IN THE SUPREME COURT OF IOWA
No. 22-0303

APPEAL FROM THE
POLK COUNTY DISTRICT COURT
HON. SARAH E. CRANE, JUDGE PRESIDING
Polk Co. Law No. CVCV050638

BRADLEY A. CHICOINE, D.C., DR. BRADLEY A. CHICOINE, D.C., P.C., MARK A. NILES, D.C., NILES CHIROPRACTICE, INC., and ROD R. REBARCAK, D.C., on behalf of themselves and those like situated, Plaintiffs/Appellants

and

STEVEN A. MUELLER, D.C., BRADLEY J. BROWN, D.C., MARK A. KRUSE, D.C., KEVIN D. MILLER, D.C. and LARRY E. PHIPPS, D.C., on behalf of themselves and those like situated, Plaintiffs/Appellants

vs.

WELLMARK, INC. d/b/a WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA, an Iowa corporation, and WELLMARK HEALTH PLAN OF IOWA, INC., an Iowa corporation, Defendants/Appellees

PLAINTIFFS-APPELLANTS' OPENING BRIEF

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Argument

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1. Two separate subclasses are neededCommon Questions of Fact and Law Predominate on This Sub-issue

ROUTING STATEMENT

Plaintiffs, Iowa chiropractic physicians, appeal a ruling of the district court filed January 19, 2022, denying Plaintiffs' Motion for Class Certification. The district court misapplied the limited application of *Roland v. Annett Holdings, Inc.*, 940 N.W.2d 752 (Iowa 2020), to conclude that plaintiffs failed to show commonality and predominance under the class action rules in an interpretation of computation of individual amounts of damages, something that has never before been found to be a reason to deny class action certification. In essence, the district court has turned *Roland* into the rule and *Freeman v. Grain Processing Corp.*, 895 N.W.2d 105 (Iowa 2017), into the exception.

Accordingly, this case should be retained by the supreme court, because this case presents substantial issues in which there appears to be a conflict between a published decision of the supreme court, presents substantial issues of first impression, and presents substantial questions of enunciating or changing legal principles. Iowa R. App. P. 6.1101(2)(b), (c), & (f).

STATEMENT OF THE CASE

Plaintiffs appeal the Ruling of January 18, 2022, of the Polk County District Court denying class action certification of a class of essentially all Iowa licensed doctors of chiropractic who have provided chiropractic services in Iowa to "members" of Wellmark defendants, the members consisting of (1) employees and their families of Iowa employers who have purchased health insurance products from Wellmark defendants, and/or (2) employees and their families of Iowa private and governmental employer entities who have chosen by written contract to self-fund the medical provider expenses of their employees. Plaintiffs allege a cause of action for violation of Iowa Code, Section 553.4 of the Iowa Competition Act: "A contract, combination, or conspiracy between two or more persons shall not restrain or monopolize trade or commerce in a relevant market." The alleged conspiracy is in part an agreement by Wellmark defendants and the Iowa private and governmental self-funded employers to pay medical providers, such as plaintiff chiropractors, a fee set by Wellmark defendants with a contractual stipulation of the providers that they will not balance bill the patient.

This appeal is related to four appellate decisions of this Court[1]and has been the direct subject of one appellate decision of this Court[2] and one appellate decision of the United States Court of Appeals for the Eleventh Circuit[3].

The *Mueller* set of plaintiffs are also named plaintiffs in this *Chicoine* case for purposes of preserving their alternative claim that they have the right to bring a second action by reason of Iowa Code § 614.10 (2016).[4]

Chicoine Plaintiffs bring this action on behalf of themselves and a class of Iowa-licensed doctors of chiropractic (1) who are citizens of the state of Iowa as of the date of filing of this petition (October 5, 2015) and/or (2) who have been citizens of Iowa at all times during their Iowa licensure as doctors of chiropractic after May 20, 2004, which is four years prior to the filing of the Plaintiffs' First Amendment to Petitioner for Damages, for Permanent Injunction and for

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[1] *Mueller v. Wellmark, Inc.*, 818 N.W.2d 244 (Iowa 2012) (*Mueller I*); *Mueller v. Wellmark, Inc.*, 861 N.W.2d 563 (Iowa 2015), *rehearing denied*, 861 N.W.2d 563 (Iowa 2015) (*Mueller II*); *Wellmark, Inc. v. Iowa Dist. Ct. for Polk Cty.*, 890 N.W.2d 636 (Iowa 2017); *Abbas v. Iowa Insurance Division*, 893 N.W.2d 879 (Iowa 2017).
[2] *Chicoine v. Wellmark, Inc.*, 894 N.W.2d 454 (Iowa 2017).
[3] *In re Blue Cross Blue Shield Antitrust Litigation*, 2018 WL 7152887, 2018-2 Trade Cases P80,611 (11th Cir. 2018).
[4] "If, after the commencement of an action, the plaintiff, for any causes except negligence in its prosecution, fails therein, and a new one is brought within six months thereafter, the second shall, for the purposes herein contemplated, be held a continuation of the first."

