CASE NO. 16-8064
UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

EAGLEMED LLC, a Delaware Limited Liability company, et al.,	)
Plaintiffs - Appellees	)
	)
vs.	)
	)
JOHN COX, in his official capacity as Director of the Wyoming Department of Workforce Services, et al.,	)
Defendants - Appellants.	)

On Appeal from the United States District Court For the District of Wyoming
The Honorable Judge Alan B. Johnson
D.C. No. 15-CV-00026-ABJ

BRIEF OF AMICUS CURIAE TEXAS MUTUAL INSURANCE COMPANY
IN SUPPORT OF APPELLANTS AND REVERSAL

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CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and 29.4(c)(1) and (4), *Amicus Curiae* states the following:

Texas Mutual Insurance Company is a Texas not-for-profit mutual insurance company. It is owned by its policyholders, and provides workers' compensation insurance for the benefit of its policyholders and their workers. It is not a subsidiary or affiliate of any other corporation. No publicly held corporation owns 10 percent or more of its stock.

Texas Mutual has an interest in the outcome of this case. Texas Mutual is Texas's largest workers' compensation insurer. In recent years, Texas Mutual has been repeatedly sued in Texas state agencies and courts, and in federal courts in Texas, by air ambulance companies, including some appellees in this case. Several of these cases in state and federal courts are pending at various stages and involve the same preemption question at issue in this case: did Congress intend through the Airline Deregulation Act to preempt traditional state regulation of workers' compensation fees? Texas Mutual files this amicus brief in support of the Wyoming state officials' argument that there is no preemption of Wyoming's workers' compensation fee schedule.

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STATEMENT OF IDENTITY AND SOURCE OF AUTHORITY TO FILE

Pursuant to Federal Rule of Appellate Procedure 29(a) and (c)(4), *Amicus Curiae* state the following:

-- All parties have consented to the filing of this amicus brief.

-- *Amicus Curiae* Texas Mutual Insurance Company authorized the filing of this brief.

STATEMENT UNDER RULE 29(c)(5)

Pursuant to Federal Rule of Appellate Procedure 29(c)(5), *Amicus Curiae* states:

(A) No Party's counsel authored this brief in whole or in part;

(B) No Party or Party's counsel contributed money that was intended to fund the preparation or submission of this brief; and

(C) No person — other than *Amicus Curiae* — contributed money that was intended to fund the preparation or submission of this brief.

SUMMARY OF ARGUMENT

In deregulating the commercial airline industry with the 1978 Airline Deregulation Act ("ADA"), Congress manifested no intent to displace state workers' compensation fees paid to air ambulances. This is true both from a common sense perspective and from the Supreme Court-mandated preemption analysis directing courts "to determine whether state regulation is consistent with the structure and purpose of the [federal] statute."[1]

In passing the ADA, Congress deregulated rates of commercial airlines like Delta and American Airlines for the express purpose of forcing them to compete on price and service for consumers[2]; it did not deregulate state regulated fees for ambulance transports that involve no price competition and no consumer choice. By forcing state officials to pay billed charges that air ambulances set under fundamentally *noncompetitive* circumstances, the district court's order creates the very problems the ADA was expressly intended to solve.

Moreover, Congress could not have intended to deregulate air ambulance payment regulation. It did just the opposite when, in 1997,

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[1] *Gade v. National Solid Wastes Management Ass'n*, 505 U.S. 88, 98 (1992).
[2] *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 378-79 (1992).

it directed the Centers for Medicare and Medicaid Services ("CMS") to establish a specific Medicare air ambulance fee schedule.

Rather than simply assuming a "broad" preemptive purpose as the district court did, this Court must undertake a preemption analysis that starts with the "strong presumption against preemption in areas of the law that States have traditionally occupied,"[3] and preserves state law absent "the clear and manifest purpose of Congress" to displace it. This case involves two core state police powers: regulation of healthcare costs; and, establishing a workers' compensation system. The ADA mentions neither, and certainly contains no clear and manifest purpose to displace traditional state regulation in either area.

Amicus Curiae Texas Mutual adds important context to this Court's review of the district court's far-reaching preemption order. Texas Mutual has litigated the only case to determine air ambulance workers' compensation reimbursement on a fully-developed evidentiary record.

The district court below granted summary judgment on the basis of key incorrect factual assumptions about the air ambulance industry,

[3] *Sikkelee v. Precision Airmotive Corp.*, 822 F.3d 680, 687 (3d Cir. 2016) (citing *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996)).

including that unless the air ambulances are paid full, unregulated billed charges, they will suffer a "loss that the [air ambulance] carrier must recover from other members of the public who have the misfortune of needing air ambulance service."[4] Had full discovery been permitted below, the Wyoming defendants would have discovered facts otherwise.

Air Methods, an Appellee in this case, submitted financial data to the Texas Department of Insurance for its Texas program that showed its 2013 billed charges were 385% of its expenses.[5] Payment of Air Methods' 2013 billed charges would have thus resulted in a 285% profit margin.

Unconstrained by market forces, and reaping staggering profits in the noncompetitive environment in which they operate, air ambulances have continued to increase their charges dramatically since 2013. The Appellees' billed charges in 2016 likely would represent even greater profit margins — if anyone actually paid them (which they do not). The prospective relief the district court ordered — forced payment of full billed charges — therefore guarantees these profits on every transport of an injured worker. It turns ADA preemption into an air ambulance-

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[4] District Court Order at 30.
[5] Exhibit B -- Air Methods' Texas financial program data for 2011-2013.

specific, federally-mandated right to syphon funds virtually at will from Wyoming's state workers' compensation fund.

In contrast, the Texas judge rejected ADA preemption, and held that 149% of the Medicare rate (calculated at Congress's express direction) was the proper fee under Texas workers' compensation fee standards, after Texas Mutual gained access to and presented the Court with evidence of PHI Air Medical, LLC's ("PHI") operating expenses and price-setting policies.[6] Payments at 149% of Medicare guaranteed PHI a 9.15% profit margin on each Texas workers' compensation transport in 2010-2013.[7]

Air Methods' financial data that it submitted to the Texas Department of Insurance showed that its 2013 Texas collections were only 27-29% of its billed charges, and it also made a profit.[8]

Had the district court below allowed discovery, the state defendants would have been able to show — as Texas Mutual showed in

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[6] *See In re Reimbursement of Air Ambulance Services Provided by PHI Air Medical*, State Office of Administrative Hearings Docket No. 454-15-0681.M4 et al., pending as *Texas Mutual Insurance Co. v. PHI Air Medical, LLC*, Docket No. D-1-GN-15-004940 in the 53rd state district court of Travis County, Texas, on petition for judicial review and cross-petitions for declaratory judgment. Trial/oral argument is set for Dec. 2, 2016. The Decision and Order is attached as Exhibit A (hereafter, "Texas Decision").

[7] Texas Decision at 20 n.6.

[8] *See* Exhibit B (Air Methods' financial data filed with the Texas Department of Insurance).

its case — that applying the ADA to preempt state workers' compensation fee schedules is a perversion of Congress's intent to promote consumer-choice and competition on prices and services, and would lead to similar windfall profits. Discovery would also have shown, contrary to the district court's assumption, that no air ambulance payor groups pay billed charges. Private insurers are the highest paying of air ambulances' four major payor groups, but air ambulances are still forced to negotiate with insurance adjusters for payment. Those "negotiations" are very different from consumer purchases in the commercial airline market, and do not result in payment of billed charges. Such facts about air ambulance operations and their industry are critical to a well-informed preemption analysis.

Uninformed by such facts, the district court order compels state officials to pay the "sticker price" that no other payor group pays in the "marketplace" in which air ambulances operate. It creates a new federal right, available uniquely to air ambulances, to obtain self-determined payments from the public fisc. No preemption analysis support such an order.

This issue is one of national importance. This Court should, as the Supreme Court has repeatedly cautioned, not "assume lightly that Congress has derogated state regulation."[9] It should instead preserve Wyoming's long-standing exercise of its police powers over workers' compensation regulations.

ARGUMENT

I. Congress did not intend to override the states' workers' compensation regulation of air ambulance fees.

A. The air ambulance industry is not a part of and does not operate anything like the commercial airline industry that Congress deregulated.

Congress deregulated the commercial airline industry for the benefit of the American "traveling and shipping public,"[10] so that airlines would be required to compete with each other for consumers based on price, routes, and service.[11] Because of the ADA, airline consumers can price shop and decide whether to take the flight or ship the package for the price being charged, or whether to drive instead of fly, or even skip the trip altogether.

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[9] *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654 (1995).
[10] Exhibit D (H.R. Rep. No. 95-1211) at 73 (1978).
[11] *Abdullah v. American Airlines, Inc.*, 181 F.3d at 373 (3d Cir.) (quoting *Morales*, 504 U.S. at 378-79 (1992)).

Air ambulance passengers — and the governmental and private insurers who largely pay for the transports — can make no such choices. Air ambulances transport patients in need of medical care, not the "traveling and shipping public." Air ambulances do not ship packages and provide flights for business and recreational travel. Instead, they — just like their ground counterparts — provide a service that has now become a ubiquitous part of the American healthcare delivery system.

When commercial airlines or parcel companies set their prices, that price is what the consumer pays, after comparing them to airlines' prices and services. Not so for air ambulances. As shown in detail below, air ambulance payors are not consumers who pay first and then take a flight or ship a package. Air ambulance passengers are injured people who are placed on board a medical transport vehicle, and their insurance company pays the bill after the flight. Neither the patient nor the insurer has agreed to pay the charges before the flight — neither even knows what the charge is until they get a bill after the flight.

Other than the fact that they fly, rather than drive, air ambulances have nothing in common with the commercial airlines Congress intended to deregulate in passing the ADA.

B. The Texas case showed that air ambulances operate in a healthcare market that lacks consumer choice.

In Texas, PHI sought recovery of its billed charges before the Texas Department of Insurance and before a state administrative law judge. Following a failed removal effort, that case is now before a state district judge. Texas Mutual shares with the Court the key facts from that case that undercut the district court's apparent assumption that air ambulances operate in a competitive market that Congress intended to protect from state rate regulation. Such context is needed here, where the district court ruled on an incomplete record.

The district court assumed that Wyoming's "fee schedule creates a loss that the carrier must recover from other members of the public who have the misfortune of needing air ambulance service."[12] This statement assumes that payment of billed charges is both the norm, and necessary for air ambulance providers to recover their costs. The facts are otherwise.

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[12] District Court Order at 30.

An air ambulance company's major payor groups are (1) Medicare — based on a national air ambulance fee schedule; (2) Medicaid — rates that states set, usually as a percentage of Medicare rates; (3) the self-insured or uninsured, who pay almost nothing; and, (4) out-of-network private insurance, mostly employer-provided health plans. These different types of payors pay different amounts for air ambulance transports. None pays billed charges. The Texas judge awarded PHI 149% of Medicare on the ground that that was the average of what all PHI's payors paid from 2010 to 2013.[13]

The record developed in the Texas case shows that workers' compensation covered only 2 to 3% of PHI's 2010-13 Texas transports. Medicare is by far the largest single payor, and Medicaid is second. Together, Medicare and Medicaid pay for roughly half of all transports and do so according to fee schedules set by the federal government and by states.

Medicare's air ambulance rates are the result of a Congressional directive to CMS to set a fee schedule in a negotiated rulemaking with

[13] Texas Decision at 20.

the industry.[14] CMS phased in the fees from 2002-06.[15] Medicare rates appear to be quite lucrative for air ambulances, as the number of air ambulances nationally tripled after Congress directed CMS to implement the new fee schedule.[16]

The self-insured pay whatever the air ambulance providers can extract by collection efforts and threatening and pursuing litigation, but most such patients pay little or nothing.

Private insurers are air ambulances' most lucrative payors. Air ambulance providers generally refuse to enter into healthcare insurance networks, where in-network providers negotiate payment rates with the insurance companies. Instead, air ambulances bill the insurer their full charges and threaten collections and litigation (including against the

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[14] Section 4531(b)(2) of the 1997 Balanced Budget Act (Pub.L. 105–33, 111 Stat. 251) added Section 1834(l) to the Social Security Act, which mandated the implementation of a national ambulance fee schedule for Medicare Part B ambulance transports on or after April 1, 2002. 42 U.S.C. § 1395m(l). *See also* 67 Fed. Reg. 9100 *et seq.* (adopting new Medicare ambulance fee schedule); and 42 C.F.R. § 410.40 *et seq.* and § 414.601 *et seq.* (Medicare ambulance fee schedule regulations).

[15] *See generally*, 67 Fed. Reg. 9100 *et seq.* (adopting new Medicare ambulance fee schedule); 42 C.F.R. § 410.40 *et seq.* and § 414.601 *et seq.* (prescribing Medicare ambulance fee schedule regulations).

