

## Calendar No. 579

110TH CONGRESS }  
2d Session }

SENATE

{ REPORT  
{ 110-263

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### VETERANS EMERGENCY CARE FAIRNESS ACT OF 2007

—————  
FEBRUARY 25, 2008.—Ordered to be printed  
—————

Mr. AKAKA, from the Committee on Veterans' Affairs,  
submitted the following

### R E P O R T

[To accompany S. 2142]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (S. 2142) to amend title 38, United States Code, to require the Secretary of Veterans Affairs to reimburse veterans receiving emergency treatment in non-Department of Veterans Affairs facilities for such treatment until such veterans are transferred to Department facilities, and for other purposes, having considered an amended version of the same, reports favorably thereon, and recommends that the bill, as amended, do pass.

#### INTRODUCTION

On October 4, 2007, Committee member Senator Sherrod Brown introduced S. 2142, the proposed "Veterans Emergency Care Fairness Act of 2008." On October 24, 2007, the Committee held a hearing on pending veterans' health legislation at which testimony on an amended version of S. 2142, among other bills, was offered by: Michael J. Kussman, MD, MS, MACP, the Department of Veterans Affairs' Under Secretary for Health; Carl Blake, National Legislative Director, Paralyzed Veterans of America; and Joy J. Ilem, Assistant National Legislative Director, Disabled American Veterans. The witnesses expressed support for S. 2142 on behalf of their respective organizations. VA supported the legislation, and Under Secretary Kussman indicated that VA was also working on improving the reimbursement process for veterans receiving emergency care at non-VA facilities.

## COMMITTEE MEETING

After carefully reviewing the testimony from the foregoing hearing, the Committee met in open session on November 14, 2007, to consider, among other legislation, an amended version of S. 2142. The Committee agreed by voice vote to report favorably S. 2142, as amended, to the Senate.

## SUMMARY OF S. 2142 AS REPORTED

S. 2142, as reported (hereinafter, “the Committee bill”), would amend sections 1725 and 1728 of title 38, United States Code, to make reimbursement for emergency care received at non-VA facilities mandatory for eligible veterans.

Section 2(a) would make the reimbursement of veterans for emergency care received at non-VA facilities mandatory by amending section 1725 of title 38. The amended text would also clarify when VA’s obligation to reimburse ends by more clearly defining the conditions for transfers and patient stabilization.

Section 2(b) would amend section 1728 of title 38 to conform to section 1725 by making the provision mandatory. To ensure consistency, “care and services” would be replaced by “emergency treatment.” A new subsection, subsection (c), would also be added in order to use a consistent definition of “emergency treatment,” as defined in proposed new section 1725(f)(1).

## BACKGROUND AND DISCUSSION

The Committee bill was developed in response to the need for clearer procedures for reimbursement by VA when veterans receive emergency care at non-VA facilities.

Under current law, section 1728 of title 38 authorizes the Secretary to pay the expenses incurred by a veteran for emergency treatment services when delay of such services would have been hazardous to the life or health of the veteran; treatment of a service-connected disability; treatment of a non-service-connected disability aggravating a service-connected disability; treatment of any disability of a veteran with a permanent and total disability; or for a covered vocational rehabilitation purpose. Expenses incurred after the medical emergency has ended, and after the point in time when the veteran may be transferred safely to VA or another Federal facility, may not be reimbursed. Pursuant to current section 1725, the Secretary may also reimburse a veteran for expenses incurred for emergency treatment provided at a non-VA facility for a non-service connected disability.

VA’s interpretation of the existing authority for emergency care reimbursement has created difficulties for veterans and non-VA hospitals seeking reimbursement. A November 16, 2005, VA Office of General Counsel memorandum supported a narrow interpretation of the statutory authorities, particularly in the context of an emergency that has terminated, thereby ending the obligation to pay. VA’s interpretation has tended to favor the denial of reimbursement claims for continuing care where a transfer attempt is made but VA does not have a bed available. The problems with securing reimbursement can make transfers to alternative (and potentially more suitable) facilities for treatment difficult when VA does not have a bed available.

