What States Can Do to Address Out-of-Network Air Ambulance Bills

Erin C. Fuse Brown, Alex McDonald, and Ngan T. Nguyen

There are few legal protections for consumers facing out-of-network air ambulance bills, a type of surprise medical bill posing a serious and growing financial threat to patients. The vast majority of air ambulance transports are out-of-network, and prices are high and continuing to rise.

Journalists have repeatedly reported on shocking out-of-network air ambulance bills in order to shine a light on the problem. Out-of-network air ambulance bills often affect consumers in rural areas who may need air transport to reach remote hospitals in an emergency, but they also can affect patients who need rapid transport between hospital facilities. For example, Sonna Anderson, a 60-year-old judge from Bismark, North Dakota, was thrown from her horse, hit her head, and broke her ribs. Despite protesting that she did not believe that an air ambulance was necessary, she was flown by Valley Med Flight to a hospital and charged $54,727. Valley Med Flight was not in-network with Anderson's health plan, which paid $13,698, leaving Anderson with a $41,029 bill.[1] In another case, Jessica and Adam Tosh's infant son, James, was transported by Life Flight from the neonatal intensive care unit at a hospital in Oregon to Seattle Children's Hospital, where James ultimately passed away. Life Flight, who was out-of-network with the Tosh's insurance plan, billed the Tosh family $49,000, and though insurance paid $15,000, the Tosh family personally owed the $34,000 balance.[2]

These reports illustrate the financial toll of out-of-network air ambulance bills on patients and their families and highlight several common features of the problem. Consumers receive out-of-network air ambulance bills when they receive transport services from an air ambulance provider who is not a participating provider in the consumer's insurance network. When the service is delivered out-of-network, the air ambulance provider bills its full, undiscounted charges to the consumer's insurer. Consumers' health insurance plans are not obligated to pay the out-of-network air ambulance charges. Even if the patient's health plan pays a part of the bill, an out-of-network air ambulance provider may bill the patient for the difference between the provider's full charges and the amount paid by the patient's insurance plan, an industry practice known as "balance billing." Consumers are then left with a substantial surprise medical bill. Although

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The Journal of Law, Medicine & Ethics, 48 (2020): 462-473. © 2020 The Author(s)
DOI: 10.1177/1073110520958869

Medicare and Medicaid prohibit balance billing, there is no such protection for privately insured patients.

If a privately insured patient needs air ambulance transport, the risk of receiving an out-of-network ride and a surprise medical bill is exceedingly high. In a study of 2014 to 2017 Health Care Cost Institute data covering three national insurers, Fuse Brown and colleagues estimated that among privately insured patients, more than three-quarters of air ambulance transports are out-of-network with the patient's health insurance plan.[3] And 40% of privately insured air ambulance patients are at risk of receiving a balance bill for an out-of-network transport, averaging nearly $20,000.[4] The reason the prevalence of potential balance bills was not higher (40% of air ambulance transports resulted in potential balance bills despite that 77% that were out-of-network) was that insurance companies paid the out-of-network air ambulance providers' full, billed charges 48% of the time to protect their members from balance bills. Another study by Chhabra and colleagues based on data from one large national insurer estimated that 73% of privately insured patients who received air ambulance services between 2013 and 2017 were at risk of receiving a surprise medical bill, and the median surprise bill was $21,698.[5]

Sonna Anderson, a 60-year-old judge from Bismark, North Dakota, was thrown from her horse, hit her head, and broke her ribs. Despite protesting that she did not believe that an air ambulance was necessary, she was flown by Valley Med Flight to a hospital and charged $54,727. Valley Med Flight was not in-network with Anderson's health plan, which paid $13,698, leaving Anderson with a $41,029 bill.

Out-of-network air ambulance bills are driven by the same market failures as surprise medical bills in other emergency contexts. In an emergency, the patient is unable to negotiate the price, choose an in-network provider, or decline the service. Patients are unable to avoid out-of-network providers in an emergency, and insurers are unable to steer patients to in-network air ambulance providers. The ability to balance bill also distorts the prices paid by private payers.[6] It means that there is no incentive for air ambulance companies to go in-network because they will not gain more service volume and will be paid more if they stay out-of-network. But even when they do contract with payers, the in-network rates are quite high with only modest discounts off of charges.[7] The private market has not disciplined prices or supply of air ambulance services, and it has failed to create incentives for air ambulance providers to contract with health plans, which would protect patients from surprise balance billing.

The air ambulance industry has been changing as well. Despite relatively low demand, there has been a marked increase in the number of air ambulance bases in recent years.[8] As a result, the cost-per-transport has increased, leading to commercial price increases. Median air ambulance charges doubled from about $15,000 to $30,000 between 2010 and 2014.[9] Average total charges and in-network amounts paid to air ambulance providers by health insurers grew 28% between 2014 and 2017.[10] Air ambulance charges, which are the provider's list prices before any discounts, were 4.1 to 9.5 times greater than Medicare rates in 2016, and the ratio of charges to Medicare rates increased 46 to 61% between 2012 and 2016.[11]

These market failures require regulatory intervention, and it follows that states should serve that regulatory function with their traditional experience and authority over health insurance and health care providers. Several states have tried to serve that regulatory function. To an even greater extent than ordinary surprise medical bills, however, states are unable to shield consumers from out-of-network air ambulance bills. Unlike other health care providers, air ambulances are considered air carriers under the federal Airline Deregulation Act (ADA), and courts have declared that most state efforts to protect consumers from out-of-network air ambulance bills are preempted by ADA. The Act's sweeping preemption clause makes a federal solution particularly necessary for surprise medical bills from air ambulances. Yet, congressional inaction and political stalemates force states to push forward with novel approaches to protect their residents from surprise out-of-network air ambulance bills.

