UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT
717 MADISON PLACE, N.W.
WASHINGTON, D.C. 20439

PETER R. MARKSTEINER
CLERK OF COURT

CLERK'S OFFICE
202-275-8000

May 4, 2022

NOTICE OF DOCKETING

Federal Circuit Docket No.: 2022-1754

Federal Circuit Short Caption: Kimmel v. Secretary of Veterans Affairs

Date of Docketing: May 4, 2022

Originating Tribunal: Department of Veterans Affairs

Originating Case No.: Petition for review pursuant to 38 U.S.C. § 502

Petitioner: Joshua Kimmel, Amanda Wolfe

A petition for review has been filed and assigned the above Federal Circuit case number. The court's official caption is included as an attachment to this notice. Unless otherwise noted in the court's rules, the assigned docket number and official caption or short caption must be included on all documents filed with this Court. It is the responsibility of all parties to review the Rules for critical due dates. The assigned deputy clerk is noted below and all case questions should be directed to the Case Management section at (202) 275-8055.

CERTIFIED LIST: The agency or arbitrator is directed to forward the certified list as promptly as possible but no later than 40 days from the date of this notice.

The following filings are due within 14 days of this notice:

- Entry of Appearance or Notice of Unrepresented Person. (Fed. Cir. R. 47.3.)
- Certificate of Interest. (Fed. Cir. R. 47.4; not required for unrepresented and federal government parties unless disclosing information under Fed. Cir. R. 47.4(a)(6))
- Docketing Statement. Note: The Docketing Statement is due in 30 days if the United States or its officer or agency is a party in the appeal. (Fed. Cir. R. 33.1 and the Mediation Guidelines; no docketing statement is required in cases with an unrepresented party)

- Statement Concerning Discrimination in MSPB or arbitrator cases. (Fed. Cir. R. 15(c); completed by petitioner only)
- Fee payment or appropriate fee waiver request, if the docketing fee was not prepaid (see Fee Payment below).

FILING DOCUMENTS: Each counsel representing a party must be a member of the court's bar and registered for the court's electronic filing system. Parties represented by counsel must make all filings through the court's electronic filing system.

Unrepresented parties may choose to submit case filings to the court either in paper or through the court's electronic filing system; electronic filing will only be permitted for unrepresented parties after successful registration for the court's electronic filing system and submission of a completed Notice of Unrepresented Person Appearance. Fed. Cir. R. 25(a). The court's Electronic Filing Procedures may be accessed at www.cafc.uscourts.gov/contact/clerks-office/filing-resources.

CONTACT INFORMATION: Electronic filers, or unrepresented parties registered to receive electronic service, must update their contact information in their PACER service center profile whenever their contact information changes. Counsel must file an amended Entry of Appearance and unrepresented parties must file an amended Notice of Unrepresented Person Appearance whenever contact information changes. Fed. Cir. R. 25(a)(5).

FEE PAYMENT: Unless the filing fee was prepaid, fee payment must be submitted within fourteen days after this notice. Fed. Cir. R. 52(d). For outstanding docketing fees due to this court, electronic filers must pay the fee using the event Pay Docketing Fee through the court's electronic filing system. Fed. Cir. R. 52(e). Docketing fees due to other courts, such as U.S. District Courts, the U.S. Court of Appeals for Veterans Claims, and non-vaccine cases at the U.S. Court of Federal Claims, must be submitted to those courts in accordance with their procedures. A filer wishing to proceed without fee payment must submit a motion for leave to proceed in forma pauperis, or other fee waiver request, within fourteen days.

OFFICIAL CAPTION: The court's official caption is attached and reflects the lower tribunal's caption pursuant to Fed. R. App. P. 12(a), 15(a), and 21(a). Please review the caption carefully and promptly advise this court in writing of any improper or inaccurate designations.

/s/ Peter R. Marksteiner
Peter R. Marksteiner
Clerk of Court

By: M. Ames, Deputy Clerk

Attachments:

- Official caption
- Paper Copies of General Information and Forms (to unrepresented parties only):
  - General Information and Overview of a Case in the Federal Circuit
  - Notice of Unrepresented Person Appearance
  - Informal Brief
  - Informal Reply Brief (to be completed only after receiving the opposing party's response brief)
  - Motion and Affidavit for Leave to Proceed in Forma Pauperis (only to filers owing the docketing fee)
  - Supplemental in Forma Pauperis Form for Prisoners (only to filers in a correctional institution)
  - Statement Concerning Discrimination (only to petitioners in MSPB or arbitrator case)

cc: Department of Veterans Affairs

Official Caption

JOSHUA KIMMEL, AMANDA WOLFE,
Petitioners

v.

SECRETARY OF VETERANS AFFAIRS,
Respondent

Short Caption

Kimmel v. Secretary of Veterans Affairs

2022-_____

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

Joshua Kimmel and
Amanda Wolfe,

Petitioners,

v.

Denis McDonough, Secretary of Veterans Affairs,

Respondent.

PETITION FOR REVIEW PURSUANT TO 38 U.S.C. § 502

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April 29, 2022

1. Petitioners Joshua Kimmel and Amanda Wolfe—two veterans who incurred emergency medical costs at non-VA facilities—hereby petition the Court, pursuant to 38 U.S.C. § 502, for review of a 2018 regulation enacted by the Department of Veterans Affairs ("VA"). Specifically, Petitioners seek review of 38 C.F.R. § 17.1005(a)(5) (the "Regulation"), which denies insured veterans reimbursement for certain types of payments, including coinsurance payments, incurred as a result of emergency medical care provided at non-VA facilities. The Regulation is at odds with 38 U.S.C. § 1725(c)(4)(D) (the "Statute"), the Statute's legislative history, and is at odds with the canon of interpretation applied by the Veterans Court that any doubt should be resolved in the veterans' favor.

2. This case comes to this Court with a unique procedural posture. One of the Petitioners—Ms. Wolfe—challenged the Regulation through a mandamus petition filed in the U. S. Court of Appeals of Veterans Claim ("Veterans Court"). The court granted Ms. Wolfe a writ of mandamus, but on March 17, 2022, this Court reversed the Veterans Court's judgment, holding that mandamus was not available to the

petitioner. *See Wolfe v. McDonough*, 28 F.4th 1318 (Fed. Cir. 2022) ("Opinion") (**Exhibit B**).

3. In its opinion, however, this Court made clear that (1) the Regulation was inconsistent with the plain meaning of the Statute, Opinion at 1353-56, and (2) petitioner "could have petitioned this court (and still can) for review of the [Regulation] pursuant to 38 U.S.C. § 502," *id.* at 1359.

4. By this action, Ms. Wolfe and Mr. Kimmel accept this Court's invitation to file a § 502 Petition, and now seeks to have the Regulation declared invalid, and for certain additional relief as explained below.

5. This Petition first explains the background that led to the passage of the Statute in 2010 and the Regulation in 2018, and why the Regulation must be invalidated.

6. This Petition concerns reimbursement to veterans for the costs they incurred as a result of receiving emergency care at non-VA facilities. While a veteran can obtain medical care without cost at VA facilities, when a veteran needs emergency medical care, going to a VA facility is often not feasible. Some veterans, however, have non-VA

medical insurance (either private insurance or a government-sponsored insurance such as Medicare or Medicaid). For simplicity, we refer to non-VA medical insurance as "Other Health Insurance" or OHI. OHI often provides some coverage for emergency medical care rendered at non-VA facilities.

7. Prior to 2010, Congress provided that veterans *without* OHI were eligible for reimbursement by VA for the full cost of emergency medical care provided at non-VA facilities, but veterans *with* OHI were barred from reimbursement by VA for any part of the emergency medical care at non-VA facilities not covered by the veteran's OHI. Veterans with OHI therefore remained liable to pay any costs not covered by their insurance, leading to the anomaly that veterans with OHI ended up paying more money for emergency medical care than veterans who had no insurance.

8. Congress sought to correct this anomaly. 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 obtained at a non-VA facility. The ECFA amended subsection (c)(4) of

Section 1725 by ensuring that VA would be responsible as "secondary payer" if a third party was "financially responsible for part of the veteran's emergency treatment expenses." 38 U.S.C. § 1725(c)(4)(B).

9. Following passage of the ECFA, the VA first adopted a regulation which stated that reimbursement would occur 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). This regulation was invalidated by the Veterans Court on the ground that it was inconsistent with the plain language of Section 1725. *See Staab v. McDonald*, 28 Vet. App. 50 (2016).

10. In 2018, two years after *Staab* was decided, VA issued a new regulation—the Regulation at issue here—which prohibited reimbursement only when the veteran has a health plan contract that *fully* extinguishes the veteran's liability for the emergency treatment. 83 Fed. Reg. 979 (Jan. 9, 2018). However, the Regulation also forbid VA from reimbursing a veteran "for any copayment, *deductible, coinsurance*, or similar payment" incurred during emergency treatment at non-VA hospitals. *Id.* (emphasis added). This was a clear expansion

of the language in 38 U.S.C. § 1725(c)(4)(D), which forbid reimbursement of "any copayment or similar payment" and made no mention of deductibles or coinsurance. The Regulation, codified as 38 C.F.R. § 17.1005(a)(5), is attached herewith as **Exhibit A**.

11. In its Opinion (**Exhibit B**), this Court addressed the appropriate interpretation of 38 U.S.C. § 1725(c)(4)(D). This Court explained:

> [w]e conclude that the correct reading of the statute is one in which a deductible is a "similar payment" to a copayment, but coinsurance is not. Rather, coinsurance is the very type of partial coverage that Congress did not wish to exclude from reimbursement. This interpretation gives meaning to all terms and provisions in the statute and is also consistent with the plain meaning of the terms: copayments and deductibles are fixed quantities which become known once insurance is purchased, while coinsurance is a variable quantity that becomes known only after medical expenses are incurred and is quintessentially partial coverage.

Id. at 1356.

12. This Court held that its interpretation was supported by the Statute's legislative history. This Court held that, although the legislative history is "sparse," it supports its reading that coinsurance was not excluded from reimbursement as a "similar payment." *Id.*

13. In view of this Court's interpretation of the Statute, the Regulation is unlawful.

14. ***Petitioner Joshua Kimmel:*** Petitioner Joshua Kimmel had a medical emergency for which he obtained care at Brandon Regional Hospital, a non-VA medical facility, from October 29 to October 31, 2016. According to Mr. Kimmel's Explanation of Benefits ("EOB"), his private insurer, Cigna, covered a portion of the expenses incurred during his October 2016 episode of care, and Mr. Kimmel was personally liable for $2,353.19 for the services he received at Brandon Regional Hospital. The lion's share of this amount, $1,853.19 was coinsurance, and $500.00 was categorized as "copay/deductible." Mr. Kimmel's redacted EOB is attached herewith as **Exhibit C**.

15. Mr. Kimmel paid the $2,353.19 by taking money out of his 401(k) plan, causing him substantial harm as described in the declaration attached herewith as **Exhibit D**.

16. Mr. Kimmel timely filed a request for reimbursement from VA, and, at VA's request, supplied a copy of his EOB to VA in February 2018. In May 2019, Mr. Kimmel received a letter from VA, attached herewith as **Exhibit E**, stating that although VA had properly rejected

his claims for lack of needed information (i.e., lack of an EOB), his rejection letter had "incorrectly stated that VA cannot reimburse claims if the Veteran has other health insurance (OHI)." The May 2019 letter went on to state an EOB "is required for VA to determine if VA reimbursement is allowable" and VA has "requested the EOB . . . from your community provider." *Id.* The May 2019 letter also noted "VA has no legal authority to pay a Veteran's cost shares, deductibles, or copayments associated with their other health insurance." *Id.*

17. In August 2020, Mr. Kimmel received a letter from VA notifying him that the May 2019 letter (**Exhibit E**) contained an interpretation of the applicable statute that was wrong under *Wolfe v. Wilkie*, 32 Vet. App. 1 (2019); acknowledging the impact of that incorrect interpretation on the veteran's decision as to whether to continue pursuing reimbursement, encouraging him to submit the needed information, and concluding that "[o]nce the needed information is received your claim will be processed in accordance with current applicable law." *See* **Exhibit F** (VA's template of the letter sent to Mr. Kimmel).

18. In October 2020, a letter was submitted to VA on behalf of Mr. Kimmel, enclosing another copy of the Kimmel EOB that he had previously sent to VA in 2018. In December 2020, Mr. Kimmel received a telephone call from a VA representative advising him that the VA would work with the Brandon Regional Hospital billing department to ensure that he would be reimbursed. From this telephone call to the date of this Petition, Mr. Kimmel has not received any payment or further correspondence from VA or the hospital regarding this episode of care.

19. ***Petitioner Amanda Wolfe:*** Petitioner Amanda Wolfe had a medical emergency for which she received care at Mercy Medical Center, a non-VA facility in Clinton, Iowa from September 16 to September 17, 2016. As a result of the medical care she received, Ms. Wolfe incurred $22,348.25 in costs. After her employer-sponsored health insurance paid a portion of the costs to the medical provider, Ms. Wolfe was personally liable for $2,558.54—of which $2,354.41 was "coinsurance" and $202.93 was attributable to a "copayment." Ms. Wolfe's redacted EOBs are attached herewith as **Exhibit G**.

20. Ms. Wolfe timely submitted a claim for reimbursement of the costs she was left personally liable for as a result of her September 2016 emergency care visit. VA denied Ms. Wolfe's reimbursement claim by letter dated February 7, 2018 (**Exhibit H**), on that ground that "[p]rior payer's . . . patient responsibility (deductible, coinsurance, co-payment) [is] not covered." On July 12, 2018, Ms. Wolfe filed a Notice of Disagreement ("NOD") with VA, 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)." A copy of Ms. Wolfe July 12, 2018 NOD is attached herewith as **Exhibit I**.

21. VA responded to Ms. Wolfe's NOD by letter dated August 14, 2018, attached herewith as **Exhibit J**, in which VA acknowledged receipt of her NOD but stated that, it anticipated an unspecified delay in deciding her appeal in light of the "volume of appeals." At the request of VA, Ms. Wolfe filed an amended NOD on October 8, 2018, in which she restated her position as to VA's adjudication of her claim in

letter form. VA responded to Ms. Wolfe's amended NOD by letter dated November 20, 2018, in which it stated that Ms. Wolfe would not be reimbursed and concluded: "Our decision is final; appeal closed."

22. On November 30, 2018, Ms. Wolfe, along with Mr. Peter Boerschinger, filed a Petition for Class Relief in the Nature of a Writ Mandamus ("Petition for Mandamus") seeking to invalidate 38 C.F.R. § 17.1005(a)(5) and enjoin the Secretary from denying veterans reimbursement for coinsurance and deductible payments incurred during emergency medical visits to non-VA facilities. On November 22, 2019, during the pendency of the proceedings regarding the Petition for Mandamus, the Board of Veterans' Appeals (the "Board") issued a decision granting Ms. Wolfe's claim for reimbursement. A copy of the Board's decision granting Ms. Wolfe's appeal is attached herewith as **Exhibit K**.

23. What followed VA's adjudication of Ms. Wolfe's claim as transmitted in the November 20, 2018 letter is the series of legal actions described, *supra* at ¶¶ 2-3, most recently including this Court's reversal of the Veterans Court's decision to grant Ms. Wolfe mandamus relief while concurrently acknowledging that the Regulation is

inconsistent with the plain meaning of the Statute, *See Wolfe v. McDonough*, No. 20-1958 (Fed. Cir. Mar. 17, 2022) at pp. 13-15. As of the filing of this Petition, Ms. Wolfe has still not been reimbursed, as described in the declaration attached herewith as **Exhibit L**.

24. Therefore, pursuant to 38 U.S.C. § 502, Petitioners respectfully request that the Court review 38 C.F.R. § 17.1005(a)(5), and further respectfully request that the Court hold unlawful and set aside the Regulation, and order any further relief that the Court finds appropriate, including an award of attorneys' fees for Petitioners.

25. This Court has jurisdiction to hear Petitioners' challenge to the VA's regulations under 38 U.S.C. § 502, in accordance with the Administrative Procedures Act, 5 U.S.C. § 702 *et seq*.

26. On April 1, 2022, prior to filing this Petition, Petitioners' counsel emailed counsel for VA at the Department of Justice ("DOJ") to inquire about VA's plans in light of this Court's reversal of the Veterans Court's decision granting Ms. Wolfe mandamus relief. On April 4, 2022, counsel for Petitioners and counsel at DOJ discussed the issue by phone. As of the parties' April 4, 2022 call, counsel for DOJ could not

specify what VA planned to do, but stated that DOJ hoped to have a more definitive answer in three weeks' time, by April 25, 2022.

On April 25, 2022, counsel for DOJ informed Petitioners' counsel via email that "VA has paused processing claims that could/would be impacted by the Federal Circuit's decision while VHA [Veterans Health Administration] determines how to move forward with appropriate processing in accordance with the Court's decision. VA is hoping to make specific decisions on how to proceed, and to resume processing claims soon." On a follow-up call the same day between DOJ and Petitioners' counsel could not specify what claims VA had paused—i.e., the *Wolfe* class members' claims or newly filed claims; (2) how VA had implemented the pause; or (3) a date certain when VA would make a decision about how to proceed and whether to resume adjudicating claims using the unlawful regulation.

27. The Regulation was enacted in February 2018. As a result, this Petition is being filed within six (6) years after the issuance of the action(s) challenged in the petition as prescribed by Federal Circuit Rule 15(f).

