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## Rural Health Inequity and the Air Ambulance Abyss: Time to Try a Coordinated, All-Payer System

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## RURAL HEALTH INEQUITY AND THE AIR AMBULANCE ABYSS: TIME TO TRY A COORDINATED, ALL-PAYER SYSTEM

*Melissa Ballengee Alexander\**

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## I. INTRODUCTION

The year 2020 has seen the incredibly disparate impact of COVID-19 on traditionally marginalized populations.<sup>1</sup> While racial inequities are unacceptable, less reported rural health disparities are also deeply problematic.<sup>2</sup> Patients admitted to smaller hospitals were *three times* more likely to die from COVID-19 than patients at larger hospitals.<sup>3</sup> This unequal outcome reflects longstanding, systemic health disparities.<sup>4</sup> Independent of COVID-19, rural populations face significant access, cost, and quality disadvantages.<sup>5</sup> To combat this injustice, our

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<sup>1</sup> See *COVID-19 Hospitalization and Death by Race/Ethnicity*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Aug. 18, 2020), [www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html](http://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html) [<https://perma.cc/9JHD-J8Z6>] (documenting that historically disadvantaged racial minorities have contracted COVID-19 at 3 times the rate of whites, required hospitalization at 5 times the rate of whites, and died at higher rates than whites).

<sup>2</sup> Drawing a connection between the health inequities faced by many racial minorities and rural dwellers should not be construed as minimizing the distinct harms inflicted upon historically disadvantaged racial minorities. Rural inequality does not stem from the same ignoble history of *de jure* discrimination, nor is living in a rural area an immutable trait. Nonetheless, any significant inequality in access to or quality of health care unjustly perpetuates and exacerbates second-class citizenship.

<sup>3</sup> Shruti Gupta et al., *Factors Associated With Death in Critically Ill Patients with Coronavirus Disease 2019 in the US*, 180 J. AM. MED. ASS'N 1436 (2020) (Patients admitted to hospitals with fewer than 50 ICU beds were 3 times more likely to die from COVID-19 than patients treated at larger hospitals); Daniela J. Lama, *The Care They Need*, N.Y. TIMES (Aug. 9, 2020), [www.nytimes.com/2020/08/04/opinion/sunday/covid-rural-hospitals.html](http://www.nytimes.com/2020/08/04/opinion/sunday/covid-rural-hospitals.html) (given rural hospital inequities, more transfers may be necessary to avoid COVID deaths). Of course, many small hospitals are not rural, but all rural hospitals are small (at least as defined by the study). For example, in Wyoming, the hospital with the *most* ICU beds is Cheyenne Regional Medical Center with 15 ICU beds, significantly less than the 50-ICU bed cap for a small hospital. *Wyoming Hospital Capacity*, WYO. DEP'T OF HEALTH (last visited Sept. 10, 2020), [sites.google.com/wyo.gov/exec-covid19/hospital-resources](https://sites.google.com/wyo.gov/exec-covid19/hospital-resources). The disparate impact of COVID deaths amongst patients at small hospitals is even higher than the disparity by race, with blacks dying at 2.1 times the rate of white, non-Hispanic patients. Compare *id.*, with *COVID-19 Hospitalization and Death by Race/Ethnicity*, *supra* note 1.

<sup>4</sup> See *infra* Part III. Rural populations face significant health and economic disparities, regardless of race or ethnicity. *About Rural Health*, CTRS. FOR DISEASE CONTROL AND PREVENTION, [www.cdc.gov/ruralhealth/about.html](http://www.cdc.gov/ruralhealth/about.html) (last visited July 8, 2020) [<https://perma.cc/975P-FYSN>] (“Rural Americans face numerous health disparities compared with their urban counterparts.”); Nicole Huberfeld, *Rural Health, Universality, and Legislative Targeting*, 13 HARV. L. & POL'Y REV. 241, 248–51 (2018) (describing rural health disparities and noting that “rural patients are sicker and poorer than urban patients on the whole”). Further, it is worth noting that the majority of American Indian and Alaskan Native people live in rural areas. SARAH DEWEES & BENJAMIN MARKS, FIRST NATIONS DEV. INST., *TWICE INVISIBLE: UNDERSTANDING RURAL NATIVE AMERICA* 1 (2017).

<sup>5</sup> *About Rural Health*, *supra* note 4; Huberfeld, *supra* note 4, at 248–51.

country must be prepared to make structural changes.<sup>6</sup> This article focuses on air ambulances because of the vital role such transports play in access to care for rural Americans; it proposes cost and access reform that would benefit all Americans but are critically needed to advance rural health equity.<sup>7</sup>

A story illustrates the current air ambulance problem.<sup>8</sup> On a wintery day, a twenty-five-year-old teacher suffers serious trauma in a car accident. The rural hospital nearby cannot provide the acute care she needs to survive, so an air ambulance flies her to a nearby city medical center.<sup>9</sup> The teacher survives, but she receives a balance bill for \$60,000, despite having private health insurance, because the only available air ambulance was out-of-network.<sup>10</sup> She did not choose to be transported by air ambulance nor did she select the provider.<sup>11</sup> Nonetheless, because she cannot afford to pay \$60,000 out-of-pocket, creditors compel the teacher to file for personal bankruptcy. Her credit is ruined.

While the teacher's account is fictional, it unfortunately reflects all too common problems with air ambulance cost, billing, and insurance today. Three-

<sup>6</sup> See *Health Equity Considerations & Racial & Ethnic Minority Groups*, CTNS. FOR DISEASE CONTROL AND PREVENTION (July 24, 2020), [www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html](http://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html) [<https://perma.cc/4MD4-JJX3>] (“Long-standing systemic health and social inequities have put many people from racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19.”); see, e.g., Mary Blankenship & Richard Reeves, *From the George Floyd Moment to a Black Lives Matter Movement, in Tweets*, BROOKINGS (July 10, 2020), [www.brookings.edu/blog/up-front/2020/07/10/from-the-george-floyd-moment-to-a-black-lives-matter-movement-in-tweets/](http://www.brookings.edu/blog/up-front/2020/07/10/from-the-george-floyd-moment-to-a-black-lives-matter-movement-in-tweets/) [<https://perma.cc/G35S-7F4X>].

<sup>7</sup> An air ambulance is a helicopter or fixed-wing airplane with specialized medical equipment that transports patients more efficiently over long distances or difficult terrain not well suited for traditional ground ambulance transport. See *infra* Section II.A.

<sup>8</sup> This story is fictional, but see reported news stories. See, e.g., Megan Messerly, *Between Life and Death, Patients Left with Little Choice on Air Ambulance Costs in Rural Nevada*, NEVADA INDEPENDENT (Oct. 6, 2019, 2:00 AM), [thenevadaindependent.com/article/between-life-and-death-patients-left-with-little-choice-on-air-ambulance-costs-in-rural-nevada](http://thenevadaindependent.com/article/between-life-and-death-patients-left-with-little-choice-on-air-ambulance-costs-in-rural-nevada) [<https://perma.cc/7DE7-2GA6>]; Christina Caron, *Families Fight Back Against Surprise Air Ambulance Bills*, N.Y. TIMES (Apr. 17, 2020), [www.nytimes.com/2020/04/17/parenting/air-ambulance-bills.html](http://www.nytimes.com/2020/04/17/parenting/air-ambulance-bills.html).

<sup>9</sup> See MARLA KUGEL ET AL., XCENDA, AIR MEDICAL SERVICES COST STUDY REPORT 14 (2017) (87 million Americans would not be able to receive Level I trauma care in a timely manner without air ambulance transport); Rachel Bluth, *Why Air Ambulance Bills are Still Sky-High*, NAT'L PUB. RADIO (June 14, 2019), [www.npr.org/sections/health-shots/2019/06/14/732174170/why-air-ambulance-bills-are-still-sky-high](http://www.npr.org/sections/health-shots/2019/06/14/732174170/why-air-ambulance-bills-are-still-sky-high) [<https://perma.cc/Z95F-JH5N>] (“More than 80 million people can get to a Level 1 or 2 trauma center within an hour only if they're flown by helicopter . . .”).

<sup>10</sup> A “balance bill” is a bill sent to the patient for the difference between a provider's charges and the amounts paid by private health insurance. Erin C. Fuse Brown, *Consumer Financial Protection in Health Care*, 95 WASH. U. L. REV. 127, 138 (2017) [hereinafter 2017 Fuse Brown]. A healthcare provider's service is “out-of-network” if the provider has not negotiated an “in-network” agreement with the patient's insurance provider. These concepts and their significance for patients are discussed in greater detail. See Section II.C.

<sup>11</sup> See GOV'T ACCOUNTABILITY OFF., AIR AMBULANCE: AVAILABLE DATA SHOW PRIVATELY-INSURED PATIENTS ARE AT FINANCIAL RISK 7 (2019) [hereinafter 2019 GAO REPORT]; see also Ge Bai et al., *Air Ambulances with Sky-High Charges*, 38 HEALTH AFFS. 1199 (2019).

fourths of air ambulance transports are out-of-network, and the average balance bill sent to patients greatly exceeds the savings held by most Americans.<sup>12</sup> Providers are asking the uninsured and under-insured to pay up to 9.5 times the rate paid by Medicare.<sup>13</sup> These inequitable cost and cost-shifting problems are getting worse each year, and they are disproportionately borne by rural populations who can least afford them.<sup>14</sup>

In addition to cost and cost-shifting issues, there are supply challenges. In some areas, oversupply of air ambulances has dramatically increased prices, as more providers spread their high fixed costs over fewer patients.<sup>15</sup> In other areas, there are not enough air ambulances available within a reasonable response time.<sup>16</sup> The problem is particularly acute in rural areas, which rely heavily on air ambulance transport to address gaps in access to care.<sup>17</sup> The air ambulance market evidences market failure in supply and price.<sup>18</sup>

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<sup>12</sup> Karan R. Chhabra et al., *Most Patients Undergoing Ground and Air Ambulance Transportation Receive Sizable Out-of-Network Bills*, 39 HEALTH AFFS. 777, 779 (2020) (71% of air ambulance transports for insureds covered by large national plans involved out-of-network billing; the average balance bill amount was \$21,698); Erin Fuse Brown et al., *Out-of-Network Air Ambulance Bills: Prevalence, Magnitude, and Policy Solutions*, 98 MILBANK Q. 747, 748 (2020) [hereinafter 2020 Fuse Brown]; Kathleen Elkins, *Here's How Much Money Americans Have in Savings at Every Income Level*, CNBC (Oct. 11, 2018, 12:02 AM), [www.cnbc.com/2018/09/27/heres-how-much-money-americans-have-in-savings-at-every-income-level.html](http://www.cnbc.com/2018/09/27/heres-how-much-money-americans-have-in-savings-at-every-income-level.html) [https://perma.cc/VV2Z-424C] (median American household has \$11,700 in savings as of 2018).

<sup>13</sup> Bai et al., *supra* note 11, at 1195. Providers charge patients with private insurance rates 4.1 to 9.5 times the Medicare reimbursement rate. *Id.*; see *infra* Section II.C.3.

<sup>14</sup> See John Hargraves & Aaron Bloschichak, *Air Ambulances – 10 Year Trends in Costs and Use*, HEALTH CARE COST INST. (Nov. 7, 2019), [healthcostinstitute.org/emergency-room/air-ambulances-10-year-trends-in-costs-and-use](http://healthcostinstitute.org/emergency-room/air-ambulances-10-year-trends-in-costs-and-use) [https://perma.cc/KM4K-R4EL]; Bai et al., *supra* note 11, at 1197–98 (charges increased 60% from 2012–2016; charge ratios with Medicare rates likewise increased 46–61%).

<sup>15</sup> Henry H. Perritt, Jr., *Medics, Markets, and Medicare*, 43 RUTGERS COMPUT. AND TECH. L.J. 37, 44–45 (2017) [hereinafter *Medics, Markets, and Medicare*]; ConsumersUnion, *Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation*, HEALTH POL'Y REP. 3 (Mar. 2017), [advocacy.consumerreports.org/wp-content/uploads/2017/04/Up-In-The-Air-Inadequate-Regulation-for-Emergency-Air-Ambulance-Transportation.pdf](http://advocacy.consumerreports.org/wp-content/uploads/2017/04/Up-In-The-Air-Inadequate-Regulation-for-Emergency-Air-Ambulance-Transportation.pdf) [https://perma.cc/2CWC-N94Q]; see *infra* Section II.E.

<sup>16</sup> See WYO. DEP'T OF HEALTH, WYOMING MEDICAID COORDINATED AIR AMBULANCE NETWORK 1115 WAIVER APPLICATION 4 (2019) [hereinafter WYOMING WAIVER]; Elan Head, *FAA Reauthorization Act Could Mean Changes for Air Ambulance Industry*, VERTICAL (May 24, 2018), [verticalmag.com/news/faa-reauthorization-act-mean-changes-air-ambulance-industry/](http://verticalmag.com/news/faa-reauthorization-act-mean-changes-air-ambulance-industry/) [https://perma.cc/F8ZT-DEVL] (“[T]he most recent ADAMS map shows that there are still many rural areas with limited air medical coverage . . .”).

<sup>17</sup> COUNCIL ON MED. SERV., CMS REPORT 2-I-18: AIR AMBULANCE REGULATIONS AND PAYMENTS 1 (2018); WYOMING WAIVER, *supra* note 16; Lama, *supra* note 3.

<sup>18</sup> See Bai et al., *supra* note 11, at 1199 (concluding that significantly increasing prices, in the context of underused provider capacity, lack of price transparency, and inability to shop for or even select the provider, likely indicates market failure); see *infra* Section II.F.

While in many ways, air ambulances mirror balance billing and market challenges that are endemic in the U.S. healthcare system, air ambulances also have unique preemption barriers, market characteristics, and rural impacts.<sup>19</sup> As a result, air ambulances necessitate distinct analysis. Reflecting this, several states have recently passed laws or taken administrative action to provide new consumer protections for air ambulance patients; at the same time, courts have held that federal aviation law preempts most state reforms.<sup>20</sup> This article wades into the air ambulance debate. It argues that when federal preemption stands in the way of progress, it must be curtailed.<sup>21</sup> When deregulation perpetuates health disparity, it cannot be justified.<sup>22</sup> When cost-shifting forces patients into ruinous medical debt unnecessarily, it must end.<sup>23</sup> When a broken market predictably exacerbates health inequality, it cannot continue to determine both access and cost.

This article adds to existing scholarship on air ambulances, rural health, price discrimination, Medicaid waivers, and all-payer networks in several ways. First,

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<sup>19</sup> See *infra* Part II.

<sup>20</sup> See, e.g., MONT. CODE ANN. §§ 33-2-2302, -2305 (2019); N.M. STAT. ANN. § 59A-57-4 (LexisNexis 2020); N.M. CODE R. § 13.10.21.8 (LexisNexis 2020); N.D. CENT. CODE § 26.1-47-09 (2019); WYO. STAT. ANN. § 26-5-103(a)(ii) (2020); *Bailey v. Rocky Mountain Holdings, LLC*, 889 F.3d 1259, 1262, 1268–69 (11th Cir. 2018) (holding Florida law prohibiting balance billing preempted by ADA as applied to air ambulances); *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 755 (4th Cir. 2018) (holding West Virginia statutory maximum reimbursement and prohibition on balance billing for workers' compensation preempted by ADA as applied to air ambulances); *Guardian Flight, LLC v. Godfread*, 359 F. Supp. 3d 744, 752–54 (D.N.D. 2019) (holding North Dakota statutory prohibition on balance billing preempted by ADA as applied to air ambulances); *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 938–41 (D.N.D. 2016) (holding North Dakota statutory division of air ambulance providers into primary and secondary call lists preempted by ADA). *But see* *Tex. Mut. Ins. Co. v. PHI Air Medical, LLC*, No. 18-0216, 2020 Tex. LEXIS 615, at \*2–5, 63 TEX. SUP. CT. J. 1462 (Tex. June 26, 2020) (holding air ambulance carrier failed to show the fair and reasonable reimbursement standard had a significant effect on its prices and that the ADA does not preempt this state standard).

<sup>21</sup> When acting within its enumerated powers, the federal government is supreme, and its laws and regulations can “preempt” state and local laws. U.S. CONST. art. VI, cl. 2; *Hillsborough Cnty. v. Automated Med. Lab'ys, Inc.*, 471 U.S. 707, 712 (1985) (holding that the Supremacy Clause renders invalid state laws that interfere with, or are contrary to, federal law); *Kurns v. R.R. Friction Prods. Corp.*, 565 U.S. 625, 630 (2012) (finding that federal law can preempt state law by virtue of the Supremacy Clause).

<sup>22</sup> See Derek Carr et al., *Equity First: Conceptualizing a Normative Framework to Assess the Role of Preemption in Public Health*, 98 MILBANK Q. 131 (2020) (arguing in favor of an equity-first preemption framework in which preemption is viewed as positive for public health when it advances health equity and negative when it hinders equity).

<sup>23</sup> See David U. Himmelstein et al., *Medical Bankruptcy: Still Common Despite the Affordable Care Act*, 109 AM. J. PUB. HEALTH 431, 432 (2019) (67.5% of debtors cite medical debt and issues as contributing to their bankruptcy, even after increased rates of insurance coverage under the Affordable Care Act); Uwe E. Reinhardt, *The Many Different Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time for a More Rational All-Payer System?*, 30 HEALTH AFFS. 2125 (2011) (arguing that an all-payer system of healthcare would better control costs and result in more equitable patient charges).

it highlights the federal government's reckless disregard for the predictable way in which deregulation of air ambulances and the accompanying cost, billing, and access problems exacerbate rural inequality.<sup>24</sup> Second, it provides an in-depth legal analysis of Wyoming's innovative Section 1115 waiver application and endorses a coordinated, all-payer air ambulance system with quality benchmarks as a reform model.<sup>25</sup> Third, it argues that, when faced with overwhelming evidence that another department's deregulatory approach jeopardizes the health and well-being of Americans and perpetuates health disparities, the U.S. Department of Health and Human Services (HHS) must be willing to grant waivers that test state regulatory approaches.<sup>26</sup>

Section II outlines current problems with air ambulances, including high cost, under-insurance, cost-shifting, preemption barriers, over and under-supply, and structural market failure. Section III describes rural health disparities and emphasizes how rural Americans have no choice but to rely heavily on air ambulances to plug gaps in access to life-saving care, yet can least afford to pay uncontrolled prices. Section IV canvases state legislative and administrative efforts at air ambulance reform, focusing, in particular, on Wyoming and its first in the nation Medicaid waiver application. Section V argues that HHS should

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<sup>24</sup> Henry H. Perritt, Jr. has written several excellent articles on air ambulances. See, e.g., Henry H. Perritt, Jr., *An Arm and a Leg: Paying for Helicopter Air Ambulances*, 2016 U. ILL. J.L. TECH. & POL'Y 317 (2016) [hereinafter *An Arm and a Leg*] (analyzing air ambulance economics and safety; proposing keeping Medicare reimbursement rates flat, providing state and local subsidies in rural areas, and exempting air ambulances from the ADA); Henry H. Perritt, Jr., *No Way to Run an "Airline": Surviving an Air Ambulance Ride*, 82 J. AIR L. & COM. 83 (2017) [hereinafter *No Way to Run*] (similar with new safety analysis). His scholarship recognizes the close connection between air ambulance supply and price, the unique importance air ambulances play in rural healthcare, and the need for Congress to exempt air ambulances from ADA preemption. This article connects some of those points to health equity scholarship, updated data, Medicaid waivers, and a model coordinated all-payer approach with quality benchmarks. This article also reaches a different conclusion regarding the ability of the air ambulance market to regulate supply, the acceptability of price discrimination, and the ethics of requiring rural communities to either do without life-saving access or to finance such access locally.

<sup>25</sup> A recent publication from renowned health law scholar Erin Fuse Brown and others provides new empirical data on privately insured persons' out-of-network air ambulance bills, describes legal barriers, and proposes solutions. 2020 Fuse Brown, *supra* note 12. This article was drafted before Fuse Brown's article was published, ironically, based in part on Fuse Brown's prior scholarship. Fuse Brown's 2020 article suggests ending ADA preemption and utilizing either government rate setting or a competitive bidding/public utility regulation approach to address air ambulance price failure. Her article briefly discusses Wyoming's waiver application. *Id.* at 766, 769–70. This article concurs that government involvement in price setting or bidding is necessary but also extols the benefit of a government-coordinated system to counter market supply failure and the merits of quality benchmarks to avoid quality tradeoffs. This article also uniquely focuses on rural health equity and provides a detailed scholarly analysis of how Wyoming's Medicaid Coordinated Air Ambulance System meets the requirements of a Section 1115 waiver and could provide other health reform benefits.

<sup>26</sup> See *infra* Parts II, III, notes 343–44 and accompanying text.



grant Wyoming's waiver and supports the broader proposition that HHS has an obligation to test regulation when deregulation threatens the health and wellbeing of Americans and exacerbates health inequalities. Section VI prescribes a model for air ambulance reform. To address rural health disparities and structural market failure, air ambulance needs a coordinated, all-payer global budget system with universal access and quality benchmarks.

## II. AIR AMBULANCE PROBLEMS: AN EXTREME FORM OF PAYMENT CHALLENGES FACING THE UNITED STATES HEALTHCARE SYSTEM, WITH NARROW NETWORK, COST-SHIFTING, PREEMPTION, AND COST AND SUPPLY MARKET TWISTS

Air ambulance services are a vital part of our healthcare system, especially in rural areas. Nonetheless, this section describes how air ambulances reflect some of the worst problems in the United States healthcare system: high cost, balance billing, underinsurance, cost-shifting, preemption, and dysfunctional markets. It discusses the unique hurdles facing air ambulance markets and regulation. Patients seldom determine utilization or select their air ambulance providers. The emergency nature of air ambulance service generally prevents price shopping, and the lack of significant provider choice exacerbates provider price control. Most patients are under-insured for air ambulance transport because providers and insurers lack normal incentives to reach negotiated in-network agreements. These challenges are made worse by significant cost-shifting from government-insured patients to privately insured patients. Further, federal Airline Deregulation Act (ADA) preemption adds yet another barrier to ever-present Employee Retirement Income Security Act (ERISA) preemption restrictions on state healthcare reforms. Preemption prevents states from addressing cost, as well as gaps in access and oversupply that detrimentally impact health and price. To devise an effective solution, one must understand the fundamental structural problems and the forces that perpetuate them.

### A. *Air Ambulance Services Provide Essential, Life-Saving Care*

Air ambulances play a critical role in the delivery of healthcare.<sup>27</sup> There are two types of air ambulance transport, helicopter and fixed-wing. Helicopter air ambulances can reach accident or injury sites potentially inaccessible to ground ambulances and can transport patients quicker from an accident site to a hospital or between hospitals.<sup>28</sup> Fixed-wing air ambulance services provide high-quality

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<sup>27</sup> *An Arm and a Leg*, *supra* note 24, at 327–28; KUGEL ET AL., *supra* note 9, at 14 (“Air medical services improve access to Level 1 trauma centers for an additional 87 million Americans (27% of the population) who would not otherwise be able to receive emergent care in a timely manner.”).

