Iowa Department of Inspections and Appeals
Division of Administrative Hearings
Wallace State Office Building – Third Floor
Des Moines, Iowa 50319

IN THE MATTER OF LYLE H. ABBAS, D.C., ET AL., Petitioners, v. WELLMARK, INC., D/B/A WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA AND WELLMARK HEALTH PLAN OF IOWA, INC., Respondents.	)	Docket No. 12IID026 **PROPOSED DECISION**

The parties to this proceeding are Petitioners Lyle H. Abbas, D.C., Dow Bates, D.C., Bradley Brown, D.C., Sidney Carter, D.C., Brad Chicoine, D.C., Russell Cox, D.C., Paul Eberline, D.C., Joseph Geelan, D.C., Richard Haas, D.C., Rex Jones, D.C., Keith Klemme, D.C., Elizabeth Kressin, D.C., Steven Kraus, D.C., Mark Kruse, D.C., Rodney Langel, D.C., Ronald Masters II, D.C., Kevin Miller, D.C., Steven Mueller, D.C., Mark Niles, D.C., Valorie Prahl, D.C., Jennifer Rassmussen, D.C., Rod Rebarcak, D.C., Randal Stange, D.C., Lance Vanderloo, D.C., Kenneth Van Wyk, D.C., and Ben Winecoff, D.C. and Respondents Wellmark, Inc., d/b/a Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. The Insurance Division transferred the dispute to the Division of Administrative Hearings for a contested case hearing.

The hearing was held September 16-18, 2013 at the Wallace State Office Building. Attorneys Glenn Norris, Steven Wandro, and John Parmeter represented Petitioners. Dr. Anthony Hamm, D.C. testified on behalf of Petitioners. Petitioners Brown, Rebarcak, and Kruse also testified. Attorneys Hayward Draper and Scott Sundstrom represented Respondents. Assistant General Counsel Michele Druker, Vice President of Health Networks Michael Fay, Executive Vice President Laura Jackson, Barton McCann, M.D., Ronald Evans, D.C., and Michael Blaess, D.O., and Susan Voss testified on behalf of Respondents. Respondents also called Petitioners Chicoine and Bates as witnesses.[1] Exhibits 1, 2, 28, 32, 36, 37, 41, 42, 49, 52, A through P, and R through Z were admitted into the record.

[1] During the hearing, Draper, a licensed attorney, also performed a demonstrative procedure with a chiropractic tool known as an Activator on Faith Robinson, an employee of his law firm.

STIPULATIONS

On August 28, 2013, the parties filed a Second Updated and Substituted Stipulation Regarding Order of Proof at Hearing and Petitioners' Prima Facie Case, Exhibit 1, with attachments, as follows:

1. Petitioners will present this Stipulation as their prima facie case for the hearing in this matter, including "Wellmark, Inc.'s July 1, 2013, PPO Fees for Selected CPT and Provider Types," which is attached and which the Petitioners will designate as Exhibit 1. Petitioners claim that the difference in the amount of the fees paid to chiropractors for the same or similar CPT codes as compared to what is paid to MDs and DOs, including the differences in the fees paid for CMT codes as opposed to OMT codes, constitutes a violation by Wellmark, Inc. of Iowa Code § 514F.2.

2. The parties further stipulate that the fees shown on Exhibit 1 are not used by Wellmark Health Plan of Iowa (WHPI), which instead contracts with the Iowa Chiropractic Physicians Clinic (ICPC) to provide a chiropractic network and pays ICPC at a capitated rate, and that ICPC's reimbursement for the CPT codes listed on the attached exhibit is less overall than the fees paid to chiropractors by Wellmark's PPO. Petitioners claim that this constitutes a violation by WHPI of Iowa Code § 514F.2. WHPI typically pays other providers, and in particular MD's and DO's pursuant to the fee schedules and not a contracted network with a capitated rate.

3. WHPI's Blue Advantage coverage includes a provision with regard to a referral from the member's primary care physician being required after twelve chiropractic visits for a particular condition, as set forth in the attached portion of the current Blue Advantage Benefit Certificate. Petitioners claim that this constitutes a violation by WHPI of Iowa Code section 514F.2.

4. Once Petitioners have submitted this Stipulation and the attached exhibits at the commencement of the hearing in this matter, Respondents may present witnesses and exhibits concerning their provider network systems, fee structures and otherwise responsive to Petitioners' prima facie case which Respondents claim involves no violation of Iowa Code § 514F.2. Petitioners may use additional exhibits in cross-examination. Petitioners may then present witnesses and exhibits supporting their claim of violations of Iowa Code § 514F.2, including any evidence within the scope of the parties' Stipulation of Issues for Decision that they claim to be a violation of Iowa Code § 514F.2, as shown by the discovery in this contested case, with Respondents' rebuttal if any and closing arguments by both counsel starting with Petitioners.

Petitioners agreed the Stipulation sets forth the only issues to be decided in this case.

