document current health status,

[6]In addition to DOD federal civilian deployment records, other documentation reviewed included data from information systems used by the components to capture deployment and related health information. Although we found these data not to be sufficiently reliable for (1) identifying the universe of DOD federal civilian deployments or (2) use as the sole source for reviewing the health and immunization information for all DOD federal civilian deployments, we found the information systems to be sufficiently reliable when used as one of several sources in our review of deployment records.

experiences, environmental exposures, and health concerns related to their work while deployed.

Pre-deployment Health Assessments

DOD's force health protection and surveillance policies required the components to assess the medical condition of federal civilians to ensure that only medically fit personnel deploy outside of the United States as part of a contingency or combat operation.[7] At the time of our review, the policies stipulated that all deploying civilian personnel were to complete pre-deployment health assessment forms within 30 days[8] of their deployments, and health care providers were to review the assessments to confirm the civilians' health readiness status and identify any needs for additional clinical evaluations prior to their deployments.

While the components that we included in our review had procedures in place that would enable them to implement DOD's pre-deployment health assessment policies, it was not clear to what extent they had done so. Our review of deployment records and other documentation at the selected component locations found that these components lacked documentation to show that some federal civilian personnel who deployed to Afghanistan and Iraq had received the required pre-deployment health assessments. For those deployed federal civilians in our review, we found that, overall, a small number of deployment records (52 out of 3,771) were missing documentation to show that they had received their pre-deployment health assessments, as reflected in table 1.

[7]DOD Instruction 1400.32, *DOD Civilian Workforce Contingency and Emergency Planning Guidelines and Procedures*, April 24, 1995; DOD Instruction 6490.3, *Implementation and Application of Joint Medical Surveillance for Deployments*, August 7, 1997; DOD Directive 6490.2, *Comprehensive Health Surveillance*, October 21, 2004; and Office of the Chairman, The Joint Chiefs of Staff, Memorandum MCM-0006-2, *Updated Procedures for Deployment Health Surveillance and Readiness*, February 1, 2002.

[8]Subsequent to our review, DOD established a requirement that pre-deployment health assessments must be confirmed as current within 60 days prior to the expected deployment date.

Table 1: DOD Federal Civilian Deployment Records Lacking Documentation of Pre-deployment Health Assessments

Location	Number of federal civilian deployment records reviewed	Number (and percent) with no documentation in either records or data files
Army		
Fort Benning CONUS Replacement Center[a]	578	2 (0.3)
Fort Bliss CONUS Replacement Center[a]	2,977[b]	0 (0.0)[b]
U.S. Army Corps of Engineers Transatlantic Programs Center	127	2 (1.6)
Total	**3,682**	**4**
Navy		
Naval Air Depot Cherry Point	52	19 (36.5)
Total	**52**	**19**
Air Force		
Andrews Air Force Base	10	9 (90.0)
Hill Air Force Base	8	5 (62.5)
Hurlburt Field	12	11 (91.7)
Wright-Patterson Air Force Base	7	4 (57.1)
Total	**37**	**29**
Grand Total	**3,771**[c]	**52**

Source: GAO analysis of documentation from DOD federal civilian deployment records and component medical databases.

Note: CONUS refers to the continental United States.

[a]DCMA federal civilians deployed through Forts Benning and Bliss CONUS Replacement Centers. At Fort Benning, we selected a probability sample of 238 out of 606 deployment records for deployed federal civilians; consequently, the numbers and percentages shown are weighted estimates to provide 95 percent confidence with a margin of error of 5 percentage points.

[b]Although the Army deploys its federal civilian personnel at three primary sites, Fort Bliss deployed the largest number of federal civilians during our time frame. We reviewed the entire universe of deployment records for federal civilian personnel deployed from this location because the records were being maintained electronically, which facilitated the review of all records. According to the program manager and database administrator, the quality of these data, in terms of their completeness and accuracy, is questionable because there are no assurances that all DOD federal civilian personnel who deployed are included in the database.

[c]Deployed federal civilians included in our review may have deployed more than once during our deployment time frame; consequently, there may be fewer than 3,771 unique federal civilians.

As shown in table 1, the federal civilian deployment records we included in our review showed wide variation by location regarding documentation of pre-deployment health assessments, ranging from less than 1 percent to more than 90 percent. On an aggregate component-level basis, at the Navy

location in our review, we found that documentation was missing for 19 of the 52 records in our review. At the Air Force locations, documentation was missing for 29 of the 37 records in our review. In contrast, all three Army locations had hard copy or electronic records which indicated that almost all of their federal deployed civilians had received pre-deployment health assessments.

Pre-deployment Immunizations

In addition to completing pre-deployment health assessment forms, DOD's force health protection and surveillance policies stipulated that all DOD deploying federal civilians receive theater-specific immunizations to address possible health threats in deployment locations.[9] Immunizations required for all civilian personnel who deployed to Afghanistan and Iraq included: hepatitis A (two-shot series); tetanus-diphtheria (within 10 years of deployment); smallpox (within 5 years of deployment); typhoid; and influenza (within the last 12 months of deployment).

As reflected in table 2, based on the deployment records maintained by the components at locations included in our review, the overall number of federal civilian deployment records lacking documentation of only one of the required immunizations for deployment to Afghanistan and Iraq was 285 out of 3,771. However, 3,313 of the records we reviewed were missing documentation of two or more immunizations.

[9] *U.S. Central Command, Individual Protection and Individual/Unit Deployment Policy,* January 6, 2005, and DOD Instruction 1400.32, *DOD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures,* April 24, 1995.

Table 2: DOD Federal Civilian Deployment Records Lacking Documentation of Required Immunizations

Location	Number of federal civilian deployment records reviewed	Number (and percent) missing only one immunization	Number (and percent) missing two or more immunizations
Army			
Fort Benning CONUS Replacement Center[a]	578	246 (42.6)	195 (33.7)
Fort Bliss CONUS Replacement Center[a]	2,977[b]	0 (0.0)	2,977 (100.0)
U.S. Army Corps of Engineers Transatlantic Programs Center	127	25 (19.7)	85 (66.9)
Total	**3,682**	**271**	**3,257**
Navy			
Naval Air Depot Cherry Point	52	8 (15.4)	39 (75.0)
Total	**52**	**8**	**39**
Air Force			
Andrews Air Force Base	10	2 (20.0)	7 (70.0)
Hill Air Force Base	8	0 (0.0)	3 (37.5)
Hurlburt Field	12	3 (25.0)	3 (25.0)
Wright-Patterson Air Force Base	7	1 (14.3)	4 (57.1)
Total	**37**	**6**	**17**
Grand Total	**3,771[c]**	**285**	**3,313**

Source: GAO analysis of documentation from DOD federal civilian deployment records and component medical databases.

Note: CONUS refers to the continental United States.

[a]DCMA federal civilians deployed through Forts Benning and Bliss CONUS Replacement Centers. At Fort Benning, we selected a probability sample of 238 out of 606 deployment records for deployed federal civilians; consequently, the numbers and percentages shown are weighted estimates to provide 95 percent confidence with a margin of error of 5 percentage points.

[b]Although the Army deploys its federal civilian personnel at three primary sites, Fort Bliss deployed the largest number of federal civilians during our time frame. We reviewed the entire universe of deployment records for federal civilian personnel deployed from this location because the records were being maintained electronically, which facilitated the review of all records. According to the program manager and database administrator, the quality of these data, in terms of their completeness and accuracy, is questionable because there are no assurances that all DOD federal civilian personnel who deployed are included in the database.

[c]Deployed federal civilians included in our review may have deployed more than once during our deployment time frame; consequently, there may be fewer than 3,771 unique federal civilians.

At the Army's Fort Bliss, our review of its electronic deployment data determined that none of its deployed federal civilians had documentation

to show that they had received immunizations. Officials at this location stated that they believed some immunizations had been given; however, they could not provide documentation as evidence of this.

Pre-deployment Medical Screenings

DOD policies required deploying federal civilians to receive certain screenings, such as for tuberculosis and HIV.[10] Table 3 indicates that, at the time of our review, 55 of the 3,771 federal civilian deployment records included in our review were lacking documentation of the required tuberculosis screening; and approximately 35 were lacking documentation of HIV screenings prior to deployment.

[10] *U.S. Central Command, Individual Protection and Individual/Unit Deployment Policy*, January 6, 2005, and DOD Instruction 1400.32, *DOD Civilian Workforce Contingency and Emergency Planning Guidelines and Procedures*, April 24, 1995.

Table 3: DOD Federal Civilian Deployment Records Lacking Documentation of Current Tuberculosis or HIV Screenings

Location	Number of federal civilian deployment records reviewed	Number (and percent) missing tuberculosis screening	Number (and percent) missing HIV screening
Army			
Fort Benning CONUS Replacement Center[a]	578	2 (0.3)	12 (2.1)
Fort Bliss CONUS Replacement Center[a]	2,977[b]	3 (0.1)	2 (0.1)
U.S. Army Corps of Engineers Transatlantic Programs Center	127	28 (22.0)	2 (1.6)
Total	**3,682**	**33**	**16**
Navy			
Naval Air Depot Cherry Point	52	10 (19.2)	10 (19.2)
Total	**52**	**10**	**10**
Air Force			
Andrews Air Force Base	10	6 (60.0)	0 (0.0)
Hill Air Force Base	8	5 (62.5)	0 (0.0)
Hurlburt Field	12	1 (8.3)	8 (66.7)
USAF Wright-Patterson	7	0 (0.0)	1 (14.3)
Total	**37**	**12**	**9**
Grand Total	**3,771[c]**	**55**	**35**

Source: GAO analysis of documentation from DOD federal civilian deployment records and component medical databases.

Note: CONUS refers to the continental United States.

[a]DCMA federal civilians deployed through Forts Benning and Bliss CONUS Replacement Centers. At Fort Benning, we selected a probability sample of 238 out of 606 deployment records for deployed federal civilians; consequently, the numbers and percentages shown are weighted estimates to provide 95 percent confidence with a margin of error of 5 percentage points.

[b]Although the Army deploys its federal civilian personnel at three primary sites, Fort Bliss deployed the largest number of federal civilians during our time frame. We reviewed the entire universe of deployment records for federal civilian personnel deployed from this location because the records were being maintained electronically, which facilitated the review of all records. According to the program manager and database administrator, the quality of these data, in terms of their completeness and accuracy, is questionable because there are no assurances that all civilian personnel who deployed are included in the database.

