

No. 18-0216  
IN THE SUPREME COURT OF TEXAS

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TEXAS MUTUAL INSURANCE COMPANY, et al.  
Petitioners,  
v.  
PHI AIR MEDICAL, LLC,  
Respondent.

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On Petition for Review from the  
Third Court of Appeals at Austin, Texas, No. 03-17-00081-CV

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**INSURER-PETITIONERS'  
BRIEF ON THE MERITS**

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## TABLE OF CONTENTS

IDENTITY OF PARTIES AND COUNSEL .....	i
TABLE OF CONTENTS.....	iii
TABLE OF AUTHORITIES .....	vi
ABBREVIATIONS AND RECORD CITATIONS .....	xiii
STATEMENT OF THE CASE.....	xiv
STATEMENT OF JURISDICTION .....	xvi
ISSUES PRESENTED .....	xvii
REASONS TO GRANT REVIEW .....	1
STATEMENT OF FACTS .....	4
1. The McCarran-Ferguson Act .....	4
2. The Airline Deregulation Act .....	4
3. Air ambulance economics.....	5
4. Texas workers’ compensation payments to air ambulances.....	11
5. Balance billing of injured workers.....	15
SUMMARY OF ARGUMENT .....	16
I. The McCarran-Ferguson Act.....	16
II. The Airline Deregulation Act.....	19
III. Preemption’s consequences would be chaotic and uncertain .....	20
ARGUMENT .....	22
I. The Court Below Erred in Its McCarran-Ferguson Analysis.....	22

A.	The McCarron-Ferguson question is whether the Texas workers’ laws setting benefits workers’ compensation insurers must pay medical providers on claims made under the policies were “enacted for the purpose of regulating the business of insurance.” .....	22
B.	The challenged laws were “enacted for the purpose of regulating the business of insurance.” .....	23
1.	Texas adopted the challenged laws to rescue the Texas workers’ compensation insurance market by reforming its regulation .....	23
2.	Under <i>Fabe</i> , the challenged Texas laws fall squarely within McCarran-Ferguson’s first clause .....	28
3.	The court of appeals erred in holding that insurer payment of policy benefits to healthcare providers cannot, as a matter of law, be part of the business of insurance .....	32
4.	The court below misapplied <i>Royal Drug</i> and <i>Pireno</i> .....	34
II.	The Airline Deregulation Act Does Not Preempt State Law Setting Workers’ Compensation Insurance Payments to Air Ambulances .....	40
A.	Under Supreme Court preemption law, courts must discern Congress’s actual intent “not only” through text .....	42
B.	Congress did not intend to preempt regulation of healthcare payments to air ambulance companies .....	48
C.	The Airline Deregulation Act’s preemption text does not compel preemption here .....	50
III.	The Court of Appeals Failed to Consider the Drastic Consequences .....	54
A.	Even if there is preemption, Texas insurers owe, at most, the amounts required under Texas workers’ compensation insurance law because that is what their contracts require .....	55
B.	To attempt to collect billed charges, PHI would have to	

balance bill and sue injured workers.....	56
C. The Airline Deregulation Act does not preempt the balance billing ban, which is essential to the viability and the constitutionality of the Texas workers' compensation insurance system.....	58
CONCLUSION AND PRAYER.....	61
CERTIFICATE OF COMPLIANCE.....	63
CERTIFICATE OF SERVICE.....	64
APPENDIX.....	65

## TABLE OF AUTHORITIES

### Federal Cases

<i>Air Evac EMS, Inc. v. Sullivan</i> , 331 F. Supp. 3d 650 (W.D. Tex. 2018, appeal pending in the 5th Circuit, Case No. 18-50722) .....	41
<i>Air Evac EMS, Inc. v. Cheatham</i> , 910 F.3d 751 (4th Cir. 2018) .....	41
<i>Alessi v. Raybestos-Manhattan, Inc.</i> , 451 U.S. 504 (1981).....	47
<i>Altria Grp., Inc. v. Good</i> , 555 U.S. 70 (2008).....	42
<i>American Airlines, Inc. v. Wolens</i> , 513 U.S. 219 (1995).....	43, 47, 48
<i>American Bankers Ins. Co. of Florida v. Inman</i> , 436 F.3d 490 (5th Cir. 2006) .....	29, 38
<i>Arizona v. Inter Tribal Council of Ariz., Inc.</i> , 570 U.S. 1 (2013).....	4, 22
<i>Barnett Bank of Marion County, N.A. v. Nelson</i> , 517 U.S. 25 (1996).....	59
<i>BFP v. Resolution Trust Corp.</i> , 511 U.S. 531 (1994).....	45
<i>EagleMed, LLC v. Cox, et al.</i> , 868 F.3d 893 (10th Cir. 2017) .....	2, 23, 41, 45, 54
<i>Gobeille v. Liberty Mut. Ins. Co.</i> , 136 S.Ct. 936 (2016).....	43, 47
<i>Group Life &amp; Health Ins. Co. v. Royal Drug Company</i> 440 U.S. 205 (1979).....	17, 18, 32, 35, 36, 37

<i>Highmark, Inc. v. UPMC Health Plan, Inc.</i> , 276 F.3d 160 (3d Cir. 2001) .....	37
<i>Hodges v. Delta Airlines, Inc.</i> , 44 F.3d 334 (5th Cir. 1995) .....	3, 19, 41, 44
<i>Hughes v. Talen Energy Mktg., LLC</i> , 136 S.Ct. 1288 (2016).....	3
<i>Humana v. Forsyth</i> , 525 U.S. 299 (1999).....	23
<i>Ky. Ass’n of Health Plans, Inc. v. Miller</i> , 538 U.S. 329 (2003).....	37
<i>Lawler v. Gov’t Employees Ins. Co.</i> , 569 So.2d 1151 (Miss. 1990).....	39
<i>Life Partners, Inc. v. Morrison</i> , 484 F.3d 284 (4th Cir. 2007) .....	39
<i>Medtronic, Inc. v. Lohr</i> , 518 U.S. 470 (1996).....	3, 42, 53
<i>Metropolitan Life Ins. Co. v. Mass., et al.</i> , 471 U.S. 724 (1985).....	2, 16, 33, 34
<i>Morales v. Trans World Airlines, Inc.</i> , 504 U.S. 374 (1992).....	43, 47, 50
<i>N.Y. State Conf. of Blue Cross &amp; Blue Shield Plans v. Travelers Ins. Co.</i> , 514 U.S. 645 (1995).....	19
<i>Proctor v. State Farm Mut. Auto. Ins. Co., et al.</i> , 675 F.2d 308 (D.C. Cir. 1982). .....	34
<i>Public Citizen v. United States Dep’t of Justice</i> , 491 U.S. 440 (1989).....	50

<i>Puerto Rico v. Franklin Cal. Tax-Free Trust</i> , 136 S.Ct. 1938 (2016) .....	45, 46, 47
<i>Randall v. Sorrell</i> , 548 U.S. 230 (2006).....	57
<i>Retail Clerks Int’l Ass’n v. Schermerhorn</i> , 375 U.S. 96 (1963).....	41
<i>Riverview Health Institute LLC v. Medical Mutual of Ohio</i> , 601F.3d 505 (6th Cir. 2010) .....	34
<i>Rush Prudential HMO, Inc. v. Moran</i> , 536 U.S. 355 (2002).....	37
<i>Safety Nat. Cas. Corp. v. Certain Underwriters At Lloyd's, London</i> , 587 F.3d 714 (5th Cir. 2009) (en banc) .....	4
<i>SEC v. Nat’l Securities, Inc.</i> , 393 U.S. 453 (1969).....	31
<i>Texas Pharmacy Ass’n v. Prudential Ins. Co. of Am.</i> , 105 F.3d 1035 (5th Cir. 1997) .....	29
<i>Union Labor Life Ins. Co. v. Pireno</i> , 458 U.S. 119 (1982). .....	17, 18, 30, 32, 34, 35
<i>U.S. Dep’t of Treasury v. Fabe</i> , 508 U.S. 491 (1993).....	<i>passim</i>
<i>Valley Med Flight, Inc. v Dwelle</i> , 171 F. Supp. 3d 930 (D.N.D. 2016).....	23
<b>State Cases</b>	
<i>American Motorists Ins. Co. v. Fodge</i> , 63 S.W.3d 801 (Tex. 2001).....	20
<i>Apollo Enterprises, Inc. v. ScripNet, Inc.</i> , 301 S.W.3d 848 (Tex. App.—Austin 2009, no pet.).....	25, 26

<i>Aranda v. Ins. Co. of North America</i> , 748 S.W.2d 210 (Tex. 1988).....	59
<i>Delta Airlines, Inc. v. Black</i> , 116 S.W.3d 745 (Tex. 2003).....	3, 41
<i>Fredericksburg Care Co., L.P. v. Perez</i> , 461 S.W.3d 513 (Tex. 2015).....	19, 37, 38
<i>Geeslin v. State Farm Lloyds</i> , 255 S.W.3d 786 (Tex. App. –Austin 2008, no pet.).....	57
<i>Gunn v. McCoy</i> , 554 S.W.3d 645 (Tex. 2018).....	52
<i>Haygood v. Escobedo</i> , 356 S.W.3d 390 (Tex. 2011).....	10
<i>In re North Cypress Medical Center Operating Co., Ltd.</i> , 559 S.W.3d 128 (Texas 2018) .....	10, 51
<i>Lawrence v. CDB Services, Inc.</i> , 44 S.W.3d 544 (Tex. 2001).....	25, 59
<i>Ojo v. Farmers Group, Inc.</i> , 356 S.W.3d 421 (Tex. 2011) .....	22
<i>Patient Advocates v. Texas Workers’ Compensation Commission</i> , 136 S.W.3d 643 (Tex. 2004) .....	1, 27
<i>PHI Air Medical, LLC v. Texas Mutual Ins. Co., et al.</i> , 549 S.W.3d 804 (Tex. App.–Austin, January 31, 2018, pet. filed) .....	13, 15, 65
<i>Texas Med. Ass’n v. Tex. Workers’ Comp. Comm’n</i> , 137 S.W.3d 342 (Tex. App. –Austin 2004, no pet.) .....	11, 28
<i>Texas Mut. Ins. Co. v. Ruttiger</i> , 381 S.W.3d 430 (Tex. 2012).....	18, 24, 26, 28, 45, 59

<i>Texas Workers' Compensation Comm'n v. Garcia</i> , 893 S.W.2d 504 (Tex. 1995).....	18, 21, 24, 25, 26, 27
--	------------------------

**Federal Statutes**

11 U.S.C. § 101.....	46
11 U.S.C. § 903.....	46
15 U.S.C. § 1012.....	2, 15, 17, 23, 28, 65
42 U.S.C. § 1395.....	8, 12
49 U.S.C. § 41713.....	17, 42, 65

**State Statutes**

TEX. GOVT. CODE § 22.001 .....	16
TEX. INS. CODE § 2052.002 .....	29
TEX. LABOR CODE § 401.011 .....	29
TEX. LABOR CODE § 402.021 .....	25, 27
TEX. LABOR Code § 406.002(a).....	25
TEX. LABOR Code § 408.001 .....	26, 60
TEX. LABOR CODE § 408.021 .....	25
TEX. LABOR CODE § 408.027 .....	26, 31
TEX. LABOR CODE § 413.011 .....	25, 27, 28, 52, 65
TEX. LABOR CODE § 413.031 .....	12, 20, 30, 32, 54
TEX. LABOR CODE § 413.042 .....	15, 32, 56
TEX. LABOR CODE § 414.002 .....	17, 31

TEX. LABOR CODE § 415.002 ..... 32

**State Appellate Rules**

TEX. R. APP. P. 9.4 ..... 63

**Federal Regulations**

42 C.F.R. § 410.40 ..... 8

42 C.F.R. § 414.601 ..... 8

67 Fed. Reg. 9100 ..... 8

**State 401.011 Regulations**

28 TEX. ADMIN. CODE § 134.1 ..... 14, 52

28 TEX. ADMIN. CODE § 134.203 ..... 12, 52

**Other Authorities**

*Sompo Japan Insurance Co. of America v. PHI Air Medical*,  
DWC Docket No. M4- 08-6757-01) ..... 12

Biennial Report to the 86th Legislature, Division of Workers’ Compensation  
(TDI Dec. 2018)  
<https://www.tdi.texas.gov/reports/dwc/documents/2018dwcbienlrpt.pdf>  
..... 1, 25

CNN.com article “Sky high prices for air ambulances hurt those they are helping,”  
at: <https://www.cnn.com/2018/11/26/health/air-ambulance-high-price/index.html> ...  
..... 7, 11

New York Times’ feature article at:  
<https://www.nytimes.com/2015/05/06/business/rescued-by-an-air-ambulance-but-stunned-at-the-sky-high-bill.html> ..... 7

ABC News “Nightline” feature “Sky Rage”:[http://abcnews.go.com/US/sky-rage-bills-debt-lawsuits-follow-helicopter medevac/story?id=37669153](http://abcnews.go.com/US/sky-rage-bills-debt-lawsuits-follow-helicopter-medevac/story?id=37669153)  
 (viewed January 16, 2019)..... 7

1997 Balanced Budget Act, Sec. 1834, codified at 42 USC § 1395m.  
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.htm> (viewed January 1, 2019) ..... 8

Texas Workers’ Compensation and Employers Liability Insurance Policy—Part One, Section B, available at:  
<http://www.tdi.texas.gov/wc/regulation/documents/Endform.pdf> ..... 29, 65

FAA Reauthorization Act of 2018, Pub. L. No. 115-254, § 418..... 7

Frankfurter, Some Reflections on the Reading of Statutes, 47 Colum. L. Rev. 527, 539–540 (1947)..... 45

Texas Workers’ Compensation Act (subtitle A, title 5 of the Texas Labor Code). 13

Pub. L. No. 95-504, 92 Stat. 1705, 1706 ..... 5, 52

## ABBREVIATIONS AND RECORD CITATIONS

RR#:# (witness)	Volume and page number of the three-volume Reporter's Record created at SOAH. For example, page 45 of volume 2 of the Reporter's Record is cited as RR2:45. The name of the witness testimony cited is identified in the parenthetical.
CR:#	The one-volume District Court Clerk's Record. For example, pages 5-9 of the Clerk's Record are cited as CR:5-9.
AR:Ins. Ex.#	Insurers' Exhibits in the administrative record created at SOAH.
AR:PHI Ex.#	PHI's Exhibits in the administrative record.
Apdx. ____	Material contained in the Appendix accompanying this Brief.
PHI, ____	The court of appeals' opinion, <i>PHI Air Medical, LLC v. Texas Mutual Ins. Co., et al.</i> , 549 S.W.3d 804 (Tex. App.—Austin, pet. filed).
Division	Texas Department of Insurance, Division of Workers' Compensation.
The Act	Texas Workers' Compensation Act (subtitle A, title 5 of the Texas Labor Code)
Texas Mutual	Petitioner Texas Mutual Insurance Company
Insurers	Texas workers' compensation insurers filing this petition for review: Texas Mutual, Hartford Underwriters Insurance Company, TASB Risk Management Fund, Transportation Insurance Company, Truck Insurance Exchange, Twin City Fire Insurance Company, Valley Forge Insurance Company, and Zenith Insurance Company
PHI	Respondent PHI Air Medical, LLC

## STATEMENT OF THE CASE

***Nature of the Case  
and Parties:***

Suit for judicial review of a workers' compensation insurance medical fee dispute decision of the State Office of Administrative Hearings, combined with cross-petitions for declaratory judgment.

PHI Air Medical, LLC (PHI), an air ambulance provider, sought benefits under workers' compensation insurance policies. Insurers paid 125% of the applicable Medicare rate under a Texas Department of Insurance, Division of Workers' Compensation fee rule.

PHI filed fee disputes, arguing that the 1978 Airline Deregulation Act preempts state law setting insurance payments and requires the Division to order payment of PHI's full billed charges.

***State Office of  
Administrative Hearings:***

Administrative Law Judge Craig Bennett

***SOAH Disposition:***

ALJ Bennett ruled against preemption. He held the 125% of Medicare rule did not apply, and adjudicated the amounts due as 149% of Medicare's air ambulance rate. Apdx. C (CR15-42).

***Trial Court:***

53rd Judicial District Court, Travis County, the Hon. Stephen Yelenosky. Hon. Jan Soifer signed the Final Judgment after Judge Yelenosky retired.

***Trial Court Disposition:***

PHI and Insurers filed judicial review appeals. PHI's was dismissed as untimely. Both sides sought declaratory judgment on preemption. The Division intervened, aligning with Insurers.

On cross summary judgment motions, the trial court ruled against preemption and held 125% of Medicare sufficient under Texas workers' compensation law. Apdx. B (CR:1459-1461).

***Court of Appeals:***

Third Court of Appeals; Opinion by Justice Puryear joined by Justices Bourland and Field.

***Court of Appeals' Disposition:***

Reversed and remanded. *PHI Air Medical, LLC v. Texas Mutual Ins. Co., et al.*, 549 S.W.3d 804 (Tex. App.–Austin, January 31, 2018, pet. filed). Apx. A.

The court of appeals held that the ADA preempted Texas workers' compensation insurance regulation of insurer payments to air ambulances. *Id.* at \*4. It held that the McCarran-Ferguson Act, which protects state laws enacted to regulate the "business of insurance," 15 U.S.C. § 1012(b), did not apply. *Id.* at \*7.

The court of appeals did not address the appropriate insurance benefit payment amount or the Texas Workers' Compensation Act ban on medical providers balance billing workers. It remanded to the trial court for further proceedings. *Id.*

***Petitioners***

The Division and eight insurers petitioned for review. This Court ordered briefs on the merits.

## **STATEMENT OF JURISDICTION**

This Court has jurisdiction under Government Code section 22.001(a) because the errors of law committed by the court of appeals are of such importance to the jurisprudence of this State that they require correction.

## ISSUES PRESENTED

1. The McCarran-Ferguson Act precludes preemption of state laws enacted “for the purpose of regulating the business of insurance,” unless the federal statute “specifically relates to the business of insurance.” 15 U.S.C. § 1012(b). The Airline Deregulation Act, 49 U.S.C. § 41713, does not mention insurance, but the court below held that it preempts Texas laws setting medical benefits the insurer must pay under state-mandated workers’ compensation insurance policies.

**Were Texas workers’ compensation insurance medical benefit statutes and rules “enacted for the purpose of regulating the business of insurance”?**

2. The Airline Deregulation Act ended federal rate-regulation of commercial airlines in favor of price competition. Congress included a preemption clause so that states could not undo this federal deregulation. Congress did not mention air ambulances, which do not operate in competitive markets. Congress did not deregulate Medicare or Medicaid regulation of payments to air ambulances.

**Did the Airline Deregulation Act preempt Texas regulation of workers’ compensation insurance payments to air ambulances?**

## REASONS TO GRANT REVIEW

267,000 Texas employers and 8.4 million employees depend on Texas workers' compensation insurance for fast, certain, and efficient insurer payments for work-related injuries. *See* Apdx. J, Biennial Report to the 86th Legislature, Division of Workers' Compensation (TDI Dec. 2018) at 9.<sup>1</sup>

In hundreds of disputes they filed at the Division, air ambulance companies claim the Airline Deregulation Act preempts the State of Texas's plenary power to regulate workers' compensation insurance payments on their claims.

Preemption would undercut 1989 reforms to the Texas workers' compensation insurance market that saved it from collapse. Rapidly increasing medical costs and lengthy *de novo* litigation were causing insurers and employers to exit the market, leaving more and more workers uninsured. In response, the Legislature required the Division to set medical fees to achieve effective cost control, and made its benefit determinations binding pending judicial review. *Texas Workers' Compensation Comm'n v. Garcia*, 893 S.W.2d 504, 515 (Tex. 1995); *Texas Workers' Comp. Comm'n v. Patient Advocates of Texas*, 136 S.W.3d 643, 652 (Tex. 2004)

The McCarran-Ferguson Act protects state laws "enacted for the purpose of regulating the business of insurance" from inadvertent preemption. 15 U.S.C.

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<sup>1</sup> Also available at: <https://www.tdi.texas.gov/reports/dwc/documents/2018dwcbienlrpt.pdf> (viewed January 21, 2019).

§ 1012(b). The court of appeals, however, held that it does not protect these laws setting insurance policy medical benefits.

The court of appeals held that Texas workers' compensation insurance medical benefit laws were not enacted for the purpose of regulating the business of insurance. That theory is contrary to *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491 (1993) and the Texas Workers' Compensation Act's intent, and fails under a "common sense view of the matter." *See Metropolitan Life Ins. Co. v. Mass., et al.*, 471 U.S. 724, 728, 740 (1985) (mandated medical benefit laws, including setting benefit payments, regulate the business of health insurance).

The court of appeals also held that the Airline Deregulation Act preempts Texas regulation of workers' compensation insurer medical benefit payments to air ambulance providers. That holding is also erroneous. Congress did not seek such preemption when it deregulated the commercial airline industry. One court to have reached that result decried it as "unfortunate," creating an "ill-conceived intersection" of "financially sound workers' compensation programs" and "skyrocketing air-ambulance bills." *EagleMed LLC v. Cox*, 868 F.3d 893, 906 (10th Cir. 2017). Because of the fundamentally different and "warped" nature of air ambulance markets as compared to the airline consumer market, ADA preemption in this context actually undermines Congress's purpose of promoting free-market bargaining for services. *Id.* at 903.

The court of appeals, like every other court that has found such preemption, held that analysis of Congressional intent is limited to a strict reading of the preemption clause's text, no matter how unintended the result. *PHI*, 549 S.W.3d at 811 n.8 (agreeing with *EagleMed*'s discussion of "intent" quoted above).

But the "purpose of Congress" is "the ultimate touchstone in every preemption case." *Hughes v. Talen Energy Mktg., LLC*, 136 S.Ct. 1288, 1297 (2016); *Delta Airlines, Inc. v. Black*, 116 S.W.3d 745, 748 (Tex. 2003). Although an express preemption clause settles "whether" Congress intended some preemption, "the *scope* of its intended invalidation of state law" presents a different question. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485-86 (1996). To decide scope, courts must consider "not only" the text, but also "the structure and purpose of the statute as a whole," through "reasoned understanding of the way in which Congress intended the statute and its surrounding regulatory scheme to affect business, consumers and the law." *Id.*

Congress cannot have intended to preempt state workers' compensation regulation of insurance benefits paid to air ambulances. Congress deregulated the commercial airline and shipping industries so that the free market, not government regulators, could determine prices. It said nothing about air ambulances, which provide a healthcare service paid for mostly by government programs at rates set

by regulators. Medicare and Medicaid regulated air ambulance payments before the Airline Deregulation Act and have done so ever since.

The court of appeals’ holding “put[s] at risk the validity and effectiveness of laws that Congress did not intend to disturb and that a State has deemed important to its scheme of governance.” *Arizona v. Inter Tribal Council of Ariz., Inc.*, 570 U.S.1, 21 (2013) (Kennedy, J., concurring). This Court should grant the petitions and restore state control over Texas workers’ compensation insurance regulation.

## **STATEMENT OF FACTS**

### **1. The McCarran-Ferguson Act.**

In 1944, the U.S. Supreme Court subjected insurance companies to federal antitrust laws. Seeing that decision as “a threat to state power to tax and regulate the insurance industry,” Congress “enacted the McCarran–Ferguson Act within a year.” *Fabe*, 508 U.S. at 499–500.

Under the McCarran-Ferguson Act, federal laws will not be “construed to invalidate, impair, or supersede’ state law unless the Act of Congress ‘specifically relates to the business of insurance.’” *Safety Nat. Cas. Corp. v. Certain Underwriters At Lloyd’s, London*, 587 F.3d 714, 720 (5th Cir. 2009) (*en banc*).

### **2. The Airline Deregulation Act.**

Before 1978, the Civil Aeronautics Board (CAB) set interstate airline rates. The Airline Deregulation Act (ADA), seeking “an air transportation system which

relies on competitive market forces to determine the quality, variety and price of air services,” ended CAB regulation. Apdx. F (ADA original text, Pub. L. No. 95-504, 92 Stat. 1705).

### **3. Air ambulance economics.**

Air ambulance transports are of two types: 30% transport from accident scenes to hospitals, while 70% transport stabilized patients from one hospital to another.<sup>2</sup>

***No competitive market pricing:*** Air ambulances do not operate in competitive consumer markets. Insurers’ expert testified: “the preconditions for a competitive market do not exist: there is no choice of providers and there is no opportunity for price negotiation.”<sup>3</sup> PHI’s expert “agree[d]” that “it doesn’t fit the free market and the sort of traditional ingredients that we would look for to determine whether a market was competitive....”<sup>4</sup>

***Billed charges:*** PHI seeks orders compelling insurers to pay its full billed charges. Neither patients nor payors have agreed to pay those charges.

Like other kinds of healthcare providers, each air ambulance company sets its own charges, and no one regulates how it sets its charges or caps the amounts.<sup>5</sup>

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<sup>2</sup> RR1:35 (Frazier).

<sup>3</sup> AR:Ins. Ex. 46, PHI EX. 2, at 4 (¶ 7(g)).

<sup>4</sup> AR: Deposition Transcripts and Exhibits: John Schneider Depo. Tr. at 199.

<sup>5</sup> RR1:30 (Frazier); *id.* at 214 (Luke, testifying that “we do not have” a “regulated market”); RR2:494-95 (Stanek, testifying that PHI increases its charges quarterly, on average, and

Nor do market forces control charges. “We’ve seen a dramatic increase in billed charges that [is] untethered to any market forces. There’s no explanation in the marketplace as to why these charges have increased dramatically.”<sup>6</sup>

PHI raised its charges 13 times during 2010-13.<sup>7</sup> PHI raised charges 75% when its costs had risen “about 11%.”<sup>8</sup>

PHI can raise its charges without worrying about losing business because there is “no price shopping” by either “the healthcare payor or the patient.”<sup>9</sup>

Both payors and patients learn of the charges when they receive the bills.<sup>10</sup> PHI does not include its charges on its form asking patients to assign insurance benefits to PHI and promise to pay PHI amounts not covered by insurance.<sup>11</sup>

Air ambulances get business not from patients or payors, but from “referral sources,”—“local fire departments or ground ambulances” for scene responses, hospitals for interfacility transfers.<sup>12</sup> Referral sources “don’t pay for the service.”<sup>13</sup>

In 2010-2013, PHI’s charges were “285% to 382% of their expenses.”<sup>14</sup>

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admitting that it has never decreased charges and does not attempt to “quantify” any alleged market forces when increasing charges).

<sup>6</sup> RR1:23-24 (Frazier).

<sup>7</sup> RR2:433 (Stanek); PHI Ex. 12 at 20.

<sup>8</sup> RR1:189 (Luke). PHI raised its 1/1/2010 base charge \$11,492 to \$20,119 as of 10/1/2013. *See* AR:PHI Ex. 12 at 20.

<sup>9</sup> RR1:44 (Frazier); *see also* RR2:498-99 (Stanek, testifying that PHI does not account for any change in business volume when it increases charges).

<sup>10</sup> RR2:375-76 (Pierce); RR1:33 (Frazier).

<sup>11</sup> AR:Ins. Ex. 21; RR2:400 (Pierce).

<sup>12</sup> RR1:30-31 (Frazier).

<sup>13</sup> *Id.* at 31.

As shown in a Stanford Medical School study, ambulance charges greatly exceed operating costs.<sup>15</sup> Air ambulance “sky high” charges and balance billing of patients have drawn national attention.<sup>16</sup> In 2018, Congress established a commission within the Department of Transportation to recommend “steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, consistent with current legal authorities regarding consumer protection” against abusive air ambulance business practices. FAA Reauthorization Act of 2018, Pub. L. No. 115-254, § 418.

***Payments for air ambulance transports:*** PHI’s billed charges are “not,” its CFO admits, “what we expect to collect.”<sup>17</sup> Like most health care providers, PHI and other air ambulance companies rarely, if ever, collect full billed charges.

PHI classifies its payors in four groups: Medicare, Medicaid, “self-pay,” and “private insurance.”<sup>18</sup> They pay widely varying amounts.

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<sup>14</sup> RR1:228 (Luke).

<sup>15</sup> AR:Ins. Ex. 188 at 19 (Table 1) (Delgado et al., *Cost-Effectiveness of Helicopter Versus Ground Emergency Medical Services for Trauma Scene Transport in the United States*, ANN. EMERG. MED (Oct. 2013)).

<sup>16</sup> See, e.g., CNN.com article “Sky high prices for air ambulances hurt those they are helping,” at: <https://www.cnn.com/2018/11/26/health/air-ambulance-high-price/index.html> (viewed January 16, 2019); New York Times’ feature article at: <https://www.nytimes.com/2015/05/06/business/rescued-by-an-air-ambulance-but-stunned-at-the-sky-high-bill.html> (viewed January 16, 2019), and ABC News “Nightline” feature “Sky Rage”: <http://abcnews.go.com/US/sky-rage-bills-debt-lawsuits-follow-helicopter-medevac/story?id=37669153> (viewed January 16, 2019).

<sup>17</sup> RR2:502 (Stanek).

<sup>18</sup> AR:PHI Ex 50 at 1.

Medicare air ambulance payments are set by CMS. Government regulators had set Medicare payments to air ambulances for decades before the 1978 Airline Deregulation Act, and have continued to do so in the four decades since.

In 1997 Congress changed the way Medicare pays for ground and air ambulance transports, requiring CMS to set new per-transport payments after a negotiated rulemaking with the industry.<sup>19</sup> CMS used the stakeholders' best estimate of industry costs, and chose "the maximum air ambulance total amount designated by" the stakeholder committee.<sup>20</sup>

CMS phased the new fee schedule from 2002 to 2006, and updates it annually for inflation. Medicare pays a fixed fee for each flight and a fee per mile of transport, and transports from rural zip codes are paid 50% more.<sup>21</sup>

Medicare paid for 29% of PHI's transports in Texas during 2010-13.<sup>22</sup> In 2010 Medicare's average payment was 27% of PHI's charges. Because PHI kept raising charges faster than inflation, by 2013 Medicare payments averaged 16% of PHI's charges.<sup>23</sup>

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<sup>19</sup> RR1:46 (Frazier), discussing the 1997 Balanced Budget Act, Sec. 1834, codified at 42 USC § 1395m.

<sup>20</sup> See AR:Ins. Ex. 57 (67 Fed.Reg. 9100 *et seq.*).

<sup>21</sup> AR:Ins. Ex. 187 (Medicare ambulance fee schedules 2006-2014); Ins. Ex. 57 (67 Fed. Reg. 9100 *et seq.*, adopting new Medicare ambulance fee schedule); Ins. Ex. 119 (42 C.F.R. § 410.40 *et seq.* and § 414.601 *et seq.*) (prescribing Medicare ambulance fee schedule regulations).

<sup>22</sup> AR:PHI Ex. 12 at 26; RR2:441 (Stanek).

<sup>23</sup> AR:PHI Ex. 12 at 26.

Medicaid paid for 16% of PHI's 2010-13 Texas transports.<sup>24</sup> Medicaid healthcare payments are set by state regulators acting under federal law.<sup>25</sup> In Texas, Medicaid paid at about 70% of the Medicare rate.<sup>26</sup>

"Self-pay" accounted for 17% of PHI's 2010-13 Texas transports.<sup>27</sup> Most payors in this category are uninsured. In Texas, they paid a 2010-13 average of 0 to 2% of PHI's billed charges.<sup>28</sup>

"Private insurers" paid for 38% of PHI's 2010-13 transports.<sup>29</sup> This group consists mostly of employer-provided group health insurers or self-funded ERISA plans. PHI also includes workers' compensation, Tricare, and "other" insurers.<sup>30</sup>

Unlike Medicare, Medicaid and workers' compensation insurance, what private health insurers pay healthcare providers is generally not set by regulation. Air ambulance companies generally do not negotiate their fees in advance, either within insurance networks or in preferred provider agreements with third-party

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<sup>24</sup> AR:PHI Ex. 50 at 1; PHI Ex. 12 at 26; RR2:441 (Stanek),

<sup>25</sup> See Apdx. K, GAO report explaining States "setting [Medicaid] payment rates" and regulating "the business of insurance."). "States can establish their own Medicaid provider payment rates within federal requirements...." <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.htm> (viewed January 1, 2019).

<sup>26</sup> RR1:254 (Luke).

<sup>27</sup> AR:PHI Ex. 50 at 1.

<sup>28</sup> AR:PHI Ex. 12 at 26.

<sup>29</sup> AR:PHI Ex. 50 at 1.

<sup>30</sup> AR:PHI Ex. 12 at 26.

administrators. “Intentionally,” air ambulance companies “remain out of [insurance] network[s].”<sup>31</sup>

Instead, after the transport, the company bills the insurer and/or the patient. It then uses “the specter of balance billing” the patient for out-of-network services “as a weapon ... to ensure that they get a good portion of their billed charges” paid by the insurer.<sup>32</sup>

This is a familiar business tactic for healthcare providers. “[F]ew patients today ever pay a hospital’s full charges,” but many hospitals set their charges “as high as possible” for leverage in their out-of-network claims against insurers.<sup>33</sup>

For air ambulances, this is their primary business model. They do not collect their billed charges, but PHI’s 2010-2013 collections from “private insurers” as a group averaged from 42% to 78% of PHI’s billed charges.<sup>34</sup>

PHI has one contract for an agreed-upon price for transports in Texas, with the UT Medical Branch at Galveston. In return for UTMB referring all transports of its state prisoner patients, PHI agreed to be paid the “Medicare Ambulance Fee Schedule.”<sup>35</sup>

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<sup>31</sup> RR1:37 (Frazier).

<sup>32</sup> *Id.* at 44, 122 (Frazier).

<sup>33</sup> These facts are explained in *In re North Cypress Medical Center Operating Co., Ltd.*, 559 S.W.3d 128, 136 (Tex. 2018) (quoting *Haygood v. Escobedo*, 356 S.W.3d 390, 393 (Tex. 2011)).

<sup>34</sup> AR:PHI Ex. 12 at 26.

<sup>35</sup> AR:Ins. Ex. 5.

***PHI's resulting average payments and profits:*** Seventy-two percent of all of the payments PHI collected for 2010-13 Texas transports were at 125% of Medicare or less.<sup>36</sup> The average payment was equivalent to 149% of Medicare.<sup>37</sup>

At 149% of Medicare, PHI made an average 9.15% profit from 2010-2013.<sup>38</sup> Its average budgeted profit was 7.49%.<sup>39</sup> PHI's 2010-13 billed charges averaged 467% of Medicare.<sup>40</sup> If PHI had been paid full billed charges on all transports, its operating profit margin would have ranged from 185% in 2010 to 282% in 2013.<sup>41</sup>

#### **4. Texas workers' compensation payments to air ambulances.**

Workers' compensation insurance covered only 2 to 3% of PHI's 2010-13 Texas transports and accounted for 4% of PHI's collections.<sup>42</sup>

As amended in 2001, the Labor Code requires Medicare-based workers compensation medical benefits. *See Texas Med. Ass'n v. Texas Workers' Comp. Comm'n*, 137 S.W.3d 342, 346 (Tex. App.—Austin 2004, no pet.).

During the period covered in the record (2010-2013), Insurers paid air ambulances 125% of Medicare, the amount set under the Division's 2008 general

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<sup>36</sup> RR1:226 (Luke)

<sup>37</sup> RR2:284-85, 329-330 (Luke).

<sup>38</sup> RR2:284, 329-30; *see also* Apdx. D at 24 (¶ 21).

<sup>39</sup> AR:PHI Ex. 12 at 31 (PHI's Texas Program Budgets). 7.49% is the average budgeted net earnings before taxes as a percentage of budgeted net revenue.

<sup>40</sup> AR:Ins. Ex. 156 at TMIC0009849.

<sup>41</sup> AR:Ins. Ex. 46 at TMIC0001234; Ins. Ex. 2 at PHI000007 (PHI Selected Financial Data) RR2:502 (Stanek, calculating profit margin based on billed charges).

<sup>42</sup> RR1:229 (Luke).

rule for providers other than hospitals and pharmacies, Rule 134.203. 28 TEX. ADMIN. CODE § 134.203(d)(1). Until 2012, PHI and other air ambulance companies accepted insurer payments at 125% of Medicare.<sup>43</sup>

In 2012, air ambulance companies began filing medical fee disputes at the Division. They contended that the ADA preempts the Labor Code's medical fee standards and Division Rule 134.203, and requires the Division to order insurers to pay the ambulance companies' full billed charges.<sup>44</sup>

These medical fee disputes began before a Division Medical Dispute Resolution Officer. *See generally*, 28 Tex. Admin. Code §§ 133.307, 134.900. An MDRO is not a lawyer, and makes a decision based on written submissions, without discovery, evidence or hearing. *Id.* The MDROs initially agreed with PHI on preemption, but their only authority is to apply Texas workers' compensation fee laws,<sup>45</sup> so they dismissed the cases.<sup>46</sup>

As authorized under Labor Code sections 413.031 and 413.0312 and Division fee dispute rules, PHI sought *de novo* review at SOAH.<sup>47</sup>

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<sup>43</sup> *See, e.g.*, AR:PHI Ex. 49 (*Sompo Japan Ins. Co. of Am. v. PHI Air Medical*, Docket No. M4-08-6757-01).

<sup>44</sup> *See* AR:Ins. Ex. 1.

<sup>45</sup> "In resolving disputes over the amount of payment due" for healthcare services, "the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules." TEX. LABOR CODE § 413.031(c).

<sup>46</sup> *See, e.g.*, AR:Ins. Ex. 62-7.

<sup>47</sup> *Id.*

Administrative Law Judge (ALJ) Craig Bennett ruled that the ADA does not “determin[e] the payment amount from” Insurers, and the McCarran-Ferguson Act precludes preemption because Texas’ “workers’ compensation system ... is directly related to the business of insurance,” while the ADA “does not regulate insurance.”<sup>48</sup>

ALJ Bennett also rejected preemption on the grounds that PHI has “no direct right of recovery from [Insurers], but must “rely on the [insurance policy] contract” to claim any payment from Insurers.<sup>49</sup> Because the policies limit benefits to what the Labor Code allows, “any recovery by PHI against [Insurers] would be limited to ... the medical fee guidelines or any other fee rules.”<sup>50</sup>

He remanded the fee disputes for Division MDROs to determine whether the Insurers’ payments at 125% of Medicare satisfied Texas workers’ compensation law.

Then MDROs began holding Rule 134.203 inapplicable to air ambulance services. They awarded PHI its full billed charges,<sup>51</sup> relying on PHI’s representation that its charges “represent the cost of doing business, plus a very

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<sup>48</sup> Apdx. C (SOAH Threshold Ruling) at 1.

<sup>49</sup> *Id.* at 3.

<sup>50</sup> *Id.*

<sup>51</sup> *See, e.g.*, AR:Ins. Ex. 62 (Insurer request for SOAH hearing attaching Division findings and decision).

modest profit margin.”<sup>52</sup> (The SOAH hearing established that PHI’s representation was incorrect.<sup>53</sup>)

Insurers sought *de novo* review at SOAH. PHI renewed its preemption arguments. ALJ Bennett then held a three-day contested case hearing.

Judge Bennett reaffirmed that McCarran-Ferguson precludes preemption.<sup>54</sup>

He held that Division Rule 134.1(f) controls. Rule 134.1(f) is a default rule that applies if no fee rule sets the reimbursement amount due. It requires case-by-case adjudication under the statutory medical fee standards for rulemakings.<sup>55</sup> In workers’ compensation jargon, this is called “fair and reasonable” adjudication.

In order to “guarantee” PHI a profit, ALJ Bennett held PHI was entitled to the average amount that all payors and patients, combined, had paid PHI in Texas in 2010-2013, the equivalent of 149% of Medicare.<sup>56</sup>

The district court reversed, holding that 125% of Medicare—the amount the Insurers paid on the claims—met the Labor Code’s standards. The Third Court of

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<sup>52</sup> AR:Ins. Ex. 3 (PHI’s submission to Division MFDR) at 1.

<sup>53</sup> The average of all payments to PHI for all Texas transports 2010-13 was much, much less than full billed charges, but produced a 9.15% operating profit. Paid at full charges, PHI’s 2010-13 transports would have provided PHI with operating profits of 185-282%. AR:Ins. Ex. 46 at 5; *id.* at Figure 3-1 (TMIC0001234).

<sup>54</sup> Apdx. D, CR:17.

<sup>55</sup> *Id.* at 29.

<sup>56</sup> *Id.* at 36. Judge Bennett assumed that the Labor Code’s standards guarantee each healthcare provider a profit. *Id.* Insurers disagree, contending that “effective medical cost control” requires setting any excess over the Medicare payment at the minimum sufficient to ensure reasonable access to each type of care. PHI sought to subsidize the uninsured and patients covered by Medicare and Medicaid with increased workers’ compensation payments. Insurers contend that the standards expressly prohibit such subsidization.

Appeals did not reach this issue, because it found ADA preemption of those standards; it remanded for “further proceedings.” *PHI*, 549 S.W.3d at 816.

### **5. Balance billing of injured workers.**

Balance billing patients for the difference between insurer payments and billed charges is part of PHI’s business model. The Labor Code bans this tactic within Texas workers’ compensation insurance: a provider “may not pursue a private claim against a workers’ compensation claimant for all or part of the cost of the health care service.” TEX. LABOR CODE § 413.042(a).

Though it pled a challenge to this ban “in the alternative,” *see PHI*, 549 S.W.3d at 816, in the court of appeals PHI argued that it “**challenged both the reimbursement system and the balance-billing prohibition as preempted by the ADA.**”<sup>57</sup> PHI now asserts that the Texas Workers’ Compensation Act “could easily be severed so that the Act no longer caps air ambulance rates, but still protects injured workers and their employers.”<sup>58</sup>

The court of appeals held the Labor Code and Division rules setting the insurance policy’s medical benefits preempted. It did not order the Division to require Insurers to pay PHI its billed charges. It did not reach the balance billing provision. *PHI*, 549 S.W.3d at 816.

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<sup>57</sup> PHI’s Brief of Appellant (June 5, 2017) at 9 (emphasis in original)

<sup>58</sup> PHI Response to Petition at 14 n. 35.

## SUMMARY OF ARGUMENT

### I. The McCarran-Ferguson Act.

The court of appeals held that Texas workers' compensation insurance laws setting medical benefits required by the state-written policy were not "enacted for the purpose of regulating the business of insurance." *PHI*, 549 S.W.3d at 812-16. Its theory was that such laws regulate the amounts insurers pay third-party health care providers who are "not 'within the insurance entity [sic]'," and that those laws are not "specifically directed at the insurance industry." *Id.* at 814.

The court of appeals' theory is contrary to *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 503 (1993), the lead McCarran-Ferguson Act case. It is contrary to the Texas Workers' Compensation Act's purposes. And it is contrary to the "common sense view of the matter." *Metropolitan Life Ins. Co.*, 471 U.S. at 728, 740.

*First*, state laws that "prescrib[e] the terms of the insurance contract" are laws that "directly" regulate the business of insurance. *Fabe*, 508 U.S. at 502-03. State laws governing "the actual performance of an insurance contract" are also laws enacted for the purpose of regulating the business of insurance. *Id.* at 503. The Texas laws at issue here do both.

Texas law mandates a standard form of insurance policy for workers' compensation insurers. It defines the insurance policy benefit the insurer must pay as the amount required by Texas workers' compensation law:

**PART ONE - WORKERS COMPENSATION INSURANCE**

**A. How This Insurance Applies**

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

**B. We Will Pay**

We will pay promptly when due the benefits required of you by the workers compensation law.

**C. We Will Defend**

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

Apdx. H.

Texas law allows PHI to make a claim for payment of these benefits. When Insurers pay PHI, they are performing their central obligation under the policy—paying benefits on behalf of the injured worker. TEX. LABOR CODE § 414.002(c).

*Second*, the opinion below erred on McCarran-Ferguson because it misapplied two cases: *Group Life & Health Ins. Co. v. Royal Drug Company*, 440 U.S. 205 (1979), and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).

Both *Royal Drug* and *Pireno* preceded *Fabe*. *Fabe* expressly clarified that neither case excludes the payment of benefits under the policy from the ‘business of insurance,’ as we understood that phrase in *Pireno* and *Royal Drug*. To hold otherwise would be mere formalism.” *Fabe*, 508 U.S. at 503.

Moreover, even under *Royal Drug's* and *Pireno's* rationale, the Texas laws PHI challenges regulate the “business of insurance.” They prescribe insurance policy terms—the “fundamental principle of insurance.” *Pireno*, 458 U.S. at 131.

Unlike PHI, the *Royal Drug* and *Pireno* plaintiffs did not challenge insurance policy terms, or state regulation of those terms. They brought antitrust challenges to private agreements between insurers and healthcare providers. Here, a Texas workers’ compensation insurer’s payment to PHI *is* its performance of its most central policy obligation—*i.e.*, to pay medical benefits on behalf of the insured worker. *See* TEX. LABOR CODE § 414.002(c).

**Third**, both *Royal Drug* and *Pireno* concerned McCarran-Ferguson’s second clause, which concerns a narrow exemption for private activity from antitrust law.

McCarran-Ferguson’s first clause, in contrast, covers the “broad category of laws enacted for the purpose of regulating the business of insurance,” including those that “possess the end, intention or aim of adjusting, managing or controlling the business of insurance.” *Fabe*, 508 U.S. at 505. The 1989 Texas Legislature amended the Texas Workers’ Compensation Act for such purposes. *See Texas Mut. Ins. Co. v. Ruttiger*, 381 S.W.3d 430, 439 (Tex. 2012); *Garcia*, 893 S.W.2d at 512.

The court of appeals’ McCarran-Ferguson errors stem in part from “confusion” and “chaos” in the McCarran-Ferguson jurisprudence. *See*

*Fredericksburg Care Co., L.P. v. Perez*, 461 S.W.3d 513, 521 n.2 (Tex. 2015).

This Court should resolve that confusion and prevent the chaos that would result from erroneous preemption.

## **II. The Airline Deregulation Act.**

Congress did not intend for the ADA to preempt state workers' compensation insurance regulation of payments to air ambulances.

In holding otherwise, the court of appeals disregarded decades of Supreme Court jurisprudence that demands more evidence of the intended scope of preemption than an “uncritical[ly] literal[ist]” application of “unhelpful” preemption text. *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655-56 (1995). Courts must look “to the objectives of the [preemption] statute as a guide to the scope of the state law that Congress understood would survive.” *Id.*

The court of appeals did not do so. It instead adopted a “facile” literalist approach that would extend ADA preemption to state laws that were plainly beyond Congress's deregulatory goals and preemption intent. *See Hodges v. Delta Airlines, Inc.*, 44 F.3d 334, 337 (5th Cir. 1995) (rejecting ADA preemption of state personal injury claims for airline crew negligence on board as not relating to “services” within the scope of ADA preemption's clause).

### **III. Preemption’s consequences would be chaotic and uncertain.**

PHI and the court of appeals refuse to face the consequences preemption would have.

Preemption would replace the policy limits mandated by the State with a void. As to air ambulance claims the policy’s only benefits term would necessarily read: any time an air ambulance provider makes a claim under the policy, “We will pay UNKNOWN—PREEMPTED”. Preemption would leave unspecified how insurers and state regulators must calculate the insurance benefit payments insurers must make to air ambulances.

The Division enforces the insurers’ payment obligation under this policy only by enforcing the state laws PHI seeks to preempt.<sup>59</sup> The Division has the exclusive jurisdiction to do so.<sup>60</sup> Preemption would therefore even leave unclear what tribunal(s) could adjudicate payment amounts, and how. This would undo regulation of the business of Texas workers’ compensation insurance in a way that damages the viability and threatens the constitutionality of such insurance.

PHI seeks to somehow force Insurers to pay its unilaterally set billed charges, which are several times higher than its fully allocated costs and what Medicare would pay. But nothing in the Airline Deregulation Act requires anyone to pay charges he, she or it has not voluntarily agreed to.

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<sup>59</sup> See TEX. LABOR CODE § 413.031(c).

<sup>60</sup> See *American Motorists Ins. Co. v. Fodge*, 63 S.W.3d 801, 803 (Tex. 2001).

As a matter of the insurance policy contract's plain terms, a Texas workers' compensation insurer's *only* obligation is to pay the benefits required under Texas workers' compensation law—not the provider's billed charges. PHI musters no authority in support of the idea that Congress intended for the Airline Deregulation Act to rewrite state-regulated workers' compensation insurance policies for the special benefit of air ambulance company profits.

In its main brief to the court of appeals, PHI argued that the Labor Code's caps on what insurers pay, "combined with the 'balance billing' prohibition is preempted because they limit PHI's recovery for its services" and prevent it from recovering its full billed charges. PHI's Brief as Appellant (June 5, 2017) at p. 12; see also pp. 9,13, 14, 15, 20, 22, 23, 36. PHI now says it challenges the ban on balance billing only in the alternative. Ultimately, however, for PHI to pursue any claim to its billed charges, it would have to sue injured workers and establish that it is entitled, under some source of law, to be paid whatever it bills.

The Labor Code ban on billing workers protects the fundamental bargain of the unique Texas system for workers: healthcare for work-related injuries paid for entirely by the insurer. The constitutionality of the unique Texas system depends on that ban. *See Garcia*, 893 S.W.2d at 521. Again, the idea that Congress intended airline deregulation policy to disrupt state regulation protecting injured workers is absurd.

“[O]verextending a federal statute’s pre-emptive reach...put[s] at risk the validity and effectiveness of laws that Congress did not intend to disturb and that a State has deemed important to its scheme of governance.” *See Arizona v. Inter Tribal Council of Ariz., Inc.*, 570 U.S. 1, 21 (2013) (Kennedy, J., concurring) ().

## ARGUMENT

### I. The Court Below Erred in Its McCarran-Ferguson Analysis.

#### A. The McCarran-Ferguson question is whether the Texas workers’ laws setting benefits workers’ compensation insurers must pay medical providers on claims made under the policies were “enacted for the purpose of regulating the business of insurance.”

Congress adopted the McCarran-Ferguson Act to “restore the supremacy of the States in the realm of insurance regulation.” *Fabe*, 508 U.S. at 507. It imposes, “in effect, a clear statement rule” that state laws regulating insurance are not generally preempted. *Id.* at 507.

The “declared policy of the MFA is to ensure that state legislatures are able to regulate the business of insurance without unintended federal interference.” *Ojo v. Farmers Group, Inc.*, 356 S.W.3d 421, 430 (Tex. 2011).

The McCarran-Ferguson Act’s first clause provides:

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance ... unless such Act specifically relates to the business of insurance.

15 U.S.C. § 1012(b). This case turns on whether the Labor Code provisions at issue, and Division rules promulgated thereunder, were enacted “for the purpose of regulating the business of insurance.”

McCarran-Ferguson’s first clause forecloses preemption if (1) the state law is “for the purpose of regulating the business of insurance,” (2) the federal law does not “specifically relat[e] to the business of insurance,” and (3) the federal law would “invalidate, impair or supersede” the state law. *Humana, Inc. v. Forsyth*, 525 U.S. 299, 307 (1999). PHI concedes the second and third factors.

**B. The challenged laws were “enacted for the purpose of regulating the business of insurance.”**

Some workers’ compensation systems do not involve private insurance at all. *See, e.g., EagleMed*, 868 F.3d at 904 (noting that other states have structured their workers’ compensation programs to operate through private insurance companies”); *Valley Med Flight, Inc. v Dwelle*, 171 F. Supp. 3d 930, 945-47 (D.N.D. 2016) (distinguishing the Texas system of regulated private insurance for purposes of McCarran-Ferguson). The Texas Legislature created a private, but highly regulated, insurance market for workers’ compensation.

**1. Texas adopted the challenged laws to rescue the Texas workers’ compensation insurance market by reforming its regulation.**

The court of appeals held that the “overall goals of the [Texas Workers’ Compensation] Act and these particular provisions are not specifically directed at

the insurance industry.” *PHI*, 549 S.W.3d at 814. It held that they instead “ensur[e] prompt medical care for injured workers without these workers having to resort to the legal system.” *Id.*

This reasoning is flawed because the way in which the Texas laws at issue ensure such care for workers is by regulation of the business of such insurance. Specifically, Texas law sets the amounts of insurance policy benefits that state-licensed insurance companies must pay the healthcare providers, and regulators and courts enforce those insurance policy payments.

The Texas Workers’ Compensation Act is *both* a tort-reform law *and* a law “specifically directed at the [Texas workers’ compensation] insurance industry.” The Act replaces “resort to the legal system” with a state-regulated *insurance system*. See *Ruttiger*, 381 S.W.3d at 441 (noting that an “employee benefits from *workers’ compensation insurance* because it saves the time and litigation expense inherent in proving fault in a common law tort claim”) (quotation omitted, emphasis added). The Labor Code replaces uncertain personal injury damages with fast and no-fault payments of *insurance policy benefits*. See *Garcia*, 893 S.W.2d at 523. Texas workers’ compensation insurance is “a comprehensive scheme whereby employees who are covered by workers’ compensation insurance and incur ‘compensable’ injuries are provided the exclusive remedy of ‘workers’

compensation benefits’ . . . in lieu of common-law remedies.” *Apollo Enterprises, Inc. v. ScripNet, Inc.*, 301 S.W.3d 848, 860 (Tex. App.—Austin 2009, no pet.).

Even among state workers’ compensation systems “structured to operate through private insurers,” the Texas insurance system is unique because it is voluntary. *See Lawrence v. CDB Servs., Inc.*, 16 S.W.3d 35, 41-42 (Tex. App.—Amarillo 2000), *aff’d*, 44 S.W.3d 544 (Tex. 2001). Insurance coverage is optional for both the employer and the worker. *Id.*; *see also* TEX. LABOR CODE § 406.002(a).