FINDINGS OF FACT

Wellmark, Inc. is an Iowa mutual insurance company doing business as Wellmark Blue Cross and Blue Shield of Iowa. Wellmark, Inc. is the parent company of WHPI, which is an Iowa health maintenance organization ("HMO"). The Division regulates the

Wellmark entities. The Division does not regulate the employer self-funded plans Wellmark administers. This case involves allegations concerning Wellmark's preferred provider organization ("PPO"), self-funded plans administered by Wellmark, and WHPI.

I. Preferred Provider Organization

Wellmark operates a PPO in Iowa and South Dakota with a network of health care providers. Consumers participating in the PPO may seek care from providers outside the PPO network, but may incur higher out-of-pocket costs for those services. Wellmark's PPO has three groups of provider specialties, medical doctors ("MDs") and doctors of osteopathic medicine ("DOs"), allied specialties, and facility providers. Wellmark keeps "track of probably about 55 to 60 MD/DO specialties and 15 to 20 allied provider specialties. . . , [and] 10 to 16 facility provider types." (Tr. I at 117). Chiropractors fall in the category of allied specialties, with other professionals, including, but not limited to, physical therapists, social workers, and psychologists. The majority of licensed chiropractors in Iowa participate in the PPO.

A. Current Procedural Terminology

The American Medical Association ("AMA") publishes the Current Procedural Terminology, Professional Edition. All physicians and insurers in the United States use the Current Procedural Terminology for billing. The Current Procedural Terminology "is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians." (Exhibit G-1 at v). "The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services. . . ." (Exhibit G-1 at v). The individual codes for services listed in the Current Procedural Terminology are referred to as CPT codes. Wellmark uses the CPT codes for provider billing.

B. Premiums and Sustainability

In 2008, Wellmark's Board of Directors set a sustainability goal for premiums because premiums were rising at a rate higher than the Consumer Price Index ("CPI"). The sustainability goal is to keep premiums in line with the CPI.

The biggest drivers of premiums are unit fee cost, how much is paid for each unit of service, utilization, how many services are provided, and technology, which includes the new drugs and equipment. Fay stated in recent years, "the introduction of new drugs and technology into healthcare, tend to be a big driver of costs in certain years." (Tr. I at 148.). While utilization and technology affect premiums and provider reimbursement or fees, the evidence presented by the parties focused on unit fee cost.

C. Unit Fee Cost

Wellmark reimburses providers for services by assigning a unit fee cost for the service by CPT code. The unit fee cost is also referred to as the maximum allowable fee. The evidence at hearing revealed the unit fee cost for chiropractors is lower than for MDs

and DOs for three types of CPT codes: (1) the manipulation codes; (2) the x-ray codes; and (3) the evaluation and management codes. Petitioners contend the different fees violate Iowa Code section 514F.2.

Fay is a member of the Network Economics Team at Wellmark. The team includes members who are specialists in insurance and provider billing. Fay and his team are responsible for managing unit fee cost only. Other officials at Wellmark oversee utilization and technology costs. Fay reported Wellmark uses a regular process annually when determining the unit fee cost for services, which includes using the Centers for Medicare and Medicaid ("CMS") Relative Value Units ("RVUs").

Fay testified when determining unit fee cost, Wellmark uses "a conversion factor to convert the relative value scale into an actual fee unit cost." (Tr. I at 124). Fay testified, "[w]e create what we call conversion factors and then you multiply the conversion factor, which is a dollar figure, times the RVU and that gets you to the unit fee cost." (Tr. I at 172).

1. <u>CMS RVUs</u>

CMS uses the Resource Based Relative Value System ("RBRVS") developed by physicians at Harvard for Medicare provider reimbursement. Fay explained, the RBRVS "is a relative scale of comparing one procedure to another on a number of different factors so it gives you an overall sort of scale that comes back to an average of 1." (Tr. I at 122). CMS publishes a list of RVUs for each specialty, considering: (1) the time it takes the specialty to perform the type of procedure; (2) the specialty's technical skill to perform the type of procedure; (3) the judgment exercised by the specialty for the type of procedure; (4) the stress incurred by the specialty with regard to the type of procedure; (5) the specialty's practice expenses to perform the type of procedure; and (6) the specialty's malpractice insurance cost.[2] The CMS RVUs are reviewed every five years and are published in the Federal Register. The most recent review was completed in 2012. Payment under the CMS RVU system is based on the resources required to provide the service.

In developing the annual unit fee cost for services, Fay and his team use the RVUs developed by CMS by CPT code. Wellmark implemented the RBRVS system on January 1, 1999. Prior to the conversion, Wellmark had multiple fees per CPT code. Some of the CPT codes differed by geography, specialty, and type of network. With the conversion in 1999, Wellmark tried to "move to a more standard, state-wide approach." (Tr. I at 218). This case concerns Wellmark's current process.

CMS determines the RVUs through survey data from licensed practitioners. With the time factor, CMS asks practitioners to estimate the time it takes to perform a particular procedure. CMS also inquires about the intensity of the work, as compared to other

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[2] There were originally three RVUs, which are encompassed in the current six RVUs. The first four factors used to be known as the Work RVU, the fifth was known as the Practice RVU, and the sixth was known as the Malpractice RVU.

reference codes for other services. A 31 member committee, which includes chiropractic members, reviews the RUV factors. The committee then makes recommendations to CMS.