[c]Deployed federal civilians included in our review may have deployed more than once during our deployment time frame; consequently, there may be fewer than 3,771 unique federal civilians.

Post-deployment Health Assessments

DOD's force health protection and surveillance policies also required returning DOD federal civilian personnel to undergo post-deployment health assessments to document current health status, experiences, environmental exposures, and health concerns related to their work while deployed.[11] At the time of our review, the post-deployment process began within 5 days of civilians' redeployment from the theater to their home or demobilization processing stations. DOD's policies required civilian personnel to complete a post-deployment assessment that included questions on health and exposure concerns. A health care provider was to review each assessment and recommend additional clinical evaluation or treatment as needed.

As reflected in table 4, our review of deployment records at the selected component locations found that these components lacked documentation to show that most deployed federal civilians (3,525 out of 3,771) who deployed to Afghanistan and Iraq had received the required post-deployment health assessments upon their return to the United States. At the time of our review, federal civilian deployment records lacking evidence of post-deployment health assessments ranged from 3 at the U.S. Army Corps of Engineers Transatlantic Programs Center and Wright-Patterson Air Force Base, respectively, to 2,977 at Fort Bliss.

[11] *U.S. Central Command, Individual Protection and Individual/Unit Deployment Policy,* January 6, 2005, and DOD Instruction 1400.32, *DOD Civilian Workforce Contingency and Emergency Planning Guidelines and Procedures,* April 24, 1995.

Table 4: DOD Federal Civilian Deployment Records Lacking Documentation of Post-deployment Health Assessments

Location	Number of federal civilian deployment records reviewed	Number (and percent) with no documentation in records or data files
Army		
Fort Benning CONUS Replacement Center[a]	578	502 (86.9)
Fort Bliss CONUS Replacement Center[a]	2,977[b]	2,977 (100.0)
U.S. Army Corps of Engineers Transatlantic Programs Center	127	3 (2.4)
Total	**3,682**	**3,482**
Navy		
Naval Air Depot Cherry Point	52	15 (28.8)
Total	**52**	**15**
Air Force		
Andrews Air Force Base	10	9 (90.0)
Hill Air Force Base	8	6 (75.0)
Hurlburt Field	12	10 (83.3)
Wright-Patterson Air Force Base	7	3 (42.9)
Total	**37**	**28**
Grand Total	**3,771[c]**	**3,525**

Source: GAO analysis of documentation from DOD federal civilian deployment records and component medical databases.

Note: CONUS refers to the continental United States.

[a]DCMA federal civilians deployed through Forts Benning and Bliss CONUS Replacement Centers. At Fort Benning, we selected a probability sample of 238 out of 606 deployment records for deployed federal civilians; consequently, the numbers and percentages shown are weighted estimates to provide 95 percent confidence with a margin of error of 5 percentage points.

[b]Although the Army deploys its federal civilian personnel at three primary sites, Fort Bliss deployed the largest number of federal civilians during our time frame. We reviewed the entire universe of deployment records for federal civilian personnel deployed from this location because the records were being maintained electronically, which facilitated the review of all records. According to the program manager and database administrator, the quality of these data, in terms of their completeness and accuracy, is questionable because there are no assurances that all civilian personnel who deployed are included in the database.

[c]Deployed federal civilians included in our review may have deployed more than once during our deployment time frame; consequently, there may be fewer than 3,771 unique federal civilians.

Lack of Centralized Deployment Information Hinders the Overall Effectiveness of Force Health Protection and Surveillance for Deployed Federal Civilian Personnel

Beyond the aforementioned weaknesses found in the selected components' implementation of force health protection and surveillance requirements for deploying federal civilians, as a larger issue, we noted in our 2006 report that DOD lacked comprehensive, centralized data that would enable it to readily identify its deployed civilians, track their movements in theater, or monitor their health status, further hindering efforts to assess the overall effectiveness of its force health protection and surveillance capabilities. The Defense Manpower Data Center is responsible for maintaining the department's centralized system that currently collects location-specific deployment information for military servicemembers, such as grid coordinates, latitude/longitude coordinates, or geographic location codes.[12] However, at the time of our review, DOD had not taken steps to similarly maintain centralized data on its deployed federal civilians. In addition, DOD had not provided guidance that would require its components to track and report data on the locations and movements of DOD federal civilian personnel in theaters of operations. In the absence of such a requirement, each DOD component collected and reported aggregated data that identified the total number of DOD federal civilian personnel in a theater of operations, but each lacked the ability to gather, analyze, and report information that could be used to specifically identify individuals at risk for occupational and environmental exposures during deployments.

In previously reporting on the military services' implementation of DOD's force health protection and surveillance policies in 2003, we highlighted the importance of knowing the identity of servicemembers who deployed during a given operation and of tracking their movements within the theater of operations as major elements of a military medical surveillance system.[13] We further noted the Institute of Medicine's finding that documentation on the location of units and individuals during a given deployment is important for epidemiological studies and appropriate medical care during and after deployments. For example, this information allows epidemiologists to study the incidences of disease patterns across populations of deployed servicemembers who may have been exposed to diseases and hazards within the theater, and health care professionals to treat their medical problems appropriately. Without location-specific

[12]DOD Instruction 6490.3, *Implementation and Application of Joint Medical Surveillance for Deployments*, August 7, 1997.

[13]GAO, *Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance*, GAO-03-1041 (Washington, D.C.: Sept. 19, 2003).

information for all of its deployed federal civilians and centralized data in its department-level system, DOD limits its ability to ensure that sufficient and appropriate consideration will also be given to addressing the health care concerns of these individuals.

At the time of our review, DOD also had not provided guidance to the components that would require them to forward completed deployment health assessments for all federal civilians to the Army Medical Surveillance Activity, where these assessments are supposed to be archived in the Defense Medical Surveillance System, integrated with other historical and current data on personnel and deployments, and used to monitor the health of personnel who participate in deployments. The overall success of deployment force protection and surveillance efforts, in large measure, depends on the completeness of health assessment data. In our report, we noted that the lack of such data may hamper DOD's ability to intervene in a timely manner to address health care problems that may arise from DOD federal civilian deployments to overseas locations in support of contingency operations.

DOD Has Taken Steps to Address Policy Shortcomings

With increases in the department's use of federal civilian personnel to support military operations, we noted in our report that DOD officials have recognized the need for more complete and centralized location-specific deployment information and deployment-related health information on its deployed federal civilians. In this regard, we further noted that in August 2006, the Office of the Under Secretary of Defense for Personnel and Readiness issued revised policy and program guidance that generally addressed the shortcomings in DOD's force health protection and surveillance capabilities.[14] The revised policy and guidance, that became effective in December 2006, require the components within 3 years, to electronically report (at least weekly) to the Defense Manpower Data Center, location-specific data for all deployed personnel, including federal civilians. In addition, the policy and guidance require the components to submit all completed health assessment forms to the Army Medical Surveillance Activity for inclusion in the Defense Medical Surveillance System.

Nonetheless, in our 2006 report we noted that DOD's new policy is not comprehensive enough to ensure that the department will be sufficiently

[14]DOD Instruction 6490.3, *Deployment Health*, August 11, 2006.

informed of the extent to which its components are complying with existing health protection requirements for its deployed federal civilians. Although the policy requires DOD components to report certain location-specific and health data for all of their deployed personnel, including federal civilians, we noted that it does not establish an oversight and quality assurance mechanism for assessing and ensuring the full implementation of the force health protection and surveillance requirements by all DOD components that our prior work has identified as essential in providing care to military personnel.

To strengthen DOD's force health protection and surveillance for its deployed federal civilians, in our 2006 report, we recommended that DOD establish an oversight and quality assurance mechanism to ensure that all components fully comply with its requirements. In February 2007, the Office of the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness published a new instruction[15] on force health protection quality assurance. This policy applies to military servicemembers as well as applicable DOD and contractor personnel. The new policy requires the military services to implement procedures to monitor key force health protection elements such as pre- and post-deployment health assessments. In addition, the policy requires each military service to report its force health protection and quality assurance findings to the Assistant Secretary of Defense (Health Affairs) through the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness. In our June 2007 report[16] on DOD's compliance with the legislative requirement to perform pre- and post-deployment medical examinations on military servicemembers, we noted that DOD lacked a comprehensive oversight framework to help ensure effective implementation of its deployment health quality assurance program, which included specific reporting requirements and results-oriented performance measures to evaluate the services' adherence to deployment health requirements. Also, we noted in our 2007 report that the department's new instruction and planned actions indicate that DOD is taking steps in the right direction. We stated and still believe that if the department follows through with its efforts, it will be responsive to several of our reports'

[15]DOD Instruction 6200.05, *Force Health Protection (FHP) Quality Assurance Program*, February 16, 2007.

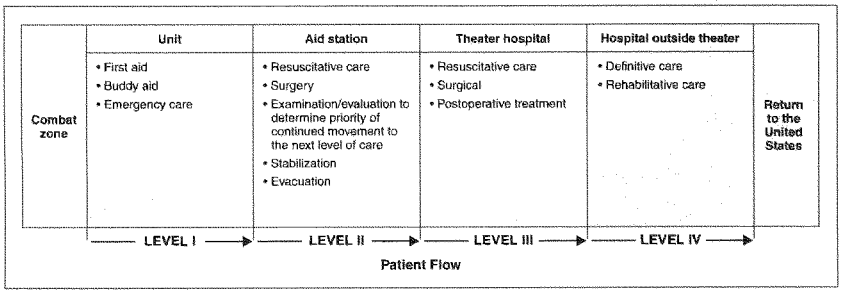
[16]GAO, *Defense Health Care: Comprehensive Oversight Framework Needed to Help Ensure Effective Implementation of a Deployment Health Quality Assurance Program*, GAO-07-831 (Washington, D.C.: June 22, 2007).

recommendations to improve DOD's force health protection and surveillance for the Total Force.

DOD Has Established and Implemented Medical Treatment Policies Which Provide for the Care of Its Deployed Federal Civilians

In our 2006 report, we found that DOD had established medical treatment policies that cover its federal civilians while they are deployed to support contingency operations in Afghanistan and Iraq, and available workers' compensation claims we reviewed confirmed that those deployed federal civilians received care consistent with the policies. These policies state that DOD federal civilians who require treatment for injuries or diseases sustained during overseas hostilities may be provided care under the DOD military health system.[17] DOD's military health system provides four levels of medical care to personnel who are injured or become ill while deployed, as shown in figure 1.