Declaratory Judgment in *Mueller*, filed May 20, 2008). They seek damages from Defendant Wellmark, Inc. d/b/a Wellmark Blue Cross and Blue Shield of Iowa ("Wellmark BCBS") and Defendant Wellmark Health Plan of Iowa, Inc. ("WHPI") (collectively "Wellmark") for combination and conspiracy to restrain or monopolize trade or commerce in a relevant market being the purchase of health care services from health care practitioners in the geographic area of Iowa. The unnamed co-conspirators, the Iowa governmental and private employers who self-fund the purchase of health care services for employees and their families, are not party defendants and no damages are claimed against them individually in this lawsuit beyond those against Wellmark defendants for the discriminatorily low price agreed to in the Wellmark and WHPI annual practitioner price schedules. It has been confirmed in the depositions of the Wellmark executive in charge of determining practitioner services pricing that the annual practitioner price schedules are the only prices actually paid by Wellmark defendants in a given year and are not illustrative or suggested prices. (Non-Conf.[5] App., Vol. I, pp. 652, 700; Conf. App., Vol. II, pp. 139 (50:24 to 52:9), 140-42 (54:6 to 62:14) (Fay)).

[5] "Non-Conf. App., Vol. I" refers to the Appendix Vol. I of record items for which there is no designation of confidentiality. "Conf. App., Vol. II" refers to the Appendix Vol. II of record items which have been designated confidential.

Plaintiffs seek for themselves and all similarly situated individuals compensatory and statutory damages; injunctive relief from the unreasonable horizontal restraints on competition, trade, and commerce committed by the Wellmark defendants; an award of double their actual damages due to the Wellmark defendants' egregious conduct; interest at the maximum legal rate; court costs; reasonable attorneys' fees; and all such other and further relief to which Plaintiffs are justly entitled. (Non-Conf. App., Vol. I, p. 195-96). Plaintiffs have requested a jury trial. (*Id.*, Vol. I, p. 196).

It is remarkable that the pattern and course of conduct of Wellmark is uniform and undifferentiated as to all Iowa chiropractors. There is no variation to Wellmark's treatment of any particular Iowa chiropractor; all are treated the same way and are subject to the same combination and conspiracy in restraint of trade. Wellmark compensates all services of Iowa chiropractors at rates per service substantially less than for the same or substantially similar services by its MD/DO or PA/NP providers, and WHPI discriminates uniformly only against chiropractors in its HMO products. All Iowa chiropractors are damaged in their business by the same amount per unit of service provided. The nationally established standard recognized by Wellmark is common for all chiropractors, MD/DOs, PA/NPs, and PTs and is an easily applied measure of the per unit differential, if any, between the various practitioner groups and does not depend on an individual difference

between any chiropractor. The facts of this case are common as to all plaintiffs and class members and the legal issues in this case are the same for all plaintiffs and all class members.

Plaintiffs, Iowa chiropractor physicians, brought this antitrust class action on October 5, 2015, against two Iowa Wellmark corporations for combination and conspiracy in restraint of trade or commerce in setting prices paid for chiropractic services at a discriminatory low level and in restricting patient access to and coverage for chiropractic treatment. (Non-Conf. App., Vol. I, p. 31(Petition)). Defendants, Wellmark, Inc. d/b/a Wellmark Blue Cross and Blue Shield of Iowa, an Iowa corporation, and Wellmark Health Plan of Iowa, Inc., an Iowa corporation, (collectively, "the Wellmark defendants") moved to stay this case in favor of multi-district litigation pending in the Northern District of Alabama, *In re Blue Cross Blue Shield Antitrust Litigation*, MDL No. 2406 (N.D. Ala., Case No. 2:13-cv-20000) ("MDL 2406"). Following a contested hearing on January 22, 2016, the district court granted the stay on January 28, 2016. (1/28/16 Stay Ruling at p. 9).

Plaintiffs applied to this Court for interlocutory appeal. (No. 16-0364, 2/25/16 Application) for Interlocutory Appeal). The Court granted Plaintiffs' application on April 11, 2016. (4/11/16 Order). This Court reversed the stay order of the district court in an opinion dated April 21, 2017. *Chicoine v. Wellmark, Inc.*, 894 N.W.2d 454

(Iowa 2017). Procedendo was issued to the Clerk of Polk County District Court on May 15, 2017.

On June 14, 2017, Blue Cross and Blue Shield Association moved to intervene in the proceedings. (Non-Conf. App., Vol. I, p. 57). On the same day, before there could be a hearing or determination of BCBSA's motion to intervene, Wellmark defendants removed the case to the United States for the Southern District of Iowa based upon the unruled upon BCBSA motion to intervene. (*Id.*, Vol. I, p. 62). After extensive litigation in the Judicial Panel on Multidistrict Litigation, before the United States District Court for the Northern District of Alabama (*Id.*, Vol. I, p. 71), and on appeal to the United States Court of Appeals for the Eleventh Circuit, the Northern District of Alabama issued an Order on April 9, 2018 to remand the case back to Polk County District Court. (*Id.*, Vol. I, pp. 78, 79). The Eleventh Circuit affirmed the remand order on January 10, 2019. (*Id.*, Vol. I, p. 90). The Polk County District Court received the docket back on February 11, 2019. (*Id.*, Vol. I, p. 64).

