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Appendix A

IN THE SUPREME COURT OF TEXAS

No. 18-0216

TEXAS MUTUAL INSURANCE COMPANY, HARTFORD UNDERWRITERS INSURANCE COMPANY, TASB RISK MANAGEMENT FUND, TRANSPORTATION INSURANCE COMPANY, TRUCK INSURANCE EXCHANGE, TWIN CITY FIRE INSURANCE COMPANY, VALLEY FORGE INSURANCE COMPANY, et al.,

Petitioners,

v.

PHI AIR MEDICAL, LLC,

Respondent.

Argued: Feb. 25, 2020
Decided: June 26, 2020

OPINION

JUSTICE BUSBY delivered the opinion of the Court, in which JUSTICE GUZMAN, JUSTICE LEHRMANN, JUSTICE BOYD, JUSTICE DEVINE, and JUSTICE BLACKLOCK joined.

JUSTICE BLAND filed a concurring opinion, in which JUSTICE LEHRMANN, JUSTICE BOYD, and JUSTICE BLACKLOCK joined.

JUSTICE GREEN filed a dissenting opinion, in which CHIEF JUSTICE HECHT joined.

This is a case about federalism. When joining our Union, each State retained fundamental aspects of its sovereignty. This sovereignty includes the police power to provide a compensation system for injured workers. Although the Federal Government can preempt a State's exercise of sovereignty by enacting an inconsistent federal law on a subject within its constitutionally enumerated powers, it has no power to order that State to regulate the subject in a particular way. The questions presented here include (1) whether Texas's exercise of its police power to require that private insurance companies reimburse the fair and reasonable medical expenses of injured workers is preempted by a federal law deregulating aviation; and, if so, (2) whether that federal law requires Texas to mandate reimbursement of more than a fair and reasonable amount for air ambulance services.

We answer both questions no. As to the first, because Texas's general reimbursement standards do not refer expressly to air ambulance providers like respondent PHI, they are preempted by the federal Airline Deregulation Act (ADA) only if they have a "forbidden significant effect upon fares." *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 388 (1992). The record does not show that the price of PHI's service to injured workers is significantly affected by a reasonableness standard for third-party reimbursement of those services, so the ADA does not preempt that standard.

Regarding the second question, the relief PHI seeks through preemption is an order requiring the insurance company petitioners to reimburse its billed charges fully under Texas law. This request misunderstands the nature and scope of federal preemption of state law.

Courts agree that the ADA does not require States to provide for payment of air ambulance charges. Instead, PHI is trying to use the ADA's preemption clause to have it both ways under state law: PHI relies on Texas law requiring that private insurers reimburse it for air ambulance services to injured workers, yet it argues that the Texas standards governing the amount of that reimbursement are preempted. The Supreme Court of the United States unequivocally rejected this stratagem in *Dan's City Used Cars, Inc. v. Pelkey*, observing that any preemption under a similarly worded federal law would displace the entire state-law regime. 569 U.S. 251, 265 (2013). Thus, PHI would be substantially worse off if it succeeded on its preemption claim, as insurers would no longer have any obligation to reimburse it at all.

Moreover, PHI's attempt to use federal preemption to compel full reimbursement under state law runs headlong into the Tenth Amendment to our Federal Constitution. As the federal anticommandeering doctrine recognizes, Congress lacks the power to change state law. Litigants cannot invoke preemption to avoid this constraint, which is fundamental to the structure of our government.

For these reasons, we hold that the ADA does not preempt Texas's general standard of fair and

reasonable reimbursement as applied to air ambulance services, nor does it require that Texas compel private insurers to reimburse the full charges billed for those services. We therefore reverse the judgment of the court of appeals and reinstate the trial court's judgment declaring that Texas law is not preempted.

I

PHI Air Medical, LLC is one of the country's leading providers of emergency air ambulance services, and it has significant operations in Texas. PHI is licensed to operate as an air carrier by the Federal Aviation Administration and as an air taxi by the United States Department of Transportation. PHI is thus subject to federal oversight, including laws and regulations that address safety and unfair or anti-competitive practices. *See, e.g.*, 49 U.S.C. § 41712(a); 14 C.F.R. pt. 135. But PHI need not obtain a certificate of public convenience and necessity or comply with the associated federal economic regulations. *See* 14 C.F.R. § 298.3(a)-(b) (2005).

Upon the request of first responders or medical professionals, PHI provides its services without regard to a patient's insurance status or ability to pay. *See* 25 Tex. Admin. Code § 157.36(b)(9)-(10), (14). In recent years, PHI alleges its costs have risen; simultaneously, it says, payors in the industry—often insurers—have increasingly sought to avoid paying PHI's billed charges in full. These factors and others,[1] PHI claims, have pressed PHI to raise prices to

[1] PHI cites heavy discounts required for Medicare and Medicaid patients.

sustain itself. The amount that air ambulance providers may recover from workers' compensation insurers forms the basis of this dispute.

A

In 1913, the Texas Legislature enacted the Texas Workers' Compensation Act (TWCA) to respond "to the needs of workers, who, despite escalating industrial accidents, were increasingly being denied recovery." *SeaBright Ins. v. Lopez*, 465 S.W.3d 637, 642 (Tex. 2015) (quoting *Kroger Co. v. Keng*, 23 S.W.3d 347, 349 (Tex. 2000)). In enacting the TWCA, the Legislature balanced two competing interests: providing compensation for injured employees and protecting employers from the costs of litigation. *Id.* The Legislature struck a balance between these interests by permitting workers to "recover from subscribing employers without regard to the workers' own negligence" while "limiting the employers' exposure to uncertain, possibly high damages awards permitted under the common law." *Id.* The TWCA thus "allows employees to receive 'a lower, but more certain, recovery than would have been possible under the common law.'" *Id.* (quoting *Kroger Co.*, 23 S.W.3d at 350). The Legislature revamped the TWCA in 1989 and created the Texas Workers' Compensation Commission—now the Division of Workers' Compensation at the Texas Department of Insurance—to implement and enforce its provisions. *Tex. Workers' Comp. Comm'n v. Patient Advocates of Tex.*, 136 S.W.3d 643, 646-47 (Tex. 2004) (citing Tex. Lab. Code § 402.061).

Under the TWCA, employers may purchase insurance from private companies to cover workers

who are injured on the job. When PHI transports an injured worker covered by such insurance, Title 5 of the Texas Labor Code and its associated regulations apply. *See* Lab. Code §§ 401.007-419.007. A health care provider that treats injured workers, like PHI, has a direct statutory claim for reimbursement from a workers' compensation insurer, *id.* § 408.027(a), and the provider may contract with the insurer to determine the amount of reimbursement. *Id.* § 413.011(d-4). Absent a contract, the reimbursement amount is governed by fee guidelines promulgated by the Division. *Id.* §§ 413.011, .012. These guidelines establish maximum reimbursement amounts for providers. *Id.* § 408.028; 28 Admin. Code § 134.1(a).

When the Division has not adopted an applicable guideline, the insurer must reimburse the provider for its services up to a "fair and reasonable" amount. Lab. Code § 413.011(d);[2] 28 Admin. Code § 134.1(a), (e)-(f).[3]

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[2] Section 413.011(d) provides:

> Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

[3] An insurer is not required to reimburse the provider more than the prescribed "maximum allowable rate," defined as "the maximum amount payable to a health care provider [without] a contractual fee arrangement that is consistent with" Labor Code section 413.011 and Division rules. 28 Admin. Code § 134.1(a). If payment is determined under the fair and reasonable standard,

If the insurer does not reimburse the full amount of the provider's billed charges, the provider generally may not "balance bill" its customer—the covered worker—directly for the unpaid portion. *See* Lab. Code § 413.042. A provider dissatisfied with the amount an insurer pays may seek review by the Division. *Id.* § 413.031(a). In turn, a party who disagrees with the Division's ruling is entitled to a contested case hearing conducted by the State Office of Administrative Hearings and, ultimately, to judicial review. *Id.* § 413.031(k), (k-1).

B

Until 2012, when this dispute arose, insurers had been reimbursing PHI for its services at 125% of the Medicare rate for air ambulance services, citing the Division's fee guideline for providers other than hospitals and pharmacies. *See* 28 Admin. Code § 134.203(d)(1). But in 2012, PHI and other air ambulance providers began filing fee disputes with the Division, seeking to recover the full amount of their billed charges. This particular suit represents a fraction of the air ambulance fee disputes pending agency review: it concerns thirty-three transports that PHI provided between 2010 and 2013 to patients covered by workers' compensation insurance. No contract between PHI and the insurers of those thirty-three patients (petitioners here) sets a predetermined reimbursement amount.[4]

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that rate is deemed the maximum allowable rate. *See id.* § 134.203(d)(3), (f).

[4] PHI has one contract for an agreed-upon price for intrastate transports with the University of Texas Medical Branch at Galveston. According to PHI, this contract covers less than 1% of

Before the Division, PHI argued that the federal ADA preempted the TWCA's fee schedules and reimbursement standards. According to PHI, the effect of ADA preemption was to require that the insurers pay its billed charges in full. The Division agreed. But an administrative law judge (ALJ) disagreed following a contested case hearing, holding that the ADA did not preempt the TWCA and its reimbursement scheme. The ALJ relied on the McCarran-Ferguson Act, a federal statute that saves or "reverse-preempts" state laws regulating the business of insurance. *See* 15 U.S.C. §§ 1011-15. Having held that the McCarran-Ferguson Act rendered ADA preemption inoperative, the ALJ concluded that PHI was entitled to reimbursement under the TWCA's standards.

Concerning the amount of reimbursement required, PHI argued that it should receive the full amount of its billed charges and that the amount previously paid by the insurers—125% of the Medicare air ambulance rate—would reflect a loss on each transport. The insurers argued that 125% of the Medicare rate was appropriate under rule 134.203, the Division's fee guideline for providers other than hospitals and pharmacies. *See* 28 Admin. Code § 134.203.[5] Alternatively, the insurers argued that

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PHI's annual transports, and the Branch is not a party to this dispute.

[5] The insurers contended that subsection (d)(1) of this rule established 125% of the Medicare rate as the maximum allowable reimbursement for air ambulances because a Medicare fee schedule exists for air ambulances.

125% of the Medicare rate was a fair and reasonable fee for PHI's services.

The ALJ agreed with PHI that the Division's fee guidelines do not set reimbursement rates for air ambulances at 125% of Medicare.[6] As the parties had no contractual rate, the ALJ held that a fair and reasonable rate—which he determined to be 149% of the Medicare rate for air ambulances—must be paid. 28 Admin. Code §§ 134.1(e)(3), .203(d)(3), (f); *see also* Lab. Code § 413.011(d).

After the ALJ rendered a final decision, PHI and the insurers sought judicial review. Each requested a declaratory judgment regarding preemption. The insurers also challenged the conclusion that 149% of

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[6] Though the parties disputed rule 134.203's applicability to air ambulance providers, the ALJ did not decide whether that rule applied because the fair and reasonable standard would determine reimbursement either way. Assuming arguendo that rule 134.203 did apply, the ALJ concluded that contrary to the insurers' assertions, subsection (d)(1) would not set reimbursement at 125% of the Medicare rate for air ambulance services. Subsection (d)(1) provides that the maximum allowable reimbursement rate for certain services shall be 125% of the fee prescribed in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies fee schedule. 28 Admin. Code § 134.203(d)(1). Because air ambulance fees are not addressed in that fee schedule, the ALJ concluded subsection (d)(1) would not apply to PHI. As subsection (d)(2) likewise would not apply because there is no Texas Medicaid fee schedule for air ambulance services, reimbursement would be decided according to the fair and reasonable reimbursement standard per subsection (d)(3). The same result would be true if rule 134.203 did not apply at all: rule 134.1 provides that reimbursement "in the absence of an applicable fee guideline or a negotiated contract" shall be determined by "a fair and reasonable reimbursement amount." 28 Admin. Code § 134.1(e)(3).

the Medicare reimbursement rate was fair and reasonable for these transports. The Division intervened, siding with the insurers in opposing preemption. All parties moved for summary judgment.

Following a hearing, the trial court denied PHI's motion for summary judgment and granted summary judgment for the Division and the insurers. The court declared that the ADA does not preempt the TWCA's reimbursement provisions and that the insurers did not owe more than 125% of the Medicare amount. PHI appealed and the court of appeals reversed, holding that the TWCA's reimbursement provisions are preempted by the ADA and are not saved by the McCarran-Ferguson Act. 549 S.W.3d 804, 809, 816 (Tex. App.—Austin 2018). The Division and the insurers sought our review, and we granted their petitions.

II

A

In this Court, the parties again dispute whether the ADA preempts the TWCA's reimbursement provisions and, if so, whether the McCarran-Ferguson Act reverse-preempts those provisions because they regulate the business of insurance. Because we conclude that the ADA does not preempt the TWCA's reimbursement scheme, we do not decide whether the McCarran-Ferguson Act applies.

Whether the ADA preempts the TWCA's reimbursement guidelines is a question of law we review de novo. *See Thompson v. Tex. Dep't of Licensing & Regulation*, 455 S.W.3d 569, 571 (Tex. 2014) (per curiam); *Baker v. Farmers Elec. Co-op.*, 34 F.3d 274, 278 (5th Cir. 1994) ("Preemption is a

question of law reviewed *de novo*."). "When both sides move for summary judgment and the trial court grants one motion and denies the other, the reviewing court should review both sides' summary judgment evidence and determine all questions presented." *FM Props. Operating Co. v. City of Austin*, 22 S.W.3d 868, 872 (Tex. 2000). The reviewing court should render the judgment that the trial court should have rendered. *Id.*

B

"Federal preemption of state law follows from the Framers' core commitment to dual sovereignty, which is a defining feature of our Nation's constitutional blueprint." *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 760 (4th Cir. 2018) (cleaned up). "The Constitution limited but did not abolish the sovereign powers" the States claimed in declaring their independence, leaving them "a residuary and inviolable sovereignty." *Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1475 (2018) (quoting The Federalist No. 39, at 245 (Clinton Rossiter ed., 1961)). Our constitutional structure "indirectly restricts the States by granting certain legislative powers to Congress" and including a Supremacy Clause—a "rule of decision" instructing "that when federal and state law conflict, federal law prevails and state law is preempted." *Id.* at 1476, 1479.

When acting within its enumerated powers, "Congress's choices range from complete reliance on state policy to complete preemption of state law, with many iterations of 'cooperative federalism' between these extremes." *Air Evac*, 910 F.3d at 761. Yet congressional power is limited, and "all other

legislative power is reserved for the States, as the Tenth Amendment confirms." *Murphy*, 138 S. Ct. at 1476. "[C]onspicuously absent from the list of powers given to Congress is the power to issue direct orders to the governments of the States." *Id.*

The States' retained police powers include the power to provide a compensation system for injured workers, as Texas has done. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981).[7] In many States, a government entity acts as the employers' insurer, paying benefits to injured workers and reimbursing certain expenses they have incurred. In Texas, however, employers contract with private insurance carriers to perform these functions, and state laws and regulations define the insurers' obligations to reimburse health care providers for their services to covered workers. *See* Lab. Code § 406.051. Each insurance policy incorporates these laws and regulations, obligating the insurer to pay the benefits they require.

The following Texas laws and regulations are particularly relevant to our analysis of PHI's preemption challenge. Under the TWCA, as explained above, a health care provider like PHI has a direct claim for reimbursement from an insurer. *Id.* § 408.027(a). Because the ALJ determined the Division has no fee guideline for air ambulance services, the insurers are required to reimburse PHI

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[7] *See also N.Y. Cent. R.R. v. White*, 243 U.S. 188, 206 (1917); *Lykes Bros. S.S. Co. v. Esteves*, 89 F.2d 528, 530 (5th Cir. 1937) ("[T]he state in the exercise of its police power may impose absolute liability upon the employer [for worker injuries] regardless of the existence of actionable negligence.").

for its services up to a "fair and reasonable" amount. *See id.* § 413.011(d); 28 Admin. Code §§ 134.1(a), (e)-(f), .203(d)(3), (f). The insurers reimbursed PHI less than the full amount of its billed charges, and the parties dispute whether the amount the insurers reimbursed is fair and reasonable. Given the TWCA's prohibition against "balance billing," PHI has not billed its customers—the covered workers—for the remainder. *See* Lab. Code § 413.042.

According to PHI, the federal act deregulating the airline industry (the ADA) expressly preempts Texas's laws and regulations requiring insurers to reimburse it a fair and reasonable amount for air ambulance services; therefore, it is entitled to an order compelling the insurers to reimburse its billed charges fully under state law. The court of appeals erred in agreeing with PHI for two reasons. As Part III shows, the federal ADA does not preempt the Texas fair and reasonable standard for reimbursement. Yet even if the ADA had that preemptive effect, it does not—and, as a constitutional matter, could not—provide PHI the remedy it seeks, as we explain in Part IV.

III

A

"In 1978, Congress enacted the ADA, which deregulated the airline industry in order to encourage market competition, lower prices, advance innovation and efficiency, and increase the variety and quality of air transportation services." *Sabre Travel Int'l, Ltd. v. Deutsche Lufthansa AG*, 567 S.W.3d 725, 737 (Tex. 2019). "To ensure that the States would not undo federal deregulation with regulation of their own," Congress included an express preemption clause.

Morales, 504 U.S. at 378. The clause provides that "a State . . . may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier." 49 U.S.C. § 41713(b)(1).

The insurers do not challenge the power of Congress to preempt state law on this subject. Rather, the first disputed question is whether this clause preempts the particular Texas laws and regulations PHI challenges here. To answer that question correctly, it is important to be clear about what PHI is challenging and what it is not.

In this Court, PHI only briefs a challenge to Texas's general "fair and reasonable" standard, which defines how much of PHI's charges to its customers the insurers are obligated to reimburse. PHI is not presently challenging Texas's prohibition on PHI balance billing its customer directly.[8] In other words, PHI would rather be paid by the insurers than by its customers. This choice is understandable, as insurers are likely more able to pay and balance billing has become a subject of national concern. *See Air Evac*, 910

[8] In the trial court, PHI sought a declaration in the alternative that the balance-billing prohibition is preempted. The trial court granted summary judgment against PHI on preemption. On appeal, PHI ultimately told the court of appeals it was challenging the balance-billing prohibition only in the alternative. The court of appeals did not reach that challenge, holding instead that the reimbursement standard is preempted. *See* 549 S.W.3d at 816 ("We limit our decision to the rules and statutes related to reimbursement rates and explicitly do not address the balance-billing provision, as PHI has explained that it only attacks that provision in the alternative and that it would prefer to leave the balance-billing prohibition intact.").

