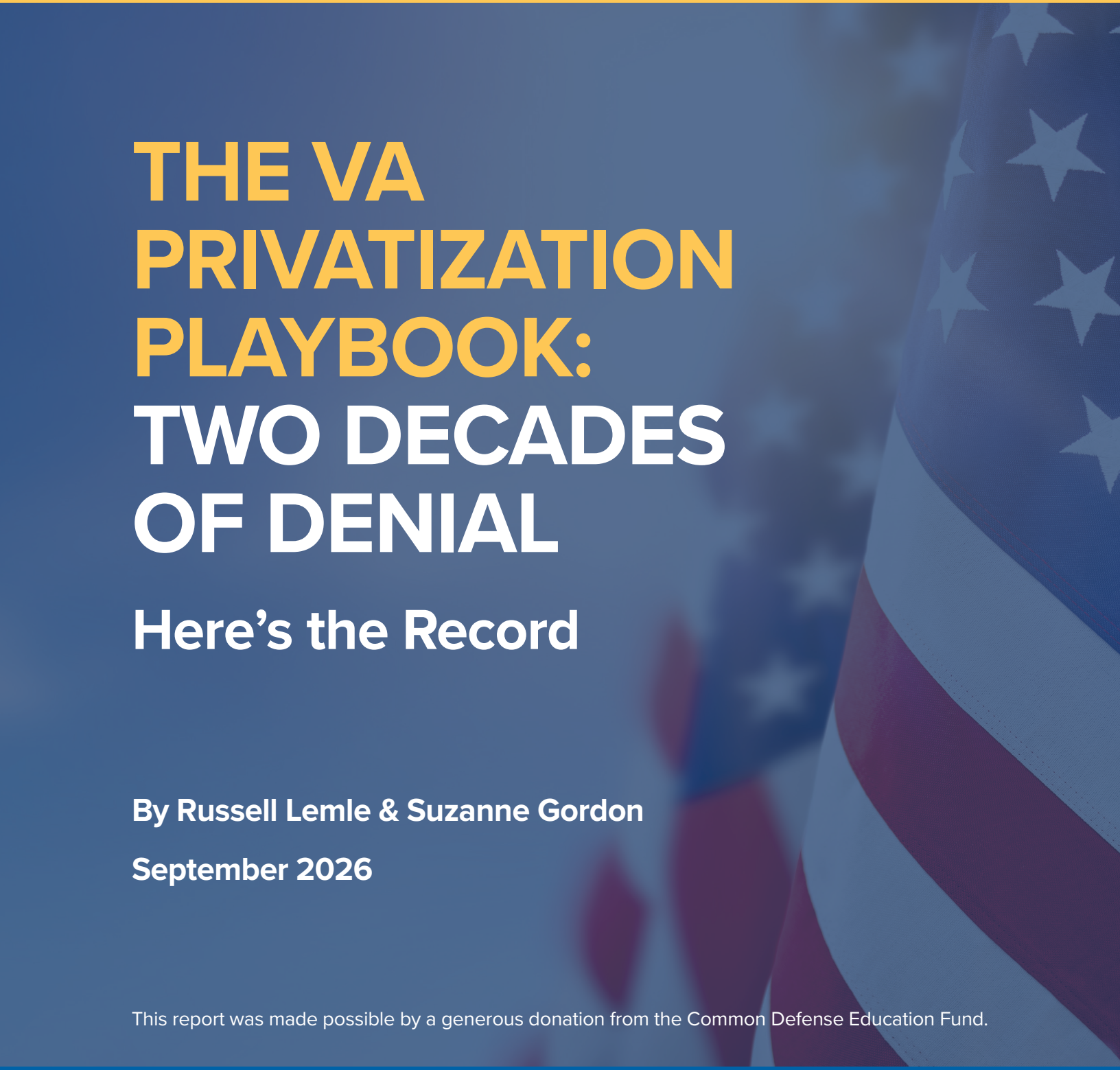
VETERANS HEALTHCARE POLICY INSTITUTE



THE VA PRIVATIZATION PLAYBOOK: TWO DECADES OF DENIAL

Here's the Record

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September 2026

This report was made possible by a generous donation from the Common Defense Education Fund.

Introduction

For nearly two decades, a powerful privatization movement has targeted the nation's largest and only publicly funded, fully integrated, national healthcare system. Its goal is to redirect more veteran healthcare—and the taxpayer dollars that pay for it—out of the Veterans Health Administration (VHA), the Department of Veterans Affairs' (VA) direct care system, and into the hands of private-sector providers through the government-financed Veterans Community Care Program (VCCP), known as "community care."

This shift in funding and patients into the private sector threatens the VA's ability to serve veterans and the nation through its four congressionally mandated missions. The first is delivering high-quality clinical care to veterans. The second is training the next generation of the country's health professionals, including physicians, nurses, psychologists, and members of dozens of other disciplines. The third is serving as a research powerhouse, which has produced pathbreaking innovations like the first practical implantable cardiac pacemaker. The fourth is backing up the Defense Department and civilian health systems in national emergencies. All four rest on the same foundation: a fully staffed, fully funded clinical enterprise. Limit staffing and funding, and all four contract together.

As survey after survey has confirmed, veterans strongly reject VA privatization. In 2015, Lake Research Partners and Chesapeake Beach Consulting conducted a bipartisan survey of a sample of veterans in which Republicans outnumbered Democrats. It found that 64 percent of veterans opposed privatizing VA, and four in five opposed replacing VA care with private-sector vouchers. A Veterans of Foreign Wars (VFW) poll of 10,000 members in 2017 found that 92 percent want the VA improved, not dismantled. As that poll summarized: "Very few respondents believe veterans should be given a universal healthcare card or believe the VA healthcare system should be dismantled by creating a subsidy-based private health insurance for veterans, shutdown completely and outsourced to the private sector."

Veterans' historical opposition has thus presented a dilemma for privatization advocates and helps explain why so many have denied that privatization is their goal. VA Secretary Doug Collins has implemented one measure after another straight from the privatization playbook while insisting the idea has never crossed his mind. Pressed by Senator Tammy Duckworth at a 2026 Senate Committee on Veterans' Affairs (SVAC) hearing about why he was "increasing your budget for privatization while you're cutting VA direct care," he snapped, "When you say we're privatizing, you're wrong, it's just flat out wrong."

To determine whether "privatization" is in fact occurring, it helps to define what the term covers.

What Is VA Privatization?

In a 2016 *Washington Post* Fact Checker column, reporter Michelle Ye Hee Lee chastised Senator Jon Tester of Montana and Representative Mark Takano of California for suggesting that the Koch-financed Concerned Veterans for America (CVA) supported VA privatization. According to Lee, CVA could not possibly be championing VA privatization because it was not proposing the wholesale transfer of VA's services to the private sector.

Lee's view reflects that of many Americans, who associate privatization with the kind of abrupt change that occurs, for example, when a city council contracts out garbage collection. On a given date, the Department of Public Works stops picking up the trash and a private contractor, with its own trucks and workforce, takes over.

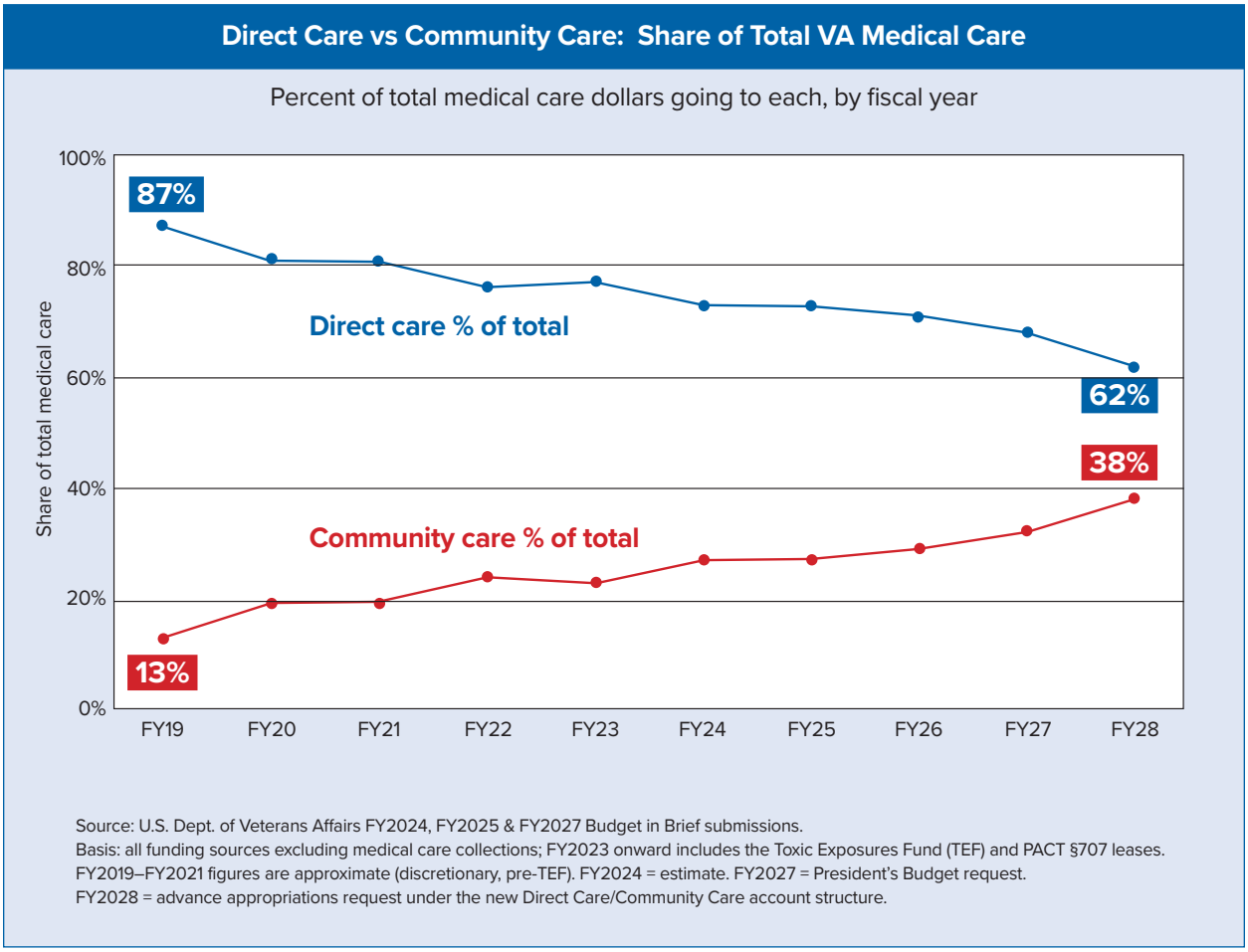
In "The Meaning of Privatization," a 1988 essay that remains a classic in the literature, sociologist Paul Starr placed wholesale transfer of this kind at one end of a broad spectrum. At that extreme end, as in the trash collection case, privatization means handing over an entire government service to a private contractor. More common, and for the VA more insidious, is what Starr calls privatization by attrition (what others call privatization by a thousand cuts). This is the incremental shifting of functions from the public to the private sector, stopping short of dismantling the agency outright. Privatization by attrition starves public services of funds and personnel, while eroding public confidence in the government's ability to meet basic needs.

