UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

Vet.App. No. 14-0957

RICHARD W. STAAB,

Appellant,

v.

ROBERT A. McDONALD,
Secretary of Veterans Affairs

Appellee.

BRIEF FOR APPELLANT

Louis J. George
Patrick A. Berkshire
Barton F. Stichman
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STATEMENT OF THE ISSUES

I. Whether the Board of Veterans' Appeals (the "Board") erred as a matter of law in holding that partial coverage for medical expenses under Medicare bars entitlement to unreimbursed medical expenses under the plain meaning of 38 U.S.C. § 1725?

II. Whether the Board's interpretation of 38 U.S.C. § 1725 contradicts the legislative history of the Emergency Care Fairness Act of 2010?

III. Whether the Board's reading of 38 U.S.C. § 1725 is overly restrictive and contravenes the purpose and spirit of the Emergency Care Fairness Act of 2010?

IV. Whether the applicable regulation, 38 C.F.R. § 17.1002(f), is contrary to the statute and therefore invalid?

V. Alternatively, even if Medicare coverage precluded reimbursement for some treatments, whether the Board's denial of reimbursement for all treatments is still contrary to 38 U.S.C. § 1725?

STATEMENT OF THE CASE

Appellant Richard W. Staab (hereinafter, "Appellant" or "Mr. Staab") appeals the December 6, 2013 decision of the Board, holding that he is ineligible for payment or reimbursement of unauthorized medical expenses incurred for emergency medical services provided at a non-VA medical facility from December 27, 2010 through December 31, 2011. (Record (R.) 3-9).

STATEMENT OF FACTS

Appellant Richard W. Staab served honorably in the United States Air Force from November 1952 to November 1956. He received the National Defense Service Medal, the Korean Service Medal, the United Nations Service Medal, and the Good Conduct Medal. (R. 471).

In December 2010, Appellant suffered a heart attack that was followed by a stroke. He received cardiovascular and related treatment and rehabilitative care from December 27, 2010, through December 31, 2011. The services were provided at CentraCare Health System, St. Cloud Hospital, North Clinic, St. Benedict's Senior Community Center, and related clinics. He incurred expenses of $48,000, representing the approximate cost of medical car incurred during and following his heart attack and stroke on December 27, 2010, and which was not covered by Medicare. (R. 401 (399-412)). The claim was denied in multiple decisions dated in July 2011 by the VA Medical Center in St. Cloud, Minnesota. (R. 906-920; 923-955). The reasons for the denials included the fact that the veteran had other insurance coverage or a third party paid for the claim. (R. 932-936, 938-942 (923-955)). The veteran filed a timely Notice of Disagreement, with exhibits and affidavits, in May 2012. (R. 449-464). Appellant claimed that he was incapacitated due to his heart attack and stroke and was unable to secure pre-authorization for non-VA treatment, and neither he nor his family was advised to seek pre-approval. (R. 449-464).

In a Statement of the Case dated in August 2012, the VA stated that clinical review determined that the care Appellant received was not emergent and that VA was available to provide care. (R. 898-903). Appellant filed a timely VA Form 9, Appeal to Board of Veterans' Appeals, disputing the decision and Statement of the Case, in September 2012. (R. 399-412).

Appellant presented sworn testimony at a hearing before the Board of Veterans' Appeals. (R. 257-266). At the hearing, Appellant and his representative discussed his

medical care during the period in question and his contention that his care was emergent. (R. 261 (257-266)).

On December 6, 2013, the Board affirmed the denial of Appellant's claim under 38 U.S.C. § 1725 solely because he was covered by Medicare. (R. 8 (3-9)). The Board explained that since Appellant's claim was being denied due to a lack of legal merit, the duty to assist did not apply to his case. (R. 5-6 (3-9)). Furthermore, the Board stated that because the claim was being denied as a matter of law, "the issue of whether the medical care was emergent or not is irrelevant." (R. 6 (3-9)). Although the Board acknowledged that Appellant was seeking reimbursement for medical expenses not covered by Medicare, the Board concluded that since he was covered "in whole or in part" by a health care contract, VA was not authorized to pay or reimburse unauthorized medical expenses. (R. 8 (3-9)) (citing 38 C.F.R. § 17.1002(g)).