Figure 1: Overview of the Levels of DOD Medical Care Provided While Deployed



Source: Assistant Secretary of Defense for Health Affairs.

Medical treatment during a military contingency begins with level one care, which consists of basic first aid and emergency care at a unit in the theater of operation. The treatment then moves to a second level of care, where, at an aid station, injured or ill personnel are examined and

[17]DOD Directive 1404.10, *Emergency Essential (E-E) DOD U.S. Citizen Civilian Employees*, April 10, 1992, and DOD 1400.25-M, *Department of Defense Civilian Personnel Manual*, April 12, 2005.

evaluated to determine their priority for continued movement outside of the theater of operation and to the next (third) level of care. At the third level, injured or ill personnel are treated in a medical installation staffed and equipped for resuscitation, surgery, and postoperative care. Finally, at the fourth level of care, which occurs far from the theater of operation, injured or ill personnel are treated in a hospital staffed and equipped for definitive care. Injured or ill DOD federal civilians deployed in support of contingency operations in Afghanistan and Iraq who require level four medical care are transported to DOD's Regional Medical Center in Landstuhl, Germany.

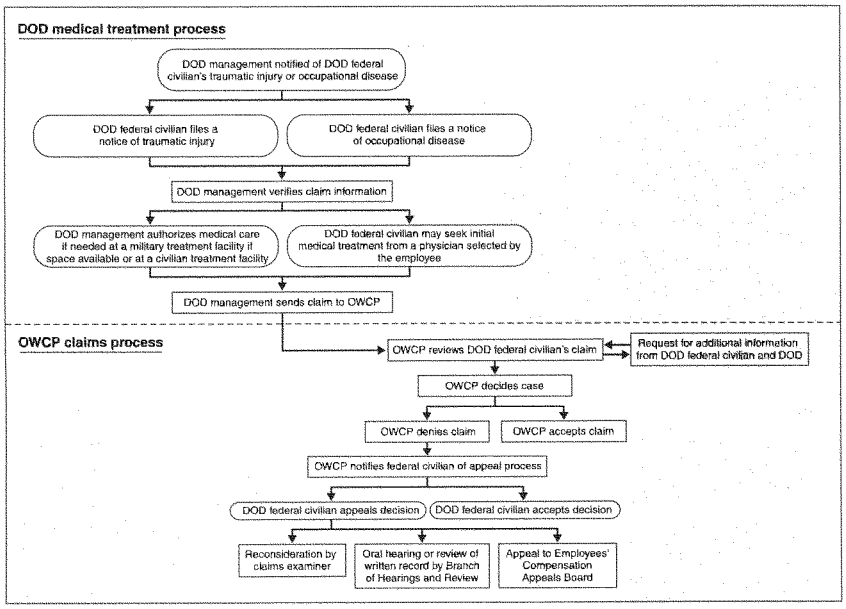
In our 2006 report, we found that injured or ill DOD federal civilians who cannot be returned to duty in theater are evacuated to the United States for continuation of medical care. In these cases (or where previously deployed federal civilians later identify injuries or diseases and subsequently request medical treatment), DOD's policy provides for its federal civilians who require treatment for deployment-related injuries or occupational illnesses to receive medical care through either the military's medical treatment facilities or civilian facilities. The policy stipulates that federal civilians who are injured or become ill as a result of their deployment must file a FECA claim[18] with DOD, which then files a claim with the Department of Labor's Office of Workers' Compensation Programs (OWCP).

The Department of Labor's OWCP is responsible for making a decision to award or deny medical benefits. OWCP must establish—based on evidence provided by the DOD civilian—that the employee is eligible for workers' compensation benefits due to the injury or disease for which the benefits are claimed. To obtain benefits under FECA, as noted in our report, DOD federal civilians must show that (1) they were employed by the U.S. government, (2) they were injured (exposed) in the workplace, (3) they have filed a claim in a timely manner, (4) they have a disabling medical condition, and (5) there is a causal link between their medical condition and the injury or exposure. Three avenues of appeal are provided for employees in the event that the initial claim is denied: (1) reconsideration by an OWCP claims examiner, (2) a hearing or review of the written record by OWCP's Branch of Hearings and Review, and (3) a review by the

[18]The Federal Employees' Compensation Act, 5 U.S.C. §§ 8101 et seq., is a comprehensive workers' compensation law for federal employees.

Employees' Compensation Appeals Board. DOD's medical treatment process and the OWCP's claims process are shown in figure 2.

Figure 2: Medical Treatment and Claims Processes for DOD Federal Civilians Who Require Treatment for Deployment-Related Injuries or Diseases After They Return to the United States



Source: GAO analysis.

Note: OWCP refers to the Office of Workers' Compensation Programs.

Overall, the claims we reviewed showed that the DOD federal civilians who sustained injuries or diseases while deployed had received care that was consistent with DOD's medical treatment policies. Specifically, in

reviewing a sample of seven workers' compensation claims (out of a universe of 83)[19] filed under the Federal Employees' Compensation Act by DOD federal civilians who deployed to Iraq, we found that in three cases where care was initiated in theater the affected federal civilians had received treatment in accordance with DOD's policies. For example, in one case, a deployed federal civilian was treated for traumatic injuries at a hospital outside of the theater of operation and could not return to duty in theater because of the severity of the injuries sustained. The civilian was evacuated to the United States and received medical care through several of the military's medical treatment facilities as well as through a civilian facility. Further, in all seven claims that we reviewed, DOD federal civilians who requested medical care after returning to the United States, had, in accordance with DOD's policy, received initial medical examinations and/or treatment for their deployment-related injuries or illnesses and diseases through either military or civilian treatment facilities. While OWCP has primary responsibility for processing and approving all FECA claims for medical benefits, the scope of our review did not include assessing actions taken by the Department of Labor's OWCP in further processing workers' compensation claims for injured or ill civilians and authorizing continuation of medical care once their claims were submitted for review.

DOD Provides Special Pays and Benefits to Deployed DOD Federal Civilian and Military Personnel, but the Types and Amounts Differ

Our 2006 report found that DOD provides a number of special pays and benefits to its federal civilian personnel who deploy in support of contingency operations, which are generally different in type and in amount from those provided to deployed military personnel. It should be noted that while DOD federal civilian and military personnel are key elements (components) of the Total Force, each is governed by a distinctly different system. Both groups receive special pays, but the types and amounts differ. DOD federal civilian personnel also receive different types and amounts of disability benefits, depending on specific program provisions and individual circumstances. In 2003, we designated federal disability programs as a high-risk area because of continuing challenges with modernizing those programs.[20] Importantly, our work examining

[19]Our actual review of claims filed by DOD federal civilians was limited to those who had deployed to Iraq because the responsible DOD officials were unable to identify the specific claims that had been filed by those federal civilians who had deployed to Afghanistan. We selected and reviewed a non-probability sample of workers' compensation claims to reflect a range of casualties, including injuries, physical and mental illnesses, and diseases.

[20]GAO, *High-Risk Series: An Update*, GAO-07-310 (Washington, D.C.: January 2007), 83-84.

federal disability programs has found that the major disability programs are neither well aligned with the 21st century environment nor positioned to provide meaningful and timely support. Further, survivors of deceased DOD federal civilian and military personnel generally receive comparable types of cash survivor benefits—lump sum, recurring, or both—but benefit amounts differ for the two groups. Survivors of DOD federal civilian personnel, however, almost always receive lower noncash benefits than military personnel.

Deployed DOD Federal Civilian and Military Personnel Generally Receive Various Special Pays to Compensate Them for Conditions of Deployment, but the Types and Amounts Differ

DOD federal civilian and military personnel are both eligible to receive special pays to compensate them for the conditions of deployment. As shown in table 5, some of the types of special pays are similar for both DOD federal civilian and military personnel, although the amounts paid to each group differ. Other special pays were unique to each group.

Table 5: Overview of Selected Types of Special Pays for Deployed DOD Federal Civilian and Military Personnel

Type of special pay	Civilian personnel	Military personnel
Premium pay	Overtime, night differential, Sunday/holiday work, compensatory time off	No equivalent
Post differential (Civilian) Hardship duty pay (Military)	35 percent of basic pay	$100 per month
Danger pay (Civilian) Hostile fire pay/imminent danger pay (Military)	35 percent of basic pay	$225 per month
Family separation allowance	No equivalent	$250 per month
Combat zone tax exclusion	No equivalent	For enlisted personnel, all compensation is tax-free; officers are capped at $6,724.50 per month
Savings deposit program	No equivalent	10 percent interest on savings deposits up to $10,000

Source: GAO analysis of military and federal data.

DOD Federal Civilian and Military Personnel Receive Different Types and Amounts of Disability Benefits, Depending on Specific Program Provisions and Individual Circumstances

In the event of sustaining an injury while deployed, DOD federal civilian and military personnel are eligible to receive two broad categories of government-provided disability benefits—disability compensation[21] and disability retirement.[22] However, the benefits applicable to each group vary by type and amount, depending on specific program provisions and individual circumstances. Within these broad categories, there are three main types of disability: (1) temporary disability, (2) permanent partial disability, and (3) permanent total disability. In 2003, we designated federal disability programs as a high-risk area because of continuing challenges with modernizing those programs. Importantly, our work examining federal disability programs has found that the major disability programs are neither well aligned with the 21st century environment nor positioned to provide meaningful and timely support.[23]

Temporary Disability Benefits

Both DOD federal civilian and military personnel who are injured in the line of duty are eligible to receive continuation of their pay during the initial period of treatment and may be eligible to receive recurring payments for lost wages. However, the payments to DOD federal civilian personnel are based on their salaries and whether the employee has any dependents, regardless of the number, which can vary significantly, whereas disability compensation payments made by the Department of Veterans Affairs (VA) to injured military personnel are based on the severity of the injury and their number of dependents, as shown in table 6. DOD federal civilian personnel are eligible to receive continuation of pay (salary) for up to 45 days, followed by a recurring payment for wage loss which is based on a percentage of salary and whether they have any dependents, up to a cap.[24] In contrast, military personnel receive continuation of pay of their salary for generally no longer than a year, followed by a recurring VA disability compensation payment for wage loss

[21]Under workers' compensation and veterans' compensation programs, benefits typically include medical treatment for the injury, vocational rehabilitation services, and cash payment to replace a percentage of the individual's loss in wages while injured and unable to work.