Dr. McCann testified that nearly 100% of all health insurance carriers use the RVUs for determining unit fee cost for services because the RVUs are created with input from service providers and service providers believe the RVUs are fair and reasonable. Fay testified Wellmark uses the RVUs to determine the unit fee cost because the RVUs are considered to be reliable and Wellmark does not have to pay a fee for using the RVUs.

2. Conversion Factors

In determining unit fee cost for services, Wellmark uses conversion factors. Fay testified Wellmark has approximately "10 to 12 conversion factors" for MDs and DOs and five for chiropractors. (Tr. I at 241, 244). Not all of the conversion factors are increased from year to year. Some decrease from year to year.

Medicare uses a single conversion factor for reimbursement. Fay reported a single conversion factor would not work for Wellmark because if Wellmark used a single conversion factor, "we would have a very broad network of primary care and probably no participating specialists." (Tr. I at 174). Fay explained Medicare's population differs significantly from Wellmark's population. Medicare's population is over age 65, with different medical needs. Wellmark's population includes younger members who require pediatric and maternity services. Fay noted pediatric and maternity services are big drivers of healthcare costs.

3. Process for Determining the Unit Fee Cost for Services

As discussed above, Wellmark uses the CMS RVUs for each CPT code multiplied by internal conversion factors to determine the unit fee cost for services.

a. Existing and Additional Funds for the Fee Schedule

When determining the annual unit fee cost for services Fay's team starts with "the new money we have to put into the fee schedule" in addition to what Wellmark paid in the previous year, or the historical data. (Tr. I at 145, 215). Each year Wellmark's Senior Leadership Team, which includes Fay's supervisor, Jackson, provides Fay's team with a pool of dollars to use for provider fees. The pool of dollars relates to premiums paid to Wellmark. Fay's team is not involved in setting the pool of dollars. Each year Wellmark's Senior Leadership Team increases the pool of funds, while trying to achieve Wellmark's sustainability goal of keeping premiums in line with the CPI.

b. Historic Claims Data

Fay and his team also look at the historic claims data by CPT code from the previous 12 months to see "the movement of more volume in a certain range of codes or less volume." (Tr. I at 197). Wellmark looks at the categories by provider type and service to

determine the volume and mix of services. Fay and his team examine whether there are more office visits, or changes from individual lab tests to panels. Fay explained, "[t]o do our calculations to spend the money that we got from senior leadership, we have to use a consistent base and so that mix of volume – those units are what we use as a base so we take that base times the current fee schedule and then times the proposed fee schedule to see where we are in relationship to that pool of dollars being spent." (Tr. I at 197).

c. Network Adequacy[3]

Fay reported network adequacy is an important component to unit fee cost. Network adequacy includes a geographic component because the PPO members are spread throughout Iowa and South Dakota. When there is a shortage of providers in a certain area, Wellmark may increase the fees for those providers. Competition in the marketplace factors into the determination. If fees are set too low, Wellmark could lose network adequacy because providers will not participate in the PPO. This has been a problem in the past and is a present concern. Several years ago PPO members seeking surgical services in the Sioux Falls area had to see an out-of-network anesthesiologist for anesthesia services, which increased costs. The PPO members were dissatisfied with the anesthesiologist for not participating in the PPO and with Wellmark because out-of-pocket costs were higher.

Fay noted Wellmark has never had a problem with network adequacy for chiropractors. In Iowa, the family practice MDs and DOs make up the largest group of specialty providers, followed by chiropractors and nurse practitioners. Fay identified psychiatry as "a shortage in general for Iowa's availability of having enough" in addition to primary care. (Tr. I at 162).

Fay testified that "[a]s part of our annual update for our professional fee schedule, we do look at what's the impact of the new fees compared to the current fees for each specialty that we track." (Tr. I at 159). When there is a shortage in an area, Fay and his team will identify the unique CPT codes for the specialty, and put money into the unique CPT code or codes for that specialty. Fay and his team accomplish this by looking at the historic claims data with modeling using an Access database.

In 2013/2012, psychiatry received a large increase because of network adequacy concerns. The increase was not for all DOs and MDs, but rather for the specialty of psychiatry. Fay reported, "[w]e take the pool of money and determine this amount is going toward the MD DO cohort and this goes to the allied and inside the allied it is allocated to each of the different provider types." (Tr. I at 165). Increases are dealt with by CPT code.