Privatization proponents mobilize a standard set of arguments to defend their proposals. The central one, drawn from libertarian, small-government, and conservative ideologies, rests on efficiency and quality: the private sector can provide better services at lower cost than the government can. A second holds that privatization offers more choice of products and services, which is always unequivocally good.

Advocates of privatization never use the P word when describing their aims for VA healthcare. They instead claim their proposals give more choices to veterans—especially those living in rural and remote areas. They argue that more private-sector options produce quicker, more convenient, higher-quality care than the VA provides. As VA Secretary Collins said at his confirmation hearing, the objective is to make it "easier for veterans to get their healthcare when and where it's most convenient for them."

In presenting the history of VA privatization, we want to be clear that we support the judicious use of private-sector care to supplement what the VA delivers. VA has purchased such care on a case-by-case basis since World War I. For more than a century, when a clinician familiar with a veteran and their condition attested that VA could not furnish what was needed, either because it was unavailable within the system or no VA facility was nearby, VA paid for non-VA care. In fiscal 2014, the year the Choice Act passed, the Congressional Budget Office calculated that care purchased in the community accounted for about 12 percent of VHA's medical care budget. Since 2014, that share has climbed every year. VA's own fiscal 2028 request, using a slightly different formula, projects community care would constitute 38 percent of the total medical care request.

The following chart presents the share of total VA medical care funding from fiscal 2019 to 2028.



The trend is unmistakable. Healthcare dollars and patients are relentlessly moving from the public system to the private one. Earlier this month, the VA awarded ten-year "CCN Next Gen" contracts worth a combined $1 trillion to four private administrators, clearly anticipating dramatic increases in community care spending into the future.

What are the consequences of such an escalation in spending? Staff and resources are cut, so services contract. Appointments are delayed. Infrastructure is left to decay. Employees and their unions are under attack. In-house care then becomes both financially and politically unsustainable. As fewer veterans use the VA for care, per-patient costs rise, which supplies a further argument: VA care is no longer cost effective. Taxpayers can hardly be expected to fund two robust healthcare systems for veterans at once. The result of this dynamic—what Starr calls privatization by attrition—is closure of VA services, then programs, and finally entire facilities.

Building the Movement 2008–2014

Some proponents of VA privatization candidly admit that its gradual erosion is key to their strategy. "This isn't a one-year fight," CVA's executive director Dan Caldwell said in 2018. "This isn't a two-year fight. This is a fight that is going to extend beyond the [current] administration."

That fight began in earnest during the 2008 presidential campaign, when candidate John McCain proposed providing veterans a card they could take to private doctors. That August, at a town hall in Lima, Ohio, a father told the senator that his son, a veteran, had waited months for a VA appointment. McCain responded, "I want to give every one of these veterans a plastic card. And you take that plastic card, and you go to the doctor or the health care provider of your choice, and you get the treatment you need."

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>
> —Sen. John McCain, 2008

He repeated the idea later that month to veterans who attended the Veterans of Foreign Wars (VFW), the American Legion, and Disabled American Veterans (DAV) conventions. The campaign platform proposed a Veterans' Care Access Card under the heading "Our Veterans Must Be Given Alternative Means Of Access To Health Care And Freedom Of Choice." It delineated the qualifying criteria: drive time, appointment wait time, and urgency of need, and denied that the access card would "replace or privatize existing programs."

The VFW's national legislative director said the card would undermine the system. DAV warned it would raise costs and force rationing. House Committee on Veterans' Affairs Chairman Bob Filner (D-CA) said the plan was "foolhardy and would be the death of the VA health care system."

The conservative Heritage Foundation enthusiastically endorsed it: "His (McCain's) plan would also encourage expanding coverage options for Medicaid enrollees and veterans… Opening access to private health insurance and integrating consumer-directed models would give these vulnerable populations more control of their personal health care decisions." It was, in their words, McCain's "vision for health care reform underscored by a **principled commitment to personal freedom.**"

In 2010, Charles and David Koch—by then the wealthiest and most prominent libertarians in the country—helped defeat a defender of VA healthcare, backing oil industry executive Bill Flores against Chet Edwards, a pro-VA Democrat from Texas. As a member of the Veterans Affairs Appropriations subcommittee and in other House posts, Edwards had secured new educational benefits for the children of service members, created a public–private military family housing program, and helped raise veterans' healthcare funding by 70 percent. He received the Award of Merit, the highest award given by the Military Coalition, which represents thirty-six military and veteran groups, and had the support of the National Rifle Association and the Texas Farm Bureau.

In his campaign, Edwards accused Flores of favoring privatization of both Social Security and the VA. Deflecting these criticisms, Flores argued that he merely wanted to let veterans see private doctors at government expense if they did not want to travel to a VA hospital. A television blitz featuring Senator John McCain declared that Flores' "ideas to improve veterans' health care are exactly the same as mine." Flores trounced Edwards by twenty-five points.

In 2011, with $2 million in seed money from the Kochs and their donor network, the Vets for Economic Freedom Trust was founded to promote conservative positions on the VA and DoD. The Kochs also worked through the Cato Institute, which they funded and which argued that veterans' healthcare should be left to private institutions.

In 2012, the Kochs relaunched Vets for Economic Freedom Trust as Concerned Veterans for America. CVA recruited a small cadre of veterans, including Pete Hegseth as chief executive officer (now Secretary of Defense), and Darin Selnick, later a White House and VA adviser in Trump's first administration.

CVA also built close ties to Florida Congressman Jeff Miller, Republican chair of the House Committee on Veterans' Affairs. Miller was a fierce advocate of redirecting veteran care to private providers, and invited CVA testimony. Florida's new Republican senator, Marco Rubio—another Koch favorite whom CVA called a "VA reform champion"—promoted CVA-inspired legislation to strip VA employees of workplace rights.

The Kochs' investment in CVA paid off decisively when CVA seized on a problem of VA's own making. In 2011, VA's Under Secretary for Health Robert Petzel directed that every appointment be scheduled within fourteen days of a patient's desired date, later adding a seven-day benchmark for primary care. VISN and medical center directors were scored against these new wait-time measures and their bonus eligibility turned on meeting them.

The targets were unattainable without new staff. Fourteen days would have strained any health system, public or private, and the VA was trying to meet it with tens of thousands of vacancies from retirements, transfers, and promotions, but lacked the funds to fill them. Earlier VA workforce projections had warned that roughly 44 percent of VHA employees would become eligible for retirement by the end of 2012, underscoring a longstanding recruitment and retention challenge.

Bernie Sanders, then chairing SVAC, tried to close the staffing gap. He held hearings to document the problems and lay the groundwork for remedial legislation. In early 2014, he lined up top VA officials, the American Legion, and other VSOs behind the Comprehensive Veterans Health and Benefits and Military Retirement Pay Restoration Act, which would have provided roughly $21 billion over ten years for VA hiring, infrastructure, and expanded benefits. The bill would also have created education and peer support programs for family members and caregivers of veterans with mental health disorders, expanded dental coverage, provided more VA services for survivors of military sexual assault, and expanded the family caregiver program to all veterans with a serious service-connected disability—including pre-9/11 veterans. Miller scuttled the bill in the Republican-controlled House, and McCain rallied the Republican Senate minority to block it.

Phoenix: A Real Failure Followed by a False Narrative and the Choice Act, 2014–2016

Eight weeks after Sanders' bill was blocked, the fourteen-day appointment-wait-time target produced what unfunded mandates almost always produce. On April 23, 2014, CNN reported a whistleblower's claim that forty veterans enrolled at the Phoenix VA Health Care System had died waiting for appointments, and that staff had placed thousands of patients on concealed waitlists.

A VA systemwide audit and the Office of Inspector General (OIG) both confirmed that schedulers at Phoenix and elsewhere had kept records making wait times appear shorter than they were, and that some administrators drew performance bonuses based on those records. The failure was real and demanded accountability.

Media outlets across the country piled on, reporting not only the rigged schedules but the claim that the delays had killed forty veterans. That second allegation—deaths, not falsified records—is what tarred the whole system, and it did so long after the evidence for it collapsed.

A count of people who died while waiting is not a finding that they died because they waited. Nearly everyone who dies of an illness dies with an appointment on the calendar. That is not what killed them.

