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***STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
July 24, 2014***

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

Thank you for inviting DAV to testify today about the Department of Veterans Affairs (VA) health care access crisis, the recent actions of the VA to respond to this crisis, and what changes need to be made now to ensure that veterans can access high-quality and timely health care in the future.

As the nation's largest veterans service organization comprised completely of wartime disabled veterans, DAV has an enormous stake in making certain that VA provides high-quality health care, and that it does so in a timely manner. Our 1.2 million members—all of whom were wounded, injured or made ill from their military service—regularly receive care at VA's Community-Based Outpatient Clinics (CBOCs), medical centers and other facilities. We have over three hundred National Service and Transition Service Officers who also use the VA system and nearly two hundred hospital coordinators covering every VA medical center. DAV also has thousands of Department and Chapter Service Officers and fraternal leaders who use VA, as well as a transportation network which provides more than 770,000 rides for veterans to and from VA health care facilities each year. Overall, we work directly with millions of veterans enrolled in the VA health care system and that experience informs our opinions and judgments.

Mr. Chairman, when the allegations of secret waiting lists, falsification of medical appointment records and the destruction of official documents in Phoenix, Fort Collins, Cheyenne, Austin, and other sites first came to light we were outraged; but like you, we wanted to wait for all the facts to come in before reaching final conclusions. Since then, VA's Office of Inspector General has confirmed enough information to make clear that management failures resulted in breakdowns of VA's scheduling system that left thousands of veterans without timely access to care. We continue to fully support ongoing investigations to determine exactly what happened and who is responsible for the attempts to obscure the true picture of access problems at VA facilities and whether any laws were broken. We continue to demand full accountability for those responsible for creating and continuing such flagrant violations, as well as for those who knew about them but failed to take action. Veterans and all Americans deserve to know that their government operates honestly and ethically, and when any federal employee, manager or director violates laws, regulations, rules or the public trust, they must be held accountable, no matter who or where they are in VA.

Given the serious allegations, including many that VA has already conceded occurred, we continue to recommend that outside, independent third-party auditors and investigators be brought in to ensure the objectivity and credibility of ongoing investigations, and to help regain the full trust of veterans and the American people. Further, it is imperative that VA continue to release all data, information, findings and conclusions of every internal and external investigation or audit to both Congress and the American public as soon as available.

Mr. Chairman, the breakdown in VA's management and accountability, as well as the reckless and potentially criminal actions of individuals within VA are truly shocking and absolutely unacceptable. And Congress and the Administration must work together to take appropriate steps to ensure that such management breakdowns do not occur ever again.

However, the underlying access crisis that created the waiting lists and ultimately led to these inexcusable actions was hardly shocking or unpredictable. In fact, DAV and our partners in *The Independent Budget* (IB) have been warning for years that a continual pattern of inadequate resources would lead to increased rationing and decreased access to care, and that veterans would be the ones who would be harmed.

A HISTORY OF VETERANS HEALTH CARE ACCESS PROBLEMS

As some of you may recall, a little over a decade ago, VA faced a similar and even more serious crisis over access to VA health care, as hundreds of thousands of veterans – peaking at 310,000 in July 2002 – were found to be waiting *six months or longer* just to receive primary care medical appointments. Tens of thousands more waited for specialty care.

In May 2003, a presidential task force (PTF) appointed by President George W. Bush to study how to “Improve Health Care Delivery for Our Nation’s Veterans” reported the following: “*As of January 2003, at least 236,000 veterans were on a waiting list of six months or more for a first appointment or an initial follow-up – a clear indication of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide required care.*” The PTF concluded that there was a “*mismatch in VA between demand for access and available funding...*”

This mismatch had already been confirmed when then-VA Secretary Anthony Principi in January 2003 issued regulations to reduce future demand by closing access to the VA health care system to new Priority 8 veterans. Since Secretary Principi was unable to request additional appropriations to meet the needs of all veterans seeking care at VA, he determined it necessary to limit access. Unfortunately, this mismatch would continue for most of the next decade.

