Appendix – Underlying Evidence

(1) VHA as Model for High-Value Healthcare

The VHA delivers perhaps the highest value healthcare in the nation. This is not our opinion. It is a fact supported by extensive research on the core components of healthcare value: quality and cost.

Quality: By any definition, in study after study, VHA's 170 hospitals and nearly 1200 clinics meet and usually exceed the quality of care provided elsewhere. Subjectively, over 90% of VA patients—on VA and independent surveys alike—report high trust in VHA and prefer it as their primary source of healthcare. Objectively, VA patients have better outcomes across a range of conditions when treatment occurs within VHA, and lower mortality when ambulances bring them to VHA emergency rooms. Various veteran subgroups also fare better under VHA care than their veteran counterparts—or the civilian public—fare with non-VHA providers. This is true both for "general medical populations" (like diabetic patients, who have fewer complications when treated at VHA clinics) and for highly complex ones including

- veterans with psychiatric conditions (whose suicide rates are lower when they receive VHA vs. non-VHA care)
- veterans on dialysis (who have lower mortality when their dialysis takes place within VHA)
- veterans experiencing homeless (of whom some 55% have been housed since 2008)
- veterans with Hepatitis C (of whom nearly 80% were cured, at VHA, by a forward-thinking campaign which leveraged upfront investment in expensive antivirals to stem downstream suffering from *more* expensive liver complications)

Cost: High-value preventive investments like Hep C eradication are a hallmark of VHA care. They are possible because VA's lifetime insurance coverage and capitated payment model promote cost-control measures for which private insurers and for-profit health systems lack incentive. Bulk drug pricing at steep discounts is another VHA practice which profit-driven pharmaceutical companies are incentivized to oppose; which Medicare part D plans are prohibited by law from negotiating; and which commercial pharmacy benefits managers (PBMs)—via opaque manufacturer rebates and formulary practices and vertical integration with insurers or dispensing pharmacies—untether from the free market.

For these reasons and more, cost-effectiveness research confirms that VHA care is generally less expensive as well as more effective. As above, this is true across multiple medical conditions, for studies comparing

- VHA patients vs. non-veterans (who tend to be less medically complex, and whose costs should be lower unless driven by something other than medical need)
- VHA care vs. veteran care funded by non-VA entities (e.g., Medicare, for dually enrolled veterans seen at non-VA hospitals).
- VHA-delivered care vs. VA-funded Community Care.

In a nation where healthcare expenditures, often taxpayer funded, approach 20% of Gross Domestic Product—and where dropping life expectancy is especially notable among the rural and working-class patients overrepresented among veterans—one might view VHA's high-value track record as a cause for celebration (if not a model for reform). Yet many VA and congressional leaders promote an alternate, false narrative in which VHA is a bloated, change-averse bureaucracy and the private sector is the solution.

(2) **Community Care Origin Story: Myth vs. Reality**

To support the narrative of VHA dysfunction, VHA critics cite "claims backlogs" and "wait times" as their areas of greatest concern. The first critique—backlogs in veterans' applications for service-related disability and healthcare benefits—has little to do with the Veterans Health Administration. Though largely outside the scope of this letter, these benefits share concerning echoes of a larger VA privatization trend and will receive brief mention in our next footnote.

The second critique—wait times for healthcare at VHA clinics—is inconsistent with evidence. Though VA leaders have repeatedly described these wait times as "going up" in recent years, VA's own website describes VHA wait times decreasing as of last analysis in early 2024 (to 17 and 22 days for mental health and primary care appointments, respectively). These wait times compare favorably with those the community.

Though not consistent with the evidence, concern about wait times *is* consistent with rhetoric surrounding a past VA scandal which Community Care growth was intended to remedy. To quote a member of Congress in July: "There is a reason the MISSION Act and Community Care exist. And the reason was because people were dying waiting for care at the VA." This quote references events still known throughout VA as the "2014 Wait Time Scandal," and it misrepresents those events as we understand them to have occurred:

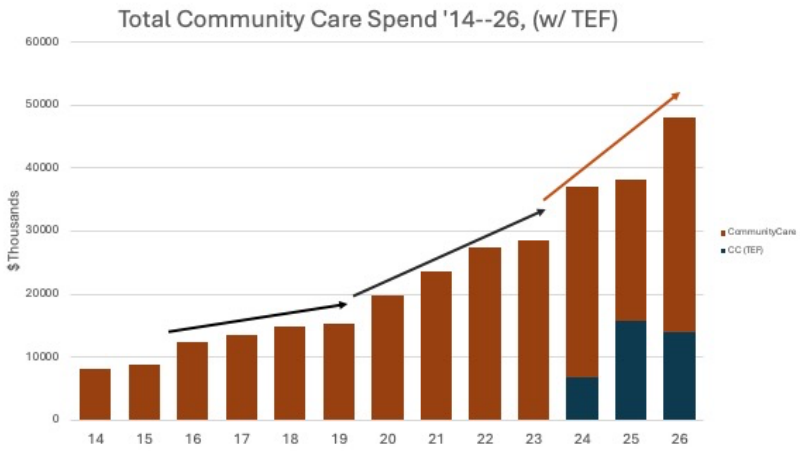
- In February 2014, a whistleblower alleged that some 40 veterans died while waiting for appointments at a VA medical center in the Southwest.
- In April, these allegations were announced before the House Veterans Affairs Committee
- During the same hearing, the Committee Chair shared a separate allegation that VHA schedulers had manipulated records to feign compliance with new 14-day wait time standards.
- In June, a national audit of all appointments scheduled in VHA in the previous year—some 6 million—showed 96% were scheduled within 30 days (VA's current wait-time standard for non-urgent care)
- In August, VA's Inspector General (IG) published an exhaustive report on the original whistleblower complaint—including manual reviews of some 3400 patients' charts from the southwestern VA
    - The report identified 6 veterans who had died while waiting for care, but that most were waiting for routine visits unrelated to their cause of death, and/or had severe chronic conditions whose trajectories would not have been altered by more timely treatment.
    - In all cases, investigators were "unable to conclusively assert that excessive delays caused the deaths of these veterans."
- In July 2014, one month before the IG report was released, Congress passed "emergency" legislation—the Veterans' Choice Act—which, for the next three years, broadly expanded VA's role as payor for purchased (community) healthcare services.
- In so doing, it "upended how VA has done business for the last 70 years." This statement was made by the CEO of the Concerned Veterans of America (CVA). The quote goes on to credit CVA for "exposing and driving the [wait time] crisis from the very beginning," and for being "central to [the Choice Act] in every aspect."
- Concerned Veterans for America was founded in 2011. Its main activities focused not on veterans' services but on 2012 electoral politics. Its main funding came not from veteran members but from a donor network organized by two brothers for whom "voucherizing" VHA had played a minor role in a larger anti-government agenda.
- The CEO's statement above was made at the brothers' donor summit in June 2014. It concludes: "Throughout [the Wait Time Scandal], CVA and its network partners intentionally broadened debate to include big government dysfunction in general, further fortifying new skepticism about what government run healthcare does."

(3) **The VA's Largest Sources of Waste and Abuse**

Over the last 10 years VA has funded two healthcare systems: the VHA's direct care system, and the Veterans Community Care Program. The results of this natural experiment are telling and unequivocal.

From 2014-2018, Community Care appropriations were time-limited and capped around $10 billion. Though private sector expenditures grew relatively slowly during that time, the program was rife with waste—most notably by the Third-Party Administrators. Some 25% of spending—around $1.9 billion—went not to veterans' outsourced healthcare, but to administrative fees charged by the two insurance companies who received single source contracts to build a Community Care provider network, schedule Community Care appointments, reimburse non-VA providers, and transfer medical records. Records retrieval from Community Care providers, though also outside the scope of this letter, remains a problem. (Its solution—replacing VHA's first-in-class, highly-rated, homegrown electronic health record with an unproven commercial product from healthcare-naive tech giant Oracle—via another no bid contract whose projected costs now approach $50B—may be a cure worse than the disease.)

Since 2018, Community Care spending has increased more dramatically, after passage of the VA MISSION Act. Short for "Maintaining Internal Systems while Strengthening Outside Network," the MISSION Act indefinitely extended the Choice Act's private sector funding stream, with no mechanism for cost containment (or quality control), and expanded eligibility criteria to all veterans living more than 30 minutes from their nearest VA (60% of all VA patients). Since then, Community Care referrals have increased modestly—mainly due to drive-time eligibility rather than long VHA wait times. Yet Community Care expenditures have risen dramatically from $14.8B in 2018 to an estimated $40.9B in Fiscal Year '25. This increase in per-referral and per-provider costs—which we hope VA investigation will further elucidate—suggests that some Community providers have become adept extracting the maximum amount of revenue per veteran.



