





# Air Ambulance *Rescuer or Rescued?*

By Bernard F. Diederich

What air carrier charges more than \$35,000 for a 20-minute trip across town and yet has a growing number of people seeking its services? What operator charges such transportation rates and yet gets paid less than half of what they charge the majority of the time—if they get paid at all? What air operation has no less than three levels of federal oversight and multiple levels of state regulation? What vital air service do you receive yet is often not one that you even directly request? What transportation service is involved that you can pay for in advance and yet hope that you never use? What air service stretches worldwide and is worth whatever the price, which can exceed \$150,000, when you simply must have it?

The special-emergency services of an air ambulance are unique, complex, little understood, and often misunderstood. Let's take a closer look at the complexities of this life-or-death-emergency air-transportation service. We will briefly review the definition of an air ambulance operator, the various types of operators as well as the various types of their operations, some of the regulatory difficulties they face, and ultimately the problems that threaten their smooth operation and very existence.

## **PARSING THE POSSIBILITIES**

While not intending to be overly legal, attention to the legal underpinnings of the air ambulance is essential to properly understanding its role in the air transport system. An air ambulance is first and foremost

an air carrier and is authorized as such by the Federal Aviation Administration (FAA) and U.S. Department of Transportation (DOT) for safety and economics, respectively.<sup>1</sup>

## **Air Carrier**

Air carrier is the statutory term defined in the U.S. Transportation Code (49 USC §§ 101 *et seq.*) as any person who undertakes to engage in air transportation, meaning the carriage of persons as a common carrier for compensation or hire.<sup>2</sup>

Although the term common carrier is not defined in the Code, it is an old and well-established term (at common law) that has been defined in numerous decisions of the Interstate Commerce Commission, the Civil Aeronautics Board (CAB), DOT, and the courts. Briefly, a common carrier is defined as one that holds itself out to undertake for hire, by any means whether directly or indirectly (further discussion of indirect below), the transportation of passengers or property from place to place and so invites the patronage of the public. The principal determinant is the *holding out* test, that is, whether the person holds itself out to serve, within the limits of its facilities, anyone who applies for its services.<sup>3</sup> A holding out of services may be evinced by any means—classically, advertising. But even in the absence of advertising, a carrier's course of conduct, indicating a willingness to serve indiscriminately all who apply for service or the mere fact that it provides services for all who apply, is sufficient to support a *holding-out* finding.<sup>4</sup>

Ultimately, the Transportation Code requires that an air carrier may provide air transportation only if it holds DOT authority for such transportation. 49 USC § 41101.

Although the term air transportation is statutorily defined to include only interstate movements, foreign movements, and the carriage of mail (see 49 USC § 40102(a)(5)), that definition is incomplete when considering modifications from legislative history and case law. An operator might not carry any interstate patients over state borders and still be an authorized air carrier. The fact that a carrier does not carry traffic over state boundaries is not dispositive of the issue. If an operator obtains air-carrier authorization from the department, to include exemption authority under 14 CFR Part 298, it is thereafter an authorized air carrier regardless of the territorial location of its day-to-day flights. At the time of the Airline Deregulation Act of 1978,<sup>5</sup> Congress made clear that shared federal-state jurisdiction over air carriers, as existed earlier in some instances at the CAB, was ended and that DOT was directed, through the federal-preemption provision (discussed below), to fully occupy the economic regulation of air carriers.<sup>6</sup> See also 14 CFR § 399.111. Thus, an air ambulance operating on a purely intrastate basis is an air carrier, entitled to the preemption protections, where it holds DOT-air-carrier authority and yet never crosses a state line.<sup>7</sup>

A question might arise over the element of *compensation or hire* in any determination of common-carrier status, yet it's always secondary to the holding-out test and in any case is generally mercurial and noncompelling. No absolute definition of the term is statutorily provided; case law suggests that compensation does not necessarily include an element of profit, whereas hire does; however, profit or loss has no bearing on the issue; and the furnishing of a transportation service on a gratuitous basis could under certain circumstances be in common carriage.<sup>8</sup>

In any case, the common-carrier tests and standards are not meant to be talismanic but only to help agencies, as well as individuals,<sup>9</sup> determine if the subject activity is truly of a nonpublic nature to be left free of government concern and oversight, or whether it has grown and crossed into the commercial world, dealing with members of the general public and providing them with a service that substantially competes with other regulated companies and thus should be uniformly regulated under the established rules for the safety and benefit of all. In a seminal common-carriage case, the CAB pursued an unauthorized carrier claiming that as long as it was competing commercially in the market for the patronage of the general public, it was immaterial that the service offered would be attractive only to a limited group or that it may be performed pursuant to special contract. And it was also immaterial that, in terms of the carrier's own bookkeeping, the transportation may be furnished at cost, at a loss, or even without charge. The reviewing court of appeals found that the CAB had fairly interpreted the underlying statute in a way that made effective economic regulation under it possible by bringing within the regulatory scheme all those who competed in the commercial market in the business of offering air transportation to the public generally.<sup>10</sup>

## Federal Preemption

After CAB sunset and airline deregulation, the relationship between air carriers and the various states in which they operate changed dramatically. While CAB, in some instances, shared economic regulation of the airlines with the states, in the post-world of the Airline Deregulation Act of 1984, and in particular its federal-preemption provision, the states are subject to an express-preemption measure that prohibits them from “enact[ing]

or enforce[ing]” any provision that “relates to” the “prices, routes, or services” of an air carrier in the sale and operation of its air-transportation services. 49 USC § 41713. Note that the provision at 41713 contains an *express*-preemption provision devoid of the inexact weighing and balancing in other preemption types (implied, filed, conflict, frustration-of-purpose/obstacle). As mentioned, the legislative history of 41713 makes it clear that Congress intended to end dual federal-state economic regulation of airlines. Further, Congress sought to ensure that the resulting voids (after exit of the fuller federal regulatory regime of the CAB) would not be filled by a state seeking to continue the same or similar utility-type regulations.<sup>11</sup> Congress enacted the provision to allow the marketplace to establish airline prices, routes, and services.