[16] In 1997, there were approximately 350 air ambulance helicopters in the United States. By 2014, according to the industry-sponsored Atlas and Database of Air Medical Services (ADAMS), there were 1,020 air ambulance helicopters in the United States. Excerpts from the ADAMS 2014 publication is attached as Exhibit E.

insured) as a weapon to coerce payment of as much of their billed charges as possible. Private insurers still, despite these collection tactics, do not pay "sticker price."[17]

There is no consumer price competition for air ambulance services. Air ambulances increase their billed charges whenever and by as much as they choose — without experiencing any decline in business volume. In the Texas case, the undisputed evidence showed that PHI increased it charges on average four times a year from 2010 to 2013, constituting a more than 75% increase over that period.[18] Air ambulance operating costs increased by only 11% in that same timeframe.[19] Unlike the commercial airlines who compete on price, PHI never lowered its prices.

Air ambulance billed charges have recently become so high that many accuse them of price gouging.[20] The *New York Times* reports that

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[17] *See* Exhibit A -- Texas Decision at 19 ("Basically, workers' compensation patients would be paying 'sticker price' while numerous other patient populations are allowed to pay less than that.").

[18] PHI did so on average four times a year from 2010 to 2013, constituting a more than 75% increase over that period. Exhibit F (PHI's 2010-2013 chargemaster). PHI's base charge as of Jan. 1, 2010 was $11,492. As of Oct. 1, 2013 it was $20,510.

[19] Texas Hrg. Tr. Vol. 1 at 189-190.

[20] Peter Eavis, *Helicopter to the E.R.: Air Ambulances Offer a Lifeline, and Then A Sky-High Bill*, N.Y. TIMES, May 5, 2015, available here: http://www.nytimes.com/2015/05/06/business/rescued-by-an-air-ambulance-but-stunned-at-the-sky-high-bill.html?_r=0 (website visited October 11, 2016). ABC News' Frontline also televised an episode called "Sky-Rage: Bills, Debt, Lawsuits

Appellee Air Methods' average 2014 bill was $40,766 compared to "roughly $17,262 five years earlier."[21] An industry spokesman claimed "the cost of an average flight was $9,000 to $10,000,"[22] but that was likely too high. A Stanford Medical School study calculated the actual average cost at $6,400 to $7,800.[23]

Prices unknown to consumers when they receive the service, that no one pays, and that exceed operating costs by hundreds of percentage points are not the air carrier "prices" that Congress intended to protect from state regulation.

C. State workers' compensation fee rules are immune from ADA preemption.

The United States Supreme Court explained in *N.Y. Conference of Blue Cross v. Travelers Ins.*:

> [W]here federal law is said to bar state action in fields of traditional state regulation, we have worked on the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.[24]

Follow Helicopter Medevac Trips." It can be watched here: http://abcnews.go.com/Nightline/video/sky-rage-bills-debt-lawsuits-follow-helicopter-medevac-37710320

[21] *Id.*

[22] *Id.*

[23] *See* Exhibit G (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)., at tbl. 1).

[24] 514 U.S. at 655 (citations and quotation marks omitted).

Workers' compensation regulation is a traditional exercise of the States' police powers that Congress has manifestly intended *not* to displace. Courts have construed the ADA preemption provision to stop short of superseding the States' regulations in fields they have traditionally occupied, including contract disputes and tort laws. In passing the ADA, Congress made no mention of displacing state workers' compensation regulations. To nonetheless allow such displacement here would be inconsistent with Congress's stated goal of empowering consumers by forcing airlines to compete with each other on prices, routes and services.

1. Congress deregulated commercial airline prices.

Congress passed the ADA for two purposes: (1) to deregulate the commercial airline market, and (2) to "promote safety of flight of civil aircraft"[25] for "the American traveling and shipping public."[26] While it makes sense for air ambulances to comply with federal air safety

[25] 49 U.S.C. § 1421(a).

[26] Exhibit D (excerpts from H.R. Rep. No. 95-1211 (1978)) at *73. The House Report accompanied the House version of the bill. The Conference Committee adopted the House bill (with one exception not relevant here). For the legislative history of the ADA generally, *see Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 425–26 (1992) (Stevens, J., dissenting).

regulations, as the district court noted,[27] patients flown from hospitals or scenes of accidents are not the "traveling and shipping public." They are patients receiving a medical transport, and their health insurance usually pays for the service— just as with any other healthcare service. Airline tickets are not paid for by healthcare insurers; they are purchased directly by consumers.

The ADA's rate deregulation goals include "encouraging entry into air transportation markets by new and existing air carriers and the continued strengthening of small air carriers to ensure a more effective and competitive airline industry."[28] The House Report described

[27] The district court concluded that because air ambulances are subject to safety and licensing regulation by the FAA, they would also be subject to economic regulation under the ADA. District Court Order at 29. That is a false equivalence. The differing reasons for federal preemption of (i) aircraft safety regulation on the one hand, and (ii) economic regulation of air carriers on the other hand, is well recognized in the case law. The former is absolute while the latter is not. *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624, 633 (1973) (Aircraft safety considerations requires "uniform and exclusive systems of federal regulation if the congressional objectives underlying the Federal Aviation Act are to be fulfilled."); *Abdullah v. American Airlines, Inc.*, 181 F.3d 363, 367 (3d Cir. 1999) (acknowledging entirely different bases for absolute federal preemption of aircraft safety regulation and less pervasion preemption of ADA's economic regulation).

Air ambulance helicopters are subject to federal licensing and safety regulations applicable to *all helicopters*. No one disputes that. But preemption of rate regulation is entirely different. As a result, the facile argument that because air ambulances are subject to federal licensing and safety regulation, they must also be subject to ADA rate deregulation never gets off the ground. The former is consistent with the purpose of ADA, the latter is not.

[28] 49 U.S.C. § 40101(a)(4), (13).

deregulating "coach" and "first-class" ticket pricing.[29] Air ambulance patients, by contrast, have no such choices between national and regional airlines, or between coach and first-class tickets. Theirs is a non-discretionary ride to a hospital in a helicopter while strapped to a hospital-like bed, with a nurse and medication on board.

2. Congress has demonstrated its intent that air ambulances continue to be subject to fee regulation by directing CMS to create a Medicare air ambulance fee schedule.

The ADA was enacted in 1978 to federally deregulate commercial airline rates. Congress included a preemption provision in order "[t]o ensure that the States would not undo federal deregulation with regulation of their own…[by] prohibiting the States from enforcing any law 'relating to rates, routes or services of any air carrier."[30]

In the 38 years since Congress passed the ADA, no one seriously argued that air ambulances were the intended beneficiaries of rate deregulation — until recently. But in the air ambulance industry, there was no federal rate deregulation. Just the opposite. In 1997, 19

[29] Exhibit D (H.R. Rep. No. 95-1211, at *6, *9, *11, *73).
[30] *Abdullah*, 181 F.3d at 373 (quoting *Morales*, 504 U.S. at 378-79).

years after passing the ADA, Congress required Medicare to set air ambulance fees.[31]

States similarly regulate what workers' compensation pays for air ambulance medical transports. Many, including Texas, base workers' compensation fees on Medicare. The Texas Decision, concerning 2010-2013 transports, found the proper fee to be 149% of Medicare.[32]

Congress could not have intended deregulation of air ambulance payments while at the same time directing CMS to set a fee-schedule.

Similarly, the Supreme Court in *Travelers Ins.* that the "history of Medicare regulation" of hospital fees "confirmed[ed] that Congress never envisioned ERISA preemption as blocking state healthcare cost control."[33] The history of Medicare regulation of air ambulance fees confirms that Congress never envisioned the ADA as blocking state workers' compensation fees.

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[31] *See* 42 U.S.C. § 1395m(l), Social Security Act Section 1834(l), added by section 4531(b)(2) of the 1997 Balanced Budget Act (Pub. L. 105-33, 111 Stat. 251) (mandating a national Medicare Part B ambulance fee schedule).
[32] Texas Decision at 20-22.
[33] 514 U.S. at 667 n.6 (1995).

3. The ADA embodies no "clear and manifest purpose" to preempt state workers' compensation regulation of air ambulance fees.

The Supreme Court uses "the starting presumption that Congress does not intend to supplant state law."[34] The Court uses that presumption even when there is an express preemption clause. "The question of the substance and scope of Congress' displacement still remains."[35]

No Supreme Court or federal court of appeals has applied the ADA to preempt state workers' compensation or other insurance or labor regulations as applied to air ambulances. Even as to commercial airlines, the Supreme Court has cautioned against broadly displacing state authority to determine quintessentially state-level issues just because they happen to affect airlines.[36] Following that "cautionary note," the Fifth Circuit held that the ADA did not preempt an American Airlines employee's cause of action under the Texas Workers'

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[34] *Id.* at 654.

[35] *Altria Group, Inc. v. Good*, 555 U.S. 70, 76 (2008).

[36] *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 233 (1995) (holding that Congress did not intend to preempt state-level resolution of "the range of contract claims relating to airline rates, routes or services. The ADA contains no hint of such a role for the federal courts."); *Morales* 504 U.S., 388-89, 390 (1992) ("Some state actions may affect [airline fares] in too tenuous, remote or peripheral a manner to have pre-emptive effect.").

Compensation Act for retaliation after filing a workers' compensation claim.[37]

The Supreme Court held in *Travelers Ins.* that Congress's most broadly preemptive statute, ERISA, did not preempt New York regulations imposing surcharges on hospital rates because "nothing" in ERISA's language "or the context of its passage indicates that Congress chose to displace general healthcare regulation, which historically has been a matter of local concern."[38]

The same is true here. There is no mention in the ADA or its legislative history of healthcare, air ambulance fees, or state workers' compensation fee schedules.

4. Workers' compensation is traditional state regulation.

"States possess broad authority under their police powers to regulate the employment relationship to protect workers within the State. Child labor laws, minimum and other wage laws, laws affecting occupational health and safety, and ***workmen's compensation laws*** are

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[37] *Anderson v. Am. Airlines, Inc.*, 2 F.3d 590, 507 (5th Cir. 1993) ("Following the Supreme Court's cautionary note in *Morales*, we can safely conclude that the Aviation Act does not pre-empt a claim for money damages under article 8307c.").
[38] *Id.* at 661.

only a few examples."[39] Likewise, "[c]ourts have found that labor laws, such as a state prevailing wage statute, are not preempted by [the Federal Airlines Deregulation Act]."[40]

Congress has taken special care not to interfere with workers' compensation. In 1948, it excluded from federal court jurisdiction, even diversity jurisdiction, all civil actions arising under state workers' compensation laws.[41] Congress excluded state workers' compensation even from its most broadly preemptive legislation, ERISA.[42]

The specifics of workers' compensation systems vary from state to state. Texas, like many states, regulates private insurers' workers' compensation policies, premiums, and benefits, including fees paid for healthcare. Wyoming, like several other states, is the sole insurer.

All systems, however, have the same core components. All replace the expensive, time-consuming and arbitrary determination of liability and damages under the common law of torts. All pay injured workers

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[39] *De Canas v. Bica*, 424 U.S. 351, 356 (1976) (emphasis added).
[40] *Hamilton v. United Airlines, Inc.*, 960 F. Supp. 2d 776, 785 (N.D. Ill. 2012) (citing *Californians for Safe & Competitive Dump Truck Trans. v. Mendonca*, 152 F.3d 1184, 1188 (9th Cir. 1998)).
[41] *See* 28 U.S.C. § 1445(c).
[42] *See*, *e.g.*, ERISA § 4(b)(3), 29 U.S.C. § 1003(b)(3)) (ERISA's exclusion of state workers' compensation laws from preemption); *see also* Affordable Care Act, 42 U.S.C. §300gg-91(c)(1)(D) (defining benefits not subject to requirements).

state-determined benefits — income, disability, and health benefits — without regard to fault. All systems are designed to pay benefits quickly, inexpensively and with certainty. The costs are funded out of premiums paid by the employers.

Workers' compensation is, in substance, the earliest (and remains the most important) state-level tort reform law. It is thus precisely the comprehensive, traditional state regulation for which the strong presumption against federal preemption exists.

5. State workers' compensation fees for air ambulance transports would not frustrate the purposes of the ADA.

The district court failed to consider the structure and purpose of the ADA as a whole. As the Supreme Court has stated, a court's "ultimate task in any pre-emption case is to determine whether state regulation is consistent with the structure and purpose of the statute as a whole."[43] The district court ignored that directive.

The district court relied solely on the "plain wording" of the ADA's preemption of state laws "relating to" "air carriers'" rates, together with

[43] *Gade v. National Solid Wastes Management Ass'n*, 505 U.S. 88, 98 (1992).

case law recognizing the "'broad preemptive purpose'" of the ADA.[44] It did not identify anything establishing Congress' clear and manifest intent that the ADA preempt state workers' compensation laws as applied to air ambulances.

