Vet. App. No. 18-6091

IN THE UNITED STATES COURT OF APPEALS
FOR VETERANS CLAIMS

AMANDA JANE WOLFE and PETER E. BOERSCHINGER,
Petitioners,

v.

ROBERT L. WILKIE,
Secretary of Veterans Affairs,
Respondent.

RESPONDENT'S RESPONSE TO PETITIONERS' AMENDED PETITION FOR CLASS RELIEF IN THE NATURE OF A WRIT OF MANDAMUS

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TABLE OF CONTENTS

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Petitioners,	)	
v.	)	Vet. App. No. 18-6091
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Pursuant to U.S. Vet.App. Rule 21(d) and the Order of this Court dated February 1, 2018, Respondent, Robert L. Wilkie, Secretary of Veterans Affairs, respectfully opposes Petitioners' amended petition for class relief in the nature of a writ of mandamus.

INTRODUCTION

Petitioner Amanda Jane Wolfe (Wolfe) petitioned this Court on October 30, 2018, for extraordinary relief in the nature of a writ of mandamus, for herself and a class of persons similarly situated, declaring that 38 C.F.R § 17.1005(a)(5) is invalid. Amended Petition (Am. Pet.) at 1. That regulation in part governs VA's responsibility to reimburse veterans for emergency medical care they receive for non-service-connected conditions at non-VA facilities. Specifically, it obligates VA to deny reimbursement for copayments, coinsurance, and deductible payments

incurred during emergency visits to non-VA hospitals for non-service-connected conditions. 38 C.F.R. § 17.1005(a)(5). In the amended petition, Wolfe seeks to represent a class of petitioners that consists of all individuals who have been, or will be, harmed by Section 17.1005(a)(5) and asks the Court to (1) declare the regulation invalid, (2) enjoin the Secretary from denying reimbursement to veterans affected by the regulation, (3) invalidate all decisions already made by the Secretary under the regulation, and (4) order readjudication of the invalidated decisions. Am. Pet. at 2–3.

Wolfe's claim lacks merit in every respect, from its jurisdictional foundations, to its substantive challenge to Section 17.1005(a)(5), to its request for class-based relief. First, Wolfe has not demonstrated a clear and indisputable entitlement to the extraordinary relief she seeks, as this Court lacks jurisdiction to entertain her direct regulatory challenge. She missed her opportunity to bring an action attacking that regulation in the Federal Circuit, and she cannot remedy that error by asking this Court to act outside its jurisdiction. Further, Wolfe has not shown that she lacks an adequate alternative means to obtain the requested relief, as she concedes that she is vigorously pursuing her own administrative appeal of the denial of her claim.

Second, even if the Court finds that it has jurisdiction to consider the validity of Section 17.1005(a)(5) in this context, that regulation is consistent with its enabling legislation, the Emergency Care Fairness Act (ECFA), codified at 38 U.S.C. § 1725(c)(4)(D), which provides that the Secretary may not reimburse

veterans for “any copayment or similar payment” owed to a third party or an insurer for emergency medical care for non-service-connected conditions. Despite Wolfe’s arguments to the contrary, the Secretary’s regulation represents a reasonable interpretation of the ECFA and, for that reason, it deserves appropriate deference. Wolfe’s own reading of the ECFA would render its language a nullity, and the Supreme Court has long instructed that statutes may not be read in this way.

Finally, assuming any relief at all is appropriate for Wolfe, class-based relief is not. Wolfe is inconsistent in defining her putative class, and that inconsistency leaves little confidence in the merits of her request for class certification. Moreover, the circumstances of Wolfe’s own reimbursement claim, including her present administrative appeal, render her claim atypical of the proposed class and make her an unsuitable class representative. Most importantly, class-based relief simply makes no sense in the context of Wolfe’s regulatory challenge: if the Court invalidates Section 17.1005(a)(5) as she requests, all claimants with non-final reimbursement claims will be entitled to take advantage of that ruling, whether or not they are part of this litigation. Under these circumstances, Wolfe has not carried her burden to show that class-based relief is useful or appropriate.

Two months after Wolfe filed her original petition, on January 1, 2019, she submitted a motion for leave to amend her petition to join a new petitioner, Peter E. Boerschinger (Boerschinger), who sought to assert a different claim on behalf

a new class. In an order dated February 1, 2019, the Court granted Wolfe leave to file her amended petition and to join Boerschinger in this action.

Boerschinger alleges that he and the class of VA benefits claimants he seeks to represent received incorrect VA notices and letters in response to their requests for reimbursement of emergency medical expenses incurred at non-VA hospitals for non-service-connected conditions. Am. Pet. at 1–2. He asserts that VA erroneously instructed claimants that in order to be eligible for reimbursement, they must have neither whole nor partial health insurance coverage. *Id.* at 17–19. That information is inconsistent with *Staab v. McDonald*, 28 Vet.App. 50 (2016), which invalidated a former VA regulation prohibiting reimbursement if the claimant had any insurance coverage. *Id.*

Boerschinger's concern about VA's letters is well-taken, and the Secretary is even now engaging in fulsome efforts to address the substance of his claim. Nevertheless, his request for a class-based writ should fail. He is well within the period available to him to seek review of the denial of his reimbursement claim, which has been readjudicated and properly denied on the ground that the remaining balance of his hospital bill consists of a deductible owed as part of his Medicare coverage. Thus, like Wolfe, he has an adequate alternative remedy that obviates the need for extraordinary relief, and the potential for appellate review of his claim means his claim is atypical of the class and that he cannot be a reliable

class representative. For these reasons, both Wolfe's and Boerschinger's requests for extraordinary relief on a class basis should be denied.

BACKGROUND

I. Petitioner Wolfe

Wolfe alleges that in September 2016, she suffered an acute episode of appendicitis (a non-service-connected condition) that required an emergency laparoscopic appendectomy. Am. Pet. at 9. The procedure was performed at Mercy Medical Center in Clinton, Iowa, a non-VA healthcare facility. *Id.* Her employer-sponsored insurance contract provided benefits that covered nearly all of the hospital bill. *Id.* The non-covered amount, $2,558.34, consisted of a copayment of $202.93 and a coinsurance obligation of $2,355.41. *Id.*

Wolfe submitted a claim to VA for reimbursement of the balance of the bill. *Id.* at 10. Her claim was denied in a decision dated February 7, 2018, as the amount for which she sought reimbursement was comprised of a copayment and coinsurance, both of which are excluded under Section 17.1005(a)(5). *Id.* On July 12, 2018, Wolfe filed a Notice of Disagreement (NOD). *See id.* VA acknowledged receipt of the NOD on August 14, 2018. *Id.* A Statement of the Case (SOC) is forthcoming.

II. Petitioner Boerschinger

In April 2018, Boerschinger received non-service-connected emergency medical care from a non-VA provider in Michigan. *Id.* at 11. Claims were later submitted to VA for reimbursement of certain costs associated with that care. *Id.*

On November 27, 2018, VA sent Boerschinger a letter denying reimbursement, giving the reason as: "veteran must not have coverage under a health-plan contract for payment or reimbursement, in whole or in part, for the emergency treatment." *Id.*, Exhibit (Ex.). I. Attached to the amended petition are other letters sent to other reimbursement claimants which, while they do not reflect a denial of a claim on the same ground as applicable to Boerschinger, list as one eligibility criterion that the claimant not have health insurance coverage, *see* Am. Pet., Exs. J, K, L, M, N, O.

On March 13, 2019, VA readjudicated Boerschinger's reimbursement claims. Declaration of Dr. Kameron L. Matthews, Deputy Under Secretary for Health for Community Care, VHA, attached hereto as Ex. 1, ¶ V.i. The denial notification is attached hereto as Exhibit 2. Reimbursement was again denied, but not for the reason that Boerschinger had whole or partial other insurance. Ex. 2. Rather, reimbursement was denied because the remaining cost for his emergency care consists of a deductible he owes as part of his Medicare Part A coverage, which VA cannot reimburse pursuant to Section 17.1005(a)(5). *Id.* Boerschinger has been afforded a one-year period to appeal this decision. *Id.*

ARGUMENT

I. Wolfe's Regulatory Challenge Lacks a Jurisdictional Foundation, Is Without Substance, and Presents No Reason for Granting Relief on a Class Basis.

A. Wolfe's Amended Petition Does Not Satisfy the Demanding Prerequisites for the Issuance of Extraordinary Relief.

It has been firmly established that, in addition to its appellate jurisdiction, this Court possesses jurisdiction under the All Writs Act, 28 U.S.C. § 1651(a), to issue extraordinary writs to VA officials. *See, e.g.*, *Erspamer v. Derwinski*, 1 Vet.App. 3, 7 (1990)*; Cox v. West*, 149 F.3d 1360, 1363 (Fed. Cir. 1998). However, it is equally clear that "'[t]he remedy of mandamus is a drastic one, to be invoked only in extraordinary situations.'" *Lane v. West*, 12 Vet.App. 220, 221 (1999) (*quoting Kerr v. U.S. Dist. Court*, 426 U.S. 394, 402 (1976)).

Before the Court may issue a writ, three conditions must be satisfied. The petitioner must demonstrate: (1) a clear and indisputable right to the writ; and (2) lack of adequate alternative means to obtain the desired relief, thus ensuring that the writ is not used as a substitute for the appeals process; and also (3) the Court must be convinced, given the circumstances, that the issuance of the writ is warranted. *Cheney v. U.S. Dist. Court,* 542 U.S. 367, 380–81 (2004). This Court has stressed the need for a petitioner seeking extraordinary relief to demonstrate a "clear and indisputable" entitlement and the lack of adequate alternative means to obtain the requested relief. *Erspamer*, 1 Vet.App. at 10 (citing *Bankers Life &*

Casualty Co. v. Holland, 346 U.S. 379, 384 (1953)). An extraordinary writ is not suitable in this case because Wolfe does not satisfy either requirement.

The primary relief Wolfe seeks is for this Court to declare 38 C.F.R. § 17.1005(a)(5) invalid. Wolfe argues that Section 17.1005(a)(5), which prohibits VA from reimbursing a veteran "for any copayment, deductible, coinsurance, or similar payment" incurred during emergency treatment at non-VA facilities for non-service-connected conditions, is inconsistent with the ECFA, which provides that the Secretary may not reimburse veterans for "any copayment or similar payment" owed to a third party or an insurer for such emergency care, *see* Am. Pet. at 13–17; 38 U.S.C. § 1725(c)(4)(D). Following from that premise, Wolfe asks the Court to enjoin the Secretary from denying reimbursement to veterans affected by the regulation, invalidate all decisions already made by the Secretary under the regulation, and order readjudication of the invalidated decisions.

1. Wolfe Lacks a Clear and Indisputable Right to Relief, as She Asks This Court to Act Outside Its Jurisdiction to Invalidate Section 17.1005(a)(5).

Pursuant to 38 U.S.C. § 7252(a), this Court has exclusive jurisdiction to review decisions of the Board of Veterans' Appeals (Board). The Court has the power to affirm, modify, or reverse a decision of the Board or to remand the matter, as appropriate. 38 U.S.C. § 7252(a). The extent of this Court's review is, however, limited in scope by 38 U.S.C. § 7261. That Section permits the Veterans Court, *inter alia*, "[i]n any action brought under this chapter [38 U.S.C. §§ 7251, *et seq.*],"

to hold unlawful and set aside decisions, findings, conclusions, rules, and regulations issued or adopted by the Secretary in excess of statutory jurisdiction. *Id.* § 7261(a)(3)(C).

Wolfe lacks a clear and indisputable right to the writ she seeks because this Court does not have jurisdiction to directly review VA regulations outside the scope of its appellate review of a final Board decisions. *Id.* §§ 7252, 7261. Indeed, Section 7261(a) specifically confines the Veterans Court's jurisdiction to review VA regulations to actions brought under Chapter 7251, *et seq.* As discussed below, Wolfe asks this Court to invalidate Section 17.1005(a)(5) on its face, but that power lies solely with the U.S. Court of Appeals for the Federal Circuit (Federal Circuit). *See id.* §§ 502, 7292.

"It is a 'well-established principle that federal courts, as opposed to state trial courts of general jurisdiction, are courts of limited jurisdiction marked out by Congress.'" *Livingston v. Derwinski*, 959 F.2d 224, 225 (Fed. Cir. 1992) (citing *Aldinger v. Howard*, 427 U.S. 1, 15 (1976)). In 1988, Congress enacted the Veterans' Judicial Review Act (VJRA), Pub. L. No. 100-687, 102 Stat. 4105 (codified as amended in various sections of Title 38), creating the Veterans Court and generally authorizing it to review claim denials by the Board. The statute expressly prohibited the Veterans Court from reviewing any challenge to the validity of the VA disability rating schedule. 38 U.S.C. § 7252(b); *Wingard v. McDonald*, 779 F.3d 1354, 1357 (Fed. Cir. 2015).

The VJRA originally provided two means for the Federal Circuit to review VA actions related to benefits. First, it allowed any party to appeal a decision of the Veterans Court to the Federal Circuit and gave exclusive jurisdiction to the Federal Circuit to consider challenges to the validity of a statute or regulation, or to the interpretation thereof, and the interpretation of constitutional and statutory provisions, to the extent presented and necessary for a decision. 38 U.S.C. § 7292(c). Second, Congress provided that the Federal Circuit, without Veterans Court involvement, could directly review VA actions in adopting, revising, or refusing to adopt or revise regulations, and Congress invoked the procedures and standards of the Administrative Procedure Act to govern that review. *Id.* § 502; *Wingard*, 779 F.3d at 1358; *Wanner v. Principi*, 370 F.3d 1124, 1128 (Fed. Cir. 2004). In 2008, Congress modified the statutory scheme by broadly authorizing direct review of VA regulations by the Federal Circuit. *See* 38 U.S.C. § 502; *Wingard*, 779 F.3d at 1358. However, Congress left unchanged the bar preventing the Veterans Court from directly reviewing VA regulations, including those involving the rating schedule. *Wingard*, 779 F.3d at 1358.

