Federal Preemption of State Regulation Over Air Ambulances

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Introduction

Following the rapid expansion of the air ambulance industry in recent years, many state and local agencies have increased their efforts to regulate air ambulances. At the same time, faced with increasing and often conflicting regulations, legally sophisticated air ambulance providers commonly are raising the question of whether state and local agencies have regulatory authority over issues that are already heavily regulated by federal agencies.

It has long been recognized that federal aviation law preempts certain types of state and local regulation in the air ambulance arena. This was first illustrated by a 1986 decision of the Minnesota Supreme Court[1] and subsequently reaffirmed by a state attorney general's opinion in Arizona[2] and a federal district court decision in Missouri.[3] These historical precedents, discussed further below, addressed exclusionary laws such as requirements for certificates of need or public convenience and necessity.

More recently, in a series of developments, the federal government and two other federal courts weighed in on a variety of air ambulance preemption issues, providing a detailed view of how key federal agencies and at least two federal courts now view preemption in the air ambulance setting. These recent developments include letters from the U.S. Department of Transportation (DOT), the parent agency of the Federal Aviation Administration (FAA), finding that a variety of requirements under laws or proposed laws in Texas, Hawaii, Florida, and North Carolina are preempted. The disfavored laws include not only certificate of need and similar exclusionary laws, but also state insurance mandates, required hours of operation, aviation equipment requirements, regulations providing for independent state enforcement of FAA regulations, and accreditation mandates that would indirectly impose preempted requirements. In two other significant developments, a federal court in Tennessee overturned that state's requirement for instrument landing capabilities on preemption grounds and a federal court in North Carolina invalidated a number of state laws governing air ambulances in that jurisdiction. Another preemption lawsuit in Colorado remains pending. Finally, both the DOT and the Texas Attorney General have opined that Texas regulations restricting membership programs are preempted.

Collectively, these recent developments affirm and expand upon prior precedents indicating that federal preemption limits state and local regulation bearing on aircraft safety and certain economic issues. However, both the DOT and the courts have preserved the ability of state and local authorities to regulate primarily medical issues. The following provides the background for the recent developments and then explores their implications.

Historical Background

Following a series of crashes between aircraft operating under separate flight rules, Congress enacted the Federal Aviation Act in 1958 (the Act).[4] The Act was intended to establish a single, uniform scheme of nationwide regulation for air carriers.

In 1978, Congress amended the Act by passing the Airline Deregulation Act (ADA).[5] The primary focus of the ADA was on the creation of a competitive market environment for air carriers nationwide. To prevent state interference with competitive market forces, Congress included a preemption provision that expressly prohibits a state or its local subdivisions from enacting or enforcing any statute or regulation "related to a price, route, or service of an air carrier."[6] Congress has authority to enact this type of preemption provision under the Supremacy Clause of the U.S. Constitution, which provides that laws passed by the federal government "shall be the supreme Law of the Land; and the judges in every state shall be bound thereby," regardless of any contrary law passed by a state.[7]

The preemption clause in the ADA has been very broadly interpreted by the U.S. Supreme Court and other courts.[8] The courts have held that by preempting any state laws "*related to* a price, route or service," Congress intended to preclude states and local agencies from enacting any statutes or regulations pertaining to or having a bearing on rates, routes, or services of air carriers, even if the state or local provision in question does not expressly refer to these issues. In other words, preemption may apply if a state or local regulation has a direct or indirect impact on rates, routes, or services of an air carrier, even if it does not specifically address these issues.

Because air ambulance providers are air carriers, the preemption provision applies to them. The first reported collision between the ADA's preemption clause and state

regulation of air ambulance providers occurred when Hiawatha Aviation of Rochester, Inc., sued the Minnesota Department of Health in the mid-1980s over that state's licensing legislation, which required certificate-of-need (CON) type findings as a condition of licensure. In 1986, the Minnesota Supreme Court held that the licensing statute was unenforceable because it conflicted with the ADA by limiting the number of air ambulance services doing business within the State.[1] However, the court held that the State retained authority over the delivery of medical care, including medical staffing, personnel, and equipment requirements. That case was followed by an opinion of the Arizona Attorney General stating that the state could not enforce "economic regulation under the certificate of need statutes" previously enacted by that state, but could enforce statutes related to "essential public health and safety matters" dealing with the "medical needs of passengers."[2]

Ten years later, in a lawsuit by Rocky Mountain Holdings against the state of Missouri, a federal district court struck down a statute requiring a determination of "public convenience and necessity" as a condition of licensure.[3] The court held that "in making the determination of public convenience required by the Missouri provision," the state was making decisions having a connection with or reference to the rates, routes, or services of an air carrier, in violation of the ADA.