In *N.Y. Conference of Blue Cross v. Travelers*, the Supreme Court reversed a lower court decision that was based solely on the "related to" language contained in the ERISA preemption statute. Rejecting the lower court's "uncritical literalism," the Court held that one must go beyond the "unhelpful" statutory preemption language and "look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive."[45] At issue there was a state surcharge on certain insurer plans. Hospital "cost uniformity was almost certainly not an object of [ERISA] pre-emption," so the state statutes imposing hospital surcharges were not inconsistent with ERISA's purpose and not preempted.[46]

In *Adbu-Brisson v. Delta Airlines, Inc.*, the Second Circuit applied that approach to Delta Airlines' contentions that pilots' age discrimination claims were preempted by the ADA. "Delta is unable to

[44] District Court Order at 27 (quoting *Morales*, 504 U.S. at 383).
[45] *Travelers*, 514 U.S. 645, 656.
[46] *Id.* at 662.

establish that enforcing the city and state human rights laws in this case would frustrate the purpose of the ADA."[47]

The Court observed: "The ADA was based on a Congressional assumption that 'maximum reliance on competitive market forces' would best further 'efficiency, innovation, and low prices' as well as 'variety [and] quality . . . of air transportation services . . . ."[48] Further, "[p]ermitting full operation of New York's age discrimination law will not affect competition between airlines—the primary concern underlying the ADA. . . . [W]hether an airline discriminated on the basis of age (or race or sex) has little or nothing to do with competition or efficiency."[49]

Air ambulances do not compete for consumers on price. Unlike consumers of airline tickets, neither the patient nor the payor knows the price before the flight occurs. Unlike airline consumers, air ambulance patients presumably need the ambulance transport regardless of price. State workers' compensation fees for air ambulance transports do not displace consumer driven free-market prices because there are none.

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[47] 128 F.3d 77, 84 (2nd Cir. 1997).
[48] *Id.* (quoting *Morales v. Trans World Airlines, Inc.*, 504 U.S. at 378).
[49] *Id.*

The district court, in passing, acknowledged that fact when it noted that "[t]he rapid response required in an emergency flight obviates any opportunity to negotiate price and terms."[50] That undeniable fact is enough from which to conclude that Congress did not intend to protect air ambulance "prices" because those prices are not determined by the same fundamental free market forces — consumer choice — that Congress intended to promote with the ADA.

D. The McCarran-Ferguson Act is a specific protection for state-level insurance regulations – including workers' compensation – from federal preemption.

The McCarran-Ferguson Act precludes federal preemption of a state regulation of the "business of insurance" unless the federal statute "specifically relates to the business of insurance." 15 U.S.C. § 1012(b). The ADA does not specifically relate to the business of insurance.

The McCarran-Ferguson Act was enacted to "restore the supremacy of the States in the realm of insurance regulation," and imposed, "in effect, a clear statement rule" that state laws regulating insurance are not generally preempted.[51]

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[50] District Court Order at 31
[51] *Id.*

The Texas Decision held that the McCarran-Ferguson Act reverse preempts any possible ADA preemption of Texas workers' compensation insurance regulation of fees for medical transports.[52]

The district court held that the McCarran-Ferguson Act does not reverse preempt as to Wyoming's workers' compensation system, because the State is the insurer, collecting the premiums and paying the benefits. This conclusion is, at a minimum, questionable. That Wyoming, like many states, chose to become the sole insurer for work-related injuries does not mean there is no "insurance" at issue. As Medicare illustrates, the federal government can be the sole insurer of a line of insurance. As Medicaid illustrates, so can a state.

In states like Texas, which operates its workers' compensation system through a comprehensively regulated private insurance market, the McCarran-Ferguson analysis is straightforward. As the Texas judge concluded, no serious doubt exists that the Texas Department of Insurance is regulating insurance within the meaning of the McCarran-

[52] Texas Decision at 4—5.

Ferguson Act when it regulates the amount of insurance benefits an insurer must pay under an insurance policy it has sold.[53]

The Supreme Court settled that same question in a series of decisions. The McCarran-Ferguson Act protects state regulation of "the contract between the insurer and the insured" against federal preemption.[54] The "core of the 'business of insurance'" includes "enforcement" of the insurance policy.[55] The "actual performance of an insurance contract" includes paying benefits, "an essential part of the 'business of insurance.'"[56] A "direct" regulation of the business of insurance would be a state statute "***prescribing the terms of the insurance contract*** or . . . setting the rate charged by the insurance company."[57]

"Prescribing the terms of the insurance contract," and establishing a regulatory scheme for "enforcement" of Texas workers' compensation insurance policies, is precisely what the Texas workers' compensation law does.[58]

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[53] *See* Texas Decision at 5.
[54] *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 128 (1982).
[55] *SEC v. Nat'l Securities, Inc.*, 393 U.S. 453, 460 (1969).
[56] *United States Dep't of the Treasury v. Fabe*, 508 U.S. 491, 505 (1993).
[57] *Id.* at 502-03 (emphasis added).
[58] *See* Texas Decision at 5.

The McCarran-Ferguson Act should equally apply to protect Wyoming's workers' compensation system from inadvertent federal preemption. State workers' compensation insurance laws — however the various states choose in an exercise of their police powers to implement them — should be protected from federal preemption stemming from statutes that do not "specifically" regulate insurance.

To hold otherwise would be to create an incongruous patchwork of preemption depending on how the various states chose to implement workers' compensation insurance. Under the district court's rationale, the regulation of payments by state-regulated private insurers would not be preempted, but those same payment limitations would be preempted by the ADA when they are applied directly by the states themselves. The employers who subscribe to workers' compensation and who ultimately bear the cost of the workers' compensation system should not be treated differently simply because they must subscribe to a state-run program rather than to state-regulated private insurance. Nothing in the ADA would support such an arbitrary result. Indeed, such an absurd result underscores the point: States can choose their precise mechanisms for implementing their police powers in areas they

traditionally regulate, without the fear of inadvertent federal preemption.

II. The District Court erred in granting injunctive relief that requires the State to pay the air ambulance providers' billed charges.

The parties will brief whether the *Ex parte Young*, 208 U.S. 123 (1908), exception to Eleventh Amendment sovereign immunity allows a federal court to decide that billed charges are what the State owes and to order state officials to make such payments.

As the state officials explain in their brief, in order for the air ambulances to obtain any declaratory or injunctive relief under *Ex parte Young*, they must satisfy the fundamental requirement of showing that the State is attempting to take some sort of illegal or unconstitutional enforcement action.[59] The State's workers' compensation fee schedules are no such thing. They set out what the State will pay to air ambulances that provide medical transports to injured workers covered by the state workers' compensation system. Absent the providers' claims for those published fees, the State of Wyoming has no obligation to pay air ambulance providers *anything*, and the air ambulances (like all other healthcare providers who treat

[59] *See* Appellants' Opening Brief at 52.

injured workers) have no claim against the Wyoming workers' compensation system *at all*. In other words, absent the State's workers' compensation system that taxes employers and uses those revenues to compensate treatment of workplace injuries, the air ambulance providers have no right to recover anything from the State. Paying the air ambulances' claims at the published, fee-schedule rates cannot be what the Supreme Court meant by an illegal or unconstitutional state enforcement action.

Astonishingly, the district court not only held the fee schedule preempted, but also ordered the Wyoming officials to pay the air ambulance providers' full billed charges.[60] The ADA, when it applies, says the states cannot regulate airline prices. It says nothing about compelling any payors, including the states, to pay whatever an air ambulance provider charges. Ordering this relief is, simply put, a bridge too far.

Assuming, *arguendo*, that preemption was proper, what should follow is that the State payor would be in precisely the same position as

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[60] Amended Judgment at 2 ("It is further ORDERED, ADJUDGED, AND DECREED that the named state officials and their employees and agents are required to compensate air ambulance entities the full amount charged for air ambulance services.").

private payors. Private payors — mainly private health insurers — are obviously not compelled by the ADA to pay billed charges. In their version of price negotiations with private insurers, air ambulances attempt to extract the highest possible payments from private insurers by threatening to balance bill and sue the insured. Although this is plainly not the "market" Congress intended to protect from rate regulation, it is the "market" in which air ambulances operate. If ADA preemption eliminates the State's fee schedule, the State would be rendered an unregulated payor just like any other private entity payor, and the air ambulances would have to accept whatever payments they manage to negotiate with the State.

CONCLUSION

Amicus Curiae Texas Mutual Insurance Company respectfully asks that this Court reverse the District's Court's summary judgment order as to the Airline Deregulation Act's preemption of Wyoming's workers' compensation fee schedule.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

As required by Fed. R. App. P. 32(a)(7)(c), I certify that this brief is proportionally spaced and contains 5,779 words. I relied on my word processor to obtain the count and it is Word Version 10.

I certify that the information on this form is true and correct to the best of my knowledge and belief formed after reasonable inquiry.

By: */s/Matthew Baumgartner*
Matthew Baumgartner

CERTIFICATE OF PRIVACY REDACTIONS, DIGITAL SUBMISSION & VIRUS SCAN

I hereby certify that the digital submission of the Appellees' Brief is an exact copy of the written document filed with the clerk ad it has been scanned for viruses with the most recent version of Malwarebytes Anti-Maleware Version v2016.09.02.07, on October 4, 2016 and, according to that program is free of viruses. In addition, I certify all required privacy redactions have been made.

By: */s/Matthew Baumgartner*
Matthew Baumgartner

CERTIFICATE OF SERVICE

I hereby certify that on the 11th day of October, 2016, I filed the foregoing document with the Clerk of the Court. I also certify that the foregoing document is being served this day on all counsel of record listed below.

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Index of Attachments

A Decision and Order in *In re Reimbursement of Air Ambulance Services Provided by PHI Air Medical*, State Office of Administrative Hearings Docket No. 454-15-0681.M4 et al., pending as *Texas Mutual Insurance Co. v. PHI Air Medical, LLC*, Docket No. D-1-GN-15-004940 in the 53rd state district court of Travis County, Texas.

B Air Methods financial data filed with the Texas Department of Insurance.

C Excerpted witness testimony in the Texas case.

D House Report 95-1211 (1978), accompanying the Airline Deregulation Act of 1978 (excerpts).

E Atlas & Database of Air Medical Services (ADAMS) 2014 database showing number of air ambulances (excerpts).

F PHI's discovery responses in Texas case showing its chargemaster from 2010-2013 (page 20, excerpted)

G 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). Table shows calculation of average cost per air ambulance flight by distance of transport, based on Medicare data (Table 1 excerpted).

EXHIBIT A

JML

State Office of Administrative Hearings

SLS RECEIVED

SEP 09 2015

CLAIMANT:

FILE NO:

Cathleen Parsley
Chief Administrative Law Judge

September 8, 2015

All Parties of Record (See Attached Service List) **VIA REGULAR MAIL**

RE: Docket No. 454-15-0681.M4, et al.; In Re: Reimbursement of Air Ambulance Services Provided by PHI Air Medical

Dear Parties:

Enclosed please find the Decision and Order in the above-referenced case.

Sincerely,

Craig R. Bennett
Administrative Law Judge

CRB/ls
Enclosure

xc: Tiffany Duarte, Texas Department of Insurance, Division of Workers- Compensation, Legal Services Division, 7551 Metro Center Drive, Ste. 100, MS-11, Austin, Texas 78744-1609 (1 - Hearing CD) – VIA INTERAGENCY MAIL

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

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

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ATTACHMENT 1

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

	§	**BEFORE THE STATE OFFICE**
IN RE:	§	
	§	
REIMBURSEMENT OF AIR AMBULANCE SERVICES PROVIDED BY PHI AIR MEDICAL	§	**OF**
	§	
	§	
	§	
	§	**ADMINISTRATIVE HEARINGS**

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.

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There are essentially two primary issues in this case: (1) does the federal Airline Deregulation Act (ADA)[1] 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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[1] Specifically, 49 U.S.C. § 41713(b).

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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.[2]

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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[2] 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.

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III. THRESHOLD LEGAL ISSUE

As noted above, a threshold legal issue exists—namely, whether the TWCA is preempted by the ADA.[3] 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,[4] 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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[3] 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.

[4] 15 U.S.C. § 1011-1015.

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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.[5] So, the ALJ now turns to that act's reimbursement provisions.

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[5] 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.

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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)].

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- 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.[6]

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."[7] 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[8]

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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[6] 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.

[7] *See* Decision and Order, 454-12-5501 (Oct. 31, 2012) at 3-5, for a detailed discussion of the burden of proof.

[8] 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.

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(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

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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.[9] Carriers argue that 125% of Medicare meets these criteria.[10]

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[9] 28 Tex. Admin. Code § 134.1(f).

[10] 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.

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To demonstrate that 125% of Medicare is fair and reasonable, Carriers presented the testimony of Dr. Ron Luke, an expert economist.[11] 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.[12] 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.[13] Because of this, Dr. Luke testified that 125% of Medicare still ensured access to care.

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[11] 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.

[12] See Carriers' Exs. 46 and 50; Tr. Vol. 1 at 303.

[13] Tr. Vol. 1 at 217-18.

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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.[14]

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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[14] Tr. Vol. 2 at 311; Carriers' Ex. 189 at 35.

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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.[15]

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.

[15] 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.

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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.[16] 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

[16] 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.

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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."[17] 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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[17] 28 Tex. Admin. Code § 134.203(f).

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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?[18]

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

[18] 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.

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provider to operate at a loss is not fair or reasonable unless the provider has been shown to be inefficient.[19] 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,[20] they cannot be used as the sole basis, even with a conversion factor applied.[21] 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"[22] 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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[19] For example, inefficiency might be shown if a provider incurs significantly higher operating costs than other providers in the same or a comparable market.

