
Veterans Law Review

COMMENTARY

UNREASONABLE DELAY ACCESSING HEALTH CARE THROUGH THE VA: HOW TO IMPROVE VETERANS' ACCESS TO MENTAL HEALTH CARE AND INCREASE VA ACCOUNTABILITY

NAOMI AHSAN

INTRODUCTION	68
I. CURRENT POLITICAL CONTEXT FOR VA ACTION	69
II. CURRENT STATUTORY AND REGULATORY REGIME	71
III. BARRIERS TO ACCESSING VA HEALTH CARE	74
IV. JUDICIAL REVIEW OF DELAYS IN ACCESSING VA HEALTH CARE	76
V. THE VETERANS ACCESS, CHOICE AND ACCOUNTABILITY ACT OF 2014	82
VI. RECOMMENDATIONS	83
CONCLUSION	86

Unreasonable Delay Accessing Health Care Through the VA: How to Improve Veterans' Access to Mental Health Care and Increase VA Accountability

Naomi Ahsan¹

INTRODUCTION

I finally got to the VA for help and was diagnosed with PTSD but not enough to get a disability [rating high enough to receive monetary compensation or priority for health care]. I was shot down three times. I've still got anger in me. I thought I'd be taken care of for life when I joined the service, but when they let you go, they let you go.

—Art, Marine Corps Veteran²

The law authorizes health care for veterans with service-connected health conditions through the Department of Veteran Affairs (the VA).³ But some veterans cannot access the benefits⁴ they are eligible for until their situation is beyond repair. Marine Cameron Anestis, after serving in Iraq and returning home to Kentucky in 2009, reached out to a local Kentucky VA medical facility for assistance with psychological issues that had developed during his 2009 deployment to Iraq.⁵ Just hours after he was turned away from two VA medical facilities, he fatally shot himself at his home, leaving behind a wife and young daughter.⁶

Congress passed the Veterans' Access, Choice and Accountability Act of 2014 ("Veterans Access Act")⁷ in response to increased public awareness of veteran mental health issues, including suicide and

¹ Naomi Ahsan is an associate at Keller and Heckman LLP in Washington, D.C. She received her Juris Doctorate from the American University Washington College of Law and her Bachelor's of Science in Neuroscience from the University of Rochester.

² BARRY R. SCHALLER, *VETERANS ON TRIAL: THE COMING COURT BATTLES OVER PTSD* 185 (2012) (quoting the author's interview of a Marine given the pseudonym "Art," who was deployed to the Persian Gulf during the first Gulf War).

³ 38 U.S.C. § 1710 (2012) (establishing veterans' eligibility for hospital care and medical services as administered by the VA); *see also* 38 U.S.C. § 1701(5)(B) (defining "hospital care" to include "such mental health services, consultation, professional counseling, marriage and family counseling, and training for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as the Secretary considers appropriate"); 38 U.S.C. § 1701(6) (defining "medical services" to include medical examinations, treatment, rehabilitative services, surgical services, optometric and podiatric services, preventive health services, certain medical equipment, and "such other supplies or services as the Secretary determines to be reasonable and necessary." Note that Medicare is also administered under a standard of providing items and services that are "reasonable and necessary" under 42 U.S.C. § 1395 (2012), which provides that Medicare may only pay for what is "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member").

⁴ Disability benefits are important benefits for service-connected health conditions, especially because veterans' health conditions may preclude full-time employment. However, this Comment focuses on health benefits, because more analysis has focused on disability benefits than health benefits, and access to health benefits may have a unique ability to prevent veteran suicides by alleviating the symptoms of mental illness that are factors. The terminology may be confusing, because the required criteria for awards of disability benefits and for health benefit priority group assignments both include a "service-connected disability rating," also referred to as a "service-connected disability." *See* 38 U.S.C. § 1110 (2012) (explaining that "service-connected" means that a disability resulted from an injury or disease incurred in the line of duty during active military service); 38 U.S.C. § 1153 (2012) (explaining that "service-connected" also applies to aggravation or a preexisting injury or disease during active military service).

⁵ Eric Katz, *Why Obama's Mental Health Initiatives Will Leave Many Veterans Without Help*, DEFENSE ONE (Sept. 3, 2014), <http://www.defenseone.com/management/2014/09/why-obamas-mental-health-initiatives-will-leave-many-veterans-without-help/93092/> (providing the background of a Marine's suicide, which involved mental health issues). Cameron Anestis's widow successfully sued the VA for failing to provide emergency medical attention. *See infra* Part IV.

⁶ *See* Katz, *supra* note 5 (discussing past failures to provide mental health care and explaining that the executive actions that President Obama announced in August 2014 will not be sufficient for addressing all the problems veterans currently face in accessing care for mental health issues).

⁷ Veterans Access to Care through Choice, Accountability, and Transparency Act of 2014 ("Veterans Access Act"), Pub. L. No. 113-146,

long wait times for VA health care appointments. The Veterans Access Act expands access to mental health care providers for veterans who currently receive VA health benefits—particularly for veterans assigned to lower priority groups of VA health benefits. However, the statute does not address the barriers to care arising from long wait times both for initial screening appointments and the adjudication of the service-connected injury claims that qualify veterans for coverage, categorize their rates of co-payment for care, and determine their priority for care at VA medical facilities.⁸

This Comment analyzes existing VA statutes and regulations and proposes several actions to improve veterans' access to care for mental health issues and increase the VA's accountability for any lack of access. Part I discusses the current political context for actions that will improve access, analyzes the increasing burden of veterans with posttraumatic stress disorder (PTSD),⁹ and reviews the recent scandals at the VA and subsequent executive actions. Part II reviews the history of the VA's health care system and the statutes and regulations that currently apply. Part III discusses barriers to accessing VA care, including legal difficulties with benefits eligibility determinations, reluctance to seek care based on stigma and the questionable confidentiality of mental health records, dishonorable discharges that disqualify veterans from receiving benefits, and long wait times for appointments. Part IV examines whether judicial review has been effective in addressing barriers to accessing VA care and concludes that VA adjudicative bodies are effectively inaccessible due to backlogs, and that federal courts provide an alternative forum only in limited circumstances. Part V analyzes whether the Veterans' Access Act addresses barriers to accessing VA care and examines the lack of judicial remedies available to challenge those barriers. Part VI offers recommendations for the VA, federal courts, and Congress to address the problems accessing health care and available judicial remedies. This Comment concludes that the Veterans' Access Act takes important steps to expand veterans' access to health benefits and care for mental health issues, but additional efforts are needed.

I. CURRENT POLITICAL CONTEXT FOR VA ACTION

Mental health is an increasingly critical area for the VA for two reasons. First, veterans have returned from Afghanistan and Iraq with unprecedented rates of traumatic brain injuries (TBI).¹⁰ In the past, service members were more often killed by the same circumstances of combat.¹¹ Innovation in body and vehicle

§ 101(b), 128 Stat. 1754 (2014) (establishing several new procedures for holding the VA accountable to Congress, and for funding private medical care for veterans eligible for VA health benefits).

⁸ *Id.* § 101(b)(1)(A), 128 Stat. at 1756 (explaining that a veteran is an eligible veteran for purposes of the section establishing access to private providers if, as of August 1, 2014, the veteran is enrolled in the VA's patient enrollment system); *see also* 38 C.F.R. § 17.36(b) (2015) (providing that when veterans enroll for health benefits, they are assigned to one of eight groups corresponding to the priority of their care, based on the severity of the veteran's service-connected disability).

⁹ Among the conditions for which veterans may seek mental health care, this Comment focuses on posttraumatic stress disorder (PTSD) because of its connection to the particular combat conditions that members of the military have experienced in Operations Enduring Freedom, Iraqi Freedom, and New Dawn. *See* SCHALLER, *supra* note 2, at 7 (explaining how combat PTSD can be distinguished from PTSD observed in the general population and describing the conditions of combat that members of the military have experienced in Iraq and Afghanistan, which are very unpredictable). However, PTSD is often comorbid with other mental health issues, such as traumatic brain injury and depressive disorders, in addition to conditions outside the mental health realm. *See id.* at 17 (explaining that PTSD, traumatic brain injury, and depressive disorders regularly appear together in various combinations).

¹⁰ *See* BARTON F. STICHMAN ET AL., VETERAN BENEFITS MANUAL 210-11 (2013) (explaining that traumatic brain injury (TBI) is considered a "signature disability" of the Afghanistan and Iraq conflicts, and that the increased incidence of TBI has been linked to increased exposure from blasts of improvised explosive devices, improved protective equipment, improved combat medicine, and improved screening and diagnosis).

¹¹ *See* Nema Milaninia, *The Crisis at Home Following the Crisis Abroad: Health Care Deficiencies for U.S. Veterans of the Iraq and Afghanistan Wars*, 11 DEPAUL J. HEALTH CARE L. 327, 328-29 (2008) (discussing how unconventional warfare has resulted in high degrees of mental stress even in the absence of physical injuries, and how the VA system is incapable of handling the current number of patients in need of mental health care assistance).

protective equipment has improved survival rates from shrapnel injuries caused by blasts from improvised explosive devices (IEDs), but it cannot prevent IED blast waves from injuring the brain.¹² Second, recently returned veterans have also exhibited PTSD at higher rates than veterans of past wars.¹³ Projections from current data suggest that thirty-five percent of all military service members deployed to Afghanistan and Iraq will develop PTSD.¹⁴ PTSD is, in turn, a risk factor for various other issues, such as depression,¹⁵ substance abuse,¹⁶ homelessness,¹⁷ and cardiovascular disease.¹⁸ Veterans with PTSD are less likely to find and retain employment upon their return to the United States.¹⁹ Their families are also much more likely to suffer when they come home.²⁰ PTSD in a parent can lead to long-term damage to a child's development.²¹

Suicide is probably the most known and documented consequence of PTSD and related mental health disorders.²² An average of approximately twenty-two veterans committed suicide each day in 2010,²³ and the VA has acknowledged that at least 1,000 suicide attempts are made every month by veterans of all eras.²⁴ For veterans with depression and a history of depressive episodes, the

¹² See Gregg Zoroya, *How the IED Changed the U.S. Military*, USA TODAY (Dec. 19, 2013), <http://www.usatoday.com/story/news/nation/2013/12/18/ied-10-years-blast-wounds-amputations/3803017/> (explaining the various incidences of new health issues observed among military service members who survive explosions of improvised explosive devices).