Although the ADA preemption provision and the foregoing opinions deal primarily with "*express* preemption" of economic regulation, a number of court decisions outside the air ambulance context have held that other provisions of the Act *impliedly* preempt any state or local regulation over aviation safety issues. The rationale of these decisions is that the Act's coverage of these issues was intended by Congress to be comprehensive, to the exclusion of any concurrent state regulation. In effect, federal law in the area of aviation safety "occupies the field." Under this doctrine, known as "implied" or "field" preemption, concurrent state regulation is preempted even if it is not in conflict with federal law. As indicated below, the recent developments address both express and implied preemption.

Recent Developments

DOT Letters to Texas

The first of these developments unfolded in Texas. Throughout the past few years, the Texas state government weighed the most effective means of regulating the air ambulance industry. The issue has been under study by the Air Medical Committee of the Governor's EMS and Trauma Advisory Council (the Committee). In a meeting of the Committee in August 2006, its chairperson posed several questions to the Office of General Counsel (OGC) of the Department of State Health Services. Those questions included:

1. To what extent does the Federal Aviation Act limit the state's ability to establish regulations regarding aviation safety issues, including minimum standards for aircraft, pilots, weather minimums, etc.?
2. If the state is restricted from establishing its own aviation safety standards, can it require air ambulance providers to be accredited by an outside organization which has its own minimum standards regarding these same issues?
3. To what extent does the Act limit the state's ability to establish regulations on aviation related to issues such as rates, insurance requirements, or where and when providers can fly?
4. Does the Act limit the state's ability to regulate the medical services provided inside the air ambulance, including minimum requirements for medical equipment and the training and licensing requirements of the medical crew?
5. Are the restrictions imposed upon the state by the Act limited to providers who perform interstate (as opposed to intrastate) transports?

In a memorandum dated November 17, 2006,[9] and a verbal report given November 19, 2006, the Texas OGC answered the Committee's questions. To summarize, the OGC opined that "[Department of State Health Services] cannot establish regulations that deal with aviation safety or economic issues such as rates, advertising, scheduling, and some issues dealing with insurance." This preemption would apply regardless of whether the transfer of the patient is interstate or intrastate. However, OGC opined that the state could establish laws relating to the quality of care provided within the cabin of an aircraft.

At the Committee's request, Texas OGC sent its opinion to DOT to determine whether it agreed with these conclusions. In a letter dated February 20, 2007,[10] DOT Deputy Assistant General Counsel James R. Dann responded, "In general, we found your memorandum to be accurate in its description of the areas in which state regulation of air ambulances is preempted by federal law." The DOT then went on to elaborate on its views.

For purposes of analysis, the DOT categorized the state's potential areas of regulation into three areas: aviation safety, economic requirements, and medical services. The DOT stated that "federal preemption of state transportation regulation is most extensive in connection with aviation safety." However, "[g]eneralization is more difficult when it comes to preemption of state economic regulation given both the great variety of such classifications falling under the general rubric of economic regulation, and the wide variability of impacts that such regulations may have upon air carriers." Thus, the DOT stated that "economic regulation that affects air carriers, and proposals for such regulation, are best reviewed on an ad hoc basis." It indicated that, as a general rule, the primary guidepost in determining whether such regulation is permissible is whether it is "related to a price, route, or service of an air carrier." With respect to the third category of potential regulation, medical regulation, the DOT stated that "states would be most free to

enact and enforce state or local requirements with regard to medical services, particularly as delivered to patients/passengers in cabins of the aircraft."