The district court denied BCBSA motion to intervene on November 19, 2019. (Non-Conf. App., Vol. I, p. 151). On December 3, 2019, Wellmark filed a motion to dismiss the *Mueller* plaintiffs, asserting res judicata and lack of conspiracy because of indefiniteness. (*Id.*, Vol. I, p. 163) In response, Plaintiffs filed a Third Amended and Substituted Petition at Law (Revised) on January 3, 2020, which

withdrew the *Mueller* plaintiffs as class representatives, but they remained named plaintiffs. (*Id.*,Vol. I, p. 168). By Order of January 7, 2020, the district court denied dismissal of the *Mueller* plaintiffs with prejudice. (*Id.*, Vol. I, p. 198). On January 13, 2020, Wellmark defendants filed a second motion to dismiss or for more specific statement. (*Id.*, Vol. I, p. 201). After hearing (*Id.,* Vol. I, p. 224), the district court entered an order dated March 9, 2020, denying the second motion to dismiss. (*Id.*, Vol. I, p. 267). In that order, the district court ruled that the self-funded entity made an agreement on buyer at a price set by Wellmark before there was any performance of administrative services. (*Id.*, Vol. I, pp. 270-71).

Pursuant to the Scheduling Order in place, Plaintiffs filed their Motion for Class Determination on March 13, 2020. (Non-Conf. App., Vol. I, p. 275). Because of the intervening circumstance of COVID and the need for certain discovery responses, Wellmark defendants did not file their resistance to the motion for class certification until October 23, 2020. (Conf. App., Vol. II, p. 941). Plaintiffs then filed their reply brief pursuant to schedule on November 13, 2020. (*Id.*, Vol. II, p. 2248).

In the meantime, Wellmark filed a motion for order to cease inappropriate communications on May 5, 2020. The district court held a hearing on the matter but did not rule on the motion. (5-17-20 Order Setting Hearing).

The district court, Judge Heather Lauber, presiding, held a hearing by ZOOM in the class certification motion on January 29, 2021. (Non-Conf. App., Vol. I, p. 422). On the day before the hearing, Plaintiffs filed 10 documents in support of their damages theory (Conf. App., Vol. II, pp. 2258-2302), that were referred to and used in Plaintiffs' presentation to the court. This proof was discussed by Mr. Wandro for the plaintiffs in the hearing on class determination of January 29, 2021, before Judge Lauber on pp. 4:10 to 15:8 (Non-Conf. App., Vol. I, App. 425:10 to 436:8) and particularly by visual slide 7. (*Id.*, Vol. I, App. 425:18 to 429:10; Conf. App., Vol. II, p. 2302 (Slide 7)). It was also discussed by Mr. Norris for plaintiffs at pp. 91:10 to 99:20. (Non-Conf. App., Vol. I, pp. 512:10 to 520:20).

Unfortunately, Judge Lauber became ill in 2021 and did not rule on the motion. On October 20, 2021, Chief Judge Huppert transferred this case from Judge Lauber to Judge Crane, a business court judge. (*Id.*, Vol. I, pp. 1456, 1459).

Judge Crane held an additional class action determination hearing on November 19, 2021 (*Id.*, Vol. I, p. 1464 (transcript)) and issued the Order Denying Class Certification on January 18, 2022. (*Id.*, Vol. 1, p. 1755). Plaintiffs filed Notice of Appeal from the January 18, 2022 Order on February16, 2022. (*Id.*, Vol. I, p. 1775).

STATEMENT OF THE FACTS

The Representative Plaintiffs and the class of plaintiffs all are doctors of chiropractic ("DCs" or "chiropractors") licensed and in active practice in Iowa during some or all of the relevant period of May 20, 2004, to present. (Non-Conf. App., Vol. I, App. 168 (Pet.[6] ¶¶ 1, 6, & 13)). Defendant Wellmark, Inc. d/b/a Wellmark Blue Cross and Blue Shield of Iowa ("Wellmark BCBS") and Defendant Wellmark Health Plan of Iowa, Inc. ("WHPI") (collectively "Wellmark") are Iowa corporations. (*Id.*, Vol. I, pp. 175-76 (Pet. ¶¶ 7-9)).

A. The Historic Basis of Wellmark's Boycott and Discrimination Against Chiropractic

Blue Cross is the name for the portion of Wellmark's business that purchases services provided by Iowa hospitals (institutions) for members. Blue Cross is not involved in this case. Blue Shield is the name for the portion of Wellmark's business that historically purchases services for members provided by Iowa health care providers, primarily allopathic and osteopathic physicians and surgeons (MDs and DOs).

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[6] "Pet." refers to Plaintiffs' Third Amended Petition (Revised), filed December 21, 2019, which is the operative petition. May 20, 2004 is four years prior to the filing of the Plaintiffs' First Amendment to Petition for Damages, for Permanent Injunction and for Declaratory Judgment (App. 1-37) in *Mueller et al v. Wellmark, Inc., et al*, Law No. 107471 (Polk Co., Iowa, Dist. Ct., filed May 20, 2008, which tolls (Iowa R. Civ. P. 1.277) the four-year statute of limitations (Iowa Code § 553.16(2)).

The Iowa Medical Society created Blue Shield of Iowa by filing Articles of Incorporation with the Iowa Secretary of State on April 12, 1945. First, however, it obtained authority from the from the 51st Iowa General Assembly, by the enactment of Iowa Acts, 51st G.A., chapter 209 (1945), which was included in Iowa Code, Chapter 514 (1946).