¹³ SCHALLER, *supra* note 2, at 16-17 (discussing several studies on the current prevalence of PTSD).

¹⁴ *Id.* at 17-18 (noting that PTSD may take years to manifest, meaning the prevalence will ultimately be greater than what can currently be measured).

¹⁵ See Leo Sher et al., *Posttraumatic Stress Disorder, Depression and Suicide in Veterans*, CLEVELAND CLINIC J. MED. 92 (Feb. 2012) (demonstrating that combat veterans are more likely to have suicidal ideation, often associated with PTSD and depression, and are also more likely to act on a suicidal plan). The authors explain that eighty percent of patients with PTSD meet the criteria for at least one other psychiatric disorder, that symptoms overlap significantly for PTSD and depression, and that the coexistence of PTSD and depression increases the risk of suicidal ideation and behavior. See *id.* at 93-94; see also Milaninia, *supra* note 11, at 328-29 (discussing the high rates of PTSD observed among veterans of the wars in Iraq and Afghanistan, and the many related issues for veterans and their families); Jacob B. Natwick, *Unreasonable Delay at the VA: Why Federal District Courts Should Intervene and Remedy Five-Year Delays in Veterans' Mental-Health Benefits Appeals*, 95 IOWA L. REV. 723, 727-28 (2009) (discussing numerous possible consequences for veterans returning from combat with PTSD and depression, including a higher risk of suicide).

¹⁶ See Kipling M. Bohnert, et al., *The Association Between Substance Use Disorders and Mortality Among a Cohort of Veterans with Posttraumatic Stress Disorder: Variation by Age Cohort and Mortality Type*, 128 DRUG & ALCOHOL DEPENDENCE 98, 98 (2013) (suggesting that veterans afflicted with both PTSD and substance abuse disorders face a greater risk of death and assessing the combined impact of drug or alcohol use disorders in association with PTSD using findings from veterans returning from Iraq and Afghanistan).

¹⁷ See Jack Tsai et al., *Homeless Veterans Who Served in Iraq and Afghanistan: Gender Differences, Combat Exposure, and Comparisons with Previous Cohorts of Homeless Veterans*, 40 ADMIN. & POLICY IN MENTAL HEALTH & MENTAL HEALTH SERV. RESEARCH 400, 400 (2012) (showing that sixty-seven percent of homeless Iraq and Afghanistan veterans in the studied sample had PTSD, whereas earlier cohorts of homeless veterans had shown PTSD rates between eight percent and thirteen percent).

¹⁸ RAND CTR. FOR MILITARY HEALTH POLICY RESEARCH, *INVISIBLE WOUNDS OF WAR: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY* 131-32 (Terri Tanielian & Lisa H. Jaycox eds., 2008), <http://www.rand.org/pubs/monographs/2008/RANDMG720.pdf> [hereinafter RAND CTR.].

¹⁹ *Id.* at 137-40 (concluding that veterans with PTSD are as much as three times less likely to be employed than veterans with no mental health disorder, and are frequently less productive and lower-earning workers than veterans with no mental health disorder).

²⁰ *Id.* at 141-46 (determining that intimacy and relationship satisfaction are negatively affected by PTSD, and that individuals with PTSD have a higher risk of domestic violence due to problems restraining anger and aggression); see also Amy N. Fairweather, *Compromised Care: The Limited Availability and Questionable Quality of Health Care for Recent Veterans*, 35 HUMAN RIGHTS 2, 3 (2008) (stating that reports of divorce and family violence among veterans are on the rise).

²¹ Patricia Lester et al., *The Long War and Parental Combat Deployment: Effects on Military Children and At-Home Spouses*, 49 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 310, 310 (2011) ("parental distress . . . and cumulative length of parental combat-related deployments during the child's lifetime independently predicted increased child depression and externalizing symptoms").

²² Carl Andrew Castro & Sara Kintzle, *Suicides in the Military: The Post-Modern Combat Veteran and the Hemingway Effect*, 16 CURRENT PSYCHIATRY REPORTS 460, 461 (2014) ("[B]eginning in 2004, hospitalizations increased for depression and PTSD, consistent with early findings showing an increase in suicide rates of Army personnel in Iraq, and well before the observed overall Army increase in suicide rates from 2008 to present."); RAND CTR., *supra* note 18, at 129 ("Depression, PTSD, and TBI all increase the risk for suicide.").

²³ Castro & Kintzle, *supra* note 22, at 460.

²⁴ See Fairweather, *supra* note 20, at 4 (discussing the phenomenon of veterans' high rates of suicide); see generally Lindsay I. McCarl, *"To Have No Yesterday": The Rise of Suicide Rates in the Military and Among Veterans*, 46 CREIGHTON L. REV. 393, 399-405 (2013)

risk of suicide attempts is eleven times greater than that of the general population.²⁵ Minnesota Representative Tim Walz introduced a bill in the House of Representatives to address this issue—the Clay Hunt Suicide Prevention for American Veterans Act, named for an Iraq and Afghanistan Marine who shot and killed himself in 2011.²⁶

The high rate of veteran suicide suggests that veterans do not have adequate access to VA health care for PTSD and other health issues due to unacceptably long wait times for appointments. The VA has only recently begun to get credible measures of wait times.²⁷ Falsification of records about wait times²⁸ fueled a scandal that led to the resignation of former VA Secretary Eric Shinseki on May 30, 2014,²⁹ and precipitated the passage of the Veterans Access Act in August of 2014. President Obama also announced several executive actions on August 26, 2014, that dealt with conducting suicide prevention trainings, expanding mental health peer support to veterans being treated in primary care settings, and automatically enrolling military personnel receiving mental health care in the Department of Defense system into mental health treatment programs by the VA.³⁰

II. CURRENT STATUTORY AND REGULATORY REGIME

Health care was originally made a benefit of U.S. military service by Congress in 1884,³¹ but the origins of the modern system date back to when the VA began implementing managed care practices in 1995.³² VA health care is administered by the Veterans Health Administration (VHA), headed by the VA

(providing comparative analysis of suicide rates in veterans of past and current wars, including World Wars I and II, the Vietnam War, the Persian Gulf War, and the Iraq and Afghanistan Wars).

²⁵ See Natwick, *supra* note 15, at 728.

²⁶ See Katz, *supra* note 5 (discussing recent efforts in Congress to address the problems that veterans currently face in accessing mental health care); Clay Hunt Suicide Prevention for American Veterans Act, Pub. L. No. 114-2, 239 Stat. 30 (2015).

²⁷ See VA Secretary Robert McDonald, *A Message from the Secretary: An Open Letter to America's Veterans* (Nov. 5, 2014), <http://www.va.gov/opa/choiceact/documents/Open-Letter-to-Veterans.pdf> (providing updates on implementation of Veterans Access Act and notifying veterans about how to access private health care when faced with increased wait times due to lack of available appointments within a desired thirty-day period or by the date determined to be medically necessary by a physician).

²⁸ See Dennis Wagner & Michelle Ye Hee Lee, *Scathing VA Report Stirs Outcry for Accountability*, AZ CENT. (Aug. 27, 2014, 7:24 AM), <http://www.azcentral.com/story/news/arizona/investigations/2014/08/26/scathing-va-report-stirs-outcry-accountability/14665455/> (describing reactions to the final investigative report of the Office of Inspector General (“OIG”) on the Phoenix VA system’s problems in August 2014). Physicians Sam Foote and Katherine Mitchell asserted that forty-five examples in the OIG report show delayed care likely resulted in premature deaths or harm to patients’ quality of life. *Id.*; see also Katie Zezima, *Everything You Need to Know About the VA—and the Scandals Engulfing It*, WASH. POST (May 30, 2014), <http://www.washingtonpost.com/blogs/the-fix/wp/2014/05/21/a-guide-to-the-va-and-the-scandals-engulfing-it/> (providing overview of the wait-time falsification scandal, which began in April 2014 when a retired doctor at the VA hospital in Phoenix alleged that long wait times may have contributed to the deaths of as many as forty veterans and noting a preliminary investigation’s finding that delays and falsified records were widespread throughout the VA system).

²⁹ See Michael D. Shear & Richard A. Oppel, Jr., *V.A. Chief Resigns in Face of Furor on Delayed Care*, N.Y. TIMES, May 31, 2014, at A1; see also Associated Press, *VA Moves to Fire Four Senior Executives Due to Scandal*, CBS NEWS (Oct. 6, 2014), <http://www.cbsnews.com/news/va-moves-to-fire-4-senior-executives-due-to-scandal/> (describing the first dismissals of VA officials since Congress passed the Veterans Access Act, including a top purchasing official at the VHA, directors of VA hospitals in Pittsburgh and Dublin, Georgia, and a regional hospital director in central Alabama); see also Emily Wax-Thibodeaux, *VA Secretary: Happy Veterans Day, ‘Largest Restructuring’ of VA Underway*, WASH. POST (Nov. 10, 2014), <http://www.washingtonpost.com/blogs/federal-eye/wp/2014/11/10/va-secretary-happy-veterans-day-massive-restructuring-of-va-underway/> (quoting VA Secretary McDonald as saying “the largest restructuring in the department’s history is under way,” and noting that McDonald’s announcements of at least thirty-five people facing disciplinary action, with as many as a thousand to follow).