After offering the foregoing general comments, the DOT letter goes on to address each of the questions and conclusions discussed in OGC's memorandum. The DOT agreed with OGC's conclusion that "federal law and regulations preempt the states from establishing requirements dealing with aviation safety." In addressing the potential use of private accreditation as a surrogate for direct state regulation, the DOT stated:

> *"It is axiomatic that a state may not regulate indirectly what it cannot regulate directly. If a state cannot itself regulate matters of aviation safety, it cannot achieve the same result indirectly, by requiring the 'accreditation' of a body that sets aviation safety standards. If, however, the matter is not preempted – as would be the case in various areas dealing exclusively with medical care – then the result is permissible and can be attained either directly with specific state requirements, or indirectly, through accreditation requirements."*

The DOT's discussion of the accreditation issue suggests that a requirement for accreditation would only be permissible if the accreditation standards related solely to medical care issues and did not encroach into aviation safety or preempted economic issues. Therefore, a state probably may not require accreditation by an organization that imposes both aviation safety and medical care standards. (A federal lawsuit currently pending against the State of Colorado may result in a ruling on this issue. The lawsuit, filed by Eagle Air Med, asks the court to prohibit the Colorado Department of Public Health and Environment from requiring it to be accredited by the Commission on Accreditation of Medical Transport Services [CAMTS]. Colorado statutes currently require that all air ambulances be accredited by CAMTS.[11])

In addressing economic regulation, the DOT agreed with the Texas OGC that the ADA "would preempt any state regulation relating to rates, advertising, scheduling, and routing of air ambulances." As to insurance requirements, the DOT noted that federal law and regulations expressly address requirements of air carrier liability insurance for injuries, death, and/or property damage to third parties caused by the crash of an aircraft. Therefore, the DOT "would consider state requirements for such or similar insurance, or minimum coverage levels" for insurance, to be preempted. However, the DOT stated that if a state wishes to require professional liability insurance for a flight crew, an area not touched by federal aviation regulations, the DOT would not view this as preempted. Other types of insurance would have to be addressed on a case-by-case basis.

Although OGC did not ask the DOT about a state's authority to impose potentially exclusionary regulations such as CONs or certificates of public convenience and necessity, the DOT letter noted that it had previously issued an opinion to the state of Arizona concluding that state legislation providing for such requirements is preempted. The DOT also advised the state that it cannot regulate air ambulance providers' rates, operating and response times, bases of operations, or accounting and reporting systems, nor can it impose bonding requirements.

Consistent with the earlier pronouncements on the issue, the DOT concurred with OGC's conclusion that the state is free to regulate medical services provided inside the air ambulance, including establishing minimum requirements for medical equipment as well as training and licensure requirements for the medical crew. The DOT cautioned, however, that "flight safety aspects" of medical care, such as "safe storage of equipment," could not be regulated by the state. Further, because the Act does have some minimum requirements for medical personnel aboard an aircraft when acting in their capacity as flight crew members rather than medical personnel, preemption could have an impact on requirements encroaching on such issues. The DOT stated "[b]ecause this area is often not reducible to bright line standards, we suggest that a particular equipment/service issue with possible FAA safety implications be raised with local FAA safety inspectors for their review."

Finally, the DOT indicated, as a practical matter, the distinction between interstate and intrastate air ambulance service is irrelevant for purposes of preemption under the Act. The DOT stated that while "[i]t is technically correct that [the ADA's] preemption is limited to services performed in interstate" transportation, "the realities of modern aviation, coupled with the realities of modern commercial activity, make the distinction between interstate and intrastate activities all but academic." The DOT reasoned that, as a practical matter, all air ambulance providers would likely be viewed as engaging in interstate commerce under applicable legal standards, even in a state the size of Texas.

Subsequently, the Texas OGC submitted a follow-up inquiry regarding whether state officials could act, through their own licensing requirements, to insure that FAA requirements are being followed by air ambulance operators. The DOT opined in a second letter that "a state may not establish a duplicative regulatory regimen to insure that federal aviation requirements are being met."[12] The DOT noted that the Act reflects Congress' intent to establish a single, uniform system of aviation safety regulation under federal auspices, and that federal statutes and regulations pervasively occupy the field of aviation safety. The DOT opined that:

> *Permitting a state to impose its own rules, even to simply assure that federal aviation safety requirements are being met, would frustrate the congressional objective of a single uniform system of aviation regulation because it would create bureaucratic redundancies, duplicative enforcement regimens, and potentially inconsistent interpretations and enforcement approaches.*

The DOT stated, however, that "the state may examine any records of corporate operations and activities that it is authorized to obtain under state law." In the event the state determines that federal requirements are not being satisfied, the state could not impose independent enforce-

ment action, but would be limited to contacting responsible federal authorities, who could request that the matter be investigated and enforcement action be taken as appropriate.