<sup>28</sup> Hargraves & Bloschichak, *supra* note 14; *An Arm and a Leg*, *supra* note 24, at 327–28. Approximately three-fourths of air ambulance transports are in helicopters. COUNCIL ON MED.

care during longer distance air travel.<sup>29</sup> Air ambulances serve more than 550,000 patients a year.<sup>30</sup> In time-sensitive emergencies, air ambulance transport is often necessary to enable patients to reach medical care during the “golden hour,” 60 minutes after trauma or medical emergency, when administering care has the greatest likelihood of avoiding deterioration or death.<sup>31</sup> A quarter of Americans, 85 million people, could not access appropriate trauma care within an hour without an air ambulance.<sup>32</sup> Nationwide, but especially in rural areas, Americans need timely access to air ambulances to avoid premature death and disability.<sup>33</sup>

### *B. Air Ambulance Costs are Already Astronomical and Continue to Rise*

Despite (or perhaps because of) their valuable role in healthcare delivery, air ambulance services have increasingly become the target of public outcry and state scrutiny.<sup>34</sup> This is largely due to the rising cost of air ambulance services, which have increased by 144% (helicopters) to 166% (fixed-wing planes) from 2008 to 2017, significantly more than the cost of care, air travel, and ground ambulance services combined over the same period.<sup>35</sup> Today, the median price of an air ambulance trip is \$36,000 in a helicopter or \$40,600 in a fixed-wing airplane transport.<sup>36</sup> This high cost contrasts sharply with the average cost in the

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SERV., *supra* note 17, at 1. Air ambulance fixed-wing planes are typically used for longer distance airport-to-airport travel, and they generally require a ground ambulance on both ends of the trip. *Id.*

<sup>29</sup> COUNCIL ON MED. SERV., *supra* note 17.

<sup>30</sup> *Id.* at 2.

<sup>31</sup> *Id.* at 1; Bluth, *supra* note 9 (“More than 80 million people can get to a Level 1 or 2 trauma center within an hour only if they’re flown by helicopter . . .”).

<sup>32</sup> Richard Sherlock, *Protect Air Ambulance Services that Fill the Health Care Access Gap in Rural America*, THE HILL (May 25, 2018, 10:05 AM), thehill.com/blogs/congress-blog/health-care/389347-protect-air-ambulance-services-that-fill-the-health-care [https://perma.cc/YN6W-RMFH] (Sherlock is president of Association of Air Medical Services, the industry group for air ambulances); KUGEL ET AL., *supra* note 9, at 14; Bluth, *supra* note 9; COUNCIL ON MED. SERV., *supra* note 17, at 2.

<sup>33</sup> David Michaels et al., *Helicopter Versus Ground Ambulance: Review of National Database for Outcomes in Survival in Transferred Trauma Patients in the USA*, TRAUMA SURGERY ACUTE CARE OPEN (MAR. 6, 2019), www.ncbi.nlm.nih.gov/pmc/articles/PMC6461140/ [http://dx.doi.org/10.1136/tsaco-2018-000211] (comparable trauma patients transferred by air were 57% less likely to die than those transported by ground); COUNCIL ON MED. SERV., *supra* note 17, at 1; N. Clay Mann et al., *Injury Mortality Following the Loss of Air Medical Support for Rural Interhospital Transport*, 9 ACAD. EMERGENCY MED. 694 (2002) (patients in rural areas are four times more likely to die without access to air ambulance).

<sup>34</sup> See, e.g., Letter from State Ins. Comm’rs to U.S. House of Representative Members (Nov. 7, 2019), www.naic.org/documents/government\_relations\_191107.pdf [https://perma.cc/LS2P-L3AA] [hereinafter State Ins. Letter] (describing consumer complaints and advocating the inclusion of air ambulance providers in any federal surprise billing legislation).

<sup>35</sup> Hargraves & Blossichak, *supra* note 14.

<sup>36</sup> 2019 GAO REPORT, *supra* note 11, at 17. Seventy-four percent of all air ambulance transports are by helicopter. COUNCIL ON MED. SERV., *supra* note 17, at 1.

United Kingdom of roughly \$3,100 per mission—less than a tenth of the average U.S. cost.<sup>37</sup>

Air ambulance bills vary widely, often in a seemingly irrational manner, and can be as high as hundreds of thousands of dollars.<sup>38</sup> Air travel itself is costly, and having a highly trained pilot, paramedic, and trauma nurse, as well as sophisticated equipment available 24/7, is inherently expensive.<sup>39</sup> Yet, as discussed below, some carriers appear to be charging patients “rents,” amounts beyond that which is economically necessary to retain the amount and quality of services, suggesting a dysfunctional market.<sup>40</sup> Even more troubling, the unconstrained price problem appears to be worst in rural areas, where an air ambulance is critical to bridge the gap in access to care.<sup>41</sup> Air ambulance transport services need a more effective cost containment strategy.

### *C. Patients are Suffering Financial and Emotional Distress because of Balance Billing, Underinsurance, and High Air Ambulance Costs*

#### *1. The Average Balance Bill is Unpayable at Two-Thirds Annual Income*

“Balance billing” and under-insurance exacerbate air ambulance cost concerns.<sup>42</sup> Balance billing occurs when providers seek the difference between

<sup>37</sup> See AIR AMBULANCES UK, [www.airambulancesuk.org](http://www.airambulancesuk.org) (last visited Dec. 17, 2020) [<https://perma.cc/Z3J3-TU8L>]; COUNTRY CURRENCY RATES, [www.countrycurrencyrates.com](http://www.countrycurrencyrates.com) (last visited June 22, 2020) (calculated as of same date).

<sup>38</sup> Jen Christensen, *Sky-High Prices for Air Ambulances Hurt Those They Are Helping*, CABLE NEWS NETWORK (Nov. 26, 2018, 4:04 PM), [www.cnn.com/2018/11/26/health/air-ambulance-high-price/index.html#:~:text=Sonna%20Anderson%20was%20charged%20%2454%2C000,little%20has%20brought%20them%20relief](http://www.cnn.com/2018/11/26/health/air-ambulance-high-price/index.html#:~:text=Sonna%20Anderson%20was%20charged%20%2454%2C000,little%20has%20brought%20them%20relief) [<https://perma.cc/KA68-WM3B>]; see also Bluth, *supra* note 9 (reporting bills ranging from \$28,000 to \$97,000). Price variability based on distance or medical justification is to be expected, of course, but this does not explain these wide price discrepancies.

<sup>39</sup> KUGEL ET AL., *supra* note 9, at 14 (cost report prepared for The Association of Air Medical Services and Members).

<sup>40</sup> Bai et al., *supra* note 11, at 1195 (finding “market failure,” describing private insurance rates 4.1 to 9.5 times the Medicare rate); see also *infra* Section II.F.

<sup>41</sup> Messerly, *supra* note 8; COUNCIL ON MED. SERV., *supra* note 17, at 1–2.

<sup>42</sup> See, e.g., State Ins. Letter, *supra* note 34 (describing consumer complaints and advocating the inclusion of air ambulance providers in any federal surprise billing legislation). Surprise billing is, by definition, a problem, but balance billing in and of itself is not always bad. If a patient has a choice of another provider who offers a reasonably equivalent service without balance billing, is aware of the amount of the balance bill in advance, and chooses the more expensive provider, a balance billing arrangement arguably enhances choice (at least for those affluent enough to be able to pay). However, balance billing operates in a more fraught ethical space in an emergency, when there is no practical choice of equivalent provider without a balance bill, or when the patient is unaware of the magnitude or even the existence of the balance billing liability. Air ambulance transport balance billing almost always occurs in one or more of these contexts.

their unilaterally determined “charges” and the amounts paid by private health insurance or workers’ compensation directly from patients.<sup>43</sup> Federal regulations generally prohibit providers from balance billing for Medicare and Medicaid, but this leaves other patients who need to be transported by air ambulance vulnerable to crushing transport bills.<sup>44</sup> Air ambulance providers balance bill privately insured patients \$21,698 on average, a devastating sum for most Americans, especially because these amounts are in addition to any deductibles or other cost-sharing obligations.<sup>45</sup>

An example using average statistics illustrates how unmanageable the problem has become. An individual with an annual income of \$34,000 pays health insurance premiums of \$1,500 per year.<sup>46</sup> If that individual needs air ambulance transport, he or she can expect to be billed \$36,000.<sup>47</sup> The individual will have to pay a deductible of \$1,655, before insurance even contributes.<sup>48</sup> Then, insurance will pay the carrier what it deems appropriate less the patient’s cost-sharing obligation of approximately \$2,800.<sup>49</sup> The patient remains responsible for the balance of

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<sup>43</sup> 2019 GAO REPORT, *supra* note 11, at 2; 2017 Fuse Brown, *supra* note 10, at 138.

<sup>44</sup> NICOLE HUBERFELD ET AL., *THE LAW OF AMERICAN HEALTH CARE* 294–95 (1st ed. 2017) (“Other rules and regulations in the ACA limit various billing practices in Medicare, Medicaid, and the Exchanges, including prohibitions on “balance billing” patients for amounts not covered by insurance . . . .”); 2019 GAO REPORT, *supra* note 11, at 2, 6, 18. The uninsured suffer as a result of the high cost of air ambulance, market dysfunction, and cost shifting, but they do not suffer from balance billing or surprise billing per se. These phenomena plague Americans who have health insurance that should protect them from devastating financial ruin if a health problem occurs but sadly often fails to do so.

<sup>45</sup> Chhabra et al., *supra* note 12, at 777–78, 780 (median out-of-network charges billed for air transport were \$21,698); Joan Stephenson, *Solutions for Air Ambulance Surprise Billing in Holding Pattern*, J. AM. MED. ASS’N NETWORK (Mar. 4, 2020), [jamahealthforum.com/channels/health-forum/fullarticle/2762706](http://jamahealthforum.com/channels/health-forum/fullarticle/2762706) [<http://dx.doi.org/10.1001/jamahealthforum.2020.0281>] (“Such balance bills are on top of co-payments or other types of cost sharing that patients typically pay under their insurance coverage.”).

<sup>46</sup> Median annual personal income was \$34,317 in 2018. FRED®, *Real Median Personal Income in the United States*, FED. RESRV. BANK OF ST. LOUIS, [fred.stlouisfed.org/series/MEPAINUSA672N](http://fred.stlouisfed.org/series/MEPAINUSA672N) (last updated Sept. 16, 2020). In 2019, the average workers’ contribution to annual employer-based health insurance premiums for an individual was \$1,489. *Average Annual Single Premium per Enrolled Employee for Employer-Based Health Insurance*, KAISER FAM. FOUND. (2019), [www.kff.org/other/state-indicator/single--coverage/?currentTimeframe=0&sortModel={%22colld%22:”Location”,%22sort%22:”asc”}](http://www.kff.org/other/state-indicator/single--coverage/?currentTimeframe=0&sortModel={%22colld%22:”Location”,%22sort%22:”asc”}) [<https://perma.cc/RL7R-3SBN>].

<sup>47</sup> 2019 GAO REPORT, *supra* note 11, at 17.

<sup>48</sup> In 2019, the average single deductible employer-sponsored health insurance was \$1,655. *Benchmark Employer Survey Finds Average Family Premium Now Top \$20,000*, KAISER FAM. FOUND. (Sept. 25, 2019), [www.kff.org/health-costs/press-release/benchmark-employer-survey-finds-average-family-premiums-now-top-20000/](http://www.kff.org/health-costs/press-release/benchmark-employer-survey-finds-average-family-premiums-now-top-20000/) [<https://perma.cc/P44V-LFFD>].

<sup>49</sup> This example assumes a cost-sharing obligation of 20% and that insurance covers \$14,000 of the air ambulance bill. This amount was selected by subtracting the average bill of \$36,000 by the average balance bill of approximately \$22,000.

the bill, \$21,698.<sup>50</sup> Thus, the insured patient faces total financial exposure of \$27,653: \$1,500 for health insurance premiums, \$1,655 for deductible, \$2,800 for cost-sharing, and \$21,698 for the balance bill. To put this financial liability in perspective, it would constitute 82% of pre-tax income for most Americans and more than twice the entire savings of the whole household.<sup>51</sup> Most Americans cannot pay a bill of this size and will face the financial and emotional distress of collection efforts or even bankruptcy.<sup>52</sup>

## 2. *Narrow Networks and Lack of Choice Render Insurance Illusory for 75% of Americans*

The majority of these large air ambulance charges also constitute “surprise billing.” Surprise bills are unanticipated and involuntary higher bills received from out-of-network providers for care during an emergency or while at an in-network facility.<sup>53</sup> Large surprise bills for air ambulance transport services are far too common.<sup>54</sup>

These crippling air ambulance bills reflect pervasive under-insurance. Three-fourths of air ambulance transports are out-of-network, rendering insured Americans at high risk of unexpectedly large, often unpayable, bills.<sup>55</sup> This rate of out-of-network bills is more than three times the average rate for hospital emergency care.<sup>56</sup> Yet, surprise billing, even in that context, is considered such

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<sup>50</sup> Chhabra et al., *supra* note 12, at 777–78, 780 (median out-of-network charges billed for air transport were \$21,698).

<sup>51</sup> Elkins, *supra* note 12 (The median American household has \$11,700 in savings as of 2018); *Real Median Personal Income in the United States*, *supra* note 46 (median annual personal income was \$33,706 in 2018).

<sup>52</sup> See Elkins, *supra* note 12; *Real Median Personal Income in the United States*, *supra* note 46.

<sup>53</sup> 2017 Fuse Brown, *supra* note 10, at 136–37. Surprise bills are a subset of balance bills. All surprise bills are balance bills but the converse is not true, although in the context of air ambulance, most balance bills are also surprise bills. Surprise bills for air ambulance often manifest when, during an emergency, a patient is transported on an out-of-network air ambulance selected by the first responder or a physician. Such bills can also arise when a patient who is receiving care at an in-network hospital is transferred to another hospital (which may also be in-network) by an out-of-network air ambulance provider. There is no inherent difference in the surprise bill itself based on which way it manifests. In both instances, the patient faces an unexpectedly high bill.

<sup>54</sup> 2020 Fuse Brown, *supra* note 12, at 747.

<sup>55</sup> *Id.*; see also Chhabra et al., *supra* note 12, at 779 (71% of air ambulance transports for insureds covered by large national plans involved out-of-network billing); 2019 GAO REPORT, *supra* note 11, at 16 (In 2017, 69% of air ambulance transports were out-of-network).

<sup>56</sup> See Christopher Garmon & Benjamin Chartock, *One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills*, 36 HEALTH AFFS. 177, 179–80 (2017); Zach Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills – An Unwelcome Surprise*, 375 NEW. ENG. J. MED. 1915, 1916 (2016).

a serious problem that twenty-nine states have passed laws limiting it.<sup>57</sup> Surprise bills plague Americans who have worked hard to obtain increasingly expensive health insurance coverage.<sup>58</sup> In exchange for costly premiums, the insured expect to be protected from financial ruin if a health emergency occurs, but for air ambulance transport, in the majority of cases, large balance bills render such protection illusory.<sup>59</sup>

The significantly higher than normal percentage of out-of-network bills for air ambulance services stems from several factors. First, structurally, first responders or physicians typically select the air ambulance provider, usually without regard to the patient's insurance plan.<sup>60</sup> The patient is generally not involved in the choice of air ambulance provider.<sup>61</sup> Second, air ambulance transport often occurs in an emergency when shopping for an in-network provider is infeasible.<sup>62</sup> Third, there is often not an in-network provider reasonably available.<sup>63</sup>

Narrow insurance networks contribute substantially to the unreasonably high percentage of out-of-network air ambulance bills, leaving many patients

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<sup>57</sup> Maanasa Kona, *State Balance-Billing Protections*, THE COMMONWEALTH FUND (Sept. 16, 2020), [www.commonwealthfund.org/publications/maps-and-interactives/2020/apr/state-balance-billing-protections](http://www.commonwealthfund.org/publications/maps-and-interactives/2020/apr/state-balance-billing-protections) [https://perma.cc/4VSK-BRE6]. Wyoming is not currently one of the twenty-nine states with balance billing protections. While this statistic references “balance-billing,” it is defined to track surprise billing. Frequently, the two terms are used interchangeably or imprecisely. In the context of air ambulance, approximately 70% of balance billing results from surprise billing, so there is substantial overlap between the problems. Chhabra et al., *supra* note 12, at 781; 2019 GAO REPORT, *supra* note 11, at 16. Generally, however, all surprise billing constitutes balance billing, but not all balance billing meets the definition of surprise billing.

<sup>58</sup> 2017 Fuse Brown, *supra* note 10, at 136–40.

<sup>59</sup> *Id.*; see also George A. Nation III, *Contracting for Healthcare: Price Terms in Hospital Admission Agreements*, 124 DICK. L. REV. 91, 139–40 (2019) [hereinafter *Contracting for Healthcare*] (arguing that patients who are treated in an emergency should not be liable for provider charges but rather only for the reasonable market value of the medical care received pursuant to quasi-contract, in the context of hospital charges).

<sup>60</sup> 2019 GAO REPORT, *supra* note 11, at 7.

<sup>61</sup> *Id.*

<sup>62</sup> 2017 Fuse Brown, *supra* note 10, at 136–37.

<sup>63</sup> See 2020 Fuse Brown, *supra* note 12 (over 75% of air ambulance transports are out of network); Chhabra et al., *supra* note 12, at 779 (71% of air ambulance transports for insureds covered by large national plans involved out-of-network billing); 2019 GAO REPORT, *supra* note 11, at 16 (In 2017, 69% of air ambulance transports were out-of-network.); Mann et al., *supra* note 33 (gaps remain in rural air ambulance coverage); WYOMING WAIVER, *supra* note 16, at 4 (inadequate coverage in areas); Head, *supra* note 16 (“[T]he most recent ADAMS map shows that there are still many rural areas with limited air medical coverage . . . .”); RANDALL MACINTOSH, REVIEW OF SAMPLING EXTRAPOLATION METHODOLOGIES, EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT CLAIM AUDITS 21 (2006) (“[S]mall counties may have only one provider.”); HAW. STATE HEALTH PLANNING AND DEV. AGENCY, EMERGENCY APPLICATION – CERTIFICATE OF NEED PROGRAM, APPLICATION NO. 06-07E, 3 (2006) (when air ambulances are down for maintenance there can be “two or sometimes only one aircraft to cover the entire state”).

unknowingly under-insured.<sup>64</sup> Patients are under-insured when, despite being covered by health insurance, they remain at significant financial risk for medical costs.<sup>65</sup> Insurance networks are considered “narrow” when there are few or no “in network” providers reasonably available for a medically necessary service.<sup>66</sup> The problem is endemic for air ambulance transport services because both air ambulance providers and insurers have little incentive to enter into in-network contracts with agreed upon payment rates.<sup>67</sup> Air ambulance providers are reluctant to accept reduced in-network payment amounts because, unlike other healthcare services, being in-network does not tend to increase the volume of patients.<sup>68</sup> After all, first responders and physicians typically select the provider, and they generally do so based on proximity or relationship, not the patient’s insurance plan.<sup>69</sup> At the same time, insurers likewise have little incentive to reach contractual agreements with air ambulance providers because the cost of air ambulances is high, yet most consumers do not anticipate needing air ambulance coverage when selecting insurance.<sup>70</sup> As a result, in-network contracts are less common for air ambulance services than for other types of healthcare, and the patient who needs an air ambulance often ends up caught in the middle with an overwhelming bill.<sup>71</sup> The balance billing problem associated with air ambulance transport reflects strategic behavior on the part of both providers and insurers.<sup>72</sup> Unfortunately, the unjust out-of-network problem is so pervasive that under-insurance is the norm for air ambulance services.<sup>73</sup>

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<sup>64</sup> 2019 GAO REPORT, *supra* note 11, at 7–8.

<sup>65</sup> Sara R. Collins et al., *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse*, THE COMMONWEALTH FUND (May 20, 2015), [www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-underinsurance-and-how-rising-deductibles-will-make-it](http://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-underinsurance-and-how-rising-deductibles-will-make-it) [<https://perma.cc/58GV-BXQR>] (defining patients facing out-of-pocket healthcare costs, excluding premiums, exceeding 10% or more of household income as under-insured).

<sup>66</sup> Valerie Blake, *Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform*, 16 MINN. J.L. SCI. & TECH. 63, 64, 68–69 (2015).

<sup>67</sup> 2019 GAO REPORT, *supra* note 11, at 8.

<sup>68</sup> *Id.* at 7–8.

<sup>69</sup> *Id.* at 7.

<sup>70</sup> *Id.* at 7–8.

<sup>71</sup> *Id.* at 2, 8.

<sup>72</sup> David A. Hyman & Benedic Ippolito, *Arbitration Not the Answer to Fix Surprise Medical Billing*, REAL CLEAR POL’Y (Feb. 12, 2019), [www.realclearpolicy.com/articles/2019/02/12/arbitration\\_not\\_the\\_answer\\_to\\_fix\\_surprise\\_medical\\_billing\\_111042.html](http://www.realclearpolicy.com/articles/2019/02/12/arbitration_not_the_answer_to_fix_surprise_medical_billing_111042.html) [<https://perma.cc/NG94-AECX>] (describing surprise medical bills as strategic behavior; providers rely on large balance bills most often when patients do not choose their provider).

<sup>73</sup> See Blake, *supra* note 66, at 122 (narrow networks are morally problematic and cannot be justified even if broader networks will result in higher premiums).

### 3. *Cost Shifting, Total Lack of Price Control, or Both Exacerbate the Balance Billing Problem*

Despite balance billing concerns, air ambulance carriers dispute that price controls or prohibitions on balance billing are appropriate.<sup>74</sup> They cite low reimbursement rates for Medicare and Medicaid, poor coverage by private insurance contracts, and losses on uninsured patients, as well as expensive costs to provide service, as driving balance bills for insured Americans.<sup>75</sup> They argue that better reimbursement rates for government-insured patients, reasonable in-network private insurance rates, and mandatory disclosure of costs would decrease balance billing.<sup>76</sup> They warn that limiting air ambulance charges or restricting balance billing could leave large swaths of rural America without access to air transport coverage.<sup>77</sup>

The air carriers' position may not be wholly without merit. Air ambulance providers charge uninsured and privately insured patients 4.1 to 9.5 times the Medicare reimbursement rate.<sup>78</sup> Average Medicaid rates are lower still.<sup>79</sup> This apparent cost shifting raises serious ethical concerns, especially when applied to low-income populations. While lower reimbursement rates for government-insured patients are common, the extent of the differential for air ambulance transport is not.<sup>80</sup> Ground ambulances charge privately insured patients 1.7 to 2.8 times the Medicare reimbursement rate.<sup>81</sup> For other healthcare, commercial insurers pay 1.6 times the Medicare reimbursement rate on average.<sup>82</sup> Air ambulance price discrimination occurs at four times the typical rate.<sup>83</sup>

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<sup>74</sup> Bluth, *supra* note 9.

<sup>75</sup> *Id.*

<sup>76</sup> *Id.* (stating that greater transparency would encourage more in-network agreements).

<sup>77</sup> Samantha Liss, *Air Ambulance Industry on Defense as Surprise Billing Debate Heats Up*, HEALTHCARE.DIVE (July 10, 2019), [www.healthcarediver.com/news/air-ambulance-industry-on-defense-as-surprise-billing-debate-heats-up/558388](http://www.healthcarediver.com/news/air-ambulance-industry-on-defense-as-surprise-billing-debate-heats-up/558388) [<https://perma.cc/6HW3-C53R>] ("The industry group representing air ambulance services is warning that bases are at risk of closing, particularly in rural areas, if Congress passes a bill banning surprise billing . . ." or dictates out of network rates).

<sup>78</sup> Bai et al., *supra* note 11, at 1195. The Medicare reimbursement rate is the amount HHS pays a provider who provides a covered service to a Medicare patient. HHS sets these rates with input from providers and other stakeholders.

<sup>79</sup> KUGEL ET AL., *supra* note 9, at 13.

<sup>80</sup> See Frank Griffin, *Fighting Overcharged Bills from Predatory Hospitals*, 51 ARIZ. ST. L.J. 1003, 1013 (2019) ("[C]ommercial insurers pay 1.6 times the Medicare reimbursement rate on average.").

<sup>81</sup> Bai et al., *supra* note 11, at 1197.

<sup>82</sup> Griffin, *supra* note 80, at 1013.

<sup>83</sup>  $1.6 \times 4 = 6.4$ . Griffin, *supra* note 80, at 1013 (insurers typically pay 1.6 times the Medicare reimbursement rate); Bai et al., *supra* note 11, at 1195 (air ambulance providers charge uninsured and privately insured patients 4.1 to 9.5 times the Medicare reimbursement rate).