Section 1 of chapter 209 (1945) (amended Iowa Code § 8895.01 (1939)(which became Iowa Code § 514.1 (1946)) allows that a corporation under the provisions of chapter 504 (Non-Profit Corporations) "organized for the purpose of establishing, maintaining, and operating a plan whereby medical and surgical service may be provided at the expense of said corporation, by duly licensed physicians and surgeons, osteopathic physicians, or osteopathic physicians and surgeons, to subscribers under contract, entitling each subscriber to medical and surgical service, as provided in said contract, shall be governed by the provisions of this chapter [chapter 514] and shall be exempt from all other provisions of the insurance laws of this state."

Additional amendments to what became Iowa Code ch. 514 (1946) by Iowa Acts, 51st G.A., chapter 209 (1945) are:

> 514.4 Directors. At least a majority of the directors of a medical service corporation must be at all times physicians or surgeons, osteopathic physicians, or osteopathic physicians and surgeons, who have contracted or may contract with such corporation' to render to its subscribers medical or surgical service. The board of directors of such corporation shall consist of at least nine members. [C39, §8895.04; 51GA, ch 209, §3]

> 514.5 Contracts for service. Any medical service corporation organized under the provisions of this chapter may enter into contracts with subscribers to furnish medical and surgical service through physicians and surgeons, osteopathic physicians, or osteopathic physicians and surgeons. [C39, §8895.05; 51GA, ch 209, §4]

In 1939, the American Medical Association ("AMA") approved the concept of prepayment medical service plans and promulgated approval standards for such plans. The AMA set up the associated medical care plans ("AMCP") "to administer the approval program" for Blue Shield plans. In 1972, the AMA-sponsored AMCP changed its name to Blue Shield Medical Care Plans, then it became the National Association of Blue Shield Plans, and then later the Blue Shield Association. In 1982, the Blue Cross and Blue Shield names and marks were brought under the control of one organization, the Blue Cross and Blue Shield Association, which was governed by its member plans. By the early 1980s, the Blue system was suffering from declining reserves, increasing financial instability, decreasing customer satisfaction, and declining business volume. *In re Blue Cross Blue Shield Antitrust Litigation*, 308 F. Supp. 3d 1241, 1248-49 (N.D. Ala. 2018).

The American Medical Association (AMA) and its officials instituted a boycott of chiropractors in the mid-1960s by informing AMA members that chiropractors were unscientific practitioners and that it was unethical for medical physician to associate with chiropractors.

The purpose of the boycott was to contain and eliminate the chiropractic profession. The AMA sought to spread the boycott to other medical societies. *Wilk v. American Medical Ass'n*, 671 F. Supp. 1465, 1471 (N.D. Ill. 1987), *aff'd* 895 F.2d 352 (7th Cir. 1990). In the early 1960s the AMA had become concerned that medical physicians were cooperating with chiropractors. In 1963, the AMA hired, as its General Counsel, Robert Throckmorton, the author of the Iowa Medical Society's plan to contain chiropractic in Iowa. The AMA's objective was the complete elimination of the chiropractic profession. In November 1963, the AMA authorized the formation of the Committee on Quackery under the AMA's Department of Investigation. In 1964, the committee's primary goal was to contain and eliminate chiropractic. *Id.*, 671 F. Supp. at 1473.

In 1966, the AMA adopted an anti-chiropractic resolution, recommended by the AMA Board of Trustees and adopted by the House of Delegates, which called chiropractic an unscientific cult. This label implicitly invoked Principal 3 of the AMA's Principles which made it unethical for a physician to associate with an unscientific practitioner. In 1967, the AMA Judicial Council issued an opinion under Principle 3 specifically holding that it was unethical for a physician to associate professionally with chiropractors. "Associating professionally" would include making referrals of patients to chiropractors, accepting referrals from chiropractors, providing diagnostic, laboratory, or

radiological services for chiropractors, teaching chiropractors, or practicing together in any form. *Id.*

B. Refusal of Blue Shield of Iowa to Cover Services of Iowa Chiropractic Physicians

The Iowa Chiropractic Society and its members made several efforts in the 1970's and 1980's to have Blue Cross and Blue Shield of Iowa join with the chiropractors to amend Iowa Code ch. 514 to include coverage of Iowa chiropractors. Blue Shield of Iowa refused to give its consent to any such amendment and the Iowa legislature did not move any bill without Blue Shield's consent. On the other hand, Blue Cross and Blue Shield of Iowa did work with dentists, podiatrists, pharmacists, optometrists and other provider groups to be included in Iowa Code, Chapter 514.

In 1979, the Health Care Equalization Committee ("HCEC") of the Iowa Chiropractic Society ("ICS") brought suit against the Iowa Medical Society, Blue Shield of Iowa, the American Medical Association and others for a conspiracy under the federal antitrust laws to restrain commerce through a boycott aimed at eliminating chiropractic in Iowa and elsewhere. HCEC was assignee of the claims of over 150 Iowa member chiropractors of ICS in the action for damages and injunctive relief. Blue Shield of Iowa asserted the state action defense first announced in *Parker v. Brown*, 317 U.S. 341 (1943). *Health Care Equalization Committee of Iowa Chiropractic Soc. v. Iowa*

Medical Soc., 501 F. Supp. 970, 975 (S.D. Iowa 1980), *aff'd* 851 F.2d 1020 (8th Cir. 1988).