To answer the question of cause, OIG physicians and nurses examined the health records of 3,409 Phoenix patients for delays tied to scheduling and access. Testifying before the Senate Committee on Veterans' Affairs, the Inspector General summed up what they found: twenty-eight cases where delay had negatively affected the quality of care, including six patients who died, but no instance where he could say delay had caused the death.

Jeff Miller and CVA never made that crucial distinction. *The Washington Post's* Fact Checker did, on September 2, 2014, in a story headlined "Overblown Claims of Deaths and Waiting Times at the VA." The Post concluded that widely reported allegations had attributed deaths to wait times without sufficient evidence. By then it no longer mattered. Five weeks earlier, Congress had passed the Choice Act, which pushed VA patients and funds into the private sector.

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The scandal also cost Eric Shinseki his job; he resigned May 30. CVA had been calling for the Secretary's resignation well before it helped break the Phoenix story. When the American Legion demanded the same, CVA's Hegseth immediately praised the Legion's stand as courageous and its moral authority as unimpeachable.

Richard Burr, the ranking Republican on SVAC, published an open letter commending the Legion and attacked other veteran service organizations for not joining the Legion's call. Pressuring them to condemn the agency, Burr argued that the leadership of these other VSOs was "more interested in defending the status quo within VA." Stephen Trynosky, *a* VA official who wrote an incisive monograph about the end of comity in veterans' politics, observed that Burr's assault represented something VSOs had not previously confronted: the demand that they "modify their policy preferences to avoid losing access and influence" with Republicans on Veterans' Affairs Committees.

CVA mounted a coordinated campaign including rallies in cities around the country, opinion pieces in regional papers, attack ads, and lobbying Congress. Cato capitalized on the controversy to advocate that "veterans with service-connected illnesses should have the option of going outside the department for care… the VA should merely pay the bills, much like Medicare."

Coverage of the "Phoenix scandal," led by *The New York Times* and CNN, established a template of the VHA as a broken system. The mainstream media used it for the next decade, and legislators invoked it to justify every privatization bill that followed.

The Choice Act

On May 9, McCain addressed a town hall in Arizona, calling for investigation and—like his 2008 campaign—granting veterans the option to pick providers outside the VA. Three weeks later he joined a trio of Republican senators—with a fourth, Senator Jerry Moran, signing on the same day—in introducing the Veterans Choice Act of 2014, which would let veterans who could not get a timely VA appointment, or who lived too far from a facility, seek care from any Medicare or TRICARE provider. It supplied the framework for the compromise Sanders and McCain reached—the Veterans Access, Choice, and Accountability Act (also referred to as the Choice Act), signed by President Obama that August. Under the act, veterans could get private care at VA expense if they faced waits longer than thirty days or lived more than forty miles from the nearest VA facility. These new outsourcing rules were meant to run for three years and then terminate.

Democrats felt they had little choice but to go along with the rushed bill, Trynosky wrote, because they "collectively stood the most to lose politically from a failure to respond quickly to the VHA scheduling scandal. Republicans quickly deployed partisan arguments to tie the issue to other failures within the Federal government. The scandal was further injected into the races of vulnerable Democratic Senate incumbents to associate them with the Obama administration."

CVA's statement at a Koch donor summit in June 2014 took credit for "driving the wait-time crisis from the very beginning." CVA later would add: "The Phoenix VA scandal was a pivotal event in veterans care…and led the way for landmark legislation that would dramatically change how veterans receive their care."

"Choice" would prove an ingeniously misleading word. It suggests a veteran can simply pick a private provider. Advocates describing the Choice Program, and its successor the Veterans Community Care Program, have never corrected this false impression. In reality, a veteran has that option only if VA first determines that he meets specific eligibility criteria.

The word implies something further: that the VA should have no role in deciding eligibility at all. Remove that function and the foundation upon which the whole system rests crumbles.

Of the $16.3 billion Congress allocated in the legislation, $10 billion went to purchase care in the community through the new Choice Program. Just $5 billion was earmarked for hiring VA clinical staff—far less than what Sanders had proposed six months earlier and nowhere near enough to close staffing gaps.

Two private companies, TriWest Healthcare Alliance and Health Net, were hired to manage the outside network: recruiting and paying private providers, scheduling appointments, and sharing medical records. TriWest secured its share despite settling a False Claims Act suit for $10 million in 2011 for overbilling the government and losing its Defense Department healthcare contract—the company's only one.

VA leaders minimized this offense and awarded nearly half of its then-called "Patient-Centered Community Care" contract to TriWest. In November 2014, VA added Choice to that contract. TriWest was headquartered in McCain's home state of Arizona, and its president, David McIntyre, had previously worked on McCain's Senate staff.

For Sanders, the three-year time limit had been the concession that made Choice palatable—proof it was an emergency measure, not an enduring shift. For McCain, it was a foot in the door, and after the bill's passage, he began drafting legislation to not only make the program permanent but expand it.

Critics saw a privatizing dynamic being unleashed. The American Federation of Government Employees, the American Psychological Association, the National Association of Social Workers, the Association of VA Psychologist Leaders, the Association of VA Social Workers, and the Nurses Organization of Veterans Affairs all warned that funding an expanding Choice Program would eventually jeopardize VA facilities. Congress, they believed, would not underwrite two open-ended budgets forever. Whenever it capped them, the money would be taken from medical centers and community clinics—cutting providers and programs and shrinking the system.

Simultaneously, the Veterans Healthcare Policy Institute (VHPI) was formed with the mission to inform veterans organizations, advocacy groups, federal officials, researchers, and the public about how the privatization of VA services would adversely impact veterans' care quality, government budgets, as well as democracy itself.

The Commission on Care

The Choice Act also created the Commission on Care, charged with recommending the agency's future direction. Its fifteen members included medical industry executives, like Toby Cosgrove, CEO of the Cleveland Clinic, who stood to gain financially if privatization became VA's future. House Committee Chairman Jeff Miller named CVA's Darin Selnick as a commissioner. Stewart Hickey, the National Executive Director of AMVETS, a CVA ally, had another seat. Michael Blecker, a Vietnam veteran who directed the San Francisco non-profit Swords to Plowshares, and Phillip Longman, author of the book *Best Care Anywhere: Why VA Healthcare Would Work Better for Everyone*, were the only members of the commission who supported the public provision of healthcare for veterans.

Selnick joined the commission with a blueprint already in hand. In February 2015, a CVA taskforce he directed published a report, *Fixing Veterans Health Care, whose* centerpiece, the Veterans Independence Act, would have converted VA into an insurance program and spun its hospitals into a separate nonprofit government corporation. A BRAC-style commission would name the VA medical centers to be closed. The plan did not merely move government-delivered care to the private sector. It also proposed shrinking whatever remained. A veteran enrolling after a set date would qualify for VA-paid care only if he had a service-connected disability—and new criteria would narrow who received those designations in the first place. Further, it would turn back the clock by thirty years, to a time when outpatient care for conditions unrelated to military service was available only to a narrow subset of veterans—a policy that compromised a veteran's health by leaving some illnesses untreated.

The Veterans Independence Act was never introduced. Its agenda nonetheless drove Republican veterans' legislation for the next decade. Rather than one comprehensive bill, the components were disaggregated and moved separately, each eventually attached to other popular programs.

The commission relied on independent assessments the Choice Act mandated, several authored by RAND. The assessments confirmed that VA lacked clinicians and needed infrastructure investment. Even with the VA under-resourced, they found that its inpatient care matched or exceeded care at non-VA hospitals, and that its outpatient care outperformed the private sector on almost every quality measure. To sustain that performance, RAND recommended hiring more staff and paying clinicians competitively—a solution complicated by the statutory ceiling that capped what VA could pay. A majority of commissioners ignored those findings.

The commission's final report considered the cost of several models for expanding access to community care. The one they chose for their recommendation would shift up to 60 percent of eligible care out of VA facilities. That would be expensive enough. But it also priced other alternatives—among them Alternative 3, which would let veterans select community care without a VA referral, an arrangement many privatizers have continued to advocate. Stripping out VA's referral and care-management controls, the commission estimated, would add roughly $124 billion a year by year five and $152 billion by year ten, on top of what VA spends for medical care.

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Those calculations were based on veteran demographics, healthcare utilization surveys, and research on how cost-sharing shapes consumption. Four factors drove the astronomical price tag:

- First, veterans who are not currently enrolled in the VA who use existing insurance to receive private care would have every incentive to switch to VA-paid coverage. The VA's minimal cost-sharing would cut their out-of-pocket expenses below what any commercial plan charges.
- Second, veterans currently receiving VA care who don't qualify for community care under existing rules would opt for this new pathway to private-sector care without referral or authorization—including access to the more than 6,500 intensive outpatient and residential rehabilitation programs nationally, where a 45-day stay can run as high as six figures.
- Third, the commission warned that, without proper cost controls, expenses would skyrocket—a prediction that has proven remarkably accurate. (As we elaborate below, multiple studies have since documented that the VCCP employs unnecessarily expensive tests, procedures, and appointments, with excessive costs billed directly to the government. The VA Office of Inspector General has consistently found weak operational oversight.)
- Fourth, there would be substantial one-time costs to build a new referral and billing infrastructure and train community providers to use it.

Michael Blecker wrote a dissent to the majority report, warning that incremental privatization would undermine the VA and eventually cause it to break apart. Darin Selnick and Stewart Hickey also dissented—for the opposite reason, faulting the report for outsourcing too little.

DAV supported the idea that community providers could supplement VA care but was emphatic that "veterans should first be provided access to VA providers, with community providers reserved for veterans facing access challenges. Taking away VA's ability to manage workflow within these integrated networks would lead to rising costs, less coordination and lower quality of care, ultimately causing VA health care services and facilities to close, which would be devastating."

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What the Choice Data Had Already Shown

In making their recommendations, the commissioners set aside the evidence already accumulating about the Choice Program's failures.