Exhibit J shows the increases and decreases by specialty over time. According to Exhibit J, in 2013/2012, the pool of money provided by Wellmark's Senior Leadership for

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[3] Fay also testified his team also considers whether or not providers are participating in a performance program when determining unit fee cost. The performance program allows providers to earn an incentive on top of the unit fee cost. The testimony at hearing revealed chiropractors generally have not chosen to participate in the incentive program for the PPO.

chiropractic care increased at a greater rate than 11 of the specialty groups, with some groups receiving decreases in the available pool of money. Only six specialty groups had increases in their pools of money greater than chiropractors. Some specialty groups consisting of MDs and DOs received lower increases or even decreases in the available pool of money during this period. Chiropractors only received increases in the available pool of money. Wellmark did not decrease the available pool of money for chiropractors. In contrast, seven of the 13 MD and DO specialty groups, experienced at least one decrease in the available pool of money from 2007/2006 through 2013/2012.

d. RUV Factors

Wellmark uses the CMS RVU for each CPT code when calculating the unit fee cost. Two of the disputed sets of codes, x-ray, and evaluation and management or office visits do not have CMS RVU factors because chiropractic x-ray and office visits are not covered services under Medicare. Fay testified that in creating conversion factors for chiropractic x-ray and office visits, Wellmark considers the six individual RVU factors to determine the unit fee cost, including: (1) the time it takes the specialty to perform the type of procedure; (2) the specialty's technical skill to perform the type of procedure; (3) the judgment exercised by the specialty for the type of procedure; (4) the stress incurred by the specialty with regard to the type of procedure; (5) the specialty's practice expenses to perform the type of procedure; and (6) the specialty's malpractice insurance cost.

1. Chiropractic Practice

Dr. Brown is a licensed chiropractor working as a sole practitioner in Iowa. Dr. Brown completed two years of postsecondary study at the University of Northern Iowa and then enrolled in Palmer College of Chiropractic. After four years of study at Palmer, he received a doctorate of chiropractic degree and commenced practicing.

Dr. Brown's wife works for him full-time in exchange for rent for her yoga studio and massage therapy room. Dr. Brown also pays an assistant who is not licensed for $14 per hour. Dr. Brown's malpractice insurance premium is $1,500 per year.[4]

Dr. Evans is also a licensed chiropractor. Dr. Evans testified the cost of malpractice insurance for a chiropractor is $1,500 to $1,800 per year.

Dr. Brown typically works from 8:30 a.m. through 11:45 a.m., and from 2:00 p.m. through 5:15 p.m., Monday, Tuesday and Thursday each week. On Wednesdays he works until 12:00 p.m.

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[4] Following the hearing Wellmark filed a Post-Hearing Request for Additional Finding of Fact, which was resisted. The Motion raises discovery disputes previously raised by Wellmark before hearing in its "Request for Finding of Fact". The prior Motion was filed after the discovery deadline closed and was denied for that reason on September 11, 2013. The current motion is also a discovery motion and is denied.

2. DO Practice

Dr. Blaess is a licensed DO who is board certified in family practice. Dr. Blaess attended four years of medical school and completed a post-graduate residency. Dr. Blaess works in family practice and urgent care. Dr. Blaess performs osteopathic manipulation after performing structural exams and looking for abnormal placement of bone or tissue in the spine or joints. Dr. Blaess reported his overall practice expenses are $450,000 per year.

3. MD/DO and Chiropractic Practice Differences

Dr. Evans reported the stress MDs and DOs experience is greater than the stress chiropractors experience because MDs and DOs have to provide care after hours, are on-call, and have to ensure patients are being monitored because of medication orders. Chiropractors do not prescribe and monitor prescriptions.

Dr. Evans noted the typical chiropractor treats acute neuromuscular injuries, primarily neck and back pain, through spinal manipulation, whereas MDs and DOs treat other health issues, not just neck and back pain. Dr. Evans reported MDs and DOs who are radiologists have skill and judgment chiropractors do not possess, with three to four years of additional training after completing medical school, and national board certification. Dr. Evans stated chiropractors examine x-rays to look at skeletal alignment and disease, whereas MDs and DOs look beyond skeletal alignment and disease.

Fay testified that individual chiropractors and MDs have provided information to Wellmark about their overhead expenses, and the overhead expense to run a MD practice is higher than the overhead expense for a chiropractic practice.

Dr. Evans has experience working with ARNPs and MDs. Dr. Evans testified the malpractice insurance expense for a MD is much higher than for a chiropractor, often ten times higher.

e. Provider Input

Fay testified when determining the unit fee cost, Wellmark obtains information about fees from individual providers and groups, including the Iowa Chiropractic Society and Iowa Medical Society. Fay stated Wellmark has had numerous meetings with representatives from the Iowa Chiropractic Society for input on billing categories for Wellmark's conversion factors. Fay testified, "[t]hey told us that these categories made logical sense, that manipulation therapy is the most commonly billed as the data shows in Exhibit K, that we should focus most of our attention on the manipulation code unit fee cost." (Tr. I at 192). Fay noted 67% of the units billed to Wellmark are for manipulation, 27% of the units billed to Wellmark are for therapy, and 1.5% of the units bills to Wellmark are for radiology. In response to the input Wellmark received from the Iowa Chiropractic Society, Wellmark "targeted most of the increase with our updates

into the manipulation category," which may have resulted in no increase or a very small increase in evaluation and management. (Tr. I at 193).

Wellmark's standard fee updates go into effect the first of July each year. In 2008/2007 Wellmark received a request from chiropractors for an off-cycle fee adjustment effective in October or November, in addition to the updates from July. In response to the request, Wellmark's Senior Leadership Team provided Fay and his team "an additional amount of money to put just into the chiropractic fee schedule." (Tr. I at 194).