³⁰ See Gregory Korte, *Obama to Veterans: New Culture of Accountability at VA*, USA TODAY (Aug. 26, 2014), <http://www.usatoday.com/story/news/politics/2014/08/26/obama-veterans-american-legion/14607759/> (summarizing President Obama’s announcement of nineteen executive actions on August 26, 2014).

³¹ See Michael J. Jackonis et al., *War, Its Aftermath, and U.S. Health Policy: Toward a Comprehensive Health Program for America's Military Personnel, Veterans, and Their Families*, 36 J.L. MED. & ETHICS 677, 679 (2008) (explaining the history of the VA as well as its statutory mandates).

³² See STICHMAN ET AL., *supra* note 10, at 717 (explaining the organization of the VA health care system).

Undersecretary for Health,³³ which has a mission of serving veterans by “providing exceptional health care that improves their health and well-being.”³⁴ The VA is charged by statute³⁵ to provide veterans with necessary medical services, including mental health care, from the VHA,³⁶ and the provision of care is required to be timely and acceptable in quality.³⁷ The VHA is further required to provide readjustment counseling and mental health services “upon request.”³⁸

The VHA geographically divides the country into twenty-one Veterans Integrated Service Networks (“VISNs”),³⁹ which individually manage and coordinate care within their boundaries through VA medical centers and Community-Based Outpatient Clinics (“CBOCs”).⁴⁰ Most veterans access VA health care through CBOCs.⁴¹ CBOCs are outpatient primary care access points located in areas with a high concentration of veterans, and they tend to be located within one or two hours’ driving distance from one of the 153 VA medical centers.⁴² CBOCs have, however, been slow to integrate mental health services.⁴³ There are over 800 such clinics, but most do not provide mental health care services, despite the fact that one out of every three soldiers returning from Iraq visited a VA medical center for mental health treatment within one year of returning home.⁴⁴ By 2009, all VA medical centers were staffed with a suicide prevention officer, but CBOCs were not.⁴⁵

Unlike Medicare or Medicaid, the VHA operates through a capped annual aggregate appropriation, rather than an open-ended entitlement funding authority that can grow as the need increases.⁴⁶ All veterans honorably discharged are generally eligible to enroll at any time.⁴⁷ Health care is rationed among eight active priority groups.⁴⁸ Priority group assignment is based on discharge status,

³³ *Id.*

³⁴ Veterans Health Admin., *About VHA*, U.S. DEP’T OF VETERANS AFFAIRS, <http://www.va.gov/health/aboutVHA.asp> (last visited Oct. 28, 2016); see Jackonis et al., *supra* note 31, at 680 (providing history and background on the origin of veterans’ health benefits).

³⁵ Veterans’ Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (codified as amended in scattered sections of 38 U.S.C.) (establishing two eligibility categories for veterans to receive health care and requiring VHA to manage the provision of hospital care and medical services through an enrollment system based on a system of priorities). The first category of veterans eligible to receive health care includes veterans with service-connected disabilities, former prisoners of war, veterans exposed to toxic substances and environmental hazards such as Agent Orange, veterans whose attributable income and net worth are not greater than an established “means test,” and veterans of World War I. The second category includes veterans with no service-connected disabilities and with attributable incomes above the means test. See also 38 U.S.C. § 101(16) (2012); 38 C.F.R. §§ 4.1-4.31 (2015) (providing that the VA determines whether veterans have service-connected disabilities and assigns disability ratings from zero percent to one hundred percent, in increments of ten percent, based on the severity of the disability).

³⁶ 38 U.S.C. §§ 1701(5)(B), 1710 (2012).

³⁷ *Id.* § 1705(b)(1) (“the Secretary . . . shall ensure that the system will be managed in a manner to ensure that the provision of care to enrollees is timely and acceptable in quality”).

³⁸ *Id.* § 1712A (requiring that “[u]pon the request of any individual [who has served on active duty in an area at a time during which hostilities occurred in that area], the Secretary shall furnish counseling” to assist the veteran in readjusting to civilian life, and providing that counseling “may include a comprehensive individual assessment of the individual’s psychological, social, and other characteristics to ascertain whether . . . the individual has difficulties associated with readjustment to civilian life”).

³⁹ *Veterans Health Administration Locations*, U.S. DEPT. OF VETERANS AFFAIRS, http://www2.va.gov/directory/guide/division_flash.asp?dnum=1 (listing all VA health care facilities in the VA system) (last visited Aug. 1, 2016).

⁴⁰ See STICHMAN ET AL., *supra* note 10, at 717.

⁴¹ See Andrew Silverio, *Constitutional Law—Ninth Circuit Guts the VA: Amidst Alarming PTSD and Suicide Rates, The Current System Violates Veterans’ Rights to Health Care—Veterans for Common Sense v. Shinseki*, 644 F.3d 845 (9th Cir. 2011), 8 J. HEALTH & BIOMEDICAL L. 117, 118-19 (2012) (discussing facilities that veterans go to for their VA health care).

⁴² See Jackonis et al., *supra* note 31, at 681.

⁴³ See Silverio, *supra* note 41, at 119.

⁴⁴ *Id.* at 118-19, 131 n.11.

⁴⁵ *Id.* at 131 n.11.

⁴⁶ See Jackonis et al., *supra* note 31, at 680.

⁴⁷ 38 C.F.R. § 17.36(d)(1) (2015) (explaining that a veteran who wishes to be enrolled must apply by submitting a completed VA Application for Health Benefits to a VA medical facility).

⁴⁸ 38 U.S.C. § 1705(a) (2012) (establishing priority groups based on percentage disability rating—Priority Group One receives the highest

length of active duty, financial need, and whether the veteran has a condition (disability) that occurred or began during active service.⁴⁹ Current law provides that “[n]ew combat veterans . . . have a presumption of service-connected eligibility and may enroll for five years after separation from the military and are placed in Priority Group Six unless otherwise qualified for a higher priority group.”⁵⁰

Wait times for appointments depend partly on a veteran’s priority group assignment.⁵¹ Before the Veterans Access Act, “only Priority Group One veterans are ‘guaranteed’ a primary or specialized appointment within thirty days.”⁵² To be placed in Priority Group One, a veteran must be at least fifty percent disabled due to service-connected disability.⁵³

If a veteran has to wait for an appointment, he or she can appeal that determination, but only if it came from a medical practitioner; to do so, a veteran must lodge a complaint to a “Patient Advocate,” who is an employee of the VHA and a colleague of the doctor or nurse whose decision is being challenged.⁵⁴ The Patient Advocate forwards the complaint to the center’s Chief of Staff, whose decision can be further appealed to the Director of the VISN.⁵⁵ If a veteran disagrees with the Director’s decision, he or she “can ask the VISN Director to request an external review.”⁵⁶ The veteran is not automatically notified of the results.⁵⁷ If the VISN director refuses to share the results of the external review with the veteran, the only manner in which the veteran might obtain the results would be through a Freedom of Information Act request.⁵⁸ A veteran cannot appeal the determination that he or she should go on a wait list for care if it was an administrative decision.⁵⁹

A veteran may also appeal his or her priority group assignment by filing a Notice of Disagreement (“NOD”).⁶⁰ The NOD allows the veteran to appeal the doctor’s determination about whether benefits are needed to the Board of Veterans’ Appeals (BVA).⁶¹ The BVA then issues a decision.⁶² Following an unfavorable decision by the BVA, the veteran may appeal to the United States Court of Appeals for Veterans’ Claims (the CAVC), an Article I Court.⁶³ A veteran can pursue further appellate

priority, while Priority Group Eight receives the lowest).

⁴⁹ *Id.* § 1701(1) (defining “disability” as any “disease, injury, or other physical or mental defect”).

⁵⁰ Fairweather, *supra* note 20, at 4.

⁵¹ *See id.* (“Health care is then rationed among seven active priority groups”).

⁵² *Id.* Wait-time goals are defined as “not more than [thirty] days from the date on which a veteran requests an appointment for hospital care or medical services” from the VA. 38 U.S.C. § 101(s)(1) (2012).

⁵³ 38 U.S.C. § 1705(a)(1).

⁵⁴ VETERANS HEALTH ADMIN., VHA PATIENT ADVOCACY PROGRAM (2005) [hereinafter VHA PATIENT ADVOCACY HANDBOOK], http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1303 (establishing the Patient Advocacy Program in accordance with VHA Directive 1050.2); *see also* *Veterans for Common Sense v. Peake*, 563 F. Supp. 2d 1049, 1068 (N.D. Cal. 2008) (listing claims made by Veterans for Common Sense and explaining appeals process for veteran health benefits).

⁵⁵ *See Veterans for Common Sense*, 563 F. Supp. 2d at 1068-69.

⁵⁶ *Id.* at 1069.

⁵⁷ *Veterans for Common Sense v. Shinseki*, 644 F.3d 845, 855 (9th Cir. 2011), *vacated*, 678 F.3d 1013 (9th Cir. 2012); *see also* Silverio, *supra* note 41, at 120-21 n.17 (discussing the difference between appeals processes that veterans may access and the process of federal court litigation).

⁵⁸ *Veterans for Common Sense*, 644 F.3d at 855; *see generally* 5 U.S.C. § 552(a)(2) (2012).

⁵⁹ *Veterans for Common Sense*, 563 F. Supp. 2d at 1068.

⁶⁰ 38 C.F.R. § 20.201(b) (2015) (providing that “written communication from a claimant or his or her representative expressing dissatisfaction or disagreement with an adjudicative determination by the agency of original jurisdiction and a desire to contest the result will constitute a Notice of Disagreement”).

⁶¹ *Id.* § 20.101 (establishing the Board of Veterans’ Appeals’ jurisdiction).

