IN THE UNITED STATES COURT OF APPEALS
FOR VETERANS CLAIMS

RICHARD W. STAAB,	)	
	)	
Appellant,	)	
	)	Vet. App. No. 14-0957
v.	)	
	)	
DAVID J. SHULKIN, M.D.,,	)	
Secretary of Veterans Affairs,	)	
	)	
Appellee.	)	

APPELLEE'S OPPOSED MOTION TO STAY THE PRECEDENTIAL EFFECT OF *STAAB V. MCDONALD*, 28 VET.APP. 50 (2016)

Pursuant to the Court's decision in *Ribaudo v. Nicholson*, 20 Vet.App. 552 (2007), Appellee, David J. Shulkin. M.D., Secretary of Veterans Affairs (Secretary), respectfully moves this Court to stay the precedential effect of the Court's decision in *Staab v. McDonald*, 50 Vet.App. 50 (2016). On September 20, 2016, the Secretary filed an appeal of *Staab* before the U.S. Court of Appeals for the Federal Circuit (Federal Circuit). The Secretary electronically filed a corrected opening brief on February 7, 2017.

In *Butts v. McDonald,* 28 Vet.App. 74, 86 (2016), the Court noted that while the Secretary is bound by a Court decision, he can seek a stay in the adjudication of claims until the Federal Circuit renders a decision on appeal. The determination whether to grant a motion to stay the precedential effect of a decision pending appeal lies entirely within the

Court's discretion. 20 Vet.App. at 560. In exercising its discretion, the Court considers the following four criteria: (1) the likelihood of success on the merits of the moving party's appeal; (2) whether the moving party will suffer irreparable harm in the absence of a stay; (3) the impact on the non-moving party of that stay; and (4) the public interest. 20 Vet.App. at 560. As explained below, consideration of the *Ribaudo* factors weighs strongly in favor of granting a stay in this case.

Likelihood of Success on the Merits of the Appeal

The first criterion is met because there is a strong likelihood of success on the merits. As explained in *Ribaudo v. Nicholson*, 21 Vet.App. 137, 142 (2007), the determination of likelihood of success does not require a showing of mathematical probability of success. The Secretary must demonstrate only that circumstances present a fair ground for litigation and produce a good reason to maintain the status quo pending further deliberate review. When a Court delves into an area with little precedent and interprets layers of legal authority (e.g. a statute and regulation), as this Court did in *Staab*, the chances of a different ruling on appeal, and basis for issuing a stay pending that appeal, increase. *Ribaudo v. Nicholson*, 21 Vet.App. 137, 142-143 (2007). This case presents the following substantial questions of statutory interpretation that have not been addressed previously by the courts.

When 38 U.S.C. § 1725 was first enacted, Congress made clear the distinction between the situation where a Veteran has coverage for the costs of non-VA emergency treatment under a health-plan contract in section 1725(b)(3)(B) and the situation where a Veteran has "other" legal or contractual recourse from a third party by which to obtain payment for these costs in section 1725(b)(3)(C). *See* H.R. Rep. 106-237, at 38. The structure of section 1725(b)(3) supports this distinction. Section 1725(b)(3)(B) and (b)(3)(C) are not a single eligibility criterion. They are not separated by the word "or" but instead separated by semi-colons and the word "and" following the penultimate paragraph. Thus, this provision is conjunctive, not disjunctive. *Reese Bros. v. United States*, 447 F.3d 229, 235-36 (3rd Cir. 2006) (quoting *Am. Bankers Ins. Group v. United States*, 408 F.3d 1328, 1332 (11th Cir. 2005)). By ignoring this distinction, this Court failed to apply the "preeminent canon of statutory interpretation requir[ing a court] to presume that [the] legislature says in a statute what it means and means what it says there." *BedRoc Ltd. v. United States*, 541 U.S. 176, 183 (2004) (internal quotation marks and citation omitted).

Moreover, the plain meaning of "no entitlement" in section 1725(b)(3)(B) means the Veteran must have no such entitlement to care or benefits under a health-plan contract whatsoever. *See Reiter v. Sonotone*

Corp., 442 U.S. 330, 339 (1979) ("In construing a statute we are obligated to give effect, if possible, to every word that Congress used.")

When amending section 1725 in 2010, Congress made only limited changes to this law, notably making no changes to 38 U.S.C. § 1725(b)(3)(B) and only a single change to the definition of a health-plan contract (not applicable to the facts here). While some of the legislative history in support of the 2010 amendments and the definitional provisions in 38 U.S.C. 1725(f)(3)(E) might be construed as being supportive of the Court's interpretation, that history still cannot override the unambiguous language of subsection (b)(3)(B), which Congress left wholly intact. Moreover, at the time of the 2010 amendments, Congress is presumed to have been aware of VA's long-standing interpretation of (b)(3)(B) embodied in its regulations, which preserved the distinction found in law, *i.e.*, the distinction between situations involving health-plan contracts and other situations involving third parties. VA maintained that distinction when updating the regulations to accord with the 2010 amendments. *See Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities*, 77 Fed. Reg. 23,615-01 (Dep't of Veterans Affairs Apr. 20, 2012).

Congress, though presumably aware of VA's longstanding interpretation, did not take any action to amend (b)(3)(B) in 2010.

Nonetheless, the Court in *Staab* applied the amendatory changes made to (b)(3)(C) in 2010 to (b)(3)(B) to support its interpretation. In so doing, the Court failed to give separate provisions in the statute independent meaning. *See Black Warrior Riverkeeper, Inc. v. Black Warrior Minerals, Inc.*, 734 F.3d 1297, 1303 (Fed. Cir. 2013) ("If two possible meanings exist for a provision, we should interpret the statute in a manner that gives all provisions independent operation.").

Equally important to VA's likelihood of success on the merits, even if the Federal Circuit finds that 38 U.S.C. § 1725 is ambiguous on the question whether a Veteran entitled to care under a health-plan contract can recover part of his or her treatment expenses from VA, this Court should have deferred to VA's longstanding interpretation of the statute. *Terry v. Principi*, 340 F.3d 1378, 1383 (Fed. Cir. 2003) (citation omitted) (citing, inter alia, *Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843-44 (1984)) (The Court will "sustain a regulation that is consistent with the language of the statute and is a plausible or reasonable interpretation of the law" and "[s]ubstantial deference is given to the statutory interpretation of the agency authorized to administer the statute."). VA's considered judgment that Veterans who have health-plan contracts cannot recover from VA is reasonable, a proper exercise of its

broad rulemaking authority, pre-dates the 2010 Amendment, and is consistent with the original intent of the 1999 Act.

These substantial questions of statutory interpretation will be considered by the Federal Circuit, and they present a fair ground for litigation and a strong basis for maintaining the status quo pending appellate review. To help inform your decision, we have enclosed the corrected brief filed with the Federal Circuit. See Appendix A.

Irreparable Harm

The facts of this case also satisfy the second criterion, as the Secretary will suffer irreparable harm in the absence of a stay. VA cannot immediately implement the Court's decision in *Staab* and re-adjudicate this Veteran's claim (and other affected claims as discussed in greater detail below) because section 1725 does not define VA's payment liability where partial payment of the Veteran's non-VA emergency treatment expenses has been made under the Veteran's own health-plan contract. Because the statute does not define all necessary terms governing VA payment that would be necessary to implement the decision, including payment methodology and limitations, VA must fill the gaps in the statute through rulemaking. In addition to promulgating regulations, VA must invest in technological changes to its claims processing system to address claims no longer barred under the Court's interpretation of section 1725(b)(3)(B)

(and otherwise eligible under section 1725). Such efforts are labor-intensive, time-consuming, and very costly.

Policy program officials, revenue officials, rulemaking professionals, legal and other subject matter experts across the Department have already been directly involved in this undertaking and will continue until its completion. Preliminary steps have been completed to craft the regulations and identify computer needs, and absent a grant of the stay, VA will need to proceed with costly software upgrades and continued investment of resources. The cost impact developed by VA, and discussed in greater detail below, assumed and accounted for additional labor requirements. The hours dedicated to this project to date have been substantial. VA's heavy and irreversible investment in rulemaking and implementing the *Staab* decision will continue in the absence of a stay, despite the fact that a strong possibility exists that the *Staab* decision may be reversed. A grant of the stay would prevent this potentially irreversible harm regarding lost time, labor, and other VA resources. Until this matter is decided by the Federal Circuit, VA should apply its resources to health care programs that would undisputedly benefit Veterans now.

One must also consider the irreversible harm that would result to claimants if a stay is not granted. Assuming VA is able to adjudicate pending claims (i.e., those affected by the *Staab* decision) before the

Federal Circuit issues its decision and assuming too that *Staab* is reversed on appeal, claimants would have been treated differently depending solely on the stage of these proceedings. VA would also have an obligation to recover what would then be viewed as prior erroneous VA payments. This would entail another significant investment of VA labor and resources and any such recovery would create a hardship for those claimants who had reasonably relied in the interim on VA's payment to cover the costs of the Veterans' non-VA emergency treatment. Claimants would be cast into an accounting chaos, and Veterans could find themselves liable for these costs even though they have made no provision to cover these costs because they believed it would be covered by VA.

Reimbursement claims impacted by the decision (i.e., claims that would have been denied solely because the Veteran had coverage under a health-plan contract) are steadily accruing while we undertake the necessary administrative and rulemaking steps described above. We note that an emergency room visit generates multiple claims for reimbursement based on the acuity of the care required by the Veteran. Such claims may include both institutional charges (hospital charges) and professional services (physician/individual providers). VA estimates that an outpatient emergency room visit will generate 4 claims for reimbursement, including both facility fees and professional charges, and an inpatient hospital

admission will generate approximately 8 claims for reimbursement. Certain emergency transportation claims will also be affected by the *Staab* decision. The volume of claims affected by the Court's decision in *Staab* is indeed significant. From April 8, 2016 through February 1, 2017, VA suspended further consideration of 372,855 claims under section 1725 pending completion of the rulemaking.

VA estimates the total cost of the *Staab* decision to be within the following ranges: $75,207,000 to $272,610,000 for 2017; $394,154,000 to $1,456,103,000 over a 5-year period; and $1,757,973,000 to $6,547,312,000 over a 10-year period.[1] [2]

The grant of a stay would prevent harm to the Department pending appeal in a case with a considerable practical impact that could result in multiple re-adjudications of these claims and in vital and finite resources being irreversibly diverted from other health care programs authorized

---

[1] These figures are estimates and may increase if Veterans' reliance on non-VA emergency treatment grows in response to this ruling, if it is sustained. VA has revised the figures reflected in its original motion to stay before the Veterans Court, in which it stated that the implementation costs would exceed $2.5 billion over five years and over $10.7 billion over ten years.