The regulation at issue here, 38 C.F.R. § 17.1005(a)(5), was published in the Federal Register as an interim final rule on January 9, 2018. *See* 83 Fed. Reg. 974 (Jan. 9, 2018). Pursuant to Rule 47.12(a) of the Federal Circuit's Rules of Practice, Wolfe had 60 days from issuance to seek direct review of this regulation under 38 U.S.C. § 502. Fed. Cir. R. 47.12(a) ("An action for judicial review under

38 U.S.C. § 502 of a rule and regulation of the Department of Veterans Affairs must be filed with the clerk within 60 days after issuance of the rule or regulation or denial of a request for amendment or waiver of the rule or regulation."). Wolfe did not avail herself of this option despite the fact that her claim for reimbursement was denied under the provisions of Section 17.1005(a)(5) in a February 7, 2018 administrative decision, Am. Pet., Ex. E—well within the 60-day window to launch a direct challenge to that regulation in the Federal Circuit. That window having now closed, Wolfe asks this Court to do something it cannot do: directly review and invalidate a VA regulation outside the limited scope of its jurisdiction. Because this Court lacks jurisdiction to provide the relief Wolfe seeks in this context, she has failed to demonstrate clear and indisputable entitlement to a writ. Her amended petition should be denied on this basis.

2. Wolfe Has Adequate Alternative Means to Seek Her Requested Relief Through Her Pending Administrative Appeal.

When, as here, a petitioner has not demonstrated that she has a clear and indisputable right to a writ, a court need not address whether there is an adequate alternative remedy or whether the issuance of a writ is warranted. *Kelley v. Shinseki*, 26 Vet.App. 183, 192 (2013). Nevertheless, should the Court reach these issues, the Secretary submits that Wolfe has failed to demonstrate that she lacks an adequate alternative means to obtain her desired relief.

Wolfe has an active appeal pending before the agency. Hence, not only does she have an adequate alternative means available to obtain the relief she seeks, she is actively pursuing that avenue of relief. Indeed, as she concedes in her amended petition, in July 2018 she filed an NOD in response to the February 2018 administrative decision denying her claim for reimbursement of a copayment and coinsurance under Section 17.1005(a)(5). Am. Pet., Ex. F.

Wolfe asserts that because the Board is bound by VA regulations and cannot invalidate Section 17.1005(a)(5), the process of appealing to the Board would be a fruitless endeavor. Am. Pet. at 19–20. Moreover, that process would take too long, in her view, and is therefore not an adequate alternative means to obtain the relief she seeks. *Id.* These assertions are not only speculative, they ignore fundamental constraints on the proper deployment of extraordinary relief.

First, Wolfe does not suggest that there has been any undue delay in her appeal thus far. Her appeal is moving steadily through the administrative process. Second, Wolfe's claim that a writ is warranted simply because the appellate process is too slow for her ignores the well-settled principle that a writ is not a substitute for the regular appeals process. *Cheney,* 542 U.S. at 380–81. Indeed, to prove that she is not seeking a writ to end-run around the usual appellate process, Wolfe must satisfy the Court that the harm she experienced resulted "from an abuse of [] power, or refusal to exercise it," as the duration of normal appellate processes are but an "inconvenience . . . we must take it Congress contemplated

in providing that only final judgments should be reviewable." *Roche v. Evaporated Milk Ass'n*, 319 U.S. 21, 30–31 (1943).

While the Secretary acknowledges that the agency of original jurisdiction and the Board are bound by Section 17.1005(a)(5)—a regulation the Secretary believes is consistent with 38 U.S.C. § 1725(c)(4)(D)—Wolfe remains free to appeal any adverse Board decision to this Court if she continues to disagree with the regulation. If she initiates such an appeal, this Court will then have jurisdiction to consider whether Section 17.1005(a)(5) exceeds the statutory authority provided in the ECFA. *See* 38 U.S.C. §§ 7252, 7261. Thus, the ordinary appellate process, which was triggered when Wolfe filed her July 2018 NOD, represents an adequate alternative means to obtain the relief she seeks. Her desire to short-circuit that process is no basis on which to grant extraordinary relief. Indeed, allowing her petition to proceed will only serve to encourage others to end-run around the established appellate process—the very opposite of the purpose of extraordinary writs.

B. Section 17.1005(a)(5) Is Valid and Consistent with Both Its Enabling Legislation and the Court's Decision in *Staab*.

Should the Court determine that it does have jurisdiction to directly review the validity of a VA regulation in the context of a petition for extraordinary relief, the Secretary submits that VA's January 2018 amendments to 38 C.F.R. § 17.1005(a)(5) are a permissible construction of the enabling statute, 38 U.S.C.

§ 1725(c)(4)(D). Wolfe offers no credible reason to depart from the usual deference due the Secretary's construction.

"'Words are not pebbles in alien juxtaposition; they have only a communal existence; and not only does the meaning of each interpenetrate the other, but all in their aggregate take their purport from the setting in which they are used. . . .'" *Shell Oil Co. v. Iowa Dep't of Revenue*, 488 U.S. 19, 25 n.6 (1988) (quoting *Nat'l Labor Relations Bd. v. Federbush Co.,* 121 F.2d 954, 957 (2d Cir. 1941)). "When interpreting a statute, . . . courts must consider not only the bare meaning of each word but also the placement and purpose of the language within the statutory scheme." *Barela v. Shinseki*, 584 F.3d 1379, 1383 (Fed. Cir. 2009) (citing *Bailey v. United States*, 516 U.S. 137, 145 (1995)). "The meaning of statutory language, plain or not, thus depends upon context." *Id.* (citing *Brown v. Gardner*, 513 U.S. 115, 118 (1994)).

Under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984), if a statute is silent or ambiguous with respect to the specific matter at issue, a court does not simply impose its own construction of the statute. Rather, the question becomes whether the agency's approach represents a permissible construction of the statute. An agency's construction need only be a reasonable interpretation of the statute. *Id.* at 844; *Disabled Am. Veterans v. Gober*, 234 F.3d 682, 691 (Fed. Cir. 2000) (an agency may resolve ambiguity left by Congress, so long as its actions are reasonable and consistent in light of statute

and Congress' intent), *cert. denied*, 532 U.S. 973 (2001). In determining whether a particular construction is valid, the agency's construction is entitled to "considerable weight" and a reviewing court's deference. *Chevron,* 467 U.S. at 844.

On February 1, 2010, Congress amended 38 U.S.C. § 1725 by enacting the ECFA, which expanded veterans' eligibility for reimbursement for emergency treatment furnished in a non-VA facility for non-service-connected conditions. Pub. L. 111-137, 123 Stat. 3495 (2010). Section 1725 includes two provisions that limit the amount of VA reimbursement. Section 1725(c)(1)(A) requires VA to establish limitations on reimbursement, including the maximum amount payable under Section 1725(a). This requirement applies equally to the so-called "secondary payer" provisions added by the ECFA and codified in Section 1725(c)(4).

Section 1725(c)(4)(A) provides that if a veteran has contractual or legal recourse against a third party that would only in part extinguish her liability to an emergency treatment provider, and payment for the treatment may be made both under Section 1725 and by the third party, then the amount payable by VA is to be the amount by which the costs for the emergency treatment exceed the amount payable or paid by the third party up to the maximum payable amount under Section 1725(c)(1)(A). 38 U.S.C. § 1725(c)(4)(A). Section 1725(c)(4)(B) also provides that in any case in which a third party is financially responsible for part of the veteran's emergency treatment expenses, the Secretary shall be the

secondary payer. *Id.* § 1725(c)(4)(B). Neither of these provisions limiting the amount of VA reimbursement, nor Section 1725(c)(4)(D), has been amended since their original enactment as part of the ECFA.

1. 38 C.F.R. § 17.1005(a)(5) Is a Reasonable Regulatory Interpretation of 38 U.S.C. § 1725(c)(4)(D).

Wolfe argues that Section 17.1005(a)(5), which prohibits VA from reimbursing veterans "for any copayment, deductible, coinsurance, or similar payment" incurred during emergency treatment at non-VA facilities for non-service-connected conditions, 38 C.F.R. § 17.1005(a)(5), is inconsistent with 38 U.S.C. § 1725(c)(4)(D), which provides that the Secretary may not reimburse veterans for "any copayment or similar payment" owed to a third party or an insurer for such emergency care. 38 U.S.C. § 1725(c)(4)(D); Am. Pet. at 13–15. The Secretary disagrees. Section 17.1005(a)(5) is consistent with the language of Section 1725(c)(4)(D) and represents a reasonable regulatory interpretation of the statute entitled to considerable deference in this Court.

Wolfe contends that deductibles and coinsurance are not the types of "similar payments" that Congress intended to bar from reimbursement in Section 1725(c)(4)(D). Am. Pet. at 13–14. Notably, however, she does not identify what types of payments are contemplated by this language if not these. VA's approach to interpreting the broad language "any . . . similar payment" gives meaning to the statutory language chosen by Congress and is both rational and reasonable.

A copayment is a fixed amount paid by an insured for a covered health service, after any applicable deductible has been satisfied by the insured. Copayment is a commonly employed type of cost-sharing tool that ensures plan subscribers do not abuse or over-use their insurance benefits. Apart from premium payments, having a personal financial stake in each episode of care is generally thought to make a subscriber seek and access health care services only when clinically necessary, thereby avoiding unnecessary use of benefits and achieving desired cost-avoidance for the insurer.

Deductibles and coinsurance are also cost-sharing tools used in the health insurance industry and, as such, share the same basic function or purpose as copayments. A deductible is a specified amount an insured agrees to pay out of pocket for her health care in a year. Once the deductible has been paid by the insured, the insurer will pay for covered services, minus any applicable copayment. Coinsurance is health insurance in which the insured is required to pay a fixed percentage of the cost of medical expenses after the deductible has been paid, with the insurer paying the remaining expenses.

While these three costs have different names and are calculated in different ways, their purpose is the same; they discourage clinically unnecessary treatment. Hence, these forms of payment for which the insured is responsible fall within the broad category of “cost-sharing” obligations agreed to by an insured in exchange for coverage under the health plan contract. Consequently, even though

deductibles and coinsurance have distinct technical meanings and differ in their formulae—and thus ultimate dollar levels—when compared to copayments, they serve a common, similar cost-sharing function, and each subscriber agrees voluntarily to pay them in exchange for enrollment and coverage.

VA is not alone among Federal programs in viewing cost-sharing in this way. For instance, the Centers for Medicare and Medicaid Services (CMS) define cost-sharing for Basic Health Programs as "any expenditure required by or on behalf of an enrollee with respect to covered health benefits; such term includes deductibles, coinsurance, copayments, or similar charges. . . ." 42 C.F.R. § 600.5. CMS also defines cost-sharing in the context of Medicaid as "any copayment, coinsurance, deductible, or other similar charge." *Id.* § 447.51.

Further, these types of cost-sharing devices are routinely grouped and governed together for purposes of federal health care benefits. When CMS implemented the Affordable Care Act (the collective term for the Patient Protection and Affordable Care Act, Pub. L. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152) and the Social Security Act to provide standards and requirements for cost-sharing for Basic Health Programs and Medicaid, respectively, CMS did not distinguish between different types of cost-sharing obligations. Rather, it relied on "cost sharing" as an umbrella term capturing deductibles, coinsurance, copayments, and similar charges. *See* 42 C.F.R. § 600.500 *et seq.* (implementing Section 1331(a) of the Affordable Care

Act); *id.* § 447.50 *et seq.* (implementing Sections 1902(a)(14), 1916, and 1916A of the Social Security Act).

Moreover, if deductibles and coinsurance are not "similar payment[s]" to copayments, as Wolfe alleges, VA is not aware of any other form of payment that would be. She identifies none. *See* Am. Pet. at 13–14. Consequently, Wolfe's interpretation would render the language "or similar payment" in Section 1725(c)(4)(D) a nullity, in violation of well-settled principles of statutory construction. A statute must be interpreted "'so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant. . . .'" *Corley v. United States*, 556 U.S. 303, 314 (2009) (quoting *Hibbs v. Winn*, 542 U.S. 88, 101 (2004)). If Congress intended the limitation in Section 1725(c)(4)(D) to include copayments only, it would not have included the phrase "or similar payment" in the statute. Instead, Congress included that phrase and gave VA broad authority to interpret it through regulations prescribed by the Secretary. Specifically, Section 1725(c)(1)(B) provides that "[t]he Secretary, in accordance with regulations prescribed by the Secretary, shall . . . delineate the circumstances under which such payments may be made." 38 U.S.C. § 1725(c)(1)(B).

Section 1725(c)(4)(D) plainly directed that payments other than copayments be excluded from reimbursement, provided they are similar to copayments. Faced with this instruction, VA had to identify and consider other, similar payments for

which a veteran may be responsible under a health plan contract. Simply put, VA can find no payments more similar to a copayment than deductibles and coinsurance. Like copayments, they serve as cost-sharing measures which the subscriber has freely agreed to pay as a condition of insurance coverage. Congress may always amend Section 1725(c)(4)(D) as it deems necessary, but, as now phrased, VA must interpret the language "or similar payment" to have meaning, and it has done so reasonably through its regulations. Wolfe's view of the similarity requirement would read this language out of the statute entirely.[1]

Congress' use of the phrase "or similar payment" also affords VA the regulatory flexibility to align this provision's scope with evolving health insurance practice and terminology. In fact, this is not at all unusual. In Section 1916A of the

[1]In response to this litigation, members of Congress have begun to consider amending Section 1725—specifically, striking Section 1725(c)(4)(D) in its entirety. (The draft bill to that effect is attached hereto as Exhibit 3.) Preliminary discussions suggest that Congress intends such an amendment to ensure that cost-sharing amounts veterans owe to their private insurer for emergency care at non-VA facilities for non-service-connected conditions, including copayments, coinsurance, and deductibles, are always paid by the Secretary.