[20] *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."

[21] Tex. Lab. Code § 413.011(b).

[22] Tex. Lab. Code § 413.011(b).

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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

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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."[23] The TWCA generally prohibits

[23] Tex. Lab. Code § 413.011(d).

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reimbursements that are excessive when compared to the amounts paid by equivalent populations.[24] 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

[24] 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.

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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.[25] 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.[26] 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.[27] 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

[25] Tr. Vol. 2 at 284, 304-05.

[26] 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%.

[27] 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.

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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

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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.[28]

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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[28] 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.

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VI. 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.

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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.

CONFIDENTIAL
Pursuant to Tex. Lab. Code
§ 402.083

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.

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

ATTACHMENT 1

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

2360954.1

EXHIBIT B

RECEIVED
JUN 12 2014
LEGAL DEPARTMENT

GARDERE

attorneys and counselors ▪ www.gardere.com

Leslie Ritchie Robnett
Direct Dial: 512-542-7140
Direct Fax: 512-542-7340
Email: lrobnett@gardere.com

June 6, 2014

Via Hand Delivery
Martha Luevano
Medical Fee Dispute Resolution Manager
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Ste. 100
Austin, Texas 78744

Re: Requestors' Medical Fee Dispute Resolution Response Packet

Dear Ms. Luevano:

We represent Air Methods Corporation (which operates in Texas as Native American Air Ambulance and Rocky Mountain Helicopters), the "AMGH Companies" (which operate in Texas as Air Evac EMS, Inc., EagleMed LLC, Med-Trans Corporation and REACH Air Medical Services, LLC), and PHI Air Medical (collectively, the "Requestors") in the medical fee disputes for which you requested responses in your May 7, 2014 correspondence.

Enclosed in this packet, you will find a specific position statement from each client, in addition to a global response from our law firm that places the evidence submitted in the context of Texas law. Exhibit 1 to each of our firm's letter lists which disputes pertain to each client.

Thank you for your attention to this matter. If you have any questions, please do not hesitate to contact me.

Respectfully,

Leslie Ritchie Robnett
Texas State Bar No. 24065986

DEFENDERS OF TOMORROW™

SELECTED FINANCIAL DATA OF THE COMPANY

Basis for Patient Transport Revenue Charge Structure - Texas as of 12/31/2013

Expenses associated with patient revenue in Texas	Aug-Dec 2011	FY2012	FY2013
Government Contract Adjustment Expense	9,603,234	26,191,269	33,037,124
Bad Debt Expense	4,787,266	12,296,301	14,494,094
Total Non Aircraft Operating Center Expense	2,599,303	7,751,805	10,334,336
Total Aircraft Operating Expense	1,129,254	3,315,783	2,808,327
Total Depreciation and Amortization	342,559	829,727	1,156,267
Aircraft Lease/Interest Expense	88,267	454,942	371,222
Total General & Administrative Expense	623,908	1,852,839	2,200,523
Sub-Total	19,173,791	52,692,665	64,401,893
10% Margin Targeted	1,917,379	5,269,267	6,440,189
Tax Expense @ 39%	747,778	2,055,014	2,511,674
Total	21,838,948	60,016,946	73,353,756
Actual Patient Transports	573	1,456	1,559
Average charge necessary	38,113	41,220	47,052
Actual Average Charge	34,950	37,407	41,671
Actual Pre-Tax Margin	4%	3%	1%
Budgeted Patient Transports	566	1,555	1,711
Difference	7	(99)	(152)

Sincerely,

Jonathan Collier
Senior Vice President, Western Operations
AIR METHODS CORPORATION

EXHIBIT C

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

TEXAS MUTUAL INSURANCE COMPANY,	)	BEFORE THE STATE OFFICE
Petitioner,	)	OF
PHI AIR MEDICAL,	)	
Respondent.	)	ADMINISTRATIVE HEARINGS

****

HEARING ON THE MERITS

WEDNESDAY, APRIL 22, 2015

VOLUME 1

****

BE IT REMEMBERED THAT at 8:51 a.m., on Wednesday, the 22nd day of April, 2015, the above-entitled matter came on for hearing at the State Office of Administrative Hearings, William P. Clements, Jr., Building, 300 West 15th Street, Room 407-A, Austin, Texas 78701, before CRAIG BENNETT, Administrative Law Judge. The following proceedings were reported by Jodi Cardenas, Certified Shorthand Reporter.

1 morning about the increase in Air Methods' charges?
2 A. Yes.
3 Q. Does this demonstrate a similar increase as
4 that testified to by Mr. Frazier with regard to Air
5 Methods' charges?
6 A. It does, and -- and we've actually had some
7 additional figures later on. But I think graphically,
8 this presents it quite well.
9 MR. LOUGHLIN: Mr. Garcia?
10 (Pause in proceedings)
11 Q. (BY MR. LOUGHLIN) Doctor, can you tell us what
12 Figure 10 shows?
13 A. Yes. This is the increases in the base and
14 mileage charge amounts that PHI reported in its response
15 to interrogatories. And as you can see, they have
16 increased charges multiple times during each calendar
17 year. And if you look at the bottom, the percentage
18 increase in charges, 2010 to 2013, which is a period of
19 really three years, they've increased 75 percent.
20 Q. So, Doctor, what was the base charge on
21 January 1st, 2010?
22 A. $11,492.
23 Q. And what was the base charge on October 1st,
24 2013, less than three years later?
25 A. $20,119.

1 Q. Is that increase explained by inflation?

2 A. No. As you can see below the inflation over

3 the same period was only about 11 percent.

4 Q. How does that increase compare to the rate of

5 inflation there?

6 A. Well, what, almost seven times?

7 Q. Doctor, are you ready to move to the next

8 slide?

9 A. Yes, I think so.

10 Q. Doctor, can you tell us what Figure 11 shows?

11 A. Yes. What we have here is the PHI data that I

12 guess is the counterpart to the Air Methods' data that

13 Mr. Frazier was discussing, and what it shows in Texas

14 is that they had a decline from 2010 to 2013 in their

15 number of transports and that that also occurred

16 nationwide for PHI. So the total number of transports

17 is -- is going down.

18 Can you scroll down some, please? Even

19 more. There we go. What you see is that even though

20 that was occurring, that they substantially increased

21 their number of aircraft in service, so I believe

22 Mr. Frazier said more aircraft chasing fewer flights,

23 and that appears to be the case for PHI.

24 And if you scroll some more for me. So

25 that if you look at transports per aircraft, what you

1 SOAH DOCKET NO. 454-15-0681.M4, et al.

2 TEXAS MUTUAL INSURANCE COMPANY,	)	BEFORE THE STATE OFFICE
3 Petitioner,	)	
4	)	OF
PHI AIR MEDICAL,	)	
5 Respondent.	)	ADMINISTRATIVE HEARINGS

6

7

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8

9 HEARING ON THE MERITS

10 THURSDAY, APRIL 23, 2015

11 VOLUME 2

12

****

13

14 BE IT REMEMBERED THAT at 8:10 a.m., on
15 Thursday, the 23rd day of April, 2015, the
16 above-entitled matter came on for hearing at the State
17 Office of Administrative Hearings, William P. Clements,
18 Jr., Building, 300 West 15th Street, Room 407-A, Austin,
19 Texas 78701, before CRAIG BENNETT, Administrative Law
20 Judge. The following proceedings were reported by
21 Steven Stogel, Certified Shorthand Reporter.
22
23
24
25

1 APPEARANCES
2
3 FOR THE PETITIONER, TEXAS MUTUAL INSURANCE COMPANY:
4 Mr. Matthew Baumgartner
GRAVES, DOUGHERTY, HEARON & MOODY
5 401 Congress Avenue, Suite 2200
Austin, Texas 78701
6 (512) 480-5793
mbaumgartner@gdhm.com
7
8
FOR THE PETITIONERS, TWIN CITY FIRE INSURANCE COMPANY,
9 HARTFORD UNDERWRITERS INSURANCE COMPANY, ZENITH
INSURANCE COMPANY, TRANSPORTATION INSURANCE COMPANY,
10 TRUCK INSURANCE COMPANY, VALLEY FORGE INSURANCE COMPANY,
AND TASB RISK MANAGEMENT FUND:
11
Mr. James M. Loughlin
12 STONE, LOUGHLIN & SWANSON, LLP
3508 Far West Boulevard
13 Austin, Texas 78731
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14 jloughlin@slsaustin.com
15
16 FOR THE RESPONDENT:
17 Mr. Andres Medrano
Ms. Leslie Ritchie Robnett
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20 amedrano@gardere.com
lrobnett@gardere.com
21
22
23
24
25

1 Mr. Garcia, is to blow up that -- well, just blow up all
2 the data, I suppose. Okay.
3 So as a percentage of expenses on a given
4 flight -- and we're talking about, you know, whether
5 the -- as I just read, whether the market-driven
6 charges -- not payments or some other thing, but
7 charges -- represent the cost of doing business plus a
8 very modest profit margin. And if you just take -- as
9 we discussed at the outset, take the transports plus the
10 average bill charged, that gets you your charges, your
11 gross billed charges. Right?
12 A Approximately, yes.
13 Q So that average billed charge number represents
14 a gross -- that's a gross billed charge per flight.
15 Right?
16 A Yes.
17 Q And you can easily do the costs -- the costs of
18 doing business on a per flight basis by taking that
19 number of transports -- let's take 2013 for
20 hypothetical -- or for argument's sake, I guess --
21 3,776. And if you take your total expenses there --
22 it's a little bit of a fuzzy number, but it's
23 31,584,811. Are you with me?
24 A Yes.
25 Q And if you divide that by the total number of

1 flights, you get a cost per flight number?
2 A Yes.
3 Q Okay. Of 8,364. And if you just take -- this
4 is just based an your own data here. If you just take
5 that cost number -- you look at your actual expenses,
6 that same $31 million number, and divide it by 8,364,
7 what do you get?
8 A You want to do 31 million divided by 8,364?
9 Q Oh, sorry. 31 -- I might have said the wrong
10 thing totally. 31,927, because we're doing it on a per
11 flight basis, divided by 8,364?
12 MR. MEDRANO: Can counsel clarify where
13 8,364 is coming from?
14 MR. BAUMGARTNER: We just calculated that
15 as the cost per flight.
16 JUDGE BENNETT: I guess where I'm not
17 clear is this 31.9 that you're talking about. What 31.9
18 are you referring to?
19 MR. BAUMGARTNER: Where did I get that?
20 That's the billed charges. That's the billed charges
21 per flight. That's the very bottom number. That's
22 gross billed charges, and I was just asking questions
23 earlier to establish that that is represented on a per
24 flight basis of their total billed charges.
25 Q (BY MR. BAUMGARTNER) So now we calculated the

1 8,364 as an expense per flight. So now it's just a
2 simple division problem, 31,927 divided by 8,364. What
3 do you get?
4 A When I do that math, I get 3.8.
5 Q 3.8. So a 380 percent margin of cost as a
6 percentage of expenses on a given flight?
7 A The 380 percent --
8 Q The charges --
9 A -- is -- this 31,927 is our average billed
10 charge.
11 Q Right. So 300 --
12 A It's not what we expect to collect.
13 Q It's what you expect this court to order should
14 be paid in this case. Right?
15 A That is our average billed charge, yes.
16 Q Okay. So $31,927 is the charge and is an
17 expense of the $8,364 expensed per flight. That's
18 382 percent. Right?
19 A 382 percent, yes.
20 Q And if you take out the 100 percent that's
21 represented by the expenses, you get a 280 percent
22 profit margin. Right?
23 A Yes.
24 Q And you believe that's -- you still stand by
25 the statement that the market-driven charges represent

1 the cost of doing business plus a very modest profit
2 margin?
3 MR. BAUMGARTNER: I have nothing further,
4 Your Honor.
5 JUDGE BENNETT: Any additional cross?
6 MR. LOUGHLIN: I did have a few questions.
7 I didn't hear Mr. Stanek's last response. Did he
8 answer?
9 MR. BAUMGARTNER: Oh. I thought he
10 nodded. Sorry.
11 JUDGE BENNETT: He didn't answer, and you
12 said that's all you had. So you didn't ask for him to
13 answer, so I just moved on.
14 MR. BAUMGARTNER: I thought he nodded.
15 Sorry. Fair enough.
16 RECROSS-EXAMINATION
17 BY MR. LOUGHLIN:
18 Q I guess I'll begin my cross by asking you to
19 answer Mr. Baumgartner's question.
20 A The -- on the 280 percent?
21 Q Yes.
22 A So the answer would be yes, but there's other
23 items to consider in that statement.
24 Q Mr. Garcia, can we go back to Exhibit 50,
25 please? It's the hypothetical scenarios.