Significantly, this pricing differential is also increasing rapidly. The difference between the provider-charged rate and Medicare reimbursement rate increased 46–61% from 2012 through 2016.<sup>84</sup> This raises a serious question: is the government bearing the full cost of government-insured patients? If not, this may help to explain the unreasonable financial burden currently facing privately insured and uninsured air ambulance patients. Government-insured patients make up the majority of air ambulance patients.<sup>85</sup> Government rates must cover their costs. Privately insured patients are only 32% of the market.<sup>86</sup> They cannot afford to bear the costs of the other two-thirds of patients, nor is it ethical to require them to risk their financial security by forcing them to do so.<sup>87</sup> Pinning cost shifting on the uninsured, who tend to be low income, is even more unconscionable.<sup>88</sup>

There is another explanation for the unacceptably large differential, however. It is possible that government rates are reasonable, and the extreme differential actually reflects a complete lack of price control in the air ambulance market.<sup>89</sup> Put differently, the fact that air ambulance charges are a significantly higher multiple of the Medicare reimbursement rate, indicates a significant inequity. However, it may be that the charged rate for privately insured and uninsured patients is too high, the Medicare rate is too low, or both. Solving the balance billing problem will require minimizing or eliminating the price differential so that non-government-pay patients are not burdened with more than their fair share of air ambulance costs.

#### 4. *Receiving Unpayable Bills Causes Psychological Stress and Financial Harm*

Air ambulance carriers also oppose price regulation on the grounds that balance billing and surprise billing problems are overstated. They argue balance bills pressure insurance companies to pay a more reasonable amount and that the actual amounts paid by patients tend to be far lower than amounts billed.<sup>90</sup> While true, this argument ignores the psychological and financial consequences caused

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<sup>84</sup> Bai et al., *supra* note 11, at 1199.

<sup>85</sup> 2019 GAO REPORT, *supra* note 11, at 6 (In 2016, 35% of air ambulance patients had Medicare, 32% were privately insured, 21% had Medicaid, and 9% were uninsured).

<sup>86</sup> *Id.*

<sup>87</sup> See Griffin, *supra* note 80, 1003–05 (describing how differential pricing exploits uninsured and out-of-network patients); Reinhardt, *supra* note 23 (cost shifting is unethical).

<sup>88</sup> See Griffin, *supra* note 80, at 1003–05.

<sup>89</sup> See *An Arm and a Leg*, *supra* note 24, at 393–401 (arguing Medicare reimbursement rates should not be increased, blaming oversupply and lack of price control).

<sup>90</sup> Alex Ruoff, *Air Ambulance Companies Defend ‘Balance Billing’ of Patients*, BLOOMBERG GOV’T (Jan. 15, 2020, 4:36 PM), [about.bgov.com/news/air-ambulance-companies-defend-balance-billing-of-patients](https://perma.cc/3LQE-EJ3B) [https://perma.cc/3LQE-EJ3B] (balance bills are necessary to pressure insurance companies and less than 1% of air ambulance revenues are received directly from patients).

by receiving an unpayable medical bill, being pursued by debt collectors, and having medical debt reported to credit agencies.<sup>91</sup>

Often, air ambulance bills are uncollectible, but this is hardly a consolation to a patient who faces financial ruin.<sup>92</sup> Medical debt contributes to more than half of all personal bankruptcies in the United States.<sup>93</sup> Moreover, even when air ambulance bills are ultimately resolved for a much lower amount, after a provider accepts a reduction or an insurer pays more, the patient suffers during the interim. Being pursued and caught in the middle between providers and insurance companies hurts patients' emotional wellbeing.<sup>94</sup> Receiving an unpayable medical bill and experiencing collection efforts trigger significant stress.<sup>95</sup>

Large balance bills for air ambulance services personify how our current healthcare system sets up a predictable trade-off. On one hand, receiving care provides a patient substantial benefit in terms of improved morbidity and mortality. On the other hand, the often unpayable medical bill resulting from such care can threaten a patient's social, financial, and psychological well-being.<sup>96</sup> In fact, some patients report that an air ambulance saved their life, only to ruin it.<sup>97</sup> Because of high cost, balance billing, under-insurance, and differential pricing, bills for air ambulance transport services are causing hundreds of thousands of insured Americans serious financial and emotional distress each year.<sup>98</sup>

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<sup>91</sup> Matthew B. Lawrence, *The Social Consequences Problem in Health Insurance and How to Solve It*, 13 HARV. L. & POL'Y REV. 593, 595, 660 (2019) (describing "social consequences" associated with the health care billing system for privately insured patients in the U.S.); Daniel Aaron, *Why Our Health Care Is Incomplete: Review of "Exposed" (Part I)*, BILL OF HEALTH (Feb. 11, 2020), blog.petriefrom.law.harvard.edu/2020/02/11/why-our-health-care-is-incomplete-review-of-exposed-part-i/#more-28398 [https://perma.cc/89H3-E4XG] (reviewing CHRISTOPHER T. ROBERTSON, EXPOSED (2019) to argue that cost exposure in health care causes stress and has been shown to be medically harmful).

<sup>92</sup> Air ambulance bills are often uncollectible because the average bill amount is almost double the average American household's savings. See *supra* Part II. Patients simply lack the financial wherewithal to make full payment.

<sup>93</sup> Griffin, *supra* note 80, at 1006.

<sup>94</sup> See Lawrence, *supra* note 91, at 602.

<sup>95</sup> *Id.* at 647.

<sup>96</sup> See *id.* at 596, 628–29; 2019 GAO REPORT, *supra* note 11, at 6.

<sup>97</sup> Kaiser Health News, 'Financially Devastating' Air Ambulance Rides Can Both Save Lives and Ruin Them, KAISER FAM. FOUND. (Aug. 20, 2019), khn.org/morning-breakout/financially-devastating-air-ambulance-rides-can-both-save-lives-and-ruin-them/ [https://perma.cc/437X-CQAG].

<sup>98</sup> See Chhabra et al., *supra* note 12, at 78–81; 550,000 x .4 = 220,000. COUNCIL ON MED. SERV., *supra* note 17, at 2 (550,000 patients are transferred by air ambulance each year); 2020 Fuse Brown, *supra* note 12 (2 in 5 air ambulance patients receive balance bill).

*D. Federal Preemption Hinders States' Ability to Regulate Air Ambulances*

States have shown a willingness to adopt consumer protections to combat harmful air ambulance pricing and billing practices.<sup>99</sup> Unfortunately, implementation of state reform efforts, which would have provided empirical data on potential solutions from experimentation, has largely been blocked by federal preemption.<sup>100</sup> There are three basic types of preemption: express preemption, field preemption, and conflict preemption.<sup>101</sup> Express preemption applies when the federal government expressly states that federal law supersedes state law.<sup>102</sup> The ADA explicitly provides that “a State . . . may not enact or enforce a law, regulation, or other provision . . . related to a price, route, or service of any air carrier[.]”<sup>103</sup> Based on this language, the United States Supreme Court has repeatedly held the ADA creates express preemption that broadly prohibits any state laws relating to “airline ‘rates, routes, or services.’”<sup>104</sup>

The text of the ADA does not explicitly reference air ambulance transport services, and the United States Supreme Court has not considered an air ambulance case. Nevertheless, the Fourth, Eighth, Tenth, and Eleventh Circuit courts, as well

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<sup>99</sup> See, e.g., MONT. CODE ANN. §§ 33-2-2302, -2305 (2019); N.M. STAT. ANN. § 59A-57-4 (2020); N.M. CODE R. § 13.10.21.8 (LexisNexis 2020); N.D. CENT. CODE § 26.1-47-09 (2019); WYO. STAT. ANN. § 26-5-103(a)(ii) (2020).

<sup>100</sup> See, e.g., *Bailey v. Rocky Mountain Holdings, LLC*, 889 F.3d 1259, 1262, 1268–69 (11th Cir. 2018) (holding Florida law prohibiting balance billing preempted by ADA as applied to air ambulances); *Air Evac. EMS, Inc. v. Cheatham*, 910 F.3d 751, 755 (4th Cir. 2018) (holding West Virginia statutory maximum reimbursement and prohibition on balance billing for workers’ compensation preempted by ADA as applied to air ambulances); *Guardian Flight, LLC v. Godfred*, 359 F. Supp. 3d 744, 752–54 (D.N.D. 2019) (holding North Dakota statutory prohibition on balance billing preempted by ADA as applied to air ambulances); *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 938–41 (D.N.D. 2016) (holding North Dakota statutory division of air ambulance providers into primary and secondary call lists preempted by ADA). *But see* *Tex. Mut. Ins. Co. v. PHI Air Medical, LLC*, No. 18-0216, 2020 Tex. LEXIS 615, at \*2–5, 63 TEX. SUP. CT. J. 1462 (Tex. June 26, 2020) (holding air ambulance carrier failed to show the fair and reasonable reimbursement standard had a significant effect on its prices and that the ADA does not preempt this state standard).

<sup>101</sup> *Cap. Cities Cable, Inc. v. Crisp*, 467 U.S. 691, 698–99 (1984).

<sup>102</sup> *Hillsborough Cnty. v. Automated Med. Lab’ys, Inc.*, 471 U.S. 707, 713 (1985).

<sup>103</sup> 49 U.S.C. § 41713(b)(1).

<sup>104</sup> *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383–84 (1992) (holding that the ADA preempts state consumer protection laws as applied to airline fare advertisements, interpreting ADA preemption broadly to include even indirect effect if the state law has a significant impact on price, route, or service); *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 224 (1995) (holding that the ADA preempts state-imposed Illinois Consumer Fraud Act claims arising out of the airlines’ frequent flyer program but not self-imposed breach of contract claims); *Northwest, Inc. v. Ginsberg*, 572 U.S. 273, 276 (2014) (holding that the ADA also preempts state-imposed common law good faith and fair dealing claims arising out of the airlines’ frequent flyer program because such laws effect rate and would undermine the purpose of the ADA).

as numerous district courts, have almost uniformly held that ADA preemption extends to air ambulance carriers.<sup>105</sup> This conclusion rests on the fact that air ambulances fall within the common meaning of “air carrier,” and the ADA does not expressly exempt them.<sup>106</sup>

Some courts have recognized that federal preemption of state regulation of air ambulances does not serve the purpose behind the ADA.<sup>107</sup> Congress enacted the ADA in 1978 to deregulate the airline industry in hopes that a market-driven approach would improve efficiency, innovation, prices, and quality.<sup>108</sup> Given the time-sensitive, emergency nature of most air ambulance transport, the general lack of choice of carrier, and the market dysfunction discussed below, these goals do not fit air ambulances.<sup>109</sup> Moreover, considering the essential role air ambulances play in the United States healthcare system, especially in rural areas, it is inexplicable that the government regulates (or more accurately, deregulates) air ambulances solely as air carriers and not as part of the healthcare system.<sup>110</sup> Nonetheless, in light of the plain language of the statute, most courts to date have invalidated any state legislation or regulation relating to price, route, or service for air ambulances.<sup>111</sup>

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<sup>105</sup> *Cheatham*, 910 F.3d at 755; *Ferrell v. Air EVAC EMS, Inc.*, 900 F.3d 602 (8th Cir. 2018); *EagleMed LLC v. Cox*, 868 F.3d 893 (10th Cir. 2017); *Schneberger v. Air Evac Ems, Inc.*, 749 F. App'x. 670 (10th Cir. 2018); *Bailey*, 889 F.3d at 1262, 1268–69; *see, e.g.*, *Stout v. Med-Trans Corp.*, 313 F. Supp. 3d 1289 (N.D. Fla. 2018); *Dwelle*, 171 F. Supp. 3d at 938–41; *Concovich v. Air Evac Ems, Inc.*, No. 15-cv-0294-MJR-DGW, 2016 WL 843276 (S.D. Ill. Mar. 4, 2016) (ADA preempts challenge to air ambulance bill based on Illinois Consumer Fraud and Deceptive Trade Practices Act); *EagleMed, LLC v. Travelers Insurance*, 424 P.3d 532 (Kan. Ct. App. 2018) (ADA preempts state workers' compensation billing limits). *But see Tex. Mut. Ins. Co.*, 2020 Tex. LEXIS 615, at \*2–5.

<sup>106</sup> *See, e.g.*, *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 733 (E.D.N.C. 2008).

<sup>107</sup> *See, e.g.*, *Cox*, 868 F.3d at 903 (recognizing that ADA preemption of air ambulance regulation appears inconsistent with the ADA's stated purpose, but finding that inconsistency irrelevant when statutory language is unambiguous).

<sup>108</sup> *Morales*, 504 U.S. at 378.

<sup>109</sup> *Bai et al.*, *supra* note 11, at 1199; 2019 GAO REPORT, *supra* note 11, at 6.

<sup>110</sup> *Mann et al.*, *supra* note 33; WYOMING WAIVER, *supra* note 16, at 4; *see also About Rural Health*, *supra* note 4 (discussing long distance travel to emergency and specialty care as a cause of poor rural health outcomes); *ConsumersUnion*, *supra* note 15, at 2.

<sup>111</sup> *Bailey v. Rocky Mountain Holdings, LLC*, 889 F.3d 1259, 1262, 1268–69 (11th Cir. 2018); *Air Evac. EMS, Inc. v. Cheatham*, 910 F.3d 751, 755 (4th Cir. 2018); *Guardian Flight, LLC v. Godfread*, 359 F. Supp. 3d 744, 752–54 (D.N.D. 2019); *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 938–41 (D.N.D. 2016). *But see Tex. Mut. Ins. Co. v. PHI Air Medical, LLC*, No. 18-0216, 2020 Tex. LEXIS 615, at \*2–5, 63 TEX. SUP. CT. J. 1462 (Tex. June 26, 2020). State regulations that are unrelated to price, route or service generally survive preemption analysis. So, for example, state efforts to restrict air ambulance subscription services, as part of the state regulation of insurance, have been upheld. *Godfread*, 359 F. Supp. 3d at 753. States may also regulate the healthcare providers who render care during air ambulance transport, but state efforts to prohibit balance billing or to coordinate carriers have been preempted.

Because states cannot regulate anything with significant effect on air carrier price, route, or service, some states have focused on regulating insurers regarding their air ambulance coverage.<sup>112</sup> Under the McCarran-Ferguson Act, states have the power to regulate the business of insurance.<sup>113</sup> However, federal preemption limits this state authority as well.<sup>114</sup> ERISA preempts state laws as applied to self-funded, employer-sponsored insurance, including employer-sponsored health plans.<sup>115</sup> This leaves states able to regulate private health insurance purchased on the individual market and those employer-based plans that are not self-insured.<sup>116</sup> Because the majority of Americans (56%) obtain health insurance through employer-based plans, and 61% of employer-sponsored health plans are partially or fully self-funded, a large gap remains.<sup>117</sup> States cannot provide even insurance-focused protections to address air ambulance bills for more than a third of healthcare insurance consumers.<sup>118</sup>

Consequently, the juxtaposition of ADA and ERISA preemption significantly curtail states' ability to solve air ambulance problems.<sup>119</sup> Congress modeled ADA preemption on ERISA preemption, and both laws couple an extremely deregulatory federal approach with sweepingly broad state preemption.<sup>120</sup> This combination creates vacuum preemption, sometimes called "dead zones," where federal authority has not acted but states are prohibited from acting to address a problem.<sup>121</sup> At present, federal preemption largely prohibits states from protecting

<sup>112</sup> See, e.g., CAL. INS. CODE § 10126.65 (Deering 2020); MONT. CODE ANN. § 2-18-716 (2019); *id.* § 20-25-1316; N.D. CENT. CODE § 26.1-47-09 (2019).

<sup>113</sup> 15 U.S.C. § 1012.

<sup>114</sup> 29 U.S.C. §§ 1001–03.

<sup>115</sup> *Id.*; *id.* § 1144. An employer that provides "self-funded" insurance must pay all or most of the cost of employee claims as they occur, retaining risk and responsibility for employee claims. In contrast, under a "fully-insured" plan, an employer pays a set premium each month regardless of the claims actually made by employees.

<sup>116</sup> *Id.* § 1144(b)(2)(A), (B).

<sup>117</sup> EDWARD R. BERCHICK ET AL., U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE U.S.: 2017 (2018), [www.census.gov/library/publications/2018/demo/p60-264.html](https://www.census.gov/library/publications/2018/demo/p60-264.html) [https://perma.cc/D2GX-2VWG] (56% employer-based insurance, 19.3% Medicaid, 17.2% Medicare, 16% direct purchase coverage, 4.8% military coverage, 8.8% uninsured); see GARY CLAXTON ET AL., EMPLOYER HEALTH BENEFITS: 2019 ANNUAL SURVEY (2019).

<sup>118</sup> EDWARD R. BERCHICK ET AL., *supra* note 117 (56% x 61% = 34.16%). Of course, sometimes, state regulation of other insurance does impact the self-funded, employer-sponsored market that states cannot regulate directly.

<sup>119</sup> See, e.g., *Stout v. Med-Trans Corp.*, 313 F. Supp. 3d 1289 (N.D. Fla. 2018); *Valley Med Flight, Inc. v. Dwell*, 171 F. Supp. 3d 930, 938–41 (D.N.D. 2016); *Concovich v. Air Evac Ems, Inc.*, No. 15-cv-0294-MJR-DGW, 2016 WL 843276, at \*3 (S.D. Ill. Mar. 4, 2016).

<sup>120</sup> Michael C. Duff, *Wyoming's Continued Struggles with Air Ambulances and Federal Preemption*, WORKERS' COMPENSATION L. PRO. BLOG (Feb. 16, 2020), [lawprofessors.typepad.com/workerscomplaw/2020/02/wyomings-continued-struggles-with-air-ambulances-and-federal-preemption.html](https://lawprofessors.typepad.com/workerscomplaw/2020/02/wyomings-continued-struggles-with-air-ambulances-and-federal-preemption.html) [https://perma.cc/FHD5-WZ7A].

<sup>121</sup> *Id.*; ConsumersUnion, *supra* note 15, at 1.

consumers from excessive air ambulance bills, even though consumers are crying for help.<sup>122</sup>

*E. Persistent Oversupply and Gaps in Access Suggest a Need for Air Ambulance Coordination*

Federal preemption also prevents states from coordinating or regulating the placement of air ambulance bases and helicopters, despite evidence of harmful, uneven availability in the current air ambulance system.<sup>123</sup> States cannot use the “certificate-of-need” process or other means to ensure all citizens have adequate access to life-saving care or to prohibit costly oversupply.<sup>124</sup> Only the federal government has the power to regulate or coordinate availability, and so far, it has declined to do so.<sup>125</sup> This preemption without substantive regulation jeopardizes health, especially of rural Americans, and contributes to excessively high air ambulance prices.

For years, data has suggested that oversupply in some areas contributes to higher than necessary air ambulance prices.<sup>126</sup> The number of air ambulances more than doubled from 2002 to 2008.<sup>127</sup> Then, in the five-year period from 2012 to 2017, providers established more than a hundred new helicopter bases.<sup>128</sup> This rapid supply-side growth failed to be offset by similar growth in demand.<sup>129</sup> As a result, providers’ desire to recoup the high, fixed costs associated with operating air ambulance transport service over fewer patients per provider drove price increases.<sup>130</sup>

Simultaneously, however, other areas of the country are experiencing gaps in access that can lead to longer wait and transport times with sometimes deadly

<sup>122</sup> Bai et al., *supra* note 11, at 1199.

<sup>123</sup> 49 U.S.C. § 41713(b)(1); *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383–84 (1992); WYOMING WAIVER, *supra* note 16, at 3–7; 2019 GAO REPORT, *supra* note 11, at 16–20.

<sup>124</sup> *Medics, Markets, and Medicare*, *supra* note 15, at 42–43; *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 736 (E.D.N.C. 2008). The “certificate-of-need” process allows states to control the supply and location of health care resources by requiring regulatory approval in advance. BARRY FURROW ET AL., *HEALTH LAW* 830–31 (8th ed. 2018) (“[T]he market for health care remains highly dysfunctional.”).

<sup>125</sup> 49 U.S.C. § 41713(b)(1).

<sup>126</sup> *ConsumersUnion*, *supra* note 15, at 3; *see also Medics, Markets, and Medicare*, *supra* note 15, at 44–45.

<sup>127</sup> COUNCIL ON MED. SERV., *supra* note 17, at 2.

<sup>128</sup> 2019 GAO REPORT, *supra* note 11, at 11.

<sup>129</sup> *Medics, Markets, and Medicare*, *supra* note 15, at 44.

<sup>130</sup> *An Arm and a Leg*, *supra* note 24, at 325 (“When fewer flights are available to each operator, fixed costs drive up their average per-flight hour and per-mission cost.”).

consequences, especially in rural areas.<sup>131</sup> Distribution of air ambulance services should turn on evidence-based benchmarks for emergency medical services' response time, highway crash volume, and similar proof of need so that patients do not die or suffer avoidable morbidity and costs are not unnecessarily high.<sup>132</sup> Because the market does not efficiently regulate, undersupply or oversupply can linger for years with devastating consequences for the health and financial wellbeing of impacted individuals.<sup>133</sup> This uneven distribution of air ambulance services needlessly undermines the health and prosperity of Americans and exacerbates inequities in rural areas.

### *F. A Dysfunctional Market Perpetuates Air Ambulance Cost and Supply Problems*

Air ambulances' rapidly rising costs, wide variability in charges, and over and under-supply suggest market failure.<sup>134</sup> Healthcare markets are notoriously dysfunctional for a multitude of reasons, but the problem appears unusually acute in the context of air ambulance transport services.<sup>135</sup> There are several reasons for this.

First, structurally, the party controlling demand is price insensitive.<sup>136</sup> As discussed above, first responders and physicians, who neither consume nor pay for air ambulances, typically determine if a patient utilizes an air ambulance, as well as which carrier to use.<sup>137</sup> Neither first responders nor physicians have an economic incentive to shop for the best price, and they typically select a provider based on relationship or proximity rather than the patient's insurance plan and likely bill.<sup>138</sup>

Second, air ambulance services are often provided in a time-sensitive emergency when price shopping is infeasible.<sup>139</sup> A first responder or physician's

<sup>131</sup> 2019 GAO REPORT, *supra* note 11, at 12–16; Mann et al., *supra* note 33; WYOMING WAIVER, *supra* note 16, at 4; Head, *supra* note 16 (“[T]he most recent ADAMS map shows that there are still many rural areas with limited air medical coverage . . .”).

<sup>132</sup> WYOMING WAIVER, *supra* note 16, at 3–4.

<sup>133</sup> See 2020 Fuse Brown, *supra* note 12, at 748 (concluding that the air ambulance market fails to discipline supply).

<sup>134</sup> Bai et al., *supra* note 11, at 1199; 2019 GAO REPORT, *supra* note 11, at 6.

<sup>135</sup> FURROW ET AL., *supra* note 124, at 481 (“[T]he market for health care remains highly dysfunctional.”).

<sup>136</sup> *No Way to Run*, *supra* note 24.

<sup>137</sup> 2019 GAO REPORT, *supra* note 11, at 7; see also Bai et al., *supra* note 11, at 1199 (“Patients lack control over which air ambulance provider transports them.”).

<sup>138</sup> 2019 GAO REPORT, *supra* note 11, at 7.

<sup>139</sup> See COUNCIL ON MED. SERV., *supra* note 17, at 1.

job is to save a patient's life or to prevent avoidable morbidity, and when minutes matter, cost comparison is unrealistic.<sup>140</sup>

Third, the lack of time to shop is made worse by lack of price transparency.<sup>141</sup> First responders, physicians, and patients typically do not know the cost of a particular air ambulance provider for a particular patient.<sup>142</sup> The cheapest provider for one patient may be the most expensive for another depending on insurance. Therefore, market failure occurs due to imperfect (or non-existent) information.<sup>143</sup>

Fourth, even if the incentive, time, and information to compare carriers existed, first responders and physicians generally have few, if any, choices regarding provider.<sup>144</sup> Only one or few air ambulance providers may be reasonably available.<sup>145</sup> When one or few suppliers control the market, the suppliers will control the price.<sup>146</sup> In the air ambulance market, ever-rising cost, seemingly untethered from efficient provision of service, reflects the unequal power air ambulance providers have in setting price.<sup>147</sup> Air ambulance providers often have market control, enabling them to set the price of transport well above the cost of providing such services.<sup>148</sup>

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<sup>140</sup> 2019 GAO REPORT, *supra* note 11, at 7.

