IN THE UNITED STATES COURT OF APPEALS
FOR VETERANS CLAIMS

AMANDA JANE WOLFE,	)	
individually and on behalf of others	)	
similarly situated,	)	
	)	
Petitioner,	)	
	)	
v.	)	Vet. App. No. _______
	)	
ROBERT WILKIE,	)	
in his capacity as	)	
Secretary of Veterans Affairs,	)	
	)	
Respondent.	)	

PETITION FOR CLASS RELIEF IN THE NATURE OF A WRIT OF MANDAMUS

Pursuant to Court Rule 21, Petitioner Amanda Jane Wolfe, on behalf of herself and those similarly situated (collectively, the "Class"), seeks declaratory and injunctive relief in the nature of a writ of mandamus invalidating 38 C.F.R. § 17.1005(a)(5) and enjoining Respondent Secretary of Veterans Affairs Wilkie ("the Secretary") from denying members of the Class reimbursement for coinsurance and deductible payments incurred during emergency visits to non-Department hospitals. The Department of Veterans Affairs' ("VA") policy of denying reimbursement for these expenses, as expressed in 38 C.F.R. § 17.1005(a)(5), is at odds with the plain meaning of 38 U.S.C. § 1725(c)(4)(D), its legislative history, and policy interests in favor of expanding veterans' benefits. Further, the VA's policy conflicts with this Court's decision in *Staab v. McDonald*, 28 Vet. App. 50 (2016), by absolving the VA from reimbursing veterans who must visit non-VA hospitals for emergency treatment and are then left with expensive bills that are not covered by the veteran's insurance, and by providing a disincentive for veterans to obtain or continue health insurance. This Court should invalidate this regulation and order the Secretary to reimburse veterans for coinsurance and deductibles that (a) are incurred by veterans in seeking emergency medical treatment at a non-VA hospital, and (b) are not covered by the veteran's health insurance carrier.

RELIEF SOUGHT

Petitioner respectfully requests the following relief:

First, that the Court grant Petitioner's request to represent a class of similarly-situated individuals, all of whom have been or will be harmed by the Secretary's unlawful regulation in that the VA has already denied or will deny in the future, in whole

or in part, their claims for reimbursement of emergency medical expenses incurred at non-VA facilities on the ground that the expenses are part of the deductible or coinsurance payments for which the veteran was responsible.

Second, that the Court declare that the applicable regulation, 38 C.F.R. § 17.1005(a)(5), is contrary to the statute, 38 U.S.C. § 1725(c)(4)(D), and therefore invalid to the extent that it forbids the VA from reimbursing veterans for coinsurance and deductible payments incurred while visiting non-VA hospitals for emergency treatment.

Third, that the Court enjoin the Secretary from denying reimbursement to veterans for coinsurance and deductible payments for emergency visits to non-VA hospitals.

Fourth, that the Court (a) 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 class for medical expenses deemed to be part of the veteran's deductible or coinsurance; and (b) order the Secretary to re-adjudicate these reimbursement claims in accordance with the Court's decision on the proper interpretation of 38 U.S.C. § 1725(c)(4)(D); and

Fifth, that the Court order such other relief as may be appropriate in the interest of justice and in aid of the Court's jurisdiction.

JURISDICTION

This Court has the power to issue a writ of mandamus pursuant to 28 U.S.C. § 1651(a) in aid of its prospective jurisdiction pursuant to 38 U.S.C. § 7252. This Court has supervisory jurisdiction over the Secretary pursuant to 38 U.S.C. § 7261(a) to "interpret constitutional, statutory, and regulatory provisions, and determine the meaning or applicability of the terms of an action of the Secretary" and to "compel action of the

Secretary unlawfully withheld or unreasonably delayed." *See also Erspamer v. Derwinski*, 1 Vet. App. 3, 7 (1990). This Court also is empowered by 28 U.S.C. § 1651(a), 38 U.S.C. § 7264(a), and the Court's inherent authority to certify and adjudicate this case as a class action. *See Monk v. Shulkin*, 855 F.3d 1312, 1318-22 (Fed. Cir. 2017).