The Legislature has determined that keeping premiums down is essential to encouraging more employers to subscribe, thereby covering more workers. *Garcia*, 893 S.W.2d at 512. The Legislature and the Division regulate insurance benefits in order to ensure “effective medical cost control.” TEX. LABOR CODE § 413.011(d); *id.* at § 402.021(b)(3); *see also* Apdx. J, Biennial Report to the 86th Legislature (Division of Workers’ Compensation, Dec. 2018) at 4-10.

Texas-licensed insurers sell workers’ compensation insurance policies to employers, and both the employer and employee are insured entities. The result is a tripartite contractual relationship among the employer, the employee, and the workers’ compensation insurer. *See Lawrence*, 16 S.W.3d at 41.

Injured workers receive income replacement and no-fault lifetime medical benefits. TEX. LABOR CODE § 408.021. Insurance benefits are a covered worker’s

“exclusive remedy” as against the employer for a work-related injury, and employers receive immunity from tort claims (with certain statutorily-defined exceptions). *Id.* at § 408.001(a).

The Act further gives each medical provider the right to make claims under the insurer’s policy that covers the employee and to be paid policy benefits directly. Providers like PHI receive prompt insurer payments instead of having to sue judgment-proof workers or submit subrogation claims in tort suits. *Apollo Enterprises*, 301 S.W.3d at 860; TEX. LABOR CODE § 408.027(a).

In 1989, the Texas Legislature completely rewrote the Texas Workers’ Compensation Act in response to “unusually heavy criticism of the system,” including “its costs to employers.” *Ruttiger*, 381 S.W.3d at 439. The flaws in the system, including skyrocketing medical expenses, had “reached crisis proportions.” *Garcia*, 893 S.W.2d at 512. Specifically:

Medical costs for injured workers ... began increasing at a much higher rate than medical costs outside the compensation system. These increases helped cause compensation insurance premiums to more than double between 1984 and 1988. By 1988, the cost of workers’ compensation to Texas employers was among the highest in the nation. Business groups claimed that these spiraling costs forced large businesses to locate operations elsewhere and forced small businesses to cease operations or opt out of coverage.

*Id.* (internal citations omitted).

The 1989 Legislature made two major reforms to ensure the affordability and availability of such insurance, and thus the viability of the insurance market.

First, it capped what insurers must pay for each type of medical service at levels designed to “achieve effective medical cost control.” TEX. LABOR CODE § 413.011(d); *see also, id.* at § 402.021(b)(3).

This reform was crucial because the new Act provided compensation “for all medical costs...with no limit as to amount or time,” and barred insurers from settling their “liability for lifetime medical care.” *Garcia*, at 893 S.W.2d at 513-14. The only limit on the insurer’s policy obligation to pay medical benefits are the laws at issue here, which set the amount of medical benefits required by services covered by the policies. These amounts, set by state regulators under the Labor Code’s standards, are essential to the Texas workers’ compensation insurance system because they are Legislature’s tool for keeping premiums down and more workers covered. *Id.* at § 413.011(a)–(d).

This Court upheld the agency’s authority to cap healthcare benefit payments by insurers to providers in *Patient Advocates v. Texas Workers’ Compensation Commission*, 136 S.W.3d 643, 652 (Tex. 2004).

The Labor Code’s medical benefit standards are not solely concerned with cost control, however. They also reflect statutory goals of (i) ensuring “quality of medical care” through payments high enough to ensure that workers have enough access to medical care, and (ii) achieving standardization and efficiency by requiring payment amounts to be based on those set by Medicare. *See* TEX. LABOR

CODE § 413.011(a)-(d); *Texas Med. Ass'n*, 137 S.W.3d at 346-47. These are legitimate goals of the state's regulation of the business of workers' compensation insurance.

The second major 1989 reform was to limit the role of court litigation in work-related injury insurance disputes. The market was collapsing in part because the old law allowed *de novo* jury trials and stayed payment of benefits until final non-appealable judgment. The result was that the agency's decisions did not matter, workers were not getting fast and certain benefits, and employers were not getting immunity from expensive, time-consuming and uncertain litigation. *Ruttiger*, 381 S.W.3d at 440. The 1989 Act made the benefit decisions of the Division's predecessor agency binding pending judicial review, and review of medical fee disputes on the agency record. *Id.*

**2. Under *Fabe*, the challenged Texas laws fall squarely within McCarran-Ferguson's first clause.**

*Fabe* is the lead case on the first clause of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b). Under *Fabe*, "[t]he broad category of laws enacted 'for the purpose of regulating the business of insurance' consists of laws that possess the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance." *Id.* at 505. The Texas Workers' Compensation Act, and the specific provisions PHI challenges, possess that "end, intention, or aim."

Authority to sell workers' compensation insurance in Texas requires "a certificate ... that includes authorization to write workers' compensation insurance." TEX. LABOR CODE § 401.011(28). Every such insurer must use the Texas Department of Insurance's "standard...and...uniform policy for workers' compensation insurance." TEX. INS. CODE § 2052.002(a). That insurance policy requires the insurer to "pay ... the benefits required ... by the workers' compensation law." Apdx. H.<sup>61</sup>

Regulation of "the terms of the insurance policy between the insurer and insured" is the regulation of the "business of insurance." *Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1041 (5th Cir. 1997). State law may itself form a term of the insurance policy, incorporated by reference. *American Bankers Ins. Co. of Florida v. Inman*, 436 F.3d 490, 494 (5th Cir. 2006). State laws that "directly regulate the 'business of insurance'" include those that "prescrib[e] the terms of the insurance contract." *Fabe*, 508 at 502-03.

The mandatory Texas workers' compensation insurance policy specifies the benefits each such insurer must pay by this language: "the benefits required ... by the workers' compensation law." Defining benefits by incorporating payments set by state regulation is a critical and distinctive feature of Texas workers' compensation insurance. In many other lines of insurance, the insurance company

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<sup>61</sup> Texas Workers' Compensation and Employers Liability Insurance Policy—Part One, Section B, available at: <http://www.tdi.texas.gov/wc/regulation/documents/Endform.pdf>

writes policy limits into the policy, usually in negotiation with the insured (*i.e.*, the greater the premium, the higher the limits). Setting policy limits is how insurance companies define and limit the amount of risk they assume by issuing policies. *See, e.g., Pireno*, 458 U.S. at 131 (“[T]he fundamental principle of insurance [is] that the insurance policy defines the scope of risk assumed by the insurer from the insured.”).

PHI challenges the state laws that prescribe the workers’ compensation insurance policy’s *only* medical claim limits. In this case, because state regulation sets the precise amount of the payment for any medical service, the laws at issue also define the policy’s medical benefits. When Texas workers’ compensation insurers pay those medical benefits to providers, including PHI, they are performing their primary obligation under the policy—they are paying benefits.

“[T]he actual performance of an insurance contract” also “falls within the ‘business of insurance’ . . . .” *Fabe*, 508 U.S. at 503. The “actual performance of an insurance contract” includes paying benefits, which is “an essential part of the ‘business of insurance.’” *Id.* at 505.

The Division both sets and enforces the benefits required by the state-written policy. TEX. LABOR CODE § 413.031(c) (“In resolving disputes over the amount of payment due for [medical] services...the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules.”). State

laws concerning “enforcement” of the insurance policy also regulate the “core of the ‘business of insurance.’” *SEC v. Nat’l Securities, Inc.*, 393 U.S. 453, 460 (1969).

Thus, PHI challenges the very provisions of state law that regulate insurance contract terms, and the insurer’s performance and Division’s enforcement of the insurer’s policy duties to pay medical benefits.

The Labor Code also spells out the mechanics of this insurance in a way that leaves no doubt that it regulates the core aspects of the business of workers’ compensation insurance:

Labor Code section 408.021 creates the worker’s “entitle[ment] to” and “insurance carrier[] liability for medical benefits.”

Section 408.027(a)-(b) requires the “health care provider” to “submit a claim for payment to the insurance carrier” and the insurer to “pay, reduce, deny or determine to audit the health care provider’s claim” with 45 days.

Section 408.027(f) requires the insurer’s medical fee payment to “be in accordance with the fee guidelines authorized under this subtitle.”

The insurer pays the policy’s healthcare benefits, as defined by the Division, directly to the provider, “on behalf of workers’ compensation claimants who receive medical services.” *See id.* at §§ 414.002(c), 408.027(a)-(b).

Under these provisions, the Insurers' payments to PHI are beyond cavil the "actual performance" of the policy.

The Division enforces Insurers' obligations to pay insurance policy benefits to PHI, through medical fee dispute resolution—a process PHI invoked here. TEX. LABOR CODE § 413.031. If an insurer were to pay less than the Division-ordered amount, it would face significant fines. *Id.* at § 415.002.

The Labor Code also prohibits providers from "balance billing" workers for the differences between their billed charges and insurance payments. TEX. LABOR CODE § 413.042(a) (A provider "may not pursue a private claim against a workers' compensation claimant for all or part of the cost of the health care service."). This provision of the Labor Code "caps" the amount any provider may receive for treatment of an injured worker at the insured amount.

**3. The court of appeals erred in holding that insurer payment of policy benefits to healthcare providers cannot, as a matter of law, be part of the business of insurance.**

The court of appeals relied on two McCarran-Ferguson antitrust/second-clause cases: *Group Life & Health Ins. Co. v. Royal Drug Company*, 449 U.S. 205 (1979), and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982). *See PHI*, 549 S.W.3d at 814-15. Both cases preceded *Fabe*. *Fabe* left "no doubt" that McCarran-Ferguson's key language does not mean what PHI contends. 508 U.S. at 503.

The most dangerous error the court of appeals made was its holding that health insurance is not the “business of insurance” because a healthcare provider “is not ‘within the insurance entity’ [*sic*] and instead is a healthcare provider.” *See PHI*, 549 S.W.3d at 814.

As a matter of “common sense,” this proposition cannot be correct. *See, e.g., Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. at 740 (mandated medical benefit laws, including setting payments for mandated insurance policy benefits, regulate the health insurance, under a “common sense view of the matter.”). If an insurer’s payment to a third party can *never* be part of the business of insurance, McCarran-Ferguson would have no application to many major types of insurance that transfer to the insurer the risk of the insured’s liability to third parties.

Such policies include all forms of health insurance (which pays medical providers), and also includes auto (which pays repair shops), general liability (which by definition pays a third party), and even life insurance (which pays death benefits to a designated beneficiary). But the U.S. Supreme Court has recognized that “statutes regulating the substantive terms of [such] insurance contracts have become commonplace in all 50 States over the last 30 years. Perhaps the most familiar are those regulating the content of automobile insurance policies.” *Id.* at 728. The court of appeals’ rationale for excluding insurance payments to medical providers from the “business of insurance” is, therefore, plainly incorrect.

Moreover, *Fabe*'s holdings that the writing of insurance policy terms and the payment of insurance policy benefits are the "business of insurance" do not make any exception for many types of insurance policies under which insurers pay benefits to "third-parties." *See Fabe*, 508 U.S. at 502-04.

Health insurance, and other insurance lines in which insurers pay benefits to a "third-party" on the insured's behalf (*e.g.*, auto, health, and general liability), *are* the "business of insurance." *See Metropolitan Life Ins. Co.*, 471 U.S. at 728, 740 (mandated benefit laws regulate the business of health insurance); *Riverview Health Institute LLC v. Medical Mutual of Ohio*, 601 F.3d 505, 519 (6th Cir. 2010) (Ohio laws setting health insurance payments to providers regulate the business of insurance); *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 312 (D.C. Cir. 1982) ("payment of [auto] damage repair claims is a...basic part of the contractual obligation owed by the insurance company to the insured, whether or not the payment is made to the insured or on his behalf.")

#### **4. The court of appeals misapplied *Royal Drug* and *Pireno*.**

The court below misapplied *Royal Drug* and *Pireno* in four more respects.

*First*, McCarran-Ferguson's second, antitrust-specific clause is to be narrowly interpreted, since "exemptions from the antitrust laws are to be narrowly construed." *Royal Drug*, 449 U.S. at 231. But the first clause is broader:

The broad category of laws enacted "for the purpose of regulating the business of insurance" consists of laws that possess the "end, intention,

or aim” of adjusting, managing, or controlling the business of insurance. Black’s Law Dictionary 1236, 1286 (6th ed. 1990). This category necessarily encompasses more than just the “business of insurance.”

*Fabe*, 508 U.S. at 505.

As has been shown, the Texas Legislature’s end, intention and aim was to adjust, manage and control the business of workers’ compensation insurance in Texas—specifically, to set benefits at a level that achieves “effective medical cost control” as a way to keep premiums down and encourage employers to buy policies.

**Second**, *Fabe* came 11 years after *Pireno* and 14 years after *Royal Drug*, and emphasized that both cases are consistent with *Fabe*’s holdings that laws regulating the business of insurance include those that prescribe the terms of the insurance policy, performance of those terms, and enforcement of such performance. *Fabe*, 508 U.S. at 503 (“There can be no doubt that the actual performance of an insurance contract falls within the ‘business of insurance,’ as we understood that phrase in *Pireno* and *Royal Drug*.”).

*Royal Drug* and *Pireno* themselves recognized that the “business of insurance” (even for antitrust immunity at issue in those cases) includes the setting of policy limits. *Pireno* explained that “the fundamental principle of insurance [is] that the insurance policy defines the scope of risk assumed by the insurer from the insured.” *Pireno*, 458 U. S. at 131.

*Third*, unlike the present case, both *Pireno* and *Royal Drug* concerned agreements that were *not* the insurance policies and whose terms were *not* required by state law. *Royal Drug* held that Blue Shield’s side agreements with pharmacies were not immune from antitrust claims. 440 U.S. at 231. *Pireno* held that an insurer’s use of peer review doctors was not exempt from antitrust challenge. 458 U.S. at 130.

The court of appeals treated the Texas laws prescribing the insurance policy’s benefit terms as if they were “*like*” the “separate agreements” in *Royal Drug*. *PHI*, 549 S.W.3d at 814 (“like the provisions at issue in *Royal Drug*, [Texas insurance benefit laws] serve to minimize the Insurer’s costs and maximize their profits”). This is clear error. *Royal Drug*’s holding was based on the *difference between* separate agreements and the insurance policy. *See* 440 U.S. at 213 (“[petitioners] confuse the obligations of Blue Shield under its insurance policies...and the agreements between Blue Shield and the participating pharmacies”).

The Fifth Circuit recognized that *Royal Drug*’s “ruling ... turned on the fact that ‘the Pharmacy Agreements are not between the insurer and the insured.’” *Texas Pharmacy Association*, 105 F.3d at 1041 (5th Cir. 1997)<sup>62</sup> (quoting *Royal*

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<sup>62</sup> Though *Texas Pharmacy* was an ERISA preemption case, its holding applies here because, under the law governing ERISA preemption at the time, “to determine whether a State law is

*Drug*, 440 U.S. at 210). The Fifth Circuit pointed out that *Royal Drug* itself “explained that ‘this is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharmacies, may not be the ‘business of insurance’ within the meaning of the Act.’” *Id.* (quoting *Royal Drug*, 440 U.S. at 230 n.37).<sup>63</sup>

**Fourth**, the court of appeals misapplied the three so-called “*Pireno* factors.” *Pireno* identified three non-dispositive factors for determining the business of insurance in antitrust cases. *Id.* at 129-33.

“[W]hether courts must apply” them in a McCarran Ferguson “first clause” case is unclear, given the “confusion” and “chaos” of the case law. *See Perez*, 461 S.W.3d at 521 n.2. The “factors were developed in cases that characterized conduct by private actors, not state laws.” *See Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 340 (2003) (citing *Pireno*, 458 U.S. at 126).<sup>64</sup>

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exempt from ERISA preemption” required “examin[ing] the meaning of the phrase ‘business of insurance’ in the McCarran–Ferguson Act.” *Id.*

<sup>63</sup> The Supreme Court in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) distinguished *Pireno* on the same basis. *Rush* and *Pireno* both involved an insurer’s use of a “peer review” committee process. In *Pireno*, “[t]he policy said nothing on the matter.” *Id.* at 374. But in *Rush*, on the other hand, the challenged state law created a right to peer review that could be enforced directly against the contracting insurer and thus amounted to the insurer’s policy obligations. *Id.* at 373-75.

<sup>64</sup> *See also Highmark, Inc. v. UPMC Health Plan, Inc.*, 276 F.3d 160, 167 n.1 (3d Cir. 2001) (stating that *Fabe’s* distinction between the first and second clauses of section 2(b) “makes it difficult, if not impossible, to apply *Pireno*” to determine whether the first clause prevented the Lanham Act from preempting a state law prohibiting deceptive and false insurance claims).

Even if the *Pireno* factors could apply here, there is no need to analyze each in detail. As this Court has recognized, *Fabe* held that “performance of an insurance contract satisfies all three *Pireno* factors.” *Perez*, 461 S.W.3d at 524.

If, however, the *Pireno* factors do apply and if they must be analyzed individually, each is easily met.

The first factor is whether the insurer’s activity at issue “has the effect of transferring or spreading a policyholder’s risk.” *Fabe*, 508 U.S. at 503. As a matter of law, the medical benefit laws PHI challenges supply the policy’s only terms that both define and limit benefits. Defining and limiting benefits required by the policy is “fundamental[ly]” how insurers limit the risk they assume in the insurance policy. *Pireno*, 458 U.S. at 131.

The Fifth Circuit has held that the first factor is met by state regulation that much less directly regulates the business of insurance than the challenged Texas laws (which define policy benefits). In *American Bankers Ins. Co. of Florida v. Inman*, 436 F.3d 490, 494 (5th Cir. 2006), the Fifth Circuit held that a Mississippi law preventing arbitration of uninsured motorist claims meets the first *Pireno* factor in part because the no-arbitration provision “is codified as part of the Mississippi Uninsured Motorist Coverage Act and ‘[t]he terms and provisions of the Mississippi Uninsured Motorist Coverage Act are written into every automobile liability policy issued in the state.’” It “regulates risk” because the risk

of potential jury verdicts against insurers is spread across the insureds. *Id.* (quoting *Lawler v. Gov't Employees Ins. Co.*, 569 So.2d 1151, 1153 (Miss. 1990)).<sup>65</sup>

Similarly, in *Texas Pharmacy Association*, the Fifth Circuit held that a statute that “influenced which costs were ultimately borne by the insurer and which were borne by the beneficiary, and whether insurers would be willing to offer pharmacy coverage at all,” necessarily affected the spreading of risk and thus met the *Pireno* test. 105 F.3d at 1041.

Here, *both* aspects of the Texas workers’ compensation law at issue—the medical benefit laws, and the balance billing prohibition—“regulate risk” directly.

The second *Pireno* factor is whether the practice “is an integral part of the policy relationship between the insurer and insured.” *Id.* at 129. Insurance policy terms setting benefits and payment of benefits plainly meet this test.

The third factor is “whether the practice is limited to entities within the insurance industry.” *Id.* at 133. The Supreme Court developed it for antitrust cases to facilitate “intra-industry cooperation” that would normally violate antitrust laws.

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<sup>65</sup> See also *Life Partners, Inc. v. Morrison*, 484 F.3d 284, 295, 299 (4th Cir. 2007) (state act regulating viatical settlements “focused on selling insurance policies and the altering of insurance contracts,” and “surely satisf[ied] the factors listed in *Pireno*. . . . Even as the Court in *Pireno* noted that none of the enumerated criteria was ‘necessarily determinative,’ . . . the Court in *Kentucky Association of Health Plans*, considering the business of insurance in the context of ERISA, later chose to make a ‘clean break’ from the *Pireno* factors insofar as they might be restrictive, relying on a ‘common-sense understanding’ of whether the state law ‘substantially affect[ed] the risk-pooling arrangement between the insurer and the insured.’ *Ky. Ass’n of Health Plans*, 538 U.S. at 341, 123 S.Ct. 1471. Speaking in even broader terms, the Supreme Court has held that “[s]tatutes aimed at protecting or regulating [the] relationship [between insurer and insured], directly or indirectly, are laws regulating the ‘business of insurance.’ *National Securities*, 393 U.S. at 460, 89 S.Ct. 564 (emphasis added).”).

*Id.* at 129. Applying it in any first clause case is therefore especially problematic. And, indeed, PHI has never offered a credible explanation of the role this factor serves in a first clause case.

Assuming this factor must be addressed, the court below misapplied it. The court incorrectly held “PHI is not ‘within the insurance entity’ [sic] and instead is a health-care provider that deals with insurance companies to seek reimbursement for its services.” *PHI*, 549 S.W.3d at 814. The challenged regulations, however, apply directly to Texas workers’ compensation insurers and dictate their policy obligations. They appear in Texas Administrative Code Title 28 (“Insurance”). The Texas Department of Insurance’s Division of Workers’ Compensation adopted them to set what Texas workers’ compensation insurers must pay as insurance policy benefits. Payment of insurance policy benefits “is confined entirely to entities within the insurance industry.” *Fabe*, 508 U.S. at 504.

For these reasons, the McCarran-Ferguson Act precludes ADA preemption here.

## **II. The Airline Deregulation Act Does Not Preempt State Law Setting Workers’ Compensation Insurance Payments to Air Ambulances.**

The court of appeals appears to concede that preemption does not advance the “ADA’s intent.” *PHI*, 549 S.W.3d at 811 n. 8.

The court of appeals “agree[d] with” *EagleMed*’s statements “about the ADA’s intent as it relates to the setting of air ambulance rates.” *Id.* *EagleMed*

recognized that preemption of the state’s fee schedule as to air ambulances was “unfortunate,” creating an “ill-conceived intersection” with “states’ attempts to administer financially sound workers’ compensation programs in the face of skyrocketing air-ambulance bills,” and undermining Congress’s competitive-market intentions, because of the “warped market of air-ambulance services.” *EagleMed*, 868 F.3d at 902-03, 906.

Two errors are common to the decision below, the *Eagle Med* decision, and decisions in other jurisdictions that have held the Airline Deregulation Act preempts state regulation of insurance payments to air ambulances. *E.g.*, *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 763-65 (4th Cir. 2018); *Air Evac EMS, Inc. v. Sullivan*, 331 F. Supp. 3d 650, 661-664 (W.D. Tex. 2018, appeal pending in the 5th Circuit, Case No. 18-50722). First, those courts held themselves bound by the preemption clause text and not free to consider Congress’s actual intent. Second, those courts did not apply, or even address, Supreme Court case law providing the required preemption analysis.

“The purpose of Congress” is “the ultimate touchstone in every preemption case.” *Delta Airlines, Inc. v. Black*, 116 S.W.3d 745, 748 (Tex. 2003), (quoting *Retail Clerks Int’l Ass’n v. Schermerhorn*, 375 U.S. 96, 103 (1963)). Special rules of statutory construction for preemption cases require close inquiry

into what changes Congress intended to make to the law. *Medtronic*, 518 U.S. at 485-86.

**A. Under Supreme Court preemption law, courts must discern Congress’s actual intent “not only” through text.**

An inquiry into Congress’s actual intent is essential here, because the text of the Airline Deregulation Act’s preemption clause is not self-explanatory:

Except as provided in this subsection, a State, political subdivision of a State, or political authority of at least 2 States may not enact or enforce a law, regulation, or other provision having the force and effect of law *related to* a *price*, route, or service of an *air carrier* that may provide air transportation under this subpart.

49 U.S.C. § 41713(b)(1) (emphases added).

An express preemption clause settles “whether” Congress intended some preemption; it does not settle “the *scope* of its intended invalidation of state law.” *Medtronic*, 518 U.S. at 485.

As to the “scope” of intended invalidation of state law, the question is “the structure and purpose of the statute as a whole.” *Id.* That is “revealed not only in the text, but through the reviewing court’s reasoned understanding of the way in which Congress intended the statute and its surrounding regulatory scheme to affect, business, consumers and the law.” *Id.*

“[W]hen the text of a pre-emption clause is susceptible of more than one plausible reading, courts ordinarily ‘accept the reading that disfavors pre-emption.’” *Altria*, 555 U.S. at 77 (2008) (citation omitted).

Before wiping out a state police power law, the court must find that it was “the clear and manifest purpose of Congress” to do so. *Travelers*, 514 U.S. at 655 (quotations omitted).

As in the ERISA statute, the Airline Deregulation Act preemption clause uses the extremely broad language “related to.” The Supreme Court has thus applied its ERISA preemption analysis to the ADA’s “related to” language. *See Morales*, 504 U.S. at 384.

The Court held the broad term “related to” in ERISA’s express preemption clause “unhelpful” in ascertaining Congressional purpose. *Travelers*, 514 U.S. at 655-56. The Court’s “need for workable standards” in determining the scope of preemption “has led the Court to reject ‘uncritical literalism.’” *Gobeille v. Liberty Mut. Ins. Co.*, 136 S.Ct. 936, 943 (2016) (holding that ERISA’s preemption clause cannot be “taken to extend to the further stretch of its indeterminacy.”).

“[M]uch more” than a literal application of the preemption clause is therefore mandatory “in accounting for the ADA’s preemption of the state regulation in question.” *Wolens*, 513 U.S. at 224. The court must also examine whether the state laws were “inconsistent with the ADA’s deregulatory purpose.” *Id.*

*Wolens* rejected preemption of state law contract claims against commercial airlines even though they impact, and in that uncritically literal sense, are “related

to” airline prices. The Court did so in part because preemption would frustrate, not advance, the ADA’s purposes. *Id.* at 224. The same is true here, as explained below.

*Wolens* gave another reason for rejecting a literal application of ADA preemption: it is simply not “plausible that Congress meant to channel into federal courts the business of resolving, pursuant to judicially fashioned federal common law, the range of contract claims relating to airline rates.” *Id.* at 232. Here, it is similarly not “plausible” that Congress meant to channel disputes over state workers’ compensation insurance regulation of payments for healthcare services into federal courts—or, for that matter, to disrupt the various states’ systems in place for adjudicating workers’ compensation claims.

The Fifth Circuit has applied the Supreme Court precedents against preemption based only on the ADA’s preemption clause language. *Hodges v. Delta Airlines, Inc.*, 44 F.3d 334, 337-38 (5th Cir. 1995), rejected a purely textual approach to ADA preemption as “facile,” since any state tort claim against airlines may “relate to” airline services, but it was clearly not Congress’s purpose in deregulating the commercial airline market to displace state personal injury law.

In so holding, the Fifth Circuit found “significant” that neither “the ADA nor its legislative history indicates that Congress intended to displace the application of state tort law to personal physical injury inflicted by aircraft operations, or that

Congress even considered such preemption.” *Id.* at 338. The same is true here of *both* air ambulances and Texas (or any state’s) workers’ compensation insurance laws, adopted as an alternative to state tort litigation over work-related injuries.

Preemption would (as discussed in Part III below) create chaotic uncertainty for insurers, employers, workers and regulators in what this Court described as a “hermetic” regulatory regime. *Ruttiger*, 381 S.W.3d at 459.

The U.S. Supreme Court has cautioned against just such outcomes:

Federal statutes impinging upon important state interests “cannot ... be construed without regard to the implications of our dual system of government.... [W]hen the Federal Government takes over ... local radiations in the vast network of our national economic enterprise and thereby radically readjusts the balance of state and national authority, those charged with the duty of legislating [must be] reasonably explicit.”

*BFP v. Resolution Trust Corp.*, 511 U.S. 531, 544 (1994) (Scalia, J., quoting Frankfurter, *Some Reflections on the Reading of Statutes*, 47 COLUM. L. REV. 527, 539–540 (1947)).

In support of the erroneous proposition that only the text of the preemption clause counts, PHI and the other air ambulance companies rely mainly on *Puerto Rico v. Franklin Cal. Tax-Free Trust*, 136 S.Ct. 1938, 1946 (2016). *See, e.g., EagleMed*, 868 F.3d at 903. *Puerto Rico* holds no such thing.

In *Puerto Rico* the *scope* of the federal Bankruptcy Code’s preemption clause, 11 U.S.C. 903(1), was undisputed—it prohibits states from enacting their own municipal bankruptcy schemes.

Puerto Rico had enacted its own bankruptcy law in response to its fiscal crisis. The federal Bankruptcy Code preemption clause, 11 U.S.C. section 903(1), “prohibits States from creating their own bankruptcy processes for their insolvent municipalities.” *Puerto Rico*, 136 S.Ct. at 1947, *id.* at 1949 (Sotomayor, J., dissenting).

Before 1984, “the definition of ‘State’ had “included Puerto Rico since it first became a Territory of the United States in 1898,” the same year the first Federal Bankruptcy Act was enacted. *Id.* at 1945. Congress amended “the term ‘State’” in 1984 to “include[] the District of Columbia and Puerto Rico *except for the purpose of defining who may be a debtor under chapter 9 of this title.*” *Id.* (quoting 11 U.S.C. § 101(52)) (emphasis added). The majority thus held that “[t]he 1984 amendment precludes Puerto Rico from authorizing its municipalities to seek relief under Chapter 9, but it does not remove Puerto Rico from the reach of Chapter 9’s pre-emption provision.” *Id.* at 1946.

The dissent would have held that the preemption clause “should not” still apply to Puerto Rico since, under the amendment to the definition of State, “no

Puerto Rican municipality can access Chapter 9”—even though Puerto Rico was not excluded from the Bankruptcy Code’s preemption provision. *Id.* at 1952.

*Puerto Rico*’s bankruptcy code analysis provides no guidance for the preemption question here, for several reasons.

First, federal law predominates in bankruptcy. In contrast, workers’ compensation is a traditional state function with which Congress generally does not interfere. *See, e.g., Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981) (holding workers’ compensation awards “obviously ... subject to the State’s police power”).

Second, *Puerto Rico* did not involve preemption language analogous to the Airline Deregulation Act’s. In the same term, the Supreme Court reiterated its purpose-based preemption analysis due to the “need for workable standards” in determining the scope of ERISA preemption. *Gobeille*, 136 S.Ct. at 943 (again “reject[ing] ‘uncritical literalism.’”). As noted above, ERISA’s preemption standards apply to ADA preemption. *See Morales*, 504 U.S. at 384.

Third, *Puerto Rico* did not reverse the Court’s many decades of preemption doctrine requiring a context-based approach designed to guard against unintended federal overreach. It did not, for example, reverse the analysis in *Wolens*, where the Court noted that “much more” than a literal application of the preemption clause is mandatory “in accounting for the ADA’s preemption of the state

regulation in question.” *Wolens*, 513 U.S. at 224. There, the Court held that courts must also examine whether the state laws were “inconsistent with the ADA’s deregulatory purpose.” *Id.*

This Court must, therefore, seek to determine Congress’s actual intent.

**B. Congress did not intend to preempt regulation of healthcare payments to air ambulance companies.**

In *Travelers*, despite the literal text of ERISA’s preemption clause, the Court found Congress did not intend to displace New York laws imposing surcharges on patient bills covered by certain ERISA plans—regulations intended to increase the costs of such plans and encourage the purchase of lower-cost insurance.

The Court noted that the “history of Medicare regulation” of hospital fees “confirm[s] that Congress never envisioned ERISA pre-emption as blocking state healthcare cost control” by regulating such fees. *Travelers*, 514 U.S. at 667 n.6.

The same is true of the Airline Deregulation Act. Its intent is to foster free market price competition (free from government regulation), but in large part air ambulance payments are set by direct government regulation. Nearly half of PHI’s 2010-13 transports in Texas were paid for at fees set by direct government regulation (Medicare 29%, Medicaid 16%).<sup>66</sup> When Congress adopted the Airline Deregulation Act, Medicare fees for ambulance services were set by federal regulators. The federal regulator was the predecessor to CMS, *not* the Civil

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<sup>66</sup> RR2:441 (Stanek).

Aeronautics Board (whose airline rate regulations the ADA eliminated). Congress reaffirmed Medicare regulation in 1997 when it ordered CMS to adopt an air ambulance fee schedule in a negotiated rulemaking with the industry.

Similarly, when Congress adopted the Airline Deregulation Act, Medicaid fees for ambulance services were set by government regulators. Those regulators are *state* regulators, acting under within the guidelines provided by federal Medicaid statute and regulations.

Air ambulances cannot seriously contend that Congress actually intended to deregulate federal, and preempt state, regulation of healthcare payments to air ambulances. As shown herein, PHI's business model survives on the basis of payments set directly by state and federal regulators. The air ambulance industry is fueled by federally-regulated healthcare payments. Medicare's 1997 adoption of the new fee schedule was followed by dramatic growth in the private for-profit air ambulance industry—a tripling of the number of helicopters nationwide, from 350 to over 1,000 in 2015.<sup>67</sup> This industry is the very opposite of a federal-deregulated free market. Preemption here would thus clearly not serve any ADA deregulation purpose. And PHI has never explained how these two opposite outcomes—*i.e.*, (i) deregulation of state workers' compensation healthcare payments to air

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<sup>67</sup> RR1:24, 47-48 (Frazier); Ins. Ex. 120 at 10 (air ambulance industry report).

ambulances, and (ii) Medicare and Medicaid’s regulation of such payments—could possibly both serve ADA’s purposes.

Preemption here would also not advance the purpose of the ADA preemption provision itself: to “ensure that the States would not undo federal deregulation with regulation of their own.” *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 384 (1992). There was never any federal deregulation of air ambulance payments.

Preemption of air ambulance insurance payments set by Texas workers’ compensation regulators, despite continued regulation of such payments by federal and state Medicare and Medicaid regulators, would at the very least be an odd result. This Court can rely on Supreme Court authority and reject that odd result. *See Public Citizen v. U.S. Dep’t of Justice*, 491 U.S. 440, 454 (1989) (citation omitted) (rejecting interpretations that ““compel an odd result”).

**C. The Airline Deregulation Act’s preemption text does not compel preemption here.**

Read as part of the whole “structure and purpose” of the Airline Deregulation Act, and bringing to bear the “reasoned understanding” that Congress intended to end CAB regulation of commercial airline and parcel shipping prices but not Medicare and Medicaid regulation of air ambulance healthcare payments, the ADA text does not compel preemption.

In addition, the court of appeals' application of the ADA's text to the Texas laws was clearly wrong. It held the Texas insurance benefit laws place "limits on the rates an air ambulance may *charge*" and that PHI's "*billed rate* cannot be anything other than a price." *PHI*, 549 S.W.3d at 810 n.7 (emphases added).

As this Court has repeatedly recognized in the hospital context, what a healthcare provider charges on its bill, on the one hand, and what an insurer or government program owes under a policy or regulation, on the other hand, are completely different. What the provider collects is the actual price.

In language equally applicable to air ambulance companies, this Court has recognized that hospital charges are "frequently uncollected" and "arbitrary." *In re North Cypress Medical Center Operating Co., Ltd.*, 559 S.W.3d at 132. "Hospitals have developed a two-tier pricing system: (1) the 'list price,' which serves as a starting point for negotiations, similar to the sticker price one might find when purchasing a vehicle; and (2) the 'actual price,' which is what private insurers, Medicaid and Medicare, and other groups actually pay after negotiations." *Gunn v. McCoy*, 554 S.W.3d 645, 673-74 (Tex. 2018), citing *Haygood*, 356 S.W.3d at 393. Here, PHI's collections almost never match its billed charges, and instead range from zero to 78% of its charges.<sup>68</sup>

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<sup>68</sup> AR:PHI Ex. 12 at 26.

Here, the challenged laws concern the benefit amount that insurers must pay under their policies, not what an air ambulance may charge. *See* TEX. LABOR CODE § 413.011 (“The commissioner shall adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems ...”); 28 TEX. ADMIN. CODE 134.1(g) (“The insurance carrier shall consistently apply fair and reasonable reimbursement amounts ....”); *Id.* § 134.203(g),(h) (defining required “reimbursement” amounts)

In the ADA, when Congress said “prices” it was plainly referring to market prices (it expressly said so in the ADA itself<sup>69</sup>) rather than insurance payments on medical claims. When applied to commercial airlines and shipping services, “price” has a plain meaning: a *contract price* established in competitive markets with multiple sellers and buyers making voluntary sales and purchases. Commercial airlines offer competing flights and prices online, over the telephone, and at the ticket counter. Passengers (and shippers of goods) consider price, convenience, and quality, and accept one of those offers. The price charged equals the price paid. *See Medtronic*, 518 U.S. at 485-86 (requiring the scope of intended preemption to be determined by reference to the preemption text, the surrounding statutory text, “the structure and purpose of the statute as a whole,” and a

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<sup>69</sup> Apdx. F (ADA original text, Pub. L. No. 95-504, 92 Stat. 1705).

“reasoned understanding of the way in which Congress intended the statute and its surrounding regulatory scheme to affect business, consumers and the law.”).

Here, both sides’ expert economists and PHI’s own executives agree that air ambulance pricing does not fit the competitive market model behind airline deregulation. PHI’s CFO admits its billed charges are not contract prices—they are “not what we expect to collect.”<sup>70</sup> PHI’s expert admits the industry “doesn’t fit the free market.”<sup>71</sup> Insurers’ expert testified, unrebutted, that “the preconditions for a competitive market do not exist: there is no choice of providers and there is no opportunity for price negotiation.”<sup>72</sup> Thus, it is undisputed that there is no advance negotiation between a willing buyer and a willing seller to establish a market “price” in the ADA sense. The market forces that the ADA intended to promote in deregulating the airline do not operate in the air ambulance industry either to constrain air ambulance company charges or to set payments.

If, when passing a deregulation statute that paved the way for market-based contracts for air transportation, Congress also intended the term “price” to include state regulations on medical benefits required by insurance policies, it would have used much different language and expressed a much different purpose.

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<sup>70</sup> RR2:502.

<sup>71</sup> AR:Depositions:Schneider Depo. Tr. at 199.

<sup>72</sup> AR:Ins. Ex. 46, PHI Ex. 2 at 4 (¶7(g)).

### **III. The Court of Appeals Failed to Consider the Drastic Consequences.**

The court of appeals failed to address the consequences of preemption for Texas insurers, workers, and employers. They would be drastic.

*EagleMed* at least acknowledged a problem. PHI—like other air ambulances across the country—seeks state orders compelling payments of their billed charges. The Airline Deregulation Act plainly provides no authority for that result. It does not require anyone to pay “whatever rates [air ambulances] choose to charge them,” or indeed to make “any payment of air-ambulance claims whatsoever.” *EagleMed*, 868 F.3d at 906. Government-compelled payment of unilaterally set air ambulance charges is the very opposite result of the ADA’s free market objective.

Moreover, the Division cannot, as an agency delegated specific authority by the Legislature, order any award of workers’ compensation insurance payments other than those authorized by statute. “In resolving disputes over the amount of payment due the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules.” TEX. LABOR CODE § 413.031(c).

Misapplied preemption would thus raise two critically important questions for all participants within the Texas workers’ compensation system: (i) who would owe air ambulance companies what amounts for transports of injured workers, and (ii) who would decide both who must pay and the amount of payment?

Setting aside that Congress certainly did not envision disrupting Texas' scheme for answering those questions (an issue the court of appeals ignored by calling it a "policy" problem, 549 S.W.3d at 811 n.8), neither the court below nor PHI has ever explained how the standard form insurance policy would operate, or how air ambulance workers' compensation claims would be adjudicated, after preemption.

*EagleMed* said state workers' compensation payments on air ambulance claims are still, necessarily, "a question of state law" even after preemption. 868 F.3d at 906. But it did not identify what state law would control, nor why the Wyoming state law fee schedule would be preempted, but some other state law would not be. Here, those questions would have to be answered both as to workers' compensation insurers and as to workers.

**A. Even if there is preemption, Texas insurers owe, at most, the amounts required under Texas workers' compensation insurance law because that is what their contracts require.**

A Texas insurer's only obligation to pay healthcare providers is the payment required by Texas workers' compensation law because that is what the policy the insurer sold says: "We will pay promptly when due the benefits required ...by the workers' compensation law." Apx. H.

ALJ Bennett was right that PHI has "no direct right of recovery from [Insurers], but must "rely on the [insurance policy] contract" to claim any payment

from Insurers.<sup>73</sup> The contract is the only source of a Texas workers' compensation insurer's duty to pay for healthcare services to an injured worker covered under that policy. Without the contract, there is no connection between the insurer and its payment, on the one hand, and PHI, on the other hand.

The contract terms would define what an insurer would owe on the claim even if the Division's regulation of healthcare fees were preempted because there is no other amount the insurer could possibly owe. As ALJ Bennett ruled, "any recovery by PHI against [Insurers] would be limited to ... the medical fee guidelines or any other fee rules" since that is what the contract provides.<sup>74</sup> That result would be consistent with *EagleMed's* ruling that, even after preemption, state law must determine the payment.

**B. To attempt to collect billed charges, PHI would have to balance bill and sue injured workers.**

The Labor Code provides that a healthcare provider "may not pursue a private claim against a workers' compensation claimant for all or part of the cost of the health care service." TEX. LABOR CODE § 413.042(a).

In its main brief to the court of appeals, PHI challenged both the cap set by Texas regulators on what insurers owe on behalf of covered workers and the ban on providers balance billing workers for the rest of its billed charges. It recognized

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<sup>73</sup> Apdx. C at 3.

<sup>74</sup> *Id.*

that the two regulatory provisions, “combined,” prevent it from trying to collect its billed charges.<sup>75</sup>

PHI then reversed its position and told the court of appeals it challenged the ban on balance billing only “in the alternative.” *PHI*, 549 S.W.3d at 816. PHI now says the Labor Code “could easily be severed so that the Act no longer caps air ambulance rates, but still protects injured workers and their employers” from its putative balance billing tactics. *See* PHI Response to Petition at 14 n.35.

PHI makes no attempt to explain how this could be done. “Severance” does not solve the problem. Even if it could be done (which it cannot be<sup>76</sup>), all that it would accomplish is the creation of a void in the workers’ compensation laws concerning medical benefits owed under the policy. Severance would not redefine the insurance policy’s medical benefit.

PHI, of course, does not really seek *severance* of the medical benefit laws. It seeks payment of its full billed charges by state order—a result that severance

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<sup>75</sup> *See* PHI’s Br. as Appellant at 9, 12-15, 20, 22-23, 36.

<sup>76</sup> An invalid portion of a statute cannot be severed, leaving the rest of the statute intact, if doing so would “require ‘the court to write words into the statute, to leave gaping loopholes in the statute, or to foresee which of many different possible ways the legislature might respond to the constitutional objections.’” *Geeslin v. State Farm Lloyds*, 255 S.W.3d 786, 799 (Tex. App. – Austin 2008, no pet.) (quoting *Randall v. Sorrell*, 548 U.S. 230, 262 (2006)). Severing the Labor Code medical benefit standards and nullifying the Division rules promulgated thereunder would quite literally “leave a gaping loophole in the statute” (as well as the policy) as applied to air ambulance claims—which are undoubtedly some of the more expensive charges an injured worker could face. As explained above with regard to the laws setting the insured amount of such claims, and below as to the balance billing ban in the statute, eliminating these laws would undo the fundamental bargain of workers’ compensation that undergirds its constitutionality in Texas.

plainly does not lead to. PHI's transparent objective is to obtain preemption of the medical benefit laws now, so that it can use the threat of balance billing and suing injured workers within the Texas workers' compensation system to pressure regulators to order Insurers to pay full billed charges.

**C. The Airline Deregulation Act does not preempt the balance billing ban, which is essential to the viability and the constitutionality of the Texas workers' compensation insurance system.**

If the Court reaches the balance billing ban, it should hold that McCarran-Ferguson protects it as a critical regulation of “[t]he relationship between the insurer and the insured.” *Fabe*, 508 U.S. at 503. “Statutes aimed at protecting or regulating this relationship [between insurer and insured], directly or indirectly, are laws regulating the ‘business of insurance,’” and are not preempted. *Id.* at 501 (brackets in original).

The worker is an insured person under the policy. The worker's main policy benefits are fast, no-fault, statutorily defined income replacement and medical benefits, paid by the insurer.

PHI cannot credibly contend that Congress, in deregulating the airline industry, actually intended to strip injured workers of protection against air ambulance healthcare provider suits seeking payment of billed charges the worker never agreed to pay. The Airline Deregulation Act does not give commercial airlines the power to impose prices on unwilling passengers and shippers; it

protects contracts between willing passengers and willing commercial airlines. Any preemption would therefore be “inadvertent,” resulting only from a federal statute “that describes an affected activity in broad, general terms, of which the insurance business happens to constitute one part,” and precluded by McCarran-Ferguson. *See Barnett Bank of Marion County, N.A. v. Nelson*, 517 U.S. 25, 39 (1996).

The ban on balance billing is essential both to the constitutionality and to the practical viability of the Texas workers’ compensation insurance system. Both the employer and the worker are insureds under the “tripartite” Texas workers’ compensation insurance policy. *Lawrence*, 16 S.W.3d at 41. “The constitutionality of the Workers’ Compensation Act rests on the contractual nature of this agreement.” *Aranda*, 748 S.W.2d 210, 212 (Tex. 1988).<sup>77</sup>

Specifically, the Labor Code satisfies the “open courts” provision of the Texas constitution because the worker receives Division-determined insurer-paid benefits in exchange for surrendering his right to bring common-law causes of action against his employer. *See Garcia*, 893 S.W.2d at 521-23. If every air ambulance company could sue every worker it transports for more than the insurer was required to and did pay under the policy, that would breach the bargain.

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<sup>77</sup> This Court overruled *Aranda* on bad-faith claims-handling in light of the 1989 reforms to the Labor Code, but did not disturb *Aranda*’s recognition of the tripartite workers’ compensation insurance contract. *Ruttiger*, 381 S.W.3d at 451.

Such workers would likely seek their state constitutional right to sue their employers for negligence, to the extent of whatever additional amount (if any) the air ambulance company sued the worker for (under whatever body of non-preempted state law such determinations would be made).

For the same reason, the balance billing ban is crucial to the practical viability of Texas workers' compensation insurance. In return for paying premiums, employers receive full protection against costly and uncertain tort litigation because the state-mandated benefits paid by the insurer are the injured worker's exclusive remedy.<sup>78</sup>

If, however, every injured employee transported by an air ambulance could be sued for billed charges, and each employee could bring the employer into the lawsuit, subscribing employers would also lose the benefit of the Texas workers' compensation insurance bargain, and their incentive to subscribe.

Preemption would thus resurrect the fatally flawed old system of case-by-case tort and collections suits for air ambulance worker's compensation disputes. Congress manifestly did not intend that outcome when it deregulated the airline industry.

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<sup>78</sup> TEX. LABOR CODE § 408.001(a).

## CONCLUSION AND PRAYER

Insurers pray that this Court grant this Petition for Review, reverse the court of appeals, and remand the case to that court for determination of whether the trial court properly applied Texas law to the 33 fee disputes.

Respectfully submitted,

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## **CERTIFICATE OF COMPLIANCE**

Pursuant to TEX. R. APP. P. 9.4(i)(3), I certify that the foregoing document complies with the word count limitations set out in TEX. R. APP. P. 9.4(i)(2)(B) It contains 13,686 words, excluding any parts exempted by TEX. R. APP. P. 9.4(i)(1). In making this Certificate of Compliance, I am relying on the word count provided by the software used to prepare the document. This is a computer-generated document created in Microsoft Word, using 14-point Times New Roman typeface for body text and 12-point Times New Roman typeface for footnotes.

/s/ Matthew Baumgartner  
Matthew Baumgartner

## CERTIFICATE OF SERVICE

I hereby certify that on the 22nd of January, 2019, I electronically filed the foregoing with the Clerk of the Court using TexasOnline E-File System and certify that a true and correct copy of the foregoing was served electronically on the following counsel of record:

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## APPENDIX

<b><u>Tab</u></b>	<b><u>Document</u></b>
A	Court of appeals opinion: <i>PHI Air Medical, LLC v. Texas Mutual Ins. Co., et al.</i> , 549 S.W.3d 804 (Tex. App.–Austin, January 31, 2018, pet. filed), and Final Judgment.
B	Final Judgment of the trial court, <i>Texas Mutual Ins. Co., et al. v. PHI Air Medical, LLC</i> , Cause No. D-1-GN-15-004940, In the Judicial District, Travis County (January 11, 2017).
C	Decision and Order of the State Office of Administrative Hearings, <i>In re Reimbursement of Air Ambulance Services Provided by PHI Air Medical</i> , Docket No. 454-15-0681.M4, et al. (September 8, 2015).
D	Texas Labor Code § 413.011
E	Airline Deregulation Act of 1978, Public Law 95-504, 92 Stat. 1705-54 (October 24, 1978)
F	McCarran-Ferguson Act, 15 U.S.C. § 1012.
G	Texas Department of Insurance’s standard Workers’ Compensation and Employers Liability Insurance Policy
H	Airline Deregulation Act, preemption clause, 49 U.S.C. § 41713

# TAB A

**TEXAS COURT OF APPEALS, THIRD DISTRICT, AT AUSTIN**

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**JUDGMENT RENDERED JANUARY 31, 2018**

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**NO. 03-17-00081-CV**

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**PHI Air Medical, LLC, Appellant**

**v.**

**Texas Mutual Insurance Company; Hartford Underwriters Insurance Company;  
TASB Risk Management Fund; Transportation Insurance Company; Truck Insurance  
Exchange; Twin City Fire Insurance Company; Valley Forge Insurance Company;  
Zenith Insurance Company; and Texas Department of Insurance,  
Division of Workers' Compensation, Appellees**

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**APPEAL FROM THE 53RD DISTRICT COURT OF TRAVIS COUNTY  
BEFORE JUSTICES PURYEAR, FIELD, AND BOURLAND  
REVERSED AND REMANDED -- OPINION BY JUSTICE PURYEAR**

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This is an appeal from the judgment rendered by the trial court on January 11, 2017. Having reviewed the record and the parties' arguments, the Court holds that there was reversible error in the judgment. Therefore, the Court reverses the trial court's judgment and remands the case to the trial court for further proceedings. Appellees shall pay all costs relating to this appeal, both in this Court and the court below.

549 S.W.3d 804  
Court of Appeals of Texas, Austin.

PHI AIR MEDICAL, LLC, Appellant

v.

TEXAS MUTUAL INSURANCE COMPANY;  
[Hartford Underwriters Insurance Company](#);  
TASB Risk Management Fund; Transportation  
Insurance Company; Truck Insurance Exchange;  
Twin City Fire Insurance Company; Valley  
Forge Insurance Company; Zenith Insurance  
Company; and Texas Department of Insurance,  
Division of Workers' Compensation, Appellees

NO. 03-17-00081-CV

|  
Filed: January 31, 2018

#### Synopsis

**Background:** Air-ambulance company and workers' compensation insurers sought judicial review of decision of Office of Administrative hearings, which determined that certain provisions of Texas Workers' Compensation Act and related administrative rules were not preempted by the federal Airline Deregulation Act and that company should recover 149% of Medicare rate for its services. The 53rd Judicial District Court, Travis County, No. D-1-GN-15-004940, Jan [Soifer](#), J., determined that the Airline Deregulation Act did not preempt the Workers' Compensation Act and that insurers could not be asked to pay more than 125% of Medicare amount. Company appealed.

**Holdings:** The Court of Appeals, [David Puryear](#), J., held that:

[1] an air-ambulance service, as an air taxi operator, is an air carrier that may provide air transportation under the statute requiring the carrier to hold a certificate, while exempted from certain certification requirements as permitted by statute;

[2] the preemption provision of the Airline Deregulation Act applies to air-ambulance services;

[3] under the plain language of the preemption provision of the Airline Deregulation Act, the Act preempts the provisions of the Texas Workers' Compensation Act and related administrative rules that limit the rates that air-ambulance providers may charge for transporting injured employees; and

[4] preempted provisions of Texas Workers' Compensation Act and related administrative rules did not regulate "business of insurance," and thus were not reverse-preempted by McCarran-Ferguson Act.

Reversed and remanded.

West Headnotes (13)

#### [1] Aviation

✦ [Who are carriers](#)

#### Aviation

✦ [Eligibility for and subjects of certificates in general](#)

An air-ambulance service, as an air taxi operator, is an air carrier that may provide air transportation, for purposes of the statute requiring an air carrier to hold a certificate before providing air transportation, while exempted from certain certification requirements, under the statute permitting the Secretary of Transportation to exempt certain classes of carriers if the Secretary considers it necessary and "decides that the exemption is consistent with the public interest." 49 U.S.C.A. §§ 40109(c), 41101(a).

2 Cases that cite this headnote

#### [2] Aviation

✦ [Regulation in general](#)

#### Aviation

✦ [Rates and tariffs in general](#)

#### States

✦ [Aviation;airports](#)

The preemption provision of the Airline Deregulation Act, which prohibits a State or political subdivision from enacting or

enforcing “a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier[.]” applies to air-ambulance services. 49 U.S.C.A. § 41713(b)(1).

1 Cases that cite this headnote

**[3] States**

🔑 Unemployment compensation and workers' compensation

**Workers' Compensation**

🔑 Preemption

Under the plain language of the preemption provision of the Airline Deregulation Act, which prohibits a State or political subdivision from enacting or enforcing “a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier[.]” the Act preempts the provisions of the Texas Workers' Compensation Act and related administrative rules that limit the rates that air-ambulance providers may charge for transporting injured employees. 49 U.S.C.A. § 41713(b)(1); Tex. Labor Code Ann. §§ 413.011, 415.021, 415.0211, 415.0215, 415.022, 415.023, 415.024, 415.025, 415.031, 415.032, 415.033, 415.034, 415.035, 415.036; 28 Tex. Admin. Code §§ 134.1(e), 134.1(f), 134.203(d), 134.203(f).