DOT Opinion Letter to Hawaii

In a letter dated April 23, 2007, from DOT Acting General Counsel Rosalind A. Knopp to Gregory S. Walden, the DOT responded to a request for an opinion from a private provider as to whether Hawaii's CON law, as applied to air ambulances, was preempted by federal law. Although the state had already made its own determination that its CON requirement was preempted after discussions with the DOT, the DOT nevertheless decided to formally weigh in on the Hawaii requirements. (In June 2006, the Hawaii State Health Planning and Development Agency and the Hawaii Attorney General determined that the state could not require a CON for air ambulances to operate in Hawaii, after a protest made by the prospective provider.) Consistent with prior precedent, the DOT opined that the CON requirement was preempted.

The DOT then evaluated other Hawaii requirements for air ambulance services, including requirements that providers maintain liability insurance in the amount required by FAA rules, operate 24 hours a day, and maintain certain medical equipment and supplies.

The DOT found the insurance requirement preempted because the DOT itself "administers a comprehensive regimen addressing aircraft accident liability insurance requirements for air carriers," as authorized by federal statute. The DOT stated that, "we consider such [federal] regulation to be pervasive, fully occupying the field." Therefore, although the state contended that it merely checks for aircraft insurance in an amount equal to the amount required by DOT, the DOT found this "redundant regulatory regimen with independent enforcement capabilities" to be unacceptable. The DOT stated that federal law addressing this issue "leaves no room for state efforts to 'supplement' in this manner the federal accident liability insurance regimen." Thus, the DOT made it clear that in an area which is preempted by federal law, even state requirements that mimic federal requirements are impermissible.

The DOT then turned its attention to Hawaii's requirement that any air ambulance service "shall be operative 24 hours daily" with a 24-hour telephone answering capability as well as 24-hour availability for pilot, medical crew, and a physician. The DOT stated that "while such full-service features for emergency air service may be desirable from a state policy perspective, we believe the requirement for an air carrier to be able to operate 24-hours a day is preempted on at least two grounds."

First, the DOT found that the 24-hours-a-day requirement runs afoul of the express preemption provision of the ADA, prohibiting all state or local laws that relate to rates, routes, or services. The DOT opined that states may not "prescribe particular hours or times of operations," since "such requirements 'relate to' air carrier 'service' within the meaning of the [preemption] statute." The DOT reasoned that "[a] key purpose of the [ADA] was to insure that the services offered by air carriers are ones dictated by the competitive market and not by any regulatory body." Second, the DOT found that the 24-hour requirement "intrudes on regulations and operations specifications for aircraft and crew operations, which are within the plenary authority of the FAA." The DOT noted that:

> *Matters concerning aviation safety . . . are under the exclusive jurisdiction of the FAA and, therefore, are preempted by federal law. To the extent that Hawaii's 24-hour operability requirement would require equipment and flight crew capabilities that are different from those needed for FAA approvals, that requirement, and any similar requirements, would improperly encroach on the federal regulatory scheme.*

In a footnote, the DOT noted that state or local governments who enter into procurement contracts with air ambulance providers, and are therefore functioning as "customers" rather than as "regulators," could secure a 24-hour commitment from an air ambulance operator through the non-regulatory mechanism of a contract.

Finally, the DOT addressed the issue of a state's ability to require specific medical equipment on air ambulances. While the DOT stated that Hawaii's requirements for items such as "patient oxygen mask, litters, blankets, sheets, and trauma supplies" were allowable, the DOT cautioned that states would not be allowed to use these requirements as a means of indirectly encroaching on preempted areas. Specifically, the DOT stated that "it is possible that a state medical program, ostensibly dealing with only medical equipment/supplies aboard aircraft, could be so pervasive or so constructed as to be indirectly regulating in the preempted economic area of air ambulance prices, routes or services."