As discussed further below, some have claimed that the federal-preemption provision makes the air ambulance mix of federal and state-regulated aspects a most difficult arrangement and have sought to nullify. Whatever their leanings, the law is clear and the arrangement has worked for these 35-plus years. An exchange at the Supreme Court level on that issue of carrier preemption is instructive. During Supreme Court oral argument in the important *Rowe* case<sup>12</sup>, Justice Antonin Scalia asked counsel for the concerned carriers (FedEx and UPS) why they had acquiesced in the errant moves by the states (Maine and New York) to require them to make customer checks for minors who might have ordered cigarettes in violation of a state health prohibition before making any package deliveries. Scalia then answered his own rhetorical question in effect saying, “I know, you wanted to go-along/get-along. ... But you can't engage in such an attempted modification of federal preemption law with impunity ... even under threat of state criminal penalties. ... The provision is there to keep carrier/consumer costs at low levels. ... Consumers may well have rights to challenge any such carrier action and get money damages.” Justices Samuel Alito, Anthony Kennedy, and John G. Roberts then joined in by lecturing that carriers (especially the dominant ones) under federal-preemption standards cannot simply accede to the state in activities preempted by law (thus determining for themselves the new scope of the preemption standards) to the possible detriment of smaller carriers, producing a new kind of transportation service that would not have existed in the normal marketplace.<sup>13</sup> That is clearly not permitted.

## Air and Medical Parts With Multiple Oversight

To add some of the uniqueness in a typical air-ambulance-aircraft operation, it is important to understand that air-ambulance operations are a combination of air and medical subparts. The “front” of the operation is that of an air carrier, with the speed and mobility that only it can provide. The “back” of the operation is that of a mini-medical emergency room, with the equipment and personnel that are so important in that golden hour between trauma and full medical attention that can save lives.

Even more unique than federal air-carrier entry authorization is the fact that, with the combination of air and medical subparts, the air ambulance comes under a special regulatory mix. While the air-carrier part is subject to exclusive federal authority for its FAA air-carrier safety and DOT economic authority<sup>14</sup>, the medical part is subject to a wide range of both federal and state authorities. DOT and FAA have never exercised any preemptive jurisdiction over the medical part as an air-carrier service but instead have made clear that the key medical aspects are under state jurisdiction

(with some federal jurisdiction at the Department of Health and Human Services due to the pervasive HHS Medicare and Medicaid programs).<sup>15</sup> At the state level, an array of units oversee air ambulance medical aspects, typically ranging from a state medical office to regional ones and even local ones. While the mix can be harmonious, it has produced some issues regarding possible over-reach by the state units in derogation of the 41713 preemption provisions.

### Types of Operators/Operations

In an approximate review of overall air-ambulance operations, helicopters are about three-quarters of the industry, and the remaining 20-plus percent are fixed-wing aircraft. Slightly over half of industry operations are interfacility (hospital to hospital) transfers, while about one-third are on-scene responses to an accident or injury, and slightly more than 10 percent of industry operations include organ, medical-supply, and specialty-medical-team transport.<sup>16</sup>

### Direct and Indirect Air Carriers

Due to the broad statutory definition of an air carrier, including any person who either directly or indirectly engages in holding out air-transportation services, an air carrier may be either a direct or an indirect one. A direct air carrier is the traditional airline we all know and use, owning/leasing its equipment, employing numerous support people, and operating in its own right as a true entrepreneurial risk-taker in the direct pricing and offering of its services. An indirect air carrier is not so engaged in the airline operational side of the business, and, while holding out an air service to the public in its own name (thus a statutory air carrier), does not operate its own aircraft and crew but contracts for the “lift” of a direct air carrier to supply its actual air-transport movement. The more familiar type of indirect air carrier is an air freight forwarder, who offers a cargo transportation service to the public but has no aircraft or pilots of its own and instead contracts with a direct air carrier for freight movement. *See* 14 CFR Part 296.

The air-ambulance industry has its own direct and indirect air carriers. The air ambulance operating as a direct air carrier must have FAA Part 121 (large aircraft) or Part 135 (smaller aircraft) safety authority as well as Office of the Secretary of Transportation (OST) economic authority under either a carrier/class-specific order or a Part 298 air taxi exemption authorization. *See* 14 CFR Parts 121, 135 & 298. The Part 298 authorization process for direct air ambulances is fairly simple, requiring the mere filing of an application form with the FAA and the maintenance of prescribed levels of liability insurance.<sup>17</sup> Of course, the FAA safety review leading to the issuance of particular direct air ambulance op specs (operating specifications) and FAA safety authorization is more pronounced.

The process for indirect air ambulance authorization is quite simple, because the CAB (later followed by DOT) has by order issued a blanket economic exemption authorization to all prospectives allowing them to hold out, arrange, and coordinate the air ambulance services of a direct air ambulance. CAB/DOT Order 83-1-36 (in Docket 41218) (1983). To obtain and hold the authorization of Order 83-1-36, the indirect air-ambulance operator must comply with the two key provisions of the order.<sup>18</sup> First, it must use only a direct air carrier holding FAA and DOT air-ambulance authority, and second, it must provide safe and adequate service, equipment,

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and facilities in the conduct of the operations.<sup>19</sup> In that they have no aircraft or crews, the FAA does not require any safety authorizations for indirect air ambulances. Indirect air carriers must be distinguished from mere sales agents of air carriers who, while they are offering air transportation, are not doing so in their own right. Such agents are not engaged in any entrepreneurial function or any risk-taking in the direct sale of the transportation, have no capital investment in the precise product, and at the end of the day can simply put the air-transportation service “back on the shelf” without any loss if it is unsold.<sup>20</sup>

### Air Ambulance Services

A listing of the numerous levels of air ambulance services might be helpful to establish the wide array involved. In advancing degree of complexity, an air ambulance service might involve:

- A direct air ambulance responding to a call to transport from hospital to hospital a critically ill patient, along with a full medical team and appropriate supplies and equipment.
- An indirect air ambulance responding to a call to transport a critically ill patient, as well as arrange for a full medical team with appropriate supplies and equipment, on a direct air ambulance for a cross-country flight.
- A rotary-wing direct air-ambulance operator responding to a remote accident scene, with full medical teams, supplies, and equipment, carrying numerous patients to various sites for emergency treatment, for extended periods.
- Full hospital operating-room-in-the-sky operations.

