IN THE UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

AMANDA JANE WOLFE and **PETER E. BOERSCHINGER**,	)	
Petitioners,	)	
v.	)	Vet. App. No. 18-6091
ROBERT L. WILKIE, Secretary of Veterans Affairs,	)	
Respondent.	)	

RESPONDENT'S RESPONSE TO THE COURT'S MAY 31, 2019 ORDER

Pursuant to the Court's Order of May 31, 2019, Respondent, Robert L. Wilkie, Secretary of Veterans Affairs, respectfully responds to the Court's questions posed in that Order.

In its May 31, 2019 Order, the Court directed the Secretary to provide information concerning the system of reimbursement for emergency-treatment costs incurred by veterans for non-service-connected conditions at non-VA facilities pursuant to the Emergency Care Fairness Act (ECFA), 38 U.S.C. § 1725. Specifically, the Court ordered the Secretary to provide the following information: (1) what type of emergency treatment charges VA has covered under the ECFA; (2) how much money has been paid out under the ECFA as of the date of the Order; (3) a comparison of how claims were handled and reimbursed—*i.e.*, what types of charges VA reimbursed, how much money VA paid, and how VA handled claims from uninsured versus partially insured veterans—before and after the

decision in *Staab v. McDonald*, 28 Vet.App. 50 (2016); and (4) any other information the Secretary deems relevant as to the implementation of the ECFA. Further, the Court ordered the Secretary to state the number of claimants in Categories A, B, and C of the corrective action plan as defined by the Secretary during oral argument, as of the date of the Court's Order. The Secretary will address each of these matters in turn below.

1. Types of Emergency Treatment Charges Covered Under the ECFA

The Court's first question is what types of charges VA will cover under the reimbursement scheme defined in the ECFA. The answer is that VA will cover any charge for which the statutory and regulatory eligibility criteria are met; neither the reimbursement eligibility criteria nor the limitations on reimbursement turn on the type of emergency service provided.

None of the reimbursement criteria talk about the nature of the service at issue. *See* 38 U.S.C. § 1725(b); 38 C.F.R. §§ 17.1002, 17.1003. Instead, the fundamental requirement is that the services were employed to treat a medical emergency. *See* 38 U.S.C. § 1725(f)(1). Because medical emergencies can take many forms and require varied modes of treatment, the reimbursement scheme is not limited to certain types of services. As 38 C.F.R. § 17.1002 explains, the universe of charges encompassed here includes "medical services, professional services, ambulance services, ancillary care and medication[.]" Thus, so long as the reimbursement criteria are met, the Secretary will reimburse for services as

diverse as hospital facility fees, ambulance transportation, care by emergency-room physicians, anesthesiology, radiology, laboratory testing and diagnostics, and medications dispensed to treat an emergency condition, to name just a few examples.[1]

Indeed, the statute and regulations provide that VA's reimbursement authority extends beyond the emergency room itself, as long as the services are directly related to the emergency. Assuming the eligibility criteria are met, VA will pay for all services until the veteran reaches a level of clinical stability sufficient to be moved to a VA facility. *See* 38 U.S.C. § 1725(f)(1)(C); 38 C.F.R. § 17.1005(b). What's more, if the veteran is clinically stable but the appropriate VA facility lacks bed space, VA will continue to pay for the veteran's non-emergency treatment at the non-VA facility for the condition that resulted in the emergency episode. *See* 38 C.F.R. § 17.1005(c).

That said, Congress set forth in the ECFA several express limitations on the Secretary's reimbursement authority. First, the Secretary was required to establish a maximum amount payable for each type of emergency service. 38 U.S.C. § 1725(c)(1). The Secretary adopted a regulation which sets the maximum amount payable by reference to the veteran's personal liability and the Medicare fee

[1]It is also important to remember that the ECFA reimbursement scheme applies only to emergency treatment for non-service-connected conditions provided at non-VA facilities. VA pays in full for emergency treatment at a non-VA facility for a service-connected condition. 38 U.S.C. § 1728.

schedule. 38 C.F.R. § 17.1005(a). Any provider can unilaterally decide to reject such a payment within 30 days of receipt. 38 U.S.C. § 1725(c)(3). This means that, no matter how one defines the Secretary's obligation to pay, any provider may, in its sole discretion, refuse to accept VA's payment and instead pursue the veteran directly for the full amount the provider wishes to charge for its services.