One year later, at a hearing of this Committee in February 2004, Secretary Principi was asked whether VA's budget request to the Office of Management and Budget (OMB) included the full amount VA had estimated was needed, and in response he stated unequivocally, “*I asked OMB for \$1.2 billion more than I received.*”

A year later, in February 2005, the IB told Congress that, “*Access is the primary problem in veterans health care,*” and warned that “*without funding for increased clinical staff, veterans demand for health care will continue to outpace VHA's [Veterans Health Administration] ability to supply timely health care services.*”

Just a couple of months later, then-VA Secretary Jim Nicholson testified to this Committee that the Administration's FY 2005 budget would fall short and later submitted a formal request for an additional \$975 million, which Congress subsequently appropriated. Then, just weeks later, VA also requested an additional \$2 billion above what it had requested for FY 2006 earlier in the year.

Although VA's funding has increased in absolute dollars, relative to rising demand for services and rising cost of care, it was not enough and access remained a problem. In January 2008, VA reported that there were still about 110,000 veterans waiting more than 30 days for appointments, clearly illustrating what the PTF said would happen if the "mismatch" between demand and funding was not addressed.

In addition to repeatedly warning Congress about inadequate resource levels for VA health care, the IB also expressed our growing concerns that VA was not accurately or honestly measuring waiting times. In February 2010, the IB said that, "*VHA's measurement system for outpatient waiting times ... lacked credibility.*"

In February 2012, the IB again told Congress that, "*...the VHA measurement system for outpatient waiting times continues to lack credibility,*" and also warned that for FY 2012, "*... the VA budget request, and ultimately the funding provided through the appropriations process, was insufficient for VA to meet the demand on the health care system.*"

In December 2012, the General Accountability Office (GAO) reported long wait times for outpatient medical appointments and found that the metrics provided by VHA were "unreliable." Furthermore, GAO found that VHA's scheduling policy and training documents were "unclear" and led to inconsistent reporting of wait times.

In February 2013, the IB told Congress that, "*... the number of veterans waiting is neither publicly reported nor accessible... and should be made available on a facility-to-facility basis...*" and that, "*...this information must also be tested for validity and reliability.*" We also recommended that, "*...VHA needs to improve data systems that record and manage waiting lists...*"

Once again this past February, the IB recommended that, "*VHA should make public its reports by VA facility, indicating the number of veterans [who are] waiting periods beyond the current access-to-care standards,*" and that data on waiting lists "*... must also be validated.*"

The IB also warned Congress and the Administration that the VA's budget for both FY 2014 and the advance appropriations request for FY 2015 "*...will not begin to meet the projected needs of veterans already in the system and those coming to VA for the first time.*"

And just two weeks ago, on July 10th, the Congressional Budget Office (CBO) issued a revised report on H.R. 3230 and estimated that, "*...under current law for 2015 and CBO's baseline projections for 2016, VA's appropriations for health care are not projected to keep pace with growth in the patient population or growth in per capita spending for health care – meaning that waiting times will tend to increase...*"

Mr. Chairman, in 1905, American philosopher and writer George Santayana famously wrote that, “...those who cannot remember the past are condemned to repeat it.”

The question before us today is whether we will repeat the mistakes of the past, or whether we will learn from a clear and consistent historical pattern? History shows that when VA fails to ask for full funding, or when Congress fails to provide it, the inevitable outcome is rationing of health care, decreased access and waiting lists.

That is not to say that VA’s management failures did not contribute to this crisis; they did. Nor that some VA leaders, managers and employees do not need be held fully accountable for their failures; they do. There is no doubt that serious problems uncovered by this Committee, reported in the media and validated by the VA’s OIG are real and must be corrected. The recent report by the White House Deputy Chief of Staff Rob Nabors’ reached this same conclusion stating that VA acted, “...with little transparency or accountability with regards to its management of the VA medical structure.” DAV agrees.

