STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
THE STATE OF THE DEPARTMENT OF VETERANS AFFAIRS
HEALTH CARE SYSTEM, A SYSTEM WORTH SAVING

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Chairman Specter and Members of the Committee, thank you for allowing me to testify today. Last September during a hearing before a joint session of the Committees on Veterans' Affairs, I made a promise to report back to you and your colleagues the results of my extensive visits to VA medical facilities across the United States. This final report spotlights my personal observations during visits to 60 VA medical facilities.

These visits were thorough, in depth, and probing. I preceded these visits by providing a list of specific questions to each facility to answer and return to The American Legion. Initially, I asked each VA medical facility director a few questions while meeting with them. However, over the course of my visits, the number of questions I asked increased as I became aware of the areas that needed extra attention.

Enrollment

In 1996, Congress enacted legislation authorizing all eligible veterans to enroll in the VA health care system, within existing appropriations. This legislation changed years of complicated rules and regulations governing eligibility to health care. The complexity of this paradigm created confusion among providers, as well as patients. Frequently, rules were bent, stretched, or ignored to meet the health care needs of patients. There were no defined health benefits packages, no reliable data projecting future patient population, and no major effort to capture third-party reimbursements or co-payments for the treatment of nonservice-connected medical conditions. Access to the system was severely limited to only three groups of veterans: service-connected disabled veterans, other disabled veterans, and economically indigent veterans. VA's patient population in 1996 was about 10 percent of the total veterans' population.

Once VA opened enrollment, it attracted new patients for several reasons:

- Quality of health care provided,
- Patient safety record,
- Accessibility,
- Pharmaceutical program,
- Specialized Services, especially long-term Care,
- Affordability, and

- VA's affiliation with medical schools.

Following the eligibility reform of 1996, many Medicare-eligible veterans enrolled in the VA health care system, not only for access to quality medical care, but also to benefit from VA's low co-payment prescription program. Initially, VA's co-payment for nonservice-connected medications was $2 per 30-day supply. Even when Congress allowed VA to increase this co-payment from $2 to $7, veterans continued to enroll. Now VA has an enrolled patient population of nearly 7 million veterans, over half of them are also Centers of Medicare and Medicaid Services (CMS) beneficiaries as well.

In January 2003, the VA Secretary suspended enrollment of Priority Group 8 veterans – regardless of their service-connected disabilities, their third-party insurance coverage, or their ability to pay for care. Those with service-connected disabilities are authorized to seek treatment of their service-connected medical condition, but are not authorized to enroll for treatment of their nonservice-connected medical conditions.

From the very beginning of my term as National Commander, I was aware of lengthy waiting lists for primary care; however, I did not grasp the magnitude of the problem until I began to visit VA medical centers. Initially, I thought these waiting lists were just regional problems, but soon realized it was system wide. I discovered the deplorable conditions resulting from VA's inability to meet its own established acceptable access standards. VA's access standard for a primary care appointment is 30 days – extremely modest compared to nearly every other health care delivery system, public or private. Personally, I would find that standard unacceptable for my private health care system. In actuality, some veterans have waited longer than the standards – even as long as two years or more. Clearly, a patient could die while waiting for care – and, sadly, some have. Unfortunately, only a few isolated exceptions are meeting VA's own acceptable access standards for primary care.

As staggering statistics of thousands of veterans waiting 6 months or longer for their initial VA appointments became public knowledge, I was reminded of a statement made by former National Commander F.W. Galbraith during an American Legion meeting in 1920: "*The trouble is that the men in these hospitals are 'cases.' They are represented by so many pieces of paper in some bureau in Washington. We want to humanize the whole thing, and say, 'Here is Jim Smith's case, my friend. What do you propose to do about him?' That is the thing that we want to do, and we can do it. It is our primary motive for living.*"

To evaluate the severity of this situation, The American Legion developed a program to put a "human face" on the growing problem – thus the "I Am Not a Number" campaign began. Veterans across America were asked to share their personal experiences in the VA health care system. These are my comrades, not just statistics. Thousands of veterans responded to The American Legion's survey between November 2002 and February 2003. Stories of frustration stretch from coast-to-coast.