- The program did not deliver on its central promise. In its first year, only approximately half of veterans who opted for community care got an appointment.
- A September 2018 Inspector General audit found that Health Net and TriWest had collected $101.4 million in overpayments in a single year—$66.1 million from duplicate billing and $35.3 million from other payment errors. An earlier audit, covering the program's first two years, had already identified duplicate payments and payment-rate errors in Choice claims.

- A September 2016 GAO review found the contractors deficient in verifying Choice physicians' credentials—Health Net failed to document some physicians' authority to prescribe controlled substances, and TriWest could not show it had verified most of the physicians in the sample. VHA had no strategy for overseeing either contractor's compliance.

The contractors' fees, paid on top of those that went to providers, represented a substantial share of the program. VA paid Health Net and TriWest $295 every time it handed them a referral, whether or not the veteran was seen—up from the $45 to $123 the same companies had charged for largely the same work before Choice.

A 2018 ProPublica and PolitiFact analysis, using VA Inspector General figures and referral counts published by the Congressional Research Service, estimated that the two companies collected roughly $1.6 billion in administration fees against just under $6 billion in medical payments to providers. That's an administrative loss ratio of 24 percent, well above the 15 to 20 percent ceiling the Affordable Care Act imposes on commercial insurers.

The Choice Act also added another powerful constituency—the healthcare industry (hospitals, physicians, insurers, pharmaceutical and medical equipment companies)—to the movement for VA outsourcing. Eyeing the tens of billions allocated annually for veterans' healthcare (and far more since), the industry joined the privatization movement.

During the second quarter of 2014, the American Hospital Association (AHA) spent at least $60,000 in direct lobbying expenses in favor of the Choice Act. Seventy-nine organizations registered to lobby on the bill in all, among them United Health and the Hospital Corporation of America (HCA).

TriWest and UnitedHealth had already been courting the VSOs. For example, in 2012, Iraq and Afghanistan Veterans of America (IAVA) reported receiving over $500,000 from the TriWest Healthcare Alliance and between $100,000 and $249,000 from United Healthcare Military & Veterans Services.

None of this prompted a reassessment. Few lawmakers questioned the third-party administrators' role in coordinating veterans' healthcare, or the steady outsourcing itself. The opposite happened: working with Senators Jon Tester and Johnny Isakson, McCain secured the program's permanent extension and expansion in the VA MISSION Act of 2018.

The MISSION Act: Permanent Infrastructure for Privatization, 2016–2018

In April 2016, McCain and Senator Thom Tillis introduced the Care Veterans Deserve Act. It would have made the Choice Program permanent, extended eligibility to every veteran enrolled in VA care, and required VA to contract with a network of private clinics for veterans to receive healthcare with no VA pre-authorization or copayment.

The American Legion, the VFW, Disabled American Veterans and Paralyzed Veterans of America opposed it. Testifying at the SVAC hearing in May, they warned that expanding eligibility to all enrolled veterans would fray an integrated system that serves veterans better than the alternative. Three days later McCain accused them of opposing community care altogether. Their joint response: "What we are against is unrealistic proposals that promise unlimited choice, which in itself is unsustainable, and in reality, could force millions of veterans to lose the option to use VA health care, which could ultimately shift the financial cost of care onto every veteran. Grandiose proposals such as Senator McCain's plan to give every veteran a Choice Card to purchase unlimited health care in the private sector without any management could cost hundreds of billions of dollars, according to estimates by the Office of Management and Budget. This while Congress balks at spending just a few hundred million to fund critically needed VA hospitals and clinics."

The bill died in committee, as did its House companion.

When candidate Donald Trump first released a VA plan in October 2015, CVA dismissed it. Hegseth, then its chief executive, called the proposal "painfully thin" and "unserious." Nine months later—introduced on stage by Jeff Miller—Trump released a ten-point plan that, as ProPublica later reported, "resembled the CVA's priorities. In fact, six of the proposals drew directly on CVA ideas. Three of them aimed to make it easier to fire employees; a fourth advocated the creation of a reform commission; and two involved privatizing VA medical care." Immediately after the election, Mark Takano, the House Committee on Veterans' Affairs Ranking Member, declared, "Our first priority is holding Donald Trump accountable to his campaign promise that he will not privatize the Department of Veterans Affairs."

President Trump appointed Darin Selnick as senior adviser to VA Secretary David Shulkin. Though reporting to Shulkin, he soon began developing his own policy proposals and dealing directly with lawmakers. Pushed out in mid-2017 after clashing with Shulkin over privatization, he relocated to the White House Domestic Policy Council—where, in ProPublica's assessment, he became the administration's most effective proponent for privatization.

A bipartisan bill to make the Choice Program permanent began taking shape in 2017. McCain and Senator Jerry Moran were able to significantly modify it. Moran represented Kansas, home state of

Koch Industries. According to *Newsweek*, over the course of his career, the Kochs were his second largest contributor.

Moran and McCain introduced a competing bill. As they stated in their rationale, "In the wake of the scandal in care at VA hospitals in Phoenix and around the country, we vowed to guarantee our veterans timely access to quality treatment." It required that access standards cover every service in VA's medical benefits package, and, more consequentially, they said the VA Secretary should develop access standards. Leaving the development of access standards to the Secretary was the key move—and the exact opposite of what CVA had demanded when Obama was president. As the Choice Act was being negotiated, Hegseth wrote to Congress: "The final conference bill must reflect clear standards—no more than 21 days or 60 miles—to define what constitutes excessive wait times, or excessive travel, for VA care. The VA must not be permitted to set their own standard for what constitutes 'excessive' waits or travel."

CVA, AMVETS and the American Legion, now favoring privatization bills, were among its listed supporters.

VA officials warned lawmakers that those criteria might raise costs by $60 billion to $80 billion a year and force VA to cannibalize its own facilities to pay for private care. Shulkin himself cautioned: "If you get the access standards wrong, it can have disastrous effects. Whether intentionally or not, you could end up diluting the ability to maintain a strong VA. If access standards are too broad, the impact on the budget could end up being so significant that it would essentially become a system that's spending out of control." Other VA officials assured Democrats that Shulkin would designate outsourcing for only a few narrow categories.

"If you get the access standards wrong, it can have disastrous effects. Whether intentionally or not, you could end up diluting the ability to maintain a strong VA."

—VA Secretary David Shulkin

The McCain-Moran eligibility language was inserted into the VA MISSION Act, introduced in 2018, and promoted as President Trump's signature veteran-friendly legislation. As a VA spokesman told ProPublica, Selnick "helped write the MISSION Act," adding that "no one is more qualified to advise on the law's implementation." CVA testified that MISSION "incorporated many of the recommendations of the 2015 Fixing Veterans' Health Care Task Force convened by CVA, namely by creating the Veterans Community Care Program (VCCP)."

By March 2018, David Shulkin was out of the picture, fired because, as he said in a *New York Times* op-ed titled "Privatizing the V.A. Will Hurt Veterans," "They saw me as an obstacle to privatization who had to be removed." The White House spokesman rebutted, "There are no discussions about privatizing (the VA). We look forward to continuing our work with Congress to reform and strengthen the VA Choice program to provide our veterans with more choice in their health care." In Shulkin's place, Trump appointed Robert Wilkie as VA Secretary. Wilkie would quickly write the regulations that fast-tracked outsourcing.

Three elements of the MISSION Act shaped everything that followed:

1. It created the **Veterans Community Care Program (VCCP),** a permanent private-sector network assembled and administered by contracted third-party administrators—initially TriWest Healthcare Alliance and Optum, a UnitedHealth Group subsidiary—eventually encompassing more than 1.7 million private providers.

2. It directed the VA Secretary to **establish access standards covering every service in VA's medical benefits package.** The law did not specify how those standards should be determined but rather gave the Secretary broad latitude to define them. If the VA could not meet whatever the Secretary later designated as the trigger, the veteran became eligible for community care.

3. It established an **Asset and Infrastructure Review (AIR) Commission,** empowered to recommend closing, downsizing, or repurposing VA medical facilities based on market assessments comparing private-sector and VA capacity in each region.

All the major veterans service organizations backed MISSION—including those that had, as discussed above, repeatedly warned against its central mechanisms. A core justification for their support was the fact that the bill contained a sweetener that was a high priority to them. The VA Caregiver Program—a monthly stipend, health coverage, travel reimbursement, respite care, and training stipends to caregivers of severely disabled veterans—only covered the post-9/11 veteran population. By opening the Caregiver Program to veterans of every era, the MISSION Act would correct what they called an "injustice."

Another inducement was the "best medical interest" criterion: a veteran and a referring clinician could agree together that community care was the right option. That official criterion would later be co-opted by privatizers as a vehicle to extend eligibility to everyone.

The VSOs also assumed Congress would fund the new community care program indefinitely without ever shrinking the VA system itself. One would have thought they'd know better. Four years earlier, forty-one senators had blocked Sanders' bill—$21 billion for hiring and infrastructure, backed by every veterans organization. The message was not subtle. Republicans had shown they were perfectly willing to say "no" to funding the VA workforce.

Only five senators, including Sanders, voted against MISSION; in the House, seventy members, all Democrats, opposed it. House Democratic leader Nancy Pelosi warned that the law was positioned to "dismantle" VA care rather than supplement it.

Selnick returned to the VA as a senior adviser to Secretary Robert Wilkie and held a seat on the executive steering committee running MISSION implementation. The access standards he helped write set the thresholds low. Any veteran facing a twenty-day wait or a thirty-minute drive for VA primary care or mental health became eligible for community care; for specialty appointments, the triggers

were twenty-eight days and sixty minutes. Telehealth was not counted as access. These standards were so generous that overnight one-third of VA patients qualified automatically, regardless of whether a VA facility was closer or could see them sooner.