Having separately written about what federal policies Congress should pursue,[12] this article focuses on what *states* can do to protect consumers from out-of-network air ambulance bills. Part I canvasses the existing legal landscape for state efforts to regulate air ambulance billing practices. Part II then explores possible state approaches to curtail out-of-network air

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ambulance bills that could evade federal preemption by the ADA. These state solutions include: (1) establishing a public or nonprofit air ambulance service to compete with for-profit providers; (2) prohibiting balance billing by air ambulance providers; and (3) regulating dubious air ambulance membership programs.

I. Existing Legal Landscape for Air Ambulance Regulation

A. Federal Law

In 1978, Congress passed the Airline Deregulation Act (ADA),[13] which contained an express preemption clause that prohibits the enactment and enforcement of any state regulation "related to a price, route, or service of an air carrier."[14] The ADA successfully deregulated the airline industry for competitive market forces to improve efficiency and innovation and reduce commercial fares. The ADA has been interpreted to apply also to air ambulance carriers.[15] To be sure, not everyone agrees with this interpretation.[16] However, in the case of air ambulances, the demand for services are inelastic and not subject to typical market forces because, as previously illustrated, patients cannot predict their need for the services nor make choices about which air ambulance services or providers to use in an emergency situation. Thus, air ambulance providers have been able to increase prices with little market constraint or transparency.[17]

Since the ADA's enactment, states have repeatedly, through creative legislation, attempted to quell the exorbitant charges their citizens face. Yet, courts generally find such state regulations preempted under the ADA's broad and sweeping "related to" language. The Supreme Court stated that "relating to" can be interpreted to mean having a "connection with," "reference to," or an "effect [that] is only indirect" on airline rates, routes, or services, or even having consistent statutory purpose as the ADA.[18] The preemption clause "displace[s] all state laws that fall within its sphere…"[19]

A narrow, potential statutory save that states could invoke is through reverse preemption under the McCarran-Ferguson Act. McCarran-Ferguson's enactment assured states' "preeminent role" in regulating the insurance industry.[20] If a state law's purpose is to regulate the "business of insurance,"[21] non-insurance-related federal statutes, like the ADA, would not preempt the state law.[22] However, the McCarran-Ferguson Act has rarely provided a winning outcome for the states.[23]

Furthermore, even if state insurance regulation is a potential avenue to protect consumers from out-of-network air ambulance bills under the McCarran-Ferguson Act, the reach of such regulation is limited by another federal statute, the Employee Retirement Income Security Act of 1974 (ERISA). ERISA itself broadly preempts state laws that relate to employee benefit plans.[24] In particular, states are unable to apply their insurance regulations to *self-funded* employee health benefit plans under ERISA, which cover more than 60% of those with employer-based coverage.[25] The practical consequence is that if a state law regulates health insurance plans (e.g., by requiring them to hold members harmless from out-of-network balance bills), these requirements will not apply to self-funded, employer-based plans or their members.

With this framework of legal obstacles in mind, the next section discusses how states have sought to address out-of-network air ambulance bills with innovative legislation and how the McCarran Ferguson Act has seldom saved such legislation from ADA preemption.

B. Attempted State Regulation of Air Ambulances

States have attempted to regulate air ambulance billing through a variety of different legislative strategies, such as licensing, workers compensation plan fees schedules, and even preferred call lists. However, these legislative attempts have largely been unsuccessful after air ambulance companies have challenged them in court as preempted by the ADA.

1. LICENSING AND CERTIFICATE OF NEED LAWS

Early attempts of state air ambulance regulation came under state licensure and certificate of need (CON) laws. In the context of other health care services, CON laws are state regulatory procedures to approve the establishment or expansion of a facility or service line in a particular area. CON laws aim to limit the creation of duplicative services and excess health care facilities, which could lead to overutilization of services and increased costs. State licensure and CON requirements can provide the state with regulatory oversight of the entry and supply of health care services, including the ability to condition approval on the provider's compliance with state requirements. Thus, early air ambulance regulation required air ambulances to apply for state approval before providing in-state services.[26] Federal and state courts ruled that the ADA preempted state laws requiring air ambulances to obtain a license or CON.[27] The courts reasoned that the purpose of a licensing or CON law directly contravened the "pro-competition" goal underlying the ADA because it placed gate-keeping control in state hands,[28] impacting air ambulance provider rates, routes, and services.[29]

Some state attorneys general across the country capitulated and recommended revision of their state CON laws to exclude air ambulance services.[30] The

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U.S. Department of Transportation issued guidelines on CON laws in 2015, taking the position that application of state CON laws to air ambulances would be invalid because they "could be used by a state to erect economic barriers to entry into the air ambulance market."[31]

2. WORKERS' COMPENSATION FEE SCHEDULES

Several states opted to establish reimbursement caps for air ambulance services through state-regulated workers' compensation fee schedules.[32] Workers' compensation plans rarely have contracts with providers, so statutory or regulatory fee schedules establish the payment rates to protect the plan and injured worker from having to pay full charges. State workers' compensation regulations require providers to accept the fee schedule rates as payment in full, which precludes balance billing or seeking full charges from the plan. The air ambulance industry challenged these laws under the ADA preemption framework. Courts have held that application of state workers' compensation fee schedules to air ambulances regulate air carriers' prices and are thus preempted. A recent split among courts has emerged, however, opening the possibility that not all workers' compensation rules will be preempted by the ADA.