⁶² *Id.*

⁶³ 38 U.S.C. § 7252(a) (2012) (providing that the United States Court of Appeals for Veterans Claims (CAVC) shall have exclusive jurisdiction to review decisions of the Board of Veterans’ Appeals).

review to the United States Court of Appeals for the Federal Circuit (Federal Circuit) and ultimately to the United States Supreme Court (Supreme Court).⁶⁴ Most cases do not reach beyond the BVA level, as many veterans give up their claims after long delays, and those veterans who choose to further appeal the decision face many obstacles in addition to even longer delays.⁶⁵ Simply reaching the BVA level can take years, because the VA is not subject to any time limits at any stage of the appeals process.⁶⁶

III. BARRIERS TO ACCESSING VA HEALTH CARE

There are several reasons that veterans do not timely access the health care that the VA is charged with providing, particularly for mental health issues. These include arduous and confusing legal procedures regarding establishing and appealing the disability ratings that establish access to health benefits; veterans' reluctance to seek out care for mental health issues; bars to receiving benefits because of dishonorable discharges based on conduct connected with PTSD; and the long wait times that enrolled veterans encounter when they try to make a health care appointment.

A. Difficulties in Establishing and Appealing Service-Connected Disability Ratings Used to Determine Eligibility for VA Health Care Benefits

One issue relating to access to care is difficulty in proving an injury's connection to service.⁶⁷ Like the ailments in toxic tort suits,⁶⁸ PTSD can take many years to manifest, tolling the enhanced benefits eligibility period.⁶⁹ Relating details of the traumatic experience is itself often a trigger for PTSD symptoms and a prime reason why veterans abandon claims.⁷⁰ In addition, many veterans are ill-equipped to handle the process successfully.⁷¹ The many hurdles—bureaucracy, rules, regulations, procedures, and paperwork—can be overwhelming.⁷² A veteran claiming disability must file more than twenty administrative forms.⁷³ The District Court for the Northern District of California noted that “because of the limited formal education of the majority of recent veterans, many had difficulty applying for and ultimately receiving the benefits to which they were legally entitled.”⁷⁴ To be more specific,

⁶⁴ *Id.* § 7292 (providing that after the CAVC decides a case, any party to the case may obtain a Federal Circuit review of the decision with respect to “the validity of a decision of the Court on a rule of law or of any statute or regulation (other than a refusal to review the schedule of ratings for disabilities adopted under section 1155 of this title) or any interpretation thereof (other than a determination as to a factual matter) that was relied on by the Court in making the decision”).

⁶⁵ See Natwick, *supra* note 15, at 729, 738 (explaining the appeals process).

⁶⁶ Silverio, *supra* note 41, at 121 n.21 (explaining 2011 findings that veterans who initiate a direct appeal wait an average of 336 days to receive a decision on their cases; those who file a Notice of Disagreement and choose to obtain a Statement of the Case before filing an appeal with the BVA wait on average 1,419 days—3.9 years—to receive a decision on their appeal).

⁶⁷ See Fairweather, *supra* note 20, at 4 (explaining the barriers and difficulties that veterans face in applying for disability benefits based on service injuries).

⁶⁸ Anthony Z. Roisman et al., *Preserving Justice: Defending Toxic Tort Litigation*, 15 *FORDHAM ENVTL. L. REV.* 191, 195 (2004) (noting that in toxic tort cases, the perceived injury may not manifest until long after the exposure to a toxic substance).

⁶⁹ Fairweather, *supra* note 20, at 4 (“PTSD and some physical ailments associated with combat can take many years to manifest”). This issue has been explicitly recognized and addressed by the VA in the context of exposure to Agent Orange and certain other herbicide agents in Vietnam. See, e.g., 38 U.S.C. § 1116 (2012) (establishing presumption of service connection for certain diseases associated with exposure to herbicide agents while serving in Vietnam “notwithstanding that there is no record of evidence of such disease during the period of such service”).

⁷⁰ Fairweather, *supra* note 20, at 4.

⁷¹ *Id.*

⁷² Jacksonis, et al., *supra* note 31, at 684 (discussing the reasons why veterans struggle with application and appeals processes).

⁷³ Alexandra S. Haar, *Sweet Dreams Aren't Made of These: How the VA's Disability Compensation Program Leaves Veterans Alone in the Nightmare of Posttraumatic Stress Disorder*, 88 *WASH. U. L. REV.* 969, 985 (2011).

⁷⁴ Silverio, *supra* note 41, at 121 (discussing *Veterans for Common Sense v. Peake*, 563 F. Supp. 2d 1049, 1070 (N.D. Cal. 2008)).

“[eighty-two percent] of the Army personnel deployed have a high school diploma or less, [and eighty-nine percent] of the Marines deployed have a high school diploma or less.”⁷⁵

Veterans also are obstructed from accessing health care by time-consuming difficulties with their benefits determinations.⁷⁶ Between October 2007 and March 2008, at least 1,467 veterans died while waiting for a final decision on their benefits appeals.⁷⁷ On average, veterans who pursue an appeal of their benefits decision must wait five years before a decision is reached.⁷⁸ Further, one analysis found that of the claims the Board remanded for further development in the first three months of 2008, “nineteen to forty-four percent are ‘avoidable remands’ stemming from errors made at the regional level and resulting in significant further delay.”⁷⁹

B. Veterans’ Reluctance to Seek Care Specifically for Mental Health Issues

An additional problem is that not all service members and veterans seek care of their own volition, possibly due to the stigma of a diagnosis or to the fear of implications for retention and promotion, as communications with a military psychotherapist are not guaranteed to be confidential.⁸⁰ In 2006, “[d]espite the high number of soldiers with mental health concerns, only [twenty to forty percent] of veterans showing evidence of psychological harm actually sought mental health care.”⁸¹ The VHA cannot proactively reach out to veterans to give them mental health care they have never solicited or previously received.⁸² If outgoing service members were not previously in the mental health system, they are free to reenter civilian life without any mandatory psychological care.⁸³

C. Dishonorable Discharges Bar Veterans from Receiving VA Health Care

Bad conduct discharges disqualify veterans from receiving disability benefits or health care.⁸⁴ This is primarily an issue for veterans of the recent wars who suffer from PTSD, and who are discharged from the military for behavior stemming from their combat injury.⁸⁵ It has been noted that it is “common for the performance of service members with TBI or PTSD to suffer, whether from diminished capacity, self-medicating substance issues, or reckless or reclusive behaviors symptomatic with these

⁷⁵ *Id.* at 121 n.19 (quoting *Veterans for Common Sense*, 563 F. Supp. 2d at 1070).

⁷⁶ Natwick, *supra* note 15, at 729.

⁷⁷ *Id.* at 742-43.

⁷⁸ *Id.* at 725.

⁷⁹ See Silverio, *supra* note 41, at 121 (citing *Veterans for Common Sense*, 644 F.3d at 859-60).

⁸⁰ Milaninia, *supra* note 11, at 330 (discussing the reasons that veterans may not voluntarily seek care, including stigma); Caroline Brown, *The Urgent Need for Confidential Psychological Care for U.S. Military*, THE ATLANTIC (Jan. 8, 2013), <http://www.theatlantic.com/health/archive/2013/01/the-urgent-need-for-confidential-psychological-care-for-us-military/266381/> (suggesting that greater confidentiality is needed in military-provided psychological care because active duty service members do not confide in military psychotherapists for fear of stigma and retribution).

⁸¹ Milaninia, *supra* note 11, at 329, 329 n.13.

⁸² See Madeline McGrane, *Post-Traumatic Stress Disorder in the Military: The Need for Legislative Improvement of Mental Health Care for Veterans of Operation Iraqi Freedom and Operation Enduring Freedom*, 24 J. L. & HEALTH 183, 202-03 (2010) (“A mental health examination is only offered to a veteran after he or she seeks medical attention.”).

⁸³ 38 U.S.C. § 1720F (establishing a suicide prevention program for veterans). This section was passed as an amendment to Title 38 of the United States Code, and it is known as the Joshua Omvig Veterans Suicide Prevention Act. See McGrane, *supra* note 82, at 196-97.

⁸⁴ 38 U.S.C. § 5303 (2012); 38 C.F.R. § 3.12 (2015) (discussing the effect character of discharge has on the availability of benefits); see Fairweather, *supra* note 20, at 4; see also Dan Lamothe, *Long Road Still Ahead for Vietnam Veterans Seeking PTSD-Related Discharge Upgrades*, WASH. POST (Sept. 4, 2014), <http://www.washingtonpost.com/news/checkpoint/wp/2014/09/04/long-road-still-ahead-for-vietnam-veterans-seeking-ptsd-related-discharge-upgrades/> (explaining that, since 1980, it has been possible for veterans to receive a medical discharge for PTSD).

⁸⁵ See Rebecca Izzo, *In Need of Correction: How the Army Board for Correction of Military Records Is Failing Veterans with PTSD*, 123 YALE L. J. 1587, 1589 (suggesting that tens of thousands of veterans with bad discharges have suffered from PTSD).

injuries.”⁸⁶ A bill introduced in both houses of Congress in 2013—the Servicemember Mental Health Review Act⁸⁷—addressed this concern by requiring an expanded Physical Disability Board of Review to review disability determinations for individuals who were discharged since September 11, 2001, due to unfitness for duty because of a mental health condition.⁸⁸ Any reversals would enable former service members who were not previously eligible to seek VA care.⁸⁹

D. Wait Times for VA Health Appointments

Even veterans who have established their disability rating and eligibility for VA health care and have enrolled in the health care system encounter an additional barrier to accessing VA health care: the long wait times for appointments.⁹⁰ In 2008, there were an estimated 84,450 veterans on VHA waiting lists for mental health services.⁹¹ One reason for the long wait times is the insufficient number of psychiatrists in the VA health care system; the VA Office of the Inspector General said in 2012 that the VA’s greatest challenge in the mental health area is recruiting and retaining psychiatrists.⁹² In response to increasing public outrage, particularly about the long wait times for VA health care, Congress passed the Veterans Access Act, which President Barack Obama signed into law on August 7, 2014.⁹³

IV. JUDICIAL REVIEW OF DELAYS IN ACCESSING VA HEALTH CARE

Judicial review is a tool for holding the VA accountable for delays in access to health care.⁹⁴ This Comment has described, however, that VA adjudicatory bodies are backlogged with cases such as appeals of disability ratings within the VA system, leading to long delays in resolving claims.⁹⁵ These delays would plague any claim filed with the VA.⁹⁶ Further, the CAVC is unlikely to take cases with factual questions, as the CAVC “has historically set aside over three-fourths of the BVA decisions that it reviews on merits.”⁹⁷ It is also almost impossible to appeal decisions on factual findings from the CAVC to the Federal Circuit, as the Federal Circuit has held that, except as related to constitutional issues, it

⁸⁶ See Fairweather, *supra* note 20, at 24.