[22]Disability retirement programs typically provide benefits that allow qualified individuals who are unable to work to retire earlier and/or to retire with a higher percentage of their pre-injury salary level than would otherwise be permitted with normal retirement based on age and length of service at the time of injury.

[23]GAO-07-310.

[24]Payment caps for federal civilians are based on the pay level for a General Schedule (GS)-15, step 10 position, which was $118,957 per year or ($6,608 per month without dependents or $7,435 per month with dependent) in 2006.

that is based on the degree of disability and their number of dependents, and temporary DOD disability retirement for up to 5 years.

Table 6: Temporary Disability Compensation Payments, Payment Formula, and 2006 Payment Caps for DOD Federal Civilian and Military Personnel

DOD personnel	Payment calculation for temporary partial and temporary total disability	Maximum monthly payment cap in 2006
Civilian	Continuation of pay up to 45 days, followed by a recurring payment for wage loss (based on a percentage of salary, up to a cap). • **Partial disability** (when able to work, but at a reduced salary): Payments are 66-2/3 percent of the wage loss (that is, the difference between the part-time and full-time wages) without dependents; 75 percent with dependents. • **Total disability** (when unable to work): Payments are 66-2/3 percent of the employee's average weekly wage without dependents; 75 percent with dependents.	$6,608 per month without dependents. $7,435 per month with dependents.
Military	Continuation of pay for generally no longer than a year, followed by recurring VA disability compensation payments. A servicemember's disability rating ranging from 0 to 100 percent, in 10 percent increments.[a]	Each disability rating level corresponds to an annually fixed monthly VA payment amount. During 2006, amounts ranged from $112 to $2,393 per month. **"Add-ons" to basic payments** If the disability rating is 30 percent or more, the individual is entitled to additional compensation for each dependent. During 2006, the additional amounts ranged from $40-$233 for a spouse, and $27-$91 for a child, depending on the level of disability.

Source: GAO analysis of federal statutes.

[a]Unlike civilian personnel, military personnel also can be temporarily released from service and be eligible to receive temporary DOD disability retirement benefits if they are found unfit for duty, and they may continue to receive a recurring VA disability compensation payment for wage loss. However, the amount of the DOD retirement payment is reduced (offset) dollar-for-dollar by the amount of the recurring VA payment, unless they have at least 20 years of service and can qualify for an exception to this offset due to a disability rating of 50 percent or more, or combat-related disabilities. In our report on disability benefits provided to military personnel and civilian public safety officers, we noted that the added increment available from disability retirement, even with applicable offsets, can increase military personnel's monthly benefits significantly above that of comparable public safety officers at all levels.

Permanent Partial Disability Benefits

When a partial disability is determined to be permanent, DOD federal civilian and military personnel can to continue to receive recurring compensation payments, as shown in table 7. For DOD federal civilian personnel, these payments are provided for the remainder of life as long as the impairment persists, and can vary significantly depending upon the salary of the individual and the existence of dependents. Military personnel are also eligible to receive recurring VA disability compensation

payments for the remainder of their lives, and these payments are based on the severity of the servicemember's injury and the number of dependents. In addition, both groups are eligible to receive additional compensation payments beyond the recurring payments just discussed, based on the type of impairment. DOD federal civilians with permanent partial disabilities receive a schedule of payments based on the specific type of impairment (sometimes referred to as a schedule award). Some impairments may result in benefits for a few weeks, while others may result in benefits for several years. Similarly, military personnel receive special monthly VA compensation payments depending on the specific type and degree of impairment.

Table 7: Permanent Partial Disability Compensation Payment Formulas and Time Limits on Benefits for DOD Federal Civilian and Military Personnel

	Civilian personnel	Military personnel
Compensation payments	**Payment calculation** When able to work, but at a reduced salary, payments are 66-2/3 percent of the wage loss (that is, the difference between the part-time and full-time wages) without dependents; 75 percent with dependents.[a] **Maximum period of time payments can be provided** Payments provided for the remainder of life, as long as the impairment persists. **Schedule award** Schedule of payments are based on the specific type of impairment. For example, up to 312 weeks (6 years) compensation due to the loss of an arm, or the loss (or loss of use) of any other important external or internal organ of the body.	**Payment calculation** VA basic payment amounts established annually for disability ratings ranging from 10 percent to 90 percent. During 2006, amounts ranged from $112 to $1,436 per month.[a] **"Add-ons" to basic payments** If the disability rating is 30 percent or more, the individual is entitled to additional VA compensation for each dependent. During 2006, the additional amounts ranged from $40-$233 for a spouse, and $27-$91 for a child, depending on the level of disability. Special monthly VA compensation payments up to $4,176, depending on the specific type and degree of impairment. **Maximum period of time payments can be provided** No time limit regardless of degree of impairment; payments provided for the remainder of life, as long as the impairment persists.

Source: GAO analysis of federal statutes.

[a]Under the Civil Service Retirement System (CSRS), DOD federal civilian personnel must be unfit for duty and have 5 years of service to qualify for disability retirement. Under the Federal Employees' Retirement System (FERS), civilian personnel must be unfit for duty and have 18 months of service. DOD federal civilian personnel must elect either compensation benefits or disability retirement. Military personnel who are unfit for duty are eligible for DOD disability retirement benefits if they have a disability rating of 30 percent or more regardless of length of service, or if they have 20 years or more of service regardless of disability. The amount of the DOD retirement payment is offset dollar for dollar, however, by the amount of the monthly VA compensation payment unless the servicemember has at least 20 years of service and a disability rating of 50 percent or more, or combat-related disabilities.

Permanent Total Disability Benefits

When an injury is severe enough to be deemed permanent and total,[25] DOD federal civilian and military personnel may receive similar types of benefits, such as disability compensation and retirement payments; however, the amounts paid to each group vary. For civilian personnel, the monthly payment amounts for total disability are generally similar to those for permanent partial disability described earlier, but unlike with permanent partial disabilities, the payments do not take into account any wage earning capacity. Both groups are eligible to receive additional compensation payments beyond the recurring payments similar to those for permanent partial disability. DOD federal civilians with permanent disabilities receive a schedule award based on the specific type of impairment. In addition, DOD federal civilian personnel may be eligible for an additional attendant allowance—up to $1,500 per month during 2006—if such care is needed. Military personnel receive special monthly VA compensation payments for particularly severe injuries, such as amputations, blindness, or other loss of use of organs and extremities. The payments are designed to account for attendant care or other special needs deriving from the disability. In 2003, we designated federal disability programs as a high-risk area because of continuing challenges with modernizing those programs. Our work examining federal disability programs found that the major disability programs are neither well aligned with the 21st century environment nor positioned to provide meaningful and timely support.[26]

Survivors of DOD Federal Civilian and Military Personnel Received Comparable Types of Benefits, but Benefit Amounts Differ

Survivors of deceased DOD federal civilian and military personnel generally receive similar types of cash survivor benefits—either as a lump sum, a recurring payment, or both—through comparable sources. However, the benefit amounts generally differ for each group. Survivors of civilian and military personnel also receive noncash benefits, which differ in type and amounts.

As shown in table 8, survivors of deceased DOD federal civilian and military personnel both receive lump sum benefits in the form of Social Security, a death gratuity, burial expenses, and life insurance.

[25]Permanent total disability generally means that an individual is unable to maintain gainful employment.

[26]GAO-07-310.

Table 8: Overview of the Type and Amount of Lump Sum Benefits Provided to Survivors of DOD Federal Civilian and Military Personnel

Selected types of survivor benefits	Civilian personnel	Military personnel
Social Security	Lump sum: $255	Lump sum: $255
Death gratuity	Up to $10,000	$100,000
Burial expenses	Up to $800, plus $200 for costs associated with terminating employee status	Up to $7,700
Life insurance	Basic pay, rounded to the nearest thousand, plus $2,000	Servicemembers' Group Life Insurance up to $400,000
Retirement plan	Basic death benefit of $24,866.19 (for fiscal year 2006) plus 50 percent of the civilian's final salary or an average of the civilian's highest 3 years of salary	No equivalent

Source: GAO analysis of federal data.

Survivors of deceased DOD federal civilian and military personnel are also eligible for recurring benefits, some of which are specific to each group, as shown in table 9.

Table 9: Overview of the Type and Amount of Recurring Benefits Provided to Survivors of DOD Federal Civilian and Military Personnel

Type of recurring survivor benefit	Civilian personnel	Military personnel
Social Security	Recurring payment based on earnings in covered employment	Recurring payment based on earnings in covered employment
Survivor benefit plan	No equivalent	55 percent of the military member's monthly retirement pay, offset by Dependency Indemnity Compensation
Dependency and indemnity compensation	No equivalent	$1,033 per month plus $257 per month for each dependent child, plus an additional $250 for the first 2 years for dependent children
Workers' compensation (only if the death occurs while in the line of duty)	Up to 75 percent of employee's monthly salary[a]	No equivalent
Retirement plan (included if DOD contributes to the survivor benefit)	50 percent of monthly retirement payment if the employee had 10 years of service[a]	No equivalent

Source: GAO analysis of federal data.

[a]The survivor of a deceased DOD federal civilian can choose the benefit through either the retirement plan or workers' compensation, which normally pays a higher amount.

In addition to lump sum and recurring benefits, survivors of deceased DOD federal civilians and military personnel receive noncash benefits. As shown in table 10, survivors of deceased military personnel receive more noncash benefits than do those of deceased DOD federal civilian personnel, with few benefits being comparable in type.

Table 10: Summary of Noncash Benefits Provided to Survivors of DOD Federal Civilian and Military Personnel

Noncash benefit	Civilian personnel	Military personnel
Continuation of health insurance coverage	Survivors may continue to participate in the Federal Employees' Health Benefits Program at the same cost as a federal employee if, prior to employee's death, these individuals were covered as family members under the plan.	Surviving family members of the deceased servicemember remain eligible for health care benefits under TRICARE[a] at active duty dependent rates for a 3-year period, after which they are eligible for retiree dependent rates.
Education benefits for spouse, children, or both	No equivalent	Surviving spouse and children are eligible for up to 45 months of education benefits.
Military-specific	No equivalent	Surviving spouse and children are eligible for rent-free government housing or tax-free housing allowance up to 365 days, relocation assistance, and commissary and exchange privileges.

Source: GAO analysis of federal data.

[a]TRICARE is a regionally structured program that uses civilian contractors to maintain health care provider networks that complement health care provided at military treatment facilities.