The survey form was established and distributed to help develop a global picture through self-reporting. The survey sought veterans' self-assessment of their health care delivery system. Some reports were favorable, while others were extremely critical. On the whole, those veterans

actually receiving care were pleased with the quality of that care and the professionalism of their VA health care providers. Predictably, those waiting 6-to-18 months were far more critical of the lengthy delays and perceived indifference toward their situation. Complaints of multiple rescheduled appointments were common. The results of this survey reveal problems throughout the VA health care system. The bottom line: *too many veterans are being denied timely access to quality health care*. The "waiting game" is being played at nearly every VA medical facility across the country. And, America's veterans are suffering.

The American Legion prepared a short video, which I have provided to your staff, in which veterans tell their own personal stories. I hope you and your colleagues will review this video. It highlights the obstacles encountered by the men and women – veterans of the armed forces – attempting to access the VA health care system. These individuals aren't the only ones with stories to tell. There are tens of thousands of veterans just like them, nationwide.

Mr. Chairman and Members of the Committee, if you or a member of your family were ill and in need of health care, would you find it acceptable to wait 6 months to a year for a primary care appointment? How would you feel if you were eligible to enroll as a result of your honorable military service, but were prohibited from enrolling because you earned more than $29,000 a year or lived in the wrong geographic area.

Demand vs. Funding

Recently the President's Task Force to Improve Health Care Delivery to Our Nation's Veterans (PTF) issued its final report. Among the many areas discussed in that report, one issue stands out – the current mismatch between demand for timely access to care and federal funding throughout the VA health care system. Not only does this crisis prohibit meaningful collaboration between VA and the Department of Defense (DoD), but it also causes uncertainty about VA's ability to fulfill its four primary missions.

The PTF recommended full funding of VA to care for all enrolled Priority Group 1-7 veterans. However, the best recommendation the PTF could reach to address Priority Group 8 veterans was for the President and Congress to study and resolve the mismatch problem. This was the only recommendation on which the PTF Commissioners failed to reach consensus. This is truly unfortunate since Priority Group 8 comprises the majority of veterans; therefore, future access to VA health care remains uncertain for them – at least for now.

Three PTF Commissioners offered a dissenting opinion regarding the funding of Priority Group 8 veterans, which is supported by The American Legion. The recommendations outlined in this dissenting opinion place a financial obligation on each enrolled Priority Group 8 veteran. Mr. Chairman, I would encourage you and your colleagues to consider these recommendations.

Medical Care Collection Fund (MCCF)

Although adamantly opposed by The American Legion, all third-party reimbursements and co-payments collected by VA's MCCF are scored as an offset against VA's annual discretionary appropriations. Since this money is for the treatment of nonservice-connected medical

conditions, The American Legion continues to advocate scoring MCCF as a supplement to VA's annual medical care appropriations.

During my visits, I discovered that MCCF is handled differently from medical facility to medical facility. Some MCCF activities are contracted to private collection firms, while others are done internally. This year, VA's MCCF collections were the highest ever, yet its actual collection rate is extremely low compared to the industry standard. Since VA is prohibited from collecting from CMS for the treatment of nonservice-connected medical conditions of CMS beneficiaries, VA bills CMS in order to collect from private medical supplemental policies.

With a patient population comprised of more than 3.5 million CMS beneficiaries, VA medical facilities cannot realize their full potential in MCCF collections. Nearly every VA medical facility I have visited is expected to increase MCCF collections in FY 2003. Yet, the president's budget request for FY 2004 seeks to drive away as many as 1.2 million Priority Group 7 and 8 veterans by authorizing increased co-payments and an annual enrollment fee.

Both Indian Health Services (IHS) and DoD's TRICARE effectively used third-party reimbursements, co-payments, and premiums to supplement their discretionary appropriations and resolve the demand versus funding crisis. IHS turned to third-party reimbursements from CMS and the private sector to help improve quality of care and timely access problems. DoD developed TRICARE to solve the problems and meet the cost generated by CHAMPUS in delivering timely access to quality health care for military retirees and eligible dependents. Enrollment in TRICARE, requires co-payments and premiums based on the degree of health care coverage desired. TRICARE for Life requires Medicare-eligible beneficiaries to purchase Part B coverage and DoD serves as the supplemental insurer. All three approaches appear to be meeting the health care needs of affected patient populations.

One of the interesting observations is the effective use of "certified" coders by IHS in its third-party reimbursement efforts. Although not authorized to hire "certified" coders by the Office of Personnel Management (OPM), IHS sent selected coders to attend training to become "certified." Fortunately, these "certified" coders choose to continue with IHS even though they are underpaid based on their enhanced abilities and skills. The difference in the collection rate between coders and "certified" coders is significant and cost-efficient. Certified coders within VA would help to increase third party reimbursement rates.