The fact that Congress may amend the statute in this way underscores the Secretary's argument here, as it shows that the plain language of the statute presently prohibits the Secretary from reimbursing these costs. It also highlights the impropriety of granting Wolfe's sought-after writ in these circumstances. In her effort to avoid the consequences of failing to timely challenge Section 17.1005(a)(5) in the Federal Circuit and her attempt to end-run around the usual appellate process, Wolfe has missed another opportunity to raise her concerns in a valid forum: the legislature. When so many adequate, alternative means exist for Wolfe to pursue the relief she seeks, the Court should not entertain her present invitation to enter the fray, particularly when legislative action could seriously impact the need for Court intervention in the first place.

Social Security Act, Congress defined cost-sharing as "any deduction, copayment, or similar charge." 42 U.S.C. § 1396o-1(a)(3)(B). In that Act, Congress did not specifically include coinsurance in the definition of cost-sharing, but in its regulations interpreting the Act, CMS included coinsurance in the definition of cost-sharing. *See* 42 C.F.R. § 447.51. Thus, Wolfe's reading of Section 1725(c)(4)(D) is out of touch with the statutory context, longstanding canons of statutory construction, and prior, similar legislation interpreted in similar ways by other agencies. For these reasons, the Court should not adopt it.

2. 38 C.F.R. § 17.1005(a)(5) Is Consistent with the Purpose and Spirit of 38 U.S.C. § 1725(c)(4)(D).

In addition to her textual arguments, Wolfe also asserts that Section 17.1005(a)(5) is an overly restrictive interpretation of the ECFA which contravenes the purpose and spirit of the statute. Am. Pet. at 15–17. She argues that the inclusion of deductibles and coinsurance in Section 17.1005(a)(5) encourages veterans to forego the purchase of health insurance to ensure that VA is responsible for all their out-of-pocket emergency medical care costs for non-service-connected conditions. Wolfe notes that this would leave VA, as sole payer, with increased costs. *See id.* Yet, closer consideration of Wolfe's position shows it to be unsound in theory and in practice.

VA acknowledges that those veterans eligible for reimbursement under Section 1725 who do not have health insurance would likely pay no out-of-pocket costs for emergency medical care, while many of those who do have health

insurance would likely bear some out-of-pocket costs resulting from their cost-sharing obligations that VA is prohibited from reimbursing. Still, it is highly unlikely that veterans would forego all the benefits of their personally selected health insurance plans, including access to their own outside providers for medical care, just to ensure they would have no liability for deductibles and coinsurance under Section 1725 on the off chance they need non-VA emergency treatment for a non-service-connected condition and that they meet the other statutory and regulatory criteria for reimbursement.

Those criteria highlight the limited reach of VA's reimbursement responsibility and undermine Wolfe's position. VA reimbursement for emergency medical expenses at non-VA facilities for non-service-connected conditions rests on a number of crucial prerequisites, including, for example, that the care was truly emergent in nature, that the veteran was enrolled in the VA healthcare system and had received VA medical care within the 24-month period prior to the emergency room visit, and that the veteran first exhausted her ability to seek payment on her behalf from a third-party insurer, if she had one, including by timely submitting hospital bills and appealing insurance claim denials. *See* 38 U.S.C. § 1725; 38 C.F.R. § 17.1002. The limitation that the amount at issue not be a copayment, coinsurance, or a deductible is but one of a number of important requirements for claimants seeking reimbursement. *See* 38 C.F.R. § 17.1005(a)(5). As a result, Section 1725 benefits are not guaranteed, and they are subject to a number of

administrative and medical eligibility criteria. As Congress intended, it is thus a narrow benefit, whereas the benefits under health insurance for emergency care are typically broad.

Moreover, Wolfe's prediction about veteran behavior is not borne out in reality. Approximately 75 percent of veterans enrolled in the VA health care system receive some portion of their health care outside of the VA system (referred to as the receipt of "dual care," *see* VHA Directive 2009-038, attached hereto as Exhibit 4). This suggests they enjoy the benefits and convenience of receiving dual care despite the copayments, coinsurance, and deductibles associated with their use of private or public health insurance, which are needed to obtain care in the private sector.

It is reasonable to assume that some veterans in this dual-care cohort already pay increased cost-sharing amounts when using their health insurance benefits to obtain care in the private sector. Apparently, this has not discouraged them from retaining their health insurance coverage. Thus, there is no assurance, as Wolfe seems to believe, that veterans will uniformly forgo the significant benefits of holding private insurance for their routine medical care simply to obtain free emergency-room visits at non-VA hospitals in the comparatively unlikely event of an emergency requiring treatment for a non-service-connected condition. Even brief consideration of that strategy shows it to be unwise for many veterans, and marketplace behavior demonstrates that many have not pursued it.

3. 38 C.F.R. § 17.1005(a)(5) Does Not Conflict with *Staab.*

Finally, Wolfe contends that Section 17.1005(a)(5) is inconsistent with this Court's decision in *Staab*, 28 Vet.App. 50, which invalidated the previous iteration of VA's regulation, 38 C.F.R. § 17.1002(f). Am. Pet. at 15. As explained below, there is no tension between the *Staab* decision and the present regulation.

VA's 2018 rulemaking to implement the *Staab* decision renumbered former Section 17.1005(f) as Section 17.1005(a)(5), clarified that a health plan contract is a third party for purposes of the secondary payer provisions, and updated the bar on reimbursement to include coinsurance. *See* 83 Fed. Reg. 974 (Jan. 9, 2018). Current Section 17.1005(a)(5) now states: "VA will not reimburse a veteran under this section for any copayment, deductible, coinsurance, or similar payment that the veteran owes the third party or is obligated to pay under a health-plan contract." 38 C.F.R. § 17.1005(a)(5). These changes were not strictly required by *Staab*, but because of other changes to the regulatory scheme that were required by that decision, VA is now a secondary payer to an otherwise eligible veteran's health insurance.

Whereas prior to *Staab*, VA denied the claims of veterans who had any health insurance, today VA adjudicates these claims to determine whether reimbursement is appropriate after payment by a third party, including under a health plan contract. Thus, after *Staab*, it was important for VA to clarify what forms of payment besides copayments and deductibles—which were already specified

in the regulations—were excluded from reimbursement under the limitation in Section 17.1005(a)(5).

Wolfe says that coinsurance and deductibles are subject to reimbursement under *Staab*, referencing the following language in that decision:

> 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." . . . 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.

Staab, 28 Vet.App. at 54.

Not so. In fact, the *Staab* Court's reliance on Section 1725(c)(4)(D) supports the opposite conclusion, *i.e.*, that the Court was aware of and assigned meaning to the very limitation Wolfe challenges. The Court relied upon Section 1725(c)(4)(D) to support its interpretation that, under the ECFA, a health-plan contract was intended to be a "third-party" as defined by Section 1725(f)(3). The *Staab* Court reasoned that, if VA was not intended to be a secondary payer to health insurance plans, the language "for which the veteran is responsible under a health-plan contract" in Section 1725(c)(4)(D) would have been unnecessary. *Id.* To give that language meaning, the Court had to read into Section 1725(b)(3)(B) (related to coverage under a health plan contract) the same amendments made to Section 1725(b)(3)(C), holding that partial payment of emergency treatment

expenses under a health-plan contract is not a bar to reimbursement but instead triggers the statute's secondary payer provisions. *Id.*

While the Court later stated that the ECFA was intended to cover the portion of expenses not covered by a health plan contract, that dicta must be read together with the rest of the opinion, in which the Court not only recognized but expressly relied upon the limitation in Section 1725(c)(4)(D) to support its holding. Consistent with this understanding of the statutory language, the Court did not invalidate 38 C.F.R. § 17.1005(f) when identifying program regulations then in place that conflicted with the ECFA. *See id.*

In stating that Congress intended VA to reimburse a veteran for the portion of "expenses" not covered by a health plan contract, the Court was not addressing the type of payment obligations that a veteran owes to a third party or is responsible for under a health plan contract. Rather, the Court was referring to the cost of the treatment owed to the emergency provider. More specifically, Section 1725(c)(4)(A) speaks to "the amount payable for the emergency treatment" and "costs for the emergency treatment" for which the veteran is still liable to the emergency provider. 38 U.S.C. § 1725(c)(4)(A). Section 1725(c)(4)(B) speaks to "the veteran's emergency treatment expenses" owed the provider, and Section 1725(c)(4)(C) states "[a] payment in the amount payable under subparagraph (A) shall be considered payment in full and shall extinguish the veteran's liability to the provider." *Id.* § 1725(c)(4)(B)-(C).

In sharp contrast, Section 1725(c)(4)(D) uses distinct language not found elsewhere in this subsection by referencing a copayment or similar payment owed to a third party or for which the veteran is responsible under a health-plan contract. *See id.* § 1725(c)(4)(D). The structure of the secondary payer provisions purposefully separates and distinguishes the discussion of expenses owed to the emergency provider for emergency treatment from the provision establishing a bar on reimbursement for certain payments a veteran owes to a third party or for which a veteran is responsible under a health plan contract. As a matter of text and logic, they address distinct types of expenses. Indeed, the express prohibition in Section 1725(c)(4)(D) operates as an exception to the reimbursement provisions preceding it.

Wolfe argues that the ECFA requires all expenses not paid by a health plan contract to be reimbursed by VA. In other words, she believes that VA is to reimburse or pay the cost of the emergency treatment exceeding the amount payable or paid by the third-party insurer. Am. Pet. at 16. In her view, deductibles and coinsurance are such expenses. But Wolfe's literal reading of the final sentence of the *Staab* quotation provided above would read the copayment limitation completely out of the statute, in addition to providing for reimbursement of coinsurance and deductibles.

VA agrees that part of the legislative history related to the ECFA (and the *Staab* decision as discussed above) reflects an expectation that the ECFA

effectively enabled VA to pay the entire remaining expenses owed to an emergency care provider after partial payment is made or payable under a veteran's health plan contract. However, as discussed above, the bar in Section 1725(c)(4)(D) reflects a continuing mandate for VA to limit this statute's budgetary impact by expressly precluding VA's reimbursement of copayments and similar payments. Had Congress intended for the phrase "similar payment" to exclude a deductible or coinsurance, then it could have said so or, more likely, it would not have used the words "similar payment" at all.

Congress is assumed to have been aware of VA's associated rulemaking and VA's interpretation of this provision as it concerns claims involving partial payment by other types of third parties (for purposes of 38 U.S.C. § 1725(b)(3)(C)). *Lorillard v. Pons*, 434 U.S. 575, 580 (1987) ("Congress is presumed to be aware of an administrative or judicial interpretation of a statute and to adopt that interpretation when it re-enacts a statute without change."); *Miss. ex rel. Hood v. AU Optronics Corp.*, 571 U.S. 161, 169 (2013) ("We presume that 'Congress is aware of existing law when it passes legislation.'") (quoting *Hall v. United States*, 566 U.S. 506, 516 (2012)). When enacting the ECFA in 2010, Congress saw no need to amend Section 1725(c)(4)(D) and left the original language intact. The statutory provisions in Section 1725 continue to serve a budget-limiting purpose, a purpose unchanged by the decision in *Staab*.

Indeed, if Wolfe is right about the comprehensive nature of the Secretary's secondary-payer obligation, then other reasonable requirements for reimbursement must also be tossed out. For instance, Section 1725 and its implementing regulations require that a veteran must comply with her obligations under her insurance contract, such as submitting bills or exhausting appeals of denied payments, before VA can reimburse any remaining liability. If the veteran fails to comply, she becomes responsible for paying the provider for the emergency care she received. 38 U.S.C. § 1725(c)(2); 38 C.F.R. § 17.1002(f). Yet, just like this case, that obligation arises from the veteran's contract with her insurer—something the Secretary had no part in negotiating or drafting, and something which accords the veteran significant benefits in a variety of health care contexts besides emergency treatment. It makes little sense to pick and choose which contractual obligations a veteran can ignore and still expect the Secretary to pay whatever remains due. That view truly flouts Congress' intent to limit the budgetary impact of the ECFA.

For these reasons, Section 1725(c)(4)(D) and its implementing regulation, Section 17.1005(a)(5), stand apart from the holding and rationale of *Staab*. They serve different functions and are fully consistent with the *Staab* Court's pronouncements concerning the veteran's responsibility to emergency care providers under the ECFA. Wolfe's attack on the validity of Section 17.1005(a)(5) should, therefore, be rejected.

C. Wolfe Has Not Shown that Aggregate Relief Is Useful or Appropriate in this Case.

As has been shown above, the Court lacks jurisdiction to hear Wolfe's regulatory challenge and, even if it could, the challenge itself is without merit. Yet, assuming for the sake of argument that Wolfe's claim is properly before the Court and is persuasive, she nevertheless falls well short of establishing that aggregate relief is appropriate. As explained further below, Wolfe's request for class-based relief rests on a misapprehension as to the force of this Court's precedential rulings. Moreover, her conclusory and inconsistent class allegations leave fatal doubt as to the propriety of class-based relief in this case.

1. *Monk* and the Reasons for Aggregate Litigation

In *Monk v. Shulkin*, 855 F.3d 1312, 1318–19 (Fed. Cir. 2017), the Federal Circuit determined that the Veterans Court has the authority to certify class actions or employ similar aggregate resolution procedures to resolve petitions for extraordinary relief pursuant to the All Writs Act. On remand, the *en banc* Veterans Court denied the *Monk* petitioners' request for class certification concerning their claim that delay of over one year in adjudicating veterans' administrative appeals after the filing of an NOD violated their constitutional right to due process. *Monk v. Wilkie*, 30 Vet.App. 167, 169 (2018). The Court first observed that until it adopts its own aggregate litigation rules, it will use Federal Rule of Civil Procedure 23 as a guide when class claims come before it. *Id.* at 170. To adjudicate petitions for class-based writs, the Court held that it can conduct "limited factfinding" to

determine whether the putative class meets the requirements of Rule 23, as well as to decide the merit of the underlying petition. *Id.* at 171.