DOT Letter to Florida

In a letter written to the state of Florida 6 months later in October 2007, the DOT opined that a state law requiring an ambulance provider to obtain a certificate of public convenience and necessity (PC&N) was preempted by the ADA. The DOT's opinion was written in response to a request from the Florida Department of Health for guidance as to whether federal law preempts Florida's PC&N requirement. The issue arose when Rocky Mountain Holdings, a wholly owned subsidiary of Air Methods Corporation, sought to initiate air ambulance service in Florida without obtaining a PC&N. Air Methods had argued to the state that the requirement was preempted by the ADA.

The Florida statute required an air provider to obtain a PC&N certificate from each county in which it proposed to operate. In determining whether to grant the certificate, the county was required to consider state guidelines, as well as the recommendations of local or regional trauma agencies and municipalities within its jurisdiction. Counties were free to reject applicants if they determined, for example, that the necessary services were already provided, that there was insufficient local support for additional service, that there would be adverse effects on

existing providers, or that perceived costs were not commensurate with the benefits.

Citing its prior letters to the states of Hawaii and Arizona, as well as the *Hiawatha* and *Rocky Mountain Holdings* court decisions, the DOT concluded that the state requirement is preempted by the ADA. The DOT stated:

> *Such a requirement subjects to state control the very essence of any carrier's services: the ability to even operate within the state. It also effectively regulates the routes the carrier may fly, by limiting them to within whatever counties choose to approve them (and admitting the result that, indeed, no routes whatsoever may be flown).*[13]

Tennessee Court Decision

One of the recent developments unfolded in a Tennessee lawsuit. That state enacted regulations requiring, among other things, that "[a]ll helicopters performing aero medical missions shall be equipped with avionics and instruments necessary to enable the pilot to execute an instrument approach under instrument meteorological conditions."[14] The regulations further specified the equipment necessary for such operation, including two very high frequency receivers, one non-directional beacon receiver, and one glide slope receiver.

In March 2005, the Tennessee EMS Board notified Air Evac EMS, Inc., (Air Evac) that some of its helicopters lacked equipment required by this rule. Air Evac contested the order, asserting that it met all federal requirements and that the Act preempted these state regulations.

Following unsuccessful administrative appeals, Air Evac filed a lawsuit in federal district court in Tennessee,[15] asserting that the regulations were preempted. The U.S. Department of Justice (DOJ) filed a brief on behalf of the FAA siding with Air Evac.[16] The DOJ asserted that the requirements of the Tennessee regulations "impermissibly treat federal regulations and the FAA certification process as merely a first step toward aviation safety, which may be rejected whenever the state of Tennessee disagrees with the standards set forth in federal regulations." The DOJ and FAA further argued that this approach "threatens the uniform system of regulation mandated by Congress in the Federal Aviation Act by placing aircraft operators under the control of at least 50 potential state regulators, all with potentially different views of what is necessary to ensure safe operation."

Finally, the DOJ stated in its brief that "[t]he FAA does not seek to interfere with Tennessee's ability to regulate the provision of emergency medical services to protect patient safety." As examples, the brief refers to Tennessee regulations requiring, among other medical equipment, litters and patient assessment devices onboard air ambulance helicopters. These regulations are not deemed objectionable by the federal government. However, the brief cautions that any such regulations "must be limited to the actual provision of medical services, rather than be directed toward or affect aviation safety."

The court sided with Air Evac and the DOJ. In a decision issued December 6, 2007, it held that, in regulating aircraft safety and equipment, "Congress occupies the field of air safety regulation and, thus, preempts the [State's] rules..."[15] The court cited a number of prior decisions outside the ambulance setting for the proposition that federal law establishes standards of care in the field of aviation safety and thus preempts the field from state regulation (e.g., *Green vs. B.F. Goodrich Avionics*, 409 F.3d 784, 795 [6th Cir. 2005]). The court rejected the notion that state regulations are permissible if they merely duplicate or supplement federal enactments but do not conflict with them. The court held that preemption occurs even if the regulations in question do not expressly conflict with state requirements.