Texas's workers' compensation laws limit payment to out-of-network providers, including air ambulances, to "fair and reasonable" reimbursements rates and prohibit patient balance billing.[33] Two different challenges in state and federal courts have yielded different results. In T*exas Mutual Ins. Co. v. PHI Air Medical*, the Texas Supreme Court, which is not bound by lower federal court rulings, held that the ADA does not preempt application of the state's workers compensation reimbursement limits to air ambulance providers.[34] The court reasoned that, under Texas compensation laws, out-of-network air ambulance reimbursement was not set by any mandated fee schedule, but was limited to a "fair and reasonable" amount[35] The court found that the fair and reasonable reimbursement standard was not preempted by the ADA without evidence such a standard imposed "a significant effect on its prices" as the air ambulance provider had claimed.[36]

However, in parallel federal court litigation, the federal district court in *Air Evac EMS, Inc. v. Sullivan* held that the reimbursement structure effectively restricted the amount paid to air ambulances, so the court found the reimbursement structure preempted by the ADA as an impermissible regulation of prices.[37] Additionally, the court found that McCarran-Ferguson's reverse preemption was inapplicable because, although constraining third-party costs "may well inure benefit of policyholders," the constraints are not regulating the business of insurance since a third-party's rate is "not an integral part of the policy relationship between the insurer and the insured."[38] An appeal of the Air Evac case is pending before the Fifth Circuit, which is not bound by the Texas Supreme Court's interpretation of the ADA. If the Fifth Circuit affirms, two different interpretations would persist between the federal and state courts in Texas.

Fee schedules mandated by workers' compensation laws in California,[39] Kansas,[40] North Dakota,[41] West Virginia,[42] and Wyoming[43] have been preempted by the ADA. Nevertheless, some fee-setting workers' compensation laws remain on the books with no challenge from the air ambulance industry, including in Alabama,[44] Alaska,[45] Georgia,[46] Hawaii,[47] Illinois,[48] Tennessee,[49] and the District of Columbia.[50] It is unclear whether these laws are being enforced and why they have not been challenged.

3. PREFERRED CALL LISTS

One of the more innovative approaches taken, albeit unsuccessfully, was North Dakota's 2015 House Bill 1255, which created primary and secondary lists of emergency air ambulance service operators.[51] To be on the preferred list, the statute required air ambulances to enroll as participating providers with in-state health insurers "who collectively [held] at least seventy-five percent of the health insurance coverage in the state . . ."[52] The department of health would distribute these lists to emergency medical service (EMS) personnel and dispatch, who upon receiving an air ambulance request would call a primary list provider before calling a secondary list provider.[53]

Additionally, North Dakota's law included a transparency provision, requiring air ambulance providers to provide their fee schedules upon request from the department of health or potential patient.[54] The department would compile and distribute this information to assist patients in making informed decisions.[55]

The federal district court in *Valley Med Flight v. Dwelle* found that North Dakota's air ambulance preferred call list and transparency provisions were preempted by the ADA due to its "clear and significant" impact on air ambulance prices and services.[56] The court reasoned that requiring providers to contract with certain insurers who held majority market share effectively "place[d] primary bargaining power for [] pricing" into the hands of the insurer, particularly Blue Cross Blue Shield, the state's largest insurer with more than fifty percent of the market.[57] The court went on to observe that providers not on the primary list would receive fewer calls on the secondary list, impacting their prices and services, and the mandated disclosure

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of air ambulance's fee schedules upon request affected their prices and bargaining power in the market.[58] The court concluded the law was "clearly preempted" by the ADA.[59]

4. PROHIBITION ON PATIENT BALANCE BILLING

North Dakota, along with Texas, New Mexico, and Montana, also tried prohibiting air ambulances from balance billing patients in specified emergency situations. Only New Mexico's and Montana's regulations remain intact.[60]

North Dakota passed Senate Bill 2231 in 2017,[61] requiring insurers to pay for out-of-network air ambulance transports at the average of the insurer's in-network rates for air ambulance providers in the state.[62] The statute provided that such payment would be deemed full and final payment by the covered person for the transport, the acceptance of which would eliminate the opportunity to balance bill the individual.[63] The court in *Guardian Flight, LLC v. Godfread* found this section preempted by the ADA because it sought to cap air ambulance prices at a "state-mandated rate [with] no balance billing permitted."[64]

Unlike North Dakota's law, New Mexico and Montana's laws did not prescribe a fee schedule or cap the amounts to resolve out-of-network air ambulance claims. Montana's law has not been challenged, so it is discussed in Part III below. New Mexico's law requires health plans to hold their enrollees harmless from the additional costs of receiving out-of-network emergency services.[65] When the Office of Superintendent of Insurance (OSI) opined in 2017 that these requirements prohibit balance billing by air ambulances, the air ambulance company PHI initiated a legal challenge. However, the federal district court dismissed the complaint in 2018 for lack of standing, noting that it was unclear whether PHI had failed to establish that OSI had caused its injury.[66] Even if the provider could not balance bill the patient, the court noted it was unclear whether the health plan was responsible for the provider's full charges or whether OSI could enforce the balance billing prohibition.[67] The New Mexico case leaves many unanswered questions about the enforceability and scope of the state's attempt to protect patients from out-of-network air ambulance bills. It also illustrates that a naked balance billing prohibition without a mechanism to determine out-of-network rates may provide some relief to individuals, but if the health plan simply ends up paying the full costs of out-of-network air ambulance transports, that result could increase premium costs for all plan members.