[2] VA's cost methodology accounts for the fact that cost shares owed by a Veteran under a health-plan contract are excluded from VA reimbursement by law and assumes that the volume of claims will increase and continue to increase as more Veterans and community providers learn of the *Staab* decision. Specifically, VA projects that as a result of the *Staab* decision, there will be an annual increase in claim volume of 25 per cent from FY 2018 through FY 2026.

under 38 U.S.C. chapter 17.[3] A stay would prevent this harm and should be in place until there is a final judgment in this matter.

Impact on Nonmoving Party

VA is not in a position to determine the impact of the stay on Appellant. It is noteworthy that once aware of our notice of appeal to the Federal Circuit, the Appellant did not file a motion for expedited review. In addition, Appellant has still failed to provide any evidence of the amount of medical expenses he incurred within the applicable time period. The record fails to show any documentation, receipts, or statements from any health care providers, and Appellant has not presented any evidence, other than his own unsubstantiated assertions, that he is personally liable for any emergency medical care expenses.[4]

---

[3] We acknowledge that until these steps are accomplished, emergency care providers (and affected emergency transportation carriers) who are unable to receive VA payment (until processing is possible under the new rules) may opt to seek payment instead from the Veteran. A stay would place all of these claims in a pending status and, in addition to our own direct notification efforts, help to alert current and future claimants of the need to continue to file their claims timely under their health-plan contracts. Should *Staab* be reversed, this timely filing would help to preserve their access to non-VA payment or in the alternative (*i.e.*, *Staab* is upheld) help expedite the coordination of benefits.

[4] Of course, if Appellant ultimately prevails, Appellant's claim will be duly processed once VA's new payment regulations implementing section 1725(b)(3)(B) and the technological changes needed to process these claims are each in place.

Public Interest

Finally, the public interest favors granting the requested stay. As noted above, the *Staab* decision impacts thousands of claimants. In the absence of a stay and without additional funds to provide the new reimbursement benefit created by the Court in *Staab*, Veterans across the system will unavoidably experience the effects of our re-allocating existing funds and resources from VA's medical care programs to pay for the additional costs associated with establishment of this new benefit. Other Veterans receiving VA health care benefits have an interest in ensuring no further action is taken to implement the *Staab* decision until and unless the outcome of these legal proceedings is final and the validity of the Court's interpretation is upheld.

While recognizing the Court's well-intentioned effort to interpret section 1725 in a manner that is more inclusive to benefit more Veterans with only non-service-connected disabilities, we think it noteworthy that Congress has, in general, found it appropriate as a matter of public policy to provide a greater array of benefits and higher enrollment status to Veterans with service-connected disabilities. *See, e.g.,* 38 U.S.C. §§ 1703, 1705, 1710, 1710A, 1712, etc. In fact, VA is the sole payer for the costs of Veteran's unauthorized non-VA emergency treatment for a service-connected disability under 38 U.S.C. § 1728, and Congress

requires VA to pay a far more favorable reimbursement rate (usual and customary rate) on those claims. By its decision, however, the Court effectively has disregarded this intentional distinction by Congress and has made Veterans who have no barrier in access to emergency treatment and who already have health insurance coverage available for such treatment under their health-plan contracts eligible under section 1725(b)(3)(B) to receive VA reimbursement or payment for costs not covered by their contracts. This means again that the necessary reallocation of funds and resources to reimburse this new cohort will unavoidably and adversely affect the level of funds and resources available to other Veterans receiving health care benefits under 38 U.S.C. chapter 17. The public interest strongly favors a stay, recognizing Veterans' common interest in ensuring that public, that is taxpayer, funds and resources are used as Congress directed and intended.

All the criteria have been met to justify the stay requested by the Secretary. A stay is needed to preserve administrative resources until the Federal Circuit has ruled on the appeal in this matter, particularly in view of: 1) the sheer number of claims directly affected by the *Staab* decision (both currently and in the future) accruing while these legal proceedings continue; and 2) the possibility that the Court's April 8, 2016, decision may ultimately be reversed, which again, without a stay would require the

reversal and halt of Departmental actions taken in line with that decision. By petitioning for this stay, the Secretary is seeking to avoid costly proceedings and ensure uniformity in adjudications. Staying the precedential effect of *Staab* and authorizing the stay of adjudication of cases pending before VA will accomplish these goals.

Appellant is opposed to this motion and requests the right to respond.

WHEREFORE, Appellee, David J. Shulkin, M.D., Secretary of Veterans Affairs, respectfully moves the Court to stay the precedential effect of *Staab v. McDonald*, 28 Vet.App. 50 (2016).

Respectfully submitted,

MEGHAN FLANZ
Interim General Counsel

MARY ANN FLYNN
Chief Counsel

/s/ James B. Cowden____________
JAMES B. COWDEN
Deputy Chief Counsel

/s/ Lavinia A. Derr _____________
LAVINIA A. DERR
Appellate Attorney
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420
Telephone: (202) 632-6924

Attorneys for Appellee,
Secretary of Veterans Affairs

APPENDIX A

Case No. 2016-2671

IN THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

RICHARD W. STAAB,
Claimant-Appellee,

v.

ROBERT D. SNYDER, Acting Secretary of Veterans Affairs,
Respondent-Appellant.

Appeal from the United States Court of Appeals for Veterans Claims
Case No. 14-0957

CORRECTED BRIEF FOR RESPONDENT-APPELLANT

CHAD A. READLER
Acting Assistant Attorney General

ROBERT E. KIRSCHMAN, JR.
Director

MARTIN F. HOCKEY, JR.
Deputy Director

ALEXANDER. O. CANIZARES
Trial Attorney
Department of Justice, Civil Division
Commercial Litigation Branch
P.O. Box 480, Ben Franklin Station
Washington, D.C. 20044
Telephone: (202) 305-3274

Attorneys for Respondent-Appellee

Of Counsel:

JESSICA TANNER
Attorney
Office of General Counsel, Health Care Law Group
Department of Veterans Affairs
810 Vermont Ave., N.W.
Washington, D.C. 20420

February 6, 2017

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES i

STATEMENT OF COUNSEL v

STATEMENT OF JURISDICTION........ 1

STATEMENT OF THE ISSUES........ 2

STATEMENT OF THE CASE SETTING FORTH RELEVANT FACTS 2

- I. Relevant Background Regarding 38 U.S.C. § 1725 3
  - A. The Veterans Millennium Health Care And Benefits Act........ 3
  - B. VA's Promulgation Of Regulations Pursuant To Section 1725........ 7
  - C. Congress's Amendment To Section 1725 In 2010........ 8
  - D. VA's Revised Regulations Implementing The 2010 Amendment........ 10
- III. Mr. Staab's Receipt Of Medical Expenses And Claim........ 11
- IV. The Board's December 2013 Decision Denying Mr. Staab's Claim 11
- V. The Veterans Court's Decision 12

SUMMARY OF ARGUMENT 14

ARGUMENT 16

- I. Standard of Review 16
- II. The Veterans Court Misinterpreted The Plain Language Of 38 U.S.C. § 1725 17
  - A. The Veterans Court Failed To Address The Unambiguous Language Of Section 1725(b)(3)(B) As Well As Its Original Intent 15
  - B. The Veterans Court's Interpretation Of The 2010 Amendment Is Misplaced........ 21
- III. If The Court Finds The Statute Ambiguous, It Should Defer To VA's Reasonable Interpretation 26

CONCLUSION........ 29

TABLE OF AUTHORITIES

Page

Cases

Am. Bankers Ins. Group v. United States,
408 F.3d 1328 (11th Cir. 2005) 21

Barnhart v. Thomas,
540 U.S. 20 (2003) 19

BedRoc Ltd. v. United States,
541 U.S. 176 (2004) 21

Black Warrior Riverkeeper, Inc. v. Black Warrior Minerals, Inc.,
734 F.3d 1297 (Fed. Cir. 2013) 19

Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc.,
467 U.S. 837 (1984)..27

Corley v. United States,
556 U.S. 303 (2009) 23

Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Curran,
456 U.S. 353 (1982) 21

Nat'l Org. of Veterans Advocates, Inc. v. Sec'y of Veterans Affairs,
809 F.3d 1359 (Fed. Cir. 2016) 27

Reese Bros. v. United States,
447 F.3d 229 (3rd Cir. 2006) 21

Reiter v. Sonotone Corp.,
442 U.S. 330 (1979) 18

Sears v. Shinseki,
349 F.3d 1326 (Fed. Cir. 2002) 27

Terry v. Principi,
340 F.3d 1378 (Fed. Cir. 2003) 27

Williams v. Principi,
275 F.3d 1361 (Fed. Cir. 2002) 2, 3, 17

Statutes
38 U.S.C. § 1710 3

38 U.S.C. § 1725 .... passim

38 U.S.C. § 501 27

38 U.S.C. § 7252 2

38 U.S.C. § 7292 .... 2, 16

Expansion of Veteran Eligibility for Reimbursement,
Pub. L. 111-137, 123 Stat. 3495 .... 8, 9

Rules
Fed. R. App. P. 4(a)(1)(B) 2

Regulations
38 C.F.R. § 17.1002 .... passim

38 C.F.R. § 17.1003 28

38 C.F.R. § 17.1005 .... 11, 24

38 C.F.R. § 17.36 3

38 C.F.R. § 17.38 3

38 C.F.R. §§ 17.1000-17.1008 .... 7, 10

Payment or Reimbursement for Emergency Treatment Furnished at Non-VA Facilities,
66 Fed. Reg. 36,467-01 (Dep't of Veterans Affairs Jul. 12, 2001) 8

Payment or Reimbursement for Emergency Treatment Furnished at Non-VA Facilities,
68 Fed. Reg. 3,401-01 (Dep't of Veterans Affairs Jan. 24, 2003) 7

Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities,
76 Fed. Reg. 30,598-01 (Dep't of Veterans Affairs May 26, 1011) 24

Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities,
77 Fed. Reg. 23,615-01 (Dep't of Veterans Affairs Apr. 20, 2012) 10, 11, 28

Legislative History
H.R. Rep. 106-237 (1999).. *passim*

H.R. Rep. 111-55 (2009)... 9, 23, 25, 26

S. Rep. 111-80 (2009) 9, 23

S. Hrg. 111-76 (Senate Committee on Veterans' Affairs), Apr. 22, 2009 25

Other Authorities
14 Couch on Ins. § 198:3 22

STATEMENT OF COUNSEL

Pursuant to Rule 47.5, respondent-appellant's counsel states that he is unaware of any other appeal in or from this action that previously was before this Court or any other appellate court under the same or similar title. Respondent-appellant's counsel is aware of the following cases pending before the Court of Appeals for Veterans Claims that may directly be affected by this Court's decision in this appeal. This list does not include matters before the Board of Veterans' Appeals, although we note that in *Oury v. McDonald*, CAVC No. 13-2955 (May 4, 2016), and *Anglin v. McDonald*, CAVC No. 14-4397, Apr. 27, 2016, the Court of Appeals for Veterans Claims issued remand orders based upon the decision below in this case.