Cases that cite this headnote

**[4] Statutes**

🔑 Effect of Partial Invalidity;Severability

The test for severability in the absence of an express severability clause is one of legislative intent.

Cases that cite this headnote

**[5] Insurance**

🔑 Preemption;Application of State or Federal Law

**States**

🔑 Insurance

The focus of the McCarran-Ferguson Act is on the relationship between the insurance

company and its policyholders. McCarran-Ferguson Act § 1 et seq., 15 U.S.C.A. § 1011 et seq.

Cases that cite this headnote

**[6] Insurance**

🔑 The "business of insurance" in general

**States**

🔑 Insurance

For purposes of reverse-preemption under the McCarran-Ferguson Act, a statute that regulates the business of insurance is one that is aimed at protecting or regulating the relationship between the insurer and the insured. McCarran-Ferguson Act § 1 et seq., 15 U.S.C.A. § 1011 et seq.

Cases that cite this headnote

**[7] Insurance**

🔑 Preemption;Application of State or Federal Law

**States**

🔑 Insurance

A statute need not directly regulate the business of insurance, such as by mandating certain terms of an insurance contract or setting premiums that may be charged by an insurer, to fall within the ambit of the McCarran-Ferguson Act. McCarran-Ferguson Act § 1 et seq., 15 U.S.C.A. § 1011 et seq.

Cases that cite this headnote

**[8] Insurance**

🔑 The "business of insurance" in general

**States**

🔑 Insurance

The broad category of laws enacted “for the purpose of regulating the business of insurance,” for purposes of the McCarran-Ferguson Act, consists of laws that possess the end, intention, or aim of adjusting, managing, or controlling the business of insurance.

McCarran-Ferguson Act § 2, 15 U.S.C.A. § 1012.

[Cases that cite this headnote](#)

**[9] Insurance**

🔑 Preemption; Application of State or Federal Law

**States**

🔑 Insurance

A statute must do more than affect insurance companies to fall within the ambit of the McCarran-Ferguson Act; it must focus on the relationship between the insurance company and the policyholder. McCarran-Ferguson Act § 1 et seq., 15 U.S.C.A. § 1011 et seq.

[Cases that cite this headnote](#)

**[10] Workers' Compensation**

🔑 Purpose of legislation

The purpose of the Texas Workers' Compensation Act is to provide employees with certainty that their medical bills and lost wages will be covered if they are injured. *Tex. Labor Code Ann. § 401.001 et seq.*

[Cases that cite this headnote](#)

**[11] Workers' Compensation**

🔑 Purpose of legislation

**Workers' Compensation**

🔑 Exclusiveness of Remedies Afforded by Acts

Employees benefit under the Texas Workers' Compensation Act because they are saved the time and expense of bringing a common-law tort claim, and subscribing employers benefit because they are not subject to tort claims for job-related injuries. *Tex. Labor Code Ann. § 401.001 et seq.*

[Cases that cite this headnote](#)

**[12] Insurance**

🔑 The "business of insurance" in general

**States**

🔑 **Insurance**

Insurance companies may do many things which are subject to paramount federal regulation, but only when they are engaged in the "business of insurance" does the McCarran-Ferguson Act apply. McCarran-Ferguson Act § 2, 15 U.S.C.A. § 1012.

[Cases that cite this headnote](#)

**[13] States**

🔑 Unemployment compensation and workers' compensation

**Workers' Compensation**

🔑 Preemption

Provisions of Texas Workers' Compensation Act and related administrative rules that limited rates that air-ambulance providers could charge for transporting injured employees, which provisions and rules were preempted by federal Airline Deregulation Act, did not regulate "business of insurance," and thus were not reverse-preempted by McCarran-Ferguson Act; caps on air ambulance fees did not affect relationship between insurers and subscribing employers or their injured employees, and did not act to underwrite or spread risks among insureds, but, rather, served to minimize insurers' costs and maximize their profits. McCarran-Ferguson Act § 2, 15 U.S.C.A. § 1012; 49 U.S.C.A. § 41713(b)(1); *Tex. Labor Code Ann. §§ 413.011, 415.021, 415.0211, 415.0215, 415.022, 415.023, 415.024, 415.025, 415.031, 415.032, 415.033, 415.034, 415.035, 415.036; 28 Tex. Admin. Code §§ 134.1(e), 134.1(f), 134.203(d), 134.203(f).*

[Cases that cite this headnote](#)

**West Codenotes**

**Preempted**

*Tex. Labor Code Ann. §§ 413.011, 415.021, 415.0211, 415.0215, 415.022, 415.023, 415.024, 415.025, 415.031, 415.032, 415.033, 415.034, 415.035, 415.036; 28 Tex. Admin. Code §§ 134.1(e), 134.1(f), 134.203(d), 134.203(f).*

**\*807 FROM THE DISTRICT COURT OF TRAVIS COUNTY, 53RD JUDICIAL DISTRICT, NO. D-1-GN-15-004940, HONORABLE JAN SOIFER, JUDGE PRESIDING**

**Attorneys and Law Firms**

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Before Justices [Puryear](#), [Field](#), and [Bourland](#)

**OPINION**

[David Puryear](#), Justice

This case arises out of a dispute over what reimbursement is due to appellant PHI Air Medical, LLC for its transporting of injured employees covered by workers' compensation insurance in Texas. The parties sought judicial review of a decision by the State Office of Administrative Hearings, and the trial court rendered a final judgment in favor of the appellee insurers—Texas Mutual Insurance Company, Hartford Underwriters Insurance Company, TASB Risk Management Fund, Transportation Insurance Company, Truck Insurance Exchange, Twin City Fire Insurance Company, Valley

Forge Insurance Company, and Zenith Insurance Company (collectively “the Insurers”). Because we conclude that certain provisions related to rates that can be paid for air ambulance transports are preempted by the Airline Deregulation Act (“the ADA”), we reverse the trial court’s judgment and remand the cause to the trial court for further proceedings.

**Statutory and Procedural Background**

In 1978, Congress enacted the ADA to encourage market competition, to advance efficiency and innovation, to lower prices, and to increase the variety and quality of air transportation services. *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 378, 112 S.Ct. 2031, 119 L.Ed.2d 157 (1992); see 49 U.S.C. § 40101(a) (explaining policy considerations involved in deregulation). The ADA provides:

**\*808** (b) Preemption. Except as provided in this subsection, a State ... may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.

49 U.S.C. § 41713(b).

At the state level, under the Texas Workers' Compensation Act (“the Act”), see *Tex. Lab. Code §§ 401.001-419.007*, employers may elect to self-insure or to obtain private insurance coverage to cover on-the-job injuries to their employees, *id.* §§ 406.002(a), .003. Under the Act, workers' compensation insurance generally pays benefits to an employee injured on the job regardless of fault or negligence, and the employee waives the right to sue for her injuries. *Id.* §§ 406.031, .034. This case involves the following statutes and rules:

- section 413.011 of the Act, which (1) requires the Commissioner of Workers' Compensation to adopt policies and guidelines “that reflect standardized reimbursement structures found in other health care delivery systems” by using Medicare and

Medicaid reimbursement methodologies and policies and by developing appropriate conversion and other adjustment factors, and (2) states that the guidelines “must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control,” *id.* § 413.001;

- provisions governing the assessment of administrative penalties and sanctions for violations of the Act, *id.* §§ 415.021-.036;
- the administrative rule defining “maximum allowable reimbursement” (“MAR”) that may be paid to a health-care provider and stating that certain health-care services shall be reimbursed in accordance with the Workers' Compensation Division’s fee guidelines, a negotiated contract, or if neither applies, “a fair and reasonable reimbursement rate” consistent with section 413.011 of the Act, 28 Tex. Admin. Code § 134.1(e), (f) (Tex. Dep’t of Ins., Medical Reimbursement); and
- the rule explaining that the MAR for certain coded services<sup>1</sup> shall be 125 percent of a particular Medicare fee schedule, 125 percent of the published Texas Medicaid fee schedule rate for that code if it is not included in the Medicare schedule, or, if neither applies, the “fair and reasonable” rate under section 134.1, as summarized above, *id.* § 134.203(d), (f) (Tex. Dep’t of Ins., Medical Fee Guideline for Professional Services).<sup>2</sup>

\*809 PHI provides air-ambulance services throughout Texas and elsewhere in the country. It is certified and regulated by the United States Department of Transportation pursuant to the Federal Aviation Act. When it is called upon to transport someone, it charges for that service by billing a “per-trip charge” and an additional charge for the miles transported. PHI and the Insurers disagreed on the amount that PHI could recover for its transport of injured workers covered by workers' compensation policies issued by the Insurers, and the issue was brought before the Division, as required by the Act. See Tex. Lab. Code § 413.031. The Division determined that the applicable provisions of the labor code and related rules were preempted by the ADA, and the Insurers appealed, requesting a de novo hearing at the State Office of Administrative Hearings. An Administrative Law Judge heard the matter and issued a final decision finding (1) that the federal ADA did not preempt the Act and (2) that PHI should recover 149% of the Medicare rate for such services. The Insurers and PHI sought judicial

review, and the Division intervened. Following a hearing, the trial court signed a final order declaring that the ADA did not preempt the Act and that the Insurers could not be asked to pay more than 125% of the Medicare amount. PHI appealed.

### Does the ADA apply to preempt the Act?

Our initial inquiry is whether the ADA preempts the Act, first addressing the Insurers' argument that PHI's services do not fall within the preemption provision. The preemption provision bars a state from enacting a law or rule “related to a price, route, or service of an air carrier that may provide air transportation under this subpart.” 49 U.S.C. § 41713(b-1).<sup>3</sup> The Insurers argue that PHI does not “provide air transportation” subject to preemption because it does not hold certificates under the specified subpart, Subpart II.<sup>4</sup>

[1] [2] Under Subpart II, “[e]xcept as provided in this chapter or another law,” an air carrier “may provide air transportation only if the air carrier holds a certificate under this chapter.” *Id.* § 41101(a). However, the Secretary of Transportation has the authority to exempt certain classes of carriers if he considers it necessary and “decides that the exemption is consistent with the public interest.” *Id.* § 40109(c). As applicable here, the Secretary of Transportation has established “a classification of air carrier, designated as ‘air taxi operators,’ which directly engage in the air transportation of persons” but which “[d]o not hold a certificate of public convenience and necessity and do not engage in scheduled passenger operations.” 14 C.F.R. § 298.3(a). We conclude that an air-ambulance service, as an air taxi operator, is an air carrier that may provide air transportation under Subpart II, 49 U.S.C. § 41101(a), while exempted from certain certification requirements, *id.* § 40109(c). We further conclude that the preemption provision applies to such carriers. See \*810 *id.* § 41713(b);<sup>5</sup> see, e.g., *Air Evac EMS, Inc. v. Cheatham*, No. 2:16-CV-05224, 2017 WL 4765966, at \*5 (S.D.W. Va. Oct. 20, 2017) (appeal filed Nov. 22, 2017) (noting that no other courts have ruled that air ambulances were not air carriers under ADA, observing that Department of Transportation licensed Air Evac as an air carrier, and holding “that Air Evac’s practice of providing emergency air ambulance services indiscriminately when called upon by third party

professionals, together with its certification as an air carrier by the DOT and court cases affirming this status, qualify Air Evac as an air carrier under the ADA”); *EagleMed, LLC v. Wyoming ex rel. Dep't of Workforce Servs.*, 227 F.Supp.3d 1255, 1277-78 (D. Wyo. 2016), *aff'd in part, rev'd in part* by *EagleMed LLC v. Cox*, 868 F.3d 893, 904 (10th Cir. 2017) (finding that air ambulances are “air carriers” under ADA); *Med-Trans Corp. v. Benton*, 581 F.Supp.2d 721, 732-33 (E.D.N.C. 2008) (holding that air ambulance service provider was common carrier subject to preemption provision).<sup>6</sup> Therefore, PHI, as a registered air taxi with all relevant and required certificates, is an air carrier under Subpart II.<sup>7</sup> We now turn to whether the provisions at issue are preempted.

[3] Other courts that have considered the preemptive effect of the ADA have \*811 noted the breadth of the language chosen by Congress. *See, e.g., Northwest, Inc. v. Ginsberg*, 572 U.S. 273, 134 S.Ct. 1422, 1430, 188 L.Ed.2d 538 (2014) (noting that language of ADA’s preemption provision, which applies to “a law, regulation or *other provision* having the force and effect of law” (emphasis added), is “much more broadly worded” than other legislation that expressly applies only to “a law or regulation”); *Morales*, 504 U.S. at 383-84, 112 S.Ct. 2031 (ADA’s provision “express[es] a broad pre-emptive purpose”); *Cox*, 868 F.3d at 899 (quoting from *Morales*’s discussion of provision’s broad purpose, 504 U.S. at 383-84, 112 S.Ct. 2031); *Valley Med Flight, Inc. v. Dwelle*, 171 F.Supp.3d 930, 940 (D.N.D. 2016) (“The phrase ‘related to’ in the ADA preemption clause has been construed very broadly.”); *Bailey v. Rocky Mountain Holdings, LLC*, 136 F.Supp.3d 1376, 1380 (S.D. Fla. 2015) (observing that Supreme Court has “held that the [preemption] provision should be construed broadly and [has] described its purposeful ‘sweeping nature’” (quoting *Morales*, 504 U.S. at 384-85, 112 S.Ct. 2031)). We agree. The relevant statutes and rules set the rates that can be recovered by PHI, as an air carrier, for transporting patients. Under the plain language of the ADA preemption provision, the ADA preempts those statutes and rules as far as they attempt to regulate PHI’s rates.<sup>8</sup> *See, e.g., Cox*, 868 F.3d at 904; *Cheatham*, 2017 WL 4765966, at \*6-8; *Dwelle*, 171 F.Supp.3d at 941-43; *Benton*, 581 F.Supp.2d at 736-39.

### Does the McCarran-Ferguson Act “reverse-preempt” the Act?

[4] We next ask whether the McCarran-Ferguson Act removes the Act from ADA preemption or “reverse-preempts” it. The McCarran-Ferguson Act provides:

#### (a) State regulation

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

#### (b) Federal regulation

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That ... the Sherman Act, and ... the Clayton Act, and ... the Federal Trade Commission Act, ... shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

15 U.S.C. § 1012.<sup>9</sup> The question we must answer is whether the relevant provisions \*812 of the Act and its associated rules were enacted “for the purpose of regulating the business of insurance.”<sup>10</sup> *See id.* In this inquiry, we are guided by the United States Supreme Court and federal courts that have explained what is meant by that language.

[5] [6] [7] [8] As explained by the Supreme Court, the focus of the McCarran-Ferguson Act is on “the relationship between the insurance company and its policyholders.” *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 500, 113 S.Ct. 2202, 124 L.Ed.2d 449 (1993). In other words, a statute that regulates the business of insurance is one that is aimed at protecting or regulating the relationship between the insurer and the insured. *Id.* (quoting *Securities & Exch. Comm'n v. National Secs., Inc.*, 393 U.S. 453, 460, 89 S.Ct. 564, 21 L.Ed.2d 668 (1969)); *see also Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 220-21, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979) (“References to the meaning of the ‘business of insurance’ in the legislative history of the McCarran-Ferguson Act strongly suggest that Congress understood the business

of insurance to be the underwriting and spreading of risk.”). A statute need not directly regulate “the business of insurance,” such as by mandating certain terms of an insurance contract or setting premiums that may be charged by an insurer, to fall within the ambit of the McCarran-Ferguson Act. *Fabe*, 508 U.S. at 502-03, 113 S.Ct. 2202. “The broad category of laws enacted ‘for the purpose of regulating the business of insurance’ consists of laws that possess the ‘end, intention, or aim’ of adjusting, managing, or controlling the business of insurance.” *Id.* at 505, 113 S.Ct. 2202 (quoting Black’s Law Dictionary 1236, 1286 (6th ed. 1990)).

[9] “Cases interpreting the scope of the McCarran-Ferguson Act have identified three criteria relevant to determining whether a particular practice falls within that Act’s reference to the ‘business of insurance’: ‘first, whether the practice has the effect of transferring or spreading a policyholder’s risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.’ ” *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985) (quoting \*813 *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982)).<sup>11</sup> A statute must do more than affect insurance companies—it must focus “on the relationship between the insurance company and the policyholder.” *See National Secs.*, 393 U.S. at 460, 89 S.Ct. 564 (holding that statute focused on insurance company stockholders, not on “attempting to secure the interests of those purchasing insurance policies,” and so fell outside McCarran-Ferguson Act); *see also Kentucky Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 337-39, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003) (noting in discussion of broader ERISA reverse-preemption that McCarran-Ferguson Act applies if law was enacted for purpose of regulating business of insurance, not simply if it affects insurance company’s business). In determining whether the statutes and rules at issue should be considered laws enacted for the purpose of regulating the business of insurance, we consider how they fit within the overall framework of the Act. *See Fredericksburg Care Co., L.P. v. Perez*, 461 S.W.3d 513, 520 (Tex. 2015).

In *Fabe*, the Court determined that an Ohio statute that established the priority in which an insurance company’s assets are distributed upon bankruptcy,

placing governmental claims behind policyholders’ claims and those of certain other creditors, fell within McCarran-Ferguson because it was “designed to carry out the enforcement of insurance contracts by ensuring the payment of policyholders’ claims despite the insurance company’s intervening bankruptcy,” and thus its purpose was “identical to the primary purpose of the insurance company itself: the payment of claims made against policies.” 508 U.S. at 504-06, 113 S.Ct. 2202. In *Royal Drug*, the agreements at issue limited the prices participating pharmacies would be paid for drugs, thus minimizing the insurance company’s costs and maximizing its profits, and as the Supreme Court observed, such agreements “may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the ‘business of insurance.’ ” 440 U.S. at 214, 99 S.Ct. 1067. Further, those agreements were not between the insurance company and its insureds but between the insurer and pharmacies providing services to the insureds. *Id.* at 216, 99 S.Ct. 1067. And finally, in *Pireno*, a chiropractor attacked an insurance company’s use of peer-review committees to determine whether the chiropractor’s charges were reasonable charges for necessary care. 458 U.S. at 122-23, 102 S.Ct. 3002. The Court observed that the use of the peer-review committee did not spread or underwrite a policyholder’s risk, was “distinct from [the insurer’s] contracts with its policyholders,” and was “not limited to entities within the insurance industry” because it involved “third parties wholly outside the insurance industry—namely, practicing chiropractors.” *Id.* at 130-32, 102 S.Ct. 3002.

[10] [11] “The purpose of the Texas Workers’ Compensation Act is to provide \*814 employees with certainty that their medical bills and lost wages will be covered if they are injured.” *HCBeck, Ltd. v. Rice*, 284 S.W.3d 349, 350 (Tex. 2009); *see Tex. Lab. Code* § 402.021 (goals of workers’ compensation system are that each employee be treated with dignity and respect and that each injured employee have access to fair and accessible dispute resolution process, prompt and high-quality medical care, and services necessary to facilitate his return to employment; in implementing goals, system must promote safe and healthy workplaces and provide income and medical benefits in timely and cost-effective manner).<sup>12</sup> Employees benefit under the Act because they are saved the time and expense of bringing a common-law tort claim, and subscribing employers benefit because

they are not subject to tort claims for job-related injuries. *HCBeck*, 284 S.W.3d at 350.

The specific statutes and rules at issue in this case attempt to limit the rates an air ambulance company may be reimbursed after transporting a workers' compensation claimant for medical care, which is part of the Act's goal to provide cost-effective medical care. And although the Act as a whole certainly relates to the insurance industry and contains provisions that may implicate the relationship between insurers and their insureds, the overall goals of the Act and these particular provisions are not specifically directed at the insurance industry, *see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987), or the relationship between the Insurers and their policyholders, *see Fabe*, 508 U.S. at 501, 113 S.Ct. 2202. Instead, the overarching focus of the Act is on ensuring prompt medical care for injured workers without those workers having to resort to the legal system, not on the relationship between the Insurers and their policyholders.

As in *Royal Drug*, an injured employee's paramount concern is not payment arrangements or limits on the reimbursement due to an air ambulance for transporting him after an injury but instead that he obtains prompt and high-quality air-ambulance services if they are required. *See* 440 U.S. at 213-14, 99 S.Ct. 1067. Further, PHI is not "within the insurance entity" and instead is a health-care provider that deals with insurance companies to seek reimbursement for its services. *See Pireno*, 458 U.S. at 130-32, 102 S.Ct. 3002. The caps on air ambulance fees do not affect the relationship between the Insurers and subscribing employers or their injured employees. *See Royal Drug*, 440 U.S. at 215-16, 99 S.Ct. 1067. Nor do they act to underwrite or spread risks among the insureds—like the provisions at issue in *Royal Drug*, they serve to minimize the Insurers' costs and maximize their profits. *See id.* at 214-15, 99 S.Ct. 1067. Such cost savings may have an effect on the workers' compensation system overall, but that effect is attenuated enough that we cannot consider limits on the rates an air ambulance may charge for transporting \*815 an injured employee to be "regulating the business of insurance." *See id.*

[12] "Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the McCarran-Ferguson Act apply." *National Secs.*, 393 U.S. at 459-60, 89 S.Ct. 564. The statutes and rules in

question here do not underwrite or spread policyholder risk and are not specifically directed at the "business of insurance" (as opposed to "the business of insurance companies"), but instead minimize the Insurers' costs, and thus are not subject to reverse preemption under the McCarran-Ferguson Act.<sup>13</sup> *See Cox*, 868 F.3d at 904-05 (stating that even if Wyoming workers' compensation system "establishe[d] a type \*816 of insurance," statute and schedule-setting fees for air-ambulance services were not laws "regulating the business of insurance"); *see also Life Partners, Inc. v. Morrison*, 484 F.3d 284, 294 (4th Cir. 2007) ("The 'business of insurance' refers to the marketing, selling, entering into, managing, servicing, and performing of insurance contracts."); *Dwelle*, 171 F.Supp.3d at 944 (statute that effectively capped rate for air-ambulance services did not regulate insurance carriers or performance of insurance contracts, alter or affect policies between insureds and insurers, or limit itself to entities in insurance industry); *Perez*, 461 S.W.3d at 522 (citing *Fabe* and *National Securities* and explaining that practices falling within McCarran-Ferguson Act include fixing rates, selling and advertising policies, licensing of insurance companies and agents, writing of insurance contracts and actual performance of contracts).

[13] We hold that the statutes and rules that attempt to regulate the reimbursement that may be obtained by PHI (1) are preempted by the ADA's prohibition on state attempts to regulate an air carrier's price, route or service and (2) are not "reverse-preempted" by the McCarran-Ferguson Act. We limit our decision to the rules and statutes related to reimbursement rates and explicitly do not address the balance-billing provision, as PHI has explained that it only attacks that provision in the alternative and that it would prefer to leave the balance-billing prohibition intact.

### Conclusion

Because we conclude that the provisions related to the reimbursement due to air-ambulance service providers under the Act are preempted by the federal ADA and are not subject to reverse-preemption under the McCarran-Ferguson Act, we reverse the trial court's judgment and remand the cause to the trial court for further proceedings.<sup>14</sup>

## All Citations

549 S.W.3d 804

## Footnotes

- 1 Health-care services are assigned “codes” under the Healthcare Common Procedure Coding System, which allows for more consistent billing and reimbursement. See Centers for Medicare & Medicaid Servs., HCPCS—General Information, HCPCS Background Information, <https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html> (last visited Jan. 9, 2018). The list includes more than 6,000 codes that encompass thousands of details related to the provision of health care. See <https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html> (last visited Jan. 9, 2018). For example, there are codes for a patient’s left or right side, for intravenous versus subcutaneous administration of a drug, for the kind of wheelchair or [wheelchair accessories](#) provided, for various [cancer](#) screenings, for hospital admission, for different kinds of [laparoscopic surgeries](#), for the administration of specific drugs, for the provision of various kinds of counseling services, and for speech or occupational therapy.
- 2 PHI also challenged the Act’s prohibition on “balance-billing”—which is a health-care provider’s billing of an injured employee for all or part of the cost of a provided service. [Tex. Lab. Code § 413.042\(a\)](#). However, in its reply brief, it states that it only attacks the balance-billing provision in the alternative and that it would prefer to see that provision left intact while the provisions related to the reimbursement schedule are struck.
- 3 The ADA defines an “air carrier” as “a citizen of the United States undertaking by any means, directly or indirectly, to provide air transportation,” and “air transportation” as “foreign air transportation, interstate air transportation, or the transportation of mail by aircraft.” [49 U.S.C. § 40102\(a\)\(2\), \(5\)](#).
- 4 The preemption provision is in Title 49, “Transportation,” Subtitle VII, “Aviation Programs,” Part A, “Air Commerce and Safety,” Subpart II, “Economic Regulation.”
- 5 In a letter related to whether the ADA preempts a county’s attempts to impose certain requirements on air ambulance services, the Department of Transportation took the same position, stating that “an air ambulance operator ... that holds DOT economic authority to operate as a registered air taxi under 14 CFR part 298, along with an FAA air carrier operating certificate under 14 CFR part 135, is an ‘air carrier’ for purposes of the ADA preemption provision.” Letter from Ronald Jackson, Assistant Gen. Counsel for Operations, Dep’t of Transp., to Thomas Cook, Vice Pres. & Gen. Counsel, REACH Air Med. Servs., LLC (Feb. 25, 2016), located at <https://www.transportation.gov/sites/dot.gov/files/docs/Reach%20Letter%20Final%20OCR.pdf>. The Attorney General of Texas has also observed that “[t]he preemption provision has been applied to air ambulance companies that are air carriers within the ADA definition.” [Tex. Att’y Gen. GA-0684, 2008 WL 4965344, at \\*2 \(Nov. 20, 2008\)](#) (citing cases applying ADA to air ambulances).
- 6 See also [Hughes Air Corp. v. Public Utils. Comm’n of Cal.](#), 644 F.2d 1334, 1337-38 (9th Cir. 1981) (holding “that Congress intended to include carriers exempted from [Civil Aeronautics Board] certification pursuant to section 416(b)(1) within the scope of the preemption provision”); [Hiawatha Aviation of Rochester, Inc. v. Minnesota Dep’t of Health](#), 389 N.W.2d 507, 509 (Minn. 1986) (holding under similar preemption provision that state was “preempted from controlling entry into the field of air ambulance service” when air carrier “registers under 14 C.F.R. § 298 to operate as an air taxi and is authorized by the CAB to provide an air ambulance service”).
- 7 We likewise disagree with the Insurers’ argument that the rates charged by PHI are not “prices” as contemplated by the ADA. The ADA defines “price” as a “rate, fare or charge,” [49 U.S.C. § 40102\(a\)\(39\)](#), and regardless of whether PHI is paid lowered charges under certain circumstances, its billed rate cannot be considered anything other than a “price.” See [Valley Med Flight, Inc. v. Dwelle](#), 171 F.Supp.3d 930, 942-43 (D.N.D. 2016) (provisions that had effect of capping reimbursement for air ambulance services could only be considered to directly impact prices and services under ADA); [Tex. Att’y Gen. GA-0684, 2008 WL 4965344, at \\*2-3](#) (noting that ambulance subscription program “involves an annual fee and a reduced charge for air ambulance services” and that because “[t]he regulation of the subscription program is related to the price of air ambulance services,” ADA preempted statutes and rules “to the extent these provisions relate to rates charged by air carriers providing air ambulance services”). If PHI receives an artificially low payment for its provision of services, a rate not reasonably tied to market costs such as fuel and other costs specific to air ambulances, its “rates” as billed to recipients not a part of the workers’ compensation market will have to change to cover such losses.
- 8 We reject the Insurers’ argument that we should parse Congressional intent in greater detail through a policy-related lens. Although we agree with the [Cox](#) court’s observations about the ADA’s intent as it relates to the setting of air-ambulance rates, see [EagleMed LLC v. Cox](#), 868 F.3d 893, 903-04 (10th Cir. 2017), the fact remains that the ADA preemption

clause explicitly states that any state attempts to regulate an air carrier's rates or services are preempted. See *id.* As for whether Congress knew that air ambulances would be subject to the ADA, we agree with PHI that the discussion about the possible inclusion of a subsidy to upgrade air ambulance safety seems to indicate that Congress had that knowledge when it enacted the ADA. Further, we disagree with the Insurers' assertions that the provision of air ambulance services is not subject to market forces. Although such services are not "shopped around" by the injured person before the service is provided, the record contains evidence that the market does influence the rates an air-ambulance provider will charge.

9 For an explanation of the history and purpose behind the McCarran-Ferguson Act, see *U.S. Department of Treasury v. Fabe*, 508 U.S. 491, 499-500, 113 S.Ct. 2202, 124 L.Ed.2d 449 (1993), and *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 217-20, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979).

10 We note that the Administrative Law Judge stated that the reimbursement provisions were a "non-severable part" of the overall Act. We disagree. "The test for severability in the absence of an express severability clause is one of legislative intent." *Association of Tex. Prof'l Educators v. Kirby*, 788 S.W.2d 827, 830 (Tex. 1990). The overall Act is largely not subject to preemption and can be given effect separate and apart from the specific rate-setting provisions at issue here. See *id.* at 830-31 (quoting *Texas & P. Ry. Co. v. Mahaffey*, 98 Tex. 392, 84 S.W. 646, 648 (1905)). There is no indication that the Legislature would not have passed the Act without the rate provisions as they apply to air ambulances or that the Act cannot function without those provisions as applied here. See *id.*; *Rose v. Doctors Hosp.*, 801 S.W.2d 841, 850 (Tex. 1990) (Phillips, C.J., dissenting) ("The inquiry, therefore, is whether 'the invalid part is so intermingled with all parts of the act as to make it impossible to separate them, and so preclude the presumption that the Legislature would have passed the act anyhow.'" (quoting *Sharber v. Florence*, 131 Tex. 341, 115 S.W.2d 604, 606 (1938))); see also *Anderson v. Abbott Labs.*, No. 3:11-CV-1825-L, 2012 WL 4512484, at \*6 (N.D. Tex. Sept. 30, 2012) (discussing severability in context of preemption).

11 *Pireno* and *Royal Drug* both dealt with "the scope of the antitrust immunity located in the second clause of § 2(b)" of the McCarran-Ferguson Act, not the broader first clause at issue in this case. *Fabe*, 508 U.S. at 504, 113 S.Ct. 2202; see *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982); *Royal Drug*, 440 U.S. at 231-32, 99 S.Ct. 1067. However, despite their antitrust focus, *Pireno* and *Royal Drug* are often cited for their discussions of factors to consider in determining whether a statute regulates the business of insurance, see, e.g., *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 337-39, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50-51, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), and we consider those factors in our analysis.

12 See also *In re Poly-America, L.P.*, 262 S.W.3d 337, 349-50 (Tex. 2008) (orig. proceeding) ("The Texas Workers' Compensation Act was enacted to protect Texas workers and employees. The Texas Legislature enacted the original Workers' Compensation Act in 1913 in response to the needs of workers who, despite a growing incidence of industrial accidents, were increasingly being denied recovery. In order to ensure compensation for injured employees while protecting employers from the costs of litigation, the Legislature provided a mechanism by which workers could recover from subscribing employers without regard to the workers' own negligence, while limiting the employers' exposure to uncertain, possibly high damage awards permitted under the common law." (citations omitted)).

13 The Insurers argue that the fee statutes and rules relate to the performance of an insurance contract and fall within McCarran-Ferguson. However, the focus in our inquiry is on the relationship between the Insurers and their insureds—the insurance contracts require the Insurers to provide coverage for job-related injuries—not the relationship between the Insurers and the providers of medical care. The means of payment or the rates paid by the Insurers to the health-care providers for providing medical services under such coverage do not equate to the performance of the contracts themselves.

As for the cases cited by the Insurers as examples of the application of the McCarran-Ferguson Act in the workers' compensation context, many involved disputes related to the formation of the actual insurance policies. See, e.g., *Uniforce Temp. Pers., Inc. v. National Council on Comp. Ins., Inc.*, 87 F.3d 1296, 1297-98 (11th Cir. 1996) (involving complaint related to alleged price-fixing of premiums for workers' compensation policies); *In re Workers' Comp. Ins. Antitrust Litig.*, 867 F.2d 1552, 1554 (8th Cir. 1989) (addressing dispute related to regulation and alleged price-fixing of insurance premiums); *National Union Fire Ins. Co. v. Seneca Family of Agencies*, 255 F.Supp.3d 480, 483 (S.D.N.Y. 2017) (concerning dispute related to terms to be included in documents forming insurance contract). And in *Proctor v. State Farm Mutual Automobile Insurance Company*, the court determined that alleged price-fixing between insurers as to rates paid for certain auto repairs were subject to reverse-preemption because the agreements were strictly "intra-industry" and because the cost of repairs did not merely affect premiums but was "directly related to the calculation of premiums; it is virtually a part of the ratemaking process." 675 F.2d 308, 322, 324 (D.C. Cir. 1982). Even assuming we

were bound or persuaded by the *Proctor* opinion's application of *Royal Drug*, we are not persuaded that the rates paid to air-ambulance services are likely to have a "virtual ratemaking" effect on the workers' compensation insurance market. Finally, *Cox*, as noted above, supports our conclusion, 868 F.3d at 904-05, and *Brown v. Cassens Transport Co.*, 546 F.3d 347 (6th Cir. 2008), does not provide useful guidance in this case. *Brown* discusses the Michigan workers' compensation system, observing that the benefits can be seen as a form of insurance, "thus perhaps creating an insurance-like relationship in which the employer is the 'insurer' and the employee is the 'insured,' " and also that certain provisions of the act in question regulate how an employer can self-insure, which "could be seen as part of 'the business of insurance.'" 546 F.3d at 359. However, the *Brown* court concluded that viewing the benefits as a form of insurance is "solely a matter of appearance" and concluded that because an employer already owed its employees a duty under common law to compensate the employee for workplace injuries, the system "merely creates a legislative remedy regarding the tort-liability relationship between employees and their employers, not an insurance contract." *Id.* at 359-60. The court discussed the purpose underlying the Michigan act, noting that it was focused on "providing certain recovery to employees for workplace injuries while limiting employers' liability rather than the regulation of insurance." *Id.* at 360. The court then noted that, although some provisions in the act did relate to the business of insurance (such as regulations setting required coverage in policies and prescribing certain terms that must be included), the employer involved was self-insured and thus the case implicated no insurer-insured relationship. *Id.* at 361. We do not read *Brown* as particularly helpful to our analysis, although its discussion of the underlying purpose behind Michigan's workers' compensation system lends supports to our conclusions.

- 14 Due to our resolution of the preemption issues, we need not address the other issues raised by the parties. See *Tex. R. App. P.* 47.1.

# TAB B

Cause No. D-1-GN-15-004940

TEXAS MUTUAL INSURANCE  
COMPANY, *et al.*,

Plaintiffs,

vs.

PHI AIR MEDICAL, LLC,

Defendant.

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IN THE DISTRICT COURT

53rd JUDICIAL DISTRICT

TRAVIS COUNTY, TEXAS

Filed in The District Court  
of Travis County, Texas

JAN 11 2017 BP

At 9:27 M.  
Velva L. Price, District Clerk

**FINAL JUDGMENT**

On December 2, 2016, the Court held a hearing on the merits and took under submission the following: Petitioners’<sup>1</sup> Judicial Review Brief on the Merits and Motion for Summary Judgment; Intervenor Texas Department of Insurance, Division of Workers’ Compensation’s Brief on the Merits and Motion for Summary Judgment; and Respondent PHI Air Medical, LLC’s Combined Motion for Summary Judgment and Response Brief on the Merits. After considering the parties’ motions, briefs and oral arguments, and the evidence in the record, the Court entered an Order dated December 15, 2016.

The Court **GRANTED**: Petitioners’ Motion for Summary Judgment, and Intervenor’s Motion for Summary Judgment. The Court **DENIED** Respondent’s Motion for Summary Judgment.

Petitioners have notified the Court and all parties that they withdraw their request for attorneys’ fees and costs and have requested entry of a final and appealable judgment.

<sup>1</sup> Petitioners include Texas Mutual Insurance Company, Hartford Underwriters Insurance Company, TASB Risk Management Fund, Transportation Insurance Company, Truck Insurance Exchange, Twin City Fire Insurance Company, Valley Forge Insurance Company, and Zenith Insurance Company.



**IT IS therefore DECLARED, ORDERED, ADJUDGED, AND FINALLY DECREED** that:

The 1978 Airline Deregulation Act, 49 U.S.C. § 41713, does not preempt the following provisions of Texas law: (i) the Texas Workers' Compensation Act's healthcare provider fee provisions, codified at Texas Labor Code § 413.011; (ii) the Texas Workers' Compensation Act's prohibition on billing injured workers for health care fees, codified at Texas Labor Code § 413.042; (iii) the Texas Workers' Compensation Act's authorization to the Division to assess sanctions for administrative violations, codified at Texas Labor Code §§ 415.021–415.025 and 415.031–415.036; and (iv) the Division of Workers' Compensation's regulations concerning health care provider fees, codified at 28 Texas Administrative Code §§ 134.1 and 134.203.

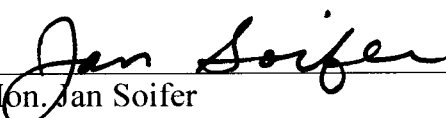
The Court further considered the Petitioners' judicial review challenge under Texas Labor Code § 413.031 and Texas Government Code, Subchapter G, Chapter 2001, to the September 8, 2015 Decision and Order of the State Office of Administrative Hearings in Docket No. 454-15-0681.M4, *et al., In Re: Reimbursement of Air Ambulance Services Provided by PHI Air Medical* ("SOAH Decision and Order"), and concluded that no additional payments greater than the 125% of Medicare amounts already paid are due. **IT IS, THEREFORE, ORDERED, ADJUDGED, AND DECREED** that the SOAH Decision and Order's award of fees equaling 149% of the applicable Medicare rate is hereby **REVERSED**, and these medical fee disputes are **REMANDED** to the State Office of Administrative Hearings for further proceedings consistent with this Judgment.

Given that the Petitioners have withdrawn their request for attorneys' fees and costs, the Court declines to award any attorneys' fees or costs, and IT IS, THEREFORE, ORDERED that all parties are to bear their respective costs of court.

All other relief not expressly granted herein is DENIED.

This Judgment resolves all claims of all parties and is intended to be and shall be final and appealable.

Signed this 11<sup>th</sup> day of January, 2017.

  
\_\_\_\_\_  
Hon. Jan Soifer  
Travis County District Judge

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**TAB C**

**DOCKET NO. 454-12-7770.M4, et al.**  
 (See attached sheet for listing of all cases)

**PHI AIR MEDICAL,**  
**Petitioner**

**V.**

**TEXAS MUTUAL INSURANCE**  
**COMPANY,**  
**Respondent**

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**BEFORE THE STATE OFFICE**

**OF**

**ADMINISTRATIVE HEARINGS**

**JOINED ORDER NO. 3**  
**RULING ON THRESHOLD LEGAL ISSUE**

This case presents a threshold legal issue—namely, whether and to what extent the federal Airline Deregulation Act of 1978 preempts the worker’s compensation statutory scheme adopted by the State of Texas. In resolving this issue, the parties have also briefed the federal McCarran-Ferguson Act, which provides for a “reverse preemption” that preserves the regulation of insurance to the states and prohibits any federal law not directly related to the business of insurance from infringing upon state laws regulating insurance.

**I. SUMMARY**

After considering the issues presented, the ALJ concludes that the Airline Deregulation Act does not preempt state workers’ compensation rules and guidelines that establish the reimbursement allowed for the air ambulance services that PHI Air Medical (PHI) rendered to injured workers (claimants). In regard to determining the payment amount from the insurance carriers, the Airline Deregulation Act has no bearing upon that in this case. Thus, the insurance carriers’ payment responsibility is not simply the usual and customary charges for the air ambulance services, but the amount allowed by the Texas workers’ compensation guidelines applied by the State of Texas in the workers’ compensation insurance statutory scheme. The basis for this conclusion is set out below.

## II. ANALYSIS

In this case, PHI seeks to recover for medical air ambulance services provided to claimants in regard to compensable injuries under Texas workers' compensation insurance. PHI seeks to be reimbursed for its services from the various workers' compensation insurance carriers (Carriers) providing coverage to the claimants. PHI has no direct contract with the Carriers. Rather, the claimants' employers contracted with the Carriers to provide insurance coverage for the claimants, who are the beneficiaries of such contracts.

Because PHI has no direct contract with the Carriers, it has only two potential grounds for recovery from Carriers. First, PHI could choose to rely upon the Texas workers' compensation statutory scheme and assert that it has a right to recover for services it provided to claimants covered by the scheme. In this scenario, PHI is directly seeking recovery through the trigger of the scheme and the rights and responsibilities it provides. The question is then whether the Airline Deregulation Act preempts all or part of that scheme to the extent it relates to matters governed by the Airline Deregulation Act. The ALJ concludes that it does not.

In particular, the McCarran-Ferguson Act explicitly reserves the regulation of insurance to the states and provides that any federal law that infringes upon that regulation is preempted by the state insurance laws, unless the federal law specifically relates to the business of insurance. In this case, there is little doubt that the workers' compensation system adopted in Texas is directly related to the business of insurance, as it establishes a comprehensive framework for providing and administering insurance for injured workers. The payment resolution processes, as well as the allowable benefit amounts set out by the Texas Department of Insurance, Division of Workers Compensation (DWC) are integrally related to the business of insurance. Thus, the ALJ concludes that the Airline Deregulation Act—which does not regulate insurance—does not preempt the ability of DWC to establish reimbursement rates, timelines for reimbursement, rules determining the extent of coverage, and numerous other requirements related to the administration of the workers' compensation insurance program, even when such regulations are applied to air ambulance providers. The insurance system itself, as established by the legislature, is designed for effective cost containment, and reimbursement rates are a key component of the entire insurance system. Thus, the medical fee guidelines and other payment rules are part of the business of insurance and, pursuant to the McCarran-Ferguson Act, the Airline Deregulation Act does not preempt and invalidate them—even when applied to air ambulance services.

Alternately, PHI might argue it is not seeking to recover through the workers' compensation insurance system, but is seeking to recover from the Carriers based solely upon the contractual obligations the Carriers

have to the insured workers. In this scenario, PHI would be, in a *de facto* sense, a subrogee of the claimants.<sup>1</sup> Since PHI would have no direct right of recovery from Carriers, but would have to rely on the contract between Carriers and claimants' employers, its right to recover would be dictated by those contracts. The applicable contracts specify that the benefits to be provided are limited to what is allowed under Texas workers' compensation law, which would include provisions requiring the reimbursement of medical care to be based upon the rates established by DWC under the medical fee guidelines or other applicable rules and statutes in the Texas workers' compensation scheme. So, as a contractual matter, any recovery by PHI against the Carriers would be limited to what is otherwise permitted under the workers' compensation system—specifically, the medical fee guidelines or any other fee rules—for that is all the contracts will permit. If PHI's right to recovery from Carriers is derived solely from the contract between Carriers and claimants' employers, the Airline Deregulation Act would again have no effect. While states may not generally be permitted to regulate matters related to air travel, private parties can certainly enter into contracts related to insurance that limit their obligations to one another and nothing in the Airline Deregulation Act can force those parties to be obligated to more than what they have contractually obligated themselves.<sup>2</sup> So, if PHI relies upon any right to recover that derives from Carrier's contractual obligations to the claimants, then PHI's claims are based upon contract and not upon a state statutory scheme.

So, under either basis—the statutory scheme or the contracts themselves—PHI's claims are limited to the amounts allowed under the Texas workers' compensation system, including the medical fee guidelines and other reimbursement guidelines or rules.

### III. CONCLUSION

In conclusion, the ALJ finds that, as a matter of law, PHI will not be entitled to receive any reimbursements greater than would otherwise be allowed under the applicable medical fee guidelines or other

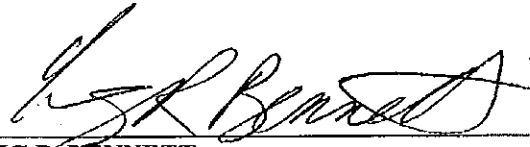
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<sup>1</sup> This is a significant consideration that shows why much of PHI's legal authority is inapplicable. Namely, PHI argues that, as a third party vendor, its involvement in this case does not implicate the business of insurance, citing *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). While such an argument might be true if, for example, PHI simply entered into a contract to provide services or goods to an insurance company, that is simply not the case here. Rather, there is no contract between PHI and Carriers, and PHI is essentially in the shoes of the insured in seeking to receive payment for insurance benefits under the contract. The ALJ believes this falls squarely within the "payment of claims made against policies" and is the "the actual performance of an insurance contract" that the Supreme Court in *U.S. Dept. of Treasury v. Fabe*, 508 U.S. 491 (1993), decided "there can be no doubt" is within the business of insurance.

<sup>2</sup> *American Airlines, Inc. v. Wolens*, 513 U. S. 219 (1995) (Noting that a contractual agreement between private parties does not have the force of state law nor is it imposed under state law; thus, such contractual agreements are not preempted by the Airline Deregulation Act).

fee rules adopted by DWC. The ALJ rejects the argument that PHI is entitled to have its reimbursement based upon its usual and customary charges because the Airline Deregulation Act prohibits otherwise. Instead, the ALJ finds that PHI is seeking to recover under either (1) a statutory scheme that constitutes the business of insurance, or (2) private contracts that have specified the limit on benefits, and those private contracts are not preempted in any manner by the Airline Deregulation Act. **Given this determination, the ALJ requests that the parties advise him, by December 6, 2013, whether they believe this case should be remanded back to DWC for dispute resolution on the merits, or whether it should proceed to hearing before SOAH.**

**SIGNED November 13, 2013.**



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**CRAIG R. BENNETT  
ADMINISTRATIVE LAW JUDGE  
STATE OFFICE OF ADMINISTRATIVE HEARINGS**

**ATTACHMENT**  
(Listing of Cases affected by Order)

SOAH DOCKET NO.	MR NO	CASE
454-12-7770.M4	M4-12-1486-01	PHIAM V. TMIC
454-12-7771.M4	M4-12-1496-01	PHIAM V. TMIC
454-12-7772.M4	M4-12-1490-01	PHIAM V. TMIC
454-12-7773.M4	M4-12-1489-01	PHIAM V. TMIC
454-12-7774.M4	M4-12-1501-01	PHIAM V. TMIC
454-12-7775.M4	M4-12-1480-01	PHIAM V. TMIC
454-12-7776.M4	M4-12-1442-01	PHIAM V. TMLIRP
454-12-7777.M4	M4-12-1451-01	PHIAM V. VFIC
454-12-7778.M4	M4-12-1476-01	PHIAM V. ZAIC
454-12-7779.M4	M4-12-1478-01	PHIAM V. NII
454-12-7780.M4	M4-12-2305-01	PHIAM V. CCS
454-12-7781.M4	M4-12-2017-01	PHIAM V. TCFIC
454-12-7782.M4	M4-12-1466-01	PHIAM V. SFIC
454-12-7783.M4	M4-12-1465-01	PHIAM V. TIC
454-12-7784.M4	M4-12-1547-01	PHIAM V. SV
454-12-7785.M4	M4-12-1448-01	PHIAM V. TMLIRP
454-12-7786.M4	M4-12-2078-01	PHIAM V. HUI
454-12-7787.M4	M4-12-1972-01	PHIAM V. XLSIC
454-12-7788.M4	M4-12-1669-01	PHIAM V. FBC
454-12-7789.M4	M4-12-1610-01	PHIAM V. TIE
454-12-7791.M4	M4-12-1974-01	PHIAM V. FBC
454-12-7792.M4	M4-12-2343-01	PHIAM V. AZIC
454-12-7793.M4	M4-12-1970-01	PHIAM V. TCFIC
454-12-7794.M4	M4-12-1980-01	PHIAM V. TMIC
454-12-7795.M4	M4-12-1471-01	PHIAM V. AAIC
454-12-7796.M4	M4-12-1611-01	PHIAM V. TMLIRP
454-12-7797.M4	M4-12-1602-01	PHIAM V. TACRMP
454-12-7798.M4	M4-12-1468-01	PHIAM V. TMIC
454-12-7799.M4	M4-12-1609-01	PHIAM V. TIC
454-12-7800.M4	M4-12-1670-01	PHIAM V. AFICA
454-12-7801.M4	M4-12-1450-01	PHIAM V. SORM
454-12-7802.M4	M4-12-1546-01	PHIAM V. WMAI
454-12-7803.M4	M4-12-1973-01	PHIAM V. IICNA
454-12-7804.M4	M4-12-1445-01	PHIAM V. SORM
454-12-7805.M4	M4-12-1457-01	PHIAM V. TMLIRP
454-12-7808.M4	M4-12-1671-01	PHIAM V. TMIC
454-12-7809.M4	M4-12-1600-01	PHIAM V. TMIC
454-12-7810.M4	M4-12-1977-01	PHIAM V. TMIC
454-12-7811.M4	M4-12-1446-01	PHIAM V. TMIC
454-12-7812.M4	M4-12-3012-01	PHIAM V. TMIC
454-12-7813.M4	M4-12-2301-01	PHIAM V. TMIC
454-12-7814.M4	M4-12-1469-01	PHIAM V. TMIC
454-12-7815.M4	M4-12-2302-01	PHIAM V. TMIC

454-12-7816.M4	M4-12-2018-01	PHIAM V. TMIC
454-12-7817.M4	M4-12-1683-01	PHIAM V. TMIC
454-12-7818.M4	M4-12-1976-01	PHIAM V. TMIC
454-12-7819.M4	M4-12-2025-01	PHIAM V. TMIC
454-12-7820.M4	M4-12-1601-01	PHIAM V. TMIC
454-12-7821.M4	M4-12-1979-01	PHIAM V. TMIC
454-12-7822.M4	M4-12-1975-01	PHIAM V. TMIC
454-12-7823.M4	M4-12-1452-01	PHIAM V. TMIC
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454-12-7825.M4	M4-12-1444-01	PHIAM V. TMIC
454-12-7826.M4	M4-12-1447-01	PHIAM V. TMIC
454-12-7827.M4	M4-12-1439-01	PHIAM V. TACRMP
454-12-7828.M4	M4-12-1458-01	PHIAM V. TACRMP
454-12-7829.M4	M4-12-1449-01	PHIAM V. TACRMP
454-12-7830.M4	M4-12-1455-01	PHIAM V. TBIC
454-12-7831.M4	M4-12-1443-01	PHIAM V. AZIC
454-12-7832.M4	M4-12-1456-01	PHIAM V. ZIC
454-12-7833.M4	M4-12-1441-01	PHIAM V. TMIC
454-12-7834.M4	M4-12-1978-01	PHIAM V. TMIC
454-12-7849.M4	M4-12-1599-01	PHIAM V. TJSIF
454-13-0040.M4	M4-12-1492-01	PHIAM V. TASBRMF
454-13-0041.M4	M4-12-1488-01	PHIAM V. ACIGIC

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## SERVICE LIST

AGENCY: Insurance, Texas Dept. of (TDD)  
 STYLE/CASE: PHIAM 0 TMIC  
 SOAH DOCKET NUMBER: 454-12-7770.M4  
 REFERRING AGENCY CASE: 12-1486

STATE OFFICE OF ADMINISTRATIVE  
 HEARINGS

ADMINISTRATIVE LAW JUDGE  
 ALJ CRAIG R. BENNETT

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# TAB D

**DOCKET NO. 454-15-0681.M4, et al.**

<b>IN RE:</b>	§	<b>BEFORE THE STATE OFFICE</b>
	§	
	§	
<b>REIMBURSEMENT OF AIR AMBULANCE SERVICES PROVIDED BY PHI AIR MEDICAL</b>	§	<b>OF</b>
	§	
	§	
	§	<b>ADMINISTRATIVE HEARINGS</b>

**TABLE OF CONTENTS**

<b>I.</b>	SUMMARY OF THE CASE.....	<b>1</b>
<b>II.</b>	JURISDICTION, NOTICE, AND PROCEDURAL HISTORY .....	<b>3</b>
<b>III.</b>	THRESHOLD LEGAL ISSUE.....	<b>4</b>
<b>IV.</b>	RECOVERY UNDER THE TEXAS WORKERS' COMPENSATION ACT .....	<b>6</b>
	<b>A.</b> Applicable Law .....	<b>6</b>
	<b>B.</b> Carriers' Arguments.....	<b>7</b>
	<b>C.</b> PHI's Arguments.....	<b>11</b>
	<b>D.</b> ALJ's Analysis.....	<b>12</b>
	<b>1.</b> Does Rule 134.203 Set Reimbursement at 125% of Medicare? .....	<b>13</b>
	<b>2.</b> Is 125% of Medicare a Fair and Reasonable Reimbursement? .....	<b>15</b>
	<b>3.</b> Are Billed Charges a Fair and Reasonable Reimbursement? .....	<b>18</b>
	<b>4.</b> Is 149% of Medicare a Fair and Reasonable Reimbursement? .....	<b>20</b>
<b>V.</b>	CONCLUSION .....	<b>22</b>
<b>VI.</b>	FINDINGS OF FACT.....	<b>23</b>
<b>VII.</b>	CONCLUSIONS OF LAW .....	<b>25</b>
	<b>ORDER</b> .....	<b>26</b>
<b>ATTACHMENT 1</b>		

**DOCKET NO. 454-15-0681.M4, et al.**

<b>IN RE:</b>	§	<b>BEFORE THE STATE OFFICE</b>
	§	
	§	
<b>REIMBURSEMENT OF AIR</b>	§	<b>OF</b>
<b>AMBULANCE SERVICES PROVIDED</b>	§	
<b>BY PHI AIR MEDICAL</b>	§	
	§	
	§	
	§	<b>ADMINISTRATIVE HEARINGS</b>

**DECISION AND ORDER**

This case involves challenges by numerous insurance companies (Carriers) to Medical Fee Dispute Resolution (MFDR) decisions by the Texas Department of Insurance, Division of Workers' Compensation (DWC) ordering additional reimbursement for air ambulance services provided by PHI Air Medical (PHI). After considering the evidence and arguments presented, the Administrative Law Judge (ALJ) finds that the proper reimbursement for the air ambulance services in dispute is 149% of the Medicare reimbursement amount. This rate reflects the per-transport average amount of revenue that allows PHI to recover its costs and earn a reasonable profit. This amount meets the statutory standards, reflects the cost of service (plus profit) for the services at issue, and allows for a reimbursement that neither unfairly subsidizes other patient populations nor requires subsidization by other populations. Consistent with this rate, the ALJ finds that PHI is entitled to additional reimbursement in the amounts reflected on Attachment 1 to this Decision and Order.