Respectfully submitted,

Dated: April 29, 2022

/s/ *Mark B. Blocker*

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Exhibit A

under 38 CFR 17.1002 (except for paragraph (e)) and 17.1003. I am aware that 38 U.S.C. 6102(b) provides that one who obtains payment without being entitled to it and with intent to defraud the United States shall be fined in accordance with title 18, United States Code, or imprisoned not more than one year, or both.''

NOTE TO §17.1004(b): These regulations regarding payment or reimbursement for emergency services for nonservice-connected conditions in non-VA facilities also can be found on the internet at *http://www.va.gov/health/elig*.

(c) Notwithstanding the provisions of paragraph (b) of this section, no specific form is required for a claimant (or duly authorized representative) to claim payment or reimbursement for emergency transportation charges under 38 U.S.C. 1725. The claimant need only submit a signed and dated request for such payment or reimbursement to the VA medical facility of jurisdiction, together with a bill showing the services provided and charges for which the veteran is personally liable and a signed statement explaining who requested such transportation services and why they were necessary.

(d) To receive payment or reimbursement for emergency services, a claimant must file a claim within 90 days after the latest of the following:

(1) The date that the veteran was discharged from the facility that furnished the emergency treatment;

(2) The date of death, but only if the death occurred during transportation to a facility for emergency treatment or if the death occurred during the stay in the facility that included the provision of the emergency treatment; or

(3) The date the veteran finally exhausted, without success, action to obtain payment or reimbursement for the treatment from a third party.

(e) If after reviewing a claim the decisionmaker determines that additional information is needed to make a determination regarding the claim, such official will contact the claimant in writing and request additional information. The additional information must be submitted to the decisionmaker within 30 days of receipt of the request or the claim will be treated as abandoned, except that if the claimant within the 30-day period requests in writing additional time, the time period for submission of the information may be extended as reasonably necessary for the requested information to be obtained.

(f) Notwithstanding paragraph (d) of this section, VA will provide retroactive payment or reimbursement for emergency treatment received by the veteran on or after July 19, 2001, but more than 90 days before May 21, 2012, if the claimant files a claim for reimbursement no later than 1 year after May 21, 2012.

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0620.)

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003; 77 FR 23617, Apr. 20, 2012; 84 FR 26307, June 5, 2019]

§17.1005 Payment limitations.

(a) Payment or reimbursement for emergency treatment (including emergency transportation) under 38 U.S.C. 1725 will be calculated as follows:

(1) If an eligible veteran has personal liability to a provider of emergency treatment and no contractual or legal recourse against a third party, including under a health-plan contract, VA will pay the lesser of the amount for which the veteran is personally liable or 70 percent of the applicable Medicare fee schedule amount for such treatment.

(2) If an eligible veteran has personal liability to a provider of emergency treatment after payment by a third party, including under a health-plan contract, VA will pay:

(i) The difference between the amount VA would have paid under paragraph (a)(1) of this section for the cost of the emergency treatment and the amount paid (or payable) by the third party, if that amount would be greater than zero, or;

(ii) If applying paragraph (a)(2)(i) of this section would result in no payment by VA, the lesser of the veteran's remaining personal liability after such third-party payment or 70 percent of the applicable Medicare fee schedule amount for such treatment.

(3) In the absence of a Medicare fee schedule rate for the emergency treatment, VA payment will be the lesser of the amount for which the veteran is personally liable or the amount calculated by the VA Fee Schedule in §17.56 (a)(2)(i)(B).

(4) Unless rejected and refunded by the provider within 30 days from the date of receipt, the provider will consider VA's payment made under paragraphs (a)(1), (a)(2), or (a)(3) of this section as payment in full and extinguish the veteran's liability to the provider. (Neither the absence of a contract or agreement between the Secretary and the provider nor any provision of a contract, agreement, or assignment to the contrary shall operate to modify, limit, or negate the requirement in the preceding sentence.)

(5) 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.

(b) Except as provided in paragraph (c) of this section, VA will not approve claims for payment or reimbursement of the costs of emergency treatment not previously authorized for any period beyond the date on which the medical emergency ended. For this purpose, VA considers that an emergency ends when the designated VA clinician at the VA facility has determined that, based on sound medical judgment, a veteran who received emergency treatment:

(1) Could have been transferred from the non-VA facility to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment, or

(2) Could have reported to a VA medical center (or other Federal facility that VA has an agreement with to furnish health care services for veterans) for continuation of treatment.

(c) Claims for payment or reimbursement of the costs of emergency treatment not previously authorized may be approved for continued, non-emergency treatment, only if:

(1) The non-VA facility notified VA at the time the veteran could be safely transferred to a VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans) and the transfer of the veteran was not accepted, and

(2) The non-VA facility made and documented reasonable attempts to request transfer of the veteran to VA (or to another Federal facility that VA has an agreement with to furnish health care services for veterans), which means the non-VA facility contacted either the VA Transfer Coordinator, Administrative Officer of the Day, or designated staff responsible for accepting transfer of patients at a local VA (or other Federal facility) and documented such contact in the veteran's progress/physicians' notes, discharge summary, or other applicable medical record.

(d) If a stabilized veteran who requires continued non-emergency treatment refuses to be transferred to an available VA facility (or other Federal facility that VA has an agreement with to furnish health care services for veterans), VA will make payment or reimbursement only for the expenses related to the initial evaluation and the emergency treatment furnished to the veteran up to the point of refusal of transfer by the veteran.

(Authority: 38 U.S.C. 1725)

[66 FR 36470, July 12, 2001, as amended at 68 FR 3404, Jan. 24, 2003; 76 FR 79071, Dec. 21, 2011; 77 FR 23618, Apr. 20, 2012; 78 FR 36093, June 17, 2013; 83 FR 979, Jan. 9, 2018]

§17.1006 Decisionmakers.

The Chief of the Health Administration Service or an equivalent official at the VA medical facility of jurisdiction will make all determinations regarding payment or reimbursement under 38 U.S.C. 1725, except that the designated VA clinician at the VA medical facility of jurisdiction will make determinations regarding §17.1002(b), (c), and (d). Any decision denying a benefit must be in writing and inform the claimant of VA reconsideration and appeal rights.

(Authority: 38 U.S.C. 1725)

[66 FR 36470, July 12, 2001, as amended at 76 FR 79072, Dec. 21, 2011]

Exhibit B

28 F.4th 1348
United States Court of Appeals, Federal Circuit.

Amanda Jane WOLFE, Peter Boerschinger, Claimants-Appellees
v.
Denis MCDONOUGH, Secretary of Veterans Affairs, Respondent-Appellant

2020-1958
|
Decided: March 17, 2022

Synopsis

Background: Veteran enrolled in Department of Veterans Affairs (VA) health care system filed petition for writ of mandamus seeking class relief invalidating regulation prohibiting reimbursement of deductibles and coinsurance for emergency treatment at non-VA facilities and ordering reimbursement for coinsurance and deductibles incurred by veterans in seeking emergency medical treatment at non-VA facilities. The Court of Appeals for Veterans Claims, 32 Vet.App. 1, certified class and granted petition. Secretary of VA appealed.

Holdings: The Court of Appeals, Dyk, Circuit Judge, held that:

[1] veteran did not have clear and indisputable right to issuance of writ invalidating portion of implementing regulation that prohibited reimbursement of deductibles and ordering reimbursement for deductibles;

[2] veteran had clear and indisputable right to issuance of writ invalidating portion of implementing regulation prohibiting reimbursement of coinsurance and ordering reimbursement for coinsurance; but

[3] veteran had options for appeal that were adequate remedies for VA's refusal to reimburse coinsurance.

Reversed.

Procedural Posture(s): On Appeal; Petition for Writ of Mandamus.

West Headnotes (11)

[1] **Armed Services** Extraordinary jurisdiction and relief

The Federal Circuit Court of Appeals has jurisdiction to review a decision by the Court of Appeals for Veterans Claims whether to grant a mandamus petition that raises a non-frivolous legal question, and to determine whether the petitioner has satisfied the legal standard for issuing the writ. 38 U.S.C.A. § 7292(d).

[2] **Mandamus** Nature and scope of remedy in general

A writ of mandamus may issue only when three conditions are satisfied: (1) the petitioner must show a clear and indisputable right to issuance of writ under relevant substantive law; (2) the petitioner must have no other adequate means to attain desired relief; and (3) even if first two prerequisites have been met, the issuing court, in the exercise of its discretion, must be satisfied that the writ is appropriate under the circumstances.

1 Cases that cite this headnote

[3] **Armed Services** Hospitalization and medical care

Armed Services Extraordinary jurisdiction and relief

Term "similar payment," as used in statute prohibiting Department of Veterans Affairs (VA) from reimbursing a veteran enrolled in VA health care system for "any copayment or similar payment" for emergency treatment at non-VA facilities, included deductibles, and thus, veteran enrolled in VA health care system did not have clear and indisputable right to issuance of writ of mandamus invalidating portion of implementing regulation that prohibited reimbursement of deductibles and ordering reimbursement for deductibles; both copayments and deductibles were fixed quantities which became known once

insurance was purchased. 38 U.S.C.A. § 1725(c)(4)(D); 38 C.F.R. § 17.1005(a)(5).

[4] **Armed Services** Hospitalization and medical care

Armed Services Extraordinary jurisdiction and relief

Term "similar payment," as used in statute prohibiting Department of Veterans Affairs (VA) from reimbursing a veteran enrolled in VA health care system for "any copayment or similar payment" for emergency treatment at non-VA facilities, did not include coinsurance, and thus, veteran enrolled in VA health care system had clear and indisputable right to issuance of writ of mandamus invalidating portion of implementing regulation prohibiting reimbursement of coinsurance and ordering reimbursement for coinsurance; copayment was fixed quantity which became known once insurance was purchased, while coinsurance was variable quantity that became known only after medical expenses were incurred and was quintessentially partial coverage that was not excluded from reimbursement. 28 U.S.C.A. § 1651; 38 U.S.C.A. § 1725(c)(4)(D); 38 C.F.R. § 17.1005(a)(5).

[5] **Statutes** Undefined terms

Unless otherwise defined, words in a statute will be interpreted as taking their ordinary, contemporary, common meaning at the time Congress enacted the statute.

[6] **Statutes** Giving effect to entire statute and its parts; harmony and superfluousness

The presumption against surplusage provides that a statute should be construed so that effect is given to all its provisions, so that no part will be inoperative, superfluous, void, or insignificant.

[7] **Mandamus** Remedy by Appeal or Writ of Error

Mandamus is unavailable when there is adequate remedy by appeal.

[8] **Mandamus** Acts of officers, boards, or private corporations

Veteran enrolled in Department of Veterans Affairs (VA) health care system had options for appeal that were adequate remedies for VA's refusal to reimburse coinsurance incurred by veterans for emergency treatment at non-VA health care facilities, barring her petition for writ of mandamus invalidating regulation prohibiting reimbursement of coinsurance and ordering reimbursement for coinsurance; when veteran petitioned for writ, she was still pursuing her administrative appeal at the VA, veteran did not content that Secretary of VA was refusing to process her claim or unreasonably delaying its adjudication, and fact that Board of Veterans' Appeals could not invalidate regulation did not make administrative appeals process futile. 28 U.S.C.A. § 1651; 38 U.S.C.A. § 1725(c)(4)(D); 38 C.F.R. § 17.1005(a)(5).

1 Cases that cite this headnote

[9] **Mandamus** Courts and judicial officers subject to mandamus

Mandamus is not available to enforce the principle of stare decisis.

[10] **Res Judicata** Public Entities and Persons Related Thereto

There is no affirmative collateral estoppel against the government.

[11] **Mandamus** Mandamus Ineffectual or Not Beneficial

Mandamus does not aid prospective jurisdiction over agency action where a party has not initiated any agency proceeding whatsoever.

West Codenotes

Prior Version Recognized as Invalid
38 C.F.R. § 17.1002(f)

Held Invalid
38 C.F.R. § 17.1005(a)(5)

***1350** Appeal from the United States Court of Appeals for Veterans Claims in No. 18-6091, Judge Joseph L. Falvey, Jr., Judge Michael P. Allen, Judge William S. Greenberg.

Attorneys and Law Firms

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Before Dyk, Reyna, and Stoll, Circuit Judges.

Opinion

Dyk, Circuit Judge.

This case involves the scope of the Department of Veterans Affairs' ("VA's") reimbursement of the cost of hospital visits to veterans enrolled in the VA health care system. The statute bars reimbursement for "any copayment or similar payment." 38 U.S.C. § 1725(c)(4)(D). The question is whether deductibles and coinsurance are encompassed within the term "similar payments."

The Secretary of the VA ("Secretary") appeals from a decision of the United States Court of Appeals for Veterans Claims ("Veterans Court") granting a petition for a writ of mandamus (1) invalidating a VA regulation prohibiting the reimbursement of deductibles and coinsurance for being within the category of "similar payments," (2) requiring the VA to readjudicate claims denied under the invalidated regulation, and (3) certifying a class of "[a]ll claimants whose claims for reimbursement of emergency medical expenses incurred at non-VA facilities VA has already denied or will deny, 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," J.A. 28.

Because deductibles are excluded from reimbursement under the correct interpretation ***1351** of the statute and other adequate remedies were available with respect to coinsurance, mandamus was inappropriate. We reverse.

BACKGROUND

I

The VA provides health care to nine million enrolled veterans through its Veterans Health Administration, the largest health care system in the country. *Veterans Health Administration*, U.S. Dep't of Veterans Affs., https://www.va.gov/health (last visited Feb. 22, 2022). Enrollment in the VA health care system is determined by statute. *See* 38 U.S.C. § 1705. For those who are enrolled, and subject to certain other criteria, the VA provides free hospital care. *See* 38 U.S.C. § 1710(a), (e); 38 C.F.R. § 17.108(d), (e). Enrolled veterans with other health care coverage, such as private insurance, Medicare, Medicaid, or TRICARE, may choose to use those sources of coverage to supplement their VA health care benefits. *VA and Other Health Insurance*, U.S. Dep't of Veterans Affs., https://www.va.gov/healthbenefits/resources/publications/hbco/hbco_va_other_insurance.asp (last visited Feb. 22, 2022). In emergencies, enrolled veterans are entitled to obtain medical care at the nearest hospital

emergency department and to seek reimbursement from the VA for the cost of treatment, with some exceptions. *Emergency Medical Care*, U.S. Dep't of Veterans Affs., https://www.va.gov/COMMUNITYCARE/programs/veterans/Emergency_Care.asp (last visited Feb. 22, 2022).

Simple on its face, the implementation of this approach was complex. Before 1999, the VA had limited authority to pay for private, non-VA emergency care for veterans. In general, it could only reimburse for emergency treatment relating to a service-connected condition or disability. 38 U.S.C. §§ 1703(a)(3), 1728 (1999); *see also* H.R. Rep. No. 106–470, at 63 (1999) (Conf. Rep.). Congress expanded the VA's authority in 1999 by adding § 1725 to title 38 of the U.S. Code in the Veterans Millennium Health Care and Benefits Act. Pub. L. No. 106-117, § 111, 113 Stat. 1545, 1553 (1999) (effective May 29, 2000).

Section 1725 as originally enacted directed the VA to reimburse veterans enrolled in the VA healthcare system for "the reasonable value of emergency treatment furnished the veteran in a non-[VA] facility" if they, among other conditions, (1) had "no entitlement to care or services under a health-plan contract" ("the contract provision") and (2) had "no other contractual or legal recourse against a third party that would, in whole or in part, extinguish" liability to the provider ("the third-party provision"). § 1725(a)(1), (b)(3)(B)–(C) (1999). These somewhat overlapping limitations reflected Congress's intent to contain "the significant potential cost" of reimbursement and ensure "that VA truly [is] a payer of last resort." H.R. Rep. No. 106-237, at 39 (1999). Congress expected VA to "act aggressively" to protect "scarce VA medical care funds" by "ascertain[ing] before authorizing any payment under this section that a veteran has no medical insurance whatsoever or any other medical coverage" and that "the veteran ... has exhausted all other possible claims and remedies reasonably available against a third party which may be liable for payment of the emergency care." *Id.* Section 1725 directed the Secretary to promulgate regulations to "establish the maximum amount payable" and "delineate the circumstances under which such payments may be made." § 1725(c)(1)(A)–(B).

Under the provisions of the 1999 legislation, veterans with even minimal health insurance coverage, such as through a state-mandated automobile insurance policy, ***1352** might wind up responsible for essentially the full cost of emergency treatment. H.R. Rep. No. 111-55, at 2–3 (2009). Congress addressed this problem in 2010 by revising § 1725 in the Emergency Care Fairness Act of 2010 ("ECFA"). Pub. L. No. 111-137, § 1, 123 Stat. 3495 (2010) (effective Feb. 1, 2010). The ECFA struck "or in part" from the third-party provision such that reimbursement was prohibited if the veteran had "other contract[ ] or legal recourse against a third party that would, *in whole*, extinguish" liability to the provider. § 1725(b)(3)(C) (emphasis added). The ECFA also added a new subsection to § 1725(c) with limitations on reimbursement, including a provision providing that "[t]he 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" ("the copayment provision"). § 1725(c)(4)(D). [1]

1 The ECFA also struck a provision that included state-mandated automobile insurance under the definition of "health-plan contract." *Compare* § 1725(f)(3)(E) (2014), *with* § 1725(f)(2)(E) (2006).