Richard C. Rawson v. Robert D. Snyder, CAVC No. 15-2234

Daniel J. Clark v. Robert D. Snyder, CAVC No. 15-2324

Ryan K. Kannegaard v. Robert D. Snyder, CAVC No. 16-0107

Harold W. Van Allen v. Robert D. Snyder, CAVC No. 16-0421

Bruce D. Williams v. Robert D. Snyder, CAVC No. 16-0844

Terrance N. Maddox v. Robert D. Snyder, CAVC No. 16-2745

Anna L. Sewell v. Robert D. Snyder CAVC No. 16-3562

David Alan Elmsley v. Robert D. Snyder CAVC No. 17-0136

Case No. 2016-2671

IN THE UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

RICHARD W. STAAB,
Claimant-Appellee,

v.

ROBERT D. SNYDER, Acting Secretary of Veterans Affairs,
Respondent-Appellant.

Appeal from the United States Court of Appeals for Veterans Claims
Case No. 14-0957

STATEMENT OF JURISDICTION

Respondent-appellant, Robert D. Snyder, Acting Secretary of the Department of Veterans Affairs (VA), appeals the United States Court of Appeals for Veterans Claims' (Veterans Court) judgment, reversing the Board of Veterans Appeals' (board) decision finding that claimant-appellee, Richard W. Staab, was not entitled to reimbursement of costs for non-VA emergency medical treatment.

The Veterans Court had jurisdiction to review the board's decision. *See* 38 U.S.C. § 7252(a). This Court possesses jurisdiction to review decisions of the Veterans Court, 38 U.S.C. § 7292(a), including non-final decisions provided the criteria articulated in this Court's decision in *Williams v. Principi*, 275 F.3d 1361

(Fed. Cir. 2002) are satisfied. Mr. Staab's appeal of the board's decision to the Veterans Court was timely, as was the Secretary's appeal to this Court filed on September 16, 2016. Appx17, Appx19;[1] *see* Fed. R. App. P. 4(a)(1)(B).

STATEMENT OF THE ISSUES

1. Whether 38 U.S.C. § 1725 requires VA to reimburse a veteran for the costs of emergency treatment at a non-VA facility when the veteran has partial coverage under Medicare Part A, which is considered a "health-plan contract" under the statute.

2. Whether the Veterans Court should have granted deference to VA's longstanding regulation, 38 C.F.R. § 17.1002(f), interpreting section 1725 to bar reimbursement to veterans with partial coverage under a health-plan contract.

STATEMENT OF THE CASE SETTING FORTH RELEVANT FACTS

The Secretary of the VA appeals the Veterans Court's decision in *Richard W. Staab v. Robert A. McDonald, Secretary of Veterans Affairs*, No. 14-0957 (Vet. App. Apr. 8, 2016), Appx1-7, reversing the board's December 6, 2013 decision finding that Mr. Staab was not entitled to reimbursement of medical expenses incurred for emergency medical services provided at non-VA facilities.

[1] "Appx__" refers to pages in the Joint Appendix.

I. Relevant Background Regarding 38 U.S.C. § 1725

A. The Veterans Millennium Health Care And Benefits Act

VA has long furnished cost-free health care to veterans for their service-connected disabilities, *i.e.*, those incurred in or aggravated in line of duty in the active military, naval, or air service. *See* 38 U.S.C. §§ 101(16), 1710; 38 C.F.R. § 17.36. The Government also provides health care for enrolled veterans with non-service-connected disabilities, subject to certain copayment obligations, if applicable. *See* 38 U.S.C. § 101(17); 38 C.F.R. § 17.38. This care is furnished at VA facilities and, as applicable and as permitted, through non-VA providers. If a veteran seeks medical care outside the VA system, such as at a private hospital, he or she (or his insurer) is generally obligated to pay for such services in full. Enrollment in VA's health care system does not require a veteran to use VA for all his or her health care needs.

The provision of emergency treatment for veterans at non-VA facilities is subject to specific requirements by statute and regulation. *See, e.g.*, 38 U.S.C. 1703(a)(3) (VA may contract with a community provider for a veteran's needed emergency care or medical services). Veterans generally remain personally responsible for the costs of their private emergency care (even if enrolled in VA's health care system), unless they qualify for either of the two statutorily-created reimbursement mechanisms established by Congress codified at 38 U.S.C. §§ 1728

(relating primarily to veterans with service-connected disabilities) and 1725 (relating primarily to veterans with non-service-connected disabilities).

Relevant here is section 1725 of title 38, under which veterans may be eligible for reimbursement from VA for costs of emergency treatment rendered by non-VA facilities for their non-service-connected disabilities. Section 1725 was enacted in 1999 as part of the Veterans Millennium Health Care and Benefits Act, Pub. L. 106-117 (the Act), whose purpose was to make VA a "payer of last resort" for emergency treatment provided to veterans at non-VA facilities. *See* H.R. Rep. 106-237, at 39 (1999) (Committee Report Re: H.R. 2116, Jul. 16, 1999) (VA "will pay for this non-VA care only when a veteran has no other recourse for payment for the care.").

Under section 1725, a veteran who receives emergency treatment at a non-VA facility may be eligible for reimbursement from VA if he or she is, among other things, "personally liable" to the provider for the treatment. 38 U.S.C. § 1725(b)(1). The statute requires that, to be personally liable, a veteran must have "no entitlement to care or services under a health-plan contract." 38 U.S.C. § 1725(b)(3)(B). The pre-2010 version of the statute also required that, to be personally liable, the veteran must have "no other contractual or legal recourse against a third party that would, in whole or in part, extinguish such liability to the provider[.]" *Id.* § 1725(b)(3)(C) (2008). As explained below, this provision was

amended in 2010 to remove the phrase "or in part." As amended in legislation taking effect in February 2010, section 1725(b) of title 38 provides, in full:

> (b) Eligibility.-- (1) A veteran referred to in subsection (a)(1) is an individual who is an active Department health-care participant who is personally liable for emergency treatment furnished the veteran in a non-Department facility.
>
> (2) A veteran is an active Department health-care participant if—
>
> (A) the veteran is enrolled in the health care system established under section 1705(a) of this title; and
>
> (B) the veteran received care under this chapter within the 24-month period preceding the furnishing of such emergency treatment.
>
> (3) A veteran is personally liable for emergency treatment furnished the veteran in a non-Department facility if the veteran--
>
> (A) is financially liable to the provider of emergency treatment for that treatment;
>
> (B) has no entitlement to care or services under a health-plan contract (determined, in the case of a health-plan contract as defined in subsection (f)(2)(B) or (f)(2)(C), without regard to any requirement or limitation relating to eligibility for care or services from any department or agency of the United States);
>
> (C) has no other contractual or legal recourse against a third party that would, in whole, extinguish such liability to the provider; and
>
> (D) is not eligible for reimbursement for medical care or services under section 1728 of this title.

The legislative history of the Act shows that, in 1999, Congress recognized the distinction between a situation in which a veteran has coverage for care under a health-plan contract such as Medicare, and various other situations in which

recourse against a third party for the expenses may be feasible. *See* H.R. Rep. 106-237, at 38 (Committee Report Re: H.R. 2116, Jul. 16, 1999) (the bill authorizes VA payments to certain veterans "who have no medical insurance and no *other* recourse for payment") (emphasis added); *id.* at 39 ("[F]or VA to be a payer of last resort, it must ascertain before authorizing any payment under this section that a veteran has no medical insurance whatsoever or any other medical coverage. It must also ascertain that the veteran or provider (as pertinent) has exhausted *all other* possible claims and remedies reasonably available against a third party which may be liable for payment of the emergency care (such as in the case of a work-related injury or a motor vehicle accident, for example)") (emphasis added); Statement of Kenneth W. Kizer, Under Secretary for Health, Department of Veterans Affairs (Hearing Before the Subcommittee on Health of the Committee on Veterans' Affairs, Serial No. 106-13, May 19, 1999), at 101 ("VA would pay for non-VA emergency care only when no other third party is liable, in whole or in part, for payment for the treatment. If the veteran has any insurance coverage that would pay for any of the furnished emergency treatment, no reimbursement would be authorized under the proposal. Moreover, if the veteran were eligible for Medicare or Medicaid, VA would not provide reimbursement for this care.").[2]

---

[2] The Conference Report for the House bill, H.R. 2116, also expressly distinguished between veterans covered by health insurance and other situations involving third parties, stating that the bill would assist "veterans who have no

Congress gave VA broad authority to implement the statute's provisions through regulations. *See* 38 U.S.C. §§ 1725(c)(1)(A)-(C). According to the legislative history, Congress was concerned about the budgetary impact of the statute, and expected VA to administer the statute in a manner that would limit costs. H.R. Rep. 106-237, at 38-39 ("The measure also provides ample authority for VA to effectively and efficiently administer this authority to ensure that scarce resources are not inappropriately paid out on claims not contemplated under this section. . . . To contain costs, the Committee has taken steps to ensure that VA will pay for this non-VA care only when a veteran has no other recourse for payment for the care.").

B. <u>VA's Promulgation Of Regulations Pursuant To Section 1725</u>

VA's implementing regulations, which took effect in January 2003, set forth the substantive conditions that must be met for payment or reimbursement to a veteran under section 1725. 38 C.F.R. §§ 17.1000-17.1008; *see Payment or Reimbursement for Emergency Treatment Furnished at Non-VA Facilities*, 68 Fed. Reg. 3,401-01 (Dep't of Veterans Affairs Jan. 24, 2003)). Under 38 C.F.R.