⁸⁷ H.R. 975, 113th Congress (2013); S. 628, 113th Congress (2013). The bills were not voted on in either chamber.

⁸⁸ U.S. COMM’N ON CIVIL RIGHTS, SEXUAL ASSAULT IN THE MILITARY 5, 43 (2013), http://www.usccr.gov/pubs/09242013_Statutory_Enforcement_Report_Sexual_Assault_in_the_Military.pdf.

⁸⁹ See Matthew E. Costellor & Martin M. Ellison, *Helping Military Veterans Navigate the Legal Framework of Discharge Upgrades*, ORANGE COUNTY LAW., Nov. 2014, at 10, 12.

⁹⁰ See Fairweather, *supra* note 20, at 3.

⁹¹ *Veterans for Common Sense v. Shinseki*, 644 F.3d 845, 855 (9th Cir. 2011).

⁹² Alicia Ault, *VA Health Care Reform Signed into Law*, CLINICAL PSYCHIATRY NEWS DIGITAL NETWORK (Aug. 7, 2014), <http://www.clinicalpsychiatrynews.com/home/article/va-health-care-reform-signed-into-law/058a4b8bee8521f459e0f6ebcb21b1be.html> (providing perspectives from the psychiatry profession on the passage of the Veterans Access Act).

⁹³ *Id.*

⁹⁴ Any suit against the VA also requires a valid waiver of sovereign immunity by the VA. See Contessa M. Wilson, *Saving Money, Not Lives: Why the VA’s Claims Adjudication System Denies Due Process to Veterans with Post-Traumatic Stress Disorder and How the VA Can Avoid Judicial Intervention*, 7 IND. HEALTH L. REV. 157, 168-69 (2010) (explaining the waiver of sovereign immunity in the context of the *Veterans for Common Sense* district court opinion, which was affirmed in part, reversed in part, and remanded with instructions). This issue is not discussed further because it was not determinative in the cases examined in this Comment.

⁹⁵ See *supra* Part III.A; see also Rory E. Riley, *Preservation, Modification, or Transformation? The Current State of the Department of Veterans Affairs Disability Benefits Adjudication Process and Why Congress Should Modify, Rather Than Maintain or Completely Redesign, the Current System*, 18 FED. CIR. B. J. 1, 19 (2009) (noting that “the CAVC has been criticized as not having the will to compel the VA to deliver timely and accurate decisions to those who present claims before it”).

⁹⁶ See Haar, *supra* note 73, at 985-87.

⁹⁷ See *id.* at 986-87.

does not have jurisdiction over the factual determinations in the CAVC's decisions.⁹⁸

Given the delays in VA's adjudicatory system and the difficulties of escalating cases within that system, this Comment assesses the effectiveness of judicial review of VA action by federal courts. *Veterans for Common Sense v. Shinseki*⁹⁹ and *Anestis v. United States*¹⁰⁰ provide recent examples of different answers to the question of whether a federal court has jurisdiction over a claim involving veterans' benefits under the Veterans' Judicial Review Act,¹⁰¹ based on the court's construction of the definition of "benefits determination."¹⁰²

A. The Veterans' Judicial Review Act

Veterans' claims are subject to preclusion from initial federal court review by the Veterans' Judicial Review Act ("VJRA").¹⁰³ The VJRA created the CAVC, an Article I court, to conduct independent judicial review of VA decisions.¹⁰⁴ The law designates certain types of legal issues as being within the jurisdiction of the VA,¹⁰⁵ including claims that require review of VA benefits decisions.¹⁰⁶ In *Anestis*, the U.S. Court of Appeals for the Sixth Circuit noted that "Section 511(a) [of the VJRA] has been interpreted to require a [federal] district court to first determine whether adjudication of the claim would require the district court to review the Secretary's decision regarding benefits."¹⁰⁷ If so, the district court lacks jurisdiction over the claim, and parties must pursue a claim with the CAVC, with the possibility of escalating to the Federal Circuit.¹⁰⁸ If the claim does not require the court to review a benefits decision, the action may move forward in federal district court.¹⁰⁹

B. Types of Potential Claims

i. The Administrative Procedure Act

The Administrative Procedure Act (APA) establishes a judicial remedy for unreasonable delays in agency action.¹¹⁰ Section 706 of the APA provides for judicial review of agency actions, giving reviewing courts the power to "compel agency action unlawfully withheld or unreasonably delayed."¹¹¹ Section 704 of the APA states, however, that only "[a]gency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court, are subject to judicial review."¹¹² Therefore, in the context of challenging a veteran's inability to access mental health care through the

⁹⁸ *Bastien v. Shinseki*, 599 F.3d 1301, 1305 (Fed. Cir. 2010).

⁹⁹ *Veterans for Common Sense v. Shinseki*, 678 F.3d 1013 (9th Cir. 2012).

¹⁰⁰ *Anestis v. United States*, 749 F.3d 520 (6th Cir. 2014).

¹⁰¹ Pub L. No. 100-687, 102 Stat. 4105 (1988) (codified at 38 U.S.C. § 511 (2012)).

¹⁰² *Anestis*, 749 F.3d at 528.

¹⁰³ *Id.* at 525-27.

¹⁰⁴ See 38 U.S.C. § 7252 (2012) (creating the CAVC); *id.* § 7261(a)(1) (empowering the CAVC to "decide all relevant questions of law, interpret constitutional, statutory, and regulatory provisions, and determine the meaning or applicability of the terms of an action of the Secretary").

¹⁰⁵ See Wilson, *supra* note 94, at 167.

¹⁰⁶ 38 U.S.C. § 511 (2012).

¹⁰⁷ *Anestis*, 749 F.3d at 525 (citing *Price v. United States*, 228 F.3d 420, 422 (D.C. Cir. 2001)).

¹⁰⁸ *Id.* at 525; *Veterans for Common Sense v. Shinseki*, 678 F.3d 1013, 1025-26 (9th Cir. 2012).

¹⁰⁹ See *Anestis*, 749 F.3d at 525.

¹¹⁰ 5 U.S.C. §§ 701-06 (2012) (noting original enactment in June 1946).

¹¹¹ *Id.* § 706.

¹¹² *Id.* § 704.

VA, a plaintiff would have to establish both that a VA agency action was final, and that the veteran had no other adequate remedy in a court in order for the district court to provide judicial review based on a waiver of sovereign immunity.¹¹³

ii. The Constitutional Right to Due Process

The Fifth Amendment to the United States Constitution requires “due process of law” for any proceeding that denies a citizen “life, liberty or property.”¹¹⁴ In this author’s opinion, viewing entitlement to health care services as property, veterans enrolled in VA health care may argue that the VA deprives them of property by denying care or delaying care to a point that care is effectively denied. To have standing for such a claim, a veteran must first show that he or she has suffered “particularized harm” that affects him or her “in a personal and individual way.”¹¹⁵

iii. Medical Malpractice

Experiencing a delay in care may be framed as the tort claim of medical malpractice under state law, with the harm being based on the worsening of a veteran’s condition.¹¹⁶ A medical malpractice claim typically requires the plaintiff to prove (1) the existence of a provider-patient relationship; (2) that the health care provider violated the applicable standard of care and thereby breached the duty to the patient (e.g., by failing to provide care); (3) that the violation of that duty caused the plaintiff legally cognizable damage; and (4) that a causal relationship exists between the violation and the alleged harm.¹¹⁷

A key difference between medical malpractice and an ordinary negligence claim is that the duty violated arises specifically from the relationship between the health care professional and the patient.¹¹⁸ This author notes, however, that a veteran filing a claim about initial difficulties in scheduling an appointment might have little to no evidence regarding the existence of a doctor-patient relationship, precisely because they have yet to see a provider. However, a veteran may also bring a medical malpractice claim alleging violation of a hospital’s duty rather than a provider’s.¹¹⁹

C. Case Studies: *Veterans for Common Sense v. Shinseki* and *Anestis v. United States*

i. Veterans for Common Sense v. Shinseki

Two veterans’ advocacy organizations, Veterans for Common Sense (“VCS”) and Veterans United for Truth, sued the VA in 2008 for delays both in adjudicating benefits appeals and providing mental health care.¹²⁰ They brought the suit in the United States District Court for the Northern District of California and sought declaratory and injunctive relief, claiming that the manner in which the VA

¹¹³ See *id.* §§ 702, 704, 706.

¹¹⁴ U.S. CONST. amend. V.

¹¹⁵ See *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992).

¹¹⁶ BARRY A. LINDAHL, 3 MODERN TORT LAW: LIABILITY AND LITIGATION § 25:1 (2d ed.) (last updated June 2015).

¹¹⁷ See *id.*

¹¹⁸ See *id.* § 25:3 (describing different ways of establishing a physician-patient relationship).