Mr. Staab timely appealed to this Court and seeks reversal of the Board's decision that even partial health care coverage under Medicare bars eligibility for any and all reimbursement by the VA under 38 U.S.C. § 1725. This appeal also challenges the validity of the applicable VA regulation.

SUMMARY OF THE ARGUMENT

The Board erred in concluding that Mr. Staab is not entitled to reimbursement for his emergency medical treatment. The Board's conclusion is based on an interpretation of 38 U.S.C. § 1725 that is at odds with the plain meaning of the statute, its legislative history, and policy interests in favor of expanding veterans' benefits. Where a veteran has health care coverage, including, for example, Medicare Part A, which might cover

only a portion of a veteran's medical expenses for emergency treatment, 38 U.S.C. § 1725 (as amended in 2010) serves as a secondary insurance, and requires the Secretary of Veterans Affairs (the "Secretary") to reimburse the veteran for the uncovered portion of his expenses. The plain meaning of the statute mandates payment by the Secretary for unreimbursed expenses when a third-party insurer does not cover the entire cost of the treatment.

Moreover, the legislative history of the Emergency Care Fairness Act of 2010 ("ECFA"), which amended 38 U.S.C. § 1725, confirms the congressional intent to require the Secretary to step in as a "secondary payer" where other health care insurers, such as Medicare, cover only a portion of the cost of a veteran's emergency treatment. Both the Congressional Report on the legislation and statements made by legislators during the consideration of the ECFA made clear that the very purpose of the ECFA was to prevent precisely the result the Board reached here—that a veteran would be left to shoulder the substantial costs of emergency treatment simply because the veteran had some coverage for a portion of the costs. The interpretation advocated by Mr. Staab is further bolstered by the strong policy interest in expanding medical benefits to veterans.

Finally, this Court should hold that the pertinent VA regulation, 38 C.F.R. § 17.1002(f), is invalid because it is contrary to the plain meaning of the statute regarding the coverage for emergency medical treatment. The regulation would make VA coverage available only if a veteran had no other outside coverage, and would not place the VA coverage in its intended role as secondary coverage.

The Board has a duty "to render a decision which grants every benefit that can be supported in law." 38 C.F.R. § 3.103(a). The law requires reimbursement of Mr. Staab's emergency medical expenses. Moreover, the Board did not offer any other reason for denying his claim (in fact, the Board stated that "the issue of whether the medical care was emergent or not is irrelevant"). (R. 6 (3-9)). Hence, the Board's legal error was prejudicial to Mr. Staab. The Board's decision therefore should be reversed.

ARGUMENT

I. Standard of Review.

Resolution of this case turns on the appropriate interpretation of a statute and regulation. A challenge to the Board's interpretation of a statute or regulation is an issue of law. *Cacatian v. West*, 12 Vet.App. 373, 376 (1999). This Court reviews questions of law under a de novo standard of review. 38 U.S.C. § 7261(a)(1); *see also Smith v. Gober*, 14 Vet.App. 227, 230 (2000) ("This Court reviews questions of law de novo without any deference to the Board's conclusion of law."). Questions of law reviewed de novo may be "set aside when such conclusions of law are 'arbitrary, capricious, an abuse of discretion, otherwise not in accordance with law.'" *Young v. Brown*, 4 Vet.App. 106, 108 (1993) (quoting 38 U.S.C. § 7261(a)(3)(A)). This case is of particular importance, as the same legal question regarding the effect of 2010 amendments to 38 U.S.C § 1725 is presented in *Oury v. McDonald*, Vet.App. No. 13-2955, presently on appeal before this Court. Appellant is not aware of any precedential decision addressing this legal issue.