Second, the Secretary cannot reimburse for emergency treatment services unless the veteran or the provider "has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such treatment." *Id.* § 1725(c)(2). In other words, the veteran or the provider must exhaust reasonable attempts to obtain payment from a third party, such as a private insurer or Medicare, before coming to VA for payment.

Finally, there is the reimbursement limitation which has become the focal point of this litigation: the Secretary "may not reimburse a veteran under this section for any copayment or similar payment that the veteran owes the third party or for which the veteran is responsible under a health-plan contract." *Id.* § 1725(c)(4)(D). As explained in his brief and at argument, the Secretary, obliged to enforce Congress' statutory command, undertook to interpret what Congress meant by the word "similar" in this provision. The Secretary concluded that, with the benefit of the explanatory clause following the word "similar," Congress was referring to cost-sharing obligations, including coinsurance and deductibles, as

cost-sharing obligations are the only types of costs an insured owes under a health plan contract which are "similar" to copayments. *See* 38 C.F.R. § 17.1005(a)(5).

In sum, neither the reimbursement eligibility criteria nor the limitations on reimbursement consider the type of emergency treatment provided. All emergency treatment charges can be reimbursed provided these criteria are met and the limitations avoided.

2. Amount Paid Pursuant to the ECFA

In its May 31, 2019 Order, the Court seeks a global figure for the amount paid pursuant to the ECFA since its enactment. VHA has provided that data, detailing the amounts paid out under the ECFA, per quarter, for the period spanning from the first quarter (Q1) of fiscal year (FY) 2010 through Q3 of FY 2019, which translates to the calendar-year period of October 2009 to June 2019. *See* Graph of "Emergency (28 U.S.C. § 1725) Claims, Amounts Paid, October 2009 to June 2019," attached hereto as Exhibit 1. VHA's analysis shows that, since enactment of the ECFA, the Secretary has paid an average of over $92,000,000 per quarter and over $360,000,000 per year. *Id.* The total amount paid pursuant to the ECFA to-date is just over $3.6 billion. *Id.*

3. Treatment of Claims Pre- and Post-*Staab*

The Court's next question seeks information concerning how VA handled and paid reimbursement claims before and after its decision in *Staab*. Prior to *Staab*, any emergency-treatment claims were automatically denied solely because

of the presence of other health insurance pursuant to 38 C.F.R. § 17.1002(f). After *Staab*, VA now assesses the amount the third party paid for these covered services to determine whether VA can pay any remaining liability.

A brief overview of the reimbursement process is helpful here. At the outset, it is important to note that although the ECFA refers to "reimbursement" for a veteran's emergency-treatment costs, this is not reimbursement in the colloquial sense; instead, like an insurance company, VA ordinarily pays providers directly rather than the veteran paying the provider and then seeking reimbursement from VA. *See* 38 U.S.C. § 1725(a)(2) (providing that VA may pay a provider directly in lieu of reimbursing a veteran). Indeed, in the vast majority of cases, VA receives "reimbursement" claims from providers directly for services rendered.

With that in mind, assume that a veteran enjoys benefits pursuant to a private or government health plan contract. He receives emergency treatment for a non-service-connected condition at a non-VA facility and lists his private or government health plan contract as his primary insurer and notes that VA is his secondary insurer—or, as the ECFA puts it, VA is his "secondary payer." 38 U.S.C. §1725(c)(4)(B). As is typical in the healthcare and health insurance industry, the provider for each claim—whether the hospital, the pharmacy, the ambulance provider, or otherwise—submits the bill for its services to the veteran's primary insurer first.

The primary insurer reviews all of the claims for that episode of emergency treatment and determines, pursuant to the provisions of the private or government health plan contract, which services are covered, which are not, and what amounts the insurer can pay for covered services. Once this process is complete, the provider, *i.e.*, the hospital, the pharmacy, the physician, the ambulance provider, or otherwise, submits its invoice to VA. VA then undertakes the same review as the primary insurer, determining what part of each claim remains unpaid, if any, and what amount of the remaining liability VA can pay.