---

health insurance or other health care coverage (including Medicare and Medicaid); have no recourse against a third party to cover their liability; and are not eligible for reimbursement under section 1728 of title 38, United States Code." H.R. Rep. 106-470, at 64 (Conf. Report Re: H.R. 2116) (Nov. 16, 1999).

§ 17.1002, payment or reimbursement for care under the statute may be made only if "all" of nine separate conditions are met. 38 C.F.R. § 17.1002(a)-(i).

Among those conditions is that the veteran has "*no* coverage under a health-plan contract for payment or reimbursement, in whole or in part, for the emergency treatment[.]" 38 C.F.R. § 17.1002(g) (effective until Jan. 19, 2012) (emphasis added), renumbered as 38 C.F.R. § 17.1002(f) (effective 2012). As VA explained in a Federal Register notice, section 1725 authorizes payment to "veterans who have no health insurance or other source of payment in whole or in part." *Payment or Reimbursement for Emergency Treatment Furnished at Non-VA Facilities*, 66 Fed. Reg. 36467-01, at 36,468 (Dep't of Veterans Affairs Jul. 12, 2001). Thus, under VA's regulation, a veteran covered by Medicare or another health-plan contract could not recover any expenses for emergency medical treatment at a non-VA facility, even if some portion of those expenses are not covered by the health-plan contract, because the veteran does not meet the statutory requirement that he or she have "no entitlement to care or services under a health-plan contract." 38 U.S.C. § 1725(b)(3)(B).

C. Congress's Amendment To Section 1725 In 2010

More than ten years after the 1999 Act, Congress amended 38 U.S.C. § 1725, making three changes that took effect in 2010. Expansion of Veteran Eligibility for Reimbursement, Pub. L. 111-137, 123 Stat. 3495 (effective Feb. 1,

2010) (the 2010 Amendment). First, it struck the phrase "or in part" in subsection 1725(b)(3)(C). Thus, whereas previously a veteran would be denied reimbursement if he or she had "other contractual or legal recourse against a third party that would, in whole or in part, extinguish such liability to the provider," now reimbursement is not precluded unless the veteran has "other contractual or legal recourse against a third party that would, in whole, extinguish such liability to the provider[.]" 38 U.S.C. § 1725(b)(3)(C) (effective Feb. 1, 2010).

Second, Congress amended the definition of "health-plan contract," striking a provision that defined that term to include state-mandated automobile insurance. *Id.* § 1725(f)(2)(E). Third, Congress added a new subsection (4) to section 1725(c) that addressed VA's responsibility to reimburse veterans who have contractual or legal recourse against a third party. Congress did not, however, change any language in section 1725(b)(3)(B)'s provision addressing health-plan contracts.

The House Report related to the 2010 Amendment states that the draft bill was intended to "allow the VA to reimburse veterans for treatment in a non-VA facility if they have a third-party insurer that would pay a portion of the emergency care." H.R. Rep. 111-55, at 3 (2009); *see* S. Rep. 111-80, at 35 (2009) (Committee Rep. re: S. 801) (the amendment would authorize reimbursement by VA "when the veteran has some insurance coverage but that coverage is not sufficient to cover the cost of the care").

D. VA's Revised Regulations Implementing The 2010 Amendment

To implement the 2010 Amendment, VA published revised regulations in 38 C.F.R. §§ 17.1000 through 17.1008. *See Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities*, 77 Fed. Reg. 23,615-01 (Dep't of Veterans Affairs Apr. 20, 2012). VA removed the phrase "or in part" from 38 C.F.R. § 17.1002(g), thus specifying that, to be eligible for VA reimbursement for emergency treatment for a condition caused by an accident or work-related injury, the veteran must have "no contractual or legal recourse against a third party that could reasonably be pursued for the purpose of extinguishing, in whole, the veteran's liability to the provider." 38 C.F.R. § 17.1002(g) (effective May 21, 2012). VA did not, however, change its requirement in 38 C.F.R. § 17.1002(f) that the veteran must have "no coverage under a health-plan contract for payment or reimbursement, in whole or in part, for the emergency treatment."

VA interpreted the statute as preserving the distinction between situations involving health-plan contracts and others involving third parties. In its notice of final rulemaking, VA rejected a commenter's proposal that the phrase "or in part" be removed from 38 C.F.R. § 17.1002(f), explaining that, although the phrase "or in part" had been removed from 38 U.S.C. § 1725(b)(3)(C), section 1725(b)(3)(B)

"had no such revision" and thus that provision "means that any entitlement, even a partial one, bars eligibility under section 1725(b)." 77 Fed. Reg. at 23,616.

Accordingly, VA declined to revise its longstanding rule denying reimbursement to veterans covered by health-plan contracts, because otherwise it would treat "a veteran with some coverage under a health-plan contract in the same manner as one without coverage[.]" *Id.* VA also adopted new provisions in 38 C.F.R. § 17.1005(e) and (f) to implement the new language in section 1725(c)(4).

II. Mr. Staab's Receipt Of Medical Expenses And Claim

In December 2010, Mr. Staab, a veteran of the United States Air Force, was hospitalized in a non-VA hospital after suffering a heart attack and one or more strokes. Appx2. He subsequently underwent open heart surgery at the same hospital. *Id.* He was discharged from the hospital in June 2011. *Id.* He was covered by Medicare during the period of his treatment. Appx3.

Mr. Staab sought reimbursement from VA for certain treatment costs from three non-VA facilities for services rendered to him on various dates between December 28, 2010 and June 24, 2011. Appx2.

The VA denied Mr. Staab's claim, and he appealed to the board. Appx22.

III. The Board's December 2013 Decision Denying Mr. Staab's Claim

In a December 2013 decision, the board rejected Mr. Staab's claim, concluding that he was not entitled to reimbursement from VA for his non-VA

care. Appx21-27. The board held that, because Mr. Staab was covered by Medicare, he was ineligible for reimbursement under 38 U.S.C. § 1725 and 38 C.F.R. § 17.1002(f) and that his claim "must be denied as a matter of law[.]" Appx23-25.

IV. The Veterans Court's Decision

On appeal, the Veterans Court reversed the board's decision, holding that Mr. Staab's partial coverage under Medicare does not bar reimbursement for the remainder of his medical expenses under 38 U.S.C. § 1725. Appx4-7. The Veterans Court found that the "plain language" of section 1725 showed that, in the 2010 Amendment, Congress intended to reimburse a veteran "for that portion of expenses not covered by a health-plan contract." Appx6.

The court noted that section 1725(b)(3)(B) provides that a veteran is "personally liable" for emergency treatment and thus eligible for reimbursement only where the veteran has "no *entitlement* to care or services under a health-plan contract." Appx5 (emphasis in original). The court interpreted the term "entitlement" to mean "an *absolute right* to a [monetary] benefit." *Id.* (emphasis in original). According to the Veterans Court, a veteran would be ineligible for reimbursement under section 1725(b)(3)(B) only where "coverage under a health-plan contract would *wholly* extinguish a veteran's financial liability." *Id.* (quoting Black's Law Dictionary (10th ed. 2014) (emphasis added by court).

The Veterans Court found that its construction of section 1725 was "consistent with the rest of subsection 1725(b)(3)," which includes other provisions that "all contemplate situations that would wholly extinguish a veteran's responsibility for payment." *Id.* The Veterans Court further noted that the term "third party" in subsections 1725(c)(4) and (f)(3) includes health-plan contracts, and that section 1725(c)(4)(A) "establishes that VA reimbursement is warranted when coverage by a third party is less than total." Appx6. The court also cited 38 U.S.C. § 1725(c)(4)(D), which provides that VA may not reimburse a veteran "for any copayment or similar payment that the veteran owes the third party or for which the veteran is responsible under a health-plan contract," reasoning that such language would be superfluous if reimbursement is barred whenever a veteran has partial coverage under a health-plan contract. *Id.*

Having concluded that the statute was unambiguous, the Veterans Court held that 38 C.F.R. § 17.1002(f) was "invalid" because it was contrary to Congress's intent in amendments to section 1725 enacted in 2010. *Id.* The court held that 38 C.F.R. § 17.1002(f) "became wholly inconsistent with the [revised] statute." *Id.* The court therefore invalidated the regulation. Appx6-7. Accordingly, the court vacated the board's decision and remanded. Appx7.

On June 29, 2016, the court denied VA's motion for panel reconsideration and held a request for full-court consideration in abeyance pending further order of

the court. Appx8-9. On July 22, 2016, the court denied the motion for full-court review in a *per curiam* opinion. Appx10. Judge Kasold dissented, stating that full-court review was warranted. Appx10-11. Also on July 22, 2016, the Veterans Court dismissed VA's request to stay the precedential effect of the decision. Appx12.

This appeal followed.

SUMMARY OF ARGUMENT

Under VA's longstanding interpretation of 38 U.S.C. § 1725, a veteran entitled to care under a health-plan contract is unable to obtain reimbursement from VA for any expenses, including those not covered by the health-plan contract. In 2010, Congress, presumably aware of VA's interpretation embodied in its regulations, amended the statute to expand the benefits available to veterans in certain ways, but chose to leave intact the eligibility criteria addressing "health-plan contracts" specifically.

The Veterans Court erred, and its decision should be reversed, for two principal reasons. First, the Court misinterpreted the plain language of 38 U.S.C. § 1725, which distinguishes between situations involving "health-plan contracts" and "other" situations in which recourse against a third party may be feasible. As amended, the statutory criteria in 38 U.S.C. § 1725 used to determine whether a veteran is "personally liable" to a provider for emergency treatment costs deal

separately with "entitlement to care or services under a health-plan contract" and "other contractual or legal recourse against a third party" such as a tortfeasor or third-party insurer. Contrary to settled canons of statutory interpretation, the Veterans Court's interpretation of the statute fails to give separate provisions in the statute independent meaning. The Veterans Court also failed to consider Congress's decision in the 2010 Amendment to remove state-mandated automobile insurance from the definition of "health-plan contract," which only makes sense if Congress understood that health-plan contract situations are treated differently.