5. WYOMING'S MEDICAID WAIVER

In a novel approach to reduce out-of-network air ambulance bills, Wyoming sought to treat air ambulances like a public utility via a Medicaid Section 1115 waiver.[68] Under the waiver, Wyoming proposed to provide all air ambulance services in the state under its Medicaid program. The state would determine the needed coverage for the entire population, reduce the number of air ambulance bases, and strategically locate them to even out access.[69] A network of air ambulance providers would be formed through a competitive bidding process, and a central call center would dispatch transport requests to the network providers.[70] Network providers would be paid via periodic flat payments, rather than on a per-service basis. For privately insured patients, the state would recoup costs from insurance companies under its Medicaid "pay-and-chase" authority.[71] Patients' cost-sharing responsibilities would be capped at the lesser of two percent of the patient's income or $5,000.[72]

In January 2020, the Centers for Medicare and Medicaid Services (CMS) rejected Wyoming's air ambulance 1115 waiver application.[73] CMS said the waiver did not "align with the core objectives of Medicaid and of section 1115."[74] Also, using section 1115(a) to circumvent other federal statutes like the ADA was not an "intended use of [its] authority."[75] Although Wyoming's waiver application foundered, the model drew national attention and made a powerful policy argument in favor of allocating air ambulance services like a public utility, particularly given the pervasive market failures in the industry.[76] Yet it remains unclear whether a state could practically convert air ambulance services to a public utility model within the constraints of ADA preemption.

II. State Solutions for Out-Of-Network Air Ambulance Bills

Although ADA preemption has invalidated most state attempts to regulate the air ambulance industry, some state models survive. These state efforts fall into three categories: (a) the establishment of a public or nonprofit air ambulance service; (b) the prohibition of balance billing without an out-of-network payment benchmark or fee schedule; and (c) the regulation of air ambulance "membership plans." Though they have evaded challenge from the air ambulance industry, there are limits to the effectiveness of these state laws at controlling rising air ambulance prices and shielding consumers from out-of-network bills. Nevertheless, if a federal solution fails to pass, states may be interested in pursuing even limited measures to combat out-of-network air ambulance bills.

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A. Public or Nonprofit Air Ambulance Service

Establishing public or nonprofit air ambulance services may be a successful way for states to protect consumers from large out-of-network air ambulance bills. In Maryland, a public air ambulance service formed after a mid-1900's helicopter donation, and in Maine, a nonprofit air ambulance company is the sole provider in the second-most rural state in the nation.

1. MARYLAND'S PUBLIC AIR AMBULANCE SERVICE

One model is for the state or a political subdivision to operate a public air ambulance service via its emergency management system (EMS), police, or highway patrol. The Maryland State Police Aviation Command has been in operation since its founding in 1954 when it received its first helicopter donation.[77] The Aviation Command comprises one of four divisions of the Maryland State Police's Support Services Bureau and is funded by taxes on motor vehicle registrations — no user of the air ambulances services are billed for the costs.[78] The Aviation Command incorporates air ambulance services into its EMS and provides all of the state's air ambulance transports originating at a remote site, such as a vehicle crash, in the woods, or anywhere that does not involve transport from a health care facility. Maryland EMS maintains and dispatches an Aviation Command air ambulance directly to any remote-site air ambulance pickup.[79]

Despite the relative effectiveness of Maryland's public air ambulance service at protecting residents from exorbitant bills if their air transport originates at remote sites, the scope of the service does not cover air ambulance transport between health facilities, which typically accounts for nearly half of all air ambulance transports.[80] These inter-facility transports in Maryland are provided by private air ambulance carriers and suffer from the same pricing and billing problems as elsewhere.

The idiosyncratic nature of the creation of the Maryland Aviation Command — prompted by a 1954 helicopter donation to the police force — may explain why other states do not have similar operating models. Although Maryland's Aviation Command has grown organically and seemingly successfully, states with a crowded market of private air ambulance companies may not enjoy the same luxury.

Despite its unique history, a public air ambulance service like the Maryland Aviation Command could be a practical and legal state solution to preventing out of network air ambulance bills. Nothing in the ADA prevents a state from entering the market to provide air ambulance services directly. The operating terms adopted for the state's own public air ambulance service — funding, dispatch, fee schedules, billing practices, etc. — would not apply to any private air ambulance providers and thus would not constitute state regulation "related to a price, route, or service of an air carrier."[81] Allowing a public provider to enter the market and compete with private carriers may indirectly affect their prices, routes, or services. But the ADA's purpose was to promote competition, so a public carrier's competitive effect on other air ambulance providers in the market is not a state *regulation* of private air carriers and thus should not be preempted by the ADA.

2. MAINE — NONPROFIT, HOSPITAL-BASED AIR AMBULANCE SERVICE

LifeFlight of Maine, a nonprofit service jointly operated with two Maine healthcare systems, Northern Light Health and Central Maine Healthcare Corporation, is the sole licensed air ambulance provider in the state.[82] As the nation's second-most rural state by population density, Maine has a steady demand for remote transport services, and LifeFlight provides services to Maine residents with three rotary-wing air ambulances and one fixed-wing air ambulance.[83] LifeFlight's services are dispatched upon a physician's request when the patient needs transport between health facilities or a request by local EMS personnel when the patient needs transport from the accident scene or remote location.[84]

As a nonprofit organization jointly operated by two Maine healthcare systems, LifeFlight falls outside the reach of the ADA's preemption provision, which only applies to regulations by "a State, a political subdivision of a State, or a political authority of at least two States."[85] Maine's example offers another possibility for states to address the problem of out-of-network air ambulance billing: enlist the help of the state's large hospital systems. The nonprofit, hospital-based air ambulance model may be harder to replicate in a market more saturated by incumbent private air ambulance providers. Nonetheless, a hospital-based, nonprofit model can compete with these private operators, and hospitals could direct service requests, particularly for interfacility transport, to their affiliated air ambulance providers.