4. Differing Reimbursement by CPT Code

a. *CMT Versus OMT*

The CPT defines chiropractic manipulation therapy or CMT as "a form of manual treatment applied by a physician or other qualified health care professional to eliminate or alleviate somatic dysfunction and related disorders." (Ex. G1 at 553). Osteopathic manipulation therapy or OMT is defined as "a form of manual treatment to influence joint and neurophysiological function." (Ex. G1 at 554). Fay testified CMT and OMT are performed at different rates in Iowa. In 2013, Iowa chiropractors sought reimbursement for over 1,000,000 CMTs from Wellmark and Iowa DOs sought reimbursement for just slightly more than 10,000 OMTs.

Both CMT and OMT are performed by region. The body regions for OMT include the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, ribcage, abdomen, and viscera. For CMT, there are five spinal regions, including the cervical, thoracic, lumbar, sacral, and pelvic, and five extraspinal regions, including the head, lower extremities, rib cage, and abdomen. The CMS RVU for OMT 1-2 regions is 0.77, and for OMT 1-2 regions is 0.92. The RVUs for CMT and OMT are determined by CMS, not Wellmark.

Fay noted the CMS RVUs for CMT and OMT differ, but that does not account for the entire variance in the unit fee cost between CMT and OMT. Because of the limited volume of OMT services performed, Wellmark uses the conversion factor for all remaining procedures for OMT, which is a miscellaneous or non-specific category.

Dr. Brown testified that when he performs an adjustment or CMT on a patient using the Activator with three levels it takes him two to five minutes to perform the CMT. If Dr. Brown were to use his hands, the procedure would take additional time.

Dr. Blaess testified it takes him five to 15 minutes to perform OMT for one to two areas, 10 to 20 minutes for three to four areas, and 15 to 30 minutes for five to six areas.

Dr. McCann testified CMS' surveys determined how long it takes a typical chiropractor and a typical DO to perform CMT or OMT, including pre-service time, where the professional briefly speaks to the patient about how they have been since the last visit, intra-service time, which is the actual manipulation, and post-service time, which includes patient instructions. For one to two regions of OMT, the survey found the

actual hands-on procedure took 10 minutes. For one to two regions of CMT, the survey found the actual hands-on procedure takes seven minutes. "And counting pre and post time," CMS found it took 14 minutes for one to two regions of OMT, and 12 minutes to perform CMT. (Tr. II at 128). Through its surveys, CMS found it takes chiropractors several minutes less time to conduct CMT than it takes a DO to conduct OMT, resulting in Medicare paying a lower unit fee cost for CMT.

Dr. McCann further reported the CMS survey showed the actual practice expense for a chiropractor performing CMT is lower than the actual practice expense for a DO performing OMT because the type of assistant typically used by chiropractors is less costly than the assistant typically used by a DO, there are differences in equipment costs, and the malpractice expense for chiropractors is lower than for DOs. Dr. McCann noted, the direct costs, which include the staff costs, supply costs, and equipment costs total $5.44 for a DO performing OMT for one to two regions, and $3.06 for a chiropractor to perform CMT for one to two regions.

b. Radiology

CMS does not provide a RVU for chiropractic radiology or x-ray because chiropractic radiology is not a covered service under Medicare. Because CMS does not have a RVU for chiropractic radiology, Fay and his team look at the services that are already in place, and apply the six factors developed by CMS, as if CMS had developed an RVU specifically for chiropractic radiology. Fay testified Wellmark adjusts the conversion factor for chiropractic radiology by applying the six categories developed by CMS and based on Wellmark's "[e]xperience, knowledge, information that's available." (Tr. I at 181).

Fay opined in looking at the six categories for radiology, it is uncertain whether there is a difference in the time needed to perform the procedure. He noted, under technical skill, few MDs and DOs take and read their own x-rays. Fay testified 85% of the MDs and DOs seeking reimbursement for radiology are board certified radiologists. Fay reported that while radiologists perform the bulk of the MD and DO x-rays billed to Wellmark, the conversion factors are not listed by individual practitioner specialty, but by groups because "[i]t would be impossible to administer a separate fee schedule for every physician." (Tr. I at 186).

Dr. McCann confirmed few DM/DO family practice physicians read their own x-rays and refer this task out to board certified radiologists. General chiropractors do not have the same training and technical skill as board certified radiologists.

Fay reported under the judgment factor, chiropractors focus on alignment of the skeletal structure when reading x-rays, whereas a board certified radiologist is looking for tumors and other conditions. Fay testified board certified radiologists evaluate x-rays for surgical procedures, and chiropractors do not.