During a Committee field hearing in New Philadelphia, Ohio, on May 29, 2007, chaired by Senator Brown, problems with the current procedures were highlighted. Specifically, community hospitals in Ohio reported encountering difficulty transferring veterans to an appropriate VA Medical Center and subsequently obtaining reimbursement following emergency care at these facilities. Terry M. Carson, Chief Executive Officer of Harrison Community Hospital, addressed the issue, testifying:

The problem that we experience has to do with treating initial emergency/urgent situations and having little success in being able to transfer veterans to the appropriate Veterans' Hospital Center. Often, we wait days to receive transfer approval, and it is not uncommon for those approvals to be withdrawn during the actual transfer, and change of direction mid-stream.

This testimony highlights the difficulties arising from the current system, which reflects the ambiguities and uncertainty of the existing statutory authorities.

Delays in the transfer from community to VA facilities can jeopardize veterans' health, and place hospitals in the position of being forced to proceed with treatments that would otherwise have been provided by VA. By delaying or refusing the acceptance of veteran transfers, VA adds unnecessary complexity to the reimbursement process. The net result is difficulty for veterans and the hospitals in receiving reimbursement for care.

#### COMMITTEE BILL

Section 2(a) of the Committee bill would amend section 1725 of title 38 in subsections (a)(1) and (f)(1). Subsection (a)(1) would be amended by replacing "may reimburse" with "shall reimburse." This change would make reimbursement for emergency care received at non-VA facilities mandatory for eligible veterans, rather than at the discretion of the Secretary.

Subsection (f)(1) would be amended to provide greater specificity regarding the termination of VA's obligation to reimburse. The ambiguities that have driven the restriction of VA's obligation to pay would be eliminated through the more specific language proposed by the Committee bill, which would specify that VA's obligation to reimburse terminates when the veteran may be transferred safely from the private facility to a VA hospital and the VA facility is capable of accepting the transfer. Alternatively, if VA does not initially have a bed available, VA's obligation to reimburse will terminate only after the veteran is actually transferred to a VA or other Federal facility, so long as the private facility made and documented reasonable efforts to transfer the veteran when he or she was first able to be transferred safely.

Section 2(b) of the Committee bill would amend section 1728 of title 38 so as to make that section, which relates to reimbursement for the emergency treatment of service-connected conditions, consistent with section 1725, as amended by section 2(a) of the Committee bill. Thus, reimbursement would also be made mandatory under Section 1728. The existing criteria, defining veteran eligibility for reimbursement for emergency care services, would be carried over in the revised statutory language.

In addition, section 2(b) would further amend section 1728 so as to strike the phrase “care and services” in current subsection (b) of section 1728, and replace that phrase with “emergency treatment.” This proposed change is designed to promote consistency between section 1725 and 1728 of title 38. This goal of consistency is further reflected in the Committee bill’s proposed addition of subsection (c) to section 1728, to adopt the same definition of “emergency treatment” that would be established in section 1725(f)(1) of the Committee bill.

#### COMMITTEE BILL COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the CBO, estimates that enactment of the Committee bill would increase spending by \$20 million in 2008 and by \$323 million over the 2009–2013 period. Enactment of the Committee bill would not affect direct spending or receipts, and would not affect the budget of state, local or tribal governments.

The cost estimate provided by CBO, setting forth a detailed breakdown of costs, follows:

CONGRESSIONAL BUDGET OFFICE,  
*Washington, DC, January 16, 2008.*

Hon. DANIEL K. AKAKA,  
*Chairman, Committee on Veterans’ Affairs,*  
*U.S. Senate, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 2142, the Veterans Emergency Care Fairness Act of 2007.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sunita D’Monte.

Sincerely,

PETER R. ORSZAG,  
*Director.*

Enclosure.

Summary: S. 2142 would require the Department of Veterans Affairs (VA) to pay for the emergency care certain veterans receive at non-VA medical facilities, or to reimburse veterans if they have paid for that care. CBO estimates that implementing S. 2142 would cost \$20 million in 2008 and an additional \$323 million over the 2009–2013 period, assuming appropriation of the estimated amounts. Enacting the bill would not affect direct spending or revenues.

S. 2142 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 2142 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans benefits and services).

	By fiscal year, in millions of dollars—					
	2008	2009	2010	2011	2012	2013
CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level .....	22	52	58	65	73	82
Estimated Outlays .....	20	49	57	64	72	81

Basis of estimate: For this estimate, CBO assumes that the legislation will be enacted around the middle of fiscal year 2008, that the estimated amounts will be appropriated each year, and that outlays will follow historical spending patterns for the VA medical services program.