### Basic Air Ambulance Models

Beginning in the early 1970s, the industry has grown along three basic operational models (listed from present to past prevalent types).

1. Community-based operations feature an independent operator setting up a base in a community and serving multiple medical facilities and localities. The operator usually holds the FAA operating certificate and employs the medical and flight crews.
2. Hospital-based operations typically involve a hospital providing medical services and staff and contracting for aviation operations. In this scenario, the aviation operator would hold the FAA certificate. Less common, the hospital owns the aircraft and conducts all aspects of the operation. Depending on state

medical triage requirements and the condition of the patient, the hospital-based aircraft may transport the patient to the affiliated hospital or some other appropriate facility. This was the prevalent helicopter model from the 1970s to about 2004.

3. Government operations are air medical operations owned and operated by a government entity, typically a city or a county. Of the three models, they are the least prevalent. Typically, government operators own their own aircraft, although they may contract for aviation services, which may be dual-purposed for police and fire operations. In most cases they do not bill for services.<sup>21</sup>

Air ambulance operations are not only a specialized air-transportation service but also a varied one. They run the gamut from direct to indirect air-carrier operators, from fixed-wing to rotary-wing aircraft, from full planeload scheduled to individual charter flights, from mere body-part to critical patient and medical team transport, and from accident scene/trauma center to cross-country hospital/hospital runs.

The elements of an air-ambulance operation may be diverse, where such items as aircraft ownership, provision of crews, holding out of services, etc., are unique and may thus call for a review of all the facts surrounding the operation in question and consideration of the various elements as a whole to make an accurate determination of air carrier status. But such has always been the situation in air carrier/common carrier cases.

## Medical Requirements

DOT (both FAA and OST) has requirements for an air ambulance to properly operate its specialized air-transportation service *qua* air carrier. While not at all pervasive, they also touch upon medical requirements.

DOT standards are not always exact. While OST has no precise medical standards for air-ambulance operators—other than its universal “safe and adequate service” standard for all air carriers (never applied in any case to a medical situation)—and the FAA claims none as well, the fact is that the FAA’s inspectors do expect some minimum equipment, personnel, and training standards in the medical area. While some minimum requirements do exist, the better inquiry is into the essence of the service. Ultimately, air-ambulance operations are special, based primarily on their medical services component, albeit not under strict DOT regulation as to the medical aspects, but they are accorded special air-operating consideration (low altitudes, immediate clearance, etc.) and are reviewed by FAA inspectors for the general adequacy of their medical features.

The essence of an air-ambulance operation, not listed in DOT standards but assumed in the nature of the service, is that it holds out a special air transportation service, providing not only the authority but the ability to quickly transport critically-ill patients (as well as body parts) over varying distances, with unspecified but locally-determined medical attention, to points both near and far, from points both simple and extreme, with special/emergency clearance often given to the operators by air-traffic handlers. As in air-carrier operations reviewed and approved at OST, the FAA reviews and approves a particular direct air-ambulance operation proposed against the proposal offered by the particular operator to ensure that it is operationally safe, with appropriate yet fairly generic op specs. Conversely, a carrier that is not air ambulance approved by

the FAA has that negative fact listed in its ops specs.

The OST and FAA do not heavily involve themselves in the nonaviation component of the air-ambulance service. The OST has no medical standards. The FAA has some minimum medical standards. While both agencies have no detailed medical standards, the medical component is no less a part of the typical air-ambulance operation. The medical aspects may range from minor to major in any one flight. However, the medical component is a key part of the combined air-operation/medical-service package.

OST has no medical requirements for the direct air ambulance, under either Part 298 exemption authorizations or individual fitness approvals. OST requires only that its indirect air ambulances, authorized by the blanket exemption of Order 83-1-36, provide “safe and adequate service, equipment and facilities in the conduct of the operations.”

While the FAA generally claims no medical standards for its air-ambulance operators, it does have some virtual standards. Understand that when an operator proposes a particular air-ambulance service, the FAA must review and approve the medical aspects at least to the extent of its air-safety aspects and to merit its special air-ambulance designation. The FAA Ops Inspectors Handbook (Order 8400.10 ch. 11, March 13, 1997, ch. 5, § 1, ¶ 1337) describes that an air ambulance aircraft must be equipped with at least medical oxygen; suction; and a stretcher, isolette, or other approved patient restraint/containment device.

Despite this listing, FAA has virtually no set medical-equipment standards for air ambulances.

That FAA publication goes on to describe that an air-ambulance operation is one in which the holding out to the public is one “providing air transportation to a person with a health condition that requires medical personnel including, but not limited to, advertising, solicitation, association with a hospital or medical-care provider.” The FAA allows that while standard air carriers may transport medical personnel as passengers who are accompanying a sick or injured person, along with in-flight patient-care equipment, they may do so solely for the patient’s comfort. If any medical care provider has determined that the medical personnel are required for the patient’s *safety*, the flight is deemed an air-ambulance operation.

The FAA presents (Ops Inspectors Handbook, ch. 5, § 4) that while medical personnel and flight crew are involved in two distinct operations, medical personnel may be considered crew members at the discretion of the operator. But if the operator desires to consider the medical personnel as crew members, they must complete initial and recurrent training programs. Additionally, all medical personnel must perform some duty in an air-ambulance aircraft that relates to the operation of the aircraft, such as assisting the flight crew in seeing and avoiding other aircraft, evaluating a landing site, coordinating with ground personnel at a landing site, and emergency shutdown of aircraft systems in a crash.