F.3d at 757. But the choice does have consequences for our preemption analysis, as we explain below.

The preemption inquiry before us is whether the state laws and regulations setting a general fair and reasonable reimbursement standard for third-party insurers are "related to a price . . . of an air carrier." 49 U.S.C. § 41713(b)(1). The ordinary meaning of "related to" is broad, reaching state provisions that have "a connection with or reference to" air carrier prices even if they are not "specifically addressed to the airline industry" or their "effect is only indirect." *Morales*, 504 U.S. at 384, 386, 388. But the reach of this statutory language is not unlimited, and "some state actions may affect airline fares in too tenuous, remote, or peripheral a manner" to be preempted. *Id.* at 390 (cleaned up). For example, the ADA did not deregulate reimbursement for air-related medical care generally,[9] and PHI does not argue that the ADA preempts the maximum fees States have set for reimbursement of air ambulance services rendered to customers covered by the federal Medicaid program.[10]

To help courts determine whether a particular state action falls on the preempted or non-preempted side of this relatedness line, the U.S. Supreme Court has developed the following test: state provisions that "express[ly] reference" air carrier prices and establish "binding requirements" are preempted. *Id.* at 388. But the ADA preempts state provisions of general

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[9] The ADA did not displace preexisting federal Medicare and Medicaid regulations that set air ambulance reimbursement rates and prohibit balance billing. *See Keefe ex rel. Keefe v. Shalala*, 71 F.3d 1060, 1062-63 (2d Cir. 1995).

[10] *See, e.g.*, 1 Admin. Code §§ 355.101(c), .8600(c)(1).

applicability only if they "have the forbidden significant effect upon fares." *Id.*

The Supreme Court has reiterated this test and extended it to another similarly worded federal preemption statute. *Rowe v. N.H. Motor Transp. Ass'n*, 552 U.S. 364, 370-71, 375 (2008).[11] And the Fifth Circuit and federal courts nationwide have applied the Supreme Court's test consistently, including in cases like this one involving state rules for reimbursement of air ambulance services. *Hodges v. Delta Airlines, Inc.*, 44 F.3d 334, 336 (5th Cir. 1995) (en banc) ("Laws of general applicability, even those consistent with federal law, are preempted if they have the 'forbidden significant effect' on rates . . . ."); *see also, e.g.*, *Air Evac*, 910 F.3d at 767; *Bailey v. Rocky Mountain Holdings, LLC*, 889 F.3d 1259, 1271 (11th Cir. 2018); *EagleMed LLC v. Cox*, 868 F.3d 893, 902 (10th Cir. 2017) ("[T]he court only needs to decide whether a particular state law or claim has a 'forbidden significant economic effect on airline rates . . .' when the state law at issue does not 'expressly refer to airline rates . . .' itself."); *Buck v. Am. Airlines, Inc.*, 476 F.3d 29, 34-35 (1st Cir. 2007); *Travel All Over the*

[11] Our dissenting colleagues suggest that *Rowe* broadens the ADA preemption test to displace any state provisions that relate to an air carrier's price by "indirectly limit[ing] the amount that [it] may charge for its services." *Post* at ___ (Green, J., dissenting). But *Rowe* reaffirms that the ADA does not preempt general state regulation unless it has "a '*significant* impact' on carrier rates, routes, or services." 552 U.S. at 375 (quoting *Morales*, 504 U.S. at 388).

World, Inc. v. Saudi Arabia, 73 F.3d 1423, 1433 (7th Cir. 1996).[12]

Here, Texas's fair and reasonable standard for reimbursement is generally applicable: it does not reference air carrier prices. We therefore apply the Supreme Court's settled preemption test, asking whether that standard has the forbidden significant effect on PHI's prices. *Morales*, 504 U.S. at 388.

B

On this record, we conclude PHI has not shown that the fair and reasonable standard for third-party reimbursement has a significant effect on its prices for carrying injured customers by air. If we were analyzing the prohibition on PHI billing its customers (unchallenged here), it would be logical to expect that prohibition to have a significant effect on PHI's prices. But it is not at all clear that adopting a reasonableness standard for reimbursement by third parties, standing alone, has a significant effect on the price of PHI's services to its customers. We recently explained in *Sabre Travel* that "[i]ncreasing an airline's cost does not automatically lead to a corresponding increase in airline ticket prices." 567 S.W.3d at 738. The same is true of limiting an air carrier's reimbursement: PHI must come forward with evidence proving that those limits have a significant effect on price to obtain a summary judgment of preemption.

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[12] The parties dispute whether the presumption against preemption also comes into play in this express preemption case. We need not reach that dispute because we conclude that the text of the ADA's express preemption clause as construed by the U.S. Supreme Court does not preempt Texas's general fair and reasonable standard for reimbursement.

PHI disagrees, arguing that "price" as used in the ADA's preemption clause includes the amount a third party may reimburse it for its services. That blanket rule not only disregards PHI's burden on summary judgment, it distorts the meaning of "price" and would expand the scope of ADA preemption dramatically, leading to absurd results.

In 1994, the Legislature defined "price" in the ADA to mean "a rate, fare, or charge." 49 U.S.C. § 40102(a)(39). As dictionary definitions show, these terms concern *how much* one charges or pays for a good or service.[13] To the extent the terms are concerned with *who* charges or pays a price, the parties to the exchange are determined by the transactional relationship.[14] Here, the parties to the transaction are PHI and the injured customer it transports by air ambulance.

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[13] *E.g.*, *Fare*, MERRIAM-WEBSTER, https://www merriam-webster.com/dictionary/fare (last visited June 22, 2020) ("[T]he price charged to transport a person."); *Price*, BLACK'S LAW DICTIONARY (11th ed. 2019) ("The amount of money or other consideration asked for or given in exchange for something else; the cost at which something is bought or sold."); *Rate*, BLACK'S LAW DICTIONARY (11th ed. 2019) ("An amount paid or charged for a good or service."); *see also Rate*, MERRIAM-WEBSTER, https://www merriam-webster.com/dictionary/rate (last visited June 22, 2020) ("[A] charge, payment, or price fixed according to a ratio, scale, or standard . . . ."); *Price*, OXFORD DICTIONARY OF ENGLISH (2017) ("[T]he amount of money expected, required, or given in payment for something.").

[14] *E.g.*, *Fare*, MERRIAM-WEBSTER, https://www.merriam-webster.com/dictionary/fare (last visited June 22, 2020) ("[T]he price charged to transport a person."); *Price*, AMERICAN HERITAGE DICTIONARY (5th ed. 2020) ("The amount of money or goods, asked for or given in exchange for something else.").

PHI has no transactional relationship with a third-party insurer, which simply receives PHI's bill for services already rendered to an injured customer covered by the policy and determines how much it will reimburse PHI on that customer's behalf. Again, evidence might show that the reimbursement rate has a significant effect on the price of the air ambulance service, but the reimbursement rate is not itself part of the price PHI charges to transport customers, as PHI contends.

The following example illustrates the results that would follow from PHI's blanket rule. The State Bar of Texas—an administrative agency that is part of our judicial branch[15]—has a policy that it will reimburse speakers at its continuing legal education courses for "airline travel at coach rates," but "such expenses [must] be reasonable according to the usual cost of products or services for which reimbursement is requested as determined by similar reimbursement requests of other participants, by practices applicable to other public agencies and institutions of the State of Texas, by other readily available reference information, and by State Bar staff experience," as well as "location[] and other circumstances."[16] Thousands of state agencies nationwide likely have similar reasonableness standards for reimbursement of airfares. Because this standard dictates the amount

[15] Tex. Gov't Code § 81.011(a).

[16] STATE BAR OF TEXAS, BOARD OF DIRECTORS POLICY MANUAL § 7.03.08(A), (B), (C)(4) (Jan. 2020).

the State Bar will reimburse for air carrier services, it would be preempted under PHI's approach.[17]

As the Supreme Court's test instructs, we should focus instead on the record of this case to determine whether Texas's fair and reasonable reimbursement standard for workers' compensation insurers has a significant effect on air ambulance prices. PHI does take note of the record, observing that the fair and reasonable reimbursement amounts determined by the trial court and some administrative actors were less than the full amount it billed. This observation misses the mark for both legal and factual reasons.

Legally, the full amount billed for air ambulance services is not the starting point for measuring significant effect. As two federal circuits have explained, the ADA does not guarantee "any payment of air-ambulance claims whatsoever," *EagleMed*, 868 F.3d at 906, much less payment of "whatever an air carrier may demand." *Air Evac*, 910 F.3d at 769. Moreover, the billed amount generally is not the product of a transactional relationship, as PHI's injured customer has not agreed to pay it. *See Ferrell v. Air EVAC EMS, Inc.*, 900 F.3d 602, 608-10 (8th Cir. 2018) (discussing injured customer's argument that he did not assent to price before his transport). Absent an agreement on price, the law implies a fair or

[17] Although the reimbursement goes to the airline customer in the State Bar example rather than directly to the air carrier as here, the economic effect is the same: each standard limits the amount available from a third party to pay for the carrier's services. We also note that, as explained in Part IV, PHI's view of preemption would prevent the State Bar from having any reimbursement policy at all for airline travel.

reasonable price: exactly the same standard Texas has adopted for determining reimbursement. *See id.* at 608-10 (explaining that result of air ambulance provider's suit against customer who did not agree to pay billed amount would be to recover fair or reasonable value of services provided); *Bendalin v. Delgado*, 406 S.W.2d 897, 900 (Tex. 1966) (discussing rule that when parties fail to specify price, courts presume "that a reasonable price was intended").

Nor do the facts bear out PHI's position that it would recover significantly less for its services under the fair and reasonable reimbursement standard. The Division concluded that the full amount billed by PHI was fair and reasonable. The ALJ disagreed. Finding that the average amount paid to PHI for services in Texas during the relevant period was 149% of the reimbursement amount under federal Medicare regulations, the ALJ held this figure was a fair and reasonable amount for workers' compensation insurers to reimburse PHI for its services to covered employees. The trial court reduced this figure to 125% of Medicare, which was the price that PHI agreed to charge the one customer with which it had a contract. The court of appeals did not reach this issue.

Thus, under the fair and reasonable standard, it is possible that the amount of PHI's reimbursement for carrying covered workers could be either (1) the full amount PHI billed, (2) the average price PHI is paid for air ambulance services, or (3) a price PHI bargained for in the market. These possibilities show that the fair and reasonable standard does not have a significant effect on PHI's prices. Under *Morales*,

therefore, the ADA does not preempt that state reimbursement standard.

C

PHI offers little authority to support its position that a State's general reasonableness standard for workers' compensation reimbursements has a significant effect on air ambulance prices and thus is preempted by the ADA. Although some federal circuits have found preemption of workers' compensation rules regarding air ambulance services in other States, those cases are different in three key respects: (1) the state rules at issue expressly referenced air ambulance prices, triggering a different part of the *Morales* preemption test; (2) the rules established a maximum fee cap and thus significantly affected air ambulance prices; or (3) the air ambulance service challenged a prohibition on billing its customer directly. The reasoning employed by those courts supports a holding of no preemption here.

For example, PHI relies heavily on the Tenth Circuit's decision in *EagleMed v. Cox*. There, the Wyoming Workers' Compensation Division set a rate schedule under which it reimbursed a maximum amount of "$3,900.66 plus $27.47 per statute mile" for air ambulance services. 868 F.3d at 898. EagleMed challenged this schedule as well as a statutory prohibition on directly "billing the injured employee for the expenses incurred." *Id.* at 900. The court held the ADA preempted these provisions because they "expressly establish a mandatory fixed maximum rate that will be paid by the State for air-ambulance services," and thus there was no need to apply the *Morales* significant-effect standard. *Id.* at 902.

The challenge to direct billing was critical to the court's analysis. It reserved judgment on whether preemption would apply if Wyoming gave air ambulance companies an option to seek reimbursement at scheduled rates or to pursue a claim against its customer directly. *Id.* at 901. And it concluded that if the Wyoming statute were read "to prevent air-ambulance companies from seeking [payment] from the workers themselves," it "would be illegally regulating air-ambulance rates by preventing any recovery from air-ambulance passengers, and the proper remedy would seem to be the preemption of this statute." *Id.* at 906 n.3.

This analysis exposes a critical flaw in PHI's preemption argument. If any part of the Texas workers' compensation reimbursement scheme significantly affects air ambulance prices, it is the prohibition on PHI billing its customer for the price of his or her flight, not reasonableness standards for third-party reimbursement.[18] PHI cannot obtain preemption of the latter by strategically declining to challenge the former in this Court. There are larger principles of federalism at stake here. Whether the Supremacy Clause displaces state law regulating a subject within its reserved powers should be decided by considering the state statutory and regulatory scheme as a whole, not just the particular provision that an individual litigant prefers to challenge.

The Fourth Circuit reached a similar conclusion in *Air Evac EMS, Inc. v. Cheatham* regarding West

[18] In addition, Texas's fact-driven standard of fair and reasonable reimbursement differs from the fixed maximum fee cap at issue in *Eagle Med*, as we discuss further below.

Virginia's reimbursement scheme. The state adopted a fee schedule of reimbursement rates for air ambulance services, backed up by statutes providing that those rates "are the maximum allowable recovery" and customers "cannot be billed directly." 910 F.3d at 758. The court concluded that these provisions were related to air ambulance prices and thus preempted because they "directly reference air ambulance payments," establish "maximum amounts that the state will pay directly to air-ambulance providers, and limit the ability of those providers to seek recovery from anyone else." *Id.* at 767 (citations omitted).

As in *EagleMed*, however, the *Air Evac* court did not address "whether the fee schedule could be maintained without either the reimbursement caps [fixing a maximum allowable recovery] or [the customer] balance-billing provisions." *Id.* at 769 n.3. That is the situation presented here, as Texas does not have fixed maximum reimbursement limits and PHI is not challenging the balance-billing prohibition. Indeed, the Texas system is even less likely to impact price, as it uses a reasonableness standard—not a fee schedule—to determine reimbursement for air ambulance services.

Finally, the Eleventh Circuit's decision in *Bailey v. Rocky Mountain Holdings* is instructive because it identifies Florida's "balance billing provision" as the "feature" of the state scheme that "has a significant effect on air carrier prices." 889 F.3d at 1270. There, the court upheld an ADA preemption challenge to part of Florida's no-fault auto insurance law regarding air ambulance services. That law allowed the insured to

choose one of two methods for determining reimbursement: (1) the insurer would reimburse 80% of reasonable expenses for medically necessary services, and the provider could bill the insured for the remainder of the reasonable fee; or (2) the insurer would reimburse 80% of the fee listed in the Medicare fee schedule, and the provider generally could not balance bill the insured. *Id.* at 1262-63. The insured's policy elected that reimbursement would be paid according to the second method, and the insurer accordingly reimbursed the air ambulance provider an amount less than its reasonable charges. *Id.* at 1263.

The court held this second method had the "forbidden significant effect" on air carrier prices because "the balance billing provision . . . reduces as a matter of law the contract price of [air carrier] services to [insured] patients," limiting the provider to a scheduled maximum fee that was less than a reasonable fee. *Id.* at 1270-71. Texas's fact-driven standard—which requires insurers to pay 100% of fair and reasonable charges—has no such effect, and PHI is not challenging the balance-billing prohibition.

In sum, these cases show that PHI's challenge is misdirected. Each case supports our conclusion that the ADA does not preempt the Texas laws and regulations requiring third-party insurers to reimburse PHI a fair and reasonable amount for services rendered to covered workers.

IV

If the ADA did preempt these reimbursement provisions, PHI contends it is entitled to an order requiring the insurers to reimburse its billed charges fully under state law. The court of appeals appeared

to agree with PHI, concluding that "the specific rate-setting provisions at issue" could be severed from the overall Texas reimbursement scheme. 549 S.W.3d at 812 n.10.

We disagree with the court of appeals for two reasons. First, if ADA preemption applies, neither state nor federal law provides for full reimbursement of air carrier bills—or for any reimbursement at all. Second, the effect of federal preemption cannot be that States must provide full reimbursement, as that outcome would violate the Tenth Amendment. For these reasons, the result of ADA preemption here would not be full reimbursement—it would be no reimbursement.

A

How much of Texas reimbursement law would ADA preemption displace? Under PHI's preemption analysis, the ADA would override all state reimbursement law as applied to air ambulance services. PHI maintains that the amount the insurer will pay for air ambulance services relates to the price of an air carrier, and therefore a reimbursement scheme dictating that amount is preempted. But if a state standard requiring reasonable third-party reimbursement is "related to" air carrier prices, 49 U.S.C. § 41713(b)(1), so is a standard requiring any other amount of reimbursement—including full reimbursement.

A full-reimbursement standard could not be spared preemption on the theory that it is consistent with the federal scheme. "Nothing in the language of § [41713(b)(1)] suggests that its 'relating to' pre-emption is limited to *inconsistent* state regulation."

Morales, 504 U.S. at 386-87. Rather, the ADA's "pre-emption provision . . . displaces all state laws that fall within its sphere, even including state laws that are consistent with [the ADA's] substantive requirements." *Id.* at 387; *see also Rowe*, 552 U.S. at 370 ("[I]n respect to pre-emption [under such a provision], it makes no difference whether a state law is 'consistent' or 'inconsistent' with federal regulation."); *Hodges*, 44 F.3d at 336. Given the comprehensive scope of ADA preemption, the court of appeals was incorrect to indicate that portions of the Texas reimbursement scheme could be saved by severance.