STATEMENT OF THE CASE

I. THE HISTORY OF 38 U.S.C. § 1725(C)(4)(D) AND 38 C.F.R. § 17.1005(A)(5)

A. Congress Amended The Statute to Expand Reimbursement Eligibility to Veterans with Health Insurance.

On February 1, 2010, Congress amended 38 U.S.C. § 1725 by enacting the Emergency Care Fairness Act (Pub. Law. No. 111-137) ("ECFA"), which expanded veterans' eligibility for reimbursement of costs of emergency treatment furnished in a non-VA facility. One critical change made by ECFA was to amend the provisions regarding the impact of third-party coverage on reimbursement eligibility. The statute provides that, for a veteran to be eligible for reimbursement, the veteran must be "personally liable for emergency treatment." 38 U.S.C. § 1725(b)(3). Before the amendment, § 1725(b)(3)(C) provided that a veteran was personally liable for emergency treatment only if he or she had "no other contractual or legal recourse against a third party that would, *in whole or in part*, extinguish such liability to the provider" (emphasis added). The ECFA amended this subsection by deleting the words "or in part," which had the effect of making a veteran eligible for reimbursement even if the veteran has health insurance, as long as that insurer's payment is partial and not full.

The other major change effected by ECFA included expansion of § 1725(c) to clarify the Secretary's responsibility for reimbursement. Section 1725(c) was amended to add subsection (c)(4), which provides in relevant part:

> (A) If the veteran has contractual or legal recourse against a third party that would only, *in part*, extinguish the veteran's liability to the provider of the emergency treatment, and payment for the treatment may be made both under subsection (a) and by the third party, ***the amount payable for such treatment under such subsection shall be the amount by which the costs for the emergency treatment exceed the amount payable or paid by the third party***, except that the amount payable may not exceed the maximum amount payable established under paragraph (1)(A).
>
> (B) 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***.
>
> (C) 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.
>
> (D) 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.

38 U.S.C. § 1725(c)(4) (emphasis added).

In particular, these additions ensured that the Secretary would be responsible as the "secondary payer" to reimburse veterans for treatment if a third party was "financially responsible for *part* of the veteran's emergency treatment expenses." § 1725(c)(4)(B) (emphasis added).

In the House Report on the ECFA, the Committee on Veterans' Affairs explained that the amendment "clearly establishes that the VA is responsible for the cost of the emergency treatment which exceeds the amount payable or paid by the third-party insurer." H.R. Rep. No. 111-55 (2009), at 6. The Committee reaffirmed that under the

amendments, the VA is a "secondary payer where a third-party insurer is financially responsible for a part of the veteran's emergency treatment expenses" and made clear the intent to "protect[] veterans" by removing their liability for remaining balances due after the third-party insurer and the VA have made payments. *Id.* Congress plainly intended to eliminate any situation in which veterans were responsible for shouldering any of the costs of their emergency medical treatment. *See generally* H.R. Rep. No. 111-55 (2009).

At the congressional hearings leading to the enactment of the 2010 amendments, one Congresswoman, speaking in support of the legislation that became the ECFA, noted that "veterans do not currently receive any reimbursement from the VA if they have third-party insurance that pays either full or a portion of the emergency care. This creates an inequity that penalizes veterans with insurance." 155 CONG. REC. H4069-01 (daily ed. Mar. 30, 2009) (statement of Rep. Halvorson). The Congresswoman explained that "H.R. 1377, as amended, eliminates this inequity by requiring the VA to pay for emergency care in a non-VA facility, even if the veteran holds a policy that will pay for any portion of their care." *Id.* (emphasis added).

Congressional supporters of the ECFA argued that it would "rightfully correct a deficiency in the law" and "fill [a] hole in veterans' health care" by "modify[ing] current law so that a veteran who has outside insurance would be eligible for reimbursement in the event that the outside insurance does not cover the full amount of emergency care." 155 CONG. REC. S13468-01 (daily ed. Dec. 18, 2009) (statement of Sen Akaka). The law was intended to "ensure that veterans are not saddled with massive emergency room

bills." 155 CONG. REC. H4069-01 (daily ed. Mar. 30, 2009) (statement of Rep. Ginny Brown-Waite).

B. The Secretary Adopts a Restrictive Regulation That Conflicts with Congress's Intention to Expand Coverage for Veterans.

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

In *Staab v. McDonald*, 28 Vet. App. 50 (2016), this Court invalidated this regulation as inconsistent with 38 U.S.C. § 1725. The Court noted that the regulation "frustrate[d] the intent of Congress to reimburse veterans who [were] not wholly covered by a health-plan contract or other third party recourse" and that "Congress clearly intended that VA be responsible for the cost of emergency treatment which exceeds the amount payable or paid by the third-party insurer." *Staab*, 28 Vet. App. at 53-55.