The statute does not define "copayment" or "similar payment," § 1725(f), but the parties agree that there are three cost-sharing mechanisms commonly used in the health insurance industry:

- A copayment is a "fixed amount that a patient pays to a healthcare provider according to the terms of the patient's health plan." *Copayment*, Black's Law Dictionary (11th ed. 2019).
- A deductible is "the portion of the loss to be borne by the insured before the insurer becomes liable for payment." *Deductible*, Black's Law Dictionary (11th ed. 2019).
- "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 and the insurer pays the remaining expenses." *Coinsurance*, Merriam-Webster, https://www.merriamwebster.com/dictionary/coinsurance (last visited Feb. 4, 2022).

After Congress passed the ECFA in 2010, the VA revised its regulations, differentiating between situations involving third-party liability and those involving healthplan contracts despite the seeming overlap between the two. It struck "or in part" from the regulation corresponding to the third-party provision, 38 C.F.R. § 17.1002(g), and added a regulation that the VA "will not reimburse a claimant ... for any deductible, copayment or similar payment that the veteran owes a third party," 38 C.F.R. § 17.1005(f). *See* Payment

or Reimbursement for Emergency Services for Nonservice-Connected Conditions in Non-VA Facilities, 77 Fed. Reg. 23615, 23,615–16, 23,618 (Apr. 20, 2012). However, the VA did not change the contract provision in the regulation, which continued to state that reimbursement required "[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) (2012) (emphasis added) ("the contract regulation"). The VA concluded that the ECFA did not alter the contract provision and that removing "or in part" from the corresponding regulation "would treat a veteran with some coverage under a health-plan contract in the same manner as one without coverage." Payment or Reimbursement, 77 Fed. Reg. at 23,616.

II

In *Staab v. McDonald*, 28 Vet. App. 50 (2016), the Veterans Court considered the ***1353** statute, as amended in 2010 by the ECFA, and the 2012 regulations. There, a veteran incurred emergency expenses at a non-VA hospital and sought reimbursement for the portion not covered by Medicare. *Id.* at 52. The Board of Veterans' Appeals ("Board") denied his claim as a matter of law under the contract regulation because Medicare covered some, but not all, of the veteran's costs. *Id.* The Veterans Court reversed the Board's determination, concluding that the regulation was invalid. *Id.* at 56. The Veterans Court did not explain the cost-sharing mechanisms involved. *Id.* at 52–53. But interpreting the language and legislative history of the ECFA, the Veterans Court found that "Congress intended that veterans be reimbursed [aside from copayments] for the portion of their emergency medical costs that is not covered by a third party insurer and for which they are otherwise personally liable." *Id.* at 55. The Secretary appealed *Staab* to this court but voluntarily withdrew the appeal. J.A. 7.

Following *Staab*, the VA revised the contract regulation to allow reimbursement when a veteran "does not have coverage under a health-plan contract *that would fully extinguish* the medical liability for the emergency treatment." 38 C.F.R. § 17.1002(f) (emphasis added); *see also* Reimbursement for Medical Treatment, 83 Fed. Reg. 974, 974–75 (Jan. 9, 2018). At the same time, the VA added coinsurance to deductibles and copayments as payments that would not be reimbursed. 38 C.F.R. § 17.1005(a)(5) (hereinafter, "the similar payments regulation"); *see also* Reimbursement for Medical Treatment, 83 Fed. Reg. at 976–77.

III

In September 2016, Amanda Wolfe, who was enrolled in VA health care, obtained emergency treatment at a non-VA health care facility, incurring expenses of $22,348.25. Her employer-sponsored healthcare contract covered most of the expenses, but she was responsible for a copayment of $202.93 and coinsurance of $2,354.41. The VA denied reimbursement of these expenses in February 2018 because "patient responsibility (deductible, coinsurance, co-payment) [is] not covered." J.A. 199. In July 2018, Ms. Wolfe filed a Notice of Disagreement ("NOD"), a predicate to an appeal to the Board of Veterans' Appeals. In October 2018, rather than await the outcome of her appeal, Ms. Wolfe filed a mandamus petition at the Veterans Court seeking class relief invalidating the similar payments regulation and ordering "the Secretary to reimburse veterans for coinsurance and deductibles ... incurred by veterans in seeking emergency medical treatment at a non-VA hospital[ ] and ... not covered by the veteran's health insurance carrier." J.A. 54. While it appears that Ms. Wolfe did not herself have an issue as to deductibles, she pursued a ruling as to deductibles on behalf of the class.

In September 2019, a three-judge panel of the Veterans Court certified Ms. Wolfe's requested class and granted her petition. On the merits, a majority of the panel determined (1) that the similar payments regulation was inconsistent with the *Staab* decision's interpretation of § 1725, and (2) that deductibles and coinsurance are not similar to copayments. The majority reasoned that "[a] deductible is not 'similar' to a copayment because, though it is fixed, it is not a relatively small fee" and that "coinsurance [is not] 'similar' to a copayment because coinsurance is neither a relatively small nor a fixed fee; it's a relatively large and variable fee based on a percentage." J.A. 33. The majority further determined that Ms. Wolfe lacked adequate alternative remedies because "disputing the regulation's validity within the administrative ***1354** appeals process amounts to 'a useless act' and would be futile because the Board doesn't have jurisdiction to invalidate the regulation." J.A. 34. Judge Falvey dissented, noting (1) that granting Ms. Wolfe's requested relief would "thwart, not aid [the Veterans Court's] appellate jurisdiction" because it "could not lead to a final Board decision reviewable by [the Veterans Court], and would, in fact, abrogate the need for such a decision," (2) that Ms. Wolfe failed to show she was clearly and indisputably correct in her interpretation of the statute, and (3) that Ms. Wolfe had an adequate remedy by appeal.

The Secretary appeals. We have jurisdiction under 38 U.S.C. § 7292(a), (c).

DISCUSSION

[1] In reviewing decisions from the Veterans Court, this court "shall ... decide all relevant questions of law, including interpreting constitutional and statutory provisions" but "may not review [ ] a challenge to a factual determination, or [ ] a challenge to a law or regulation as applied to the facts of a particular case." § 7292(d). We have "jurisdiction to review the [Veteran Court's] decision whether to grant a mandamus petition that raises a non-frivolous legal question," and to determine "whether the petitioner has satisfied the legal standard for issuing the writ." *Beasley v. Shinseki*, 709 F.3d 1154, 1158 (Fed. Cir. 2013).

[2] The All Writs Act authorizes "all courts established by Act of Congress [to] issue all writs necessary or appropriate in aid of their respective jurisdictions." 28 U.S.C. § 1651. A writ of mandamus may issue only when three conditions are satisfied: (1) the petitioner must show a "clear and indisputable" right to issuance of the writ under the relevant substantive law, (2) the petitioner must have "no other adequate means" to attain the desired relief, and (3) "even if the first two prerequisites have been met, the issuing court, in the exercise of its discretion, must be satisfied that the writ is appropriate under the circumstances." *Cheney v. U.S. Dist. Ct. for D.C.*, 542 U.S. 367, 380–81, 124 S.Ct. 2576, 159 L.Ed.2d 459 (2004) (citations omitted); *see also Bankers Life & Cas. Co. v. Holland*, 346 U.S. 379, 384–85, 74 S.Ct. 145, 98 L.Ed. 106 (1953).

I

[3] **[4]** We first consider whether, under the correct interpretation of § 1725(c)(4)(D), Ms. Wolfe has a "clear and indisputable" right. The statute provides that the "Secretary may not reimburse a veteran under this section for any copayment or similar payment." § 1725(c)(4)(D). Ms. Wolfe's right turns on whether deductibles and coinsurance are "similar payments" to copayments under the statute. The similar payments regulation interprets "similar payments" as including both deductibles and coinsurance. 38 C.F.R. § 17.1005(a)(5) ("VA will not reimburse a veteran ... 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."). For reasons set out below, we conclude that deductibles are similar to copayments and are excluded from reimbursement, but coinsurance is not similar and is not excluded.

[5] **[6]** It is a "fundamental canon of statutory construction" that "unless otherwise defined, words will be interpreted as taking their ordinary, contemporary, common meaning[ ] ... at the time Congress enacted the statute." *Perrin v. United States*, 444 U.S. 37, 42, 100 S.Ct. 311, 62 L.Ed.2d 199 (1979). The presumption against surplusage additionally provides that a "statute should be construed so that ***1355** effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant." *Hibbs v. Winn*, 542 U.S. 88, 101, 124 S.Ct. 2276, 159 L.Ed.2d 172 (2004) (citing 2A Norman J. Singer, *Statutes and Statutory Construction* § 46.06, at 181–86 (rev. 6th ed. 2000)).

To resolve this issue, we first need to address the effect of the deletion of the "or in part" language from the third-party provision, given the significance that Ms. Wolfe attributes to that statutory amendment. As noted earlier, before the enactment of the ECFA in 2010, the statute required as conditions of reimbursement that a veteran have "no entitlement to care or services under a healthplan contract" and also "no other contractual or legal recourse against a third party that would, in whole or in part, extinguish" liability to the provider. § 1725(b)(3)(B)–(C) (1999). In 2010, Congress deleted the "or in part" language from the third-party provision but left unchanged the "no entitlement" language in the contract provision, creating a potential ambiguity. § 1725(b)(3)(B)–(C). Nonetheless, in deleting the "or in part" language from the third-party provision and adding the "copayment or similar payments" provision, which equally limits the scope of both the contract and third-party provisions, Congress clearly intended for veterans with partial contract coverage not to be disqualified from reimbursement unless the payments are "copayment[s] or similar payments." The government does not argue otherwise, and we think this is the correct interpretation.

But that does not resolve the question whether deductibles and coinsurance are "similar payments" to copayments. We agree with the government that "similar payments" necessarily means that some payments that are not copayments are "similar payments." The arguments by the Veterans Court and Ms. Wolfe that "similar payments" was simply meant to include copayments when the provider used different

language to describe them are untenable. *See, e.g., Rousey v. Jacoway*, 544 U.S. 320, 324, 329, 125 S.Ct. 1561, 161 L.Ed.2d 563 (2005) (holding that "[t]o be 'similar,' an IRA must be like, though not identical to, the specific plans or contracts listed in [the statute], and consequently must share characteristics common to the listed plans or contracts" under a Bankruptcy Code provision allowing debtors to exempt "a payment under a stock bonus, pension, profitsharing, annuity, or similar plan or contract on account of ... age" from estate).

But equally untenable is the government's argument that both deductibles and coinsurance are "similar payments." If this were so, the ECFA amendments allowing veterans with partial coverage to be reimbursed would have little meaning since the similar payments language would bar all forms of cost-sharing. The government suggests that its interpretation does not render the partial coverage exclusions inoperative because the statutory effects of "similar payments" would not bar reimbursement to veterans who have hit annual or lifetime policy limits on covered costs. VA Br. at 47. But shortly after passing the ECFA, Congress passed the Affordable Care Act ("ACA"), which generally prohibited annual and lifetime caps on covered costs. *See* 42 U.S.C. § 300gg-11. The ACA had already passed the Senate when Congress enacted the ECFA amendments in 2010. It seems unlikely that Congress, in eliminating partial coverage from the third-party provision, was concerned with policy limits in view of its impending decision to eliminate such limits. [2]

[2] The Secretary also mentions that veterans with short-term limited duration ("STLD") insurance may incur reimbursable costs. It is unclear how the existence of STLD insurance should inform the meaning of "similar payments" under the statute, and the Secretary does not explain the relationship. *See* VA Br. at 47; VA Reply Br. at 21; *see also* Requirements for the Group Health Insurance Market, 69 Fed. Reg. 78,783 (Dec. 30, 2004) (defining STLD insurance plans); *Ass'n for Cmty. Affiliated Plans v. U.S. Dep't of Treasury*, 966 F.3d 782, 786 (D.C. Cir. 2020) (discussing higher deductibles associated with STLD insurance plans).

***1356** The Secretary, citing to the ACA, also argues that the similar payments regulation is a reasonable reflection of "the common understanding of which health plan expenses are 'similar' to copayments." VA Br. at 46. The ACA defines "cost-sharing" to include "deductibles, coinsurance, copayments, or similar charges" as well as "any other expenditure required of an insured individual which is [paid by the beneficiary for medical care to the extent such amounts are not compensated for by insurance or otherwise] with respect to essential health benefits covered under the plan," excluding "premiums, balance billing amounts for non-network providers, or spending for noncovered services." 42 U.S.C. § 18022(c)(3); *see also* 26 U.S.C. § 223(d)(2)(A). We do not find this persuasive. The ACA definition highlights that copayments, deductibles, and coinsurance are all cost-sharing mechanisms for purposes of introducing annual limits on cost-sharing, *see* § 18022(c)(1), but it does not answer the question of what is a "similar payment" to a copayment for purposes of the ECFA.

Having considered the interpretations offered by the Veterans Court and advanced by the parties, we conclude that the correct reading of the statute is one in which a deductible is a "similar payment" to a copayment, but coinsurance is not. Rather, coinsurance is the very type of partial coverage that Congress did not wish to exclude from reimbursement. This interpretation gives meaning to all terms and provisions in the statute and is also consistent with the plain meaning of the terms: copayments and deductibles are fixed quantities which become known once insurance is purchased, while coinsurance is a variable quantity that becomes known only after medical expenses are incurred and is quintessentially partial coverage. The Veterans Court and Ms. Wolfe urge that deductibles are similar to coinsurance for veterans who have health insurance plans with high deductibles, but there is no indication that Congress wished to distinguish high deductible plans from other plans (with lower deductibles) when determining the categories of payments excluded from reimbursement.

The legislative history, though sparse, also supports a reading that deductibles were intentionally excluded from reimbursement as a "similar payment," but coinsurance was not. When the amendment to § 1725 was first under consideration, the House bill simply struck "or in part" from the third-party provision at § 1725(b)(3)(C). H.R. 5888, 110th Cong. § 1(a) (2008). In a prepared statement, the VA noted that it did not support the amendment as drafted because it "could be interpreted to require that VA pay any copayments the veteran owes to the third party." *Hearing Before the Subcomm. on Health of the H. Comm. on Veterans Affs.*, 110th Cong. 24 (2008). When the amendment was reintroduced in the next Congress, the new bill added the "copayment or similar payment" exclusion now in the statute. H.R. 1377,

111th Cong. § 1(b) (as introduced Mar. 6, 2009). The VA stated that it now supported the bill and understood the VA's financial liability to "exclud[e] copayment or deductible amounts owed by the veteran." *Hearing Before the* ***1357** *Subcomm. on Health of the H. Comm. on Veterans Affs.*, 111th Cong. 50 (2009). There was no mention of coinsurance. Given Congress's concern with the VA's views as to the appropriate scope of the legislation, the VA's input was significant. H.R. Rep. No. 111-55, at 3 (2009) ("In addition, in response to the concerns put forth by the VA last Congress, [the bill] would clarify the reimbursement responsibilities of the VA."). In sum, the legislative history supports that Congress intended "similar payments" to include deductibles but not coinsurance. [3]

3 The Veterans Court relied on a colloquy between Representative Miller and a subcommittee staff member from the 2008 legislative hearing as evidence of Congress's intent that VA reimburse deductibles. J.A. 5 n.10. However, the bill at the time did not contain the "copayment or similar payment" exclusion. Thus, even if this exchange between a congressman and a committee staffer could have any significance, it does not show what Congress intended to exclude in a provision that only came into existence nearly a year later.

Under the correct construction of the statute, there is a "clear and indisputable" right to relief with respect to coinsurance but not deductibles. [4] We turn to the question whether mandamus was available with respect to coinsurance.

4 Because we find that Congress's intent is clear in the statute, we do not address the Secretary's arguments regarding *Chevron* deference. *See Chevron U.S.A., Inc. v. Nat. Res. Def. Council*, 467 U.S. 837, 842–43, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984).

II

[7] It is well established that mandamus is unavailable when there is an adequate remedy by appeal. In *Bankers Life*, the petitioner sought a writ of mandamus to vacate and set aside a district court's order of severance and transfer on the ground of improper venue, contending that mandamus was appropriate in part because the interlocutory order could be reviewed on appeal from final judgment in the case only after "needless expense, hardship and judicial inconvenience." 346 U.S. at 381–82, 74 S.Ct. 145. The Supreme Court rejected this argument, explaining that "the extraordinary writs cannot be used as substitutes for appeals, even though hardship may result from delay and perhaps unnecessary trial, and whatever may be done without the writ may not be done with it." *Id.* at 383, 74 S.Ct. 145 (citing *Ex parte Fahey*, 332 U.S. 258, 259–60, 67 S.Ct. 1558, 91 L.Ed. 2041 (1947); *U.S. Alkali Export Ass'n v. United States*, 325 U.S. 196, 202–03, 65 S.Ct. 1120, 89 L.Ed. 1554 (1945); *Roche v. Evaporated Milk Ass'n*, 319 U.S. 21, 31, 63 S.Ct. 938, 87 L.Ed. 1185 (1943); *Ex parte Rowland*, 104 U.S. 604, 617, 26 L.Ed. 861 (1882)). It further explained that mandamus "should be resorted to only where appeal is a clearly inadequate remedy." *Id.* at 384–85, 74 S.Ct. 145 (quoting *Fahey*, 332 U.S. at 259–60, 67 S.Ct. 1558). Our court has applied *Bankers Life* in affirming the Veterans Court's denial of a mandamus petition in the context of a benefits decision. *See Lamb v. Principi*, 284 F.3d 1378, 1384 (Fed. Cir. 2002); *see also Beasley*, 709 F.3d at 1159 (cautioning against "widespread use of the writ of mandamus as a substitute for the ordinary appeals process mandated by Congress").