Further, the FAA provides “information and guidance” to air-ambulance operators in the form of advisory circulars (*see* AC 135-14A and 135-15A) describing “levels of medical care” for operators. It describes:

- Basic Life Support (BLS) as care by the air medical provider through at least one medical person who is trained and experienced in providing care of a specified minimum level, such as recognizing respiratory and cardiac arrest, starting and maintain-

ing proper medical procedures, etc..

- Advanced Life Support (ALS) as care with a least two trained and experienced medical persons who can not only perform the basics (BLS) but also emergency critical care, such as endotracheal intubation, closed-chest cardiac compression, dysrhythmia recognition and treatment, defibrillation, etc.

While DOT may not have minimum standards per se for the medical aspects of air-ambulance operations, they exist in that the very nature of the service that DOT authorizes, polices, and ultimately requires that the operators have not only equipment but also personnel for the provision of those medical services, all found in the nature of the special air-transportation service authorized.

DOT does not have minimum standards (or any standards) for inflight services per se on commercial flights (such as meals, drinks, movies, lavatories, pillows, blankets, reading materials, and other amenities); however, it is no less a part of the standard airline service. And DOT does have tangential regulations for such nonrequired services, such as standards for alcoholic beverage service, fire standards for blankets, etc. DOT does not have air-ambulance medical standards per se, but medical personnel and equipment must nevertheless be provided in a typical air-ambulance service to be a conducting a bona fide air-ambulance operation under the particular holding out of such service by the DOT-authorized provider, lest it be engaged in an unfair and deceptive practice (see 49 USC § 41712) or a failure to meet applicable FAA aircraft operating specifications.

### **Pricing of Services**

To gain a better understanding of the manner in which air-ambulance operators handle payment for their services, especially when dealing with an indigent patient, let's follow the money in a typical helicopter emergency-medical service.

Most emergency air ambulances operate on a 24/7/365 basis and must price their services in a way that will recover the so-called cost of readiness: staffing the aircraft around the clock with a pilot and two medical attendants. Further, air ambulances have little control over the volume of transports they will do or how many of the completed transports they will get paid for. When setting their prices, they must estimate their volume and mix of paying and nonpaying transports.

Because of the nature of this particular subset of air-ambulance operations—namely, emergencies—the air-ambulance operator has no advance occasion to determine the patient's ability to pay. Within literally minutes, the air ambulance responds to the call of the dispatcher and picks up the patient at the accident/incident scene, without any opportunity or ability to make any determination of the patient's ability to ultimately pay for the expensive air-ambulance service. The need for such a rapid-response service is not his determination but that of the paramedic on the scene or, in the case of an emergency transport between hospitals, the physician who is treating the patient. The particular determination is made devoid of financial considerations. While a nonemergency air-ambulance transport may be made with financial considerations playing some part, that is simply not the case in a life-or-death situation where the golden hour between time of accident and time of appropriate medical care is critical. This is not to suggest that the emergency air-ambulance service is provided free of charge. The average air-

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ambulance-transport charge can be more than \$35,000.<sup>22</sup> The cost makes it easily one of the most expensive trips you'll ever take.

While the nature of the upfront emergency situation does not permit advance-pay consideration, it can be fully addressed/pursued by the air ambulance operator after the service is rendered. The operator is possessed of full rights to recover his charges and will use all methods to do so. Those methods of course start with a simple billing of the patient or the patient's health insurance by the operator. Medicare covers air-ambulance transportation. But Medicare coverage may not be applicable. If Medicare payments are available, they generally do not fully cover the operator's expenses, much less their charges. If no insurance coverage is involved, the air-ambulance operator is left with pursuing normal collection measures to recover its unpaid bill. In a great number of cases, the air operator is unable to collect anything for the transport and must absorb the cost, which can only be recovered by increasing the charges to those who can and do pay for it.

### **Subscription Service**

In a unique situation called subscription-service coverage, a potential patient may have purchased a form of insurance giving them protection against any out-of-pocket air-ambulance expenses for air-ambulance transport not covered by insurance or Medicare. For an annual charge in the range of \$50 to \$100, patients have the peace of mind knowing that in a time of crisis they won't have the added worry of another big expense.

### **Turbulent Skies**

While the dual air medical-ambulance service, with its multiple oversight agencies, operates smoothly in the vast majority of daily instances, there are some exceptions. The industry is dynamic, and its basic operations have undergone substantial growth and changes from its early beginnings in the 1970s through a period of expensive hospital-based operation to the existing flexible, community-based one. The industry expanded rapidly with the support provided by inclusion of air-ambulance coverage under Medicare.

### **Deregulated Versus Regulated**

Along the way some detractors were troubled with the mix resulting from a deregulated, open-market air mode and a tightly regulated, utility-type medical one. They claim that the two regimes are like mixing oil and water and cannot successfully endure. They claim that inherent medical necessities require a 24/7, go-anywhere service, but under strict carrier rate and operational controls with a limited number of operators. They see the only realistic solution as a return of the air ambulance as air carrier to a previous CAB-like regime of entry, rate, and route regulation, as well as a positioning of such controls at state levels.<sup>23</sup> They say that Congress, when placing



states under the 41713 preemption provisions, was not focused on the resulting difficulties of properly managing a large and expensive state health program. They seek amendments to 41713 that would allow states to limit air-ambulance-market entry, establish specific routes/zones for carriers, set carrier prices, and coordinate air-ambulance operations with other medically-related activities. DOT has clearly and repeatedly taken the position in court cases, and in individual air-ambulance advisory-opinion letters (more than a dozen from 1986 to present<sup>24</sup>), that air ambulances are air carriers, are protected by the full reach of the 41713 preemption provisions, and thus cannot be limited by the states in market entry, cannot have their prices regulated, cannot have their route operations restricted, cannot be restricted regarding operational hours, and cannot be restricted in numerous other areas (such as liability insurance, safety equipment, etc.) for which the DOT has prescribed federal standards.<sup>25</sup>