**I. SUMMARY OF THE CASE**

This case involves a dispute between PHI and Carriers over the proper reimbursement for medical air ambulance services provided to injured workers (claimants) for compensable injuries under Texas workers' compensation insurance. PHI has no direct contract with Carriers. Rather, the claimants' employers contracted with Carriers to provide insurance coverage for the claimants, who are the beneficiaries of such contracts.

There are essentially two primary issues in this case: (1) does the federal Airline Deregulation Act (ADA)<sup>1</sup> preempt state law that establishes the proper methodology for reimbursement of medical services under workers' compensation insurance? And (2) if state law is not preempted, what is the proper reimbursement under the Texas Workers' Compensation Act, Texas Labor Code § 401.001, *et seq.* (TWCA) for the air ambulance services at issue?

The ALJ previously determined—and continues to stand by that determination—that state workers' compensation laws establishing proper reimbursement rates for the services at issue are not preempted by the ADA. Thus, the ALJ looks to state workers' compensation statutes and rules to determine the proper reimbursement for the services at issue. After considering the evidence and the applicable statutory factors for determining a reimbursement rate, the ALJ concludes that 149% of Medicare reimbursement is the proper amount that satisfies the statutory criteria.

PHI's request to be reimbursed its billed charges is untenable under the TWCA because its billed charges do not satisfy the statutory reimbursement criteria and would result in workers' compensation patients unfairly subsidizing the vast majority of PHI's other patients. This is not acceptable under the requirements of the TWCA. Similarly, Carriers' request to pay only 125% of Medicare is inadequate, as it does not satisfy the statutory factors and would result in workers' compensation claimants having to be subsidized by other higher-paying patients. This also is inconsistent with the TWCA. In contrast, a reimbursement rate of 149% of Medicare results in PHI being reimbursed an amount that is as close to "subsidization-neutral" as possible, resulting in a reimbursement reflecting the actual average costs and reasonable profit of PHI in providing services to workers' compensation claimants. This amount satisfies the statutory criteria and avoids cross-subsidization in either direction with workers' compensation claimants.

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<sup>1</sup> Specifically, 49 U.S.C. § 41713(b).

## II. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

This matter involves 33 cases joined for hearing. Each case has its own procedural history, which is not restated here. All share a common background: they each involve the provision of air ambulance services by PHI to injured workers covered by insurance provided under the TWCA. In each case, Carriers reimbursed less than PHI's billed charges and PHI requested MFDR with DWC, seeking to be reimbursed its full billed charges. DWC initially dismissed the cases, finding that the ADA preempted application of the TWCA to the disputes. Carriers appealed to the State Office of Administrative Hearings (SOAH), and the matter was assigned to ALJ Craig R. Bennett. After taking arguments from the parties, the ALJ issued an order remanding the cases back to DWC for MFDR, finding that the ADA did not preempt application of the TWCA to the fee disputes.

Subsequently, DWC issued a decision in each of the 33 cases requiring Carriers to reimburse PHI its billed charges for the air ambulance services provided. Carriers then timely requested a hearing before SOAH to contest each of the MFDR decisions, and the 33 cases involved in this matter were joined together for hearing.<sup>2</sup>

An evidentiary hearing was convened before ALJ Craig R. Bennett on April 22-24, 2015, at SOAH's facilities in Austin, Texas. PHI appeared and was represented by attorneys Andres Medrano and Leslie Robnett. Carriers appeared and were represented by attorneys James Loughlin and Matthew Baumgartner. The record was formally closed on August 27, 2015, after the parties submitted a spreadsheet containing details on the fees in dispute. Except as to the application of the ADA, no parties have raised jurisdictional or notice challenges, and those matters are addressed in the findings of fact and conclusions of law without further discussion here.

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<sup>2</sup> Many similar air ambulance cases have subsequently been referred to SOAH, but those cases have been abated under a separate lead docket number, SOAH Docket No. 454-15-1877.M4, pending issuance of the decision in this case.

### III. THRESHOLD LEGAL ISSUE

As noted above, a threshold legal issue exists—namely, whether the TWCA is preempted by the ADA.<sup>3</sup> Previously, the ALJ found that the ADA did not preempt the TWCA and the rules implementing it because such laws were clearly directed toward regulating the business of insurance. A separate federal law, the McCarran-Ferguson Act,<sup>4</sup> explicitly reserves the regulation of insurance to the states and provides that any federal law that infringes upon that regulation is preempted by state insurance laws, unless the federal law specifically relates to the business of insurance.

The ALJ found previously that the workers' compensation system adopted in Texas is directly related to the business of insurance, as it establishes a comprehensive framework for providing and administering insurance coverage for injured workers. The payment resolution processes, as well as the allowable benefit amounts and reimbursement factors set out by statute or DWC, are integrally related to the business of insurance. Thus, the ALJ concluded that the ADA—which does not regulate insurance—does not preempt the application of the TWCA nor the ability of DWC to establish reimbursement rates, timelines for reimbursement, rules determining the extent of coverage, and numerous other requirements related to the administration of the workers' compensation insurance program, even when such regulations are applied to air ambulance providers. The insurance system itself, as established by the legislature, is designed for effective cost containment, and reimbursement rates are a key component of the system. The TWCA's reimbursement requirements, as well as medical fee guidelines and other payment rules, are part of the business of insurance and, pursuant to the McCarran-Ferguson Act, the ADA does not preempt or invalidate them, even as applied to air ambulance services.

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<sup>3</sup> PHI might argue that this is not the proper framing of the issue, but rather the issue is simply whether the TWCA's reimbursement provisions are preempted by the ADA, precluding reimbursement at an amount less than an air carrier's billed charges. However, the ALJ finds it appropriate to address the issue in the broader sense, because the TWCA's reimbursement provisions are a non-severable part of a broad regulatory scheme that affects both the price and service of an air carrier; thus, the overarching issue is whether the TWCA is preempted by the ADA.

<sup>4</sup> 15 U.S.C. § 1011-1015.

PHI filed a motion for summary disposition in this case, asking the ALJ to reconsider his prior ruling on this threshold jurisdictional question. In its motion, PHI asserts that the Texas workers' compensation laws in issue regulate the "business of insurance companies," rather than the "business of insurance." Because of this, PHI asserts that the McCarran-Ferguson Act does not provide for reverse preemption of the ADA by state law. The ALJ disagrees.

The TWCA provides a comprehensive scheme of insurance for injured workers in Texas whose employers participate. It addresses virtually every aspect of the application of workers' compensation insurance in the state, including the assurance of medical care for claimants, lost income benefits for claimants, and dispute resolution processes for all participating parties (including medical fee disputes between carriers and providers of goods or services to injured workers covered by such insurance), among other things. The TWCA does not regulate the "business of insurance companies"—rather, it directly regulates the business of insurance, specifically workers' compensation insurance. It would be hard to find a more comprehensive regulatory scheme for the business of insurance than the TWCA. PHI's efforts to characterize it otherwise are entirely misplaced.

Accordingly, the ALJ declines to reverse his prior ruling, but instead continues to find that the McCarran-Ferguson Act applies to this case and results in the TWCA preempting the application of the ADA, particularly in regard to the issue of determining the proper reimbursement owed by Carriers to PHI for the air ambulance services provided to the workers' compensation claimants at issue. Therefore, the ALJ finds that PHI is entitled to receive reimbursement only within the limits allowed by the TWCA.<sup>5</sup> So, the ALJ now turns to that act's reimbursement provisions.

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<sup>5</sup> In its motion for summary disposition, PHI also requested that, if the ALJ found that the ADA did not preempt the TWCA, then the ALJ also issue a ruling that PHI could balance bill the workers' compensation claimants who received the services. The ALJ finds that this issue goes beyond the scope of the ALJ's authority in this case and is more properly within the jurisdiction of the judiciary. Accordingly, the ALJ declines to grant the relief requested and does not spend time in this Decision and Order addressing it in more detail.

**IV. RECOVERY UNDER THE TEXAS WORKERS' COMPENSATION ACT**

**A. Applicable Law**

The TWCA requires DWC to adopt health care reimbursement policies and guidelines for reimbursement of services provided to injured claimants under insurance provided pursuant to the TWCA. DWC has adopted numerous medical fee guidelines. If a specific medical fee guideline provides for a reimbursement rate for a service, then that rate is ordinarily what is permitted. However, if a medical fee guideline has not been adopted for a particular service, then the insurance carrier is to reimburse the provider a fair and reasonable amount that is consistent with the requirements of Texas Labor Code § 413.011.

Texas Labor Code § 413.011 identifies a number of requirements for determining an appropriate reimbursement amount for services provided under the TWCA. Specifically, that statute lists the following requirements:

- The reimbursement amount is not to be simply a conversion factor or other payment adjustment factor based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services (CMS); [Texas Labor Code § 413.011(b)]
- The reimbursement amount must be fair and reasonable; [Texas Labor Code § 413.011(d)]
- The reimbursement amount must be designed to ensure the quality of medical care; [Texas Labor Code § 413.011(d)]
- The reimbursement amount must be designed to achieve effective medical cost control; [Texas Labor Code § 413.011(d)]
- The reimbursement amount may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf; [Texas Labor Code § 413.011(d)].

- The reimbursement amount must take into account the increased security of payment afforded by the TWCA. [Texas Labor Code § 413.011(d)]

So, in determining the proper reimbursement to PHI for the air ambulance services at issue, the ALJ must take into account these statutory factors.<sup>6</sup>

Because PHI prevailed in the MFDR decisions issued by DWC, Carriers have the burden of proof in this case. This is a *de novo* proceeding in which the standard of proof is simply “preponderance of the evidence.”<sup>7</sup> Thus, it is Carriers’ burden to establish, by a preponderance of the evidence, the appropriate reimbursement amount for the air ambulance services in dispute. If the preponderant evidence does not establish the appropriate reimbursement, then PHI would be entitled to receive its billed charges, because that is the amount ordered in the MFDR decisions.

#### **B. Carriers’ Arguments<sup>8</sup>**

In their closing arguments, Carriers assert that 125% of Medicare reimbursement is the proper reimbursement amount for the air ambulance services at issue. Carriers first argue that this is the amount allowed by DWC rule at 28 Texas Administrative Code § 134.203 (referred to hereafter simply as “Rule 134.203”). That rule provides, in part:

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<sup>6</sup> DWC Rule 134.1 also requires that a fair and reasonable reimbursement rate ensure that similar procedures provided in similar circumstances receive similar reimbursement, and be based on nationally recognized published studies, published DWC medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available. 28 Tex. Admin. Code § 134.1(f). These elements were not significant in the determination of a rate, and the ALJ does not analyze them in detail. Rather, the ALJ briefly discusses them in a footnote at the conclusion of this Decision and Order.

<sup>7</sup> See Decision and Order, 454-12-5501 (Oct. 31, 2012) at 3-5, for a detailed discussion of the burden of proof.

<sup>8</sup> Carriers and PHI have filed considerable briefing in this case, addressing many different arguments—numerous of which relate simply to the reliability of evidence or other tangential issues the ALJ finds unnecessary to reach. Because this is a final decision and not a proposal for decision, the ALJ does not restate the parties’ arguments in detail. Rather, the ALJ simply provides a short summary of the parties’ more significant positions.

- (d) The MAR [maximum allowable reimbursement] for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
- (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
  - (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME) medical supplies, for HCPCS; or
  - (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

Carriers assert that, although there is no listing for ambulance services (whether ground or air) in the Medicare DMEPOS, there is a Medicare Ambulance Fee Schedule that qualifies as a “published Medicare rate” within the meaning of Rule 134.203(d). Specifically, the codes for air ambulance services are A0431 [ambulance service, conventional air services, transport, one way (rotary wing)] and A0436 [rotary wing air mileage, per statute mile]. These are HCPCS Level II A codes, and Medicare sets payments for these codes in its Ambulance Fee Schedule published on CMS’s website. Thus, according to Carriers, reimbursement of air ambulance services should fall under Rule 134.203—presumably subsection (d)(1), although Carriers’ arguments are not entirely clear on this—resulting in reimbursement at 125 percent of the Medicare fee for the services.

Carriers recognize that the literal reading of this rule does not encompass air ambulance services because they are not listed in the Medicare DMEPOS, but argue that it would be an absurd result to not include them within the meaning of the rule when there is a Medicare rate established for them. Carriers argue that none of the provisions of Rule 134.203 would apply to air ambulance services if read literally. They point out that because Medicare has published a rate for air ambulance services, then Rule 134.203(d)(2) could not apply. Thus, the default is Subsection (d)(3) of Rule 134.203, which then applies Subsection (f). However, Carriers note that Subsection (f) states that it applies “[f]or products and services for which no relative value unit or payment has been

assigned by Medicare, Texas Medicaid . . . , or the Division.” Since Medicare has assigned a value for air ambulance services, albeit not in the DMEPOS, Carriers argue that Subsection (f) could not apply either.

Because of these alleged conflicts in Rule 134.203, Carriers argue that the most logical reading is to treat air ambulance services as being encompassed within the essence of Rule 134.203 [again, presumably subsection (d)(1)], as if the rate were listed on the Medicare DMEPOS even though it is not. Thus, Carriers argue that air ambulance services ought to be reimbursed at 125% of Medicare pursuant to Rule 134.203.

Carriers contend that even if Rule 134.203(d)(1) does not apply, 125% of Medicare is the fair and reasonable reimbursement amount under Rule 134.203(f). As noted above, if Rule 134.203(d)(1) and (2) do not apply, then Subsection (d)(3) applies and ultimately leads to the application of Rule 134.1, which is DWC’s catch-all provision. Under that provision, the reimbursement must simply be fair and reasonable, which means that the reimbursement (1) is consistent with the requirements of Texas Labor Code § 413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based upon nationally recognized published studies, published DWC medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.<sup>9</sup> Carriers argue that 125% of Medicare meets these criteria.<sup>10</sup>

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<sup>9</sup> 28 Tex. Admin. Code § 134.1(f).

<sup>10</sup> Carriers also spend considerable attention to briefing past workers’ compensation fee guidelines and decisions to demonstrate how 125% of Medicare is consistent with past decisions and rules. The ALJ finds it unpersuasive to attempt to determine a current reimbursement amount based upon past rules or decisions, which have been a source of near constant dispute and change over the last 15 years. For example, the DWC decisions underlying this case require reimbursement at PHI’s billed charges, but past DWC decisions have required reimbursement at 125% of Medicare. Given such conflicts, the ALJ analyzes this case under the existing legal standards alone.

To demonstrate that 125% of Medicare is fair and reasonable, Carriers presented the testimony of Dr. Ron Luke, an expert economist.<sup>11</sup> Dr. Luke testified that the Medicare reimbursement amount for air ambulance services has not kept pace with inflation and does not reflect the cost of new equipment in the industry. So, he made adjustments to account for these factors. Based upon his adjustments, he determined that the resulting fair and reasonable reimbursement amounts for the 2010-2013 time period were between 115% and 120% of Medicare for air ambulance transport charges, and between 107% and 111% of Medicare for mileage charges.<sup>12</sup> Thus, according to him, 125% of Medicare was more than fair and reasonable.

In reaching his conclusion, Dr. Luke considered the statutory factors set out in the TWCA. Dr. Luke noted that the availability of air ambulance services has grown significantly in the last decade, including within Texas, even with the existing Medicare reimbursement rates. According to Dr. Luke, this showed that the Medicare rate was sufficient to ensure access to care. Dr. Luke further analyzed the data and found that the Medicare rate would still allow for a reasonable profit if a provider operated at least 30 flights per aircraft, per month, at each of its bases. Dr. Luke noted that 125% of Medicare covers all of PHI's marginal costs and provides for an additional margin of contribution toward PHI's fixed costs and profit. Thus, according to Dr. Luke, PHI had an incentive to accept patients at the rate of 125% of Medicare because it was economically better off than if it did not accept them.<sup>13</sup> Because of this, Dr. Luke testified that 125% of Medicare still ensured access to care.

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<sup>11</sup> Dr. Luke relied on the data supplied by Jeff Frazier, another witness offered by Carriers. Mr. Frazier testified to air ambulance costs structure and expenses. The ALJ finds it unnecessary to discuss Mr. Frazier's testimony in detail, as he primarily just supplied the data relied upon by Mr. Luke. Because the ALJ disagrees with Dr. Luke's opinions, but not necessarily his data, it is unnecessary to determine whether the data he relied upon was reliable.

<sup>12</sup> See Carriers' Exs. 46 and 50; Tr. Vol. 1 at 303.

<sup>13</sup> Tr. Vol. 1 at 217-18.

Dr. Luke also testified that 125% of Medicare properly addresses the other factors in the TWCA. Namely, 125% of Medicare takes into account an equivalent population (Medicare population), allows for effective cost control (a lower payment is more “cost-controlling” by nature), and provides for the increased security of payment afforded by the TWCA. In fact, Dr. Luke noted that 125% of Medicare is actually equal to or higher than the amount paid by or on behalf of 72% of PHI’s patients.<sup>14</sup>

Finally, Carriers dispute that PHI’s proposed reimbursement of billed charges is consistent with the statutory standards. Carriers note that reimbursement at billed charges is essentially the highest reimbursement amount that would exist for any of PHI’s patient base. As such, it makes no provision for the security of payment under the TWCA, it does not achieve any cost control, and it results in a much higher reimbursement than that paid by or on behalf of equivalent populations (such as the 72% of PHI’s patients that pay at or below 125% of Medicare). Given these concerns, Carrier contends that Provider’s billed charges clearly do not satisfy the statutory criteria.

### **C. PHI’s Arguments**

PHI contends that Carriers’ methodology is fatally flawed and asserts it should receive its full billed charges.

PHI argues that Carriers’ proposed reimbursement of 125% of Medicare is simply “a conversion factor or other payment adjustment factor” based solely on Medicare rates, which is explicitly prohibited by Texas Labor Code § 413.011(b). Accordingly, PHI argues that the rate proposed by Carriers fails for this reason alone.

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<sup>14</sup> Tr. Vol. 2 at 311; Carriers’ Ex. 189 at 35.

PHI also argues that Carriers' methodology is flawed because it fails to take into account PHI's payer mix. Specifically, PHI receives a wide range of reimbursement amounts. For a relatively high percentage of patients, it receives nothing and must turn the accounts over to collections; for other patients, it receives only Medicare reimbursement rates; while for even other patients it may receive full billed charges. Overall, this payer mix allowed PHI to make an after-tax profit of approximately 5% for the period between 2010 and 2013. PHI contends that a reimbursement rate of 125% of Medicare for its services would result in losses of approximately \$10 million, if that were the reimbursement amount paid by each patient covered by insurance. This is unsustainable and would not ensure the quality of medical care. PHI asserts that its business model would not allow it to stay in business if 125% of Medicare is the amount it is allowed to collect from its non-governmental insurance patients.

Because a rate of 125% of Medicare would reflect a loss on each transport, PHI argues that rate would not ensure access to quality care. Instead, for it to continue to maintain its limited profitability, PHI argues it should be allowed to recover its full billed charges from Carriers and other private insurers.<sup>15</sup>

#### **D. ALJ's Analysis**

After getting past the threshold legal issue addressed in Section III of this decision, the sole remaining issue is deciding the proper reimbursement amount for the services in dispute. In this regard, there are two key issues presented in this case: (1) does Rule 134.203 set the reimbursement amount at 125% of Medicare; if not, then (2) what is the fair and reasonable reimbursement for the services under the applicable rules and statutes. Each of these issues is discussed below.

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<sup>15</sup> PHI addresses many other matters in its briefing—mostly attacks on Carriers' reasoning and data, which the ALJ does not discuss. However, PHI did not demonstrate how its billed charges actually satisfy the statutory standards.

**1. Does Rule 134.203 Set Reimbursement at 125% of Medicare?**

The ALJ concludes that Rule 134.203 does not establish the reimbursement amount at 125% of Medicare. In the initial MFDR decisions in the 33 cases pending in this docket, DWC determined uniformly that Rule 134.203 did not set the reimbursement at 125% of Medicare. DWC reached this decision because air ambulance services do not literally fall within the plain language of the rule. The ALJ agrees with the bulk of the reasoning set out in the DWC decisions, except as noted below.

DWC found that Rule 134.203 did not apply to air ambulance services. The ALJ does not necessarily agree with that, but finds it unnecessary to definitively decide the issue because even if Rule 134.203 applies, it leads to the same outcome. Assuming *arguendo* that Rule 134.203 applies, then the question is where air ambulance services fit in that rule.<sup>16</sup> Subsection (d) of Rule 134.203 states that “[t]he MAR for [HCPCS] Level II codes A, E, J, K, and L shall be determined as follows . . .” Because air ambulance services are billed under HCPCS Level II code A, subsection (d) appears to apply.

Under subsection (d), there are three potential grounds for reimbursement: (1) 125% of the fee listed for the code in the DMEPOS fee schedule; (2) if the code has no published Medicare rate, 125% of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither (1) nor (2) apply, then as calculated according to subsection (f) of Rule 134.203. Subsection (f) simply refers back to the general fair and reasonable reimbursement factors of Rule 134.1. There is no fee for air ambulance services listed in the DMEPOS or Texas Medicaid fee schedule, so neither subsections (d)(1) or (d)(2) apply, leaving only (d)(3) to apply, which then refers to subsection (f). Because subsection (f) takes us back to Rule 134.1, which applies the fair and reasonable standards of TWCA 413.011, this is essentially the same result as if

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<sup>16</sup> Subsections (b) and (c) do not apply, as they do not specifically apply to air ambulance services and also do not set a reimbursement of 125% of Medicare, as requested by Carriers.

Rule 134.203 did not apply. Under either scenario, the reimbursement must be determined based upon the fair and reasonable reimbursement factors established in TWCA 413.011.

The ALJ disagrees with Carriers' contention that a literal reading of Rule 134.203 renders an absurd result and, thus, should be read to encompass air ambulance services within the 125% of Medicare reimbursement rate in the rule. Specifically, Carriers' position rests on the argument that Rule 134.203(f) could not apply to air ambulance services because that subsection applies only "[f]or products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division."<sup>17</sup> Because Medicare has set a rate for air ambulance services, just not in the DMEPOS, Carriers argue that this subsection cannot apply. However, the ALJ finds that the language of subsection (f) must be read in conjunction with the rest of Rule 134.203. This would result in the reference to "relative value unit or payment" in subsection (f) to be understood as referring only to relative value units or payments otherwise covered by the other portions of Rule 134.203. Thus, subsection (f) applies when the other portions of Rule 134.203 do not apply because a relative value unit or payment encompassed within the other portions of Rule 134.203 has not been established.

Regardless, even if the ALJ is incorrect in this reading, the net result is the same: to determine fair and reasonable reimbursement, one must go back to Rule 134.1's "catch-all" provision and the standards set out in Texas Labor Code § 413.011 for fair and reasonable reimbursement. This is true either because Rule 134.203 does not apply at all, or because it does apply and subsection (f) dictates that reimbursement be based upon TWCA § 413.011 and Rule 134.1's fair and reasonable factors. So, the ALJ now turns to the analysis of those factors.

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<sup>17</sup> 28 Tex. Admin. Code § 134.203(f).

**2. Is 125% of Medicare a Fair and Reasonable Reimbursement?**

While the parties spend a great deal of time arguing over the framing of the “fair and reasonable” analysis, the case is relatively straightforward and involves one overarching question: Should workers’ compensation reimbursement amounts be higher to “make up” for the significant percentage of PHI’s patients that pay Medicare rates or below?<sup>18</sup>

Ultimately, the ALJ concludes that the statutory factors for reimbursement do not allow for workers’ compensation payments to be a source of subsidization for other classes of patients. The statutory factors envision a reimbursement amount that is fair and is designed to address the costs necessary to provide services for the patients covered by workers’ compensation insurance, not to subsidize other classes of patients. However, the reimbursement rates also should not be so low that they require PHI’s other patients to subsidize workers’ compensation patients. With this principle in mind, the ALJ turns to Carriers’ proposed reimbursement rate.

The ALJ finds that Carriers’ proposed reimbursement of 125% of Medicare is not consistent with the statutory standards. It is not fair and reasonable, as it is below the average required revenue amount that has allowed PHI to maintain a limited amount of profitability between 2010 and 2013. Put another way, if every patient that PHI served paid for air ambulance services at 125% of Medicare, PHI would have suffered losses in each of the years between 2010 and 2013. Requiring PHI to operate at a loss is not “fair and reasonable.” Although Carriers argue that the applicable workers’ compensation rules do not guarantee a profit, those rules also do not envision requiring providers to operate at a loss. The terms “fair” and “reasonable” by their very nature should ensure fairness and reasonableness to *all* parties involved—including patients, insurers, and providers. A fair and reasonable rate should allow a fair and reasonable profit to a provider. A rate that requires a

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<sup>18</sup> To be clear, it is often not the patient paying, but simply someone paying on the patient’s behalf—such as a governmental program or other third-party payer.

provider to operate at a loss is not fair or reasonable unless the provider has been shown to be inefficient.<sup>19</sup> In this case, the ALJ does not find that the evidence demonstrates that PHI is an inefficient provider, has unreasonably high costs, or is obtaining an unreasonably high profit margin.

Further, the ALJ agrees that the rate of 125% of Medicare proposed by Carriers is based solely on a conversion factor to Medicare rates, without consideration of the other statutory factors. This is prohibited by Texas Labor Code § 413.011(b). While Medicare rates should serve as a foundation for developing reimbursement rates,<sup>20</sup> they cannot be used as the sole basis, even with a conversion factor applied.<sup>21</sup> To be proper, a reimbursement must be more than simply Medicare, or some conversion factor of Medicare, without regard to the additional factors in the statute. If a conversion factor is applied, it must be developed by taking into account “economic indicators in health care”<sup>22</sup> as well as the additional criteria in Texas Labor Code § 413.011(d). In this case, Carriers’ proposed 125% of Medicare was not developed on this basis, but rather was simply developed as a conversion factor of Medicare rates—although Carriers attempted to justify it after the fact by reference to the additional statutory criteria.

However, even Carrier’s after-the-fact evidence via the testimony of Dr. Luke does not support a reimbursement of 125% of Medicare. Dr. Luke’s opinion was that lower rates would be proper (as shown by his testimony that the adjustment factors warranted a reimbursement of 115% to 120% of Medicare for air ambulance transport charges, and 107% to 111% of Medicare for mileage charges). The only way Carriers get to 125% of Medicare is through a straightforward conversion factor based solely upon Carrier’s reliance on Rule 134.203. Because air ambulance services have

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<sup>19</sup> For example, inefficiency might be shown if a provider incurs significantly higher operating costs than other providers in the same or a comparable market.

<sup>20</sup> See, e.g., Texas Labor Code § 413.011(a), which requires that DWC “adopt the most current reimbursement methodologies, models, and values or weights by the federal Centers for Medicare and Medicaid Services.”

<sup>21</sup> Tex. Lab. Code § 413.011(b).

<sup>22</sup> Tex. Lab. Code § 413.011(b).

not been shown to fall within that rule's 125% of Medicare rate provision, Carriers' use of it is essentially an impermissible use of a conversion factor.

Finally, because Carriers' proposed rate of 125% of Medicare would result in losses to PHI if it were adopted across the board for all patients covered by insurance, it is not "designed to ensure the quality of medical care" as required by Texas Labor § 413.011(d). Although Carrier's expert argues that PHI will continue to accept workers compensation patients even at 125% of Medicare, because such is additional incremental revenue that exceeds marginal variable costs associated with the services, his argument is a bit disingenuous. The statute does not simply indicate that the reimbursement must "ensure" quality medical care for some limited period of time, but it must be "designed to ensure" the provision of quality medical care to workers' compensation patients, *i.e.*, it must be designed to be a sustainable reimbursement rate over time. This is a key distinction.

Unique situations, such as already sunk fixed costs and/or the fact that workers' compensation patients make up a very small portion of PHI's business, may make it feasible for PHI to continue to provide services to those patients at a rate that does not cover the pro rata fixed costs for the services. But such a reimbursement is not objectively "designed" to ensure quality medical care; it is simply a happenstance of PHI's current financial situation. When the statute requires that a reimbursement rate be designed to ensure quality medical care, the ALJ construes that as a requirement that the reimbursement be designed to be self-sustaining—namely, a reimbursement amount that, standing alone, would incentivize the provision of services. A reimbursement rate of 125% of Medicare would not do this, because it would result in losses to PHI if it were the reimbursement rate applied to all of PHI's patients covered by insurance.

It is this "design" requirement that also justifies consideration of PHI's payer mix. Carriers' expert contends that PHI's payer mix—particularly the patients who pay nothing or very little—is not relevant to determining a fair and reasonable reimbursement rate. The ALJ disagrees. In virtually any business accounting method or regulatory rate-setting scheme, "bad debt" is considered

a legitimate business expense that must be accounted for. When considering whether a rate is “designed” to ensure access to quality medical care, the proper accounting of bad debt expenses across a company’s payer mix is a proper consideration. Thus, accounting for PHI’s payer mix, which by necessity includes PHI’s bad debt expenses, is proper.

Therefore, as discussed above, Carriers’ proposed rate will not satisfy the statutory factors because it (1) is not fair and reasonable, (2) is simply a conversion factor or other payment adjustment factor based solely on Medicare rates, which is explicitly prohibited by Texas Labor Code § 413.011(b); and (3) is not designed to ensure the quality of medical care, as required by Texas Labor Code § 413.011(d).

Although Carriers’ requested rate of 125% of Medicare has not been shown to be a proper reimbursement, the evidence they submitted has demonstrated two other things: (1) PHI’s requested reimbursement of billed charges is not consistent with the statutory standards and is not a proper reimbursement amount; and (2) a reimbursement of 149% of Medicare would satisfy the statutory standards and is the proper reimbursement amount for the services at issue.

**3. Are Billed Charges a Fair and Reasonable Reimbursement?**

The ALJ finds that PHI’s billed charges are not a proper reimbursement because they are not consistent with the statutory requirements under the TWCA. The evidence establishes that PHI recovers 125% of Medicare or less from 72% of its patients. As such, paying full billed charges (which are typically at least two to three times the Medicare rate) violates the statutory prohibition that reimbursement amounts generally “may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf.”<sup>23</sup> The TWCA generally prohibits

<sup>23</sup> Tex. Lab. Code § 413.011(d).

reimbursements that are excessive when compared to the amounts paid by equivalent populations.<sup>24</sup> A reimbursement rate that is two or three times the amount paid by approximately 72% of PHI's patients would violate this statutory prohibition.

Moreover, a reimbursement rate of billed charges, when 72% of PHI's patients reimburse at much less than this, is not designed to achieve effective medical cost control, as required by Texas Labor Code § 413.011(d). A reimbursement rate that is two or three times the rate paid by 72% of PHI's patients does not achieve effective cost control, but actually incentivizes PHI to seek out more workers compensation patients as a means to subsidize PHI's other patients.

Further, a rate that is two or three times the rate actually paid by 72% of PHI's other patients is not "fair and reasonable" to workers' compensation patients or those who pay on their behalf. Just as the "fair and reasonable" requirement dictates that a provider should not be expected to operate at a loss, it also dictates that workers' compensation patients should not be required to pay two or three times the rates paid by 72% of PHI's patients.

Finally, PHI's proposed reimbursement rate of billed charges does not take into account the increased security of payment afforded by the TWCA, as required by Texas Labor Code § 413.011(d). The implicit purpose of that portion of Texas Labor Code § 413.011(d) is to reflect the understanding that workers' compensation reimbursement rates should be *lower* than rates for many other populations because of the security of payment that comes from the existence of workers' compensation insurance. PHI's proposal would result in workers' compensation reimbursement essentially being the *highest* amount recovered by PHI among its patient populations. While some

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<sup>24</sup> In its post-hearing arguments, PHI emphasized the word "charged" in Texas Labor Code § 413.011(d), noting that the amount charged, not the amount paid, is what the focus is on when comparing to equivalent populations. However, the sentence goes on to include the language "and *paid* by that individual or someone acting on that individual's behalf." (emphasis added). Thus, the ALJ concludes that the emphasis is not simply on what was charged, but also what was paid by or on behalf of the equivalent populations.

patient populations, such as those covered by private insurance, would pay similar rates as workers' compensation patients, PHI's billed charges are the highest rates charged by PHI and reflect no discount whatsoever. Basically, workers' compensation patients would be paying "sticker price," while numerous other patient populations are allowed to pay less than that. This is not consistent with Texas Labor Code § 413.011(d).

So, neither Carriers' proposed rate of 125% of Medicare nor PHI's proposed rate of "billed charges" are consistent with the statutory standards. However, evidence in the record does provide an adequate basis to determine a reimbursement amount that is consistent with the statutory standards, and that evidence shows that 149% of Medicare satisfies the applicable criteria.

#### **4. Is 149% of Medicare a Fair and Reasonable Reimbursement?**

The evidence shows that 149% of Medicare is the amount that reflects PHI's average cost to provide service to each patient and to attain the profit it has earned the past few years.<sup>25</sup> Basically, this is the amount that, if paid by every PHI patient, would allow PHI to operate exactly as it did during the time period at issue, making a profit that Carriers' expert conceded is adequate.<sup>26</sup> This rate satisfies the statutory factors. It is fair and reasonable to all parties in that it accounts for PHI's payer mix and ensures recovery of costs and a reasonable profit without requiring workers' compensation patients to pay the highest rates to improperly subsidize the vast majority of PHI's other patient populations.<sup>27</sup> Although 149% of Medicare is still higher than the amounts recovered for a large portion of PHI's customer base, it is the most "subsidization-neutral" amount

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<sup>25</sup> Tr. Vol. 2 at 284, 304-05.

<sup>26</sup> Tr. Vol. 2 at 329. The parties clarified after the hearing that the pre-tax profit margin for 2010-2013 was approximately 9.15%, with an after-tax margin of approximately 5%.

<sup>27</sup> Although the ALJ believes that payer mix is a proper consideration in the analysis, he does not believe it is a driving factor. Rather it is a minor consideration in the fair and reasonable analysis. Thus, providers cannot rely on payer mix as a dominant reason to argue for a higher reimbursement amount, irrespective of the other statutory factors.

demonstrated by the evidence, and thus does not result in a significant subsidization of other patient populations. It also satisfies the other statutory factors, as set out below.

A rate of 149% of Medicare is not simply a conversion or other payment adjustment factor based solely on those factors as developed by the federal CMS. Although strictly speaking it is based upon the Medicare rate, the 149% adjustment is reached by taking into account PHI's costs, bad debts, and profit; thus, it is not "based solely" on the Medicare reimbursement rate.

Similarly, 149% of Medicare is designed to ensure the quality of medical care. PHI has covered its costs and made a reasonable profit at this average rate for the period between 2010 and 2013. Thus, this amount is designed to encourage PHI and other similar providers to continue to provide services and will ensure the quality of medical care.

The rate of 149% of Medicare is also designed to achieve effective medical cost control. Although it is higher than Medicare, it is significantly lower than the amount billed by PHI and paid by most of PHI's private insurers. It guarantees a reasonable profit, but does not incentivize abuse or excessive charges in the system. Because it is based upon Medicare, it is cost-controlling by design in that it is anchored to a *lower* amount. In contrast, if it were linked to a higher amount—such as if it were a percentage of billed charges—it would provide no cost control, as it would incentivize higher billed charges by providers and provide no theoretical upward limit on the reimbursement.

Also, a rate of 149% of Medicare does not appear to violate the prohibition in Texas Labor Code § 413.011(d) against reimbursement that results in payment of "a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf." While 149% of Medicare is clearly higher than Medicare, other payment rules in Texas already recognize that the Texas workers' compensation patient population is not exactly an equivalent population to the Medicare population. DWC has provided in Rule 134.203 for reimbursement at 125% of Medicare for many services and

products. This would not be permissible if the Medicare population was deemed to be strictly an equivalent population to the Texas workers' compensation population. So, while the two populations are similar in many respects, they are not exactly equivalent, and DWC reimbursement amounts are properly higher than Medicare amounts. Accordingly, the ALJ finds that 149% of Medicare does not result in a fee that violates Texas Labor Code § 413.011(d).

Finally, a rate of 149% of Medicare takes into account the increased security of payment afforded by the TWCA. It is less than the amount paid by private insurers or billed to PHI's uninsured patients. Given all of these considerations, the ALJ finds that 149% of Medicare is the proper reimbursement.<sup>28</sup>

## V. CONCLUSION

In conclusion, the ALJ finds that neither Carriers' proposed reimbursement of 125% of Medicare nor PHI's proposed reimbursement of billed charges satisfy the applicable statutory standards. However, the reimbursement rate of 149% of Medicare does satisfy the statutory standards, and that is the amount the ALJ orders be reimbursed by Carriers for the air ambulance services in issue. For each of the 33 cases involved in this joined docket, the parties have submitted a chart reflecting the amounts already paid, the total amount required at the rate of 149% of Medicare, and the remaining balance owed based upon this total amount due. Consistent with that chart, the ALJ finds that PHI is entitled to the amounts shown on the chart, and Carriers shall make payment for the "amount owed" for each case. In support of this conclusion, the ALJ makes the following findings of fact and conclusions of law.

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<sup>28</sup> Rule 134.1 also requires that a reimbursement rate ensures that similar procedures provided in similar circumstances receive similar reimbursement and be based on nationally recognized published studies, published DWC medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available. The ALJ finds these requirements are satisfied by the rate ordered in this case, as it provides a uniform reimbursement for all similarly-situated patients of PHI, across different carriers. It also is based upon Medicare rates, which are based upon nationally-recognized studies. Thus, both additional elements of Rule 134.1 are satisfied.

**VL FINDINGS OF FACT**

1. PHI Air Medical (PHI) is a licensed air ambulance provider holding an FAA Part 135 certificate and regulated by the U.S. Department of Transportation under the Federal Aviation Act.
2. PHI provides rotary wing air ambulance services from multiple independent bases in Texas, which are not operated as part of a hospital program.
3. PHI transports injured patients by air to trauma centers and other emergency facilities.
4. This case involves 33 separate dockets joined together for hearing and issuance of a single decision. Each docket involves the transport of a single patient by PHI.
5. Each of the injured workers in the 33 dockets addressed by this decision was transported by a PHI rotary wing air ambulance (RWAA) between 2010 and 2013.
6. The Texas workers' compensation insurers responsible for reimbursing PHI for the transports involved in this case are Texas Mutual Insurance Company, Twin City Fire Insurance Company, Hartford Casualty Insurance, Hartford Underwriters Insurance Company, Zenith Insurance Company, Transportation Insurance Company, Valley Forge Insurance Company, and TASB Risk Management Fund (collectively, "Carriers").
7. PHI billed each of the Carriers for each RWAA transport at issue in these dockets (i) a per-trip charge and (ii) a mileage charge for the miles PHI transported the patient. PHI billed each charge using its respective Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Level II A code: A0431 for the per-trip charge, and A0436 for the mileage charge. PHI's charges were its usual and customary charges for these services.
8. The Carriers reimbursed PHI at a rate equal to 125% of the Medicare payment rate for each code, under the assumption that the Texas Department of Insurance, Division of Workers' Compensation (DWC) fee guideline published at 28 Texas Administrative Code § 134.203(d)(1) applied and limited reimbursement to 125% of the Medicare reimbursement amount.
9. CMS publishes a Medicare payment rate for codes A0431 and A0436 annually that includes the following components: a standard payment for each code that varies by a Geographic Adjustment Factor (GAF) for each ambulance fee schedule locality area (GPCI), and a 50% add-on for each code for zip codes designated "rural" by CMS. The Medicare payment rate is updated for inflation annually.

10. PHI's charges, the Carriers' payments, and the reimbursement amount at 149% of Medicare in each of the 33 claims in the dockets at issue are attached to this Order at Attachment 1.
11. PHI sought additional reimbursement on each of the 33 claims at issue in these dockets by requesting medical fee dispute resolution (MFDR) with DWC.
12. DWC issued MFDR decisions finding that its jurisdiction was preempted by the federal Airline Deregulation Act (ADA), 49 U.S.C. § 41713(b), and declining to order any reimbursement within the Texas workers' compensation system.
13. DWC's decisions were appealed to the State Office of Administrative Hearings (SOAH) and assigned to Administrative Law Judge (ALJ) Craig R. Bennett.
14. The appeals were consolidated under lead SOAH Docket No. 454-12-7770.M4.
15. In an order dated November 13, 2013, the ALJ concluded that the Texas Workers' Compensation Act (TWCA), including its reimbursement standards, was not preempted by the ADA. Accordingly, on January 15, 2014, the ALJ remanded the cases back to DWC for MFDR on the merits.
16. In each of the cases in issue, DWC conducted MFDR and issued a decision requiring Carriers to reimburse PHI its billed charges as a fair and reasonable reimbursement.
17. Carriers timely appealed DWC's decisions and the cases were again referred to SOAH for a hearing, given new docket numbers, and assigned to ALJ Craig R. Bennett.
18. All parties received adequate notice of the time, place and nature of the hearing; the legal authority and the jurisdiction under which it was to be held; the particular sections of the statutes and rules involved; and a short, plain statement of the matters at issue.
19. On April 22-24, 2015, SOAH ALJ Craig R. Bennett held a contested case hearing in the 33 joined dockets at the William P. Clements Office Building, 300 West 15th Street, Austin, Texas 78701. Texas Mutual Insurance Company appeared through its attorney, Matthew Baumgartner. The other Carriers appeared through their attorney, James Loughlin. PHI appeared through its attorneys, Andres Medrano and Leslie Ritchie Robnett.
20. The record closed on August 27, 2015, after the parties submitted post-hearing briefs, proposed findings of fact and conclusions of law, and financial calculations requested by the ALJ.

21. Between 2010 and 2013, PHI earned a pre-tax profit margin of approximately 9.15% and an after-tax margin of approximately 5%, based on an average transport recovery of 149% of the Medicare reimbursement amount.
22. PHI's profit margin for the period between 2010 and 2013 was fair, reasonable, adequate, and not excessive.
23. A reimbursement of 125% of the Medicare reimbursement amount is equal to or higher than the amount paid by or on behalf of 72% of PHI's patients during the relevant time period.
24. A reimbursement of 125% of the Medicare reimbursement amount for the air ambulance services and mileage charges in issue is not fair and reasonable, within the meaning of the applicable statutes and rules under the TWCA.
25. A reimbursement of PHI's billed charges for the air ambulance services and mileage charges at issue is not fair and reasonable within the meaning of the applicable statutes and rules under the TWCA.
26. Reimbursement at 149% of the Medicare reimbursement amount for the air ambulance services and mileage charges at issue is fair and reasonable within the meaning of the applicable statutes and rules under the TWCA.

## VII. CONCLUSIONS OF LAW

1. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to Texas Labor Code § 413.031 and Texas Government Code chapter 2003.
2. Adequate and timely notice of the hearing was provided in accordance with Texas Government Code §§ 2001.051 and 2001.052.
3. The TWCA, Texas Labor Code § 401.001, *et seq.*, including the relevant reimbursement requirements, is not preempted by the ADA. A separate federal law, the McCarran-Ferguson Act, 15 U.S.C. § 1011-1015, explicitly reserves the regulation of the business of insurance to the states. Accordingly, reimbursement of the services at issue is governed by the TWCA and the rules applying it.
4. Carriers have the burden of proving by a preponderance of the evidence the proper reimbursement amount to be paid to PHI for the RWAA services provided to the injured workers in the 33 cases involved in this proceeding.

5. There is no maximum allowable reimbursement established by DWC for the air ambulances services and mileage charges at issue. More specifically, 28 Texas Administrative Code § 134.203 does not establish a reimbursement rate of 125% of Medicare for the air ambulance services and mileage charges in issue.
6. The reimbursement rate for the air ambulance services and mileage charges at issue in this case must be determined through application of 28 Texas Administrative Code § 134.1(f) and Texas Labor Code § 413.011.
7. The preponderance of the evidence establishes that the proper reimbursement for the RWAA services at issue, as determined after consideration of the factors in 28 Texas Administrative Code § 134.1(f) and Texas Labor Code § 413.011, is 149% of the Medicare reimbursement amount.
8. PHI is entitled to additional reimbursement from Carriers in the amounts reflected on Attachment 1 to this Decision and Order.

**ORDER**

**IT IS ORDERED** that the respective Carriers shall pay PHI the additional reimbursement amounts reflected in the "Amount Owed" column on Attachment 1 for the services provided by PHI to the injured workers involved in each of the 33 dockets addressed in this proceeding.

**SIGNED September 8, 2015.**



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**CRAIG R. BENNETT**  
**ADMINISTRATIVE LAW JUDGE**  
**STATE OFFICE OF ADMINISTRATIVE HEARINGS**

**ATTACHMENT I**

SOAH DOCKET NO	MR NO.	CASE	BILLED CHARGES	PAID AMOUNT	149% MEDICARE ALLOWABLE	AMOUNT OWED
454-15-0681.M4	M4-12-1970-02	T.C.F.I.C. v. P.H.I.A.M.	\$27,881.00	\$8,912.10	\$10,521.77	\$1,609.67
454-15-0683.M4	M4-12-2078-02	H.U.I.C. v. P.H.I.A.M.	\$17,241.00	\$4,490.66	\$5,331.67	\$841.01
454-15-0684.M4	M4-12-1456-02	Z.I.C. v. P.H.I.A.M.	\$15,388.00	\$4,550.68	\$5,399.68	\$849.00
454-15-0685.M4	M4-12-1609-02	T.C.F.I.C. v. P.H.I.A.M.	\$18,382.00	\$4,885.71	\$5,654.61	\$768.90
454-15-0686.M4	M4-12-1610-02	T.I.E. v. P.H.I.A.M.	\$23,107.00	\$5,611.74	\$6,573.59	\$961.85
454-15-0603.M4	M4-12-1451-01	V.F.I.C. v. P.H.I.A.M.	\$28,180.00	\$9,850.85	\$11,734.41	\$1,883.56
454-15-0604.M4	M4-12-2017-02	T.C.F.I.C. v. P.H.I.A.M.	\$26,551.00	\$8,560.29	\$10,164.04	\$1,603.75
454-15-0824.M4	M4-12-1492-01	T.A.S.B.R.M.F. v. P.H.I.A.M.	\$28,004.00	\$6,109.64	\$10,900.18	\$4,790.54
454-15-1446.M4	M4-12-1490-02	T.M.I.C. V. P.H.I.A.M.	\$26,782.00	\$9,084.68	\$10,806.90	\$1,722.22
454-15-1669.M4	M4-12-2301-02	T.M.I.C. V. P.H.I.A.M.	\$27,881.00	\$8,842.69	\$10,504.94	\$1,662.25
454-15-1670.M4	M4-12-2302-02	T.M.I.C. V. P.H.I.A.M.	\$17,241.00	\$4,439.00	\$5,324.06	\$885.06
454-15-1671.M4	M4-12-3012-02	T.M.I.C. V. P.H.I.A.M.	\$33,618.00	\$9,866.37	\$11,728.71	\$1,862.34
454-15-1672.M4	M4-12-1979-02	T.M.I.C. V. P.H.I.A.M.	\$24,841.00	\$8,224.64	\$9,770.25	\$1,545.61
454-15-1673.M4	M4-12-2018-02	T.M.I.C. V. P.H.I.A.M.	\$42,131.00	\$11,867.53	\$14,131.79	\$2,264.26
454-15-1674.M4	M4-12-2025-02	T.M.I.C. V. P.H.I.A.M.	\$18,951.00	\$4,711.96	\$5,605.76	\$893.80
454-15-1675.M4	M4-12-1976-02	T.M.I.C. V. P.H.I.A.M.	\$23,660.00	\$5,514.50	\$6,563.97	\$1,049.47
454-15-1676.M4	M4-12-1977-02	T.M.I.C. V. P.H.I.A.M.	\$22,440.00	\$8,439.38	\$10,016.43	\$1,577.05
454-15-1677.M4	M4-12-1978-02	T.M.I.C. V. P.H.I.A.M.	\$22,561.00	\$7,713.41	\$9,165.85	\$1,452.44
454-15-1678.M4	M4-12-1601-02	T.M.I.C. V. P.H.I.A.M.	\$38,321.00	\$7,642.81	\$9,100.62	\$1,457.81
454-15-1679.M4	M4-12-1683-02	T.M.I.C. V. P.H.I.A.M.	\$30,357.00	\$9,689.64	\$11,537.27	\$1,847.63
454-15-1680.M4	M4-12-1975-02	T.M.I.C. V. P.H.I.A.M.	\$24,841.00	\$5,464.93	\$6,487.91	\$1,022.98
454-15-1681.M4	M4-12-1468-02	T.M.I.C. V. P.H.I.A.M.	\$20,132.00	\$5,034.73	\$5,984.41	\$949.68
454-15-1682.M4	M4-12-1469-02	T.M.I.C. V. P.H.I.A.M.	\$19,678.00	\$4,873.40	\$5,785.38	\$911.98
454-15-1683.M4	M4-12-1489-02	T.M.I.C. V. P.H.I.A.M.	\$16,632.00	\$4,583.72	\$5,455.47	\$871.75
454-15-1684.M4	M4-12-1447-02	T.M.I.C. V. P.H.I.A.M.	\$19,607.00	\$7,431.09	\$8,848.51	\$1,417.42
454-15-1685.M4	M4-12-1452-02	T.M.I.C. V. P.H.I.A.M.	\$30,640.00	\$6,970.63	\$8,297.13	\$1,326.50
454-15-1686.M4	M4-12-1467-02	T.M.I.C. V. P.H.I.A.M.	\$18,176.00	\$7,390.76	\$8,801.87	\$1,411.11
454-15-1687.M4	M4-12-1441-02	T.M.I.C. V. P.H.I.A.M.	\$22,232.00	\$8,036.06	\$9,544.26	\$1,508.20
454-15-1688.M4	M4-12-1444-02	T.M.I.C. V. P.H.I.A.M.	\$25,557.00	\$8,802.36	\$10,476.57	\$1,674.21
454-15-1689.M4	M4-12-1446-02	T.M.I.C. V. P.H.I.A.M.	\$19,257.00	\$4,900.29	\$5,826.40	\$926.11
454-15-1763.M4	M4-12-1600-02	T.M.I.C. V. P.H.I.A.M.	\$19,135.00	\$7,189.11	\$5,689.23	\$0.00
454-15-1764.M4	M4-12-1671-02	T.M.I.C. V. P.H.I.A.M.	\$15,696.00	\$4,368.65	\$5,206.12	\$837.47
454-15-1765.M4	M4-12-1980-02	T.M.I.C. V. P.H.I.A.M.	\$23,701.00	\$7,955.40	\$9,438.48	\$1,483.08
						\$45,868.70

# TAB E

Vernon's Texas Statutes and Codes Annotated  
Labor Code (Refs & Annos)  
Title 5. Workers' Compensation  
Subtitle A. Texas Workers' Compensation Act  
Chapter 413. Medical Review  
Subchapter B. Medical Services and Fees (Refs & Annos)

V.T.C.A., Labor Code § 413.011

§ 413.011. Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols

Effective: January 1, 2011

[Currentness](#)

(a) The commissioner shall adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements. To achieve standardization, the commissioner shall adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet the requirements of [Section 413.053](#).

(b) In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). The commissioner shall also provide for reasonable fees for the evaluation and management of care as required by [Section 408.025\(c\)](#) and commissioner rules. This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.

(c) This section may not be interpreted in a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by [Section 1451.104, Insurance Code](#), or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle. The commissioner shall also develop guidelines relating to fees charged or paid for providing expert testimony relating to an issue arising under this subtitle.

(d) Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

(d-1) Expired.

(d-2) Expired.

(d-3) Expired.

(d-4) Notwithstanding this section or any other provision of this title, an insurance carrier, an insurance carrier's authorized agent, or a network certified under Chapter 1305, Insurance Code, arranging for non-network services or out-of-network services under [Section 1305.006, Insurance Code](#), may continue to contract with a health care provider to secure health care for an injured employee for fees that exceed the fees adopted by the division under this section.

(d-5) The commissioner and the commissioner of insurance may adopt rules as necessary to implement this section.

(d-6) Expired.

(e) The commissioner by rule shall adopt treatment guidelines and return-to-work guidelines and may adopt individual treatment protocols. Treatment guidelines and protocols must be evidence-based, scientifically valid, and outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines.

(f) In addition to complying with the requirements of Subsection (e), medical policies or guidelines adopted by the commissioner must be:

(1) designed to ensure the quality of medical care and to achieve effective medical cost control;

(2) designed to enhance a timely and appropriate return to work; and

(3) consistent with [Sections 413.013, 413.020, 413.052, and 413.053](#).