Fay noted the stress and risk MDs and DOs face differs from that chiropractors face. MDs and DOs may be called to life threatening events. The overhead or practice

expense for MDs and DOs is also higher because they employ licensed nurses. And the malpractice expense for MDs and DOs is higher. Wellmark has received some feedback "from chiropractors about what their average overhead expense is but we've also had quite a few MDs provide us with information about what their overhead costs are doing from a year to year basis." (Tr. I at 185). Fay reported the overhead to run a MD practice is higher than a chiropractic practice.

c. Evaluation and Management

Fay testified the evaluation and management codes are for office visits. As with radiology or x-ray, CMS does not have an RUV for a chiropractic office visit because a chiropractic office visit is not a covered service under Medicare. As with chiropractic radiology, Wellmark applies the six RVU factors in determining the unit fee cost for evaluation and management, discussed above. Fay reported Wellmark previously lowered the unit fee costs for chiropractic evaluation and management at the request of the Iowa Chiropractic Society when it requested fees to be shifted to the manipulation codes.

5. <u>Recommendations from Fay's Team are Reviewed by the Senior Leadership</u>

Fay brings recommendations to Jackson after analyzing the data with his team. Jackson looks at the network adequacy, and the historical mix of services, and either approves Fay's recommendations or sends Fay back to his team to make revisions.

D. Manual Language

Exhibit D is a copy of a Sample Coverage Manual for Alliance Select, which is a PPO. Druker reported the Manual does not limit payment or reimbursement for chiropractic care. Musculoskeletal treatment is specifically covered. Page 21 states most services provided by practitioners recognized by Wellmark are covered, including chiropractors. The Sample Coverage Manual notes that services provided by athletic trainers are not covered. Cosmetic surgery, Lasik surgery, massage therapy, and acupuncture are not covered services. Druker testified the other Wellmark Manuals do not limit chiropractic care from coverage. In contrast, many of the self-funded plans limit chiropractic coverage. For example, the self-funded plans in Exhibit F-2 and F-3 limit chiropractic care to a benefit of $300 or $400 per year, respectively.

II. Self-Funded Plans

Wellmark administers 100s of employer self-funded health plans. The group health plans are sponsored and funded by employers or group sponsors. Each employer or group sponsor has entered into a financial arrangement with Wellmark, where the employer or group sponsor is solely responsible for claim payment amounts for covered services provided to members. Employers with self-funded plans make autonomous decisions on benefit and plan language. Wellmark provides administrative services and provider network access only.

III. WHPI

WHPI is an HMO. HMOs are more restrictive than PPOs and contain a tight network of providers and hospitals. A consumer participating in a HMO must work through a gatekeeper MD or DO to obtain referrals for providers outside the HMO.

A. ICPC

Dr. Evans, a chiropractor, founded the ICPC, a chiropractic network. When WHPI was first being created, Dr. Evans suggested WHPI contract with a separate entity to provide a chiropractic network. Dr. Evans provided a chiropractic network to WHPI known as the ICPC. ICPC is a clinic without walls. ICPC also provides a chiropractic network to other entities, including Midlands Choice, Account Health, and Corvel.

ICPC negotiates a capitated rate with WHPI, where ICPC is paid a set amount in advance for each member in the insured plan whether the member uses the provider's health services, or not. ICPC then contracts separately with chiropractors in its network. WHPI does not control the reimbursement rate ICPC provides to its network. ICPC has entered into an agreement with WHPI each year since 1994.

Dr. Evans reported ICPC has not had any difficulty finding chiropractors to participate in the network as a result of the remuneration paid. In his experience providers want to be a part of ICPC. Dr. Evans testified ICPC is continuing to grow.

B. Referral after 12 Visits

Under WHPI's Blue Advantage a member must obtain a referral from the member's primary care physician after 12 chiropractic visits for a particular condition. The 12 visit rule is an exception, in part, to the gatekeeper principal used with most specialists because a member is permitted to see a chiropractor up to 12 times without receiving a referral from the member's MD/DO gatekeeper. Dr. Evans testified the threshold is not a limit on coverage, but is designed to ensure the member touches base with the member's primary care provider to see if the member would benefit from another type of treatment, or additional chiropractic care. The gatekeeper determines whether the member is progressing with chiropractic care or not. Dr. Evans reported that in his personal practice he has not had any patients exceed the 12 visit threshold.

CONCLUSIONS OF LAW

The Iowa Legislature created the Division to regulate and supervise the business of insurance in the state of Iowa.[5] The Insurance Commissioner is the chief executive officer of the Division.[6] The Division reviews PPO coverage manuals to ensure compliance with state law, but does not review employer self-funded plans that are governed by ERISA. Voss, a former Commissioner who worked for the Division for

[5] Iowa Code § 505.1 (2011).
[6] *Id.*

many years, testified the Division has never raised an objection to Wellmark's coverage manuals. The Division does not review the fees Wellmark and other insurers negotiate with providers.

Iowa Code chapter 514F governs utilization and cost control in Iowa. Petitioners contend Wellmark pays chiropractors lower fees than it pays to MDs and DOs for the same or similar CPT codes, in violation of Iowa Code section 514F.2. Wellmark contends Iowa Code section 514F.2 does not require parity of payment, Wellmark's differing PPO fees are not solely based on licensure, ERISA preempts application of Iowa Code section 514F.2 to the self-funded plans it administers, WHPI's use of an independent chiropractic network does not violate Iowa Code section 514.2, and WHPI's 12 visit referral rule is not a limit of coverage or solely related to licensure.