Put differently, PHI cannot have it both ways: it cannot rely on state law requiring reimbursement of air carriers while arguing that a particular state standard for measuring that reimbursement is preempted. The U.S. Supreme Court rejected that very argument in *Dan's City Used Cars*. 569 U.S. at 265. There, a towing company relied on New Hampshire law in disposing of a car for nonpayment of towing and storage fees. *Id.* at 255. The car's owner alleged the company did not comply with the law's requirements for disposal and application of proceeds, and he sued for compensation. *Id.* at 258-59. The company contended that a preemption clause similar to the ADA's blocked the owner's claims because they "related to" the "service of a[] motor carrier . . . with respect to the transportation of property." *Id.* at 264-66 (citing 49 U.S.C. § 14501(c)(1)).

The Supreme Court disagreed, explaining that "if such state-law claims are preempted, no law would govern resolution of a [disposal dispute] or afford a

remedy for wrongful disposal," as "[f]ederal law does not speak to these issues." *Id.* at 265. The company's preemption position would eliminate not only the owner's remedy but also "the sole legal authorization for a towing company's disposal [of vehicles] that go unclaimed. No such design can be attributed to a rational Congress." *Id.* "In sum," the Court said, the company "cannot have it both ways. It cannot rely on [the state] regulatory framework as authorization for [disposal] of [the owner's] car, yet argue that [the owner's] claims, invoking the same state-law regime, are preempted." *Id.*

Similarly here, if the ADA preempts a state reimbursement scheme dictating the amount an insurer will reimburse, it also preempts the scheme's requirement that insurers provide reimbursement.[19] Nor can PHI rely on federal law to compel reimbursement, as courts agree that "[f]ederal law establishes no duty for states to pay"—or require insurers to pay—"the air-ambulance claims of injured workers who are covered by state workers' compensation statutes." *EagleMed*, 868 F.3d at 906 (noting federal law lacks requirement "to make any payment . . . whatsoever, much less payment at whatever rates [air ambulance carriers] choose to charge"); *accord Air Evac*, 910 F.3d at 769. In particular, the Tenth Circuit held in *EagleMed* that the district court erred in "placing an affirmative duty

[19] The workers' compensation insurance policies do not independently require reimbursement, as they rely on the state statutory and regulatory requirements PHI claims are preempted to define the insurers' contractual reimbursement obligations.

on state officials to reimburse in full all air-ambulance claims" because "any such possible duty would exist as a creation only of state, not federal, law." 868 F.3d at 906. There is simply no authority for the notion that Congress, in deregulating the airline industry, was regulating the terms of state workers' compensation insurance policies.

In addition, like the company's contention in *Dan's City*, PHI's preemption position would irrationally leave the parties without any governing law or available remedy. As decisions of this Court and the U.S. Supreme Court recognize, federal airline regulators and federal courts are neither authorized nor equipped to take the place of state regulators and courts in handling issues regarding private insurers' reimbursement of air ambulances for their services to covered workers. "When Congress dismantled [the federal airline regulatory] regime, . . . [it] indicated no intention to establish, simultaneously, a new administrative process for DOT adjudication of private contract disputes." *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 232 (1995). "Nor is it plausible that Congress meant to channel into federal courts the business of resolving, pursuant to judicially fashioned federal common law, the range of contract claims relating to airline rates, routes, or services." *Id.*

In sum, the parties "lack . . . any vehicle for resolving" disputes over reimbursement "other than state court lawsuits" decided under state law. *Cont'l Airlines, Inc. v. Kiefer*, 920 S.W.2d 274, 280 (Tex. 1996). If that law is preempted, then there is no requirement for reimbursement at all. The court of appeals' suggestion that limits on reimbursement are

severable—allowing PHI to obtain reimbursement of its full billed charges—cannot be reconciled with the scope of ADA preemption as defined by the Supreme Court.

As the insurers point out, requiring full reimbursement could have serious consequences for the Texas workers' compensation system. According to the insurers, almost $50 million in Texas air ambulance charges were already in dispute by January 2019, and PHI's operating profit margin on its full billed charges ranges from 185% to 282%. In Wyoming, which has held that only limits on reimbursement are preempted,[20] the legislature is considering either expanding Medicaid in order to control such charges or making injured workers responsible for the balance of their bills.[21] The ADA was passed to deregulate the airline industry, not to upend the bargain struck in adopting a workers' compensation scheme. As we have explained, there is no reason to interpret the ADA to have that effect.

B

Finally, PHI cannot be correct that the effect of ADA preemption is to compel full reimbursement under state law, as that is not a permissible result of preemption in our federal system. If the Federal Government does not like state regulation of a subject that also falls within Congress's enumerated powers, the Supremacy Clause allows it to override that

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[20] *See Air Methods/Rocky Mtn. Holdings, LLC v. State ex rel. Dep't of Workforce Servs.*, 432 P.2d 476, 485-87 (Wyo. 2018).

[21] *See* Office of Injured Employee Counsel's *Amicus Curiae* Brief in Support of Petitioners at 17-18.

regulation with duly enacted laws of its own. *See* U.S. CONST. art. VI, para. 2. But nowhere in the Constitution did the States give the Federal Government the power to order them to change their own laws, as the Tenth Amendment confirms. *See* U.S. CONST. amend. X ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.").

"The anticommandeering doctrine . . . represents the recognition of this limit on congressional authority." *Murphy*, 138 S. Ct. at 1476. The doctrine acknowledges that the "Constitution . . . confers upon Congress the power to regulate individuals, not States." *New York v. United States*, 505 U.S. 144, 166 (1992). "Where a federal interest is sufficiently strong to cause Congress to legislate, it must do so directly . . . ." *Id.* at 178. "Congress may not simply commandeer the legislative processes of the States by directly compelling them to enact and enforce a federal regulatory program." *Id.* at 161 (cleaned up). Thus, "even where Congress has the authority under the Constitution to pass laws requiring or prohibiting certain acts, it lacks the power directly to compel the States to require or prohibit those acts." *Id.*

As the anticommandeering doctrine shows, courts deciding preemption challenges may not rewrite preempted state law so that it conforms to federal law. Here, state law requires reasonable reimbursement, and the federal ADA contains no reimbursement requirement. Contrary to PHI's contention, the result of ADA preemption cannot be to grant it full reimbursement under state law. That result would

amount to an illegal end run around the constitutional anticommandeering doctrine. Thus, even if PHI's preemption position were otherwise correct, it cannot constitutionally obtain the relief it seeks.

V

For these reasons, we hold PHI has not shown that Texas's fair and reasonable reimbursement standard for air ambulance services has a significant effect on its prices, and therefore the ADA does not preempt that standard. And even if ADA preemption applied, it would displace the very reimbursement requirement on which PHI relies. We therefore reverse the court of appeals' judgment, reinstate the portion of the trial court's summary judgment declaring no preemption, and remand for the court of appeals to address other issues it did not reach. *See* Tex. R. App. P. 60.2(c), (d).

J. Brett Busby
Justice

OPINION DELIVERED: June 26, 2020

JUSTICE BLAND, joined by JUSTICE LEHRMANN, JUSTICE BOYD, and JUSTICE BLACKLOCK, concurring.

The Texas Workers' Compensation Act "directly regulate[s] the 'business of insurance' by prescribing the terms of the insurance contract" and the parties' performance of those terms.[1] The Act obligates insurance carriers to directly remit payments to policy claimants according to state-prescribed insurance policies. This dispute centers on the Act's mandated claim process for one such policy claimant—an air-ambulance service.

The McCarran-Ferguson Act is a federal law that insulates state insurance laws from federal preemption. Because the Texas Legislature enacted the Workers' Compensation Act "for the purpose of regulating the business of insurance,"[2] McCarran-Ferguson saves the challenged provisions from federal preemption. The court of appeals concluded otherwise. Accordingly, I concur in reversing its judgment.

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[1] *See U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 502-03 (1993); *see also Fredericksburg Care Co. v. Perez*, 461 S.W.3d 513, 522 (Tex. 2015) ("Examples of practices that fall within the scope of [the business of insurance] include . . . . the writing of insurance contracts and the actual performance of those contracts.").

[2] 15 U.S.C. § 1012(b). *See* Tex. Lab. Code § 402.021(a)(3) (providing that one of "the basic goals of the workers' compensation system" is that "each injured employee shall have access to prompt, high-quality medical care within the framework established by this subtitle"), (b)(8) (stating that system participants "include insurance carriers" and "health care providers," which must abide by its laws and regulations).

I

McCarran-Ferguson saves from preemption any state law enacted "for the purpose of regulating the business of insurance":

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.[3]

Congress enacted McCarran-Ferguson to address the concern that federal preemption had made "inroads . . . on the tradition of state regulation of insurance."[4] It "was an attempt . . . to assure that the

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[3] 15 U.S.C. § 1012(b). McCarran-Ferguson is divided into two clauses—the second clause deals with antitrust matters and is relevant here only to the extent that it informs our reading of the first clause. *See Fredericksburg*, 461 S.W.3d at 518.

[4] *SEC v. Nat'l Sec., Inc.*, 393 U.S. 453, 458 (1969). McCarran-Ferguson was enacted after the Supreme Court's decision in *United States v. South-Eastern Underwriters Ass'n*, in which the Court held that Congress had power under the Commerce Clause to regulate insurance transactions stretching across state lines.

activities of insurance companies in dealing with their policyholders would remain subject to state regulation."[5] As the Supreme Court has recognized, "Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance."[6] Thus, McCarran-Ferguson is a "reverse-preemption" statute.[7]

McCarran-Ferguson precludes preemptive application of a federal statute if "(1) the federal statute does not specifically relate to the 'business of insurance,' (2) the state law was enacted for the 'purpose of regulating the business of insurance,' and (3) the federal statute operates to 'invalidate, impair, or supersede' the state law."[8] Only the second element is in dispute in this case. Thus, we examine whether

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322 U.S. 533, 552-53 (1944). "Prior to that decision, it had been assumed that '[i]ssuing a policy of insurance [was] not a transaction of commerce,' subject to federal regulation." *Fabe*, 508 U.S. at 499 (first alteration in original) (citation omitted). Before *South-Eastern Underwriters*, "the States enjoyed a virtually exclusive domain over the insurance industry." *Id.* (quoting *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 539 (1978)).

[5] *Nat'l Sec., Inc.*, 393 U.S. at 459; *see Fabe*, 508 U.S. at 500 ("Congress moved quickly to restore the supremacy of the States in the realm of insurance regulation.").

[6] *Nat'l Sec., Inc.*, 393 U.S. at 458 (quoting *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429 (1946)); *see Fabe*, 508 U.S. at 505 ("[T]he first clause of § 2(b) was intended to further Congress' primary objective of granting the States broad regulatory authority over the business of insurance.").

[7] *Ante* at __; *see Safety Nat'l Cas. Corp. v. Certain Underwriters at Lloyd's, London*, 543 F.3d 744, 748 (5th Cir. 2008).

[8] *Fredericksburg*, 461 S.W.3d at 518-19 (quoting *Munich Am. Reinsurance Co. v. Crawford*, 141 F.3d 585, 590 (5th Cir. 1998)).

the Texas Legislature enacted the Texas Workers' Compensation Act "for the purpose of regulating the business of insurance," such that McCarran-Ferguson protects its insurance-reimbursement provisions from federal encroachment.

II

A

"[D]etermining a state's purpose in enacting a law is fundamental to . . . [McCarran-Ferguson's] inquiry."[9] Under our "well-established rules for discerning a statute's purpose, . . . '[w]e determine legislative intent from the entire act and not just isolated portions.'"[10] Thus, we consider the Texas Workers' Compensation Act as a whole, together with the position and role of the challenged provisions found within it.[11]

In *SEC v. National Securities, Inc.*, the Supreme Court recognized that state laws that govern "the type

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[9] *Id.* at 520.

[10] *Id.* (alteration in original) (quoting *20801, Inc. v. Parker*, 249 S.W.3d 392, 396 (Tex. 2008)).

[11] *See* Tex. Lab. Code § 413.011 (reimbursement guidelines and protocols); 28 Tex. Admin. Code §§ 134.1 (medical reimbursement), .203 (medical fee guideline for professional services); *Fredericksburg*, 461 S.W.3d at 525 ("Because the test to determine whether laws are enacted for the purpose of regulating the business of insurance is broad, it is possible that a law, in its entirety, would fail to qualify for [McCarran-Ferguson's] exemption from preemption, but a specific statutory provision could qualify by 'possess[ing] the end, intention, or aim of adjusting, managing, or controlling the business of insurance.'" (second alteration in original) (quoting *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 505 (1993))).

of policy" together with "its reliability, interpretation, and enforcement" constitute "core" insurance activities:

> Congress was concerned with the type of state regulation that centers around the contract of insurance. . . . The relationship between insurer and insured, the type of policy which c[an] be issued, its reliability, interpretation, and enforcement—these [are] the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they to[o] must be placed in the same class.[12]

Thus, "[s]tatutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'"[13]

United States Department of Treasury v. Fabe is the key case that examines McCarran-Ferguson's first clause, which is "intended to further Congress' primary objective of granting the States broad regulatory authority over the business of insurance."[14] In *Fabe*, the Court considered whether an Ohio claim-priority statute governing bankrupt insurers' obligations was enacted "for the purpose of regulating the business of insurance."[15] The Court held that it

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[12] 393 U.S. 453, 460 (1969).

[13] *Id.*

[14] 508 U.S. at 505.

[15] *Id.* at 493, 504 ("[W]e must decide whether a state statute establishing the priority of creditors' claims in a proceeding to liquidate an insolvent insurance company is a law enacted 'for the purpose of regulating the business of insurance,' within the meaning of § 2(b) of the McCarran-Ferguson Act."). The Supreme

was: the statute "escape[d] pre-emption" because it was "'aimed at protecting or regulating' the performance of an insurance contract."[16] The Court emphasized that Congress, in enacting McCarran-Ferguson, made clear its "mission" to protect "continued regulation" by the states.[17] It observed that, even though "the Ohio statute does not directly regulate the 'business of insurance' by prescribing the terms of the insurance contract or by setting the rate charged by the insurance company," the "business of insurance" is not "confined entirely to the writing of insurance contracts, as opposed to their performance."[18] Accordingly, the Court concluded that "[t]here can be no doubt that the actual performance of an insurance contract falls within the 'business of insurance.'"[19] McCarran-Ferguson thus shields state laws that prescribe either the terms or the performance of insurance contracts.

The petitioners here—the Texas Division of Workers' Compensation and participating workers' compensation insurers—have a stronger case than the Ohio respondents in *Fabe*.

B

The Texas Workers' Compensation Act is a comprehensive regulatory structure for insurance carriers, employers, employees, health care providers,

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Court had only once before "had occasion to construe this phrase," in *National Securities*. *Id.* at 501.

[16] *Id.* at 493, 505 (quoting *Nat'l Sec., Inc.*, 393 U.S. at 460).

[17] *Id.* at 500 (quoting 15 U.S.C. § 1011).

[18] *Id.* at 502-03.

[19] *Id.* at 503.

and others who claim benefits under a workers' compensation policy.[20] "Insurance company" is a defined term. Under the Act, it "means a person authorized and admitted by the Texas Department of Insurance to do insurance business in this state under a certificate of authority that includes authorization to write workers' compensation insurance."[21] As we have recognized, "[i]n creating the Texas Workers' Compensation Act, the Legislature carefully balanced competing interests—of employees subject to the risk of injury, employers, and insurance carriers—in an attempt to design a viable compensation system, all within constitutional limitations."[22] Workers'

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[20] Under the Act, an "insurance carrier" is "an insurance company." Tex. Lab. Code § 401.011(27).

[21] *Id.* § 401.011(28).

[22] *In re Poly-Am., L.P.*, 262 S.W.3d 337, 352 (Tex. 2008) (orig. proceeding); *see also Tex. Mut. Ins. Co. v. Ruttiger*, 381 S.W.3d 430, 448 (Tex. 2012) ("The 1989 reforms were intended to reduce the costs to employers and provide greater benefits to injured employees in a more timely fashion. Achieving those goals required, among other changes, reducing the disparity of bargaining power between the employee and insurer . . . ."). We further explained in *In re Poly-America*:

> The Texas Legislature enacted the original Workers' Compensation Act in 1913 in response to the needs of workers who, despite a growing incidence of industrial accidents, were increasingly being denied recovery. In order to ensure compensation for injured employees while protecting employers from the costs of litigation, the Legislature provided a mechanism by which workers could recover from subscribing employers without regard to the workers' own negligence, while limiting the employers' exposure to uncertain, possibly high damage awards permitted under the common law.

compensation policies in Texas are, inherently, insurance; they are issued by private carriers, and those carriers in turn provide state-mandated coverage. Thus, "[t]he contract between a compensation carrier and an employee creates the same type of special relationship that arises under other insurance contracts"[23] And "[r]ecovery of workers' compensation benefits is the exclusive remedy of an employee covered by workers' compensation insurance coverage."[24]

The Legislature has authorized the Texas Department of Insurance to oversee the workers' compensation system.[25] "Among the[] requirements [of the Texas Workers' Compensation Act] is the legislative directive that only workers' compensation policies approved by the Texas Department of Insurance are available in Texas."[26] A mainstay of the

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262 S.W.3d at 350 (citations omitted).

[23] *Aranda v. Ins. Co. of N. Am.*, 748 S.W.2d 210, 212 (Tex. 1988), *overruled on other grounds by Ruttiger*, 381 S.W.3d at 433.

[24] Tex. Lab. Code § 408.001.

[25] *Id.* § 402.001(a). "The division of workers' compensation is established as a division within the Texas Department of Insurance to administer and operate the workers' compensation system of this state as provided by this title." *Id.* § 402.001(b).

[26] *Fairfield Ins. Co. v. Stephens Martin Paving, LP*, 246 S.W.3d 653, 658 (Tex. 2008). These state-approved policies are contracts between private insurance companies and employers; the employees of subscribing employers are the beneficiaries, and health care providers claim direct benefits under the policy. *See* Tex. Lab. Code §§ 406.003, .051, 408.001. Though optional, the Act incentivizes employers to obtain coverage. *Id.* §§ 406.004 (requiring employers who do not obtain coverage to notify the Division), .007 (requiring notice of termination of coverage), .033 (forbidding an employer from using certain defenses in an action

Act is that insurance carriers are "liable for compensation for an employee's injury without regard to fault or negligence," including state-prescribed medical benefits for covered employees who are injured on the job.[27] The Division regularly reviews insurers' records "to ensure compliance" with the Workers' Compensation Act and the commissioner's rules.[28] As part of this state-mandated system of insurance, insurance carriers and health care providers claiming reimbursement are heavily regulated.[29] By dictating the benefits that these

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brought by an employee not covered by workers' compensation insurance). Similarly, though employees may opt out of coverage, it is disfavored. *See Port Elevator-Brownsville, L.L.C. v. Casados*, 358 S.W.3d 238, 241 (Tex. 2012); Tex. Lab. Code § 406.034(b).