Even if the Court finds that 38 U.S.C. § 1725 is ambiguous on the question of whether a veteran entitled to care under a health-plan contract can recover part of his or her treatment expenses from VA, the Court should defer to VA's longstanding interpretation of the statute. VA's considered judgment that veterans who have health-plan contracts cannot recover from VA is reasonable, pre-dates the 2010 Amendment, and is consistent with the original intent of the 1999 Act. Deference to VA's interpretation is especially appropriate given Congress's intent to give VA broad discretion to administer the statute in a manner that limits costs. The Veterans Court's decision, if sustained, would impose an unfunded mandate on VA costing potentially billions of dollars in claims in the years to come.

ARGUMENT

I. Standard of Review

This Court has limited jurisdiction to review Veterans Court decisions. Under 38 U.S.C. § 7292, this Court may review a Veterans Court decision with respect to the validity of any statute or regulation "or any interpretation thereof (other than a determination as to a factual matter) that was relied in the decision of the [Veterans] Court[.]" 38 U.S.C. §§ 7292(c), (d)(1). In reviewing a Veterans Court decision, this Court must decide "all relevant questions of law, including interpreting constitutional and statutory provisions." *Id.* § 7292(d)(1).

This Court must affirm the Veterans Court's decision as to an interpretation of a regulation unless it is "(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (B) contrary to constitutional right, power, privilege, or immunity; (C) in excess of statutory jurisdiction, authority, or limitations, or in violation of a statutory right; or (D) without observance of procedure required by law." *Id.* Except with respect to constitutional issues, this Court "may not review (A) a challenge to a factual determination, or (B) a challenge to a law or regulation as applied to the facts of a particular case." *Id.* § 7292(d)(2).

This Court will depart from its strict rule of finality when the Veterans Court has remanded for further proceedings "only if three conditions are satisfied: (1)

there must have been a clear and final decision of a legal issue that (a) is separate from the remand proceedings, (b) will directly govern the remand proceedings or, (c) if reversed by this court, would render the remand proceedings unnecessary; (2) the resolution of the legal issues must adversely affect the party seeking review; and, (3) there must be a substantial risk that the decision would not survive a remand, *i.e.*, that the remand proceeding may moot the issue." *Williams*, 275 F.3d at 1364. Here, each of these three criteria is met. The Veterans Court issued a clear and final decision regarding the interpretation of 38 U.S.C. § 1725 that is separate from the remand proceedings and that will directly govern the remand proceedings. The resolution of the legal issues adversely affects VA, whose regulation has been held invalid and which would be required to pay a significant number of claims at substantial cost if the Veterans Court's decision is left intact. *See infra* p. 26. Finally, there is a substantial risk that the remand proceeding may moot the issue. Accordingly, this Court possesses jurisdiction to hear this appeal.

II. The Veterans Court Misinterpreted The Plain Language Of 38 U.S.C. § 1725

The Veterans Court interpreted 38 U.S.C. § 1725 to unambiguously require VA to pay for a veteran's emergency treatment expenses at a non-VA facility that are not covered by a health-plan contract. As explained below, the Veterans Court's interpretation of section 1725(b)(3)(B) is erroneous and should be reversed.

A. The Veterans Court Failed To Address The Unambiguous Language Of Section 1725(b)(3)(B) As Well As Its Original Intent

Section 1725(b)(3) sets forth several eligibility criteria that must be met if VA is to be responsible for emergency treatment costs under the statute. To be "personally liable" under section 1725(b)(3)(B), a veteran must have "no entitlement to care or services under a health-plan contract . . . ." The eligibility criteria in section 1725(b)(3) are separate and distinct, as indicated by the use of the conjunctive "and" after the penultimate criterion in the section.

Section 1725(b)(3)(B) specifically provides that, a veteran is personally liable for emergency treatment and thus eligible for reimbursement if he or she:

> (A) is financially liable to the provider of emergency treatment for that treatment;
>
> (B) has no entitlement to care or services under a health-plan contract . . .
>
> (C) has no other contractual or legal recourse against a third party that would, in whole, extinguish such liability to the provider; and
>
> (D) is not eligible for reimbursement for medical care or services under section 1728 of this title.

38 U.S.C. § 1725(b)(3).

In construing section 1725(b)(3)(B), the Veterans Court did not address the word "no" that precedes "entitlement." "No" means "not in any degree or manner; none at all." *No*, Dictionary.com; *see also* merriam-webster.com/dictionary (defining "no" to include "not any"). Thus, the plain meaning of "no entitlement"

in section 1725(b)(3)(B) is that, to be personally liable, the veteran must have no such entitlement to care or benefits under a health-plan contract whatsoever. *See Reiter v. Sonotone Corp.*, 442 U.S. 330, 339 (1979) ("In construing a statute we are obligated to give effect, if possible, to every word that Congress used."). By interpreting section 1725(b)(3)(B) to provide for payment or reimbursement when a veteran has partial coverage under a health-plan contract, the Veterans Court effectively rewrote the statute.

In addition, contrary to the "last antecedent" canon of construction, whereby a "limiting clause or phrase . . . should ordinarily be read as modifying only the noun or phrase that it immediately follows," *Barnhart v. Thomas*, 540 U.S. 20, 26 (2003), the Veterans Court incorrectly interpreted the phrase "in whole" in section 1725(b)(3)(C) as also modifying section 1725(b)(3)(B). But the phrase "in whole" is not found in section 1725(b)(3)(B). The court erroneously assumed that section 1725(b)(3)(B) is qualified by language in section 1725(b)(3)(C), when in fact each of those provisions is separate and should be given independent meaning. *See Black Warrior Riverkeeper, Inc. v. Black Warrior Minerals, Inc.*, 734 F.3d 1297, 1303 (Fed. Cir. 2013) ("If two possible meanings exist for a provision, we should interpret the statute in a manner that gives all provisions independent operation.").

In the 2010 Amendment, Congress amended section 1725(b)(3)(C), removing the phrase "or in part." But it did not amend section 1725(b)(3)(B). As

evidenced by the word "other," section 1725(b)(3)(C) refers to situations "other" than, *i.e.*, different or distinct from, those addressed in section 1725(b)(3)(B). Section 1725(b)(3)(B) addresses a situation in which a veteran is entitled to care under a health-plan contract, whereas section 1725(b)(3)(C) addresses situations in which a veteran may have recourse against a responsible third party "other" than pursuant to a health-plan contract, such as against a responsible tortfeasor. *See* H.R. Rep. 106-237, at 38 (the bill "would authorize VA to make reasonable payments for emergency treatment which non-VA facilities have provided certain enrolled veterans who have no medical insurance and no other recourse for payment"); *id.* at 39 (VA must ascertain that a veteran "has no medical insurance whatsoever or any other medical coverage" and "[i]t must also ascertain that the veteran or provider (as pertinent) has exhausted all other possible claims and remedies reasonably available against a third party which may be liable for payment of the emergency care (such as in the case of a work-related injury or a motor vehicle accident for example)").

If Congress had intended to treat section 1725(b)(3)(B) and (b)(3)(C) as somehow part of a single eligibility criterion, it would have used the word "or" to separate the various provisions in section 1725(b)(3). The four clauses of section 1725(b)(3), however, are all required, as evidenced by the use of semi-colons and the word "and" following the penultimate paragraph. "The usual meaning of the

word 'and' . . . is conjunctive, and 'unless the context dictates otherwise, the word 'and' is presumed to be used in its ordinary sense[, that is, conjunctively.]" *Reese Bros. v. United States*, 447 F.3d 229, 235-36 (3rd Cir. 2006) (quoting *Am. Bankers Ins. Group v. United States*, 408 F.3d 1328, 1332 (11th Cir. 2005)). The Veterans Court failed to apply the "preeminent canon of statutory interpretation requir[ing a court] to presume that [the] legislature says in a statute what it means and means what it says there." *BedRoc Ltd. v. United States*, 541 U.S. 176, 183 (2004) (internal quotation marks and citation omitted).

B. The Veterans Court's Interpretation Of The 2010 Amendment Is Misplaced

Moreover, this Court should presume that, when Congress passed the 2010 Amendment, it knew that VA had adopted regulations to prohibit reimbursement to veterans with health-plan contracts, even if part of those expenses are not covered. *See Merrill Lynch, Pierce, Fenner & Smith, Inc. v. Curran*, 456 U.S. 353, 382 n.66 (1982) ("Congress is presumed to be aware of [the] administrative . . . interpretation of a statute and to adopt that interpretation when it re-enacts a statute without change[.]") (internal quotations omitted). Congress could have expressly repudiated VA's interpretation, but chose not to do so. Congress's decision not to amend section 1725(b)(3)(B) is particularly telling in light of the 1999 Act, whose legislative history shows that Congress intended that, as a payer of last resort, VA would deny payment to a veteran with even partial health insurance coverage. H.

Rep. 106-237, at 39 (VA must confirm that "a veteran has no medical insurance *whatsoever or any other medical coverage*") (emphasis added); *id.* at 24.

We recognize that aspects of the 2010 Amendment and its legislative history complicate interpretation of the statute. For example, the definition of "third party" in the statute includes private health insurers and Medicare, specifically. 38 U.S.C. § 1725(f)(3). The definition appears to include not only first-party insurance, such as a veteran's own health insurance policy, but also other types of third-party insurance, such as a liability insurance policy owned by a third party.[3] Thus, arguably, the newly added provision in section 1725(c)(4) also applies to health-plan contracts. Moreover, the Veterans Court indicated, with some persuasive force, that section 1725(c)(4)(D), which provides that the Secretary "may not reimburse a veteran under this section for any copayment or similar payment that the veteran owes the third party or for which the veteran is responsible under a health-plan contract," would appear to be "superfluous if reimbursement is barred whenever a veteran has partial coverage from a health-plan contract[.]" Appx6 (quoting appellant's brief). And the legislative history of

---

[3] First- and third-party insurance are distinct types of insurance. First-party insurance "is a contract between the insurer and the insured to protect the insured from its own actual losses and expenses," such as health insurance. 14 Couch on Ins. § 198:3. "Third-party" insurance "is a contract to protect the insured from losses resulting from actual or potential liability to a third party." *Id.*

the 2010 Amendment contains language suggesting the bill was intended to provide assistance to a veteran who has "no other outside health insurance[.]" S. Rep. 111-80, Sept. 25, 2009, at 35 (describing draft bill as authorizing VA to "provide reimbursement for emergency care when the veteran has some insurance coverage but that coverage is not sufficient to cover the cost of care"); H. Rep. 111-55, at 6 (draft bill "clearly establishes that the VA is responsible for the cost of the emergency treatment which exceeds the amount payable or not paid by the third-party insurer").