(g) The commissioner may adopt rules relating to disability management that are designed to promote appropriate health care at the earliest opportunity after the injury to maximize injury healing and improve stay-at-work and return-to-work outcomes through appropriate management of work-related injuries or conditions. The commissioner by rule may identify claims in which application of disability management activities is required and prescribe at what point in the claim process a treatment plan is required. The determination may be based on any factor considered relevant by the commissioner. Rules adopted under this subsection do not apply to claims subject to workers' compensation health care networks under Chapter 1305, Insurance Code.

(h) A dispute involving a treatment plan required under Subsection (g) may be appealed to an independent review organization in the manner described by [Section 413.031](#).

(i) The division shall examine whether injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues and investigate whether reimbursement rates or any other barriers exist that reduce the ability of an injured employee to access those medical needs. The division shall recommend to the legislature any statutory changes necessary to ensure appropriate access to those medical needs.

**Credits**

Acts 1993, 73rd Leg., ch. 269, § 1, eff. Sept. 1, 1993. Amended by Acts 2001, 77th Leg., ch. 1456, § 6.02, eff. June 17, 2001; Acts 2003, 78th Leg., ch. 962, §§ 1, 2, eff. June 20, 2003; Acts 2005, 79th Leg., ch. 265, § 3.233, eff. Sept. 1, 2005; Acts 2005, 79th Leg., ch. 728, § 11.143, eff. Sept. 1, 2005; Acts 2007, 80th Leg., ch. 1177, § 2.

V. T. C. A., Labor Code § 413.011, TX LABOR § 413.011

Current through the end of the 2017 Regular and First Called Sessions of the 85th Legislature

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End of Document

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# TAB F

Public Law 95-504  
95th Congress

An Act

To amend the Federal Aviation Act of 1958, to encourage, develop, and attain an air transportation system which relies on competitive market forces to determine the quality, variety, and price of air services, and for other purposes.

Oct. 24, 1978

[S. 2493]

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

Airline  
Deregulation  
Act of 1978.

SHORT TITLE

SECTION 1. This Act may be cited as the "Airline Deregulation Act of 1978".

49 USC 1301  
note.

DEFINITIONS

SEC. 2. (a) Section 101 of the Federal Aviation Act of 1958 (49 U.S.C. 1301) is amended—

(1) by inserting after paragraph (13) the following new paragraphs:

"(14) 'Charter air carrier' means an air carrier holding a certificate of public convenience and necessity authorizing it to engage in charter air transportation.

"(15) 'Charter air transportation' means charter trips, including inclusive tour charter trips, in air transportation, rendered pursuant to authority conferred under this Act under regulations prescribed by the Board.";

(2) by inserting after paragraph (32) the following new paragraph:

"(33) 'Predatory' means any practice which would constitute a violation of the antitrust laws as set forth in the first section of the Clayton Act (15 U.S.C. 12).";

(3) by inserting after paragraph (35) the following new paragraph:

"(36) 'State agency' means that department, agency, officer, or other entity of a State government which has been designated according to State law as—

"(A) the recipient of any notice required under title IV of this Act to be given to a State agency; or

"(B) the representative of the State in any matter about which the Board is required, under such title IV, to consult with or consider the views of a State agency."; and

(4) by striking out paragraphs (36) and (37).

(b) Section 101 of such Act is amended by renumbering the paragraphs of such section, including all references thereto, as paragraphs (1) through (41), respectively.

DECLARATION OF POLICY

SEC. 3. (a) Section 102(a) of the Federal Aviation Act of 1958 (49 U.S.C. 1302(a)) is amended to read as follows:

“FACTORS FOR INTERSTATE AND OVERSEAS AIR TRANSPORTATION

“SEC. 102. (a) In the exercise and performance of its powers and duties under this Act with respect to interstate and overseas air transportation, the Board shall consider the following, among other things, as being in the public interest, and in accordance with the public convenience and necessity:

“(1) The assignment and maintenance of safety as the highest priority in air commerce, and prior to the authorization of new air transportation services, full evaluation of the recommendations of the Secretary of Transportation on the safety implications of such new services and full evaluation of any report or recommendation submitted under section 107 of this Act.

*Post*, p. 1709.

“(2) The prevention of any deterioration in established safety procedures, recognizing the clear intent, encouragement, and dedication of the Congress to the furtherance of the highest degree of safety in air transportation and air commerce, and the maintenance of the safety vigilance that has evolved within air transportation and air commerce and has come to be expected by the traveling and shipping public.

“(3) The availability of a variety of adequate, economic, efficient, and low-price services by air carriers without unjust discriminations, undue preferences or advantages, or unfair or deceptive practices, the need to improve relations among, and coordinate transportation by, air carriers, and the need to encourage fair wages and equitable working conditions.

“(4) The placement of maximum reliance on competitive market forces and on actual and potential competition (A) to provide the needed air transportation system, and (B) to encourage efficient and well-managed carriers to earn adequate profits and to attract capital.

“(5) The development and maintenance of a sound regulatory environment which is responsive to the needs of the public and in which decisions are reached promptly in order to facilitate adaptation of the air transportation system to the present and future needs of the domestic and foreign commerce of the United States, the Postal Service, and the national defense.

“(6) The encouragement of air service at major urban areas through secondary or satellite airports, where consistent with regional airport plans of regional and local authorities, and when such encouragement is endorsed by appropriate State entities encouraging such service by air carriers whose sole responsibility in any specific market is to provide service exclusively at the secondary or satellite airport, and fostering an environment which reasonably enables such carriers to establish themselves and to develop their secondary or satellite airport services.

“(7) The prevention of unfair, deceptive, predatory, or anti-competitive practices in air transportation, and the avoidance of—

“(A) unreasonable industry concentration, excessive market domination, and monopoly power; and

“(B) other conditions;

that would tend to allow one or more air carriers unreasonably to increase prices, reduce services, or exclude competition in air transportation.

“(8) The maintenance of a comprehensive and convenient system of continuous scheduled airline service for small communities and for isolated areas, with direct Federal assistance where appropriate.

“(9) The encouragement, development, and maintenance of an air transportation system relying on actual and potential competition to provide efficiency, innovation, and low prices, and to determine the variety, quality, and price of air transportation services.

“(10) The encouragement of entry into air transportation markets by new air carriers, the encouragement of entry into additional air transportation markets by existing air carriers, and the continued strengthening of small air carriers so as to assure a more effective, competitive airline industry.”

(b) Section 102 of such Act is amended by adding at the end thereof the following new subsection: 49 USC 1302.

“FACTORS FOR FOREIGN AIR TRANSPORTATION

“(c) In the exercise and performance of its powers and duties under this Act with respect to foreign air transportation, the Board shall consider the following, among other things, as being in the public interest, and in accordance with the public convenience and necessity:

“(1) The encouragement and development of an air transportation system properly adapted to the present and future needs of the foreign and domestic commerce of the United States, of the Postal Service, and of the national defense.

“(2) The regulation of air transportation in such manner as to recognize and preserve the inherent advantages of, assure the highest degree of safety in, and foster sound economic conditions in, such transportation, and to improve the relations between and coordinate transportation by air carriers.

“(3) The promotion of adequate, economical, and efficient service by air carriers at reasonable charges, without unjust discriminations, undue preferences or advantages, or unfair or destructive competitive practices.

“(4) Competition to the extent necessary to assure the sound development of an air transportation system properly adapted to the needs of the foreign and domestic commerce of the United States, of the Postal Service, and of the national defense.

“(5) The promotion of safety in air commerce.

“(6) The promotion, encouragement, and development of civil aeronautics.”

(c) That portion of the table of contents contained in the first section of such Act which appears under the side heading

“SEC. 102. Declaration of Policy: The Board.”

is amended by striking out

“(a) General factors for consideration.

“(b) Factors for all-cargo air service.”

and inserting in lieu thereof

“(a) Factors for interstate and overseas air transportation.

“(b) Factors for all-cargo air service.

“(c) Factors for foreign air transportation.”.

FEDERAL PREEMPTION

SEC. 4. (a) Title I of the Federal Aviation Act of 1958 (49 U.S.C. 1301 et seq.) is amended by adding at the end thereof the following new section:

## "FEDERAL PREEMPTION

## "PREEMPTION

- 49 USC 1305. "Sec. 105. (a) (1) Except as provided in paragraph (2) of this subsection, no State or political subdivision thereof and no interstate agency or other political agency of two or more States shall enact or enforce any law, rule, regulation, standard, or other provision having the force and effect of law relating to rates, routes, or services of any air carrier having authority under title IV of this Act to provide interstate air transportation.
- 49 USC 1371. " (2) Except with respect to air transportation (other than charter air transportation) provided pursuant to a certificate issued by the Board under section 401 of this Act, the provisions of paragraph (1) of this subsection shall not apply to any transportation by air of persons, property, or mail conducted wholly within the State of Alaska.
- 49 USC 1371.

## "PROPRIETARY POWERS AND RIGHTS

"(b) (1) Nothing in subsection (a) of this section shall be construed to limit the authority of any State or political subdivision thereof or any interstate agency or other political agency of two or more States as the owner or operator of an airport served by any air carrier certificated by the Board to exercise its proprietary powers and rights.

"(2) Any aircraft operated between points in the same State (other than the State of Hawaii) which in the course of such operation crosses a boundary between two States, or between the United States and any other country, or between a State and the beginning of the territorial waters of the United States, shall not, by reason of crossing such boundary, be considered to be operating in interstate or overseas air transportation.

## "EXISTING STATE AUTHORITY

"(c) When any intrastate air carrier which on August 1, 1977, was operating primarily in intrastate air transportation regulated by a State receives the authority to provide interstate air transportation, any authority received from such State shall be considered to be part of its authority to provide air transportation received from the Board under title IV of this Act, until modified, suspended, amended, or terminated as provided under such title.

## "DEFINITION

"(d) For purposes of this section, the term 'State' means any State, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, Guam, the Virgin Islands, and any territory or possession of the United States."

(b) That portion of the table of contents contained in the first section of such Act which appears under the center heading

## "TITLE I—GENERAL PROVISIONS"

is amended by adding at the end thereof

"Sec. 105. Federal preemption.

"(a) Preemption.

"(b) Proprietary powers and rights.

"(c) Existing State authority.

"(d) Definition."

REPORT ON SUBSIDY COST-SHARING, STUDY OF LEVEL OF AIR SAFETY,  
AND REPORT ON AIR CARRIER MARKETING OF TOURS

SEC. 5. (a) Title I of the Federal Aviation Act of 1958 (49 U.S.C. 1301 et seq.) is further amended by adding at the end thereof the following new sections:

“REPORT ON SUBSIDY COST-SHARING

“SEC. 106. Not later than January 1, 1980, the Board and the Secretary of Transportation, shall, separately or jointly, submit a comprehensive report to the Congress on the feasibility and appropriateness of devising formulas by which States and their political subdivisions could share part of the costs being incurred by the United States under sections 406 and 419 of this Act. Such report shall include any recommendations of the Board and the Secretary for the implementation of such cost-sharing formulas. 49 USC 1306.  
49 USC 1376.  
*Post*, p. 1732.

“SAFETY STUDY

“POLICY

“SEC. 107. (a) The Congress intends that the implementation of the Airline Deregulation Act of 1978 result in no diminution of the high standard of safety in air transportation attained in the United States at the time of the enactment of such Act. 49 USC 1307.

“REPORT

“(b) Not later than January 31, 1980, and each January 31 thereafter, the Secretary of Transportation shall prepare and submit to the Congress and the Board a comprehensive annual report on the extent to which the implementation of the Airline Deregulation Act of 1978 has affected, during the preceding calendar year, or will affect, in the succeeding calendar year, the level of air safety. Each such report shall, at a minimum, contain an analysis of each of the following: *Ante*, p. 1705.

“(1) All relevant data on accidents and incidents occurring during the calendar year covered by such report in air transportation and on violations of safety regulations issued by the Secretary of Transportation occurring during such calendar year.

“(2) Current and anticipated personnel requirements of the Administrator with respect to enforcement of air safety regulations.

“(3) Effects on current levels of air safety of changes or proposals for changes in air carrier operating practices and procedures which occurred during the calendar year covered by such report.

“(4) The adequacy of air safety regulations taking into consideration changes in air carrier operating practices and procedures which occurred during the calendar year covered by such report.

Based on such report, the Secretary shall take those steps necessary to ensure that the high standard of safety in air transportation referred to in subsection (a) of this section is maintained in all aspects of air transportation in the United States.

## “RECOMMENDATIONS

“(c) Not later than January 31, 1980, and each January 31 thereafter, the Secretary of Transportation shall submit to the Congress and the Board recommendations with respect to the level of surveillance necessary to enforce air safety regulations and the level of staffing necessary to carry out such surveillance. The Secretary of Transportation’s recommendations shall include proposals for any legislation needed to implement such recommendations.

## “REGULATIONS AND INSPECTION PROCEDURES

Review and  
report to  
congressional  
committees.

49 USC 1371.

“(d) Not later than July 1, 1979, the Secretary of Transportation shall complete a thorough review, and submit a report thereon to the appropriate authorizing committees of the Congress and to the Administrator, of the safety regulations and inspection procedures applicable to each class of air carriers subject to the provisions of title IV of this Act, in order to ensure that all classes of air carriers are providing the highest possible level of safe, reliable air transportation to all the communities served by those air carriers. Based on such review, the Administrator shall promulgate such safety regulations and establish such inspection procedures as the Administrator deems necessary to maintain the highest standard of safe, reliable air transportation in the United States.

## “REPORT ON AIR CARRIER MARKETING OF TOURS

49 USC 1308.

“SEC. 108. Not later than May 1, 1979, the Board shall prepare and submit a report to the Congress which sets forth the recommendations of the Board on whether this Act and regulations of the Board should be amended to permit air carriers to sell tours directly to the public and to acquire control of persons authorized to sell tours to the public. The report shall evaluate the effects on the following groups of allowing air carriers to sell tours:

- “(1) The traveling public.
- “(2) The independent tour operator industry.
- “(3) The travel agent industry.
- “(4) The different classes of air carriers.”.

(b) That portion of the table of contents contained in the first section of such Act which appears under the center heading

## “TITLE I—GENERAL PROVISIONS”

is amended by adding at the end thereof

“Sec. 106. Report on subsidy cost-sharing.

“Sec. 107. Safety study.

“(a) Policy.

“(b) Report.

“(c) Recommendations.

“(d) Regulations and inspection procedure.

“Sec. 108. Report on air carrier marketing of tours.”.

## APPLICATION FOR CERTIFICATE

SEC. 6. Section 401(b) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(b)) is amended—

- (1) by striking out “and shall be so verified”; and
- (2) by inserting “, and upon any community affected” immediately before the period.

## ROUTE APPLICATIONS

SEC. 7. (a) Section 401(c) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(c)) is amended to read as follows:

## “ROUTE APPLICATIONS

“(c) (1) Upon the filing of any application pursuant to subsection (b) of this section, the Board shall give due notice thereof to the public by posting a notice of such application in the office of the secretary of the Board and to such other persons as the Board may by regulation determine. The Board shall—

“(A) set such application for a public hearing;

“(B) begin to make a determination with respect to such application under the simplified procedures established by the Board in regulations pursuant to subsection (p); or

“(C) dismiss such application on the merits;

not later than ninety days after the date the application is filed with the Board. Any interested person may file with the Board a protest or memorandum of opposition to or in support of the issuance of the certificate requested by such application. Any order of dismissal of an application issued by the Board without setting such application for a hearing or beginning to make a determination with respect to such application under such simplified procedures, shall be deemed a final order subject to judicial review in accordance with the provisions of section 1006 of this Act.

“(2) If the Board determines that any application should be set for a public hearing under clause (A) of the second sentence of paragraph (1) of this subsection, an initial or recommended decision shall be issued not later than one hundred and fifty days after the date of such determination by the Board. Not later than ninety days after the initial or recommended decision is issued, the Board shall make its final order with respect to such application. If the Board does not act within such ninety-day period—

“(A) in the case of an application for a certificate to engage in interstate or overseas air transportation, the initial or recommended decision shall become the final decision of the Board and shall be subject to judicial review in accordance with the provisions of section 1006 of this Act; and

“(B) in the case of an application for a certificate to engage in foreign air transportation, the initial or recommended decision shall be transmitted to the President pursuant to section 801 of this Act.

“(3) Not later than the one-hundred-eightieth day after the Board begins to make a determination with respect to an application under the simplified procedures established by the Board in regulations pursuant to subsection (p) of this section, the Board shall issue its final order with respect to such application.

“(4) If an applicant fails to meet the procedural schedule adopted by the Board in a particular proceeding, the applicable period prescribed in paragraph (2) or (3) of this subsection may be extended by the Board for a period equal to the period of delay caused by the applicant. In addition to any extension authorized by the preceding sentence, in extraordinary circumstances, the Board may, by order delay an initial or recommended decision for not to exceed thirty days beyond the final date on which the decision is required to be made.”

(b) The amendments made by subsection (a) of this section shall

Public notice.

49 USC 1486.

Final order.

49 USC 1461.

49 USC 1371  
note.

49 USC 1371. apply to any application filed under section 401(b) of the Federal Aviation Act of 1958 on or after the one-hundred-eightieth day after the date of enactment of this Act.

(c) That portion of the table of contents contained in the first section of such Act which appears under the side heading

“Sec. 401. Certificate of public convenience and necessity.”

is amended by striking out

“(c) Notice of application.”

and inserting in lieu thereof

“(c) Route applications.”

#### ISSUANCE OF CERTIFICATE

SEC. 8. Paragraphs (1), (2), and (3) of section 401(d) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(d) (1)–(3)) are amended to read as follows:

“(d) (1) The Board shall issue a certificate authorizing the whole or any part of the transportation covered by the application, if it finds that the applicant is fit, willing, and able to perform such transportation properly and to conform to the provisions of this Act and the rules, regulations, and requirements of the Board hereunder, and that such transportation—

“(A) in the case of interstate or overseas air transportation, is consistent with the public convenience and necessity; and

“(B) in the case of foreign air transportation, is required by the public convenience and necessity;

otherwise such application shall be denied.

“(2) In the case of an application for a certificate to engage in temporary air transportation, the Board may issue a certificate authorizing the whole or any part thereof for such limited periods—

“(A) in the case of an application for interstate or overseas air transportation, as is consistent with the public convenience and necessity; and

“(B) in the case of an application for foreign air transportation, as may be required by the public convenience and necessity; if it finds that the applicant is fit, willing, and able properly to perform such transportation and to conform to the provisions of this Act and the rules, regulations, and requirements of the Board hereunder.

“(3) In the case of an application for a certificate to engage in charter air transportation, the Board may issue a certificate to any applicant, not holding a certificate under paragraph (1) or (2) of this subsection on January 1, 1977, authorizing interstate air transportation of persons, which authorizes the whole or any part thereof—

“(A) in the case of an application for interstate or overseas air transportation, for such periods, as is consistent with the public convenience and necessity; and

“(B) in the case of an application for foreign air transportation, for such periods, as may be required by the public convenience and necessity;

if it finds that the applicant is fit, willing, and able properly to perform the transportation covered by the application and to conform to the provisions of this Act and the rules, regulations, and requirements of the Board hereunder.”

## THROUGH SERVICE AND JOINT FARES

SEC. 9. Paragraph (4) of section 401(d) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(d)(4)) is amended to read as follows:

“(4) (A) Notwithstanding any other provision of this Act, any citizen of the United States who undertakes, within any State, the carriage of persons or property as a common carrier for compensation or hire with aircraft capable of carrying thirty or more persons pursuant to authority for such carriage within such State granted by the appropriate State agency is authorized—

“(i) to establish services for persons and property which includes transportation by such citizen over its routes in such State and transportation by an air carrier or a foreign air carrier in air transportation; and

“(ii) subject to the requirements of section 412 of this title, to enter into an agreement with any air carrier or foreign air carrier for the establishment of joint fares, rates, or services for such through services. 49 USC 1382.

“(B) The joint fares or rates established under clause (ii) of subparagraph (A) of this paragraph shall be the lowest of—

“(i) the sum of the applicable fare or rate for service in the State approved by the appropriate State agency, and the applicable fare or rate for that part of the through service provided by the air carrier or foreign air carrier;

“(ii) a joint fare or rate established and filed in accordance with section 403 of this Act; or 49 USC 1373.

“(iii) a joint fare or rate established by the Board in accordance with section 1002 of this Act.”. 49 USC 1482.

## UNUSED AUTHORITY

SEC. 10. (a) Section 401(d) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(d)) is amended by adding at the end thereof the following new paragraph:

“(5) (A) Except as provided in subparagraphs (B) and (G) (i) of this paragraph, if an air carrier is authorized by its certificate to provide round trip service nonstop each way between any two points in the forty-eight contiguous States or between any two points in overseas air transportation and if such air carrier fails to provide such service pursuant to published flight schedules at a minimum of five round trips per week for at least thirteen weeks during any twenty-six-week period (other than such a period during which service was interrupted by a labor dispute which lasted more than six weeks) the last day of which ends on or after the date of enactment of this paragraph and if such service, at a minimum of five round trips per week, has been provided between such points for at least thirteen weeks during such twenty-six-week period, pursuant to published flight schedules, by no more than one other air carrier, then the Board shall issue a certificate to the first applicant who, within thirty days after the last day of such twenty-six-week period, submits an application which certifies that its aircraft meet all requirements established by the Secretary of Transportation for the carriage by aircraft of persons or property as a common carrier for compensation or hire or the carriage of mail by aircraft in commerce and that it is able to conform to the rules, regulations, and requirements of the Board promulgated pursuant to this Act.

“(B) Except as provided in subparagraph (G)(ii) of this paragraph, if an air carrier is authorized to provide seasonal round trip service nonstop each way between any two points in the forty-eight contiguous States in interstate air transportation or between any two points in overseas air transportation and if such air carrier fails to provide such service pursuant to published flight schedules at a minimum of five round trips per week during half of the weeks during such season (other than such a season during which service was interrupted by a labor dispute which lasted more than 25 per centum of such season) the last day of which ends on or after the date of enactment of this paragraph and if such service, at a minimum of five round trips per week, has been provided between such points for at least half of the weeks during such season, pursuant to published flight schedules, by no more than one other air carrier, then the Board shall issue a certificate to the first applicant who, within thirty days after the last day of such season, submits an application which certifies that its aircraft meet all requirements established by the Secretary of Transportation for the carriage by aircraft of persons or property as a common carrier for compensation or hire or the carriage of mail by aircraft in commerce and that it is able to conform to the rules, regulations, and requirements of the Board promulgated pursuant to this Act.

Final order.

“(C) With respect to any application which is submitted pursuant to subparagraph (A) or (B) of this paragraph, except as provided in subparagraph (G), the Board shall issue a final order granting such certificate within fifteen days of the date of such application.

“(D) Except as provided in subparagraphs (E) and (G)(i) of this paragraph, if an air carrier is authorized by its certificate to provide round trip service nonstop each way between any two points in the forty-eight contiguous States or between any two points in overseas air transportation and if such air carrier fails to provide such service pursuant to published flight schedules at a minimum of five round trips per week for at least thirteen weeks during any twenty-six-week period (other than such a period during which service was interrupted by a labor dispute which lasted more than six weeks) the last day of which ends on or after the date of enactment of this paragraph and if such service, at a minimum of five round trips per week, has been provided between such points for at least thirteen weeks during such twenty-six-week period, pursuant to published flight schedules, by two or more other air carriers, then the Board, subject to subparagraph (F) of this paragraph, shall issue a certificate to the first applicant who, within thirty days after the last day of such twenty-six-week period, submits an application which certifies that its aircraft meet all requirements established by the Secretary of Transportation for the carriage by aircraft of persons or property as a common carrier for compensation or hire or the carriage of mail by aircraft in commerce and that it is able to conform to the rules, regulations, and requirements of the Board promulgated pursuant to this Act.

“(E) Except as provided in subparagraph (G)(ii) of this paragraph, if an air carrier is authorized to provide seasonal round trip service nonstop each way between any two points in the forty-eight contiguous States in interstate air transportation or between any two points in overseas air transportation and if such air carrier fails to provide such service pursuant to published flight schedules at a minimum of five round trips per week during half of the weeks during such season (other than such a season during which service was interrupted by a labor dispute which lasted more than 25 per centum of such sea-

son) the last day of which ends on or after the date of enactment of this paragraph and if such service, at a minimum of five round trips per week, has been provided between such points for at least half of the weeks during such season, pursuant to published flight schedules, by two or more other air carriers, then the Board, subject to subparagraph (F) of this paragraph, shall issue a certificate to the first applicant who, within thirty days after the last day of such season, submits an application which certifies that its aircraft meet all requirements established by the Secretary of Transportation for the carriage by aircraft of persons or property as a common carrier for compensation or hire or the carriage of mail by aircraft in commerce and that it is able to conform to the rules, regulations, and requirements of the Board promulgated pursuant to this Act.

“(F)(i) Except as provided in subparagraph (G) of this paragraph, with respect to any application which is submitted pursuant to subparagraph (D) or (E) of this paragraph, the Board shall issue a final order granting such certificate within sixty days of the date of such application, unless the Board finds that the issuance of such certificate is inconsistent with the public convenience and necessity. Prior to issuing such final order, the Board shall afford adequate notice and opportunity for interested persons to file appropriate written evidence and argument, but the Board need not hold oral evidentiary hearings.

Notice.

“(ii) For purposes of clause (i) of this subparagraph, there shall be a rebuttable presumption that any transportation covered by an application for a certificate submitted pursuant to subparagraph (D) or (E) of this paragraph is consistent with the public convenience and necessity.

“(G)(i) If, after the failure of any air carrier to provide the minimum level of service between any pair of points for the period of time specified in subparagraph (A) or (D) of this paragraph and before the Board receives an application from any applicant for a certificate under such subparagraph to provide air transportation between such points, the Board receives notice from such air carrier that it intends to commence service within thirty days of such notice and to provide a minimum of five round trips per week for thirteen consecutive weeks between such points and the Board has not previously received notice from such air carrier with respect to such points, the Board shall not approve such application for a certificate to provide service between such points during such thirteen-week period based upon such failure, unless such air carrier fails to provide such service during such thirteen-week period.

Notice.

“(ii) If, after the failure of any air carrier to provide the minimum level of service between any pair of points for the period of time specified in subparagraph (B) or (E) of this paragraph and before the Board receives an application from any applicant for a certificate under such subparagraph to provide air transportation between such points, the Board receives notice from such air carrier that it intends to commence service within fifteen days of the first day of the next season and to provide a minimum of five round trips per week for the first half of such season between such points and the Board has not previously received notice from such air carrier with respect to such points, the Board shall not approve such application for a certificate to provide service between such points during the first half of such period based upon such failure, unless such air carrier fails to provide such service during the first half of such period.

Revocation of  
certificate.

“(II) (i) Whenever the Board issues a certificate pursuant to subparagraph (A) or (D) of this paragraph, the air carrier receiving such certificate shall commence service pursuant to such certificate within forty-five days of such issuance. If such air carrier fails to commence service within such period, the Board shall revoke such certificate.

Revocation of  
certificate.

“(ii) Whenever the Board issues a certificate pursuant to subparagraph (B) or (E) of this paragraph to provide seasonal service, the air carrier receiving such certificate shall commence service pursuant to such certificate within fifteen days after the beginning of the first such season which begins on or after the date of such issuance. If such air carrier fails to commence service within such period, the Board shall revoke such certificate.

“(I) Not more than one certificate shall be issued under this paragraph for round trip nonstop service between two points in interstate air transportation based upon the failure of the same air carrier to provide such service between such points.

“(J) Whenever the Board issues a certificate pursuant to subparagraph (A) of this paragraph based upon the failure of any air carrier to provide the round trip service described in such subparagraph, the Board shall suspend the authority of such air carrier to provide such service, and suspend the authority of any other air carrier which failed to provide such service during the same twenty-six-week period for twenty-six weeks after the date of issuance of such certificate pursuant to subparagraph (A), or until such time within such twenty-six weeks as the air carrier to which a certificate is issued under such subparagraph fails to provide such service at a minimum of five round trips per week for at least thirteen weeks, whichever first occurs, except that the Board shall not suspend the authority of such air carriers under this subparagraph if the Board finds that such suspension is not necessary to encourage continued service between such points by the air carrier which received a certificate under subparagraph (A).”

(b) Section 401(f) of such Act is amended by striking out “hereinafter provided” and inserting in lieu thereof “provided in this section”.

#### FILL-UP RIGHTS

Sec. 11. Section 401(d) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(d)) is further amended by adding at the end thereof the following new paragraph:

“(6) Any air carrier holding a valid certificate to engage in foreign air transportation is authorized, on any scheduled flight in foreign air transportation, to transport persons, property, and mail between points in the United States between which it is authorized to operate during such flight. The authority described in the preceding sentence shall be limited to one round-trip flight per day between any such pair of points, unless the Board authorizes more than one round-trip flight per day between any such pair of points.”

#### AUTOMATIC MARKET ENTRY PROGRAM

Sec. 12. Section 401(d) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(d)) is further amended by adding at the end thereof the following new paragraph:

“(7) (A) After the first business day of each of the calendar years 1979, 1980, and 1981 and before the thirtieth day of such calendar year—

“(i) any air carrier which (I) has operated during the preceding calendar year in accordance with a certificate issued by the Board under this section which has been in force during such entire preceding calendar year, and (II) has provided air transportation of persons during such calendar year; and

“(ii) any intrastate air carrier which has a valid certificate or license issued by a State regulatory authority to engage in intrastate air transportation and which has operated more than one hundred million available seat-miles in intrastate air transportation in the preceding calendar year;

may apply to the Board for a certificate under this subparagraph to engage in nonstop service between any one pair of points in interstate or overseas air transportation (other than a pair of points either point of which is in the State of Hawaii) in addition to any pair of points authorized by any existing certificate or license held by such air carrier or intrastate air carrier, except that no air carrier may apply to engage in nonstop service between such pair of points if any air carrier has filed written notice to the Board pursuant to subparagraph (C) of this paragraph with respect to such pair of points. Not later than the sixtieth day after the date on which the Board receives an application from an applicant under this subparagraph, the Board shall issue a certificate to such applicant for the nonstop service specified in such application, unless within such sixty-day period the Board determines that the applicant is not fit, willing, and able to provide such nonstop service and to conform to the provisions of this Act and the rules, regulations, and requirements of the Board issued under this Act.

“(B) Not later than the one-hundred-twentieth day of calendar year 1979, 1980, or 1981, any air carrier which submitted an application to the Board in accordance with subparagraph (A) of this paragraph in such calendar year and—

“(i) which did not receive a certificate to provide service between the pair of points set forth in the application because of a determination by the Board under such subparagraph (A); or

“(ii) which received a certificate to provide service between such pair of points, but was not the only air carrier to receive a certificate under such subparagraph (A) during such calendar year to provide nonstop service between such pair of points;

may reapply to the Board for a certificate to engage in nonstop service between any one pair of points in interstate or overseas air transportation (other than the pair of points specified in the first application submitted to the Board by such air carrier in such calendar year and other than a pair of points either point of which is in the State of Hawaii) in addition to any pair of points authorized by any existing certificate or license held by such air carrier or intrastate air carrier, except that no air carrier may apply to engage in nonstop service between such pair of points if any air carrier has filed written notice to the Board pursuant to subparagraph (C) of this paragraph with respect to such pair of points. Not later than the sixtieth day after the date on which the Board receives an application under this subparagraph, the Board shall issue a certificate to the applicant for such nonstop service, unless within such sixty-day period the Board makes a determination with respect to the issuance of such certificate in accordance with the second sentence of subparagraph (A) of this paragraph. If the Board issues a certificate to an applicant under this subparagraph, it shall revoke any authority in any certificate which it granted to such applicant in the same calendar year under subparagraph (A) of this paragraph.

Written notice.  
*Ante.* p. 1712.

“(C) (i) Subject to clause (ii) of this subparagraph, any air carrier which is authorized pursuant to paragraph (1) or (2) of this subsection to engage in nonstop service between any pair of points in interstate or overseas air transportation on the first business day of calendar year 1979, 1980, or 1981 and which wants to preclude any other air carrier from obtaining authority under subparagraph (A) or (B) of this paragraph to engage in nonstop service between such pair of points during such calendar year may, on such day, file written notice to the Board which sets forth such pair of points. Upon receipt of any written notice under the preceding sentence, the Board shall make such notice available to the public.

Public  
availability.

“(ii) No air carrier may file a written notice under clause (i) of this subparagraph during any calendar year with respect to more than one pair of points in interstate or overseas air transportation.

Program  
modification.

“(D) (i) The Board shall, on an emergency basis, by rule, modify the program established by this paragraph, if the Board finds that—

“(I) the operation of such program is causing substantial public harm to the national air transportation system, or a substantial reduction in air service to small and medium sized communities in any region of the country;

“(II) the modification proposed by the Board is required by the public convenience and necessity in order to alleviate such harm or reduction; and

“(III) such harm or reduction identified by the Board cannot be rectified by any reasonably available means other than the modification proposed by the Board.

Any emergency modification proposed by the Board under this subparagraph shall modify such program only to the minimum extent necessary to rectify the harm or reduction identified by the Board. Any emergency modification of such program may be limited to any pair of points.

“(ii) The findings of fact by the Board in any proceeding held pursuant to this subparagraph, if supported by substantial evidence, shall be conclusive. No objection to a modification of the program proposed by the Board under this subparagraph shall be considered by a court unless such objection shall have been submitted to the Board, or if it was not so submitted, unless there were reasonable grounds for failure to do so.

Study of  
procedure.

“(E) The Board shall conduct a study of the procedure for certification of air carriers and intrastate air carriers set forth in subparagraphs (A) and (B) of this paragraph to evaluate—

49 USC 1302.

“(i) whether such procedure is consistent with the criteria set forth in section 102 of this Act; and

“(ii) the relative effectiveness of such procedure as compared with other procedures for certification set forth in this Act, including but not limited to, the procedures set forth in paragraphs (5) and (6) of this subsection and in subsection (p) of this section.

Not later than December 31, 1980, the Board shall complete such study and report the results of such study to the Congress.”.

#### EXPERIMENTAL CERTIFICATES

SEC. 13. Section 401(d) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(d)) is further amended by adding at the end thereof the following new paragraph:

*Ante.* p. 1712.

“(8) The Board may grant an application under subsection (d) (1), (2), or (3) of this section (whether the application be for permanent

or temporary authority) for only a temporary period of time whenever the Board determines that a test period is desirable in order to determine if projected services, efficiencies, methods, rates, fares, charges, or other projected results will in fact materialize and remain for a sustained period of time, or to assess the impact of the new services on the national air route structure, or otherwise to evaluate the proposed new services. In any case where the Board has issued a certificate under any one of such subsections on the basis that the air carrier holding such certificate will provide innovative or low-priced air transportation under such certificate, the Board, upon petition, or its own motion, may review the performance of such air carrier, and may alter, amend, modify, suspend, or revoke such certificate or authority in accordance with the procedures prescribed in section 401(g) of this title, on the grounds that such air carrier has not provided, or is not providing, such air transportation.” 49 USC 1371.

#### DETERMINATIONS FOR ISSUANCE OF CERTIFICATES

SEC. 14. Section 401(d) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(d)) is further amended by adding at the end thereof the following new paragraph:

“(9) (A) In any determination as to whether or not any applicant is fit, willing, and able to perform properly the air transportation specified in the application for a certificate described in paragraph (1) (A), (2) (A), or (3) (A) of this subsection and to conform to the provisions of this Act, the applicant shall have the burden of showing that it is so fit, willing, and able. *Ante*, p. 1712.

“(B) In any determination as to whether the air transportation specified in any application for a certificate described in paragraph (1) (A), (2) (A), or (3) (A) of this subsection is or is not consistent with the public convenience and necessity, an opponent of the application shall have the burden of showing that such air transportation is not consistent with the public convenience and necessity.

“(C) Transportation covered by any application for a certificate described in paragraph (1) (A), (2) (A), or (3) (A) of this subsection shall, for the purposes of such paragraphs, be deemed to be consistent with the public convenience and necessity, unless the Board finds based upon a preponderance of the evidence that such transportation is not consistent with the public convenience and necessity.”.

#### TERMS AND CONDITIONS OF CERTIFICATES

SEC. 15. (a) Paragraph (3) of section 401(e) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(e) (3)) is amended by striking out “supplemental air transportation” and inserting in lieu thereof “foreign charter air transportation”.

(b) Paragraph (4) of section 401(e) of such Act is amended by striking out the semicolon and all that follows down through the period and inserting in lieu thereof a period.

(c) Paragraph (6) of section 401(e) of such Act is amended by striking out “supplemental air carrier” and inserting in lieu thereof “charter air carrier”.

#### REMOVAL OF RESTRICTIONS

SEC. 16. Section 401(e) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(e)) is further amended by adding at the end thereof the following new paragraph:

“(7) (A) On and after the date of enactment of this paragraph, the Board shall not attach a closed-door restriction to any certificate issued under this section. Any closed-door restriction attached to any certificate issued before such date shall, on and after such date, have no force or effect. This subparagraph shall not apply to (i) a closed-door restriction applicable to air transportation between two points both of which are in the State of Hawaii, or (ii) a closed-door restriction in effect on such date which resulted from a sale, exchange, or transfer by any air carrier of its authority to provide air transportation to another air carrier.

“(B) Upon application of any air carrier seeking removal or modification of a term, condition, or limitation attached to a certificate issued under this section to engage in interstate, overseas, or foreign air transportation, the Board shall, within sixty days after the filing of such application, set such application for oral evidentiary hearings on the record or begin to consider such application under the simplified procedures established by the Board in regulations pursuant to subsection (p) of this section for purposes of eliminating or modifying any such term, condition, or limitation which it finds is inconsistent with the criteria set forth in section 102 of this Act. Applications under this paragraph shall not be subject to dismissal pursuant to section 401(c) (1) of this Act.

“(C) For purposes of this paragraph, the term ‘closed-door restriction’ means any condition attached to a certificate to provide interstate or overseas air transportation issued to any air carrier under this section which prohibits such air carrier from providing local passenger service between any pair of points between which it is authorized to operate pursuant to such certificate.”

49 USC 1302.

*Ante*, p. 1711.  
“Closed-door  
restriction.”

#### EFFECTIVE DATE AND DURATION OF CERTIFICATE

SEC. 17. Section 401(f) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(f)) is amended by striking out “ceased:” and all that follows down through the period and inserting in lieu thereof “ceased.”

#### AUTHORITY TO MODIFY, SUSPEND, OR REVOKE

SEC. 18. The first sentence of section 401(g) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(g)) is amended by inserting “or pursuant to the simplified procedures under subsection (p) of this section” after “notice and hearings”.

#### TERMINATIONS, REDUCTIONS, AND SUSPENSIONS OF SERVICE

SEC. 19. (a) Section 401(j) of the Federal Aviation Act of 1958 is amended to read as follows:

#### “TERMINATIONS, REDUCTIONS, AND SUSPENSIONS OF SERVICE

“(j) (1) No air carrier holding a certificate issued under this section shall—

“(A) terminate or suspend all air transportation which it is providing to a point under such certificate; or

“(B) reduce any such air transportation below that which the Board has determined to be essential air transportation for such point;

unless such air carrier has first given the Board, any community affected, and the State agency of the State in which such community is located, at least 90 days notice of its intent to so terminate, suspend, or reduce such air transportation. The Board may, by regulation or otherwise, authorize such temporary suspension of service as may be in the public interest. Notice.

“(2) If an air carrier holding a certificate issued pursuant to section 401 of this Act proposes to terminate or suspend nonstop or single-plane air transportation between two points being provided by such air carrier under such certificate, and such air carrier is the only air carrier certificated pursuant to such section 401 providing nonstop or single-plane air transportation between such points, at least sixty days before such proposed termination or suspension, such air carrier shall file with the Board and serve upon each community to be directly affected notice of such termination or suspension.”. 49 USC 1371.

(b) That portion of the table of contents contained in the first section of such Act which appears under the side heading

“Sec. 401. Certificate of public convenience and necessity.”

is amended by striking out

“(j) Application for abandonment.”

and inserting in lieu thereof

“(j) Terminations, reductions, and suspensions of service.”.

#### ADDITIONAL POWERS AND DUTIES OF BOARD WITH RESPECT TO CHARTER AIR CARRIERS

SEC. 20. (a) The center heading for section 401(n) of the Federal Aviation Act of 1958 is amended by striking out “SUPPLEMENTAL” and inserting in lieu thereof “CHARTER”. 49 USC 1371.

(b) Paragraphs (1) through (4) of section 401(n) of such Act are amended to read as follows:

“(n) (1) No air carrier providing air transportation under a certificate issued under this section shall commingle, on the same flight, passengers being transported in interstate or overseas charter air transportation with passengers being transported in scheduled interstate or overseas air transportation, except that this subsection shall not apply to the carriage of passengers in air transportation under group fare tariffs.

“(2) No rule, regulation, or order issued by the Board shall restrict the marketability, flexibility, accessibility, or variety of charter trips provided under a certificate issued under this section except to the extent required by the public interest, and shall in no event be more restrictive than those regulations regarding charter air transportation in effect on October 1, 1978.

“(3) Notwithstanding any other provision of this title, no certificate issued under this section shall authorize the holder thereof to provide charter air transportation between two points within the State of Alaska unless, and then only to the extent to which, the Board, in issuing or amending such certificate, may authorize after determining that such charter air transportation is required by the public convenience and necessity. This subsection shall not apply to a certificate issued under this section to a person who, before July 1, 1977, maintained its principal place of business within the State of Alaska and conducted air transport operations between points within the State of Alaska with aircraft having a certificated gross takeoff weight of more than 40,000 pounds.

“(4) No certificate issued under this section shall permit a charter air carrier to sell or offer for sale an inclusive tour in air transportation by selling or offering for sale individual tickets directly to members of the general public, or to do so indirectly by controlling, being controlled by, or under common control with, a person authorized by the Board to make such sales.”

49 USC 1371.

(c) Paragraph (5) of section 401(n) of such Act is amended—

(1) in the first sentence, by striking out “a supplemental air carrier to comply with the provisions of paragraph (1), (3), or (4) of this subsection” and inserting in lieu thereof “a charter air carrier to comply with the provisions of subsection (q) or (r) of this section”; and

(2) in the last sentence, by striking out “paragraphs (1), (3), and (4) of this subsection” and inserting in lieu thereof “subsections (q) and (r) of this section”.

(d) (1) Section 401 of such Act is amended by adding at the end thereof the following new subsections:

“INSURANCE AND LIABILITY

“(q) (1) No certificate shall be issued or remain in effect unless the applicant for such certificate or the air carrier, as the case may be, complies with regulations or orders issued by the Board governing the filing and approval of policies of insurance or plans for self-insurance in the amount prescribed by the Board which are conditioned to pay, within the amount of such insurance, amounts for which such applicant or such air carrier may become liable for bodily injuries to or the death of any person, or for loss of or damage to property of others, resulting from the operation or maintenance of aircraft under such certificate.

“(2) In order to protect travelers and shippers by aircraft operated by certificated air carriers, the Board may require any such air carrier to file a performance bond or equivalent security arrangement, in such amount and upon such terms as the Board shall prescribe, to be conditioned upon such air carrier’s making appropriate compensation to such travelers and shippers, as prescribed by the Board, for failure on the part of such carrier to perform air transportation services in accordance with agreements therefor.

“CONTINUING REQUIREMENT

“(r) The requirement that each applicant for a certificate or any other authority under this title must be found to be fit, willing, and able to perform properly the transportation covered by its application and to conform to the provisions of this Act and the rules, regulations, and requirements of the Board under this Act, shall be a continuing requirement applicable to each such air carrier with respect to the transportation authorized by the Board. The Board shall by order, entered after notice and hearing, modify, suspend, or revoke such certificate or other authority, in whole or in part, for failure of such air carrier to comply with the continuing requirement that the air carrier be so fit, willing, and able, or for failure to file such reports as the Board may deem necessary to determine whether such air carrier is so fit, willing, and able.”.

Notice and  
hearing.

(2) That portion of the table of contents contained in the first section of such Act which appears under the side heading

“Sec. 401. Certificates of public convenience and necessity.”

is amended—

(A) by striking out

“(n) Additional powers and duties of Board with respect to supplemental air carriers.”

and inserting in lieu thereof

“(n) Additional powers and duties of Board with respect to charter air carriers.”;

and

(B) by adding at the end thereof

“(q) Insurance and liability.

“(r) Continuing requirement.”.

#### PROCEDURES FOR PROCESSING APPLICATIONS

SEC. 21. (a) (1) Section 401 of the Federal Aviation Act of 1958 (49 U.S.C. 1371) is amended by adding at the end thereof the following new subsection:

“PROCEDURES FOR PROCESSING APPLICATIONS FOR CERTIFICATES

“(p) (1) The Board shall promulgate rules establishing simplified procedures for— Rules.

“(A) the disposition of applications for a certificate to engage in air transportation pursuant to subsection (d) (1), (2), or (3) of this section; and

“(B) the alteration, amendment, modification, suspension, or transfer of all or any part of any certificate pursuant to subsection (f), (g), or (h) of this section.

*Ante*, p. 1712.

49 USC 1371.

Such rules shall provide for adequate notice and an opportunity for any interested person to file appropriate written evidence and argument, but need not provide for oral evidentiary hearings. Such rules may provide that such written evidence and argument shall be filed by such person as part of a protest or memorandum filed with respect to such application under subsection (c) of this section.

“(2) The Board may use such simplified procedures in any case if the Board determines that the use of such simplified procedures is in the public interest. The rules adopted by the Board pursuant to this subsection shall, to the extent the Board finds it practicable, set forth the standards it intends to apply in determining whether to employ such simplified procedures, and in deciding cases in which such procedures are employed.”.

(2) That portion of the table of contents contained in the first section of such Act which appears under the side heading

“Sec. 401. Certificate of public convenience and necessity.”

is amended by inserting at the end thereof

“(p) Procedures for processing applications for certificates.”.

(b) (1) Section 402 of the Federal Aviation Act of 1958 (49 U.S.C. 1372) is amended by adding at the end thereof the following new subsection:

“PROCEDURES FOR PROCESSING APPLICATIONS FOR PERMITS

- Rules. “(h) The Board shall promulgate rules establishing simplified procedures for—
- “(1) the disposition of applications for a permit to engage in foreign air transportation pursuant to this section; and
- “(2) the alteration, amendment, modification, suspension, or transfer of all or any part of any permit pursuant to subsection (f) of this section.
- Notice. Such rules shall provide for adequate notice and an opportunity for all interested persons to file appropriate written evidence and argument, but need not provide for oral evidentiary hearings.”
- “(2) That portion of the table of contents contained in the first section of such Act which appears under the side heading
- “Sec. 402. Permits to foreign air carriers.”
- is amended by inserting at the end thereof
- “(h) Procedures for processing applications for permits.”

NOTICE OF TARIFF CHANGES

SEC. 22. Section 403(c) of the Federal Aviation Act of 1958 (49 U.S.C. 1373(c)) is amended to read as follows:

“NOTICE OF TARIFF CHANGES

- “(c) (1) Except as provided in paragraph (2) of this subsection, no change shall be made in any rate, fare, or charge, or any classification, rule, regulation, or practice affecting such rate, fare, or charge, or the value of the service thereunder, specified in any effective tariff of any air carrier until thirty days after notice of the proposed change has been filed, posted, and published in accordance with subsection (a) of this section, except the Board may establish an alternative notice requirement, of not less than twenty-five days, to allow an air carrier to match the fares or charges specified in another air carrier's proposed tariff. Any notice specified under this subsection shall plainly state the change proposed to be made and the time such change will take effect.
- “(2) If the effect of any proposed tariff change would be to institute a fare that is outside of the applicable range of fares specified in subparagraphs (A) and (B) of section 1002(d)(4) of this Act, or specified by the Board under section 1002(d)(7) of this Act, or would be to institute a fare to which such range of fares does not apply, then such proposed change shall not be implemented except after sixty days' notice filed in accordance with regulations prescribed by the Board.
- “(3) In exercising its power to suspend tariffs under sections 1002(g) and 1002(j) of this Act, the Board shall file and deliver a statement in writing of its reasons for such suspension, as required under section 1002(g), at least thirty days before the date on which the affected tariff would otherwise go into effect.”

49 USC 1482.

RATES OF CARRIAGE FOR PERSONS AND PROPERTY

- SEC. 23. Section 404(a)(1) of the Federal Aviation Act of 1958 (49 U.S.C. 1374(a)(1)) is amended by inserting “authorized to engage in scheduled air transportation by certificate or by exemption under section 416(b)(3) of this title” immediately before the first semicolon.
- 49 USC 1386.

## MAIL AND COMPENSATION

SEC. 24. (a) (1) Clause (3) of the second sentence of section 406(b) of the Federal Aviation Act of 1958 (49 U.S.C. 1376(b)) is amended to read as follows: "(3) the need of each such air carrier (other than a charter air carrier) for compensation for the transportation of mail sufficient to insure the performance of such service, and—

"(A) during the period beginning on the date of enactment of this clause and ending on January 1, 1983, both dates inclusive, together with all other revenue of the air carrier from the service for which the compensation is being paid; and

"(B) after January 1, 1983, together with all other revenue of the air carrier;

to enable such air carrier under honest, economical, and efficient management, to provide (except for modifications with respect to an individual point determined after January 1, 1983, to be required by the public interest, after giving interested parties an opportunity for an evidentiary hearing with respect to air transportation for such individual point) air transportation of at least the same extent, character, and quality as that provided during the year ending December 31, 1977, to maintain and continue the development of air transportation to the extent and of the character and quality required for the commerce of the United States, the Postal Service, and the national defense."

(2) Section 406(b) of the Federal Aviation Act of 1958 is amended by inserting after the second sentence the following new sentences: "Notwithstanding any other provision of this section, rates of compensation paid to any carrier under this section for service performed between the date of enactment of this sentence and January 1, 1983, shall be based on the subsidy need of such carrier with respect to service performed to points for which such carrier was entitled to receive compensation for serving during calendar year 1977. In the case of any local service carrier, such subsidy need shall be based on the adjusted eligible need of such carrier determined in a matter consistent with the provisions of Local Service Class Subsidy Rate VIII, with technical adjustments, and in the case of any other carrier receiving compensation during the twelve months ended June 30, 1978, such subsidy need shall be determined pursuant to the method in effect during the twelve months ended June 30, 1978. Any air carrier receiving compensation from the Board pursuant to this section which, before January 1, 1986, terminates service to a point for which such compensation is paid shall not, if such service is resumed by such air carrier, be eligible for compensation from the Board under this section for such service. Nothing in this subsection shall be construed as prohibiting any air carrier specified in the preceding sentence from applying for and receiving compensation for such service under section 419 of this title."

(b) Subsection (c) of such section 406 (49 U.S.C. 1376(c)) is amended by adding at the end thereof the following new sentence: "The Board shall make no payments under this section for any services performed after January 1, 1986."

## LOCAL SERVICE AIR CARRIER COMPENSATION

SEC. 25. (a) The last sentence of section 406(b) of the Federal Aviation Act of 1958 (49 U.S.C. 1376(b)) is amended as follows:

(1) By striking out "the year 1966" and inserting in lieu thereof "the years 1964, 1965, and 1966".

(2) By striking out "Rate III-A" and inserting in lieu thereof "Rates III and III-A".

(3) By striking out "order E-23850 (44 CAB 637 et seq.)" and inserting in lieu thereof "orders E-21311 and E-23850 (41 CAB 138 et seq. and 44 CAB 637 et seq.)".

49 USC 1376  
note.

(b) Section 12(b) of Public Law 95-163, Ninety-fifth Congress, approved November 9, 1977, is amended by striking out "the year 1966" and inserting in lieu thereof "the year 1964, 1965, or 1966".

#### MERGERS AND CONTROL

SEC. 26. (a) Section 408 of the Federal Aviation Act of 1958 (49 U.S.C. 1378) is amended as follows:

(1) Subsection (a) of such section 408 (49 U.S.C. 1378(a)) is amended to read as follows:

#### "ACTS PROHIBITED

"SEC. 408. (a) Except as provided in subsection (b) of this section, it shall be unlawful—

"(1) for two or more air carriers, or for any air carrier and any other common carrier or any person substantially engaged in the business of aeronautics, to consolidate or merge their properties, or a substantial portion thereof, into one person for the ownership, management, or operation of the properties previously in separate ownerships;

"(2) for any air carrier, any person controlling an air carrier, any other common carrier, or any person substantially engaged in the business of aeronautics, to purchase, lease, or contract to operate all or a substantial portion of the properties of any air carrier;

"(3) for any air carrier or person controlling an air carrier to purchase, lease, or contract to operate all or a substantial portion of the properties of any person substantially engaged in the business of aeronautics otherwise than as an air carrier;

"(4) for any foreign air carrier or person controlling a foreign air carrier to acquire control in any manner whatsoever of any citizen of the United States substantially engaged in the business of aeronautics;

"(5) for any air carrier or person controlling an air carrier, any other common carrier, or any person substantially engaged in the business of aeronautics to acquire control of any air carrier in any manner whatsoever;

"(6) for any air carrier or person controlling a certificated air carrier to acquire control, in any manner whatsoever, of any person substantially engaged in the business of aeronautics other than as an air carrier; or

"(7) for any person to continue to maintain any relationship established in violation of any of the foregoing paragraphs of this subsection."