### States Operating as Air Ambulances

A confusing area of air-ambulance law exists where states and local government units may be conducting air-ambulance operations with so-called public aircraft with FAA-safety and OST-economic oversight that is far short of that applicable to authorized air ambulances carrying members of the general public in common carriage.<sup>26</sup>

As touched on above, in the formative days of the air-ambulance industry, several state units operated air-ambulance services. The public aircraft were owned and operated by a state or local government unit. Several highly-visible public-aircraft accidents during the 1990s called into question the validity of the then-established aviation-safety laws permitting the transportation of passengers by government agencies without FAA oversight and safety compliance. In perhaps the most prominent of these accidents, the governor of South Dakota and seven other people were killed on a state-operated aircraft. In reaction, Congress changed federal law in 1994 to narrow significantly the definition of public aircraft. In the words of Sen. Larry Pressler of South Dakota, a principal advocate, the purpose of these public-aircraft amendments “is to mandate that FAA safety regulations, directives, and orders issued for civil aircraft be made applicable to all government-owned, nonmilitary aircraft engaged in passenger transport.”<sup>27</sup> Some governmental units may yet be conducting air-ambulance operations, transporting the general public under the lesser and inapplicable public-aircraft standards, with errant guidance from the FAA as a partial factor.<sup>28</sup>

The *raison d'être* of the FAA/OST carrier-licensing requirements and gradations is simple yet critical. The greater the expected usage of the operator's aircraft as well as the level/scope of its operations, the greater the requirements, moving from simple, general aviation to full common carriage. It is both reasonable and a good regulatory system, that a weekend dentist flying for pure pleasure or even a charter carrier for prize racehorses moving from Kentucky to Saudi Arabia has quite a different operation than an airline with wide-body aircraft operating 24/7 with literally hundreds of thousands of customers annually traveling to every corner of the world. Those differences compel the differences in safety and economics under DOT regulatory requirements. The ultimate point is that the general public is entitled to air-ambulance operations at the highest level of safety and economics (full safety, full insurance, and other Part 298 protections). Operations as a public aircraft require none of those protections.

### Deep Pockets

Because of their popularity and high cost, air-ambulance operations have unfortunately become the focus of strapped states and counties seeking to address ever-rising budget costs. What was \$300 for a monitoring fee last year can be \$3,000 this year, with demands for \$30,000 and more next year. Patient-transport fees can be demanded for each patient transported to a hospital. Individual counties may seek a fee for dispatch services to help defray the cost of maintaining their restricted 911 emergency network for air and ground ambulances. While the county's stated intent is simply one of dividing the costs in a fair and balanced manner among all of the ambulance users, the basic fact is that air and ground ambulances are under quite disparate regulatory regimes and should not be grouped under one-fee fairness standard. Moreover, some counties have attempted to control air-ambulance routes and services by requiring that they operate in only certain assigned geographic zones (EOAs, or exclusive operating areas) and operate 24/7.

Dating back to the mid-1950s, the Interstate Commerce Commission (ICC)—then charged with regulating all ground carriers, including ground ambulances—decided *sua sponte* that it would no longer assume jurisdiction over ground ambulances and thus effectively de-regulated them from ongoing federal oversight.<sup>29</sup> On the other hand, Congress/DOT has made it clear that it has and maintains plenary safety and economic jurisdiction of air ambulances. Thus, while ground ambulances operate under virtually no federal oversight, that is not true of air ambulances, where federal requirements are fairly extensive.<sup>30</sup> The differences are quite substantive. While a ground ambulance might properly accept an EOA designation and thus enjoy a high referral level in return for its high dispatch fee, an air ambulance by virtue of the 41713 preemption provision cannot be properly provided a “no competition” EOA award for the exclusive referrals it would receive. A state agency is preempted by 41713 from limiting air-ambulance-market entry through an EOA scheme or likely a restrictive dispatch service with the same end.<sup>31</sup>

Other provisions of the transportation code also present obstacles to any state viewing an air ambulance as a *golden goose*. The so-called Anti-Head Tax Act provision (AHTA) prohibits any state or unit of a state from levying or collecting any fee or other charge, directly or indirectly, on the sale of air transportation.<sup>32</sup> It is designed to limit state and local taxation of aviation. DOT has interpreted the provision to prohibit state charges on air carriers for such purposes as helping states defray expenses of a state cargo-inspection program.<sup>33</sup> DOT has also held that a state or local fine imposed upon a carrier for a violation of a local-carrier requirement or certain state program fees are a direct charge on the sale of the carrier's air transportation and are prohibited by the AHTA.<sup>34</sup> While the AHTA lists certain air-carrier taxes that are unobjectionable, it prohibits any charges on individual travelers (and freight) as well as the gross receipts from the sale of that transportation.<sup>35</sup>

While any quick determination of air-carrier-tax liability is risky, state charges on air ambulances for county services with any reasonable connection to the sale and operation of its air-ambulance services, with a facial tie to passenger sales volume, would appear to raise substantive AHTA-liability issues. They relate to the sale of air transportation; they involve a state unit; and they are not excused by inclusion in the statutory listing of unobjectionable charges.

## Blue Skies

Much like a good liability insurance policy, a healthy air-ambulance industry is something most people don't focus on till they need it—and when they do, it is essential. Like anything of value, it cannot be neglected but must be properly maintained lest it not be ready and able to deliver when called upon. Our national air-ambulance system is healthy and vibrant<sup>36</sup> but also constantly being tested. We can celebrate it but we must defend it (against over taxation and over regulation) to maintain its fully ready status.

Anyone who grew up on a diet of Sunday night *MASH* episodes saw the life-or-death benefits of air-ambulance services at their earliest, best, and most extreme.<sup>37</sup> Anyone who watched the front page of their newspaper in recent months saw the priceless benefits of quick air-ambulance movements for deadly Ebola patients from one stricken part of the world to a curative part.<sup>38</sup> Anyone who undertakes a summer off-road trek in the backcountry knows the utility of never being out of air ambulance reach. And anyone who travels the roads and might find themselves in a vehicle accident has to appreciate the relief that only an air ambulance might provide.