The Court then analyzed the requirements for class certification. It noted that, as a general matter, "[c]lass relief is appropriate when the class shares issues that are common to the class as a whole and when the questions of law apply in the same manner to each class member." *Id.* at 174 (citing *Califano v. Yamasaki*, 442 U.S. 682, 701 (1979)). When these requirements are met, class treatment helps conserve the resources of the parties and the court by permitting economical resolution of key issues affecting all class members. *Id.*

As for Rule 23 itself, the Court reiterated the longstanding principle that the party seeking class treatment bears the burden to establish each threshold element in Rule 23(a). *Id.* Rule 23(a) provides that a class may be certified only if:

> (1) the class is so numerous that joinder of all members is impracticable;
>
> (2) there are questions of law or fact common to the class;
>
> (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and
>
> (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a). Further, the proponent of certification must prove that her action fits within one of the three types of class actions defined in Rule 23(b). *Monk*, 30 Vet.App. at 174. The Court emphasized that "[t]he certifying court must rigorously analyze the Rule 23 prerequisites before certifying a class." *Id.*

The Court's decision to deny certification in *Monk* turned primarily on the petitioners' failure to satisfy the commonality requirement of Rule 23(a)(2). *Id.* at 175–81. Applying the teachings of *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338 (2011), the Court held that while the petitioners all alleged a violation of the same legal right to due process, the cause of the injury—delay in adjudication of appeals—had to be assessed on a case-by-case basis to determine whether it rose to the level of a constitutional violation. *Monk*, 30 Vet.App. at 176. The problem with the petitioners' class was that it was too broad; notably, it did not target some identifiable policy or practice that led to undue delay. *Id.* at 179. Additionally, the Court found that the petitioners could not operate as a Rule 23(b)(2) class because the relief the petitioners sought did not "satisfy Rule 23(b)(2)'s standard as there is no single injunction that provides relief to the class as a whole." *Id.* at 181. Instead, individual class members would be entitled to injunctions crafted with an appreciation for the specific circumstances of the delay in their respective cases. *Id.*

2. Wolfe's Request for Aggregate Relief Rests on a Fundamental Misunderstanding of the Precedential Effect of Veterans Court Decisions.

Before the Secretary reaches the Rule 23 assessment of Wolfe's proposed class action, he must engage a fundamental flaw in Wolfe's request for class relief—namely, that it rests on a remarkable misreading of the Court's case law pertaining to the precedential force of its decisions. Take away her misguided

jurisprudential view, and Wolfe's need for aggregate relief evaporates. Starting from the premise that "[t]he class action is 'an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only,'" *Comcast Corp. v. Behrend*, 569 U.S. 27, 33 (2013) (quoting *Califano*, 442 U.S. at 700–01), class action should be undertaken only when aggregate relief will be useful to the class and economical for the Court and the parties, *Monk*, 30 Vet.App. at 174. Wolfe's class claim cannot be described in this way.

Wolfe argues in favor of aggregate relief by stating that *Tobler v. Derwinski*, 2 Vet.App. 8, 14 (1991), holds that precedential Court decisions only bind from of the date they are issued. According to her, *Tobler* means that "VA is bound to follow a precedential Court decision beginning *only* on the date the precedential decision is issued." Am. Pet. at 23 (emphasis in original). In her view, "[w]ithout a class action, veterans who did not timely appeal a denial of their claims before such a final decision would be left without relief." *Id.*

Both of these assertions lack merit. First, neither this Court nor the Secretary have ever read *Tobler* to provide that Veterans Court decisions are only prospective in effect. Ordinarily, amending a statute has only prospective effect, as the legislature is effecting a change in the law. *Jones Stevedoring Co. v. Director, Office of Workers Compensation Programs*, 133 F.3d 683, 687 (9th Cir. 1997). But when a court issues a ruling interpreting or even overturning a statute, the court is merely explaining what the law always was, *Rivers v. Roadway*

Express, 511 U.S. 298, 313 n.12 (1994), as part of its duty to say what the law is, *Marbury v. Madison*, 5 U.S. 137, 1 Cranch 137, 177 (1803). Thus, taking account of rules of finality, court decisions are almost always retroactively applicable to all cases still open to direct review*. See Harper v. Virginia Dep't of Taxation*, 509 U.S. 86, 97 (1993); *Gober*, 234 F.3d at 696.

Read against this backdrop, *Tobler* stands for the proposition that precedential decisions of the Veterans Court are binding on the agency in all cases open to direct review unless and until those decisions are overturned. *Tobler*, 2 Vet.App. at 14. No decision of the Court following *Tobler* reflects any notion that Veterans Court decisions are prospective only, except in the unique case of allegations of clear and unmistakable error (CUE). Thus, this Court's decision on Wolfe's individual claim—whether Section 17.1005(a)(5) is valid or invalid—will as a matter of course govern all non-final claims pending before the Court and the agency. Indeed, if Wolfe means to say through this proceeding that she does not trust the agency adjudicative machinery to apply binding precedent issued by this Court, that concern was fully addressed long ago in *Tobler*.

Second, and equally misguided, is Wolfe's assertion that class relief is warranted to help veterans who have not timely appealed a final adjudication of their reimbursement claims. Am. Pet. at 23; *see also id.* at 20 (arguing that during the course of Wolfe's appeal, "VA would continue to deny veterans any reimbursement for coinsurance or deductibles, and any veterans who failed to

timely appeal their denials would be left without recourse even if Petitioner Wolfe ultimately prevailed"). There is no reason to suspect that the Court's order invalidating or upholding Section 17.1005(a)(5) in this action would not have immediate effect for all non-final benefits claims. To the extent Wolfe would include in her class those persons whose reimbursement claims are presently final and unappealable, her class definition strays too broadly. As *Jordan v. Nicholson*, 401 F.3d 1296, 1299 (Fed. Cir. 2005), explains, even a change in the validity of Section 17.1005(a)(5) would offer those individuals no prospect for relief, as their claims having been finally decided, they may not be revisited except when CUE is shown. Yet, it is important to appreciate that this result rests on the principle of finality of judgments, not on whether a court decision should be given retroactive effect as a general matter.

What's more, the notion that aggregate relief is appropriate simply to afford notice to claimants of new Court precedent is untethered from the true purpose of class litigation, which is to promote the efficient resolution of joint disputes. *Monk*, 30 Vet.App. at 174. Class treatment may be an effective way to correct errors of a factual nature, such as, in the *Monk* court's estimation, a specific VA policy or practice that results in unreasonable delays in processing appeals. *Id.* at 181. It makes little sense, however, in the context of Wolfe's purely legal challenge to the validity of a VA regulation. In this instance, the ordinary appellate processes are fully sufficient to apprise veterans and adjudicators of the law as found by this

Court. Accepting Wolfe's argument here could potentially lead to class treatment in every case filed in the Veterans Court simply to ensure that claimants are made aware of precedential decisions. No court has ever approved a class litigation procedure to buttress the binding nature of its rulings or as a method to publish them.

Wolfe further suggests in her amended petition that granting class relief will avoid strategic mooting of class members' claims, citing the Federal Circuit's decision in *Monk*. Am. Pet. at 22–23. Yet that case actually demonstrates why there is no danger of mooting out putative class members' claims in this action. In *Monk*, the Federal Circuit found that delays in appeal adjudication were easy to remedy on an individual basis and therefore might evade court review. *Monk*, 855 F.3d at 1314. Thus, claims of this sort might warrant application of the "capable of repetition yet evading review" form of Article III standing. *Id.* at 1317–18 (citing *U.S. Parole Comm'n v. Geraghty*, 445 U.S. 388, 398 (1980)).

Here, however, no veteran's claim for reimbursement for emergency medical expenses can evade judicial review. A claim denied can be appealed, *see* 38 U.S.C. § 7105, and Wolfe does not argue otherwise. Her claim, and the claim of any other aggrieved claimant, can be addressed in the ordinary course of the appellate process. Unless such a claim is paid in full, resolving the dispute, the claim will never disappear nor escape the attention of the appellate decisionmakers. This is because Wolfe's claim goes to the merit of reimbursement

requests—*i.e.*, whether coinsurance and deductibles are reimbursable—and not the procedural course of the appeal, as was the case in *Monk*. For that reason, potential mooting of claims is not a credible reason to grant aggregate relief in this instance.

In the end, to depart from the norm that litigation is conducted individually, *Califano*, 442 U.S. at 700–01, Wolfe could be expected to produce good reasons that a class-based writ is needful here. Indeed, that much should be expected when Wolfe asks the Court and the parties to invest additional time and resources in the resolution of a class-based dispute rather than her individual claim. Her reliance on *Tobler* is no such justification. As a result, the Court should conclude that class-based relief is neither necessary nor appropriate in this case, regardless of the ultimate decision the Court may reach as to the validity of the challenged regulation.

3. Wolfe's Amended Petition Does Not Establish the Minimum Facts Necessary to Support a Right to Aggregate Relief Under Rule 23.

Were the Court to decide that it can entertain Wolfe's petition, and that it has merit, Wolfe's request for class-based relief nevertheless does not withstand scrutiny under Rule 23. As this Court recognized in *Monk*, the Supreme Court instructs that "Rule 23 does not set forth a mere pleading standard," and a "party seeking class certification must affirmatively demonstrate his compliance with the Rule[.]" *Wal-Mart*, 564 U.S. at 350. Contrary to the Supreme Court's direction,

Wolfe's amended petition is light on facts and lacking in detail. Under the "rigorous analysis" this Court must undertake to ensure compliance with Rule 23, *id.*, the proposed class does not pass muster.

a. Numerosity

On the first element, numerosity, Wolfe must show that her class is "so numerous that joinder of all members is impracticable." Fed. R. Civ. P. 23(a)(2). She contends that given the number of individuals potentially affected by the *Staab* decision, there must be a sufficiently numerous class of persons affected by the coinsurance and deductible exclusion in Section 17.1005(a)(5). Am. Pet. at 24. On those allegations, the Secretary concedes for present purposes that the numerosity requirement is satisfied in this case. In so doing, the Secretary emphasizes that Wolfe's proposed class is limited in scope and should be viewed in that light, as will be discussed below. *See infra* Part I.C.3.b.

b. Commonality

Wolfe's own definition of her proposed class varies throughout her amended petition. That variance vitally affects the way in which the Court must view her claim for aggregate relief. Rule 23(a)(2) directs that a class action may only be maintained where "there are questions of law or fact common to the class," Fed. R. Civ. P. 23(a)(2), a question that must necessarily be evaluated by reference to the scope and nature of the class itself. Properly understood, Wolfe's proposed class is narrow; it comprises only to those claimants for whom some portion (or all)

of a reimbursement claim was denied *solely* because the amount at issue was non-reimbursable coinsurance or a deductible. The Secretary will identify Wolfe's two versions of her own class definition and then analyze why only one of them conceivably relates to her substantive claim.

As discussed above, reimbursement for emergency care at non-VA hospitals for non-service-connected conditions is subject to numerous administrative and medical eligibility criteria, including that the care was emergency care, that the veteran was enrolled in VA's healthcare system, and that the veteran complied with her obligations to seek what payment she could from her insurer. *See* 38 U.S.C. § 1725; 38 C.F.R. § 17.1002. Wolfe's substantive claim is a challenge to only one small portion of the regulatory scheme for reimbursement—*i.e.*, the exclusion of copayments, coinsurance, and deductibles from reimbursement. She argues that coinsurance and deductibles should be reimbursed because Congress did not allow the Secretary to exclude these types of costs from reimbursement. *See* Am. Pet. at 13–15; *supra* Part I.B. To understand her claim, then, Wolfe's proposed class must be held to consist of only those individuals for whom some portion of a claim for reimbursement was denied only because it consisted of non-reimbursable coinsurance or a deductible.

Her amended petition does not always reflect this understanding. In her first request for relief, Wolfe says that the class consists of all persons whose reimbursement claims were denied, in whole or in part, "on the ground that the

expenses are part of the deductible or coinsurance payments for which the veteran was responsible." Am. Pet. at 2. Later, when arguing in favor of class certification, she proposes an entirely different definition of the class, one that includes anyone who, after January 8, 2018, had a reimbursement claim denied when the amount at issue consisted either of coinsurance or a deductible. *Id.* at 22. She repeats a version of this second definition in her third request for relief, wherein she asks the Court to "invalidate the decisions made by the Secretary under 38 C.F.R. § 17.1005(a)(5) to the extent that they denied reimbursement to members of the Wolfe class for medical expenses deemed to be part of the veteran's deductible or coinsurance." *Id.* at 3.

These two class definitions are crucially different. The first properly confines the proposed class to those claimants who have met all the other requirements for reimbursement but whose claims were denied based only on the type of cost at issue—*i.e.*, coinsurance or deductibles owed to an insurer. The second does not contain this necessary limitation. It includes everyone who sought reimbursement for coinsurance or a deductible, whether or not the claimant complied with any other regulatory criterion.

Surely Wolfe's class cannot include a veteran whose reimbursement claim was denied because the care was not emergency care, or because the veteran was not an established VA patient, regardless of the nature of the amount for which reimbursement is sought. Wolfe desires to bring a focused challenge to the

application of Section 17.1005(a)(5), but her second class definition potentially includes claimants whose claims were totally unaffected by that regulation—that is, those whose claims were denied for entirely distinct and sufficient reasons. A ruling invalidating Section 17.1005(a)(5) would not benefit these individuals. In Wolfe's words, these veterans could not be classified as those who "have been or will be affected by the challenged regulation," *id.* at 17, as the existence of other adequate reasons to deny their claims means that the regulation did not in fact affect them. And even if invalidating Section 17.1005(a)(5) might remove one partial obstacle to their reimbursement claims, veterans within the second, broader class definition will be able to benefit from such a ruling whether or not they are part of Wolfe's putative class, as has been explained above. *See supra* Part I.C.2.[2]

[2]In its initial order directing the Secretary to respond to the petition, the Court framed the Wolfe class as "all individuals who have been or will be harmed by § 17.1005(a)(5)." Dec. 8, 2018, Per Curiam Order. This is consistent with the Secretary's view of the class, as one of the preconditions for membership is that the class member was or will be "harmed" by the regulation, which would exclude anyone whose claim was denied for some other fully sufficient reason.