In January 2019, Jon Tester led twenty-eight senators who signed a letter to Wilkie opposing the Department's stated intention to make veterans nearly-automatically eligible for referral to community care for all clinical services, rather than the agreement they'd reached with the Secretary to designate up to five types, like laboratory tests, X-rays, or urgent care. Further, the significant increase in overall cost of community care would likely come at the expense of VA's direct system of care. Regarding the bait and switch, they stated, "That is something we cannot support. Designating all clinical services as nearly automatic for community care would be putting the VA down a path towards privatization."

CVA was pleased with the proposed implementation regulations. Its executive director, **Dan Caldwell, told ProPublica, "This does get us closer to full choice. That's the model we want to get to."**

The First Attempt to Blow Open the Gates: The Mental Health Carve-Out, 2017

Even as permanent community care eligibility legislation was being drafted, hedge fund billionaire Steven Cohen launched a campaign aimed specifically at privatizing mental health care.

Cohen was the founder and owner of SAC Capital, which pleaded guilty to insider trading in 2013 and paid $1.8 billion, the largest such penalty in U.S. history. In 2016, Cohen founded the Cohen Veterans Network (CVN), a chain of outpatient mental health clinics for post-9/11 veterans and their families. CVN's clinics were sited close to VA facilities, within roughly fifteen miles. Under the distance rules of the Choice Act, that was too close to qualify for private referrals.

To solve that problem, Cohen hired Jeff Miller, by then out of Congress, as a lobbyist to help draft legislation eliminating VA's prior-authorization requirement for external mental health care. Veterans could walk into CVN clinics and have VA billed automatically, with no VA referral. Representative Mike Gallagher agreed to introduce the bill in 2017.

The bill collapsed under unified opposition from the major veterans service organizations. They recognized—correctly, as later events would show—that eliminating the authorization requirement for any single condition would set a precedent that private interests would exploit. As one former VA official told ProPublica at the time, "The problem is there's only so much government money in veterans' care. If you start trying to carve into that to feed things like the Cohen Veterans Network, that's actually privatization. It's going to be death by a thousand cuts."

Cohen would try again seven years later, under different cover. A 2024 bill from HVAC Chairman Mike Bost stripped VA of any authorization role over new mental health care grants, creating a third system parallel to both VA direct care and the community care program—a total network beyond VA's reach. It also resurfaced in the Take Care of America's Veterans Act, discussed below.

The Costs Compound 2019–2022

With Wilkie's access standards locked in, VCCP costs and volume began climbing in a pattern that would repeat, in ever-larger numbers, to the present day.

By 2022, VA Secretary Denis McDonough told Congress that community care's share of the clinical budget had jumped from 26 to 33 percent in a single year and predicted it could soon consume half of the VHA's clinical care budget. McDonough said relentless outsourcing would create "a 'spiral effect' in some areas where workload and talent are shifting externally and thus threaten to harm VA." McDonough told Congress "my hunch is that we should change access standards."

McDonough's own report to Congress that year contained a similarly striking admission: unchecked outsourcing threatened VA's training, research, and emergency preparedness missions, and could leave rural facilities unable to sustain enough workload to operate at their current capacity. But he never implemented his own prescribed remedy—changing the access standards that were driving the outsourcing.

Congress did no better. When community care costs first spiked, it backfilled facility budgets in full. As the pattern continued, congressional rescue stopped—and facilities began diverting money meant for in-house care into their community care budget.

VA's Quality Exceeds the Community's

The VA MISSION Act mentions the word "quality" fifty times. The law requires VCCP mental health providers to be trained to standards comparable to the VA's, particularly in areas where the VA has "special expertise." The VA developed eight core mental health-related trainings. However, only one of them—reviewing its opioid safety initiative (a twenty-to-thirty-minute task)—was required of VCCP providers.

Legislators also backed away from holding community providers to any standards, on the assumption that a training requirement would result in providers leaving the network or never joining. That fear may well have been justified. It left a crucial question unasked: what kind of community care would veterans receive?

Testifying in 2019, RAND's Carrie Farmer and Terri Tanielian identified what should always be a central concern when it comes to patient care—providing access to high-quality care and to clinicians who have expertise in treating specific conditions. The VA, the RAND staffers explained, was built for veterans with service-connected and catastrophic conditions, in settings designed by providers who understand military culture. Whether veterans sent into the private sector under MISSION would find anything comparable was unclear.

Farmer was even more forthright in 2022 in her written testimony to an SVAC hearing on access to community care. "An appointment available tomorrow that delivers poor care," Farmer told senators, "could be worse than waiting for good care"—particularly given prior RAND findings that VA care is typically equal to or better than care in the private sector.

"An appointment available tomorrow that delivers poor care could be worse than waiting for good care."

—Carrie Farmer, 2022

The results of making training voluntary were predictable. A GAO report found that between 2021 and 2023, only about 2 percent of VCCP mental health clinicians had completed even one of the eight training modules. Over 8,000 veterans flagged as active suicide risks during that period were referred to providers with no recorded training in suicide prevention at all. Anxiety and stress-related disorders accounted for nearly half of the diagnoses in these referrals, and almost none of the community providers treating them had documented PTSD or military sexual trauma (MST) training.

VCCP clinicians are far less likely than VA providers to use evidence-based psychotherapies for PTSD, depression, and related conditions. VA providers must conduct annual screenings for suicide risk, PTSD, substance use, military sexual trauma, and depression. Community mental health providers face no such requirement, and 57 percent of them don't routinely screen for the problems that appear disproportionately in veteran populations.

As noted above, the third-party administrators have little financial incentive to fix any of this—to verify that the providers in their networks meet established standards of care in treating veterans. And VA leaders have shown a pattern of turning a blind eye to the deficiencies the Inspector General has found: community providers who fail to check state databases before prescribing controlled substances, skip required trainings, never forward initial and final medical documentation, and do not report suicide attempts and deaths back to VA. Each time, VA has been explicit about its priority—a large network, whatever the consequence of keeping flawed providers in it.

Also ignored was a growing body of peer-reviewed research that documents the costs and effects of the quality trade-off Farmer described.

The most compelling evidence comes from a natural experiment involving veterans eligible for both VA and Medicare services. A veteran who calls 911 for an ambulance can land at either a VA or a private emergency department. Analyzing the data on these ED visits, Stanford's David Chan and colleagues found that VA care reduced 28-day mortality by 46 percent. The survival gains persisted at one year. A companion analysis of a larger cohort—583,248 veterans across 140 VA and 2,622 private hospitals in 46 states—found risk-adjusted 30-day mortality 20 percent lower at VA facilities.

Subsequent studies of other conditions corroborated the mortality findings (see VHPI's exhaustive compilation of peer-reviewed research contrasting VA to VCCP care). **Veterans undergoing coronary procedures, receiving chronic dialysis, or hospitalized for stroke, acute myocardial infarction, heart failure and COVID-19 in the community showed equal or higher mortality than those treated at the VA.**

The AIR Commission, 2022

Darin Selnick had inserted a provision into the MISSION Act creating an Asset and Infrastructure Review (AIR) Commission to recommend which VA facilities should be closed, consolidated, repurposed or improved. In March 2022, VA Secretary Denis McDonough released recommendations to the AIR Commission, built on market analyses largely inherited from Trump-era consultants. McDonough acknowledged that the data upon which his recommendations were made was "outdated."

The administration proposed closures anyway, shutting sixteen (of its 171) medical centers and 139 (of its roughly 1,100) outpatient clinics. The package also proposed thirteen new medical centers, one new health care center and 109 new outpatient clinics. However, no funding accompanied the new construction, and none could be guaranteed since it would depend on the actions of future administrations and future Congresses.

VA said that veterans displaced by closures would be cared for in the private sector. GAO's review faulted the department for never testing that assumption—for failing to assess whether enough community providers existed (particularly in rural areas) to see those veterans in a timely way. Working from federal health-professional shortage data, VHPI engaged in a detailed analysis of these questions, and found that, in most instances, private capacity to absorb those patients was close to nonexistent—a finding it would extend into a comprehensive fifty-state analysis in 2025.

The plan also proposed embedding VA clinical staff inside private hospitals—effectively turning VA employees into a staffing agency for the private sector. Las Vegas VA nurses had fought off the same arrangement in 2020, when local leadership floated the idea of lending VA staff to help three neighboring hospitals, two of them owned by the for-profit HCA chain, to manage VCCP patients.

The recommendations triggered immediate bipartisan backlash from unions, veterans, and a dozen senators, who refused to hold confirmation hearings for President Biden's AIR Commission nominees—killing the process before any closures could be finalized. But the damage to morale and recruitment proved lasting at targeted facilities, where "Now Hiring" signs sat beside newspaper coverage of their possible closure.

The Renewed Fight Over "Freedom," "Preference" and Self-Referral, 2022–2023

By 2022, privatization advocates had opened a new front: eliminating VA pre-authorization and utilization review.

Senator Marsha Blackburn's Veterans Health Care Freedom Act would give veterans access to portions of the VCCP without VA referral or oversight. **Funds for community care would use "appropriations otherwise made available to the Veterans Health Administration"—**money extracted directly out of local VA budgets. CVA's one-pager describes it as a three-year pilot that "**removes the set of criteria in the VA MISSION Act for community care eligibility and grants full choice**." That would ensure the vicious cycle critics had forewarned: as the private sector draws excessive dollars upstream, too little is left downstream for VA staff, programs, and facilities. In an irony perhaps lost on privatization advocates, this kind of "health care freedom" would cause millions of veterans to lose their own.

Its sponsors were crystal clear about the purpose. Senator Tuberville's release announcing the bill was headlined **"**Tuberville, Blackburn Introduce Legislation to Improve Veterans' Access to Free-Market Health Care,**"** and said it would eliminate the community care referral process altogether. Blackburn first introduced it in February 2022 and has reintroduced it twice since, the cosponsor list growing each time. It has not received a vote, but it became a template.