II. The Plain Meaning of 38 U.S.C. § 1725 Compels a Finding That The Secretary Is Responsible for Payment of Unreimbursed Medical Expenses to a Veteran Who Underwent Emergency Treatment at a Non-VA Facility And Is Only Partially Covered under a Health Care Policy.

The relevant statute, 38 U.S.C. § 1725, has three subsections that bear on this dispute. Subsection (a) provides that the Secretary will reimburse eligible veterans for the reasonable value of emergency treatment furnished in a non-VA facility. Subsection (b) sets forth the criteria for eligibility, and provides that veterans are entitled to reimbursement if they are active VA health-care participants and "personally liable for emergency treatment" provided at a non-VA facility. Subsection (b)(3) sets forth the conditions under which a veteran is deemed to be "personally liable for emergency treatment." Subsection (c) provides certain limitations on the Secretary's requirement to reimburse veterans, and subsection (c)(4) sets forth the Secretary's financial responsibilities in the circumstance in which the veteran has legal recourse against a third party provider. The meaning of these provisions and their impact on this case is further explained below.

A 38 U.S.C. § 1725(b)(3) establishes that veterans are eligible for reimbursement so long as they are not covered "in whole" by a health-plan contract or other third party recourse.

The plain meaning of subsection (b)(3) is that a veteran is eligible for reimbursement for the costs of emergency treatment so long as the veteran does not have health care coverage that would provide reimbursement for the treatment "in whole." In particular, subsections (b)(3)(B) and (C) provide that a veteran is "personally liable for

emergency treatment," and thus eligible for reimbursement by the Secretary, if the veteran:

> (B) has no entitlement to care or services under a health-plan contract . . .;
>
> (C) has no other contractual or legal recourse against a third party that would, in whole,[1] extinguish such liability to the provider; . . .

38 U.S.C. § 1725(b)(3)(B), (C). In interpreting a statute, its provisions must be read in context with regard to the statute on the whole. *See Sursely v. Peake*, 551 F.3d 1351, 1355 (Fed. Cir. 2009) (quoting *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 99 (1992)) ("[W]e must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law.").

Contrary to this well-accepted principle of statutory construction, the Board interpreted subsection (b)(3)(B) in isolation, and therefore interpreted it to preclude reimbursement unless the veteran has no entitlement to care or services under a health-plan contract whatsoever. (R. 8 (3-9)). But the Board simply ignored the subsequent qualifying clause in subsection (b)(3)(C)—"that would, *in whole*, extinguish such liability." 38 U.S.C. § 1725(b)(3) (emphasis added). The Board's interpretation is inconsistent with the plain language of the statute. *See McEntee v. Merit Sys. Prot. Bd.*, 404 F.3d 1320, 1328 (Fed. Cir. 2005) ("Statutory interpretation begins with the language of the statute, the plain meaning of which we derive from its text and its structure.").

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[1] The 2010 amendments to this statute specifically removed "or in part" from the eligibility requirements of section 1725(b)(3)(C), thereby updating the statute to provide that a veteran is eligible for reimbursement unless a health-plan contract or other third party coverage extinguishes the veteran's liability "in whole."

When subsections (b)(3)(B) and (C) are read together, the clause from subsection (b)(3)(C)—"that would, in whole, extinguish such liability"—plainly applies to both a "health-plan contract" and to "other contractual or legal recourse against a third party." The net effect of these two subsections is that a veteran is only barred from receiving reimbursement for the cost of emergency medical treatment if the costs are *wholly* covered by another party.