Some courts frame the present problem as one of constitutional standing. To offer a justiciable case or controversy, a litigant must have suffered an injury in fact, the injury must be traceable to the defendant's conduct, and the injury must be redressable through the requested relief. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992). Applied here, *Lujan* indicates that the putative members of Wolfe's broader class lack standing, as members whose claims were denied for fully sufficient reasons in addition to Section 17.1005(a)(5) would not have suffered an injury by reason of the regulation, could not trace their injury to the application of the regulation, and could not have their injury redressed by a ruling invalidating the regulation.

Lujan offers useful insight into the shortcomings of Wolfe's broader class definition. Yet the Courts of Appeal are divided on whether a class must be defined such that each member will have standing or whether only the class representative

To the extent Wolfe clings to the second, broader definition of the class, such a class would fail on rudimentary principles of commonality as explored in *Monk*. In that case, the petitioners' claims of delay, although all premised on the constitutional right to due process, had to be evaluated individually. *Monk*, 30 Vet.App. at 176. The governing legal standards made clear that a specific instance of delay could be deemed reasonable or unreasonable only upon consideration of the particular factual circumstances underlying the delay. *Id.*

So too, here, if Wolfe attempts to include in her class anyone who sought reimbursement for coinsurance or deductibles but did not necessarily comply with other requirements for reimbursement, then the denial of payment in each class

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need show that he has standing. *See In re Deepwater Horizon*, 739 F.3d 790, 800–01 (5th Cir. 2014) (discussing Circuit split); *see also Tyson Foods, Inc. v. Bouaphakeo*, 136 S. Ct. 1036, 1050 (2016) (noting that standing of absent class members was an issue of "great importance" but declining to address it). For that reason, some courts find that in the context of class certification, concerns about uninjured absent class members are better addressed as problems under Rule 23 itself rather than as problems with standing. *See Bruno v. Quten Research Inst., LLC*, 280 F.R.D. 524, 533 (C.D. Cal. 2011); *Calvo v. City of N.Y.*, 14-CV-7246 (VEC), 2018 U.S. Dist. LEXIS 56311, at *7 (S.D.N.Y. Apr. 2, 2018) ("Ultimately, the Article III standing inquiry must be examined through the prism of the class definition; . . . a class cannot be certified if any person captured within the class definition lacks Article III standing."). The Secretary believes that the present analysis, which focuses on Rule 23's requirements, adequately addresses the deficiencies in Wolfe's broader class definition without requiring this Court to take a stand on the Circuit split concerning uninjured absent class members. Should the Court find a decision on this question necessary, however, the Secretary maintains that a class must be defined in a way that each member has standing. Commentators note that the opposite rule "gives rise to the logical absurdity of allowing a federal court to litigate the rights of claimants who have no standing[.]" 15 Moore's Fed. Prac.—Civil § 101.61 (2018).

member's case could turn on a multitude of circumstances having nothing to do with the validity of Section 17.1005(a)(5). Deploying the broader class definition would mean that there is no one common contention, the truth or falsity of which "will resolve an issue that is central to the validity of each one of the claims in one stroke," *Wal-Mart*, 564 U.S. at 350, as the claims within the broader class definition do not uniformly depend upon the validity of Section 17.1005(a)(5). In other words, because a ruling invalidating that regulation might be only marginally relevant to a particular class member's reimbursement claim, such a ruling would not represent a "'common [answer] apt to drive the resolution of the litigation.'" *Id.* (quoting Nagareda, *Class Certification in the Age of Aggregate Proof*, 84 N.Y.U. L. Rev. 97, 131–32 (2009)) (emphasis omitted). Wolfe's broader class definition would overwhelm her narrow regulatory challenge with indispensable individualized factual inquiries not suitable for aggregate resolution. *See M.D. ex rel. Stuckenberg v. Perry*, 675 F.3d 832, 840 (5th Cir. 2012) (observing that after *Wal-Mart*, commonality is no longer satisfied merely when resolution of a legal issue will affect a significant number of class members, but instead when all of the class member's claims depend on that common issue).

Only Wolfe's narrower class definition arguably complies with the teachings of *Monk*. The Court noted that if the petitioners in that case had alleged the existence of a specific policy that resulted in unreasonable delays in processing appeals, commonality might have been established. *Monk*, 30 Vet.App. at 179.

Wolfe's narrower class definition reflects the suggestion of the *Monk* Court in that it limits itself to those veterans purportedly harmed by a single policy, codified in Section 17.1007(a)(5).

It is unclear whether Wolfe's varying class definitions are no more than an oversight. But, should Wolfe force the Court to choose between her fluctuating definitions of the putative class, the Court should confine this action to her narrower definition.

c. Typicality

In addition to her erratic class definition, Wolfe's cursory pleadings fail to demonstrate that her claim is typical of that of the class, or that she will fairly and adequately protect the class' interests. Fed. R. Civ. P. 23(a)(3)-(4). Whereas numerosity and commonality evaluate the sufficiency of the class itself, the typicality and adequacy-of-representation elements probe the sufficiency of the named class representative. *Hassine v. Jeffes*, 846 F.2d 169, 177 n.4 (3d Cir. 1988).

First, on the question of typicality, Wolfe must show that her individual claim arises from the same course of conduct and gives rise to the same legal theories as other class members. *Alpern v. UtiliCorp United*, 84 F.3d 1525, 1540 (8th Cir. 1996). Identity of circumstances is not required, but Wolfe must satisfy the Court that she is an appropriate class representative insofar as she shares the interests of the class as a whole. *Deiter v. Microsoft Corp.*, 436 F.3d 461, 467 (4th Cir. 2006).

While in many cases the commonality and typicality requirements merge, each serves an important and distinct function. 5 Moore's Fed. Prac.—Civil § 23.23 ("Despite their similarity . . . the commonality and typicality requirements serve different functions. The commonality requirement tests the definition of the class itself, while the typicality requirement focuses on how the named plaintiff's claims compare to the claims of other class members."). Typicality thus "screen[s] out class actions in which the legal or factual position of the representatives is markedly different from that of other members of the class even though common issues of law or fact are present." 7A Charles Wright & Arthur Miller, Fed. Prac. & Proc. § 1764 (3d ed. 2017).

Importantly, where the named class representative will likely be subject to a unique defense that will play a "major role" in the disposition of her individual claim, her claim is not typical of the class. *Beck v. Maximus, Inc.*, 457 F.3d 291, 300 (3d Cir. 2006); *Hanon v. Dataproducts Corp.*, 976 F.2d 497, 508 (9th Cir. 1992); *Gary Plastic Packaging Corp. v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 903 F.2d 176, 180 (2d Cir. 1990), *overruled on other grounds*, *Microsoft Corp. v. Baker*, 137 S. Ct. 1702 (2017); *J.H. Cohn & Co. v. Am. Appraisal Assocs.*, 628 F.2d 994, 999 (7th Cir. 1980). This is because typicality, reduced to its essence, requires that "as goes the claim of the named plaintiff, so go the claims of the class." *Broussard v. Meineke Discount Muffler Shops, Inc.*, 155 F.3d 331, 340 (4th Cir. 1998).

In this case, Wolfe alleges that she submitted a claim for reimbursement which was denied. She filed an NOD and awaits an SOC which may either resolve her claim in her favor or pave the way for her appeal to continue to the Board. As her claim is in appellate status, it must and will be reviewed by agency decisionmakers in due course. *See* 38 U.S.C. § 7105. This leaves the potential that the denial of her claim will be overturned or that some other ground for denying the claim will appear from further investigation of the underlying facts. *See Monk*, 30 Vet.App. at 173 (observing that even after an NOD is issued, VA must continue to develop a claim as appropriate and provide a detailed rationale for its decision in an SOC).

For that reason, Wolfe's claims are not typical of the class she seeks to represent. A forthcoming SOC or Board decision may affect her claim in a way that other class members will not experience, since her class allegations are not tied to whether the claimant's claim has been denied and is on appeal. Should her claim be fully resolved on a different ground than originally stated, or if the denial is reversed and she is paid the amount she seeks, she will no longer share common interests with the class. Such a turn of events would give rise to defenses that, while central to the disposition of her individual claim, may not pertain to other class members. *Beck*, 457 F.3d at 300; *see also Medrano v. Nicholson*, 21 Vet.App. 165, 170 (2007) (fully favorable decisions on benefits claims may not be reviewed by the Court). This, in turn, calls into question her ability to zealously

represent the class' interests before the Court. *Gary Plastic Packaging Corp.*, 903 F.2d at 180 (class certification should be denied where "there is a danger that absent class members will suffer if their representative is preoccupied with defenses unique to it"). Further, to the extent the denial is continued as a result of Section 17.1005(a)(5), that result stems from the validity of the regulation and, in any event, Wolfe has a remedy available to her through appeal to the Court. *See supra* Parts I.A, I.B.

While the prospective outcome of her administrative appeal is not presently known, this in fact cuts against her request for class relief. In ordinary class litigation, "actual, not presumed, conformance with Rule 23(a) [is] . . . indispensable." *Gen. Tele. Co. of S.W. v. Falcon*, 457 U.S. 147, 160 (1982). That principle holds true here, and then some.

d. Adequacy of Representation

For similar reasons, Wolfe cannot show that she will be an adequate class representative as required by Rule 23(a)(4). Rule 23(a)'s adequacy requirement provides that the named plaintiff must "'fairly and adequately protect the interests of the class.'" *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 625 (1997) (quoting Fed. R. Civ. P. 23(a)(4)). This rule "serves to uncover conflicts of interest between named parties and the class they seek to represent." *Id.* Critically, "a class representative must be part of the class and 'possess the same interest and suffer the same injury' as the class members." *East Tex. Motor Freight Sys., Inc. v.*

Rodriguez, 431 U.S. 395, 403 (1977) (quoting S*chlesinger v. Reservists Comm. to Stop the War*, 418 U.S. 208, 216 (1974)). Given that both typicality and adequacy query the sufficiency of the class representative, analysis of both requirements is closely related. *See In re Schering Plough Corp. ERISA Litig.*, 589 F.3d 585, 602 (3d Cir. 2009).

Thus, where factual differences between the named representative's claim and the putative class members' claims create a likelihood of unique defenses to the representative's claim, courts discern a potential conflict in the representative's incentive to vigorously pursue the absent class members' claims. *Id.* Here, as explained above, Wolfe's attempt to end-run around the normal course of her administrative appeal creates significant doubt about whether her interests will remain aligned with the class she seeks to represent. Should those interests change as she receives further VA assistance and appellate review, who will ensure the absent class members' interests are protected? *Cohn*, 628 F.2d at 999 ("[T]he presence of even an arguable defense peculiar to the named plaintiff . . . may destroy the required typicality of the class as well as bring into question the adequacy of the named plaintiff's representation. The fear is that the named plaintiff will become distracted by the presence of a possible defense applicable only to him so that the representation of the rest of the class will suffer.") (internal citations omitted)). In proceeding as she has chosen to do, Wolfe has fashioned the very adequacy problems that destabilize her class claim.

e. Certification as a Rule 23(b)(2) Class

As with the question of commonality, if Wolfe's narrower class definition is the benchmark for her proposed class, the Secretary agrees with her that Rule 23(b)(2) is the proper form of class action to effectuate her requested relief. *See supra* Part I.C.3.b. That Rule allows class treatment in circumstances where "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2). Assuming for a moment that the Court declares Section 17.1005(a)(5) invalid, a single injunction or declaration against the regulation would afford relief to each claimant who was actually harmed by the denial of a reimbursement claim on the basis of that regulation. *Wal-Mart*, 564 U.S. at 360–61. Of course, as explained above, a precedential ruling invalidating the regulation would have precisely the same effect without the need for aggregate relief.

However, should Wolfe maintain a request to proceed on her broader class definition, *see supra* Part I.C.3.b, Rule 23(b)(2) would no longer be a viable framework. Although Wolfe would, in the case of her broader class definition, "superficially structur[e] [her] case around a claim for class-wide injunctive and declaratory relief" focused on the validity of Section 17.1005(a)(5), in reality an injunction against enforcement of the regulation would "would merely initiate a process through which highly individualized determinations of liability and remedy

are made; this kind of relief would be class-wide in name only, and it would certainly not be final." *Jamie S. v. Milwaukee Pub. Sch.*, 668 F.3d 481, 499 (7th Cir. 2012). There would be no assurance—indeed, no likelihood—that an injunction would grant relief to all class members indivisibly. *Wal-Mart*, 564 U.S. at 360 (Rule 23(b)(2) "does not authorize class certification when each individual class member would be entitled to a different injunction or declaratory judgment against the defendant"). Put differently, should the broader class become the focus of this litigation, a morass of individual liability and defense issues would arise concerning the nature of each claim denial, destroying the uniformity of relief required by Rule 23(b)(2) and the usefulness of class proceedings as a way to conveniently resolve the disputes of all class members. *See Barnes v. Am. Tobacco Co.*, 161 F.3d 127, 143 (3d Cir. 1998). As such, Rule 23(b)(2) would not be an appropriate vehicle for such a class claim.

II. Boerschinger's Request for a Writ Is Without Merit, Yet the Secretary Is Undertaking Considerable Efforts to Rectify the Problem He Has Identified.

Boerschinger asserts a claim different from Wolfe's. He alleges that his reimbursement claim was denied solely because he had insurance coverage. Am. Pet. at 17. Additionally, he alleges that he and other claimants received letters listing as a requirement for reimbursement that the claimant not have any kind of insurance coverage. *Id.* at 18. This, he asserts, is inconsistent with *Staab* and violates claimants' Fifth Amendment right to due process, whether or not the claim

in question was actually denied on this basis. *Id.* at 19 (citing *Cushman v. Shinseki*, 576 F.3d 1290, 1298 (Fed. Cir. 2009)). Boerschinger defines his putative class as follows:

> All VA claimants who, on or after April 8, 2016, (i) filed a request, or had a request pending, with the VA for reimbursement for payments incurred for emergency medical treatment at a non-VA facility; and (ii) received a letter from the VA stating or indicating that one of the criteria for reimbursement is that the veteran has no coverage under a health plan contract.

Id. at 22.

A. Despite the Unavailability of a Writ in These Circumstances, VA Is Pursuing Numerous Avenues to Afford the Boerschinger Class the Relief It Seeks.