<sup>141</sup> See 2017 Fuse Brown, *supra* note 10, at 161.

<sup>142</sup> See, e.g., *This Is How Much Air Medical Transport Costs*, AIR MED. BLOG (June 1, 2017), [airmed.com/Blog/June-2017/This-is-How-Much-Air-Medical-Transport-Costs](https://perma.cc/KC55-KYSM) [https://perma.cc/KC55-KYSM] (patients usually do not know how much air ambulance will cost); Bai et al., *supra* note 11, at 1199 (Patients cannot “check provider network status or conduct price comparisons in the midst of an emergency serious enough to require air ambulance service”).

<sup>143</sup> See COUNCIL ON MED. SERV., *supra* note 17, at 1; 2019 GAO REPORT, *supra* note 11, at 7; Bai et al., *supra* note 11, at 1199. Unlike the other structural factors causing air ambulance market failure, lack of price transparency could likely be improved without regulatory control of the market.

<sup>144</sup> Bai et al., *supra* note 11, at 1196–99; GOV'T ACCOUNTABILITY OFF., AIR AMBULANCE: DATA COLLECTION AND TRANSPARENCY NEEDED TO ENHANCE DOT OVERSIGHT (2017) [hereinafter 2017 GAO REPORT] (finding market concentration).

<sup>145</sup> See, e.g., Head, *supra* note 16 (“[T]he most recent ADAMS map shows that there are still many rural areas with limited air medical coverage . . . .”); RANDALL MACINTOSH, *supra* note 63, at 21 (“[S]mall counties may have only one provider.”); HAW. STATE HEALTH PLANNING, *supra* note 63 (when air ambulances are down for maintenance there can be “two or sometimes only one aircraft to cover the entire state”).

<sup>146</sup> See, e.g., Irena Asmundson, *Supply and Demand: Why Markets Tick*, INT'L MONETARY FUND (Feb. 24, 2020), [www.imf.org/external/pubs/ft/fandd/basics/suppdem.htm](https://www.imf.org/external/pubs/ft/fandd/basics/suppdem.htm) [https://perma.cc/JTB6-KW6R].

<sup>147</sup> Bai et al., *supra* note 11, at 1195; *Medics, Markets, and Medicare*, *supra* note 15 (describing consolidated air ambulance industry); see also 2020 Fuse Brown, *supra* note 12, at 764 (“The low volume of air ambulance services likely also contributes to the lack of price constraints.”).

<sup>148</sup> Bai et al., *supra* note 11, at 1195.



Air carriers need to be paid a reasonable rate for their services, but the evidence is clear that air ambulance deregulation has failed.<sup>149</sup> The market simply does not efficiently regulate air ambulance price or supply.<sup>150</sup> Given that the party “buying” air ambulance services is not the same party paying, that the “choice” of provider often occurs in an emergency when shopping is unrealistic, and that there are usually few, if any, choices of provider, the market cannot and will not function effectively. The government must step in and provide services or regulate price and supply.

### III. RURAL HEALTH INEQUITY AND A STRUCTURAL RELIANCE ON AIR AMBULANCE SERVICES

Out-of-control balance billing and supply problems are endemic across the United States, but the impact is disproportionately felt in rural areas, which already suffer significant health disparities.<sup>151</sup> “Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.”<sup>152</sup> Overall, people who live in rural areas tend to be sicker and poorer.<sup>153</sup> Rural Americans are also more likely to die from stroke, unintentional injury, chronic lower respiratory disease, cancer, and heart disease than their urban counterparts.<sup>154</sup> The difference in mortality rate between rural and urban Americans has tripled since in 1999.<sup>155</sup> These unjust outcomes are avoidable and result from several factors, including inadequate access to health care.<sup>156</sup>

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<sup>149</sup> In contrast, deregulation has had a positive impact on consumer welfare with regard to commercial flights, causing prices to decrease significantly. *See, e.g.*, Gerald Cook, *A Review of History, Structure, and Competition in the U.S. Airline Industry*, 7 J. AVIATION/AEROSPACE ED. & RSCH. 33, 37–38 (1996).

<sup>150</sup> These market inefficiencies may also be compounded by the shift from non-profit hospital-based providers to for-profit providers. *An Arm and a Leg*, *supra* note 24, at 324. While it is important not to oversimplify the significance of formal legal structure, it is likely not coincidence that during the same time the percentage of non-profit, hospital-based air carriers decreased and for-profit carriers increased, prices rose precipitously.

<sup>151</sup> *About Rural Health*, *supra* note 4 (“Rural Americans face numerous health disparities compared with their urban counterparts.”); ConsumersUnion, *supra* note 15, at 2.

<sup>152</sup> *Adolescent and School Health*, CTRS. FOR DISEASE CONTROL AND PREVENTION, [www.cdc.gov/healthyyouth/disparities/index.htm](http://www.cdc.gov/healthyyouth/disparities/index.htm) (last visited July 12, 2020) [<https://perma.cc/W77L-NLQK>].

<sup>153</sup> *Id.* (providing rural Americans tend to be sicker and have higher rates of poverty); Huberfeld, *supra* note 4, at 248–51 (describing rural health disparities and noting that “rural patients are sicker and poorer than urban patients on the whole”).

<sup>154</sup> *About Rural Health*, *supra* note 4.

<sup>155</sup> ABBY HOFFMAN & MARK HOLMES, N.C. RURAL HEALTH RSCH. PROGRAM, REGIONAL DIFFERENCES IN RURAL AND URBAN MORTALITY TRENDS (2017) (from 1999 to 2015, the difference in mortality rate between rural and urban Americans tripled from a 6% difference to an 18% difference).

<sup>156</sup> *Health Disparities*, *supra* note 152.

In fact, the inequality in rural health outcomes reflects the unique affordability, quality of care, and access challenges confronting rural communities.<sup>157</sup> Ability to pay for care is a significant barrier to rural health equity.<sup>158</sup> Rural communities tend to be less affluent and care tends to cost more in rural areas.<sup>159</sup> As a result, rural Americans struggle to afford care, suffering from a system that rations care primarily based on ability to pay.<sup>160</sup> This cost barrier is made worse by the fact that our healthcare system relies heavily on insurance through state-based plans. Because rural populations tend to be older and sicker, and the population more spread out, insurance premiums cost more in rural states.<sup>161</sup> As a result of higher premiums, lower socio-economic status, and other factors, rural populations are less likely to be covered by health insurance.<sup>162</sup> The combination of lower incomes, less insurance coverage, and lower population density creates a perfect storm that makes it very difficult to afford care and even more challenging to spread the cost of uncompensated or undercompensated care amongst others who can afford to bear it.<sup>163</sup>

Compounding these cost issues, rural communities struggle to attract and retain qualified healthcare providers.<sup>164</sup> Worker shortages are common, and even without shortages per se, the model of care in rural communities often relies on

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<sup>157</sup> *Healthcare Access in Rural Communities*, RURAL HEALTH INFO. HUB, [www.ruralhealthinfo.org/topics/healthcare-access](http://www.ruralhealthinfo.org/topics/healthcare-access) (last visited July 8, 2020) [<https://perma.cc/ULY5-KPM3>]. The older average age of population in rural areas also plays a role in poorer health. *Id.*

<sup>158</sup> See CAROL ADAIRE JONES ET AL., U.S. DEP'T OF AGRIC., HEALTH STATUS AND HEALTH CARE ACCESS OF FARM AND RURAL POPULATIONS (2009) (Rural communities report cost of care as a barrier at higher rates than those in urban areas).

<sup>159</sup> James Teufel et al., *Rural Health Systems and Legal Care: Opportunities for Initiating and Maintaining Legal Care After the Patient Protection and Affordable Care Act*, 35 J. LEGAL MED. 81, 82 (2014); Kathryn E. Artnak et al., *Cost and End-of-Life-Care: Health Care Accessibility for Chronic Illness Mgmt. and End-of-Life Care: A View from Rural America*, 39 J.L. MED. & ETHICS 140, 143 (2011) (providing that rural populations tend to be poorer).

<sup>160</sup> JONES ET AL., *supra* note 158, at iv (stating rural communities report cost of care as a barrier at higher rates than those in urban areas); Huberfeld, *supra* note 4, at 251–53.

<sup>161</sup> ABIGAIL R. BARKER ET AL., RUPRI CTR. FOR RURAL HEALTH POL'Y ANALYSIS, HEALTH INSURANCE MARKETPLACES: ISSUER PARTICIPATION AND PREMIUM TRENDS IN RURAL PLACES 3 (2018).

<sup>162</sup> EDWARD R. BERCHICK ET AL., U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE U.S.: 2018 (2019); Artnak et al., *supra* note 159, at 143.

<sup>163</sup> Dustin Bleizeffer & Mason Adams, *Transition in Coal Country: Downturn Drives Medicaid Expansion Appeal*, LARAMIE BOOMERANG B2 (July 5, 2020) (in rural areas, “there aren't enough people with adequate insurance to help cover the costs of healthcare services”).

<sup>164</sup> *Healthcare Access in Rural Communities*, *supra* note 157; *Preventing Chronic Diseases and Promoting Health in Rural Communities*, CTRS. FOR DISEASE CONTROL AND PREVENTION, [www.cdc.gov/chronicdisease/resources/publications/factsheets/rural-health.htm](http://www.cdc.gov/chronicdisease/resources/publications/factsheets/rural-health.htm) (last visited Nov. 15, 2020) [<https://perma.cc/3JLR-AJCA>] (“Rural counties have fewer health care workers, specialists (such as cancer doctors), critical care units, emergency facilities, and transportation options.”); Artnak et al., *supra* note 159, at 144.

less credentialed or less specialized health professionals.<sup>165</sup> It is common for rural areas to utilize nurse practitioners rather than physicians and general physicians rather than specialists or subspecialists. This model often requires patients to travel long distances when they need more acute or specialized care.<sup>166</sup>

Rural populations also face geographic access barriers.<sup>167</sup> Even for routine care, rural populations frequently must travel longer distances than their urban counterparts.<sup>168</sup> At times, travel to necessary care can be an hour away, and the result is often delayed or avoided care with detrimental health outcomes.<sup>169</sup> The distance to appropriate care poses a particularly pernicious threat to health in emergencies.<sup>170</sup>

Given these challenges, affordable air ambulance service is vital to bridge access and quality gaps in rural healthcare.<sup>171</sup> In areas where an appropriate medical provider may be hours away by ground, air ambulance carriers can substantially decrease travel time.<sup>172</sup> In emergencies, faster transportation can be the difference between life and death.<sup>173</sup> Reliance on air ambulance transport has grown over the last decade as more than a hundred rural hospitals have closed and even those that remain open increasingly rely on regional medical centers to provide higher level

<sup>165</sup> Teufel et al., *supra* note 159, at 82; Artnak et al., *supra* note 159, at 143; Amanda Peacher, *Despite Doctor Shortage, Refugee Physicians Face Big Hurdles to Practicing*, WYO. PUB. MEDIA (May 2, 2018), [www.wyomingpublicmedia.org/post/despite-doctor-shortage-refugee-physicians-face-big-hurdles-practicing#stream/0](http://www.wyomingpublicmedia.org/post/despite-doctor-shortage-refugee-physicians-face-big-hurdles-practicing#stream/0) [<https://perma.cc/XD99-Y394>] (“[Wyoming] has some of the worst doctor shortages of all U.S. states.”).

<sup>166</sup> Lisa Knapp, *Chapter 2: Analysis of Wyoming’s Demographics and the Health Care Workforce*, in *HEALTH CARE WORKFORCE NEEDS IN WYOMING: UPDATE 2017* at 15 (David Bullard et al. eds., 2017) (“[I]ndividuals living in rural areas . . . have fewer available doctors and other health care providers, and must travel longer distances for health care.”).

<sup>167</sup> *About Rural Health*, *supra* note 4.

<sup>168</sup> *Id.*; Knapp, *supra* note 166, at 15 (“[I]ndividuals living in rural areas . . . must travel longer distances for health care.”).

<sup>169</sup> Artnak et al., *supra* note 159, at 144–45; Mann et al., *supra* note 33.

<sup>170</sup> *Healthcare Access in Rural Communities*, *supra* note 157; *About Rural Health*, *supra* note 4.

<sup>171</sup> COUNCIL ON MED. SERV., *supra* note 17, at 1–2; Mann et al., *supra* note 33; WYOMING WAIVER, *supra* note 16, at 4; *see also About Rural Health*, *supra* note 4 (discussing long distance travel to emergency and specialty care as a cause of poor rural health outcomes); ConsumersUnion, *supra* note 15, at 2; Artnak et al., *supra* note 159, at 143 (“Residents face worse outcomes and more complications partly because of transportation problems . . .”); Mann et al., *supra* note 33, at 698 (deaths increased when access to air ambulance decreased).

<sup>172</sup> Zachary J. Rhinehart, *The Association Between Air Ambulance Distribution and Trauma Mortality*, 257 *ANNALS OF SURGERY* 1147 (2013) (air ambulance is usually faster than ground ambulances); Mann et al., *supra* note 33, at 698 (air ambulance reduces transport times).

<sup>173</sup> Robin Warshaw, *Health Disparities Affect Millions in Rural U.S. Communities*, AAMCNEWS (Oct. 31, 2017), [www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities](http://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities) [<https://perma.cc/BA9F-MPT7>]; Mann et al., *supra* note 33; COUNCIL ON MED. SERV., *supra* note 17, at 1–2.

care.<sup>174</sup> This shift away from offering comprehensive care locally in rural areas has been stark. While hospital closures have been widely reported, the impact of consolidating services to medical centers hours away may actually be even more profound. For example, in Riverton, Wyoming, the local hospital had 230 employees in 2013; today it has less than 40.<sup>175</sup> It remains “open”, but no longer provides the services it once did.<sup>176</sup> As a result, local air ambulance transport has increased more than five-fold over the same time period.<sup>177</sup>

Such consolidations may save money for the healthcare system overall, but they decrease geographic accessibility and make care less affordable for individuals in rural areas, individuals who can least afford additional access and cost barriers.<sup>178</sup> Structurally, our healthcare system has chosen to shift to a model that relies on air ambulance transport to provide appropriate care to rural America.<sup>179</sup> Yet, the cost of this transport is not shared system-wide.<sup>180</sup> Instead, America asks the relatively small percentage of rural individuals unlucky enough to need air ambulance transport to bear the entire, currently devastating, cost alone. This is unjust. In order to move toward health equity, this country will have to fundamentally change its rural healthcare model or create a more affordable, accessible air ambulance system for rural Americans.

Deregulation has failed. Given structural market failure, it seems clear that states or the federal government must step in and regulate air ambulance price and supply to promote health and to avoid exacerbating rural health inequity. The question becomes, where do we go from here?

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<sup>174</sup> 176 *Rural Hospital Closures: 2005 – Present (134 Since 2010)*, U.N.C. CHAPEL HILL, [www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/](http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/) [<https://perma.cc/DU5Z-QK9F>]; Bluth, *supra* note 9, at 2 (noting increasing reliance on air ambulance, as more than 100 rural hospitals have closed since 2010); Consumers Union, *supra* note 15, at 2; *An Arm and a Leg*, *supra* note 24, at 328–29.

<sup>175</sup> Clair McFarland, *Riverton Looks to CARES Funds for New Hospital*, POWELL TRIB. (July 21, 2020), [www.powelltribune.com/stories/riverton-looks-to-cares-funds-for-new-hospital,26319](http://www.powelltribune.com/stories/riverton-looks-to-cares-funds-for-new-hospital,26319) [<https://perma.cc/44DW-BYHS>].

<sup>176</sup> *Id.*

<sup>177</sup> *Id.*

<sup>178</sup> See SHARITA R. THOMAS ET AL., U.N.C. G. SHEPS CTR. HEALTH SERVS. RSCH., A COMPARISON OF CLOSED RURAL HOSPITALS AND PERCEIVED IMPACT (2015) (closure or conversion of rural hospitals leads to decreased geographic accessibility and increased EMS costs); *An Arm and a Leg*, *supra* note 24, at 328–29.

<sup>179</sup> THOMAS ET AL., *supra* note 178; *An Arm and a Leg*, *supra* note 24, at 328–29; Bluth, *supra* note 9, at 2 (providing eighty million Americans can only reach a Level 1 or 2 trauma center within an hour if flown by air ambulances).

<sup>180</sup> See Chhabra et al., *supra* note 12, at 777–78, 780; 2020 Fuse Brown, *supra* note 12, at 748 (discussing average patient bill for air ambulance transport).

#### IV. EFFORTS AT SOLUTION: STATES KEEP TRYING BUT FACE PREEMPTION HURDLES; THE FEDERAL GOVERNMENT HAS FAVORED FURTHER STUDY

Many states, especially in rural areas, have been working hard to address the air ambulance problems that plague their citizens, but so far, the federal government has stymied these efforts.<sup>181</sup> This section utilizes Wyoming as a case study to illustrate how rural states have tried various administrative and legislative remedies to combat air ambulance challenges, focusing, in particular, on an innovative, first in the nation, Medicaid-administered all-payer air ambulance network proposal.<sup>182</sup> Then, it discusses other remedies enacted by states and a proposed federal remedy.

Wyoming is one of the nation's most rural states, and it reflects many of the challenges rural states face with healthcare and air ambulance services.<sup>183</sup> The quality of Wyoming's healthcare ranks 42nd in the nation, and yet, it has among the highest health insurance premiums.<sup>184</sup> It averages just five people per square mile, whereas the average population density in the United States is eighty-seven people.<sup>185</sup> Vast expanses of open land and sparse population make Wyoming

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<sup>181</sup> See, e.g., *Bailey v. Rocky Mountain Holdings, LLC*, 889 F.3d 1259, 1262, 1268–69 (11th Cir. 2018) (holding Florida law prohibiting balance billing preempted by ADA as applied to air ambulances); *Air Evac. EMS, Inc. v. Cheatham*, 910 F.3d 751, 755 (4th Cir. 2018) (holding West Virginia statutory maximum reimbursement and prohibition on balance billing for workers' compensation preempted by ADA as applied to air ambulances); *Guardian Flight, LLC v. Godfread*, 359 F. Supp. 3d 744, 752–54 (D.N.D. 2019) (holding North Dakota statutory prohibition on balance billing preempted by ADA as applied to air ambulances); *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 938–41 (D.N.D. 2016) (holding North Dakota statutory division of air ambulance providers into primary and secondary call lists preempted by ADA). *But see Tex. Mut. Ins. Co. v. PHI Air Medical, LLC*, No. 18-0216, 2020 Tex. LEXIS 615, at \*2–5, 63 TEX. SUP. CT. J. 1462 (Tex. June 26, 2020) (holding air ambulance carrier failed to show the fair and reasonable reimbursement standard had a significant effect on its prices and that the ADA does not preempt this state standard).

<sup>182</sup> An “all-payer” rate setting approach charges the same rate to all payers, whether government-insured, privately insured, or uninsured.

<sup>183</sup> Wyoming has the smallest population of any state in the U.S., yet the ninth largest area in square miles. *2010 Census: Population Density Data*, U.S. CENSUS BUREAU, [www.census.gov/data/tables/2010/dec/density-data-text.html](http://www.census.gov/data/tables/2010/dec/density-data-text.html) (last visited Dec. 17, 2020) [<https://perma.cc/AH98-RLMJ>] (table showing Wyoming has the smallest population of any U.S. state); *Wyoming Facts and Symbols*, STATE OF WYO., [www.wyo.gov/about-wyoming/wyoming-facts-and-symbols](http://www.wyo.gov/about-wyoming/wyoming-facts-and-symbols) (last visited July 1, 2020) [<https://perma.cc/WP4Q-NF5X>] (Wyoming is the ninth largest state at 97,914 square miles).

<sup>184</sup> Bleizeffer & Adams, *supra* note 163, at B2 (citing U.S. News and World Report ranking); Louise Norris, *Wyoming Health Insurance Marketplace: History and News of the State's Exchange*, HEALTHINSURANCE.ORG (Nov. 5, 2020), [www.healthinsurance.org/wyoming-state-health-insurance-exchange/](http://www.healthinsurance.org/wyoming-state-health-insurance-exchange/) [<https://perma.cc/R759-3HNB>] (providing that Wyoming health insurance premiums are among the highest in the nation).

<sup>185</sup> *What is Rural*, WYO. DEP'T OF HEALTH, [health.wyo.gov/publichealth/rural/officeofruralhealth/what-is-rural/](http://health.wyo.gov/publichealth/rural/officeofruralhealth/what-is-rural/) (last visited Oct. 10, 2020) [<https://perma.cc/ZZ4U-SPDG>] (Wyoming

beautiful, but those same characteristics have also resulted in serious healthcare access challenges.<sup>186</sup> Patients routinely must travel long distances to receive appropriate care, and provider shortages are endemic.<sup>187</sup> Statewide coordination and affordable transport are essential to minimize gaps in access in care.<sup>188</sup> In Wyoming, as in most rural areas, air ambulance transport service “is nothing short of necessary, lifesaving infrastructure.”<sup>189</sup>

*A. State Efforts to Enforce Reasonable Rates and Prohibit Balance Billing in Worker’s Compensation Often Preempted*

As a result, perhaps it is no surprise that Wyoming, like North Dakota and Montana, has been at the forefront of legislative and administrative efforts to regulate air ambulance rates, billing, access, and supply.<sup>190</sup> The air ambulance dispute in Wyoming begins several years ago with Wyoming’s attempt to enforce a workers’ compensation rate schedule.<sup>191</sup> Wyoming’s Workers’ Compensation Act only allows payment of medical care that is “appropriate and reasonable in accordance with its adopted fee schedules.”<sup>192</sup> Implementing this requirement, Wyoming established a maximum reimbursement rate for workers’ compensation for air ambulance transport, as it has for other types of covered care.<sup>193</sup> Simultaneously, Wyoming prohibited air ambulance providers who sought workers’ compensation reimbursement from balance billing patients for additional amounts, just as all

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averages 5.17 people per square mile); *2010 Census*, *supra* note 183 (U.S. average population per square mile was 87.4 in 2010).

<sup>186</sup> *What is Rural*, *supra* note 185.

<sup>187</sup> Knapp, *supra* note 166, at 15 (“[I]ndividuals living in rural areas . . . have fewer available doctors and other health care providers, and must travel longer distances for health care.”); Peacher, *supra* note 165 (“[Wyoming] has some of the worst doctor shortages of all U.S. states.”).

<sup>188</sup> WYOMING WAIVER, *supra* note 16, at 4–7.

<sup>189</sup> Letter from Mark Gordon, Wyo. Governor, to Sec’y Alex M. Azar II, U.S. Dep’t Health and Human Servs., at 1 (Oct. 15, 2019), [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wy/wy-medicaid-air-ambulance-network-pa.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wy/wy-medicaid-air-ambulance-network-pa.pdf) [https://perma.cc/CB3Q-PEWD] [hereinafter Governor Gordon Letter].

<sup>190</sup> See WYO. STAT. ANN. §§ 27-14-401(e), -501(a) (2020); WYO. CODE R. 053-0021-9 § 8 (LexisNexis 2020); H.R. HB0194, 65th Leg. Gen. Sess. (Wyo. 2019); WYOMING WAIVER, *supra* note 16.

<sup>191</sup> *EagleMed LLC v. Wyoming*, 227 F. Supp. 3d 1255 (D. Wyo. 2016), *aff’d in part and rev’d in part*, *EagleMed LLC v. Cox*, 868 F.3d 868 (10th Cir. 2017).

<sup>192</sup> WYO. STAT. ANN. § 27-14-401(b).