Under two different sections of law, VA currently has the authority to reimburse certain veterans or to pay for emergency care provided at non-VA facilities. S. 2142 would amend and enhance those authorities. Based on information from VA, CBO estimates that by requiring VA to pay for longer (on average) lengths of stay in private medical facilities, the bill would cost \$20 million in 2008 and another \$323 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

#### *Reimbursements under current law*

Under 38 U.S.C. 1725, VA may reimburse veterans or pay for emergency treatment of a nonservice-connected condition, if VA is the payer of last resort. Under this section of law, emergency treatment is defined as care or services provided for a medical emergency where a prudent layperson could reasonably expect that a delay in seeking medical attention would be hazardous to life or health. According to VA data on payments made under 38 U.S.C. 1725, VA paid a total of \$123 million in 2006—\$103 million for inpatient treatment provided to about 18,200 veterans (\$1,200 per day, for an average length of stay of 4.7 days) and \$20 million for ancillary care.

Under 38 U.S.C. 1728, VA may reimburse certain veterans with service-connected conditions or those who are covered for purposes of a vocational rehabilitation program if medical professionals determine that a medical emergency exists. Data from VA on payments made under 38 U.S.C. 1728 indicate that in 2006 VA paid \$83 million for treatment provided to 7,800 veterans (\$1,900 per day, for an average length of stay of 5.6 days).

Under both sections of current law, VA can make payments only until the veteran's condition has stabilized and he or she can be transferred safely to a VA or other federal facility, regardless of whether any such facility is actually available to accept such a transfer.

#### *Additional reimbursements under S. 2142*

S. 2142 would amend those authorities by establishing the prudent layperson definition of emergency treatment for both sections of law and requiring VA to pay for treatment until the veteran is transferred to a VA or other federal facility, or the veteran is otherwise discharged from the hospital. Under the bill, some veterans who incur medical costs after they are deemed to be stable but before they are transferred to a VA or other federal facility would now be eligible for additional payments from VA.

Data from the 2005 National Hospital Discharge Survey indicate that male patients over age 45 who were admitted through the emergency department stayed in the hospital for an average of 5.4 days. CBO estimates that under the bill, the average length of stay for which veterans would be reimbursed would rise from 4.7 days to 5.4 days, and VA's costs under 38 U.S.C. 1725 would increase by \$10 million in 2008 and by an average of \$30 million a year over the 2009–2013 period, assuming appropriation of the estimated amounts. (Costs rise sharply starting in 2009, because CBO assumes the bill would be enacted in mid-2008.)

Based on information from VA, CBO estimates that under S. 2142, veterans who are eligible for reimbursement under 38 U.S.C. 1728—primarily veterans with service-connected disabilities—would be reimbursed for hospital stays averaging 6.6 days. CBO also expects that by establishing a prudent layperson definition of medical emergencies, the bill would increase the number of eligible veterans by 5 percent each year. Thus, CBO estimates that under the bill, costs under 38 U.S.C. 1728 would rise by \$10 million in 2008 and by an average of \$35 million a year over the 2009–2013 period, assuming appropriation of the estimated amounts.

Intergovernmental and private-sector impact: S. 2142 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Estimate prepared by: Federal costs: Sunita D'Monte; Impact on state, local, and tribal governments: Lisa Ramirez-Branum; Impact on the private sector: Victoria Liu.

Estimate approved by: Theresa Gullo, Deputy Assistant Director for Budget Analysis.

#### REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

#### TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee at its November 14, 2007, meeting. On that date, the Committee, by voice vote, ordered S. 2142, as amended, reported favorably to the Senate.

#### AGENCY REPORT

On October 24, 2007, Michael J. Kussman, MD, MS, MACP, the Department of Veterans Affairs Under Secretary for Health, appeared before the Committee and submitted testimony on, among other things, the Veterans Emergency Care Fairness Act of 2007. Excerpts of this statement are reprinted below:

## STATEMENT OF THE VIEWS OF THE ADMINISTRATION

Michael J. Kussman, MD, MS, MACP, Under Secretary for Health  
for the Department of Veterans Affairs

Good morning Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services. With me today is Walter A. Hall, Assistant General Counsel. I will address the five bills on today's agenda and then I would be happy to answer any questions you and the Committee members may have.