Concluding Observations

DOD currently has important policies in place that relate to the deployment of its federal civilians. Moreover, DOD's issuance of its new instruction on force health quality assurance further indicates that DOD is taking steps in the right direction. If the department follows through with its efforts, we believe it will strengthen its force health protection and surveillance oversight for the Total Force.

Mr. Chairman and Members of the Subcommittee, this concludes my prepared statement. I would be happy to answer any questions you may have.

Contacts and Acknowledgments

If you or your staffs have any questions about this testimony, please contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Key contributors to this testimony include Sandra B. Burrell, Assistant Director; Julie C. Matta; and John S. Townes.

Prepared Statement

of

The Honorable Patricia S. Bradshaw

Deputy Under Secretary of Defense

(Civilian Personnel Policy)

Before the

Oversight and Investigations Subcommittee

House Armed Services Committee

"Benefits and Medical Care Offered to Civilian Employees Deployed to Iraq and Afghanistan"

September 18, 2007

NOT FOR PUBLICATION UNTIL RELEASED BY THE COMMITTEE

INTRODUCTION

Mr. Chairman and Subcommittee members thank you for the invitation to be here today. I appreciate this opportunity to discuss the Department of Defense (DOD) views on medical care coverage for injured deployed civilians and to highlight the various benefits and incentives available to Federal civilian employees who volunteer to serve in Iraq and Afghanistan. DOD civilian employees have a long and proud history of serving with and supporting our military members. Today, our civilian workforce is transforming into one that is more global and expeditionary to meet the Department's 21st century mission requirements.

Since 2001, we have had approximately 1,500 DOD civilian employees deployed to Afghanistan and over 6,000 civilian employees to Iraq. Currently, we have approximately 300 civilian employees serving in Afghanistan and 1,750 in Iraq. These brave civilians are working side-by-side with our military members in support of our national security mission. These employees fill a variety of support positions in the fields of Accounting and Budget, logistics, Equipment maintenance and repair, information technology, intelligence, and foreign languages. Most recently, working with the State Department, we developed and led an initiative to use a capabilities-based approach to meeting Provincial Reconstruction Team (PRTs) requirements. Civilian employees volunteered for assignments on the PRTs based upon skills and capabilities not inherent in their current positions. Typically, civilians are deployed based on their position

responsibilities. The Department had well over a thousand resumes from DoD civilians who were willing and available to help in the rebuilding of Iraq.

Under the Department's current authority, the Department can deploy DoD civilian employees to hostile or combat areas based upon their position responsibilities. Positions that require the added responsibilities of serving with U.S. Forces when all other personnel have been evacuated are designated as Emergency-Essential (E-E). Positions are announced with the E-E requirements and employees sign statements agreeing to the terms of the position requirements before they are hired. In circumstances where a position is identified as E-E after someone is hired, the incumbent is provided advance notice of the requirement, and if necessary, assistance in locating a non-EE position. Although the Department has the authority to forward deploy DoD civilians based upon their position responsibilities, DoD civilian employees generally apply for or volunteer for such opportunities. These employees contribute their talent to joint, integrated national security mission requirements.

We have learned from focus group sessions the reasons why our employees volunteer for this type of assignments. The reasons vary from a desire to serve our Country, witness results on the ground, and engage in this type of mission-focused work. They state that it is an honor and a privilege to serve our Country and to support our war fighters through such deployments.

In return, our DOD civilians bring back broadened perspectives, critical experiences, and a deeper understanding of their role in support of DoD's expanding missions. The men and women who answer this call are making a critical difference in the support of the Department's U.S. Forces, interagency and coalition partners.

INCENTIVES TO SERVE

Thanks to you, the Congress, we have also been able to offer additional financial incentives to our Federal civilian employees serving in Iraq and Afghanistan. Deployed civilians assigned into the United States Central Command or CENTCOM area of responsibility, as part of their compensation package, receive a 35 percent Danger Pay allowance, a 35 percent Foreign Post Differential, and coverage by the increased premium pay limitation of $212,100.

In addition, I also want to thank the Congress for passage last year of Public Law 109-234, Section 1063, which authorized agencies, through Fiscal Year 2008, to provide allowances, benefits, and gratuities comparable to those provided to members of its Foreign Service. These included such benefits as an enhanced death gratuity travel, home leave, and rest and recuperation breaks.

Additionally, employees serving in Iraq and Afghanistan for 30 consecutive days or 60 non-consecutive days are eligible for the Secretary of Defense Global War on Terrorism (GWOT) medal. This medal is a campaign

medal and was created to recognize and honor the contributions of our DoD civilians in direct support of the Department's contingency operations. Those who pay the ultimate sacrifice and are injured or killed in theater may be eligible to receive the Defense of Freedom medal. This medal is the civilian equivalent of the military's Purple Heart.

MEDICAL SCREENING AND CARE FOR DEPLOYED CIVILIANS

As the Department's DoD civilian support expanded in theaters of operation, policies have been implemented to provide injured DoD deployed civilian employees pre and post deployment assessments, prompt and professional medical treatment, both in theater and upon their return to the United States. Last year the Department updated and re-published DoD Instruction 6490.03, "Deployment Health". This instruction requires that the DOD Components execute a comprehensive deployment health program. This Specifically, the instruction outlines health protection requirements for DOD civilians who deploy and is consistent with the requirements for deploying military personnel. This regulation requires essential pre- and post-deployment health assessments. These processes include mental health assessments. Further our policies require that the scope of care provided shall be equivalent to that received by our active duty military personnel.

Prior to deploying, DOD civilian employees are required to obtain a physical examination. The purpose of this examination is to determine the

presence of any nondeployable medical condition which is identified by the Combatant Commands along with required immunizations. These employee records are reviewed as part of our civilian employee's pre-deployment processing. If any nondeployable medical condition is identified during this review, the employee is not permitted to deploy. These records provide a baseline for the medical screen that is conducted upon the employee's return from deployment.

Regrettably, our employees are not immune to the dangers associated with some of these global and expeditionary assignments. To date, in Iraq we have had 116 employee injuries and seven deaths. Currently we have four claims for Post-Traumatic Stress Disorder and two claims for traumatic brain injury that have been accepted by the Department of Labor, Office of Workers Compensation Program.

Approximately half of the reported injuries involved no loss of work time or medical expenses beyond the initial injury and medical treatment. The remaining half of injured employees (those with reported lost work time and those who required additional medical procedures) were assigned a Department of Labor nurse case manager to assist in coordinating the health care requirements.

Any civilian employee injured in theater receives immediate medical attention equitant to our military members. Deployed civilians who were treated

in theater continue to be eligible for treatment in an MTF or private sector medical facility upon their return to the U.S. for compensable illnesses, diseases, wounds or injuries under the Department of Labor (DoL) Office of Workers' Compensation (OWC) Programs. This care is provided at no cost to employees. Additionally, deployed DoD civilians who later identify compensable illnesses, diseases, wounds or injuries under the Department of Labor Worker Compensation programs are eligible for treatment in an MTF or private sector medical facility at no cost them. The DOL program also provides coverage for lost wages and death benefits for surviving spouses and dependents.

Furthermore, DOD policy mandates that federal civilian employees returning from a deployment to a military contingency operation must be scheduled for a face-to-face health assessment with a trained health care provider within 30 days after returning to home or to the processing station. This assessment must include a discussion of mental health or psychosocial issues commonly associated with deployments. These employees are required to have a reassessment within 90-180 days after return to home station.

GAO REVIEW OF MEDICAL CARE FOR DEPLOYED CIVILAN EMPLOYEES

GAO conducted a review in September 2006 of the medical and health protections for deployed DOD civilians. Their sample of seven DOD cases revealed that DOD civilians had received treatment in accordance with DOD

policies. Notwithstanding these findings, there are one case where a series of mistakes were made. One of those cases involved a Department of the Army employee who was one of the early employees injured in Iraq. After receiving medical treatment at an MTF, and being MEDEVACed to the United States, he was initially denied medical treatment at a MTF. This was inconsistent with the Department's policies. However, we learned that these policies are sometimes not known or well-understood. The Department acknowledges the difficulties that this Army employee encountered. My staff and I have been personally working with the Department of the Army officials, at the highest levels, to resolve the issues and concerns. The Department is taking deliberate steps to communicate these policies more clearly and broadly on a regular and recurring basis.

The Department is committed to providing the best possible care to its injured DoD military and civilian employees who have made great sacrifices for our Nation. This particular case highlighted the need to further improve the communication, management, and coordination of medical care for our civilian employees. As soon as the Department became aware of his circumstances, the Department took immediate steps to resolve them. As a result, of these early errors, we have been working on improving the policies for deployed civilians as well as the their communication.

CONCLUSION

In summary, our civilian employees play an integral role in supporting our military members around the globe. We are proud of our brave men and women who volunteer for these type of assignments. The Department is working to ensure that the compensation and benefits for their service is fair and equitable. We are reviewing and updating our guidance regarding medical care for our deployed civilian employees and taking steps to correct our early mistakes, and to clarify and disseminate our policies. Thank you for the opportunity to present our views on the medical care coverage for injured deployed civilians and to highlight the various benefits and incentives available to Federal civilians who volunteer to work to Iraq and Afghanistan. I look forward to your questions.

STATEMENT OF SHELBY HALLMARK

DIRECTOR

OFFICE OF WORKERS' COMPENSATION PROGRAMS

EMPLOYMENT STANDARDS ADMINISTRATION

U.S. DEPARTMENT OF LABOR

BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON ARMED SERVICES

U.S. HOUSE OF REPRESENTATIVES

September 18, 2007

Chairman Snyder, Ranking Member Akin, and Members of the Subcommittee:

My name is Shelby Hallmark, and I am the Director of the Office of Workers' Compensation Programs (OWCP) for the Employment Standards Administration of the U.S. Department of Labor.

I appreciate having this opportunity to discuss OWCP's role in providing benefits under the Federal Employees' Compensation Act (FECA) to federal civilian employees of the armed services and overseeing the provision of benefits under the Defense Base Act to civilian contractors injured while working in Iraq and Afghanistan.

Federal Employees' Compensation Act

OWCP's Division of Federal Employees' Compensation (DFEC) administers FECA which provides workers' compensation coverage to three million federal and Postal workers around the world for employment-related injuries and occupational diseases. Benefits include wage replacement, payment for all reasonable and necessary medical treatment for work related injury or disease and, where necessary, medical and

vocational rehabilitation assistance in returning to work. The program has 12 district offices nationwide.