EXHIBIT D

H.R. REP. 95-1211, H.R. Rep. No. 1211, 95TH Cong., 2ND
Sess. 1978, 1978 U.S.C.C.A.N. 3737, 1978 WL 8603 (Leg.Hist.)
P.L. 95-504, AIRLINE DEREGULATION ACT OF 1978
SEE PAGE 92 STAT. 1705
SENATE REPORT (COMMERCE, SCIENCE, AND TRANSPORTATION
COMMITTEE) NO 95-631, FEB. 6, 1978 (TO ACCOMPANY
S. 2493)
HOUSE REPORT (PUBLIC WORKS AND TRANSPORTATION COMMITTEE)
NO. 95-1211, MAY 19, JULY 31, 1978 (TO ACCOMPANY
H.R. 12611)
HOUSE CONFERENCE REPORT NO. 95-1779, OCT. 12, 1978
(TO ACCOMPANY S. 2493)
CONG. RECORD VOL. 124 (1978)
DATES OF CONSIDERATION AND PASSAGE
SENATE APRIL 19, OCTOBER 14, 1978
HOUSE SEPTEMBER 21, OCTOBER 15, 1978
THE SENATE BILL WAS PASSED IN LIEU OF THE HOUSE BILL AFTER
AMENDING ITS LANGUAGE TO CONTAIN MUCH OF THE TEXT OF THE
HOUSE BILL.
THE HOUSE REPORT (THIS PAGE) AND THE HOUSE CONFERENCE
REPORT (P. 3773) ARE SET OUT.

(CONSULT NOTE FOLLOWING TEXT FOR INFORMATION ABOUT OMITTED
MATERIAL. EACH COMMITTEE REPORT IS A SEPARATE DOCUMENT ON WESTLAW.)

HOUSE REPORT NO. 95-1211

MAY 19, JULY 31, 1978

*1 **3737 THE COMMITTEE ON PUBLIC WORKS AND TRANSPORTATION, TO WHOM WAS REFERRED THE BILL (H.R. 12611) TO AMEND THE FEDERAL AVIATION ACT OF 1958 TO IMPROVE AIR SERVICE AND PROVIDE FLEXIBILITY IN AIR FARES, HAVING CONSIDERED THE SAME, REPORT FAVORABLY THEREON WITH AN AMENDMENT AND RECOMMEND THAT THE BILL AS AMENDED DO PASS.

* * * *

1. THE NEED FOR REGULATORY REFORM

THE EXISTING REGULATORY SYSTEMS GOVERNING AIRLINES WAS ESTABLISHED IN 1938 AND HAS NOT BEEN SUBSTANTIALLY CHANGED SINCE THAT DATE.

DURING THE LAST TWO CONGRESSES, THE AVIATION SUBCOMMITTEE HAD EXTENSIVE HEARINGS ON THE NEED FOR REFORM OF THE EXISTING REGULATORY SYSTEM. 36 DAYS OF HEARINGS WERE HELD AND TESTIMONY WAS RECEIVED FROM MORE THAN 200 WITNESSES, REPRESENTING SUCH DIVERSE PARTIES AS MEMBERS OF CONGRESS, AND ADMINISTRATION, THE ACADEMIC COMMUNITY, AIRLINES REGULATED BY THE CIVIL AERONAUTICS BOARD, INTRASTATE AIRLINES, AIRPORT OPERATORS, LABOR UNIONS, STATE

THE POLICY CRITERIA WHICH HAVE BEEN INTERPRETED TO ALLOW ANTICOMPETITIVE POLICIES HAVE BEEN THE REQUIREMENTS THAT THE CAB 'FOSTER SOUND ECONOMIC CONDITIONS' IN AIR TRANSPORTATION, PROMOTE 'ADEQUATE ECONOMICAL AND EFFICIENT SERVICE BY AIR CARRIERS AT REASONABLE CHARGES' AND DEVELOP 'COMPETITION TO THE EXTENT NECESSARY TO ASSURE THE SOUND DEVELOPMENT OF AN AIR TRANSPORTATION SYSTEM.' ALTHOUGH THESE CRITERIA ON THEIR FACE DO NOT APPEAR TO REQUIRE PROTECTIONIST POLICIES, THEY HAVE BEEN SO INTERPRETED BY CAB.

H.R. 12611 CHANGES THE POLICY STATEMENT FOR INTERSTATE AND OVERSEAS AIR TRANSPORTATION. THE REVISED STATEMENT MODIFIES THE CRITERIA QUOTED ABOVE AND DIRECTS THE BOARD TO STRESS COMPETITION, LOW-FARE SERVICE, *6 ENTRY BY NEW CARRIERS, AND AVOIDANCE OF INDUSTRY CONCENTRATION. THE BOARD IS ALSO REQUIRED TO DEVELOP PROGRAMS TO REPLACE CARRIERS HOLDING UNUSED AUTHORITY AND TO DEVELOP A REGULATORY ENVIRONMENT IN WHICH DECISIONS WILL BE REACHED PROMPTLY. THE BOARD IS FURTHER DIRECTED TO CONTINUE ITS PROGRAM OF STRENGTHENING SMALLER AIR CARRIERS.

**3742 THE POLICY STATEMENT MAKES IT CLEAR THAT INCREASED RELIANCE UPON COMPETITION MUST NOT RESULT IN ANY DETERIORATION IN SAFETY. THE BOARD IS DIRECTED TO GIVE THE HIGHEST PRIORITY TO MAINTAINING SAFETY AND TO PREVENTING DETERIORATION IN ESTABLISHED SAFETY PROCEDURES. THE BOARD IS ALSO REQUIRED TO TAKE ACCOUNT OF THE INTERESTS OF INDUSTRY EMPLOYEES BY ENCOURAGING FAIR WAGES AND EQUITABLE WORKING CONDITIONS.

THE REVISED POLICY STATEMENT DIRECTS THE BOARD TO ENCOURAGE AIR SERVICE AT MAJOR URBAN AREAS THROUGH SECONDARY OR SATELLITE AIRPORTS. THE BOARD IS FURTHER DIRECTED TO ENCOURAGE THE DEVELOPMENT OF SERVICE TO SECONDARY OR SATELLITE AIRPORTS BY SPECIALIST AIR CARRIERS. WHOSE SOLE RESPONSIBILITY WOULD BE TO SERVE THE SECONDARY OR SATELLITE AIRPORTS.

(II) NEW PUBLIC CONVENIENCE AND NECESSITY TEST (SEC. 7)

UNDER EXISTING LAW, CAB IS REQUIRED TO GRANT APPLICATIONS FOR INTERSTATE AND OVERSEAS TRANSPORTATION (DEFINED AS SERVICE TO U.S. POSSESSIONS AND TERRITORIES) IF THE PROPOSED SERVICE IS 'REQUIRED BY THE PUBLIC CONVENIENCE AND NECESSITY.' THE AIR SERVICE IMPROVEMENT ACT CHANGES THE TEST TO WHETHER THE PROPOSED SERVICE 'IS CONSISTENT WITH' THE PUBLIC CONVENIENCE AND NECESSITY. THIS CHANGE WILL LESSEN THE BURDEN WHICH EXISTING LAW PLACES ON THE PROPONENT OF A ROUTE AWARD. THIS SHOULD MAKE IT LESS OF A FINANCIAL BURDEN FOR A COMMUNITY TO PARTICIPATE IN A CAB PROCEEDING TO IMPROVE AIR SERVICE.

(III) UNUSED AUTHORITY (SEC. 8)

UNDER EXISTING LAW AND CAB POLICIES, THERE IS NO REQUIREMENT THAT CERTIFICATED CARRIERS PROVIDE NONSTOP SERVICE IN EVERY MARKET IN WHICH THEY ARE AUTHORIZED TO DO SO. IN FACT, THE AIRLINES USE ONLY A SMALL PERCENTAGE OF THEIR NONSTOP AUTHORITY. A SURVEY CONDUCTED BY THE DEPARTMENT OF TRANSPORTATION INDICATED THAT THE DOMESTIC CARRIERS ARE AUTHORIZED TO PROVIDE NONSTOP SERVICE IN APPROXIMATELY 28,000 MARKETS AND THAT THEY ACTUALLY PROVIDE NONSTOP SERVICE IN 4,500 OF THESE

(VI) EXPERIMENTAL CERTIFICATES (SEC. 11)

AS IT DEVELOPS A MORE COMPETITIVE AIRLINE SYSTEM, THE CAB MAY FIND IT DESIRABLE TO ISSUE TEMPORARY, EXPERIMENTAL CERTIFICATES TO CARRIERS PROPOSING LOW FARES OR NEW TYPES OF SERVICE. THE BOARD MAY ALSO FIND IT DESIRABLE TO AMEND OR REVOKE AN EXPERIMENTAL CERTIFICATE IF THE CARRIER FAILS TO PROVIDE THE INNOVATIVE OR LOW-FARE SERVICE WHICH WAS THE BASIS FOR ISSUING ITS CERTIFICATE. SECTION 11 OF H.R. 12611 ALLOWS THE BOARD TO GRANT TEMPORARY CERTIFICATES FOR EXPERIMENTAL PURPOSES AND TO AMEND OR REVOKE THESE CERTIFICATES IN ACCORDANCE WITH THE PROCEDURES OF SECTION 401(G) IF THE CERTIFICATE HOLDER FAILS TO PROVIDE THE SERVICE PROPOSED.

(VII) RESTRICTION REMOVAL (SEC. 12)

UNDER EXISTING LAW, THE CAB HAS AUTHORITY TO REMOVE CERTIFICATE RESTRICTIONS WHICH LIMIT THE SERVICE A CARRIER CAN PROVIDE (SUCH AS RESTRICTION REQUIRING A CARRIER TO MAKE A STOP AT ONE CITY WHEN OPERATING BETWEEN TWO OTHER CITIES). HOWEVER, EXISTING LAW DOES NOT IMPOSE ANY DEADLINES ON CAB FOR CONSIDERATION OF APPLICATIONS TO REMOVE CERTIFICATE RESTRICTIONS.

CERTIFICATE RESTRICTIONS CREATE ECONOMIC INEFFICIENCY BY PREVENTING CARRIERS FROM PROVIDING THE BEST POSSIBLE SERVICE FOR THE PUBLIC. TO FACILITATE REMOVAL OF UNNECESSARY RESTRICTIONS, THE AIR SERVICE IMPROVEMENT ACT PROHIBITS THE CAB FROM DISMISSING ANY APPLICATIONS FOR REMOVAL OF CERTIFICATE RESTRICTIONS, AND REQUIRES CAB TO BEGIN PROCEEDINGS ON THESE APPLICATIONS WITHIN 60 DAYS AFTER THEY ARE FILED. HOWEVER, THE ACT DOES NOT ADD SPECIAL SUBSTANTIVE PROVISIONS FOR THE BOARD TO CONSIDER IN PASSING ON THESE APPLICATIONS, AND THESE APPLICATIONS WILL BE CONSIDERED UNDER THE REGULAR CRITERIA FOR CERTIFICATE AMENDMENTS.

***9** (B) FARE FLEXIBILITY (SEC. 27)

UNDER EXISTING LAW, AIRLINES WISHING TO CHANGE THEIR FARES MUST SEEK APPROVAL FROM CAB. IF THE BOARD IS NOT SATISFIED WITH THE FARES WHICH AN AIRLINE PROPOSED, IT MAY PRESCRIBE THE FARES TO BE CHARGED.

****3745** OPERATING UNDER THESE PROVISIONS, THE BOARD IN THE EARLY 1970'S ESTABLISHED A FORMULA FOR DETERMINING COACH AND FIRST-CLASS FARES. UNDER THE FORMULA, THE FARE LEVEL IS DETERMINED BY THE AVERAGE COSTS OF ALL CARRIERS AND THERE ARE DETAILED PROVISIONS ON EXCLUSION AND INCLUSION OF COSTS. THE FORMULA REQUIRES THAT FARES BE SET AT A UNIFORM RATE PER MILE (WHICH CHANGES FOR DIFFERENT MILEAGE BLOCKS) THROUGHOUT A CARRIER'S ROUTE SYSTEM.

THE INFLEXIBILITY AND RIGIDITY OF THIS UNIFORM FORMULA HAS CONCERNED BOTH INDUSTRY AND CONSUMER REPRESENTATIVES. THE LATTER HAVE BEEN PARTICULARLY CONCERNED THAT THE BOARD'S FORMULA DOES NOT PERMIT COACH FARES TO BE REDUCED IN SELECTED MARKETS. THIS HAS DISCOURAGED EXPERIMENTS WITH LOWER FARES IN MARKETS WHICH MIGHT BE ABLE TO SUPPORT THEM.

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PUBLIC CONVENIENCE AND NECESSITY. THIS LEAVES THEM FREE TO ENTER AND EXIT FROM MARKETS AND SET THEIR FARES WITHOUT CAB AUTHORIZATION.

IN RECOGNITION OF THEIR IMPORTANT ROLE IN THE AIR TRANSPORT SYSTEM, THE COMMUTERS NEED ACCESS TO LARGER EQUIPMENT. IN RECENT YEARS, THE COMMUTERS HAVE BEEN REPLACING THE REGIONAL CARRIERS AT SMALL COMMUNITIES. BETWEEN 1970 AND 1975, THE NUMBER OF SMALL COMMUNITIES (UNDER 10,000 POPULATION) SERVED BY REGIONAL CARRIERS DECREASED 13 PERCENT WHILE THE NUMBER OF SUCH COMMUNITIES SERVED BY COMMUTERS INCREASED 21 PERCENT. THE COMMUTERS HAVE ALSO BEEN PLAYING IN INCREASINGLY IMPORTANT ROLE IN THE ALL-CARGO FIELD.