While some would put the air-ambulance system under heavy financial or re-regulatory pressures with demands for extreme charges and revamped operations, it should be clear that the system, much like our overall medical system, is at a world-best level and should be allowed to advance on its present course.

While some have pictured problems in the air-ambulance business, a more balanced review would note that over the 35-plus years of air carrier deregulation, reliance on marketplace factors to set such key production factors as availability and price has produced a high and desirable level of price/service options for the benefit of the public. The air-ambulance industry has grown substantially over that period.<sup>39</sup> Air safety has improved, not decreased, under the open market structure. Arguments of the detractors for legislative change were at times based on statements that were anecdotal, inconsistent, and simply repeats of general attacks on airline deregulation. All should thus be most reluctant to forsake the proven, flexible marketplace system for a return to a failed one of expensive, oppressive regulatory restraints.

It remains for all of us to stay informed about and protective of that priceless national asset, not perfect but now well-honed through 40 years of testing, and productively advancing. ☺



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## Endnotes

<sup>1</sup>Simply stated, after the sunset of the CAB in 1984 (which regulated air-carrier entry and industry economics) those functions were largely transferred to DOT. Safety jurisdiction continued and remained with the FAA, a modal administration within DOT. To gain air-carrier status, a prospective must obtain both FAA safety authority as well as DOT economic authority. Beginning at CAB, and continuing at DOT, air-carrier economic authority can take several forms, ranging from the full and formal air-carrier certificate (albeit in a much reduced level of procedure, post-CAB sunset) to the so-called exemption authority (*see* 14 CFR Part 298), applicable to air ambulances, where minimum steps (filing of a form and the maintenance of requisite insurance; exempted from more onerous requirements) will establish air-ambulance economic operating authority. As a technical matter, the administrative functions surrounding air ambulance exemption authority were transferred from DOT (Office of the Secretary) to FAA more than 10 years ago.

<sup>2</sup>49 USC §§ 40102(a)(2), (a)(5) & (a)(25).

<sup>3</sup>*See, for example, Stimson Lumber Co. v. Kunkendall*, 275 U.S. 207, 211 (1927); *Page Airways Inc., Investigation*, 6 CAB Reports 1061 (1946); *Liederbach Common Carrier Application*, 32 M.C.C. 387 (1942); *M&R Investment Company Inc., d/b/a Dunes Hotel and Casino, et al., Enforcement Proceeding*, 33 CAB Reports 1, 13-14 (1961); *Las Vegas Hacienda Inc., and Henry F. Price, Enforcement Proceeding*, 31 CAB Reports 415 (1960), *order affirmed*, 298 F.2d 430 (C.A. 9, 1962), *cert denied* 369 U.S. 885.

<sup>4</sup>*Intercontinental, U.S. Inc.*, 41 CAB Reports 583 at 601-02 (1965).

<sup>5</sup>P. L. 95-504, Oct. 24, 1978, 92 Stat. 1705, 49 USC §1301 *et seq.* later codified at 49 USC § 401 *et seq.*

<sup>6</sup>With the Airline Deregulation Act, Congress moved to end frustrating and confusing dual federal-state regulation of air-carrier operations. *See* section-by-section analysis of H.R. 8813, Cong. Rec. Sept. 23, 1977, H 10007-8; 95th Cong. 2D. Sess. House Report No. 95-1211, at 16. The new single federal extends beyond coverage of certificated airlines to include air-ambulance operations with simple *exemption* authority, both interstate and intrastate. *See* 14 CFR § 399.110 (1979-2003); CAB Policy Statement-83; 44 Fed. Reg. 9951; 68 Fed. Reg. 43882.

<sup>7</sup>*See* DOT letter discussing issue and leaving virtually no argument for state regulation of DOT-authorized air ambulances operating purely intrastate transportation. Letter of DOT Deputy Assistant General Counsel James R. Dann to Texas Assistant General Counsel Donald Jansky, Feb. 20, 2007.

<sup>8</sup>*Las Vegas Hacienda (C.A.)*, *supra* note 3, at 436, n 16; *Consolidated Flower Shipments Inc.* 16 CAB Reports 804-05, 88-199 (1953); *M&R Investment*, *supra* note 3, at 15; *Hacienda Hotels*, 26 CAB Reports 372, 377 & 384 (1958).

<sup>9</sup>Under a little-known or used provision of the transportation code, an individual air carrier has specific federal-court standing to bring its own injunctive action against a competing carrier for engaging in “unauthorized air transportation.” The competing carrier is an “interested person” (previously termed a “party in interest”) in a suit to enforce the Code requirement of a DOT authorization to provide air transportation as an air carrier. 49 USC §§ 46108 & 41101(a)(1). *See* CAB amicus briefs in *Monarch Travel Services Inc. v. Associated Cultural Clubs Inc.*, 466 F. 2d 552 (9 C.A.



1972); case discussed at 39 J. Air L. & Com. 463 (1973).

<sup>10</sup>*Las Vegas Hacienda Inc. v. CAB*, 298 F. 2d 430 at 436 (C.A. 9 1962).

<sup>11</sup>See full and expert discussion by former CAB attorney at John W. Freeman, *State Regulation of Airlines and The Airline Deregulation Act of 1978*, 44 JOURNAL OF AIR LAW & COMMERCE 747, 754-55 (1979).

<sup>12</sup>In the case of *Rowe v. New Hampshire Motor Transp. Assn.*, 552 U.S. 304 (2008), the Supreme Court found the express-preemption provision in the Transportation Code applies to shipments by small-package express carriers (a preemption provision virtually identical to 41713 applicable to air carrier's; see 49 USC §§14501(c)(1) and 41713(b)(4)(a)) prevented the states from requiring small-package carriers (FedEx and UPS) to support state efforts to halt illegal tobacco sales to state minors by checking the age of recipients before package delivery of email orders, in spite of their strong health-of-minors argument. The court found that the preemption provision was clearly applicable and moreover had no health exception (however beneficial the cause).