The use of the word "other" in subsection (b)(3)(C) confirms that both clauses should be read together. Under the statute, to be eligible for reimbursement, a veteran must have "no entitlement to care or services under a health-plan contract" or "*other* contractual or legal recourse against a third party that would, in whole, extinguish such liability to the provider." 38 U.S.C. § 1725(b)(3)(B), (C) (emphasis added). According to the Merriam-Webster Dictionary, "other" is "used to refer to all the members of a group except the person or thing that has already been mentioned." Merriam-Webster Online Dictionary, HTTP://WWW.MERRIAM-WEBSTER.COM (Jan. 5, 2015). Thus, the use of the word "other" suggests that what follows is something ("contractual or legal recourse against a third party that would, in whole, extinguish such liability to the provider") that includes what had been previously mentioned ("a health-plan contract"). The clause "that would, in whole, extinguish such liability to the provider" is used to describe the group that includes all nouns in the sentence ("health-plan contract" and "contractual or legal recourse").

This reading comports with the ordinary, common usage of the word "other." The ordinary usage of the word "other" is as a connector between two items that are

considered members of the same group. Consider, for example, an instruction to "avoid eating pizza or other foods that are unhealthy." The use of the word "other" would naturally be read to mean that "pizza" is included in the group of "foods that are unhealthy." By contrast, if one were instructed to "avoid eating apples or other foods that are unhealthy," this instruction would be illogical, as the phrase would indicate (counterfactually) that apples are included in the group of "foods that are unhealthy."

The same construction and interpretation applies to the use of the word "other" in subsection (b)(3). When subsections (b)(3)(B) and (b)(3)(C) are read together, as joined by the word "other," a health-plan contract only bars reimbursement when it would "in whole, extinguish such liability to the provider." As a result, a veteran like Mr. Staab who is only covered in part by a health-plan contract, including Medicare, would be eligible for reimbursement by the Secretary under a plain reading of the statute.

B 38 U.S.C. § 1725(c) further establishes that reimbursement is available when a veteran has partial coverage pursuant to a health-plan contract.

Even if there were any ambiguity in the eligibility provisions of subsection (b)(3) (and there is not), subsection (c) conclusively establishes that reimbursement is available for veterans with partial coverage by a health-plan contract. Under subsection (c)(4)(A), where third party coverage only extinguishes the veteran's liability in part, "the amount payable for such treatment under such subsection ***shall*** be the amount by which the costs for the emergency treatment exceed the amount payable or paid by the third party. . ." § 1725(c)(4)(A) (emphasis added). In subsection (f)(3)(E), "third party" is defined to

include health-plan contracts, such as Medicare.[2] Subsection (c)(4)(B) further provides that where a "third party is financially responsible for part of the veteran's emergency treatment expenses, the Secretary ***shall*** be the secondary payer." § 1725(c)(4)(B) (emphasis added). Reading these provisions together, the statute is clear that where the cost of emergency treatment exceeds the amount payable by *any* third party (in this case, Medicare), the Secretary is the "secondary payer" and responsible for reimbursement of any uncovered amounts.

Additionally, the statute provides 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." 38 U.S.C. § 1725(c)(4)(D). This provision would be superfluous if reimbursement is barred whenever a veteran has partial coverage from a health-plan contract, as the Board contends. There would be no need to specifically bar reimbursement of "any copayment or similar payment" "for which the veteran is responsible under a health-plan contract" because, under the Board's view, *all* reimbursement is already barred by subsection (b)(3)(B) when the veteran has a health-plan contract. The Board's interpretation would therefore render the portion of subsection (c)(4)(D) relating to copays as surplusage, which is plainly inappropriate. *See Splane v. West*, 216 F.3d 1058, 1068 (Fed. Cir. 2000)

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[2] 38 U.S.C. § 1725(f)(3)(E) defines "third party" to mean, among other things, "[a] person or entity obligated to provide, or to pay the expenses of, health services under a health-plan contract." 38 U.S.C. § 1725(f)(2) defines a "health-plan contract" to include "[a]n insurance program described in section 1811 of the Social Security Act (42 U.S.C. 1395c)," i.e., Medicare.