[8] Here, Ms. Wolfe had options for appeal that were adequate remedies. When she petitioned for the writ, Ms. Wolfe was still pursuing her administrative appeal at the VA. There has been no showing that this was an inadequate remedy. To be sure, mandamus might be available if the appeals process were being unreasonably delayed, but that possibility is no help to Ms. Wolfe. First, such a mandamus order ***1358** could only compel action on the appeal. [5] It could not dictate a particular outcome. *See Bankers Life*, 346 U.S. at 383, 74 S.Ct. 145 (mandamus does not function to "control the decision of the trial court"); *see also Kramer v. Wilkie*, 842 F. App'x 599, 604–05 (Fed. Cir. 2021) ("A writ of mandamus may not be used to compel an outcome-specific order."). Second, as the Veterans Court dissent noted, Ms. Wolfe did "not contend that the Secretary is refusing to process her claim, unreasonably delaying its adjudication, or performing any other action that would prevent her dispute from making its way to" the Veterans Court. J.A. 37–38. If Ms. Wolfe continued to follow the appeals process prescribed in title 38, she would have received a Board decision appealable to the Veterans Court.

5 *See Martin v. O'Rourke*, 891 F.3d 1338, 1343 (Fed. Cir. 2018) (citing *Telecomms. Rsch. & Action Ctr. v. FCC*, 750 F.2d 70, 76 (D.C. Cir. 1984)); *Monk v. Shulkin*, 855 F.3d 1312, 1318 (Fed. Cir. 2017)

(citing *Cox v. West*, 149 F.3d 1360, 1363 (Fed. Cir. 1998)) ("[T]he Veterans Court has the power to ... order[ ] the Board to issue a final determination in a case where it had not already done so.").

Ms. Wolfe notes the Veterans Court's finding that the administrative appeals process would have been "futile because the Board doesn't have jurisdiction to invalidate the regulation." J.A. 34. We rejected this reasoning in *Ledford v. West*, 136 F.3d 776, 780 (Fed. Cir. 1998). The fact that the Board could not address the issue does not mean that the appeals process is futile. In considering an individual case, the Veterans Court and this court can consider a regulation's validity. 38 U.S.C. §§ 7261(a)(3), 7292; *see, e.g., Gardner v. Brown*, 5 F.3d 1456 (Fed. Cir. 1993). We additionally note that Ms. Wolfe could have petitioned this court (and still can) for review of the similar payments regulation pursuant to 38 U.S.C. § 502, and Ms. Wolfe has not alleged that this avenue is futile or subject to delay. Indeed, the mandamus proceeding itself appears to constitute the very kind of non-case-specific review of the regulations that is vested exclusively in this court under § 502. *See Preminger v. Sec'y of Veterans Affs.*, 632 F.3d 1345, 1352 (Fed. Cir. 2011).

[9] **[10]** Ms. Wolfe next contends that mandamus is available to ensure compliance with the Veterans Court's earlier decision in *Staab*. The Veterans Court majority characterized *Staab* as "the definitive and authoritative interpretation of section 1725," J.A. 7, and Ms. Wolfe argues that the VA's departure from *Staab* constitutes "extraordinary misconduct" because *Staab* is "binding on the VA," Wolfe Br. at 26, 10. There is no basis for these allegations, and both the Veterans Court majority and Ms. Wolfe misunderstand the situation. Mandamus might be appropriate to ensure compliance with the judgment in an individual case, *see Clinton v. Goldsmith*, 526 U.S. 529, 536, 119 S.Ct. 1538, 143 L.Ed.2d 720 (1999), but mandamus is not available to enforce the principle of stare decisis. *Staab* did not afford equitable relief barring enforcement of the regulations and constitutes simply an unreviewed decision of the Veterans Court that is not binding on this court or on the government outside of that individual case except as a matter of stare decisis at the Veterans-Court level of review. [6] Moreover, *Staab* cannot be read to ***1359** foreclose the VA, even at the Veterans Court level, from arguing for the validity of a different regulation than the one at issue in *Staab*.

[6] It is well-established that there is no affirmative estoppel against the government. *See United States v. Mendoza*, 464 U.S. 154, 158, 104 S.Ct. 568, 78 L.Ed.2d 379 (1983) ("[N]onmutual offensive collateral estoppel is not to be extended to the United States."); *Nat'l Org. of Veterans' Advocs., Inc. v. Sec'y of Veterans Affs.*, 260 F.3d 1365, 1373 (Fed. Cir. 2001) (rejecting application of collateral estoppel against the VA because "the only effect of the [Veterans Court's earlier decisions] is as a matter of stare decisis").

Ms. Wolfe next argues that mandamus is available in aid of the Veterans Court's prospective jurisdiction because the VA, through supposed misrepresentations in various communications, has deterred individuals from pursuing their benefits claims and appeals. The Veterans Court similarly found that the VA's communications regarding entitlements under the similar payments regulation as well as the regulation itself create "a chilling effect" on would-be claimants. J.A. 17. The answer to this again is twofold. First, this cannot justify mandamus with respect to Ms. Wolfe herself; she was not deterred and filed an appeal with the VA.

[11] Second, as to veterans who never filed claims, even assuming Ms. Wolfe could serve as the class representative, mandamus does not aid prospective jurisdiction where a party has not initiated any proceeding whatsoever. *See In re Tennant*, 359 F.3d 523, 530 (D.C. Cir. 2004) (mandamus unavailable where petitioner never initiated a proceeding with the agency because "a proceeding of *some* kind" that "might lead to an appeal" is a preliminary requirement to consider writ); *Mylan Labs. Ltd. v. Janssen Pharmaceutica, N.V.*, 989 F.3d 1375, 1380 (Fed. Cir. 2021) (court has prospective jurisdiction only after petition filed with agency); *see also FTC v. Dean Foods Co.*, 384 U.S. 597, 599, 86 S.Ct. 1738, 16 L.Ed.2d 802 (1966) (mandamus available because FTC initiated a proceeding); *see generally* 33 Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 8313 (2d ed.). We have no occasion to determine what forms of equitable relief might be available if the government inappropriately deterred potential claimants from pursuing their claims.

Ms. Wolfe additionally argues that "mandamus is proper to avoid delay in resolving important issues." Wolfe Br. at 62 (citing *Schlagenhauf v. Holder*, 379 U.S. 104, 111, 85 S.Ct. 234, 13 L.Ed.2d 152 (1964); *In re Google LLC*, 949 F.3d 1338, 1341–42 (Fed. Cir. 2020)). But the cases she relies on involved situations where appeal was not an adequate remedy or where a special need arose due to conflicting district court

decisions on a recurring issue, circumstances that are absent here. [7]

7 In *Schlagenhauf*, the petitioner alleged that a federal district court was without power to order the mental and physical examination of a defendant under Federal Rule of Civil Procedure 35. 379 U.S. at 110, 85 S.Ct. 234. Such liberty concerns, once violated, could not have been vindicated after the fact by appeal.
In *Google*, this court issued a writ ordering the district court to dismiss a case for lack of venue because it was unlikely that "these issues [would] be preserved and presented to this court through the regular appellate process." 949 F.3d at 1342–43. The *Google* court also noted "a significant number of district court decisions that [had] adopt[ed] conflicting views on the basic legal issues presented." *Id.* at 1342; *see also In re Volkswagen*, No. 22-108, 28 F.4th 1203, 1207, (Fed. Cir. Mar. 9, 2022); *In re Micron*, 875 F.3d 1091, 1095 (Fed. Cir. 2017).

Ms. Wolfe finally argues that the writ was necessary to correct a clear abuse of discretion under *La Buy v. Howes Leather Co.*, 352 U.S. 249, 257–58, 77 S.Ct. 309, 1 L.Ed.2d 290 (1957). [8] Reprising her arguments ***1360** about *Staab*'s allegedly binding effect, as evidence of a clear abuse of discretion, Ms. Wolfe points to the VA's "errors" in communicating with veterans about their entitlement to reimbursement, overestimating the monetary impact of *Staab*, failing to correct outdated information on its website, and the VA's adopting "a unilateral moratorium on claim processing, an interim final rule that lacked good cause, a regulation that circumvented both the statute and *Staab*, its refusal to pay veterans like Ms. Wolfe, and ongoing misrepresentations." Wolfe Br. 47. Ms. Wolfe's argument is again founded on the flawed premise that *Staab* was the final word on the subject matter and that the VA somehow acted improperly in adopting a new regulation after *Staab*.

8 *La Buy* involved a district court judge who referred antitrust cases for trial before a master despite being able to "dispose of the litigation with greater dispatch and less effort than anyone else" due to his "knowledge of the cases ... [and] long experience in the antitrust field." 352 U.S. at 255–56, 77 S.Ct. 309. The Court held that the judge's referrals, which numbered eleven cases in six years, "amounted to little less than an abdication of the judicial function...." *Id.* at 256, 258, 77 S.Ct. 309.

Because we conclude that mandamus was inappropriate, we need not and do not reach the issue of class certification.

CONCLUSION

Mandamus was not available in this case because the petitioner did not have a clear and indisputable right with respect to deductibles and had other adequate legal remedies by appeal. We reverse the Veterans Court's grant of the petition for a writ of mandamus.

REVERSED

COSTS

No costs.

All Citations

28 F.4th 1348, Med & Med GD (CCH) P 307,290

End of Document

Exhibit C

Cigna
PO Box 188061
Chattanooga, TN 37422 - 8061

CIGNA HEALTH AND LIFE INSURANCE COMPANY
AS AGENT FOR DIGITAL HANDS, LLC 00614248

JOSHUA KIMMEL
[redacted]

Customer service
Call the number on the back of your ID card or
1-866-494-2111
MyCigna.com
If you have any questions about this document, please call Customer Service at the number above. Please have your reference number ready.

Service dates
October 29, 2016 - October 31, 2016

Reference # / ID
[redacted]

Account name / Account #
[redacted]

THIS IS NOT A BILL.
Your health care professional may bill you directly for any amount that you owe.

Explanation of benefits

for a claim received for JOSHUA KIMMEL, Reference # [redacted]

Summary of a claim for services on October 29, 2016- October 31, 2016

for services provided by BRANDON REGIONAL HOSPITAL.

Amount Billed	$29,018.66	This was the amount that was billed for your visit on 10/29/2016 through 10/31/2016.
Discount	$19,252.73	**You saved $19,252.73.** Cigna negotiates discounts with health care professionals and facilities to help you save money.
What my plan paid	$7,412.74	Cigna paid $7,412.74 to BRANDON REGIONAL HOSPITAL.
What I Owe	$2,353.19	This is the amount you owe after your discount, what your plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid when you received care may reduce the amount you owe.
You saved	**92%**	You saved $26,665.47 (or 92%) off the total amount billed. This is a total of your discount and what your plan paid. To maximize your savings, visit MyCigna.com or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities.

[redacted]

PLEASE SEE CLAIM DETAILS ON PAGE 3.

Definitions

Amount billed: The amount charged by the health care professional or facility (physician, hospital, etc.) for services provided to you or your covered dependents.
Amount not covered: The portion of the amount billed that was not covered or eligible for payment under your plan. Examples include charges for services or products that are not covered by your plan, duplicate claims that are not your responsibility and any charges submitted that are above the maximum amount your plan pays for out-of-network care.
Coinsurance: A percentage of covered expenses you pay after you meet your deductible. The remaining balance in your healthcare account may be used to pay your deductible.
Copay: A flat fee you pay for certain covered services such as doctor visits or prescriptions. You can use the money in your reimbursement account to pay this fee.
Deductible: The portion of submitted charges applied towards your deductible. Your deductible is the amount you need to pay each year before your plan starts paying benefits. You meet your deductible by using the money in your health care account, then your own money.
Discount: The amount you save by using a health care professional or facility (doctor, hospital, etc) that belongs to a Cigna network. Cigna negotiates lower rates with its in-network doctors, hospitals and other facilities to help you save money.
In-network: A group of health care professionals and facilities (doctors, hospitals, labs, etc) that offer discounts on services based on their relationship with Cigna. Using in-network services gives you significant discounts, which help you stretch your health care account money further.
Out-of-network: Health care professionals and facilities (doctors, hospitals, labs, etc) that do not belong to the Cigna network. Depending on your plan, you can use out-of-network services, but you may pay more for the same services, and you might have to file a separate claim for reimbursement.
What my plan paid: The portion of the billed amount that was paid by your health care plan.
What I owe: The portion of the billed amount that is your responsibility. This amount might include your deductible, coinsurance, any amount over the maximum reimbursable charge, or products or services not covered by your plan.

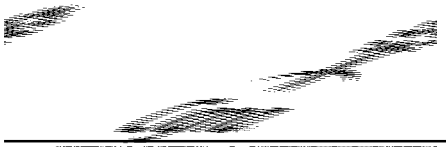
In the event a claim is denied

Rights of review and appeal

If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on the front of this form.

If you're not satisfied with this decision, you can start the Appeal process by sending a written request to the address listed in your plan materials within 180 days of receipt of this explanation of benefits (unless a longer time is permitted by your plan). Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g. benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your name 2) Account number from the front of this form 3) ID number from the front of this form 4) Name of the patient and relationship and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records and other information about your claim, free of charge.
- You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you may also bring legal action under section 502(a) of ERISA following our review and decision.



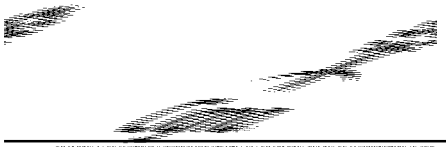
Claim received for JOSHUA KIMMEL
Reference # [redacted]
ID

THIS IS NOT A BILL

Claim Detail

Cigna received this claim on November 8, 2016 and processed it on November 9, 2016.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/ Deductible	What my plan paid	% paid	Coinsurance*	What I owe	See notes
BRANDON REGIONAL HOSPITAL, Patient # 727177974 PO BOX 402160 ATLANTA GA 30384-2160											
10/29/16-10/31/16	ROOM AND BOARD	3,684.00	17,571.19	0.00	9,112.00	500.00	6,889.60	80	1,722.40	2,222.40	PAA
10/29/16-10/31/16	INPATIENT SERVICES	151.28	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	INPATIENT SERVICES	307.26	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	INPATIENT SERVICES	61.71	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	INPATIENT SERVICES	4,368.12	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	INPATIENT SERVICES	188.79	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	INPATIENT SERVICES	2,169.82	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	INPATIENT SERVICES	2,117.30	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	INPATIENT SERVICES	1,398.42	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	INPATIENT SERVICES	3,579.24	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	INPATIENT SERVICES	3,458.57	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	RADIOLOGY	4,859.68	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
10/29/16-10/31/16	INPATIENT SERVICES	2,335.47	1,681.54	0.00	653.93	0.00	523.14	80	130.79	130.79	PDC



Claim received for JOSHUA KIMMEL
Reference # [redacted]
ID

THIS IS NOT A BILL

Claim Detail (continued)

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/ Deductible	What my plan paid	% paid	Coinsurance*	What I owe	See notes
10/29/16-10/31/16	INPATIENT SERVICES	339.00	0.00	0.00	0.00	0.00	0.00	0	0.00	0.00	
Total		**$29,018.66**	**$19,252.73**	**$0.00**	**$9,765.93**	**$500.00**	**$7,412.74**		**$1,853.19**	**$2,353.19**	

** After you have met your deductible, the costs of covered expenses are shared by you and your health plan. The percentage of covered expenses you are responsible for is called coinsurance.*

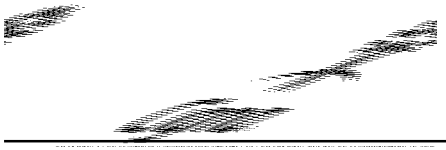
Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description typically governs this, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.

What I need to know for my next claim

You have paid a total of $500.00 toward your $500.00 individual network deductible for the calendar year
You have paid a total of $500.00 toward your $1,000.00 family network deductible for the calendar year
You have paid a total of $2,456.11 toward your $3,000.00 individual network out-of-pocket maximum for the calendar year
You have paid a total of $3,076.11 toward your $6,000.00 family network out-of-pocket maximum for the calendar year
The balances shown above are as of Nov 09, 2016, the day the claim was finalized. However, the balances on the website are updated daily, so the balances shown here may not match those listed on your participant website at MyCigna.com.

Notes

PAA - CIGNA NETWORK DISCOUNT APPLIED. MEMBER NOT LIABLE.
PDC - CIGNA NETWORK DISCOUNT APPLIED. MEMBER NOT LIABLE.