Notwithstanding these issues, the Veterans Court's construction should be rejected because it would render section 1725(b)(3)(B) superfluous. Under the court's reading, any veteran whose expenses are wholly covered by Medicare or another health-plan contract necessarily would be denied reimbursement under section 1725(b)(3)(C) because he or she would have "recourse" against a third party, *i.e.*, his or her insurer, which would render section 1725(b)(3)(B) inoperative. Such a construction should be avoided. *See Corley v. United States*, 556 U.S. 303, 314 (2009) ("a statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant") (internal quotations omitted). Thus, the phrase "that would, in whole, extinguish such liability to the provider" cannot be read to apply to section

1725(b)(3)(B), but rather applies to "other" situations covered by section 1725(b)(3)(C).

With respect to Congress's adoption of a new section 1725(c)(4), that language was plainly intended to make conforming changes necessary to give effect to the 2010 Amendment, and does not speak to health-plan contracts, specifically. It does not somehow implicitly amend section 1725(b)(3)(B). While section 1725(c)(4)(D) clarifies that a veteran cannot be reimbursed for a copayment or similar payment, that does not necessarily compel the conclusion that the veteran can be reimbursed for other types of expenses not covered by insurance. For example, under that provision, a veteran could not be reimbursed for a copayment paid on a claim under a third party's liability insurance policy, *i.e.*, an insurance policy of which a third party is the policyholder, which is consistent with VA's position. Also, the Veterans Court did not appear to consider that VA interpreted 38 U.S.C. § 1725(c)(4)(D) as relating only to section 1725(b)(3)(C), and not section 1725(b)(3)(B)'s language related to health-plan contracts. 38 C.F.R. § 17.1005(f) (2012); *Payment or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities*, 76 Fed. Reg. 30,598-01, 30,599 (Dep't of Veterans Affairs May 26, 2011).

The 2010 Amendment indicates that Congress did not intend to disturb the rule applied to health-plan contracts, with one narrow exception. In particular, the

Veterans Court did not address Congress's decision to amend the definition of "health-plan contract" in the 2010 Amendment. By striking a provision that defined that term to include state-mandated automobile insurance, 38 U.S.C. § 1725(f)(2)(E), Congress demonstrated that it understood that reimbursement would continue to be barred if the definition of "health-plan contract" remained the same, and that it wanted to treat veterans injured in automobile accidents differently from other situations involving health insurance. The legislative history indicates that Congress wanted to help a veteran injured in a motor vehicle accident to recover from VA what could not be obtained from a third-party insurer. H.R. Rep. 111-55, at 2-3 (noting that proposed amendment would address a situation in which a veteran has "minimal health coverage through a state-mandated automobile insurance policy" that does not pay the full cost of treatment).[4]

If the Veterans Court is correct that the statute unambiguously does not bar reimbursement to a veteran if part of his expenses are covered by a health-plan contract, there would have been no need to amend the definition of "health-plan contract" as Congress did. The changed language only makes sense if Congress

[4] *See also* S. Hrg. 111-76 (Senate Committee on Veterans' Affairs), Apr. 22, 2009, at 41-42 (VA letter discussing proposal to amend the definition of "health-plan contract" in section 1725(f)(2)(E) and noting estimated costs of implementation).

understood that, apart from state-mandated vehicle insurance, the existing rule in section 1725(b)(3)(B) related to "health-plan contracts" would remain unchanged and have operative meaning.

Finally, the Veterans Court overlooked that the Congressional Budget Office's (CBO) estimated costs to implement the 2010 Amendment are far lower than the costs now estimated by VA. During consideration of the 2010 Amendment, CBO estimated, based upon information from VA, that the proposed legislation would result in about 700 new claims a year over the 2010 to 2014 period, and about 2,000 claims for emergency treatment provided over the 2005 to 2009 period, resulting in additional costs of "$1 million a year." H.R. Rep. 111-55, at 3; *see also* S. Hrg. 111-76, Apr. 22, 2009, at 42 (VA estimated costs of implementing S. 404 to be $500,000 for fiscal year 2010, $3 million over five years, and $7.8 million over ten years). VA presently estimates that implementing the Veterans Court's decision could cost far more: between $75 million and $272 million in the first year alone, between $394 million and $1.4 billion over five years, and between $1.7 billion and $6.5 billion over ten years.[5] Although the

[5] These figures are estimates and may increase if veterans' reliance on non-VA emergency treatment grows in response to this ruling, if it is sustained. VA has revised the figures reflected in its motion to stay before the Veterans Court, in which it stated that the implementation costs would exceed $2.5 billion over five years and over $10.7 billion over ten years. Appx49-50.

assumptions underlying these estimates have changed somewhat since 2009, the significant cost difference between the CBO estimate and VA's current estimate is telling.

III. If The Court Finds The Statute Ambiguous, It Should Defer To VA's Reasonable Interpretation

If the Court finds that the statute is ambiguous, it should defer to VA's interpretation of the statute, which was reasonable and entitled to deference.

The Court will "sustain a regulation that is consistent with the language of the statute and is a plausible or reasonable interpretation of the law" and "[s]ubstantial deference is given to the statutory interpretation of the agency authorized to administer the statute." *Terry v. Principi*, 340 F.3d 1378, 1383 (Fed. Cir. 2003) (citation omitted) (citing, *inter alia*, *Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843-44 (1984)). When analyzing a statute under *Chevron*, the first step is to determine "whether Congress has directly spoken to the precise question at issue" by employing "traditional tools of statutory construction." 467 U.S. at 842, 843 n.9. "If the intent of Congress is clear, that is the end of the matter; for the court . . . must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43. This Court has also recognized that "where the meaning of a statutory provision is ambiguous, we must take care not to invalidate otherwise reasonable regulations simply because they do not provide for a pro-claimant outcome in every imaginable case." *Nat'l Org. of Veterans*

Advocates, Inc. v. Sec'y of Veterans Affairs, 809 F.3d 1359, (Fed. Cir. 2016) (quoting *Sears v. Shinseki*, 349 F.3d 1326, 1331-32 (Fed. Cir. 2002)).

VA's interpretation of the statute is reasonable and a proper exercise of its broad rule-making authority. 38 U.S.C. § 501(a). VA reasonably concluded that, while Congress removed the phrase "or in part" from section 1725(b)(3)(C), it did not modify section 1725(b)(3)(B), thus demonstrating that it intended no change in VA's longstanding rule barring any reimbursement whatsoever if a veteran had coverage for care under a health-plan contract. *See* 77 Fed. Reg. at 23,616.

The Veterans Court narrowly focused on the 2010 Amendment, without giving due consideration to the original intent of the 1999 Act, and VA's pre-2010 interpretation of the Act consistent with that intent. H.R. Rep. 106-237, at 38. VA acted in accordance with the 1999 statute when it promulgated 38 C.F.R. § 17.1002(f) long before the 2010 Amendment. The Veterans Court appears to have acknowledged as much, noting that section 17.1002(f) "reiterated the statutory command" of section 1725. Appx6. The Veterans Court faulted VA for not "remedy[ing]" its regulation after the 2010 Amendment, but fails to recognize that the 2010 Amendment had no effect upon section 1725(b)(3)(B). The Veterans Court's opinion is also internally inconsistent insofar it invalidated 38 C.F.R. § 17.1002(f) but did not disturb 38 C.F.R. § 17.1003(c), which includes similar language regarding reimbursement of emergency transportation expenses.

Moreover, the substantial budgetary impact of the Veterans Court's decision weighs heavily in favor of deferring to VA's interpretation of the statute. As noted above, if upheld, the ruling would require VA to pay claims that have heretofore been denied, resulting in an unbudgeted cost potentially reaching into the billions of dollars over several years. Deferring to VA's interpretation would recognize these substantial costs, and Congress's expectation that VA would promulgate regulations and take steps to contain costs. *See* 38 U.S.C. §§ 1725(c)(1)(A)-(C).[6]

Accordingly, to the extent that the statute is ambiguous, the Veterans Court's decision to reject VA's interpretation of 38 U.S.C. § 1725 and to invalidate 38 C.F.R. § 17.1002(f) was contrary to law and should be reversed.

CONCLUSION

For the foregoing reasons, we respectfully request that the Court reverse the judgment below.

CHAD A. READLER
Acting Assistant Attorney General

[6] *See also* H.R. Rep. 106-237, at 38-39 ("The measure also provides ample authority for VA to effectively and efficiently administer this authority to ensure that scarce resources are not inappropriately paid out on claims not contemplated under this section. . . . In the interest of ensuring that scarce VA medical care funds are protected, the Committee expects that VA will act aggressively in this regard both in the development of implementing policies as well as in the day-to-day management of this new authority, to ensure that it is obtaining all needed information from both the veteran and the provider of care.").

ROBERT E. KIRSCHMAN, JR.
Director

s/Martin F. Hockey, Jr.
MARTIN F. HOCKEY, JR.
Deputy Director

s/Alexander O. Canizares
ALEXANDER. O. CANIZARES
Trial Attorney
Department of Justice, Civil Division
Commercial Litigation Branch
P.O. Box 480, Ben Franklin Station
Washington, D.C. 20044
Telephone: (202) 305-3274

Attorneys for Respondent-Appellee

Of Counsel:

JESSICA TANNER
Attorney
Office of General Counsel, Health Care
Law Group
Department of Veterans Affairs
810 Vermont Ave., N.W.
Washington, D.C. 20420

February 6, 2017

CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that on the 7th day of February, 2017, a copy of the Corrected Brief for Respondent-Appellee was filed electronically. This filing was served electronically to all parties by operation of the Court's electronic filing system.

/s/ Alexander O. Canizares

ADDENDUM – CAVC DECISION

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 14-0957

RICHARD W. STAAB, APPELLANT,

V.

ROBERT A. MCDONALD,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

On Appeal from the Board of Veterans' Appeals

(Decided April 8, 2016)

Louis J. George, *Patrick A. Berkshire*, and *Barton F. Stichman*, all of Washington, D.C., were on the brief for the appellant.

Leigh A. Bradley, General Counsel, *Mary Ann Flynn*, Chief Counsel, *Richard Mayerick*, Deputy Chief Counsel, and *Lavinia A. Derr*, Appellate Attorney, all of Washington, D.C., were on the brief for the appellee.

Before LANCE, PIETSCH, and GREENBERG, *Judges*.