The Secretary amended the regulation again, purportedly to comply with *Staab*. 83 Fed. Reg. 979 (Jan. 9, 2018). 38 C.F.R. § 17.1002(f) was amended to prohibit

reimbursement only when the veteran has a health plan contract that *fully* extinguishes medical liability for the emergency treatment. *See id.* At the same time, however, the Secretary amended 38 C.F.R. § 17.1005(a)(5) to forbid the VA from reimbursing a veteran "for any copayment, deductible, coinsurance, or similar payment" incurred during emergency treatment at non-VA hospitals, an expansion of the exclusion in 38 U.S.C. § 1725(c)(4)(d) for reimbursement of "copayments or similar payments."

In amending these regulations effective January 9, 2018, the VA stated that "all claims [for reimbursement] involving partial payment from a health-plan contract pending on April 8, 2016 [the date of the decision in *Staab*] have been held in abeyance pending [this amended rule]. Therefore, all such . . . claims will be processed using the regulatory revisions published in this rule." 83 Fed. Reg. 979 (Jan. 9, 2018).

II. PETITIONER'S EMERGENCY MEDICAL TREATMENT AND DENIAL OF REIMBURSEMENT.

In September 2016, Petitioner suffered an acute episode of appendicitis that required an emergency laparoscopic appendectomy. The procedure was performed at Mercy Medical Center in Clinton, Iowa, a non-VA healthcare facility. She was required to stay overnight for recovery and was released the following day, having incurred expenses of $22,348.25. After payment by her employer-sponsored healthcare contract, she was left responsible for $2,558.54. Of this amount, $202.93 was attributable to a "copayment" and $2,354.41 was attributable to "coinsurance." She submitted a claim for reimbursement of these amounts with Iowa City VA Health Care System in Iowa City, Iowa, but her claim was denied pursuant to the VA's January 2018 amended regulation in

a decision dated February 7, 2018. The stated reason for the denial was that the "[p]rior payer's . . . patient responsibility (deductible, coinsurance, co-payment) [is] not covered." On July 12, 2018, Petitioner filed a Notice of Disagreement ("NOD"), stating that "[t]he [VA's] policy of denying reimbursement for deductibles and coinsurance, as expressed in 38 C.F.R § 17.1005(a)(5), is at odds with the plain meaning of 38 U.S.C. § 1725(c)(4)(D), its legislative history, and policy interests in favor of expanding veterans' benefits," and that "the VA's Policy conflicts with *Staab v. McDonald*, 28 Vet. App. 50 (2016)." Petitioner received a response from the VA on August 14, 2018, which acknowledged receipt of Petitioner's NOD but stated that, due to its current volume of appeals, it anticipated an unspecified delay in deciding Petitioner's appeal.[1]

STANDARD OF REVIEW

The Court has authority to "hold unlawful and set aside . . . regulations issued . . . by the Secretary . . . found to be – (A) . . . not in accordance with law . . . and (C) . . . in violation of a statutory right." 38 U.S.C. § 7261(a)(3). Further, the Court has authority to "compel action of the Secretary unlawfully withheld . . . ." 38 U.S.C. § 7261(a)(2). A challenge to the Secretary's interpretation of a statute or regulation is an issue of law. *Cacatian v. West*, 12 Vet. App. 373, 376 (1999); *Lane v. Principi*, 339 F.3d 1331, 1339 (Fed. Cir. 2003), which this Court reviews *de novo*. *See* 38 U.S.C. § 7261(a)(1); *Smith v. Gober*, 14 Vet. App. 227, 230 (2000). If the meaning of a statute is clear from its plain

[1] At the request of the VA, Petitioner filed an additional NOD on October 9, 2018, which restated Petitioner's position in letter form.

language, that meaning controls the question and that is the end of the matter. *See Chevron*, 467 U.S. at 842-43; *Tropf v. Nicholson*, 20 Vet. App. 317, 320 (2006).