However, the Nabors’ report also concluded that the primary reason for access and scheduling problems was, “the need for additional resources... doctors, nurses, and other health professionals; physical space; and appropriately trained administrative personnel.” In May, the VA OIG also reported the same finding from its preliminary investigation about waiting lists, stating that, “The highest scored single barrier or challenge was lack of provider slots...” So if we are to prevent history from repeating, we must not only address the management problems, we must also address the resource and capacity gaps.

INADEQUATE MEDICAL CARE FUNDING FOR MORE THAN A DECADE

Mr. Chairman, over the past decade, DAV and our partners in the IB have presented testimony to this Committee and others detailing shortfalls in VA’s medical care and construction budgets. In the prior ten VA budgets, the amount of funding for medical care requested by the Administration and ultimately provided to VA by Congress was more than \$7.8 billion less than what was recommended by the IB. Over just the past five years, the IB recommended \$4 billion more than VA requested or Congress approved and for next year, FY 2015, the IB has recommended over \$2 billion more than VA requested.

Even worse, the funding shortfalls that we have consistently pointed out have been exacerbated by annual budget gimmicks that replace actual dollars to be appropriated with projected savings from proposed “management efficiencies” and “operational improvements.” As GAO has consistently pointed out, VA’s projections of such future “savings” have rarely, if ever, been documented or substantiated, leaving VA facilities short of the funding needed to provide medical care to all veterans using the system.

For example, in a June 2011 report (GAO-11-622), GAO stated that, “If the estimated savings for fiscal years 2012 and 2013 do not materialize and VA receives appropriations in the amount requested by the President, VA may have to make difficult trade-offs to manage within the resources provided.” It is exactly those tradeoffs that put veterans on waiting lists.

A similar problem involves VA replacing appropriated dollars in their budget requests with anticipated collections from third party insurers. When the actual amounts collected through the Medical Care Collection Fund (MCCF) fall short of the projected levels, as has been the case almost every year, VA is once again forced to make do with less than its actuarial model estimates is needed to provide care to enrolled veterans. If just these two “gimmicks” were removed from the budgets proposed by the Administration and subsequently approved by Congress, VA would have had significantly greater resources, billions more, with which to increase staffing and better address access issues that have become so prevalent now.

Mr. Chairman, these gimmicks are well known to those who regularly examine VA’s budget submissions. For example, this Committee’s Views and Estimates letter to the Senate Budget Committee on March 2012 stated, “...*we are concerned about VA claiming savings without any real way of transparently measuring whether they, in fact, occurred.*”

Senate VA Committee Chairman Sanders expressed these same concerns in his Views and Estimates letter to the Senate Budget Committee this year, stating that “*based upon operational efficiencies identified as cost savings in previous VA budgets, I am concerned there will be a similar shortfall next fiscal year.*” He went on to express concerns about the “...*potential impact that failing to achieve the identified costs savings may have on VA’s provision of health care.*”

INFRASTRUCTURE FUNDING GAP LIMITED VETERANS’ ACCESS

The other major contributor to VA’s access crisis is the lack of physical space to examine and treat veterans seeking medical care. Over the past decade, the amount of funding requested by VA for major and minor construction, and final amount appropriated by Congress, has been more than \$9 billion less than what the IB has estimated was needed to allow VA sufficient space to deliver timely, high-quality care. Over the past five years alone, that shortfall is more than \$6.6 billion and for next year the VA budget request is more than \$2.5 billion less than the IB recommendation.

But it’s not just the IB saying this, VA’s own internal analysis confirms the size of the infrastructure funding shortfall. According to VA’s Strategic Capital Investment Plan (SCIP), which is their methodology for determining infrastructure needs, VA should invest between \$56 to \$69 billion in facility improvements over the next ten years; that would require somewhere between \$5 to \$7 billion annually. However, the Administration’s budget requests over the past four years have averaged less than \$2 billion annually for major and minor construction and for non-recurring maintenance. The fact that VA has consistently requested less infrastructure funding than actually needed is also well known to those who regularly examine VA’s budget and appropriations requests.

