BEFORE THE IOWA INSURANCE COMMISSIONER

IN THE MATTER OF	)	
	)	**Decision and Declaratory Order**
LYLE H. ABBAS, D.C. et al.	)	
	)	Commissioner File No. 78786
Petitioners,	)	
	)	

This matter is now before Insurance Commissioner Nick Gerhart following an evidentiary hearing before an administrative law judge with the Division of Administrative Hearings in the Iowa Department of Inspections and Appeals that was held on September 16 – 18, 2013.[1]

This matter was initiated with the filing of a document titled "Request for Contested Case Proceeding" on November 30, 2012.

Commissioner Gerhart became insurance commissioner on February 1, 2013, replacing Susan E. Voss.

PARTIES AND JURISDICTION

1. The matter was commenced with the filing of a "Request for Contested Case Hearing" ("Request") by Lyle H. Abbas, D.C. and twenty-five other chiropractors ("Petitioners").

2. The Petitioners' Request is a 13 page document, and concludes with a prayer for relief, including the following:

> e. That a decision be entered decreeing that Wellmark Licensees [Wellmark, Inc. and Wellmark Health Plan of Iowa, Inc. (hereafter "Wellmark companies")] are in violation of Iowa Code § 514F.2 and Rule 191-27.6 (514F) in the particulars stated above;
>
> f. That Wellmark Licensees be ordered to modify their fee schedules to conform to the requirements of Iowa Code § 514F.2 and Rule 191-27.6 (514F);

[1] The hearing was held on September 16, 17 and 18, 2014 before Heather Palmer. There were three days of testimony, and the proceedings are reported in Volumes I, II, and III. References to the transcript in this decision will be indicated by volume and page number ("Tr. Vol. __, p.__").

g. That the Commissioner impose civil penalties for violation of Insurance Division Rules, Chapter 27 in the amount and pursuant to the procedure stated in Insurance Division Rule 191-27.7(514F).

3. No provision in Iowa Code, Chapter 514F creates a private cause of action for providers such as the Petitioners. *Mueller v. Wellmark*, 818 N.W.2d 244, 255 – 256 (Iowa 2012).

4. Furthermore, Iowa Code, Chapter 514F does not grant to the insurance commissioner the judicial authority to vindicate the disputes of private parties, whether the complaining entities are health care insurance policyholders or health care providers. Iowa Code, Chapter 514F exhibits no legislative intent to transform the insurance commissioner into an insurance claims court.

5. To the contrary, the administrative enforcement powers of the insurance commissioner to prosecute alleged violations of Iowa Code, Chapter 514F on behalf of the state of Iowa, resides exclusively in the office of the insurance commissioner, not with the Petitioners. The Iowa Supreme Court summarized it in the following manner:

> Pursuant to the legislature's authorization, the insurance commissioner has adopted administrative rules regulating preferred provider arrangements and detailing administrative enforcement powers. *See* Iowa Admin. Code r[ule]. 191–27 (governing preferred provider arrangements). The insurance commissioner determined civil penalties for violating preferred provider arrangements regulations "shall be imposed in the amount, and pursuant to the procedure, set forth in Iowa Code sections 507B.6, 507B.7, and 507B.8." *Id.* r[ule]. 191–27.7. The operative statutes and rules authorize the insurance commissioner to issue charges, hold hearings, and levy civil penalties up to $50,000 for improper preferred provider arrangements, all subject to judicial review. *See* Iowa Code §§ 507B.6–8. *Seeman* [*Seeman v. Liberty Mutual Insurance Co.*, 322 N.W.2d 35 (Iowa 1982)] relied on such administrative procedures in holding the Insurance Trade Practices Act did not create an implied private cause of action. 322 N.W.2d at 42 (citing Iowa Code sections 507B.6, 507B.7, 507B.8, the enforcement powers in the Insurance Trade Practices Act).

Mueller, at 256 (*emphasis added*).

6. The insurance commissioner has assigned the duty of determining whether to initiate an enforcement action by filing a statement of charges involving unfair trade practices or unfair method of competition to the Market Regulation Bureau. Iowa Admin. Code 191 – 1.1(3) provides, in pertinent part:

1.1(3) The market regulation bureau is responsible for the following:
a. Ensuring fair treatment of consumers and preventing unfair or deceptive trade practices in the insurance and securities marketplaces. Inquiries from the public are answered and consumer complaints regarding insurance producers, insurers, broker-dealers, securities agents, investment advisers, and investment adviser representatives are received, reviewed, and investigated. Administrative actions are taken where appropriate, and criminal matters are referred to prosecutors for potential action.