S. 2142 "VETERANS EMERGENCY CARE FAIRNESS ACT OF 2007"

S. 2142 would make mandatory, standardize, and enhance the two existing authorities the Secretary has to pay for expenses incurred in connection with a veteran's receipt of emergency treatment in a non-VA facility. The two authorities under which the Secretary may currently pay these claims are discretionary in nature ("may reimburse" as opposed to "shall reimburse") and cover different veteran populations and use different standards to define a medical emergency.

As background, the Secretary is authorized to pay the reasonable expenses incurred by a veteran for non-VA emergency treatment of a service-connected disability, a non-service-connected disability aggravating a service-connected disability, any disability of a veteran with a permanent and total disability, or for a covered vocational rehabilitation purpose. In these claims, VA medical professionals must determine whether a medical emergency existed (i.e., if there was an actual emergency of such nature that delay in obtaining treatment would have been hazardous to life or health). Expenses incurred after the medical emergency has ended, that is, after the point in time the veteran could have been transferred safely to VA or another Federal facility, may not be reimbursed.

The Secretary may also reimburse or pay a veteran for expenses incurred for non-VA emergency treatment of a non-service connected disability. In these claims, the law requires use of a prudent layperson standard to determine the need for the non-VA emergency treatment. Thus, if it turns out that the veteran's condition was not an actual medical emergency, VA can still pay the expenses if a prudent layperson would have thought it reasonable for the veteran to seek immediate medical treatment. This happens, for instance, when a veteran goes to the nearest emergency room because of the belief he or she is having a heart attack but turns out only to have a severe case of heartburn. Similar to claims for service-connected conditions, the Secretary is only authorized to pay for the emergency treatment expenses, and the emergency ends at the point the veteran can be transferred safely to a VA facility or other Federal facility.

S. 2142 would amend both existing authorities by requiring the Secretary to pay the expenses of any veteran who meets eligibility criteria. It would also standardize these programs by applying the prudent layperson definition of "emergency treatment" in both situations. And most importantly it would define "emergency treat-

ment” as continuing until (1) the point in time the veteran can be transferred safely to a VA or other Federal facility, or (2) such time as a VA facility or other Federal facility agrees to accept such transfer if, at the time the veteran could have been transferred safely, the non-VA provider makes and documents reasonable attempts to transfer the veteran to a VA facility or other Federal facility.

VA strongly supports S. 2142; effective emergency room reimbursement has been an issue of concern to the Department. In fact, VA is in the process of drafting regulations to address these concerns within the authority it has under current law.

It is VA’s expectation that facilities aggressively work to accept the transfer of a veteran in these situations. We are aware, however, that there have been cases where VA has been unable to find a facility that had the bed, capability, staff, or resources needed to furnish the care required by the veteran. In those cases, which we believe are the exception and not the norm, the non-VA providers ultimately billed the veterans for those expenses. This can impose a serious monetary hardship for our beneficiaries.

S. 2142 would properly put the financial onus on the Department to provide appropriate care either in the VA or Federal system or at the non-VA facility. Enrolled veterans are eligible for needed hospital or medical care. Good medical practice demands we furnish such care in a manner that advances a seamless continuum of care and reduces fragmentation of such care. Clearly these goals are best achieved by bringing the veteran into the VA health care system as soon as possible. In those rare cases where VA cannot immediately agree to accept the patient transfer, it would be entirely appropriate for VA to be responsible for the expenses related to the veteran’s needed continued hospital care in the private facility until the point VA can take over.

When VA initiated drafting regulations for this program choice, it determined funds were available within the FY2008 President’s Budget level for this expanded benefit.

As a final and more technical matter, I would like to clarify that if a veteran currently meets the eligibility criteria on which his or her claim is based, VA invariably pays the claim. Thus, changing the Secretary’s authority from “may” to “shall” for purposes of both types of claims would have no practical effect. Nevertheless, we do not object to such a change.