<sup>13</sup>See transcripts of recent case oral arguments at Supreme Court Internet site. See *Rowe* case transcript, No. 06-457, at pp. 27, 32-33 & 45-46.

<sup>14</sup>To be clear, the unit within DOT that directly deals with air-carrier economic-entry issues, transferred from CAB at its sunset, is within the Office of the Secretary, hereinafter OST or DOT (except for Part 298 exemption authorizations moved from OST to FAA; see note 2 *supra*).

<sup>15</sup>State regulations serving "primarily a patient care objective are properly within the states' regulatory authority." *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 740 (E.D.N.C. 2008); *Hiawatha Aviation of Rochester v. Minn. Department of Health*, 389 N.W. 2d 507, 509 (Minn. 1986). See DOT position at Dann to Jansky letter, *supra* note 7, at 5.

<sup>16</sup>Estimates of air-ambulance industry expert, Bill Bryant, a principal in the consulting firm of Sierra Health Group, in Golden, Colo.

<sup>17</sup>DOT has a number of insurance requirements in place for air ambulances. Under DOT regulations at 14 CFR Part 205, air ambulances must maintain minimum-prescribed levels of accident-liability insurance. Any additional state requirement for such accident-liability insurance would be preempted. There are nevertheless a number of other insurable interests in an air-ambulance operation, such as emergency medical-service providers in an air-ambulance operation, which are not covered by DOT and could thus be properly subject to state requirements. Note that failure to maintain proper insurance violates DOT Part 205 and, by operation of law, renders a carrier's authority ineffective and subjects the carrier and its principals to DOT-enforcement action. See 14 CFR Part 205 and white paper at *DOT Notice to Airlines and Companies Writing Aviation Insurance Policies*, May 16, 2003.

<sup>18</sup>Of course where an operator is holding out an air-ambulance service, either direct or indirect, without appropriate FAA/OST authority, it is subject to DOT-enforcement action. See remedial DOT-enforcement action and orders to cease and desist as well as collection of civil penalties issued against violating indirect air-carrier operators at:

– Order 2001-2-9, Feb. 15, 2011, in Docket 2011-0003.

– Order 2009-6-18, June 23, 2009, in Docket 2009-0001.

– Order 2009-4-17, April 27, 2009, in Docket 2009-0001.

<sup>19</sup>See 49 USC § 41702 for air-carrier statutory requirement to provide safe and adequate service.

<sup>20</sup>For an expert and helpful guide to the nuances involved in parsing out directs, indirects, agents, and brokers in air transportation, see DOT white paper *The Role of Air Charter Brokers in Arranging Air Transportation*, DOT OFFICE OF AVIATION ENFORCEMENT AND PROCEEDINGS, Oct. 8, 2004.

<sup>21</sup>Descriptions of industry expert Bryant, *supra* note 16.

<sup>22</sup>Estimate of industry expert Bryant, *supra* note 16.

<sup>23</sup>See testimony of Thomas Judge on behalf of the *Patient First Air Ambulance Alliance* before the House Transportation and Infrastructure Committee, Aviation Subcommittee, April 22, 2009.

<sup>24</sup>The DOT letters are issued by a law office within their Office of General Counsel. A partial listing, with copies of the letters, can be found at [www.dot.gov/mission/administrations/general-counsel/elibrary](http://www.dot.gov/mission/administrations/general-counsel/elibrary). A further partial, summary listing can be found in a GAO report on air ambulances, *Air Ambulance: Effects of Industry Changes on Services Are Unclear*, GAO-10-907, Sept. 2010, at Appendix III. A review of the key court cases, as well as DOT and state attorneys general opinion letters related to the air-ambulance industry, especially preemption issues, can be found in the GAO report at Appendix III, Tables 4 and 5. The report states that the DOT opinions have helped to clarify the relationship between federal and state oversight and regulation of the air ambulance industry. See report at opening statement.

<sup>25</sup>For a thorough review of the air-ambulance preemption provisions, see R. Michael Scarano Jr. and Bill Bryant, *Federal Preemption of State Regulation Over Air Ambulances*, 28 AIR MEDICAL JOURNAL 77 (2009).

<sup>26</sup>Aircraft used by U.S. operators can be roughly classified as either: (1) public aircraft for the military and public operators or (2) civil aircraft for all the other operators. See 49 USC § 40102(a)(17) and (41). While local governments may engage in full air-ambulance operations as an air carrier, they might avoid virtually all FAA and OST requirements where they fashion their operations so that their aircraft fit the restrictive definition of so-called public aircraft and thus need only comply with Part 91 (FAA's very general aircraft-operation requirements), avoiding other DOT requirements—most important, fitness reviews, insurance requirements, and other safety requirements. See 14 CFR Parts 91, 204, 205, 121 and 135. By fitting within the public aircraft definition/regime, the governmental unit might avoid any question that they are engaged in common carriage and thus subject to the full regulatory requirements therein involved. Under the transportation code, public aircraft (pertinent here) are ones that are operated in the performance of a governmental function—namely a litany of purposes with a public service bent, including search-and-rescue as well as other governmental functions—but not for compensation, namely as a commercial operator or an air carrier, and never carrying the general public unless acting as crew members or "whose presence is required to perform or is associated with the performance of a governmental function." 49 USC § 40125(a) & (b).

<sup>27</sup>140 CONG. REC. S14419- S14420 Oct. 6, 1994) (statement of

Sen. Pressler); see also 60 Fed. Reg. 5237, 5239 (1995).

<sup>28</sup>See expert review of the issues by former FAA attorney Irene Howie, *Curing the Confusion: Who Regulates Government Air Medical Flight Safety?*, 22 THE AIR & SPACE LAWYER 3 (2009). States such as Maryland and county units in the states of Florida, New York, California and Pennsylvania may continue to transport members of the general public under so-called public aircraft operations.