¹¹⁹ See, e.g., *Anestis v. United States*, 749 F.3d 520 (6th Cir. 2014) (bringing federal tort claim alleging that VA committed medical malpractice by not treating her husband).

¹²⁰ *Veterans for Common Sense v. Shinseki*, 678 F.3d 1013, 1017 (9th Cir. 2012).

provides mental health care and disability benefits violated both statutory¹²¹ and constitutional rights.¹²² The district court found for the VA on all claims.¹²³ VCS appealed to the United States Court of Appeals for the Ninth Circuit (the Ninth Circuit), which affirmed the district court's conclusion that the VA's Regional Office procedures satisfied due process and further held that the district court did not have jurisdiction to reach the remaining issues.¹²⁴ The Supreme Court denied VCS's petition for certiorari.¹²⁵

In reaching its conclusion, the Ninth Circuit decided that, under the VJRA, the district court lacked jurisdiction to consider VCS's various claims for relief related to the VA's provision of mental health care, including its challenge to the lack of procedures by which veterans could appeal the VA's administrative scheduling decisions.¹²⁶ The Ninth Circuit reasoned that there was no way for the district court to resolve whether the VA acted in a timely and effective manner in regard to the provision of mental health care without touching on benefits decisions; it would have to evaluate the circumstances of individual veterans and their requests for treatment and determine whether the VA had handled those requests properly.¹²⁷ However, a dissenting opinion concluded that the majority's interpretation of VJRA Section 511 has "nearly universal sweep" and thus precluded any federal court from determining whether the VA properly handled requests for treatment.¹²⁸

The Ninth Circuit construed a definition of "benefit" that did not distinguish between a disability benefits determination and provision of mental health care.¹²⁹ The Court said that mental health care and disability compensation are both "clearly 'benefits,' so any 'question of fact or law' that 'affects the provision of [those benefits] by the Secretary' falls under the ambit of [VJRA] section 511."¹³⁰ The Court cited the definition of "benefit" as "any payment, service, . . . or status, entitlement to which is determined under laws administered by the [VA] pertaining to veterans and their dependents and survivors."¹³¹

ii. *Anestis v. United States*

After his deployment to Iraq for about nine months, Marine Cameron Anestis returned home to Lexington, Kentucky in April 2009.¹³² On August 17, 2009, Mr. Anestis's parents urged him to seek medical treatment at the local VA hospital after he emotionally described a traumatic incident to them which apparently involved two children's deaths.¹³³ He went to the Leestown Road VA clinic, "one of four divisions of the Lexington VA medical center."¹³⁴ Mr. Anestis recounted traumatic experiences in Iraq to the intake clerk, who noticed that he was in a disturbed mental state and might be suicidal.¹³⁵

¹²¹ See *id.*; see also 5 U.S.C. §§ 704, 706 (2012); 38 U.S.C. § 1705(b)(1) (2012) ("the Secretary shall ensure that the system will be managed in a manner to ensure that the provision of care to enrollees is timely and acceptable in quality").

¹²² *Veterans for Common Sense*, 678 F.3d at 1017 (alleging violations of the Due Process Clause of the Fifth Amendment of the United States Constitution).

¹²³ *Id.* at 1018.

¹²⁴ *Id.* at 1037.

¹²⁵ Petition for Writ of Certiorari, *Veterans for Common Sense v. Shinseki*, 133 S.Ct. 840 (2013) (No. 12-296).

¹²⁶ *Veterans for Common Sense*, 678 F.3d at 1037.

¹²⁷ *Id.* at 1028-29.

¹²⁸ *Id.* at 1040 (Shroeder, J., dissenting).

¹²⁹ *Id.* at 1026.

¹³⁰ *Id.*

¹³¹ *Id.* (citing 38 C.F.R. § 20.3(e) (2015)).

¹³² *Anestis v. United States*, 52 F. Supp. 3d 854, 856 (E.D. Ky. 2014).

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

However, Mr. Anestis seemed not to be enrolled for VA health benefits.¹³⁶ In accordance with the facility's operating procedures, the clerk referred Mr. Anestis to the Cooper division of the Lexington VA system, where Mr. Anestis could properly enroll for benefits and access emergency care.¹³⁷ Mr. Anestis then traveled to the Cooper division, where he was also turned away because he did not have his DD Form 214 with him.¹³⁸ Mr. Anestis then went home to find the form.¹³⁹ Unable to find it, he became enraged, physically assaulting his wife and threatening to kill her before he shot himself.¹⁴⁰

Under the Federal Tort Claims Act ("FTCA"),¹⁴¹ Mr. Anestis's widow, Tiffany Anestis, sued the United States for medical malpractice in the United States District Court for the Eastern District of Kentucky (the Eastern District of Kentucky), contending that the VA had a duty to treat Mr. Anestis when he presented himself at their Kentucky facilities with an emergent condition.¹⁴² The Eastern District of Kentucky granted the United States's motion to dismiss on the grounds that the VJRA deprived it of jurisdiction to hear the claim.¹⁴³

On appeal, the United States Court of Appeals for the Sixth Circuit (the Sixth Circuit) held that the VJRA applied only to benefits determinations, and as the decisions of the Leestown and Cooper VA clinics did not constitute a benefits determination, the VJRA did not deprive federal courts of jurisdiction over Ms. Anestis's claim.¹⁴⁴ In analyzing whether Section 511a of the VJRA precludes federal courts from determining whether the VA properly handled requests for treatment, the Sixth Circuit noted that the D.C. Circuit had "reject[ed] any implication that all action or inaction by the VA represents a type of 'service'" and concluded that it had jurisdiction over Tiffany Anestis's case because it did not involve a review of a benefits determination.¹⁴⁵

The reasoning was that Tiffany Anestis did not challenge the VA's decisions and actions regarding Cameron Anestis's application for benefits or his eligibility or enrollment status; she did not argue that he should have been eligible for VA benefits.¹⁴⁶ Rather, she asserted that in turning him away from the VA when he was in a "state of emergency," the VA had violated its duty as a hospital, irrespective of his status as a veteran.¹⁴⁷ As the Sixth Circuit noted, "VA policy [at the time] required its facilities to provide medical care to anyone in urgent need of assistance, even if the individual was ineligible for benefits or did not present a hard copy of his DD Form 214, or was not even a veteran."¹⁴⁸ Tiffany Anestis argued that the "VA violated standards of medical care and its own policies by refusing treatment when Cameron presented himself at two VA facilities in a state of emergency."¹⁴⁹ Thus, her claim did not require review of any benefits determination.¹⁵⁰

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.* at 857; see Nat'l Archives & Records Admin., *DD Form 214, Discharge Papers and Separation Documents*, <https://www.archives.gov/st-louis/military-personnel/dd-214.html> (last reviewed Aug. 15, 2016) (explaining that the DD Form 214 is a Certificate of Release or Discharge from Active Duty, issued by the U.S. Department of Defense upon a military service member's retirement, separation, or discharge from active-duty military service).

¹³⁹ *Anestis*, 52 F. Supp. 3d at 857.

¹⁴⁰ *Id.*

¹⁴¹ 28 U.S.C. § 1346 (2012).

¹⁴² *Anestis v. United States*, 749 F.3d 520, 522 (6th Cir. 2014).

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 525.

¹⁴⁵ *Id.* at 525-27 (quoting *Thomas v. Principi*, 394 F.3d 970, 975 (D.C. Cir. 2005)).

¹⁴⁶ *Id.* at 527.

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

The Sixth Circuit distinguished the plaintiff's claims in *Anestis* from those in *Veterans for Common Sense*, resolving confusion regarding how to apply the reasoning from *Veterans for Common Sense* to cases like *Anestis*.¹⁵¹ The Sixth Circuit held that VCS's claim was like the one in *Beamon v. Brown*,¹⁵² because the district court clearly would have needed to review a benefits determination in order to reach a decision.¹⁵³ The Sixth Circuit contrasted that fact pattern with that of *Anestis*, concluding that adjudicating Tiffany Anestis's claim did not require the court to review the VA Secretary's determination of benefits and was not a claim involving "benefits masked in tort language."¹⁵⁴

The Sixth Circuit expressly rejected the United States's argument that, despite the fact that the claims in *Anestis* were labeled as torts, they involved a benefits determination because Tiffany Anestis claimed the VA had failed to adhere to their internal policies when Cameron Anestis sought treatment.¹⁵⁵ The Court explained that under such an "expansive interpretation of 'benefits determinations', a person could never sue the VA in [federal] district court . . . for failure to provide medical treatment"; such an interpretation would be overbroad.¹⁵⁶

iii. Comparison of *Veterans for Common Sense* and *Anestis*

Veterans for Common Sense involved claims based on the APA and the Due Process Clause of the Fifth Amendment of the United States Constitution (Fifth Amendment) that addressed system-wide problems in VA administration rather than individual veterans.¹⁵⁷ In contrast, *Anestis* presented a medical malpractice claim under the FTCA that was based on an individual Veteran's experience with a VA facility that was obliged to abide by the laws of the state wherein it was located.¹⁵⁸ Reviewing these cases together suggests that if a veteran's eligibility for benefits in the form of medical care is not a material question of fact, the veteran may be able to sue the VA in federal court for his or her inability to access care through tort claims such as medical malpractice.¹⁵⁹ However, *Veterans for Common Sense* shows that it will be difficult to prevail on a claim based on the Fifth Amendment without asserting harms to individual veterans.¹⁶⁰ Furthermore, under the Ninth Circuit's opinion in *Veterans for Common Sense*, the VJRA seems to insulate the VA from APA-based liability in federal court for unreasonable delays, because it precludes federal courts other than the CAVC from making initial determinations about agency adjudications regarding benefits eligibility.¹⁶¹

The distinction between cases that the VJRA does or does not preclude from federal court review "lies in whether the failure or denial of treatment resulted from a decision by the VA or was the result of the VA's

¹⁵¹ *Id.* at 526.