Likewise, the Moran-Sinema Veterans' HEALTH Act contained a "veteran preference" option that would have made private care available to every enrolled veteran regardless of clinical need, wait time, or distance.

A Senate Democratic bill from Jon Tester proposed self-referral for routine vaccinations as well as vision and hearing care. The list did not remain narrow for long. At the same hearing, witnesses including representatives of the VFW and America's Warrior Partnership argued that self-referral should extend to mental health, substance use, podiatry, prosthetics, laboratory work, and dermatology.

A ten-organization coalition—spanning nurses, psychologists, physicians, dentists, social workers, optometrists, physician assistants, and nurse anesthetists, along with the American Psychological Association and the Veterans Healthcare Policy Institute—cautioned Congress, in an official statement for the record, that these bills "would eliminate the VHA as we know it." In a 2023 article "What if the Veterans Health Administration Goes Away?," the DAV issued a warning: what would happen to millions of veterans—including those with war-related injuries civilian providers are ill-equipped to treat—if VHA care disappeared.

Cost Overruns and a Buried Warning, 2024

After passage of the Choice Act, community care became a runaway train. With the number of veterans being referred to the private sector accelerating dramatically, spending increased by 15 to 20 percent a year.

A second driver was the payment model itself. Fee-for-service rewards volume, and once VA makes a referral it has no control over the amount or type of services the veteran receives. A range of studies bears this out:

- VCCP providers were nearly twice as likely as VA clinicians to give men with low-risk prostate cancer expensive, aggressive, medically unnecessary surgery or radiation rather than evidence-based watchful waiting.
- VCCP providers used costlier imaging—MRI rather than CT or X-ray—at higher rates than VA providers did.
- VA hospital care following an ER visit cost 21 percent less than care in the private sector, primarily because private hospitals performed more high-cost procedures.
- Among US men with a diagnosis of prostate cancer, Medicare beneficiaries were significantly more likely to receive unnecessary "guideline-discordant" (and potentially harmful) prostate cancer imaging than men treated only at the VHA.
- Community care patients with diabetes receiving primary care had higher mean total costs than VA patients, primarily driven by increased inpatient and prescription drug expenses in community care.
- VA providers were nine times more likely to use cost-effective home tests for sleep apnea rather than expensive laboratory-based testing.

Inspector General audits found community providers billing in ways that suggest "upcoding," i.e., billing a higher-paying code than the service warranted. The December 2021 review examined payments for evaluation and management services—taking a history, examining a patient, making decisions about care—and found they had risen from $67.5 million in fiscal 2017 to $303.6 million in fiscal 2020, roughly 350 percent in three years. More than 37,900 non-VA providers had billed significantly more high-level codes than the average for their specialties. The same review found 45,600 providers were paid $37.8 million for evaluation and management billed separately from procedures whose global surgery payments already covered them. The VA had not reviewed the documentation as required.

Other audits found the same pattern elsewhere. Over a two-year period, VA improperly paid $136 million for acupuncture and chiropractic claims, half to three-quarters of which were not authorized, not allowed as coded, or lacked supporting documentation. A 2024 report questioned $200 million in prescription

costs for which community providers never submitted the required justifications; the third-party administrators had developed formulary training, and fewer than 2 percent of providers completed it.

At a 2023 Senate hearing, Senator Bill Cassidy asked VA officials whether providers found to chronically overtreat veterans should simply be dropped from the network. They equivocated. The Inspector General's own remedy for widespread overbilling was more billing education—as if tens of thousands of clinicians had made the same rookie error, correctable by an hour with a CPT manual. These are providers who have spent years, in many cases decades, in American healthcare and well understand what's to be gained by aggressive billing.

The Red Team

With costs and referrals to the VCCP both escalating, the VA convened a Red Team of outside healthcare experts led by Dr. Kenneth W. Kizer, the former VA Under Secretary for Health widely credited with designing the VA's modern integrated system in the 1990s. The panel was asked to evaluate whether the VCCP was delivering the high-quality, timely, conveniently located care it had promised.

Its report confirmed the vicious cycle others had predicted. Rising community care costs were straining the direct-care budget, diminishing direct-care capacity and pushing still more veterans into community care. Because this dynamic would eventually force the closure of VA facilities or elimination of services outright, the panel bluntly concluded that persistent outsourcing to, and spending for, community care represented an "existential threat" to VA healthcare, one that would ultimately eliminate choice for the millions of veterans who prefer VA direct care.

The Red Team made thirteen recommendations. VHPI estimated what implementing just two of them would save, using fiscal 2024 community care allocations: more than $18 billion a year. Transferring veterans to VA inpatient beds after community emergency care accounts for $10.9 billion of that—84 percent of community emergency spending goes to inpatient admissions at the receiving hospital. Providing geriatric and extended care in-house would save another $7.3 billion. McDonough implemented none of the recommendations. He had promised the panel that the report would be publicly released and widely publicized but then buried it instead. It was, however, leaked to Congress and the media.

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Republicans, alarmed at how thoroughly the Red Team report undercut their narrative about the success of community care, went on the counterattack. In June 2024, Senator Moran, then SVAC ranking member, led nineteen Republican colleagues in a letter to McDonough rejecting the report's premise. They suggested the panel's conclusion had been biased by selective data VA leaders had supplied. If the VA needed more resources, they wrote, it should find money by cutting non-patient-care spending and rooting out waste rather than restricting access to the community.

The Heritage Foundation's Budget Blueprint for FY 2023 and Project 2025 Roadmap, 2022–2024

During the 2024 presidential campaign, the most intense debate over veterans' healthcare centered on Project 2025, the Heritage Foundation's roadmap for a second Trump term. It contained chapters on reshaping agencies across the federal government. Its chapter on the Department of Veterans Affairs was written by Brooks Tucker, who had served as VA chief of staff during Trump's first term.

It called for reviving an asset and infrastructure review process of VA's national medical markets, faulting the Senate Committee on Veterans' Affairs for lacking the political will to confirm the AIR commissioners. It proposed limiting infrastructure spending on aging VA campuses, which would inevitably lead to their closure. And it recommended hiring more private companies to perform disability medical examinations.

Heritage's Budget Blueprint for Fiscal Year 2023 went further, proposing to end enrollment for Priority Groups 7 and 8, i.e., the seventeen percent of enrolled veterans who have no service-connected designation and whose incomes exceed VA's threshold. It also recommended barring disability compensation for conditions like tinnitus whenever a veteran filed an initial claim more than ten years after discharge.

President Trump and other Republican privatization advocates denied knowledge of Project 2025 and its agenda. Nonetheless, its veteran healthcare proposals resurfaced in 2025 and 2026 legislation and in actions the Trump administration took within weeks of the inauguration.

Collins, Mass Firings, and the ACCESS Act, 2025

In his second administration, President Donald Trump nominated Doug Collins to be VA Secretary. The former Georgia congressman had been an ally of CVA in the House, championing three bills the organization backed that laid the groundwork for outsourcing and for weakening VA employees' workplace protections. CVA welcomed his nomination, saying he would be uniquely positioned to follow the intent of Congress rather than act on the department's institutional interest.

Asked at his January 2025 confirmation hearing to commit to opposing Project 2025 proposals, including stripping benefits from veterans rated below 30 percent, Collins declined. "I've not been a part of Project 25," he told Senator Blumenthal, "haven't even read it."

"There will always be a VA for the veteran," Collins then testified. The question was what kind. Would it deliver clinical care in fully funded and staffed facilities, sustaining its three other missions along with it—or would it pay for care delivered by private providers, and abandon them?

In the House, HVAC ranking member Mark Takano was blunt: "Republicans are insistent that they don't want to 'privatize' VA, but they complain about the money that VA is spending on healthcare services. Where do my colleagues think the money to pay private healthcare providers is coming from? It is the same pot of money."

VA employees received the same Fork in the Road memo as the rest of the federal workforce. They were informed that "The way to greater American prosperity is encouraging people to move from lower productivity jobs in the public sector to higher productivity jobs in the private sector" and were encouraged to resign before their position might be eliminated.

Collins fired more than 2,400 VA probationary employees in February 2025—over 1,400 in a single day—in what the department labeled non-mission-critical positions. Hundreds of vendor contracts were cancelled. About 370 researchers faced possible termination, disrupting and canceling studies for stroke-prediction, advanced cancer trial enrollment and prevention of dementia and heart disease. Collins also announced plans to cut 83,000 positions from within the VA in the next year or two, then downscaled the figure to roughly 30,000 after public and congressional pushback.

Collins' Attack on VA Unions

A central element of the privatization playbook is an attack on public employees and the unions that represent them. At his confirmation hearing, Doug Collins promised he would launch no such attack, pledging to "be the biggest cheerleader for every VA employee out there who is getting up every morning, doing it right [and] making sure we are taking care of our veterans." Asked about Trump's plan to end remote work arrangements at the agency, he acknowledged that "a large portion of the

VA workforce is unionized and they're in contracts" so "we're going to work together to get people back to work."

Weeks later, he signed on to Trump's attempt to cancel collective bargaining rights for most VA union members—on the grounds that they perform "national security work." The March 2025 executive order invoked a provision of the 1978 Civil Service Reform Act (CSRA), that had long allowed the government to exclude intelligence and some federal law enforcement personnel from union representation. Under the administration's reading, two-thirds of the federal workforce, across eighteen agencies including the VA, would lose contract coverage on national-security grounds.

In April and August 2025, Secretary Collins announced the termination of collective bargaining agreements and the deduction of union dues from paychecks. VA unions affected include the American Federation of Government Employees (AFGE), the National Federation of Federal Employees (NFFE), National Nurses United (NNU), the Service Employees International Union (SEIU), and its affiliate, the National Association of Government Employees (NAGE).