ARGUMENT

The Court may grant a writ of mandamus compelling VA officials to act when the petitioner has demonstrated a clear and indisputable right to the writ, has shown a lack of adequate alternative means to attain the desired relief, and has convinced the Court that, given the circumstances, the issuance of the writ is warranted. *See Cheney v. U.S. Dist. Court*, 542 U.S. 367, 380-81 (2004). Further, this Court may certify classes for aggregate relief when doing so would "promot[e] efficiency, consistency, and fairness, and improv[e] access to legal and expert assistance by parties with limited resources." *Monk v. Shulkin*, 855 F.3d 1312, 1320-21 (Fed. Cir. 2017). This Court should certify the proposed class for aggregate relief and issue the requested writ of mandamus.

I. THE VA'S JANUARY 2018 AMENDMENTS TO 38 C.F.R. § 17.1005(A)(5) ARE CONTRARY TO LAW.

A. The Plain Meaning of 38 U.S.C. § 1725 Compels a Finding That the Secretary Is Responsible for Reimbursement of Coinsurance and Deductible Payments to a Veteran Who Undergoes Emergency Treatment at a Non-VA Facility.

38 U.S.C. § 1725(c)(4)(D) only explicitly bars reimbursement of *copayments* incurred by veterans during emergency visits to non-VA hospitals. The Secretary's interpretation of "similar payments" also to include "deductibles" and "coinsurance" is not consistent with either the plain language of the statute or Congress's intent in EFCA to eliminate veterans' liability for emergency medical care.

A copayment is a specific form of cost-sharing that is typically a minimal, fixed amount. *See, e.g.*, 38 C.F.R. § 17.111. A copayment is distinguishable from other forms of cost-sharing such as deductibles and coinsurance. Specifically, in contrast to copayments, the term coinsurance means the "percent of costs that the enrollee must pay."[2] This may mean that a patient must pay a certain percentage of the cost of inpatient hospital services; it is not a predetermined dollar figure, like a copayment. Thus, coinsurance has the potential to be an exorbitant amount. A deductible is separately defined as the amount an insured must pay each year before the insurance source pays its share.[3] This amount widely varies by the type of plan and can be thousands of dollars. Both coinsurance and deductibles can be very large costs, whereas copayments are more likely to be much smaller, and are often no more than $20 to $50. Thus, coinsurance and deductibles are not "similar" to copayments.

In other statutory contexts, Congress has used specific terms to include other forms of cost-sharing that differ significantly from copayments. *See, e.g.*, 38 U.S.C. § 1729(a)(3) (noting that VA may recover from third parties in certain circumstances even if the "payment of a *deductible or copayment* by the veteran" is not paid by the veteran) (emphasis added). Had Congress intended that deductibles or coinsurance be excluded from reimbursement by VA, it would have used such language. Instead, copayment and "similar payment" indicates that only payment obligations that are

[2] CMS, MLN Matters Number MM10405 (Dec. 8, 2017).
[3] CMS, Yearly deductible for drug costs, available at https://www.medicare.gov/part-d/costs/deductible/drug-plandeductibles.html.

minimal and fixed are to be excluded from reimbursement. Petitioner's medical bills in this case are illustrative, as her coinsurance was over ten times the amount of her copayment, and she was left responsible for over $2,500 in medical expenses.

Further, 38 U.S.C. § 1725(c)(4)(b) provides that "[i]n 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" (emphasis added). This provision clearly establishes that the Secretary is responsible for the reimbursement of any uncovered amounts. But by interpreting "copayments or similar payments" to include coinsurance and deductible payments, the Secretary has used the exception to swallow the rule and has made the veteran the secondary payer.

B. The Secretary's Reading of the Statute Is Overly Restrictive and Contravenes the Purpose and Spirit of the Amendments.

As explained in the Statement of the Case, Section I, *supra*, the legislative history of the ECFA consistently reflects Congress's intent that veterans be made whole when forced to incur costs at non-VA hospitals in emergency situations. The Secretary's regulation undermines this clear intent in several ways.

First, 38 U.S.C. § 1725 was amended with the intent to make the VA, not the veteran, responsible for the excess cost of emergency services after the third-party insurance had paid its share. *See* 155 Cong. Rec. H4069-01 (daily ed. Mar. 30, 2009) (statement of Rep. Halvorson). By expanding the exception to include coinsurance and deductibles, the Secretary has diminished (in many cases completely eliminated) the

VA's responsibility for payment and increased the veterans' responsibility for payment. This result is directly contrary to the express intent of the amendments in the ECFA.