Specialized Services

Most notable among the health care services provided by VA are its specialized services, especially spinal cord injury, geriatrics, prosthetics, blind rehabilitation, and long-term care. As the veterans' population ages, greater demand for these services are anticipated, particularly, long-term care. The Millennium Health Care and Benefits Act of 1999 mandated VA to provide long-term care for all veterans rated 70 percent or more service-connected. Currently, VA is not meeting the mandated inpatient bed levels also prescribed by this legislation. I did not visit a single VA long-term care program without a waiting list.

I am greatly concerned that mental health and long-term care inpatient beds are not included in the current CARES "market plans" developed by each VA medical facility. Ignoring these

services does not diminish demand by veterans with Alzheimer's or dementia. Mr. Chairman and Members of the Committee, these veterans answered the nation's call to national service – it is time for the nation to answer their calls for assistance.

Staffing Shortages

The VA health care system is blessed with many dedicated employees – both health care providers as well as the support staff. The former Secretary Jesse Brown may have officially coined the phrase *Putting Veterans First*, but most VA employees institutionalized the concept decades earlier. Unfortunately, VA has failed tremendously in the recruitment of health care professionals and other support positions. Nearly every VA medical facility expressed staffing shortages stemming from one of three sources – normal staffing shortages, inadequate salaries, and the Federalization of Guard and Reserve personnel in support of the War on Terrorism and Operation Iraqi Freedom.

Additionally, medical research must be funded at levels adequate to continue VA's long tradition of ground breaking medical advances. The research opportunities available through VA continue to be a strong incentive to attract health care professionals.

A serious review of performance standards, compensation, and actual work performed by "part-time" physicians is desperately needed. During my visits, I learned of a serious problem with some "part-time" physicians receiving compensation, but performing no services. This is absolutely unacceptable and does not reflect favorably on the medical facility director or those responsible for monitoring employees' attendance and performance of duties. At a time of lengthy waiting periods for primary care and specialized care appointments, the unauthorized absence of "part-time" health care providers is inexcusable. It would seem timesheets and work schedules should document work performance before paychecks are released. There must be a better tracking system to monitor and evaluate the job performance of "part-time" physicians.

Organizational Structure

While visiting VA medical facilities, I noticed a change in management styles and philosophies from one VISN to the next. It seemed as though there were 21 distinct VA systems instead of one. The effort to decentralize the management and leadership of VA appears to have created inconsistencies in focus and conflicting policies and directives. Unilateral actions by individual VISN directors do not improve the system as a whole and seem to lack coordination of efforts. Clearly, subjective budgetary decisions have taken their toll on some VA medical systems to efficiently meet the needs of the local patient population. The most obvious example is the loss of inpatient beds for specialized services such as mental health and long-term care. Some MCCF collection practices are clearly more successful than others. Management efficiencies also cover the spectrum, but do not reflect a unified VA system. Performance standards seem to vary from VISN to VISN.

Medical School Affiliations

Currently, there are 126 accredited medical schools in the United States. VA Medical Centers (VAMC) have formal affiliations with 107 of these medical schools and some 1,200 other

educational institutions. The value of medical school affiliations to the national health care system has been well demonstrated. VA provides critical clinical settings for physician trainees. The high level of care provided by VA medical facilities is the result, in part, of numerous external accrediting agencies and the supervision of residents who consider the educational role as a critical component of their VA duties.

Medical research is yet another large component of medical school affiliations. Staff physicians affiliated with medical schools customarily hold academic positions, including tenured positions, provide direct patient care, teach students, advise residents, and conduct research – all of which contribute to excellence in a teaching hospital environment.

Capital Assets Realignment for Enhanced Services (CARES)

CARES remains a major topic of concern in every VA community I visited. The fear of the unknown spawned the question, "Do you think they will close this facility?" This uncertainty causes anxiety among health care providers, medical researchers, patients, and support staff. The individual marketing plans are being carefully crafted to meet the anticipated health care needs of the local veterans' community, but are being altered by external guidelines from the VA Central Office in Washington, D.C. Recently, the VA Central Office returned local marketing plans of some 20 medical facilities for additional review. This seems inconsistent with the intent of having locally generated marketing plans developed to meet the health care needs of their patient population.