Assuming for present purposes that the veteran meets all of the statutory and regulatory eligibility criteria for reimbursement, VA's review is relatively straightforward: for services not covered in any proportion by the veteran's primary insurance, VA will make a payment on the veteran's behalf for those services, up to the maximum amount payable under VA regulations. *See* 38 C.F.R. § 17.1005(a). As previously noted, the provider can reject this payment within 30 days, but if this does not occur, VA's payment will extinguish the veteran's liability for the service in question. 38 U.S.C. § 1725(c)(4)(C).

The change to this system precipitated by *Staab* is that when the primary insurer's payment is only partial, leaving some personal liability for the veteran, VA's pre-*Staab* approach was to deny reimbursement for the remaining amount because even a partial payment from a third party removed its authority to provide reimbursement under 38 C.F.R. § 17.1002(f). After *Staab* invalidated that

regulation, VA now analyzes claims involving partial payments by third parties to determine whether it can pay any portion of the veteran's remaining liability.

Take the case of Petitioner Boerschinger as an example. His episode of emergency treatment generated 14 different claims for different medical services. Medicare Part A partially paid one of these claims—the hospital facility fee. VA paid the remaining 13 claims, including emergency-room physician services, radiology services, and pharmacy charges amounting to over $4,000 paid on his behalf to these providers. Mr. Boerschinger's only personal liability after payment by Medicare Part A and VA was his cost-share obligation with respect to the one service Medicare A paid for—the facility fee from the private hospital. That, as explained above, is beyond the reach of the Secretary's authority to reimburse.

The foregoing discussion demonstrates that under the ECFA, VA operates as a secondary payer after any partial payment by a third party in the emergency-treatment context. If the veteran meets the applicable reimbursement criteria, VA will pay the veteran's remaining personal liability, up to the maximum allowable amount, after payment by the primary insurer, taking account of limitations like the cost-share exclusion. For uninsured veterans, determination of the maximum allowable amount is more straightforward because there are no third-party payments and, therefore, no cost-shares to factor into the determination of the allowable amount. The *Staab* decision had no effect on this circumstance.

Against the backdrop of this claims processing system, the Secretary concludes with additional empirical information to give a sense of the scope and magnitude of the reimbursement scheme both before and after *Staab*. Data for the period preceding *Staab*—spanning Q1 of FY 2010 to Q3 of FY 2016—reveals that approximately 16.3 million claims were received, 15.9 million claims were processed, and $2.3 billion was paid. *See* Exhibit 1; Graph of "Emergency (38 U.S.C. § 1725) Claims, Received and Processed, October 2009 to June 2019," attached hereto as Exhibit 2. Post-*Staab*—a period covering Q4 of FY 2016 up to Q3 of FY 2019—approximately 11.6 million claims were received, 11.7 million claims were processed, and $1.3 billion was paid. *See* Exhibit 1; Exhibit 2.[2]

4. Number of Claimants in Corrective Action Plan Categories

The Court's final query relates to the Secretary's corrective action plan, defined in his response to the Amended Petition. The Court requests the number of claimants in each of the three Categories A, B, and C, as defined by the Secretary during oral argument. The number of claimants in each category described at oral argument pertain to claims that were processed following

[2]As Exhibit 2 shows, there was a spike in the number of claims processed in Q2 of FY 2018. This is due to VA's lifting the suspension placed on claims involving the presence of other health insurance during the pendency of *Staab* and the associated rulemaking. Note that the "processed" column in Exhibit 2 includes claims that were rejected, denied, and paid. Only the number of claims paid are presented in Exhibit 1.

promulgation of VA's revised regulations implementing the Court's decision in *Staab*. *See* 38 Fed.Reg. 974 (Jan. 9, 2018).

According to VHA, there are 42,050 veterans in Category A, *i.e.*, those with claims that were incorrectly denied because of the presence of other health insurance. There are 348,608 veterans in Category B, *i.e.*, those with claims that were denied for reasons other than the presence of other health insurance, but who were 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. There are 229,990 veterans in Category C, *i.e.*, those with claims that were rejected as incomplete (not denied), but who were 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.

WHEREFORE, Respondent, Robert L. Wilkie, Secretary of Veterans Affairs, respectfully submits this response to the Court's May 31, 2019 Order.