While smaller community hospitals might not have the resources or the demand to establish their own non-profit air ambulance service, large consolidated healthcare systems (pervasive in most hospital service areas) may possess the resources to operate or contract with a hospital-based air ambulance service. Smaller independent hospitals that frequently transfer to larger, tertiary hospitals could participate via a joint venture or contractual affiliation.

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The state can use its regulatory authority over hospitals to encourage hospitals to enter into arrangements with an air ambulance provider or to encourage hospitals to establish their own air ambulance service and provide that hospitals must require affiliated air ambulance providers to contract with all the health plans the hospital does. The ADA should not preempt state regulation of *hospitals* that encourages establishment of nonprofit air ambulance services. Any effects on air ambulance prices, routes, or services would be the product of private negotiations or the market entry of a new nonprofit provider, not a regulatory command of the state.

Finally, a state could consider a model that blends Maryland's and Maine's approaches, with a public, EMS-operated air ambulance service for remote-site pickups that can dramatically reduce costs, coupled with establishment of a hospital-based model for interfacility transports that can reduce out-of-network billing.

The California law suggests a potential way forward, however. A state could tie something the air ambulance industry wants, such as a Medicaid rate increase, to something it would oppose, like a balance-billing prohibition with an out-of-network benchmark pegged to a multiple of Medicare rates. If an air ambulance provider challenges the latter as preempted by the ADA (or fails to comply on that basis) then the invalidation of the out-of-network payment standard would rescind the Medicaid rate increase provision. This sort of reverse-severability clause may allow the state to reach a regulatory *détente*, with the industry voluntarily acquiescing to an otherwise-preemptable regulation by conditioning the receipt of a desired rate increase upon acquiescence.

B. State Balance Billing Restrictions for Air Ambulance

As mentioned above in Part II, states have attempted to curtail balance billing and surprise out-of-network charges by air ambulances the way they have for ordinary surprise medical bills. Most surprise medical billing laws contain two components: (1) a prohibition on balance-billing and other consumer protections that hold the patient harmless from out-of-network bills; and (2) a mechanism to determine how much the patient's health plan owes the out-of-network provider.[86] Both are necessary: the former protects patients from receiving balance bills, and the latter constrains out-of-network rates. Without the price constraint, health plans often end up paying the provider's inflated out-of-network charges, and these costs are eventually passed on to consumers in the form of higher premiums. In nearly half of out-of-network air ambulance transports, the patient's health plan pays the out-of-network air ambulance provider its full billed charges, perhaps to shield their members from exorbitant balance bills.[87] However, ADA preemption means that states can only pursue the hold harmless provisions, divorced from a regulatory constraint on out-of-network charges.

An example is Montana's Senate Bill 44, which limits air ambulance balance billing via state insurance regulation.[88] Passed in 2017, SB 44 requires health insurers to hold patients harmless from the additional costs of out-of-network air ambulance costs and creates a nonbinding dispute resolution process to determine the amount the health insurer owes an out-of-network air ambulance provider.[89] Once the insurer notifies the air ambulance provider that it will assume responsibility for the member's costs, the air ambulance provider may not balance bill the covered individual or seek any additional payments beyond the in-network cost-sharing amount.[90] The hold-harmless requirement shifts all excess out-of-network costs to the health insurance plan. If the insurer and provider disagree on a reimbursement rate, they may engage in a nonbinding dispute resolution process to determine the fair market value of the services provided before seeking a court remedy.[91]

Since its passage, officials report that Montana's legislation resulted in fewer consumer complaints, and uncertainty over the law's effect has encouraged air ambulance providers to enter into negotiations with insurers.[92] To date, no legal challenge has been filed against SB 44. It is possible that air ambulance carriers are pleased with the result, perhaps indicating

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insurers are paying close to billed charges in many cases. The law does not statutorily prescribe or limit the rate the provider is paid, only that negotiations of payment proceed without the patient, and thus does not implicate the ADA. It is also possible that reverse preemption by the McCarran-Ferguson would save Montana's law from ADA preemption because SB 44 alters the relationship between the insured and the insurer by requiring the insurer to take responsibility in resolving the out-of-network charges. However, ERISA preemption limits the applicability of a law like Montana's to fully insured health plans, and those individuals with self-funded employer coverage would not be protected.[93]

In 2019, California passed Assembly Bill 651 to extend funding for air ambulance services under the state's Medicaid program and to prohibit balance billing by air ambulances.[94] The Act reauthorized a penalty on vehicle traffic violations to fund a Medi-Cal reimbursement increase for air ambulance services.[95] On the consumer protection side, AB 651 prohibits air ambulance providers from balance billing patients. But unlike California's broader surprise medical billing law, which benchmarks out-of-network payments to 125% of Medicare rates, AB 651 is silent about the mechanism for determining out-of-network rates.[96] The air ambulance industry supported the bill, likely because the bill also increased the state's Medicaid reimbursement rates for air ambulances.

The passage of Montana and California's balance billing laws without industry challenge is telling. It appears that a naked balance billing prohibition, absent any mechanism to constrain out-of-network payment amounts from the health insurer, would not be preempted by the ADA because it is not a regulation that relates to air ambulance rates — it limits *who* the air ambulance company may bill, but not *how much*.[97] This solution seems a concession to the air ambulance industry because it allows the air ambulance providers to continue to demand, and be paid, their inflated out-of-network charges. It provides no incentive for air ambulance providers to go in-network or negotiate with health plans. But it does protect consumers from balance billing, so it is an important half-measure even if it does little to control costs.