What Judge William C. Stuart said about state action is very telling about the failure of Blue Shield of Iowa to obtain legislative approval of coverage for Iowa governmental and private self-funded employers a little later on:

> "Chapter 514 of the Iowa Code clearly expresses a policy excluding chiropractic services from coverage by health care service corporations. Throughout that chapter, the state legislature repeatedly stated precisely the particular services covered. No mention is ever made of chiropractors, the practice of chiropractic or Chapter 151 of the Iowa Code which governs aspects of the practice of chiropractic, including licensing. The Court believes that the omission of any mention of chiropractic coverage in Chapter 514 directly suggests that the legislature intended to prohibit coverage of their activities by health care service corporations.
>
> "The legislative history of Chapter 514 supports this conclusion. As originally enacted in 1939, the original law applied to hospital services only; it contained no authorization of a health service plan covering medical or surgical services provided by physicians or other health care practitioners. Acts, 48 G.A., Reg. Sess., Ch. 222 (1939). The statute was amended in 1945 for the purpose of "authoriz(ing) nonprofit corporations to contract to furnish medical and surgical service to subscribers and to contract for the furnishing of such service with physicians and surgeons, osteopathic physicians or osteopathic physicians and surgeons." Acts, 51 G.A. Reg.Sess., Ch. 209 (1945).
>
> "Chapter 514 has been subject to further amendment since 1945. Each subsequent pertinent amendment by the legislature extended coverage in health care service plans to include other services. ('Dental services were added in 1955. Acts, 56 G.A., Reg.Sess., Ch. 244 (1955). Podiatric services were added in 1965. Acts, 61 G.A., Reg.Sess., Ch. 397 (1965). Pharmaceutical Services were added in 1967. Acts, 62 G.A., Reg.Sess. Ch.

> 369 (1967). The most recent addition came in 1969 and resulted in coverage of optometric services. Acts, 63 G.A., Reg.Sess., Ch. 271 (1969).') The Iowa legislature, however, has never exercised its judgment on behalf of the citizens of Iowa to permit health care service corporations to cover chiropractic services."

HCEC of ICS v. Iowa Medical Soc., 501 F. Supp. at 989-90.

C. The Iowa General Assembly Passed HF 2219 in 1986 Session Effectively Mandating Coverage of the Services of Iowa Chiropractic Physicians

After several years of attempting to secure Blue Shield of Iowa's consent to support a bill in the Iowa General Assembly amending Iowa Code ch. 514 to specify that Blue Shield of Iowa (a medical services corporation) must provide coverage for services of Iowa chiropractors, the Iowa Chiropractic Society and Iowa chiropractors secured the passage in the Iowa House of Representatives of HF 2219 on March 11, 1986. It permitted medical and surgical services corporations to include chiropractors in medical and surgical plans. It amended Code ch. 507B, Unfair Insurance Trade Practices, by stating "Language in a policy or a payment or reimbursement practice which unfairly discriminates against a method of lawful practice or a physician as defined in section 135.1 shall not be approved by the commission and is prohibited."

The lobbyist for Blue Cross and Blue Shield of Iowa told senators and representatives that BCBSI would resist mandatory coverage

of chiropractic but would agree to an optional coverage of chiropractors. The ICS presented the representatives with an amendment to HF 2219 which modified the bill to provide of optional coverage of chiropractors by corporations subject to chapters 509 (mutual health insurance companies), chapter 514 (medical services corporations), and 514B (Health Maintenance Organizations). The amended HF 2219 was passed by the House and the Senate and signed into law by Governor Branstad, effective July 1, 1986.

H.F. 2219, as passed, essentially mandated chiropractic coverage by health insurance companies (H.F. 2219, § 2, which became Iowa Code § 509.3(7)), by health service corporations (essentially BC/BS of Iowa) (H.F. 2219, §§ 4 & 5, which became Iowa Code §§ 514.5, 2nd ¶, & 514.7, 3rd ¶)), and by prepaid group plans (HMOs)(H.F. 2219, §7, which became Iowa Code § 514B.1(2)(c)). The "option" is found in the second sentence of mandated coverage, which states: "The policy shall provide that the policyholder may reject the coverage or provision if the coverage or provision for diagnosis or treatment of a human ailment by a chiropractor is rejected for all providers of diagnosis or treatment for similar human ailments licensed under chapter 148, 150, 150A, or 151." For example, the policyholder could reject coverage for ailments of the back or spine, but the rejection would have to be for all diagnosis or treatment of the back or spine by MDs, DOs, and DCs. Such a health insurance policy,

of course, would be unmarketable, because physician visits for back ailments constitute a huge percentage of visits to physicians, be they MD, DO or DC. (Vol. 1, App. 596-97, 601-03).

Each of the mandated coverage statutes also state language similar to that in Iowa Code § 509.3(7):

> "A policy of group health insurance may limit or make optional the payment or reimbursement for lawful diagnostic or treatment service by all licensees under chapters 148 and 151 on any rational basis which is not solely related to the license under or the practices authorized by chapter 151 or is not dependent upon a method of classification, categorization, or description based directly or indirectly upon differences in terminology used by different licensees in describing human ailments or their diagnosis or treatment."