[27] Tex. Lab. Code § 406.031(a).

[28] *Id.* § 414.004(a); *see also id.* § 414.002(a)(3) ("The division shall monitor for compliance with commissioner rules, this subtitle, and other laws relating to workers' compensation and the conduct of persons subject to this subtitle. Persons to be monitored include . . . insurance carriers.").

[29] *See, e.g.*, *id.* §§ 402.021(b)(8) ("It is the intent of the legislature that . . . the workers' compensation system of this state must . . . effectively educate and clearly inform each person who participates in the system as a claimant, employer, insurance carrier, health care provider, or other participant of the person's rights and responsibilities under the system and how to appropriately interact within the system."), 408.021(d) ("An insurance carrier's liability for medical benefits may not be limited or terminated by agreement or settlement."), 408.024 ("[T]he commissioner may relieve an insurance carrier of liability for health care that is furnished by a health care provider or another person selected in a manner inconsistent with the requirements of this subchapter."), 415.002-.003 (enumerating administrative violations by an "insurance carrier" and a "health care provider").

insurance policies must afford, the Legislature regulates insurance policy terms. Participating insurance companies thus "contract to secure an employer's liability and obligations and to pay compensation by issuing a workers' compensation insurance policy."[30] The "contract for coverage must be written on a policy and endorsements approved by the Texas Department of Insurance."[31] Accordingly, "[t]he terms of worker's compensation insurance policies include provisions of the worker's compensation statutes."[32]

Like the Workers' Compensation Act as a whole, the specific provisions challenged in this case regulate the business of insurance. These payment provisions require an insurance carrier to remit an amount determined by the Division under the coverage afforded.[33] An insurance carrier must remit this payment directly to a claimant like PHI Air Medical, LLC, the air-ambulance service provider in this case.[34]

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[30] *Id.* § 406.051(a).

[31] *Id.* § 406.051(b); *see also* Tex. Ins. Code § 2052.002(a) ("The commissioner shall prescribe standard policy forms and a uniform policy for workers' compensation insurance.").

[32] *Transcon. Ins. Co. v. Crump*, 330 S.W.3d 211, 233 (Tex. 2010) (Johnson, J., concurring). State law may itself form a term of the insurance policy, incorporated by reference. *Am. Bankers Ins. Co. of Fla. v. Inman*, 436 F.3d 490, 494 (5th Cir. 2006).

[33] *See* Tex. Lab. Code § 413.011; 28 Tex. Admin. Code §§ 134.1(a), (e)-(f), .203.

[34] Tex. Lab. Code §§ 408.027(a) ("A health care provider shall submit a claim for payment to the insurance carrier . . . ."), 413.042 ("A health care provider may not pursue a private claim against a workers' compensation claimant for all or part of the cost of a health care service provided to the claimant by the

As PHI Air concedes, the Workers' Compensation Act "governs payment for claims for health care providers—such as PHI—who provide services to workers' compensation patients." PHI Air has no contract with any workers' compensation insurance carrier. Rather, under the Act, PHI Air submits invoices to insurance carriers directly as *claims on insurance policies*. To facilitate uniform payments, the Division has adopted reimbursement rates. If no guideline exists for a particular service, the insurance carrier must reimburse the provider the Division's determination of a "fair and reasonable amount," consistent with section 413.011 of the Texas Labor Code.[35] Read separately and together, these

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provider unless: (1) the injury is finally adjudicated not compensable . . . ; or (2) the employee violates Section 408.22 relating to the selection of a doctor . . . .").

[35] *See ante* at __. Section 413.011 directs the commissioner to "adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems." Tex. Lab. Code § 413.011(a). It provides that the "[f]ee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control." *Id.* § 413.011(d). The rules specify that "'[m]aximum allowable reimbursement' . . . is defined as the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with § 413.011 of the Labor Code, and Division rules." 28 Tex. Admin. Code § 134.1(a). Further, "fair and reasonable reimbursement" must:

> (1) be consistent with the criteria of Labor Code § 413.011;
>
> (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and

provisions prescribe the benefits an insurance carrier must afford to a health-care-provider claimant, like PHI Air, which invokes the policy as a third-party beneficiary of the insurance contract.[36]

The Workers' Compensation Act thus is the foundation for every workers' compensation insurance policy issued in Texas.[37] Laws that "directly regulate

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> (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Id. § 134.1(f).

[36] *Ante* at __ ("Each insurance policy incorporates these laws and regulations, obligating the insurer to pay the benefits they require."); *see also* TEX. DEP'T OF INS., TEXAS WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY MANUAL, WORKERS' COMPENSATION & EMPLOYERS LIABILITY INSURANCE POLICY: WC 00 00 00 B (2d reprt. 2011), https://www.tdi.texas.gov/wc/regulation/documents/endform.pdf. The standard policy form states: "We will pay promptly when due the benefits required of you by the workers[']compensation law." *Id.* at Sec. B. It further provides: "This insurance conforms to the parts of the workers[']compensation law that apply to . . . benefits payable by this insurance." *Id.* at Sec. H.

[37] *See* Tex. Lab. Code § 406.051(b) ("The contract for coverage must be written on a policy and endorsements approved by the Texas Department of Insurance."); *Fairfield Ins. Co. v. Stephens Martin Paving, LP*, 246 S.W.3d 653, 658 (Tex. 2008) ("[I]f the employer purchases workers' compensation insurance, the employer must adhere to the statutory and regulatory guidelines of the Workers' Compensation Act. Among these requirements is the legislative directive that only workers' compensation policies approved by the Texas Department of Insurance are available in Texas."); *see also Wausau Underwriters Ins. Co. v. Wedel*, 557 S.W.3d 554, 557 (Tex. 2018) (noting that the Department of Insurance has "promulgated and mandated [endorsements] for use in Texas workers'-compensation policies" and opining that

the 'business of insurance'" include those that "prescrib[e] the terms of the insurance contract."[38] Through its provisions, the Act prescribes payment terms under workers' compensation policies, without reference to any separate contractual agreement. The reimbursement amount, and the formula for determining that amount, is part of every policy; it is the payment responsibility assumed by a private insurance company in the insurance contract. Unlike some other states, the Texas workers' compensation system operates through private insurance companies—there is no Texas workers' compensation without private insurance.[39] The "actual performance of an insurance contract" includes paying benefits under the policy, which is "an essential part of the 'business of insurance.'"[40]

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the waiver at issue accordingly was "not freely negotiated by the parties" and "no ordinary policy").

[38] *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 502-03 (1993).

[39] *Ante* at __ ("In many States, a government entity acts as the employers' insurer, paying benefits to injured workers and reimbursing certain expenses they have incurred. In Texas, however, employers contract with private insurance carriers to perform these functions, and state laws and regulations define the insurers' obligations to reimburse health care providers for their services to covered workers." (citing Tex. Lab. Code § 406.051)); *see also* Tex. Lab. Code §§ 406.002 ("Except for public employers and as otherwise provided by law, an employer may elect to obtain workers' compensation insurance coverage."), .003 ("An employer may obtain workers' compensation insurance coverage through a licensed insurance company or through self-insurance as provided by this subtitle.").

[40] *Fabe*, 508 U.S. at 505.

Because Texas relies on private insurers, it is different from states in which a state fund pays out benefits. In *EagleMed LLC v. Cox*, the Tenth Circuit held that McCarran-Ferguson did not shield Wyoming's workers' compensation laws from preemption.[41] But Wyoming has "an industrial-accident fund—financed by [the non-insurance] industry and underwritten by the state."[42] The Tenth Circuit found this distinguishing feature critical, observing that it was "not persuaded" that the Wyoming statute "regulate[d] the business of insurance simply because *other states* have structured their workers' compensation programs to operate through private insurance companies."[43] The court did not view Wyoming's state fund as one that spread policyholder risk, which the Supreme Court has held is an important feature of a law that regulates the "business of insurance."[44]

In contrast, the Texas Workers' Compensation Act specifies the coverage a private insurer must afford—and the payment of scheduled medical benefits—in exchange for the premium paid by employer-policyholders. The premium the insurance carrier charges participating employers is based on the coverage state law requires it to provide. If the coverage afforded under the policy increases, it follows that the premium charged to policyholders for that

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[41] 868 F.3d 893, 905 (10th Cir. 2017).

[42] *Id.* at 897.

[43] *Id.* at 904 (emphasis added).

[44] *Id.* at 905; *see also Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129-30 (1982); *Grp. Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 213-14 (1979).

coverage will increase too.[45] PHI Air insists that the Workers' Compensation Act does not apply to it and, consequently, demands that it be paid more than the Division's regulations allow. But if insurance carriers must pay PHI Air more than state law requires (i.e., if the coverage under the policy is expanded to require a higher reimbursement amount than the state's mandated rate), then premiums must rise to reflect the change. Raising the premium is the way that the risk of increased claims cost is spread across all policyholders.

III

A

The Supreme Court's decisions in *Group Life & Health v. Royal Drug Co.* and *Union Labor Life Insurance Co. v. Pireno* do not support PHI Air's argument that McCarran-Ferguson does nothing to shield the Texas Workers' Compensation Act from federal encroachment.

In *Royal Drug*, the Supreme Court held that an insurer's third-party contracts with pharmacies were not part of the business of insurance exempt from federal antitrust laws.[46] The Court explained that those third-party agreements were ancillary to the promises made in insurance contracts because "policyholders are basically unconcerned with arrangements made between Blue Shield and

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[45] Thus, the argument in *EagleMed* that no risk is underwritten or spread by Wyoming's laws and regulations is inapplicable. *EagleMed LLC*, 868 F.3d at 905.

[46] *Royal Drug Co.*, 440 U.S. at 210, 232-33.

participating pharmacies."[47] The Court observed that the pharmacy agreements were "legally indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low and thereby also keep low the level of premiums charged to their policyholders."[48]

Royal Drug involved third-party agreements. In this case, however, the challenged payment terms are dictated by state law and the insurance policy itself. No similar state regulatory scheme was at issue in *Royal Drug*—the relationship between the pharmacies and the insurance company was not state-mandated, nor did *Royal Drug* involve claims brought under an insurance policy. Unlike the pharmacies in *Royal Drug*, PHI Air has no ancillary agreement with a private insurer that it seeks to enforce. And here, of course, PHI Air seeks to charge insurance carriers *more* than the amount afforded under state law and their insurance policies.

Further, *Royal Drug* examines McCarran-Ferguson's second clause, which exempts the "business of insurance" from antitrust regulation, not the first clause at issue in this case.[49] The second clause is a "narrow[]" exemption from antitrust laws.[50] In contrast, the first clause covers a "broad category of laws" that are "enacted 'for the purpose of regulating

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[47] *Id.* at 214.

[48] *Id.* at 215.

[49] *Id.* at 210.

[50] *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982).

the business of insurance.'"[51] Recognizing this distinction, the Supreme Court later noted in *Fabe*, a first-clause case, that the first clause of McCarran-Ferguson's section 2(b) is "not so narrowly circumscribed":

> The language of § 2(b) is unambiguous: The first clause commits laws "enacted . . . for the purpose of regulating the business of insurance" to the States, while the second clause exempts only "the business of insurance" itself from the antitrust laws. To equate laws "enacted . . . for the purpose of regulating the business of insurance" with the "business of insurance" itself . . . would be to read words out of the statute.[52]

In *Royal Drug*, the Court explained that "[t]he Pharmacy Agreements are not 'between insurer and insured.' They are separate contractual arrangements between [the insurance carrier] and pharmacies engaged in the sale and distribution of goods and services other than insurance."[53] Here, in contrast, the contractual arrangements between the covered employee, subscribing employer, insurance carrier, and medical provider claiming benefits under the policy are not "separate."

Like *Royal Drug*, the *Pireno* case also concerned section 2(b)'s antitrust clause and its application to third-party agreements not governed by insurance

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[51] *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 505 (1993).

[52] *Id.* at 504 (alterations in original). The Supreme Court "refuse[d]" to "read words out of the statute." *Id.*

[53] *Royal Drug Co.*, 440 U.S. at 216.

policies. In *Pireno*, the Supreme Court considered whether an outside peer-review committee that advised an insurer about charges for chiropractic services was "exempt from antitrust scrutiny as part of the 'business of insurance.'"[54] The Court held that the insurer's agreement with the peer-review service did not implicate the business of insurance because the peer-review process was "a matter of indifference to the policyholder, whose only concern is *whether* his claim is paid, not *why* it is paid."[55] In contrast, the payment provision that the air-ambulance service challenges here is a part of the insurance contract that is regulated by statute. There was no corresponding policy provision or state statute requiring peer review in *Pireno*. Instead, the insurers' private agreements with third parties were at issue.

Later, in *Fabe*, the Supreme Court clarified its holdings in *Pireno* and *Royal Drug*, observing that the cases "held only that 'ancillary activities' that do not affect performance of the insurance contract or enforcement of contractual obligations do not enjoy the antitrust exemption for laws regulating the 'business of insurance.'"[56]

B

Pireno, though not directly applicable to this case, outlined three "non-dispositive"[57] conditions for deciding, in a second-clause case, whether a "practice"

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[54] 458 U.S. at 126.

[55] *Id.* at 132, 134.

[56] *Fabe*, 508 U.S. at 503.

[57] *Fredericksburg Care Co. v. Perez*, 461 S.W.3d 513, 521 (Tex. 2015).

pertains to the "business of insurance."[58] Courts should consider whether:

(1) the practice has the effect of transferring or spreading a policyholder's risk; (2) the practice is an integral part of the policy relationship between the insurer and the insured; and (3) the practice is limited to entities within the insurance industry.[59] Applying these conditions to a state statute (not an insurance "practice"), does not change the result.[60] As the Supreme Court later recognized in *Fabe*, a regulation directed toward the "performance" of an insurance contract satisfies the *Pireno* test.[61] An insurance company's payment to PHI Air is *performance* of a

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[58] *Pireno*, 458 U.S. at 129.

[59] *Fredericksburg*, 461 S.W.3d at 521 (quoting *Munich Am. Reinsurance Co. v. Crawford*, 141 F.3d 585, 590-91 (5th Cir. 1998)); *see also Pireno*, 458 U.S. at 129. In *Fredericksburg*, we held that a law relating to agreements to arbitrate health care liability claims under the Texas Medical Liability Act was not enacted "for the purpose of regulating the business of insurance." 461 S.W.3d at 528. Unlike the Texas Workers' Compensation Act, the law at issue in that case has "no bearing on whether a claim is paid or coverage is denied, nor does it prescribe the terms of insurance contracts or set the rates that insurance companies can charge." *Id.* at 525. In contrast, the Workers' Compensation Act mandates the "type" of policy that must be issued and payments that a carrier is obligated to make under the policy. Establishing an insurance framework is not central to the Medical Liability Act. "Insurance carrier" and "insurance company" are not even defined terms. *See* Tex. Civ. Prac. & Rem. Code § 74.001.

[60] We applied the *Pireno* factors in *Fredericksburg* to assist with our analysis of McCarran-Ferguson's first clause, noting that they were "non-dispositive." 461 S.W.3d at 521.

[61] *Fabe*, 508 U.S. at 503-04.

central policy obligation—the payment of medical benefits under the policy.

The Texas Workers' Compensation Act's reimbursement provisions dictate an insurers' payment obligations for claims brought under the policy, thereby defining the medical losses that the insurer agrees to cover for its employer policyholders. The costs of these covered claims are spread over all policyholders through an insurance premium charged to employer policyholders (whether or not they have asserted a claim). Because the reimbursement provisions that PHI Air challenges define the scope of the coverage afforded for claims made under the policies, those provisions are integral to the policy relationship. And because the reimbursement provisions spread an individual policyholder's risk associated with liability for an individual employee's injury to all who participate in the system, they transfer a policyholder's risk to the pool of policyholders. The insurance carriers cover that risk in the amount dictated by state law.[62]

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[62] In *Genord v. Blue Cross & Blue Shield of Michigan*, the Sixth Circuit held that McCarran-Ferguson did not shield Blue Cross from a federal civil RICO claim. 440 F.3d 802, 803, 809 (6th Cir. 2006). In *Genord*, doctors sued to enforce their third-party billing agreements with Blue Cross, alleging that Blue Cross "systematically denied" payments, as the agreements required. *Id.* at 804. Relying on *Royal Drug*, the Sixth Circuit held that these third-party billing agreements did not have the "aim of regulating a practice that has the effect of transferring or spreading policyholder risk" and thus were ancillary to the policy relationship. *Id.* at 806, 808. The Sixth Circuit instead characterized the provisions as merely regulating "billing-code invoicing arrangement[s] with health care providers." *Id.* at 808. Unlike the doctors in *Genord*, PHI Air does not seek to enforce a

The challenged reimbursement regulations reach insurers, employer policyholders, employees, and those directly claiming statutory benefits under the policy of insurance (medical providers). The regulatory framework governs the various aspects of the intertwined relationships among those parties. The Act thus meets *Pireno*'s "non-dispositive" factors.

IV

Ultimately, the air-ambulance service provider in this case seeks the relatively secure direct payment of *insurance policy benefits* in lieu of attempting to collect from the users of its services in the private marketplace. As PHI Air concedes, it directly billed insurers under their insurance policies and seeks payment under the coverage afforded. By opportunistically relying on the Airline Deregulation Act, PHI Air seeks to benefit from federal preemption without the market forces of deregulation, and from direct payment for its services without the state regulations that constrain all others who seek payments under workers' compensation policies. In other words, PHI Air charges and claims insurance benefits under the Workers' Compensation Act like a health care provider, not like the air-taxi service that purportedly brings it within the Airline Deregulation Act.