The California law suggests a potential way forward, however. A state could tie something the air ambulance industry wants, such as a Medicaid rate increase, to something it would oppose, like a balance-billing prohibition with an out-of-network benchmark pegged to a multiple of Medicare rates.[98] If an air ambulance provider challenges the latter as preempted by the ADA (or fails to comply on that basis) then the invalidation of the out-of-network payment standard would rescind the Medicaid rate increase provision. This sort of reverse-severability clause may allow the state to reach a regulatory *détente*, with the industry voluntarily acquiescing to an otherwise-preemptable regulation by conditioning the receipt of a desired rate increase upon acquiescence.

C. Regulation of Air Ambulance Membership Plans

Air ambulance providers have also begun marketing membership plans to consumers, particularly in rural areas, as a protection against the risk of expensive out-of-pocket costs for emergency transport. States should regulate these plans to protect their residents from potential consumer abuse. Under such a program, "members" pay an annual fee, and in return, the air ambulance company will write-off any transport costs exceeding the member's health insurance coverage, but only if they receive transport services from their membership plan provider. These membership programs are dubious in value. First, these non-refundable and non-transferable memberships do not apply to all air ambulance providers, and members have no choice of which provider is called or responds during their emergency, so their membership program benefits may never be invoked.[99] Second, members must first exhaust their health insurance claims processes, including denials and appeals, before their membership benefits take effect.[100] Lastly, air ambulance companies may be marketing membership plans to Medicare and Medicaid beneficiaries, who are legally protected from balance billing and thus would have no need for a membership plan.

Although air ambulance membership plans have been marketed as a "safety net," the contractual and practical aspects of these membership programs have raised concerns with state insurance officials and policymakers.[101] Hence, states have begun regulating air ambulance membership programs, either through a strict ban[102] or by requiring them to be licensed with the state's insurance department.[103] The Department of Transportation has opined that the ADA would preempt state regulation of subscription or membership programs.[104] Yet, in the only challenge brought thus far against a state regulation of membership programs, the court in *Guardian Flight* upheld the North Dakota law banning air ambulance subscription programs.[105] The court found that the state could ban these subscriptions as a form of insurance because they are undisputedly contracts in which members pay a fee to the air ambulance provider and the provider assumes the members' risk for the enormous bill if the catastrophic event happens.[106] Their clear aim is to spread risk and is thus protected by the McCarran-Ferguson Act.[107]

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https://doi.org/10.1177/1073110520958869 Published online by Cambridge University Press

Although membership plan regulation does not solve the main problem of out-of-network billing, these membership programs are rife with consumer abuse and have questionable value. States should regulate these plans, not because it will bring down the costs of air ambulance transports, but because consumers need protection against this separate profit-line peddled by an increasingly unscrupulous industry.

III. Conclusion

The problem of out-of-network air ambulance bills is a particularly pernicious form of surprise medical bill. These bills seem particularly unfair due to their emergent nature, relative infrequency, and sky-high costs. Currently, there are few legal protections for consumers facing out-of-network air ambulance bills, which make up the large majority of air ambulance transports. Despite bold state efforts to curtail air ambulance billing practices, most of these state laws have been preempted by the federal Airline Deregulation Act. Therefore, a federal solution is ideal. In the absence of federal action, states must push forward in the meantime with novel approaches. Although they may be limited, states have avenues of authority and tools that they could use to protect consumers from out-of-network air ambulance bills, and they are motivated to use what authority they have.

Note

This work was supported by a grant from Arnold Ventures. Prof. Fuse Brown also reports personal fees from National Academy for State Health Policy, outside the submitted work

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12. *Id.*
13. Airline Deregulation Act of 1978, Pub. L. No. 95-504 § 4(a), 92 Stat. 1707 (codified at 49 U.S.C. § 41713(b)(1)).
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19. *Id.* at 387.
20. *Valley Med Flight v. Dwelle*, 171 F. Supp. 3d 930, 943 (D.N.D. 2016).
21. "Business of insurance" regulation under the McCarran-Ferguson means laws focusing on the relationship between the insurer and the policyholder. *Id.*
22. 15 U.S.C. § 1012(b) (1947) ("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.").
23. *See e.g.*, *Dwelle*, 171 F. Supp. 3d at 944–47 (finding North Dakota's laws governing preferred call lists and workers compensation benefits not qualified to receive McCarran-Ferguson reverse preemption since neither law regulated insurance contracts or the relationship between an insurer and the insured but only aimed at imposing restrictions on the air ambulance provider); *EagleMed LLC v. Cox*, 868 F.3d 893, 905 (10th Cir. 2017) (same for Wyoming worker compensation statute); *Air Evac EMS, Inc. v. Sullivan*, 331 F. Supp. 3d 650, 667 (W.D. Tex. 2018) (same for Texas worker compensation statute); *PHI Air Med., LLC v. Texas Mut. Ins. Co.*, 549 S.W.3d 804, 812–16