Benefits under the FECA are payable for both traumatic injuries (injuries sustained during the course of a single work shift) and occupational diseases (medical conditions sustained as a result of injury or exposure occurring over the course of more than one work shift). Benefits are paid from the Employees' Compensation Fund and employing agencies are billed annually for the benefits paid for their employees from the Fund.

The Federal Employees' Compensation program will make payments to the injured worker to: replace lost wages, paid at two-thirds of the employees' salary if there are no dependents or three-fourths if there is at least one dependent; provide monetary award to injured workers for permanent impairment of limbs and other parts of the body; and provide benefits to survivors in the event of a work related death.

Claims for benefits under the FECA are usually filed by the injured worker through their employing agency. Staff in the 12 program district offices are responsible for reviewing the claims and determining whether the circumstances of the case meet the requirements of the FECA for entitlement to benefits. The evidence submitted must establish that the applicant is a federal civilian employee who filed a timely claim for benefits for a medical condition sustained as a result of a work related incident or exposure. If the evidence submitted is not sufficient to establish the claim, DFEC district office claims staff will advise the claimant and employing agency of the deficiencies in the evidence, explain the evidence which is needed to establish the claim and provide additional time for submission of the necessary evidence. If the deficiency is medical in nature, the claims staff may communicate directly with the treating physician or may arrange for the claimant to be seen for a second opinion medical examination.

If the claim is denied or the claimant disagrees with the benefit level awarded, the claimant has several rights of review including an oral hearing; a review of the written

record by an OWCP hearing representative who is outside of the district office making the entitlement determination; or a reconsideration of the case by a senior claims examiner within the district office who was not previously involved in prior entitlement decisions. In these circumstances, the claimant may submit additional evidence in support of the claim. Moreover, a claimant may request review by the Employees' Compensation Appeals Board (ECAB), which is the highest authority in federal workers' compensation claims adjudication. The ECAB's review is based solely upon the case record at the time of the adverse formal decision and new evidence is not considered.

OWCP does not generally track injury claims by country of origin, but we have identified 194 claims filed with DFEC for injuries sustained by federal civilian employees while working in Iraq since 2004. (To ensure that war zone cases are carefully managed, OWCP established a separate numbering sequence for such claims.) About one quarter of these injuries arose directly out of armed conflict and some are the result of routine accidents or exposures. Of that number, there have been 10 death claims filed.

Additionally, there have been 11 claims filed for various emotional conditions and four claims for traumatic brain injuries. A total of $1,714,119.51 has been paid out in medical benefits, lost wages and death benefits for this group of workers and their families. Of the claims identified, 56 have been denied because they did not meet the requirements for entitlement under the FECA. These claims were denied either because there was no medical evidence establishing that a medical condition was sustained or because the medical evidence failed to establish a causal connection between the work-related event and the diagnosed medical condition. Claimants have multiple opportunities to obtain review of a denial including requests for reconsideration or a hearing where additional evidence may be submitted, or appeal of that decision to the ECAB.

OWCP works closely with the employing agencies to ensure that individuals with serious injuries, especially those wounded in combat zones, receive prompt services. FECA beneficiaries have the right to choose their own physician and all medical costs

associated with the injury are paid in full with no co-payment from the injured worker. Once the beneficiary has recovered from the injury, OWCP works with the employing agency, or if necessary, a new employer, to assist in return to work.

In addition to FECA benefits, federal agencies are authorized to pay the survivors of federal employees who die in the performance of their duties a variety of death gratuities depending on the particular circumstances of each case.

For privacy reasons, I should not discuss the particulars of an individual claimant's case in this hearing. However, to be responsive to the Subcommittee's request, we will provide a separate letter to address the case that was mentioned in the hearing invitation letter. I can state for the record that we do not use separate FECA diagnosis codes for combat injuries because conditions such as traumatic brain injuries, amputations, and Post-Traumatic Stress Disorders can be sustained in non-combat circumstances as well. Medical conditions are coded under the International Classification of Diseases (ICD) coding system, which covers all recognized injuries and physical conditions, and the Diagnostic and Statistical Manual of Mental Disorders (DSM). These codes are related to the individual's medical diagnoses, regardless of the cause or source of injury.

Defense Base Act

Our mission under the Defense Base Act (DBA), an extension of the Longshore and Harbor Workers' Compensation Act, is to oversee the provision of benefits by private insurance companies and self-insured employers to civilian contractors to federal agencies. We track the delivery of such benefits, maintain limited records concerning the claims, provide informal dispute resolution services, and offer technical assistance to contractors, contracting agencies, insurers and others in the system.

The benefits provided to civilian contractors under the DBA are an extension of those provided in the Longshore Act, and include wage replacement, medical services, and,

under certain limited conditions, rehabilitation services. Claimants are generally entitled to two-thirds of their wages, with an annually adjusted maximum weekly benefit of $1114 (effective 10/1/06). The DBA, like most other workers' compensation systems, provides benefits for both temporary and permanent disability, and survivor benefits in the case of fatalities.

Benefit levels for the two programs, FECA and DBA, are generally similar in structure, eligibility requirements, and definitions, except that FECA pays most claimants at 75% of their pre-injury salary (due to the availability of adjustment for dependents). Similar to other workers' compensation benefits, both programs' payments are tax-free.

The DBA provides protection to both American civilians and to foreign nationals who work overseas under contract to the federal government. These contracts arise primarily from the Department of Defense, the Department of State, and the United States Agency for International Development. DBA insurance is required under these contracts, and is usually purchased by the contractors from either AIG, CNA, or ACE USA, the three major insurance companies authorized by OWCP to offer DBA policies. Subcontractors are required to provide the same coverage, with the responsibility reverting to the prime contractor if a subcontractor should be found uninsured in case of a claim.

The delivery of DBA benefits, while subject to the array of claims disputes common to any workers' compensation program, has been challenging for some Iraqi nationals' claims. The mere delivery of correspondence from a U.S. federal agency or a U.S. based insurance company may identify the recipient as a 'collaborator' to insurgents in Iraq, placing the claimant or his survivors at great risk of personal attack. Further, language and cultural challenges, the lack of banking and medical services, and simple fear of filing on the part of claimants have made the timely adjustment of some claims to Iraqis difficult.

The insurance industry has, however, improved its handling of these challenging circumstances. The major insurers have established local claims handling resources in the Mideast, in some cases utilizing local, Arabic-speaking private attorneys to assist Iraqi claimants. Their efforts continue, and OWCP monitors their work closely through our case management activities in our district offices and through our ongoing meetings with industry leaders.

As is expected during times of war, the number of claims under the DBA has risen over the years. The annual reported DBA claim total has risen from 804 in 2003, to 5,749 in 2006. For 2007, we expect to receive more than 14,000 DBA claims, primarily from Iraq and Afghanistan.

PTSD and Traumatic Brain Injuries

Mr. Chairman, we are aware that the Subcommittee is particularly concerned about individuals who incur war-related head wounds and psychological impacts (generally categorized as Post-Traumatic Stress Disorder or (PTSD). Both of OWCP's programs have paid special attention to these conditions.

Under the FECA program, any medical condition can be accepted as long as the probative medical evidence establishes the condition was caused, accelerated or aggravated by the employment-related incident or exposure. This includes mental disorders, traumatic brain injuries and any other medical condition that may be a consequence of an injury sustained on the battlefield. Most conditions, including psychiatric disorders, traumatic brain injuries, burns, open wounds, hearing loss, and amputations also occur in non-combat situations and are accepted if the evidence supports that such conditions arose out of the employees' federal employment.

Medical conditions which are accepted as having arisen out of the established work incident or exposure are expressed based on the International Classification of Diseases. These codes have been developed to classify diseases and a wide variety of

signs, symptoms, abnormal findings, complaints, and external causes of injury or disease. Every health condition can be assigned to a unique category and given a code, up to six characters long. The International Classification of Diseases is published by the World Health Organization and is used world-wide for morbidity and mortality statistics, reimbursement systems and automated decision support in medicine.

The injured federal worker is entitled to receive all medical services, appliances or supplies which a qualified physician prescribes or recommends and which OWCP considers necessary to treat the work-related injury. The injured worker has the initial choice of physician for treatment. Referrals to other specialists are also permitted so long as the treatment is for a condition that has been accepted as arising out the workers' employment.

As noted above, our records indicate that 11 cases have been filed by civilian federal employees involving emotional or stress conditions arising from service in the Iraq theater, and four involving traumatic brain injuries. All but two of the emotional claims have been accepted, and all of the traumatic brain injury claims have been accepted.

Under DBA, OWCP has been working closely with the contracting agencies, contractors, and the insurance companies providing DBA coverage since the start of federal contracting activities in Afghanistan and Iraq. Our efforts have focused primarily on three areas: first, providing education about the Act to all involved; second, ensuring that coverage is present in all contracts; and, third, making sure that the insurance companies are providing high quality, timely claims management service.

OWCP's compliance assistance efforts include:

- Meeting frequently with the contracting officers from the three major contracting agencies, Defense, State, and USAID to be certain that contracting officers understand the requirement for insurance coverage.

- Convening five well-attended, day-long seminars and half-day 'DBA 101' workshops for the industry to provide general information about the DBA, its requirements, and its implementation.
- Holding many roundtable meetings with insurance industry leadership to address challenges and encourage sharing of best practices used in adjusting the complex claims arising from the war zones, especially those coming from foreign nationals.
- Holding focused meetings with insurance company representatives specifically on PTSD case handling in the war zone context.
- Responding promptly to thousands of inquiries from claimants, employers, insurers, attorneys, and others about requirements under the DBA.

Each of these OWCP initiatives has improved the delivery of benefits to claimants by enhancing understanding, coverage, and claims service.

The insurance company's responsibility includes ensuring that a disease is present and is work-related before providing benefits for it, and scheduling expert medical evaluations and collecting medical information can be time-consuming. For these reasons, identifying, treating, and paying for PTSD claims can take more time than typical traumatic-injury-only claims. Nevertheless, the key DBA insurers involved in Iraq, with intense compliance assistance from OWCP, have improved their handling of these claims, and have shared best practices in addressing the difficult circumstances associated with these claims.

OWCP is sensitive to the hardships endured by federal and contractor employees in the war zone, and seeks to ensure that the best possible service is provided to these individuals. We continue to work closely with our colleagues in the Department of Defense and other agencies to coordinate services to injured federal workers, and with the contracting agencies, insurers and attorneys responsible for handling DBA contractor employees' cases.