<sup>193</sup> *Id.* § 27-14-401(e) (“If transportation by ambulance is necessary, the division shall allow a reasonable charge for the ambulance service at a rate not in excess of the rate schedule established by the director under the procedure set forth for payment of medical and hospital care.”); WYO. CODE R. 053-0021-9 § 8 (i.e. maximum reimbursement for rotary-wing air ambulance transport \$3,900.66 plus \$27.47 per statutory mile).

health care providers who elect to receive workers' compensation reimbursement are limited.<sup>194</sup>

Air ambulance service providers sued contesting the state maximum reimbursement rate and balance billing prohibition.<sup>195</sup> In 2017, the Tenth Circuit held that the ADA preempts the Wyoming's Workers' Compensation Act and related regulations as applied to rate setting for air ambulance services.<sup>196</sup> The court found that Wyoming remains free to determine the maximum amount its workers' compensation fund will reimburse a provider, but federal law prohibits Wyoming (or any state) from restricting the rate air ambulance carriers may charge.<sup>197</sup> The court rejected the argument that the air ambulance carriers had voluntarily chosen to accept the reduced rate as total payment by opting to take workers' compensation reimbursement.<sup>198</sup> This left the Wyoming's Workers' Compensation program with a Hobson's choice.<sup>199</sup> It could either: (1) abandon the "grand bargain" of workers' compensation, wherein workers injured on the job give up their right to sue in exchange for having necessary medical costs covered or (2) pay the high rates unilaterally set by air ambulance carriers, rates that the state deemed excessive and problematic for the economic viability of the fund.<sup>200</sup> So far, Wyoming's Workers' Compensation program has chosen to negotiate and pay the amounts charged by air ambulance carriers, but the state is also clearly looking for a better solution.<sup>201</sup>

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<sup>194</sup> WYO. STAT. ANN. § 27-14-501(a) ("Fees or portions of fees for injury related services or products rendered shall not be billed to or collected from the injured employee.").

<sup>195</sup> *EagleMed*, 227 F. Supp. 3d at 1261.

<sup>196</sup> *EagleMed LLC v. Cox*, 868 F.3d 893, 907 (10th Cir. 2017).

<sup>197</sup> *Id.* at 905.

<sup>198</sup> *Id.* at 901.

<sup>199</sup> A Hobson's Choice is "the necessity of accepting one of two or more equally objectionable alternatives." MERRIAM-WEBSTER DICT., [www.merriam-webster.com/dictionary/Hobson%20s%20choice](http://www.merriam-webster.com/dictionary/Hobson%20s%20choice) (last visited Nov. 9, 2020) [<https://perma.cc/445F-V9AA>].

<sup>200</sup> See *Air Methods/Rocky Mountain Holdings, LLC v. Wyoming Dep't of Workforce Servs.*, 2018 WY 128, 432 P.3d 476 (Wyo. 2018) (holding that WYO. STAT. ANN. § 27-14-401(e), as severed, required the Division to pay the full amount billed by the air ambulance carriers, but refusing to consider the Division's argument, not made below, that it could limit payment to its rate schedule so long as carriers remained able to balance bill injured workers for any remaining amounts). Several other states have likewise attempted to apply routine workers' compensation rate restrictions and balance billing prohibitions to air ambulance carriers, only to have courts hold that the ADA preempts these state laws. See, e.g., *EagleMed, LLC v. Travelers Ins.*, 424 P.3d 532 (Kan. Ct. App. 2018); *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751 (4th Cir. 2018); see also David B. Torrey et al., *Recent Developments in Workers' Compensation and Employers' Liability Law*, 53 TORT TRIAL & INS. PRAC. L.J. 703, 726–28 (2018) (briefly discussing ADA preemption of air ambulance price regulation in the context of workers' compensation).

<sup>201</sup> In addition to proposing an all-payer system, Wyoming's legislature has considered a new proposed bill relating to air ambulance coverage for injured workers.

*B. Wyoming's Section 1115 Waiver Application for a Medicaid Coordinated, All-Payer Air Ambulance Network*

In 2019, Wyoming opted to try a more universal approach to air ambulance cost, billing, cost-shifting, and supply problems. The state legislature passed House Bill 194 authorizing the Wyoming Department of Health (WDH) to attempt to expand Medicaid coverage of air ambulance transport services to all Wyoming residents.<sup>202</sup> The legislation sought to create a comprehensive all-payer air ambulance system administered by WDH through Wyoming's Medicaid program.

*1. Medicaid and Section 1115 Waiver Background*

To understand Wyoming's proposal and the challenges it has faced, it is helpful to start with some background on Medicaid and its Section 1115 "demonstration project" waiver program. Medicaid is a cooperative federal-state program that pays for covered health care for certain low-income individuals.<sup>203</sup> Congress enacted Medicaid in order to assist states in furnishing medical assistance to low-income families with dependent children and aged, blind, or disabled individuals.<sup>204</sup>

Medicaid is typically a payer of last resort.<sup>205</sup> Beneficiaries must assign the state any rights they have "to payment for medical care from any third party."<sup>206</sup> Similarly, state Medicaid agencies must hold third parties responsible before paying a claim, and if they learn of liable third parties after paying a claim, state Medicaid programs are obligated to chase the liable third party when it is cost effective to do so.<sup>207</sup>

States create and administer their own Medicaid plans within federal guidelines.<sup>208</sup> To receive federal funds, states must submit plans to the Centers for

<sup>202</sup> H.R. HB0194, 65th Leg. Gen. Sess. (Wyo. 2019). The bill also instructed WDH to negotiate with HHS for any necessary Section 1115 waiver. *See id.*

<sup>203</sup> 42 U.S.C. § 1396-1. Some scholars contend that the federal-state relationship under Medicaid since the ACA should be described as "dynamic, adaptive, pragmatic, negotiated, and robust in both horizontal and vertical intergovernmental activity" rather than merely "cooperative federalism." Abbe R. Gluck & Nicole Huberfeld, *Health Care Federalism and Next Steps in Health Reform*, 46 J.L. MED. & ETHICS 841, 842 (2018). This article utilizes the traditional descriptive phrase but does not contest that the relationship between states and the federal government under Medicaid is more complex.

<sup>204</sup> 42 U.S.C. § 1396-1 (Social Security Act).

<sup>205</sup> CTRS. FOR MEDICARE & MEDICAID SERVS., DEFICIT REDUCTION ACT IMPORTANT FACTS FOR STATE POLICYMAKERS: THIRD PARTY LIABILITY IN THE MEDICAID PROGRAM (2007) ("By law, the Medicaid program is the payer of last resort.").

<sup>206</sup> 42 U.S.C. § 1396k(a)(1)(A). So, Medicaid only pays for healthcare after all other third-party sources of payment, like private automobile insurance if care results from a car accident, have been exhausted.

<sup>207</sup> 42 C.F.R. § 433.139(b)(1), (c) (2020).

<sup>208</sup> *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004) (recognizing that "once a State elects to join the [Medicaid] program, it must administer a state plan that meets federal requirements").



Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.<sup>209</sup> Because of the unique joint federal-state structure, Medicaid plans vary considerably from state to state.<sup>210</sup>

While states enjoy significant flexibility in structuring their Medicaid programs, state choices are not wholly unfettered. Federal law limits state variation in important ways.<sup>211</sup> For example, federal law sets both a floor and ceiling for income eligibility for beneficiaries.<sup>212</sup> It also imposes certain mandatory, medically necessary benefits for eligible beneficiaries.<sup>213</sup> There are a variety of requirements, and if states wish to receive federal funds and participate in the Medicaid program, their plans must comply with all federal rules or they must obtain a waiver.<sup>214</sup>

Section 1115 of the Social Security Act allows HHS to waive certain federal Medicaid program requirements when statutory requirements are met.<sup>215</sup> Specifically, HHS may approve a state “experimental, pilot, or demonstration project” that is “likely to assist in promoting the objectives of the program.”<sup>216</sup> Congress included Section 1115 to ensure that federal Medicaid requirements did not “stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients.”<sup>217</sup> Longstanding policy also mandates that successful Section 1115 waivers be budget-neutral for the federal government.<sup>218</sup>

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<sup>209</sup> See 42 U.S.C. §§ 1396a(b), 1316(a); *About Us*, CTRS. FOR MEDICARE & MEDICAID SERVS., [www.medicaid.gov/about-us/index.html](http://www.medicaid.gov/about-us/index.html) (last visited July 3, 2020) [<https://perma.cc/2B6Q-Q5XL>] (CMS is an agency of HHS).

<sup>210</sup> FURROW ET AL., *supra* note 124, at 680; Letter from Calder Lynch, Dir., Ctrs. for Medicare & Medicaid Servs., to Michael Ceballos, Dir., Wyo. Dep’t Health, at 2 (Jan. 3, 2020), [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wy/air-ambulance/wy-medicaid-air-ambulance-network-cms-state-ltr-20200103.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wy/air-ambulance/wy-medicaid-air-ambulance-network-cms-state-ltr-20200103.pdf) [<https://perma.cc/3JNQ-8UR6>] (denying Wyoming’s waiver in part over budget neutrality concerns).

<sup>211</sup> FURROW ET AL., *supra* note 124, at 679; see, e.g., 42 U.S.C. § 1396a.

<sup>212</sup> 42 U.S.C. § 1396a(a)(10)(A)(i).

<sup>213</sup> *Id.* § 1396a(a)(10)(A).

<sup>214</sup> *Id.* § 1396b; ELIZABETH HINTON ET AL., KAISER FAM. FOUND., SECTION 1115 MEDICAID DEMONSTRATION WAIVERS: THE CURRENT LANDSCAPE OF APPROVED AND PENDING WAIVERS (2019).

<sup>215</sup> 42 U.S.C. § 1315.

<sup>216</sup> *Id.*

<sup>217</sup> S. Rep. No. 87-1589, at 19 (1962), as reprinted in 1962 U.S.C.C.A.N. 1943, 1961.

<sup>218</sup> Letter from Timothy Hill, Acting Dir., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs. (SMD# 18-009) (Aug. 22, 2018), [www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD18009.pdf](http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD18009.pdf) [<https://perma.cc/8CJJ-UV5M>]; FURROW ET AL., *supra* note 124, at 692; John Holahan et al., *Insuring the Poor Through Section 1115 Medicaid Waivers*, 14 HEALTH AFFS. 199, 200 (1995).

When the requirements for a waiver are met, HHS has some discretion to grant or deny a waiver based on its policy priorities.<sup>219</sup> Over the years, CMS has granted Section 1115 waivers for a wide variety of experimental state healthcare reform efforts. For example, several states used Section 1115 waivers in the 1990s to test managed care models in an effort to expand access while controlling cost.<sup>220</sup> More recently, some states have used waivers to create a targeted response to the opioid epidemic.<sup>221</sup> Controversially, states have also recently sought waivers to add so-called work requirements to Medicaid eligibility.<sup>222</sup> For years, CMS guidance for Section 1115 waivers included the goal of increasing insurance coverage, but in November 2017, under the Trump administration, CMS removed that goal.<sup>223</sup> CMS's current goals still include improving access to services and advancing innovative payment models to drive greater value for Medicaid.<sup>224</sup>

## 2. Wyoming's Current Medicaid Air Ambulance Coverage

Wyoming Medicaid currently funds medically necessary transport, including air ambulance, for eligible beneficiaries under appropriate conditions.<sup>225</sup> Wyoming Medicaid pays participating air ambulance providers on a fee-for-service basis.<sup>226</sup> Federal law prevents air ambulance transport services that contract with Medicaid from balance billing Medicaid beneficiaries.<sup>227</sup> Therefore, Medicaid beneficiaries do not currently experience the balance billing problems discussed above, although they may suffer from gaps in air ambulance access or quality failures.

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<sup>219</sup> HINTON ET AL., *supra* note 214.

<sup>220</sup> Holahan et al., *supra* note 218, at 200.

<sup>221</sup> HINTON ET AL., *supra* note 214.

<sup>222</sup> *Id.*

<sup>223</sup> *Id.*; *About Section 1115 Demonstrations*, CTRS. FOR MEDICARE & MEDICAID SERVS., [www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html](http://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html) (last visited July 3, 2020) [<https://perma.cc/U7TM-MWEX>].

<sup>224</sup> *Id.*

<sup>225</sup> WYO. DEP'T OF HEALTH, WYO. MEDICAID CLIENT HANDBOOK: YOUR GUIDE TO WYO. MEDICAID (2019), [health.wyo.gov/wp-content/uploads/2020/05/Wyoming-Medicaid-Handbook.pdf](http://health.wyo.gov/wp-content/uploads/2020/05/Wyoming-Medicaid-Handbook.pdf) [<https://perma.cc/9YJC-KPBN>] [hereinafter WYO. MEDICAID CLIENT HANDBOOK]; WYO. DEP'T OF HEALTH, CMS 1500 ICD-10 MANUAL 162 (July 1, 2020), [wymedicaid.portal.conduent.com/manuals/Manual\\_CMS-1500\\_07.01.2020.pdf](http://wymedicaid.portal.conduent.com/manuals/Manual_CMS-1500_07.01.2020.pdf) [<https://perma.cc/6RNF-LQNS>] [hereinafter CMS 1500] (patient must have a life threatening condition, be in an inaccessible location, or air ambulance transport must be more cost effective).

<sup>226</sup> CMS ICD-10 MANUAL, *supra* note 225. A "fee-for-service" payment model pays providers for each service provided to each patient. This contrasts with a "global" or "capitated" payment model in which payment is set in advance for a particular group of patients over a given period of time, regardless of actual utilization of services.

<sup>227</sup> 42 C.F.R. § 447.15 (2020); Medicaid Program; Miscellaneous Corrections, 45 Fed. Reg. 24,878, 24,889 (Apr. 11, 1980).

### 3. *Wyoming's Section 1115 Waiver Application for a Medicaid Coordinated, All-Payer Air Ambulance Network*

In October 2019, Wyoming submitted a first in the nation Section 1115 Waiver Application for a Medicaid Coordinated Air Ambulance Network.<sup>228</sup> Citing the essential nature of air ambulance transport in Wyoming, Governor Mark Gordon requested a waiver “to implement a comprehensive all-payer air ambulance system through [the] Wyoming Medicaid program[.]”<sup>229</sup> Wyoming’s goal was to obtain greater control over how much its citizens pay for air ambulance services and how much of such services are provided.<sup>230</sup>

Wyoming’s plan has five essential parts. First, the state sets standards for statewide air ambulance service, including quantity and quality.<sup>231</sup> Second, the state solicits bids and selects providers offering flat rate, fixed-price contracts.<sup>232</sup> Third, the state establishes a call center that routes all air ambulance transports to the contracted providers.<sup>233</sup> Fourth, while the state pays contractors, it recoups funds from private payers, Medicare, other public payers, and individuals using Medicaid Third Party Liability (TPL) “pay and chase” authority.<sup>234</sup> Fifth, some patients will be required to contribute to the cost of their air ambulance utilization through income-based cost-sharing for inter-facility transports (but not 9-1-1 scene response).<sup>235</sup> However, the maximum total out-of-pocket expenditure any patient who participates in the Medicaid program will be asked to pay is \$5,000.<sup>236</sup>

Wyoming’s waiver request targets the principle concerns of healthcare reform: cost, quality, and access.<sup>237</sup> The primary function of Wyoming’s application is to drive down cost.<sup>238</sup> All patients transported in the state would become eligible for Medicaid air ambulance coverage.<sup>239</sup> Aside from income-based cost-sharing,

<sup>228</sup> WYOMING WAIVER, *supra* note 16.

<sup>229</sup> Governor Gordon Letter, *supra* note 189.

<sup>230</sup> *Id.*

<sup>231</sup> WYOMING WAIVER, *supra* note 16, at 3.

<sup>232</sup> *Id.*

<sup>233</sup> *Id.*

<sup>234</sup> *Id.*

<sup>235</sup> *Id.*

<sup>236</sup> *Id.* at 16.

<sup>237</sup> *Id.* at 7; FURROW ET AL., *supra* note 124, at 1 (“Cost, quality, access and choice are the chief concerns of the health care system . . .”).

<sup>238</sup> Governor Gordon Letter, *supra* note 189, at 1.

<sup>239</sup> WYOMING WAIVER, *supra* note 16, at 13 (Wyoming’s proposal extends the Medicaid air ambulance transport benefit to “all persons requiring an air ambulance flight in Wyoming, regardless of residency or income level”).

providers would be prohibited from pursuing patients for balance bills.<sup>240</sup> Current Medicaid beneficiaries would continue to pay nothing.<sup>241</sup> An individual with an average income, who would currently face total financial exposure of roughly \$28,000, could now satisfy his or her air ambulance obligation in full by paying only \$674.<sup>242</sup> Even more affluent individuals would only be required to pay a fifth as much.<sup>243</sup> Air ambulance transport and life-saving emergency care would no longer result in avoidable financial ruin and emotional distress.

To accomplish this result, Wyoming's proposed Medicaid-managed, all-payer system, would utilize a competitive bid process, harnessing the power of the free market to create a network of participating air ambulance providers who are willing and qualified.<sup>244</sup> As the single payer statewide, Wyoming would try to leverage superior purchasing power to negotiate contracts with providers on a fixed-price basis, with Medicaid making periodic flat payments rather than paying on a fee-for-service basis.<sup>245</sup> The expectation being that this all-payer approach would result in lower cost per transport because statewide coordination would eliminate oversupply, utilization review would curtail overutilization, and a consolidated buyer would be able to negotiate more favorable price terms.<sup>246</sup>

Wyoming's plan requires traditional third-party payers to continue to fund air ambulance transport. Private health insurance would contribute an average cost-based rate that includes administrative fees.<sup>247</sup> State agencies, including the Department of Workforce Services which administers workers' compensation, and Medicaid would compensate the general air ambulance account on a capitated basis.<sup>248</sup> Wyoming's proposal treats air ambulance transport like a public utility, a regulated monopoly.<sup>249</sup>

The state's waiver application also reflects quality initiatives. It seeks to improve air ambulance quality by imposing standard requirements on contracted air ambulance carriers.<sup>250</sup> Wyoming's plan requires that carriers obtain

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<sup>240</sup> *Id.* at 16.

<sup>241</sup> *Id.*

<sup>242</sup> See *supra* Section II.C.1; WYOMING WAIVER, *supra* note 16, at 16 ( $\$33,706 \times .02 = \$674$ ).

<sup>243</sup> *Id.* (comparing \$28,000 to maximum cost-sharing of \$5,000).

<sup>244</sup> *Id.* at 1.

<sup>245</sup> *Id.* at 1–2.

<sup>246</sup> *Id.* at 7–8.

<sup>247</sup> *Id.* at 36.

<sup>248</sup> *Id.* at 23. See also WYO. STAT. ANN. § 42-4-123 (2020); *id.* §§ 26-4-102(b), 104(n); *id.* § 9-3-219; *id.* § 27-14-401(j) (all statutory payments to the air ambulance coverage fund are contingent on federal approval).

<sup>249</sup> WYOMING WAIVER, *supra* note 16, at 1 (describing as akin to a public utility).

<sup>250</sup> *Id.* at 1, 3.

accreditation through the Commission on Accreditation of Medical Transport Systems, which only half of the carriers currently operating have.<sup>251</sup> It also requires carriers to meet operational benchmarks such as response times, staffing levels, and training.<sup>252</sup> Wyoming also plans to set evidence-based clinical and care delivery benchmarks.<sup>253</sup> In addition to these carrier requirements, Wyoming intends to improve quality by planning the state air ambulance network around the state's systems of care and by monitoring carrier compliance with requirements through a comprehensive quality improvement program.<sup>254</sup> These quality initiatives, if successful, would improve the quality of care for currently eligible Medicaid beneficiaries, as well as for the newly eligible Air Ambulance Expansion group.<sup>255</sup>

Wyoming's plan also aims to combat gaps in access and oversupply. It does so through planning, linking contracted base locations and air carrier capacity with crash volume, emergency response times, population, available adequate healthcare services, and other evidence-based need factors.<sup>256</sup> The plan then relies on a centralized call center to direct all air ambulance carriers statewide to this network.<sup>257</sup> By planning and coordinating air ambulance services statewide, Wyoming could remove oversupply and address gaps in access so that this life-saving care is reasonably available to everyone at a more affordable price.

#### 4. *CMS's Denial of Wyoming's Innovative Experiment*

While Wyoming's proposal attempted to thoughtfully address the triple aim of healthcare reform, CMS denied the waiver in a short letter in January 2020.<sup>258</sup> CMS reasoned, “[u]sing the Medicaid administrative structure to provide services to other individuals in the state as a mechanism to avoid the application of federal aviation law is a clear departure from the core, historical mission of the Medicaid program to provide health coverage to the Medicaid eligible population.”<sup>259</sup> CMS also refused to approve the waiver because Wyoming failed to convince

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<sup>251</sup> *Id.* at 3.

<sup>252</sup> *Id.*

<sup>253</sup> *Id.*

<sup>254</sup> *Id.*

<sup>255</sup> *Id.* at 3, 13 (defining the Air Ambulance Expansion group to include “all persons requiring air ambulance flights in Wyoming, regardless of residency or income level”).

<sup>256</sup> WYOMING WAIVER, *supra* note 16, at 4–7.

<sup>257</sup> *Id.*

<sup>258</sup> Letter from Calder Lynch, *supra* note 210 (denying Wyoming Medicaid Coordinated Air Ambulance Network Section 1115 Waiver request). Even if CMS had granted the waiver, it is not clear how courts would have responded to a federal preemption challenge of Wyoming's law.

<sup>259</sup> *Id.*

the director that it would be budget-neutral for the federal government.<sup>260</sup> While committing to continue to work with the state, CMS offered no alternative solutions for an all-payer air ambulance network that it would approve.<sup>261</sup>

Ironies abound. Wyoming is one of twelve states that has refused to expand Medicaid under the Patient Protection and Affordable Care Act (ACA) in favor of stricter, Medicaid categorical, eligibility requirements.<sup>262</sup> Yet, it sought a waiver to expand coverage to its entire population (albeit only for air ambulance transport).<sup>263</sup> Meanwhile, CMS denied the waiver, citing “the core, historical mission of the Medicaid program to provide health coverage to the Medicaid eligible population.”<sup>264</sup> However, at roughly the same time, CMS approved several states’ Section 1115 waiver applications to enact Medicaid work requirements (later invalidated by courts), despite undisputed evidence such waivers would reduce health coverage to historically Medicaid-eligible populations.<sup>265</sup>

While CMS denied Wyoming’s waiver, the proposal may still have achieved some of its desired result. A month after the waiver denial, Blue Cross Blue Shield—the largest private health insurer in Wyoming and the only insurer on the ACA exchange—agreed to an in-network contract with Air Methods, the largest air ambulance service in the country.<sup>266</sup> Moreover, Wyoming has not given up on an all-payer network. After CMS rejected the initial waiver application, the Legislature charged WDH with continuing to negotiate with CMS and voted to continue to pursue an all-payer solution through the Medicaid program.<sup>267</sup> As Wyoming said in its application, “we do not believe Wyoming Medicaid can improve air ambulance services [] without a comprehensive, all-payer solution.”<sup>268</sup>

### C. Regulating Air Ambulance Membership Plans as Insurance

In addition to its more universal, all-payer proposal, Wyoming’s legislature also passed new consumer protection laws relating to air ambulances in the last year. In particular, a revision to Wyoming Statute Section 26-5-103(a)(ii) altered

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<sup>260</sup> *Id.*

<sup>261</sup> *Id.*

<sup>262</sup> *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND., [www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/](http://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/) (last visited July 1, 2020) [<https://perma.cc/N632-MV3G>] [hereinafter *Kaiser Interactive Map*].

<sup>263</sup> WYOMING WAIVER, *supra* note 16.

<sup>264</sup> Letter from Calder Lynch, *supra* note 210, at 2.

<sup>265</sup> See, e.g., Letter from Demetrios Kouzoukas, Principal Deputy Admin., to Stephen Miller, Comm’r, (Jan. 12, 2018), [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/health/ky-health-cms-appvl-011218.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/health/ky-health-cms-appvl-011218.pdf) [<https://perma.cc/PF6C-6HHU>].