D. The Iowa Medical Society Loses Direct Control of Blue Shield of Iowa in 1984

The admonition in footnote 40 of *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 232 n. 40, 99 S. Ct. 1084 n. 40 (1979), citing a 1978 Report of the Subcommittee on Oversight and Investigations of the United States House of Representatives' Committee on Interstate and Foreign Commerce finding that there was a serious conflict of interest problem created by physician domination of most Blue Shield boards of directors, was a precipitating cause of the Iowa General Assembly passage in 1983 and 1984 of amendments to Iowa Code § 514.4 (1982). Iowa Acts 1983 (70 G.A.) ch. 27, §§ 12, 15; Iowa Acts 1984 (70 G.A.) ch. 1282, § 1, eff. June 3, 1984.

Blue Cross of Iowa and Blue Shield of Iowa brought an injunction action in federal district court against defendant, the Insurance Commissioner of the State of Iowa, on August 16, 1984. *Blue Cross of Iowa v. Foudree*, 606 F. Supp. 1574 (S.D. Iowa 1985). Section 514.4, as amended, required the Commissioner to promulgate rules establishing a process for nomination of subscriber-nominees for nonprofit health service corporation boards. The Commissioner was directed to provide for each corporation an independent subscriber nominating committee, comprised of subscribers, to select all subscriber nominees and provider nominees until the two-thirds subscriber board majority requirement was met. Section 514.4 also provided that after the two-thirds majority requirement was met, the board of directors would select all subscriber and provider nominees. Although Section 514.4 allowed for petitioning for nomination by both subscribers and providers, it has been interpreted by the Commissioner to vest veto power over such petitions for nomination in the independent subscriber nominating committee until the two-thirds subscriber majority was in place and, subsequently, in the boards of director. Section 15 of the new law, Act of April 26, 1983, Ch. 27, § 15, 1983 Iowa Acts 46, requires that each nonprofit health service corporation shall have a simple subscriber board majority by August 1, 1984, and a two-thirds subscriber board majority by August 1, 1985. *Id.*, 606 F. Supp. at 1577-78.

> "After the enactment of Section 514.4, both plaintiffs' management and executive committees recommended to plaintiffs' boards that, for various business- and policy-related reasons, plaintiffs comply with Section 514.4. Nonetheless, the plaintiffs' boards decided to go forward with litigation."

Id. at 1598. The U.S. District Court for the Southern District of Iowa, Hon. William C. Stuart, Chief Judge, concluded that Section 514.4, as amended, did not violate due process of law as a taking without just compensation or violate the impairment of contracts clause in the U.S. Constitution, and entered judgment in favor of the Commissioner. *Id.* at 1580, 1581 & 1582.

E. Relationship Between Health Care Providers and Wellmark – Practitioner Services Agreement

Wellmark has contracted with Iowa health care providers, including Iowa chiropractic physicians, to serve as network providers for its traditional indemnity[7] products, its preferred provider

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[7] Indemnity insurance is the traditional way property and health insurance worked. When the insured suffers a loss (including paying for health care provider and institutional services) the insured makes claim for the loss incurred and the insurance company indemnifies the insured by writing a check to cover to loss that the insured incurred and paid for. Except for the health services company concept that Blue Shield employed under Iowa Code, ch. 514, where Blue Shield contracted directly with the health care provider to pay the provider fee directly as the subscriber incurred it, most other health insurance companies doing business in Iowa in the 1980s offered indemnity products. And apparently Blue Shield did also to some extent, but for the most part, Blue Shield offered its subscribers a direct health care provider service by contract with the provider on behalf of the subscriber. (Conf. App., Vol. II, pp. 194:18 to 206:20 (Voss)).

organizations ("PPOs") and /or its health maintenance organizations ("HMOs"), which serve as regional networks of Iowa health care providers for Wellmark's "covered members," for which subscribers directly pay Wellmark a premium in exchange for coverage. Additionally, Wellmark contracts with Iowa self-funded governmental and ERISA self-funded employers, with whom Wellmark agrees to use its provider networks with the provider price fixed by Wellmark for a network access fee, even though the self-funded employers do not have any direct contractual agreements with the health care providers. *See* Pet. ¶¶ 27-32, 34, 42-52, 57. (Non-Conf. App., Vol. I, pp. 185-86, 188-90).

The Representative Plaintiffs and the class of plaintiffs have all signed the Wellmark Practitioner Services Agreements with Wellmark BCBS and/or WHPI during some or all of the relevant period of May 8, 2004, to present. These agreements are for health care services provided in Iowa to patients who are members of Wellmark indemnity insurance products and preferred provider products. (*Id.*, Vol. I, Ap. 607-72). Over 90% of Iowa licensed and practicing chiropractic physicians have signed Wellmark Practitioner Services Agreements. (Conf. App., Vol. II, p. 126 (Ex. 41L)).

Wellmark also contracts with over 95% of the Iowa health care providers who are licensed medical doctors ("MDs"), doctors of osteopathic medicine and surgery ("DOs"), physician assistants ("PAs"), certified and registered nurse practitioners ("CNP/RNPAs") and

physical therapists ("PTs") through Wellmark Practitioner Services Agreements. (*Id.*) These health care providers are also Wellmark Network Providers. The chiropractic physicians and other health care providers, as identified in paragraphs 4 and 5, are called Wellmark Network Providers.