Respectfully submitted,

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EXHIBIT 1:
Graph of Emergency (28 U.S.C. § 1725) Claims,
Amounts Paid, October 2009 to June 2019

Emergency (38 U.S.C. § 1725) Claims, Amounts Paid
October 2009 to June 2019

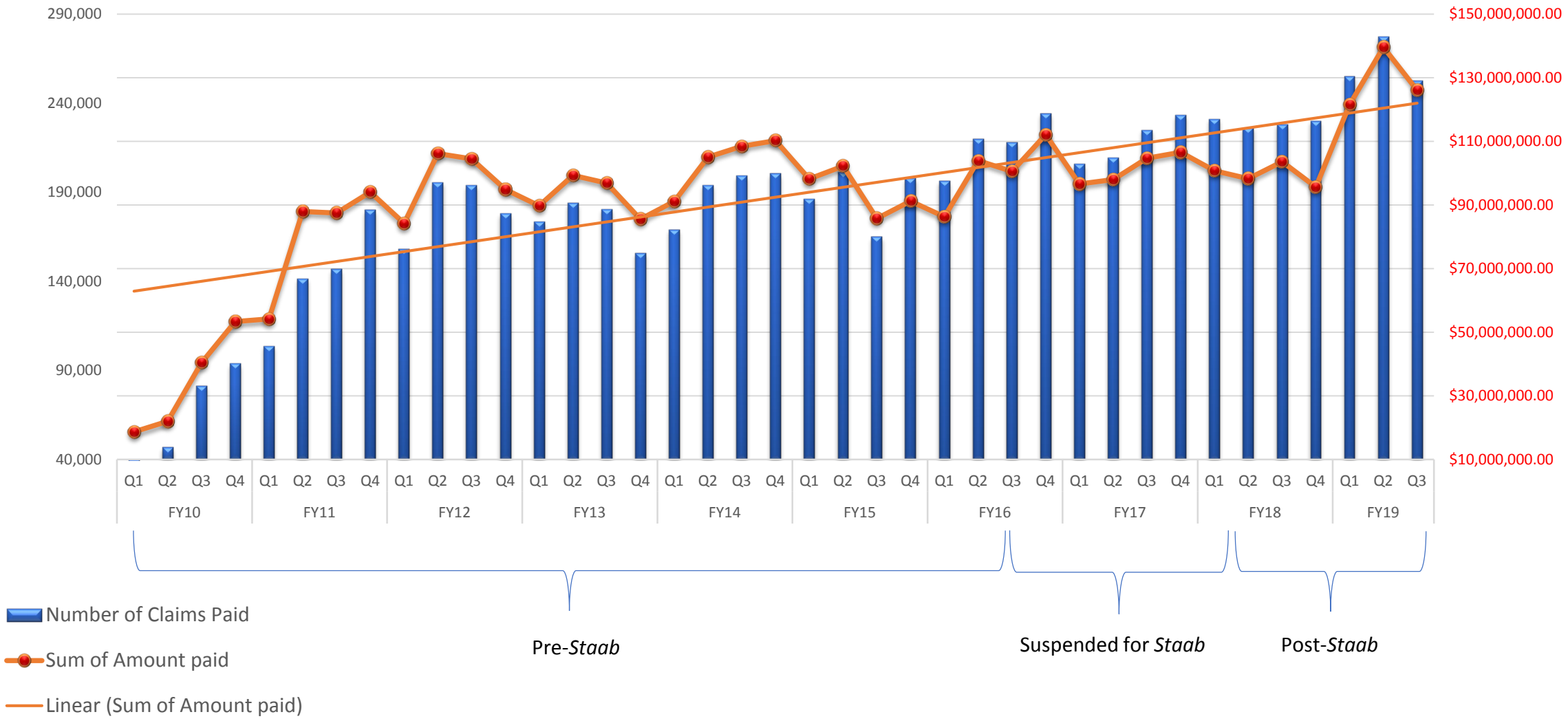

EXHIBIT 2:
Graph of Emergency (38 U.S.C. § 1725) Claims,
Received and Processed, October 2009 to June 2019

Emergency (38 U.S.C. § 1725) Claims, Received and Processed
October 2009 to June 2019