<sup>266</sup> Stephenson, *supra* note 45.

<sup>267</sup> H.R. HB0172 (2020) 65th Leg., 2019 Sess. (Wyo. 2019).

<sup>268</sup> WYOMING WAIVER, *supra* note 16, at 3.

the definition of “disability insurance” to include air ambulance membership or subscription plans.<sup>269</sup> This change mandated that any air ambulance company selling memberships must become licensed as a disability insurance company by April 1, 2020.<sup>270</sup> The new legislation also requires air ambulance membership plans to meet Wyoming Department of Insurance (WDOI) standards, including basic consumer protection requirements.<sup>271</sup> The WDOI must now review and approve air ambulance membership policies, ensure companies offering plans meet financial solvency requirements, investigate consumer complaints, and enforce compliance.<sup>272</sup>

These reforms should help improve transparency and provide accountability if misleading or deceptive statements are used to sell memberships.<sup>273</sup> However, they do not appear to address the concern that air ambulance membership may provide only an illusory benefit to some patients.<sup>274</sup> Most membership plans only provide coverage if the same air ambulance company that sold the patient the membership plan also transports the patient. Such is often not the case, and then, the patient remains liable for the large balance bill and the patient’s membership provides no benefit.<sup>275</sup> Membership plans also sometimes sell to Medicare beneficiaries who have coverage for air ambulance even without paying this additional premium.<sup>276</sup>

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<sup>269</sup> WYO. STAT. ANN. § 26-5-103(a)(ii) (2020) (amending definition of disability insurance to read: “insurance of any kind on human beings against disablement or expense resulting from sickness, including subscription or membership plans relating to air ambulance transport services”); *Air Ambulance Licensing Overview*, WYO. INS. DEP’T, da1f597b-a-84cef9ff-s-sites.googlegroups.com/a/wyo.gov/doi/Air Ambulance Overview.pdf (last visited July 1, 2020) [https://perma.cc/R3NS-GSHV].

<sup>270</sup> WYO. STAT. ANN. § 26-5-103(a)(ii).

<sup>271</sup> *Air Ambulance Licensing Overview*, *supra* note 269 (“Companies selling air ambulance memberships and subscriptions must show that they are financially solvent so they can pay claims when a claim occurs, and they must file their policies with the DOI so the DOI can ensure the policies comply with Wyoming law . . . [including] various consumer protections contained in the Insurance Code.”).

<sup>272</sup> *Id.*

<sup>273</sup> State legislation and regulation treating air ambulance membership subscription plans as insurance enables states to license providers, supervise, and hold accountable. These insurance laws show states are not wholly without power to protect consumers from perceived abusive practices in connection with air ambulances. However, they also reveal the limits of state power. Transparency and accountability for any unfair and deceptive trade practices in connection with membership services is a step forward, but such laws do not address the fundamental air ambulance challenges.

<sup>274</sup> ConsumersUnion, *supra* note 15, at 1; Sarah Tribble, *Air Ambulances Woo Rural Consumers with Memberships that May Leave Them Hanging*, NAT’L PUB. RADIO (Sept. 14, 2019).

<sup>275</sup> ConsumersUnion, *supra* note 15, at 14; Tribble, *supra* note 274.

<sup>276</sup> *Air Methods Ends Membership Program*, J. EMER. MED. SERV. (Nov. 25, 2019), www.jems.com/2019/11/25/air-methods-ends-membership-program/ [https://perma.cc/2KD6-YE5D] (“Medicare Part B beneficiaries are already covered for air medical services without a membership . . . Air Methods is challenging other companies in the industry to [stop selling memberships] and refund membership payments made by Medicare beneficiaries.”).

Air ambulance companies have responded in a variety of ways to this new regulation. Some air ambulance companies stopped providing membership services.<sup>277</sup> One company, Air Methods, stopped providing memberships, agreed to refund membership fees paid by Medicare beneficiaries, and committed to increase in-network insurance agreements.<sup>278</sup> Another company completed the necessary requirements and has been licensed by WDOI to continue selling membership plans.<sup>279</sup> While such legislation only addresses a tangential aspect of air ambulance cost, billing, and access problems, it does suggest that state legislative activity sometimes increases public pressure on air ambulance companies in a way that causes positive reforms that the state likely could not legislate directly.<sup>280</sup>

#### *D. Other State Efforts that Have Not Been Preempted*

Other states have tried three additional solutions to address air ambulance problems, within the confines of federal preemption. First, Montana, North Dakota, and California recently passed “hold harmless” laws regulating insurance to specifically limit patient balance billing to in-network cost-sharing amounts.<sup>281</sup> These laws take the patient out of the middle and leave insurance companies and air ambulance providers to reach agreements on amounts due.<sup>282</sup> Second, Montana has also established an independent dispute resolution procedure to determine the fair market value of air ambulance services.<sup>283</sup> This law does not improve the market for air ambulance itself, but it does provide a procedural mechanism for resolving billing disputes.<sup>284</sup> Third, several states have implemented new

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<sup>277</sup> Zac Taylor, *Ruling Stops Operation of Air Ambulance Service*, CODY ENTERPRISE (Apr. 15, 2020), [www.codyenterprise.com/news/local/article\\_bd066ff0-7f4d-11ea-a876-4f517dd0f19a.html](http://www.codyenterprise.com/news/local/article_bd066ff0-7f4d-11ea-a876-4f517dd0f19a.html) [<https://perma.cc/4VU4-9HZZ>] (AirMedCare Network will cease selling membership for Wyoming transport); Tom Lacock, *State Offers Guidance on Air Ambulance Memberships*, WYO TODAY (Apr. 20, 2020), [wrrnetwork.com/2020/04/23/state-offers-guidance-on-air-ambulance-memberships/](http://wrrnetwork.com/2020/04/23/state-offers-guidance-on-air-ambulance-memberships/) [<https://perma.cc/8CDJ-SL6D>] (Air Methods ended its membership program).

<sup>278</sup> *Air Methods Ends Membership Program*, *supra* note 276 (Air Methods Ends Membership Program, agrees to refund any membership fees paid by Medicare beneficiaries, and commits to increase in-network agreements, although one in four still currently out-of-network).

<sup>279</sup> Eric Barlow & Lloyd Larsen, *New Air Ambulance Law Helps Safeguard Wyoming Consumers*, LARAMIE BOOMERANG (Apr. 10, 2020), [www.laramieboomerang.com/laramie/new-air-ambulance-law-helps-safeguard-wyoming-consumers/article\\_80dbc0ee-b1a0-5f8e-88a2-e33a1e7137f8.html](http://www.laramieboomerang.com/laramie/new-air-ambulance-law-helps-safeguard-wyoming-consumers/article_80dbc0ee-b1a0-5f8e-88a2-e33a1e7137f8.html) [<https://perma.cc/E23T-CCQB>] (WDOI has authorized one air ambulance membership company).

<sup>280</sup> 2019 GAO REPORT, *supra* note 11, at 23–24 (describing other state success at using public pressure to spur reform).

<sup>281</sup> See, e.g., CAL. INS. CODE § 10126.65 (Deering 2002); MONT. CODE ANN. § 2-18-716 (2019); *id.* § 20-25-1316; N.D. CENT. CODE § 26.1-47-09 (2019).

<sup>282</sup> See CAL. INS. CODE § 10126.65 (Deering 2002); MONT. CODE ANN. § 2-18-716 (2019); *id.* § 20-25-1316; N.D. CENT. CODE § 26.1-47-09 (2019). Because of ERISA preemption, however, these laws only regulate insurance that is not employer-based and self-funded, leaving roughly a third of all private insurance unregulated. 29 U.S.C. § 1144(b)(2)(A), (B).

<sup>283</sup> MONT. CODE ANN. § 2-18-718; *id.* § 20-25-1318.

<sup>284</sup> See *id.* § 2-18-718; *id.* § 20-25-1318.



disclosure requirements so that patients in need of air ambulance transport must be provided information on network status and given the opportunity to choose providers whenever possible.<sup>285</sup> These laws seek to improve access to information in the market. Each of these approaches is discussed more in Section V below, but all reflect compromises imposed by preemption.<sup>286</sup>

### *E. Federal Deregulation and Study, but Imminent Breakthrough is Possible*

Given the interstate nature of many air ambulance flights and preemption, a federal solution to the air ambulance problems would be ideal.<sup>287</sup> Yet, so far, the federal government has proven unwilling to take any substantive action to either protect consumers or regulate the air ambulance market. Instead, Congress has merely studied the issue. Congress has sought two reports from the Government Accountability Office on costs and risks associated with air ambulances.<sup>288</sup> Congress has also required the collection of certain new air ambulance data and ordered the creation of an advisory committee on air ambulance billing issues.<sup>289</sup> The resulting Air Ambulance Advisory Committee met for the first time in January 2020 and is scheduled to release a report with recommendations.<sup>290</sup> After it issues its report to the Department of Transportation, the director will have six months to make a recommendation to Congress.<sup>291</sup> While, ideally, the result of this process would be for Congress to amend the ADA to exempt air ambulances from preemption, this result appears unlikely, at least as long as the Senate remains controlled by Republicans who favor deregulation.

A more likely federal remedy could arise if Congress passes a general healthcare bill limiting balance billing. Congress has proposed some such bills, and while not all apply to air ambulance transport, some do.<sup>292</sup> Broad federal legislation limiting balance billing could solve the balance billing concerns raised herein and it would

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<sup>285</sup> See, e.g., N.D. CENT. CODE § 23-16-17; *id.* § 23-27-04.10; UTAH CODE ANN. § 26-8a-107 (LexisNexis 2020).

<sup>286</sup> See *infra* Part VI.

<sup>287</sup> See 2020 Fuse Brown, *supra* note 12, at 747.

<sup>288</sup> 2017 GAO REPORT, *supra* note 144; 2019 GAO REPORT, *supra* note 11; see also Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, § 4, 131 Stat. 135, 137 (2017) (joint explanatory statement); 163 CONG. REC. H3949, H3954 (daily ed. May 3, 2017) (requesting 2019 GAO REPORT, *supra* note 11).

<sup>289</sup> FAA Reauthorization Act of 2018, Pub. L. No. 115-254, 132 Stat. 3186 (2018) (hereinafter “FAA Act”).

<sup>290</sup> See *Air Ambulance and Patient Billing Advisory Committee*, U.S. DEP’T OF TRANSP. (Oct. 22, 2020), [www.transportation.gov/airconsumer/AAPB](http://www.transportation.gov/airconsumer/AAPB) [<https://perma.cc/8AKW-8VMR>].

<sup>291</sup> FAA Reauthorization Act of 2018 §§ 418, 420.

<sup>292</sup> Jack Hoadley et al., *Update on Federal Surprise Billing Legislation: New Bills Contain Key Differences*, THE COMMONWEALTH FUND (Feb. 20, 2020), [www.commonwealthfund.org/blog/2020/update-surprise-billing-legislation-new-bills-contain-key-differences](http://www.commonwealthfund.org/blog/2020/update-surprise-billing-legislation-new-bills-contain-key-differences) [<https://perma.cc/R4Z8-L6DD>]; S.1895, 116th Cong. (2019–2020); H.R. 2328, 116th Cong. (2019).

have the benefit of uniformity across states, but such legislation would not address potential supply concerns and could even exacerbate them. Only time will tell if Congress can be persuaded to substantively address air ambulance problems.<sup>293</sup>

#### V. CMS SHOULD GRANT WYOMING'S MEDICAID COORDINATED AIR AMBULANCE SYSTEM WAIVER IF ADA PREEMPTION CONTINUES

Until Congress acts, this section explains why Wyoming's proposed Medicaid coordinated air ambulance network satisfies the requirements of a Section 1115 demonstration project and should be granted. The Social Security Act requires that a waiver program meet two basic requirements.<sup>294</sup> First, it must be experimental, testing new ways of dealing with problems confronting public assistance recipients.<sup>295</sup> Second, it must be likely to promote the objectives of Medicaid, helping to furnish access to care for low-income families and individuals.<sup>296</sup> Wyoming's proposal satisfies both requirements. Therefore, CMS should exercise its discretion to grant the waiver to help address rural health inequality and to test broader universal care reforms.

##### A. A Coordinated All-Payer Air Ambulance Network is Experimental

Turning to the first Social Security Act requirement, Wyoming's plan easily satisfies the pilot experiment requirement as an innovative payment model.<sup>297</sup> While Maryland has experimented with an all-payer network in the context of hospital care, no state has previously implemented an all-payer network for air ambulances, despite compelling evidence of problems with cost, cost-shifting, and supply.<sup>298</sup> Similarly, while some other healthcare services have migrated successfully from fee-for-service to flat fees or capitated payment models, no state has tried this approach for air ambulance services.<sup>299</sup>

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<sup>293</sup> Some bills being considered by Congress only seek to improve consumer disclosures. Such solutions are inadequate given structural market failure that will not be solved by improved disclosures. 2020 Fuse Brown, *supra* note 12, at 747.

<sup>294</sup> 42 U.S.C. § 1315.

<sup>295</sup> *Id.*

<sup>296</sup> *Id.*

<sup>297</sup> See Leonardo Cuello, *Medicaid Waivers: Courts Must Step in When the Exception Becomes the Rule*, 46 J.L. MED. & ETHICS 892, 892–93 (2018) (arguing Medicaid waivers are appropriate for pilots with research value that help furnish access to care, although skeptical of the propriety of waivers with statewide scale).

<sup>298</sup> See *Maryland All-Payer Model*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 22, 2020), [innovation.cms.gov/innovation-models/maryland-all-payer-model](https://innovation.cms.gov/innovation-models/maryland-all-payer-model) [<https://perma.cc/G2MA-ZV87>] (describing Maryland's unique all-payer network for hospital care).

<sup>299</sup> See, e.g., 2020 Fuse Brown, *supra* note 12, at 766 (citing Wyoming plan as creative air ambulance solution). A "fee-for-service" payment model pays providers for each service provided to each patient. This contrasts with a "global" or "capitated" payment model in which payment is set in advance for a particular group of patients over a given period of time, regardless of actual utilization of services.

Wyoming's proposal personifies an innovative payment model in a subset of the healthcare market experiencing significant price and supply market failure. As such, it also satisfies the first requirement as an experiment in improving access to services. The proposal adopts a planned system that integrates the states' rural hospital and emergency medical services capacity with life-saving transport to reduce gaps in access and improve efficiency.<sup>300</sup> Improving access and efficiency would be virtually impossible without a coordinated approach.<sup>301</sup> Given the importance of access to transport at an efficient price in rural areas, this aspect of the plan alone could justify granting the waiver.

However, the plan also tests desirable quality of care reforms. The planned system imposes new, evidence-based operational and care delivery benchmarks, requires accreditation, and implements a quality improvement program.<sup>302</sup> This oversight and accountability has the potential to improve quality, access, and efficiency. As an innovative payment, access, and quality initiative, Wyoming's plan is just the sort of problem-solving test that Congress enacted Section 1115 to encourage.<sup>303</sup>

Some might dispute this conclusion, arguing that Wyoming's program primarily attempts to solve cost, billing and supply problems for those *outside* of Medicaid rather than those inside it.<sup>304</sup> However, this contention is inaccurate and reflects a limited view of the "problems of public welfare recipients" requirement.<sup>305</sup> Wyoming's access and quality improvement initiatives do address problems or potential problems confronting current Medicaid recipients.<sup>306</sup> Medicaid beneficiaries are likely to benefit from the proposed planned system that combats insufficient access to timely air ambulance transport in parts of the state and overuse of air ambulance in other parts. Similarly, monitoring evidence-based performance metrics and creating a feedback loop for quality improvement could materially benefit existing Medicaid beneficiaries. Even if Wyoming's proposal provides greater total benefit to those outside the program by also addressing significant cost and billing concerns, this does not take away from the plan's potential to solve supply and quality problems for current

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<sup>300</sup> WYOMING WAIVER, *supra* note 16, at 3–7.

<sup>301</sup> *Id.* at 7.

<sup>302</sup> *Id.* at 3.

<sup>303</sup> See *About Section 1115 Demonstrations*, *supra* note 223; Section 1115, S. Rep. No. 87-1589, as reprinted in 1962 U.S.C.C.A.N. 1943, 1961 (1962).

<sup>304</sup> CMS seemingly implied this critique in its denial letter. Letter from Calder Lynch, *supra* note 210, at 2 ("Using the Medicaid administrative structure to provide services to other individuals in the state as a mechanism to avoid the application of federal aviation law is a clear departure from the core, historical mission of the Medicaid program to provide health coverage to the Medicaid eligible population").

<sup>305</sup> See 42 U.S.C. § 1315.

<sup>306</sup> WYOMING WAIVER, *supra* note 16, at 3–7.

beneficiaries. This is especially true when, as here, statewide coordination and regulation would be impossible without a waiver.

Moreover, when evaluating a waiver, CMS should consider increased access to affordable care for all individuals, even if those individuals are not Medicaid-eligible in the particular state. After all, many low-income individuals who would qualify for Medicaid or subsidized health insurance premiums in other states do not qualify in Wyoming, a state that has not expanded Medicaid and has relatively strict eligibility requirements.<sup>307</sup> An adult working a minimum wage job full-time would not qualify for Medicaid in Wyoming unless pregnant.<sup>308</sup> Yet, earning just over \$15,000 a year, there is no way that individual could afford to pay average air ambulance charges of \$36,000 to \$41,000.<sup>309</sup> Therefore, if this person needed an air ambulance, he or she would almost certainly end up pursued by a collection agency and with ruined credit, perpetuating the cycle of poverty and increasing the likelihood of needing public assistance.<sup>310</sup> In contrast, under Wyoming's waiver proposal, this low-income individual, who would be Medicaid-eligible in thirty-eight other states, would only be obligated to pay \$300, a much more manageable amount.<sup>311</sup> CMS should treat such economically vulnerable individuals as targets of the federal healthcare program.

It is likewise important to consider that “public welfare recipients” are not a static group. Even individuals earning the median U.S. income of \$34,000 likely could not afford health insurance in Wyoming and, even if they could, they could not pay the average air ambulance balance bill of \$22,000.<sup>312</sup> Similar to the minimum wage worker, these middle-class workers would be financially ruined

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<sup>307</sup> See *Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level*, KAISER FAM. FOUND. (Jan. 1, 2020), [www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel={%22colId%22:Location,%22sort%22:asc}](http://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel={%22colId%22:Location,%22sort%22:asc}) [<https://perma.cc/N8K5-Q2RN>]; RACHEL GARFIELD ET AL., KAISER FAM. FOUND., *THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID* (2020).

<sup>308</sup> *Minimum Wage*, U.S. DEP'T LAB., [www.dol.gov/general/topic/wages/minimumwage](http://www.dol.gov/general/topic/wages/minimumwage) (last visited Oct. 10, 2020) [<https://perma.cc/EVJ8-BMVC>] (federal minimum wage is \$7.25 per hour). Wyoming's state minimum wage is lower at \$5.15 per hour, but the federal minimum wage was used for this example. WYO. DEP'T OF WORKFORCE SERVS., *WYOMING-SPECIFIC LABOR LAW POSTERS*, WYO. STATE MINIMUM WAGE (2020), [wyomingworkforce.org/\\_docs/labor/labor-law-wyoming.pdf](http://wyomingworkforce.org/_docs/labor/labor-law-wyoming.pdf) [<https://perma.cc/ZWN9-S7BU>]; *Medicaid Income Requirements*, WYO. DEP'T HEALTH, [health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/medicaid-income-requirements/](http://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/medicaid-income-requirements/) (last visited Oct. 10, 2020) [<https://perma.cc/D3TF-WTK6>]. \$7.25/hour x 40 hours/week x 52 weeks/year = \$15,080.

<sup>309</sup> \$7.25/hour x 40 hours/week x 52 weeks/year = \$15,080. See *Minimum Wage*, *supra* note 308 (federal minimum wage is \$7.25 per hour); 2019 GAO REPORT, *supra* note 11, at 17.

<sup>310</sup> See 2017 Fuse Brown, *supra* note 10, at 130; Lawrence, *supra* note 91, at 605–07.

<sup>311</sup> WYOMING WAIVER, *supra* note 16, at 16.

<sup>312</sup> Chhabra et al., *supra* note 12, at 780.

by a single air ambulance trip.<sup>313</sup> Sadly, overwhelming medical bills frequently push hard-working Americans into needing public assistance in some form.<sup>314</sup> Any individual who is low-income enough to become impoverished as a result of an air ambulance bill should fall within the group CMS considers in evaluating the merits of Wyoming's Section 1115 air ambulance waiver.

*B. A Coordinated All-Payer Air Ambulance Network Promotes the Objectives of Medicaid*

For similar reasons, Wyoming's proposal satisfies the second requirement of a waiver program; it promotes the objectives of Medicaid.<sup>315</sup> Originally, Medicaid sought to assist low-income families and individuals who were also elderly, blind, or disabled pay for healthcare.<sup>316</sup> Since the enactment of the ACA, however, Congress has expanded the objective of Medicaid to a more universal access goal.<sup>317</sup> The current program works to provide medical assistance to most low-income individuals and families.<sup>318</sup> Without question, Wyoming's waiver would assist more low-income individuals and families in paying for healthcare.<sup>319</sup>

On one hand, perhaps the analysis is that simple. On the other, CMS must consider the specific federal requirements a state seeks to waive and the potential future implications of such waiver on the Medicaid program. Wyoming's application sought waiver of three federal Medicaid requirements: (1) eligibility, (2) third party liability recovery, and (3) free choice of provider.<sup>320</sup>

*1. A Universal Eligibility Waiver Creates Opportunities to Test Broader Healthcare Reform*

The most significant waiver Wyoming's proposal requests relates to Medicaid eligibility. Ordinarily, Medicaid eligibility is limited to certain low-income individuals and families.<sup>321</sup> Wyoming's proposal would make anyone requiring

<sup>313</sup> See Lawrence, *supra* note 91, at 606 (medical bankruptcy "is largely a middle-class phenomenon" (citation omitted)).

<sup>314</sup> See *id.* at 608–09.

<sup>315</sup> 42 U.S.C. § 1315.

<sup>316</sup> See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

<sup>317</sup> Huberfeld, *supra* note 4, at 241.

<sup>318</sup> *Subsidized Coverage*, HEALTHCARE.GOV, [www.healthcare.gov/glossary/subsidized-coverage/](http://www.healthcare.gov/glossary/subsidized-coverage/) (last visited Oct. 10, 2020) [<https://perma.cc/VS9Z-CK5B>]. The ACA retains immigration status limitations on eligibility. *Health Coverage of Immigrants*, KAISER FAM. FOUND. (Mar. 18, 2020), [www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/](http://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/) [<https://perma.cc/7N7A-TNAS>].

<sup>319</sup> See WYOMING WAIVER, *supra* note 16, at 16.

<sup>320</sup> See Social Security Act § 1902(a)(10) (eligibility), 1902(a)(23) (free choice of provider), 1902(a)(25) (third party liability recovery); WYOMING WAIVER, *supra* note 16, at 36.

<sup>321</sup> See 42 U.S.C. § 1396a(a)(10)(A)(i).

air ambulance transport in the state eligible for the limited air ambulance benefit, regardless of residency or income level.<sup>322</sup> Some might argue that open eligibility could threaten Medicaid's viability and purpose by diluting, at least theoretically, limited funds across the general population, but that risk does not appear to be significant in the context of Wyoming's waiver request.<sup>323</sup> First, CMS will only approve the waiver if Wyoming establishes that the demonstration program will be income-neutral to the federal government.<sup>324</sup> In short, at least in the pilot stage, this program will not jeopardize funds that would otherwise be spent on more socio-economically disadvantaged residents.<sup>325</sup>

Second, the premise behind the ACA expansion of Medicaid was that everyone should be able to afford access to needed health care.<sup>326</sup> Of course, the ACA currently falls short of that goal, as many individuals still lack insurance or are under-insured.<sup>327</sup> Nonetheless, Wyoming's proposal operates in that vein and offers an experiment in universal access to otherwise unaffordable life-saving care.<sup>328</sup>

Air ambulance transport services make an ideal segment of the healthcare market for a government-coordinated, all-payer, universal care pilot. The life-saving and emergency nature of air ambulance transport creates a special moral imperative to ensure timely, accessible, and affordable care for all.<sup>329</sup> Access is already provided without regard to ability to pay.<sup>330</sup> So, the goal should be to obtain quality care in a cost-effective manner and to charge for such care in a just way. The status quo does neither. It relies on a market that has failed to regulate price or supply efficiently.<sup>331</sup> Then, it charges privately insured and uninsured patients unpayable amounts, including expenses that appear to be unfairly shifted from government-insured patients.<sup>332</sup> Given this cost and cost-shifting problem,

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<sup>322</sup> WYOMING WAIVER, *supra* note 16, at 13.