As National Commander, I created The Veterans Affairs Facility Advisory Committee on CARES (VAFACC) to The American Legion's Veterans Affairs and Rehabilitation Commission. The committee's charge was to review the VISN Market Plans, Planning Initiatives, and VA Facility Assessment Reports relating to the CARES process, keeping in mind VISNs were tasked to cut 10 percent of their vacant space by 2004 and 30 percent by 2005.

The VAFACC developed an independent assessment of the facility recommendations resulting from the CARES process. The committee was composed of experts in the fields of construction, engineering, veterans' benefits, medical school affiliations, health care policy, health care delivery, and health care administration.

Committee members reviewed each Market Plan and Planning Initiative submitted to the National CARES Planning Office (NCPO) for each of the 20 VISNs going through Phase II of CARES.

After a thorough review of the proposed Market Plans, the VAFACC raised the following concerns:

- **Funding** - Clearly, billions of dollars in discretionary appropriations will be needed to accomplish the new construction and renovations approved in the final CARES plan. CARES is an ongoing process and incremental changes are anticipated. With the proposed consolidations and transferring of services, it is imperative that no veteran experience any delays in timely access to the delivery of quality health care, and patient safety must not

diminish. No VA medical facilities should be closed, sold, transferred or downsized until the proposed movement of services is complete and veterans are being treated in the new locations. Funding levels should be adequate to ensure services are available during periods of transition.

- **Veterans' Population –** There is some concern that the projected veterans' population is underestimated. Certainly with regard to long-term care, mental health, domiciliary, and other specialized care populations, the CARES process has yet to incorporate projections.

- **Long-Term Care –** VA spent close to $3.3 billion on long-term care in fiscal year (FY) 2002. With the enactment of the Millennium Health Care Act, demand will most likely increase due to the aging of the veteran population over the next decade. VA estimates that the number of veterans most in need of long-term care, those veterans 85 and older, will more than double to about 1.3 million in 2012. Yet, even with these numbers, veterans' long-term care needs and projected growing demand was omitted from the CARES process.

- **Mental Health -** Due to several factors concerning the initial projections, NCPO and several other experts are reviewing the mental-health inpatient and outpatient projections. Because of the questionable demand decline in several markets, networks were instructed to plan for increases in mental-health services only. VA must include accurate mental health projections in order to ensure effective recommendations from the CARES process.

- **Domiciliary –** The inappropriate distribution of domiciliary beds based on demand projections gave rise to several policy and programmatic concerns and questions. Because the original projections were based upon a national average utilization rate, the model redistributed beds from existing domiciliaries to areas where there are none. For those reasons, further study is needed and projections must be revised before the next planning cycle.

- **Unutilized Space –** Among the criteria the VISNs were tasked to evaluate was unutilized space. The VISN performance measure was a reduction of 10 percent by 2004 and 30 percent by 2005. According to VA's Office of Facilities Management (OFM), VA facility assets include 5,300 buildings; 150 million square feet of owned and leased space; 23,000 acres of land – the total replacement value of all elements is estimated at $38.3 billion. OFM assessed and graded 3,150 buildings for a total of 135 million square feet with correction costs estimated at $4.5 billion. These assessments were used at the local level as a tool to help manage medical centers and VISN's vacant or underutilized space.

  More development is needed by the VISNs to effectively utilize unused space in lieu of selling or demolishing these buildings. Once the buildings are gone, there will be no way of getting them back. Before any unutilized space is sold, transferred, destroyed, or otherwise disposed of, the CARES process must consider alternative uses of that space to include: services for homeless veterans, long-term care, and the expansion of existing services to alleviate the extreme backlog of patients waiting to receive care at many VA medical facilities. Such considerations were lacking in most of the VISN Market Plans.

- **Contracting Care -** Throughout the VA health care system, contracting out of care is very prevalent, especially the Community Based Outpatient Clinics (CBOCs). While contracting out of care is necessary in some circumstances, the wholesale use of this health care delivery tool should be exercised with caution. In certain areas, it will be difficult at best based on availability of approved medical staffing and the contract fee schedules.

  Contracting out of care was extensive in the VISN proposals. Some VISNs made the blanket statement that care would be contracted out to meet excess demand in 2012 and 2022. That is not much of a plan. What if the resources are not available? Additionally, VA's history with contracting is not enviable. VISN 10 proposed contracting with local providers/hospitals for inpatient beds to bring their access standards from the current 32 percent to 83 percent in 2012. That is an enormous gap to cover through contracted care. VISN 6 proposed 19 new CBOCs. VA-wide, there are more than 130 new CBOCs planned to enhance access to care.