Mr. Chairman, we appreciated the attention given to the VA infrastructure shortfall in the Committee’s Views and Estimates letter from March 2012, in which you stated that, “*We believe that the Administration failed to request sufficient funding for non-recurring maintenance...*” Similarly, we appreciated you raising the infrastructure issue with former Secretary Shinseki again last year, when you referenced the IB’s testimony regarding the \$25 billion major construction backlog, pointing out that the Administration’s FY 2014 budget plan proposed,

“...\$342 million for major construction, putting us on a course, I believe, for completion of all projects in 70 years.”

And earlier this year at a Senate Appropriations Subcommittee hearing, Senator Tim Johnson stated what almost everyone in the room already knew about VA’s inadequate infrastructure request:

Quality VA medical care cannot be provided in substandard facilities, and yet the VA’s investment in major and minor construction and non-recurring maintenance is woefully inadequate and falling further behind every year. If these shortfalls are not addressed soon, patient care will suffer.

Unfortunately, neither the House nor the Senate ultimately took any actions to significantly increase funding in recent years for VA’s construction and facility maintenance accounts above the Administration’s inadequate requests, ignoring not just the IB’s recommendations, but VA’s internal SCIP analysis. This failure to build, maintain and replace VA’s hospitals and clinics limits the space in which veterans can be treated and as we have seen, directly impacts the timeliness and quality of care. For example, in Phoenix, where the whistle was first blown on the falsification of wait times, they have been waiting for years to open a new outpatient clinic to handle the rapid growth in veteran patients. However, due to insufficient total appropriations provided for VA’s infrastructure over the past decade, the Phoenix clinic has been forced to wait years in the funding queue, only reaching the top this budget cycle, a day late and a dollar short.

Mr. Chairman, the debate over whether there is a mismatch between demand for VA health care services and the resources provided to VA is a settled issue. Not only is the historical record clear, why else would the House vote 426-0 and the Senate vote 93-3 for legislation to expand veterans’ access to health care that CBO estimated could cost at least \$30 billion in the first two years, and up to \$54 billion annually after that, if there was already enough money? So the only question that remains is when, where and how new resources should be directed in order to most effectively increase veterans’ access to health care in the short term and in the long term.

CONGRESSIONAL RESPONSE TO VETERANS’ ACCESS CRISIS

In June, both the House and Senate passed legislation to dramatically expand the provision of non-VA care to veterans, however there are significant differences between the two bills in terms of when such care is authorized, how it is coordinated, and how it would be scored and paid for by the federal government. There are also questions over how non-VA providers will integrate their medical records into VA’s electronic health record system so that there is seamless record keeping to ensure integrated care and patient safety? And even if VA has the resources to pay for non-VA care, are there sufficient, qualified health care professionals available in every community to provide such care? Simply giving a veteran a plastic card and wishing them good luck in the private sector is no substitute for a fully coordinated system of health care.

Currently, a House-Senate Conference Committee is meeting to examine these questions and develop a compromise. However, since most of the work of the Conference Committee is

not done in open sessions, DAV and 19 other leading veterans and military service organizations wrote to the conferees on June 17th to put forward a series of comments that reflected our shared view of what needed to be accomplished. Although we all have different missions, memberships and perspectives on the best path forward, we all shared one overriding principle: “...no veteran who is eligible for VA health care should be forced to wait too long or travel too far to get medical treatment and services they have earned...”

In our united view, the first priority for Congress and VA “...must be to ensure that all veterans currently waiting for treatment ...are provided access to timely, convenient health care as quickly as medically indicated.” Second, we all agreed that when VA is unable to provide the care in VA facilities, “...VA must be involved in the timely coordination of and fully responsible for the payment for all authorized non-VA care.” Third, we stated that supplemental funding for this year and additional funding for next year must be provided to pay for the temporary expansion of non-VA purchased care. Further, Congress and VA must not rely on the typical budgetary gimmicks, such as “management efficiencies”, whose use in the past directly contributed to the current crisis.