¹⁵² 125 F.3d 965 (6th Cir. 1997) (considering a putative class action brought by veterans to challenge delays in processing veterans' benefits, and concluding the claims were barred by the Veterans' Judicial Review Act).

¹⁵³ *Anestis*, 749 F.3d at 527.

¹⁵⁴ *Id.* at 528.

¹⁵⁵ *Id.* at 527-28; *Jones v. United States*, 727 F.3d 844, 849 (8th Cir. 2013) (stating that in determining preclusion under 38 U.S.C. § 511(a) (2012), courts must look through the label of an allegation to the claim's "substance").

¹⁵⁶ *Anestis*, 749 F.3d at 528; *see also* *Engine Mfrs. Ass'n v. S. Coast Air Quality Mgmt. Dist.*, 541 U.S. 246, 252 (2004) (quoting *Park 'N Fly, Inc. v. Dollar Park & Fly, Inc.*, 469 U.S. 189, 194 (1985) for the assertion that "[s]tatutory construction must begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose").

¹⁵⁷ *Veterans for Common Sense v. Shinseki*, 678 F.3d 1013, 1017 (9th Cir. 2012).

¹⁵⁸ *Anestis*, 749 F.3d at 522.

¹⁵⁹ *See* 38 U.S.C. § 511(a) ("The Secretary shall decide all questions of law and fact necessary to a decision by the Secretary under a law that affects the provision of benefits by the Secretary to veterans or the dependents or survivors of veterans.").

¹⁶⁰ *Veterans for Common Sense*, 678 F.3d at 1027.

¹⁶¹ *Id.* at 1037.

negligence in failing to abide by a legal duty” independent of benefits determinations.¹⁶² *Anestis* involves the latter; it was based on standards of care that govern medical facilities in Kentucky.¹⁶³ The federal courts would not have jurisdiction over cases like *Veterans for Common Sense*, which the Sixth Circuit described as clearly involving challenging the VA’s decision to deny, delay, reduce, or administer benefits.¹⁶⁴

Analysis of these cases demonstrates that the federal courts cannot compel VA action to remediate systemic access problems based on APA claims. In *Veterans for Common Sense*, the Fifth Amendment claim was decided in favor of the VA,¹⁶⁵ and it is unlikely that an opposite decision will be reached in future cases. The federal courts may decide in favor of individual plaintiffs in medical malpractice suits based on inability to timely access appropriate mental health care,¹⁶⁶ but this is a retrospective action that may not take place until an affected veteran has worsened or died.¹⁶⁷ Many veterans and their families do not have the means to bring a private action, even if they are statutorily entitled to more care or higher quality care than they receive, which limits their access to judicial remedies because they are not entitled to lawyers in civil cases.¹⁶⁸ Thus, veterans have very limited prospects for judicial remedies outside the VA system and the CAVC for their inability to timely access appropriate medical care.

V. THE VETERANS ACCESS, CHOICE AND ACCOUNTABILITY ACT OF 2014

The Veterans Access Act aims to expand access to care through two main strategies. First, the Veterans Access Act appropriates funds for hiring new medical staff¹⁶⁹ and entering new leases for VA facilities.¹⁷⁰ Second, the Act authorizes coverage of care outside the VA system for veterans who are unable to get an appointment at a VA medical facility within VHA wait-time goals or who live more than forty miles from the nearest VA medical facility.¹⁷¹ The law also instates new responsibilities for the VA to report to Congress on various metrics, including wait times.¹⁷²

To address the problem of long wait times and the recent scandal about falsifying records of wait times, section 206 of the Veterans Access Act requires the Secretary to publish wait times for scheduling an appointment at VA facilities in the Federal Register and on a public website for each VA medical center.¹⁷³ This section also requires the VA to publish online current wait times for appointments in primary and specialty care at each VA medical center.¹⁷⁴ Section 203 required VA to review, through the

¹⁶² *Anestis*, 749 F.3d at 527.

¹⁶³ *Id.*

¹⁶⁴ *Veterans for Common Sense*, 678 F.3d at 1030-31.

¹⁶⁵ *Id.* at 1037.

¹⁶⁶ *See Anestis*, 749 F.3d at 529.

¹⁶⁷ *Zezenia*, *supra* note 28 (stating that “veterans have died while waiting for care, though there is no known link between the deaths and delays”); *see generally* Silverio, *supra* note 41.

¹⁶⁸ Silverio, *supra* note 41, at 121 (“[B]ecause of the limited formal education of the majority of recent veterans, many had difficulty applying for and ultimately receiving the benefits to which they were legally entitled. The application process is complex and wrought with procedural pitfalls, and the appeals process for benefits decisions is equally intimidating”).

¹⁶⁹ *See Wax-Thibodeaux*, *supra* note 29 (reporting that Secretary McDonald stated that he plans to hire “about 28,000 medical professionals . . . including about 2,500 mental health professionals”).

¹⁷⁰ Veterans Access Act § 801, 128 Stat. at 1801-02.

¹⁷¹ *Id.* § 101, 128 Stat. at 1755-57.

¹⁷² *See, e.g., id.* § 206, 128 Stat. at 1780-81; *see also* David Wood, *VA Mental Health Care Delays, Staff Shortages, Plague Veterans*, HUFFINGTON POST: POLITICS (Jun. 4, 2014), http://www.huffingtonpost.com/2014/05/24/va-mental-health-delays_n_5380739.html (explaining the scope of the problem of delays in veterans’ accessing care for mental health issues and the guidelines concerning such delays).

¹⁷³ Veterans Access Act § 206, 128 Stat. at 1780-81.

¹⁷⁴ *Id.*

use of a technology task force, the needs of the VA with respect to the appointment scheduling system and software.¹⁷⁵ The task force was required to report to Congress, not later than forty-five days after the date of enactment, with specific actions that the VA could take to improve its scheduling system and software and a determination regarding whether an existing off-the-shelf system could meet the VA's scheduling and access needs.¹⁷⁶ The VA was required to implement the recommendations of the task force deemed to be feasible, advisable, and cost-effective within one year.¹⁷⁷

Through the Veterans Access Act, Congress has addressed the problem of long wait times by introducing a program to fund access to private practitioners, increasing the VA's staff of mental health care providers and the number of VA facilities, and establishing new methods of overseeing the VA to prevent errors and misconduct in the scheduling and wait time calculation processes.¹⁷⁸ However, as noted above, this Comment identifies three other problems with access to health care: dishonorable discharges based on PTSD-related behavior, service members' reluctance to voluntarily seek care from military psychotherapists who may break confidentiality, and difficulties and delays in the VA's system for establishing and appealing service-connected disability ratings used to determine eligibility for VA health care benefits. The new statute does not change the legal bases for dishonorable discharges, exceptions to doctor-patient privilege in military mental health services, or applications and appeals of disability ratings.

VI. RECOMMENDATIONS

This Comment has reviewed ways of holding the VA accountable for delays in accessing health care for service-connected mental health issues through both new procedures for Congressional oversight established by the Veterans Access Act and judicial review of VA action or inaction. The discussion of judicial review shows that there are very limited circumstances in which a veteran can expect a remedy in federal district court for the inability to timely access VA health care.¹⁷⁹ The VA's own adjudicatory system is backlogged and unable to deliver timely remedies.¹⁸⁰ *Veterans for Common Sense* illustrates the difficulties of establishing jurisdiction in federal courts, as well as of succeeding on a claim about system-wide problems rather than about an individual.¹⁸¹ This Part proposes several actions for the VA, Congress, and the Article III courts to take to reduce the frequency of veterans' legal problems with accessing health benefits.

A. Making PTSD Screenings Routine in Military Primary Care

First, screening for PTSD should be routine in both military and VA primary care settings.¹⁸² Screening for major depression is becoming routine in military primary care settings, and this should be the case for PTSD as well.¹⁸³ This screening is one of the ways that the VA could procedurally address

¹⁷⁵ *Id.* § 203, 128 Stat. at 1777.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ *Id.* (providing a technology task force for review); *id.* § 206, 128 Stat. at 1780-81 (requiring the publication of wait times and scheduling); *id.* § 801, 128 Stat. at 1801-02 (setting the appropriation amounts for use by the Secretary).

¹⁷⁹ See generally *supra* Part IV.

¹⁸⁰ See *supra* Part III.A.

¹⁸¹ See *Veterans for Common Sense v. Shinseki*, 678 F.3d 1013, 1028 (9th Cir. 2012) (finding no jurisdiction over claims for relief regarding provision and scheduling of VA mental health care).

¹⁸² See Milaninia, *supra* note 11, at 330 ("studies clearly suggest that the standard practices should be expanded to include consideration for PTSD").