AIRCRAFT OF 40 TO 55 SEAT CAPACITY, SUCH AS THE F-27 AND CONVAIR 580, MAY BE THE MOST EFFICIENT AIRCRAFT FOR SOME OF THE MARKETS NOW SERVED BY THE COMMUTERS. IN ADDITION, SOME OF THE REGIONAL CARRIERS, WHICH NOW USE F-27S AND CONVAIR 580S TO SERVE SMALL AND MEDIUM-SIZED COMMUNITIES, MAY CONVERT TO ALL-JET FLEETS OF 90 SEATS OR GREATER CAPACITY. IF THIS OCCURS, THE COMMUTERS WILL BE CALLED UPON TO SERVE ADDITIONAL MARKETS FOR WHICH 40 TO 50 SEAT AIRCRAFT WOULD BE MOST EFFICIENT. AN EXTENDED EXEMPTION WOULD PERMIT COMMUTERS TO OPERATE 50-SEAT AIRCRAFT OF THIS CAPACITY.

THE BILL GRANTS COMMUTERS AN EXEMPTION TO OPERATE AIRCRAFT WITH A CAPACITY OF UP TO 56 PASSENGERS OR 18,000 POUNDS OF CARGO. THE BILL FURTHER PROVIDES THAT THE BOARD MAY INCREASE THESE AIRCRAFT LIMITS WHEN IT FINDS THAT THE PUBLIC INTEREST SO REQUIRES.

(II) JOINT FARES FOR COMMUTERS (SECS. 15 AND 27)

UNDER EXISTING LAW, THE CAB REQUIRES CERTIFICATED AIRLINES TO ESTABLISH JOINT FARES WITH OTHER CERTIFICATED CARRIERS, IN ACCORDANCE WITH A FORMULA FOR DETERMINING THE JOINT FARE AND DIVIDING THE REVENUES BETWEEN THE PARTICIPATING CARRIERS. THE CAB HAS EXTENDED THESE REQUIREMENTS TO COMMUTER CARRIERS WHICH REPLACE CERTIFICATED CARRIERS AT SUSPENDED POINTS, BUT THE BOARD HAS NOT ESTABLISHED GENERAL REQUIREMENTS FOR JOINT FARES BETWEEN CERTIFICATED CARRIERS AND COMMUTERS.

EXCLUSION OF COMMUTERS FROM THE JOINT FARE PROGRAM INJURES BOTH COMMUTERS AND THE TRAVELING PUBLIC.

UNDER THE CAB'S FORMULA, JOINT FARES ARE LOWER THAN THE SUM OF THE LOCAL FARES CHARGED BY THE TWO LOCAL CARRIERS INVOLVED IN PROVIDING THE CONNECTING TRANSPORTATION. THE COMMUTER AIRLINE ASSOCIATION OF AMERICA ESTIMATE THAT EXTENSION OF THE CAB'S JOINT FARE PROGRAM TO COMMUTER AIRLINES WOULD SAVE THE PUBLIC $5 TO $34 MILLION A YEAR IN AIR FARES.

***11** THE BOARD'S FAILURE TO REQUIRE THAT CERTIFICATED AIRLINES ESTABLISH JOINT FARES WITH COMMUTERS ALSO MAY PLACE THE COMMUTERS AT A COMPETITIVE DISADVANTAGE IN MARKETS WHERE THEY COMPETE WITH CERTIFICATED CARRIERS. MOREOVER, THE COMMUTERS LOSE REVENUES BY NOT PARTICIPATING ****3747** IN THE JOINT FARE PROGRAM. THE COMMUTER AIRLINE ASSOCIATION ALSO STATED THAT THE CAB'S

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SITUATIONS SIMILAR TO THE ONE THE INDUSTRY FACED SEVERAL YEARS AGO WHEN REPORT INTERNATIONAL ATTEMPTED TO GAIN AN UNUSUALLY LARGE SHARE OF THE VOTING STOCK OF PAN AMERICAN.

BOB STUMP.

*73 ADDITIONAL VIEWS OF ELLIOTT H. LEVITAS

I HAVE GIVEN MY SUPPORT TO THE BILL REPORTED BY THE SUBCOMMITTEE ON AVIATION, THE 'AIR SERVICE IMPROVEMENT ACT OF 1978,' H.R. 12611, ALTHOUGH THERE ARE SOME PARTS WHICH I DO NOT FAVOR, AS IN THE CASE WITH OTHER MEMBERS OF THE SUBCOMMITTEE. HOWEVER, ON THE WHOLE IT IS A WELL-BALANCED, REASONABLE PROPOSAL FOR MEANINGFUL REGULATORY REFORM. I THINK THE MEMBERS SHOULD BE PROUD OF OUR ACCOMPLISHMENT, AND I COMMEND IT TO OUR COLLEAGUES IN THE HOUSE.

THE UNITED STATES HAS THE FINEST AND SAFEST AVIATION SYSTEM IN THE WORLD, AND IT HAS GENERALLY PERFORMED OUTSTANDING SERVICE FOR THE AMERICAN TRAVELING AND SHIPPING PUBLIC. NEVERTHELESS, THE INDUSTRY HAS BEEN HIGHLY REGULATED SINCE ITS INCEPTION, AND THE PRESENT REGULATORY SYSTEM HAS NOT ALWAYS BEEN IN THE BEST FINANCIAL INTEREST OF THE CARRIERS AND THE CONSUMERS. CONGRESS NOW HAS THE OPPORTUNITY TO MAKE **3768 SOME CHANGES IN THE EXISTING RESTRICTIVE, SNAIL-PACED REGULATORY SYSTEM IN WHICH THE INDUSTRY OPERATES.

CONSUMERS, PASSENGERS, PRESENT AND PAST ADMINISTRATIONS, ECONOMISTS, AND SOME INDUSTRY LEADERS HAVE CALLED FOR CHANGES IN THE PRESENT CAB SYSTEM OF REGULATION; IN FACT, CAB CHAIRMAN ALFRED KAHN HAS BEEN A MOST VOCAL PROPONENT OF REGULATORY REFORM. EVEN THOUGH MUCH OF WHAT NEEDS TO BE DONE TO IMPROVE THE REGULATORY SYSTEM IS NOW BEING DONE BY THE CAB, SUCH AS GRANTING THE CARRIERS BLANKET FARE REDUCTION AUTHORITY, GRANTING PERMISSIVE ENTRY AUTHORITY FOR MULTIPLE ENTRIES, AND ELIMINATING ORAL HEARINGS IN SOME CASES, THE BOARD NEEDS A NEW CHARTER TO BE ASSURED THAT IT HAS A LEGAL BASIS FOR INSTITUTING THESE STREAMLINED AND LESS RESTRICTIVE POLICIES.

THE TIME HAS COME TO MOVE DECISION MAKING TO THE PRIVATE BOARDROOMS OF THE INDUSTRY AND AWAY FROM THE LAWYERS, ECONOMISTS, AND BUREAUCRATS AT THE CAB. FREE ENTERPRISE HAS SERVED OUR COUNTRY WELL, AND IT IS TIME TO MOVE THE AIRLINE INDUSTRY INTO A MORE COMPETITIVE ARENA WHERE IT WILL HAVE AN OPPORTUNITY TO GROW IN A PERIOD OF HEALTHY AND PROFITABLE COMPETITION. THE ULTIMATE BENEFICIARY WILL BE THE CONSUMER, THE TRAVELING PUBLIC.

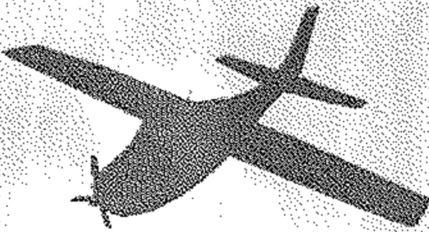
THE QUESTION IS OF COURSE HOW WE SHOULD ACCOMPLISH THE TRANSITION. WE HAVE HEARD A GREAT DEAL OF TALK ABOUT 'DEREGULATION' WHEN WHAT HAS ACTUALLY BEEN MEANT IS 'RE-REGULATION.' SOME BILLS WHICH HAVE BEEN INTRODUCED, INCLUDING THE ONE PASSED BY THE SENATE, DO NOT DEREGULATE BUT MERELY 'RE-REGULATE' THE SYSTEM USING ARBITRARY, UNTESTED FORMULAS WHICH BY THE ADMISSION OF CHAIRMAN KAHN HIMSELF WILL REQUIRE AN INCREASED CAB STAFF TO ADMINISTER. NOTHING WOULD BE MORE DISRUPTIVE TO THE INDUSTRY AND THE TRAVELING PUBLIC THAN MOVING PRECIPITOUSLY FROM A HIGHLY REGULATED INDUSTRY TO VIRTUALLY NO REGULATION AT ALL. AND CAN

EXHIBIT E

ADAMS 2014

Atlas & Database of Air Medical Services

A National GIS Database



12th Edition
September, 2014

National and State Maps
Showing Main & Satellite Base Locations
for Rotor and Fixed Wing
Air Medical Services

Insurers' Exhibit 120

TMIC0008862

4 NATIONAL & STATE OVERVIEW OF AIR MEDICAL COVERAGE IN 2014

Figure 1 is a map of the United States showing main and satellite base locations of all the Rotor Wing and Fixed Wing Air Medical Services in the US in 2014. The gold stars indicate main office locations and the gray circles indicate 10 minute fly circles around each base where a RW is stationed[2]. The size of the 10 minute fly circle varies with the cruise speed of the particular RW make and model resident at that base. The white blocks show bases (airports) where Fixed Wing aircraft are based. Summary statistics on numbers of services, bases and aircraft are provided at the bottom of the figure.

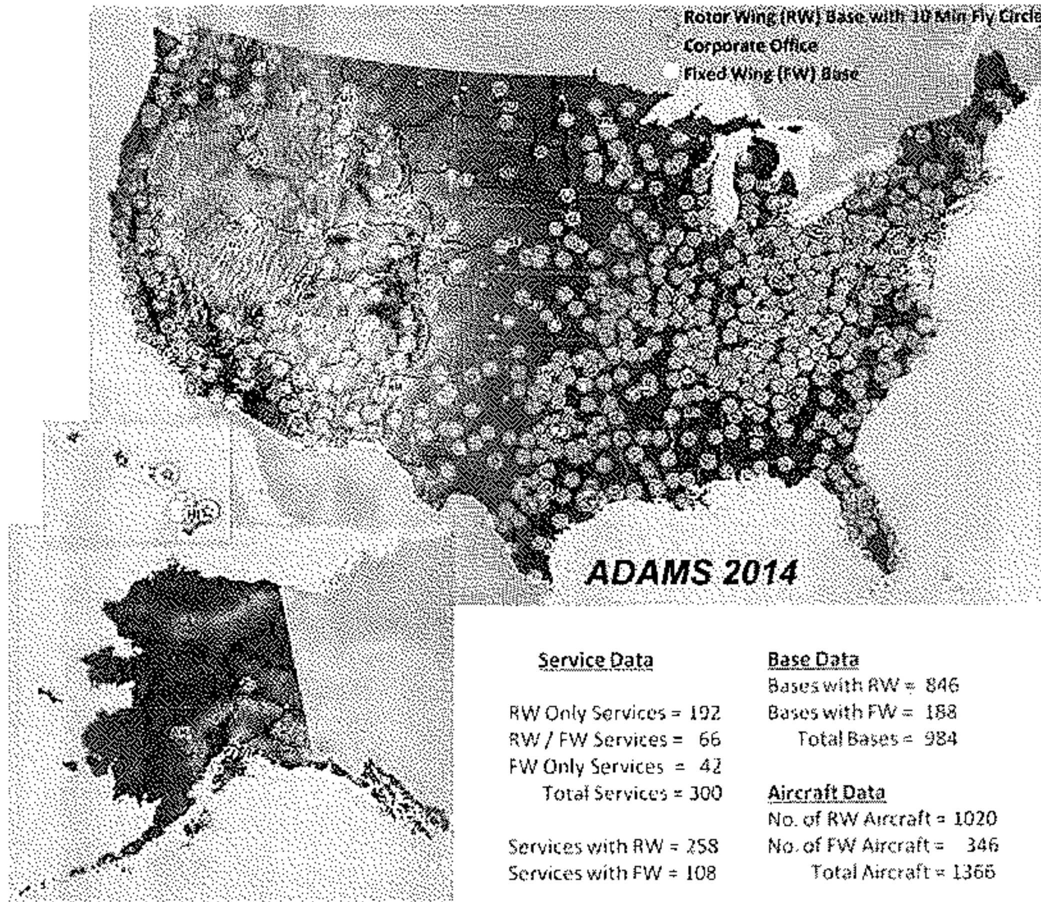


Figure 1. Air Medical Service Main & Satellite Rotor & Fixed Wing Base Locations.