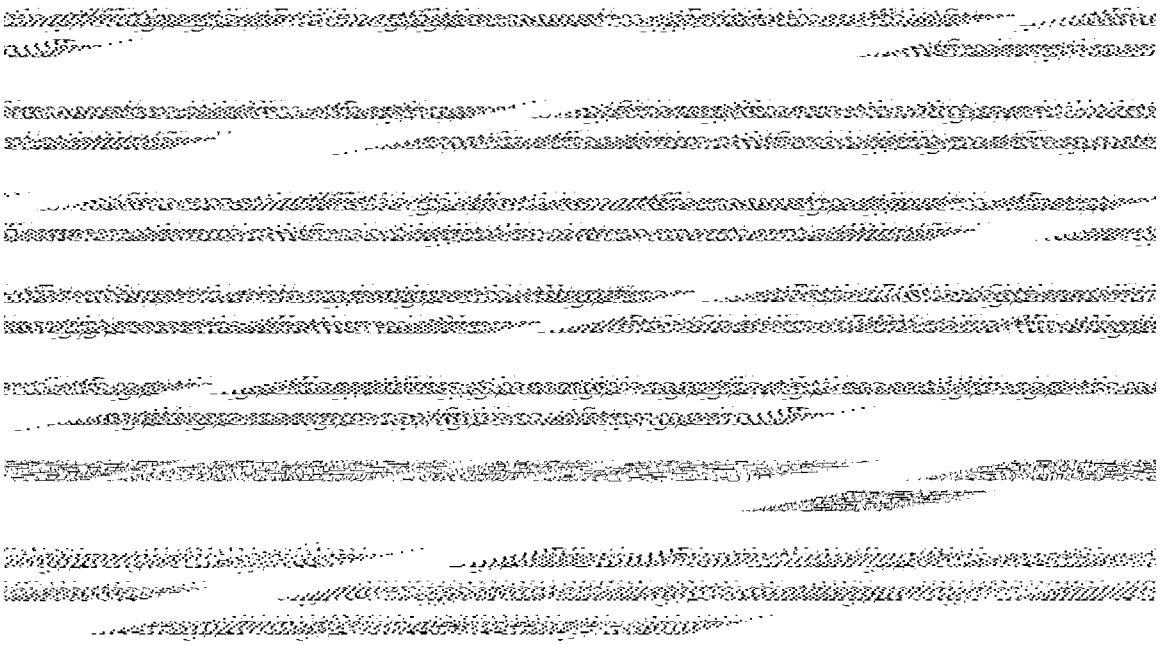


Claim received for JOSHUA KIMMEL
Reference # [redacted]
ID

THIS IS NOT A BILL

Additional appeal information related to the Patient Protection and Affordable Care Act of 2010

If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, please either contact your Health Care Professional, or go to http://www.cigna.com/privacy/privacy_healthcare_forms.html or call the Customer Service number on the back of your ID card.
If you are not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements. For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.askebsa.dol.gov.



[redacted]

RETAIN THIS FOR YOUR RECORDS.

Exhibit D

AFFIDAVIT OF JOSHUA KIMMEL

I, Joshua Kimmel, declare:

1. I served honorably in the United States Army from 1994 until my discharge as an E-5 in October 1999.

2. I currently live in Dade City, Florida.

3. I suffer from several service-connected conditions, including nerve damage in my arm; as well as conditions in my back, knees, ankles, spine, etc. I currently have a 70% total disability rating.

4. In late 2016 I was living in Brandon, Florida and the closest VA Hospital to me was 45 to 60 minutes away.

5. My elbow began to display numerous troubling symptoms, including swelling and pain, and I went to see my non-VA primary care physician ("PCP"). My PCP advised that I go to the emergency room ("ER") immediately, as I had an infection in my elbow that posed a risk of amputation of my arm; as well as potentially death.

6. As the closest VA hospital was 45 to 60 minutes away, I went to the local ER at Brandon Regional Hospital.

7. The doctors informed me that my infection was at risk of spreading to my joints and my bloodstream and immediately prescribed antibiotics to stop staphylococcus infection from spreading from the cellulitis.

8. I remained in the hospital from October 29, 2016, to November 1, 2016.

9. I have, and had at the time, Cigna health insurance, which took care of the bulk of the bill.

10. I was left with a payment of $2,353.00.

11. After my medical emergency, I referred the hospital to the VA to pay the remaining balance of my bill. However, when the VA failed to pay, the hospital sent my bill to a collections agency, which at first constantly contacted me regarding payment. I always referred them to the VA as it was my understanding the VA was responsible for paying this bill. Eventually the collections agency stopped contacting me.

12. I found out that the debt hurt my credit score months later when I attempted to refinance my house but was unable to due to my impaired credit score.

13. I was forced to take money out of my retirement plan in order to pay this debt so I could begin rebuilding my credit score and financial health.

14. Since my ER incident I have spent countless hours battling the hospital, the collections agency, VA patient care and others to get this resolved. I have contacted veterans service organization ("VSOs"), law firms and my senator.

15. I am still unable to refinance my home.

16. To this day, VA has not covered a single penny of the cost of the October 2016 emergency medical care that I received from Brandon Regional Hospital.

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

Dated: 12/10/2019

Joshua Kimmel

JoshKimmel is personally known to me. executed 12/10/19 Hillsborough County Florida

NOTARY PUBLIC STATE OF FLORIDA
REBECCA FIORE
Commission # GG 188001
Expires March 27, 2022
Bonded Thru Budget Notary Services

Exhibit E

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

VHA OCC
PO Box 469060
Denver CO 80246-9060

May 2019

Department of Veterans Affairs

79 99 41690 **********AUTO**ALL FOR AADC 335
Joshua Ray Kimmel
34184 Oak Hammock Dr
Dade City, FL 33523-8746

Dear Joshua Kimmel,

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

The Department of Veteran Affairs (VA) recently received and processed a claim for emergency treatment furnished to you by a non-VA provider in connection with the episode(s) of care listed on reverse side.

Your claim was properly rejected for lack of needed information, as described below, but there was content in the rejection notice that may have been misleading or confusing. In describing the criteria for reimbursement under 38 U.S.C. 1725, the notice incorrectly stated that VA cannot reimburse claims if the Veteran has other health insurance (OHI). In fact, when a Veteran has OHI, VA is a secondary payer, meaning VA pays after any payment by OHI up to the VA maximum allowable amount, provided all the criteria for VA reimbursement are met.

Your claim was rejected because our records indicate you have OHI, but we do not have an Explanation of Benefits (EOB) or other remittance from the insurance company or your provider to show what was paid by OHI. This information is required for VA to determine if VA reimbursement is allowable.

We have requested the EOB or Remittance Advice from your community provider. You may also submit this information. If required information is not received, we cannot take any further action.

It is important to note that VA has no legal authority to pay a Veteran's cost shares, deductibles, or copayments associated with their other health insurance.

If you or your provider have already submitted OHI information or you have any questions, please contact us at 1-877-466-7124.

Scott Fromm
Executive Director, Delivery Operations

**Please see reverse side for Episode of Care Date(s)*

Exhibit F

Rejected, and Rejection Letter Contained Erroneous Language (Template 4)

This letter is being sent to you by the Department of Veteran Affairs (VA) as a result of an Order of the U.S. Court of Appeals for Veterans Claims ("the Court") in the class action known as *Wolfe v. Wilkie,* 32 Vet. App. 1 (2019) ('the *Wolfe* case"). VA received and processed your claim or claims for reimbursement of costs you incurred in connection with the episode(s) of care referenced in this notice. Between January 8, 2018 and February 8, 2019, you received one or more notices from VA stating that your claim was rejected because we lacked information needed to process the claim.

Your claim was initially rejected for lack of needed information, as described below, but there was content in the rejection notice that may have been misleading or confusing. In describing the criteria for reimbursement under 38 U.S.C. 1725, the notice incorrectly stated that VA cannot reimburse claims if the Veteran has other health insurance (OHI).

After you received notice that your claim or claims were rejected, VA may have mailed you a second notice stating that VA lacked authority under the applicable statute, 38 U.S.C. 1725, to reimburse Veterans for the coinsurance and deductible amounts they owed under their health insurance plan. On September 9, 2019, the Court ruled in the *Wolfe* case that VA's interpretation of the applicable statute was wrong and that VA cannot deny reimbursement of coinsurance and deductible amounts owed by a veteran under a health insurance plan.

Although your claim was initially rejected because VA lacked information necessary to process the claim, we recognize that your decision as to whether to continue to pursue your reimbursement claim or claims may have been impacted by VA's erroneous statement of the law.

If you have not submitted the needed information, we encourage you to do so. Once the needed information is received, your claim will be processed in accordance with current applicable law.

{Signature}

{Contact Information}

Exhibit G

COLONY BRANDS, INC.
1112 7TH AVENUE
MONROE WI 53566

Forwarding Service Requested

**********SCH 3-DIGIT 612
3083 1 AT 0.399 15
AMANDA J WOLFE
[redacted]

Customer Service

Date: 10/10/16
Group: 325 COLONY BRANDS, INC.
EOB#: 1610105058

Claim status information or other questions relating to coverage may be answered by contacting the Customer Service number at 800-240-7976 and follow the prompts.

As a reminder --- All specialty visits require Pre-Certification.

Explanation of Benefits

Patient Name: AMANDA J WOLFE
Claim Number: 201609230684

Provider: MERCY MEDICAL CENTER CLINTON

Dates of Service	Procedure Description	Charge Amount	Ineligible Amount	Discount Amount	Deductible Amount	Copay Amount	Co-ins Amount	R & C Amount	Penalty Amount	Remark Code	Paid Amount	Paid To	You May Owe
09/16-09/16/2016	PHARMACY-GENERAL CLASSIFICATION	$352.00	$0.00	$35.20	$200.00	$200.00	$23.36	$0.00	$0.00	1	$93.44	PROVIDER	$223.36
09/17-09/17/2016	PHARMACY-GENERAL CLASSIFICATION	$3.25	$0.00	$0.32	$2.93	$2.93	$0.00	$0.00	$0.00	1	$0.00	NO PAYMT	$2.93
09/16-09/16/2016	IV THERAPY-GENERAL CLASSIFICATION	$553.00	$0.00	$55.30	$0.00	$0.00	$99.54	$0.00	$0.00	1	$398.16	PROVIDER	$99.54
09/16-09/16/2016	IV THERAPY-GENERAL CLASSIFICATION	$128.00	$0.00	$12.80	$0.00	$0.00	$23.04	$0.00	$0.00	1	$92.16	PROVIDER	$23.04
09/16-09/16/2016	IV THERAPY-GENERAL CLASSIFICATION	$244.00	$0.00	$24.40	$0.00	$0.00	$43.92	$0.00	$0.00	1	$175.68	PROVIDER	$43.92
09/16-09/16/2016	IV THERAPY-GENERAL CLASSIFICATION	$120.00	$0.00	$12.00	$0.00	$0.00	$21.60	$0.00	$0.00	1	$86.40	PROVIDER	$21.60
09/16-09/16/2016	LABORATORY-GENERAL CLASS	$87.00	$0.00	$8.70	$0.00	$0.00	$15.66	$0.00	$0.00	1	$62.64	PROVIDER	$15.66
09/16-09/16/2016	LABORATORY-CHEMISTRY	$136.00	$0.00	$13.60	$0.00	$0.00	$24.48	$0.00	$0.00	1	$97.92	PROVIDER	$24.48
09/16-09/16/2016	LABORATORY-CHEMISTRY	$170.00	$0.00	$17.00	$0.00	$0.00	$30.60	$0.00	$0.00	1	$122.40	PROVIDER	$30.60
09/16-09/16/2016	LABORATORY-CHEMISTRY	$134.00	$0.00	$13.40	$0.00	$0.00	$24.12	$0.00	$0.00	1	$96.48	PROVIDER	$24.12
09/16-09/16/2016	LABORATORY-HEMATOLOGY	$93.00	$0.00	$9.30	$0.00	$0.00	$16.74	$0.00	$0.00	1	$66.96	PROVIDER	$16.74
09/16-09/16/2016	LABORATORY-BACTERIOLOGY AND MICROBIOLOGY	$172.00	$0.00	$17.20	$0.00	$0.00	$30.96	$0.00	$0.00	1	$123.84	PROVIDER	$30.96
09/16-09/16/2016	LABORATORY-BACTERIOLOGY AND MICROBIOLOGY	$172.00	$0.00	$17.20	$0.00	$0.00	$30.96	$0.00	$0.00	1	$123.84	PROVIDER	$30.96
09/16-09/16/2016	LABORATORY-BACTERIOLOGY AND MICROBIOLOGY	$105.00	$0.00	$10.50	$0.00	$0.00	$18.90	$0.00	$0.00	1	$75.60	PROVIDER	$18.90
09/16-09/16/2016	LABORATORY-UROLOGY	$75.00	$0.00	$7.50	$0.00	$0.00	$13.50	$0.00	$0.00	1	$54.00	PROVIDER	$13.50
09/16-09/16/2016	LABORATORY PATHOLOGICAL-HISTOLOGY	$226.00	$0.00	$22.60	$0.00	$0.00	$40.68	$0.00	$0.00	1	$162.72	PROVIDER	$40.68
09/16-09/16/2016	CT SCAN-BODY SCAN	$2,663.00	$0.00	$266.30	$0.00	$0.00	$479.34	$0.00	$0.00	1	$1,917.36	PROVIDER	$479.34
09/16-09/16/2016	OPERATING ROOM SERVICES-GENERAL CLASS	$7,414.00	$0.00	$741.40	$0.00	$0.00	$1,312.41	$0.00	$0.00	1 2	$5,249.64	PROVIDER	$1,312.41
		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$110.55		$0.00
09/16-09/16/2016	ANESTHESIA-GENERAL CLASSIFICATION	$2,391.00	$0.00	$239.10	$0.00	$0.00	$0.00	$0.00	$0.00	1	$2,151.90	PROVIDER	$0.00
09/16-09/16/2016	EMERGENCY ROOM-GENERAL CLASS	$1,422.00	$0.00	$142.20	$0.00	$0.00	$0.00	$0.00	$0.00	1	$1,279.80	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$61.00	$0.00	$6.10	$0.00	$0.00	$0.00	$0.00	$0.00	1	$54.90	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$57.00	$0.00	$5.70	$0.00	$0.00	$0.00	$0.00	$0.00	1	$51.30	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$168.00	$0.00	$16.80	$0.00	$0.00	$0.00	$0.00	$0.00	1	$151.20	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$59.00	$0.00	$5.90	$0.00	$0.00	$0.00	$0.00	$0.00	1	$53.10	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$90.00	$0.00	$9.00	$0.00	$0.00	$0.00	$0.00	$0.00	1	$81.00	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$50.00	$0.00	$5.00	$0.00	$0.00	$0.00	$0.00	$0.00	1	$45.00	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$174.00	$0.00	$17.40	$0.00	$0.00	$0.00	$0.00	$0.00	1	$156.60	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$68.00	$0.00	$6.80	$0.00	$0.00	$0.00	$0.00	$0.00	1	$61.20	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$59.00	$0.00	$5.90	$0.00	$0.00	$0.00	$0.00	$0.00	1	$53.10	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$52.00	$0.00	$5.20	$0.00	$0.00	$0.00	$0.00	$0.00	1	$46.80	PROVIDER	$0.00
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$255.00	$0.00	$25.50	$0.00	$0.00	$0.00	$0.00	$0.00	1	$229.50	PROVIDER	$0.00

Patient Name: AMANDA J WOLFE
Claim Number: 201609230684

Provider: MERCY MEDICAL CENTER CLINTON

Dates of Service	Procedure Description	Charge Amount	Ineligible Amount	Discount Amount	Deductible Amount	Copay Amount	Co-ins Amount	R & C Amount	Penalty Amount	Remark Code	Paid Amount	Paid To	You May Owe
09/16-09/16/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$200.00	$0.00	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00	1	$180.00	PROVIDER	$0.00
09/17-09/17/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$73.00	$0.00	$7.30	$0.00	$0.00	$0.00	$0.00	$0.00	1	$65.70	PROVIDER	$0.00
09/17-09/17/2016	DRUGS REQUIRING SPECIFIC IDENTIFICATION DRUGS	$60.00	$0.00	$6.00	$0.00	$0.00	$0.00	$0.00	$0.00	1	$54.00	PROVIDER	$0.00
09/16-09/16/2016	GENERAL CLASS RECOVERY ROOM	$2,056.00	$0.00	$205.60	$0.00	$0.00	$0.00	$0.00	$0.00	1	$1,850.40	PROVIDER	$0.00
	CLAIM TOTALS	**$20,142.25**	**$0.00**	**$2,014.22**	**$0.00**	**$202.93**	**$2,249.81**	**$0.00**	**$0.00**				
									Total Payment		**$15,675.**		**$2,452.74**

Patient Name: AMANDA J WOLFE
Claim Number: 201609261550

Provider: KELSEY J MORAN MD

Dates of Service	Procedure Description	Charge Amount	Ineligible Amount	Discount Amount	Deductible Amount	Copay Amount	Co-ins Amount	R & C Amount	Penalty Amount	Remark Code	Paid Amount	Paid To	You May Owe
09/16-09/16/2016	CT ABD & PELVIS W/CONTRAST	$321.23	$0.00	$174.38	$0.00	$0.00	$0.00	$0.00	$0.00	1	$146.85	DOCTOR	$0.00
	CLAIM TOTALS	**$321.23**	**$0.00**	**$174.38**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**				
									Total Payment		**$146.85**		**$0.00**

Patient Name: AMANDA J WOLFE
Claim Number: 201609270437

Provider: SHARON L MARGUGLIO NP

Dates of Service	Procedure Description	Charge Amount	Ineligible Amount	Discount Amount	Deductible Amount	Copay Amount	Co-ins Amount	R & C Amount	Penalty Amount	Remark Code	Paid Amount	Paid To	You May Owe
09/16-09/16/2016	BLD# COMPL AUTO HHRWP&AUTO DIFFIAL	$49.00	$0.00	$36.86	$0.00	$0.00	$0.00	$0.00	$0.00	1	$12.14	PROVIDER	$0.00
09/16-09/16/2016	URINE PREGNANCY TST VIS COLOR CMPRSN METHS	$44.00	$0.00	$33.91	$0.00	$0.00	$0.00	$0.00	$0.00	1	$10.09	PROVIDER	$0.00
09/16-09/16/2016	URNLS DIP STICK/TABLET RGNT AUTO MIC	$36.00	$0.00	$30.97	$0.00	$0.00	$0.00	$0.00	$0.00	1	$5.03	PROVIDER	$0.00
09/16-09/16/2016	COLLJ VEN BLD VNPNXR	$16.00	$0.00	$11.96	$0.00	$0.00	$0.00	$0.00	$0.00	1	$4.04	PROVIDER	$0.00
	CLAIM TOTALS	**$145.00**	**$0.00**	**$113.70**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**				
									Total Payment		**$31.30**		**$0.00**

Patient Name: AMANDA J WOLFE
Claim Number: 201609270450

Provider: SHARON L MARGUGLIO NP

Dates of Service	Procedure Description	Charge Amount	Ineligible Amount	Discount Amount	Deductible Amount	Copay Amount	Co-ins Amount	R & C Amount	Penalty Amount	Remark Code	Paid Amount	Paid To	You May Owe
09/16-09/16/2016	OFFICE OUTPT NEW 20 MINUTES	$147.00	$0.00	$44.56	$0.00	$0.00	$0.00	$0.00	$0.00	1	$102.44	PROVIDER	$0.00
	CLAIM TOTALS	**$147.00**	**$0.00**	**$44.56**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**				
									Total Payment		**$102.44**		**$0.00**

Remark Code Description

Code	Description
1	PHCSHD PPO DISCOUNT Patient is not responsible for this amount
2	Your individual out of pocket amount has been met for this calendar year.