Iowa Code section 514F.2 provides:

> Nothing in the chapters of Title XIII, subtitle 1, of the Code shall be construed to prohibit or discourage insurers, nonprofit service corporations, health maintenance organizations, or self-insurers for health care benefits to employees from providing payment of benefits or providing care and treatment under capitated payment systems, prospective reimbursement rate systems, utilization control systems, incentive systems for the use of lease restrictive and least costly levels of care, preferred provider contracts limiting choice of specific provider, or other systems, methods or organizations designed to contain costs without sacrificing care or treatment outcome, provided these systems do not limit or make optional payment or reimbursement for health care services on a basis solely related to the license under or the practices authorized by chapter 151 or on a basis that is dependent upon a method of classification, categorization, or description based upon differences in terminology used by different licensees under the chapters of Title IV, subtitle 3, of the Code in describing human ailments or their diagnosis or treatment.

Petitioners contend this provision precludes Respondents from paying different fees to chiropractors than to MDs and DOs licensed under Iowa Code chapter 148 for the same or similar service or procedure.

I. ERISA Preemption of Self-Funded Plans

Wellmark administers 100s of self-funded health plans governed by the Employee Retirement Security Program ("ERISA"), 29 U.S. C. section 1101, *et seq.* Many of the self-funded health plans place limits on chiropractic coverage in Iowa. Petitioners contend the self-funded health plans are subject to Iowa Code section 514F.2. Wellmark argues ERISA preempts Iowa Code section 514F.2 from application to the self-funded plans.

When determining whether federal law preempts a state statute, the courts examine congressional intent.[7] Preemption may be express or implied and "is compelled whether Congress' command is explicitly stated in the statute's language or implicitly contained in its structure and purpose."[8]

When enacting ERISA, Congress included an express preemption clause displacing state action with respect to private employee benefit programs.[9] ERISA contains in exception to preemption, under the "savings clause" for state insurance regulation, but also contains a "deemer clause" that "exempts self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the savings clause."[10] The Eighth Circuit Court of Appeals has held "the effect of the deemer clause is that self-funded ERISA plans are exempt from state regulation insofar as that regulation relates to the plans."[11] Iowa Code section 514F.2 regulates coverage under self-funded health care plans. As a matter of law, ERISA preempts Iowa Code section 514F.2 from application to the self-funded plans.

II. Plain Meaning of Iowa Code chapter 514F.2 Precludes Limits based Solely on Licensure

Petitioners contend Iowa Code section 514F.2 prohibits Wellmark from paying chiropractors different fees than it pays to MDs and DOs for the same or similar services. Wellmark avers Iowa Code section 514F.2 does not require parity of payment between chiropractors and other types of providers, and that legal holding is dispositive of all issues in this case.

The terms "limit" and "make optional" are not defined in Iowa Code chapter 514F or by rule. The Iowa Supreme Court has held that when construing a statute,

> The goal of statutory construction is to determine legislative intent. We determine legislative intent from the words chosen by the legislature, not what it should or might have said. Absent a statutory definition or an established meaning in the law, words in the statute are given their ordinary and common meaning by considering the context within which they are used. Under the guise of construction, an interpreting body may not extend, enlarge, or change the meaning of a statute.[12]

When the Iowa Legislature has not defined a word or there is not a particular and appropriate meaning in the law, the courts give the words of a statute "their plain or

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[7] *FMC Corp. v. Holliday*, 498 U.S. 52, 56-57 (1990).
[8] *Id.* (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983)).
[9] *Daley v. Marriott Int'l, Inc.*, 415 F.3d 889, 894 (8th Cir. 2005).
[10] *Id.*
[11] *Id.* at 894-95 (concluding the deemer clause exempted Marriott's self-funded plan from Nebraska's mental health parity law, requiring parity between mental and physical health services).
[12] *Gartner v. Iowa Dep't of Pub. Health*, 830 N.W.2d 335, 348 (Iowa 2013) (quoting *Auen v. Alcoholic Beverages Div.*, 679 N.W.2d 586, 590 (Iowa 2004)).

ordinary meaning."[13] The Iowa Supreme Court has found a dictionary provides an acceptable method of determining the appropriate meaning of words in a statute.[14]

Webster's Dictionary defines the term "limit" as "something that bounds, restrains or confines," and the term "optional" as "not compulsory."[15] The plain meaning of the statute precludes insurers from restraining or restricting payment or reimbursement solely based on licensure. The statute does not require payment parity, but that is not dispositive in this case as a matter of law. While there is no evidence the PPO makes optional payment to chiropractors, based on the plain meaning of the statute it is necessary to consider whether Wellmark limits fees to chiropractors solely based on licensure.

III. The PPO Payment Differences are not Solely Related to Licensure

PPOs are regulated under 191 IAC chapter 27. A preferred provider is defined as a health care provider or group of providers who have contracted to provide a specific service pursuant to a preferred provider agreement.[16]

The evidence at hearing revealed there are three types of CPT codes where Wellmark's unit fee costs for chiropractors are lower than for MDs and DOs: (1) the manipulation codes; (2) the x-ray codes; and (3) the evaluation and management codes. Petitioners contend the different unit fee costs violate Iowa Code section 514F.2. The statute does not preclude insurers from considering licensure when developing a payment system. The statute precludes insurers from basing a differential pay system solely on licensure.