("We must construe a statute . . . to give effect and meaning to all its terms."); *Astoria Fed. Sav. & Loan Ass'n v. Solimino*, 501 U.S. 104, 112 (1991) (statutes should be construed "so as to avoid rendering superfluous" any statutory language); *Bailey v. United States*, 516 U.S. 137, 146 (1995) ("we assume that Congress used two terms because it intended each term to have a particular, nonsuperfluous meaning").

III. The Legislative History of the Emergency Care Fairness Act of 2010 Confirms That Veterans Are Eligible for Reimbursement by the Secretary if Emergency Treatment is Only Partially Covered by a Health Care Policy.

On February 1, 2010, Congress amended 38 U.S.C. § 1725 by enacting the Emergency Care Fairness Act (Pub. Law. No. 111-137) ("ECFA"), expanding veteran eligibility for reimbursement for emergency treatment furnished in a non-VA facility. One critical change made by the ECFA was to amend the provisions regarding the impact of third-party coverage. Before the amendment, section 1725(b)(3)(C) provided that a veteran would satisfy the eligibility requirement of being personally liable for emergency treatment if he or she had "no other contractual or legal recourse against a third party that would, *in whole or in part*, extinguish such liability to the provider." (emphasis added). The ECFA amended this subsection by deleting the words "or in part," which has the effect of eliminating any bar on veterans receiving reimbursement by the Secretary for non-VA emergency care when the claimant is entitled to partial payment from a third party.

The other major change to the statute included expansion of section 1725(c) to clarify the Secretary's responsibility for reimbursement.[3] Section 1725(c) was amended to add subsection (c)(4), which provides in relevant part:

> (A) If the veteran has contractual or legal recourse against a third party that would only, *in part*, extinguish the veteran's liability to the provider of the emergency treatment, and payment for the treatment may be made both under subsection (a) and by the third party, the *amount payable for such treatment under such subsection shall be the amount by which the costs for the emergency treatment exceed the amount payable or paid by the third party*, except that the amount payable may not exceed the maximum amount payable established under paragraph (1)(A).
>
> (B) In any case in which a third party is financially responsible for part of the veteran's emergency treatment expenses, the *Secretary shall be the secondary payer*.
>
> (C) A payment in the amount payable under subparagraph (A) shall be considered payment in full and shall extinguish the veteran's liability to the provider.
>
> (D) The Secretary may not reimburse a veteran under this section for any copayment or similar payment that the veteran owes the third party *or for which the veteran is responsible under a health-plan contract*.

38 U.S.C. § 1725(c)(4) (emphasis added). In particular, these additions ensure that the Secretary will be responsible as the "secondary payer" to reimburse veterans for

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[3] The other amendment to the statute was the elimination of what formerly had been 38 U.S.C. § 1725(f)(2)(E), which had defined "heath-plan contract" to include state or local law requiring health coverage through automobile insurance. However, this change was likely made for the purposes of simplification, because this type of health coverage was already covered by the broader definition in subsection 1725(f)(2)(A). The Board's conclusion that this change indicates that the 2010 amendments were *only* intended to allow reimbursement of claims in the narrow circumstance in which costs were partially covered by such automobile insurance is inconsistent with the remainder of the amendments to the statute discussed above.

treatment if a third party was "financially responsible for *part* of the veteran's emergency treatment expenses." § 1725(c)(4)(B) (emphasis added).

When reviewing the Board's interpretation of a statute *de novo*, the Court should consider whether Congress has directly spoken to the precise question at issue. 38 U.S.C. § 7261(a)(1). Here, Congress has done so, but the Board interpreted the law in a contrary manner. In the House Report on the ECFA, the Committee on Veterans' Affairs explained that the amendment "clearly establishes that the VA is responsible for the cost of the emergency treatment which exceeds the amount payable or paid by the third-party insurer." H.R. Rep. No. 111-55 (2009), at 6. The Committee reaffirmed that under the amendments, the VA is a "secondary payer where a third-party insurer is financially responsible for a part of the veteran's emergency treatment expenses" and provided that this "protects veterans" by removing their liability for remaining balances due after the third-party insurer and the VA have made payments. *Id.* Notably, nowhere in the legislative history is there any indication that Congress intended to grant reimbursement when a veteran has partial coverage under only certain types of third party insurance that do not also qualify as "health-plan contracts" under the statute. Congress plainly intended to avoid any situation where veterans in the VA health system were responsible for shouldering any of the costs of their emergency medical treatment. *See generally* H.R. Rep. No. 111-55 (2009).