It was this intrusion into state insurance regulation by unrelated federal laws that Congress

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third-party agreement, nor does it allege that an insurer has failed to perform under a third-party agreement. To the extent a reimbursement rate is mandated by Texas law as part of the coverage afforded under the policy, it is an integral part of an insurance policy.

stopped. Because the McCarran-Ferguson Act shields the Texas Workers' Compensation Act's insurance provisions from federal preemption, it is appropriate that we reverse and remand. I therefore respectfully concur.

Jane N. Bland
Justice

OPINION DELIVERED: June 26, 2020

JUSTICE GREEN, joined by CHIEF JUSTICE HECHT, dissenting.

This case requires us to determine whether the federal Airline Deregulation Act (ADA) preempts the Texas Workers' Compensation Act's (TWCA) reimbursement scheme as it relates to air-ambulance transport claims. The Court concludes that it does not because PHI Air Medical, LLC (PHI) cannot show that the challenged reimbursement scheme "relate[s] to a price, route, or service of an air carrier." 49 U.S.C. § 41713(b)(1). Because I believe that a reimbursement scheme that regulates the amount an insurer must pay to reimburse an air carrier is such a law, I would conclude that the challenged scheme is preempted by the ADA. Additionally, I would conclude that the McCarran-Ferguson Act (MFA) does not save the reimbursement scheme because neither the TWCA nor its reimbursement scheme was "enacted . . . for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b). Therefore, I respectfully dissent.

I. Airline Deregulation Act

When Congress enacted the ADA, it included a broad preemption provision to prevent states from passing laws that would undo federal deregulation. *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383-84 (1992). That express preemption clause states that the ADA preempts state "law[s] related to a price, route, or service of an air carrier." 49 U.S.C. § 41713(b)(1). Thus, for the ADA to preempt the TWCA's reimbursement scheme, that scheme must

(1) "relate[] to a price, route, or service" (2) "of an air carrier."[1] *Id.*

The United States Supreme Court has frequently acknowledged the breadth of the ADA's "related to" provision and unequivocally stated that it "is much more broadly worded" than comparable preemption provisions. *Nw., Inc. v. Ginsberg*, 572 U.S. 273, 283 (2014); *see Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 229 n.5 (1995); *Morales*, 504 U.S. at 384-85; *see also Rowe v. N.H. Motor Transp. Ass'n*, 552 U.S. 364, 370-71 (2008). The ADA preempts a state law if it "ha[s] a connection with, or reference to [air] carrier '[prices], routes, or services'"; if the state law affects a price, route, or service, even indirectly; or if the state law has a "significant impact" on Congress's deregulatory or preemption-related objectives. *Rowe*, 552 U.S. at 370-71 (emphasis removed) (citations omitted). The ADA's preemption provision is not limited to only those state laws that prescribe a price, route, or service. *Morales*, 504 U.S. at 385 (noting that if the ADA only preempted state laws prescribing a price, then it would have stated it preempts state laws that "regulate" rather than "relate to" a price, route, or service of an air carrier). Rather, it includes those state laws that "encroach upon the area of exclusive federal concern." *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). But the ADA will not preempt a state law if it is related in "'too tenuous, remote, or peripheral a manner' to have pre-emptive

[1] I agree with the Court that PHI qualifies as an air carrier as defined by the ADA.

effect." *Morales*, 504 U.S. at 390 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983)).

The TWCA's reimbursement scheme is related to an air ambulance's prices because it indirectly limits the amount that an air carrier may charge for its services. Under the TWCA, when an air-ambulance transport renders a service that qualifies as a medical benefit under Texas workers' compensation insurance, it must bill that amount to the insurer. Tex. Lab. Code § 408.027(a). And the insurer is responsible for paying that claim. *Id.* § 408.027(b). Further, the payment must be "in accordance with the fee guidelines authorized under" the TWCA and its corresponding regulations. *Id.* § 408.027(f). Consistent with this authorization, the Labor Code and the Division of Workers' Compensation (Division) have standardized the amount an insurance provider must pay for a transport from companies like PHI. Namely, the Labor Code identifies that the reimbursement amount "must be fair and reasonable" in a way that "ensure[s] the quality of medical care" and administers "medical cost control." *Id.* § 413.011(d); *see* 28 Tex. Admin. Code § 134.1(f). All parties agree that such a requirement means an insurer may not pay, either by its own determination or after review by the Division, an amount that exceeds a "fair and reasonable" rate. *See* Tex. Lab. Code § 413.011(d); 28 Tex. Admin. Code § 134.1(f).

Thus, rather than limit what price an air ambulance may charge the insurer, the reimbursement scheme refocuses its limitation on the amount the insurer must pay. In reality, there is no difference. It does not matter whether PHI cannot

recoup the price of its services because it is limited in what it can charge or because the insurer is limited in what it must pay. Put differently, if state law required PHI to bill an insurance company a "fair and reasonable" rate, would that limit not relate to an air carrier's price, even though it would directly limit what an air carrier may charge? I think it must. *See Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 942 (D.N.D. 2016) (holding that the ADA preempted a North Dakota law limiting the amount that air-ambulance transports could bill to an amount consistent with the insurance provider's fee schedule). Surely, then, "compelling or restricting" a specific payment relates to a price. *Morales*, 504 U.S. at 389 (citing *Ill. Corp. Travel, Inc. v. Am. Airlines, Inc.*, 889 F.2d 751, 754 (7th Cir. 1989)); *Air Evac EMS, Inc. v. Sullivan*, 331 F. Supp. 3d 650, 663 (W.D. Tex. 2018) ("Because the TWCA effectively determines what [an air-ambulance transport company] can charge by restricting the amount it can receive for its services, the [reimbursement scheme] relate[s] to [an air carrier]'s prices."). Either statutory regime compels the same result, and both would be "designed" to relate to a price of an air carrier. *See Morales*, 504 U.S. at 386 (quoting *Ingersoll—Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990)) ("[A] state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect."). And Congress, when it decided to deregulate air carrier prices, did so with the understanding that its deregulation would allow air carriers to set their own prices—not the state or those who pay air carriers consistent with state guidelines. *See id.* at 378.

Other courts have held that state-law caps on insurer reimbursement for air-ambulance transports are preempted by the ADA because such laws establish a mandatory fixed maximum rate for reimbursement. *See EagleMed LLC v. Cox*, 868 F.3d 893, 902 (10th Cir. 2017). And the Court today relies on *Cox* to distinguish Texas's reimbursement scheme. The Court concludes that because the TWCA's reimbursement scheme is a generally applicable law that does not expressly state what an insurer must pay an air-ambulance provider, then it is preempted only if it has a forbidden significant effect on PHI's prices. *Ante* at ___. The Court goes on to hold that, because the fair and reasonable amount required by the TWCA could be consistent with PHI's billed price, the reimbursement scheme does not relate to PHI's prices as a matter of law given that it does not always have that forbidden effect. *Ante* at ___. Yet the Supreme Court has stated that the ADA preempts even those state laws "'consistent' . . . with federal regulation." *Rowe*, 552 U.S. at 370 (citing *Morales*, 504 U.S. at 386-87). Thus, evidence that a state regulation could result in the same price that an air carrier would set itself as a result of deregulation does not mean that law does not "relate[] to" "a price" of an air carrier. 49 U.S.C. § 41713(b)(1). And the record reflects that the reimbursement scheme does relate to PHI's prices.

After the insurers paid PHI based on the reimbursement scheme, PHI sought a medical fee dispute resolution before the Division, which ultimately concluded that reimbursement should be "fair and reasonable," amounting to 125 percent of Medicare service rates. The administrative law judge determined on appeal that the "fair and reasonable"

rate was 149 percent of Medicare service rates. PHI asserted, in defense of its claim that insurers should pay the price that they are billed, that the ADA preempts the TWCA. *See Scarlett v. Air Methods Corp.*, 922 F.3d 1053, 1061 (10th Cir. 2019) (concluding that the ADA could be used defensively to entitle an air-ambulance provider to its billed charge). The administrative law judge then ordered the insurers to pay an amount consistent with this newly determined "fair and reasonable" amount. Under both approaches—125 or 149 percent—the amount owed was less than the amount PHI charged. After the adjustment, the requisite payment for each transport would be between $9,989 and $28,000 less than the price charged to the insurer. This underpayment "surely 'relates to' price." *See Morales*, 504 U.S. at 389 (citing *Ill. Corp. Travel*, 889 F.2d at 754).

The fact that the court in *Cox* struck both the balance-billing prohibition and the limit on insurer reimbursement is telling. 868 F.3d at 901. If the Court is correct in its suggestion today that PHI is the victim of its own pleading, *ante* at___, and the TWCA is not preempted because the balance-billing prohibition was only challenged in the alternative, then why is it that *Cox* specifically concluded that limiting the amount that an insurer can reimburse is related to price? 868 F.3d at 901. In other words, if balance billing is truly what relates to price here, then why was a scheme that capped reimbursement at a fixed amount relevant to whether that cap relates to price? I see no distinction.

The TWCA's reimbursement scheme plainly sets a maximum amount for which PHI can be

compensated by the insurer, which PHI is statutorily required to bill for its services. *See* TEX. LAB. CODE § 408.027(a)-(b). That maximum amount is a fair and reasonable price as determined by the insurer or the Division. *See id.* § 413.011(d); 28 TEX. ADMIN. CODE § 134.1(f). At best, this is the price that these parties believe the market would set, rather than the amount that the market actually sets. *See Morales*, 504 U.S. at 378; *see also EagleMed, LLC v. Travelers Ins.*, 424 P.3d 532, 539 (Kan. Ct. App. 2018) (concluding that the ADA preempts "a price sanctioned by the State rather than one determined by market forces as Congress intended"). The scheme thus clearly relates to PHI's prices because it controls the amount that PHI is entitled to collect from the insurer, the party from whom the TWCA prescribes reimbursement of medical benefits. *See* Tex. Lab. Code § 408.027(a)-(b).

In *Sabre Travel International, Ltd. v. Deutsche Lufthansa AG*, 567 S.W.3d 725 (Tex. 2019), we concluded that a tortious interference claim was "too tenuous, remote, or peripheral" to an air carrier's prices to be preempted by the ADA. *Id.* at 738. The tortious interference claim arose from a booking company's conduct that occurred after an airline ticket was purchased and independently of determining the price of a ticket. *Id.* We explained that the passive booking costs imposed on an airline company by a third-party booking agent went to airline cost alone, and not price. *Id.* at 737-38. Sabre could not demonstrate that those third-party costs were anything more than costs, and thus those costs were "too tenuous, remote, or peripheral" to the airline's prices for purposes of preemption. *Id.* at 738. Here, PHI has shown that the TWCA's reimbursement

scheme goes directly to price, as the scheme determines the amount that insurers will reimburse air-ambulance providers for their services. And the record indicates that application of that reimbursement scheme to PHI has a clear effect on what it collects from the insurers responsible for payment of medical benefits.

The Supreme Court has said that the ADA "stops States from imposing their own substantive standards with respect to [prices], routes, or services, but not from affording relief to a party who claims and proves that an airline dishonored a term the airline itself stipulated." *Wolens*, 513 U.S. at 232-33. That is why state laws that relate to price, and not breach-of-contract claims that relate to price, are preempted by the ADA. When breach-of-contract claims are at issue, air carriers have electively set their own terms. *Id.* "[T]he ADA's overarching deregulatory purpose . . . mean[s] 'States may not seek to impose their own public policies or theories of competition or regulation on the operations of an air carrier.'" *Id.* at 229 n.5 (citation omitted). The TWCA does just that. It imposes standards that regulate the amount an air carrier like PHI may collect from those required to pay medical benefits, effectively limiting what it may charge. For these reasons, I would hold that the TWCA's reimbursement scheme "relate[s] to a price . . . of an air carrier." 49 U.S.C. § 41713(b)(1).

II. McCarran-Ferguson Act

Although I would conclude that the ADA preempts the TWCA's reimbursement scheme, the scheme can nevertheless be saved by the MFA's "reverse preemption" provision if the TWCA in

general, or its reimbursement scheme in particular, qualifies as a law enacted for the purpose of regulating the business of insurance. 15 U.S.C. § 1012(b). Because the TWCA and its origins show that the Legislature enacted the TWCA as a tort reform measure, and the United States Supreme Court has prescribed a particular meaning to the term "business of insurance," I would conclude that the statute, both as a whole and with respect to the challenged reimbursement scheme, was not enacted for the purpose of regulating the business of insurance.[2]

A. Purpose, Structure, and Effect of the TWCA

Analyzing whether the MFA reverse preempts a state statute requires a two-tiered approach. First, we "consider[] the overall purposes, structural framework, and effect of the entire state law" in determining whether the MFA saves the reimbursement scheme from preemption. *Fredericksburg Care Co. v. Perez*, 461 S.W.3d 513, 521 (Tex. 2015). If the law in its entirety was not enacted

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[2] To be sure, parts of the TWCA very well may be laws enacted for the purpose of regulating the business of insurance, and the concurrence today notes a few in its analysis. However, those provisions, while instructive on whether the TWCA was enacted to regulate the business of insurance, do not transform the TWCA into such a law. Rather, the MFA would protect those provisions from preemption if challenged. *See U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 508-09 (1993) (holding that only *part* of an Ohio statute prioritizing certain creditors and policyholders over the federal government in bankruptcy was a law enacted for the purpose of regulating the business of insurance). And, as discussed in Part II.B, the provisions that are directly challenged—the reimbursement scheme that regulates what an insurer must pay a provider—fall short of how the Supreme Court has interpreted and applied the MFA.

for the purpose of regulating the business of insurance, then we proceed to determine whether the specifically challenged provisions fall within the ambit of the MFA. *Id.* at 525. Guiding this analysis, though, is the language of the MFA itself. Although we analyze the statute holistically and then particularly, we must be mindful that the MFA is about "the relationship between the insurance company and its policyholders." *Fabe*, 508 U.S. at 501. State laws may come within the scope of the MFA if they control "the type of policy which could be issued, its reliability, interpretation, and enforcement." *SEC v. Nat'l Sec., Inc.*, 393 U.S. 453, 460 (1969). Regardless of these considerations, our focus should be on whether the statute is "aimed at protecting or regulating [the insurer-policyholder] relationship, directly or indirectly." *Id.* Thus, I begin with whether the TWCA was enacted to regulate the insurer-policyholder relationship.

The concurrence relies on the fact that the TWCA allows the Texas Department of Insurance to "administer and operate the workers' compensation system" and directs the Department to approve those policies administered in Texas to conclude that the TWCA falls within the scope of the MFA. *Ante* at ___; *see* Tex. Lab. Code § 402.001; *Fairfield Ins. Co. v. Stephens Martin Paving, LP*, 246 S.W.3d 653, 658 (Tex. 2008). This approach, though, conflates mechanisms with purpose. We have previously recognized that while the TWCA may offer employees relief as insurance beneficiaries and employers coverage as policyholders, the TWCA exists to assist both the employee and employer with job-related injuries:

> The purpose of the Act is to provide employees with certainty that their medical bills and lost wages will be covered if they are injured. An employee benefits from workers' compensation insurance because it saves the time and litigation expense inherent in proving fault in a common law tort claim. But a subscribing employer also receives a benefit because it is then entitled to assert the statutory exclusive remedy defense against the tort claims of its employees for job related injuries.

Tex. Mut. Ins. Co. v. Ruttiger, 381 S.W.3d 430, 441 (Tex. 2012) (quoting *HCBeck, Ltd. v. Rice*, 284 S.W.3d 349, 350 (Tex. 2009)); *see Tex. Workers' Comp. Comm'n v. Garcia*, 893 S.W.2d 504, 511 (Tex. 1995). As the Division recognizes, the TWCA offers an alternative to the common law, under which "injured workers were [often] denied recovery." *Garcia*, 893 S.W.2d at 510 (citation omitted). This was in response to harsh complete defenses employers could invoke to limit or avoid liability. *Id.* The original act eliminated these complete defenses in exchange for a prohibition on an injured employee's ability to bring a claim against a subscribing employer in a variety of circumstances. *See* Act of Mar. 29, 1913, 33d Leg., R.S., ch. 179, §§ 1, 3, 1913 Tex. Gen. Laws 429, 429-30. At the heart of this exchange was the *employer-employee relationship* and the resolution of job-related injuries. In this way, the purpose of the original act was to ensure the injured employee's entitlement to certain benefits

while maintaining an employer's limited liability.[3] *Id.* §§ 3, 6-16, 1913 Tex. Gen. Laws 429, 430-32; *see Garcia*, 893 S.W.2d at 510-11. We have explained:

> The Employers' Liability Act of 1913 replaced the common law negligence remedy with limited but more certain benefits for injured workers. Acts of 1913, 33d Leg., ch. 179. The Texas act, which was part of a nationwide compensation movement, was perceived to be in the best interests of both employers and employees. . . . Employees injured in the course and scope of employment could recover compensation without proving fault by the employer and without regard to their or their coworkers' negligence. Acts of 1913, ch. 179, pt. I, §§ 7-12. In exchange, the employer's total liability for an injury was substantially limited. *Id.* § 3. Although employers were allowed to opt out of the system, the act discouraged this choice by abolishing all the traditional common law defenses for non-subscribers. *Id.* § 1.

Garcia, 893 S.W.2d at 510-11 (footnote omitted).

Because the original workers' compensation act proved unsatisfactory for a variety of reasons, the Legislature adopted a revised TWCA that attempted to restore the tradeoff contemplated under the original version. *Id.* at 511-12; *see* Tex. Lab. Code § 408.001(a);

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[3] The Act even said as much: "An Act relating to employers' liability and providing for the compensation of certain employe[e]s and their representative and beneficiaries. . . ." Act of Mar. 29, 1913, 33d Leg., R.S., ch. 179, 1913 Tex. Gen. Laws 429, 429.

see also Tex. Lab. Code § 402.021(d). It did so without modifying its intent. Even after the amendments, the TWCA continues to protect both the injured worker and the employer by ensuring recovery for on-the-job injuries without regard to the employee's own negligence, while limiting the employer's liability. *See Ruttiger*, 381 S.W.3d at 441; *In re Poly-Am., L.P.*, 262 S.W.3d 337, 350 (Tex. 2008). That the Legislature offers the employee relief through private insurance does not transform the entire TWCA into a law enacted for the purpose of regulating the business of insurance. *See Fabe*, 508 U.S. at 502-03, 508-09 (concluding that though a portion of a statute was enacted for the purpose of regulating the business of insurance, the entire statute was not). To conclude otherwise would require that we ignore the history and origins of the TWCA itself. *See Waak v. Rodriguez*, ___ S.W.3d ___, ___ (Tex. 2020).