7. In this case, we have not issued a statement of charges.

8. Rather than issue a statement of charges upon receipt of complaints, Commissioner Susan E. Voss, shortly following her departure from the Insurance Division, testified on behalf of the Wellmark companies in support of their defense to the alleged violations. Former Commissioner Voss testified that providers with complaints could "go to the Division" (Tr. Vol. I, p. 33). Former Commissioner Voss also testified that the Iowa Insurance Division does not have any role or authority with regard to the amount of the fees negotiated between a health insurance carrier and its network providers (Tr. Vol. I, p. 38, 41 – 42). This regulatory decision was made by then Commissioner Voss even though the Division received complaints from varied health care providers, including chiropractors, physician assistants and advanced nurse practitioners (Tr. Vol. I, p. 42). Former Commissioner Voss testified that while serving as commissioner, she had given an informal opinion that no action under § 514F.2 was appropriate based upon an informal complaint from the Chiropractic Society (Tr. Vol. I, p. 53 – 56).

9. On December 14, 2012, the Petitioners and the Wellmark companies submitted a stipulation, which tendered the following issues for decision to then Insurance Commissioner Voss:

1. Are the fees paid by Wellmark, Inc., to chiropractors unlawfully discriminatory in violation of Iowa Code § 514.2?

(a) Does the Wellmark annual fee schedule for the year beginning July 1, 2012, applicable to individual or other fully-insured coverages limit payment for health care services on a basis solely related to the license under or the practices authorized by Iowa Code chapter 151 in such a manner as to violate the provisions of Iowa Code § 514F.2?

(b) Does the Wellmark annual fee schedule for the year beginning July 1, 2012, applicable to self-funded group health plans that are administered by Wellmark, or to Blue Card claims administered by

Wellmark, limit payment for health care services on a basis solely based related to the license under or the practices authorized by Iowa Code chapter 151 in such a manner as to violate the provisions of Iowa Code § 514F.2?

2. Is the capitated payment plan used for chiropractic coverage by Wellmark Health Plan of Iowa, Inc., unlawfully discriminatory in violation of Iowa Code § 514F.2?

(a) Does the capitated services payment system which Wellmark Health Plan of Iowa, Inc., has put in place for its Blue Advantage coverage for payment for services of Iowa chiropractors limit payment for health care services on a basis solely related to the license under or the practices authorized by Iowa Code chapter 151 in a manner that violates Iowa Code § 514F.2?

(b) Does the provision in the capitated services payment system used for Wellmark Health Plan of Iowa, Inc.'s Blue Advantage coverage violate the provisions of Iowa Code § 514F.2 with regard to a referral from the member's primary care physician being required after 12 chiropractic visits for a particular condition?

10. These questions were jointly presented by Petitioners and the Wellmark companies. Clearly, these questions have the character of a request for a declaratory order, not an action for enforcement.[2] The appropriate procedure to address the questions raised is, therefore, a declaratory order under Iowa Code §17A.9 and Iowa Admin. Code rule 191–2. The hearing in this matter was not improvidently held as Iowa Code § 17A.9(5)(b) provides agencies with wide discretion to schedule proceedings.

11. Whether or not intentional, an insurance commissioner cannot, absent express statutory authority, delegate to a private party her authority to "issue charges" alleging statutory violations, or seeking cease and desist orders and financial penalties. As suggested at the oral argument by one of the Insurance Division's enforcement attorneys on September 22, 2014, private citizens are not authorized to issue charges and prosecute an enforcement action under the Iowa Code §§ 507B.6, 507B.7, and 507B.8 of the Unfair Trade Practices Act, nor under Iowa Admin. Code rule 191–27, an action alleging violations of Iowa Code § 514F.2. If the courts were to find this extraordinarily broad principle of "standing" before the insurance commissioner in the definition of "contested case" in Iowa Code §17A.2(5), such a ruling would literally "throw open" the doors of the insurance commissioner's office. We would be unable to keep pace with numerous demands to

[2] Enforcement relief such as a cease and desist order and civil penalties could have significant regulatory consequences for the Wellmark companies.

hold hearings and write insurance claim decisions if required to adjudicate every consumer and provider complaint alleging unfair trade practices or unfair methods of competition.