GREENBERG, *Judge*: This is a case of statutory interpretation. The appellant, Richard W. Staab, appeals through counsel a December 6, 2013, Board of Veterans' Appeals (Board) decision that denied entitlement to reimbursement of medical expenses incurred for emergency medical services provided at non-VA medical facilities from December 27, 2010, through December 31, 2011. Record (R.) at 3-9. The appellant argues that the Board erred in finding him ineligible for reimbursement under 38 U.S.C. § 1725 because (1) under the plain meaning of the statute, the partial coverage of his medical expenses by Medicare does not render him ineligible for reimbursement; (2) the legislative history of amendments to section 1725 supports this reading and application of the statute; (3) the Secretary's regulation concerning eligibility for reimbursement, 38 C.F.R. § 17.1002(f), is inconsistent with the statute and invalid; and (4) the Board provided an inadequate statement of reasons or bases for denying reimbursement for *all* of the appellant's treatments, failing to determine which of his treatments were not covered by Medicare at all. Appellant's Brief (Br.)

at 5-18. On February 3, 2016, the appellant filed a motion for oral argument.

This appeal is timely, and the Court has jurisdiction over the case pursuant to 38 U.S.C. §§ 7252(a) and 7266. As the Board failed to properly apply the statute and relied on an invalid regulation in denying the appellant's claim, the Court will vacate the Board's December 2013 decision, reverse the Board's determination that the appellant's partial coverage by Medicare is a legal bar to reimbursement, and remand to the Board for readjudication the matter of the appellant's entitlement to reimbursement for the claimed medical treatment. Additionally, because oral argument would not "materially assist in the disposition of this appeal," the appellant's motion will be denied. *Janssen v. Principi*, 15 Vet.App. 370, 379 (2001) (per curiam); *see Mason v. Brown*, 8 Vet.App. 44, 59 (1995).

The appellant had active service in the U.S. Air Force from November 1952 to November 1956 as a ground radio operator (29350). R. at 471 (DD Form 214). In December 2010, the appellant suffered a heart attack and one or more strokes, and was hospitalized in a non-VA hospital. R. at 260, 451-55. At that hospital, he subsequently underwent open heart surgery. R. at 405. He was ultimately discharged from the hospital in June 2011. R. at 455. During the appellant's treatment, his care was not coordinated with VA, and concerning his medical treatment he sought no approval or authorization from VA. R. at 457.

VA denied the appellant's claims for reimbursement of the costs of his medical care from (1) CentraCare Laboratory Services between April 18, 2011, and June 24, 2011; (2) St. Cloud Hospital between December 28, 2010, and March 3, 2011; (3) St. Benedict's Center between January 7, 2011, and April 15, 2011. R. at 906-55. The cost of this care has been estimated by the appellant to be approximately $48,000. R. at 455.

In May 2012, the appellant argued to VA that he could not have obtained VA pre-approval for the treatment because the stroke he suffered had rendered him unable to think clearly and communicate. R. at 455. He also alleged that his family was not apprised of any need to coordinate his care or coverage with VA. R. at 457. In May 2013, the appellant's attorney stated at a hearing before the Board that VA did not try to have the appellant placed at a nearby VA facility during the time of his care; that the appellant's heart attack and stroke were emergent; and that if approval for reimbursement is granted, the appellant would be able to provide an exact amount of costs he incurred from his medical treatment. R. at 260-62.

In December 2013, the Board issued the decision now on appeal, denying entitlement to reimbursement for the appellant's non-VA medical care. R. at 3-9. The Board stated that the appellant was ineligible for reimbursement under 38 U.S.C. § 1725 because he is covered by Medicare, and that "[t]he claim must be denied as a matter of law, and the issue of whether the medical care was emergent or not is irrelevant." R. at 6. The Board acknowledged that the appellant was seeking only "reimbursement for the portion of medical expenses not covered by Medicare," but citing 38 C.F.R. § 17.1002(f), stated that "the fact that not all of the medical expenses from this treatment were covered completely by Medicare is not relevant under the foregoing regulation." R. at 8.

VA will reimburse a veteran for the reasonable value of emergency treatment furnished the veteran in a non-VA facility if the veteran is personally liable for the treatment and an active participant in the VA health care system. 38 U.S.C. § 1725(a), (b)(1). According to that statute, a veteran qualifies as "personally liable" if he or she

> (A) is financially liable to the provider of emergency treatment for that treatment;
> (B) has no entitlement to care or services under a health-plan contract (determined, in the case of a health-plan contract as defined in subsection (f)(2)(B) or (f)(2)(C), without regard to any requirement or limitation relating to eligibility for care or services from any department or agency of the United States);
> (C) has no other contractual or legal recourse against a third party that would, in whole, extinguish such liability to the provider; and
> (D) is not eligible for reimbursement for medical care or services under section 1728 of this title [for reimbursement of emergency medical treatment costs for service-connected disabilities].

38 U.S.C. § 1725(b)(3). Subsection (f)(2)(B) of section 1725 refers to insurance programs described in sections 1811 and 1831 of the Social Security Act ("Medicare"), and subsection (f)(2)(C) of section 1725 refers to state plans for medical assistance approved under title XIX of the Social Security Act ("Medicaid"). In December 2009, section 1725 was amended to its present form, to "allow the VA to reimburse veterans for treatment in a non-VA facility if they have a third-party insurer that would pay a portion of the emergency care." H.R. REP. 111-55, at 3.[1]

---

[1]On March 30, 2009, Representative Debbie Halvorson brought the bill amending 38 U.S.C. § 1725, H.R. 1377, to a vote in the House, where it passed. 155 CONG. REC. H4069 (Mar. 30, 2009). On December 18, 2009, the bill was discharged from a Senate committee and brought to a Senate vote, with unanimous consent, by Senator Robert Menendez. 155 CONG. REC. S13468 (Dec. 18, 2009). In remarks concerning the bill before the vote, Senator Daniel Akaka, Chairman of the Committee on Veterans' Affairs, stated that "H.R. 1377 would modify current law so that a

The Secretary has adopted a regulation that states, in part, that a condition for reimbursement for emergency treatment under 38 U.S.C. § 1725 will be made only if "[t]he veteran has no coverage under a health-plan contract for payment or reimbursement, in whole or in part, for the emergency treatment." 38 C.F.R. § 17.1002(f) (2015). In an April 20, 2012, notice of final rulemaking, the Secretary stated that "section 1725(b)(3)(B) requires that the veteran have 'no entitlement to care or services under a health-plan contract,' which means that any entitlement, even a partial one, bars eligibility under section 1725(b)," and the Secretary refused to remove the language "or in part" from 38 U.S.C. § 17.1002(f). 77 Fed. Reg. 23,615-16 (2012).

First, the Court will address the Secretary's contention that "neither the evidence of record nor [the] [a]pellant's brief demonstrate[s] that any case or controversy associated with this claim presently exists" because "the record and [a]pellant's brief are devoid of a specific amount charged" for the medical services in question. Secretary's Br. at 3. However, the appellant has asserted, and the record shows, that the cost of the medical care in question that has been documented in the record is estimated by the appellant to be approximately $48,000. R. at 399-412, 455; Appellant's Br. at 2. Thus, the Secretary's argument in this regard is incorrect and must fail. *See Polovick v. Nicholson*, 24 Vet.App. 257, 258 (2006) ("A justiciable controversy is not a difference or dispute of a hypothetical or abstract character; it must be definite and concrete, touching the legal relations of parties having adverse legal interests." (quoting *Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 240 (1937))).

Next, the Court agrees with the appellant's contention that the Board's application of 38 U.S.C. § 1725 frustrates the intent of Congress to reimburse veterans who "are not wholly covered by a health-plan contract or other third party recourse." Appellant's Br. at 6. The Board finds that "the fact that not all of the medical expenses from this treatment were covered completely by Medicare is not relevant," but this finding is incorrect. R. at 8.

The Court reviews *de novo* the legal question whether the intent of Congress is unambiguously expressed in 38 U.S.C. § 1725, or whether Congress left a gap for VA to fill. *See Chevron v. Nat'l Resources Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984); *Lane v. Principi*,

---

veteran who has outside insurance would be eligible for reimbursement in the event that the outside insurance does not cover the full amount of the emergency care. In essence, VA would become the payer of last resort in such cases." *Id.* The bill was ultimately approved as law on February 1, 2010.

339 F.3d 1331, 1339 (Fed. Cir. 2003) ("[I]nterpretation of a statute or regulation is a question of law . . . ."). If the meaning of 38 U.S.C. § 1725 is clear from its plain language, that meaning controls the question and that is the end of the matter. *See Chevron*, 467 U.S. at 842-43 ("If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress . . . . "); *Tropf v. Nicholson*, 20 Vet.App. 317, 320 (2006).

Subsection(b)(3)(B) of 38 U.S.C. § 1725, states that a veteran is personally liable for emergency treatment if the veteran has "no *entitlement* to care or services under a health-plan contract" (emphasis added). The term "entitlement" means "an *absolute right* to a (usu. monetary) benefit." BLACK'S LAW DICTIONARY (10th ed. 2014) (emphasis added); *see Nielson v. Shinseki*, 23 Vet.App. 56, 59 (2009) ("It is commonplace to consult dictionaries to ascertain a term's ordinary meaning."). Thus, subsection 1725(b)(3)(B) appears to contemplate a situation when coverage under a health-plan contract would *wholly* extinguish a veteran's financial liability. *See Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 409 (1993) ("The starting point in interpreting a statute is its language."); *Myore v. Nicholson*, 489 F.3d 1207, 1211 (Fed. Cir. 2007) ("'Statutory interpretation begins with the language of the statute, the plain meaning of which we derive from its text and its structure.'" (quoting *McEntee v. Merit Sys. Prot. Bd.*, 404 F.3d 1320, 1328 (Fed. Cir. 2005))).

This reading of subsection 1725(b)(3)(B) is consistent with the rest of subsection 1725(b)(3). *See Gazelle v. McDonald*, __ Vet.App. __, __, 2016 WL 386543, at *2 (U.S. Vet. App. Feb. 2, 2016) (holding that statutes "must be considered as a whole and in the context of the surrounding statutory scheme"). Subsections 1725(b)(3)(A), (C),and (D) all contemplate situations that would wholly extinguish the veteran's responsibility for payment, whether because the veteran owes nothing to the provider of emergency treatment (§ 1725(b)(3)(A)), because a contractual or legal recourse against a third party would extinguish the veteran's liability in whole (§ 1725(b)(3)(C)), or because the veteran is eligible for reimbursement under section 1728 (§ 1725(b)(3)(D)). Thus, it follows that subsection (B), to be consistent with the remainder of the subsection, must contemplate a health-plan contract covering the treatment *in full*.