Table 1 lists the number of air medical services headquartered in each state as well as the number of out-of-state services with bases in that state. This is followed by the number of bases with RW, the number with FW and the total number of bases in the state. Note that if a single air medical service has a base with both RW and FW, the base is included in the RW base inventory and in the FW base inventory, but included once in the total base inventory. For this reason, the sum of 'Bases with RW' and 'Bases with FW' may or may not equal 'Total Bases' in the state.

In addition to an inventory of bases, Table 1 also includes data on the number of RW and FW aircraft in each state. To place all these data in context, state populations and geographic area are provided for reference. National totals for each category are provided at the bottom of the table.

Figures 2 and 3 are bar charts which graphically display the information in Table 1. Finally, Table 2 lists the number of each type of service (RW only, RW/FW, FW only) headquartered in each state.

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[2] Note that a 10-minute fly circle actually translates into a ~20 minute response time since 7 to 12 minutes are usually required for initial preflight and launch.

Table 1. 2014 State Summary of Air Medical RW & FW Services, Bases & Aircraft Currently in ADAMS.

State	Services Headqrtd in State	Out of State Services w/Bases in State	Bases with RW	Bases with FW	Total Bases (a)	RW Aircraft (b)(c)	FW Aircraft (b)(c)	Total Aircraft (b)	State Population (Y2010)	Total State Area (Sq Mi) (d)
Alabama	5	2	13	2	15	14	3	17	4,779,736	52,423
Alaska	11	1	8	18	23	32	39	71	710,231	656,425
Arizona	9	3	51	12	61	57	16	73	6,392,017	114,006
Arkansas	4	5	17	2	19	17	6	23	2,915,918	53,182
California	31	3	64	15	75	100	24	124	37,253,956	163,707
Colorado	6	4	19	7	25	17	12	29	5,029,196	104,100
Connecticut	1	0	2	0	2	2	0	2	3,574,097	5,544
D.C.	2	1	2	0	2	4	0	4	601,723	68
Delaware	2	0	4	0	4	6	0	6	897,934	2,489
Florida	27	1	34	10	44	44	25	69	18,801,310	65,758
Georgia	7	2	25	3	28	29	24	53	9,687,653	59,441
Hawaii	3	1	5	7	11	6	9	15	1,360,301	10,932
Idaho	3	1	9	5	11	10	6	16	1,567,582	83,574
Illinois	10	4	21	4	24	26	5	31	12,830,632	57,918
Indiana	7	2	20	2	22	22	3	25	6,483,802	36,420
Iowa	6	3	11	2	13	12	5	17	3,046,355	56,276
Kansas	4	0	9	6	14	10	9	19	2,853,118	82,282
Kentucky	2	3	29	1	29	30	1	31	4,339,367	40,411
Louisiana	4	2	12	3	13	13	8	21	4,533,372	51,843
Maine	1	0	3	0	3	2	0	2	1,328,361	35,387
Maryland	2	3	13	1	13	18	2	20	5,773,552	12,407
Massachusetts	2	0	4	1	4	4	1	5	6,547,629	10,555
Michigan	8	3	12	6	15	13	15	28	9,883,640	96,810
Minnesota	4	2	12	4	15	18	7	25	5,303,925	86,943
Mississippi	3	4	11	0	11	11	0	11	2,967,297	48,434
Missouri	8	3	35	2	36	36	2	38	5,988,927	69,709
Montana	5	5	7	8	14	7	11	18	989,415	147,046
Nebraska	4	3	9	2	11	10	2	12	1,826,341	77,358
Nevada	3	3	7	8	14	10	11	21	2,700,551	110,567
New Hampshire	1	0	2	0	2	3	0	3	1,316,470	9,351
New Jersey	5	3	11	0	11	17	0	17	8,791,894	8,722
New Mexico	4	4	23	8	29	24	16	40	2,059,179	121,593
New York	9	0	20	5	21	29	4	33	19,378,102	54,475
North Carolina	10	1	20	2	21	22	4	26	9,535,483	53,821
North Dakota	3	1	4	3	6	4	6	10	672,591	70,704
Ohio	9	3	40	2	41	46	5	51	11,536,504	44,828
Oklahoma	3	2	23	2	25	23	9	32	3,751,351	69,903
Oregon	5	1	10	4	12	10	7	17	3,831,074	98,386
Pennsylvania	11	0	38	0	38	46	0	46	12,702,379	46,058
Rhode Island	0	0	0	0	0	0	0	0	1,052,567	1,545
South Carolina	5	3	12	2	14	12	2	14	4,625,364	32,007
South Dakota	4	0	4	3	6	4	5	9	814,180	77,121
Tennessee	5	1	27	1	28	31	1	32	6,346,105	42,146
Texas	18	4	77	10	83	86	18	104	25,145,561	268,601
Utah	3	1	14	4	16	17	5	22	2,763,885	84,904
Vermont	0	0	0	0	0	0	0	0	625,741	9,615
Virginia	8	2	17	0	17	22	0	22	8,001,024	42,769
Washington	3	1	11	6	13	14	11	25	6,724,540	71,303
West Virginia	1	1	10	0	10	11	0	11	1,852,994	24,231
Wisconsin	8	3	11	4	15	15	4	19	5,686,986	65,503
Wyoming	1	4	4	3	5	4	3	7	563,626	97,818
2014 Totals	**300**	**99**	**846**	**188**	**984**	**1020**	**346**	**1366**	**308,745,538**	**3,787,419**

a) If a single air medical service has a base with both RW and FW, the base is included in RW base inventory and in FW base inventory but included once in Total Bases. Therefore, sum of 'Bases with RW' and 'Bases with FW' may or may not equal 'Total Bases' in State.

b) State RW/ FW totals for Alaska and North Carolina include aircraft from selected military units which are routinely used in civilian rescue. Alaska: 17 RW & 8 FW from Air National Guard and Coast Guard; North Carolina: 3 RW from Marine Corps Air Station.

c) Throughout fleet, 51 RW and 2 FW are listed as SPARES

d) State total area (land & water) from http://www.netstate.com which references World Almanac of the USA by A Carpenter and C Provorse, 1996.

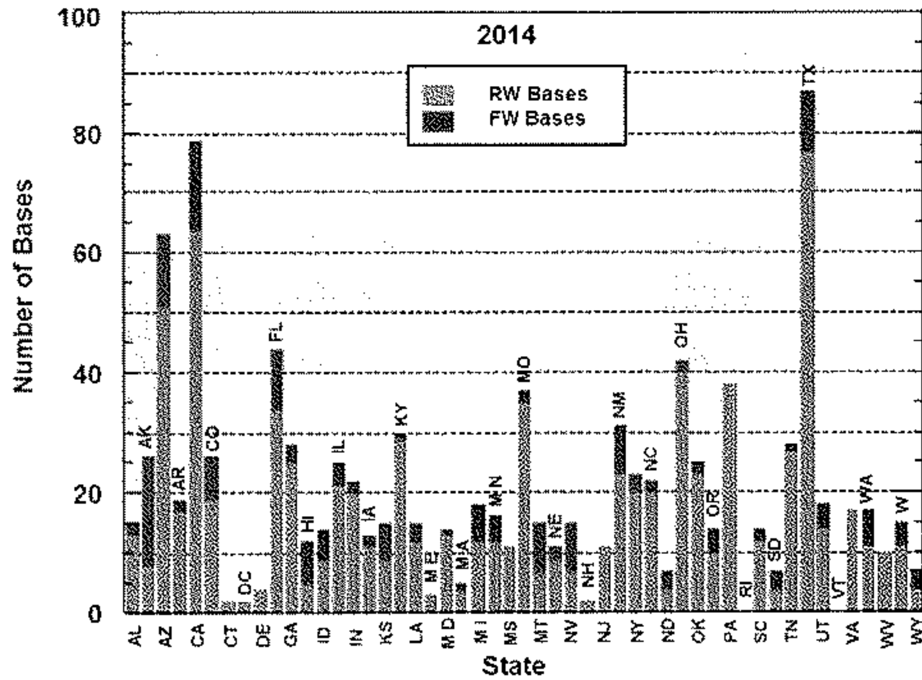


Figure 2. Bar Chart Showing Number of Bases with RW and Bases with FW by State in 2014.

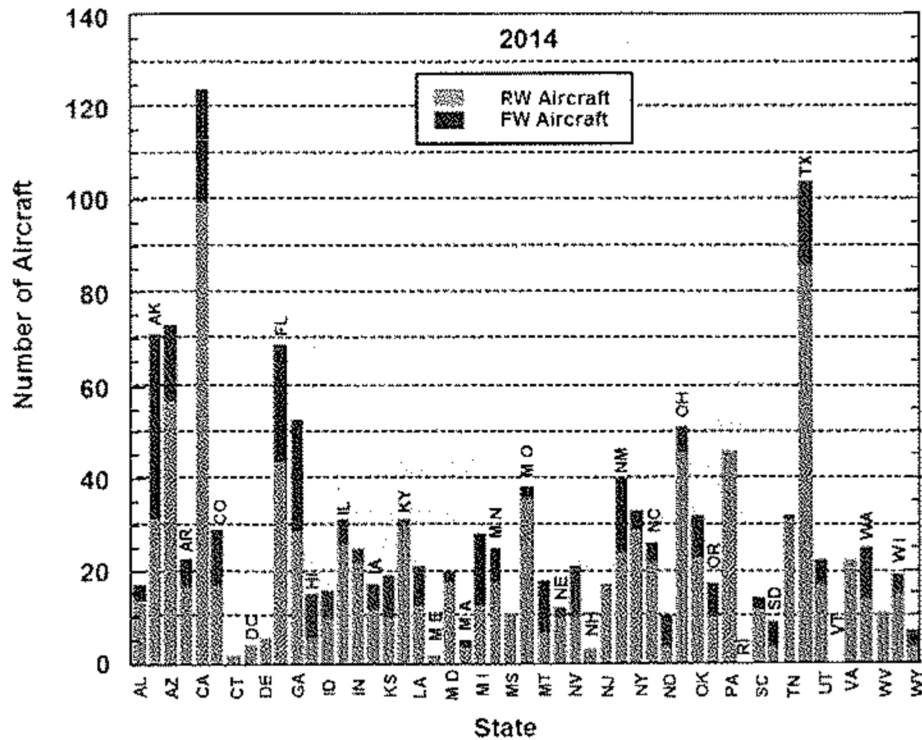


Figure 3. Bar Chart Showing Number of Aircraft by Type (RW & FW) and by State in 2014.

Table 2. Service Types Headquartered in Each State in 2014

State	RW only Services	RW / FW Services	FW only Services	Total Services Hdqrt in State
Alabama	3	0	2	5
Alaska	2	4	5	11
Arizona	4	5	0	9
Arkansas	2	0	2	4
California	22	5	4	31
Colorado	2	3	1	6
Connecticut	1	0	0	1
Delaware	2	0	0	2
Dist. of Columbia	2	0	0	2
Florida	19	1	7	27
Georgia	4	0	3	7
Hawaii	2	1	0	3
Idaho	0	3	0	3
Illinois	8	0	2	10
Indiana	6	0	1	7
Iowa	6	0	0	6
Kansas	2	2	0	4
Kentucky	1	1	0	2
Louisiana	2	2	0	4
Maine	1	0	0	1
Maryland	1	1	0	2
Massachusetts	1	1	0	2
Michigan	5	2	1	8
Minnesota	1	2	1	4
Mississippi	3	0	0	3
Missouri	5	3	0	8
Montana	0	3	2	5
Nebraska	4	0	0	4
Nevada	1	0	2	3
New Hampshire	1	0	0	1
New Jersey	5	0	0	5
New Mexico	1	2	1	4
New York	6	3	0	9
North Carolina	9	1	0	10
North Dakota	2	1	0	3
Ohio	7	2	0	9
Oklahoma	2	0	1	3
Oregon	0	3	2	5
Pennsylvania	11	0	0	11
Rhode Island	0	0	0	0
South Carolina	5	0	0	5
South Dakota	1	3	0	4
Tennessee	4	1	0	5
Texas	11	4	3	18
Utah	0	3	0	3
Vermont	0	0	0	0
Virginia	8	0	0	8
Washington	0	2	1	3
West Virginia	1	0	0	1
Wisconsin	6	1	1	8
Wyoming	0	1	0	1
	192	**66**	**42**	**300**
Total Services with RW = 258 / Total Services with FW = 108				

EXHIBIT F

DOCKET NO. 454-15-0681.M4, et al. (See Attachment 1 List)

IN RE:	§	BEFORE THE STATE OFFICE OF
	§	
REIMBURSEMENT OF AIR	§	
AMBULANCE SERVICES PROVIDED BY	§	
PHI AIR MEDICAL	§	ADMINISTRATIVE HEARINGS
	§	
	§	
	§	
	§	FOR THE STATE OF TEXAS

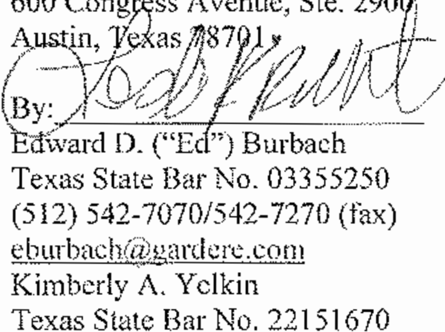
PHI AIR MEDICAL'S FIRST AMENDED RESPONSES AND OBJECTIONS TO CARRIERS' FIRST WRITTEN INTERROGATORIES AND FIRST REQUESTS FOR PRODUCTION OF DOCUMENTS

TO: Petitioners, by and through their attorney of record, James M. Loughlin, Stone Loughlin & Swanson, LLP, P.O. Box 30111, Austin, Texas 78755

COMES NOW, PHI Air Medical, the Respondent in the above-entitled and -numbered cause, and pursuant to Rule 196.2 and 197.2, supplemented by State Office of Administrative Hearings ("SOAH") Procedural Rule 1 TAC §155.251, hereby provides the attached First Amended Responses and Objections to the Carriers' First Written Interrogatories and First Requests for Production of Documents.