The Practitioner Services Agreements are form contracts. Under these form agreements, Wellmark has the sole ability to determine the rate or percentage of compensation the chiropractors receive for services covered by its members' insurance plan. *See* Pet. at ¶ 39 (Vol. I, p. 187). Wellmark also determines limitations and/or exclusions for coverage. *See, e.g.,* Pet. at ¶ 2(a), (d), (g), (h); ¶ 59(a), (d), (g), (h) (*Id.*, pp. 170-73, 191-93*)*.

Healthcare providers such as the Plaintiff Chiropractors must enter into the above-referenced form Practitioner Services Agreements with Wellmark in order to participate in Wellmark's indemnity and PPO networks, HMO, or both. *See* Pet. at ¶¶ 33-35, 40 (*Id.*, pp. 186-87). If the providers do not enter into these form agreements, Wellmark's covered members "are less likely to use that health care provider, because the covered member would then have to pay out of pocket for services that would otherwise be covered by their health insurance plan." *See id.* at ¶ 36. Accordingly, providers have a financial interest to participate in Wellmark's PPO or HMO, or both. *See id.* at ¶ 38.

The Practitioner Agreement contains a no balance billing clause: "except as expressly provided herein, provider agrees to: (a) accept payment made by Wellmark as full payment for covered services furnished to members except to the extent of deductibles, coinsurance and/or copayments; (b) not bill members for any balance attributable to covered services other than deductibles, coinsurance and payments; and (c) seek payment from members for any such deductibles, coinsurance and/or copayments." (Non-Conf. App., Vol. I, pp. 645, 661, 693 (Art. 8, Sec. 8.2)). Exhibit A to the 2001 Wellmark Practitioner Agreement states:

> Provider agrees payment for Covered Services provided by Provider shall be the lesser of Provider's billed charge or the maximum allowable fee established from time to time by Wellmark. The maximum allowable fee established by Wellmark from time to time will be based upon the Resource Based Relative Value System ("RBRVS") that includes Relative Value Units ("RVUs"); geographic adjustment and conversion factors; a Wellmark determined adjustment factor; statistically derived customary charge, based upon the same service when performed by most providers with comparable skills and training within the state of Iowa or, as applicable, another state; and commercially available fee schedules, payment values and methods developed from time to time by Wellmark. Fee schedules for illustrative purposes only are provided to provider in separate documents" (*Id.*, p. 668)

With respect to the annual fee schedules prepared by Mike Fay, he says they are the maximum allowable fees actually paid by Wellmark and WHPI and are not just illustrative. (Conf. App., Vol. II, pp. 139 (50:24 to 52:9), 140-42 (54:6 to 62:14) (Fay)).

F. Relationship Between Iowa Self-Fundeds and Wellmark

Defendants Wellmark BCBS and WHPI enter into Administrative Services Agreements with numerous Iowa self-funded ERISA employers and self-funded governmental employers based upon non-negotiable terms in an identical form contract. (Non-Conf. App., Vol. I, pp. 1024 (bottom of cover), 1044 (same), 1071 (same)). These agreements concern the self-fundeds' payment for and use of Wellmark's PPO and HMO provider network to buy provider services for their employees. *See Pet.* at ¶¶ 2(a), 44, 47-49, 59(a), (c), & (d). (Non-Conf. App., Vol. I, pp. 170, 188-89, 191-92). These entities "self-fund" their employees' health insurance plans by paying the employees' claims themselves, instead of paying Wellmark a premium to have Wellmark pay the claims. *See* Pet. at ¶ 43. (*Id.*)

Under these agreements, the self-fundeds agree to the following, among other terms:

a. To pay Wellmark an Administrative Fee for claims administrative services. (ASA ¶¶ 1.1, 1.2 (*Id.*, Vol. I, pp. 1025, 1045, 1072));

b. To pay Wellmark an additional Network Access Fee "to gain the collective advantages of the network of providers with which Wellmark . . . has a contract for the provision of covered services." This alleged price fixing fee is a percentage of

the difference between what the provider chiropractor usually bills and the Maximum Allowable Fee Wellmark sets in its annual provider fee schedules. (ASA ¶¶ 1.21, 1.22 (*Id.*, Vol. I, pp. 1027, 1047, 1074));

c. That Wellmark has "sole discretion" to set the "Maximum Allowable Fee." (ASA ¶ 6.1 (*Id.*, Vol. I, pp. 1034-35, 1057, & 1084));

d. That Wellmark is responsible for negotiating and entering into separate payment agreements with providers. (*Id.*);

e. That chiropractic benefits under the self-fundeds' employee plans are determined by price and coverage limitations and/or exclusions that Wellmark sets. (ASA ¶ 3.1(b) & (c) (*Id.*., Vol. I, pp. 1030, 1052, 1078-79)).

See Pet. at ¶¶ 2, 12; 16; 44-62 (Non-Conf. App., Vol. I, pp. 170-73, 177, 179-81, 188-94).