<sup>29</sup>*Dennis Common Carrier Application*, 63 MOTOR CARRIER CASES 66, at 69 (1954).

<sup>30</sup>In the classic description of the close federal/airline industry connection, Justice Robert H. Jackson in *Northwest Airlines v. Minnesota*, 322 U.S. 292, 303 (1944) described: “Federal control is intensive and exclusive. Planes do not wander about the sky like vagrant clouds. They move only by Federal permission, subject to Federal inspection, in the hands of Federally certified personnel, and under an intricate system of Federal commands.” In contrast to areas historically subject to state regulation, operations of an air carrier engaged in air transportation have always been intensively and virtually exclusively regulated by the federal government. DOT Order 98-12-27 at 44.

<sup>31</sup>In addition, as mentioned, because of the dual air/medical nature of an air-ambulance operation, and the resulting medical services jurisdiction of HHS, that department has requirements that may apply under its Medicare/Medicaid programs. An HHS statute makes it a crime for parties on either side of a transaction to “offer, pay, solicit or receive” any remuneration to purposefully induce the referral of Medicare/Medicaid air ambulance services. 42 USC § 1320-7b(b). The Office of Inspector General (OIG) at HHS cautions that inflated payments to a state in return for access to emergency medical service patients may constitute a prohibited kickback. 68 Fed. Reg. 14245, at 14253 (2003). Restricted state 911 dispatch service programs, with inflated fees demanded of air-ambulances in return for program access, may raise serious air-ambulance-liability issues.

<sup>32</sup>49 USC § 40116; Pub. L. 93-44, 87 Stat. 90 (1973).

<sup>33</sup>*Hawaii Inspection Fee Proceeding*, DOT Order 2012-1-16,

Jan. 24, 2012.

<sup>34</sup>*Id.* at 18.

<sup>35</sup>The AHTA lists acceptable state taxes on air carriers as: property taxes (if no higher than similar companies), net income taxes, franchise taxes, or sales or use taxes on the sale of goods or services (such as jet fuel). But see detailed discussion of close questions surrounding such fuel taxes at 58 JOURNAL OF AIR LAW & COMMERCE 103 (1992).

<sup>36</sup>The operating companies are supported by dozens of trade associations, such as AAMS, Association of Air Medical Services; CAMTS, Commission of Accreditation of Medical Transport Services; AMOA, Air Medical Operators Association; HAI, Helicopter Assoc. Int’l; NPAA, Nonprofit Air Ambulance Alliance; NASEMSO, National Assoc. of State EMS Officials; IAFP, Int’l Assoc. of Flight Paramedics; and others.

<sup>37</sup>The TV hit ran for 11 years (1972 to 83) with the lifesaving times and antics of the 4077th Mobile Army Surgical Hospital (MASH) unit in South Korea, highlighted by such things as company clerk “Radar” O’Reilly’s uncanny ability to hear incoming helicopters with patients in advance of anyone, expanding slightly the lifesaving golden hour for quick treatment. The final episode became the most-watched TV show in American history, with 106 million viewers.

<sup>38</sup>While the immediate Ebola threat subsided, the specter of such a repeat disaster remains and haunts many, with extra precautions and procedures continuing behind the scenes. See Ebola Guidance for Airlines on the Internet.

<sup>39</sup>In a recent, significant FAA rule-making proceeding to strengthen air ambulance safety requirements (FAA docket 2010-0982), the FAA had occasion to report on the size of U.S. helicopter emergency-medical service (HEMS) operations. During 2003 to 2008, the industry underwent a 54 percent increase in the number of helicopters in operation. In 2009, some 74 HEMS operators flew approximately 850 helicopters, with the operators ranging in size from one aircraft to the largest operator being the 10th largest air carrier in the nation.

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### Endnotes

<sup>1</sup>*California v. Ciralo*, 476 U.S. 207 (1986).

<sup>2</sup>14 C.F.R. § 91.119.

<sup>3</sup>*Florida v. Riley*, 488 U.S. 445 (1989).

<sup>4</sup>*United States v. Boyster*, 436 F. 3d 986 (8th Cir. 2006).

<sup>5</sup>*People v. Pollock*, 796 P.2d 63 (Colo.App. 1990).

<sup>6</sup>“Unmanned Aircraft Systems” GAO-12-981, September 2012, p.36.

<sup>7</sup>*Presidential Memorandum: Promoting Economic Competitiveness While Safeguarding Privacy, Civil Rights, and Civil Liberties in Domestic Use of Unmanned Aircraft Systems* (Feb. 15, 2015), available at [www.whitehouse.gov/the-press-office/2015/02/15/presidential-memorandum-promoting-economic-competitiveness-while-safegua](http://www.whitehouse.gov/the-press-office/2015/02/15/presidential-memorandum-promoting-economic-competitiveness-while-safegua).

<sup>8</sup>This definition is derived from section 331(8) of the FAA Modernization and Reform Act of 2012 (Public Law 112-95, 126 Stat 72, Feb. 14, 2012).

<sup>9</sup>Restatement Second of Torts, section 652B (1976).

<sup>10</sup>*Dieteman v. Time Inc.*, 449 F. 2d 245 (9th Cir. 1971); Am. Jur. 2d, Privacy § 50.

<sup>11</sup>See M. Ryan Calo, *The Drone as Privacy Catalyst*, 64 STAN L. REV. ONLINE 29 (2011) [“Tort recovery founders on the question of damages.”]

<sup>12</sup>See 49 U.S.C. 46301, where fines of \$25,000 per violation or per flight are typical.

<sup>13</sup>See, for example, 49 U.S.C. 46311, where imprisonment for two years is the penalty for unlawful disclosure of information.

<sup>14</sup>*I.C.U. Investigations Inc. v. Jones*, 780 So.2d 685 (Ala. 2000).

<sup>15</sup>Am Jur 2D, *Assault and Battery*, § 60.