(2) Subsection (b) of such section 408 (49 U.S.C. 1378(b)) is amended to read as follows:

#### "POWER OF BOARD

"(b) (1) In any case in which one or more of the parties to a consolidation, merger, purchase, lease, operating contract, or acquisition of control, specified in subsection (a) of this section is an air carrier

holding a valid certificate issued by the Board under section 401(d) of this section to engage in interstate or overseas air transportation, a foreign air carrier, or a person controlling, controlled by, or under common control with, such an air carrier or a foreign air carrier, the person seeking approval of such transaction shall present an application to the Board, and, at the same time, a copy to the Attorney General and the Secretary of Transportation, and thereupon the Board shall notify the persons involved in the transaction and other persons known to have a substantial interest in the proceeding, of the manner in which the Board will proceed in disposing of such application. Unless, after a hearing, the Board finds that the transaction will not be consistent with the public interest or that the conditions of this section will not be fulfilled, it shall, by order, approve such transaction, upon such terms and conditions as it shall find to be just and reasonable and with such modifications as it may prescribe, except the Board shall not approve such transaction—

*Ante*, p. 1712.

“(A) if it would result in a monopoly or would be in furtherance of any combination or conspiracy to monopolize or to attempt to monopolize the business of air transportation in any region of the United States; or

Monopolization.

“(B) the effect of which in any region of the United States may be substantially to lessen competition, or to tend to create a monopoly, or which in any other manner would be in restraint of trade, unless the Board finds that the anticompetitive effects of the proposed transaction are outweighed in the public interest by the probable effect of the transaction in meeting significant transportation conveniences and needs of the public, and unless it finds that such significant transportation conveniences and needs may not be satisfied by a reasonably available alternative having materially less anticompetitive effects.

Competition.

The party challenging the transaction shall bear the burden of proving the anticompetitive effects of such transaction, and the proponents of the transaction shall bear the burden of proving that it meets the significant transportation conveniences and needs of the public and that such conveniences and needs may not be satisfied by a less anticompetitive alternative.

“(2) In any case in which the Board determines that the transaction which is the subject of the application does not affect the control of an air carrier directly engaged in the operation of aircraft in air transportation, and determines that neither the Attorney General, nor the Secretary, nor any other person disclosing a substantial interest in the transaction then currently is requesting a hearing, the Board, no sooner than 30 days after publication in the Federal Register of notice of the Board's intention to dispose of such application without a hearing (a copy of which notice shall be furnished by the Board to the Attorney General and the Secretary not later than the day following the date of such publication), may determine that the public interest does not require a hearing and, in accordance with the standards set forth in subparagraphs (A) and (B) of paragraph (1) of this subsection, by order, approve or disapprove such transaction.

Notice.  
Publication  
in Federal  
Register.

“(3) (A) In any case in which none of the parties to a consolidation, merger, purchase, lease, operating contract, or acquisition of control, specified in subsection (a) of this section, is an air carrier holding a valid certificate issued by the Board under section 401(d) of this title to engage in interstate or overseas air transportation, a foreign air carrier, or a person controlling, controlled by, or under common control with, such an air carrier or a foreign air carrier, any person seeking

Application  
filing.

approval of such transaction shall file with the Board not later than the forty-fifth day before the effective date of such transaction, a statement of its intent to enter into any of the prohibited acts set forth in subsection (a) of this section. The Board may, within forty-five days after the date of such filing, require such person to file an application for approval pursuant to the requirements of paragraph (1) of this subsection if it finds either that the proposed transaction may monopolize, tend to monopolize, or otherwise restrain competition in air transportation in any section of the country or that the person may not be fit, willing, and able to properly perform the transportation authorized by any license which is a part of such transaction and to conform to the provisions of this Act and the rules, regulations, and requirements of the Board issued pursuant to this Act. Subject to subparagraph (B) of this paragraph, if the Board fails to require such person to file an application pursuant to such paragraph (1) within such forty-five days, the proposed transaction shall not be subject to subsection (a) of this section.

“(B) If the Board determines that any transaction is not subject to subsection (a) of this section as a result of the last sentence of subparagraph (A) of this paragraph and such transaction received such statutory exemption due to any fraud, misrepresentation, or omission of relevant and material facts, the Board may, pursuant to rules which it is authorized to prescribe, make such transaction subject to subsection (a) of this section.”

49 USC 1378.

(b) Section 408(c) of such Act is amended by inserting “any person controlling such air carrier,” after “air carrier,” the first place it appears in such subsection.

#### INTERLOCKS

Sec. 27. (a) Section 409 of the Federal Aviation Act of 1958 (49 U.S.C. 1379) is amended by striking out the center heading of such section and the center heading for subsection (a) of such section and inserting in lieu thereof the following section center heading:

#### “INTERLOCKING RELATIONSHIPS”.

(b) Section 409 of the Federal Aviation Act of 1958 is also amended by striking out “Sec. 409. (a)” and inserting in lieu thereof “Sec. 409.”

(c) Section 409 (as amended by subsections (a) and (b) of this section) is amended as follows:

(1) Paragraphs (1), (2), and (3) are each amended by striking out “is engaged in any phase of” and inserting in lieu thereof “is substantially engaged in the business of”.

(2) Paragraphs (4), (5), and (6) are each amended by striking out “engaged in any phase of” and inserting in lieu thereof “substantially engaged in the business of”.

Repeal.

(d) Section 409(b) of the Federal Aviation Act of 1958 (49 U.S.C. 1379(b)) is hereby repealed.

(e) That portion of the table of contents contained in the first section of the Federal Aviation Act of 1958 which appears under the center heading

#### “TITLE IV—AIR CARRIER ECONOMIC REGULATION”

is amended by striking out

“Sec. 409. Prohibited interests.

“(a) Interlocking relationships.

“(b) Profit from transfer of securities.”

and inserting in lieu thereof

“Sec. 409. Interlocking relationships.”.

## AGREEMENTS

SEC. 28. (a) Section 412(a) of the Federal Aviation Act of 1958 (49 U.S.C. 1382(a)) is amended—

(1) by inserting in the subsection center heading “AFFECTING FOREIGN AIR TRANSPORTATION” immediately after “AGREEMENTS”; and

(2) by inserting “foreign” immediately after “affecting”.

(b) Section 412(b) of such Act is amended by inserting “affecting foreign air transportation” immediately after “agreement” each place it appears in such section.

(c) Section 412 of such Act is further amended by adding at the end thereof the following new subsections:

“FILING AND APPROVAL OF AGREEMENTS AFFECTING INTERSTATE OR OVERSEAS AIR TRANSPORTATION

“(c) (1) Any air carrier may file with the Board a true copy, or, if oral, a true and complete memorandum, of any contract or agreement (whether enforceable by provisions for liquidated damages, penalties, bonds, or otherwise), or a request for authority to discuss possible cooperative working arrangements, affecting interstate or overseas air transportation and in force on the effective date of this subsection, or thereafter entered into, or any modification or cancellation thereof, between such air carrier and any other air carrier, foreign air carrier, or other carrier.

“(2) (A) The Board shall by order disapprove any contract, agreement, or request filed pursuant to paragraph (1) of this subsection, whether or not previously approved by it, that it finds to be adverse to the public interest or in violation of this Act, and shall by order approve any contract, agreement, or request, or any modification or cancellation thereof, that it does not find to be adverse to the public interest, or in violation of this Act, except that—

“(i) the Board may not approve or, after periodic review, continue its approval of any such contract, agreement, or request, or any modification or cancellation thereof, which substantially reduces or eliminates competition, unless it finds that the contract, agreement, or request is necessary to meet a serious transportation need or to secure important public benefits and it does not find that such need can be met or such benefits can be secured by reasonably available alternative means having materially less anticompetitive effects;

“(ii) the Board may not approve any contract or agreement between an air carrier not directly engaged in the operation of aircraft in air transportation and a common carrier subject to the Interstate Commerce Act, as amended, governing the compensation to be received by such common carrier for transportation services performed by it; and

“(iii) the Board may not approve any such contract or agreement, or any modification or cancellation thereof, that limits the level of capacity among air carriers in markets in which they compete, that fixes rates, fares, or charges between or among air carriers (except for joint rates, fares, or charges).

“(B) In any proceeding before the Board involving the application of the standards set forth in subparagraph (A) (i) of this paragraph, the party opposing the proposed contract, agreement, or request shall have the burden of proving the reduction or elimination of competition, and the availability of alternative means having less anticompeti-

tive effects, and the party defending the proposed contract, agreement, or request shall have the burden of proving transportation need or public benefits.

“(C) The findings required by subparagraph (A) (i) of this paragraph, shall be included in any order of the Board approving or disapproving any contract or agreement, or any memorandum of any contract or agreement, or any modification or cancellation thereof, or any request.

“PROCEEDINGS UPON FILING

Written  
notice.

“(d) Upon the filing of any contract or agreement, or any modification or cancellation thereof, or any request for authority to discuss possible cooperative working arrangements, pursuant to subsection (a) or (c) of this section, the Board, in accordance with regulations which it prescribes, shall provide to the Attorney General and the Secretary of Transportation written notice of, and an opportunity to submit written comments on, the filed document. The Board may, upon its own initiative or if requested by the Attorney General or such Secretary, hold a hearing, in accordance with regulations prescribed by the Board, to determine if a contract or agreement, or request for discussion authority, whether or not previously approved, is consistent with the provisions of this Act.”.

Hearings.

(d) That portion of the table of contents which appears under the side heading

“Sec. 412. Pooling and other agreements.”

is amended by striking out

- “(a) Filing of agreements required.
- “(b) Approval by Board.”

and inserting in lieu thereof

- “(a) Filing of agreements affecting foreign air transportation required.
- “(b) Approval by Board.
- “(c) Filing and approval of agreements affecting interstate or overseas air transportation.
- “(d) Proceedings upon filing.”.

MUTUAL AID AGREEMENTS

SEC. 29. (a) Section 412 of the Federal Aviation Act of 1958 (49 U.S.C. 1382) is amended by adding at the end thereof the following new subsection:

“MUTUAL AID AGREEMENTS

“(c) (1) Notwithstanding any other provision of law, any mutual aid agreement between air carriers which was approved by the Board before the date of enactment of this subsection and which is in effect on such date of enactment shall be deemed disapproved and not in effect on and after such date of enactment.

“(2) No air carrier shall enter into any mutual aid agreement with any other air carrier, unless such air carrier files a true copy of such agreement with the Board and the Board approves such agreement pursuant to the provisions of this section. Notwithstanding subsection (c) of this section, the Board shall not approve any such agreement unless such agreement provides (A) that any air carrier will not receive payments for any period which exceed 60 per centum of the direct operating expenses during such period, (B) that benefits under the agreement are not payable for more than eight weeks during any labor strike, and that such benefits may not be for losses incurred

during the first thirty days of any labor strike, and (C) that any party to such agreement will agree to submit the issues causing any labor strike to binding arbitration pursuant to the Railway Labor Act if the striking employees request such binding arbitration.

45 USC 151.

“(3) For purposes of this subsection, the term—

“(A) ‘mutual aid agreement’ means any contract or agreement between air carriers which provides that any such air carrier will receive payments from the other air carriers which are parties to such contract or agreement for any period during which such air carrier is not engaging in air transportation, or is providing reduced levels of service in air transportation, due to a labor strike; and

“Mutual aid agreement.”

“(B) ‘direct operating expenses’ includes interest expenses but does not include depreciation or amortization expenses.”.

“Direct operating expenses.”

(b) That portion of the table of contents contained in the first section of the Federal Aviation Act of 1958 which appears under the side heading

“Sec. 412. Pooling and other agreements.”

is amended by inserting at the end thereof

“(e) Mutual aid agreements.”.

#### ANTITRUST EXEMPTION

SEC. 30. (a) Section 414 of the Federal Aviation Act of 1958 (49 U.S.C. 1384) is amended to read as follows:

#### “ANTITRUST EXEMPTION

“SEC. 414. In any order made under section 408, 409, or 412 of this Act, the Board may, as part of such order, exempt any person affected by such order from the operations of the ‘antitrust laws’ set forth in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12) to the extent necessary to enable such person to proceed with the transaction specifically approved by the Board in such order and those transactions necessarily contemplated by such order, except that the Board may not exempt such person unless it determines that such exemption is required in the public interest.”.

49 USC 1378, 1379, 1382.

(b) That portion of the table of contents contained in the first section of such Act which appears under the center heading

#### “TITLE IV—AIR CARRIER ECONOMIC REGULATION”

is amended by striking out

“Sec. 414. Legal restraints.”

and inserting in lieu thereof

“Sec. 414. Antitrust exemption.”.

#### EXEMPTION AUTHORITY

SEC. 31. (a) Section 416(b) (1) of the Federal Aviation Act of 1958 (49 U.S.C. 1386(b) (1)) is amended to read as follows:

#### “EXEMPTIONS

“(b) (1) Except as provided in paragraph (2) of this subsection, the Board, from time to time and to the extent necessary, may exempt from the requirements of this title or any provision thereof, or any rule,

regulation, term, condition, or limitation prescribed thereunder, any person or class of persons if it finds that the exemption is consistent with the public interest.

49 USC 1386.

(b) Section 416(b) of such Act is amended by adding at the end thereof the following new paragraph:

“(3) The Board may by order relieve foreign air carriers who are not directly engaged in the operation of aircraft in foreign air transportation from the provisions of this Act to the extent and for such periods as such relief may be in the public interest.”.

#### COMMUTER EXEMPTION

SEC. 32. Section 416(b) of the Federal Aviation Act of 1958 (49 U.S.C. 1386(b)) is further amended by adding at the end thereof the following new paragraphs:

49 USC 1371.

“(4) Subject to paragraph (5) of this subsection, any air carrier in air transportation which provides (A) passenger service solely with aircraft having a maximum passenger capacity of less than fifty-six passengers, or (B) cargo service in air transportation solely with aircraft having a maximum payload capacity of less than eighteen thousand pounds, shall be exempt from the requirements of subsection (a) of section 401 of this title, and of such other sections of this Act as may be prescribed in regulations promulgated by the Board, if such air carrier conforms to such liability insurance requirements and such other reasonable regulations as the Board shall from time to time adopt in the public interest. The Board may by regulation increase the passenger or property capacities specified in this paragraph when the public interest so requires.

“(5) The exemption from section 401 of this title or any other requirement of this Act shall not apply to any air transportation by any air carrier between points both of which are in the State of Alaska, or one of which is in the State of Alaska and the other in Canada, unless such air carrier also holds authority to provide such air transportation from the State of Alaska.

“(6) Any air carrier operating within the State of Alaska pursuant to the exemption from section 401 of this title shall not be subject to any limitation, promulgated by the Board, on the number or location of points to be served by such air carrier, or any limitation on the frequency of service by such air carrier to points within such State, unless the Board, after a hearing, finds that the operation of such air carrier substantially impairs the ability of a certificated air carrier to provide the service authorized by its certificate, including but not limited to, the minimum service requirement for such State specified in section 419(c)(2) of this title.”.

*Infra.*

#### SMALL COMMUNITY AIR SERVICE

SEC. 33. (a) Title IV of the Federal Aviation Act of 1958 is amended by adding at the end thereof the following new section.

#### “SMALL COMMUNITY AIR SERVICE

##### “GUARANTEED ESSENTIAL AIR TRANSPORTATION

“Eligible point.”  
49 USC 1389.

“SEC. 419. (a) (1) For purposes of this subsection, the term ‘eligible point’ means any point in the United States to which, on the date of enactment of this section, any air carrier—

“(A) is providing service pursuant to a certificate issued to such carrier under section 401 of this title; or

“(B) is authorized pursuant to such certificate to provide such service, but such service is suspended on such date of enactment.

“(2) (A) With respect to each eligible point which on the date of enactment of this section is served by not more than one air carrier holding a certificate issued under section 401 of this title, not later than the last day of the one-year period beginning on such date of enactment, the Board, after considering the views of any interested community and the State agency of the State in which such community is located, shall determine what is essential air transportation for such point.

49 USC 1371.

“(B) With respect to any eligible point which on the date of enactment of this section is served by more than one air carrier holding a certificate issued under section 401 of this title and which thereafter receives service by not more than one such air carrier, not later than the last day of the six-month period beginning on the date on which the Board receives notice that service to such point will be provided by not more than one such air carrier, the Board, after considering the views of any interested community and the State agency of the State in which such community is located, shall determine what is essential air transportation to such point.

“(C) The Board shall periodically review the determination of what is essential air transportation to each eligible point, and may, based upon such review and consultations with any interested community and the State agency of the State in which such community is located, make appropriate adjustments as to what is essential air transportation to such point.

Review.

“(3) No air carrier shall terminate, suspend, or reduce air transportation to any eligible point below the level of essential air transportation established by the Board under paragraph (2) unless such air carrier—

“(A) if such air carrier—

“(i) holds a certificate issued under section 401 of this title, or

“(ii) does not hold such a certificate, but is receiving compensation pursuant to paragraph (5) of this subsection for service to such eligible point,

has given the Board, the appropriate State agency or agencies, and the communities affected at least ninety days notice prior to such termination, suspension, or reduction; and

“(B) if such air carrier does not hold such a certificate and is not receiving compensation pursuant to paragraph (5) of this subsection for service to such eligible point, has given the Board, the appropriate State agency or agencies, and the communities affected at least thirty days notice prior to such termination, suspension, or reduction.

“(4) Whenever the Board determines that essential air transportation will not be provided to any eligible point without compensation—

“(A) the Board shall provide notice that applications may be submitted by any air carrier which is willing to provide essential air transportation to such point for compensation under this subsection. In selecting an applicant to provide essential air transportation to such point for compensation the Board shall, among other factors, specifically consider—

“(i) the desirability of developing an integrated linear system of air transportation whenever such a system most adequately meets the air transportation needs of the communities involved;

“(ii) the experience of the applicant in providing scheduled air service in the vicinity of the communities for which essential air transportation is proposed to be provided; and

“(iii) notwithstanding the provisions of clause (ii), with respect to any eligible point in the State of Alaska, the experience of an applicant in providing scheduled air service, or significant patterns of nonscheduled air service pursuant to an exemption granted pursuant to section 416 of this title, in Alaska; and

49 USC 1386.

Compensation  
rate,  
establishment.

“(B) the Board shall establish, in accordance with the guidelines promulgated under subsection (d) of this section, a rate of compensation to be paid for providing such essential air transportation.

“(5) The Board shall make payments of compensation under this subsection at times and in a manner determined by the Board to be appropriate. The Board shall continue to pay compensation to any air carrier to provide essential air transportation to any eligible point only for so long as the Board determines it is necessary in order to maintain essential air transportation to such eligible point.

Service  
extension.  
*Ante*, p. 1720.

“(6) Notwithstanding section 401(j) of this title, if an air carrier has provided notice to the Board under paragraph (3) of such air carrier's intention to suspend, terminate, or reduce service to any eligible point below the level of essential air transportation to such point, and if at the conclusion of the applicable period of notice the Board has not been able to find another air carrier to provide essential air transportation to such point, the Board shall require the carrier which provided such notice to continue such service to such point for an additional 30-day period, or until another air carrier has begun to provide essential air transportation to such point, whichever first occurs. If at the end of such 30-day period the Board determines that no other air carrier can be secured to provide essential air transportation to such eligible point on a continuing basis, either with or without compensation, then the Board shall extend such requirement for such additional 30-day periods (making the same determination at the end of each such period) as may be necessary to continue air transportation to such eligible point until an air carrier can be secured to provide essential air transportation to such eligible point on a continuing basis.

49 USC 1376.

“(7) (A) If any air carrier (i) which is providing air transportation to any eligible point, and (ii) which is receiving compensation under this subsection or under section 406 of this title for providing such air transportation to such point, is required by the Board to continue service to such point beyond the date on which such air carrier would, but for paragraph (6) of this subsection, be able to suspend, terminate, or reduce service to such point below the level of essential air transportation to such point, then after such date such air carrier shall continue to receive such compensation until the Board finds another air carrier to provide essential air transportation to such point.

Losses,  
compensation.  
49 USC 1371.

“(B) If the Board requires an air carrier which holds a certificate issued under section 401 of this title and which is providing air transportation to any eligible point without compensation pursuant to paragraph (5) of this subsection or section 406 of this title to continue to provide essential air transportation to such point beyond the 90-day notice period after which, but for paragraph (6) of this subsection, such air carrier would be able to suspend, terminate, or reduce service to such point below essential air transportation for such point, then the Board shall compensate such air carrier for any losses that the air carrier incurs in complying with this subparagraph after the last day of such 90-day period, except that the Board shall not make any pay-

ments under this subparagraph, to any trunk air carrier for service to such point after the last day of the one-year period beginning on the date on which any payment is made to such air carrier under this subparagraph for service to such point.

“(C) If the Board requires an air carrier which does not hold a certificate issued under section 401 of this title, but which is providing air transportation to any eligible point without compensation pursuant to paragraph (5) of this subsection or section 406 of this title to continue to provide essential air transportation to such point beyond the 30-day notice period after which, but for paragraph (6) of this subsection, such air carrier would be able to suspend, terminate, or reduce service to such point below essential air transportation for such point, then the Board shall compensate such air carrier for any losses that such air carrier incurs in complying with this paragraph after the last day of such 30-day period. 49 USC 1371.  
49 USC 1376.

“(9) During any period for which the Board requires any air carrier to continue providing air transportation to an eligible point which such air carrier has proposed to terminate, reduce, or suspend, the Board shall continue to make every effort to secure an air carrier to provide at least essential air transportation to such eligible point, on a continuing basis.

“(10) Unless the Board has determined what is essential air transportation for any eligible point pursuant to paragraph (2) of this subsection, the Board shall, upon petition of any appropriate representative of such point, prohibit any termination, suspension, or reduction of air transportation which reasonably appears to deprive such point of essential air transportation, until the Board has completed such determination. Petition.

“(11) (A) After January 1, 1983, any air carrier may file an application with the Board seeking to have any compensation provided under section 406 of this title to the air carrier then serving an eligible point terminated in order to allow the applicant air carrier to provide air transportation to that eligible point for compensation under this section. The Board shall grant such application, after notice and a hearing if requested by the air carrier receiving subsidy under section 406, taking into consideration the objectives specified in subparagraphs (A) (i) and (ii) of paragraph (5) of this subsection, if the applicant can show that termination of the compensation being paid under section 406, and that the provision of service by such applicant with compensation under this section, will result in a substantial— Application.  
Notice and hearing.

“(i) improvement in the air service being provided such eligible point; and

“(ii) decrease in the amount of compensation that will be required to continue essential air transportation to such eligible point.

“(B) After January 1, 1983, any air carrier may file an application with the Board seeking to have the compensation provided under this section to the air carrier then serving an eligible point, and which has been serving such eligible point for at least two years preceding the date on which such application is filed, terminated in order to allow the applicant air carrier to provide essential air transportation to such eligible point for compensation under this section. The Board shall grant such application, after notice and a hearing if requested by an air carrier receiving compensation under this section, taking into consideration the objectives specified in subparagraphs (A) (i) and (ii) of paragraph (4) of this subsection, if the applicant air carrier can show that termination of the compensation being provided to the air carrier Application.  
Notice and hearing.

then serving such eligible point, and the provision of essential air transportation for compensation under this section by the applicant air carrier will result in a substantial—

“(i) improvement in the air transportation being provided such eligible point with no increase in the amount of compensation then being paid; or

“(ii) decrease in the amount of compensation that will be required to continue essential air transportation to that eligible point.

“(C) In disposing of each application filed under this subsection, the Board shall, in addition to considering the objectives specified in subparagraphs (A) (i) and (ii) of paragraph (4), solicit and give great weight to the opinions of the communities affected by the proposed replacement of an air carrier under this subsection.

“OTHER AIR SERVICE

- “Eligible point.” “(b) (1) For purposes of this subsection, the term ‘eligible point’ means—
- 49 USC 1371. “(A) any point in the United States which has been deleted from a certificate issued under section 401 of this title between July 1, 1968, and the date of enactment of this section, both dates inclusive, and which the Board designates pursuant to paragraph 2 of this subsection; and
- “ (B) any other point in the State of Alaska or Hawaii designated by the Board under paragraph 2 of this subsection.
- Eligible point designation, rules. “(2) (A) Not later than January 1, 1980, after considering the views of State agencies and other interested parties, the Board shall, by rule, establish objective criteria for designating points as eligible points. In establishing or modifying such criteria, the Board shall consider, among other factors, the level of traffic generated by the point concerned, its future traffic generating potential, the cost to the Federal Government of providing essential air transportation to such point, the alternative means of transportation available to the residents of such point for access to the national transportation system and its principal communities of interest, and the degree of isolation of such point from the national air transportation system. The Board may, from time to time, by rule, modify the criteria established by it under this subparagraph.
- Review. “(B) Not later than January 1, 1980, the Board shall begin to review each point described in paragraph (1)(A) of this subsection to determine whether such point shall be designated as an eligible point under the criteria established under subparagraph (B) of this paragraph. The review and designation of each such point shall be completed before January 1, 1982.
- “ (C) On or after January 1, 1982, the Board, upon application by any interested party, may designate any point an eligible point under the criteria established under subparagraph (B) of this paragraph (i) if such point is in the State of Alaska or the State of Hawaii, and (ii) if such designation would not increase the total number of points receiving a subsidy under this section and section 406 of this title above the total number of points receiving a subsidy under such section 406 on July 1, 1968.
- 49 USC 1376. “(3) The designation of any point by the Board under paragraph (2) of this subsection as an eligible point may be withdrawn if the point no longer meets the criteria for designation as an eligible point.
- Withdrawal.

“(4) (A) With respect to any point which the Board designates as an eligible point pursuant to paragraph (2) of this subsection, not later than the last day of the six-month period beginning on the date on which the Board makes such designation, the Board, after considering the views of any interested community and the State agency of the State in which such community is located, shall determine what is essential air transportation to such point. Determination, consultation.

“(B) The Board shall periodically review the determination of what is essential air transportation to each eligible point, and may, based upon such review and consultations with any interested community and any State agency of the State in which such community is located, make appropriate adjustments as to what is essential air transportation to such point. Review.

“(5) Whenever the Board determines that essential air transportation will not be provided to any eligible point without compensation—

“(A) the Board shall provide notice that applications may be submitted by any air carrier which is willing to provide essential air transportation to such point for compensation under this subsection. In selecting an applicant to provide essential air transportation to such point for compensation, the Board shall, among other factors, specifically consider— Notice.

“(i) the desirability of developing an integrated linear system of air transportation whenever such a system most adequately meets the air transportation needs of the communities involved; Applicant selection.

“(ii) the experience of the applicant in providing scheduled air service in the vicinity of the communities for which essential air transportation is proposed to be provided; and

“(iii) notwithstanding the provisions of clause (ii), with respect to any eligible point in the State of Alaska, the experience of an applicant in providing scheduled air service, or significant patterns of nonscheduled air service pursuant to an exemption granted pursuant to section 416 of this title, in Alaska; and 49 USC 1386.

“(B) the Board shall establish, in accordance with the guidelines promulgated under subsection (d) of this section, a rate of compensation to be paid for providing such essential air transportation. Compensation rate, establishment.

“(6) The Board shall make payments of compensation under this subsection at times and in a manner determined by the Board to be appropriate. The Board shall continue to pay compensation to any air carrier to provide essential air transportation to any eligible point only for so long as the Board determines it is necessary in order to maintain essential air transportation to such eligible point. Payments.

“(7) Prior to terminating, suspending, or reducing essential air transportation to any eligible point, an air carrier— Notice.

“(A) if such air carrier—

“(i) holds a certificate issued under section 401 of this title, or 49 USC 1371.

“(ii) does not hold such a certificate, but is receiving compensation pursuant to paragraph (6) of this subsection for service to such eligible point, shall give the Board, the appropriate State agency or agencies, and the communities affected at least ninety days notice prior to such termination, suspension, or reduction; and

“(B) if such air carrier does not hold such a certificate and is not receiving compensation pursuant to paragraph (6) of this subsection for service to such eligible point, shall give the Board,

the appropriate State agency or agencies, and the communities affected such notice (not to exceed 30 days), as the Board shall by regulation prescribe.

Application.

“(8) (A) After January 1, 1983, any air carrier may file an application with the Board seeking to have the compensation provided under this subsection to the air carrier then serving an eligible point, and which has been serving such eligible point for at least 2 years preceding the date on which such application is filed, terminated in order to allow the applicant air carrier to provide essential air transportation to such eligible point for compensation under this subsection. The Board shall grant such application, after notice and a hearing if requested by an air carrier receiving compensation under this section, taking into consideration the objectives specified in subparagraphs (A) (i) and (ii) of paragraph (5) of this subsection, if the applicant can show that termination of the compensation being provided to the air carrier then serving such eligible point, and that the provision of essential air transportation for compensation under this subsection by the applicant, will result in a substantial—

Notice and hearing.

“(i) improvement in the air transportation being provided such eligible point with no increase in the amount of compensation then being paid; or

“(ii) decrease in the amount of compensation that will be required to continue essential air transportation to that eligible point.

“(B) In disposing of each application filed under this paragraph, the Board shall, in addition to considering the objectives specified in subparagraphs (A) (i) and (ii) of paragraph (5), solicit and give great weight to the opinions of the communities affected by the proposed replacement of an air carrier under this subsection.

#### “LEVEL OF SAFETY

“Commuter air carrier.”

*Ante*, p. 1732.

Compensation and service, conditions.

“(c) (1) For purposes of this subsection the term ‘commuter air carrier’ means an air carrier exempt from any requirement of this Act under section 416 (b) (3) of this title.

“(2) Notwithstanding section 416 (b) of this title, the Board shall not provide any compensation under this section to any commuter air carrier to provide service to any eligible point, and the Board shall prohibit any commuter air carrier from providing service to any eligible point, unless the Board determines that such commuter air carrier—

“(A) is fit, willing, and able to perform such service; and

“(B) that all aircraft which will be used to perform such service and all operations relating to such service will conform to the safety standards established by the Administrator under paragraph (3) of this subsection.

Safety standard regulations.

“(3) Not later than the one-hundred-eightieth day after the date of enactment of this paragraph, the Administrator, by regulation, shall establish safety standards (A) for aircraft being used by commuter air carriers to provide any service described in paragraph (2) of this subsection, and (B) for all operations relating to such service. Such safety standards shall become effective not later than the last day of the eighteenth month which begins after such date of enactment and shall impose requirements upon such commuter air carriers to assure that the level of safety provided to persons traveling on such commuter

air carriers is, to the maximum feasible extent, equivalent to the level of safety provided to persons traveling on air carriers which provide service pursuant to certificates issued under section 401 of this title. 49 USC 1371.

“GUIDELINES FOR COMPENSATION

“(d) The Board shall, by rule, establish guidelines to be used by the Board in computing the fair and reasonable amount of compensation required to insure the continuation of essential air transportation to any eligible point. Such guidelines shall include expense elements based upon representative costs of air carriers providing scheduled air transportation of persons, property, and mail, using aircraft of the type determined by the Board to be appropriate for providing essential air transportation to the eligible point. Rule.

“INSURANCE

“(e) No air carrier shall receive any compensation under this section unless such air carrier complies with regulations or orders issued by the Board governing the filing and approval of policies of insurance or plans for self-insurance in the amount prescribed by the Board which are conditioned to pay, within the amount of such insurance, amounts for which such air carrier may become liable for bodily injuries to or the death of any person, or for loss of or damage to property of others, resulting from the operation or maintenance of aircraft.

“DEFINITION

“(f) For purposes of this section, the term ‘essential air transportation’ means scheduled air transportation of persons to a point provided under such criteria as the Board determines satisfies the needs of the community concerned for air transportation to one or more communities of interest and insures access to the Nation’s air transportation system, at rates, fares, and charges which are not unjust, unreasonable, unjustly discriminatory, unduly preferential, or unduly prejudicial, and—

“Essential air transportation.”

“(1) with respect to air transportation to any point (other than in the State of Alaska), in no case shall essential air transportation be specified as fewer than two daily round trips, 5 days per week, or the level of service provided by air carriers to such point based on the schedules of such air carriers in effect for calendar year 1977, whichever is less; and

“(2) with respect to air transportation to any point in Alaska, essential air transportation shall not be specified at a level of service less than that which existed for such point during calendar year 1976, or two round trips per week, whichever is greater, unless otherwise specified under an agreement between the Board and the State agency of the State of Alaska, after consultation with the community affected.

“DURATION OF PROGRAM

“(g) This section shall cease to be in effect after the last day of the ten-year period which begins on the date of enactment of this section.”.

(b) That portion of the table of contents which appears under the center heading

## "TITLE IV—AIR CARRIER ECONOMIC REGULATION

is amended by adding at the end thereof

"Sec. 419. Small community air service.

"(a) Guaranteed essential air transportation.

"(b) Other air service.

"(c) Level of safety.

"(d) Guidelines for compensation.

"(e) Insurance.

"(f) Definitions.

"(g) Duration of program."

## PRESIDENTIAL REVIEW OF INTERNATIONAL ROUTE CASES

SEC. 34. Section 801(a) of the Federal Aviation Act of 1958 (49 U.S.C. 1461(a)) is amended to read as follows:

## "THE PRESIDENT OF THE UNITED STATES

"SEC. 801. (a) The issuance, denial, transfer, amendment, cancellation, suspension, or revocation of, and the terms, conditions, and limitations contained in, any certificate authorizing an air carrier to engage in foreign air transportation, or any permit issuable to any foreign air carrier under section 402 of this Act, shall be presented to the President for review. The President shall have the right to disapprove any such Board action concerning such certificates or permits solely upon the basis of foreign relations or national defense considerations which are within the President's jurisdiction, but not upon the basis of economic or carrier selection considerations. Any such disapproval shall be issued in a public document, setting forth the reasons for the disapproval to the extent national security permits, within sixty days after submission of the Board's action to the President. Any such Board action so disapproved shall be null and void. Any such Board action not disapproved within the foregoing time limits shall take effect as action of the Board, not the President, and as such shall be subject to judicial review as provided in section 1006 of this Act."

49 USC 1372.

Disapproval,  
issuance.

49 USC 1486.

## ASSESSMENT OF CIVIL PENALTIES

SEC. 35. (a) Paragraph (1) of subsection (a) of section 901 of the Federal Aviation Act of 1958 (49 U.S.C. 1471(a)(1)) is amended by inserting after the fourth sentence thereof the following new sentences: "The amount of any such civil penalty for any violation of any provision of title IV of this Act, or any rule, regulation, or order issued thereunder, or under section 1002(i) of this Act, or any term, condition, or limitation of any permit or certificate issued under title IV shall be assessed by the Board only after notice and an opportunity for a hearing and after written notice upon a finding of violation by the Board. Judicial review of any order of the Board assessing such a penalty may be obtained only pursuant to section 1006 of this Act."

(b) Paragraph (2) of subsection (a) of such section 901 is amended to read as follows:

"(2) Any civil penalty may be compromised by the Secretary of Transportation in the case of violations of title III, V, VI, or XII of this Act, or any rule, regulation, or order issued thereunder, or by the National Transportation Safety Board in the case of violations of title VII of this Act, or any rule, regulation, or order issued thereunder, or by the Postmaster General in the case of regulations issued by him.

Notice and  
hearing.

49 USC 1371.

49 USC 1482.

Compromise.

49 USC 1341,  
1401, 1421,  
1441.

The amount of such penalty when finally determined or fixed by order of the Board, or the amount agreed upon in compromise, may be deducted from any sums which the United States owes to the person charged.”

PROCEDURES FOR CIVIL PENALTIES

SEC. 36. (a) The first sentence of subsection (b) (1) of section 903 of the Federal Aviation Act of 1958 (49 U.S.C. 1473(b)(1)) is amended by inserting “or assessed” immediately after “imposed”.

(b) The second sentence of subsection (b) (1) of such section 903 is amended by inserting “with respect to proceedings involving penalties other than those assessed by the Board,” immediately after “except that”.

RATES

SEC. 37. (a) Subsection (d) of section 1002 of the Federal Aviation Act of 1958 (49 U.S.C. 1482(d)) is amended—

(1) in paragraph (1), by inserting “or (4)” immediately after “paragraph (2)”; and

(2) by adding at the end thereof the following new paragraphs:

“(4) The Board shall not have authority to find any fare for interstate or overseas air transportation of persons to be unjust or unreasonable on the basis that such fare is too low or too high if—

“(A) with respect to any proposed increase filed with the Board on or after July 1, 1979 (other than any proposed increase in any fare filed by any air carrier if such proposed fare is for air transportation between any pair of points and such air carrier provides air transportation to 70 per centum or more of the persons traveling in air transportation between such points on aircraft operated by air carriers with certificates issued under section 401 of this Act), such proposed fare would not be more than 5 per centum higher than the standard industry fare level for the same or essentially similar class of service, except that, while no increase of any fare within the limits specified in this subparagraph may be suspended, an increase in such fare, above the standard industry fare level shall be found unlawful if that increase results in a fare which is unduly preferential, unduly prejudicial, or unjustly discriminatory; or

“(B) with respect to any proposed decrease filed after the date of enactment of this paragraph, the proposed fare would not be more than 50 per centum lower than the standard industry fare level for the same or essentially similar class of service, except that this provision shall not apply to any proposed decrease in any fare if the Board determines that such proposed fare would be predatory.

In determining whether any fare for air transportation of persons is unjust or unreasonable on the basis that it is too high, the Board shall take into consideration reasonably estimated or foreseeable future costs and revenues for a reasonably limited future period during which the fare at issue would be in effect.

“(5) In any Board proceeding under paragraph (1) of this subsection with respect to interstate or overseas air transportation of persons, the party opposing any fare or charge on the basis that it is too low shall have the burden of proving that the fare or charge is too low.

“(6) (A) For purposes of paragraph (4) of this section, ‘standard industry fare level’ means the fare level (as adjusted only in accordance with subparagraph (B) of this paragraph) in effect on July 1, 1977, for each interstate or overseas pair of points, for each class of

Unjust or unreasonable fares, findings.

49 USC 1371.

“Standard industry fare level.”

service existing on that date, and in effect on the effective date of the establishment of each additional class of service established after July 1, 1977.

Adjustments.

“(B) The Board shall, not less than semiannually, adjust each standard industry fare level specified in subparagraph (A) by increasing or decreasing such fare level, as the case may be, by the percentage change from the last previous period in the actual operating cost per available seat-mile for interstate and overseas transportation combined. In determining the standard, the Board shall make no adjustment to costs actually incurred.

Service classes, rules.

“(C) Not later than July 1, 1979, the Board shall issue rules modifying the rules governing those classes of service in existence on July 1, 1977, which classes provide lower fare levels during off-peak periods, so as to expand the period of availability of such classes. The Board shall allow any air carrier to establish additional classes of service in accordance with the objectives of subsection (e) (5) of this section or as may be otherwise consistent with the public interest.

Rule.

“(7) The Board may by rule increase the percentage specified in paragraph (4) (B) of this subsection.

Complaint.

“(8) Whenever a complaint is filed with the Board by a civic party under this subsection alleging that any individual or joint fare or charge demanded, charged, collected, or received for interstate or overseas air transportation is or will be unjustly discriminatory, unduly preferential, unduly prejudicial, or predatory, the Board shall grant, deny, or dismiss such complaint within ninety days after such complaint is filed.”.

49 USC 1482.

(b) Subsection (e) of such section 1002 is amended to read as follows:

“RULE OF RATEMAKING

“(e) In exercising and performing its power and duties with respect to determining rates, fares, and charges described in paragraph (1) of subsection (d) of this section, the Board shall take into consideration, among other factors—

49 USC 1302.

“(1) the criteria set forth in section 102 of this Act;

“(2) the need for adequate and efficient transportation of persons and property at the lowest cost consistent with the furnishing of such service;

“(3) the effect of prices upon the movement of traffic;

“(4) the desirability of a variety of price and service options such as peak and off-peak pricing or other pricing mechanisms to improve economic efficiency and provide low-cost air service; and

“(5) the desirability of allowing an air carrier to determine prices in response to particular competitive market conditions on the basis of such air carrier's individual costs.”.

Uniform method.

49 USC 1482a.

(c) (1) Whenever the Board pursuant to its authority under section 1002 of the Federal Aviation Act of 1958 (49 U.S.C. 1482) prescribes a uniform method generally applicable to the establishment of joint fares, and the divisions thereof, between air carriers holding certificates issued under section 401 of such Act, it shall make such uniform method applicable to the establishment of joint fares, and the divisions thereof, between such air carriers and commuter air carriers.

49 USC 1371.

Notice.

Any commuter air carrier which has an agreement with any air carrier to provide service for persons and property which includes transporta-

tion over its routes and transportation by such air carrier in air transportation shall provide at least ninety days notice to such air carrier and to the Board prior to modifying, suspending, or terminating such service, and if such commuter air carrier fails to provide such notice, any uniform method made applicable to the establishment of joint fares, and the divisions thereof, between air carriers and commuter air carriers in accordance with the preceding sentence shall not apply to such commuter air carrier.

(2) For purposes of this subsection—

(A) the terms “air carrier” and “Board” have the meanings given such terms in the Federal Aviation Act of 1958; and

(B) the term “commuter air carrier” means any air carrier operating pursuant to section 416(b)(3) of the Federal Aviation Act of 1958 (49 U.S.C. 1386(b)(3)) who operates at least five round trips per week between one pair of points, pursuant to flight schedules.

(3) Paragraph (1) of this subsection shall apply to any uniform method described in such paragraph which the Board prescribes on or after December 27, 1974.

Definitions.

49 USC 1301  
note.

#### TIME REQUIREMENTS

SEC. 38. (a) Title X of the Federal Aviation Act of 1958 (49 U.S.C. 1481 et seq.) is amended by adding at the end thereof the following new section:

#### “TIME REQUIREMENTS

“SEC. 1010. In the case of any application or other written document submitted to the Board under section 408, 409, 412, or 416 of this Act on or after the one-hundred-eightieth day after the date of enactment of this section, the Board shall—

Final order  
or decision,  
issuance.  
49 USC 1490.  
49 USC 1378,  
1379, 1382.

“(1) if the Board orders an evidentiary hearing, issue a final order or decision with respect to such written document, not later than the last day of the twelfth month which begins after the submission of such document, except in the case of an application submitted under section 408 of this Act, the Board shall issue its final order or decision not later than the last day of the sixth month after submission; or

“(2) if the Board does not order an evidentiary hearing, issue a final order or decision with respect to such document, not later than the last day of the sixth month which begins after the date of the submission of such document.”

(b) That portion of the table of contents contained in the first section of such Act which appears under the center heading

#### “TITLE X—PROCEDURE”

is amended by adding at the end thereof

“Sec. 1010. Time requirements.”.

#### WITHHOLDING OF INFORMATION

SEC. 39. Section 1104 of the Federal Aviation Act of 1958 (49 U.S.C. 1504) is amended to read as follows:

## “WITHHOLDING OF INFORMATION

49 USC 1504.

“SEC. 1104. Any person may make written objection to the public disclosure of information contained in any application, report, or document filed pursuant to provisions of this Act or of any information obtained by the Board, the Secretary of State, or the Secretary of Transportation pursuant to the provisions of this Act stating the grounds for such objection. Any information contained in such application, report, or document, or any such other information obtained by the Board, the Secretary of State, or the Secretary of Transportation, shall be withheld from public disclosure by the Board, the Secretary of State, or the Secretary of Transportation, as the case may be, if disclosure of such information would prejudice the formulation and presentation of positions of the United States in international negotiations and adversely affect the competitive position of any air carrier in foreign air transportation. The Board, the Secretary of State, or the Secretary of Transportation, as the case may be, shall be responsible for classified information in accordance with appropriate law, except that nothing in this section shall authorize the withholding of information by the Board, the Secretary of State, or the Secretary of Transportation from the duly authorized committees of Congress.”.

## SUNSET PROVISIONS

SEC. 40. (a) The Federal Aviation Act of 1958 (49 U.S.C. 1301 et seq.) is amended by adding at the end thereof the following new title:

## “TITLE XVI—SUNSET PROVISIONS

## “TERMINATION OF CIVIL AERONAUTICS BOARD AND TRANSFER OF CERTAIN FUNCTIONS

## “TERMINATION OF AUTHORITY

49 USC 1551.

“SEC. 1601. (a) (1) The following provisions of this Act (to the extent such provisions relate to interstate and overseas air transportation of persons) and the authority of the Board with respect to such provisions (to the same extent) shall cease to be in effect on December 31, 1981:

*Ante*, p. 1712.

“(A) Sections 401(d) (1), (2), and (3) of this Act (insofar as such sections require a determination of consistency with the public convenience and necessity and insofar as section 401(d) (3) prohibits persons holding certificates under section 401(d) (1) or (d) (2) from obtaining certificates to provide interstate or overseas charter air transportation of persons).

“(B) Section 401(d) (8) of this Act.

“(C) Section 401(e) (1) of this Act (insofar as such section permits the Board to specify terminal and intermediate points).

“(D) Section 401(j) of this Act (except with respect to essential air transportation).

“(E) Sections 401(n) (1) and (4) of this Act.

“(F) Section 404(a) of this Act (insofar as such section requires any air carrier to provide air transportation authorized by its certificate).

49 USC 1375.

“(G) Section 405(b) of this Act (insofar as such section requires the filing of any statement or schedule by any air carrier).

“(2) The following provisions of this Act (to the extent such provisions relate to interstate and overseas air transportation of persons) and the authority of the Board with respect to such provisions (to the same extent) shall cease to be in effect on January 1, 1983:

“(A) Section 403 of this Act.

49 USC 1373.

“(B) Section 404 of this Act (except insofar as such section requires air carriers to provide safe and adequate service).

49 USC 1374.

“(C) Section 407 (b) and (c) of this Act.

49 USC 1377.

“(D) Sections 1002 (d) (1) and (d) (2), (e), (g), (h), and (i) of this Act.

*Ante*, p. 1741.

“(3) The authority of the Board under sections 408 and 409 of this Act (relating to interstate and overseas air transportation) and the authority of the Board under section 414 of this Act (relating to such sections 408 and 409) is transferred to the Department of Justice on January 1, 1983.

49 USC 1378,  
1379.

49 USC 1384.

“(4) Title II of this Act shall cease to be in effect on January 1, 1985.

49 USC 1321.

#### “TRANSFER OF CERTAIN AUTHORITY

“(b) (1) The following authority of the Board is transferred to the following Federal departments and instrumentalities:

“(A) The authority of the Board under sections 406 (b) (3) and (c) of this Act to provide compensation for air transportation to small communities and under section 419 of this Act is transferred to the Department of Transportation.

*Ante*, p. 1725.

*Ante*, p. 1732.

“(B) The authority of the Board under this Act with respect to foreign air transportation is transferred to the Department of Transportation which shall exercise such authority in consultation with the Department of State.

“(C) The authority of the Board under sections 408 and 409 of this Act (relating to foreign air transportation), the authority of the Board under section 412 of this Act, and the authority of the Board under section 414 of this Act (relating to such sections 408, 409, and 412) is transferred to the Department of Justice.

49 USC 1382.

“(D) The authority of the Board under this Act with respect to the determination of the rates for the carriage of mails in interstate and overseas air transportation is transferred to the Postal Service and such authority shall be exercised through negotiations or competitive bidding.

“(2) Any authority transferred under paragraph (1) of this subsection shall take effect on January 1, 1985.

#### “REPORT AND ASSESSMENT BY BOARD

“(c) Not later than January 1, 1984, the Board shall prepare and submit to the Congress a comprehensive review of the Board's implementation of the provisions of this Act during the preceding initial period of this Act's existence, and a comprehensive review of each of the Board's programs under this Act. Each such review shall be made available to the committee or committees of the Senate and House of Representatives having jurisdiction with respect to the annual authorization of funds for the Board and its programs for the fiscal year beginning October 1, 1983.

Review,  
submittal  
to Congress.

## "ELEMENTS OF BOARD CONSIDERATION

Review provisions.

"(d) The comprehensive review of the Board's implementation of this Act, prepared for submission under subsection (c), shall include—

"(1) a detailed comparison of the degree of competition within the airline industry as of the year preceding enactment of this section and the final year covered by the review;

"(2) a comparison of the degree of pricing competition in the industry during those two one-year periods;

"(3) a comparison of the extent of unused authority held by the industry during those two one-year periods, with details as to the number of nonstop route segments which have been transferred from one carrier to another under section 401(d)(5) of his Act;

*Ante*, p. 1713.

"(4) an assessment of the degree to which agreements approved under section 412 of this Act have affirmatively or negatively affected the degree of competition within the industry;

49 USC 1382.

"(5) a comparison of the extent of air transportation service provided to small communities during the two one-year periods specified above, together with details as to the comparative subsidy costs during these two periods;

"(6) an assessment of the degree, if any, to which the administrative process has been expedited under this Act;

"(7) an assessment of the impact of the foregoing changes upon the national air transportation system in terms of benefits or detriments to the traveling and shipping public, the Postal Service, and the national defense, and the benefits and detriments to air carriers, certificated and uncertificated; and

"(8) the Board's opinion as to whether the foregoing changes in combination, have improved or harmed this Nation's domestic air transportation system and the United States-flag foreign air transportation system.

Continuation, opinion and recommendations.

This assessment shall be accompanied by a detailed opinion from the Board as to whether the public interest requires continuation of the Board and its functions beyond January 1, 1985, and, if it is the Board's conclusion that it should continue to exist, detailed recommendations as to how the provisions of this Act should be revised to insure continued improvement of the Nation's air transportation system beyond January 1, 1985. The Board's assessment under this subsection shall also be accompanied by a comparative analysis of procedures under section 801 of this Act before and after the date of enactment of the Airline Deregulation Act of 1978, together with the Board's opinion as to the benefits of each set of procedures.

49 USC 1461.

## "ELEMENTS FOR EACH COMPREHENSIVE REVIEW

"(e) Each comprehensive review of the Board's programs under this Act, prepared for submission under subsection (c) of this section, shall include—

"(1) an identification of the objectives intended for the program, and the problem or need which the program was intended to address;

"(2) an identification of any other programs having similar or potentially conflicting or duplicative objectives;

“(3) an assessment of alternative methods of achieving the purposes of the program;

“(4) a justification for the authorization of new budget authority, and an explanation of the manner in which it conforms to and integrates with other efforts;

“(5) an assessment of the degree to which the original objectives of the program have been achieved, expressed in terms of the performance, impact, or accomplishments of the program and of the problem or need which it was intended to address, and employing the procedures or methods of analysis appropriate to the type or character of the program;

“(6) a statement of the performance and accomplishments of the program in each of the previous four completed fiscal years and in the year of submission, and of the budgetary costs incurred in the operation of the program;

“(7) a statement of the number and types of beneficiaries or persons or entities by the program;

“(8) an assessment of the effect of the program on the national economy, including, but not limited to, the effects on competition, economic stability, employment, unemployment, productivity, energy consumption and conservation, and price inflation, including costs to consumers and to businesses;

“(9) an assessment of the impact of the program on the Nation's health and safety;

“(10) an assessment of the degree to which the overall administration of the program, as expressed in the rules, regulations, orders, standards, criteria, and decisions of the officers executing the program, are believed to meet the objectives of the Congress in enacting this Act;

“(11) a projection of the anticipated needs for accomplishing the objectives of the program, including an estimate if applicable of the date on which, and the conditions under which, the program may fulfill such objectives;

“(12) an analysis of the services which could be provided and performance which could be achieved if the program were contained at a level less than, equal to, or greater than the existing level; and

“(13) recommendations for necessary transitional requirements in the event that funding for such program is discontinued, including proposals for such executive or legislative action as may be necessary to prevent such discontinuation from being unduly disruptive.”

(b) That portion of the table of contents contained in the first section of such Act is amended by inserting at the end thereof

“TITLE XVI—SUNSET PROVISIONS

“SEC. 1601. Termination of Civil Aeronautics Board and transfer of certain functions.

“(a) Termination of authority.

“(b) Transfer of certain authority.

“(c) Report and assessment by Board.

“(d) Elements for Board consideration.

“(e) Elements for each comprehensive review.”

AMENDMENTS TO THE AIRPORT AND AIRWAY DEVELOPMENT ACT  
OF 1970

Air carrier  
airport  
designation.  
49 USC 1729.

SEC. 41. (a) Section 29 of the Airport and Airway Development Act of 1970 is amended—

(1) by striking out “Notwithstanding” and inserting in lieu thereof the following:

“(a) SERVICE BY INTRASTATE AIR CARRIER.—Notwithstanding”; and  
(2) by inserting at the end thereof the following new subsection:

“(b) SUSPENDED OR DELETED SERVICE.—Notwithstanding any other provision of this title, any public airport which, on the date of enactment of the Airline Deregulation Act of 1978, is regularly served by an air carrier (other than a charter air carrier) certificated by the Civil Aeronautics Board under section 401 of the Federal Aviation Act of 1958 shall be deemed to be an air carrier airport (other than a commuter service airport) for the purposes of this title. This subsection shall cease to be in effect after September 30, 1980.”

49 USC 1371.

49 USC 1711.

(b) Paragraph (1) of section 11 of the Airport and Airway Development Act of 1970 is amended by striking out “(other than a supplemental air carrier)” and inserting in lieu thereof “(other than a charter air carrier)”.

GOVERNMENT GUARANTEE OF EQUIPMENT LOANS

SEC. 42. (a) (1) The first sentence of the first section of the Act entitled “An Act to provide for Government guarantee of private loans of certain air carriers for purchase of modern aircraft and equipment, to foster the development and use of modern transport aircraft by such carriers, and for other purposes”, approved September 7, 1957 (49 U.S.C. 1324 note) (hereinafter in this section referred to as the “Act”), is amended by inserting “and to promote the development of local, feeder, and short-haul charter air transportation of cargo” after “and short-haul air transportation”.

(2) The second sentence of the first section of the Act is amended by inserting “, charter air carriers, commuter air carriers, and intrastate air carriers” immediately after “air carriers”.

Definitions.  
49 USC 1324  
note.