Finally, all of the VSOs and MSOs agreed that whatever actions VA or Congress takes to address the current access problems must “...protect, preserve and strengthen the VA health care system so that it remains capable of providing a full continuum of high-quality, timely health care to all enrolled veterans.” We cautioned that if Congress intends to create a two-year program to expand non-VA care, it must also simultaneously take the necessary actions to “...strengthen VA health care delivery, expand access and capacity, reallocate resources and ensure that overall VA funding matches its mission.”

These are the standards a united veterans community laid out for Congress one month ago as you considered how to respond to the access crisis. Although the Conference Committee has not yet reached a compromise, VA has taken some significant actions to address this crisis.

VA PROPOSAL TO EXPAND HEALTH CARE ACCESS

Last week, Acting Secretary Sloan Gibson testified before the Senate Veterans’ Affairs Committee about the progress made over the past two months in addressing health care access problems. According to Secretary Gibson, the VHA has already reached out to over 160,000 veterans to get them off wait lists and into clinics. VHA accomplished this by adding more clinic hours, aggressively recruiting to fill physician vacancies, deploying mobile medical units, using temporary staffing resources, and expanding the use of private sector care. Gibson also testified that VHA made over 543,000 referrals for veterans to receive non-VA care in the private sector – 91,000 more than in the comparable period a year ago. In a VA press release, VA stated that it had reduced the New Enrollee Appointment Report (NEAR) from its peak of 46,000 on June 1, 2014 to 2,000 as of July 1, 2014, and that there was also a reduction of over 17,000 Veterans on the Electronic Waiting List since May 15, 2014.

Secretary Gibson testified that after re-examining its resources needs in light of the revelations of secret waiting lists and hidden demand, VA was requesting supplemental resources totaling \$17.6 billion to be spent over the remainder of this fiscal year through the end

of FY 2017. This supplemental funding would average between \$5 billion to \$6 billion per fiscal year, significantly less than what either the House or Senate proposal is estimated to cost.

The majority of this new funding, approximately \$8.1 billion, would be used to expand access to VA health care over the next three fiscal years by hiring up to 10,000 new clinical staff, including 1,500 new doctors, nurses and other direct care providers. That funding would also be used to cover the cost of expanded non-VA purchased care, with the focus shifting over the three years from non-VA purchased care to VA-provided care as internal capacity increased. The next biggest portion would be \$6 billion for VA's physical infrastructure, which according to Secretary Gibson would include 77 lease projects for outpatient clinics that would add about 2 million square feet, as well as 8 major construction projects and 700 minor construction and non-recurring maintenance projects that together could add roughly 4 million appointment slots at VA facilities. The remainder of the VA supplemental request would go to information technology enhancements, including scheduling, purchased care and project coordination systems, as well as a modest increase of \$400 million for additional VBA staff to address the claims and appeals backlogs.

Mr. Chairman, comparing this supplemental funding request to the historical funding shortfalls identified by the IB, and taking into account the progress achieved by VA over the past two months and the questions about legislative proposals under consideration by the Conference Committee, we are convinced that the request by Secretary Gibson is a reasonable and intelligent way to expand access now, while building capacity to avoid future access crises in the future. Unlike the proposals in the Conference Committee, the VA proposal would have an immediate impact on increasing access to care for veterans today by building upon VA's expanded access initiatives underway and sustaining them over the next three years. Furthermore, by investing in new staffing and treatment space, VA would be able to continue providing this expanded level of care internally, even while increasing its use of purchased care when and where it is needed.

By contrast, the House and Senate bills would take significant time to be implemented and would not create permanent new capacity. There are also significant questions regarding care coordination, provider reimbursement and overall costs of the contracting-out programs envisioned by the House and Senate proposals. Given the massive scale of what those bills propose, upwards of \$50 billion annually if continued in future years according to CBO, it seems like a reasonable and responsible investment to spend less than \$6 billion each of the next three years, particularly since it would create permanent new capacity to treat veterans in the VA system. The fact that both bills being considered in the Conference Committee have sunset provisions approximately two years from enactment also raises a very serious question about how the increased demand created through generous private health care programs will be met once that authority ends. If VA doesn't have the capacity today to meet its current demand, and the facts prove they don't, how will VA be able to meet significantly increased demand in the future unless smart investments in the VA system are made today?