Because Boerschinger can seek timely appellate review of the revised denial of his reimbursement claim, he is not entitled to extraordinary relief. Additionally, his proposed class definition, like Wolfe's, is overbroad, and the facts of Boerschinger's case show that he cannot nor can he operate as an adequate class representative. Those matters will be addressed further below. Nevertheless, the Secretary takes seriously Boerschinger's allegations of error with respect to VA's emergency-care reimbursement system. As described below, the Secretary is already in the process of addressing each of the items of relief Boerschinger seeks.

Context is important to appreciate the nature of the problem presented and how to remedy it. The Veterans Health Administration (VHA) suspended reimbursement claim adjudications after *Staab* and during the period it was drafting

revised regulations to comply with that ruling. Declaration of Dr. Kameron L. Matthews, Deputy Under Secretary for Health for Community Care, VHA, attached hereto as Ex. 1, ¶ III.a–c. Although VHA revised its regulations to implement *Staab*, it did not concurrently update all letter templates used in the claims adjudication process to reflect the revised reimbursement eligibility criteria. *Id.* ¶ III.d. Thus, language remained in VHA correspondence that erroneously advised veterans that their claim could not be granted if they had whole or partial other health insurance. *Id.* VHA issued letters with this erroneous language beginning on January 9, 2018. *Id.* ¶ III.c.

In the amended petition, Boerschinger seeks a Court order granting the following relief for himself and his putative class: (1) invalidating decisions made by the Secretary to the extent that they denied reimbursement to veterans for medical expenses on the ground that the veteran has coverage under a health plan contract; (2) ordering the Secretary to readjudicate these reimbursement claims in accordance with current law; (3) enjoining the Secretary from issuing any communication to veterans that incorrectly states that one of the criteria for reimbursement is that the veteran has no coverage at all under any health plan contract; (4) ordering the Secretary to re-issue all communications sent to claimants since the *Staab* decision issued on April 8, 2016 which incorrectly stated that one of the criteria for reimbursement is that the veteran have no coverage at all under a health plan contract; and (5) ordering the Secretary to re-set the

deadlines applicable to veterans who received this correspondence for appealing denial of their reimbursement claims. Am. Pet. at 3–4.

Even in the short months since he was first apprised of Boerschinger's claim, the Secretary has undertaken robust, continuing efforts to address the problem Boerschinger identifies and consider each form of relief listed above. First, VHA halted adjudication of all emergency-care reimbursement claims that were missing needed information or did not meet the criteria for reimbursement under 38 C.F.R. § 1725 on February 8, 2019 pending further instruction. Ex. 1, ¶ III.e.

Second, VHA has crafted a corrective action plan that will apprise all affected veterans of the error in its post-*Staab* letters and confer renewed appellate rights on all veterans whose claims have been denied, whether based on the presence of other health insurance or not. *Id.* ¶ IV. The affected claimants have been divided into three categories. Category A, which includes those veterans whose claims were denied based on the presence of other health insurance, will receive a letter from VHA advising them of the mistaken adjudication and notifying them that their claims will be reopened and readjudicated. *Id.* ¶ IV.a. These letters will be issued beginning in April 2019. *Id.* Upon readjudication, Category A claimants will receive a letter informing them of the results of the readjudication and affording them a new one-year period in which to appeal any adverse decision. *Id.*

Claimants in Category B, which includes veterans whose claims were denied for reasons other than the presence of other health insurance, will be treated similarly. *Id.* ¶ IV.b. Corrected denial notices will be mailed beginning in May 2019 which advise these veterans that VHA's prior correspondence included the incorrect other-health-insurance reimbursement eligibility criterion. *Id.* The corrected notices will state the correct eligibility criteria and will afford these veterans a new one-year appeal period based on the date of the corrected notice. *Id.*

Finally, Category C includes claimants whose claims were not denied but were instead rejected as incomplete. *Id.* ¶ IV.c. As Dr. Matthews explains, a rejection is not a denial; it simply means that some portion of the record is incomplete and that adjudication cannot occur until the missing information is gathered. *Id.* ¶ III.d, n.1. For Category C claimants, VHA will mail corrected rejection notices starting in May 2019. *Id.* ¶ IV.c. These corrected notices will advise veterans of the other-health-insurance error and the correct eligibility criteria for reimbursement. *Id.*

In addition to the specific steps outlined above for the various categories of affected claimants, VHA has taken global corrective action with respect to its reimbursement claims processing system. *Id.* ¶ IV.d. This includes revising all of its letter templates to remove the erroneous other-health-insurance criterion. *Id.* ¶ IV.d.1. All VHA correspondence issued after February 14, 2019 will reflect this

revision. *Id.* ¶ IV.d.2. Further, all revised correspondence will direct claimants to a single customer service call center line to ensure any questions they may have are answered in a consistent manner. *Id.* ¶ IV.d.3. Finally, VHA will monitor its claims processing system software to ensure that this error does not recur. *Id.* ¶ IV.d.4.

While VA regrets the lingering error in its correspondence templates after *Staab*, the plan laid out above will be comprehensive and effective in addressing that problem for all affected claimants. Indeed, the present corrective action plan satisfies each item of relief Boerschinger has requested. More detailed action plans and a more definitive timeline will be developed as needed as VHA works through these initial steps.

B. Boerschinger May Appeal the Denial of His Own Claim and Therefore Cannot Resort to a Writ.

The Secretary has undertaken wide-ranging corrective action with respect to the issue Boerschinger has identified and has generated definite plans for completing the remedial process. However, these efforts should not distract from the deficiencies in Boerschinger's claim for an extraordinary writ on a class basis.

Boerschinger challenges the result of his reimbursement claim, *i.e.*, its denial. Am. Pet. at 11. His putative class broadly includes claimants who would be confused by incorrect statements of the law in VA letters, regardless if their claim was denied for the reason that the claimant had other health insurance. *Id.* at 17–18. But Boerschinger's individual claim is different, as he alleges that his claim was, in fact, erroneously denied on this ground. *See id.* at 3 (requesting as relief

that the Court invalidate such erroneous denials of reimbursement). Of course, the nature of his claim is now fundamentally different, as VA has readjudicated his reimbursement claim and found that it should be denied because his remaining liability to the provider consists of a deductible he owes as part of his Medicare Part A coverage. Ex. 1, ¶ V.i; Ex. 2. Thus, he falls within the ambit of Wolfe's regulatory challenge, and his claim fails for the same reasons—namely, that the regulation is lawful, and any substantive challenge to it in this Court may be heard only on appeal from the Board at the conclusion of the administrative appeals process.

Yet, whatever the reason for the denial of Boerschinger's claim, an allegation that his claim has been erroneously denied is just the sort of error the appellate process exists to remedy. The issuance of a writ to afford him relief is therefore inappropriate. Recall that the core function of a writ is to provide relief in instances where the usual appellate process cannot. *Cheney,* 542 U.S. at 380–81. The Supreme Court has instructed that although delay is inherent in obtaining appellate review, such inconvenience does not itself authorize a court to grant extraordinary relief. *Roche*, 319 U.S. at 30–31.

Boerschinger's reimbursement claim was readjudicated and denied in a letter dated March 13, 2019. Ex. 2. As he is informed in that letter, he is free to appeal the denial of his claim. 38 U.S.C. § 7105. Indeed, his right to initiate an appeal will persist for a year from the date of the letter. Ex. 2. He is therefore well

within the window of time to challenge the agency's decision if he disagrees with it, as his co-petitioner has done.

Because Boerschinger may still seek appellate review of the denial of his claim, a writ is foreclosed to him. *Bankers Life*, 346 U.S. at 383. Notably, as is the case with Wolfe's claim, here Boerschinger challenges the merit of the agency's decision. This stands in stark contrast to the types of claims typically brought in a writ petition. For instance, a claimant asserting undue delay in the adjudication of his administrative appeal may have little recourse, outside a writ, to force the agency to move more quickly on his claim. It is not the sort of harm for which he could bring a separate claim within the VA benefits system. Many writs presented to this Court are of this type—a procedural problem arising during the course of agency adjudication that would otherwise be unreviewable by later appellate decisionmakers.

Yet in the amended petition, Boerschinger simply asserts that the agency got its decision wrong. Allegations of substantive error in agency adjudications are precisely what the appellate process was designed to address. Unlike a petitioner challenging the procedural course of his appeal, apart from the ultimate grant or denial of benefits, here Boerschinger wants a different final result on the adjudication of his claim, and the appellate structure exists to provide that remedy.

In short, Boerschinger's claim is ripe for ordinary appellate review. It is not a case where extraordinary relief is appropriate, since a writ, which end-runs around

the usual appellate process, is justified only when that process will not be able to provide adequate relief. *See supra* Part I.A.2. Just like Wolfe, Boerschinger's belief that the appellate process is too sluggish is not relevant; writs do not exist as expedient substitutes for appeals. *Cheney,* 542 U.S. at 380–81.

C. Because His Claim Has Now Properly Been Denied, and Because He Has a Viable Avenue for Appellate Review, Boerschinger's Claim Is Atypical of the Class and He Cannot Be an Adequate Class Representative.

Appellate review remains open to Boerschinger. As a result, he cannot show that his claim is typical of the class he seeks to represent, nor is there any assurance that he will remain a zealous advocate for the class' interests. For purposes of the class certification analysis, the Secretary concedes that Boerschinger's proposed class satisfies the following threshold elements: numerosity, commonality, and viability as a Rule 23(b)(2) class. *See supra* Part I.C.3.

The commonality concession comes, however, with the same qualification described above with respect to Wolfe's proposed class definition. Like the putative Wolfe class, which purports to include many claimants unaffected by the operation of Section 17.1005(a)(5), Boerschinger's class sweeps too broadly, too. The effect of defective notice differs greatly among the prospective members of Boerschinger's class. Some may have brought claims that were properly denied for reasons other than the existence other health insurance. Some may have chosen not to appeal for a reason other than the insurance criterion.

Boerschinger's class definition does not differentiate between these claimants, and because of this it seeks overbroad relief that cannot hope to drive the resolution of this litigation. *Wal-Mart*, 564 U.S. at 350; *M.D. ex rel. Stuckenberg*, 675 F.3d at 840. Thus, the Secretary concedes only the viability of a narrow class definition, focused on those whose claims were improperly denied based on application of the insurance criterion.

On top of overbreadth concerns, Boerschinger's unique circumstances present obstacles to his class claim. First, should he timely seek review of the denial of his reimbursement claim—and ample time remains for him to do so—his claim will receive further factual and legal development. As with Wolfe's claim, this may reveal that Boerschinger faces unique defenses to his claim atypical of those maintainable against the class. *Cohn*, 628 F.2d at 999. Thus, correction of the legal error committed during the initial adjudication may nevertheless not change the proper outcome as to Boerschinger's claim, which has at this time been appropriately adjudicated and denied pursuant Section 17.1005(a)(5). As a result, he has not shown that class-based relief is warranted.

CONCLUSION

A rigorous evaluation of Wolfe's petition for class relief shows it to be misguided. First, the Court lacks the authority to entertain it, as it cannot hear direct regulatory challenges outside the context of ordinary appeals. Second, Wolfe continues to pursue her administrative appeal, undermining her contention that

she lacks an adequate alternative remedy outside the present writ. Third, Section 17.1005(a)(5) is itself a reasonable, valid construction of Congress' broad mandate embodied in Section 1725(c)(4)(D).

Finally, even putting all those obstacles aside, class relief is truly unnecessary for each aggrieved claimant to vindicate her rights. Class relief exists to promote efficiency and economy of litigation. *China Agritech, Inc. v. Resh*, 138 S. Ct. 1800, 1811 (2018). Yet litigating a direct regulatory challenge on a class basis will unduly delay these proceedings with no discernable advantage, as ancient principles of judicial power will already provide any potential class member the benefit Wolfe seeks if the Court views her individual claim favorably. For that reason, the Court should decline to issue the class-based relief Wolfe requests.

Boerschinger's claim present different challenges, challenges the Secretary has already taken great strides to address. While the Secretary works diligently to correct the regrettable error with respect to reimbursement claims and letters like the one sent to Boerschinger, the fact remains that Boerschinger's request for extraordinary, class-based relief is without merit. The claim he presents in this proceeding—that VA applied an incorrect legal standard in adjudicating his reimbursement claim—is indistinguishable from the types of claims made in appeals this Court hears every day. That appellate process is, and must be, Boerschinger's avenue to pursue relief. Further, as his claim has been

readjudicated and properly denied based on the application of Section 17.1005(a)(5), his entitlement to relief fails for all the reasons applicable to Wolfe.

For these reasons, the Secretary respectfully requests that the Court deny Petitioners' amended petition for a writ of mandamus.

Respectfully submitted,

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EXHIBIT 1

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DECLARATION OF KAMERON L. MATTHEWS, M.D., JD, FAAFP

I, Kameron L. Matthews, M.D., JD, FAAFP, pursuant to 28 U.S.C. § 1746, declare under penalty of perjury the following:

I. I am the Deputy Under Secretary for Health for Community Care, Veterans Health Administration (VHA). This declaration is in response to the U.S. Court of Appeals for Veterans Claims February 1, 2019, order in the matter of Amanda Jane Wolfe and Peter E. Boerschinger, Petitioners, 18-6091, directing the Secretary to respond to Petitioners' Amended Petition for Class Relief in the Nature of a Writ of Mandamus. The facts attested to herein are based on my personal knowledge.

II. **Court Proceedings**

a. On January 1, 2019, Petitioner Amanda Jane Wolfe (Wolfe) submitted a motion for leave to amend her petition for class relief in the nature of a writ of mandamus to join a new petitioner, Peter E. Boerschinger (Boerschinger).

b. On February 1, 2019, the Court granted Wolfe leave to file her amended petition and to join Boerschinger.

c. Boerschinger alleges that he and the class of VA benefits claimants he seeks to represent received incorrect VA notices and letters in response to their requests for reimbursement of emergency medical expenses incurred at non-VA hospitals for treatment of non-service connected (NSC) conditions.

d. Boerschinger asserts that VA erroneously instructed claimants that in order to be eligible for reimbursement, they must have neither whole nor partial health insurance coverage. This instruction is inconsistent with *Staab v. McDonald*, 28 Vet.App. 50 (2016), which invalidated a former VA regulation prohibiting reimbursement if the claimant had any insurance coverage.