- **Enhanced Use Lease Agreements –** With Enhanced Use Lease Agreements (EU) VA can maximize return from property that is not being fully utilized. EU leases also allow VA to reduce or eliminate facility development and maintenance costs. Through the use of EU leases, VA can receive cash or "in-kind" consideration (such as facilities, services goods, or equipment).

  Several of the VISNs proposed enhanced use lease agreements with the public and private sectors. Uses include homeless shelters or housing, cultural arts centers, cemeteries, inpatient beds, mental health services and many other veterans' service enhancing ideas.

  VA should continue to seek opportunities in the area of enhanced use leasing. It can certainly have a positive impact on service delivery to veterans and the local community.

  There have been 27 projects awarded so far. The VA Secretary has 23 on the priority list with over 50 more currently in development. Clearly, VA is continuing to urge the VISNs to consider using this valuable tool even more. However, the committee recognizes that the approval process involved in obtaining an enhanced use lease is lengthy and complex.

- **VA/DoD Sharing -** There are many opportunities for sharing between VA and the Department of Defense (DoD). The VISN Market Plans contain many proposals addressing the possibility of service sharing to increase access to health care for veterans. Both VA and DoD benefit from these agreements and every effort should be made by the VISNs to pursue this avenue in order to save money through cost avoidance, in particular pharmaceuticals, supplies and maintenance services.

  Extra effort on the part of these agencies to cooperate is essential to the success of sharing agreements. Some parts of the country are reluctant to "share" services or programs between agencies. It is imperative that we overcome that obstacle and look to the future of providing quality health care and reasonable access to this nation's veterans.

The American Legion will remain an active partner with VA during this critical process of realigning the agency's capital assets to better serve America's veterans. Recent developments in the CARES process serve to reinforce some of my concerns. The Under Secretary for Health has sent back the Market Plans to 15 VISNs/20 facilities with instructions to further develop other options and look at further consolidating inpatient services in many of the facilities. Additionally, the CARES Commission hearings have been postponed until August 2003, another 60 days. Delays such as these give rise to many questions and concerns on the part of the stakeholders.

Recommendations

Capital Asset Realignment For Enhanced Services (CARES) – The American Legion recommends an open and transparent process that continually and fully informs VSOs of CARES initiatives, criteria, proposals and time frames. Any CARES recommendations should be considered in the context of a fully utilized VA health care delivery system that takes into consideration the tenets of the GI Bill of Health, VA/DoD sharing, the Veterans Millennium Health Care and Benefit Act and the mission of the Department of Homeland Security. VA must also provide a list of capital assets to the Department of Homeland Security for consideration in strategic planning at the local, state, and national level.

Medicare Reimbursement – The American Legion recommends Medicare Reimbursement for VA on a fee-for-service basis for the treatment of nonservice-connected medical conditions of enrolled, Medicare-eligible veterans. Additionally, veterans should be authorized to participate in the Medicare + Choice option by choosing VA as their primary health care provider.

Medical School Affiliations – The American Legion supports the mutually beneficial affiliations between VA and the medical schools of this nation. The American Legion also recommends appropriate representation of VA Medical School affiliates as stakeholders on any national task force, commission, or committee established to deliberate on veterans' health care.

Mandatory Funding for VA Medical Care **–** The American Legion recommends that Congress designate VA medical care as mandatory spending and provide discretionary funding required to fully operate other programs within VHA's budgetary restrictions. Additionally, Congress should provide supplemental appropriations for budgetary shortfalls in VHA's mandatory and discretionary appropriations to meet the health care needs of America's veterans.

Expanded Third-Party Reimbursement **--** The American Legion recommends the following to improve accessibility to VA health care and expand third party reimbursement:

- All enrolled veterans would be required to identify their public/private health insurers.

- VA would be authorized as a Medicare provider and be permitted to bill, collect and retain all or some defined portion of third-party reimbursements from CMS for the treatment of non-service-connected medical conditions.

- VA should be authorized to offer a premium-based health insurance policy to any enrolled veteran having no public/private health insurance.

- All enrolled veterans would be required to make co-payments for the treatment of non-service connected medical conditions and prescriptions.

- All enrolled veterans with no public/private health insurance would agree to make co-payments for treatment of non-service connected medical conditions.