12. Nevertheless, as a three day hearing has already been held in this matter and all interested parties will benefit from finality in this action, I conclude that I have discretion to preside over a declaratory order proceeding, and therefore jurisdiction to review the decision of the administrative law judge as a proposed Declaratory Order to be issued under Iowa Code § 17A.2.

13. On August 28, 2013, the parties filed a Second Updated and Substituted Stipulation Regarding Order of Proof at Hearing and Petitioners' Prima Facie Case.

> 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.

14. The Commissioner takes up for consideration and decision as a petition for declaratory order, the November 30, 2012 request for contested case hearing, the December 14, 2012 stipulation and the August 28, 2013 second updated and substituted stipulation, filed by the Petitioners, and issues the following declaratory order:

QUESTION PRESENTED 1(a)

Does the Wellmark annual fee schedule for the year beginning July 1, 2012, applicable to individual or other fully-insured coverages limit payment for health care services on a basis solely related to the license under or the practices authorized by Iowa Code chapter 151 in such a manner as to violate the provisions of Iowa Code § 514F.2?

15. Iowa Code § 514F.2 provides, as follows:

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.

16. Wellmark, Inc. is an Iowa mutual insurance company doing business as Wellmark Blue Cross and Blue Shield of Iowa. Wellmark, Inc. ("Wellmark") utilizes a preferred provider organization ("PPO") to contain costs. Wellmark's utilization control systems are within the scope of Iowa Code chapter 514F.

17. Wellmark's July 1, 2013, PPO Fees for Selected CPT and Provider Types differentiate 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.

18. First, I must declare the meaning of Iowa Code § 514F.2. 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.[3]

19. I conclude that Wellmark is not in violation of § 514F.2, because we declare that Iowa Code § 514F.2 does not prohibit insurers, nonprofit service corporations, health maintenance organizations, or self-insurers for health care benefits to employees from engaging in any particular act or practice.

20. To the contrary, the intent of § 514F.2 is plain from its sentence structure. The first phrase reads as follows:

> 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, ...

---

[3] *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)).

The intent of this phrase is to provide authorization insurers to use certain utilization and cost control systems. This intent was achieved by stating that no other statute in the Iowa insurance code can be interpreted to prohibit these measures. This interpretive directive is then followed with a condition:

> ... 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.

This second phrase simply qualifies the first phrase. Even if an insurer's systems did limit or make optional payment on a basis solely related to the license, and Wellmark's did not, the condition or qualification in this phrase would still require that the insurance commissioner in seeking enforcement allege and prove a statutory or regulatory provision that actually does prohibit a limit or making optional payment or reimbursement. I declare that the prohibition is not found in § 514F.2.

21. Examples of mandated coverage or coverage offers that are related to certain providers are found in Iowa Code §§ 509.3, 514.7, and 514B.1. Restrictions on variance in copayments and coinsurance are found in Iowa Code §514C.29. Questions regarding violations of these sections have not been presented by the Petitioners.

22. Notwithstanding the above declaration of law, I conclude that even if §514F.2 was interpreted to preclude conduct, based upon the facts presented Wellmark did not violate any law.

23. 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,

> 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.[4]

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

[4] *Gartner, at* 348 (Iowa 2013) (quoting *Auen v. Alcoholic Beverages Div., id.*).

or ordinary meaning."[5] The Iowa Supreme Court has found a dictionary provides an acceptable method of determining the appropriate meaning of words in a statute.[6]

24. Webster's Dictionary defines the term "limit" as "something that bounds, restrains or confines," and the term "optional" as "not compulsory."[7] The plain meaning of this qualification is that other statutes may be interpreted to prohibit or discourage utilization or cost control systems restraining or restricting payment or reimbursement based solely 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 Wellmark's PPO makes optional payment to chiropractors, based on the plain meaning of the statute, it would then be necessary to consider whether Wellmark limits fees to chiropractors solely based on licensure.

25. I conclude that any limitation of fees or reimbursement by Wellmark is based upon numerous other factors that have been well established through information gathered in these proceedings.

26. 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. Vol. I, p. 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.

27. 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.

---

[5] *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).

[6] *Id.*

[7] *Merriam-Webster's Collegiate Dictionary* (10th Ed. 1998).

28. Michael D. Fay, who testified for Wellmark, is the Vice President for Health Networks at Wellmark. (Tr. Vol. I, p. 109).