¹⁸³ See, e.g., *VHA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder in Adults* 21 (The Management of

how stigma serves as a barrier to veterans seeking care.¹⁸⁴ The VA could issue a directive to its health system employees and integrate instruction into existing training programs and materials under its statutory authority to prescribe rules and regulations to carry out laws administered by the VA.¹⁸⁵ The VA could even make such screenings for PTSD mandatory.¹⁸⁶

The VA might see mandatory screenings as an inefficient use of its limited resources, especially when many veterans currently refuse voluntary screenings. Further, making the screenings mandatory infringes on the autonomy of veterans and their right to privacy. However, mandatory screenings could be justified by the high rates of PTSD among veterans recently returned from Afghanistan and Iraq and the fact that early intervention can prevent the progression of PTSD as well as other health and social problems.¹⁸⁷

B. Simplifying the Evidentiary Burden for Service-Connected PTSD

One way to simplify the administrative structure of disability rating determinations is to repeal 38 C.F.R. § 3.304(f), the special regulation that pertains only to the award of compensation benefits for PTSD.¹⁸⁸ Then, claims for health benefits for PTSD would be adjudicated under the general three-element service connection regulation that serves as a catch-all for all service connection claims not specially governed by another regulation, which requires only (1) the existence of a present disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship between the present disability and the disease or injury incurred or aggravated during service.¹⁸⁹ Alternatively, the VA could adopt a presumption of service connection for veterans with PTSD who served in Afghanistan or Iraq.¹⁹⁰

The VA may wish to maintain its use of the special regulation for PTSD in order to distinguish veterans who are truly debilitated by PTSD from those who are not and thus do not have the same need for disability benefits.¹⁹¹ However, repealing the special PTSD regulation could make the process of applying for a disability rating easier for veterans and reduce the frequency of remands by reducing the number of theories of entitlement considered and the number of elements adjudicated.¹⁹² Adopting a presumption of service connection would make disability benefits applications even easier for veterans with PTSD.¹⁹³

Major Depressive Disorder Working Grp., Version 3.0, 2016), <http://www.healthquality.va.gov/guidelines/MH/mdd/MDDFULL053013.pdf>.

¹⁸⁴ See Milaninia, *supra* note 11, at 330-31; Charles W. Hoge et al., *Mental Health Problems, Use of Mental Health Services, and Attrition After Returning After Deployment to Iraq or Afghanistan*, 295 J. AM. MED. ASS'N 1023, 1030 (2006).

¹⁸⁵ 38 U.S.C. § 1710 (2012); *see id.* § 501(a) (providing that “the Secretary has authority to prescribe all rules and regulations which are necessary or appropriate to carry out the laws administered by the [VA] and are consistent with those laws,” including regulations regarding “the method of taking and furnishing [proof and evidence] in order to establish the right to benefits” and regarding “the methods of making investigations and medical examinations”).

¹⁸⁶ *See id.* § 501(a).

¹⁸⁷ *See supra* Part III.

¹⁸⁸ 38 C.F.R. § 3.304(f) (2015); Sarah K. Mayes, *Unraveling the PTSD Paradox: A Proposal to Simplify the Adjudication of Claims for Service Connection for Posttraumatic Stress Disorder* 6 VETERANS L. REV. 125, 128 (2014) (explaining that this special regulation creates an evidentiary burden for PTSD claims based on a need to distinguish PTSD from “normal” psychological consequences of combat, by lifting the stressor criterion “out of the realm of medical evidence and setting it firmly in place as a factual determination to be made by the adjudicator”).

¹⁸⁹ 38 C.F.R. § 3.304(a) (referring to § 3.303 for the basic elements of service connection).

¹⁹⁰ *See* Alison Atwater, *When Is a Combat Veteran a Combat Veteran?: The Evidentiary Stumbling Block for Veterans Seeking PTSD Disability Benefits*, 41 ARIZ. ST. L.J. 243, 269 (2009) (proposing that there should be a presumption of service connection for PTSD as there is with Vietnam veterans and conditions associated with herbicide exposure).

¹⁹¹ *See* Mayes, *supra* note 188, at 128.

¹⁹² *Id.* at 176.

¹⁹³ *See* Atwater, *supra* note 190, at 269.

C. Improving the Administrative Procedures for Disability Rating Applications

The VA should also evaluate the effectiveness of quality assurance activities that prevent errors in benefits decisions.¹⁹⁴ This may include expanding or changing the training procedures for adjudicators on disability claims arising from PTSD and monitoring individual adjudicators' rates of remands.¹⁹⁵ In its response to this recommendation from the Government Accountability Office (GAO) in a 2014 report, the VA has stated that it will incorporate quality assurance into a new database system of benefits claims.¹⁹⁶ The VA should also build on the findings of the GAO to further investigate the reasons for benefits claims remands and long processing times, which, in turn, fuel delays in receiving care.¹⁹⁷

The VA should also adopt new, streamlined procedures for handling urgent mental health care requests,¹⁹⁸ with the possibility of expediting disability rating appeals for veterans at high risk for suicide to receive access to mental health care.¹⁹⁹ Although the BVA and Regional Offices are currently required to provide "expeditious treatment" for remanded claims, such a directive has thus far proven ineffective.²⁰⁰ To address this shortcoming, the VA should also adopt deadlines for processing times at each level of its adjudicatory system.²⁰¹

D. Increasing the Confidentiality of Military Mental Health Care

Veterans are often reluctant to seek care that they are entitled to for service-connected mental health issues due to the perceived lack of doctor-patient confidentiality.²⁰² Service members on active duty are wary of the possibility that the military's knowledge of a mental health diagnosis may hinder promotion or retention decisions through official or unofficial means.²⁰³ In fact, communications with a military psychotherapist were not privileged at all until 1999, when President William Clinton established the rule²⁰⁴ with an Executive Order²⁰⁵ under his Article 36(a) authority.²⁰⁶ The existing rule has many exceptions, and the boundaries of the rule are unclear.²⁰⁷ Defining the boundaries of the doctor-patient privilege more clearly may put service members at ease in accessing the military

¹⁹⁴ See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-50, VETERANS' DISABILITY BENEFITS: IMPROVEMENTS COULD FURTHER ENHANCE QUALITY ASSURANCE EFFORTS 25 (2014).

¹⁹⁵ See Riley, *supra* note 95, at 12 (explaining that while increasing the staff for benefits administration would help, this alone would not be sufficient—the VA should also implement adequate supervisory and training procedures).

¹⁹⁶ U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 198, at 26.

¹⁹⁷ See Riley, *supra* note 95, at 11-13.

¹⁹⁸ See Silverio, *supra* note 41, at 129-30 (discussing how even a lower "average" wait time of a few months for mental health care would be an unnecessary delay for veterans with PTSD, who should be considered "high priority").

¹⁹⁹ *Id.*

²⁰⁰ See Riley, *supra* note 95, at 19-20 (discussing the need for Congressional intervention to instruct the CAVC to impose "deadlines" by which to complete remand directives).

²⁰¹ *Id.*

²⁰² See Brown, *supra* note 80 (describing one active-duty Marine's fear that seeking psychiatric care while still in service could affect his discharge status).

²⁰³ See *id.*

²⁰⁴ MANUAL FOR COURTS-MARTIAL, UNITED STATES, MIL. R. EVID. 513 (2002) (establishing protection of psychotherapist-patient privilege for the military) [hereinafter MANUAL FOR COURTS-MARTIAL].

²⁰⁵ Exec. Order No. 13,140, 64 Fed. Reg. 55,115, 55,116-18, 55,122 (Oct. 12, 1999).

²⁰⁶ 10 U.S.C. § 836 (2012) (providing that the President may prescribe rules for military justice).

²⁰⁷ MANUAL FOR COURTS-MARTIAL, *supra* note 204 (listing exceptions to doctor-patient privilege, such as "when necessary to ensure the safety and security of military personnel, military dependents, military property, classified information, or the accomplishment of a military mission"); see also Stacy Flippin, *Military Rule of Evidence (MRE) 513: A Shield to Protect Communications of Victims and Witnesses to Psychotherapists*, 2003 ARMY L. 1, 1 (2003).

psychotherapists that have been made available to them rather than private practitioners for whom they must pay out of pocket.²⁰⁸ The President should thus amend the Military Rule of Evidence on doctor-patient privilege.

E. Defining “Benefits Determination” for the Purposes of the VJRA

This Comment has discussed *Veterans for Common Sense* and *Anestis*, in which the Ninth and Sixth Circuits construed the VJRA’s definition of “benefits determination” differently to determine whether the federal courts had jurisdiction over the questions at issue.²⁰⁹ Congress may put all doubts to rest about the federal courts’ jurisdiction over claims relating to veterans’ health benefits by codifying a definition of “benefits determination” for the purposes of the VJRA.

Until that time, federal courts should not follow the Ninth Circuit’s definition, which includes “any decision made by the Secretary in the course of making benefits determinations.”²¹⁰ An overbroad definition would mean that under no circumstances could anyone ever sue the VA in federal district court for failure to provide medical treatment.²¹¹ Rather, courts should follow the Sixth Circuit and construe “benefits determination” more narrowly, so that the VA can still be liable in federal court for some failures to uphold its legal duties to provide care.

CONCLUSION

The availability of appropriate health care for veterans is important to national security, particularly in a nation that depends on voluntary service.²¹² Many potential recruits are influenced by the experience of veterans in their families and communities, including how they are treated during and after their service.²¹³ Studies conducted prior to Operations Enduring Freedom, Iraqi Freedom, and New Dawn show that “mental disorders are the leading medical correlate with attrition from military service.”²¹⁴ Comprehensive primary care, including health care for mental health issues, “has long been recognized as a foundation of military readiness.”²¹⁵ Access to health care “thus has a direct impact on the nation’s long-term ability to sustain a capable fighting force.”²¹⁶ The VA needs to strike a better balance with its administrative procedures of ensuring efficient use of health care resources and providing medical treatment without overly burdensome procedural protections. Otherwise, the Veterans Access Act’s effects will be limited.

²⁰⁸ Brown, *supra* note 80 (noting a service member’s choice to see a civilian psychologist due to concerns about confidentiality).

²⁰⁹ See *supra* Part IV.

²¹⁰ *Veterans for Common Sense v. Shinseki*, 678 F.3d 1013, 1025 (9th Cir. 2012) (quoting *Broudy v. Mather*, 460 F.3d 106, 115 (D.C. Cir. 2006)).

²¹¹ See *Anestis v. United States*, 749 F.3d 520, 528 (6th Cir. 2014).

²¹² See *Jackonis et al.*, *supra* note 31, at 678.

²¹³ *Id.* at 683.

²¹⁴ *Milaninia*, *supra* note 11, at 332.

²¹⁵ *Jackonis et al.*, *supra* note 31, at 683.

²¹⁶ *Id.*