The structure of the TWCA demonstrates that its purpose is to provide a policy tradeoff between the employer and employee with respect to on-the-job injury claims. *See Tex. W. Oaks Hosp., LP v. Williams*, 371 S.W.3d 171, 186 (Tex. 2012). The concurrence asserts that the TWCA is administered through private insurers and thus cannot be accomplished without private insurance contracts. *Ante* at ___. While that is true for *subscribing* employers, the concurrence fails to recognize that workers' compensation insurance is but one remedy the Legislature envisioned to improve an employee's recovery for on-the-job injuries and an employer's protection in that process. *See* Tex. Lab. Code § 406.033(a) (removing common law defenses in workers' compensation claims for non-subscribing

employers). When the structure of the TWCA is examined, its purpose to offer employee and employers alike a remedy for on-the-job injuries becomes visible.[4]

First, the TWCA incentivizes employers to opt in. *See id.* It encourages, but does not require, an employer to elect into its provisions. *See id.* § 406.002(a) ("Except for public employers and as otherwise provided by law, an employer *may* elect to obtain workers' compensation insurance coverage.") (emphasis added). If an employer elects to participate in the workers' compensation system, and the employer's employee does not opt out, then "employees

[4] For instance, imagine there are two employees: Employee A and Employee B. Employee A's employer elects to opt into workers' compensation and Employee B's employer does not. *See* Tex. Lab. Code § 406.002(a). Both employees are injured. Ideally, under the workers' compensation laws, both Employee A and Employee B should have a sufficient remedy to redress their injuries. However, Employee B would not recover through workers' compensation insurance, but because the TWCA forecloses non-subscribing employers from invoking common law defenses to recovery. *See id.* § 406.033(a). The concurrence's understanding of the TWCA—that it was enacted for the purpose of regulating the business of insurance—does not acknowledge that the employer, and not insurance, is the source of Employee B's recovery. That is not how we interpret statutes. Instead, we interpret statutes to give meaning to the statute as a whole and render no part superfluous. *See* Tex. Gov't Code § 311.021(2); *Ritchie v. Rupe*, 443 S.W.3d 856, 898 (Tex. 2014) (Guzman, J., dissenting); *In re Lee*, 411 S.W.3d 445, 453 (Tex. 2013). A reading that would leave unacknowledged half of an employee's available means of recovery does not honor that command. And this hypothetical does not account for the possibility of a third employee—Employee C—whose employer may utilize common law defenses because the employer opted into workers' compensation insurance while Employee C opted out. *See* Tex. Lab. Code § 406.034(d).

are generally precluded from filing suit against [the employer] and must instead pursue their claims through an administrative agency against the employer's insurance carrier for benefits provided for in the TWCA." *Tex. W. Oaks Hosp.*, 371 S.W.3d at 186; *see* Tex. Lab. Code § 406.031(a) (directing that the insurance carrier be liable for compensation arising out of an employee's on-the-job injury when the employer elects to participate in the workers' compensation system). If, however, "an employer forgoes workers' compensation coverage . . . it is subject to suits at common law for damages." *Tex. W. Oaks Hosp.*, 371 S.W.3d at 187. The employer that forgoes coverage may not assert as a defense in such a suit that "(1) the employee was guilty of contributory negligence; (2) the employee assumed the risk of injury or death; or (3) the injury or death was caused by the negligence of a fellow employee." Tex. Lab. Code § 406.033(a). To be successful in her suit, the employee need only show that her injury was caused by a negligent employer or its agent acting within the course and scope of its agency. *Id.* § 406.033(d).

Second, the Legislature structured the TWCA to discourage employees from opting out of their employer's elective participation in the workers' compensation system. *See Tex. W. Oaks Hosp.*, 371 S.W.3d at 186-87. The benefits offered to the employee who remains in the system include medical benefits, temporary income benefits, impairment income benefits, supplemental income benefits, and lifetime benefits. Tex. Lab. Code §§ 408.021-.162. The insurance carrier is required by statute to initiate claims within fifteen days of receiving timely notice of the claim, ensuring prompt resolution. *Id.*

§ 409.021(a). And if a carrier refuses a claim for a groundless reason, it is subject to administrative penalties. *Id.* § 409.022(c). Further, the insurance carrier is required to compensate the injury "without regard to fault or negligence" of the employee or employer. *Id.* § 406.031(a); *see Tex. W. Oaks Hosp.*, 371 S.W.3d at 186 ("But employees need not prove the employer's negligence for workers' compensation recovery . . . ."). While the TWCA allows employees to opt out of their employer's participation in coverage, Tex. Lab. Code § 406.034(a)-(b), the employer then retains all common law defenses in a suit brought by that employee, including the employee's own negligence. *Id.* § 406.034(d). For such an employee, compensation occurs once litigation is complete or settlement is reached.

> Thus, the workers' compensation construct contemplates two systems, one in which covered employees may recover relatively quickly and without litigation from subscribing employers and the other in which non[-]subscribing employers, or the employers of employees who have opted not to accept workers' compensation coverage, are subject to suit by injured employees to recover for their on-the-job injuries.

Tex. W. Oaks Hosp., 371 S.W.3d at 187.

The United States Supreme Court has consistently stated that first-clause MFA cases,[5] like

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[5] The first clause of the MFA reads: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business . . . ."

the one before us, apply to state statutes whose purpose is to regulate the relationship between insurer and policyholder. *Fabe*, 508 U.S. at 501 (citing *Nat'l Sec.*, 393 U.S. at 460). Rather than regulating the relationship between insurer and policyholder, the structure of the TWCA supports a conclusion that its purpose is to regulate the relationship between employer and employee. Unlike *Fabe*, in which the Supreme Court noted that the state "priority statute was enacted as part of a complex and specialized administrative structure for the regulation of insurance companies from inception to dissolution," *id.* at 494, the TWCA creates a system that manages on-the-job injury claims between employee and employer.

Although the workers' compensation system is administered by private insurance providers, resulting in private insurance contracts, that does not obviate the fact that its *purpose* and structure is to manage on-the-job injury disputes between employer and employee. *See* 15 U.S.C. § 1012(b); *Cox*, 868 F.3d at 904 (concluding that even if Wyoming's workers' compensation statute were similar to Texas's privatized approach, the MFA would not apply because neither is directed at the business of insurance). Thus, the effect of the TWCA's compensation system "is to empower the" employee and employer to participate in the TWCA, not for insurance carriers to provide insurance—although

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15 U.S.C. § 1012(b). The second clause allows application of the Sherman Act and Clayton Act "to the business of insurance to the extent that such business is not regulated by State law." *Id.*

that may also be a collateral consequence of the system. *See Fabe*, 508 U.S. at 494.

In *Fredericksburg Care Co.*, we rejected the beneficiaries' request to look past the purpose and structure of the Texas Medical Liability Act to conclude that its potential lowering of insurance premiums meant that it was enacted for the purpose of regulating the business of insurance. 461 S.W.3d at 524. Similarly, here, the fact that the system includes the issuance of insurance contracts does not alter the purpose and structure of the TWCA, which facilitates resolution of on-the-job injury issues between employers and employees.

B. Application of the TWCA's Reimbursement Scheme

Although the TWCA as a whole was not enacted "for the purpose of regulating the business of insurance," its reimbursement scheme may still fall within the scope of the MFA. 15 U.S.C. § 1012(b); *see Fabe*, 508 U.S. at 505; *Fredericksburg Care Co.*, 461 S.W.3d at 525. The approach to whether the MFA applies nevertheless remains the same and focuses on whether the challenged provision addresses "the relationship between the insurance company and the policyholder." *Fabe*, 508 U.S. at 501 (quoting *Nat'l Sec.*, 393 U.S. at 460); *see Fredericksburg Care Co.*, 461 S.W.3d at 526-27 (citations omitted) ("Much like the rest of Chapter 74, section 74.451 has little to do with the 'relationship between the insurance company and its policyholders.'").

The concurrence concludes that the parties here have a stronger case that the TWCA and its challenged provisions regulate the business of

insurance than the parties in *Fabe*. *Ante* at ___. In *Fabe*, pursuant to a state statute, the Ohio Superintendent of Insurance ordered that the United States, as an obligee, receive fifth priority in an insurance company's liquidation. 508 U.S. at 494-95. This would place the United States, which under federal law would normally receive first priority in liquidation, *see* 31 U.S.C. § 3713(a)(1)(A)(iii), behind a variety of creditors, including insurance "policyholders' claims" and "claims of general creditors." *Fabe*, 508 U.S. at 495. The Supreme Court noted that while the Ohio priority statute fell short of "prescribing the terms of the insurance contract or . . . setting the rate charged by the insurance company," the statute nevertheless regulated the business of insurance because giving priority to a policyholder amounted to "the actual performance of an insurance contract." *Id.* at 502-03. The Court distinguished *Pireno*, a second-clause case, by reasoning that the Ohio law determined whether a policy was performed, while *Pireno* dealt with why a policy was performed. *Id.* at 503 (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 132 (1982)).

The reimbursement scheme at issue here affects the amount an insurance company must pay a service provider, not whether the policyholder's contract is performed. *See Pireno*, 458 U.S. at 132 (holding that a state law did not regulate the business of insurance when it established a process that was "a matter of indifference to the policyholder, whose only concern is *whether* his claim is paid, not *why* it is paid"). Under the TWCA, the benefit conferred to a policyholder and beneficiary is that neither will be liable for services that fall within the policy's scope of coverage. Tex.

Lab. Code § 408.021. And the insurance company assumes the payment obligation for those covered services, including the medical benefit. *Id.* §§ 401.011(31), 408.021. After the insurance company has concluded that an air-ambulance transport falls within the scope of the medical benefit, and the insured has received the benefit promised to it under the policy, the reimbursement scheme then determines the amount that the insurance company owes the medical service provider. Thus, the reimbursement scheme does not operate to determine *whether* a claim is covered; it operates to determine the amount owed to the service provider. *See Fabe*, 508 U.S. at 503-04; *Pireno*, 458 U.S. at 132. Indeed, the benefit conferred to the policyholder is not the amount an insurance company will pay for the claim, but rather that the insurance company will pay for medical benefits arising under the policy. *See Sullivan*, 331 F. Supp. 3d at 666-67 ("[The TWCA's] policy benefit conferred is the movement of the obligation to pay an air ambulance provider from the insureds to the insurer . . . ."). The employer and injured employee, unlike the policyholders in *Fabe*, need not rely on the challenged reimbursement scheme to receive benefits under the workers' compensation system. *See* 508 U.S. at 503-04.

The Tenth Circuit in *Cox* reached the same conclusion in interpreting Wyoming laws that regulated reimbursement for air-ambulance transports under Wyoming's workers' compensation system. 868 F.3d at 897, 904-05. The Wyoming law allowed reimbursement at "a reasonable charge . . . not in excess of the rate schedule established by the director," *id.* at 898, similar to the

Texas reimbursement scheme. *See* Tex. Lab. Code § 413.011; 28 Tex. Admin. Code §§ 134.1(a), (e)-(f), .203. The court held that the Wyoming law fell outside the scope of the MFA's first clause not because of how Wyoming structured its law—that is, through a state fund rather than private insurance—but because the fee schedule was unrelated to the insurer-policyholder relationship. *Cox*, 868 F.3d at 904-05 (citing *St. Bernard Hosp. v. Hosp. Serv. Ass'n of New Orleans, Inc.*, 618 F.2d 1140, 1145 (5th Cir. 1980)) ("[E]ven if we were to accept the argument that Wyoming's state-run workers' compensation system establishes a type of insurance, we are not persuaded that [the reimbursement scheme] are laws 'regulating the business of insurance.'"). The reimbursement scheme here, too, exists separate and apart from the insurer-policyholder relationship because it relates to the payment of a service and not the scope of coverage.[6]

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[6] The concurrence notes that the reimbursement scheme identifies the scope of coverage, but the scope of coverage is determined by the policy and whether the employee incurs a medical benefit as determined by the policy. *Ante* at ___; *see Exxon Mobil Corp. v. Ins. Co. of the State of Pa.*, 568 S.W.3d 650, 657 (Tex. 2019). The reimbursement scheme dictates the amount an insurer will pay for the policy obligation, and the Supreme Court has recognized that an arrangement that will limit an insurer's costs for obligations arising under a policy is not the business of insurance. *See Grp. Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 213-14 (1979). And notably, but for the balance-billing prohibition that prevents a health care provider from recouping the remainder of the unpaid bill from the injured employee, *see* Tex. Lab. Code § 413.042, any additional payment would be sought from the injured employee and not the policy-holding employer. Thus, the scope of the benefit is *not* the amount

The concurrence is correct that the first clause of the MFA is broader than the second clause, but the meaning of "business of insurance" is the same in both. *See Fabe*, 508 U.S. at 504-05 (focusing on the meaning of "laws 'enacted . . . for the purpose of regulating'" to conclude that the first clause is more expansive than the second clause). That is, if a state law does not involve "the business of insurance," then it was not "enacted . . . for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b); *see Fabe*, 508 U.S. at 504-05. And in *Group Life & Health Insurance Co. v. Royal Drug Co.*, a second-clause case, the Supreme Court addressed the meaning of business of insurance in the context of payment arrangements between insurers and third-party service providers. 440 U.S. at 213. There, the Supreme Court concluded that the "business of insurance" did not extend to pharmacy arrangements that existed to "minimize the costs" of the insurer but provided no benefit to the insurer other than that its costs would be fixed. *Id.* at 213-14; *see Genord v. Blue Cross & Blue Shield of Mich.*, 440 F.3d 802, 804-07 (6th Cir. 2006) (concluding that reimbursement arrangements mandated by law are not laws enacted for the purpose of regulating the business of insurance). Similarly, here, the reimbursement scheme exists to "minimize the costs" of the workers' compensation insurance carrier. *Royal Drug*, 440 U.S. at 213; *see* Tex. Lab. Code § 413.011; 28 Tex. Admin. Code §§ 134.1(a), (e)-(f), .203. In this context, the promise made to an employer is that "[the] insurance carrier is liable for compensation for an

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the service will cost but whether the service qualifies for the type of coverage provided.

employee's injury." Tex. Lab. Code § 406.031(a). The employer is indifferent to the reimbursement formula that affects the insurer and a third-party service provider. *See Royal Drug*, 440 U.S. at 214 (footnote omitted) ("So long as [the policyholder's prescription cost is fixed], policyholders are basically unconcerned with arrangements made between [the insurer] and participating pharmacies.").

And even if a reimbursement arrangement is mandated by law, that does not mean the MFA protects that arrangement. *Genord*, 440 F.3d 802. Relying on *Royal Drug*, the Sixth Circuit in *Genord* held that a Michigan law obligating health care corporations to enter into reimbursement arrangements with various medical service providers was not a law enacted for the purpose of regulating the business of insurance. *Id.* at 803, 808. The Michigan law, like the law at issue here, mandated terms of the reimbursement arrangement. *Id.* at 803-04; *see* Tex. Lab. Code § 413.011; 28 Tex. Admin. Code §§ 134.1(a), (e)-(f), .203. Although the law allowed an insurance provider to enter into its own arrangements with medical service providers in limited instances, the law required that—similar to the Texas reimbursement scheme—the service provider "accept payment at the regulated rate." *Genord*, 440 F.3d at 804 (citation omitted); *see* Tex. Lab. Code § 413.011; 28 Tex. Admin. Code §§ 134.1(a), (e)-(f), .203. Because the reimbursement law did not relate to the coverage of claims for policyholders, but instead to what was owed to service providers, it was not an integral part of the insurance relationship. *Genord*, 440 F.3d at 808 (citing *Royal Drug*, 440 U.S. at 214). Similarly, the TWCA's reimbursement scheme is not integral to the

insurance relationship because the policyholders are unaffected and unconcerned with insurers' reimbursement to service providers under the scheme. *See id.* Instead, the prescribed amount that an insurance carrier must pay a third party is not an insurance benefit, but rather an attempt to control the insurer's costs. Thus, these provisions are not "aimed at protecting or regulating" the performance of an insurance contract, *Nat'l Sec.*, 393 U.S. at 460, but rather "the business of insurers." *Royal Drug*, 440 U.S. at 211.

Finally, applying the non-dispositive *Pireno* factors produces the same conclusion that the reimbursement scheme is not part of the "business of insurance." *See Pireno*, 458 U.S. at 129. *Pireno* identified three non-dispositive criteria for evaluating whether a practice is part of the "business of insurance," including whether: "(1) the practice has the effect of transferring or spreading a policyholder's risk; (2) the practice is an integral part of the policy relationship between the insurer and the insured; and (3) the practice is limited to entities within the insurance industry." *Fredericksburg Care Co.*, 461 S.W.3d at 521 (citations omitted). Having already addressed how the provisions relate to the insured-insurer relationship, I turn to the first and third factors.