Summary

The history of the veterans' health care system is a lengthy story of evolution. Although its mission is simply stated in President Lincoln's Second Inaugural Address – *to care for him who shall have borne the battle, his widow and his orphan* – financial obligation toward meeting that mission continues to lag. VA has never faced a shortage of patients, but has always endured financial pressures. From the beginning, VA was open to any veteran in need, until the 1980s when Congress enacted legislation that divided veterans into three groups – service-connected veterans, economically indigent veterans, and all other veterans. For the first time, honorable military service wasn't enough to qualify a veteran for access to a VA medical facility.

From the founding of this great country to the present, America has recognized its obligation to the men and women of the armed forces – past, present, and future. As a grateful nation, providing timely access to quality health care, transitional assistance from military service to civilian life, timely adjudication of disability claims, and a final resting place continue to be a moral, ethical, and legal obligation.

Recently, new terms like "core veterans" and "traditional users" have been used to serve as justification for America's failure to meet the health care needs of its veterans. Yet, neither term appears in title 38, United States Code. Such terms appear only in the minds of bureaucrats. Veterans' status has always had a direct correlation to honorable military service. A veteran is a veteran. So why has Congress and VA chosen to place veterans in separate priority groups? How could service-connected veterans in Priority Group 8 be denied enrollment in the VA health care system, when nonservice-connected veterans in Priority Group 7 can enroll? Neither Social Security nor Medicare places beneficiaries in priority groups, so why are veterans treated differently?

Neither Social Security nor Medicare has limitations placed on beneficiaries like Priority Group 8 veterans based solely on means testing or the HUD geographic index. Why the inequity?

Granted financial contributions are normally made to both Social Security and Medicare throughout a beneficiary's working life, but few Americans (less than 10 percent) make a personal commitment toward national security as do veterans. If Social Security and Medicare beneficiaries are "guaranteed" funding or "guaranteed" timely access to medical care, why are veterans treated differently?

It seems entitlement to Social Security benefits and Medicare coverage is unquestioned by Congress. Yet, a veteran's entitlement to timely access to health care – even for those willing to pay – is always being questioned, budget year after budget year.

There seems to be a misconception among certain groups that designating VA Medical Care as a mandatory funding item within the Federal Budget would provide free health care for all veterans. This is not true. Mandatory Funding for VA Medical Care will provide a more accurate mechanism for funding VA Medical Care at a level that will ensure VA has the ability to serve all eligible veterans and to meet it's self-imposed access standards – 30 days for a primary care appointment, 30 days for a specialty care appointment and an average wait time of 20 minutes to be seen by a VA physician.

Years of under-funding have created the current crisis in VA health care. Budgetary constraints have led to staffing shortages, elimination of services and unmet demand for care. Rationing health care by denying access to Priority Group 8 veterans is not the answer. Charging an annual enrollment fee for certain Priority Groups is not the answer. Raising co-payments for outpatient services is not the answer. Raising co-payments for prescriptions is not the answer. Designating VA Medical Care as a mandatory funding item within the Federal Budget is a solid step toward improving accessibility of health care for all veterans and The American Legion fully supports this.

Mr. Chairman, veterans have served, are serving, and will continue to serve this nation in an uncharacteristic manner – putting duty, honor, and country before self. Many national leaders have issued the challenge for Americans to serve this nation as a member of the armed forces, both on active-duty and in the Reserve components. Fortunately, every day men and women freely accept that challenge.

If America can find the money to bail out failed savings and loans institutions, commit troops to peacekeeping missions, rebuild foreign governments, provide health care for third world countries, and forgive loans to foreign countries, then, surely, America can find the money to provide the needed care for America's veterans. This is what veterans want, and I believe it is what America believes is right. Those same soldiers, sailors, airmen, and Marines securing the safety of foreign citizens may one day turn to VA for their health care needs. I am committed to ensuring that those brave men and women have a VA that can provide the care they need.

Not far from here are the acres of white headstones at Arlington National Cemetery that serve as a constant reminder that the cost of freedom is a recurring debt paid every day by men and women in uniform. Each headstone represents a debt that can never be repaid. We honor those men and women by caring for their comrades. This is something that no one disputes, yet is it also something that we as a nation can do better – we will do better – we must do better.

Mr. Chairman and Members of the Committee, that concludes my testimony. I ask that an electronic version of the final report be included in the record.