<sup>323</sup> While Medicaid currently poses an uncapped financial obligation to the government, spending too much could still cause future benefits or eligibility to be reduced.

<sup>324</sup> Letter from Calder Lynch, *supra* note 210, at 2.

<sup>325</sup> *See id.*

<sup>326</sup> Huberfeld, *supra* note 4, at 241.

<sup>327</sup> GARFIELD ET AL., *supra* note 307.

<sup>328</sup> WYOMING WAIVER, *supra* note 16, at 16.

<sup>329</sup> *See* Blake, *supra* note 66, at 122 (arguing moral imperative of ending under-insurance and protecting very sick from large health bills; not specifically discussing air ambulances). *See also* 42 U.S.C. § 1395dd. Through the Emergency Medical Treatment and Labor Act (EMTALA), the federal government has long recognized the special importance of emergency, life-saving services being available to all without regard to ability to pay. *Id.* It is worth noting, however, that while EMTALA ensures access to stabilizing care for emergency medical conditions in hospitals, it does not adequately address the financial consequences of such care. *Id.*

<sup>330</sup> COUNCIL ON MED. SERV., *supra* note 17, at 2.

<sup>331</sup> *See supra* Part II.

<sup>332</sup> *See supra* Part II.

and how oversupply contributes to it, ensuring access while containing cost likely requires a government-coordinated, all-payer approach.<sup>333</sup>

Political debates have raged over the last year, especially amongst Democratic presidential candidates, regarding the relative benefits and costs of an all-payer system or other models of universal care.<sup>334</sup> Wyoming's proposal presents a unique opportunity to add empirical data to that discussion. Wyoming's waiver program would collect evidence on a universal, all-payer approach in a discrete segment of the healthcare market.<sup>335</sup> As a Section 1115 demonstration project, such data and the reports analyzing it would be publicly available and easily accessible, likely spurring more experimentation with all-payer, universal care models.<sup>336</sup>

The result could be revolutionary. If a conservative state buys in to universal care, even in part, and demonstrates its effectiveness, it could create a political breakthrough with other skeptical, conservative states. In this way, Wyoming's proposal could help spark broader universal care initiatives.<sup>337</sup>

Even if broader adoption of some baseline of universal care remains unrealized, the potential benefits of Wyoming's proposed experiment far exceed data collection.<sup>338</sup> Universalizing this small part of Medicaid could de-stigmatize participation in the program, and increase broad-based support for Medicaid.<sup>339</sup>

<sup>333</sup> See *supra* Part II.

<sup>334</sup> See, e.g., Kevin Uhrmacher et al., *Where 2020 Democrats Stand on Health Care*, WASH. POST (Apr. 8, 2020), [www.washingtonpost.com/graphics/politics/policy-2020/medicare-for-all/](http://www.washingtonpost.com/graphics/politics/policy-2020/medicare-for-all/).

<sup>335</sup> WYOMING WAIVER, *supra* note 16, at 11–12.

<sup>336</sup> See *State Waiver List*, MEDICAID.GOV, [www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html?f\[0\]=state\\_waiver\\_status\\_facet:1561&f\[1\]=waiver\\_authority\\_facet:1566#content](http://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html?f[0]=state_waiver_status_facet:1561&f[1]=waiver_authority_facet:1566#content) (last visited Oct. 29, 2020) [<https://perma.cc/6HGD-NDTC>].

<sup>337</sup> See Erin C. Fuse Brown & Elizabeth McCuskey, *Could States Do Single-Payer Health Care?* HEALTH AFFS. BLOG (July 22, 2019), [www.healthaffairs.org/doi/10.1377/hblog20190717.466249/full/](http://www.healthaffairs.org/doi/10.1377/hblog20190717.466249/full/) [<https://perma.cc/6EBU-TTFD>] [hereinafter 2019 Fuse Brown] (“The road to reform often starts with the states . . . Significant health reforms tested at the state level may pave the road to better policy at the national level.”).

<sup>338</sup> This article takes no position on universalizing all health care. Equity likely requires at least some baseline of universal care, but before such reform, Americans need to embrace a willingness to consider the cost benefit of government-paid care.

<sup>339</sup> Income-based programs often experience stigma that universal benefit programs do not. See, e.g., AN END TO STIGMA CHALLENGING THE STIGMATIZATION OF PUBLIC ASSISTANCE AMONG OLDER ADULTS AND PEOPLE WITH DISABILITIES, NAT’L COUNCIL ON AGING (2016) (“Programs structured as universal benefits or “social insurance” such as Social Security and Medicare are substantially less stigmatized than means tested benefits such as SNAP or Medicaid.”). Removing income eligibility requirements for air ambulance could decrease this stigma.

Wyoming's plan requires everyday citizens who are transported by air ambulance to apply for Medicaid in order to avoid financially ruinous balance billing.<sup>340</sup> Through this process, Medicaid becomes universalized.<sup>341</sup> Wyoming's proposal promises to test a universal care, all-payer model, in a way that decreases health disparity and, if successful, could lead to other efforts to transform our healthcare system.

### 2. *Third Party Liability Recovery is Necessary to Recoup Costs of an All-Payer System*

While universal eligibility presents exciting opportunities, Wyoming's proposed third party liability recovery plan appears to add additional administrative expenses to an already inefficient, insurance-based healthcare system.<sup>342</sup> This is unfortunate, as every dollar spent on administration is a dollar that could have been spent providing care. Nonetheless, Wyoming's "pay and chase" system appears to be a necessary evil, at least in the short-term, bridging the currently fragmented, insurance-based healthcare system to payment for a universal care approach. Moreover, single-payer systems generally have lower administrative costs.<sup>343</sup> So, it is possible that the administrative savings associated with the all-payer capitated model will offset the administrative expenses associated with the pay and chase process.<sup>344</sup>

### 3. *CMS Should Waive Free Choice of Provider When Patients Do Not Select the Provider or Have Choice Regardless of Insurance Status*

Losing the choice of any willing and qualified provider is also not a positive, although it appears to be a mostly theoretical loss in the context of air ambulance

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<sup>340</sup> WYOMING WAIVER, *supra* note 16, at 16–17.

<sup>341</sup> In fact, if a new administration wants to implement the ACA rather than repeal it, it might try a horse trade: CMS will approve the air ambulance waiver if Wyoming agrees to adopt Medicaid expansion. Given Wyoming's continual consideration of Medicaid expansion, such a compromise might be successful. Such an approach would be consistent with the pragmatic and flexible approach to Section 1115 waivers the Obama administration regularly took after passage of the ACA. Gluck & Huberfeld, *supra* note 203, at 842–43.

<sup>342</sup> Wyoming's application seeks the ability to "pay and chase" third parties who would otherwise be liable to cover air ambulance transport for the Air Ambulance Expansion population. WYOMING WAIVER, *supra* note 16, at 36. The potentially liable third parties include Medicare, private insurers and self-insured plans. *Id.* The waiver contemplates that Medicaid will charge these third parties based on an average cost-based rate that includes administrative and reserving fees. *Id.*

<sup>343</sup> Emily Gee & Topher Spiro, *Excess Administrative Costs Burden the U.S. Health Care System*, CTR. FOR AM. PROGRESS (Apr. 8, 2019), [www.americanprogress.org/issues/healthcare/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/](http://www.americanprogress.org/issues/healthcare/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/) [<https://perma.cc/M4TG-JX8L>] (countries with single-payer systems tend to have lower administrative costs).

<sup>344</sup> *Id.* (countries with multi-payer systems with strict rate regulation also have lower administrative costs than the US).



services.<sup>345</sup> Any loss of choice is also outweighed by the significant potential benefits of a planned, universal, all-payer system. Normally, the federal free choice of provider requirement plays an important role in the Medicaid program, attempting to ensure that Medicaid beneficiaries do not become second-class citizens unable to select their provider the way individuals with private insurance can.<sup>346</sup> This freedom of choice is especially significant in the context of family planning services and other areas where patient healthcare goals and provider moral beliefs may be in tension.<sup>347</sup> It is likewise critical in providing acceptable care to patients who have historically experienced, or who fear, provider discrimination based on gender identity, sexual orientation, race, or another characteristic.<sup>348</sup> Whenever feasible, autonomy and choice should guide healthcare decision-making.<sup>349</sup>

Free choice of provider is substantially less important, however, in the context of a coordinated all-payer air ambulance network. First, and most significantly, the patient does not typically select the air ambulance provider anyway.<sup>350</sup> Therefore, the waiver presents little or no change. Second, the proposed waiver treats Medicaid beneficiaries, privately insured patients, and uninsured patients alike.<sup>351</sup> Accordingly, concerns about treating public assistance recipients as undeserving or incapable of choice do not come into play. Everyone experiences the same lack of choice.<sup>352</sup> Third, air ambulance transport is generally a one-time, technical service that does not tend to trigger the value conflicts of, for example, a family planning provider nor the same risk of discriminatory interactions building over time such as, for example, a dialysis provider.<sup>353</sup> For these reasons, and given the potential

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<sup>345</sup> 2019 GAO REPORT, *supra* note 11, at 7 (patient does not usually choose air ambulance provider).

<sup>346</sup> 42 U.S.C. § 18116; *id.* § 1396a(a)(23)(A) (A state Medicaid plan: “must . . . provide that . . . any individual eligible for medical assistance . . . may obtain such assistance from any institution . . . qualified to perform the service or services required . . . who undertakes to provide [] such services.”); *State Medicaid Manual*, Pub. No. 45, CTRS. FOR MEDICARE & MEDICAID SERVS. § 2100 (last modified Sept. 8, 2005) (Congress included the free choice of provider provision to safeguard beneficiaries’ right to choose among available providers, just as individuals with private insurance do); *O’Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980) (holding that Section 23(A) gives beneficiaries the “absolute right” to choose among qualified providers “without governmental interference”).

<sup>347</sup> Jennifer Oliva & Melissa Alexander, *Rewritten Opinion*, *Does v. Gillespie*, 867 F.3d 1034 (8th Cir. 2017), in *FEMINIST JUDGMENTS: REWRITTEN HEALTH LAW OPINIONS* (Seema Mohapatra & Lindsay F. Wiley, eds.) (forthcoming 2021).

<sup>348</sup> *Id.*

<sup>349</sup> See Wendy Netter Epstein, *Nudging Patient Decision-Making*, 92 WASH. L. REV. 1255, 1264 (2017) (recognizing the importance most scholars attach to autonomy in healthcare decision-making).

<sup>350</sup> 2019 GAO REPORT, *supra* note 11, at 7.

<sup>351</sup> WYOMING WAIVER, *supra* note 16, at 13, 36.

<sup>352</sup> *Id.* at 36.

<sup>353</sup> See, e.g., Oliva & Alexander, *supra* note 347 (heightened importance of free choice of provider for family planning); *Payton v. Weaver*, 131 Cal.App.3d 38, 43–44 (Cal. Ct. App.

upside offered by the proposal, CMS should waive the free choice of provider requirement, even though the requirement can be essential in other contexts.

In summary, Wyoming's plan satisfies both statutory requirements for a Section 1115 waiver and presents significant potential benefits for healthcare reform. Conservatives and liberals alike should embrace a universal, all-payer approach to care where empirical evidence shows this structure can decrease cost, while improving access and quality. Demonstration projects are an ideal way to gather such data and to test ways to begin universalizing certain care within our system.<sup>354</sup>

*C. CMS Should be Willing to Grant a Waiver to Test Regulation When Necessary to Improve Health and Further Health Equity, Even if Another Department Has Adopted a Deregulatory Scheme*

It is unclear that CMS recognized the considerable opportunities associated with Wyoming's plan, but the agency's reluctance to grant the waiver turned primarily on federal preemption concerns.<sup>355</sup> CMS did not want its administrative structure used as a means to avoid federal aviation law.<sup>356</sup> However, this article argues that CMS, as a division of HHS, should take the exact opposite position under the circumstances.

When a state presents evidence that federal preemption unnecessarily perpetuates health inequity and stymies needed health reforms, it is HHS's obligation, as the primary federal health agency, to step in and test the desirability of federal preemption.<sup>357</sup> The Department of Transportation, which currently oversees air ambulances, lacks health expertise and focus.<sup>358</sup> Meanwhile, HHS's mission is "to enhance and protect the health and well-being of all Americans."<sup>359</sup>

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1982) (no obligation to continue to treat disruptive patient, but patient complained of repeated discrimination during weekly dialysis).

<sup>354</sup> 2019 Fuse Brown, *supra* note 337 ("State single-payer proposals . . . present[] an experiment well-suited to the laboratories of the states. States' experimentation with single-payer care could test various models and inform federal health reform debates . . .").

<sup>355</sup> Letter from Calder Lynch, *supra* note 210, at 1.

<sup>356</sup> *Id.*

<sup>357</sup> See Carr et al., *supra* note 22, at 131–49 (2020) (arguing in favor of an equity-first preemption framework in which preemption is viewed as positive for public health when it advances health equity and negative when it hinders equity); Dayna Bowen Matthew, *Justice and the Struggle for the Soul of Medicaid*, 13 J. HEALTH L. & POL'Y 29, 31 (2019) ("The soul of Medicaid is and always has been to achieve justice in health care.").

<sup>358</sup> *Air Ambulance Service*, U.S. DEP'T OF TRANSP. (Aug. 20, 2020), [www.transportation.gov/individuals/aviation-consumer-protection/air-ambulance-service](https://www.transportation.gov/individuals/aviation-consumer-protection/air-ambulance-service) [<https://perma.cc/SB36-6LX4>] (The U.S. Department of Transportation regulates the prices, routes, or service of air ambulances, including any consumer protection complaints relating thereto).

<sup>359</sup> *About HHS*, U.S. DEP'T OF HEALTH AND HUMAN SERVS., [www.hhs.gov/about/index.html](https://www.hhs.gov/about/index.html) (last visited July 14, 2020) [<https://perma.cc/U2T2-M7UZ>].

Yet, HHS is not currently protecting the health and well-being of Americans who need air ambulance transport and are not already eligible for public insurance.<sup>360</sup> Air ambulance access is uneven, and those who are transported generally receive overwhelming balance bills that undermine their emotional and financial well-being.<sup>361</sup> Rural Americans, who are already poorer and sicker, in particular, depend on air ambulances to plug gaps in their already fragile healthcare system.<sup>362</sup> Refusing to help reform a broken system that leaves Americans with crushing healthcare bills and uneven healthcare access, unjustly perpetuates and exacerbates health and economic disparities.<sup>363</sup>

When federal preemption operates at the intersection of two very disparate areas of the law, communication, compromise, and small-scale experimentation are critical. Having one department wholly usurp a shared area of law, while the other department wholly defers—despite evidence of harmful impacts on the area it oversees—should be seen as inappropriate deference. Respect for another department cannot justify derogation of a department mission. HHS must adopt a new approach.

If HHS facilitates experimentation that furthers its central mission, it can provide important empirical data to Congress without running afoul of the separation of powers doctrine. The ADA broadly prohibits a state from imposing laws or regulation relating to air carrier price, route, or service, but it does not curtail other federal agencies, like HHS, from acting within separately granted authority.<sup>364</sup> While a federal agency should not facilitate an end-run around preemption lightly, when justified by mission and equity, a federal agency can and should serve as a gatekeeper for discrete experiments that develop data to demonstrate the need for preemption exemption.<sup>365</sup> Air ambulance deregulation has failed, and only government intervention can combat the health and well-being harms caused by structural market failure.<sup>366</sup> Here, HHS should grant Wyoming's Medicaid Coordinated Air Ambulance Waiver as part of its mission to protect the health and well-being of Americans, especially in rural areas.<sup>367</sup>

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<sup>360</sup> See *supra* Parts II, III.

<sup>361</sup> See *supra* Sections II.C., II.E.

<sup>362</sup> See *supra* Part III.

<sup>363</sup> “Of all the forms of inequality, injustice in healthcare is the most shocking and inhuman.” Mathew, *supra* note 357, at 29 (quoting Dr. Martin Luther King, Jr.).

<sup>364</sup> See 49 U.S.C. § 41713.

<sup>365</sup> See Carr et al., *supra* note 22.

<sup>366</sup> See *supra* Part II; *An Arm and a Leg*, *supra* note 24, at 397 (arguing to end ADA preemption).

<sup>367</sup> CMS also expressed concerns about Wyoming's plan guaranteeing budget neutrality for the federal government. Letter from Calder Lynch, *supra* note 210, at 2. Governor Gordon promised to make Medicaid whole, and CMS was not specific regarding the basis for its lingering concerns. *Id.*; Governor Gordon Letter, *supra* note 189. Further explanation and negotiation may be necessary, but given the governor's word and the legislature's commitment, it does not seem like this concern

VI. A COMPREHENSIVE AIR AMBULANCE SOLUTION SHOULD  
INCLUDE COORDINATION, AN ALL-PAYER GLOBAL BUDGET SYSTEM,  
UNIVERSAL ACCESS, AND EVIDENCE-BASED QUALITY BENCHMARKS

Of course, it is not yet known whether Wyoming's particular Medicaid coordinated, all-payer air ambulance network can solve existing cost, cost-shifting, and supply problems. However, the plan does appear well-targeted to address many of the problems identified with air ambulances. This section suggests that a comprehensive solution to the air ambulance problems, whether by the state or federal government, should include coordination, universal access, an all-payer global budget, and incentives tied to evidence-based quality benchmarks.<sup>368</sup> It outlines why each of these characteristics are essential to combat an identified air ambulance problem and why other proposed solutions will not accomplish the same results.

*A. A Coordinated System is Necessary to Address Uneven Access and Supply*

As discussed above, Americans, especially in rural states, face uneven air ambulance access.<sup>369</sup> Insufficient air ambulance coverage can result in avoidable death or disability.<sup>370</sup> Oversupply can result in higher prices, which also has serious detrimental effects on the well-being of patients.<sup>371</sup> States have a strong incentive to avoid both, and the market has proven inefficient in addressing supply.<sup>372</sup> Accordingly, the only way to effectively ensure optimal air ambulance access is to plan and regulate access using evidence-based benchmarks that tie expected need to local hospital and emergency medical system capabilities.<sup>373</sup>

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poses an insurmountable barrier. Worst case scenario, a bond, insurance, or other financial guarantee could resolve the issue.

<sup>368</sup> It goes without saying that this model shares many characteristics with Wyoming's proposal. However, the model is not identical, and it attempts to add value by explaining the characteristics that appear essential to comprehensive air ambulance reform.

<sup>369</sup> WYOMING WAIVER, *supra* note 16, at 4–6; ConsumersUnion, *supra* note 15, at 3; *see also Medics, Markets, and Medicare*, *supra* note 15, at 44–45.

<sup>370</sup> Michaels et al., *supra* note 33; Mann et al., *supra* note 33; COUNCIL ON MED. SERV., *supra* note 17, at 1.

<sup>371</sup> *Medics, Markets, and Medicare*, *supra* note 15, at 44–45.

<sup>372</sup> *See supra* Section II.E.

<sup>373</sup> *See* SHERRY GLIED ET AL., THE COMMONWEALTH FUND, CONSIDERING “SINGLE PAYER” PROPOSALS IN U.S.: LESSONS FROM ABROAD (2019) (describing policy setting role played by federal and regional governments in other countries that have better health outcomes than the United States at lower per capita costs). *But see An Arm and A Leg*, *supra* note 24, at 399 (arguing that, without ADA preemption, the air ambulance market can regulate supply). Perritt may have a different view if he revisited the issue with updated data today, but if not, we disagree. The air ambulance market problems are structural. The supply problems are persistent. *See supra* Section II.E. Ending preemption alone will not solve market dysfunction.

Erin Fuse Brown and her co-authors propose rate setting or a competitive bidding/public utility regulation approach to determine price, but they do not discuss state regulation of air ambulance

A coordinated statewide system, like Wyoming proposes, does this, whereas other proposed reforms do not.<sup>374</sup> Reforms limiting balance billing, providing a procedural mechanism to resolve rate disputes, or requiring disclosures to improve price transparency fail to equalize access. Because such reforms do not address supply, they may inadvertently undermine critical access (if they drive up the cost of health insurance or do not pay providers a reasonable rate) and are unlikely to optimally contain cost, even if they decrease balance billing.<sup>375</sup> A coordinated, evidence-based approach is needed to achieve optimal air ambulance supply.

### *B. An All-Payer System with Reasonable Cost-Sharing Avoids Inequitable Cost Shifting*

An all-payer system with universal access and income-based cost-sharing minimizes inequitable cost shifting for air ambulances.<sup>376</sup> Currently, air ambulance

supply. 2020 Fuse Brown, *supra* note 12, at 767–70. The least amount of regulation consistent with accessible, quality care at an efficient price should be the goal. However, given the life-saving and time-sensitive nature of air ambulance service, the close connection between supply and price, and uncertainty regarding what would constitute a reasonable rate, I remain convinced that state regulation of supply is necessary, especially for rural areas. See 2020 Fuse Brown, *supra* note 12, at 767 (“[N]o market-based reference point is available in the absence of a functioning market.”).

<sup>374</sup> See, e.g., *supra* Section II.E. (other state reforms targeting insurance coverage, information disclosures, and a dispute resolution process for rate disputes); 2020 Fuse Brown, *supra* note 12 (proposing rate setting or rate bidding); *An Arm and a Leg*, *supra* note 24 (proposing ending preemption, relying on the market, and adding local subsidies as appropriate).

A well-managed regional or nationwide system could address uneven access even better than a statewide system. Air ambulance service areas are usually based on geographic distance and travel time, not state lines. As a result, and because the nearest hospital with an appropriate level of care may be in another state, 30% of air ambulance flights cross state lines. *AAMS Position on ADA Exemption*, ASS’N OF AIR MED. SERVS. (Aug. 6, 2018, 7:56 PM), [aams.org/aams-position-on-the-airline-deregulation-act-ada/](https://perma.cc/SV4G-MWGX) [https://perma.cc/SV4G-MWGX]. Accordingly, regional or national planning would likely be superior to state management, if such a system could be implemented while preserving the goal of improving rural health equity.

<sup>375</sup> See 2019 GAO REPORT, *supra* note 11, at 8. In fact, while there may be benefits to government rate setting, one significant concern is that if the government sets the rate too low, it could increase gaps in air ambulance access, especially for already vulnerable rural populations. While this problem would likely be resolved over time, that would be small consolation to any individuals who lost their lives unnecessarily as a result of inadequate access to air ambulance transport.

<sup>376</sup> Reinhardt, *supra* note 23 (all-payer systems better control costs and are more equitable); Erin Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L.J. 85, 129–132, 139 (2015) [hereinafter 2015 Fuse Brown] (all-payer strategies must be a key part of controlling health care spending); Thomas Rice & Kenneth E. Thorpe, *Income-Related Cost Sharing in Health Insurance*, 12 HEALTH AFFS. 21, 23 (1993) (cost-sharing should be tied to patient income or ability to pay).