Mr. Chairman, I would be pleased to answer any questions that you or the other members of the Committee may have.

QUESTIONS AND ANSWERS SUBMITTED FOR THE RECORD

SEPTEMBER 18, 2007

QUESTIONS SUBMITTED BY MR. SNYDER

BENEFITS AND MEDICAL CARE FOR FEDERAL AND U.S. CONTRACTOR EMPLOYEES DEPLOYED TO IRAQ AND AFGHANISTAN[1]

Dr. SNYDER. What are the congressional requirements for medical tracking of deployed military servicemembers and civilians?

Ms. FARRELL. Following GAO's May 1997 report,[2] Congress enacted legislation[3] that required the Secretary of Defense to establish a medical tracking system to assess the medical condition of servicemembers before and after deployments to locations outside of the United States. Specifically, the legislation required the following:

"(a) SYSTEM REQUIRED—The Secretary of Defense shall establish a system to assess the medical condition of members of the armed forces (including members of the reserve components) who are deployed outside the United States or its territories or possessions as part of a contingency operation (including a humanitarian operation, peacekeeping operation, or similar operation) or combat operation.

"(b) ELEMENTS OF SYSTEM—The system described in subsection (a) shall include the use of pre-deployment medical examinations and post-deployment medical examinations (including an assessment of mental health and the drawing of blood samples) to accurately record the medical condition of members before their deployment and any changes in their medical condition during the course of their deployment. The post-deployment examination shall be conducted when the member is redeployed or otherwise leaves an area in which the system is in operation (or as soon as possible thereafter).

"(c) RECORDKEEPING—The results of all medical examinations conducted under the system, records of all health care services (including immunizations) received by members described in subsection (a) in anticipation of their deployment or during the course of their deployment, and records of events occurring in the deployment area that may affect the health of such members shall be retained and maintained in a centralized location to improve future access to the records.

"(d) QUALITY ASSURANCE—The Secretary of Defense shall establish a quality assurance program to evaluate the success of the system in ensuring that members described in subsection (a) receive pre-deployment medical examinations and post-deployment medical examinations and that the recordkeeping requirements with respect to the system are met."

This legislation was amended by a provision in the John Warner National Defense Authorization Act for Fiscal Year 2007.[4] The current legislation amends elements of the system and the quality assurance program as well as adds criteria for referral for further evaluations and minimum mental health standards for deployment. Specifically, the current legislation requires the following:

"(a) SYSTEM REQUIRED—Not changed by the current legislation.

"(b) ELEMENTS OF SYSTEM—

(1) The system described in subsection (a) shall include the use of pre-deployment medical examinations and post-deployment medical examinations (including an assessment of mental health and the drawing of blood samples) to accurately record the medical condition of members before their deployment and any changes in their medical condition during the course of their deployment. The post-deployment examination shall be conducted when the member is redeployed or otherwise

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[1] GAO, *DOD Civilian Personnel: Medical Policies for Deployed DOD Federal Civilians and Associated Compensation for Those Deployed,* GAO–07–1235T (Washington, D.C.: Sept. 18, 2007).

[2] GAO, *Defense Health Care: Medical Surveillance Improved Since Gulf War, but Mixed Results in Bosnia,* GAO/NSIAD–97–136 (Washington, D.C.: May 13, 1997).

[3] National Defense Authorization Act for Fiscal Year 1998, Pub. L. No. 105–85, § 765 (1997) (codified at 10 U.S.C. § 1074f). DOD established force health protection and surveillance policies aimed at assessing and reducing or preventing health risks for its deployed federal civilian personnel.

[4] John Warner National Defense Authorization Act for Fiscal Year 2007, Pub. L. No. 109–364, § 738 (2006) (codified at 10 U.S.C. § 1074f).

leaves an area in which the system is in operation (or as soon as possible thereafter).

(2) The pre-deployment and post-deployment medical examination of a member of the armed forces required under paragraph (1) shall include the following:

(A) An assessment of the current treatment of the member and any use of psychotropic medications by the member for a mental health condition or disorder.

(B) An assessment of traumatic brain injury.

"(c) RECORDKEEPING—Not changed by the current legislation.

"(d) QUALITY ASSURANCE—

(1) The Secretary of Defense shall establish a quality assurance program to evaluate the success of the system in ensuring that members described in subsection (a) receive pre-deployment medical examinations and post-deployment medical examinations and that the recordkeeping requirements with respect to the system are met.

(2) The quality assurance program established under paragraph (1) shall also include the following elements:

(A) The types of healthcare providers conducting post-deployment health assessments.

(B) The training received by such providers applicable to the conduct of such assessments, including training on assessments and referrals relating to mental health.

(C) The guidance available to such providers on how to apply the clinical practice guidelines developed under subsection (e)(1) in determining whether to make a referral for further evaluation of a member of the armed forces relating to mental health.

(D) The effectiveness of the tracking mechanisms required under this section in ensuring that members who receive referrals for further evaluations relating to mental health receive such evaluations and obtain such care and services as are warranted.

(E) Programs established for monitoring the mental health of each member who, after deployment to a combat operation or contingency operations, is known—

(i) to have a mental health condition or disorder; or

(ii) to be receiving treatment, including psychotropic medications, for a mental health condition or disorder.

"(e) CRITERIA FOR REFERRAL FOR FURTHER EVALUATIONS—The system described in subsection (a) shall include—

(1) development of clinical practice guidelines to be utilized by healthcare providers in determining whether to refer a member of the armed forces for further evaluation relating to mental health (including traumatic brain injury);

(2) mechanisms to ensure that healthcare providers are trained in the application of such clinical practice guidelines; and

(3) mechanisms for oversight to ensure that healthcare providers apply such guidelines consistently.

"(f) MINIMUM MENTAL HEALTH STANDARDS FOR DEPLOYMENT—

(1) The Secretary of Defense shall prescribe in regulations minimum standards for mental health for the eligibility of a member of the armed forces for deployment to a combat operation or contingency operation.

(2) The standards required by paragraph (1) shall include the following:

(A) A specification of the mental health conditions, treatment for such conditions, and receipt of psychotropic medications for such conditions that preclude deployment of a member of the armed forces to a combat operation or contingency operation, or to a specified type of such operation.

(B) Guidelines for the deployability and treatment of members of the armed forces diagnosed with a severe mental illness or post traumatic stress disorder.

(3) The Secretary shall take appropriate actions to ensure the utilization of the standards prescribed under paragraph (1) in the making of determinations regarding the deployability of members of the armed forces to a combat operation or contingency operation."

Dr. SNYDER. What work has GAO conducted on this topic?

Ms. FARRELL. Since the 1990s, GAO has highlighted shortcomings with respect to the Department of Defense's (DOD) ability to assess the medical condition of servicemembers both before and after their deployments. Following GAO's May 1997 report, Congress enacted legislation (codified at 10 U.S.C. § 1074f) that required the Secretary of Defense to establish a medical tracking system for assessing the medical condition of servicemembers before and after deployments.

In September 2003, we reported that the Army and Air Force did not comply with DOD's force health protection and surveillance requirements for many servicemembers deploying in support of Operation Enduring Freedom in Central

Asia and Operation Joint Guardian in Kosovo.[5] Specifically, our review disclosed problems with the Army's and Air Force's implementation of DOD's force health protection and surveillance requirements in the following areas: (1) deployment health assessments, (2) immunizations and other pre-deployment requirements, and (3) the completeness of medical records and centralized data collection. Our September 2003 report also raised concerns over a lack of DOD oversight of department-wide efforts to comply with health surveillance requirements. Specifically, we reported that an effective quality assurance program had not been established at the Office of the Assistant Secretary of Defense for Health Affairs or at the Offices of the Surgeons' General of the Army or Air Force to help ensure compliance with force health protection and surveillance policies. We believed that the lack of such a system was a major cause of the high rate of noncompliance and thus recommended that the department establish an effective quality assurance program to ensure that the military services comply with the force health protection and surveillance requirements for all servicemembers. The department concurred with our recommendation, and in January 2004 began implementation of its deployment health quality assurance program.

In September 2004, we reported similar issues related to DOD's ability to effectively manage the health status of its reserve forces.[6] Specifically we noted that DOD's centralized database had missing and incomplete pre-deployment health assessment questionnaires because not all of the required health information collected from reserve component members had reached DOD's central data collection point. We recommended that the Secretary of Defense take steps to ensure that pre-deployment health assessment questionnaires are submitted to the centralized data collection point as required. DOD concurred with our recommendation and noted that revised guidance was currently in coordination to clarify the requirement for submitting pre-deployment health assessments to the centralized database.

In November 2004, we reported that overall compliance with DOD's force health protection and surveillance policies for servicemembers who deployed in support of Operation Iraqi Freedom varied by service, by installation, and by policy requirement.[7] At that time, we did not evaluate the effectiveness of DOD's deployment health quality assurance program because of the relatively short time of its implementation.

In October 2005, we reported that evidence suggested that reserve component members have deployed into theater with pre-existing medical conditions that could not be adequately addressed in theater.[8] We also reported that DOD had limited visibility over the health status of reserve component members after they are called to duty and is unable to determine the extent of care provided to those members deployed with pre-existing medical conditions despite the existence of various sources of medical information. We recommended that the Secretary of Defense determine what pre-existing medical conditions should not be allowed into specific theaters of operations and to take steps to ensure that each service component consistently utilizes these as criteria for determining the medical deployability of its reserve component members. We also recommended that the Secretary of Defense explore using existing tracking systems to track those who have treatable pre-existing medical conditions in theater. DOD partially concurred with our recommendation concerning the identification of pre-existing medical conditions that would preclude deployment and noted that the services had made advances in identifying some pre-existing conditions that would preclude deployment, but also stated that due to the ever changing nature of theater of operations this list could never be fully comprehensive or fully enforceable. DOD also concurred with our recommendation pertaining to the use of existing tracking systems to track treatable pre-existing medical conditions. Specifically, DOD indicated that ongoing refinements to these systems based on lessons learned would improve the documentation of medical conditions throughout the military services including information concerning reserve members with pre-existing conditions.

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[5] GAO, *Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance,* GAO–03–1041. (Washington, D.C.: Sept. 19, 2003).

[6] GAO, *Military Personnel: DOD Needs to Address Long-term Reserve Force Availability and Related Mobilization and Demobilization Issues,* GAO–04–1031. (Washington, D.C.: Sept. 15, 2004).