IMPORTANCE OF SUSTAINING THE VA HEALTH CARE SYSTEM

Mr. Chairman, we greatly appreciate your clear statements that you want to fix, not get rid of the VA health care system. However, it has become evident that the current crisis has become an opportunity for some to push an ideological agenda to dramatically shrink or

eliminate the VA health care system. In fact just last week, at a think tank event that you were scheduled to speak at, one of the so-called experts said that in his view the current access crisis proves that VA should be eliminated altogether, and that veterans should simply be given vouchers or cards to fend for themselves in the private sector. We could not disagree more strongly.

In our view the VA health care system is both indispensable and irreplaceable; there is no substitute for it. Based upon our collective knowledge and experience, we continue to believe that veterans are now and will be better served in the future by a robust VA health care system than by any other model of care. While there are both serious access and management problems that must be corrected, the VA health care system is an essential part of America's health care system. VA today operates nearly 1,700 sites of care including 152 hospitals, 820 community-based and mobile outpatient clinics, 300 Vet Centers for psychological counseling and other facilities that provide vital health care and services to millions of veterans. VA provides medical services to more than 6 million veterans annually, out of almost 9 million enrolled in the VA system.

In addition, VA's clinical research program has elevated the American standard of care and invented cutting edge devices and treatment techniques that have improved the lives of millions of veterans and non-veterans in areas such as spinal cord injury, blind rehabilitation, amputation care, advanced rehabilitation (such as polytrauma and traumatic brain injury), prosthetics, post-traumatic stress disorder, substance-use disorder, multiple sclerosis, diabetes, Alzheimer's, Parkinson's and dementia.

It is also worth noting that in addition to providing high-quality health care to veterans, VA is also the largest single provider of health professional training in the world. Each academic year, VA helps train over 100,000 students in the health professions through its academic affiliation with 152 schools of medicine and over 1,800 schools in total.

DEBUNKING MYTHS ABOUT VA HEALTH CARE

Unfortunately, while there has been much good reporting on the problems in the VA health care system, there has also been a tremendous amount of false and distorted information in the media, much of it repeated by some in Congress. For example, some Members of Congress have stated that VA funding rose over 250 percent during the past decade while the number of veterans has dropped from about 25 million to just over 21 million, thereby concluding that the VA health care system is overfunded and highly inefficient. While those numbers individually are accurate, linking them together creates a highly misleading inference. The reality is that most of the increase in VA's overall budget goes to mandatory benefits, such as disability compensation and G.I. Bill education payments, not to the health care system. VA health care funding has grown from \$33.5 billion to \$55.1 billion in real dollars, a 64 percent increase over the past decade, however there are more, not fewer, veterans in the health care system, contrary to assertions by some. The number of veterans treated by VA rose 39 percent but most importantly, utilization increased by 95 percent, as outpatient visits nearly doubled from 46.9 million in 2002 to 91.7 million in 2013. In addition, the complexity and cost of specialized care for traumatic brain injury, prosthetics, burns and other wounds of war has risen significantly, further straining VA's ability to deliver timely, high-quality health care to enrolled veterans.

Another false argument being made by some is that since VA carries over unobligated funding from one year to the next, \$500 million or more per year, the cumulative total would be the sum of each year's individual total. Using this logic, they argue that VA received about \$4.5 billion more in appropriations than was needed during that timeframe, and then assert that this proves VA is flush with cash and that "money is not an issue."

However, as can be demonstrated easily, carryover funding is subtracted from, not added to, the budget request for the next fiscal year. Carryover funding is not extra funding for the next fiscal year, rather it is forwarded into and becomes part of the next year's budget, and therefore the request for future appropriations is reduced by the amount of the expected carryover. It is mathematically incorrect to add each year's carryover and use that cumulative total, since each year's carryover of "unobligated" balances is no longer "unobligated" once it is carried over; at that point it becomes part of the next year's baseline budget.