Erin Fuse Brown advocates using “some multiple of Medicare rates” to benchmark out-of-network rates. 2020 Fuse Brown, *supra* note 12, at 769. This could greatly reduce cost shifting and price discrimination (from 4.1 to 9.5 times the Medicare rate to a much lower multiple), but

providers charge uninsured and privately insured patients up to 9.5 times as much as government insured patients.<sup>377</sup> This dramatic price discrimination is inequitable and unfair, especially to lower-income rural patients. Government-insured patients are not necessarily the most vulnerable. Medicare eligibility is based primarily on age or disability, not socio-economic status.<sup>378</sup> As a result, affluent patients can and do participate.<sup>379</sup> Meanwhile, significant gaps remain in the provision of government healthcare assistance, especially for adults without children in non-expansion states and for immigrants.<sup>380</sup> Moreover, even if government insurance captured the most financially at-risk patients, which it does not, it would still be inequitable to require the relatively small percentage of privately insured patients, who need air ambulance services, to subsidize the high

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it would also perpetuate the inequity of cost shifting. There is no reason to force a small minority of under-insured or uninsured patients to absorb the cost of government-insured patients. The cost of government-insured patients should be spread evenly across the entire U.S. population, and price discrimination should be eliminated. Any other result disproportionately disadvantages already poorer rural populations who utilize air ambulances at higher rates for structural reasons, unjustly exacerbating inequalities.

Not all scholars agree that price discrimination is unethical. Some argue that differential pricing reflects market-driven discounts that purchase new value from the provider. *See, e.g.,* George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425, 446–49 (2013). Professor Nation argues that an all-payer system would be disruptive to the market and create inefficiency, suggesting instead less pervasive restrictions on the amounts charged to uninsured and under-insured patients. *See id.* at 451–52.

I am not (yet) ready to argue in favor of an all-payer system for all aspects of the healthcare market, but in the context of air ambulance, market disruption seems like a necessity (given current market failures), and it is difficult to imagine worse inefficiency. Moreover, as discussed below, merely restricting rates charges to self-pay patients would not address many fundamental problems with air ambulances.

With regard to price discrimination more generally, I remain skeptical. There may be instances when differential pricing encourages individuals who can afford health insurance to purchase it or when insurers are able to decrease the price of care by guaranteeing an increase in volume to an in-network provider, but the harms seem greater and more likely. In most instances, those least able to bear additional costs are the ones paying more, exacerbating inequality. Further, it is not at all clear that whatever slight benefit may theoretically be obtained is not off-set by the increased administrative costs associated with differential pricing. Even if equity and administrative costs did not counsel against differential pricing, market efficiency might. Differential pricing hinders price transparency, which leads to market dysfunction.

<sup>377</sup> Bai et al., *supra* note 11, at 1195.

<sup>378</sup> *Who is Eligible for Medicare?*, U.S. DEP'T OF HEALTH & HUM. SERVS., [www.hhs.gov/answers/medicare-and-medicare/who-is-eligible-for-medicare/index.html](http://www.hhs.gov/answers/medicare-and-medicare/who-is-eligible-for-medicare/index.html) (last visited Nov. 10, 2020) [<https://perma.cc/L2N3-LMPJ>].

<sup>379</sup> *Medicare Benefits Wealthy Most*, THE NAT'L BUREAU OF ECON. RSCH., [www.nber.org/digest/sep97/w6013.html](http://www.nber.org/digest/sep97/w6013.html) (last visited Nov. 10, 2020) [<https://perma.cc/4N9N-RG4D>] (“[T]hose who benefit the most from Medicare are the wealthiest older Americans, not the poorest ones,” due to longer life expectancy and greater use of medical services).

<sup>380</sup> GARFIELD ET AL., *supra* note 307, at 1, 7.

cost of providing care to government-insured patients.<sup>381</sup> The costs of government-insured patients should be spreading across the general population.<sup>382</sup>

An all-payer system seeks to establish the efficient price at which providers will supply needed care to all.<sup>383</sup> Providers are then paid that price for patients requiring care, regardless of insurance status. When such a system is coupled with appropriate income-based cost-sharing, each patient is charged only his or her equitable share for services received.<sup>384</sup> This decreases the magnitude of balance bills and mitigates some of the structural factors currently driving rural health cost inequity.

While conservatives may object that providing all-payer universal access to care is too expensive, that argument holds substantially less weight in the context of emergency air ambulance transport.<sup>385</sup> These services are already provided without regard to ability to pay.<sup>386</sup> As a result, an all-payer universal access system does not increase costs (and for the reasons discussed below, should actually reduce costs). This payment model simply results in a more equitable distribution of charges associated with services already provided.<sup>387</sup> Given harms caused by the current system, which routinely charges uninsured and privately insured patients amounts they cannot pay and should not in fairness be assessed, an all-payer pricing system could materially improve health and equity.

In contrast, state legislation that requires disclosures to improve price transparency, limits balance billing, or provides a procedural mechanism to resolve

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<sup>381</sup> See *An Arm and a Leg*, *supra* note 24, at 397 (describing significant burden on “very small minority of patients”).

<sup>382</sup> The best way to spread such costs is to have government reimbursement rates capture the full cost of care, less perhaps any reduction in profit providers take to fulfill a moral obligation or to obtain tax benefit. While an all-payer system does not change the rate of reimbursement for Medicare patients, it does provide valuable data on what that reimbursement rate should be. This is especially valuable in markets like air ambulance where the true cost to provide care remain highly debated.

<sup>383</sup> In an all-payer system that was not based on a global budget, the price might be adjusted for rural areas, longer distances, or other factors that drive increased expense.

<sup>384</sup> See Rice & Thorpe, *supra* note 376, at 23–24. In other contexts, cost-sharing plays an incentive purpose, deterring patient’s overuse or misuse of care, however imperfectly. The potential moral hazard concern carries less weight for air ambulance cost-sharing, however, because the patient does not order the transport. To be effective, any proper utilization incentive would need to focus on first responders and physicians who order transports.

<sup>385</sup> While largely beyond the scope of this article, evidence suggests that to further health equity the United States will have to adopt universal access to more essential and cost-effective care.

<sup>386</sup> COUNCIL ON MED. SERV., *supra* note 17, at 2.

<sup>387</sup> Perritt acknowledges that the market is unlikely to assure adequate access to air ambulance in rural areas, but he argues that rural areas should subsidize their own air ambulance needs, rather than asking states or the national government to share this burden. *An Arm and a Leg*, *supra* note 24, at 401–03. This approach would widen the already sizeable gap in health outcomes and financial wealth between urban and rural areas.

rate disputes does not directly address the inequity of price shifting. Network status disclosures may decrease the number of out-of-network transports, at least when an appropriate in-network provider is timely available, but they will not prevent price discrimination nor spread the costs of uncompensated or under-compensated care.<sup>388</sup>

Limiting balance billing typically allows price discrimination to continue, although often at a lower multiple of the Medicare reimbursement rate.<sup>389</sup> It does not generally provide any relief to uninsured patients.<sup>390</sup> Moreover, even if limiting balance billing successfully decreases the magnitude of price discrimination a *particular* patient faces, it likely simply obscures the inequitable cost-shifting problem by forcing insurance companies to pay more.<sup>391</sup> If insurance companies must pay more, they will almost certainly increase insurance premiums, deductibles, or cost-sharing obligations to pass on these costs.<sup>392</sup> This will leave more patients uninsured or under-insured.<sup>393</sup> Therefore, while limiting balance billing could spread uncompensated care and government-insured costs among the privately insured, it would not spread costs equitably across the entire population. Further, increased insurance costs associated with this method would likely leave more patients uninsured or under-insured, decreasing the air ambulance balance billing problem only to cause a broader access to care problem with even more detrimental results.

A procedural mechanism for resolving rate disputes would likewise not resolve price discrimination optimally.<sup>394</sup> Independent dispute resolution provides

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<sup>388</sup> Michaels et al., *supra* note 33; COUNCIL ON MED. SERV., *supra* note 17, at 1.

<sup>389</sup> See, e.g., COLO. REV. STAT. § 12-30-113 (2020); MO. REV. STAT. § 376.690 (2020).

<sup>390</sup> See, e.g., COLO. REV. STAT. § 25-3-122 (limiting billing from a “covered person”); CONN. GEN. STAT. § 20-7f (2020); IND. CODE ANN. § 27-8-10-3.2 (LexisNexis 2020).

<sup>391</sup> Proponents of balance billing limits might argue that limiting balance billing will incentivize providers and insurance companies to reach in-network agreements, correcting market failure by forcing parties with more equal bargaining power to come to an agreement. There is some evidence that balance billing laws motivate more in-network agreements, and in-network agreements do tend to decrease costs, at least somewhat. 2019 GAO REPORT, *supra* note 11, at 22. It is hard to imagine, however, that insurance companies, who currently cover an unusually small amount of air ambulance charges, could assume responsibility for rates air ambulance providers would accept without incurring new expenses that the insurance companies would look to pass on to consumers.

<sup>392</sup> 2019 GAO REPORT, *supra* note 11, at 8; see also Lawrence, *supra* note 91, at 602–04 (describing “regulatory whack-a-mole” where limiting what the patient pays without addressing underlying cost drivers simply causes insurers to increase premiums or other out-of-pocket patient costs).

<sup>393</sup> One way a patient can be under-insured is if the patient has insurance but is unable to use it effectively because the patient cannot afford to pay associated deductible or cost-sharing amounts.

<sup>394</sup> These processes typically consider a multiple of the Medicaid reimbursement rate, the average in-network rate, or the average rate actually paid. See *Contracting for Healthcare*, *supra* note 59, at 139–49 (discussing the best way to determine reasonable rates in the context of hospital rates).



a mechanism to address out-of-network and uninsured rates for a particular patient.<sup>395</sup> Such a process provides no mechanism, however, to spread the cost of uncompensated care and government-insured patients across the population.<sup>396</sup> As a result, this process will either require uninsured and under-insured patients to continue to subsidize uncompensated and government-insured care, or it will fail to give providers reasonable reimbursement for all care provided. In conclusion, an all-payer system for air ambulance, with income-based cost-sharing expectations, uniquely avoids unnecessary and inequitable cost-shifting and reducing rural health inequity.

*C. An All-Payer, Global Budget Payment System with Universal Access and Reasonable Cost-Sharing Addresses Cost Containment, Balance Billing, and Under-Insurance*

Of course, states or the federal government could regulate the supply of services and prohibit price discrimination without regulating rates, but that approach would not resolve the other problems plaguing air ambulances.<sup>397</sup> An all-payer, global budget payment system with universal access and reasonable cost-sharing is well-targeted to contain costs and should combat balance billing and under-insurance in a dysfunctional market.

First, single-payer or all-payer systems usually result in lower prices.<sup>398</sup> Most other economically developed countries utilize some version of single-payer or all-payer system and all have far lower healthcare costs per person as well as better morbidity and mortality outcomes than the United States.<sup>399</sup> Moreover, all-payer experiments in the United States, like Maryland's all-payer hospital

<sup>395</sup> See, e.g., MONT. CODE ANN. § 2-18-718 (2019); *id.* § 20-25-1318.

<sup>396</sup> See, e.g., *id.* § 2-18-718; *id.* § 20-25-1318.

<sup>397</sup> For example, to prevent the exploitation of uninsured and under-insured patients, Frank Griffin has advocated for a national law limiting hospital charges to some limit above reasonable rates, as determined by prices actually paid. Griffin, *supra* note 80, at 1025.

<sup>398</sup> Reinhardt, *supra* note 23 (all-payer systems better control costs); 2015 Fuse Brown, *supra* note 376, at 90–91, 129–30 (concluding that all-payer strategies must be a key part of controlling health care spending); see also Gee & Spiro, *supra* note 343 (countries with single-payer systems tend to have lower administrative costs).

This article proposes an all-payer approach rather than single-payer one because there are currently so many different payers in the United States healthcare system. However, the same efficiencies and perhaps even greater ones could be obtained through a single-payer system.

<sup>399</sup> Roosa Tikkanen & Melinda Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?*, THE COMMONWEALTH FUND (Jan. 30, 2020), [www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019](https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019) [https://perma.cc/E9RU-299T] (U.S. spends more on health care, yet has the lowest life expectancy and the highest rate of avoidable death, the primary cause is paying too high of prices); Gerard Anderson et al., *It's Still the Prices, Stupid: Why the U.S. Spends So Much on Health Care, and a Tribute to Uwe Reinhardt*, 39 HEALTH AFFS. 87, 87–95 (2019) (high prices cause U.S. to spend more per capita

system, likewise have shown decreased costs.<sup>400</sup> These results stand to reason, as a single-payer or all-payer system gives the purchaser more power to control price.<sup>401</sup> An air ambulance all-payer approach could more effectively contain costs.

Second, to ensure the cost containment benefits of an all-payer system, a flat fee or global budget can be important.<sup>402</sup> Otherwise, providers may increase volume to offset lower prices.<sup>403</sup> Evidence-based benchmarks and utilization review deter over-utilization, but financial incentives should also align with utilization goals.<sup>404</sup> A flat fee approach accomplishes this and also provides predictability and stability of income or expense to both providers and the payer.<sup>405</sup>

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than other countries); GLIED ET AL., *supra* note 373, at 1–8 (comparing role of private insurance and federal versus regional control in various countries).

<sup>400</sup> HEALTHCARE VALUE HUB, ALTARUM, RESEARCH BRIEF NO. 1, HOSPITAL RATE SETTING: SUCCESS IN MARYLAND BUT CHALLENGING TO REPLICATE 4 (2020), [www.healthcarevaluehub.org/advocate-resources/publications/hospital-rate-setting-promising-challenging-replicate](http://www.healthcarevaluehub.org/advocate-resources/publications/hospital-rate-setting-promising-challenging-replicate) [<https://perma.cc/4C6T-AHK5>]; SUSAN HABER ET AL., RTI INT'L, EVALUATION OF THE MARYLAND ALL-PAYER MODEL, VOL. I: FINAL REPORT (2019) (pursuant to CMS Contract No. HHSM-500-2010-00021I).

<sup>401</sup> Skeptics may argue that Wyoming's particular flat-fee-bid approach could make cost containment difficult to achieve. After all, the air ambulance market is consolidated, and current providers have a vested interest in retaining unilateral price setting at a high price point. Most all-payer models successfully contain costs by setting rates. Given Wyoming's relatively small market, it is not clear that air ambulance providers will bid truly efficient prices, especially since providers bear additional risk in a fixed-fee model. They may choose to forego the short-term profits associated with providing service throughout Wyoming in an effort to avoid other states adopting this approach.

On the other hand, Wyoming's bid approach harnesses, or attempts to harness supply-side provider competition more in keeping with U.S. capitalistic values. It is difficult to predict the success of this approach, and cost containment failure is possible, especially initially. Nonetheless, Wyoming's plan includes regular data collection and analysis. So, if the initial model fails, Wyoming will be well situated to make adjustments, like migrating to a rate setting model.

To increase the likelihood of creating a more efficient price, Wyoming should consider two things, if it has not already. First, Wyoming might consider adding high/low parameter adjustments to its flat fee, at least in the first few years. Adding such parameters would decrease some risk borne by the providers while still retaining the financial incentive to avoid over-utilization. Wyoming also might encourage Montana or other surrounding state to seek a similar waiver and adopt the experiment at the same time to increase the size of the market and therefore the cost of refusal to participate on favorable terms. A joint-compact approach could also enable planning to include cross-border bases and coverage, which would increase efficiency, as 30% of current air ambulance transport operates across state lines.

<sup>402</sup> HEALTHCARE VALUE HUB, *supra* note 400, at 4 (discussing the importance of a global budget in an all-payer system to prevent the incentive to make up for lower prices with increased volume).

<sup>403</sup> *Id.*

<sup>404</sup> *Id.*

<sup>405</sup> One downside to global budgets is that they do shift financial risk to the provider, which can inadvertently increase the efficient budget price. Over time, with more predictably volume and expenses, this problem tends to minimize, but initially, it may make sense to share this risk by including a pre-determined adjustment to the global budget if volume meets unexpected highs or lows.

Third, a coordinated, all-payer system, with a global budget and universal access should resolve the balance billing problem. Coordination should decrease cost by eliminating oversupply.<sup>406</sup> An all-payer system should likewise decrease cost by empowering the state, as the only payer, to have greater market control over price.<sup>407</sup> Meanwhile, a global budget will reinforce these gains by eliminating any incentive to over-utilize services.<sup>408</sup> At the same time, bringing payment for all air ambulance services within an all-payer, global budget will also significantly decrease, if not eliminate, cost shifting.<sup>409</sup> This will further decrease the balance billing problem, as privately insured payers will no longer be asked to pay many times as much as government-insured payers.<sup>410</sup>

While a coordinated, all-payer system, with universal access will, by definition, ensure access to life-saving air ambulance services and should contain costs and eliminate sky-high balance bills, funding this system remains an issue.<sup>411</sup> Patients who receive air ambulance transport should have reasonable cost-sharing obligations. Some patients can afford to contribute more to the cost of their air ambulance flights than others. A system that ties cost-sharing to income or a combination of income and assets will equitably distribute costs.<sup>412</sup> Expressly regulating patient contribution amounts ensures that patients contribute to expenses they incur but at a rate that is affordable, avoiding unnecessary emotional and financial harms.

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<sup>406</sup> See, e.g., WYOMING WAIVER, *supra* note 16, at 4–7 (proposing a coordinated system to reduce oversupply and explaining how that coordination should also decrease cost).

<sup>407</sup> See, e.g., TRISH RILE ET AL., NAT'L ACAD. FOR STATE HEALTH POL'Y, CROSS-AGENCY STRATEGIES TO CURB HEALTH CARE COSTS: LEVERAGING STATE PURCHASING POWER 15–16 (2019), [www.nashp.org/wp-content/uploads/2019/04/States-Leverage-Purchasing-Power.pdf](http://www.nashp.org/wp-content/uploads/2019/04/States-Leverage-Purchasing-Power.pdf) [<https://perma.cc/Q77A-7PK8>] (arguing that large purchasers can leverage better prices and describing state efforts to consolidate purchasing to contain costs); *An Arm and a Leg*, *supra* note 24, at 395–96 (describing the price-setting market power that large purchasers like Medicare and Medicaid enjoy to set prices at or only slightly above costs).

<sup>408</sup> HEALTHCARE VALUE HUB, *supra* note 400, at 4.

<sup>409</sup> See *An Arm and a Leg*, *supra* note 24, at 395–96 (“In the absence of a universal, single-payer health care system, price discrimination will continue to be the norm in health care, including [] air ambulance transportation.”).

<sup>410</sup> See Bai et al., *supra* note 11, at 1195 (privately insured air ambulance patients currently pay 4.1 to 9.5 times the Medicare reimbursement rate).

Air ambulance is already provided in emergency situations without regard to ability to pay. COUNCIL ON MED. SERV., *supra* note 17, at 2. However, the current system does not include a mechanism to spread the cost of uncompensated or undercompensated care equitably across the population.

<sup>411</sup> See Reinhardt, *supra* note 23 (single-payer systems help contain costs).

<sup>412</sup> Rice & Thorpe, *supra* note 376, at 23–24 (cost-sharing should be tied to patient income or ability to pay); Reinhardt, *supra* note 23 (replacing price discrimination with an all-payer system would ensure equitable payment).

Other reforms only address one aspect of the problem and, therefore, do not seem likely to produce equivalent results.<sup>413</sup> For example, reforms limiting balance billing address immediate patient harms caused by large, unpayable air ambulance bills, but, because they do not address oversupply, high prices, over-utilization, or cost-shifting, they will likely increase overall insurance costs.<sup>414</sup> This unintended result is likely to cause potentially larger cost and access harms to patients.<sup>415</sup> Similarly, procedural mechanisms providing for more efficient resolution of air ambulance rate disputes, in addition to increasing administrative costs, do not combat fundamental air ambulance problems like oversupply.<sup>416</sup> Likewise, laws requiring disclosure of insurance network status do not contain costs, nor they do address oversupply or cost-shifting.<sup>417</sup> If the federal government steps forward to regulate or to free states from ADA and ERISA preemption, a more comprehensive regulatory approach that sets supply and price seems likely to yield better results.

*D. Monitoring Evidence-Based Quality Benchmarks Should Improve Quality and Access and Avoid Trade-Offs*

The last significant piece required for effective air ambulance reform is a system of evidence-based quality benchmarks, coupled with a utilization review system that holds providers accountable for performance.<sup>418</sup> Quality review is essential to prevent providers from short-changing patients to increase profits in a global budget.<sup>419</sup> When providers are held accountable on quality metrics, it removes the financial incentive to achieve cost-savings by failing to provide needed services or cutting corners on the services provided, ensuring patients receive the amount and quality of care they deserve.<sup>420</sup>

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<sup>413</sup> See *infra* Section IV.D.

<sup>414</sup> 2019 GAO REPORT, *supra* note 11, at 8.

<sup>415</sup> *Id.*

<sup>416</sup> See, e.g., MONT. CODE ANN. § 2-18-718 (2019); *id.* § 20-25-1318 (2019).

<sup>417</sup> See, e.g., N.D. CENT. CODE § 23-16-17 (2019); *id.* § 23-27-04.10 (2019); UTAH CODE ANN. § 26-8a-107 (LexisNexis 2020).

<sup>418</sup> See *No Way to Run*, *supra* note 24, at 99–100, 105–08 (describing need for better utilization review); see also AM. COLL. OF EMERGENCY PHYSICIANS, POLICY STATEMENT: APPROPRIATE AND SAFE UTILIZATION OF HELICOPTER EMERGENCY MEDICAL SERVICES 1–2 (2018) (importance of following utilization guidelines regarding patient selection and clinical benefit for air ambulance transport); COUNCIL ON MED. SERV., *supra* note 17, at 2 (a third of air ambulance transports may be medically unnecessary); see also, e.g., Kristin Edwards et al., *Air Ambulance Outcome Measures Using Institutes of Medicine and Donabedian Quality Frameworks: Protocol for a Systematic Scoping Review*, 9 SYST. REV. 72 (2020) (proposing quality benchmarks using Institute of Medicine and Donabedian quality frameworks).

<sup>419</sup> See HEALTHCARE VALUE HUB, *supra* note 400, at 1–7 (discussing importance of quality metrics and provider accountability for same).

<sup>420</sup> *Id.*

## VII. CONCLUSION

The broken air ambulance market results in significant cost, billing, and access problems. These problems cause emotional and financial harms and can lead to worse health outcomes. They threaten all Americans but take a disproportionate toll on rural populations, exacerbating rural health inequity. The system must be structurally reformed.

The best solution will require the federal government or states to coordinate universal access through an all-payer system with a global budget and incentives tied to evidence-based quality benchmarks. This will require action by the federal government: regulating cost and supply directly, granting a Section 1115 waiver to allow such a program through Medicaid, or, at minimum, exempting air ambulances from ADA preemption on rates, routes, and service. Piecemeal reforms cannot achieve the same results. Lack of cost control, supply problems, egregious price discrimination, and under-insurance must all be addressed. Direct regulation would be more efficient if politically possible, but if not, health and wellbeing needs justify a Section 1115 waiver, especially in rural areas.

A Section 1115 waiver, like the one proposed by Wyoming, meets the statutory requirements of the Social Security Act. It tests valuable payment system, access, and quality reforms. Further, it serves the objectives of Medicaid because it attempts to improve quality and access to affordable life-saving healthcare for Americans who cannot currently afford it. The waiver provides additional benefit as a small-scale test of universal health care, in a dysfunctional market. Such empirical data is critical for evaluating future health care reforms.

While HHS has expressed reluctance to grant such a waiver in deference to federal aviation law's deregulatory approach to air ambulances, HHS should reconsider its stance. HHS's core mission is to protect the health and wellbeing of Americans, and air ambulance reform is necessary to fulfill this mission. Air ambulances are part of both the healthcare system and the air carrier system. Neither HHS nor the Department of Transportation should derogate their regulatory duties within their unique spheres.

In conclusion, air ambulance deregulation perpetuates cost, cost-shifting, and supply problems that predictably undermine health and exacerbate rural health disparities. The federal government cannot continue to ignore the role deregulation plays in perpetuating inequality. Congress or HHS must step forward and regulate air ambulance price and supply, or free states to do so, to address structural market failures and to begin to combat rural health inequity.