North Carolina Court Decision

Another recent development occurred on September 26, 2008, when a federal district court in North Carolina issued an important ruling in a closely watched preemption case, *Med-Trans Corporation vs. Dempsey Benton, Secretary of the North Carolina Department of Health and Human Services, et al.i.*[17] The case involved a challenge by Med-Trans to several provisions of North Carolina's air ambulance licensing and regulatory regimen. In a thoughtful and carefully reasoned 32-page opinion, the court agreed with Med-Trans that North Carolina's CON requirement and several other provisions of the North Carolina air ambulance licensing law are preempted by the ADA or, in some cases, the aviation safety provisions of the Federal Aviation Act. However, the court found that a number of other provisions in the North Carolina law are not preempted because they primarily regulate medical care.

The decision represents the most comprehensive and definitive ruling to date addressing the important distinction between state and local laws which encroach upon federally preempted issues such as aviation safety and air carrier rates, routes and services on the one hand, and non-preempted laws governing medical care on the other.

Med-Trans filed the lawsuit on June 18, 2007, after being denied a CON by the North Carolina Department of Health and Human Services (NCDHHS). Under North Carolina's CON law, Med-Trans is authorized to pick up patients in North Carolina for transport to facilities in South Carolina, and to transport patients in South Carolina to North Carolina, but is prohibited from performing purely in-state transports from point to point within North Carolina. Med-Trans challenged the CON requirement on the grounds that it violated the ADA. Med-Trans also challenged a variety of other North Carolina provisions based on the express preemption provision of the ADA, implied preemption or both theories.

The court decided the case by ruling on a motion for judgment on the pleadings filed by Med-Trans, without the benefit of discovery. The threshold issue decided by the court was whether North Carolina's CON law and the other provisions challenged under the ADA were preempted as to purely intrastate operations. The State of North Carolina argued that the ADA has no preemptive effect because it applies only to interstate air commerce, while the North

Carolina laws in question apply solely to intrastate transports between points in North Carolina.

The court sided with Med-Trans on this issue. It held that because Med-Trans engages in interstate transport for some of its patients, the ADA and its preemptive effect extend to all of its operations, including those that are strictly intrastate. The court also relied on the fact that Med-Trans holds a Part 135 Certificate from the FAA, authorizing it to operate in the 48 contiguous United States and the District of Columbia.

After determining that the ADA applied to Med-Trans' intrastate operations, the court found that the CON law was preempted. It observed that "the purposes underlying [the] CON law," which included replacing market forces with regulatory determinations as to when new providers would be permitted to operate, "directly contravene the procompetitive purposes underlying the ADA."

The court then analyzed numerous other provisions in the North Carolina law challenged by Med-Trans. The following summarizes the court's conclusions and analysis regarding each.

Requirement for Approval by Local Officials to Offer Services. Med-Trans challenged certain North Carolina statutes and regulations that, separate and apart from the CON requirement, collectively require it to obtain the approval of local officials prior to offering intrastate services. These included provisions requiring: a valid EMS provider license to be issued at the State's discretion, affiliation with an EMS system, a franchise where required by local law, and an EMS peer review committee, which must include "county government officials." Med-Trans alleged that these provisions provide local officials with unfettered discretion to block a provider's entry into the marketplace.

The court found that this claim presents "a closer question, as it bears on the territory of medical oversight." However, because the regulations in question "do not limit the discretion of these county officials to simply refuse to provide their approval or participation, thereby preventing Med-Trans from entering the market in North Carolina," the court found them preempted.

Requirement that a Provider Define its Service Area and Routes. Med-Trans challenged a provision requiring that an applicant seeking approval to provide specialty care transports within North Carolina must have "a defined service area." The court found that this provision was preempted because it related to a provider's routes. The court saved from preemption, however, a requirement for a provider to have a written plan for transporting patients to appropriate facilities when diversion or bypass plans are in effect, since this related primarily to a patient care issue.

Requirement that Providers have Service Availability 24 Hours per Day. The court also agreed with Med-Trans that a North Carolina provision requiring a specialty care transport program to make "service continuously available on a 24-hour per day basis" was preempted. The court reasoned that "[t]he regulation forces plaintiff to provide services it may not wish to provide," thereby violating the ADA.