Second, the ECFA sought to protect veterans from being "saddled with massive emergency room bills." 155 CONG. REC. H4069-01 (daily ed. Mar. 30, 2009) (statement of Rep. Ginny Brown-Waite). While the exception on reimbursement for copayments does not frustrate this goal—given that copayments are usually small, fixed amounts—the same cannot be said for coinsurance and deductibles, which, as explained above, are typically much larger payments. Indeed, Petitioner's coinsurance payment for her emergency treatment was more than $2,000; her copayment was minimal.

Finally, one of the goals of the ECFA was to remove the disincentive for veterans to obtain third-party insurance that had existed under the prior version of the statute. *See* 155 CONG. REC. H4069-01 (daily ed. Mar. 30, 2009) (statement of Rep. Roe). Under that prior version, veterans who had no insurance at all would receive full reimbursement from the VA for emergency treatment at non-VA hospitals, but veterans with third-party insurance could be stuck with large bills. The Secretary's regulation creates the same disincentive that Congress sought to eliminate. The Secretary's regulation leads to the absurd result that Petitioner here would have saved herself over $2,500 by having no insurance, even though that result would have caused the VA to pay more than $20,000.

C. The Secretary's Interpretation of the Statue Statute Conflicts With This Court's Decision in *Staab*.

The Secretary's position is also at odds with this Court's decision in *Staab v. McDonald*, 28 Vet. App. 50 (2016). Under *Staab*, applicable veterans are eligible for

reimbursement for non-covered medical expenses even where the veteran has partial coverage from a third-party insurer. This necessarily means that the remaining medical expenses after payment by the third-party insurer, such as coinsurance amounts, are eligible for reimbursement. Further, as this Court noted, the applicable statute "was amended to its present form, to 'allow the VA to reimburse veterans for treatment in a non-VA facility if they have a third-party insurer that would pay a portion of the emergency care.'" *Staab* at 53, quoting H.R. REP. 111-55, at 3. The remaining portion, whether it is called coinsurance or deductibles, would be eligible for reimbursement. To include coinsurance and deductibles in the exclusion would be inconsistent with the *Staab* ruling, as it would leave veterans with responsibility for substantial amounts of medical expenses. Indeed, in Petitioner's case, the entire cost of emergency treatment in excess of the amount payable by the third-party insurer was attributable to copayment, coinsurance, and deductible, and therefore Petitioner received the same amount of reimbursement from the VA that she would have under its pre-*Staab* regulations—$0.00.

II. PETITIONER LACKS ADEQUATE ALTERNATIVE MEANS TO OBTAIN THE RELIEF SOUGHT.

Petitioner has no alternative to relief apart from appealing to this Court. Though Petitioner has recently filed a notice of disagreement, neither the agency of original jurisdiction (AOJ) nor the Board of Veterans' Appeals can provide relief that is inconsistent with the Department's regulations. See, e.g., 38 C.F.R. § 19.5 ("[T]he Board is bound by applicable statutes, regulations of the Department of Veterans Affairs, and precedent opinions of the General Counsel of the Department of Veterans Affairs.").

Because the AOJ and Board are bound by VA regulations, they cannot invalidate 38 C.F.R. § 17.1005(a)(5), nor can they reimburse Petitioner for her coinsurance or deductible payments given the language of the regulation. Petitioner's only avenue to obtain relief she seeks is from this Court, and the process of appealing to the Board, receiving a decision, and appealing to this Court is inadequate because it would take years to complete. *See Martin v. O'Rourke*, No. 17-1747 (Fed. Cir. 2018) at 5-6 ("Overall, the average time from the filing of a Notice of Disagreement to issuance of a BVA decision is over five years."). During that time, the 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 ultimately prevailed. *See Tobler v. Derwinski,* 2 Vet. App. 8, 14 (1991) (the VA is bound to follow a precedential Court decision beginning *only* on the date the precedential decision is issued, and not retroactively). Thus, Petitioner and the Class lack means of an adequate alternative to obtain the relief they seek.