Mr. Staab's reading of the applicable statutes is further supported by congressional hearings leading to the enactment of the 2010 amendments. One congresswoman, speaking in support of the legislation that became the ECFA, noted that "veterans do not

currently receive any reimbursement from the VA if they have third-party insurance that pays either full or a portion of the emergency care. This creates an inequity that penalizes veterans with insurance." 155 CONG. REC. H4069-01 (daily ed. Mar. 30, 2009) (statement of Rep. Halvorson). The congresswoman explained that "H.R. 1377, as amended, eliminates this inequity by requiring the VA to pay for emergency care in a non-VA facility, even if the veteran holds *a policy* that will pay for any portion of their care." *Id.* (emphasis added). Another representative noted that "[c]urrent law allows VA to reimburse a veteran for emergency treatment . . . only if the veteran does not have any other entitlement to pay from a *private party*. . . . H.R. 1377, as amended, would change current law to authorize VA to cover additional expenses in cases where a veteran receives only partial payment from a *third party*." *Id.* (statement of Rep. Roe) (emphasis added). These statements reflect an understanding by Congress that if *any* "policy," "private party," or "third party" would fail to pay for *any* portion of a veteran's care, the veteran would be eligible for reimbursement by the VA under the amended statute. To narrowly construe the statute to allow for reimbursement when a veteran has partial coverage from only certain types of insurance, but not from a health-plan contract, would defy logic and common sense, and would hinder the intent of the ECFA.

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

law was intended to "ensure that veterans are not saddled with massive emergency room bills." 155 CONG. REC. H4069-01 (daily ed. Mar. 30, 2009) (statement of Rep. Ginny Brown-Waite). The Board's interpretation of the law, in contrast, would re-open the very hole that Congress intended to fill and would saddle veterans with the substantial costs of emergency treatment that Congress intended to prevent.

IV. Any Other Reading of the Statute Would Be Overly Restrictive and Contravene the Purpose and Spirit of the Amendments.

A conclusion that 38 U.S.C. § 1725 mandates reimbursements where health care policies, such as Medicare, only cover a portion of a veteran's emergency treatment would also comport with the intent of the statute as amended. The purpose of the ECFA was to "expand veteran eligibility for reimbursement by the Secretary of Veterans Affairs (VA) for emergency treatment furnished in a non-Department facility." H.R. Rep. No. 111-55 (2009), at 2. It was intended to remedy for the fact that "many veterans are without the financial resources to shoulder such a cost" of medical bills from a non-VA hospital when they have only minimal coverage and are "unaware that the VA would not be responsible for such emergency care." *Id.* at 3.

Moreover, even if the statutory language in isolation was subject to more than one interpretation, the Board's unfavorable interpretation "conflicts with the beneficence underpinning VA's veterans benefits scheme, and a more liberal construction is available that affords a harmonious interplay between provisions." *Trafter v. Shinseki*, 26 Vet.App. 267, 272 (2013). This is particularly true here, where the legislative history

plainly demonstrates Congress's intent to expand veterans' benefits for uncovered emergency treatment.

V. The Applicable VA Regulation, 38 C.F.R. § 17.1002(f), Is Contrary to the Statute and Invalid.

In denying reimbursement to Mr. Staab, the Board relied on 38 C.F.R. § 17.1002(f). (R. 7-8 (3-9)). This regulation requires that a claimant have no coverage under a health-plan contract for payment, in whole or in part, for the emergency treatment. 38 C.F.R. § 17.1002(f) (2014) (added by 77 Fed. Reg. 23,615 (April 20, 2012) (Final Rule)).