(b) Section 2 of the Act is amended to read as follows:  
“Sec. 2. As used in this Act—

“(1) ‘aircraft purchase loan’ means any loan, or commitment in connection therewith, made for the purchase of commercial transport aircraft, including spare parts normally associated therewith;

“(2) ‘air carrier’ means any air carrier holding a certificate of public convenience and necessity issued by the Civil Aeronautics Board under section 401(d)(1) of the Federal Aviation Act of 1958 (49 U.S.C. 1371(d)(1));

49 USC 1301.

“(3) ‘charter air carrier’ has the meaning given such term in section 101(14) of the Federal Aviation Act of 1958;

“(4) ‘charter air transportation’ has the meaning given such term in section 101(15) of the Federal Aviation Act of 1958;

“(5) ‘commuter air carrier’ means any air carrier operating pursuant to section 416(b)(3) of the Federal Aviation Act of 1958 (49 U.S.C. 1386(b)(3)) who operates at least five round trip flights per week between one pair of points in accordance with published flight schedules;

“(6) ‘intrastate air carrier’ means any citizen of the United States who undertakes, whether directly or indirectly or by a lease or any other arrangement, to engage primarily in intrastate air transportation (as such term is defined in section 101(26) of the Federal Aviation Act of 1958); and

49 USC 1301.

“(7) ‘Secretary’ means the Secretary of Transportation.”

(c) Section 3 of the Act is amended to read as follows:

Eligible  
lenders.  
49 USC 1324  
note.

“SEC. 3. The Secretary is authorized to guarantee any lender against loss of principal or interest on any aircraft purchase loan made by such lender to—

“(1) any air carrier whose certificate (A) authorizes such air carrier to provide local or feeder air service, (B) authorizes scheduled passenger operations the major portion of which are conducted within the State of Hawaii, (C) authorizes operations (the major portion of which is conducted either within Alaska or between Alaska and the forty-eight contiguous States), within the State of Alaska (including service between Alaska and the forty-eight contiguous States, and between Alaska and adjacent Canadian territory), or (D) authorizes metropolitan helicopter service,

“(2) any charter air carrier for the purchase of any all-cargo nonconvertible aircraft,

“(3) any commuter air carrier, or

“(4) any intrastate air carrier.

Such guarantee shall be made in such form, on such terms and conditions, and pursuant to such regulations, as the Secretary deems necessary and which are not inconsistent with the provisions of this Act.”

(d) Section 4 of the Act is amended to read as follows:

Restrictions.  
49 USC 1324  
note.

“SEC. 4. (a) Subject to subsection (b) of this section, no guaranty shall be made—

“(1) extending to more than the unpaid interest and 90 percent of the unpaid principal of any loan;

“(2) on any loan or combination of loans for more than 90 percent of the purchase price of the aircraft, including spare parts, to be purchased therewith;

“(3) on any loan whose terms permit full repayment more than 15 years after the date thereof;

“(4) wherein the total face amount of such loan, and of any other loans to the same air carrier, charter air carrier, commuter air carrier, or intrastate air carrier or corporate predecessor of such air carrier, charter air carrier, commuter air carrier, or intrastate air carrier guaranteed and outstanding under the terms of this Act exceeds \$100,000,000;

“(5) unless the Secretary finds that, without such guaranty, in the amount thereof, the air carrier, charter air carrier, commuter air carrier, or intrastate air carrier would be unable to obtain necessary funds for the purchase of needed aircraft on reasonable terms;

“(6) unless the Secretary finds that the aircraft to be purchased with the guaranteed loan is needed to improve the service and efficiency of operation of the air carrier, charter air carrier, commuter air carrier, or intrastate air carrier;

“(7) unless the Secretary finds that the prospective earning power—

“(A) of the applicant air carrier or charter air carrier, together with the character and value of the security pledged, furnish (i) reasonable assurances of the applicant’s ability to repay the loan within the time fixed therefor, and (ii) reasonable protection to the United States; and

“(B) of the applicant commuter air carrier or intrastate air carrier, together with the character and value of the security pledged, furnish (i) reasonable assurances of the applicant’s ability and intention to repay the loan within the time fixed therefor, to continue its operations as a commuter air carrier or intrastate air carrier, and to the extent found necessary by the Secretary, to continue its operations as a commuter air carrier or intrastate air carrier between the same route or routes being operated by such applicant at the time of the loan guarantee, and (ii) reasonable protection to the United States; and

“(8) on any loan or combination of loans for the purchase of any new turbojet-powered aircraft which does not comply with the noise standards prescribed for new subsonic aircraft in regulations issued by the Secretary acting through the Administrator of the Federal Aviation Administration (14 CFR part 36), as such regulations were in effect on January 1, 1977.

“(b) No guaranty shall be made by the Secretary under subsection (a) of this section on any loan for the purchase of any all-cargo nonconvertible aircraft by any charter air carrier in an amount which, together with any other loans guaranteed and outstanding under this Act to such charter air carrier, or corporate predecessor of such charter air carrier, would result in the ratio of the total face amount of such loans to \$100,000,000 exceeding the ratio of the amount of charter air transportation of such charter air carrier provided to medium, small, and non-hub airports during the twelve-month period preceding the date on which the application for such guaranty is made by such charter air carrier to the total amount of charter air transportation of such charter air carrier during such twelve-month period.”

(e) Section 8 of the Act is amended to read as follows:

“SEC. 8. The authority of the Secretary under section 3 of this Act shall terminate five years after the date of enactment of this section.”

#### EMPLOYEE PROTECTION PROGRAM

SEC. 43. (a). GENERAL RULE.—(1) The Secretary of Labor shall, subject to such amounts as are provided in appropriation Acts, make monthly assistance payments, or reimbursement payments, in amounts computed according to the provisions of this section, to each individual who the Secretary finds, upon application, to be an eligible protected employee. An eligible protected employee shall be a protected employee who on account of a qualifying dislocation (A) has been deprived of employment, or (B) has been adversely affected with respect to his compensation.

(2) No employee who is terminated for cause shall receive any assistance under this section.

(b) MONTHLY ASSISTANCE COMPUTATION.—(1) An eligible protected employee shall, subject to such amounts as are provided in appropriation Acts, receive a monthly assistance payment, for each month in which he is an eligible protected employee, in an amount computed by

Termination  
date.  
49 USC 1324  
note.  
*Ante*, p. 1749.

Payment by  
Labor  
Secretary.  
49 USC 1552.

Eligibility.

the Secretary. The Secretary, after consultation with the Secretary of Transportation, shall, by rule, promulgate guidelines to be used by him in determining the amount of each monthly assistance payment to be made to a member of each craft and class of protected employees, and what percentage of salary such payment shall constitute for each applicable class or craft of employees. In computing such amounts for any individual protected employee, the Secretary shall deduct from such amounts the full amount of any unemployment compensation received by the protected employee.

Guideline  
rules,  
consultation.

(2) If an eligible protected employee is offered reasonably comparable employment and such employee does not accept such employment, then such employee's monthly assistance payment under this section shall be reduced to an amount which such employee would have been entitled to receive if such employee had accepted such employment. If the acceptance of such comparable employment would require relocation, such employee may elect not to relocate and, in lieu of all other benefits provided herein, to receive the monthly assistance payments to which he would be entitled if this paragraph were not in effect, except that the total number of such payments shall be the lesser of three or the number remaining pursuant to the maximum provided in subsection (e).

Relocation.

(c) ASSISTANCE FOR RELOCATION.—If an eligible protected employee relocates in order to obtain other employment, such employee shall, subject to such amounts as are provided in appropriation Acts, receive reasonable moving expenses (as determined by the Secretary) for himself and his immediate family. In addition, such employee shall, subject to such amounts as are provided in appropriation Acts, receive reimbursement payments for any loss resulting from selling his principal place of residence at a price below its fair market value (as determined by the Secretary) or any loss incurred in cancelling such employee's lease agreement or contract of purchase relating to his principal place of residence.

(d) DUTY TO HIRE PROTECTED EMPLOYEES.—(1) Each person who is a protected employee of an air carrier which is subject to regulation by the Civil Aeronautics Board who is furloughed or otherwise terminated by such an air carrier (other than for cause) prior to the last day of the 10-year period beginning on the date of enactment of this section shall have first right of hire, regardless of age, in his occupational specialty, by any other air carrier hiring additional employees which held a certificate issued under section 401 of the Federal Aviation Act of 1958 prior to such date of enactment. Each such air carrier hiring additional employees shall have a duty to hire such a person before they hire any other person, except that such air carrier may recall any of its own furloughed employees before hiring such a person. Any employee who is furloughed or otherwise terminated (other than for cause), and who is hired by another air carrier under the provisions of this subsection, shall retain his rights of seniority and right of recall with the air carrier that furloughed or terminated him.

49 USC 1371.

(2) The Secretary shall establish, maintain, and periodically publish a comprehensive list of jobs available with air carriers certificated under section 401 of the Federal Aviation Act of 1958. Such list shall include that information and detail, such as job descriptions and required skills, the Secretary deems relevant and necessary. In addition to publishing the list, the Secretary shall make every effort to

Job list,  
establishment  
and  
publication.

assist an eligible protected employee in finding other employment. Any individual receiving monthly assistance payments, moving expenses, or reimbursement payments under this section shall, as a condition to receiving such expenses or payments, cooperate fully with the Secretary in seeking other employment. In order to carry out his responsibilities under this subsection, the Secretary may require each such air carrier to file with the Secretary the reports, data, and other information necessary to fulfill his duties under this subsection.

Reports and  
data, filing.

Negotiations.

(3) In addition to making monthly assistance or reimbursement payments under this section, the Secretary shall encourage negotiations between air carriers and representatives of eligible protected employees with respect to rehiring practices and seniority.

(e) PERIOD OF MONTHLY ASSISTANCE PAYMENTS.—(1) Monthly assistance payments computed under subsection (b) for a protected employee who has been deprived of employment shall be made each month until the recipient obtains other employment, or until the end of the 72 months occurring immediately after the month such payments were first made to such recipient, whichever first occurs.

(2) Monthly assistance payments computed under subsection (b) for a protected employee who has been adversely affected relating to his compensation shall be paid for no longer than 72 months, so long as the total number of monthly assistance payments made under this section for any reason do not exceed 72.

(f) RULES AND REGULATIONS.—(1) The Secretary may issue, amend, and repeal such rules and regulations as may be necessary for the administration of this section.

(2) The rule containing the guidelines which is required to be promulgated pursuant to subsection (b) of this section and any other rules or regulations which the Secretary deems necessary to carry out this section shall be promulgated within six months after the date of enactment of this section.

(3) The Secretary shall not issue any rule or regulation as a final rule or regulation under this section until 30 legislative days after it has been submitted to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Public Works and Transportation of the House of Representatives. Any rule or regulation issued by the Secretary under this section as a final rule or regulation shall be submitted to the Congress and shall become effective 60 legislative days after the date of such submission, unless during that 60-day period either House adopts a resolution stating that that House disapproves such rules or regulations, except that such rules or regulations may become effective on the date, during such 60-day period, that a resolution has been adopted by both Houses stating that the Congress approves of them.

Submittal to  
Congress.

“Legislative  
day.”

(4) For purposes of this subsection, the term “legislative day” means a calendar day on which both Houses of Congress are in session.

(g) AIRLINE EMPLOYEES PROTECTIVE ACCOUNT.—All payments under this section shall be made by the Secretary from a separate account maintained in the Treasury of the United States to be known as the Airline Employees Protective Account. There are authorized to be appropriated to such account annually, beginning with the fiscal year ending September 30, 1979, such sums as are necessary to carry out the purposes of this section, including amounts necessary for the

Appropriation  
authorization.

administrative expenses of the Secretary related to carrying out the provisions of this section.

(h) **DEFINITIONS.**—For the purposes of this section—

(1) The term “protected employee” means a person who, on the date of enactment of this section, has been employed for at least 4 years by an air carrier holding a certificate issued under section 401 of the Federal Aviation Act of 1958. Such term shall not include any members of the board of directors or officers of a corporation.

(2) The term “qualifying dislocation” means a bankruptcy or major contraction of an air carrier holding a certificate under section 401 of the Federal Aviation Act of 1958, occurring during the first 10 complete calendar years occurring after the date of enactment of the Airline Deregulation Act of 1978, the major cause of which is the change in regulatory structure provided by the Airline Deregulation Act of 1978, as determined by the Civil Aeronautics Board.

49 USC 1371.

(3) The term “Secretary” means the Secretary of Labor.

(4) The term “major contraction” means a reduction by at least 7½ percent of the total number of full-time employees of an air carrier within a 12-month period. Any particular reduction of less than 7½ percent may be found by the Board to be part of a major contraction of an air carrier if the Board determines that other reductions are likely to occur such that within a 12-month period in which such particular reduction occurs the total reduction will exceed 7½ percent. In computing a 7½-percent reduction under this paragraph, the Board shall not include employees who are deprived of employment because of a strike or who are terminated for cause.

(i) **TRANSFER OF AUTHORITY OF THE BOARD.**—The authority of the Board under this section is transferred to the Department of Transportation on January 1, 1985.

(j) **TERMINATION.**—The provisions of this section shall terminate on the last day the Secretary is required to make a payment under this section.

#### LABOR DISPUTE

**SEC. 44.** Within ten days after the date of enactment of this section the President, pursuant to section 10 of the Railway Labor Act, shall create a board to investigate and report on the dispute between Wier Air Alaska, Incorporated, and the Air Line Pilots Association. Such board shall report its findings to the President within thirty days from the date of its creation.

Emergency board.  
45 USC 160.

#### COLLECTION OF FEES, CHARGES, AND PRICES

**SEC. 45.** Notwithstanding any other provisions of law, neither the Secretary of Transportation nor the Administrator of the Federal Aviation Administration shall collect any fee, charge, or price for any approval, test, authorization, certificate, permit, registration, conveyance, or rating relating to any aspect of aviation (1) which is in excess of the fee, charge, or price for such approval, test, authorization, certificate, permit, registration, conveyance, or rating which was in effect on January 1, 1973, or (2) which did not exist on January 1,

Review and approval by Congress.  
49 USC 1341 note.

1973, until all such fees, charges, and prices are reviewed and approved by Congress.

CONTINUITY FOR CERTAIN CERTIFICATES

49 USC 1301  
note.

Sec. 46. Any reference in any law, rule, regulation, or document of the United States to a supplemental air carrier or supplemental air transportation shall be deemed to be a reference to a charter air carrier or charter air transportation, respectively.

EXISTING DETERMINATIONS

49 USC 1301  
note.

Sec. 47. All orders, determinations, rules, regulations, permits, contracts, certificates, rates, and privileges which have been issued, made, or granted, or allowed to become effective, by the President, the Civil Aeronautics Board, or the Postmaster General, or any court of competent jurisdiction, under any provision of law repealed or amended by this Act, or in the exercise of duties, powers, or functions, which are vested in the Board, and which are in effect at the time this Act takes effect, shall continue in effect according to their terms until modified, terminated, superseded, set aside, or repealed by the Board, or by any court of competent jurisdiction, or by operation of law.

Approved October 24, 1978.

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LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 95-1211 and No. 95-1211 pt. 2, accompanying H.R. 12611 (Comm. on Public Works and Transportation) and No. 95-1779 (Comm. of Conference).

SENATE REPORT No. 95-631 (Comm. on Commerce, Science, and Transportation).  
CONGRESSIONAL RECORD, Vol. 124 (1978):

Apr. 19, considered and passed Senate.

Sept. 14, 21, H.R. 12611 considered and passed House; passage vacated and S. 2493, amended, passed in lieu.

Oct. 14, Senate agreed to conference report.

Oct. 15, House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 14, No. 43:  
Oct. 24, Presidential statement.

# TAB G

United States Code Annotated  
Title 15. Commerce and Trade  
Chapter 20. Regulation of Insurance (Refs & Annos)

15 U.S.C.A. § 1012

§ 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

Currentness

**(a) State regulation**

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

**(b) Federal regulation**

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [[15 U.S.C.A. 41 et seq.](#)], shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

**CREDIT(S)**

(Mar. 9, 1945, c. 20, § 2, 59 Stat. 34; July 25, 1947, c. 326, 61 Stat. 448.)

15 U.S.C.A. § 1012, 15 USCA § 1012

Current through P.L. 115-281. Also includes P.L. 115-283 to 115-333, and 115-335 to 115-338. Title 26 current through P.L. 115-442.

# TAB H

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY**

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows:

**GENERAL SECTION**

**A. The Policy**

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

**B. Who Is Insured**

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

**C. Workers Compensation Law**

Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item

3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

**D. State**

State means any state of the United States of America, and the District of Columbia.

**E. Locations**

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A. states unless you have other insurance or are self-insured for such workplaces.

**PART ONE - WORKERS COMPENSATION INSURANCE**

**A. How This Insurance Applies**

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

**B. We Will Pay**

We will pay promptly when due the benefits required of you by the workers compensation law.

**C. We Will Defend**

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

# TAB I

United States Code Annotated  
Title 49. Transportation (Refs & Annos)  
Subtitle VII. Aviation Programs  
Part A. Air Commerce and Safety (Refs & Annos)  
Subpart II. Economic Regulation (Refs & Annos)  
Chapter 417. Operations of Carriers (Refs & Annos)  
Subchapter I. Requirements

49 U.S.C.A. § 41713

§ 41713. Preemption of authority over prices, routes, and service

Effective: November 20, 1997

[Currentness](#)

**(a) Definition.**--In this section, “State” means a State, the District of Columbia, and a territory or possession of the United States.

**(b) Preemption.**--**(1)** Except as provided in this subsection, a State, political subdivision of a State, or political authority of at least 2 States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.

**(2)** Paragraphs (1) and (4) of this subsection do not apply to air transportation provided entirely in Alaska unless the transportation is air transportation (except charter air transportation) provided under a certificate issued under [section 41102](#) of this title.

**(3)** This subsection does not limit a State, political subdivision of a State, or political authority of at least 2 States that owns or operates an airport served by an air carrier holding a certificate issued by the Secretary of Transportation from carrying out its proprietary powers and rights.

**(4) Transportation by air carrier or carrier affiliated with a direct air carrier.**--

**(A) General rule.**--Except as provided in subparagraph (B), a State, political subdivision of a State, or political authority of 2 or more States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier or carrier affiliated with a direct air carrier through common controlling ownership when such carrier is transporting property by aircraft or by motor vehicle (whether or not such property has had or will have a prior or subsequent air movement).

**(B) Matters not covered.**--Subparagraph (A)--

**(i)** shall not restrict the safety regulatory authority of a State with respect to motor vehicles, the authority of a State to impose highway route controls or limitations based on the size or weight of the motor vehicle or the hazardous

nature of the cargo, or the authority of a State to regulate motor carriers with regard to minimum amounts of financial responsibility relating to insurance requirements and self-insurance authorization; and

(ii) does not apply to the transportation of household goods, as defined in [section 13102](#) of this title.

**(C) Applicability of paragraph (1).**--This paragraph shall not limit the applicability of paragraph (1).

#### CREDIT(S)

(Added [Pub.L. 103-272](#), § 1(e), July 5, 1994, 108 Stat. 1143; amended [Pub.L. 103-305, Title VI, § 601\(b\)\(1\), \(2\)\(A\)](#), Aug. 23, 1994, 108 Stat. 1605, 1606; [Pub.L. 105-102](#), § 2(23), Nov. 20, 1997, 111 Stat. 2205.)

49 U.S.C.A. § 41713, 49 USCA § 41713

Current through P.L. 115-281. Also includes P.L. 115-283 to 115-333, and 115-335 to 115-338. Title 26 current through P.L. 115-442.

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End of Document

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# TAB J

# DIVISION OF WORKERS' COMPENSATION



## BIENNIAL REPORT

## TO THE 86TH LEGISLATURE

Texas Department of Insurance, Division of Workers' Compensation  
7551 Metro Center Drive, Suite 100 | Austin, Texas 78744  
512-804-4000  
[www.TDI.texas.gov](http://www.TDI.texas.gov)

This document is available online at [www.tdi.texas.gov/reports/report5.html](http://www.tdi.texas.gov/reports/report5.html)



## TEXAS DEPARTMENT OF INSURANCE

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### Division of Workers' Compensation

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4001 | (800) 252-7031 | [TDI.texas.gov](http://TDI.texas.gov) | [@TexasTDI](https://twitter.com/TexasTDI)

December 1, 2018

The Honorable Greg Abbott, Governor  
The Honorable Dan Patrick, Lieutenant Governor  
The Honorable Joe Straus, Speaker of the House

Dear Governor Abbott, Lieutenant Governor Patrick, and Speaker Straus:

In accordance with Texas Labor Code §402.066, I am pleased to submit the Texas Department of Insurance, Division of Workers' Compensation's biennial report to the 86th Texas Legislature. This report provides an update on the Texas workers' compensation system and a brief description of two legislative recommendations that I believe will improve the state's ability to effectively and efficiently regulate the workers' compensation system.

I am available to discuss any of the issues contained in the report and to provide you with technical assistance. Please contact Jeff Nelson, Director of External Relations at 512-804-4405 if you have any questions or need any additional information.

Thank you for your consideration.

Sincerely,

A handwritten signature in blue ink, appearing to read "C. Brown".

Cassie Brown  
Commissioner of Workers' Compensation

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## TABLE OF CONTENTS

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Introduction .....	3
DWC Establishes New Fraud Unit .....	4
Declining Insurance Rates and Premiums Make Coverage Affordable for Texas Employers .....	4
Employer Participation Rates Declined While Employee Coverage Rates Remained Stable in 2018 .....	8
Compliance Efforts Regarding Reporting Requirements for Non-subscribing Employers .....	12
Medical Costs Continue to Decline and Are Lower Than in Other States .....	15
Pharmacy Closed Formulary Continues to Produce Results; DWC Addresses Compound Drugs .....	19
Access to Care Improves for Injured Employees .....	22
Return-to-Work Rates Improve for Injured Employees .....	26
Work-Related Injuries Continue to Decline in Texas .....	29
Medical Disputes Continue to Decline .....	31
Designated Doctor Opinions Continue to Be a Valuable Tool for Dispute Resolution.....	34
Requests for Indemnity Dispute Resolution Decline; Majority of Disputes Involve Designated Doctor Opinions .....	38
Concluding Remarks.....	42
DWC Legislative Recommendations .....	43
Emerging Issue: Firefighter and EMT Cancer Presumption .....	47

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## INTRODUCTION

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The Texas workers' compensation system has undergone an evolution over the past 10-15 years – from an expensive system for employers that did not provide positive outcomes for injured employees, to a system that many other states now look to replicate. Claim and system costs are down, primarily driven by fewer injuries and claims, more efficient and effective medical care, fewer disputes, and better return-to-work rates for injured employees. As a result, workers' compensation insurance rates have significantly declined, encouraging more Texas employers to provide workers' compensation coverage for their employees.

In recent years, Texas has been an innovator in workers' compensation policy by implementing proven approaches found in other health care delivery systems, like evidence-based medicine, a pharmacy formulary, electronic billing, and Medicare-based fee schedules to control costs. As the administrator and regulator of the Texas workers' compensation system, the Texas Department of Insurance, Division of Workers' Compensation (DWC) continues these efforts by implementing new rules that eliminate barriers for telemedicine and increase scrutiny for compound drugs to ensure that these drugs are safe and medically necessary for injured employees.

Looking ahead, DWC's focus for the next two years will be to continue leveraging technology and its existing resources to improve administrative efficiencies for both DWC and system stakeholders. DWC will continue working on ways to increase electronic transmission of information, streamline internal business processes, open lines of communication with system stakeholders, and eliminate outdated and unnecessary regulatory requirements. Like other state agencies, DWC has also begun focusing on ways to improve succession planning within core agency functions to build institutional knowledge among staff and identify future staffing needs to support the agency's statutory mission and vision.

Going into the upcoming 86th Legislative Session, while additional improvements can be made to the Texas workers' compensation system, the system as a whole is stable. This report presents system trends that allow DWC, policymakers, and system stakeholders to gauge the relative health of the Texas workers' compensation system and consider whether additional legislative changes are necessary.

## DWC ESTABLISHES NEW FRAUD UNIT

---

In May 2016, the commissioner of workers' compensation transferred workers' compensation fraud investigations back to DWC and established a dedicated workers' compensation fraud unit. This move permits DWC to pursue fraud actions criminally and allows DWC to use its existing resources to detect and prosecute fraud. Following this transfer, the 85th Legislature passed House Bill 2053, which clarified DWC's existing statutory authority to conduct fraud investigations, provided out-of-state subpoena authority, and authorized DWC's ability to provide litigation assistance to local prosecutors in workers' compensation fraud cases. Additionally, the 85th Legislature also authorized a budget rider

Since 2016, the DWC Fraud Unit and Prosecution teams have obtained 20 indictments, secured 17 convictions and obtained orders for restitution exceeding \$612,000 for workers' compensation system participants.

for DWC to establish a dedicated workers' compensation fraud prosecutor embedded in the Travis County District Attorney's Office.

Since 2016, the DWC Fraud Unit and Prosecution teams have been actively investigating fraud referrals, pursuing prosecutions, and to date, have obtained 20 indictments, secured 17 convictions, and obtained orders for restitution exceeding \$612,000 for workers' compensation

system participants. The DWC Fraud Unit also works collaboratively with federal agencies and insurance carrier special investigative units on more complex health care provider and premium fraud cases.

## DECLINING INSURANCE RATES AND PREMIUMS MAKE COVERAGE AFFORDABLE FOR TEXAS EMPLOYERS

---

Ensuring that Texas employers have access to affordable workers' compensation insurance is an important goal for the system. The Texas Department of Insurance (TDI) Property and Casualty Actuarial Office monitors insurance rate filings and reports workers' compensation insurance metrics as part of a biennial report to the Texas Legislature on the impact of the 2005 legislative reforms on

insurance rates and premiums.<sup>1</sup> In 2017, 293 insurance companies wrote workers' compensation insurance in Texas, and the total direct written premium (the growth of an insurance company's business during a given period) for the Texas workers' compensation insurance market was about \$2.31 billion.

The top 10 insurance company groups write about 77 percent of the market. The top writer, Texas Mutual Insurance Company, currently has 42 percent of the market and serves as the insurer of last resort.

Texas continues to have a healthy workers' compensation insurance market, which encourages competition from insurance companies and allows employers to purchase workers' compensation coverage at affordable rates.

Overall, the last decade has been very profitable for insurance companies writing workers' compensation insurance in Texas. In 2017, the projected accident year combined ratio for workers' compensation in Texas was 92.3 percent.<sup>2</sup> This means that for every dollar an insurance company collects, it will pay an estimated 92.3 cents to cover losses and expenses and keep the remainder as profit. Table 1 shows the projected workers' compensation loss ratio and the combined ratio for the last decade.

Since 2003, workers' compensation insurance rates have dropped nearly 64 percent.

Texas employers have also seen insurance rates decline significantly over time, making insurance coverage more affordable. Since 2003, workers' compensation insurance rates have dropped nearly 64 percent. While insurance rates have continued

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<sup>1</sup> For additional information on the effect of the reforms on the workers' compensation insurance market, see Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, *Setting the Standard: An Analysis of the Impact of the 2005 Legislative Reforms on the Texas Workers' Compensation System, 2018 Results*.

<sup>2</sup> Two important measures of the market's financial health are the loss ratio and the combined ratio. The loss ratio is the relationship between premium collected and the losses incurred (amounts already paid out plus those amounts set aside to cover future payments) by insurance companies. The combined ratio is similar, except it compares premiums collected with the losses and expenses incurred by the insurance company.

to decline in the last decade, these rates are just the start of the workers' compensation insurance pricing process. What employers pay—the insurance premium—reflects not only rates, but also mandated rating programs, such as experience ratings and premium discounts, as well as optional rating tools, such as schedule rating plans and negotiated experience modifiers. Insurance companies use these tools to calculate an employer's insurance premium.

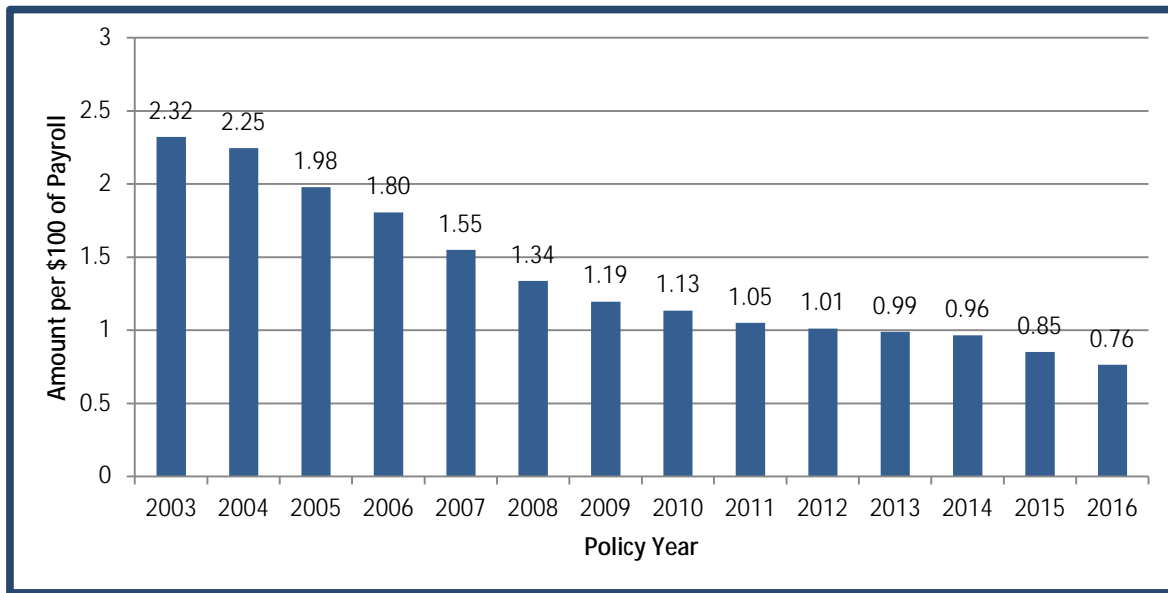
**Table 1: Projected Ultimate Calendar Year/Accident Year Loss and Combined Ratios**

Accident Year	Loss Ratio	Combined Ratio
2008	43.8%	84.5%
2009	41.7%	83.2%
2010	49.8%	93.2%
2011	50.3%	94.5%
2012	47.4%	89.6%
2013	44.2%	86.3%
2014	42.0%	83.4%
2015	38.2%	82.0%
2016	42.7%	91.8%
2017	<b>44.8%</b>	<b>92.3%</b>

Source: National Council on Compensation Insurance (NCCI) Workers' Compensation Financial Data Call (Valuation Year 2017) and TDI's compilation of the Insurance Expense Exhibit for Calendar Years Ending December 31, 2009-2017. Losses are developed to ultimate using the loss development factors from the NCCI Annual Statistical Bulletin, 2018 edition.

Figure 1 shows the average premium per \$100 of payroll for policy years 2003-2016, reflecting year-to-year changes in premiums charged. Beginning with policy year 2004, the average premium per \$100 of payroll began to decrease steadily as insurance companies lowered rates and increased the use of rating tools, such as schedule rating. As of policy year 2016, the average premium per \$100 of payroll decreased to 76 cents.

**Figure 1: Average Premium per \$100 of Payroll by Policy Year**



Source: The Texas Workers' Compensation Financial Data Call and data compiled by the National Council on Compensation Insurance, 2018.

## EMPLOYER PARTICIPATION RATES DECLINED WHILE EMPLOYEE COVERAGE RATES REMAINED STABLE IN 2018

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Texas is the only state where private-sector employers, regardless of employer size or industry, can make the choice to obtain workers' compensation coverage or become "non-subscribers" that do not participate in the workers' compensation system.<sup>3</sup> Employers who choose to not obtain workers' compensation coverage lose the protection of statutory limits on liability under the Labor Code, and may be sued for negligence by injured employees. Several states with mandatory workers' compensation laws provide statutory exemptions to allow small employers or employers from select industries to opt out of their workers' compensation systems.<sup>4</sup>

Non-subscription rates remain an important performance measure in the workers' compensation system because, in most cases, they show if employers believe the benefits of participating in the workers' compensation system outweigh the costs of obtaining the coverage. The percentage of Texas private-sector employers that were non-subscribers to the workers' compensation system decreased significantly from 2004 to 2016, from 38 percent to 22 percent. In 2018 employer non-subscription rates increased to 28 percent, which is still the second lowest percentage since 1993

About 28 percent of private, year-round employers do not have workers' compensation, and they employ about 18 percent of the private workforce in Texas.

(an estimated 105,608 private, year-round employers in 2018 were non-subscribers). This decrease since 2004 followed significant declines in workers' compensation insurance rates, including a rate

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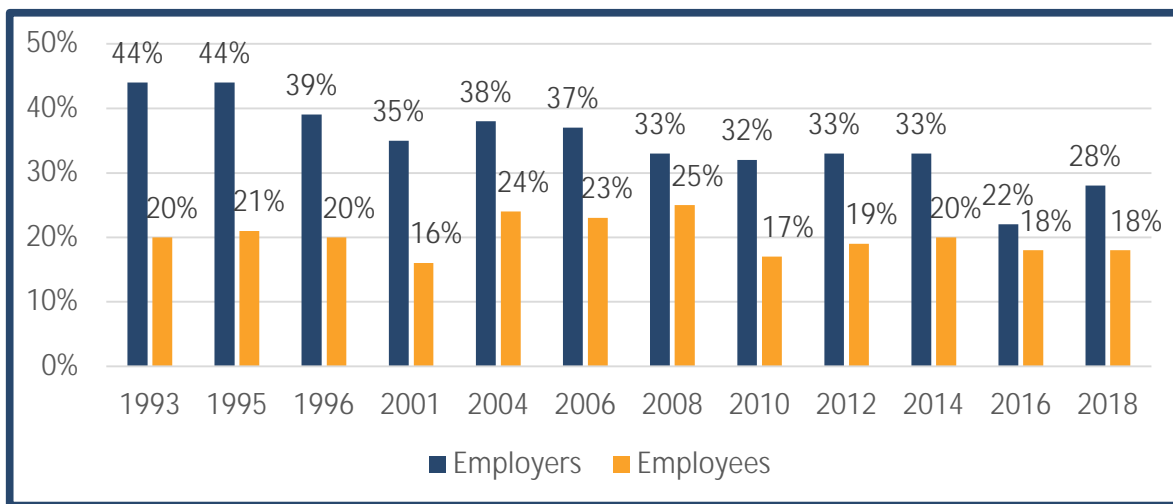
<sup>3</sup> In New Jersey, all employers must have coverage or be self-insured. Non-compliant employers are fined, and their injured employees receive income and medical benefits through the Uninsured Employers' Fund (UEF).

<sup>4</sup> Florida, for example, exempts non-construction employers with less than four employees and requires workers' compensation coverage for construction employers with one or more employees.

reduction of almost 20 percent in the last two years, making workers' compensation coverage more affordable for Texas employers.<sup>5</sup>

Although the percentage of private, year-round employers who were non-subscribers increased in 2018, the percentage of Texas employees who work for non-subscribers did not change from 2016. In 2018, an estimated 18 percent of private year-round Texas employees (representing about 1.8 million employees in 2018) worked for non-subscribing employers. Conversely, 82 percent of Texas private-sector employees (an estimated 8.4 million employees) were employed by the 72 percent of employers (an estimated 267,000 employers) that have workers' compensation coverage in Texas (see Figure 2).

**Figure 2: Percentage of Texas Employers That Are Non-subscribers and the Percentage of Texas Employees Employed by Non-subscribers, 1993-2018**



Source: Survey of Employer Participation in the Texas Workers' Compensation System, 1993 and 1995 estimates from the Texas Workers' Compensation Research Center and the Public Policy Research Institute (PPRI) at Texas A&M University; 1996 and 2001 estimates from the Research and Oversight Council on Workers' Compensation and PPRI; and 2004-2018 estimates from the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group and PPRI.

<sup>5</sup> For policies written on or after July 1, 2018, TDI approved a 13.7 percent reduction in Texas' loss costs by the National Council on Compensation Insurance, an industry ratemaking advisory organization. TDI also approved a 15 percent reduction in workers' compensation relativities for insurance companies that choose not to use loss costs in their rate calculations in 2018.

The percentage of Texas employers that have workers' compensation coverage has increased since the passage of the 2005 legislative reforms due primarily to lower insurance premiums and the increased availability of workers' compensation health care networks. Although most non-subscribing employers are small employers, about one out of every five large employers in Texas (employers with 500+ employees) does not participate in the workers' compensation system because they believe they can more effectively manage costs and ensure that their employees receive appropriate benefits as non-subscribers.

In recent years, non-subscriber rates have fluctuated, mainly for smaller employers. Overall, non-subscriber rates in 2018 declined from 2014 levels in all employer size categories, except employers with five to nine employees and large employers with 500+ employees (see Table 2). The industries with the highest non-subscription rates include health care, educational services, wholesale and retail trade, transportation, arts, entertainment, accommodation, and food services. Almost all industry sectors, except for manufacturing, have experienced reductions in employer non-subscription rates since 2014.

**TAB K**



Report to the Committee on  
Transportation and Infrastructure, House  
of Representatives

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July 2017

# AIR AMBULANCE

## Data Collection and Transparency Needed to Enhance DOT Oversight

# GAO Highlights

Highlights of [GAO-17-637](#), a report to the Committee on Transportation and Infrastructure, House of Representatives

## Why GAO Did This Study

Helicopter air ambulances reduce transport times for critically ill patients during life-threatening emergencies. Although patients typically have little to no choice over the service or provider given the often emergency nature of the transports, they might be billed for charges that have potentially devastating financial impacts. GAO was asked to review air ambulance pricing. This report examines: (1) the prices charged for air ambulance service, (2) the factors that affect prices, and (3) stakeholders' views on any actions the federal government could take to address air ambulance pricing. To answer these questions GAO analyzed 2 years of data (2010 and 2014—the latest available) on prices from CMS and a private health insurance database; interviewed 26 stakeholders, such as 8 air ambulance providers chosen to represent a range of types (hospital-affiliated and independent) and sizes; and interviewed DOT and CMS officials.

## What GAO Recommends

The Secretary of Transportation should: (1) communicate a method to receive air ambulance, including balance billing, complaints; (2) take steps to make complaint information publicly available; (3) assess available data and determine what information could assist in the evaluation of future complaints; and (4) consider air ambulance consumer disclosure requirements. DOT concurred with all but the third recommendation, stating additional information is not needed for such purposes. GAO stands by the recommendation, as discussed in this report. DOT and CMS also provided technical comments which were incorporated as appropriate.

View [GAO-17-637](#). For more information, contact Gerald L. Dillingham, Ph.D. at (202) 512-2834 or [DillinghamG@gao.gov](mailto:DillinghamG@gao.gov).

July 2017

## AIR AMBULANCE

### Data Collection and Transparency Needed to Enhance DOT Oversight

#### What GAO Found

Between 2010 and 2014, the median prices providers charged for helicopter air ambulance service approximately doubled, from around \$15,000 to about \$30,000 per transport, according to Medicare data from the Centers for Medicare & Medicaid Services (CMS) and private health insurance data. Air ambulance providers do not turn away patients based on their ability to pay and receive payments from many sources depending on the patient's coverage, often at rates lower than the price charged. For example, the Medicare median payment was \$6,502 per transport in 2014. Air ambulance providers might bill a privately-insured patient for the difference between the price charged and the insurance payment—a practice called balance billing—when the provider lacks an in-network contract with the insurer. However, due to a lack of information it is unclear to what extent patients are balance billed.

Factors such as a provider's proportion of transports provided by payer and competition may play a role in air ambulance prices charged, but data to assess these factors are not available. For example, selected providers reported that they adjust prices to receive sufficient revenue from private health insurance to account for certain lower-paid transports, such as those covered by Medicare. Price increases may also be tied to the industry's characteristics such as apparent market concentration—the three large independent providers reported operating 73 percent of the industry's total helicopters in 2016. An analysis of these factors is not possible due to a lack of currently available data such as the number of transports or the industry's composition by provider.

Selected stakeholders we spoke to proposed actions to address air ambulance pricing issues, including (1) raising Medicare rates, (2) allowing state-level regulation of air ambulance prices, and (3) improving data collection for the purposes of investigations and transparency regarding prices. Stakeholders expressed mixed views on the first two proposals but none disagreed with the third. Federal internal control standards state that management should identify and communicate information needed to achieve objectives and address risks. The Department of Transportation (DOT) has discretionary authority to investigate potentially unfair practices in air transportation or the sale of air transportation, but has not exercised this authority in regards to helicopter air ambulances. DOT officials said they need additional information about the air ambulance industry. For example, DOT officials note that they have received few air ambulance complaints since 2006 and report that consumers may not think of DOT as the place to complain. Although DOT recently modified its online form to include air ambulance complaints, it has not communicated how to file complaints. Without doing so and obtaining more industry data, DOT is missing important information needed to put complaints into the context of the overall industry that could affect its assessment on whether to pursue investigations. Further, stakeholders such as hospital staff could benefit from greater transparency as they currently have limited ability to make air ambulance decisions that serve both the financial interests and medical needs of the patient.

# Contents

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Letter		1
	Background	4
	Median Prices Charged Approximately Doubled from 2010 to 2014, and Extent of Balance Billing Is Unknown	11
	Various Factors May Play a Role in Air Ambulance Prices, but Data Are Limited	16
	Selected Stakeholders Proposed Actions Regarding Air Ambulance Pricing, Including Improved Data Collection and Transparency	21
	Conclusions	27
	Recommendations for Executive Action	28
	Agency Comments and Our Evaluation	28
<hr/>		
Appendix I	Objectives, Scope, and Methodology	30
<hr/>		
Appendix II	Comments from the Department of Transportation	33
<hr/>		
Appendix III	GAO Contact and Staff Acknowledgments	34
<hr/>		
Tables		
	Table 1: Potential for Provider's Balance Billing a Patient for a Portion of the Air Ambulance Price Charged by the Patient's Insurance Coverage	8
	Table 2: Views of 26 Selected Stakeholders Regarding Potential Federal Actions to Address Air Ambulance Prices	21
<hr/>		
Figures		
	Figure 1: Medical Crew from Helicopter Air Ambulance Transferring Patient	5
	Figure 2: Prices Charged by Providers for Helicopter Air Ambulance Service, 2010 and 2014	12
	Figure 3: Average Percentage of Selected Air Ambulance Providers' Transports and Average Payments by Key Payer in 2016	14

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## Abbreviations

ADA	Airline Deregulation Act of 1978
AMGH	Air Medical Group Holdings
CMS	Centers for Medicare & Medicaid Services
DOT	U.S. Department of Transportation
FAA	Federal Aviation Administration
HCCI	Health Care Cost Institute
OST	Office of the Secretary of Transportation

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July 27, 2017

The Honorable Bill Shuster  
Chairman  
The Honorable Peter A. DeFazio  
Ranking Member  
Committee on Transportation and Infrastructure  
House of Representatives

Air ambulances provide emergency services for critically ill patients, transporting them from the scene of an accident or from a medical facility to a hospital with a higher level of care. Air ambulance transportation is widely regarded as having a beneficial impact on improving the chances of survival and recovery for trauma victims and other critical patients, particularly in rural areas that lack readily accessible advanced-care facilities such as trauma or burn centers. Medical theory and practice hold that providing critically injured patients with medical intervention within the first hour after injury occurs—the so-called “golden hour”—can significantly improve chances for survival and recovery. Air ambulance helicopters, with their ability to land at accident sites and quickly shuttle to landing areas at or near hospitals, can reduce transport times for many patients.

Since enactment of the Airline Deregulation Act of 1978<sup>1</sup> (ADA), which deregulated the domestic air carrier industry, including air ambulance providers,<sup>2</sup> the number of air ambulance helicopters has grown steadily—from an estimated fewer than 100 helicopter air ambulances in the early 1980s to 1,045 in 2016. In the past few years, instances of “balance billing”—when patients with private health insurance are billed by providers for the difference between the air ambulance price charged and the insurer’s payment—have received attention in the news media. For

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<sup>1</sup>Pub. L. No. 95-504, 92 Stat. 1705 (1978).

<sup>2</sup>Court decisions subsequent to the passage of the ADA have determined that air ambulances are air carriers as defined in the ADA. See, e.g. *Schneberger v. Air Evac EMS, Inc.*, 2017 U.S. Dist. LEXIS 36701 (Explaining that courts have all but uniformly held that air ambulance providers are “air carriers” under the ADA); *EagleMed, LLC v. Wyoming*, 2016 U.S. Dist. LEXIS 185156; *Hiawatha Aviation of Rochester, Inc. v. Minnesota Dept. of Health*, 389 N.W. 2d 507 (Minn. 1986); *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721 (E.D. N.C., West Div. 2008). Air ambulances are considered to be on-demand air carriers, along with air taxis and helicopter tour operators.

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example, on December 4, 2015, a helicopter air ambulance patient was transported 66 miles from Tawas, Michigan, to Saginaw, Michigan. The provider, which was not contracted with the patient's insurance, charged \$35,000 for the transport. The patient's insurance paid \$6,320, leaving a balance of almost \$29,000 for which the patient was billed. The patient's family later unsuccessfully petitioned both the insurer and the state of Michigan<sup>3</sup> on this bill, noting that during the emergency, which involved a gunshot wound to the leg from a hunting accident, no alternative transport options were offered. Although most patients have little to no choice over the service or provider during air ambulance transports, they might be billed for charges that can have potentially devastating financial impacts. For example, media reports of balance billing have included a provider placing a lien on a patient's home as well as patients having their credit negatively affected or filing for bankruptcy.<sup>4</sup>

You asked us to review issues related to air ambulance operations and pricing. This report focuses on helicopter air ambulance service and examines (1) what is known about the prices charged for air ambulance service, (2) what is known about the factors that affect the prices charged for air ambulance service, and (3) what actions, if any, selected stakeholders believe the federal government should take regarding air ambulance pricing. To describe what is known about air ambulance prices charged, we analyzed data on air ambulance prices charged and payments for 2010 and 2014 from a Medicare claims database of the Department of Health & Human Services' Centers for Medicare & Medicaid Services (CMS) and from private health insurance information published by the Health Care Cost Institute (HCCI).<sup>5</sup> Although HCCI data includes approximately 40 million individuals with employer-sponsored insurance, the data may not be generalizable to the entire privately insured population. The years 2010 and 2014 were selected as they were the furthest back and most recent available from HCCI, could be compared across both data sets, and allowed us to analyze changes over time. We assessed the reliability of both data sets by reviewing related

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<sup>3</sup>Source: State of Michigan Department of Insurance and Financial Services. File No. 154884-001-SF. We do not have information on the extent to which the patient ultimately paid this balance. It is possible that the provider later discounted the bill.

<sup>4</sup>Peter Eavis, "Air Ambulances Offer a Lifeline, and Then a Sky-High Bill," *New York Times* (May 5, 2015) and Donna Rosato, "Air Ambulances: Taking Patients for a Ride," *Consumer Reports* (Apr. 6, 2017).

<sup>5</sup>See HCCI, *Data Brief: Non-Shoppable Health Care Services: Inpatient Hospitalizations* (February 2017), 9-10.

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documentation and comparing our results across both data sets and to published sources, among other things, and determined both sources were sufficiently reliable for the purposes of this report. To gauge the scope of the air ambulance industry, we analyzed available information from the Atlas & Database of Air Medical Services, 2010-2016. To describe what is known about factors affecting prices and selected stakeholders' views on actions the federal government could take to address pricing, we selected and interviewed 26 stakeholders, including representatives from: 8 air ambulance providers (3 large independent providers and 5 hospital-affiliated providers) chosen to represent a range of business model types (independent and hospital-affiliated), sizes, and known perspectives in the industry; 2 associations representing air ambulance providers; 6 groups familiar with air ambulance business and billing, such as industry analysts and consultants; 4 states active in assessing air ambulance costs and prices charged; 2 associations of state officials; 2 associations representing health insurers; and 2 groups involved with consumer policy or research. Although the views of these selected stakeholders are not generalizable to those of all air ambulance stakeholders, they represent a range of perspectives. We compared the U.S. Department of Transportation's (DOT) practices and procedures for aspects of its air ambulance oversight to federal internal control standards related to information collection and external communication.<sup>6</sup> We reviewed documentation—including pertinent laws, regulations, guidance, enforcement actions, and legal opinions—and interviewed officials from DOT and the Department of Health & Human Services' Centers for Medicare & Medicaid Services (CMS). For more detailed information on our scope and methodology, see appendix I.

We conducted this performance audit from July 2016 to July 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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<sup>6</sup>GAO, Standards for Internal Control in the Federal Government, [GAO-14-704G](#) (Washington, D.C.: September 2014).

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## Background

Air ambulance providers inhabit a unique position at the intersection of aviation and medical services. Providing air ambulance service is capital intensive and requires both aviation and medical investments (see fig. 1).<sup>7</sup> Air ambulances must be ready to deploy at a moment's notice in response to emergencies. Air ambulances are of two main types—rotor wing (helicopter) and fixed-wing aircraft. These two types of aircraft are generally used on different types of missions, with helicopters providing on-scene responses and shorter distance hospital-to-hospital transports and fixed-wing aircraft providing longer transports between airports. Because helicopter air ambulances make up approximately 74 percent of all air ambulances, this report focuses on helicopter air ambulance service.<sup>8</sup> This report also focuses on air ambulance providers that are direct air carriers.<sup>9</sup> Although most people may associate helicopter air ambulance with on-scene response to an accident such as a car accident, the majority of transports are interfacility, or from hospital to hospital. For example, Air Methods, the largest air ambulance provider, reported in June 2016 that of its total flights in the first quarter of 2016, approximately 70 percent were interfacility and 30 percent were on-scene response.

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<sup>7</sup>Aviation investments include the aircraft, aircraft maintenance, and a pilot, while medical investments include equipment and the medical crew—typically a nurse and paramedic.

<sup>8</sup>According to the Atlas & Database of Air Medical Services, there were 1,045 helicopter air ambulances and 360 fixed-wing air ambulances in 2016.

<sup>9</sup>In general, a "direct air carrier" is a person or other entity that provides or offers to provide air transportation and that has control over the operational functions involved in providing that transportation. See e.g., 14 C.F.R. § 110.2. See also, 14 C.F.R. § 197.3 (an air carrier or foreign air carrier directly engaged in the operation of an aircraft under a certificate, registration, order, or permit issued by DOT); 14 C.F.R. § 380.2 (a certificated, commuter, or foreign air carrier, or an air taxi operator registered under part 298, or a Canadian charter air taxi operator registered under part 294, that directly engages in the operation of aircraft under a certificate, authorization, permit, or exemption issued by DOT). DOT defines an "indirect air carrier" as a person or other entity, such as a flight brokerage company, that engages indirectly in air transportation operations and that uses the services of a direct air carrier.

Figure 1: Medical Crew from Helicopter Air Ambulance Transferring Patient



Source: REACH Air Medical, part of Air Medical Group Holdings. | GAO-17-637

Unlike other aviation services that are scheduled ahead of time, air ambulance transports are initiated only in response to time-sensitive medical-related events. In the case of on-scene response transports, first responders decide when air ambulance service is needed, while hospital staff make decisions regarding when to initiate interfacility transports. Because air ambulance providers transport critically sick or injured patients facing time-sensitive emergencies, patients typically have little to no ability to make cost-saving decisions, such as selecting a provider that participates in the patient's insurance or electing to be transported by ground ambulance. On the other hand, air ambulance providers respond to emergencies without regard for a patient's ability to pay and provide the same service regardless of the amount the provider will ultimately be compensated for the transport.

Air ambulance providers fall under three main types of business models, which vary on which entity makes business decisions, including setting

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prices and determining in-network agreements with private insurance. These business models are:<sup>10</sup>

- Hospital-affiliated<sup>11</sup>—may be a department of a hospital or owned by a consortium of hospitals, is typically non-profit, makes business decisions, and provides the medical crew. These providers may operate their own aviation services or contract for the services, often from companies that operate their own air ambulance service as independent providers.
- Independent—a company, typically for-profit, that handles both medical and aviation aspects and makes business decisions.
- Hybrid—joint venture between a hospital and an independent provider where the hospital typically provides the medical crew but (unlike the hospital-affiliated model) does not make business decisions, although the hospital name may be branded on the helicopter. Instead, the independent provider makes business decisions such as setting prices.

In 2007, we reported that a few large providers dominated the air ambulance industry, and in 2010, we reported that the industry had shifted since 1999 from mostly hospital-affiliated providers toward independent providers.<sup>12</sup> These trends appear to have continued. For example, in 2015 three for-profit, independent providers together reported operating 692 helicopters, or about 66 percent of the total 1,045 helicopters in the industry that year. These three providers operate helicopters that span all three business model types across multiple states. As a result, some of these 692 helicopters may be under contract for aviation services to hospital-affiliated providers, in which case the

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<sup>10</sup>There is a fourth category of providers that are operated by government entities or the military. Such providers may serve other functions in addition to air ambulance, such as search and rescue or disaster assessment. For example, the Maryland State Police operates air ambulances that also serve these other functions. Since these providers are not dedicated air ambulance providers and may offer services at no charge to residents, we excluded them from this report.

<sup>11</sup>Hospital-affiliated providers are sometimes called hospital-based or traditional providers, and independent providers are sometimes called community-based providers. We use the terms hospital-affiliated and independent throughout this report.

<sup>12</sup>GAO, Aviation Safety: Improved Data Collection Needed for Effective Oversight of Air Ambulance Industry, [GAO-07-353](#) (Washington, D.C.: Feb. 21, 2007) and Air Ambulance: Effects of Industry Changes on Services Are Unclear, [GAO-10-907](#) (Washington, D.C.: Sept. 30, 2010).