29. 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.

30. 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. Mr. 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. Vol. I, p.148). Utilization and technology also affect premiums and provider reimbursement or fees. Unit fee cost reflect those considerations, among others.

31. 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.

32. Mr. Fay is a member of the Network Economics Team at Wellmark. The team includes members who are specialists in insurance and provider billing. Mr. Fay and his team are responsible for managing unit fee cost only. Other officials at Wellmark oversee utilization and technology costs. 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").

33. 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). Mr. 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. Vol. I, p. 172).

34. CMS uses the Resource Based Relative Value System ("RBRVS") developed by physicians at Harvard for Medicare provider reimbursement. As explained by Mr. Fay, 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. Vol. I, p. 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.[8] 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.

35. In developing the annual unit fee cost for services, Mr. 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. Vol. I, p. 218). This case concerns Wellmark's current process.

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

37. As explained by Dr. McCann, 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. As explained by Mr. Fay, 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.

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

39. Medicare uses a single conversion factor for reimbursement. Mr. 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. Vol. I, p. 174). Mr. 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

[8] 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.

maternity services. Mr. Fay noted pediatric and maternity services are big drivers of healthcare costs.

40. 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.

41. When determining the annual unit fee cost for services Mr. 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. Vol. I, p. 145, 215). Each year Wellmark's Senior Leadership Team, which includes Mr. Fay's supervisor, Ms. Laura Jackson, provides Mr. Fay's team with a pool of dollars to use for provider fees. (Tr. Vol. II, p. 87). The pool of dollars relates to premiums paid to Wellmark. Mr. 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.

42. Mr. 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. Vol. I, p. 197). Wellmark looks at the categories by provider type and service to determine the volume and mix of services. Mr. Fay and his team examine whether there are more office visits, or changes from individual lab tests to panels. Mr. 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. Vol. I, p.197).

43. Mr. Fay reported network adequacy[9] 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.

[9] 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.

44. 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. Mr. Fay identified psychiatry as "a shortage in general for Iowa's availability of having enough" in addition to primary care. (Tr. Vol. I, p. 162).

45. Mr. Fay also explained 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. Vol. I, p. 159). When there is a shortage in an area, Mr. 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. Mr. Fay and his team accomplish this by looking at the historic claims data with modeling using an Access database.

46. During the period for 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. Mr. 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. Vol. I, p.165). Increases are dealt with by CPT code.

47. 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 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.

48. 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.

49. Dr. Bradley J. Brown, DC, is a licensed chiropractor working as a sole practitioner in Iowa. (Tr. Vol. III, p. 70). 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.[10]

50. Dr. Ronald C. Evans, DC, is also a licensed chiropractor. (Tr. Vol. II, p. 198). 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.

51. 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.

52. 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.

53. 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.

54. Dr. Michael L. Blaess, DO, is a licensed doctor of osteopathic medicine who is board certified in family practice. (Tr. Vol. II, p. 253 – 254). 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

[10] 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.

placement of bone or tissue in the spine or joints. Dr. Blaess reported his overall practice expenses are $450,000 per year.

55. As explained by Mr. Fay, 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.

56. 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. As stated by Mr. Fay, Wellmark has had numerous meetings with representatives from the Iowa Chiropractic Society for input on billing categories for Wellmark's conversion factors. Mr. Fay explained, "[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. Vol. I, p. 192). Mr. 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. Vol. I, p.193).

57. 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 Mr. Fay and his team "an additional amount of money to put just into the chiropractic fee schedule." (Tr. Vol. I, p. 194).

58. 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). 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.

59. 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.

60. Mr. 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.

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

62. It takes Dr. Blaess 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.

63. Dr. Barton C. McCann, MD, is a licensed medical doctor. (Tr. Vol. II, p. 97). According to Dr. McCann, 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.

64. 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.

65. 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. Mr. 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. Vol. I, p. 181).

66. Mr. 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. Mr. Fay testified 85% of the MDs and DOs seeking reimbursement for radiology are board certified radiologists. Mr. 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. Vol., p. 186).

67. 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.

68. Mr. Fay further explained that 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. According to Mr. Fay, board certified radiologists evaluate x-rays for surgical procedures, and chiropractors do not.

69. 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. Vol. I, p.185). The overhead to run a MD practice is higher than a chiropractic practice.