[7] GAO, *Defense Health Care: Force Health Protection and Surveillance Policy Compliance Was Mixed, but Appears Better for Recent Deployments,* GAO–05–120 (Washington, D.C.: Nov. 12, 2004).

[8] GAO, *Military Personnel: Top Management Attention Is Needed to Address Long-standing Problems with Determining Medical and Physical Fitness of the Reserve Force,* GAO–06–105. (Washington. D.C.: Oct. 27, 2005).

As we noted in our statement, our September 2006 report [9] on DOD's policies concerning its federal civilians who have deployed in support of operations in Afghanistan and Iraq found that DOD has established force health protection and surveillance policies aimed at assessing and reducing or preventing health risks for its deployed federal civilian personnel; however, at the time of our review, the department lacked a quality assurance mechanism to ensure the components' full implementation of its policies. To strengthen DOD's force health protection and surveillance for its deployed federal civilians, we recommended that DOD establish an oversight and quality assurance mechanism to ensure that all components fully comply with its requirements. In February 2007, the Office of the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness published a new instruction [10] on force health protection quality assurance. This policy applies to military servicemembers, as well as applicable DOD and contractor personnel. The new policy requires the military services to implement procedures to monitor key force health protection elements such as pre- and post-deployment health assessments. In addition, the policy requires each military service to report its force health protection and quality assurance findings to the Assistant Secretary of Defense (Health Affairs) through the Deputy Assistant Secretary of Defense for Force Health Protection and Readiness.

We further noted in our statement that, in our June 2007 report [11] on DOD's compliance with the legislative requirement to perform pre- and post-deployment medical examinations on servicemembers, DOD lacked a comprehensive oversight framework to help ensure effective implementation of its deployment health quality assurance program, which included specific reporting requirements and results-oriented performance measures to evaluate the services' adherence to deployment health requirements. Also, we noted in our statement that the department's new instruction and planned actions indicate that DOD is taking steps in the right direction. We stated and still believe that if the department follows through with its efforts, it will be responsive to several of our reports' recommendations to improve DOD's force health protection and surveillance for the Total Force.

Dr. SNYDER. Members of the Subcommittee asked for clarification of an individual's entitlement to Federal Employees' Compensation Act (FECA) benefits under various scenarios while on assignement to Iraq.

If an employee stationed in Iraq would be covered under FECA if he or she were injured by mortar fire while playing basketball during off hours or whether an off duty employee stationed in Iraq who was hit by mortar at a beer festival would be covered under FECA. Congressman Gingrey questioned whether the individual playing basketball would be covered under similar circumstances but the injury resulted from participation in the basketball game rather than from mortar fire.

Mr. HALLMARK. The Federal Employees' Compensation Act (FECA) states that:

> Disability or death from a war-risk hazard or during or as a result of capture, detention, or other restraint by a hostile force or individual, suffered by an employee who is employed outside the continental United States . . . is deemed to have resulted from personal injury sustained while in the performance of his duty, whether or not the employee was engaged in the course of employment when the disability or disability resulting in death occurred or when he was taken by the hostile force or individual. 5 U.S.C. § 8102(b).

A war-risk hazard is defined as a hazard arising from a war in which the United States is engaged; during an armed conflict in which the United States is engaged. The hazard may arise from the discharge of a missile; action of a hostile force or person; the discharge or explosion of munitions; the collision of vessels in a convoy or the operation of vessels or aircraft engaged in war activities. Employees who reside in the vicinity of their employment who are not living there solely due to the exigencies of their employment (local hires) are only covered while in the course of their employment.

Therefore, an injury or death of an employee deployed to Iraq resulting from mortar fire while playing basketball and/or at a beer festival would be covered under the FECA unless the disability or death was the direct result of certain statutory

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[9] GAO, *DOD Civilian Personnel: Greater Oversight and Quality Assurance Needed to Ensure Force Health Protection and Surveillance for Those Deployed,* GAO–06–1085 (Washington, D.C.: Sept. 29, 2006).

[10] DOD Instruction 6200.05, Force Health Protection (FHP) Quality Assurance Program, February 16, 2007.

[11] GAO, *Defense Health Care: Comprehensive Oversight Framework Needed to Help Ensure Effective Implementation of a Deployment Health Quality Assurance Program,* GAO–07–831 (Washington, D.C.: June 22, 2007).

exemptions, i.e. caused by willful misconduct of the employee or proximately caused by the intoxication of the injured employee.

The question of coverage in the case of an employee who sustains an injury such as broken leg as a direct result of participating in the off-duty basketball game is more complicated. As I noted in my testimony, each claim must be considered on its merits given the individual circumstances. When the employee engages in personal activities not reasonably incidental to the duties of the temporary assignment contemplated by the employer, injury occurring during such a deviation is not compensable. However, if the basketball game was an employer sponsored recreational or social activity, such injury would be covered under FECA. With regard to such recreational or social activities, the Employees' Compensation Appeals Board (SCAB) has held that such activities are covered when: they occur on the employer's premises during a lunch or recreational period as a regular incident of the employment; or the employer, by expressly or impliedly requiring participation, or by making the activity part of the service of the employee, brings the activity within the orbit of employment; or the employer derives substantial direct benefit from the activity beyond the intangible value of improvement in employee health and morale common to all kinds of recreation and social life.

While Federal employees abroad are not covered around the clock under all situations, FECA (in a manner similar to other workers' compensation systems) recognizes a number of potentially applicable doctrines that extend workers' compensation coverage for Federal employees injured in circumstances not directly related to their job duties.

- The zone of special danger doctrine provides coverage of injuries to employees sustained in foreign countries if the obligations or conditions of employment overseas expose them to hazards not common to all travelers.
- The proximity rule provides coverage for injuries suffered due to a hazardous condition proximate to the employment premises.
- The positional risk doctrine provides coverage for employees where the only connection of the employment with the injury is that employment obligations placed the employee in the particular place at the particular time when he or she was injured by some neutral force, meaning by "neutral" neither personal to the claimant nor distinctly associated with the employment.
- The rescuer doctrine provides coverage in an emergency to include any act designed to save life or property in which the employer has an interest.
- The bunkhouse rule provides coverage where an employee is injured during the reasonable use of employer provided housing which the employee is required or expected to occupy.

QUESTIONS SUBMITTED BY MR. AKIN

Mr. AKIN. We had come up with the idea that maybe our office, as a congressional office, could come up with a letter that we sent home to wives—not wives—at least try to get politically correct here—spouses, okay, something to the effect that. "I just wrote you today to let you know how proud we are of your wife or your husband that is in theater and the great work that they are doing. We want you to know that those of us in Congress appreciate that," a very personalized kind of thing with a little eagle on the top, you know, and hand signed, and then send a bunch of those to people, particularly when they have had somebody deployed for some period of time. We thought that would be at least a nice step toward building family relations and letting the family know that we are thinking about them.

I have asked my staff to work on it a number of different times and gotten nowhere, and finally came to the conclusion that the Army did not have, or the military did not have, a personnel database that they could basically go in on Congressional District 2 and pull out who we had to crank those letters out. And it gave me the sense, I wonder, if we really know where our people are. Is that along the same lines as what you are talking about?

I think medical records are even more complicated. I was just asking where the people are, you know.

I mean, I used to work for IBM, and I understand the massive programming effort that would be to put that kind of system together. Is that the sort of thing that could be farmed out to a private company like IBM or something to build that personnel system, or is that something that we as a government or as a military are equipped to do very well?

Are you familiar with the status of where that project is?

Ms. BRADSHAW. The Defense Integrated Military Human Resources System (DIMHRS) will be a fully integrated, all-Service, all-Component, military personnel and pay system that will support military personnel throughout their careers and retirement—in peacetime and war.

When fully implemented, DIMHRS will provide better service to military personnel and their families, including a timely and accurate record of service and delivery of compensation, benefits, and entitlements. DIMHRS will ensure the most efficient use of human resources in the conduct of the military mission, including support to the warfighter, and ensure visibility and accountability of military personnel to authorized users, as well as provide timely and accurate human resources information to authorized users. The system will enhance the ability to put the right person in the right place as quickly as possible (including acquisition and retention, as well as assignment and deployment).

DIMHRS will ensure the accurate assignment and tracking of personnel. Services and Components will know exactly what organization a Service member was associated with at any given point in time. For example, if a Reservist is called to active duty, attached to a Continental United States Replacement Center, further attached to a theater replacement activity, and attached to a unit within a theater of operations, DIMHRS will reflect the Service member's status and organizational association throughout that period of service. DIMHRS will also reflect the Service member's "home" organization (Reserve unit for Reservists) and all those "host" organizations to which the Service member is attached throughout the period of service. DIMHRS has the capability of nested hosts, so temporary assignments and details can be shown without losing visibility of primary home and host assignments. For classified locations, DIMHRS will capture unit associations on at least a daily basis and classified systems will track unit locations. DIMHRS will provide the ability to link to the location (for purposes of determining exposures or other incidents) through the unit. The full tracking capability requires the disconnected operations capability for use in theater.

The Under Secretary of Defense for Personnel and Readiness developed and maintains the Military Personnel and Pay Standards that are the enterprise requirements for DIMHRS.

In December 2005, the Department of the Navy (DoN) transferred the DIMHRS program acquisition to the Defense Business System Acquisition Executive under the Department's Business Transformation Agency.

The Defense Business Systems Management Committee chaired by the Deputy Secretary of Defense, is closely tracking the DIMHRS progress through monthly updates. DIMHRS is currently undergoing System Integration Testing, and is programmed for deployment to the Army in October 2008, and deployment to the Air Force in February 2009. The DoN is currently working with the Director for Program Analysis and Evaluation to determine a schedule for migration to DIMHRS. When the DoN migration is complete, the Department will have a single military personnel and pay system.

Additionally, the Department has created a temporary tracking system—called the Contingency Tracking System (CTS) Deployment file. The CTS Deployment file includes Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) data and is updated monthly. It covers the entire OEF/OIF timeline from September 11, 2001 to the present. The file contains one record for every deployment location event submitted for each member. For the purposes of building this file, an OEF/OIF "deployment" is defined as a Service Member *physically located* within the OEF/OIF combat zone or area of operations, or *specifically identified* by his/her Service as "directly supporting" the OEF/OIF mission (i.e., United States Air Force Aircrew or support personnel located outside the combat zone). A deployment must include a specific begin date and end date, and will include the member's location on specified dates if provided by the Service. The contingency tracking system does not currently include civilians or contractors.

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