Respectfully submitted,

GARDERE WYNNE SEWELL LLP
600 Congress Avenue, Ste. 2900
Austin, Texas 78701



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PHI Exhibit 12
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CERTIFICATE OF SERVICE

This is to certify that on February 12, 2015, a true and correct copy of this document was served on the following parties by electronic mail and/or facsimile.

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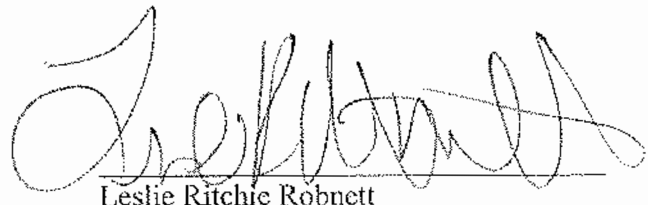

Leslie Ritchie Robnett

Company, 427 S.W.3d 396,397 (Tex. 2014).

Additionally, any communication between Carriers and PHI Air Medical are equally available to Carriers as to PHI Air Medical and are thus already subject to their possession and control. It is not the responsibility of PHI Air Medical to marshal evidence for Carriers that is already in their possession and control.

RESPONSE: PHI Air Medical stands on its objection.

REQUEST FOR PRODUCTION NO. 9:

Please produce any and all studies, records, surveys, reports, models, data compilations, communications, memoranda, or other documents or tangible things, supporting your contention that the total payment you seek to collect in this dispute: (1) is fair and reasonable; (2) will ensure the quality of medical care; (3) will achieve effective medical cost control; or (4) is not more than is paid for similar services on behalf of non-workers' compensation patients with an equivalent standard of living.

RESPONSE: Please see Requestor's Medical Fee Dispute Resolution Response Packet submitted on June 6, 2014 and the evidence attached thereto. See also Requestor's Reply to June 23, 2014 letter from the State Office of Risk Management ("SORM"); June 5, 2014 letter from Texas Mutual Insurance Company ("TMI); and June 30, 2014 Letter from Stone, Laughlin & Swanson LLP ("Stone & Laughlin") submitted on July 8, 2014 and the evidence attached thereto. These documents have been produced and bates labeled as PHI 00001-PHI 000286.

Specifically, please see Attachment Nos. 7-13 and Journal of American Medical Association, Baxter and Galvano studies, cited at FN 47 and 48 of June 6, 2014 Response Packet.

Please see also PHI Air Medical's Expert Report and the documents relied upon, produced at PHI 000836-PHI00142 and PHI 001768-PHI 001948.

REQUEST FOR PRODUCTION NO. 10:

Please produce a copy of each chargemaster in effect for air ambulance services at any time during 2010, 2011, 2012, 2013 and 2014.

OBJECTION: PHI Air Medical objects to this request for production to the extent that it requests information about services outside the State of Texas and for the year 2014 as those services are outside the scope of this fee dispute and are not relevant or reasonably tailored to seek evidence that may be relevant to this case. The disputes in this case, listed individually in Attachment A, all regard services provided in the State of Texas in the years 2010 through 2013. PHI Air Medical will respond to this request for production only for services provided in Texas for the years 2010, 2011, 2012, and 2013. PHI further objects to this request to the extent that it seeks documents that are proprietary, trade secret, or confidential business information.

RESPONSE: The chargemaster in effect for air ambulance services provided by PHI Air

Medical in Texas for the years 2010, 2011, 2012, and 2013 are as follows:

Effective Date	1/1/2010	5/1/2010	11/1/2010
Base Rate	$11,492	$12,000	$12,600
Mileage	$150	$156	$164

Effective Date	4/1/2011	7/1/2011	9/1/2011
Base Rate	$13,482	$13,886	$14,581
Mileage	$175	$181	$190

Effective Date	1/1/2012	4/1/2012	7/1/2012	10/1/2012	12/1/2012
Base Rate	$15,310	$16,075	$16,879	$17,723	$18,964
Mileage	$199	$209	$220	$231	$247

Effective Date	7/1/2013	10/1/2013 – 12/31/2013
Base Rate	$19,533	$20,510
Mileage	$254	$267

REQUEST FOR PRODUCTION NO. 11:

Please produce documents either directing a change in the chargemaster for air ambulance services at any time during 2010, 2011, 2012, 2013 and 2014, or reflecting changes made in such chargemaster during such time period.

OBJECTION: PHI Air Medical objects to this request for production to the extent that it requests information about services outside the State of Texas and for the year 2014 as those services are outside the scope of this fee dispute and are not relevant or reasonably tailored to seek evidence that may be relevant to this case. The disputes in this case, listed individually in Attachment A, all regard services provided in the State of Texas in the years 2010 through 2013. PHI Air Medical will respond to this request for production only for services provided in Texas for the years 2010, 2011, 2012, and 2013. PHI further objects to this request to the extent that it seeks documents that are proprietary, trade secret, or confidential business information.

RESPONSE: See Response to Request for Production No. 10. The tables provided in response fully show the changes made to the chargemaster use in Texas for air ambulance service for the relevant years. Additionally, documents responsive to this request have been identified and are provided in the confidential attachment marked Request for Production No. 11 at PHI 000314-PHI000334.

REQUEST FOR PRODUCTION NO. 12:

Please produce any documents prepared by or on behalf of PHI Air or in PHI Air's possession that compare the standard of living of Texas workers' compensation patients to the standard of living of any group of non-workers' compensation patients.

RESPONSE: Please see Requestor's Medical Fee Dispute Resolution Response Packet

EXHIBIT G

NIH Public Access
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Cost-Effectiveness of Helicopter Versus Ground Emergency Medical Services for Trauma Scene Transport in the United States

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Abstract

Objective—We determined the minimum mortality reduction that helicopter emergency medical services (HEMS) should provide relative to ground EMS for the scene transport of trauma victims to offset higher costs, inherent transport risks, and inevitable overtriage of minor injury patients.

Methods—We developed a decision-analytic model to compare the costs and outcomes of helicopter versus ground EMS transport to a trauma center from a societal perspective over a patient's lifetime. We determined the mortality reduction needed to make helicopter transport cost less than $100,000 and $50,000 per quality adjusted life year (QALY) gained compared to ground EMS. Model inputs were derived from the National Study on the Costs and Outcomes of Trauma (NSCOT), National Trauma Data Bank, Medicare reimbursements, and literature. We assessed robustness with probabilistic sensitivity analyses.

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Conflicts of interest: The authors have no conflicts of interest to disclose.

Author contributions: Conception and design: MKD, JDG; Acquisition of data: MKD, SW; Statistical analysis: MKD, SW, JDG; Analysis and interpretation of data: MKD, KLS, NEW, SW, DKO, JDG; Drafting of manuscript: MKD; Critical revision of manuscript for important intellectual content: KLS, NEW, SW, DKO, JDG. MKD takes responsibility for the paper as a whole.

Meeting presentations: Society for Medical Decision Making, Toronto, CA 2010 (Winner of Lee Lusted Prize for Outstanding Research); National Association of EMS Physicians, Bonita Springs, FL 2011 (Winner of Award for Best Fellow Research).

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Results—HEMS must provide a minimum of a 17% relative risk reduction in mortality (1.6 lives saved/100 patients with the mean characteristics of the NSCOT cohort) to cost less than $100,000 per QALY gained and a reduction of at least 33% (3.7 lives saved/100 patients) to cost less than $50,000 per QALY. HEMS becomes more cost-effective with significant reductions in minor injury patients triaged to air transport or if long-term disability outcomes are improved.

Conclusions—HEMS needs to provide at least a 17% mortality reduction or a measurable improvement in long-term disability to compare favorably to other interventions considered cost-effective. Given current evidence, it is not clear that HEMS achieves this mortality or disability reduction. Reducing overtriage of minor injury patients to HEMS would improve its cost-effectiveness.

Introduction

Background

Trauma is the leading cause of death for United States (U.S.) residents aged 1-44, the most common cause of years of life lost for those under age 65,[1] and exacts $406 billion per year in costs, more than heart disease or cancer.[2,3] Survival after trauma is improved by timely transport to a trauma center for severely injured patients.[4] Helicopter emergency medical services (EMS) offer faster transport than ground EMS for patients injured far from trauma centers and is considered a preferred means of transport for critically injured patients.[5] Approximately 27% of US residents are dependent on helicopter transport in order to access Level I or II trauma center care within the "golden hour" from injury to emergency department arrival.[6] However, there are conflicting data to support routine use for scene transport. Most studies have concluded that helicopter transport was associated with improved survival,[7-23] while others showed no difference.[24-30] These studies have methodological limitations and suffer from selection bias, missing physiologic data, and heterogeneity in study settings and observational study designs.

Importance

In 2010 there were over 69,700 helicopter transports for trauma to U.S. Level I and II trauma centers; 44,700 (64%) were from the scene of injury.[31] Based on the Medicare Fee Schedule, insurance companies reimburse $5,000-$6,000 more per transport than ground ambulance which means up to $200-$240 million more were spent using this modality for trauma scene transport in 2010.[32] Furthermore, a systematic review has shown than more than half of the patients flown have minor or non-life-threatening injuries that would likely have similar outcomes if transported by ground.[33] Helicopter transport also may present a safety risk. In 2008, medical helicopter crashes caused 29 fatalities, the highest number to date, provoking federal review of the safety of air medical transport.[34] Currently, there is little empirical guidance on whether the routine use of helicopter EMS for trauma scene transport represents a good investment of critical care resources.

Goals of This Investigation

Given the limitations of the helicopter EMS outcomes literature, we aimed to determine the minimum reduction in mortality or long-term disability provided by helicopter EMS for its

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Table 1

Model input assumptions

Variable	Base-Case Value	Range for Sensitivity Analysis	Reference
Distribution of Cohort Characteristics			
Age (%)		N/A	MacKenzie[4]
18-54 yr	72		
55-64 yr	11		
65-74 yr	8		
75-85 yr	9		
Male (%)	69	N/A	MacKenzie[4]
Maximal Abbreviated Injury Scale (AIS) score (%):		N/A	MacKenzie[4] NTDB 2010 analysis
"Minor Injury" Subgroup			Newgard[67]
AIS 1 (minor)	21		
AIS 2 (moderate)	26		
"Serious Injury" Subgroup			
AIS 3 (serious)	31		
AIS 4 (severe)	16		
AIS 5-6 (critical-unsurvivable)	6		
Transport Assumptions			
Mean distance traveled by helicopters for trauma scene transports in the U.S. (miles)	55	25-85	Brown,[19] Carr[68]
Probability of fatal helicopter crash in 55-mile transport	0.000009	0.0000033-0.000046	Blumen[43]
Probability of a fatal ambulance crash in 55-mile transport	0.00000034	0-0.0000015	NHTSA[44]
Helicopter cost per transport, by distance from trauma center ($)			Medicare[32]
25 miles	5,800	5,400-6,800	
55 miles (base case)	6,800	6,400-7,800	
85 miles	7,800	7,400-8,800	
ALS ground ambulance cost per transport by distance trauma center, adjusted for longer road distance ($)			Medicare[32] Diaz[36]
25 miles	900	800-1,000	
55 miles (base case)	1,100	1,000-1,300	
85 miles	1,400	1,300-1,600	
Cost to replace helicopter if crashes ($)	4,200,000	3,000,000-5,000,000	Retail website[69]
Cost to replace ambulance if crashes ($)	108,000	80,000-140,000	Retail website[70]
QALYs lost in helicopter crash	120		Assumption
QALYs lost in ground ambulance crash	30		Assumption
Clinical Assumptions			
Serious Injury Subgroup			
Mean baseline probability of in-hospital death	0.076	0.056-0.096	MacKenzie[4]
Relative risk ratio (RR) for in-hospital mortality from helicopter EMS relative to ground EMS transport (1.00 – no difference)	N/A	1.00-0.60	Ringburg,[63] Thomas,[71-73] Brown,[19, 74] Taylor,[75]

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