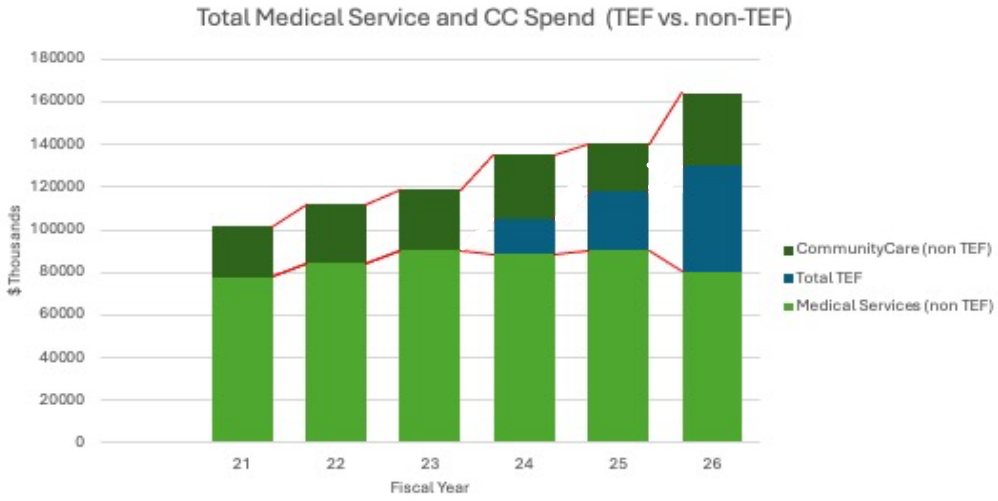
Again, VA's Third-Party Administrators remain a major source of waste, and, in some cases, fraud and abuse. In 2024, VA's OIG found that United Health, which manages Community Care for Veterans the eastern Half of the US, had overcharged the VA by $783.4 million from FY2020- May 2024 for dental services provided by community care providers. (UH argued that VA's contract did not explicitly *prevent them* from charging the VHA more than they was reimbursing the community care provider.) United Health has also been implicated charging the government some $1.3B in premiums for Medicare Advantage plans targeted to Veterans whom it also receives administrative fees—averaging $318 per claim—for processing Community Care referrals. These referrals, in turn, often flow to private hospitals and clinics ***also*** owned by United Health. Insofar as United Health ***ALSO*** conducts a large proportion of Veterans Benefits Exams, it is possible that the taxpayer may pay this single company four times for the same veteran's care: first as a recipient of (unused) Medicare Advantage premiums; second to (impartially) vouch for that veteran's eligibility to receive taxpayer-funded VA care; third for directing that care (also impartially) to a provider in VA's community care network; and then delivering that care in a way that maximizes health and minimizes cost.

(4) **Avoiding the Downward Spiral: Impacts of Community Care Spending on VA Healthcare and Veterans' Benefits**

In early 2024, an independent panel—convened by VA to assess "trends and drivers of increasing community care spending"—determined that this spending posed an "existential threat" to VHA's hospitals and clinics. "With a fixed appropriated budget and escalating community care referrals…more of VHA's clinical care budget will have to be used to support the community care program. This could create a self-perpetuating cycle in which increased community care spending results in less direct care funding [and] direct care capacity, leading to increased community care reliance and a continuous 'downward spiral' for VHA's direct care system."

To healthcare scholars and frontline providers, the "downward spiral" scenario has long seemed intuitive. As Community Care costs rise, cuts to VHA's direct care budget would seem inevitable; should struggling VA Medical Centers and Clinics close, more-expensive Community Care (which is also generally less effective) would be the only remaining "choice" for veterans. As VA's medical budget swelled from this lower value care, cuts to veterans' benefits would be a worrisome possible next step. Indeed, the elimination of VA medical benefits for veterans in Priority Groups 7 and 8, who bravely served but do not have a compensable service connected disability, has been proposed by The Heritage Foundation.

These concerns have been dismissed by some in Congress. Yet the budget sent to Congress in June, and being reconciled between the chambers right now, shows that very downward spiral taking place starting in FY26. To offset an unprecedented $12 billion (50%) increase for Community Care spending—and a staggering 167% increase for costs related to Electronic Health Record outsourcing—this budget cuts some $12 billion (17%) from VHA's direct medical care budget. These cuts are hidden somewhat by inexplicably large growth in earmarked Toxic Exposure Fund (TEF). But the cuts are there.



This figure—17%--nearly exactly matches 15% target for the agency-wide reduction in force announced last March (and cancelled in June).

(5) It is deeply worrisome a 15% staff cut was entertained—and that significant staff reductions were pursued and achieved via buyouts and other means—in a VHA system already straining to meet demand AND operating with relatively high efficiency and low administrative overhead. In 2025, VA's Inspector General reported shortages in frontline staff—physicians, nurses, psychologists—at all 139 VA Medical Centers surveyed (out of 170 total). At the same time, VHA hospitals employed proportionally 25% fewer administrators than their private sector counterparts.

If it was unclear where a 15% staff cut might come from—or why it was needed at all—where veterans would go for healthcare was a mystery. One potential answer--“Community Care”—was promoted extensively in Project 2025, a document that has left its stamp on so much of government. (Its section on “Needed VHA Reforms” pertains nearly exclusively to "strengthening Community Care.") But this answer was implausible in America’s current, often fragmented healthcare market. In August, a comprehensive 50-state analysis of healthcare services outside the VHA confirmed what we healthcare professionals knew intuitively. 89% of counties face primary care shortages; 61% of rural counties lack even a single psychiatrist; in short, the American healthcare market cannot absorb a large, rapid influx of complex veteran patients, let alone serve them with the expertise and high value they deserve and have come to expect from VHA.