First, the TWCA's reimbursement scheme does not spread or transfer policyholders' risk. *Royal Drug* held that risk sharing occurs when the insurer spreads the risk it assumes in offering a policy to a single policyholder by offering policies to other

policyholders.[7] 440 U.S. at 211 & n.7. Risk reduction through a reimbursement arrangement or scheme is not risk sharing because the reduction affects only the insurer's liability under a given policy. *Id.* at 211 n.7. Even if third-party cost constraints may "inure ultimately to the benefit of policyholders," those

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[7] The concurrence concludes that the reimbursement scheme spreads policy risk because it assists in determining policy premiums. *Ante* at ___. But a policyholder's receipt of a benefit through an insurance company's reduced cost risk is not spreading policyholder risk. *Royal Drug*, 440 U.S. at 211, 214. Commonly referred to as the Law of Large Numbers, risk sharing is risk aversion, which insurance companies accomplish by increasing the number of policyholders within a pool to make losses more predictable. *See* Michael Murray, *The Law of Describing Accidents: A New Proposal for Determining the Number of Occurrences in Insurance*, 118 Yale L.J. 1484, 1491-92 (2009). The Supreme Court in *Royal Drug* rejected the insurers' argument that arrangements with third parties that limit the amount insurers must pay for policyholder claims represent risk sharing. 440 U.S. at 211 & n.7. Instead, the Court concluded such arrangements are risk reduction. *Id.* Similarly, the TWCA's reimbursement scheme does not add to the pool of policyholders—risk share—it limits the amount that an insurance company must pay—risk reduction—to satisfy obligations to a medical service provider. *See id.* Whether an insurance company's reimbursement obligation to a provider is limited because the insurance company optionally entered into such an arrangement, or because the arrangement was prescribed by statute, has no bearing on whether the arrangement amounts to risk sharing. *Genord*, 440 F.3d at 804, 806-07. This is true even if the reimbursement arrangement results in benefits to the policyholder in the form of lower premiums. *Royal Drug*, 440 U.S. at 214 (footnote omitted) ("Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the 'business of insurance.'").

constraints are still not the business of insurance. *Id.* at 214. At most, the reimbursement scheme is simply that: a cost constraint that inures some benefit to an employer. The limits merely represent what an insurer must pay to satisfy its obligations to a service provider. The insurer assumes the responsibility to pay under the policy with the insured—risk shares—and the reimbursement scheme operates as a constraint on the insurer's costs separate and apart from the agreement with the insured. *See id.*; *Pireno*, 458 U.S. at 130-31.

Second, payments to air-ambulance transports are not to entities within the insurance industry. The Supreme Court held in *Pireno* that a New York law allowing health insurers to use a peer-review system to determine the necessity and use of chiropractic treatments did not regulate the business of insurance. 458 U.S. at 134. In discussing the third *Pireno* factor, the Supreme Court noted that the system "inevitably involve[d] third parties wholly outside the insurance industry—namely, practicing chiropractors." *Id.* at 132. The business of insurance excludes "[a]rrangements between insurance companies and parties outside the insurance industry." *Id.* at 133. Much like the chiropractors in *Pireno*, air-ambulance transports offer a service that might satisfy a benefit under an insurance policy. *See id.* at 122-23. However, also like *Pireno*, that does not render limits on what an insurer may pay an air-ambulance transport "the business of insurance." *See id.* at 132-33. The scheme is akin to an agreement between insurance companies and those outside the industry because the scheme represents the amount that an insurance company must pay to a third party to satisfy the insurer's

obligations under a policy. *See id.* at 133; *Genord*, 440 F.3d at 808-09; *Air Evac EMS, Inc.*, 331 F. Supp. 3d at 666. The reimbursement scheme's cost limits are directed not at insurers but rather at service providers. That is, the reimbursement scheme is directed at air-ambulance markets and does not represent "'*intra*-industry cooperation' in the underwriting of risks." *Pireno*, 458 U.S. at 133 (citations omitted); *see Genord*, 440 F.3d at 808 (doctors providing gynecological services are not within the insurance industry). Therefore, under *Pireno*, the TWCA's reimbursement scheme is not aimed at protecting or regulating the performance of an insurance contract and does not regulate the business of insurance.

III. Conclusion

I cannot join the Court in concluding that the TWCA's reimbursement scheme avoids or is saved from preemption. The reimbursement scheme relates to a price of an air carrier, and is thus preempted by the ADA, because it limits the amount that an air carrier may charge for its services. Further, the MFA does not reverse preempt the TWCA or its reimbursement scheme because neither was enacted for the purpose of regulating the business of insurance, as understood by the United States Supreme Court. The TWCA was enacted to manage on-the-job injury claims by encouraging participation in the workers' compensation system and discouraging parties from resorting to litigation. Further, the reimbursement scheme regulates the relationship between the insurer and third-party service providers rather than the "business of

insurance." Because I would affirm the court of appeals' judgment, I respectfully dissent.

Paul W. Green

Justice

OPINION DELIVERED: June 26, 2020

Appendix B

IN THE TEXAS COURT OF APPEALS
THIRD DISTRICT

No. 03-17-00081-CV

PHI AIR MEDICAL, LLC,

Appellant,

v.

TEXAS MUTUAL INSURANCE COMPANY, HARTFORD UNDERWRITERS INSURANCE COMPANY, TASB RISK MANAGEMENT FUND, TRANSPORTATION INSURANCE COMPANY, TRUCK INSURANCE EXCHANGE, TWIN CITY FIRE INSURANCE COMPANY, VALLEY FORGE INSURANCE COMPANY, ZENITH INSURANCE COMPANY, and TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION,

Appellees.

Filed: Jan. 31, 2018

Before Justices Puryear, Field, and Bourland

OPINION

This case arises out of a dispute over what reimbursement is due to appellant PHI Air Medical, LLC for its transporting of injured employees covered by workers' compensation insurance in Texas. The

parties sought judicial review of a decision by the State Office of Administrative Hearings, and the trial court rendered a final judgment in favor of the appellee insurers—Texas Mutual Insurance Company, Hartford Underwriters Insurance Company, TASB Risk Management Fund, Transportation Insurance Company, Truck Insurance Exchange, Twin City Fire Insurance Company, Valley Forge Insurance Company, and Zenith Insurance Company (collectively "the Insurers"). Because we conclude that certain provisions related to rates that can be paid for air ambulance transports are preempted by the Airline Deregulation Act ("the ADA"), we reverse the trial court's judgment and remand the cause to the trial court for further proceedings.

Statutory and Procedural Background

In 1978, Congress enacted the ADA to encourage market competition, to advance efficiency and innovation, to lower prices, and to increase the variety and quality of air transportation services. *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 378 (1992); *see* 49 U.S.C. § 40101(a) (explaining policy considerations involved in deregulation). The ADA provides:

> (b) Preemption. Except as provided in this subsection, a State . . . may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.

49 U.S.C. § 41713(b).

At the state level, under the Texas Workers' Compensation Act ("the Act"), *see* Tex. Lab. Code §§ 401.001-419.007, employers may elect to self-insure or to obtain private insurance coverage to cover on-the-job injuries to their employees, *id.* §§ 406.002(a), .003. Under the Act, workers' compensation insurance generally pays benefits to an employee injured on the job regardless of fault or negligence, and the employee waives the right to sue for her injuries. *Id.* §§ 406.031, .034. This case involves the following statutes and rules:

- section 413.011 of the Act, which (1) requires the Commissioner of Workers' Compensation to adopt policies and guidelines "that reflect standardized reimbursement structures found in other health care delivery systems" by using Medicare and Medicaid reimbursement methodologies and policies and by developing appropriate conversion and other adjustment factors, and (2) states that the guidelines "must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control," *id.* § 413.001;
- provisions governing the assessment of administrative penalties and sanctions for violations of the Act, *id.* §§ 415.021-.036;
- the administrative rule defining "maximum allowable reimbursement" ("MAR") that may be paid to a health-care provider and stating that certain health-care services shall be reimbursed in accordance with the Workers' Compensation Division's fee guidelines, a negotiated contract, or if neither applies, "a fair and reasonable reimbursement rate" consistent with section

413.011 of the Act, 28 Tex. Admin. Code § 134.1(e), (f) (Tex. Dep't of Ins., Medical Reimbursement); and

- the rule explaining that the MAR for certain coded services[1] shall be 125 percent of a particular Medicare fee schedule, 125 percent of the published Texas Medicaid fee schedule rate for that code if it is not included in the Medicare schedule, or, if neither applies, the "fair and reasonable" rate under section 134.1, as summarized above, *id.* § 134.203(d), (f) (Tex. Dep't of Ins., Medical Fee Guideline for Professional Services).[2]

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[1] Health-care services are assigned "codes" under the Healthcare Common Procedure Coding System, which allows for more consistent billing and reimbursement. *See* Centers for Medicare & Medicaid Servs., HCPCS—General Information, HCPCS Background Information, https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html (last visited Jan. 9, 2018). The list includes more than 6,000 codes that encompass thousands of details related to the provision of health care. *See* https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html (last visited Jan. 9, 2018). For example, there are codes for a patient's left or right side, for intravenous versus subcutaneous administration of a drug, for the kind of wheelchair or wheelchair accessories provided, for various cancer screenings, for hospital admission, for different kinds of laparoscopic surgeries, for the administration of specific drugs, for the provision of various kinds of counseling services, and for speech or occupational therapy.

[2] PHI also challenged the Act's prohibition on "balance-billing"—which is a health-care provider's billing of an injured employee for all or part of the cost of a provided service. Tex. Lab. Code § 413.042(a). However, in its reply brief, it states that it only attacks the balance-billing provision in the alternative and

PHI provides air-ambulance services throughout Texas and elsewhere in the country. It is certified and regulated by the United States Department of Transportation pursuant to the Federal Aviation Act. When it is called upon to transport someone, it charges for that service by billing a "per-trip charge" and an additional charge for the miles transported. PHI and the Insurers disagreed on the amount that PHI could recover for its transport of injured workers covered by workers' compensation policies issued by the Insurers, and the issue was brought before the Division, as required by the Act. *See* Tex. Lab. Code § 413.031. The Division determined that the applicable provisions of the labor code and related rules were preempted by the ADA, and the Insurers appealed, requesting a de novo hearing at the State Office of Administrative Hearings. An Administrative Law Judge heard the matter and issued a final decision finding (1) that the federal ADA did not preempt the Act and (2) that PHI should recover 149% of the Medicare rate for such services. The Insurers and PHI sought judicial review, and the Division intervened. Following a hearing, the trial court signed a final order declaring that the ADA did not preempt the Act and that the Insurers could not be asked to pay more than 125% of the Medicare amount. PHI appealed.

Does the ADA apply to preempt the Act?

Our initial inquiry is whether the ADA preempts the Act, first addressing the Insurers' argument that PHI's services do not fall within the preemption

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that it would prefer to see that provision left intact while the provisions related to the reimbursement schedule are struck.

provision. The preemption provision bars a state from enacting a law or rule "related to a price, route, or service of an air carrier that may provide air transportation under this subpart." 49 U.S.C. § 41713(b-1).[3] The Insurers argue that PHI does not "provide air transportation" subject to preemption because it does not hold certificates under the specified subpart, Subpart II.[4]

Under Subpart II, "[e]xcept as provided in this chapter or another law," an air carrier "may provide air transportation only if the air carrier holds a certificate under this chapter." *Id.* § 41101(a). However, the Secretary of Transportation has the authority to exempt certain classes of carriers if he considers it necessary and "decides that the exemption is consistent with the public interest." *Id.* § 40109(c). As applicable here, the Secretary of Transportation has established "a classification of air carrier, designated as 'air taxi operators,' which directly engage in the air transportation of persons" but which "[d]o not hold a certificate of public convenience and necessity and do not engage in scheduled passenger operations." 14 C.F.R. § 298.3(a). We conclude that an air-ambulance service, as an air taxi operator, is an air carrier that may provide air transportation under

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[3] The ADA defines an "air carrier" as "a citizen of the United States undertaking by any means, directly or indirectly, to provide air transportation," and "air transportation" as "foreign air transportation, interstate air transportation, or the transportation of mail by aircraft." 49 U.S.C. § 40102(a)(2), (5).

[4] The preemption provision is in Title 49, "Transportation," Subtitle VII, "Aviation Programs," Part A, "Air Commerce and Safety," Subpart II, "Economic Regulation."

Subpart II, 49 U.S.C. § 41101(a), while exempted from certain certification requirements, *id.* § 40109(c). We further conclude that the preemption provision applies to such carriers. *See id.* § 41713(b);[5] *see, e.g.*, *Air Evac EMS, Inc. v. Cheatham*, No. 2:16-CV-05224, 2017 WL 4765966, at *5 (S.D.W.Va. Oct. 20, 2017) (appeal filed Nov. 22, 2017) (noting that no other courts have ruled that air ambulances were not air carriers under ADA, observing that Department of Transportation licensed Air Evac as an air carrier, and holding "that Air Evac's practice of providing emergency air ambulance services indiscriminately when called upon by third party professionals, together with its certification as an air carrier by the DOT and court cases affirming this status, qualify Air Evac as an air carrier under the ADA"); *EagleMed, LLC v. Wyoming ex rel. Dep't of Workplace Servs.*, 227 F. Supp. 3d 1255, 1277-78 (D. Wyo. 2016), *aff'd in part,*

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[5] In a letter related to whether the ADA preempts a county's attempts to impose certain requirements on air ambulance services, the Department of Transportation took the same position, stating that "an air ambulance operator . . . that holds DOT economic authority to operate as a registered air taxi under 14 CFR part 298, along with an FAA air carrier operating certificate under 14 CFR part 135, is an 'air carrier' for purposes of the ADA preemption provision." Letter from Ronald Jackson, Assistant Gen. Counsel for Operations, Dep't of Transp., to Thomas Cook, Vice Pres. & Gen. Counsel, REACH Air Med. Servs., LLC (Feb. 25, 2016), located at https://www.transportation.gov/sites/dot.gov/files/docs/Reach%20Letter%20Final%20OCR.pdf. The Attorney General of Texas has also observed that "[t]he preemption provision has been applied to air ambulance companies that are air carriers within the ADA definition." Tex. Att'y Gen. GA-0684, 2008 WL 4965344, at *2 (Nov. 20, 2008) (citing cases applying ADA to air ambulances).

rev'd in part by EagleMed LLC v. Cox, 868 F.3d 893, 904 (10th Cir. 2017) (finding that air ambulances are "air carriers" under ADA); *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 732-33 (E.D.N.C. 2008) (holding that air ambulance service provider was common carrier subject to preemption provision).[6] Therefore, PHI, as a registered air taxi with all relevant and required certificates, is an air carrier under Subpart II.[7] We now turn to whether the provisions at issue are preempted.

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[6] *See also Hughes Air Corp. v. Public Utils. Comm'n of Cal.*, 644 F.2d 1334, 1337-38 (9th Cir. 1981) (holding "that Congress intended to include carriers exempted from [Civil Aeronautics Board] certification pursuant to section 416(b)(1) within the scope of the preemption provision"); *Hiawatha Aviation of Rochester, Inc. v. Minnesota Dep't of Health*, 389 N.W.2d 507, 509 (Minn. 1986) (holding under similar preemption provision that state was "preempted from controlling entry into the field of air ambulance service" when air carrier "registers under 14 C.F.R. § 298 to operate as an air taxi and is authorized by the CAB to provide an air ambulance service").

[7] We likewise disagree with the Insurers' argument that the rates charged by PHI are not "prices" as contemplated by the ADA. The ADA defines "price" as a "rate, fare or charge," 49 U.S.C. § 40102(a)(39), and regardless of whether PHI is paid lowered charges under certain circumstances, its billed rate cannot be considered anything other than a "price." *See Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 942-43 (D.N.D. 2016) (provisions that had effect of capping reimbursement for air ambulance services could only be considered to directly impact prices and services under ADA); Tex. Att'y Gen. GA-0684, 2008 WL 4965344, at *2-3 (noting that ambulance subscription program "involves an annual fee and a reduced charge for air ambulance services" and that because "[t]he regulation of the subscription program is related to the price of air ambulance services," ADA preempted statutes and rules "to the extent these provisions relate to rates charged by air carriers providing air

Other courts that have considered the preemptive effect of the ADA have noted the breadth of the language chosen by Congress. *See, e.g.*, *Northwest, Inc. v. Ginsberg*, 134 S. Ct. 1422, 1430 (2014) (noting that language of ADA's preemption provision, which applies to "a law, regulation or *other provision* having the force and effect of law" (emphasis added), is "much more broadly worded" than other legislation that expressly applies only to "a law or regulation"); *Morales*, 504 U.S. at 383-84 (ADA's provision "express[es] a broad pre-emptive purpose"); *Cox*, 868 F.3d at 899 (quoting from *Morales*'s discussion of provision's broad purpose, 504 U.S. at 383-84); *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 940 (D.N.D. 2016) ("The phrase 'related to' in the ADA preemption clause has been construed very broadly."); *Bailey v. Rocky Mountain Holdings, LLC*, 136 F. Supp. 3d 1376, 1380 (S.D. Fla. 2015) (observing that Supreme Court has "held that the [preemption] provision should be construed broadly and [has] described its purposeful 'sweeping nature'" (quoting *Morales*, 504 U.S. at 384-85)). We agree. The relevant statutes and rules set the rates that can be recovered by PHI, as an air carrier, for transporting patients. Under the plain language of the ADA preemption provision, the ADA preempts those statutes and rules as far as they attempt to regulate PHI's rates.[8] *See,*

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ambulance services"). If PHI receives an artificially low payment for its provision of services, a rate not reasonably tied to market costs such as fuel and other costs specific to air ambulances, its "rates" as billed to recipients not a part of the workers' compensation market will have to change to cover such losses.

[8] We reject the Insurers' argument that we should parse Congressional intent in greater detail through a policy-related

e.g., *Cox*, 868 F.3d at 904; *Cheatham*, 2017 WL 4765966, at *6-8; *Dwelle*, 171 F. Supp. 3d at 941-43; *Benton*, 581 F. Supp. 2d at 736-39.

Does the McCarran-Ferguson Act "reverse-preempt" the Act?

We next ask whether the McCarran-Ferguson Act removes the Act from ADA preemption or "reverse-preempts" it. The McCarran-Ferguson Act provides:

> (a) State regulation
>
> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) Federal regulation
>
> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or

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lens. Although we agree with the *Cox* court's observations about the ADA's intent as it relates to the setting of air-ambulance rates, *see EagleMed LLC v. Cox*, 868 F.3d 893, 903-04 (10th Cir. 2017), the fact remains that the ADA preemption clause explicitly states that any state attempts to regulate an air carrier's rates or services are preempted. *See id.* As for whether Congress knew that air ambulances would be subject to the ADA, we agree with PHI that the discussion about the possible inclusion of a subsidy to upgrade air ambulance safety seems to indicate that Congress had that knowledge when it enacted the ADA. Further, we disagree with the Insurers' assertions that the provision of air ambulance services is not subject to market forces. Although such services are not "shopped around" by the injured person before the service is provided, the record contains evidence that the market does influence the rates an air-ambulance provider will charge.