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27. Licensing rules governing medically related matters, like quality of medical services and equipment, are not preempted by the ADA. *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 740 (E.D.N.C. 2008) (invalidating only the CON requirements needed for air ambulance to enter the North Carolina market). *See also Hiawatha Aviation of Rochester, Inc. v. Minn. Dep't of Health*, 389 N.W.2d 507, 509 (Minn. 1986) (invalidating Minn. Stat. § 144.802 (1982)).
28. *Benton*, 581 F. Supp. 2d at 736; *Hiawatha*, 389 N.W.2d at 509.
29. *Id.*
30. *See e.g.* Ariz. Op. Att'y Gen. No. I87-164 (R86-112) (Dec. 28, 1987), *available at* <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwjkr8uWiK3nAhXblHIEHZSXA_sQFjAAegQIAxAB&url=http%3A%2F%2Fazmemory.azlibrary.gov%2Fdigital%2Fapi%2Fcollection%2Fagopinions%2Fid%2F9178%2Fdownload&usg=AOvVaw2278P0igMuy-wR7NhkCYUK> (last visited Jan. 31, 2020); Memorandum from Assistant Attorney General to Department of Public Health regarding Air Ambulances and Certificate of Need, *available at* <https://idph.iowa.gov/Portals/1/userfiles/61/Memo%20Air%20Ambulances%20and%20Certificate%20of%20Need%28%29.pdf> (last visited January 27, 2020).
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34. *Texas Mutual Ins. Co., et al. v. PHI Air Medical, LLC*, --- S.W.3d ----, 2020 WL 347700263, Tex. Sup. Ct. J. 1462 (Tex. 2020).
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36. The court found that PHI would not likely recover less under the fair and reasonable reimbursement standard because even the trial court's determination that the fair and reasonable reimbursement rate was 125% of Medicare rates was based on the price that PHI agreed to charge the one customer with which it had a contract. Texas Mutual Ins. Co., 2020 WL 347700263, at *8, 12.
37. *Sullivan*, 331 F. Supp. 3d at 659, 662–63.
38. *Id.* at 666. Appeal in the *Sullivan* case has been filed in the 5th Circuit (Sept. 5, 2019).
39. *Enriquez v. Couto Dairy*, Case No. ADJ6833713, 2013 WL 1276510, at *2-5 (Cal. W.C.A.B. March 28, 2013) (finding Cal. Code Regs. tit. 8, § 9789.70 a "regulation" within the Workers' Compensation Appeals Board's state constitutional power to declare preempted by the ADA, particularly since the workers' compensation reimbursement rates for air ambulances capped at 120 percent of the Medicare rate "related to" the regulation of an air carrier's rates). Although section 9789.70 was amended in 2015, the air ambulance fee schedule has since become obsolete. *See* State of California Department of Industrial Relations Division of Workers' Compensation, *Order of the Administrative Director of the Division of Workers' Compensation Official Medical Fee Schedule – Ambulance Fee Schedule Effective for Services Rendered on or after January 1, 2020* (December 24, 2019), *available at* <https://www.dir.ca.gov/dwc/FeeSchedules/AMBULANCE_FeeSchedule/Ambulance-January-2020/Order.docx> (last visited January 25, 2020) ("The CMS description of the Data Elements of the AFS Data file is attached to this Order, excluding references to air ambulance pursuant [Cal. Code Regs. tit. 8, §] 9789.70(b).").
40. *EagleMed, LLC v. Travelers Ins.*, 424 P.3d 532, 536–40 (Kan. Ct. App. 2018) (finding the fee schedule requirement for reimbursement of workers' compensation services authorized by Kan. Stat. Ann. § 44-510j preempted). Review of this case has been granted on December 19, 2018.
41. *Dwelle*, 171 F. Supp. 3d at 942–43, 947 (finding N.D. Cent. Code Ann. § 65-02-08, which allowed the Workforce Safety and Insurance to set fees for treatment provided in compensable work injury claims and prohibited against patient balance billing, preempted by the ADA and McCarran-Ferguson reverse preemption did not apply).
42. *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 766–70 (4th Cir. 2018) (finding W. Va. Code R. § 5-16-8a, which capped reimbursement for air ambulance services at 135 percent of Medicare rates or $100 for state employees with subscription agreements, preempted by the ADA).
43. *Cox*, 868 F.3d at 904–05 (finding Wyo. Stat. Ann. § 27-14-401 preempted, including its balancing billing prohibition provision, and McCarran-Ferguson reverse preemption not apply). The statute provision is being revised to remove air ambulance rate schedules, effective April 1, 2020. *See* HB0194, 65th Leg., 2019 Reg. Sess. (Wyo. 2019) (enacted), *available at* <https://www.wyoleg.gov/Legislation/2019/HB0194> (last visited Jan. 31, 2020).
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45. *See* Alaska Admin. Code tit. 8, § 45.083(i) (setting maximum fee schedule for air ambulance transports by licensed air ambulance carriers).
46. *See* Ga. Code Ann. §§ 34-9-203, 34-9-205 (these code sections expressly state providers cannot balance bill the injured employee, "charges for…services under this chapter shall be subject to the approval of the State Board of Workers' Compensation," and the fee schedules published by the Board are "presumed reasonable" charges). *See* rates for ambulance and air services rates at "April 1, 2019 Medical Fee Schedule Updates," *State Board of Workers' Compensation*, *available at* <https://sbwc.georgia.gov/document/document/ambulance-and-air-services/download> (last visited Jan. 31, 2020).
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dcd/files/2012/11/2014-Exhibit-A.pdf> (last visited Jan. 31, 2020).
48. *See* Ill. Admin. Code tit. 50, § 9110.90 ("after September 1, 2011, whenever the fee schedule does not set a specific fee for a procedure, treatment or service in the schedule, the amount of reimbursement shall be at 53.2% of actual charge").
49. *See* Tenn. Comp. R. & Regs. 0800-02-18-.02 (maximum amount of reimbursement is set by the fee schedule or at 100 percent of Medicare rate); *Tennessee's Workers' Compensation Medical Fee Schedule, available at* <https://www.tn.gov/content/dam/tn/workforce/documents/injuries/NewTNMFSHandbook2018.pdf> (last visited Jan. 31, 2020) ("Reimbursement for these services is capped at the lesser of the submitted charges, or 150% of the current Medicare rate).
50. *See* D.C. Code Ann. § 32-1507(a-1)(5) (medical services shall be billed at the rate established in the medical fee schedule adopted by the Mayor based on 113% of Medicare's reimbursement amounts).
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52. N.D. Cent. Code Ann. § 23-27-04.10(2).
53. N.D. Cent. Code Ann. §§ 23-27-04.10(3), (4)(b)(1)-(4)(b)(2).
54. N.D. Cent. Code Ann. § 23-27-04.10(5).
55. *Id.*
56. *Dwelle*, 171 F. Supp. 3d at 941–42.
57. *Id.* at 942.
58. *Id.*
59. *Id.*
60. Texas's law applied the balance billing prohibition only to workers' compensation claims. Tex. Lab. Code Ann. § 413.042. The *Sullivan* court did not address the balance billing prohibition specifically because it had found the air ambulance provider's first argument, that the worker compensation law was a form of rate restriction was preempted by ADA, persuasive. *Sullivan*, 331 F. Supp. 3d at 656, FN 4. Therefore, the alternative argument regarding preemption of the balance billing section was not examined. *Id.*
61. N.D. Cent. Code Ann. § 26.1-47-09.
62. N.D. Cent. Code Ann. § 26.1-47-09(1).
63. N.D. Cent. Code Ann. § 26.1-47-09(3).
64. *Guardian Flight, LLC v. Godfread*, 359 F. Supp. 3d 744, 755 (D.N.D. 2019). The court reasoned that N.D. Cent. Code § 26.1-47-09 is not a business of insurance regulation and is not saved by McCarran-Ferguson reverse preemption since the section does not alter the relationship of the insured and insurer, but the insurer and the provider. *Id.* at 759.
65. N.M. Stat. Ann. § 59A-57-4(B)(3)(d) (1978) (requiring managed healthcare plans to make emergency care services available to covered individuals without requiring prior authorization and ensure that appropriate out-of-network services were provided without additional cost); N.M. Stat. Ann. § 59A-22A-5(A)(1) (applying to preferred provider organizations (PPOs)); N.M. Code R. § 13.10.21.8(D)(6) (applying to health maintenance organizations (HMOs)).
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74. *Id.*
75. *Id.*
76. Fuse Brown et al., *supra* note 3.
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79. *Id.*; *see also* Maryland Health Care Commission, *Air Ambulance Study Required Under Senate Bill 770* 1, (December 2006), *available at* <http://www.vdh.virginia.gov/content/uploads/sites/23/2017/04/MarylandAirAmbulanceStudy_2006.12.pdf> (last visited January 31, 2020).
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81. 49 U.S.C. § 41713(b)(1).
82. "Vision and Mission," LifeFlight of Maine: Critical Care Transport and Training, *available at* <https://www.lifeflightmaine.org/About-Us/Mission.aspx> (last visited January 22, 2020).
83. *Id.*
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87. Fuse Brown at al., *supra* note 3.
88. *U.S. GAO*, *supra* note 8, at 21.
89. Mont. Code Ann. §§ 33-2-2302, 33-2-2305 (2017) (hold harmless provisions); Mont. Code. Ann. § 20-25-1316 (2017) (dispute resolution).
90. Mont. Code Ann. §§ 33-2-2302, 33-2-2305 (2017).
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95. *Id.*
96. *Compare* Cal. A.B. 651 (2019) (air ambulance billing) *with* Cal. A.B. 72 (2016) (surprise medical billing).
97. M. Andrews, "Loopholes Limit New California Law to Guard Against Lofty Air Ambulance Bills," *Kaiser Health News*, January 14, 2020, *available at* <https://khn.org/news/loopholes-limit-new-california-law-to-guard-against-lofty-air-ambulance-bills/> (last visited January 22, 2020).
98. The typical surprise medical billing benchmark is median in-network rates, but for air ambulances, that standard is less meaningful because the vast majority of services are out-of-network and pervasive market failures result in highly inflated in-network rates. So a multiple of Medicare rates is a more reliable benchmark for air ambulances. Fuse Brown et al., *supra* note 3.
99. "Air Ambulances Woo Rural Consumers with Memberships That May Leave Them Hanging," NPR, *available at* <https://