Without a collective bargaining agreement, VA employees lose binding grievance procedures, the right to union representation in an investigatory interview, and disciplinary protections. AFGE sued and won a preliminary injunction in March 2026 reinstating its contract. VA leaders, however, continued their efforts to terminate it, and in early August, a second federal judge ordered the contract reinstated again. Other unions like National Nurses United and the National Federation of Federal Employees did not sue the government for contract reinstatement and have no contract or recourse.

Reintroduction of the ACCESS Act

At the start of 2025, Jerry Moran, now chairing SVAC, reintroduced the bill he had brought two years earlier as the Veterans' HEALTH Act, under a new name: the Veterans' ACCESS Act. The legislation contained a pilot for unrestricted mental health and substance use disorder treatment in five regions with no VA authorization or referral, and a built-in three-year trigger to extend the model to all medical care—transforming VA from a healthcare provider into an insurance payer.

HVAC Chairman Bost co-authored an opinion with CVA's executive director praising the pilot as "full choice." Echoing a piece Darin Selnick had published months earlier, it claimed the pilot would speed care to veterans in suicidal crisis. Neither mentioned that the 2020 COMPACT Act already guarantees exactly that—emergency care at any VA or non-VA facility, no copay, for any veteran in acute suicidal crisis, enrolled or not.

The private market knows it. Residential addiction programs like The Recovery Village publicize the COMPACT Act on their websites, emphasizing less the emergency department provision than the thirty days of inpatient or crisis residential care and ninety days of outpatient treatment that follow it.

The Congressional Budget Office (CBO) scored the mental health pilot at roughly $7 million a year—on the assumption that of the more than 1.7 million veterans who receive mental health care through VA, fewer than one half of one percent would use the new option each year. VHPI's analysis,

The True Cost of the Veterans ACCESS Act Mental Health Pilot Program, argued that this CBO scoring erroneously considered the pilot as a narrow, time-limited initiative.

To gain a truer picture of the cost, VHPI turned to the Commission on Care's modeling of the same structural change to remove VA's authorization requirement. As noted above, the commission projected roughly $152 billion a year by year ten. This was on top of existing VA healthcare spending, and without accounting for harder-to-quantify losses to VA's teaching and research missions, its emergency-preparedness capacity, or care quality. What was being sold as a modest pilot would trigger open-ended growth capable of eviscerating the VA system-wide.

Surveys confirmed that proposals that would undermine the VA healthcare system are not supported by America's veterans. A poll by the veterans advocacy group Common Defense found two-thirds of veterans strongly opposed the administration's downsizing plans.

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In December 2024 congressional testimony, the VFW had expressed its own concern about outsourcing: "Care in the community is necessary for some veterans but, if given the choice, our members routinely tell us they prefer VA direct care … [The Community Care Network] is a 'leaking ship,' and shoving more people onto that ship would be detrimental to those veterans seeking care. We need to plug the holes in this problematic program before unduly adding more veterans to it."

Common Defense held a press event featuring SVAC Ranking Member Blumenthal, HVAC Ranking Member Takano and others who warned that "VA Not for Sale." Congressman Chris Deluzio identified the problem: *"It's not complicated what Trump and DOGE are doing: they are trying to dismantle and weaken the VA so much that they have an excuse to sell it off to the highest bidder." On the anniversary of D-Day, a* "**Unite for Veterans**" rally was held on the National Mall that spoke directly to the assault on the VA.

"Community Care is VA Care"

Collins' policies told a different story. When he assured the Senate that "there will always be a VA for the veteran" he did not mean that VA's in-house direct-care services would always be there. He soon tipped his hand with a new mantra: "Community Care is VA Care."

The two systems are, however, not synonymous. VA tracks and publishes its wait times; the community care program does not. VA mental health providers must offer evidence-based PTSD psychotherapy and complete veteran-specific training; community providers face neither requirement. VA mandates annual screenings for suicide risk, PTSD, substance use, military sexual trauma, and depression; community care mandates none. VA provides wraparound services—housing, benefits, social work, peer support—that community providers are not equipped to deliver and are not paid to offer. A suicide death by an active VA patient triggers a mandatory root cause analysis, which identifies processes in the system that might have contributed to this outcome and suggests corrective actions. TPAs and their pool of providers have no such obligation.

Rejecting Oversight

Paul Starr's essay on privatization identifies a further consequence when government shifts from providing services to paying for them: accountability erodes. Scrutiny stays fixed on public failures and drifts away from identical failures in the private sector. Collins has followed that page in the privatization playbook closely.

Testifying before both Veterans' Affairs Committees in May 2025, he abandoned any pretense of meeting the statutory obligation that VA furnish Congress the data it requests. A leaked spreadsheet showed his own team had calculated the savings from cutting 4,000 nurses ($1 billion) and 400 psychologists ($110 million)—at odds with his public promise not to touch direct-care staff.

Collins justified the reductions by arguing that VA had ballooned with unnecessary administrators since the 1990s. He did not mention that VA enrollment had nearly tripled over that period, from 3.4 million to more than nine million. Nor that the MISSION Act had required VA to build an entire administrative apparatus to coordinate community care referrals and monitor the care delivered. Nor that the PACT Act had extended eligibility to a new population of toxic-exposed veterans. Congress had assigned VA all three burdens, then faulted the department for carrying them.

VA's own data confirmed the erosion Collins denied. Workforce dashboards showed healthcare positions disappearing across 2025, while job announcements, applications, and new-employee onboarding all fell sharply—a pattern that would deepen with the staffing purge announced that November.

The Second Mass Purge 2025–2026

In November 2025, VA regional offices received internal directives imposing hard caps on total employee positions and instructing local medical center directors to identify vacant positions for permanent elimination over the course of the next month. The target was 37,000 additional cuts on top of roughly 35,000 positions already gone that year.

In a virtual meeting, Gregory Goins, VA's interim chief operating officer, described it as part of a deliberate shift toward a private-sector model, one in which annual business-cycle planning rather than clinical staffing methodology would determine resource levels. Goins acknowledged that if VA followed standard healthcare staffing methodology, it would need to add roughly 20 percent to its workforce—the opposite of the direction VA leadership was taking.

At one West Coast VA facility, 60 percent of unfilled positions—including twenty-three in mental health—were slated for elimination. VA's Inspector General had reported months earlier that 94 percent of VA facilities faced severe physician shortages and 79 percent severe nursing shortages. Psychology was the most frequently reported severe non-medical clinical occupational shortage.

Indeed, the current administration is deliberately shrinking mental health staff, even as demand continues to rise. Since January 2025, the department has eliminated 392 psychologist positions, 677 social worker positions, and approximately 200 psychiatrist positions from its rolls. The VA claimed most of these were vacant, and therefore "unnecessary." In December of 2025, Collins argued "All we are doing is taking unfilled and unnecessary positions off the books. Most of these positions haven't been filled in a year or more." He never explained that most of these positions remained vacant because of his own hiring freeze, a precipitous drop in applicants as VA became seen as an unstable, undesirable workplace. Nor did he acknowledge VA's longstanding difficulty recruiting to rural areas and its inability to offer competitive salaries.

Since Jan. 2025, the department has eliminated 392 psychologist, 677 social worker, and approximately 200 psychiatrist positions from its rolls.

A Senate Committee on Veterans' Affairs Democratic staff report released in January 2026, *Cuts, Cover-Ups & Chaos*, laid out the losses plainly. VA shed 35,000 healthcare employees in fiscal 2025—the first annual net loss in the department's history. Among them were 1,000 physicians, 3,000 registered nurses, and 1,500 schedulers. The physician departures alone left an estimated 1.2 million veterans without a VA provider.

The VA's recent budget submission signals even further future cuts and concedes that this will leave VA unable to meet demand: "VHA is assuming that staffing levels will decrease, which is expected to reduce VHA capacity to provide for the growing demand for VA direct care services." VA leaders

are correct about growing demand. Since 2021, over 700,000 veterans have been newly designated with a service-connected mental health disability, bringing the total to 3.1 million. GAO used VA data in projecting outpatient mental health services demand will rise 32 percent between 2021 and 2031. Yet the VA is shrinking its mental health workforce meant to meet that rising demand—and referrals to VCCP have surged in parallel, doubling between fiscal 2021 and 2024.

The VA's recent budget submission signals even further future cuts and concedes that this will leave VA unable to meet demand: "VHA is assuming that staffing levels will decrease, which is expected to reduce VHA capacity to provide for the growing demand for VA direct care services."

The Budget Numbers Tell the Story, 2026

At a May 2026 Senate hearing on VA's advance budget request, the reality behind Collins' denials appeared in his own fiscal 2028 numbers, in which every net funding increase went to private-sector care. VA's direct care budget, adjusted for inflation, would fall.

Collins and his team proclaimed privatization was not happening, and cited as proof that in 2026, the VA would spend roughly two dollars on direct care for every dollar on community care. Conveniently ignored was the fact that (as the graph near the top of our report shows), in 2019, VA spent six dollars on direct care for every dollar on community care.

This shift of funds has produced a significant degradation of services:

- VA mental health providers report therapy sessions cut from fifty minutes to thirty, and that administrators are capping the total number of sessions regardless of clinical need—directly undermining the evidence-based treatment protocols VA itself has long mandated. A House Appropriations Committee report flagged VA facilities for imposing session limits inconsistent with VA's own Directive 1160.05.
- Staff at the Reno VA Medical Center told VHPI that there is such a shortage of primary care providers that their time with veterans with multiple complex health conditions has been cut from thirty to twenty minutes.
- Primary Care–Mental Health Integration teams and Behavioral Health Interdisciplinary Program units are losing staff even as demand climbs.
- A VA Inspector General report and VHPI research document a mass exodus of radiologists from the Washington DC VA Medical Center following Collins' return-to-office orders, and radiologist shortages throughout the system.
- One media report, based on VA data, noted that damage to VA's reputation as an employer has reduced the number of applications for jobs and increased the number of people who have declined job offers. This has been confirmed in Inspector General reports.