Deductible/Out-of-Pocket Summary

Member Name	Description	Year	Amount
AMANDA J	Medical Deductible	2015	$888.05
AMANDA J	Medical Out-Of-Pckt	2015	$948.05
AMANDA J	Medical Deductible	2016	$1,000.00
AMANDA J	Medical Out-Of-Pckt	2016	$4,000.00

Your Right to Appeal

You and/or your representative may submit a written request for a review within 180 days of this notice which should include the date of your request, your printed name and/or the printed name of your representative, the information from the top portion of your Explanation of Benefits, and the date of service in question. Send this information to Colony Brands, Inc. Benefits Department at 1112 Seventh Ave. Monroe, WI 53566 or call 800-240-7976. Colony Brands, Inc. will provide a written reply to your request for review within 30 days of receipt and no later than 60 days under special circumstances..

Please call the number located above if you need diagnosis and/or treatment code information for this claim.

COLONY BRANDS, INC.
1112 7TH AVENUE
MONROE WI 53566

Forwarding Service Requested

**********SCH 3-DIGIT 612
16975 1 AT 0.399 58
AMANDA J WOLFE
[redacted]

Customer Service

Date: 10/03/16
Group: 325 COLONY BRANDS, INC.
EOB#: 1610036672

Claim status information or other questions relating to coverage may be answered by contacting the Customer Service number at 800-240-7976 and follow the prompts.

As a reminder --- All specialty visits require Pre-Certification.

Explanation of Benefits

Patient Name: AMANDA J WOLFE
Claim Number: 201609232292

Provider: RICKY P MADDOX MD

Dates of Service	Procedure Description	Charge Amount	Ineligible Amount	Discount Amount	Deductible Amount	Copay Amount	Co-Ins Amount	R & C Amount	Penalty Amount	Remark Code	Paid Amount	Paid To	You May Owe
09/16-09/16/2016	1ST OBS CARE PR D HIGH SEVERITY	$225.00	$225.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	1	$0.00	NO PAYMT	$0.00
09/16-09/16/2016	LAPS SURG APPENDEC	$1,981.00	$0.00	$1,452.99	$0.00	$0.00	$105.60	$0.00	$0.00	2	$422.41	DOCTOR	$105.60
	CLAIM TOTALS	**$2,206.00**	**$225.00**	**$1,452.99**	**$0.00**	**$0.00**	**$105.60**	**$0.00**	**$0.00**				
										Total Payment	**$422.41**		**$105.60**

Remark Code Description

Code	Description
1	This service is included in the primary procedure and should not be billed separately.
2	PHCSHD PPO DISCOUNT Patient is not responsible for this amount

Deductible/Out-of-Pocket Summary

Member Name	Description	Year	Amount
AMANDA J	Medical Deductible	2015	$888.05
AMANDA J	Medical Out-Of-Pckt	2015	$948.05
AMANDA J	Medical Deductible	2016	$1,000.00
AMANDA J	Medical Out-Of-Pckt	2016	$1,547.26

Your Right to Appeal

You and/or your representative may submit a written request for a review within 180 days of this notice which should include the date of your request, your printed name and/or the printed name of your representative, the information from the top portion of your Explanation of Benefits, and the date of service in question. Send this information to Colony Brands, Inc. Benefits Department at 1112 Seventh Ave. Monroe, WI 53566 or call 800-240-7976. Colony Brands, Inc. will provide a written reply to your request for review within 30 days of receipt and no later than 60 days under special circumstances..

Please call the number located above if you need diagnosis and/or treatment code information for this claim.

COLONY BRANDS, INC.
1112 7TH AVENUE
MONROE WI 53566

Forwarding Service Requested

**********SCH 3-DIGIT 612
15083 1 AT 0.399 54
AMANDA J WOLFE
[redacted]

Customer Service

Date: 10/31/16
Group: 325 COLONY BRANDS, INC.
EOB#: 1610312615

Claim status information or other questions relating to coverage may be answered by contacting the Customer Service number at 800-240-7976 and follow the prompts.

As a reminder --- All specialty visits require Pre-Certification.

Explanation of Benefits

Patient Name: AMANDA J WOLFE
Claim Number: 201609273361

Provider: MICHAEL L WOLTMAN MD

Dates of Service	Procedure Description	Charge Amount	Ineligible Amount	Discount Amount	Deductible Amount	Copay Amount	Co-Ins Amount	R & C Amount	Penalty Amount	Remark Code	Paid Amount	Paid To	You May Owe
09/16-09/16/2016	LEVEL III-SURG PATH GROSS&MICROSCOPIC XM	$65.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$65.00	DOCTOR	$0.00
	CLAIM TOTALS	**$65.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**				
										Total Payment	**$65.00**		**$0.00**

Deductible/Out-of-Pocket Summary

Member Name	Description	Year	Amount
AMANDA J	Medical Deductible	2015	$888.05
AMANDA J	Medical Out-Of-Pckt	2015	$948.05
AMANDA J	Medical Deductible	2016	$1,000.00
AMANDA J	Medical Out-Of-Pckt	2016	$4,000.00

Your Right to Appeal

You and/or your representative may submit a written request for a review within 180 days of this notice which should include the date of your request, your printed name and/or the printed name of your representative, the information from the top portion of your Explanation of Benefits, and the date of service in question. Send this information to Colony Brands, Inc. Benefits Department at 1112 Seventh Ave. Monroe, WI 53566 or call 800-240-7976. Colony Brands, Inc. will provide a written reply to your request for review within 30 days of receipt and no later than 60 days under special circumstances..

Please call the number located above if you need diagnosis and/or treatment code information for this claim.

COLONY BRANDS, INC.
1112 7TH AVENUE
MONROE WI 53566

Forwarding Service Requested

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AMANDA J WOLFE
[redacted]

Customer Service

Date: 10/31/16
Group: 325 COLONY BRANDS, INC.
EOB#: 1610312723

Claim status information or other questions relating to coverage may be answered by contacting the Customer Service number at 800-240-7976 and follow the prompts.

As a reminder --- All specialty visits require Pre-Certification.

Explanation of Benefits

Patient Name: AMANDA J WOLFE
Claim Number: 201610112448

Provider: CHRISTINA M SHIMAK DO

Dates of Service	Procedure Description	Charge Amount	Ineligible Amount	Discount Amount	Deductible Amount	Copay Amount	Co-ins Amount	R & C Amount	Penalty Amount	Remark Code	Paid Amount	Paid To	You May Owe
09/16-09/16/2016	EMER DEPT HIGH SEVERITY&THREAT FUNCJ	$1,177.00	$0.00	$58.85	$0.00	$0.00	$0.00	$0.00	$0.00	1	$1,118.15	PROVIDER	$0.00
	CLAIM TOTALS	**$1,177.00**	**$0.00**	**$58.85**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**				
									Total Payment		**$1,118.15**		**$0.00**

Remark Code Description

Code	Description
1	PHCSHD PPO DISCOUNT Patient is not responsible for this amount

Deductible/Out-of-Pocket Summary

Member Name	Description	Year	Amount
AMANDA J	Medical Deductible	2015	$888.05
AMANDA J	Medical Out-Of-Pckt	2015	$948.05
AMANDA J	Medical Deductible	2016	$1,000.00
AMANDA J	Medical Out-Of-Pckt	2016	$4,000.00

Your Right to Appeal

You and/or your representative may submit a written request for a review within 180 days of this notice which should include the date of your request, your printed name and/or the printed name of your representative, the information from the top portion of your Explanation of Benefits, and the date of service in question. Send this information to Colony Brands, Inc. Benefits Department at 1112 Seventh Ave. Monroe, WI 53566 or call 800-240-7976. Colony Brands, Inc. will provide a written reply to your request for review within 30 days of receipt and no later than 60 days under special circumstances..

Please call the number located above if you need diagnosis and/or treatment code information for this claim.

COLONY BRANDS, INC.
1112 7TH AVENUE
MONROE WI 53566

Forwarding Service Requested

AMANDA J WOLFE
[redacted]

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Customer Service

Date: 10/10/16
Group: 325 COLONY BRANDS, INC.
EOB#: 1610105331

Claim status information or other questions relating to coverage may be answered by contacting the Customer Service number at 800-240-7976 and follow the prompts.

As a reminder --- All specialty visits require Pre-Certification.

Explanation of Benefits

Patient Name: AMANDA J WOLFE
Claim Number: 201609215840

Provider COLE ASAY CRNA

Dates of Service	Procedure Description	Charge Amount	Ineligible Amount	Discount Amount	Deductible Amount	Copay Amount	Co-Ins Amount	R & C Amount	Penalty Amount	Remark Code	Paid Amount	Paid To	You May Owe
09/16-09/16/2016	ANESTHESIA INTRAPERITONEAL LOWER ABD W/LAPS	$750.00	$0.00	$300.00	$0.00	$0.00	$0.00	$0.00	$0.00	1	$450.00	PROVIDER	$0.00
	CLAIM TOTALS	**$750.00**	**$0.00**	**$300.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**				
									Total Payment		**$450.00**		**$0.00**

Remark Code Description

Code	Description
1	This reimbursement is in Accordance With Contracts with HEALTHSMART/HPO 888-266-3053.

Deductible/Out-of-Pocket Summary

Member Name	Description	Year	Amount
AMANDA J	Medical Deductible	2015	$888.05
AMANDA J	Medical Out-Of-Pckt	2015	$948.05
AMANDA J	Medical Deductible	2016	$1,000.00
AMANDA J	Medical Out-Of-Pckt	2016	$4,000.00

Your Right to Appeal

You and/or your representative may submit a written request for a review within 180 days of this notice which should include the date of your request, your printed name and/or the printed name of your representative, the information from the top portion of your Explanation of Benefits, and the date of service in question. Send this information to Colony Brands, Inc. Benefits Department at 1112 Seventh Ave. Monroe, WI 53566 or call 800-240-7976. Colony Brands, Inc. will provide a written reply to your request for review within 30 days of receipt and no later than 60 days under special circumstances..

Please call the number located above if you need diagnosis and/or treatment code information for this claim.

Exhibit H

DEPARTMENT OF VETERANS AFFAIRS
Iowa City VA Health Care System
Attn: Non VA Care (136B)
601 Hwy 6 West
Iowa City, IA 52246

02/07/2018

UB Claim ID#: 752227
Non-VA Medical Care Program: 38 U.S.C. §1725

WOLFE AMANDA JANE
[redacted]

Provider: MERCY MEDICAL CENTER
Episode of Care Beginning: 09/16/2016

The claim noted above has been reviewed to determine if it meets eligibility requirements for payment of non-VA emergency treatment of a non-service connected condition under 38 United States Code (U.S.C.) §1725. Based on the review, we regret to inform you that your claim does not meet the requirements and has been disapproved for the reason(s) listed below:

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

The following eligibility criteria must be met in order for the VA to reimburse the non-VA provider on your behalf:
(1) Treatment was emergent according to the prudent layperson standard;
(2) Veteran is financially liable to the provider for emergency treatment;
(3) Veteran is enrolled in the VA health care system and received treatment within a 24-month period preceding emergency care;
(4) Veteran has no coverage under a health plan contract;
(5) Veteran has no other contractual or legal recourse against a third party that would, in whole extinguish liability to the provider;
(6) VA facilities were not feasibly available and an attempt to use them beforehand would have been hazardous to life or health by prudent layperson standard; and
(7) Emergency services were provided in a hospital emergency department, a free standing urgent care clinic, or a similar facility held out as providing urgent or emergency care to the public up to the point of medical stability.

The absence of any one of these criteria precludes payment by the US Department of Veterans Affairs.

If your claim is denied for auto insurance, third party liability, please forward proof that auto insurance did not fully cover your claim. Based on the additional information the claim may be entitled for reimbursement.

If you do not agree with this decision, you have the right to appeal within one year of the denial by submitting a written notice of disagreement and providing any new or relevant information.

You may appoint a Veteran Service Organization to assist you in preparing your written notice of disagreement by completing and signing VA Form 21-22, "Appointment of Veterans Service Organization as Claimants Representative" or VA Form 21-22a, "Appointment of Individual as Claimants Representative" to appoint an accredited representative. These VA Forms are available at www.va.gov/vaforms. If you are unable to access these VA forms, you may contact us at (319) 688-3889.

Please read the information provided carefully so that you will clearly understand the procedural and appellate rights in connection with any denied services.

If you have any questions or concerns, please contact us at the above address or call (319) 688-3889.

You may contact the numbers below based on the first letter of your last name:

A-F - 319-351-1110 x7885 G-L - 319-351-1110 x6281

M-R - 319-351-1110 x7880 S- Z & Dental - 319-351-1110 x5405

Sincerely,

Iowa City VA Health Care System

Supervisor, Non-VA Care Office

Attachments:

~~Veterans Claims Assistance Act Notice (VCAA)~~
VA4107VHA, Notice of Procedural Appellate Rights

Department of Veterans Affairs

YOUR RIGHTS TO APPEAL OUR DECISION

After careful and compassionate consideration, a decision has been reached on your claim. If we were not able to grant some or all of the VA benefits you asked for, this form will explain what you can do if you disagree with our decision. If you do not agree with our decision, you may:

- Start an appeal by telling us you disagree with our decision.
- Give us evidence we do not already have that may lead us to change our decision.

This form will tell you how to appeal and how to send us more evidence. You can do either one or both of these things.

HOW CAN I APPEAL THE DECISION?

How do I start my appeal? To begin your appeal, write us a letter telling us you disagree with our decision. This letter is called your "Notice of Disagreement." If we denied more than one claim for a benefit, please tell us in your letter which claims you are appealing. ***Send your Notice of Disagreement to the address included on our decision notice letter.***

How long do I have to start my appeal? You have one year to start an appeal of our decision. ***Your*** letter saying that you disagree with our decision must be postmarked (or received by us) within one year from the date of ***our*** letter denying you the benefit. In most cases, you cannot appeal a decision after this one-year period has ended.

What happens if I do not start my appeal on time? If you do not start your appeal on time, our decision will become final. Once our decision is final, you cannot get the VA benefit we denied unless you either:

- Show that we were clearly wrong to deny the benefit **or**
- Send us new evidence that relates to the reason we denied your claim.

What happens after VA receives my Notice of Disagreement? We will either grant your claim or send you a Statement of the Case. A Statement of the Case describes the facts, laws, regulations, and reasons that we used to make our decision. We will also send you a VA Form 9, "Appeal to Board of Veterans' Appeals," with the Statement of the Case. If you want to continue your appeal to the Board of Veterans' Appeals (Board) after receiving a Statement of the Case, you must complete and return the VA Form 9 within one year from the date of our letter denying you the benefit ***or*** within 60 days from the date that we mailed the Statement of the Case to you, ***whichever is later.*** If you decide to complete an appeal by filing a VA Form 9, you have the option to request a Board hearing. Hearings often increase wait time for a Board decision. It is not necessary for you to have a hearing for the Board to decide your appeal. It is your choice.

Where can I find out more about the VA appeals process?

- You can find a "plain language" pamphlet called "How Do I Appeal," on the Internet at: http://www.bva.va.gov/How_Do_I_Appeal.asp.
- You can find the formal rules for the VA appeals process in title 38, Code of Federal Regulations, Part 20. You can find the complete Code of Federal Regulations on the Internet at: http://www.ecfr.gov. A printed copy of the Code of Federal Regulations may be available at your local law library.

YOUR RIGHT TO REPRESENTATION

Can I get someone to help me with my appeal? Yes. You can have a Veterans Service Organization representative, an attorney-at-law, or an "agent" help you with your appeal. You are not required to have someone represent you. It is your choice.

- Representatives who work for accredited Veterans Service Organizations know how to prepare and present claims and will represent you. You can find a listing of these organizations on the Internet at http://www.va.gov/vso.