III. THE RIGHT TO A WRIT IS CLEAR AND INDISPUTABLE.

Petitioner has a clear and indisputable right to a writ of mandamus. That the VA's regulation improperly leaves petitioner and other veterans who have third-party health insurance responsible for covering large portions of their emergency medical bills is no small matter. By the VA's own estimates, this regulation will affect millions of claims for billions of dollars. In a motion to this Court to stay the precedential effect of *Staab*, the VA estimated that it would receive over 2 million claims for reimbursement affected by the *Staab* decision in Fiscal Year 2017 alone, and over 68 million in the following 10-

year period. *Staab v. McDonald*, Vet. App. No. 14-0957, Appellee's Motion to Stay the Precedential Effect of *Staab v. McDonald*, 28 Vet. App. 50 (2016), at 7 (July 14, 2016) (the "*Staab* Stay Motion"). Further, the VA originally estimated that compliance with *Staab* would result in approximately $2.5 billion in costs over a 5-year period and $10.6 billion in costs over a 10-year period, but later, noting that the VA would not reimburse cost sharing expenses, revised its estimates to $1.5 billion for the five-year period and $6.5 billion for the ten-year period. *See id*; *Staab v. McDonald*, Vet. App. No. 14-0957, Appellee's Opposed Motion to Stay the Precedential Effect of *Staab v. McDonald*, 28 Vet. App. 50 (2016), at 9, n.2 (Feb. 17, 2017).

Without mandamus relief, billions of dollars in medical expenses will be pushed onto veterans who have third-party health insurance, while veterans without third-party health insurance will pay nothing for the same care. This Court should prevent the Secretary from enforcing a regulation that is clearly in conflict with the statute, that creates such a perverse incentive, and that denies veterans the reimbursement that Congress clearly intended them to receive. Issuance of the writ is therefore warranted.

IV. AGGREGATE RELIEF IS NECESSARY AND APPROPRIATE.

Petitioner seeks injunctive relief under the All Writs Act, 28 U.S.C. § 1651, on behalf of the following Class:

> All VA claimants who, on or after January 8, 2018, have been denied reimbursement for coinsurance or deductible payments incurred for emergency treatment at a non-VA hospital.

Aggregate, rather than individual, relief is necessary. The issue presented here is not unique to Petitioner; rather, it affects thousands of veterans.

This Court may grant certification to a class for purposes of seeking classwide relief. *Monk v. Shulkin*, 855 F.3d 1312, 1321 (Fed. Cir. 2017). Indeed, this Court should grant class certification when doing so would "promot[e] efficiency, consistency, and fairness, and improve[e] access to legal and expert assistance by parties with limited resources." *Id.* at 1320. Granting class certification, then classwide relief, would permit this Court to ensure in one stroke that affected VA claimants like Petitioner would no longer be adversely affected by the Secretary's failure to comply with 38 U.S.C. § 1725. As the Federal Circuit stated in *Monk*, class certification also "would help prevent the VA from mooting claims scheduled for precedential review" as the VA has done in other cases. 855 F.3d at 1321.

Further, even if this Court or the Federal Circuit were ultimately to issue a precedential decision on the merits in Petitioner's favor, a large number of similarly-situated members of the putative class would likely be left without the relief obtained by Petitioner because of *Tobler v. Derwinski,* 2 Vet. App. 8, 14 (1991). *Tobler* provides that the VA is bound to follow a precedential Court decision beginning *only* on the date the precedential decision is issued. Without a class action, veterans who did not timely appeal a denial of their claims before such a final decision would be left without relief.

Certifying this case as a class action would therefore promote efficiency, consistency, and fairness, and improve access to legal and expert assistance by parties with limited resources. Certification would result in complete and more accessible relief, consistent with Congress's intent for the veterans' benefit system to function with a "high degree of … solicitude" for all claimants. *Henderson v. Shinseki*, 562 U.S. 428, 431

(2011). It would also ensure that putative class members have access to expert legal assistance to ensure compliance with the relief, if any, granted by the Court.

This Court has stated that, until it adopts an appropriate rule on aggregate procedures, it will use Rule 23 of the Federal Rules of Civil Procedure as a guide. *Monk v. Wilkie*, No. 15-1280, 2018 WL 4043242, at *1 (Vet. App. Aug. 23, 2018). The class action criteria for actions like this one seeking injunctive relief are set forth in Rule 23(b)(2). To certify a class under Rule 23(b)(2), the movant must also satisfy the requirements of both Rule 23(a) and Rule 23(b)(2). This action easily meets these requirements.