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www.npr.org/sections/health-shots/2019/09/14/760680901/air-ambulances-woo-rural-consumers-with-memberships-that-may-leave-them-hanging> (last visited January 27, 2020); "Terms and Conditions," AirMedCare Network, *available at* <https://www.airmedcarenetwork.com/terms-conditions?_ga=2.153195896.1175877162.1580128305-153771267.1580128305> (last visited January 27, 2020).

100. *Id.*
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102. North Dakota's code section 26.1-47-08 provides that "[a]n air ambulance provider, or an agent of an air ambulance provider, may not sell, solicit, or negotiate a subscription agreement or contract relating to services or the billing of services provided by an air ambulance provider." N.D. Cent. Code Ann. § 26.1-47-08.
103. House Bill 73, codified at Mont. Code Ann. §§ 33-2-2201 – 2112 (2017) ("A private air ambulance service…shall obtain a certificate of authority from the commissioner prior to selling, soliciting, or negotiating a membership agreement in Montana;" requirements, among others, include stating "membership agreement is an insurance contract" when issued to members); Alaska Stat. §§ 21.61.105, 21.61.106 (2014) (requires air ambulances offering membership programs to register biennially with the Director of Insurance, among other operation requirements, and those providers are considered "insurers," and those membership agreements, "excepted benefits" insurance policies; "OGC Op. No. 08-07-30," New York State, *available at* <https://www.dfs.ny.gov/insurance/ogco2008/rg080730.htm> (last visited January 27, 2020) (membership or subscription plans have been interpreted to fall under New York insurance laws as early as 1986).
104. United States Department of Transportation, *supra* note 31.
105. *Guardian Flight*, *supra* note 64 at 759.
106. *Id.*
107. *Id.*

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