VA FORM JUN 2016 **4107VHA**

(Please continue reading on page 2)

- A private attorney or an "agent" can also represent you. VA only recognizes attorneys who are licensed to practice in the United States or in one of its territories or possessions. Your local bar association may be able to refer you to an attorney with experience in veterans' law. An agent is a person who is not a lawyer, but who VA recognizes as being knowledgeable about veterans' law. Contact us if you would like to know if there is a VA accredited agent in your area.

Do I have to pay someone to help me with my appeal? It depends on who helps you. The following explains the differences.

- Veterans Service Organizations will represent you for free.
- Attorneys or agents can charge you for helping you under some circumstances. Paying their fees for helping you with your appeal is your responsibility. If you do hire an attorney or agent to represent you, a copy of any fee agreement must be sent to VA. The fee agreement must clearly specify if VA is to pay the attorney or agent directly out of past-due benefits. *See* 38 C.F.R. § 14.636(g)(2). If the fee agreement provides for the direct payment of fees out of past-due benefits, a copy of the direct-pay fee agreement must be filed with us at the address included on our decision notice letter within 30 days of its execution. A copy of any fee agreement that is not a direct-pay fee agreement must be filed with the Office of the General Counsel within 30 days of its execution by mailing the copy to the following address: Office of the General Counsel (022D), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420. *See* 38 C.F.R. § 14.636(g)(3).

GIVING VA ADDITIONAL EVIDENCE

You can send us more evidence to support a claim whether or not you choose to appeal

NOTE: Please direct all new evidence to the address included on our decision notice letter. You should not send evidence directly to the Board at this time. You should only send evidence to the Board if you decide to complete an appeal and, then, you should only send evidence to the Board after you receive written notice from the Board that they received your appeal.

If you have more evidence to support a claim, it is in your best interest to give us that evidence as soon as you can. We will consider your evidence and let you know whether it changes our decision. Please keep in mind that we can only consider new evidence that: (1) we have not already seen and (2) relates to your claim. You may give us this evidence either in writing or at a personal hearing with your local VA office.

In writing. To support your claim, you may send documents and written statements to us at the address included on our decision notice letter. Tell us in a letter how these documents and statements should change our earlier decision.

At a personal hearing. You may request a hearing with an employee at your local VA office at any time, whether or not you choose to appeal. We do not require you to have a local hearing. It is your choice. At this hearing, you may speak, bring witnesses to speak on your behalf, and hand us written evidence. If you want a local hearing, send us a letter asking for a local hearing. Use the address included on our decision notice letter. We will then:

- Arrange a time and place for the hearing
- Provide a room for the hearing
- Assign someone to hear your evidence
- Make a written record of the hearing

WHAT HAPPENS AFTER I GIVE VA EVIDENCE?

We will review any new evidence, including the record of the local hearing, if you choose to have one, together with the evidence we already have. We will then decide if we can grant your claim. If we cannot grant your claim and you complete an appeal, we will send the new evidence and the record of any local hearing to the Board.

Exhibit I

OMB Control No. 2900-0321
Respondent Burden: 5 minutes
Expiration Date: 08/31/2018

Department of Veterans Affairs

APPOINTMENT OF VETERANS SERVICE ORGANIZATION AS CLAIMANT'S REPRESENTATIVE

Note - If you would prefer to have an individual assist you with your claim, you may use VA Form 21-22a, " Appointment of Individual as Claimant's Representative." VA Forms are available at www.va.gov/vaforms.

IMPORTANT - PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN ON REVERSE BEFORE COMPLETING THE FORM.

1. LAST-FIRST-MIDDLE NAME OF VETERAN	2. VA FILE NUMBER *(Include prefix)*
Amanda J. Wolfe	[redacted]

3A. NAME OF SERVICE ORGANIZATION RECOGNIZED BY THE DEPARTMENT OF VETERANS AFFAIRS *(See list on reverse side before selecting organization)*

National Veterans Legal Services Program

3B. NAME AND JOB TITLE OF OFFICIAL REPRESENTATIVE ACTING ON BEHALF OF THE ORGANIZATION NAMED IN ITEM 3A *(This is an appointment of the entire organization and does not indicate the designation of only this specific individual to act on behalf of the organization)*

Patrick Berkshire, Service Officer

3C. EMAIL ADDRESS OF THE ORGANIZATION NAMED IN ITEM 3A

patrick@nvlsp.org

INSTRUCTIONS - TYPE OR PRINT ALL ENTRIES

4. SOCIAL SECURITY NUMBER (OR SERVICE NUMBER, IF NO SSN)	5. INSURANCE NUMBER(S) *(Include letter prefix)*
[redacted]	
6. NAME OF CLAIMANT *(If other than veteran)*	7. RELATIONSHIP TO VETERAN
n/a	n/a
8. ADDRESS OF CLAIMANT *(No. and street or rural route, city or P.O., State and ZIP Code)*	9. CLAIMANT'S TELEPHONE NUMBERS *(Include Area Code)*
[redacted]	A. DAYTIME [redacted] B. EVENING n/a
	10. EMAIL ADDRESS *(If applicable)* [redacted]
	11. DATE OF THIS APPOINTMENT 07/05/2018

12. AUTHORIZATION FOR REPRESENTATIVE'S ACCESS TO RECORDS PROTECTED BY SECTION 7332, TITLE 38, U.S.C.
By checking the box below I authorize VA to disclose to the service organization named on this appointment form any records that may be in my file relating to treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia.

☒ I authorize the VA facility having custody of my VA claimant records to disclose to the service organization named in Item 3A all treatment records relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. Redisclosure of these records by my service organization representative, other than to VA or the Court of Appeals for Veterans Claims, is not authorized without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I revoke this authorization by filing a written revocation with VA; or (2) I revoke the appointment of the service organization named above, either by explicit revocation or the appointment of another representative.

13. LIMITATION OF CONSENT - I authorize disclosure of records related to treatment for all conditions listed in Item 12 except:

☐ DRUG ABUSE ☐ INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)
☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

14. AUTHORIZATION TO CHANGE CLAIMANT'S ADDRESS - By checking the box below, I authorize the organization named in Item 3A to act on my behalf to change my address in my VA records.

☒ I authorize any official representative of the organization named in Item 3A to act on my behalf to change my address in my VA records. This authorization does not extend to any other organization without my further written consent. This authorization will remain in effect until the earlier of the following events: (1) I file a written revocation with VA; or (2) I appoint another representative, or (3) I have been determined unable to manage my financial affairs and the individual or organization named in Item 3A is not my appointed fiduciary.

I, the claimant named in Items 1 or 6, hereby appoint the service organization named in Item 3A as my representative to prepare, present and prosecute my claim(s) for any and all benefits from the Department of Veterans Affairs (VA) based on the service of the veteran named in Item 1. I authorize VA to release any and all of my records, to include disclosure of my Federal tax information (other than as provided in Items 12 and 13), to my appointed service organization. I understand that my appointed representative will not charge any fee or compensation for service rendered pursuant to this appointment. I understand that the service organization I have appointed as my representative may revoke this appointment at any time, subject to 38 CFR 20.608. *Additionally, in some cases a veteran's income is developed because a match with the Internal Revenue Service necessitated income verification. In such cases, the assignment of the service organization as the veteran's representative is valid for only five years from the date the claimant signs this form for purposes restricted to the verification match.* Signed and accepted subject to the foregoing conditions.

THIS POWER OF ATTORNEY DOES NOT REQUIRE EXECUTION BEFORE A NOTARY PUBLIC

16. SIGNATURE OF VETERAN OR CLAIMANT *(Do Not Print)*	16. DATE SIGNED
Amanda Wolfe	7-12-18
17. SIGNATURE OF VETERANS SERVICE ORGANIZATION REPRESENTATIVE NAMED IN ITEM 3B *(Do Not Print)*	18. DATE SIGNED

VA USE ONLY	COPY OF VA FORM 21-22 SENT TO:	DATE SENT	ACKNOWLEDGED *(Date)*	REVOKED *(Reason and date)*
	☐ VR&E FILE ☐ EDU FILE ☐ LG FILE ☐ INSURANCE FILE			

NOTE: As long as this appointment is in effect, the organization named herein will be recognized as the sole representative for preparation, presentation and prosecution of your claim before the Department of Veterans Affairs in connection with your claim or any portion thereof.

VA FORM AUG 2015 **21-22** SUPERSEDES VA FORM 21-22, OCT 2014, WHICH WILL NOT BE USED.

OMB Approved No. 2900-0791
Respondent Burden: 30 minutes
Expiration Date: 09/30/2018

Department of Veterans Affairs

NOTICE OF DISAGREEMENT

A CLAIMANT OR HIS OR HER DULY APPOINTED REPRESENTATIVE MAY FILE NOTICE EXPRESSING THEIR DISSATISFACTION OR DISAGREEMENT WITH AN ADJUDICATIVE DETERMINATION BY THE VA REGIONAL OFFICE. A DESIRE TO CONTEST THE RESULT WILL CONSTITUTE A NOTICE OF DISAGREEMENT (NOD.) WHILE SPECIAL WORDING IS NOT REQUIRED, THE NOD MUST BE IN TERMS WHICH CAN BE REASONABLY CONSTRUED AS DISAGREEMENT WITH THAT DETERMINATION AND A DESIRE FOR APPELLATE REVIEW. (AUTHORITY: 38 U.S.C. 7105)

TO FILE A VALID NOD, THERE IS A TIME LIMIT OF *ONE* YEAR FROM THE DATE VA MAILED THE NOTIFICATION OF THE DECISION TO THE CLAIMANT. FOR CONTESTED CLAIMS INCLUDING CLAIMS OF APPORTIONMENT, THIS TIME LIMIT IS *60* DAYS FROM THE DATE VA MAILED THE NOTIFICATION OF THE DECISION TO THE CLAIMANT.

(DO NOT WRITE IN THIS SPACE)
(VA DATE STAMP)

NOTE: You can *either* complete the form online or by hand. Please print information using blue or black ink, neatly, and legibly to help process the form.

PART I - PERSONAL INFORMATION

1. VETERAN'S NAME *(First, middle initial, last)*

Amanda J Wolfe

2. VETERAN'S SOCIAL SECURITY NUMBER [redacted]

3. VA FILE NUMBER
C/CSS - [redacted]

CLAIMANT'S PERSONAL INFORMATION

4. CLAIMANT'S NAME *(First, middle initial, last)*

Amanda J Wolfe

5. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street [redacted]

Apt./Unit Number [redacted] City [redacted]

State/Province [redacted] Country [redacted] ZIP Code/Postal Code [redacted]

6. PREFERRED TELEPHONE NUMBER *(Include Area Code)* [redacted]

7. PREFERRED E-MAIL ADDRESS [redacted]

PART II - TELEPHONE CONTACT

8. WOULD YOU LIKE TO RECEIVE A TELEPHONE CALL OR E-MAIL FROM A REPRESENTATIVE AT YOUR LOCAL REGIONAL OFFICE REGARDING YOUR NOD?

☐ YES ☒ NO

(If you answered "Yes," VA will make up to two attempts to call you between 8:00 a.m. and 4:30 p.m. local time at the telephone number and time period you select below. Please select up to two time periods you are available to receive a phone call.)

☐ 8:00 a.m. - 10:00 a.m. ☐ 10:00 a.m. - 12:30 p.m. ☐ 12:30 p.m. - 2:00 p.m. ☐ 2:00 p.m. - 4:30 p.m.

Phone number I can be reached at the above checked time: _____

PART III - APPEAL PROCESS ELECTION

9. SELECT ONE OF THE APPEALS PROCESSING METHODS BELOW (See *Specific Instructions, Page 2, Part III* for additional information)

☐ Decision Review Officer (DRO) Review Process

☒ Traditional Appellate Review Process

VETERAN'S SSN [redacted]

PART IV - SPECIFIC ISSUES OF DISAGREEMENT

10. NOTIFICATION/DECISION LETTER DATE

02/07/2018

11. PLEASE LIST EACH SPECIFIC ISSUE OF DISAGREEMENT AND NOTE THE AREA OF DISAGREEMENT. IF YOU DISAGREE ON THE EVALUATION OF A DISABILITY, SPECIFY PERCENTAGE EVALUATION SOUGHT, IF KNOWN. PLEASE LIST ONLY ONE DISABILITY IN EACH BOX. YOU MAY ATTACH ADDITIONAL SHEETS IF NECESSARY.

A. Specific Issue of Disagreement	B. Area of Disagreement	C. Percentage (%) Evaluation Sought *(If known)*
Entitlement to reimbursement for emergency medical expenses incurred on 9/16/2016 at Mercy Med. Center.	☐ Service Connection ☐ Effective Date of Award ☐ Evaluation of Disability ☒ Other *(Please specify below)* 38 U.S.C. § 1725 claim	
	☐ Service Connection ☐ Effective Date of Award ☐ Evaluation of Disability ☐ Other *(Please specify below)*	
	☐ Service Connection ☐ Effective Date of Award ☐ Evaluation of Disability ☐ Other *(Please specify below)*	
	☐ Service Connection ☐ Effective Date of Award ☐ Evaluation of Disability ☐ Other *(Please specify below)*	
	☐ Service Connection ☐ Effective Date of Award ☐ Evaluation of Disability ☐ Other *(Please specify below)*	

12A. IN THE SPACE BELOW, OR ON A SEPARATE PAGE, PLEASE EXPLAIN WHY YOU FEEL WE INCORRECTLY DECIDED YOUR CLAIM, AND LIST ANY DISAGREEMENT(S) NOT COVERED ABOVE:

The Department of Veterans Affairs' ("VA") 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. Further, the VA's policy conflicts with Staab v. McDonald, 28 Vet. App. 50 (2016).

12B. DID YOU ATTACH ADDITIONAL PAGES TO THIS NOD?

☐ YES ☒ NO *(If so, how many?)*

PART V - CERTIFICATION AND SIGNATURE

I CERTIFY THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

13A. SIGNATURE Amanda Wolfe

13B. DATE SIGNED 7-12-18

PENALTY: THE LAW PROVIDES SEVERE PENALTIES WHICH INCLUDE A FINE, IMPRISONMENT, OR BOTH, FOR THE WILLFUL SUBMISSION OF ANY STATEMENT OR EVIDENCE OF A MATERIAL FACT, KNOWING IT TO BE FALSE.

Exhibit J

VA | U.S. Department of Veterans Affairs
Iowa City VA Health Care System

601 Highway 6 West
Iowa City, IA 52246
319-338-0581
1-800-637-0128
www.iowacity.va.gov

August 14, 2018

In Reply Refer to: 636-10D1B
Wolfe, Amanda (3966)

AMANDA WOLFE
[redacted]

Dear Ms. Wolfe:

This letter is in response VA Form 21-0958 (Notice of Disagreement) that we received in our office regarding the services provided to you at Mercy Medical Center in Clinton, Iowa from September 16, 2016 through September 17, 2016.

Due to the volume of appeals, we anticipate a delay. We review appeals in the order that they are received by this office. Please be assured that you will receive written notification of our decision.

Payment of healthcare services outside the VA is governed by strict federal guidelines; decisions are based upon eligibility criteria, medical necessity and availability of the service within the VA Healthcare System. In most cases, having VA pay for care in the community requires pre-authorization.

However, the VA has rules about who qualifies for coverage at Non-VA facilities, even in emergencies. Federal Regulations for payment to civilian hospitals for emergency medical treatment outside of the VA is under the provisions of Code of Federal Regulation (CFR) 38 CFR 17.1000 through 17.1008; 17.120 through 17.132 and 38 CFR 17.52 through 17.56. Eligibility for VA payment of emergency care, as well as deadlines for filing claims, depend upon a veteran's specific eligibility criteria for Non-VA medical care.

I apologize for the delay and thank you for your patience and cooperation during our review process.

If you have questions regarding the above-mentioned date of service, please feel free to call us at (319) 338-0581.

Sincerely,

VHA Office of Community Care- Claims Adjudication & Reimbursement

Exhibit K

AMANDA J. WOLFE
[redacted]

BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON, DC 20038

Date: November 22, 2019 [redacted]

AMANDA J. WOLFE
[redacted]
[redacted]

Dear Appellant:

The Board of Veterans' Appeals (Board) has made a decision in your appeal, and a copy is enclosed.

If your decision contains a	*What happens next*
Grant	The Department of Veterans Affairs (VA) will be contacting you regarding the next steps, which may include issuing payment. Please refer to VA Form 4597, which is attached to this decision, for additional options.
Remand	Additional development is needed. VA will be contacting you regarding the next steps.
Denial or Dismissal	Please refer to VA Form 4597, which is attached to this decision, for your options.

If you have any questions, please contact your representative, if you have one, or check the status of your appeal at http://www.vets.gov.

Sincerely yours,

K. Osborne
Deputy Vice Chairman

Enclosures (1)
CC: National Veterans Legal Services Program

National Veterans Legal Services Program
Ron B. Abrams
1600 K Street, NW - Suite 500
Washington, DC 20006

BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON, DC 20038

Date: November 22, 2019 [redacted]

AMANDA J. WOLFE
[redacted]
[redacted]

Dear Appellant:

The Board of Veterans' Appeals (Board) has made a decision in your appeal, and a copy is enclosed.

If your decision contains a	*What happens next*
Grant	The Department of Veterans Affairs (VA) will be contacting you regarding the next steps, which may include issuing payment. Please refer to VA Form 4597, which is attached to this decision, for additional options.
Remand	Additional development is needed. VA will be contacting you regarding the next steps.
Denial or Dismissal	Please refer to VA Form 4597, which is attached to this decision, for your options.