III. Relevant Background

a. The regulations governing VHA as a secondary payer to a third party, including a health-plan contract who made, or will make, partial payment for the costs of a Veteran's non-VA emergency treatment for an NSC condition, became effective on January 9, 2018, when VHA published revised regulations to implement the decision in *Staab*. *See* 83 Fed.Reg. 974 (Jan. 9, 2018).

b. A key change was removing 38 C.F.R. § 17.1002(f), the regulation invalidated by *Staab*, and replacing it with 38 C.F.R. § 17.1002(f), which makes clear that, assuming other eligibility criteria are met, VA reimbursement is not barred unless a Veteran's coverage under a health-plan contract would fully extinguish the Veteran's liability for the emergency treatment.

c. On January 9, 2018, VHA began processing all claims that had been suspended during the pendency of the *Staab* litigation and the drafting of the new regulations; this included all non-final claims that were pending with VHA on or after the date of the *Staab* decision, April 8, 2016. In total, approximately 1 million claims had been suspended. On January 9, 2018, VHA also began processing new claims.

d. Although VHA revised its regulations to implement *Staab*, VHA did not concurrently update all letter template language to ensure it properly explained the revised eligibility criterion related to a Veteran's coverage under a health-plan contract. As a result, correspondence issued after January 9, 2018, continued to include language stating that VHA must deny claims for reimbursement if the Veteran had any coverage under a health-plan contract. This erroneous language was used in decision denial notices ("denial notices") and rejection notices requesting additional information needed to adjudicate the claims ("rejection notices").[1]

[1]A rejection is different from a denial. A rejection notice informs the claimant what they must do in order to get the claim processed correctly. Reasons for rejection include: duplicate claims submission, missing information (*e.g.*, EOB or medical records), and ICD (International Classification of Disease)

e. VHA stopped sending rejection and denial notices for reimbursement claims for emergency treatment on February 8, 2019, and began initiating corrective actions (see below) to address the aforementioned error in denial and rejection notices.

f. VHA has categorized affected claims into three categories for purposes of taking corrective actions. These are described in detail below.

IV. Corrective Actions

a. **Category A claims**—claims that VHA incorrectly denied based on the presence of other health insurance (OHI) and sent denial notices to that effect.

1. To address this mistake, VHA will send a letter to claimants who received incorrect denial notices advising them of this error.

2. The letter will inform claimants that VHA will reopen and re-adjudicate their claims.

3. These letters will be issued beginning in April 2019.

4. Once re-adjudicated, claimants will be informed of the result of the re-adjudication and will be afforded a one-year appeal period for these claims based on the date of mailing of the new adjudication letter.

b. **Category B claims**—claims that VHA denied for reasons other than the presence of OHI, but sent denial notices which potentially included erroneous language stating that a Veteran must have no coverage under a health-plan contract for the claim to be reimbursable by VA.

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diagnosis codes that are missing or invalid. Once a rejected claim is completed or corrected, VHA proceeds to adjudicate and either grant or deny the claim.

1. To address this mistake, VHA will begin mailing corrected denial notices in May 2019.

2. The corrected denial notices will inform claimants that they received a denial notice that may have included erroneous information regarding the criteria necessary to substantiate their claim for benefits. They will be also be apprised of the correct criteria to substantiate their claims.

3. The corrected denial notices will also inform claimants that the appeal period for these claims will be reset based on the date of mailing of the corrective denial notices.

c. **Category C claims**—claims that VHA rejected as incomplete, but sent rejection notices which potentially included erroneous language stating that a Veteran must have no coverage under a health-plan contract for the claim to be reimbursable by VA.

1. To address this mistake, VHA will mail corrected rejection notices beginning in May 2019.

2. The corrected rejection notices will advise claimants that they received a rejection notice that may have included erroneous information regarding the criteria necessary to substantiate their claim for benefits. They will be also be apprised of the correct criteria to substantiate their claims and the reason(s) that their claim was rejected as incomplete.

d. **Global Corrective Action**

1. All templates in the VHA claims processing system were updated on February 14, 2019, to remove incorrect legal criteria from notice templates stating that VHA must deny claims for reimbursement if the Veteran has any coverage under a health-plan contract.

2. All VHA correspondence (denial notices and rejection notices) issued after February 14, 2019, will be issued using the revised templates.

3. All notices will steer claimants to a single customer service call center line if they have questions to ensure consistency in responses.

4. Ongoing monitoring will be performed to ensure the VHA claims processing system does not permit denial notices or rejection notices to be issued based on the Veteran's possession of coverage under a health-plan contract.

5. Quarterly checks of the language used in the software templates for denial notices and rejection notices will be conducted to ensure only the prescribed templates are used.

e. The corrective actions described herein constitute VHA's action plan to address the issues identified above. Detailed actions and a more definitive timeline will be developed as VHA works through the steps described above.

V. **Boerschinger's Reimbursement Claims**

a. Boerschinger is service connected for psoriasis, evaluated as 30 percent disabling.

b. He received non-VA emergency treatment for an NSC condition furnished by Dickinson County Healthcare (Provider) from April 1 to April 10, 2018.

c. Boerschinger was transferred to the VA Community Living Center at Oscar G. Johnson VA, Iron Mountain, Michigan on April 10, 2018, for continued treatment.

d. VA received several claims for reimbursement from the Provider for this episode of care (EOC).

e. On May 23, 2018, in accordance with its usual adjudication procedures, the EOC was submitted for clinical eligibility review. It was determined that Boerschinger is an active user (*i.e.*, enrolled in VA health care and seen within the preceding 24 months) and that his care satisfied the definition of emergency treatment.

f. Between June 14, 2018, and October 11, 2018, VA made payment on claims for ancillary services, up to the VA maximum allowable amount. Boerschinger has Medicare Part A but does not have Medicare Part B, which would have covered some of these charges.

g. On November 27, 2018, Boerschinger's claims were erroneously denied because he had OHI, *i.e.,* Medicare Part A.

h. This erroneous denial occurred due to a faulty system prompt in VHA's claims processing system that has since been corrected.

i. Boerschinger's claim was reopened and re-adjudicated on March 13, 2019. His claim was denied because the remaining liability of $1,340.00 is a deductible he owes to Medicare Part A. A new denial notice was issued. The notice informed Boerschinger that he has one year to appeal the decision.

I certify, under penalty of perjury under the laws of the United States, that the foregoing is true and correct.

Executed on **March 15, 2019**

3/15/2019

X 

Kameron L. Matthews, M.D., JD, FAAFP
VHA Deputy Under Secretary for Heath
Signed by: Kameron L. Matthews 1433120

EXHIBIT 2

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Community Care

325 East "H" Street
Iron Mountain, MI 49801-4792
http://www.va.gov/CommunityCare

DEPARTMENT OF VETERANS AFFAIRS

03/14/2019

Community Care Program: 38 U.S.C. § 1725

BOERSCHINGER, PETER E

Episode of Care Date (s): 04/01/2018 – 04/10/2018

The Department of Veterans Affairs (VA) recently processed and denied a claim for reimbursement of non-VA emergency treatment costs you incurred in connection with the episode(s) of care listed above. After further review, we have determined this claim was denied for the wrong reason.

The decision notice incorrectly stated that VA cannot reimburse claims if the Veteran has other health insurance (OHI). In fact, if a Veteran has OHI, VA is a secondary payer, meaning VA pays after any payment by OHI up to the VA maximum allowable amount, if all the criteria for VA reimbursement are met.

To correct this error, we reopened and re-adjudicated your claim. The corrected decision notice is enclosed. Please refer to the decision notice for information about your appeal rights.

It is important to note that VA has no legal authority to pay a Veteran's coinsurance, deductibles, or copayments that a Veteran owes under the terms of their other health insurance.

If you have questions, please contact me at (224)723-0777.

Respectfully,

JOHN I KEATING III
Supervisory Financial Analyst
VHA Office of Community Care (10D1B3)
224-723-0777

DEPARTMENT OF VETERANS AFFAIRS
Oscar G. Johnson Medical Center
Office of Community Care- Claims Adjudication and Reimbursement
Mail Code: CAR
325 East "H" Street
Iron Mountain, MI 49801-4792
(906)-774-3300 x32657

03/13/2019

Claim ID#: [redacted]
Reimbursement of Emergency Treatment
38 U.S.C. 1725

BOERSCHINGER PETER E
[redacted]

Provider: DICKINSON CO HEALTHCARE
Episode of Care Beginning: 04/01/2018

We received a claim for reimbursement of the costs of non-VA emergency treatment incurred by the above-named Veteran during the above-stated episode of care. Our office reviewed the claim under 38 U.S.C. 1725, the statute that governs VA reimbursement of the costs of non-VA emergency treatment for non-service-connected conditions, as implemented by 38 C.F.R.§§ 17.1000 et seq.

The claim has been denied for the following primary reason:

Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered.

In reaching this decision, we considered the following evidence: VA health care enrollment records; any records of payment by a third party, including under a health-plan contract; records relating to any service-connected conditions; VA patient records; information provided on the claim (whether electronic or paper); and medical documentation from the non-VA provider as needed.

To be eligible for VA reimbursement under 38 U.S.C. 1725, as implemented, all of the following requirements must be met:

(1) You are not eligible under 38 U.S.C. 1728 which authorizes reimbursement primarily for non-VA emergency treatment of a Veteran's service-connected condition, other condition associated with and aggravating a service-connected condition, and any disability of a veteran who has a total and permanent disability from a service-connected condition.

(2) A VA facility or other federal facility with which VA has an agreement was not feasibly

available.

(3) Your treatment was for a condition that a prudent layperson would reasonably have believed would cause jeopardy to life or health without immediate medical attention.

(4) You are financially liable to the provider for the costs of the emergency treatment after any payment by a third party, including under a health-plan contract, excluding any copayment, deductibles, coinsurance, or other similar payments owed to a third party, including those owed under a health-plan contract. This can also include automobile accident information.

(5) You are enrolled in the VA health care system and have received medical services within the 24-month period preceding your receipt of the emergency treatment.

(6) You have no other contractual or legal recourse against a third party that would, in whole, extinguish your personal financial liability to the emergency treatment provider.

(7) You received the emergency treatment in a hospital emergency department or a similar facility held out as providing emergency care.

(8) You are seeking reimbursement for treatment only up to the point you were medically stable or in the event you needed continued inpatient care after stabilization, to the point you could have been transferred to a VA and refused such transfer

(9) Your claim must be filed within 90 days of discharge; and

(10) Emergency transportation to the facility where the Veteran was transported may only be considered if reimbursement was authorized or could have been authorized for payment by a third party, including under a health-plan contract, under 38 USC 1725, as implemented.

If you do not agree with this decision, you have the right to appeal. Please reference the attached document for more information.

For questions or concerns regarding the primary basis for this denial decision, or regarding other qualifying criteria not met under § 1725, please contact 1-(800) 215-8262 option 5.

Regards,

Office of Community Care

Department of Veterans Affairs

YOUR RIGHTS TO SEEK FURTHER REVIEW OF OUR HEALTHCARE BENEFITS DECISION

If you received a VHA decision on your claim for healthcare benefits, and are dissatisfied or disagree with the decision, in whole or part, you have ONE YEAR to initiate further review by completing and submitting one of the forms described below.

What are my review options?

VA offers 3 types of review, but not all types of review are available in every case. Below is a description of each type of review and an explanation when each type is available.

This chart describes availability of review options:

Review Options	I am a Veteran, Beneficiary, or Other Person Who Paid for a Veteran or Beneficiary's treatment	I am a Service Provider (Not Under Contract)	I am a Service Provider Under Contract
Supplemental Claim	Available	Not Available	Not Available. See Contract Terms.
Higher-Level Review	Available	Not Available	Not Available. See Contract Terms.
Appeal to the Board	Available	Available	Not Available. See Contract Terms.

- **Supplemental claim.** If available, you should file a supplemental claim if VHA does not have all the evidence to accurately decide your claim.
- **Higher level review.** If available, you should file a request for higher level review if VHA has all the necessary evidence, but you would like VHA to take another look at the claim and see if a new decision can be supported.
- **Appeal to the Board of Veterans' Appeals.** You should appeal to the Board of Veterans' Appeals if you would like a Veteran's Law Judge to review your claim.

FAQs:

How do I request review by VA of my decision?

To select a review option, you must submit the appropriate form to the appropriate office for review.

For a **Supplemental Claim**, review your decision notice letter for the required forms and ways to submit the request. Either enclose or identify the NEW and RELEVANT EVIDENCE, not previously considered by VA, that you believe supports your claim. If you want VA to help you gather records, complete and return the appropriate Release of Information Form:
21-4142, Authorization to Disclose Information to the Department of Veterans Affairs (VA) or
21-4142a, General Release for Medical Provider Information to the Department of Veterans Affairs (VA).

For a **Higher-Level Review**, complete VA Form 20-0996, Decision Review Request: Higher-Level Review, and consult your decision notice letter for the required ways to submit the request.

To **Appeal to the Board**, complete VA Form 10182 - Decision Review Request: Board Appeal (Notice of Disagreement) and send the form to:
Board of Veterans' Appeals P.O. Box 27063 Washington, DC 20038 Fax: 844-678-8979
For more information on the Board of Veterans' Appeals, see https://www.bva.va.gov/.

All forms are also available at http://www.va.gov/vaforms/.

Can someone help me with my request for review?

You may be able to get assistance with your claim from a VA recognized and accredited attorney, claims agent, or Veterans Service Organization (VSO). VSOs and their representatives are not permitted to charge fees or accept gifts for their services. Only VA-accredited attorneys and claims agents may charge fees for assisting in a claim for VA benefits, and only after VA has issued an initial decision on the claim and the attorney or claims agent has complied with the power-of-attorney and the fee agreement requirements. For more information on the types of representatives available, *see* http://www.va.gov/ogc/accreditation.asp.