Requirements Related to Equipment. Med-Trans challenged several regulations that it contended impermissibly governed aviation safety, many of which addressed equipment requirements. It challenged these regulations based on implied preemption rather than the ADA. Recognizing the unique issues raised by a preemption challenge in the air medical context, the court stated:

> *The court agrees that FAA preemption in the area of aviation safety is absolute. State regulations that require air carriers to provide specific aviation safety-related equipment and to participate in safety-related training are therefore preempted. The inquiry does not end there, however; aviation safety and emergency medicine share some overlapping goals, and the two fields are not entirely distinct. Although the FAA has preemptive control of aviation safety measures, regulations regarding EMS-related equipment would not intrude on its domain.*

The court then clarified that "only those regulations governing equipment or training directly related to aviation safety are preempted." Accordingly, it found that preemption does not apply to a requirement for two-way radios for the purpose of assuring communication capability with various public safety entities in order to facilitate patient care. On the other hand, a requirement for VHF aircraft frequency transceivers, which relates primarily to aviation safety, is preempted.

Other equipment-related regulations that the court found not to be preempted include:

- Rules specifying medically related equipment, sanitation, supply and design requirements for air ambulances;
- A requirement that the State inspect air ambulances for compliance with medically related regulations;
- A requirement that air ambulances be equipped with voice communication systems for communication between the flight crew and medical crew, because these rules are necessary for proper patient care;
- A requirement for carriers to document a plan for inspecting, repairing and cleaning medical and other patient care related equipment; and
- A requirement for air ambulance providers to synchronize their voice radio communications with local EMS resources.

Requirements Regulating the Staffing and Crew Member Training. Med-Trans also challenged regulations requiring that each air ambulance be staffed by one medical responder responsible for the operation of the vehicle and for rendering assistance to the emergency medical technician and that crew members to be trained in in-flight emergencies specific to the aircraft used for the program and in aircraft safety. The court found that to the extent the first of these provisions "purports to require a helicopter pilot to provide backup medical care for EMS personnel," preemption would occur. However, it found that the "[t]he essential requirement of the rule, that an ambulance be staffed by at least two persons, remains undisturbed." It found the latter provision preempted because it focused on aviation safety training. However, the court carefully qualified this finding as follows: Because the mode of

transport can impact patient care, this should not be read to invalidate any vehicle or equipment-related training undertaken specifically for the purposes of insuring proper patient care. For example, training regarding cabin pressurization of the specific aircraft as it relates to specific medical conditions would not be precluded.

In finding that provisions "that relate primarily to patient care are not preempted," the court sought to ensure that "the state's interest in overseeing the medical aspects of air ambulance service is…not unduly compromised."

DOT and Texas Attorney General Opinions on Membership Programs. The most recent development came in the form of opinions from the DOT and the Attorney General of Texas finding that the ADA preempts a Texas regulation[18] governing membership programs, provided certain conditions are met. Those conditions include, but are not limited to, requirements that the provider obtain written authorization from the highest elected official of the political subdivision where memberships will be sold, submit all contracts and advertisements to be used in the program to the Texas DSHS, and obtain a surety bond.

After questions were raised by providers regarding the validity of the Texas regulation and its underlying statues, the DSHS asked the Texas Attorney General for a formal opinion on the issue. The Attorney General in turn sought an opinion from DOT, In a letter from DOT General Counsel D.J. Gribbin to the Hon. Greg Abbott, Texas attorney general, dated November 3, 2008, the DOT found that the Texas regulation "grants state officials broad discretion in regulating air carrier' economic arrangements with customers, and thus, we believe [the ADA] preempts the vast majority of, if not the entire, regulation."

Follwing receipt of the DOT's opinion, Abbott issued his own opinion in a letter to David L. Lakey, MD, commissioner for the Texas DHSH, dated November 20, 2008. He similarly found that "because [the regulation] relates to charges for the air ambulance services, the [ADA] preempts it as to air carriers providing interstate air ambulance services." The Attorney General further opined that the ADA would preempt any state regulation of a membership program "as applied to a ground ambulance operated as an integral part of an air ambulance service." This latter opinion would preclude membership regulation of ground ambulance providers operated as an integral part of an air ambulance service at either end of the air transport.

Implications of the Recent Developments

The DOT's opinion letters and the federal court decisions in the Tennessee and North Carolina cases confirm prior precedent and the long standing views of many industry observers that states are limited in their ability to regulate aviation safety and certain other aspects of air ambulance operation. However, they also make it clear that state and local officials retain the ability to regulate medical and patient care issues. The North Carolina decision in particular provides useful guidance as to how regulators should draw the line between preempted and non-preempted issues. The court's analysis in that case indicates that federal preemption can be applied in a manner which protects legitimate competition in the air ambulance market place, while preserving the ability of state and local officials to regulate the delivery of medical care by air medical providers.