70. 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. Mr. 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.

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

72. Exhibit D is a copy of a Sample Coverage Manual for Alliance Select, which is a PPO. Michele Druker is Vice President and Associate General Counsel for Wellmark. (Tr. Vol. I, p. 71). Ms. Druker opined the Sample Coverage Manual does not limit payment or reimbursement for chiropractic care. Musculoskeletal treatment is specifically covered. The Sample Coverage Manual on 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. Ms. Druker opined that 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.

73. 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.[11]

74. The evidence in this proceeding 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.

75. Even if § 514F.2 can be interpreted to prohibit conduct, 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.

76. 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.

77. 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

[11] 191 IAC 27.5.

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.

78. The factors used by CMS are not solely based upon licensure.

79. 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. 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.

80. I declare that Iowa Code § 514F.2 does not preclude Wellmark from the differing reimbursements in its annual fee schedule for the year beginning July 1, 2012, applicable to individual or other fully-insured coverages.

QUESTION PRESENTED 1(b)

Does the Wellmark annual fee schedule for the year beginning July 1, 2012, applicable to self-funded group health plans that are administered by Wellmark, or to Blue Card claims administered by Wellmark, limit payment for health care services on a basis solely based related to the license under or the practices authorized by Iowa Code chapter 151 in such a manner as to violate the provisions of Iowa Code § 514F.2?

81. Wellmark administers hundreds 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.

82. When determining whether federal law preempts a state statute, the courts examine congressional intent.[12] 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."[13]

[12] *FMC Corp. v. Holliday*, 498 U.S. 52, 56-57 (1990).
[13] *Id.* (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983)).

83. When enacting ERISA, Congress included an express preemption clause displacing state action with respect to private employee benefit programs.[14] 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."[15] 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."[16]

84. Iowa Code section 514F.2 regulates coverage under self-funded health care plans.

85. As a matter of law, I declare that ERISA preempts Iowa Code section 514F.2 from application to the self-funded plans.

QUESTION PRESENTED 2(a)

Does the capitated services payment system which Wellmark Health Plan of Iowa, Inc., has put in place for its Blue Advantage coverage for payment for services of Iowa chiropractors limit payment for health care services on a basis solely related to the license under or the practices authorized by Iowa Code chapter 151 in a manner that violates Iowa Code § 514F.2?

86. Wellmark, Inc. is the parent company of Wellmark Health Plan of Iowa, Inc. ("WHPI"), which is an Iowa health maintenance organization ("HMO").

87. As stated in paragraphs 18 – 20, I conclude that Wellmark is not in violation of § 514F.2, because we declare that Iowa Code § 514F.2 does not prohibit insurers, nonprofit service corporations, health maintenance organizations, or self-insurers for health care benefits to employees from engaging in any particular act or practice.

88. Notwithstanding the above declaration of law, I conclude that even if §514F.2 was interpreted to preclude conduct, based upon the facts presented WHPI is not in violation of law.

---

[14] *Daley v. Marriott Int'l, Inc.*, 415 F.3d 889, 894 (8th Cir. 2005).
[15] *Id.*
[16] *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).

89. 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.

90. Dr. Evans, DC, founded the Iowa Chiropractic Physicians Clinic ("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.

91. 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.

92. 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.

93. 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.

94. I declare that Iowa Code § 514F.2 does not preclude WHPI from entering into such an arrangement.

QUESTION PRESENTED 2(b)

Does the provision in the capitated services payment system used for Wellmark Health Plan of Iowa, Inc.'s Blue Advantage coverage violate the provisions of Iowa Code § 514F.2 with regard to a referral from the member's primary care physician being required after 12 chiropractic visits for a particular condition?

95. 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.

96. 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.

97. Dr. Evans explained that 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.

98. 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.

99. WHPI does not limit the number of chiropractic visits, but rather, the primary care provider or gatekeeper evaluates the case and authorizes additional chiropractic care, if it is needed.

100. I declare that the WHPI Blue Advantage 12 visit rule does not violate Iowa Code § 514F.2.

ORDER

The facts presented in this proceeding by document and testimony, and the laws in question, support my declaration that Wellmark, Inc, and Wellmark Health Plan of Iowa, Inc. have not violated Iowa Code §514F.2.

SO ORDERED this 21st day of October, 2014.

NICK GERHART
Commissioner of Insurance
Iowa Insurance Division

Serve parties of record.