If you have not already selected a representative, or if you want to change your representative, a searchable database of VA-recognized VSOs and VA-accredited attorneys, claims agents, and VSO representatives is available at http://www.va.gov/ogc/apps/accreditation/index.asp. Contact your local VA office for assistance with appointing a representative or visit http://www.ebenefits.va.gov.

What happens if I do not submit my request for review on time?

If you do not request a review option within the required time limit, you may only seek review through the following options:

- File a request for revision of the decision based on a clear and unmistakable error in the decision;
- If available, file a Supplemental Claim along with new and relevant evidence to support your issue(s). Where a Supplemental Claim is filed after the time limit to seek review of a decision, the effective date for any resulting award of benefits generally will be tied to the date that VA receives the Supplemental Claim.

For more information on all the available review options visit: http://www.vets.gov or contact us at the phone number listed on the decision notice you received.

EXHIBIT 3

Title: To amend title 38, United States Code, to eliminate the prohibition on reimbursement by the Department of Veterans Affairs for a copayment or similar payment paid by a veteran for emergency treatment under a health-plan contract.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ELIMINATION OF PROHIBITION ON REIMBURSEMENT BY DEPARTMENT OF VETERANS AFFAIRS FOR COPAYMENT OR SIMILAR PAYMENT FOR EMERGENCY TREATMENT UNDER A HEALTH-PLAN CONTRACT.

(a) In General.—Subsection (c)(4) of section 1725 of title 38, United States Code, is amended by striking subparagraph (D).

(b) Application.—The amendment made by subsection (a) shall apply with respect to reimbursement sought under such section for emergency treatment furnished on or after February 1, 2010.

EXHIBIT 4

Department of Veterans Affairs **VHA DIRECTIVE 2009-038**
Veterans Health Administration
Washington, DC 20420 **August 25, 2009**

VHA NATIONAL DUAL CARE POLICY

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes the VHA National Dual Care Policy which delineates a system-wide approach to the coordination and provision of medical care that optimizes the appropriateness, safety, and efficacy of care, medications, prosthetics, and supplies provided to eligible Veterans who are seen by both Department of Veterans Affairs (VA) and community providers.

2. BACKGROUND

a. Each Veteran should have a single assigned primary care provider who oversees all aspects of care. However, some patients choose to see non-VA health care providers as well as VA providers. Common reasons cited for dual care include the desire to use VA comprehensive pharmacy benefits and distance to VA acute and specialty services. Health Services Research and Development (HSR&D) studies have shown a steady increase in dual care among Medicare eligible Veterans from 1997 through 2001. In 2001, 73 percent of VA users who were Medicare eligible also used their Medicare benefits for non-VA health care. Patient characteristics associated with higher rates of dual care include but are not limited to: receiving VA Primary Care at a Community-Based Outpatient Clinic (CBOC); having medical insurance of any type; higher income; and higher level of education.

b. Coordination and continuity of care are core features of high quality primary care. Continuity of primary care has been shown to have significant benefits, including lower rates of hospitalization and lower mortality. By splitting care between two or more health systems and multiple providers, dual care may pose risks to patients. An HSR&D research study of older Medicare eligible patients found increased mortality among dual care patients compared to VA-only users. Another study of patient experiences after stroke found higher rates of re-hospitalization and death among dual care Veterans.

c. Dual care may also contribute to lower professional satisfaction for VA staff. Unlike VA inpatients whose care is managed entirely by VA staff, dual care outpatients may present with requests to VA outpatient staff to obtain medication, tests, or services ordered by non-VA providers. In such situations, VA staff experience concerns regarding legal liability and a sense that their professional skills are devalued.

d. Patients who are recipients of dual care are entitled to the same level of care as other patients. They are eligible for inclusion in the cohorts used in data collection for the various performance measures, monitors, and provider-specific reports implemented by VHA.

THIS VHA DIRECTIVE EXPIRES AUGUST 31, 2014

e. **Definitions**

(1) **Veterans Receiving Dual Care.** Veterans receiving dual care are those who receive ongoing health care in both the community and VA.

(2) **VA Providers.** VA providers are physicians, advanced practice nurses, physician assistants, and other health care professionals who provide primary care or specialty care within the limitations of their individual VA privileges or scopes of practice.

(3) **Community Providers.** Community providers are physicians, advanced practice nurses, physician assistants, and other health care professionals who provide health care to Veterans outside of VA that is not paid for by VA.

(4) **Medication Reconciliation.** Medication reconciliation is the practice of reviewing and documenting all medications (including prescription and over the counter drugs, herbals, and vitamins) that a patient is currently taking from all sources and is completed across the continuum of care as outlined by The Joint Commission National Patient Safety Goal #8.

3. POLICY: It is VHA policy to ensure that the care of Veterans receiving dual care is well coordinated, safe, documented, and appropriate and the professional autonomy and responsibility of VA providers are respected.

4. ACTION

a. **Chief Consultant for Primary Care, Office of Patient Care Services.** The Chief Consultant for Primary Care, Office of Patient Care Services, is responsible for providing national direction and education to support implementation of this Directive.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for ensuring that VISN facilities have dual care policies in place that reflect the content of this Directive.

c. **Facility Director.** The facility Director is responsible for ensuring that:

(1) Patients who receive controlled substances from VA medical centers on a chronic basis are managed by one designated VA provider.

(2) Provision of controlled substances for dual care patients is closely monitored and the patient's care closely coordinated.

(3) Dual care Veterans seeking care, medications, or supplies from VA are enrolled in VHA and have at least one visit per year with a VA provider.

(4) The Veteran is followed and managed by a VA primary care clinician or team, if the Veteran wishes to receive ongoing medication or services for primary care health needs from VA, even if some of the care is provided in the community.

(5) Patients identified as dual care users are educated by the VA provider regarding the risks.

(6) Ensuring the patient and the community provider are notified that except in the instance of fee-basis care and certain provisions in the Millennium Bill and Title 38 United States Code (U.S.C.) for emergency care (see 38 U.S.C. §§ 1725 and 1728 for previously unauthorized non-VA emergency care), VA has no responsibility to pay for testing, medications, or treatment recommended by a non-VA health care provider.

d. **VA Provider.** The VA Provider is responsible for:

(1) Managing the VA care and services that are provided to a patient receiving dual care. The treatment plans must be consistent with the VA National Formulary, VISN, and local processes for obtaining non-formulary agents.

(2) Documenting the list of non-VA providers supplied by the patient in the patient's electronic health record, and coordinating care provided by non-VA providers as made available by the patient and non-VA provider (see Att. A).

(3) Ensuring that medications or diagnostic tests are not ordered for any condition that the VA provider is not managing, or any condition the Veteran does not allow the VA provider to adequately manage.

(4) Ensuring that a treatment or medication plan recommended by community providers is not followed if the VA provider believes the plan is not medically appropriate, or if that plan conflicts with national or local policies related to prescription of non-formulary or restricted medications. The VA provider may, but is not required to, follow recommendations of community providers. When the VA Provider does not follow the recommendations of community providers, the VA provider must communicate the rationale for such decisions and alternative treatment recommendations to the patient. ***NOTE:*** *In such cases, the Veteran may use the VA clinical appeals process.*

(5) Communicating the rationale for medication changes or refusal of medications to the Veteran and documenting this communication in the patient's electronic health record.

(6) Prescribing medication and managing the care of the patient for whom the medication is being prescribed within the VA provider's clinical privileges or scope of practice and within the boundaries of the VA provider's clinical expertise. Under no circumstances will a VA provider be permitted to simply re-write prescriptions from an outside provider, unless the VA provider has first made a professional assessment that the prescribed medication is medically appropriate.

(7) Ensuring that when highly-specialized medications (e.g., chemotherapy agents, post-transplant agents, etc.) are being requested by the Veteran, a VA provider with expertise in that specific specialty sees the patient, or the prescribing VA provider is in direct verbal or written contact with a VA specialist, or is acting on the recommendations of a VA specialist. Such communication must be documented in the health record.

(8) Ensuring that laboratory tests and other necessary monitoring for high-risk medications, such as warfarin, anti-arrhythmics, lithium, chemotherapy, etc., are completed either within or outside VA and documented in the VA patient's electronic health record. If such tests are completed outside of the VA system, the Veteran must provide the results to VA staff and the results are to be documented in the VA patient's electronic health record.

(9) Completing medication reconciliation in accordance with National Patient Safety Goal #8 and local policy including medications prescribed by, or secured outside of, the VA system to diminish the potential safety risk for the dual care patient.

(10) Educating patients identified as dual care users regarding the risks of dual care and the patient's own responsibilities, which are:

(a) Informing their VA provider of all care being provided and medications prescribed by community providers.

(b) Informing the community provider of care being provided through VA. ***NOTE:*** *If a provider outside of VA requests medication lists, laboratory results, or other health records, a written request from the outside physician is needed in all instances (see 38 U.S.C. 5702). A signed written authorization by the patient is only required if the records are for conditions related to 38 U.S.C 7332, Protected Health Information, which includes Human Immunodeficiency Virus (HIV), sickle cell anemia, and drug or alcohol abuse. The patient's verbal consent is not acceptable in this circumstance. All disclosures including HIV, sickle cell anemia, and/or drug or alcohol abuse must be tracked and accounted for in the Release of Information (ROI) Records Management software or on a spreadsheet, which is then given to the Privacy Officer for the accounting of the disclosure.*

(c) Supplying the respective VA provider with the names and addresses of all community health care providers that the patient is seeing.

(d) Obtaining all necessary records and documentation from the community provider for use by the VA provider. The patient is responsible for providing the VA provider with written evidence of any treatment plan changes, medication changes, or other changes in care made by the community provider, which must include the reasons for these changes. ***NOTE:*** *Costs related to duplication of community records are the responsibility of the Veteran.*

5. REFERENCES

a. Jia H, Zheng Y, Reker DM, Cowper DC, Wu SS, Vogel WB, Young GC, Duncan PW. Multiple system utilization and mortality for veterans with stroke. Stroke; A Journal of Cerebral Circulation, 2007 Feb 1; 38(2): 355-60.

b. Wolinsky FD, An H, Liu L, Miller TR, Rosenthal GE Dual use of Medicare and the Veterans Health Administration: are there adverse health outcomes? BMC Health Services Research (Electronic Resource http://www.biomedcentral.com), 2006 Oct 9; 6: 131.

c. Shen Y, Hendricks A, Li D, Gardner J, Kazis L. VA-Medicare dual beneficiaries' enrollment in Medicare HMOs: access to VA, availability of HMOs, and favorable selection. Medical Care Research and Review, 2005 Aug 1; 62(4): 479-95.

d. Stroupe KT, Hynes DM, Giobbie-Hurder A, Oddone EZ, Weinberger M, Reda DJ, Henderson WG. Patient satisfaction and use of Veterans Affairs versus non-Veterans Affairs healthcare services by veterans. Medical Care, 2005 May 1; 43(5): 453-60.

e. Weeks WB, Mahar PJ, Wright SM. Utilization of VA and Medicare services by Medicare-eligible veterans: the impact of additional access points in a rural setting. Journal of Healthcare Management and American College of Healthcare Executives, 2005 Mar 1; 50(2): 95-106; discussion 106-7.

f. Bean-Mayberry B, Chang CC, McNeil M, Hayes P, Scholle SH Comprehensive care for women veterans: indicators of dual use of VA and non-VA providers. Journal of American Medical Womens Association, 2004 Jul 1; 59(3): 192-7.

g. Borowsky SJ, Cowper DC Dual use of VA and non-VA primary care. Journal of General Internal Medicine, 1999 May 1; 14(5): 274-80.

h. Wasson JH, Sauvigne AE, Mogielnicki RP, Frey WG, Sox CH, Gaudette C, Rockwell A. Continuity of outpatient patient medical care in elderly men. A randomized trial. Journal of the American Medical Association, 1984 Nov 2; 252(17): 2413-7.

i. VHA Handbook 1605.1, Privacy and Release of Information paragraph 9, Accounting of Disclosures.

j. The Joint Commission: National Patient Safety Goal #8: Accurately and completely reconcile medications across the continuum of care.
http://www.jointcommission.org/NR/rdonlyres/5255C16C-25BD-4F67-AFED-624233D21227/0/AHC_NPSG_Outline.pdf

6. FOLLOW-UP RESPONSIBILITY: The Office of Patient Care Services, Chief Consultant for Primary Care (11PC) is responsible for the contents of this Directive. Questions may be addressed to 202-461-7182.

7. RESCISSIONS: VHA Directive 2002-074 dated November 20, 2002, is rescinded. This VHA Directive expires August 31, 2014.

Gerald M. Cross, MD, FAAFP
Acting Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 8/27/2009

ATTACHMENT A

SAMPLE LETTER TO COMMUNITY PROVIDERS WHO CARE FOR DUAL CARE VETERANS

Dear Colleague,

Some Veterans see non-Department of Veterans Affairs (VA) health care providers in their communities but also receive care from VA. _____(Patient's Name)_____ is requesting to receive medication through VA. VA pharmacies may only fill prescriptions written by VA providers for VA-approved treatment. VA providers are held responsible for the safety and appropriateness of all the medications that they order.

We, at VA, want to meet our mutual patient's needs safely, effectively, and collaboratively. To do this, we need the Veteran's relevant health records to support the prescribed medications and supplies. The records we need include the following:

This medical information can be sent to:

Name
Address

Fax number:

Prescription medications and supplies prescribed by VA providers are limited to those medications included in the VA National Formulary. VA Formulary items are selected when proven to be clinically and cost effective. You can view the VA National Formulary at this internet link (http://www.pbm.va.gov/NationalFormulary.aspx). Medications or supplies that are not on the National Formulary are available under certain circumstances. Requests for non-formulary items require documentation that the formulary options have been tried and proven ineffective or are clearly contraindicated.

We encourage patients to provide you with medical information and reports from VA. Copies of VA records can be provided by the patient or obtained from the VA by contacting our Release of Information office at:

_____(Address) and (Phone Number)_____

We look forward to working with you. If you have any questions, please contact me at ___(phone number)___.

Sincerely,

VA Provider
Primary Care Team