To summarize, the recent DOT opinions and court decisions indicate that the following types of laws are preempted:

- CON laws and similar exclusionary provisions;
- Laws requiring approval by state or local officials with out limitation on their discretion to approve or disap prove providers;
- Provisions limiting providers' service areas, routes or bases of operation;
- Requirements for hours of operation;
- Laws governing equipment or training that are directly related to aviation safety;
- Provisions requiring aviation personnel to perform certain functions;
- Requirements for insurance or bonding that overlap with FAA requirements for injury, death or property damage coverage;
- Inspection requirements that focus on aviation safety or equipment;
- Limitations on membership programs, such as requirements for approval by local officials; and
- Other requirements affecting rates, routes, or services.

In contrast, the DOT and courts have found that laws primarily aimed at assuring appropriate medical care are not preempted. These include, but are not limited to, laws governing medical equipment and its maintenance, prescribing training and other requirements for medical personnel, requiring communications systems with ground medical personnel establishing destination requirements based on medical criteria, mandating professional liability insurance, and permitting state and local inspection for compliance with medically oriented regulations.

To many, these new precedents illustrate that current preemption law reflects a careful and appropriate balance between the procompetitive goals of the ADA and the legitimate need of state and local officials to regulate medical care. Hopefully, these authorities will be helpful to the air medical industry and to Congress in deciding whether new legislation is needed to address this issue.

References

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2. 1987 Ariz. Op. Atty. Gen. 261, Op. Atty. Gen. i87-164 (December 28, 1987).
3. *Rocky Mountain Holdings v. Ronald W. Cates, Director, Mo. Dept. of Health,* No. 97-4165-CV-C-9 (W.D. Mo. Central Div. 1997).
4. 49 U.S.C. § 40101 et seq.
5. 49 U.S.C. § 41713.
6. *See id.* at § 41713(b).
7. U.S. Constitution, Article VI, Cl. 2.
8. *Morales v. Trans World Airlines, Inc.,* 504 US 374 (1992).
9. Memorandum from Donald Jansky, Assistant General Counsel of Texas DSHS, to Air Medical Committee of GTAC dated Nov. 17, 2006.
10. Letter dated Feb. 20, 2007 from James R. Dann, Deputy Assistant General Counsel of Department of Transportation to Donald Jansky, Office of General Counsel of Texas Department of State Health Services.

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11. *Eagle Air Med Corporation; and Scenic Aviation, Inc., v. Colorado Board Of Health,* Civil Action No. 08-cv-00532-LTB-KLM (United States District Court,D. Colorado). On July 31, 2008, the court issued a procedural ruling holding that it would decline to consider the merits of the preemption claim until a concurrent investigation by the State of Colorado that been completed. In doing so, the court opined that it was not "facially conclusive" that preemption applied, but made it clear that the issue remained open for later determination. (2008 WL 3271975 (D.Colo.).
12. Letter dated May 23, 2007, from James R. Dann, a Deputy Assistant General Counsel of Department of Transportation to Donald Jansky, Office of General Counsel of Texas Department of State Health Services.
13. Letter dated October 10, 2007, from D.J. Gribbin, General Counsel, Department of Transportation, to Michael Grief, Assistant General Counsel, Florida Department of Health.
14. Tennessee Comp. R. & Regs. 1200-12-1-.05(2)(c).
15. *Air Evac EMS v. Kenneth S. Robinson, Commissioner of Health,* Case No. 3:06-0239, U.S. District Court, M. D. of Tenn.
16. Statement of Interest of United States of America filed Nov. 29, 2006, *Air Evac EMS v. Kenneth S. Robinson, Commissioner of Health,* Case No. 3:06-0239, U.S. District Court, M. D. of Tenn.
17. Case No. 5:07-CV-222-FL (Dist N.C. Sept 26, 2006).
18. Texas Administrative Code, Title 25, Section 157.11(1); see also Texas Health and Safety Code Section 773.041(a), which authorizes the regulation.

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