\* \* \* \* \*

CHANGES IN EXISTING LAW MADE BY THE COMMITTEE BILL, AS  
REPORTED

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, changes in existing law made by the Committee bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

# TITLE 38, UNITED STATES CODE

## PART II—GENERAL BENEFITS

### CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

\* \* \* \* \*

#### Subchapter III—Miscellaneous Provisions Relating to Hos- pital and Nursing Home Care and Medical Treatment of Veterans

\* \* \* \* \*

#### § 1725. Reimbursement for emergency treatment

(a) GENERAL AUTHORITY.—

(1) Subject to subsections (c) and (d), the Secretary **may reimburse** shall reimburse a veteran described in subsection (b) for the reasonable value of emergency treatment furnished the veteran in a non-Department facility.

\* \* \* \* \*

(f) DEFINITIONS.—For purposes of this section:

(1) The term “emergency treatment” means medical care or services furnished, in the judgment of the Secretary—

(A) when Department or other Federal facilities are not feasibly available and an attempt to use them beforehand would not be reasonable;

(B) when such care or services are rendered in a medical emergency of such nature that a prudent layperson reasonably expects that delay in seeking immediate medical attention would be hazardous to life or health; and

**[(C) until such time as the veteran can be transferred safely to a Department facility or other Federal facility.]**

*(C) until—*

*(i) such time as the veteran can be transferred safely to a Department facility or other Federal facility and such facility is capable of accepting such transfer; or*

*(ii) such time as a Department facility or other Federal facility accepts such transfer if—*

*(I) at the time the veteran could have been transferred safely to a Department facility or other Federal facility, no Department facility or other Federal facility agreed to accept such transfer; and*

*(II) the non-Department facility in which such medical care or services was furnished made and documented reasonable attempts to transfer the veteran to a Department facility or other Federal facility.*

\* \* \* \* \*

#### § 1728. Reimbursement of certain medical expenses

**[(a) The Secretary may, under such regulations as the Secretary shall prescribe, reimburse veterans entitled to hospital care or**

medical services under this chapter for the reasonable value of such care or services (including travel and incidental expenses under the terms and conditions set forth in section 111 of this title), for which such veterans have made payment, from sources other than the Department, where—

【(1) such care or services were rendered in a medical emergency of such nature that delay would have been hazardous to life or health;

【(2) such care or services were rendered to a veteran in need thereof

【(A) for an adjudicated service-connected disability,

【(B) for a non-service-connected disability associated with and held to be aggravating a service-connected disability,

【(C) for any disability of a veteran who has a total disability permanent in nature from a service-connected disability, or

【(D) for any illness, injury, or dental condition in the case of a veteran who

【(i) is a participant in a vocational rehabilitation program (as defined in section 3101 (9) of this title), and

【(ii) is medically determined to have been in need of care or treatment to make possible such veteran's entrance into a course of training, or prevent interruption of a course of training, or hasten the return to a course of training which was interrupted because of such illness, injury, or dental condition; and

【(3) Department or other Federal facilities were not feasibly available, and an attempt to use them beforehand would not have been reasonable, sound, wise, or practical.】

*(a) The Secretary shall, under such regulations as the Secretary prescribes, reimburse veterans eligible for hospital care or medical services under this chapter for the customary and usual charges of emergency treatment (including travel and incidental expenses under the terms and conditions set forth in section 111 of this title) for which such veterans have made payment, from sources other than the Department, where such emergency treatment was rendered to such veterans in need thereof for any of the following:*

*(1) An adjudicated service-connected disability.*

*(2) A non-service-connected disability associated with and held to be aggravating a service-connected disability.*

*(3) Any disability of a veteran if the veteran has a total disability permanent in nature from a service-connected disability.*

*(4) Any illness, injury, or dental condition of a veteran who—*

*(A) is a participant in a vocational rehabilitation program (as defined in section 3101(9) of this title); and*

*(B) is medically determined to have been in need of care or treatment to make possible the veteran's entrance into a course of training, or prevent interruption of a course of training, or hasten the return to a course of training which was interrupted because of such illness, injury, or dental condition.*

*(b) In any case where reimbursement would be in order under subsection (a) of this section, the Secretary may, in lieu of reim-*

bursing such veteran, make payment of the reasonable value of  
【care or services】 *emergency treatment* directly—

(1) to the hospital or other health facility furnishing the  
【care or services】 *emergency treatment*; or

(2) to the person or organization making such expenditure on  
behalf of such veteran.

*(c) In this section, the term 'emergency treatment' has the meaning  
given such term in section 1725(f)(1) of this title.*

\* \* \* \* \*