This reading is further bolstered in the context of the remainder of section 1725, particularly subsections 1725(c)(4) and (f)(3), which more broadly include health-plan contracts, including

Medicare, in the category of a "third party." *See* 38 U.S.C. § 1725(f)(3)(E). The statute establishes that VA reimbursement is warranted when coverage by a third party is less than total. *See* 38 U.S.C. § 1725(c)(4)(A), (B). Furthermore, 38 U.S.C. § 1725(c)(4)(D) provides that reimbursement by the Secretary will not be made "for any copayment or similar payment that the veteran owes the third party or for which the veteran is responsible under a health-plan contract." The Court agrees with the appellant's argument that "[t]his provision would be superfluous if reimbursement is barred whenever a veteran has partial coverage from a health-plan contract." Appellant's Br. at 10; *see Moskal v. United States*, 498 U.S. 103, 109 (1990) (noting "the established principle that a court should 'give effect if possible, to every clause and word of a statute'" (quoting *United States v. Menasche*, 348 U.S. 528, 538-39 (1955))). Therefore, it is clear from the plain language of the statute that Congress intended VA to reimburse a veteran for that portion of expenses not covered by a health-plan contract. *See Chevron*, 467 U.S. at 842-43; *Tropf*, 20 Vet.App. at 320.

The legislative history of the 2009 amendment to section 1725 also supports this reading, as Congress clearly intended that "VA [be] responsible for the cost of the emergency treatment which exceeds the amount payable or paid by the third-party insurer." H.R. REP. NO. 111-55 at 6; *see Conroy v. Aniskoff*, 509 U.S. 511, 517 (1993) ("The long and consistent history and the structure of this legislation therefore leads us to conclude that–*just as the language of [the statute] suggests*–Congress made a *deliberate* policy judgment . . . ." (emphasis added)).

In light of subsection 1725(b)(3)(B)'s clear meaning, the Court agrees with the appellant's contention that 38 C.F.R. § 17.1002(f) is invalid. Where a regulation is duly promulgated by the appropriate agency, "the assertion of its invalidity must be predicated either upon its being inconsistent with the statutes or upon its being in itself unreasonable or inappropriate." *United States v. Morehead*, 243 U.S. 607, 614 (1917) (Brandeis, J.). When it was originally enacted, § 17.1002(f) reiterated the statutory command of 38 U.S.C. § 1725. After Congress amended section 1725 in 2009, however, the Secretary's regulation became wholly inconsistent with the statute, and the Secretary declined to remedy this inconsistency. Congress intended that veterans be reimbursed for the portion of their emergency medical costs that is not covered by a third party insurer and for which they are otherwise personally liable, and because the regulation does not execute the language of the statute or the intent of Congress, it is invalid and will be set aside by the Court. *See* 38 U.S.C. § 7261(a)(3) (the Court shall "hold unlawful and set aside . . . conclusions, rules, and regulations

issued or adopted by the Secretary . . . found to be (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law").

Remand is thus required for the Board to readjudicate the appellant's claim and properly apply 38 U.S.C. § 1725. *See Tucker v. West*, 11 Vet.App. 369, 374 (1998) (remand is appropriate "where the Board has incorrectly applied the law . . . ."). Because the Court is remanding the appellant's claim for readjudication, it will not address the appellant's remaining argument concerning the Board's failure to determine which individual treatments were covered by Medicare. *See Dunn v. West*, 11 Vet.App. 462, 467 (1998) (remand of the appellant's claim under one theory moots the remaining theories advanced on appeal).

On remand, the appellant may present, and the Board must consider, any additional evidence and arguments, to include the remaining argument raised in this appeal if necessary. *See Kay v. Principi*, 16 Vet.App. 529, 534 (2002). This matter is to be provided expeditious treatment. *See* 38 U.S.C. § 7112; *see also Hayburn's Case*, 2 U.S. (2 Dall.) at 410, n. ("[M]any unfortunate and meritorious [veterans], whom Congress have justly thought proper objects of immediate relief, may suffer great distress, even by a short delay, and may be utterly ruined, by a long one.").

For the foregoing reasons, the appellant's February 3, 2016, motion for oral argument is denied. The Board's December 6, 2013, decision is VACATED; the determination that the appellant's partial Medicare coverage is a bar to eligibility under 38 U.S.C. § 1725 is REVERSED; and the matter of reimbursement for the appellant's claimed emergency medical care costs is REMANDED for readjudication. Further, 38 C.F.R. § 17.1002(f) is held invalid and SET ASIDE.

Not published
NON-PRECEDENTIAL

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

NO. 14-0957

RICHARD W. STAAB, APPELLANT,

V.

ROBERT A. MCDONALD,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before LANCE, PIETSCH, and GREENBERG, *Judges.*

O R D E R

Note: Pursuant to U.S. Vet. App. R. 30(a),
this action may not be cited as precedent.

On April 8, 2016, in a panel decision, the Court vacated the December 6, 2013, decision of the Board of Veterans' Appeals (Board) that denied entitlement to reimbursement of medical expenses incurred for emergency medical services provided at non-VA medical facilities from December 27, 2010, through December 31, 2011. The Court reversed the Board's determination that the appellant's partial Medicare coverage is a bar to eligibility under 38 U.S.C. § 1725. Further, the Court remanded for readjudication the matter of reimbursement for the appellant's claimed emergency medical care costs. Additionally, the Court held that 38 C.F.R. § 17.1002(f) is invalid, and the Court set aside that regulation.

On April 28, 2016, the Secretary filed a timely motion for reconsideration and/or for full-Court review. "[A] motion for . . . panel [reconsideration] . . . shall state the points of law or fact that the party believes the Court has overlooked or misunderstood." U.S. VET. APP. R. 35(e)(1). The Court did not overlook or misunderstand any argument that was properly before it. The Secretary has not presented any argument that warrants reconsideration by the panel.

Upon consideration of the foregoing, it is

ORDERED that the motion for reconsideration by the panel is denied. It is further

ORDERED that the motion for full-Court consideration is held in abeyance pending further order of the Court.

DATED: June 29, 2016 PER CURIAM.

Copies to:

Patrick Berkshire, Esq.

VA General Counsel (027)

Designated for electronic publication only

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

NO. 14-0957

RICHARD W. STAAB, APPELLANT,

V.

ROBERT A. MCDONALD,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before HAGEL, *Chief Judge*, and KASOLD, LANCE,
DAVIS, SCHOELEN, PIETSCH, and GREENBERG, *Judges.*[1]

O R D E R

Note: Pursuant to U.S. Vet. App. R. 30(a),
this action may not be cited as precedent.

On April 28, 2016, the Secretary filed a timely motion for reconsideration and/or for full-Court review of the Court's April 8, 2016, panel decision. On June 29, 2016, the Court denied the motion for reconsideration and held the motion for full-Court review in abeyance pending further order of the Court.

"Motions for full-Court review are not favored. Ordinarily they will not be granted unless such action is necessary to secure or maintain uniformity of the Court's decisions or to resolve a question of exceptional importance." U.S. VET. APP. R. 35(c). In this matter, the Secretary has not shown that either basis exists to warrant full-Court review.

Upon consideration of the foregoing, it is

ORDERED that the motion for full-Court review is denied.

DATED: July 22, 2016 PER CURIAM.

KASOLD, *Judge*, dissenting: If the "exceptional importance" criterion for granting en banc review is to mean anything at all, *see* U.S. VET.APP. R. 35(c), it must apply to cases such as this where a panel of the Court is taking the rare action of invalidating a regulation *and* the Secretary has averred that the Court's decision would have broad implications affecting multiple facets of VA's

[1] Judge Bartley has recused herself in this case.

reimbursement process. Accordingly, I dissent from the denial of en banc review.

Copies to:

Patrick Berkshire, Esq.

VA General Counsel (027)

Not published

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

NO. 14-0957

RICHARD W. STAAB, APPELLANT,

V.

ROBERT A. MCDONALD,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before LANCE, PIETSCH, and GREENBERG, *Judges*.

O R D E R

Note: Pursuant to U.S. Vet. App. R. 30(a),
this action may not be cited as precedent.

On July 14, 2016, the Secretary filed a motion to stay the precedential effect of the Court's April 8, 2016, panel decision in *Staab v. McDonald*, 28 Vet.App. 50 (2016), pending en banc review by the Court. Secretary's Motion (Mot.) at 1-13. The Secretary contends that "there is a strong likelihood of success if the request for *en banc* review is granted." *Id.* at 4. On July 15, 2016, the appellant filed a notice of intent to file an opposition to the Secretary's motion. Appellant's Notice at 1. On July 21, 2016, the appellant filed a motion for a 30-day extension of time to file his opposition. Appellant's Motion at 1.

On July 22, 2016, the Court denied en banc review of the panel decision in this matter. Therefore, the Secretary's motion to stay is moot, as the basis for granting a stay was denied. Should the Secretary choose to appeal this case, he is free to submit a new motion to stay the precedential effect of the Court's decision. *See Ribaudo v. Nicholson*, 20 Vet.App. 552, 556 (2007) (en banc). As the Court is denying the Secretary's motion to stay the precedential effect of the *Staab* decision, it also holds that the appellant's motion for an extension to oppose that motion is dismissed as moot.

Accordingly, it is

ORDERED that the Secretary's motion is DISMISSED as moot. It is further

ORDERED that the appellant's motion for an extension of time to file an opposition to the Secretary's motion is DISMISSED as moot.

DATED: July 22, 2016 PER CURIAM

Copies to:

Patrick Berkshire, Esq.

VA General Counsel (027)

Not Published

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

NO: 14-957

RICHARD W. STAAB, APPELLANT,

V.

ROBERT A. MCDONALD,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

JUDGMENT

The Court has issued a decision in this case, and has acted on a motion under Rule 35 of the Court's Rules of Practice and Procedure.

Under Rule 36, judgment is entered and effective this date.

Dated: July 22, 2016

FOR THE COURT:

GREGORY O. BLOCK
Clerk of the Court

By: /s/ Michael V. Leonard
Deputy Clerk

Copies to:

Patrick Berkshire, Esq.

VA General Counsel (027)