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hospital pays the independent provider a fixed rate and sets the prices charged for the service rather than the independent provider.

Air ambulance providers, like other medical service providers, charge standard rates for all transports but receive payments from many sources, often at varying rates. Air ambulance providers charge patients based on a pre-established lift-off fee and per mile fee, regardless of medical services provided in route. Providers then receive payments from a mix of sources, depending on the transported patient's insurance coverage.<sup>13</sup> The amount paid by private health insurance also depends on whether the provider has a contract in place with the insurer. Key payers of air ambulance service charges include:

- Medicare—a federal program for people who are 65 or older and certain younger people with disabilities, regardless of income level.
- Medicaid—a joint federal and state program for some people with limited income and resources.
- Private health insurance companies—may have a contractual in-network agreement with an air ambulance provider for a payment rate negotiated ahead of time. Without such a contract, air ambulance providers are considered out of network, and the insurance company's policies set its payment rates.
- Self-pay—patients not covered by insurance.

Whether or not an air ambulance provider may bill a patient for amounts in excess of the amount covered by insurance, as well as any deductibles, coinsurance, or copayment—called balance billing—varies based on the patient's insurance coverage. Under Medicare rules, for example, air ambulance providers are not permitted to balance bill Medicare patients for ambulance services beyond deductibles and coinsurance requirements.<sup>14</sup> With respect to Medicaid, providers participating in a state's Medicaid program are required to accept Medicaid payment as payment in full and are prohibited from collecting

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<sup>13</sup>In health care, these are usually called billed charges but we refer to them as "prices charged" throughout this report.

<sup>14</sup>See, e.g., 42 C.F.R. § 414.610 providing, in pertinent part, that "[e]ffective with implementation of the ambulance fee schedule...all payments made for services are made only on an assignment-related basis. Ambulance suppliers must accept the Medicare allowed charge as payment in full and may not bill or collect from the beneficiary any amount other than the unmet Part B deductible and Part B coinsurance amounts."

any additional amounts from Medicaid patients, other than authorized cost sharing amounts.<sup>15</sup> Patients with private health insurance might only be balance billed when the insurer and provider lack an in-network agreement, while uninsured patients might be held responsible by the provider for the entire price charged (see table 1).

**Table 1: Potential for Provider’s Balance Billing a Patient for a Portion of the Air Ambulance Price Charged by the Patient’s Insurance Coverage**

Insurance coverage	Can the patient receive a balance bill?	
	Yes	No
Medicare (participating providers)		X
Medicaid (participating providers)		X
Private Insurance: In-network with air ambulance provider		X
Private Insurance: Out-of-network with air ambulance provider	X	
Self-pay (uninsured)	X	

Source: GAO | GAO-17-637

CMS sets rates and pays claims for Medicare. Medicare payments, including beneficiary co-payments, for helicopter air ambulance service totaled approximately \$460 million in 2014.<sup>16</sup> Although CMS typically sets Medicare payment rates by considering whether payments are adequate for a relatively efficient provider,<sup>17</sup> Medicare rates for air ambulance service were last updated in 2002 as part of a negotiated rulemaking<sup>18</sup> that involved public and industry stakeholders. Beginning with the negotiated rulemaking in 2002 through 2006, CMS phased in an air ambulance fee schedule as part of a series of Medicare reforms<sup>19</sup> that were enacted into law in 1997. The fee schedule redistributed payments

<sup>15</sup>See, 42 C.F.R. § 447.15.

<sup>16</sup> Medicare beneficiaries typically have a copayment of 20 percent of the Medicare-approved amount after the deductible is met.

<sup>17</sup>CMS typically does this by examining data such as access to care, providers’ access to capital, and provider costs to provide the service. See MedPAC, “Chapter 2: Assessing payment adequacy and updating payments in fee-for-service Medicare,” Report to the Congress: Medicare Payment Policy (March 2016).

<sup>18</sup>67 Fed. Reg. 9100 (Feb. 27, 2002).

<sup>19</sup>See, e.g., Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4531(b)(2), 111 Stat. 251, 450.

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among various types of ambulance services and effectively raised the payment amounts for air ambulance service. Medicare air ambulance payments include three components: a base payment, a separate payment for mileage to the nearest appropriate facility, and a geographic adjustment factor. In addition, there is a permanent add-on payment that includes a 50 percent increase to both the base and mileage rate for rural air ambulance transports. Since 2006, CMS has adjusted rates annually, primarily based on inflation.

Although the prices, routes, and services of the air ambulance industry are largely deregulated, DOT oversees certain aspects of the industry. As air carriers, air ambulance providers fall under the ADA, which was designed to promote “maximum reliance on competitive market forces” as the means to best further “efficiency, innovation, and low prices” as well as “variety [and] quality... of air transportation.”<sup>20</sup> The ADA also contains a provision that explicitly precludes state-level regulation of matters related to air carrier rates, routes, and services.<sup>21</sup> Beyond aviation safety, which DOT’s Federal Aviation Administration (FAA) oversees in a variety of ways, DOT oversees certain aspects of the industry. DOT’s involvement with the air ambulance industry falls within the Office of the Secretary of Transportation (OST).<sup>22</sup> For example, as an air carrier, an air ambulance provider must obtain economic authority from DOT before offering service.<sup>23</sup> In addition, OST’s Office of the General Counsel issues guidance and opinion letters regarding the ADA provision that precludes state level regulation of air ambulance prices, routes, and services.<sup>24</sup> Furthermore, the Office of the Assistant General Counsel for Aviation Enforcement and Proceedings (Enforcement Office), within OST’s Office

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<sup>20</sup>49 U.S.C. §§ 40101(a)(6), (a)(12) (previously codified at 49 U.S.C. App. §§ 1301(a)(4), 1302(a)(9)). See also *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 378 (1992) (citing 49 U.S.C. App. §§ 1301(a)(4), 1302(a)(9)).

<sup>21</sup>49 U.S.C. § 41713(b).

<sup>22</sup>This report does not discuss safety issues related to air ambulances but see [GAO-07-353](#) for our previous work in this area. Since then, in 2014, the Federal Aviation Administration enacted new safety requirements for air ambulance providers. See 79 Fed. Reg. 9932 (February 21, 2014) (codified at 14 C.F.R. Parts 91, 120, and 135).

<sup>23</sup>See 49 U.S.C. § 41101. According to DOT, although all air ambulance providers must have economic authority from DOT, most, if not all, hold it in the form of an air taxi registration pursuant to 14 C.F.R. Part 298, rather than in the form of a certificate of public convenience and necessity.

<sup>24</sup>See for example, DOT, *Guidelines for the Use and Availability of Helicopter Emergency Medical Transport*, April 2015.

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of the General Counsel, has discretionary authority to investigate whether an air carrier, including an air ambulance provider, has been or is engaged in an unfair method of competition or an unfair or deceptive practice in air transportation or the sale of air transportation.<sup>25</sup>

States are involved with air ambulances in several ways and some have taken action to bring awareness to air ambulance pricing. State emergency medical services offices are responsible for licensing medical services such as emergency medical technicians and ground and air ambulances. In addition, states have the authority to regulate the business of insurance and, as a part of this function, may review insurers' health insurance plans and premium rates.<sup>26</sup> Furthermore, each state administers and operates its Medicaid program, including setting payment rates, within broad federal requirements. States across the country have attempted to gather information or raise awareness regarding air ambulance pricing. For example, state governments have held hearings, including Maryland (2015) and Pennsylvania (2017); New Mexico recently completed a study, and Florida has convened a working group to examine air ambulance pricing issues.<sup>27</sup> Meanwhile Montana developed a public website that features "frequently asked questions" about air ambulance service and provides information on pricing and the extent of contracting with insurance by provider.<sup>28</sup>

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<sup>25</sup>See 49 U.S.C. § 41712(a).

<sup>26</sup>See 15 U.S.C. §§ 1011-1015.

<sup>27</sup>New Mexico Office of Superintendent of Insurance, Air Ambulance Memorial Study Report, HM78/SM62 (January 2017).

<sup>28</sup>See Commissioner of Securities & Insurance, Office of the Montana State Auditor, "Frequently Asked Questions," Air Ambulances: What You Need to Know, accessed June 2017, <http://csimt.gov/issues-reports/air-ambulance-what-you-need-to-know/>.

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Median Prices  
Charged  
Approximately  
Doubled from 2010 to  
2014, and Extent of  
Balance Billing Is  
Unknown

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Median Prices Charged by  
Air Ambulance Providers  
Increased 76 to 113  
Percent from 2010 to 2014

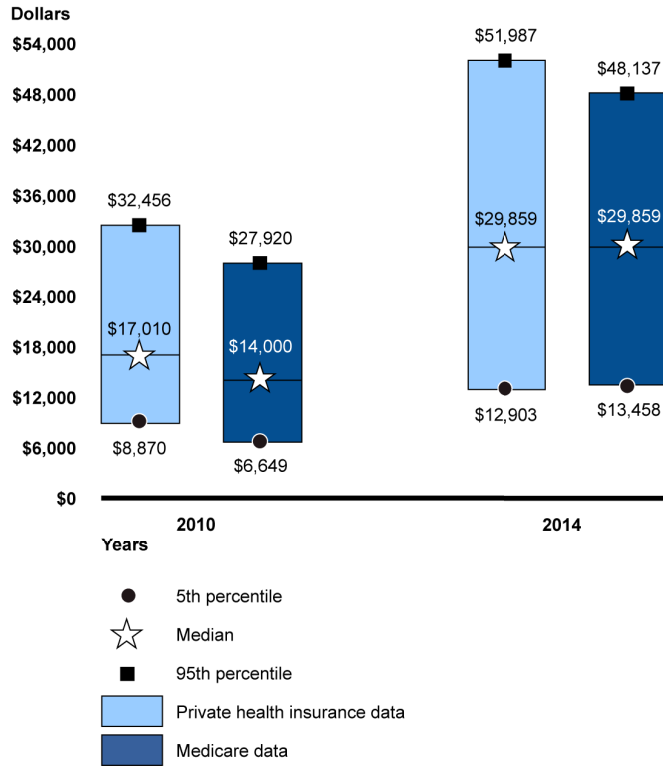
Between 2010 and 2014, the median prices charged for helicopter air ambulance service by providers approximately doubled. Specifically, according to Medicare data we analyzed, the median price providers charged for helicopter air ambulance transports increased 113 percent between 2010 and 2014. According to private health insurance data we analyzed, the median price charged increased 76 percent between 2010 and 2014 (see fig. 2). For comparison, the consumer price index increased by about 8.5 percent between 2010 and 2014.<sup>29</sup> In 2010, a transport priced at approximately \$30,000 was at the 95th percentile—meaning 95 percent of all prices charged were below that amount—according to both Medicare and private health insurance data. In 2014, a transport priced at the same amount—about \$30,000—was the median, or 50th percentile, of all prices charged according to these data, while a transport of approximately \$50,000 was at the 95th percentile. The increase in median prices charged from 2010 to 2014 may be part of a longer-term trend. For example, representatives from Air Methods, the largest air ambulance provider, reported that they have increased the average price charged per transport from \$13,000 in 2007 to \$49,800 in 2016—an increase of 283 percent over the past decade.<sup>30</sup>

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<sup>29</sup>Over this time period, the medical care services component of the CPI increased by about 13 percent and the airline fares component of the CPI increased by about 10.5 percent.

<sup>30</sup>These representatives noted the increase was needed to make up for an increased number of government-insured transports combined with a widening gap between government reimbursement and cost.

**Figure 2: Prices Charged by Providers for Helicopter Air Ambulance Service, 2010 and 2014**



Source: GAO analysis of data from the Health Care Cost Institute and the Centers for Medicare & Medicaid Services. | GAO-17-637

Notes: Private health insurance data from Health Care Cost Institute may not reflect amounts for all private sector payers.

Percentiles indicate the percentage of prices charged that are below the stated amount, for example, 95 percent of prices charged fall below the 95th percentile.

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Air Ambulance Providers  
Told Us Payments for  
Transports Are Often  
Lower than Prices  
Charged

Air ambulance transports, like many medical services, are generally paid at rates lower than the prices charged. Representatives from the eight providers we spoke to reported that transports of Medicare, Medicaid, and self-pay patients made up approximately 46 to 71 percent of their transports and were paid at particularly low rates. For example, according to Medicare data, median payments per transport increased only slightly between 2010 and 2014—from \$6,267 in 2010 to \$6,502 in 2014.<sup>31</sup> According to provider representatives, Medicaid and self-pay payments are often lower than Medicare payments.<sup>32</sup> See figure 3 for information on the proportion of provider transports and range of average payment amounts by key payer as reported to us by the eight selected providers in 2016. In contrast to the payment received, these selected providers reported average prices charged ranging from \$13,200 to \$49,800 per transport in 2016.

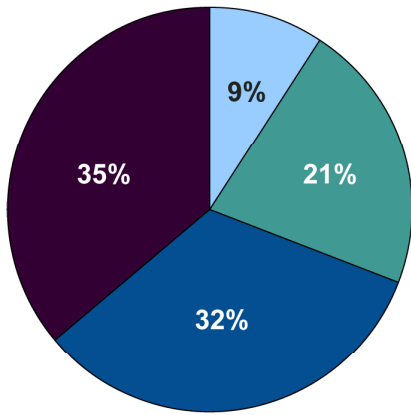
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<sup>31</sup>Like the median (or midpoint), the lower and upper ends of Medicare payments also increased only slightly between the years. In particular, the lower end payment was \$3,682 in 2010 and \$3,794 in 2014 and the upper end payment was \$8,277 in 2010 and \$8,727 in 2014. Lower end payments are at the 5<sup>th</sup> percentile and upper end payments are at the 95<sup>th</sup> percentile (percentiles indicate the percentage of payments that are below the stated amount; for example, 95 percent of payments fall below the 95<sup>th</sup> percentile).

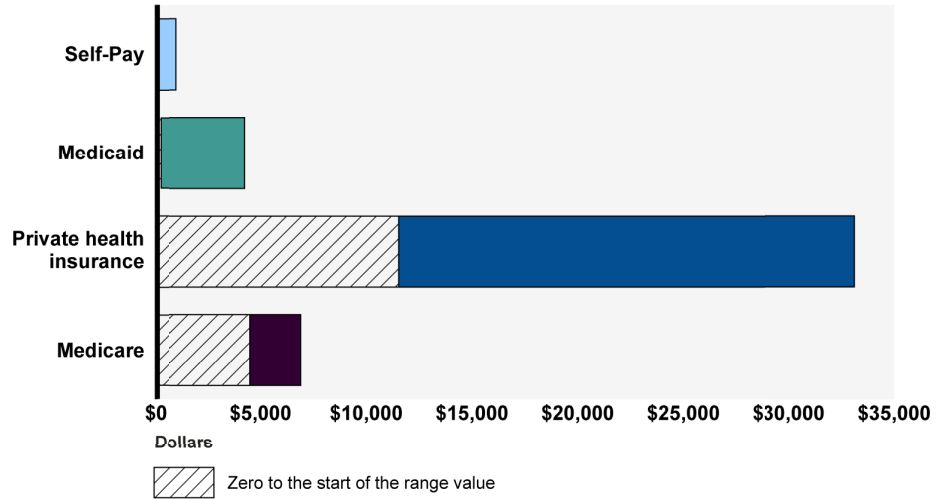
<sup>32</sup>We previously found that CMS does not have complete and reliable data needed to understand the payments states make to individual providers under Medicaid. See GAO, Medicaid: Key Issues Facing the Program, [GAO-15-677](#) (Washington, D.C.: July 30, 2015).

Figure 3: Average Percentage of Selected Air Ambulance Providers' Transports and Average Payments by Key Payer in 2016

Average percentage of total transports<sup>a</sup>



Range of average payments per transport



Source: GAO analysis of information from selected providers. | GAO-17-637

Note: The eight selected providers were chosen to represent a range of business model types, sizes, and known perspectives in the industry and included three large independent providers and five hospital-affiliated providers.

<sup>a</sup>Percentages do not add to 100 primarily because they are percentages averaged across the eight selected providers but also because some providers reported percentages that included a small "other" category, which we excluded, containing payers such as auto or military-sponsored insurance.

Representatives of the providers we spoke to said that privately insured patients account for the highest percentage of their revenue. For example, seven of the eight providers indicated that the majority of their transport revenue comes from privately insured patients, which accounted for a minority (22 to 41 percent) of their overall transports in 2016. According to an HCCI report, which includes data from three large, national private health insurers, the median payment these insurers paid per transport increased by 70 percent from 2010 to 2014, from about \$15,600 to \$26,600. As with prices charged, payment amounts increased in range between these years, with the upper end payment increasing

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more substantially than the lower end payment.<sup>33</sup> Although HCCI data includes approximately 40 million individuals with employer-sponsored insurance, according to an HCCI representative, patients in rural areas may be underrepresented in the data. Even though the HCCI data show private insurance payments increasing largely in parallel to price increases from 2010 to 2014, representatives from five of the eight providers we spoke to noted that payment rates from private insurance have been declining. Representatives from one provider noted that low payments from insurers occur in certain geographical areas, particularly rural areas, where one insurer covers a large proportion of the population and has a large share of the insurance market.

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Extent to Which Air Ambulance Providers Balance Bill Patients Is Unknown Due to Lack of Data

National data on balance billing and on the extent to which providers are contracted with insurers are unavailable. Due to a lack of such information, it is unclear to what extent patients with private health insurance are billed by providers for the difference between the air ambulance price charged and the insurer's payment (balance billing). Some states have attempted to collect balance billing information from patients. For example, Montana collected information on 39 instances of balance billing in 2015 and 2016. Likewise, Michigan reviewed 19 air ambulance balance billing cases between 2013 and 2016 which had an average balance bill of about \$31,000.<sup>34</sup>

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<sup>33</sup>In particular, the lower end payment increased from \$5,533 in 2010 to \$6,902 in 2014 while the upper end payment increased substantially—from \$29,359 in 2010 to \$49,999 in 2014. Lower end payments are at the 5<sup>th</sup> percentile and upper end payments are at the 95<sup>th</sup> percentile (percentiles indicate the percentage of payments that are below the stated amount; for example, 95 percent of payments fall below the 95<sup>th</sup> percentile).

<sup>34</sup>Neither Montana nor Michigan distinguished fixed wing from rotor wing transports in these data, so these numbers include fixed wing transports.

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## Various Factors May Play a Role in Air Ambulance Prices, but Data Are Limited

According to Selected Providers, Transport Costs and Volume, Payer Mix, and Competition May Play a Role in Increased Prices Charged

Selected providers reported that factors such as transport costs and volume, payer mix, and competition play a role in prices charged.

### Transport Costs and Volume

Costs to provide air ambulance transports are high and relatively fixed. For example, according to Air Methods representatives, to operate one air ambulance helicopter requires a staff of 13—4 pilots, 4 nurses, 4 paramedics, and a mechanic—in order to maintain around-the-clock readiness and be ready to deploy at any time. In contrast, helicopter tour operators would generally only need to employ a pilot for times when flights are arranged. Air ambulance providers' costs for air ambulance service are relatively fixed—meaning they do not increase significantly when they complete more transports. For example, personnel and the costs of helicopter ownership are the same regardless of how often the helicopter is used. Providers we spoke to noted that a small portion of their costs—such as fuel—are variable, meaning they increase with the number of transports completed. To be profitable, and thus be in business and provide service, providers must earn sufficient revenues to cover their costs, including their fixed costs. To increase revenue, a provider must increase its number of transports and/or its prices charged. When a provider has a lower transport volume, then that provider must earn higher prices on average across transports in order to be profitable. Representatives from the eight selected providers we spoke to reported average costs per transport, given current transport volumes, of \$6,000 to \$13,000 in 2016.

Representatives from the providers we spoke to agreed that average transport volume per helicopter has decreased but offered different perspectives on this change. According to the Atlas & Database of Air Medical Services, from 2010 to 2014, the number of air medical

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helicopters nationwide increased by more than 10 percent, from 900 to 1,020. Meanwhile, over the same time period, Medicare and HCCI data do not show a proportionate increase in the number of transports per Medicare or private health insurance beneficiary. Specifically, from 2010 to 2014, the number of air ambulance transports per 1,000 patients was flat for Medicare and decreased slightly among privately insured patients represented in the HCCI data.<sup>35</sup> Representatives from three providers stated that there is an issue with overcapacity or oversaturation in the industry and that the helicopters being added to the industry are in areas with existing coverage and not serving additional demand, thereby reducing the average number of transports per helicopter rather than increasing access to patients previously not covered by the service. On the other hand, representatives from four other providers told us that the decrease in transports per helicopter is due to helicopters increasingly being located in rural areas where there is greater need, but less population density, leading to fewer transports per helicopter. As noted earlier, air ambulance providers are dispatched only in response to time-sensitive medical events so have limited control over transport volume once providing service to an area.

#### Payer Mix

Providers we spoke to said their mix of payers also affects prices charged. As noted earlier, providers reported that the majority of their revenue comes from private insurance. In order to increase this revenue from private insurance, providers must increase their prices charged. Representatives from six of the eight providers we spoke to said that they adjust prices charged to receive sufficient revenue from private health insurance to account for lower-reimbursed transports. Providers have limited ability to control the payer mix—the proportion of transports reimbursed by, for example, Medicare or private health insurance—as they do not turn away patients based on insurance coverage. Representatives from three providers report that the payer mix has shifted over time from private insurance to Medicare as the population ages. For example, one large independent provider reported a 13 percent shift in transport mix from private insurance to Medicare over a 10 year period, while a hospital-affiliated provider reported that since 2013, the percentage of its transports covered by Medicare has increased from 30 to 35 percent, while the percentage of privately insured patients has decreased from 39 to 33 percent. Price increases do not proportionately

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<sup>35</sup>Specifically, the number of transports per 1,000 Medicare patients was 1.8 in both 2010 and 2014. The number of transports per 1,000 privately insured patients decreased from 0.30 in 2010 to 0.26 in 2014, according to HCCI data.

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result in higher revenues when the majority of transports are paid at lower fixed reimbursement levels. For example, representatives from one provider explained that to increase revenue 3 percent, they have to increase prices charged by 15 percent.

## Competition

The overall competitive environment of the air ambulance industry may also play a role in air ambulance prices. As noted previously, patients do not have control over decisions allocating the use of emergency air ambulance service, such as the choice of air versus ground service or between providers. As a result, patients cannot avoid out-of-network air ambulance providers. In such an environment, providers may not lose transport volume as a result of raising prices or being out-of-network with private health insurance. Consequently, air ambulance providers are not subject to the price competition that typically occurs in competitive markets, where if prices are too high, consumers will find alternatives such as a lower-priced service or provider. Furthermore, the ADA preempts state-level regulation of prices, routes, and services of air carriers, including air ambulance providers. DOT's guidance notes that once DOT has granted economic authority to an air ambulance provider, "the competitive marketplace, rather than state regulations" controls the provider's prices, routes, and services.

Based on the eight selected providers we spoke to, the large independent providers may have higher prices and be less likely to contract with insurers than hospital-affiliated providers. Representatives from the three large independent providers we spoke to reported average prices charged per transport of over \$40,000 in 2016, while representatives from the five hospital-affiliated providers reported average prices that ranged from about \$13,000 to about \$31,000. In addition, representatives from the three large independent providers we spoke to noted they generally do not have contracts with insurers, which, as noted earlier, leaves patients vulnerable to balance billing. For example, representatives from one large independent provider noted that they have contracts in place with fewer than 10 of the approximately 1,000 private insurance payers they work with per year—in other words, around one percent. A representative from a large independent provider noted that being out of network with insurance is advantageous to the provider because a patient receiving a balance bill will ask for a higher payment from the insurance company, which often results in higher payment to the air ambulance provider than having a pre-negotiated payment rate with the insurer. On the other hand, a representative from a small hospital-affiliated provider told us that as a non-profit, they feel obligated to contract with the largest

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insurer in their service area, in part because one of the hospitals the provider is affiliated with contracts with the insurer.

The nature of competition in the air ambulance industry may also be affected by the proportion of air ambulance helicopters operated by the three large independent providers, which is growing and may indicate increasing market concentration. Specifically, the three large independent providers reported operating 692 air ambulance helicopters in 2015 and 763 in 2016—an increase from about 66 to 73 percent of all helicopters in the industry.<sup>36</sup> This growth may be due to mergers and acquisitions. For example, in January 2016, Air Methods acquired Tri-State Care Flight, which had a fleet of 22 helicopters. In April 2017, the second largest air ambulance provider, Air Medical Group Holdings (AMGH) announced that it had agreed to acquire Air Medical Resource Group, adding 62 bases across 15 states to its business. In addition, the three large independent air ambulance providers are for-profit and increasingly owned by private equity firms. For example, the largest provider in the industry, Air Methods, a publicly traded company, announced in March 2017 that it had entered into an agreement to be acquired by a private equity firm for a total transaction value of approximately \$2.5 billion. Meanwhile AMGH is also held by a private equity firm and was purchased in 2015 for a reported \$2 billion.<sup>37</sup> The presence of private equity in the air ambulance industry indicates that investors see profit opportunities in the industry.

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### Lack of Data Limits Assessment of Factors Affecting Prices

Despite the above indications of factors that affect prices, an in-depth analysis of these factors is not possible due to lack of the following types of data.

- Costs to provide service: Data on providers' costs to provide service is not readily available. The Department of Health & Human Services has reported there is no national comprehensive database of ambulance service costs available.<sup>38</sup> Additionally, although the

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<sup>36</sup>This percentage was calculated using the total number of air medical helicopters reported by the Atlas & Database of Air Medical Services, which was 1,045 in 2015 and 1,045 in 2016.

<sup>37</sup>The third large independent provider—PHI Air Medical, L.L.C—is a wholly owned subsidiary of PHI, Inc., a publicly traded company.

<sup>38</sup>Department of Health and Human Services, Evaluations of Hospitals' Ambulance Data on Medicare Cost Reports and Feasibility of Obtaining Cost Data from All Ambulance Providers and Suppliers, (Washington, DC: September 2015).

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Centers for Medicare & Medicaid Services (CMS) has cost data for a portion of ambulance providers—those owned by hospitals—CMS found that these data had limitations, such as not distinguishing between air and ground ambulance transports.<sup>39</sup> Recently, a study on the costs to provide air ambulance service was prepared by Xcenda, a health care consulting firm, on behalf of the Association of Air Medical Services, an association of air ambulance providers, but this study has limitations.<sup>40</sup> The study notes its findings represent 51 percent of all air ambulance bases nationwide and therefore may not be generalizable to the whole industry. Representatives from four hospital-affiliated providers we spoke to noted they had declined to participate due to concerns over the study's independence and data security. Furthermore, according to Xcenda representatives, the study was designed to assess the adequacy of Medicare's air ambulance payment rates, which may give respondents an incentive to report high costs to justify higher Medicare payments.

- Number of transports: As noted above, transport volume is a key factor in determining the total revenues earned and costs incurred to provide service. The FAA Modernization and Reform Act of 2012 required that the FAA collect certain specified operations data for the air ambulance industry, including the number of annual transports, and report this information to Congress by 2014 and annually thereafter.<sup>41</sup> In May 2017, FAA provided its first submission under the act to Congress. The submission contains a summary of data collected from helicopter air ambulance operators from April 1, 2015, to December 31, 2015.
- Provider information, including business model type and established prices charged: As noted above, the air ambulance industry may be increasingly concentrated, which could indicate a lack of competition in the industry such as relatively few providers setting prices for a large portion of the total market. However, industry-wide data are not available, such as prices charged by provider or providers' business model types (hospital-affiliated, independent, or hybrid). Industry information may become more difficult to obtain as private equity firms increasingly own air ambulance providers. For example, upon completion of the acquisition noted above, Air Methods—the largest

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<sup>39</sup>CMS has cost data for less than 10 percent of ground and air ambulance providers, but the percentage of air ambulance providers alone is not known.

<sup>40</sup>Xcenda, Air Medical Services Cost Study Report, (March 24, 2017).

<sup>41</sup>Pub. L. No. 112-95, § 306, 126 Stat. 11, 60 (2012).

provider in the industry—will no longer be required to submit periodic reports to the U.S. Securities and Exchange Commission as is required of publicly held corporations, thereby eliminating a key source of publicly available information on the industry. As a result of the lack of industry wide data, it is unknown how the approximately 73 percent of helicopters operated by the three large providers translates into market share. Likewise, it is difficult to assess the nature of competition in the industry or even determine relationships between providers, such as what entity sets pricing for a particular provider. As noted earlier, the helicopters operated by the large independent providers include those contracted to hospital-affiliated providers that set their own prices, as well as hybrid programs where the helicopter is branded as part of the hospital system, but where the independent provider sets the prices. For example, representatives from AMGH note that one of their subsidiaries—Air Evac Lifeteam—is not generally contracted with hospitals, but another AMGH subsidiary—Med-Trans—operates mostly hospital-affiliated bases. However, according to these representatives, AMGH handles its own pricing, billing, and collections across 97 percent of all of its bases.

**Selected Stakeholders Proposed Actions Regarding Air Ambulance Pricing, Including Improved Data Collection and Transparency**

The 26 stakeholders we interviewed identified three types of potential actions to address air ambulance pricing, as shown in table 2. Stakeholders expressed mixed views on two of these actions—modifying the ADA and raising Medicare rates. None disagreed with the third action of increased data collection for the purposes of investigations—such as unfair or deceptive practices—or increased transparency regarding prices.

**Table 2: Views of 26 Selected Stakeholders Regarding Potential Federal Actions to Address Air Ambulance Prices**

Potential action	Agree	Disagree	Did not specify
Congress modifies the Airline Deregulation Act as it pertains to the air ambulance industry to allow states to have more of an oversight role	13	8	5
Centers for Medicare & Medicaid Services raise Medicare rates across the board for air ambulance service	7	10	9
Department of Transportation increases data collection for investigations and/or increases pricing transparency	11	0	15

Source: GAO | GAO-17-637

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Note: This table summarizes the opinions of the stakeholders GAO interviewed when asked about the potential actions to address air ambulance pricing issues. The most frequently cited potential actions are presented. These stakeholders were selected to represent a range of perspectives but are not generalizable to all air ambulance stakeholders.

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## Stakeholders Expressed Mixed Views on Proposed Solutions of Modifying the ADA or Medicare Payment Rates

Half of the 26 stakeholders we interviewed supported modifying or reevaluating the ADA as it pertains to the air ambulance industry in order to allow states to have more of an oversight role.<sup>42</sup> Some stakeholders said that when the ADA was enacted in 1978, the air ambulance industry was in its infancy, and so the ADA was not formulated with the unique aspects of the air ambulance industry in mind. In addition, some stakeholders told us states are best suited to regulate air ambulance service, noting that states have an incentive to protect patients from large balance bills while also ensuring access to the service. Some states, such as North Dakota, have passed legislation designed to address air ambulance billing, legislation that has subsequently been struck down in court. In particular, in 2015, the North Dakota legislature passed a statute intended to protect patients from large balance bills. It required, among other things, that air ambulance providers submit documentation indicating that they are participating providers with health insurers in the state that cover a certain proportion of the state's population in order to be listed on a "primary call list" for dispatching.<sup>43</sup> The state statute also required that air ambulance providers make their fee schedules available to certain requesters, including potential patients, upon request. However, the state statute was challenged in federal district court and in March 2016, the U.S. District Court for the District of North Dakota struck it down as being preempted, ruling that the call list requirement was "precisely the type of state regulation Congress sought to prevent...in the ADA."<sup>44</sup> North Dakota officials said they would like to see the ADA modified so they could implement such legislation. Subsequent to the ruling, North Dakota enacted a new statute in 2017 which is designed to increase transparency regarding an air ambulance provider's health insurance network status in non-emergency situations.<sup>45</sup> North Dakota officials we

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<sup>42</sup>These 13 stakeholders included representatives from 2 air ambulance providers and 1 association representing such providers, 2 associations of state officials, 3 states, 3 groups familiar with air ambulance business and billing, 1 group involved with consumer policy or research, and 1 association representing insurers.

<sup>43</sup>H. B. 1255, 64<sup>th</sup> Leg. Assemb., Reg. Sess. (N.D. 2015).

<sup>44</sup>Valley Med Flight, Inc. vs. Dwelle, 171 F. Supp. 3d 930, 941 (D.N.D., 2016).

<sup>45</sup>S. B. 2231, 65<sup>th</sup> Leg. Assemb., Reg. Sess. (N.D. 2017).

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spoke to noted that the most recent legislation, which was signed by the governor in April 2017, will likely be challenged in court.

Eight stakeholders opposed modifying the ADA and seven instead suggested raising Medicare rates as an approach to addressing high air ambulance prices.<sup>46</sup> An air ambulance provider association noted that modifying the ADA could create a “patchwork” of regulations nationwide, disrupting the regulatory certainty the industry has been built upon. This association also noted that since air ambulance providers do not turn away patients based on their ability to pay, providers have limited options to cover their costs. Two stakeholders noted that increased Medicare rates would reduce the need for air ambulance providers to increase prices, thereby alleviating pressure on patients with private health insurance.

Although raising Medicare rates across the board for air ambulance service is being promoted by some stakeholders, particularly the large independent providers, 10 other stakeholders we spoke with disagreed with this approach as a solution to addressing air ambulance pricing issues. Raising air ambulance Medicare rates is being promoted through a national campaign sponsored by several providers and a key industry association which supports legislation to raise air ambulance Medicare rates.<sup>47</sup> Meanwhile, 10 stakeholders we spoke with—2 providers, 1 association representing providers, 4 groups familiar with air ambulance business and billing, 1 selected state, 1 association of state officials, and 1 insurance association—disagreed with raising Medicare rates as a way to address balance billing. Some of these stakeholders noted that increasing Medicare rates could incentivize further growth in the industry, which could reduce the average number of transports per helicopter, putting pressure on providers to increase prices charged—thereby exacerbating the problem. Further, industry growth may be an indication that Medicare rates are not too low. We have previously reported that when rates are set too low, access to appropriate care for patients

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<sup>46</sup>The eight stakeholders that opposed modifying the ADA included four providers, three groups familiar with air ambulance business and billing, and one association representing providers. The seven stakeholders supporting raising Medicare rates as a solution were four providers, two groups familiar with business and billing, and one association representing providers.

<sup>47</sup>Save Our Air Medical Resources, accessed June 2017, <http://www.soarcampaign.com>.

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covered by Medicare may be adversely affected.<sup>48</sup> However, the growth in the number of air ambulance helicopters indicates that providers are still deciding to provide service under existing Medicare rates.

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### Some Stakeholders Suggest Data Collection and Price Transparency Could Better Inform DOT and Stakeholder Actions

Five of the 26 stakeholders we spoke to—including three groups familiar with air ambulance business and billing and two providers—told us that DOT should collect information to better understand the air ambulance industry. In addition, the federal standards for internal control state that management should identify information needed to achieve objectives and address risks. Such risks in the air ambulance industry could include:

- Matters related to industry concentration: The ADA provides that in carrying out its economic regulation authorities, DOT should consider, among other things “avoiding unreasonable industry concentration,” when determining what is in the public interest and consistent with public convenience and necessity.<sup>49</sup> As noted earlier, three large air ambulance providers operate 73 percent of the total helicopters in the industry in 2016, although the extent to which this translates into market share is unknown.
- Unfair or deceptive practices: DOT could potentially use such information to investigate concerns or complaints of unfair or deceptive practices, which, as noted previously, DOT through its Enforcement Office has discretionary authority to investigate.<sup>50</sup>

An official from DOT’s Enforcement Office noted that DOT has not exercised its discretionary authority to investigate air ambulance providers.<sup>51</sup> DOT officials noted that DOT needs additional information about the overall industry and that there is a dearth of information about the industry generally. For example, the officials told us DOT has

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<sup>48</sup>GAO, High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others, [GAO-17-317](#) (Washington, D.C.: February 15, 2017), “Medicare Program” 520.

<sup>49</sup>See 49 U.S.C. § 40101(a)(10).

<sup>50</sup>See 49 U.S.C. § 41712(a).

<sup>51</sup>However, DOT has taken enforcement actions against indirect air ambulance providers for deceptive practices. For example, DOT’s Enforcement Office has issued consent orders against indirect air ambulance providers whose advertising contained statements that “reasonably could have led a consumer to conclude that the provider was a direct air ambulance provider.” As noted previously, this report is focused on direct air ambulance providers.

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received very few air ambulance complaints. In particular, the officials said they searched their database and found a small number of complaints since 2006. DOT officials noted they believe the small number of complaints may be due to consumers not thinking of DOT when encountering issues with air ambulance pricing, and instead filing complaints with other entities such as their health insurance or state department of insurance. As noted earlier, some states have collected such information—for example together Michigan and Montana collected 58 instances of balance billing since 2013. For the commercial airline industry, which is also subject to the ADA, DOT's Enforcement Office gives consumers multiple options for filing airline service complaints, including through an online form that allows users to select from an extensive drop-down menu of U.S. and foreign air carriers. In May 2017, DOT added "air ambulance (all)" as an option on the online complaint form, with a field to manually enter an air ambulance provider's name. However, the DOT website does not have online instructions on how to file air ambulance complaints. DOT's Enforcement Office has a website with information such as how to file a complaint (by phone, mail, or online), what types of complaints to file (those about service other than safety or security issues), and how DOT uses the submitted information. It is unclear how, if at all, such information applies to air ambulance complaints. For example, DOT officials noted they would like consumers to know the boundaries of DOT's jurisdiction regarding air ambulance service. Without communicating this and other aspects such as how to file an air ambulance complaint, DOT has limited ability to understand the industry including the nature of competition that could affect its decisions on whether to pursue investigations into potential unfair or deceptive practices.

Some selected stakeholders suggested increased price transparency as a solution to address air ambulance pricing issues. In particular, nine stakeholders we spoke to—two providers, two groups familiar with air ambulance business and billing, two insurance associations, two selected states, and one group involved with consumer policy or research—noted that price transparency could provide benefits to providers and the industry, patients, insurance companies and other payers, hospitals, and first responders. Furthermore, the federal standards for internal control state that management should externally communicate information needed to achieve objectives and address risks. According to a DOT official, DOT enforces disclosure requirements due to the ADA's focus on competitive market forces, which relies on consumers having accurate and timely information on which they can make decisions. For example, for commercial airlines, DOT's Enforcement Office compiles a monthly Air

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Travel Consumer Report that includes consumer complaints submitted to DOT and is made available to the general public so consumers and others can compare the complaint records of individual airlines. Such consumer disclosure requirements are intended to enable consumers to make informed decisions on tradeoffs when selecting flights, considering such factors as provider, service quality, and price. DOT officials noted that air ambulance providers have not yet been included in the Air Travel Consumer Report but may be included if a provider reaches a certain threshold such as five complaints received in a month. However, as mentioned above, air ambulance patients may be unaware that they can file complaints with DOT. Furthermore, DOT lacks industry information to group complaints together and to identify patterns, particularly for large nation-wide providers which, as mentioned previously, operate across many states and may set prices for hybrid programs where the helicopter may be branded with a hospital's name rather than the large provider's name. Without more industry information, DOT is unable to put any such complaints into the context of the overall industry, both for the purposes of potentially investigating unfair and deceptive practices and for accurately compiling complaints for public reporting.

Although DOT has required consumer disclosures for the commercial airline industry, it has not done so for the air ambulance industry, such as disclosing to patients the prices charged for services. For example, DOT has recently issued a final rule that, among other things, requires air carriers to disclose when flights involve any code-sharing<sup>52</sup> arrangements and a supplemental notice of proposed rulemaking regarding the disclosure of baggage fees wherever fare and schedule information is provided to consumers.<sup>53</sup> DOT officials note they have not made such requirements for the air ambulance industry due in part to the emergency nature of air ambulance transports. In particular, DOT officials questioned the value of consumer disclosure requirements for the air ambulance industry given that patients have little to no choice or ability to "shop." However, a representative from a group involved with consumer policy or research noted that it is important that the public understands the price variation that exists among air ambulance providers, along with any

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<sup>52</sup>Code sharing is a marketing arrangement in which an airline places its designator code on a flight operated by another airline and sells tickets for that flight.

<sup>53</sup>Transparency of Airline Ancillary Service Fees, 82 Fed. Reg. 7536 (Jan. 19, 2017). On March 14, 2017, DOT suspended the public comment period for the supplemental notice of proposed rulemaking to allow the new administration to review and consider the action. 82 Fed. Reg. 13572 (Mar. 14, 2017).

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potential limits of their insurance coverage. Furthermore, patients are not the only “consumers” of air ambulance service. Other stakeholders make decisions regarding air ambulance service such as insurance companies that pay for transports or hospitals and first responders that initiate transports. According to a representative from an association of insurers, transparency is the first step toward a rational approach to air ambulance costs—all stakeholders need to know such fundamental aspects as average prices charged, transport frequency, and the amount insurance and patients may pay. Without such information, stakeholders may not be able to make decisions that serve the patients’ best interest. For example, if hospital staff had information on the extent to which providers in the area were contracted with insurance, such staff may make more informed decisions in selecting providers that best serve the financial interests of the patient while still maintaining the same level of care.

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## Conclusions

The ADA largely deregulated the domestic air carrier industry, including the air ambulance industry, and was intended to promote reliance on competitive market forces in order to best further quality service at low prices, among other things. Despite growth in the number of helicopters offering air ambulance service in recent years, lower air ambulance prices have not materialized. In fact, air ambulance prices have increased—approximately doubling between 2010 and 2014—and large providers report average prices charged of over \$40,000 per transport in 2016. These increases pose risks to privately insured patients who may be held responsible by the provider for a portion of these charges (balance billing). Despite media reports of balance billing, DOT officials note they have received very few air ambulance complaints since 2006, possibly because consumers do not think of DOT as a place to file such complaints. DOT recently modified its online form to include air ambulance complaints, but the website does not have instructions on how to file such a complaint. Without taking such steps, DOT is missing potential information both for its understanding of the industry and for public disclosure to enable informed decision making. Furthermore, DOT lacks data needed to assess several key aspects of the industry, ranging from basic aspects—such as the composition of the industry by provider type, prices charged by provider, or number of overall air ambulance transports—to the more complex, such as the extent of contracting between providers and insurers or extent of balance billing to patients. However, information from the eight selected providers we interviewed indicate concerning trends about the nature of competition in the industry, such as increasing prices and growing concentration of the market among three large providers. Further, the increasing role of private equity in the

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industry could further exacerbate these trends while also reducing transparency. Without better information, DOT has limited ability to understand the industry including the nature of competition that could affect its decisions on whether to take investigative or enforcement actions. Likewise, without information on the industry and pricing, stakeholders such as hospital staff have limited ability to make air ambulance decisions, such as selecting a provider that best serves the patient's financial interests without compromising the medical benefits air ambulance transports provide.

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## Recommendations for Executive Action

To increase transparency and obtain information to better inform decisions on whether to investigate potentially unfair or deceptive practices in the air ambulance industry, we recommend the Secretary of Transportation take the following four actions:

- Communicate a method to receive air ambulance-related complaints, including those regarding balance billing, such as through a dedicated web page that contains instructions on how to submit air ambulance complaints and includes information on how DOT uses the complaints.
- Take steps, once complaints are collected, to make pertinent aggregated complaint information publicly available for stakeholders, such as the number of complaints received by provider, on a monthly basis.
- Assess available federal and industry data and determine what further information could assist in the evaluation of future complaints or concerns regarding unfair or deceptive practices.
- Consider consumer disclosure requirements for air ambulance providers, which could include information such as established prices charged, business model and entity that establishes prices, and extent of contracting with insurance.

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## Agency Comments and Our Evaluation

We provided a draft of this report to DOT and CMS for review and comment. CMS and DOT provided technical comments which we incorporated as appropriate. In written comments provided by DOT (see app. II), DOT agreed with three of our recommendations but did not concur with our recommendation that DOT assess available federal and industry data and determine what information could assist in the evaluation of future complaints or concerns regarding unfair or deceptive practices. DOT noted that its analysis of a given complaint is based on

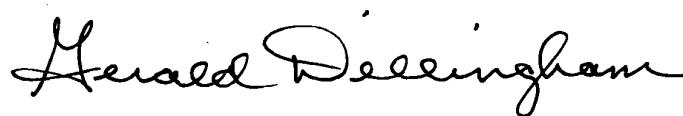
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the unique facts of each individual case, rather than on aggregate data. Therefore, DOT noted it does not believe an assessment of federal or industry data would yield information relevant to its determinations in future cases. We appreciate DOT's comments; however, we believe that this recommendation is justified. As we note in the report, the federal standards for internal control state that management should identify information needed to achieve objectives and address risks. DOT has discretionary authority to investigate air ambulance providers but to date has not done so. Although collecting consumer complaints will help DOT identify areas for further investigation, further information will help put complaints into the context of the larger industry. DOT is currently limited in its ability to conduct such an analysis for the air ambulance industry due to data limitations noted in our report, involving such basic elements as relationships between providers including what entity sets prices or the given market share or number of transports per provider. As we noted in the report there has been some efforts to collect data, such as FAA's efforts regarding the number of transports. These and other data are potential sources for DOT to better understand the helicopter air ambulance industry and evaluate whether consumer complaints indicate larger patterns of unfair and deceptive practices.

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We are sending copies of this report to the Secretary of the Department of Transportation, the CMS Administrator, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-2834 or [dillinghamg@gao.gov](mailto:dillinghamg@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.



Gerald L. Dillingham, Ph.D.  
Director, Physical Infrastructure Issues

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# Appendix I: Objectives, Scope, and Methodology

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For this work we examined: (1) what is known about the prices charged for air ambulance service, (2) what is known about the factors that affect the prices charged for air ambulance service, and (3) what actions, if any, selected stakeholders believe the federal government should take regarding air ambulance pricing.

To describe what is known about air ambulance prices charged, we analyzed and assessed the reliability of information on prices charged and amount paid for 2010 and 2014 from Medicare claims data from the Centers for Medicare & Medicaid Services (CMS) and private health insurance data published by the Health Care Cost Institute (HCCI).<sup>1</sup> Although HCCI data include data from three large national insurers and includes approximately 40 million individuals with employer-sponsored insurance, the data may not be generalizable to all privately insured patients. The years 2010 and 2014 were selected as they were the furthest back year and the most recently available year from HCCI, could be compared across both data sets, and allowed us to analyze changes over time. The price charged is the amount providers claim for two components: (1) the transport and (2) each mile that the patient is transported. The amount paid is the total amount allowed by the payer (i.e., the private insurer or Medicare); the patient may be responsible for a portion of that total amount through copays or deductibles. For Medicare, we excluded claims without both the transport and mileage components and excluded claims with mileage amounts over the 99th percentile.

To address possible issues with payments by secondary payers, we excluded claims where the payment amount was less than 10 percent of the price charged and claims that otherwise may have indicated a secondary payer. We also excluded any claims for transports with multiple patients or where an ambulance was dispatched but the patient died before being transported; these types of transports are paid at reduced rates. We also excluded outliers based on the price charged—excluding claims that were above the 99th percentile or below the 1st percentile for that year. We assessed the reliability of the data published by HCCI by reviewing related documentation, discussing the methods used with knowledgeable officials, performing data reliability checks, and comparing the findings to published information, and we determined the data were sufficiently reliable for the purposes of this report. Medicare

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<sup>1</sup>See HCCI, Data Brief: Non-Shoppable Health Care Services: Inpatient Hospitalizations, February 2017, 9-10.

claims data, which are used by the Medicare programs as a record of payments made to health care providers, are closely monitored by both CMS and contractors that process, review, and pay claims for Medicare-covered services. The data are subject to various internal controls, including checks and edits performed by the contractors before claims are submitted to CMS for payment approval. Although we did not review these internal controls, we assessed the reliability of Medicare claims and enrollment data by reviewing related CMS documentation and comparing our results to published sources. We determined that the Medicare claims and enrollment data were sufficiently reliable for the purposes of our reporting objectives.

To describe what is known about the factors affecting prices of air ambulance service, we also reviewed previous reports on costs to provide air ambulance service from the Department of Health and Human Services and by the contractor Xcenda as commissioned by the Association of Air Medical Services. We also interviewed eight selected providers and other stakeholders (as described below) regarding the prices and costs associated with their service and factors affecting prices and costs. To gauge the scope of the air ambulance industry, we also analyzed available information from the Atlas & Database of Air Medical Services, 2010—2016. Lastly, we interviewed representatives from associations regarding the costs to operate air ambulance and other on-demand air services, including the Helicopter Association International, Air and Surface Transport Nurses Association, National EMS Pilots Association, and International Association of Flight & Critical Care Paramedics. These associations were selected because they represent major cost categories of providing air ambulance service, including the aircraft and personnel.

To describe potential federal government actions to address the issue of air ambulance pricing, we reviewed documentation and interviewed officials from U.S. Department of Transportation (DOT) and the Department of Health & Human Services' Centers for Medicare & Medicaid Services (CMS). In particular, we reviewed CMS documents regarding Medicare payments for air ambulance transports. We reviewed pertinent laws and regulations and DOT guidance, enforcement actions, and legal opinions, such as the Airline Deregulation Act of 1978, the federal statute (49 U.S.C. § 41712(a)) providing DOT the authority to investigate unfair and deceptive practices, and whether there were any actions by the DOT Enforcement Office regarding air ambulances. We also reviewed DOT Enforcement Office activities regarding commercial airlines, such as the consumer complaint online web form. We compared

DOT's practices and procedures for aspects of its air ambulance oversight to federal internal control standards related to information collection and external communication.<sup>2</sup>

To describe stakeholder views on potential federal actions, we selected and interviewed 26 stakeholders, including representatives from: 8 air ambulance providers (3 large independent providers and 5 hospital-affiliated providers); 2 associations representing air ambulance providers; 6 groups familiar with air ambulance business and billing such as analysts and consultants; 4 states active in assessing air ambulance costs and prices charged; 2 associations of state officials; 2 associations representing health insurers; and 2 groups involved with consumer policy or research. Although these selected stakeholders are not generalizable to all air ambulance stakeholders, they were selected to represent a range of perspectives. For example, we selected air ambulance providers that represented a range in business model types (hospital-affiliated and independent), a range of sizes (large and small), a range of known perspectives in the industry, and geographical dispersion. There are no available data on all providers that indicates industry-wide characteristics, such as a breakdown of providers by business model type or size. In addition, we selected stakeholders familiar with air ambulance business billing to capture expertise on business aspects and also a range of views; and selected states active in assessing air ambulance prices and costs and, to the extent possible, geographically dispersed.

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<sup>2</sup>GAO, Standards for Internal Control in the Federal Government, [GAO-14-704G](#) (Washington, D.C.: September 2014).

# Appendix II: Comments from the Department of Transportation



U.S. Department  
of Transportation  
**Office of the Secretary  
of Transportation**

Assistant Secretary  
for Administration

1200 New Jersey Avenue, SE  
Washington, DC 20590

Gerald L. Dillingham  
Director, Physical Infrastructure Issues  
U.S. Government Accountability Office (GAO)  
441 G Street NW  
Washington, DC 20548

JUL 13 2017

Dear Mr. Dillingham:

The U.S. Department of Transportation is committed to ensuring that air carriers, including air ambulances, treat consumers fairly. The Department uses its authority to prohibit unfair or deceptive practices in air transportation and the sale of air transportation to monitor and sanction such practices by air carriers. While the Department has authority under the unfair or deceptive practices statute for actions by air ambulances related to air transportation, States are responsible for regulating medical services and the business of insurance. Further, the Department has limited authority and States are preempted under the Airline Deregulation Act from regulating the prices, routes, or services of an air carrier in interstate air transportation. The result is that the Department may regulate only certain aspects of an air ambulance's air transport operations, such as ensuring that its operations or any claims it makes to the public about those operations are not unfair or deceptive, and the Federal Aviation Administration regulates to ensure safety of those operations. However, the Department cannot regulate where the air ambulance offers its services, what it charges for them, or from whom it seeks payment.

Upon review of GAO's draft report, we concur with recommendations 1, 2, and 4. Although we will provide a detailed response to each of these recommendations within 60 days of the final report's issuance, we note that the nature of the information collected pursuant to implementing recommendations 1 and 2 may have a limited effect on price discipline in the air ambulance industry or change the way air ambulances bill for their services, since prices and billing practices may be related substantially to the cost of medical services and insurance reimbursement rates, as well as high capital costs of running an air carrier. With respect to recommendation 4, we are concerned about the effectiveness of disclosure requirements for a significant portion of the industry's operations, specifically transporting patients in emergencies.

We do not concur with recommendation 3. In determining whether a complaint alleges conduct that could constitute an unfair or deceptive practice, our analysis is fundamentally based on the unique facts of each individual case, rather than on aggregate data. Accordingly, we do not believe an assessment of federal or industry data would yield information relevant to our determinations in future cases.

We appreciate the opportunity to respond to the GAO draft report. Please contact Madeline M. Chulumovich, *Audit Relations and Program Improvement*, at (202) 366-6512 with any questions or if you would like to obtain additional details.

Sincerely,

Bryan Slater  
Assistant Secretary for Administration

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Gerald L. Dillingham, Ph.D., (202) 512-2834 or [dillinghamg@gao.gov](mailto:dillinghamg@gao.gov)

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## Staff Acknowledgements

In addition to the contact named above, Heather MacLeod (Assistant Director), Melissa Bodeau, Stephen Brown, Christine Brudevold, James Cosgrove, Danielle Ellingston, Geoff Hamilton, Corissa Kiyon-Fukumoto, Emily Larson, Malika Rice, Oliver Richard, Daniel Ries, Daniela Rudstein, and Monica Savoy made key contributions to this report.

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