If you have any questions, please contact your representative, if you have one, or check the status of your appeal at http://www.vets.gov.

Sincerely yours,

K. Osborne
Deputy Vice Chairman

Enclosures (1)
CC: National Veterans Legal Services Program

BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

IN THE APPEAL OF
AMANDA J. WOLFE

[redacted]
Docket No. 19-15 391

Represented by
National Veterans Legal Services Program

DATE: November 22, 2019

ORDER

Payment or reimbursement of medical expenses incurred from September 16 to 17, 2016, at Mercy Medical Center (MMC) is granted, subject to the restriction on reimbursement of copayments under 38 U.S.C. § 1725(c)(4)(D).

FINDINGS OF FACT

1. The Veteran received emergency treatment at MMC from September 16 to 17, 2016, and a Department of Veterans Affairs (VA)-related medical facility was not feasibly available.

2. The Veteran had other, non-VA insurance that paid for most of the expenses incurred from September 16 to 17, 2016, at MMC; however, she had a copayment and coinsurance not paid by such insurance.

CONCLUSION OF LAW

The criteria for payment or reimbursement of medical expenses incurred from September 16 to 17, 2016, at MMC have been met, subject to the restriction on reimbursement of copayments. 38 U.S.C. § 1725; 38 C.F.R. §§ 17.1000-1008.

IN THE APPEAL OF
AMANDA J. WOLFE [redacted]
Docket No. 19-15 391

REASONS AND BASES FOR FINDINGS AND CONCLUSION

The Veteran served on active duty from October 2002 to May 2008. This appeal is before the Board of Veterans' Appeals (Board) from a February 2018 decision of the VA Veterans Health Administration (VHA).

Pursuant to 38 U.S.C. § 1725, under certain circumstances, VA shall reimburse a veteran for the reasonable value of emergency treatment furnished the veteran in a non-Department facility. VA regulations at 38 C.F.R. §§ 17.1000 through 17.1008 constitute the requirements under 38 U.S.C. § 1725 that govern VA payment or reimbursement for non-VA emergency services furnished to a veteran for nonservice-connected conditions. 38 C.F.R. § 17.1000.

Reimbursement under 38 U.S.C. § 1725 may be provided by VA "only after the veteran or the provider of emergency treatment has exhausted without success all claims and remedies reasonably available to the veteran or provider against a third party for payment of such treatment." 38 U.S.C. § 1725(c)(2); *see also* 38 C.F.R. § 17.1002(f). If a Veteran has recourse against a third party that would partially pay for emergency treatment, subject to some limitation, the amount payable by VA for such treatment is the amount by which the costs for the emergency treatment exceed the amount payable or paid by the third party; in such cases, VA is the secondary payer only. In any case, VA may not reimburse a Veteran for any copayment or similar payment for which the Veteran is responsible under a health-plan contract with a third party. 38 U.S.C. § 1725(c)(4).

The facts of this case are essentially undisputed.

The Veteran received emergency treatment at MMC from September 16 to 17, 2016, for right lower abdominal pain with a diagnosis of acute appendicitis, and an emergency appendectomy was performed. The Veteran had other, non-VA insurance that paid for most expenses of this treatment. However, she had a copayment and coinsurance not paid by such insurance.

The agency of original jurisdiction (AOJ) has not contended, and the record does not otherwise reflect, that the Veteran did not meet the statutory and regulatory requirements for payment or reimbursement under 38 U.S.C. § 1725 for her

treatment at MMC, including all those listed under 38 C.F.R. § 17.1002 such as the emergent nature of the Veteran's condition and the lack of a feasibly available VA facility—rather, as reflected in a November 2018 VA administrative note of record, the AOJ acknowledged that the Veteran met all such criteria—save one. The sole basis of the AOJ's denial of the Veteran' claim was that, as the expenses in question were copayment and coinsurance unpaid by the Veteran's non-VA insurance, VA payment of such expenses was not permissible under 38 C.F.R. § 17.1005(a)(5), which precluded reimbursement "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."

However, in *Wolfe v. Wilkie*, No. 18-6091, 2019 U.S. App. Vet. Claims LEXIS 1604 (Sept. 9, 2019), the United States Court of Appeals for Veterans Claims (Court) invalidated 38 C.F.R. § 17.1005(a)(5), finding it contrary to 38 U.S.C. § 1725. Specifically, the Court held "§ 17.1005(a)(5) is not based on a permissible construction of section 1725(c)(4)(D) for two related, but distinct, reasons: (1) It's inconsistent with *Staab*'s interpretation of section 1725, and (2) deductibles and coinsurance aren't 'similar' to a copayment (and VA didn't explain—to defeat arbitrariness—how they're 'similar' to a copayment)." *Id.* at 51; *see also Staab v. McDonald*, 28 Vet. App. 50, 55 (2016) (holding that "it is clear from the plain language of [38 U.S.C. § 1725] that Congress intended VA to reimburse a veteran for that portion of expenses not covered by a health-plan contract"). Therefore, while there remains a statutory bar against reimbursement of any copayment (or similar payment) by VA per 38 U.S.C. § 1725(c)(4)(D), there is no permissible regulatory bar against the reimbursement of coinsurance payments.

In this case, as noted above, and as reflected in a November 2018 explanation of benefits of record, the Veteran's treatment expenses from MMC from September 16 to 17, 2016, included both a copayment and coinsurance that were not paid for by her private insurance; these remaining expenses are those at issue in this case. In light of the Court's holding in *Wolfe*, the Veteran's claim must be therefore be granted to the extent that her coinsurance expenses incurred from September 16 to 17, 2016, at MMC must be paid or reimbursed by VA (subject to the extant payment provisions of 38 C.F.R. § 17.1005 *other than* § 17.1005(a)(5)), but *not* any copayment expenses, in accordance with 38 U.S.C. § 1725(c)(4)(D).

IN THE APPEAL OF
AMANDA J. WOLFE [redacted] Docket No. 19-15 391

Accordingly, payment or reimbursement of medical expenses incurred from September 16 to 17, 2016, at MMC is granted, subject to the restriction on reimbursement of copayments under 38 U.S.C. § 1725(c)(4)(D).

JONATHAN B. KRAMER
Veterans Law Judge
Board of Veterans' Appeals

Attorney for the Board Andrew Mack, Counsel

The Board's decision in this case is binding only with respect to the instant matter decided. This decision is not precedential, and does not establish VA policies or interpretations of general applicability. 38 C.F.R. § 20.1303.

Department of Veterans Affairs

YOUR RIGHTS TO APPEAL OUR DECISION

The attached decision by the Board of Veterans' Appeals (Board) is the final decision for all issues addressed in the "Order" section of the decision. The Board may also choose to remand an issue or issues to the local VA office for additional development. If the Board did this in your case, then a "Remand" section follows the "Order." However, you cannot appeal an issue remanded to the local VA office because a remand is not a final decision. *The advice below on how to appeal a claim applies only to issues that were allowed, denied, or dismissed in the "Order."*

If you are satisfied with the outcome of your appeal, you do not need to do anything. Your local VA office will implement the Board's decision. However, if you are not satisfied with the Board's decision on any or all of the issues allowed, denied, or dismissed, you have the following options, which are listed in no particular order of importance:

- Appeal to the United States Court of Appeals for Veterans Claims (Court)
- File with the Board a motion for reconsideration of this decision
- File with the Board a motion to vacate this decision
- File with the Board a motion for revision of this decision based on clear and unmistakable error.

Although it would not affect this BVA decision, you may choose to also:

- Reopen your claim at the local VA office by submitting new and material evidence.

There is *no* time limit for filing a motion for reconsideration, a motion to vacate, or a motion for revision based on clear and unmistakable error with the Board, or a claim to reopen at the local VA office. Please note that if you file a Notice of Appeal with the Court and a motion with the Board at the same time, this may delay your appeal at the Court because of jurisdictional conflicts. If you file a Notice of Appeal with the Court ***before*** you file a motion with the Board, the Board will not be able to consider your motion without the Court's permission or until your appeal at the Court is resolved.

How long do I have to start my appeal to the court? You have **120 days** from the date this decision was mailed to you (as shown on the first page of this decision) to file a Notice of Appeal with the Court. If you also want to file a motion for reconsideration or a motion to vacate, you will still have time to appeal to the court. *As long as you file your motion(s) with the Board within 120 days of the date this decision was mailed to you,* you will have another 120 days from the date the Board decides the motion for reconsideration or the motion to vacate to appeal to the Court. You should know that even if you have a representative, as discussed below, *it is your responsibility to make sure that your appeal to the Court is filed on time*. Please note that the 120-day time limit to file a Notice of Appeal with the Court does not include a period of active duty. If your active military service materially affects your ability to file a Notice of Appeal (e.g., due to a combat deployment), you may also be entitled to an additional 90 days after active duty service terminates before the 120-day appeal period (or remainder of the appeal period) begins to run.

How do I appeal to the United States Court of Appeals for Veterans Claims? Send your Notice of Appeal to the Court at:

Clerk, U.S. Court of Appeals for Veterans Claims
625 Indiana Avenue, NW, Suite 900
Washington, DC 20004-2950

You can get information about the Notice of Appeal, the procedure for filing a Notice of Appeal, the filing fee (or a motion to waive the filing fee if payment would cause financial hardship), and other matters covered by the Court's rules directly from the Court. You can also get this information from the Court's website on the Internet at: http://www.uscourts.cavc.gov, and you can download forms directly from that website. The Court's facsimile number is (202) 501-5848.

To ensure full protection of your right of appeal to the Court, you must file your Notice of Appeal **with the Court**, not with the Board, or any other VA office.

How do I file a motion for reconsideration? You can file a motion asking the Board to reconsider any part of this decision by writing a letter to the Board clearly explaining why you believe that the Board committed an obvious error of fact or law, or stating that new and material military service records have been discovered that apply to your appeal. It is important that your letter be as specific as possible. A general statement of dissatisfaction with the Board decision or some other aspect of the VA claims adjudication process will not suffice. If the Board has decided more than one issue, be sure to tell us which issue(s) you want reconsidered. Issues not clearly identified will not be considered. Send your letter to:

Litigation Support Branch
Board of Veterans' Appeals
P.O. Box 27063
Washington, DC 20038

Remember, the Board places no time limit on filing a motion for reconsideration, and you can do this at any time. However, if you also plan to appeal this decision to the Court, you must file your motion within 120 days from the date of this decision.

How do I file a motion to vacate? You can file a motion asking the Board to vacate any part of this decision by writing a letter to the Board stating why you believe you were denied due process of law during your appeal. *See* 38 C.F.R. 20.904. For example, you were denied your right to representation through action or inaction by VA personnel, you were not provided a Statement of the Case or Supplemental Statement of the Case, or you did not get a personal hearing that you requested. You can also file a motion to vacate any part of this decision on the basis that the Board allowed benefits based on false or fraudulent evidence. Send this motion to the address on the previous page for the Litigation Support Branch, at the Board. Remember, the Board places no time limit on filing a motion to vacate, and you can do this at any time. However, if you also plan to appeal this decision to the Court, you must file your motion within 120 days from the date of this decision.

How do I file a motion to revise the Board's decision on the basis of clear and unmistakable error? You can file a motion asking that the Board revise this decision if you believe that the decision is based on "clear and unmistakable error" (CUE). Send this motion to the address on the previous page for the Litigation Support Branch, at the Board. You should be careful when preparing such a motion because it must meet specific requirements, and the Board will not review a final decision on this basis more than once. You should carefully review the Board's Rules of Practice on CUE, 38 C.F.R. 20.1400-20.1411, and *seek help from a qualified representative before filing such a motion.* See discussion on representation below. Remember, the Board places no time limit on filing a CUE review motion, and you can do this at any time.

How do I reopen my claim? You can ask your local VA office to reopen your claim by simply sending them a statement indicating that you want to reopen your claim. However, to be successful in reopening your claim, you must submit new and material evidence to that office. *See* 38 C.F.R. 3.156(a).

Can someone represent me in my appeal? Yes. You can always represent yourself in any claim before VA, including the Board, but you can also appoint someone to represent you. An accredited representative of a recognized service organization may represent you free of charge. VA approves these organizations to help veterans, service members, and dependents prepare their claims and present them to VA. An accredited representative works for the service organization and knows how to prepare and present claims. You can find a listing of these organizations on the Internet at: http://www.va.gov/vso/. You can also choose to be represented by a private attorney or by an "agent." (An agent is a person who is not a lawyer, but is specially accredited by VA.)

If you want someone to represent you before the Court, rather than before the VA, you can get information on how to do so at the Court's website at: http://www.uscourts.cavc.gov. The Court's website provides a state-by-state listing of persons admitted to practice before the Court who have indicated their availability to the represent appellants. You may also request this information by writing directly to the Court. Information about free representation through the Veterans Consortium Pro Bono Program is also available at the Court's website, or at: http://www.vetsprobono.org, mail@vetsprobono.org, or (855) 446-9678.

Do I have to pay an attorney or agent to represent me? An attorney or agent may charge a fee to represent you after a notice of disagreement has been filed with respect to your case, provided that the notice of disagreement was filed on or after June 20, 2007. *See* 38 U.S.C. 5904; 38 C.F.R. 14.636. If the notice of disagreement was filed before June 20, 2007, an attorney or accredited agent may charge fees for services, but only after the Board first issues a final decision in the case, and only if the agent or attorney is hired within one year of the Board's decision. *See* 38 C.F.R. 14.636(c)(2).

The notice of disagreement limitation does not apply to fees charged, allowed, or paid for services provided with respect to proceedings before a court. VA cannot pay the fees of your attorney or agent, with the exception of payment of fees out of past-due benefits awarded to you on the basis of your claim when provided for in a fee agreement.

Fee for VA home and small business loan cases: An attorney or agent may charge you a reasonable fee for services involving a VA home loan or small business loan. *See* 38 U.S.C. 5904; 38 C.F.R. 14.636(d).

Filing of Fee Agreements: If you hire an attorney or agent to represent you, a copy of any fee agreement must be sent to VA. The fee agreement must clearly specify if VA is to pay the attorney or agent directly out of past-due benefits. See 38 C.F.R. 14.636(g)(2). If the fee agreement provides for the direct payment of fees out of past-due benefits, a copy of the direct-pay fee agreement must be filed with the agency of original jurisdiction within 30 days of its execution. A copy of any fee agreement that is not a direct-pay fee agreement must be filed with the Office of the General Counsel within 30 days of its execution by mailing the copy to the following address: Office of the General Counsel (022D), Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420. See 38 C.F.R. 14.636(g)(3).

The Office of the General Counsel may decide, on its own, to review a fee agreement or expenses charged by your agent or attorney for reasonableness. You can also file a motion requesting such review to the address above for the Office of the General Counsel. See 38 C.F.R. 14.636(i); 14.637(d).

Exhibit L

2022-_____

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

Joshua Kimmel and
Amanda Wolfe,

Petitioners,

v.

Denis McDonough, Secretary of Veterans Affairs,

Respondent.

DECLARATION OF AMANDA WOLFE IN SUPPORT OF PETITIONERS' PETITION FOR REVIEW PURSUANT TO 38 U.S.C. § 502

I, Amanda Wolfe, declare as follows:

1. I am a veteran of the United States Coast Guard having served six years from 2002-2008. I am also a petitioning party with respect to the Petition for Review Pursuant to 38 U.S.C. § 502 to which this declaration is appended in support. I have personal knowledge of the facts set forth in this Declaration and could and would competently testify to them if called as a witness.

2. On September 16, 2016, I suffered a medical episode consisting of severe incessant pain in my torso. As a result of my pain, I found it necessary to seek urgent medical attention. With the nearest VA-affiliated hospital approximately three hours away from where I was at the time, I drove myself to the nearest emergency medical facility: Mercy Medical Center in Clinton, Iowa. There, I received medical care, including an emergency appendectomy, from September 16 to September 17, 2016.

3. Shortly after my visit to Mercy Medical Center, I received a series of documents each titled "Explanation of Benefits" ("EOB"), which specified the costs I incurred during my September 2016 medical care at Mercy Medical, and the portion of those costs covered by my employer-sponsored health insurance. In total, I incurred $22,348.25 in medical costs at Mercy Medical for my emergency care, of which $2,558.54 was not covered by my employer-sponsored health insurance. Of this $2,558.54, $202.93 was "copayment" and $2,351.51 was "coinsurance." After making payment on the portion of the medical costs I incurred that was not covered by my employer-sponsored health insurance, I

submitted a claim to the Department of Veterans Affairs for reimbursement.

4. VA denied my claim for reimbursement on February 7, 2018. On July 12, 2018, with the assistance of the National Veterans Legal Services Program ("NVLSP"), I filed a Notice of Disagreement with VA's denial of my reimbursement claim. On November 20, 2018, VA again denied my reimbursement claim, this time stating by letter that their "decision is final; appeal closed."

5. On November 30, 2018, I, along with Mr. Peter Boerschinger, and with the assistance of NVLSP, filed a Petition for Class Relief in the Nature of a Writ Mandamus ("Petition for Mandamus") for the purpose of invalidating 38 C.F.R. § 17.1005(a)(5), the regulation on which VA relied in denying my reimbursement claim. On November 22, 2019, with the legal proceedings surrounding my the Petition for Mandamus still ongoing, my reimbursement claim was granted by the Board of Veterans' Appeals (the "Board"). Despite the Board granting my claim, as of today, I have not yet received any reimbursement from VA.

Dated: April 27, 2022

/s/ Amanda Wolfe