The correct way to determine the cumulative total of "unobligated" funding is to look at the most recent carryover total, which is the true amount of "unobligated" funding over any time period. It is no different than a simple checking account. If you have a \$500 balance in your account at the end of the year that is similar to "unobligated" funding. If you maintain a \$500 balance for five straight years, you do not add them together and conclude that you now have \$2,500 of "unobligated" funding in your account; you still only have a \$500 balance. Since this year's VA budget was projected to carry over approximately \$450 million into next year, the cumulative total of carryover for the past five years would actually be \$450 million, not \$4.5 billion as some have alleged. Furthermore, since VA is now projecting to spend the entire carryover balance this year, the actual cumulative total of "unobligated" funding over the past five years will be zero.

Mr. Chairman, for some the use of carryover is a new issue; however, as you know, this is hardly a revelation to those who oversee VA's budget. As this Committee stated in its Views and Estimates letter of March 18, 2011, "*...we agree that carryover of funds from one year to the next is a prudent use of taxpayer dollars and must absolutely be built into a subsequent year's budget request... Again, we agree that permitting VA to carry money over into a subsequent fiscal year is, and always has been, an important aspect of how VA manages its resources effectively.*"

We also agree that carrying over "unobligated" funds is good fiscal management when there was no need to use that funding to provide health care access to veterans. Too often, however, VA has used "carryover" as a budget gimmick to ration access to care while reducing the need for future appropriations requests. When there is excess demand compared to available resources, as we argue has been the situation for most of the past two decades, VA must use any "unobligated" funding to meet that demand, not carry it over to the next fiscal year.

Another highly misleading statistic is the number of adverse incidents in VA hospitals that result in or contribute to patient deaths. For example, a story by the *Washington Free Beacon* last week reported that there were more than 500 such adverse incidents at VA hospitals last year, which would give the impression that the VA health care system is unsafe and certainly

less safe than private sector health care systems. However, the story fails to put this into any reasonable or rational context of modern American medicine.

According to a *Scientific American* article from September 2013, the number of people who die due to mistakes made in U.S. hospitals every year ranges from a low end estimate of approximately 100,000 to a high end estimate of up to 440,000. So how does VA compare to all other private hospitals in the US? Since there are approximately 150 VA hospitals, that would mean that there were between 3 and 4 preventable deaths per VA hospital last year. By contrast, there are approximately 5,000 private hospitals in the U.S., which would mean that there were between 20 and 100 preventable deaths per private hospital last year. That's a much different story than the one regularly being reported by the media. I would note, Mr. Chairman, that you did attempt to add some balance to that story by pointing out that, "*Like other hospital systems, VA isn't immune from human error—even fatal human error.*"

To be clear, we do not accept nor condone a single preventable death of a veteran in a VA hospital, but no health care system is perfect, and medicine is far from an exact science. When grievous medical errors result in patient harm or death, VA must act swiftly, transparently and effectively to identify and correct problems when they arise. However the distortion of facts and the manipulation of statistics by some to justify a crusade to eliminate the VA health care system is outrageous. If we are to respond to the current crisis and prevent it from recurring in the future, we must have an open and honest debate about both the causes of the access problems and the effects of the proposed solutions.

For more than a decade, DAV and our partners in the IB have been telling Congress and the Administration that the funding provided to VA was inadequate to meet current and future health care needs of veterans. We warned that a lack of sufficient health care resources, particularly clinical staffing and infrastructure, would lead to rationed care, diminished access and waiting lists. Sadly, history has proven us correct.

Given all that has transpired over the past few months, and considering the size and estimated costs of the legislation being considered by Congress to address this crisis, there can be no debate that the mismatch identified more than a decade ago continues today. Now it is up to Congress and the Administration to take the steps necessary to end the mismatch, provide VA the resources it needs, and work together with VSO stakeholders to strengthen the VA health care system now and in the future so that enrolled veterans receive high-quality, timely and convenient medical care.

That concludes my testimony and I would be happy to respond to any questions you or the Committee many have.