A. Rule 23(a)

1. Numerosity

As to numerosity, the VA's own estimates to this Court confirm that hundreds of thousands of veterans have been or will be affected by the challenged regulation. As stated above, the VA estimated that it would receive over 2 million claims for reimbursement affected by the *Staab* decision in Fiscal Year 2017 alone, and over 68 million in the following 10-year period. *Staab* Stay Motion, at 7. These estimates make clear that many veterans have already found themselves adversely affected by the VA's regulation, as nearly every third-party healthcare plan requires coinsurance and deductible payments. *See* Gary Claxton, *et al.*, *Increases in Cost-Sharing Payments Have Far Outpaced Wage Growth*, Peterson-Kaiser Health System Tracker (Oct. 4, 2017), https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/#item-start. The class therefore easily satisfies the numerosity

requirement. *See, e.g.*, *Consol. Rail Corp. v. Town of Hyde Park*, 47 F.3d 473, 483 (2d Cir. 1995) (more than forty people in a class satisfied numerosity requirement).

2. Commonality

As to commonality, "even a single [common] question" suffices to show commonality under Rule 23(a). *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 359 (2011) (second alteration in original). In *Monk v. Wilkie*, this Court found that the commonality standard was not met because the petitioners did not challenge a specific VA policy or practice, and stated that "a class proceeding is an appropriate vehicle to challenge systemic deficiencies, but only when the putative class targets specific polices or practices that allegedly violate the law." 2018 WL 4043242, at *12. This action, however, presents a common challenge to a specific VA policy that applies with equal force to each putative class member's case, as petitioner contends that 38 C.F.R. § 17.1005(a)(5) is contrary to the ECFA and is therefore invalid to the extent that it forbids the Secretary from reimbursing veterans for coinsurance and deductible payments incurred while visiting non-VA hospitals for emergency treatment.

3. Typicality

As to typicality, Petitioner's claims are typical of the claims of the putative class. All class members have been or will be adversely affected by the Secretary's failure to comply with § 1725 of the ECFA by denying them reimbursement for coinsurance or deductible payments (or both) incurred during emergency visits to non-VA hospitals.

4. Adequacy

As to adequacy, Petitioner has no interests adverse to the putative class, and she and her counsel would fairly and adequately represent the interests of the class. Petitioner's undersigned counsel has represented more than 4,000 claimants before this Court. They are experienced in litigating class action disputes, and counsel has the resources to litigate this case vigorously on behalf of the putative class at no charge to its members. *See* Declaration of Barton F. Stichman, attached hereto as Exhibit A; Declaration of Kara L. McCall, attached hereto as Exhibit C.

B. Rule 23(b)(2)

Rule 23(b)(2) authorizes certification when a defendant "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). Here, the Secretary has issued a regulation that conflicts with the ECFA and adversely affects all members of the putative class. The unlawful denial of the putative class members' claims for reimbursement can be remedied by final injunctive (or analogous) relief. Accordingly, the Rule 23(b)(2) requirement is easily satisfied.

No other considerations weigh against certification of a class. For instance, the Secretary has possession of the information and records necessary to identify the members of the putative class. *See, e.g.*, *In re Nassau Cty. Strip Search Cases*, 461 F.3d 219, 229 (2d Cir. 2006) (noting that "determining class membership would be simple" when "defendants possess records" conclusive of membership).

Finally, this Court need not require notice to putative class members in this case. Rule 23 requires notice only for damages classes that are certified under Rule 23(b)(3).

See Wal-Mart, 564 U.S. at 362. Because certification here would occur under Rule 23(b)(2), this court need not require notice. *See id.* ("Rule [23] provides no opportunity for . . . (b)(2) class members to opt out, and does not even oblige the District Court to afford them notice . . . ."). In any event, no claimant would have reason to object to membership in a class seeking to enforce the plain language of § 1725 of the ECFA.

CONCLUSION

Petitioner and other members of the Class have a statutory right to reimbursement of costs of emergency medical treatment at non-VA hospitals. This Court should grant this Petition and award aggregate injunctive relief to remedy this unjust result.

Respectfully submitted,

Date: October 30, 2018

/s/ Barton F. Stichman

Barton F. Stichman
Patrick A. Berkshire
National Veterans Legal Services Program
1600 K Street, NW, Suite 500
Washington, DC 20006-2833
(202) 621-5724

Mark B. Blocker
Kara L. McCall*
Emily M. Wexler
Lindsay K. Eastman*
Eric T. O'Brien*
SIDLEY AUSTIN LLP
One South Dearborn
Chicago, Illinois 60603
Telephone: (312) 853-7000

*Application for Pro Hac Vice Pending