At a recent House Committee on Veterans' Affairs hearing about leasing and infrastructure, the DAV testified that closing the gap between VA's aging facilities and its needed capacity would require an investment of $85 billion over the next decade. Until this year, VA's own estimates concurred. Despite this fact, its latest budget submission cut the ten-year construction figure by two-thirds, to roughly $28 billion. A reduction of that magnitude, DAV's Jon Retzer warned, could have catastrophic consequences for VA's healthcare infrastructure. A veteran VSO analyst was franker: there is only one way to read it. VA intends to shrink its physical footprint. That was an unambiguous Project 2025 aim.

The Take Care of America's Veterans Act, June–August 2026

In June 2026, Senate Committee on Veterans' Affairs Chairman Jerry Moran and House Chairman Mike Bost introduced the Take Care of America's Veterans Act (TCAVA). Negotiated without Democratic input, the 553-page package folded together more than sixty separate bills.

Its centerpiece was designed to be politically difficult to oppose: the long-stalled Major Richard Star Act, which would finally allow about 54,000 combat-injured veterans to collect both full military retirement pay and VA disability compensation. Republicans had blocked that fix three separate times over the preceding year. They were suddenly supportive—if the bill contained a financing mechanism that took VA benefits from a significant number of other veterans.

To offset the Star Act's ten-year cost, the package reduced or eliminated disability compensation for tinnitus and obstructive sleep apnea. Tinnitus is the most prevalent service-connected disability in the system; sleep apnea is typically rated at 50 percent. Many developed the conditions from documented military exposures, including defective earplugs the Pentagon never adequately tested. The provision would not only take money out of some veterans' pockets, but also potentially close off their access to VA healthcare.

This proposal could be traced back to Project 2025's recommendations that, while not naming tinnitus and sleep apnea specifically, explicitly called for "significant cost savings from revising disability rating awards for future claimants while preserving them fully or partially for existing claimants." In effect, the bill's authors disguised a benefits cut as a benefits expansion. The legislation split the veterans' community as few bills ever had. Disabled American Veterans, the VFW, Common Defense, and Iraq and Afghanistan Veterans of America denounced the trade-off as pitting one group of disabled veterans against another and warned that it would set a dangerous precedent treating earned disability ratings as a bargaining chip whenever Congress needed budgetary cover. The American Legion, AMVETS, Vietnam Veterans of America, Wounded Warrior Project, among other veterans organizations, supported it.

Less conspicuous than the offset, but far more consequential for privatization, were the bill's other provisions. Chief among them was the Critical Access for Veterans Care Act. It would give rural veterans eligible for community care who live within thirty-five miles of a designated critical access hospital a one-year unrestricted allowance for outpatient services—whatever care they wanted, with VA referral no longer required. A VHPI analysis found that 643 of the newly designated critical

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access facilities sat within thirty-five miles of an existing VA facility, meaning VA's own clinics would inevitably lose patient volume and resources. When the bill was first considered in a Senate committee hearing, Paralyzed Veterans of America's national legislative director, Morgan Brown, warned that stripping VA of its prior-authorization role would prevent VA from carrying out its essential function of coordinating and managing veterans' care system-wide.

But abolishing VA's authority to determine when a veteran qualifies for community care was in fact the bill's whole point. Its chief sponsor, Senator Kevin Cramer, said so plainly: "We can't let the VA itself determine whether a veteran is qualified to receive local care." Instead, he wanted veterans to "freely pursue VA-paid care." And he added, "I don't believe we have an obligation to sustain the bureaucracy."

VA's authorization role is what holds the two systems together. It's what stabilizes the VA's core foundation, as it does in the private insurance market. Remove it and VA writes checks for care it did not order, forcing it to downsize.

A separate TCAVA provision would consider whether "the veteran would abstain from seeking such care if required to seek such care at a facility of the Department" as a factor for eligibility for community care. The legislation also requires consideration of all relevant factors, specifies that the determination must be driven by clinical need, and provides that "no single factor is determinative." It is too close to "veteran preference" for comfort.

A further provision would hand million-dollar grants to clinics like Cohen's, undermining the whole community care referral process.

Given the privatization provisions, CVA, along with Koch's Americans for Prosperity, celebrated the bill as poised to "finish the job the MISSION Act started."

On July 16, 2026, short of votes, House Republican leadership pulled TCAVA from the floor. No date has been set for its return. Concerningly, members of Congress are reportedly searching for an alternative offset that does not cut veterans' disability compensation. If they find one, privatization provisions from the Critical Access for Veterans Care Act and ACCESS Act could survive intact. Should that occur, 54,000 veterans would gain. Millions of current and future veterans would lose ground, because the system they depend on would be weakened.

Where's The Private-Sector Capacity?

As we noted at the outset, privatization advocates argue that greater access to private-sector care will, in VA Secretary Collins' words, make it "easier for veterans to get their health care when and where it's most convenient for them." Republicans in Congress echo claims that veterans can readily find better and faster treatment outside the VA.

These policies rest on a big assumption the evidence does not support: that the country has enough hospitals, primary care providers, specialty physicians, and mental health clinicians to serve its 330 million people as well as an influx of nine million veterans.

To test that assumption, the Veterans Healthcare Policy Institute partnered with *The American Prospect* and Common Defense on an analysis of the healthcare landscape in all fifty states. State by state, we examined the supply of primary care providers, mental health professionals, and hospitals, with particular attention to rural and remote rural areas where about a quarter of all veterans live—roughly 4.7 million, 2.8 million of them enrolled in VA.

What we found was a system that cannot reliably provide basic medical and mental health services across large parts of the country. Hundreds of hospitals in rural counties and underserved areas have curtailed critical services or closed outright. Federal data show thousands of counties with significant health provider shortages.

Access to primary care is widely recognized as central to good health outcomes. Yet one important study classified 96 percent of American counties as either whole or partial primary care shortage areas, or as having markers that indicate economic, geographic, or medical vulnerability. About 92 million Americans—over a quarter of the population—live where there are not enough primary care providers.

Access to mental health care is worse. Twenty-nine percent of veterans using VA care have a diagnosed mental health condition. KFF reports that 137 million people—more than a third of the U.S. population—live in federally designated Mental Health Professional Shortage Areas. In rural counties, 81 percent have no psychiatric nurse practitioner and 65 percent have no psychiatrist. Among those who practice, one-third of psychologists and 45 percent of psychiatrists may not accept insurance. That may be one contributing factor to why the civilian suicide rate in rural communities runs about 50 percent above the urban rate.

Rural hospitals are in dire shape. The Center for Healthcare Quality and Payment Reform reports more than 100 rural hospital closures in the last decade. Since 2005, Texas has lost twenty-five, the most in the nation; Tennessee has lost ten since 2015. Many that remain open have shed critical services, like obstetrical care, chemotherapy, and general surgery.

All these figures predate the current administration's cuts. The One Big Beautiful Bill Act, signed July 4, 2025, imposes the largest healthcare spending reduction in U.S. history—reducing Medicaid by roughly a trillion dollars. Princeton's State Health and Value Strategies program projects that hospitals will lose 18 percent of their Medicaid funding, nearly $665 billion, over the next ten years.

In this environment, arguing that the private sector can absorb a large influx of veterans when it cannot provide basic services to nonveterans is not a policy position. It is magical thinking.

Conclusion: An Existential Threat to All Four Missions

For nearly two decades, privatization advocates have denied that they are gradually dismantling the VA healthcare system and converting it into an insurance payer. The record refutes that assertion.

Nearly every week, news reports and findings from independent bodies like the OIG and GAO provide fresh confirmation of the impact of privatization by attrition. Staff with veteran expertise are not replaced. A shrinking VA workforce leads to longer delays for care, which produce surges in outsourcing. Funding shortfalls for VA direct care lead to curtailed services, giving veterans fewer, not more, choices. The private sector becomes the only viable option for some veterans, whether they want that or not.

Meanwhile, Congress declines to require that community providers be trained to screen and treat veterans' complex conditions, that their outcomes be monitored and reported, or that they meet appointment-time benchmarks. Congress has rejected each of those standards on the same grounds: doing so might shrink the pool of private providers and slow the flow of referrals. Bill after bill tries to strip VA of its essential function of authorizing outside care or engaging in utilization review. The Take Care of America's Veterans Act, should it become law, would deliver a decisive blow unless its privatizing provisions are removed.

All this puts VHA's four missions at risk, negatively impacting not only every veteran, but every American.



Care Privatization is degrading VA's ability to deliver clinical care that is specifically tailored to meet the needs of veterans. Its clinical innovations, like the integration of mental health and primary care, serve as models for the non-VA system. Even if the private sector someday catches up to VA on quality (and that's a considerable "if"), it will never be an integrated, comprehensive, veteran-centric system.



Education Cuts to clinical faculty shrink VA's role in training the next generation of physicians, nurses, psychologists, and other health professionals. That may reduce the supply of clinicians available to all Americans. It will certainly decrease the number who enter practice with any experience with, and understanding of, veterans' complex health conditions.



Research Cuts to VA research will deprive generations of veterans, and other patients, of the innovations that VA has historically produced.



Emergency Preparedness Without a fully staffed and funded VA, its capacity to back up the Defense Department and to civilian health systems in a national emergency will be deeply compromised. That loss impacts every American, not only those who served in the military.

The damage can be repaired. Doing so requires Congress, veterans service organizations, and the public to abandon the belief that America can effectively operate two separate healthcare systems for veterans. It requires fully funding and staffing the VA and retaining its role as the authorizer and coordinator of care. Private-sector care must supplement the VA, not replace it.

That is the nation's promise to veterans. It is a promise not being kept.

About the Authors

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