This Court should declare the regulation to be invalid because it is inconsistent with the statute, for the reasons stated above. The VA's interpretation of the statute, as expressed in 38 C.F.R. § 17.1002(f), is not entitled to deference in this instance. Deference to an agency's statutory construction is appropriate only where "Congress has not spoken to the issue at hand, or has done so ambiguously." *Kingdomware Techs., Inc. v. United States*, 754 F.3d 923, 930-31 (Fed. Cir. 2014). In contrast, "[i]f a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect." *Chevron, U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 843 n.9 (1984). The "traditional tools of statutory construction" that a court may use in ascertaining the will of Congress include "the statute's text, structure, and legislative history, and . . . the relevant canons of [statutory] interpretation." *Kingdomware*, 754

F.3d at 931 (quoting *Delverde, SrL v. United States*, 202 F.3d 1360, 1363 (Fed. Cir. 2000)).

Here, as discussed above, the traditional tools of statutory interpretation make clear that Congress has spoken on the issue. The amended statute requires reimbursement of a veteran's emergency medical treatment where the veteran has a health-plan contract that covers the treatment only in part. The VA's interpretation of the law is contrary to the statutorily expressed will of Congress, and is therefore entitled to no deference.

VI. In the Alternative, Even If Medicare Coverage Precluded VA Reimbursement for Some Treatments, the Board's Denial of Reimbursement for All Treatments Is Contrary to the Statute.

For all the reasons discussed above, 38 U.S.C. § 1725 is properly construed as permitting reimbursement of emergency medical treatment so long as the veteran does not have health insurance that would extinguish the veteran's liability *in whole*. However, even if the Court rejects the foregoing arguments, the Court should find that the Board's denial of *all* reimbursement to Mr. Staab is still overly restrictive under 38 U.S.C. § 1725(b)(3)(A). In this case, Mr. Staab had coverage through Medicare. However, there is the possibility that some treatments were not covered at all. In this circumstance, section 1725(b)(3)(A) permits reimbursement of fees for those services for which Mr. Staab has no health plan coverage.

This reading is supported by the plain language of the statute, which provides that a veteran is eligible for reimbursement if, in relevant part, he "is financially liable to the provider of emergency treatment for *that treatment*." 38 U.S.C. § 1725(b)(3)(A)

(emphasis added). The use of the words "that treatment" in that subsection indicates that eligibility for reimbursement is determined on a treatment-by-treatment basis. For some treatments, the veteran may have health insurance coverage, and therefore (in the Board's view) be ineligible for reimbursement. But for other treatments that the veteran's health insurance does not cover at all, the veteran is effectively uninsured. For such uninsured treatments, the veteran plainly "has no entitlement to care or services under a health-plan contract" and therefore should be eligible for reimbursement.

Any other reading of the statute would be illogical. For example, under the Board's view, a veteran with dental insurance, but no other health insurance, would be denied reimbursement for even non-dental emergency medical treatment. This outcome could leave a veteran responsible for tens of thousands of dollars of emergency medical bills, contrary to the intent of Congress as discussed above.

CONCLUSION AND STATEMENT OF RELIEF SOUGHT

For the foregoing reasons, Appellant requests reversal of the Board's findings denying him entitlement to reimbursement of his medical expenses resulting from emergency treatment at a non-VA hospital for which he was partially covered by Medicare. The issues before this Court involve the Board's incorrect statutory interpretation as a matter of law. Because the Board denied Appellant's claim solely due to his coverage under Medicare, Appellant respectfully requests reversal of the Board's

decision interpreting 38 U.S.C. § 1725 as a bar to Appellant's rightful entitlement to VA reimbursement for his emergency care. Also, this Court should invalidate the regulation on which the Board relied.

Respectfully submitted,

Date: August 10, 2015

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