The evidence presented at hearing does not support Petitioners' claims. When determining unit fee cost, Wellmark uses a multi-factored approach, looking at the mix historical mix of services, network adequacy, provider input, and the CMS RVUs.

Wellmark uses the CMS RUVs for the various CPT codes. The evidence revealed CMS has assigned different values for OMT and CMT based on analysis of the six factors, including: (1) the time it takes the specialty to perform the type of procedure; (2) the specialty's technical skill to perform the type of procedure; (3) the judgment exercised by the specialty for the type of procedure; (4) the stress incurred by the specialty with regard to the type of procedure; (5) the specialty's practice expenses to perform the type of procedure; and (6) the specialty's malpractice insurance cost. The differing unit fee costs for OMT and CMT are explained in part by the differing RVUs determined by CMS. The factors used by CMS are not solely based upon licensure.

Chiropractic x-ray and evaluation and management or office visits are not covered services under Medicare. Because the services are not covered by Medicare, CMS has not developed RUVs for chiropractic x-ray and evaluation and management. Fay

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[13] *State v. Simmons*, 500 N.W.2d 58, 59 (Iowa 1993) (noting the Iowa Legislature did not define the terms exonerate or expunge in the statute).
[14] *Id.*
[15] *Merriam-Webster's Collegiate Dictionary* (10th Ed. 1998).
[16] 191 IAC 27.5.

testified at hearing Wellmark applies the same six-factor test employed by CMS in determining the RVUs for chiropractic x-ray and evaluation and management. The six factors are not solely based upon licensure. While the differences in the RVUs for the three categories of services do not fully explain the difference in the unit fee costs, the statute precludes limits solely based on licensure. The differing RVUs are not solely based on licensure. Petitioners have not proven Wellmark has violated Iowa Code section 514F.2.

IV. WHPI's Use of an Independent Chiropractic Network is Neither a Limit on Coverage nor Solely Related to Licensure

ICPC has a provider network that contracts with WHPI. ICPC negotiates a capitated rate with WHPI, where ICPC is paid a set amount in advance for each member in the insured plan whether the member uses the provider's health services, or not. ICPC then contracts separately with chiropractors in its network. WHPI does not control or limit the reimbursement rate ICPC provides to its network. Iowa Code section 514F.2 does not preclude WHPI from entering into such an arrangement.

V. WHPI's 12 Visit Rule

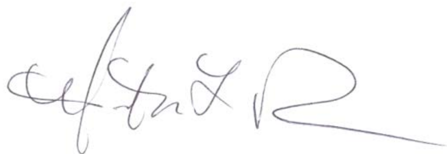
Under WHPI's Blue Advantage a member must obtain a referral from the member's primary care physician after 12 chiropractic visits for a particular condition. The 12 visit rule is an exception, in part, to the HMO gatekeeper principal used with most specialists because a member is permitted to see a chiropractor up to 12 times without receiving a referral from the member's MD/DO gatekeeper.

Dr. Evans testified the threshold is not a limit on coverage, but is designed to ensure the member touches base with the member's primary care provider to see if the member would benefit from another type of treatment, or additional chiropractic care. The gatekeeper determines whether the member is progressing with chiropractic care or not. WHPI does not limit the number of chiropractic visits, rather, the primary care provider or gatekeeper evaluates the case and authorizes additional chiropractic care, if it is needed. The 12 visit rule does not violate Iowa Code section 514F.2.

ORDER

Petitioners have not proven Wellmark has violated Iowa Code section 514F.2 ERISA preempts application of Iowa Code section 514F.2 to the self-funded health plans Wellmark administers. The plain meaning of Iowa Code section 514F.2 does not require payment parity, but precludes insurers from restraining or restricting payment or reimbursement solely based on licensure. Petitioners have failed to prove Wellmark's differing unit fee costs for services are solely based on licensure. WHPI's use of a capitated fee agreement with ICPC does not violate Iowa Code section 514F.2. The WHPI's 12 visit rule does not violate Iowa Code section 514F.2. The Division shall take any steps necessary to implement this decision.

Dated this 21st day of February, 2014.



Heather L. Palmer
Administrative Law Judge
515-281-7183

cc: Hayward Draper, Scott Sundstrom, Ryan Koopmans
Michele Druker
Glen Norris
Steven Wandro and John Parmeter
Bob Koppin

Notice

An adversely impacted party may appeal a proposed decision to the commissioner within 30 days after the issuance of the proposed decision.[17] The appeal must be filed with the commissioner's office in writing. The commissioner's office is at 330 Maple Street, Des Moines, Iowa 50319. The notice shall specify: (1) the proposed decision or order appealed from; (2) the party initiating the appeal; (3) the specific findings or conclusions to which exception is taken; (4) the grounds for relief; and (5) the relief sought.

[17] *Id.* 3.27.