> which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That . . . the Sherman Act, and . . . the Clayton Act, and . . . the Federal Trade Commission Act, . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

15 U.S.C. § 1012.[9] The question we must answer is whether the relevant provisions of the Act and its associated rules were enacted "for the purpose of regulating the business of insurance."[10] *See id.* In this

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[9] For an explanation of the history and purpose behind the McCarran-Ferguson Act, see *U.S. Department of Treasury v. Fabe*, 508 U.S. 491, 499-500 (1993), and *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 217-20 (1979).

[10] We note that the Administrative Law Judge stated that the reimbursement provisions were a "non-severable part" of the overall Act. We disagree. "The test for severability in the absence of an express severability clause is one of legislative intent." *Association of Tex. Prof'l Educators v. Kirby*, 788 S.W.2d 827, 830 (Tex. 1990). The overall Act is largely not subject to preemption and can be given effect separate and apart from the specific rate-setting provisions at issue here. *See id.* at 830-31 (quoting *Texas & P. Ry. Co. v. Mahaffey*, 84 S.W. 646, 648 (Tex. 1905)). There is no indication that the Legislature would not have passed the Act without the rate provisions as they apply to air ambulances or that the Act cannot function without those provisions as applied here. *See id.*; *Rose v. Doctors Hosp.*, 801 S.W.2d 841, 850 (Tex. 1990) (Phillips, C.J., dissenting) ("The inquiry, therefore, is whether 'the invalid part is so intermingled with all parts of the act as to make it impossible to separate them, and so preclude the presumption that the Legislature would have passed the act anyhow.'" (quoting *Sharber v. Florence*, 115 S.W.2d 604, 606 (Tex. 1938))); *see also Anderson v. Abbott Labs.*, No. 3:11-CV-1825-L,

inquiry, we are guided by the United States Supreme Court and federal courts that have explained what is meant by that language.

As explained by the Supreme Court, the focus of the McCarran-Ferguson Act is on "the relationship between the insurance company and its policyholders." *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 500 (1993). In other words, a statute that regulates the business of insurance is one that is aimed at protecting or regulating the relationship between the insurer and the insured. *Id.* (quoting *Securities & Exch. Comm'n v. National Secs., Inc.*, 393 U.S. 453, 460 (1969)); *see also Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 220-21 (1979) ("References to the meaning of the 'business of insurance' in the legislative history of the McCarran-Ferguson Act strongly suggest that Congress understood the business of insurance to be the underwriting and spreading of risk."). A statute need not directly regulate "the business of insurance," such as by mandating certain terms of an insurance contract or setting premiums that may be charged by an insurer, to fall within the ambit of the McCarran-Ferguson Act. *Fabe*, 508 U.S. at 502-03. "The broad category of laws enacted 'for the purpose of regulating the business of insurance' consists of laws that possess the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance." *Id.* at 505 (quoting Black's Law Dictionary 1236, 1286 (6th ed. 1990)).

2012 WL 4512484, at *6 (N.D. Tex. Sept. 30, 2012) (discussing severability in context of preemption).

"Cases interpreting the scope of the McCarran-Ferguson Act have identified three criteria relevant to determining whether a particular practice falls within that Act's reference to the 'business of insurance': '*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.'" *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985) (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).[11] A statute must do more than affect insurance companies—it must focus "on the relationship between the insurance company and the policyholder." *See National Secs.*, 393 U.S. at 460 (holding that statute focused on insurance company stockholders, not on "attempting to secure the interests of those purchasing insurance policies," and so fell outside McCarran-Ferguson Act); *see also Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 337-39 (2003) (noting in discussion of broader

[11] *Pireno* and *Royal Drug* both dealt with "the scope of the antitrust immunity located in the second clause of § 2(b)" of the McCarran-Ferguson Act, not the broader first clause at issue in this case. *Fabe*, 508 U.S. at 504; *see Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982); *Royal Drug*, 440 U.S. at 231-32. However, despite their antitrust focus, *Pireno* and *Royal Drug* are often cited for their discussions of factors to consider in determining whether a statute regulates the business of insurance, *see, e.g.*, *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 337-39 (2003); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50-51 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985), and we consider those factors in our analysis.

ERISA reverse-preemption that McCarran-Ferguson Act applies if law was enacted for purpose of regulating business of insurance, not simply if it affects insurance company's business). In determining whether the statutes and rules at issue should be considered laws enacted for the purpose of regulating the business of insurance, we consider how they fit within the overall framework of the Act. *See Fredricksburg Care Co., L.P. v. Perez*, 461 S.W.3d 513, 520 (Tex. 2015).

In *Fabe*, the Court determined that an Ohio statute that established the priority in which an insurance company's assets are distributed upon bankruptcy, placing governmental claims behind policyholders's claims and those of certain other creditors, fell within McCarran-Ferguson because it was "designed to carry out the enforcement of insurance contracts by ensuring the payment of policyholders' claims despite the insurance company's intervening bankruptcy," and thus its purpose was "identical to the primary purpose of the insurance company itself: the payment of claims made against policies." 508 U.S. at 504-06. In *Royal Drug*, the agreements at issue limited the prices participating pharmacies would be paid for drugs, thus minimizing the insurance company's costs and maximizing its profits, and as the Supreme Court observed, such agreements "may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the 'business of insurance.'" 440 U.S. at 214. Further, those agreements were not between the insurance company and its insureds but between the insurer and pharmacies providing services to the

insureds. *Id*. at 216. And finally, in *Pireno*, a chiropractor attacked an insurance company's use of peer-review committees to determine whether the chiropractor's charges were reasonable charges for necessary care. 458 U.S. at 122-23. The Court observed that the use of the peer-review committee did not spread or underwrite a policyholder's risk, was "distinct from [the insurer's] contracts with its policyholders," and was "not limited to entities within the insurance industry" because it involved "third parties wholly outside the insurance industry—namely, practicing chiropractors." *Id*. at 130-32.

"The purpose of the Texas Workers' Compensation Act is to provide employees with certainty that their medical bills and lost wages will be covered if they are injured." *HCBeck, Ltd. v. Rice*, 284 S.W.3d 349, 350 (Tex. 2009); *see* Tex. Lab. Code § 402.021 (goals of workers' compensation system are that each employee be treated with dignity and respect and that each injured employee have access to fair and accessible dispute resolution process, prompt and high-quality medical care, and services necessary to facilitate his return to employment; in implementing goals, system must promote safe and healthy workplaces and provide income and medical benefits in timely and cost-effective manner).[12]

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[12] *See also In re Poly-America, L.P.*, 262 S.W.3d 337, 349-50 (Tex. 2008) (orig. proceeding) ("The Texas Workers' Compensation Act was enacted to protect Texas workers and employees. The Texas Legislature enacted the original Workers' Compensation Act in 1913 in response to the needs of workers who, despite a growing incidence of industrial accidents, were increasingly being denied recovery. In order to ensure compensation for injured employees while protecting employers

Employees benefit under the Act because they are saved the time and expense of bringing a common-law tort claim, and subscribing employers benefit because they are not subject to tort claims for job-related injuries. *HCBeck*, 284 S.W.3d at 350.

The specific statutes and rules at issue in this case attempt to limit the rates an air ambulance company may be reimbursed after transporting a workers' compensation claimant for medical care, which is part of the Act's goal to provide cost-effective medical care. And although the Act as a whole certainly relates to the insurance industry and contains provisions that may implicate the relationship between insurers and their insureds, the overall goals of the Act and these particular provisions are not specifically directed at the insurance industry, *see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987), or the relationship between the Insurers and their policyholders, *see Fabe*, 508 U.S. at 501. Instead, the overarching focus of the Act is on ensuring prompt medical care for injured workers without those workers having to resort to the legal system, not on the relationship between the Insurers and their policyholders.

As in *Royal Drug*, an injured employee's paramount concern is not payment arrangements or limits on the reimbursement due to an air ambulance for transporting him after an injury but instead that he obtains prompt and high-quality air-ambulance

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from the costs of litigation, the Legislature provided a mechanism by which workers could recover from subscribing employers without regard to the workers' own negligence, while limiting the employers' exposure to uncertain, possibly high damage awards permitted under the common law." (citations omitted)).

services if they are required. *See* 440 U.S. at 213-14. Further, PHI is not "within the insurance entity" and instead is a health-care provider that deals with insurance companies to seek reimbursement for its services. *See Pireno*, 458 U.S. at 130-32. The caps on air ambulance fees do not affect the relationship between the Insurers and subscribing employers or their injured employees. *See Royal Drug*, 440 U.S. at 215-16. Nor do they act to underwrite or spread risks among the insureds—like the provisions at issue in *Royal Drug*, they serve to minimize the Insurers' costs and maximize their profits. *See id.* at 214-15. Such cost savings may have an effect on the workers' compensation system overall, but that effect is attenuated enough that we cannot consider limits on the rates an air ambulance may charge for transporting an injured employee to be "regulating the business of insurance." *See id.*

"Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the McCarran-Ferguson Act apply." *National Secs.*, 393 U.S. at 459-60. The statutes and rules in question here do not underwrite or spread policyholder risk and are not specifically directed at the "business of insurance" (as opposed to "the business of insurance companies"), but instead minimize the Insurers' costs, and thus are not subject to reverse preemption under the McCarran-Ferguson Act.[13] *See Cox*, 868 F.3d at 904-05 (stating that even if

[13] The Insurers argue that the fee statutes and rules relate to the performance of an insurance contract and fall within McCarran-Ferguson. However, the focus in our inquiry is on the

relationship between the Insurers and their insureds—the insurance contracts require the Insurers to provide coverage for job-related injuries—not the relationship between the Insurers and the providers of medical care. The means of payment or the rates paid by the Insurers to the health-care providers for providing medical services under such coverage do not equate to the performance of the contracts themselves.

As for the cases cited by the Insurers as examples of the application of the McCarran-Ferguson Act in the workers' compensation context, many involved disputes related to the formation of the actual insurance policies. *See, e.g.*, *Uniforce Temp. Pers., Inc. v. National Council on Comp. Ins., Inc.*, 87 F.3d 1296, 1297-98 (11th Cir. 1996) (involving complaint related to alleged price-fixing of premiums for workers' compensation policies); *In re Workers' Comp. Ins. Antitrust Litig.*, 867 F.2d 1552, 1554 (8th Cir. 1989) (addressing dispute related to regulation and alleged price-fixing of insurance premiums); *National Union Fire Ins. Co. v. Seneca Family of Agencies*, 255 F. Supp. 3d 480, 483 (S.D.N.Y. 2017) (concerning dispute related to terms to be included in documents forming insurance contract). And in *Proctor v. State Farm Mutual Automobile Insurance Company*, the court determined that alleged price-fixing between insurers as to rates paid for certain auto repairs were subject to reverse-preemption because the agreements were strictly "intra-industry" and because the cost of repairs did not merely affect premiums but was "directly related to the calculation of premiums; it is virtually a part of the ratemaking process." 675 F.2d 308, 322, 324 (D.C. Cir. 1982). Even assuming we were bound or persuaded by the *Proctor* opinion's application of *Royal Drug*, we are not persuaded that the rates paid to air-ambulance services are likely to have a "virtual ratemaking" effect on the workers' compensation insurance market.

Finally, *Cox*, as noted above, supports our conclusion, 868 F.3d at 904-05, and *Brown v. Cassens Transport Co.*, 546 F.3d 347 (6th Cir. 2008), does not provide useful guidance in this case. *Brown* discusses the Michigan workers' compensation system, observing that the benefits can be seen as a form of insurance, "thus perhaps creating an insurance-like relationship in which the employer is the 'insurer' and the employee is the 'insured,'" and

Wyoming workers' compensation system "establishe[d] a type of insurance," statute and schedule-setting fees for air-ambulance services were not laws "regulating the business of insurance"); *see also Life Partners, Inc. v. Morrison*, 484 F.3d 284, 294 (4th Cir. 2007) ("The 'business of insurance' refers to the marketing, selling, entering into, managing, servicing, and performing of insurance contracts."); *Dwelle*, 171 F. Supp. 3d at 944 (statute that effectively capped rate for air-ambulance services did not regulate insurance carriers or performance of insurance contracts, alter or affect policies between insureds and insurers, or limit itself to entities in insurance industry); *Perez*, 461 S.W.3d at 522 (citing

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also that certain provisions of the act in question regulate how an employer can self-insure, which "could be seen as part of 'the business of insurance.'" 546 F.3d at 359. However, the *Brown* court concluded that viewing the benefits as a form of insurance is "solely a matter of appearance" and concluded that because an employer already owed its employees a duty under common law to compensate the employee for workplace injuries, the system "merely creates a legislative remedy regarding the tort-liability relationship between employees and their employers, not an insurance contract." *Id.* at 359-60. The court discussed the purpose underlying the Michigan act, noting that it was focused on "providing certain recovery to employees for workplace injuries while limiting employers' liability rather than the regulation of insurance." *Id.* at 360. The court then noted that, although some provisions in the act did relate to the business of insurance (such as regulations setting required coverage in policies and prescribing certain terms that must be included), the employer involved was self-insured and thus the case implicated no insurer-insured relationship. *Id.* at 361. We do not read *Brown* as particularly helpful to our analysis, although its discussion of the underlying purpose behind Michigan's workers' compensation system lends supports to our conclusions.

Fabe and *National Securities* and explaining that practices falling within McCarran-Ferguson Act include fixing rates, selling and advertising policies, licensing of insurance companies and agents, writing of insurance contracts and actual performance of contracts).

We hold that the statutes and rules that attempt to regulate the reimbursement that may be obtained by PHI (1) are preempted by the ADA's prohibition on state attempts to regulate an air carrier's price, route or service and (2) are not "reverse-preempted" by the McCarran-Ferguson Act. We limit our decision to the rules and statutes related to reimbursement rates and explicitly do not address the balance-billing provision, as PHI has explained that it only attacks that provision in the alternative and that it would prefer to leave the balance-billing prohibition intact.

Conclusion

Because we conclude that the provisions related to the reimbursement due to air-ambulance service providers under the Act are preempted by the federal ADA and are not subject to reverse-preemption under the McCarran-Ferguson Act, we reverse the trial court's judgment and remand the cause to the trial court for further proceedings.[14]

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[14] Due to our resolution of the preemption issues, we need not address the other issues raised by the parties. *See* Tex. R. App. P. 47.1.

David Puryear, Justice

Reversed and Remanded
Filed: January 31, 2018

Appendix C

IN THE TEXAS DISTRICT COURT
53RD JUDICIAL DISTRICT

No. D-1-GN-15-004940

TEXAS MUTUAL INSURANCE COMPANY, et al.,
Plaintiffs,
v.
PHI AIR MEDICAL, LLC,
Defendant.

Filed: Jan. 11, 2017

FINAL JUDGMENT

On December 2, 2016, the Court held a hearing on the merits and took under submission the following: Petitioners'[1] Judicial Review Brief on the Merits and Motion for Summary Judgment; Intervenor Texas Department of Insurance, Division of Workers' Compensation's Brief on the Merits and Motion for Summary Judgment; and Respondent PHI Air Medical, LLC's Combined Motion for Summary

[1] Petitioners include Texas Mutual Insurance Company, Hartford Underwriters Insurance Company, TASB Risk Management Fund, Transportation Insurance Company, Truck Insurance Exchange, Twin City Fire Insurance Company, Valley Forge Insurance Company, and Zenith Insurance Company.

Judgment and Response Brief on the Merits. After considering the parties' motions, briefs and oral arguments, and the evidence in the record, the Court entered an Order dated December 15, 2016.

The Court **GRANTED:** Petitioners' Motion for Summary Judgment, and Intervenor's Motion for Summary Judgment. The Court **DENIED** Respondent's Motion for Summary Judgment.

Petitioners have notified the Court and all parties that they withdraw their request for attorneys' fees and costs and have requested entry of a final and appealable judgment.

IT IS therefore DECLARED, ORDERED, ADJUDGED, AND FINALLY DECREED that:

The 1978 Airline Deregulation Act, 49 U.S.C. § 41713, does not preempt the following provisions of Texas law: (i) the Texas Workers' Compensation Act's healthcare provider fee provisions, codified at Texas Labor Code § 413.011; (ii) the Texas Workers' Compensation Act's prohibition on billing injured workers for health care fees, codified at Texas Labor Code § 413.042; (iii) the Texas Workers' Compensation Act's authorization to the Division to assess sanctions for administrative violations, codified at Texas Labor Code §§ 415.021-415.025 and 415.031-415.036; and (iv) the Division of Workers' Compensation's regulations concerning health care provider fees, codified at 28 Texas Administrative Code §§ 134.1 and 134.203.

The Court further considered the Petitioners' judicial review challenge under Texas Labor Code § 413.031 and Texas Government Code, Subchapter G, Chapter 2001, to the September 8, 2015 Decision and

Order of the State Office of Administrative Hearings in Docket No. 454-15-0681.M4, *et al., In Re: Reimbursement of Air Ambulance Services Provided by PHI Air Medical* ("SOAH Decision and Order"), and concluded that no additional payments greater than the 125% of Medicare amounts already paid are due. IT IS, THEREFORE, ORDERED, ADJUDGED, AND DECREED that the SOAH Decision and Order's award of fees equaling 149% of the applicable Medicare rate is hereby REVERSED, and these medical fee disputes are REMANDED to the State Office of Administrative Hearings for further proceedings consistent with this Judgment.

Given that the Petitioners have withdrawn their request for attorneys' fees and costs, the Court declines to award any attorneys' fees or costs, and IT IS, THEREFORE, ORDERED that all parties are to bear their respective costs of court.

All other relief not expressly granted herein is DENIED.

This Judgment resolves all claims of all parties and is intended to be and shall be final and appealable.

Signed this [handwritten: 11th] day of January, 2017.

[handwritten: signature]
Hon. Jan Soifer
Travis County District Judge

Appendix D

RELEVANT STATUTORY PROVISIONS

49 U.S.C. § 41713(b)(1)

(b) Preemption.-

(1) Except as provided in this subsection, a State, political subdivision of a State, or political authority of at least 2 States may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart.

15 U.S.C. § 1012(b)

(b) Federal regulation

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.