G. Fees Paid to Chiropractors

The Representative Plaintiffs and the class of plaintiffs have all received compensation from Wellmark based upon a common fee schedule for payment of services of Iowa chiropractic physicians in the Wellmark network. The fees correlate to pertinent CPT codes used by chiropractic physicians in evaluation and management, x-ray diagnosis, physiotherapy modalities, and spinal and other body part manipulation. (Conf. App., Vol. II, pp. 2307-2580).

Iowa chiropractic physicians generally receive identical compensation for each performance of a service represented by the CPT codes. This is true whether the patient is directly insured by Wellmark (a "covered member") or whether the patient is a member employee or family member insured by the Iowa self-fundeds whose Administrative Services Agreement with Wellmark grants them access to Wellmark's network.

The Center for Medicare and Medicaid Services ("CMS") uses Relative Value Units ("RVUs") and a Resource Based Relative Value Scale ("RBRVS") to publish annual physician fee schedules, which it makes publicly available. Wellmark maintains a steady percentage relationship between the fees it pays physicians' assistants and advanced registered nurse practitioners at 85% of the MD/DO fee[8]. No further analysis is done. (Conf. App., Vol. II, pp. 137-38 (44:4 to 45:1), 141-42 (60:15 to 62:14), 147-48 (82:5 to 85:14), 173-74 (183:24-85:7) (Fay)).

[8] CMS has set the 85% of MD/DO fee for PAs and ARNPs by permanent rule for Medicare. Advanced Practice Registered Nurses, Anesthesiologist Assistants, & Physician Assistants, Center for Medicare and Medicaid Services Medicare Learning Network MLN901623 March 2022 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf at pp. 9, 17; 42 CFR 410.74 Physician Assistants' Services; 42 CFR 410.75 Nurse Practitioners' Services. It has been adopted and employed by nearly every health insurance company in the United States, including Wellmark and WHPI.

Wellmark's unit fee schedule (Conf. App., Vol. II, pp. 74, 78-79) for therapy codes is the same for MD/DO, DC and PT (physical therapists), which indicates that Wellmark does not go through a detailed analysis of the CMS factors to differentiate between MD/DO, DC and PT in terms of work (time, technical skill, judgment, and stress), practice expense, and malpractice insurance expense. (*Id.*).

To the extent that Wellmark uses or has used the CMS RVU values in determining unit fee costs (conversion factors), the only detailed analysis by Wellmark was done in 1998. (Conf. App., Vol. II, pp. 445:22 to 449:5 (Fay)). Since that time, Wellmark has made the decision to just use the total RVU value determined by CMS. *Id.*

Wellmark does not employ the CMS RBRVS system in the manner for which it was designed and for which it is used by CMS. CMS has used only one conversion factor for all CPT[9] codes since 1998. (Conf. App., Vol. II, pp. 351:19-21 (Fay), 616:8-25, 619:19 to 620:20, 624:3 to 625:22 (McCann)). Wellmark, on the other hand, employs five different conversion factors for chiropractic services, and an additional ten different conversion factors for MD/DO services. (Conf. App., Vol. II, p. 122 (Wellmark Ex. I), 461:2-6 (Fay))

[9] CPT is the Current Procedural Terminology code book published by the American Medical Association, which is the basis for the physician fee schedule. It is part of the coding system that CMS uses and that most payors (such as Wellmark and WHPI) use, referred to as HCPCS, the Healthcare Common Procedure Coding System.

Anthony Hamm, DC, who was the chiropractic representative on the AMA Specialty Society RVS Update Committee (RUC), testified that the RVUs published by the CMS are reviewed and updated every five years. The OMT codes were reviewed and updated in 2011. (Conf. App., Vol. II, pp. 771:17 to 775:1, 782:20 to 783:6, 784:2-7 (Hamm)). Dr. Hamm further testified that the difference between the RVU values for OMT[10] and CMT[11] relate to the practice expense and malpractice insurance expense factors; the work factors are about the same. (*Id.*, pp. 786:7 to 789:20 (Hamm)). In fact, Exhibit 28 (Non-Conf. App., Vol. I, pp. 710-20) shows that the work factor was the same for comparable OMT and CMT codes from 2004 to 2012 – the work factor for OMT code 98925 and CMT code 98940 was 0.45; for OMT code 98926 and CMT code 98941 was 0.65, and for OMT code 98927 and CMT code 98942 was 0.87. (*Id.*)

This became the case again in 2014 and 2015 when the CMT codes were updated – the work factor for OMT code 98925 and CMT code 98940 now is 0.46; for OMT code 98926 and CMT code 98941 now is 0.71, and for OMT code 98927 and CMT code 98942 now is 0.96. Notably, the work factor for CMT code 98943 for extraspinal (extremities) manipulation in 2014 and 2015 is also 0.46, the same as the work factor for OMT code 98925 and CMT code 98940. (Conf.

[10] OMT refers to Osteopathic Manipulative Therapy found in CPT codes 99825-29.
[11] CMT refers to Chiropractic Manipulative Therapy found in CPT codes 99840-43.

App., Vol. II, pp. 2288-89, 2295-98). Wellmark, however, pays about 16-17% as much for CMT code 98943 as for OMT code 98925, based upon no rationale whatsoever. (*Id.*). 2013:http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13A.html?DLPage=1&DLSort=0&DLSortDir=descending; 2014: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU14A.html?DLPage=1&DLSort=0&DLSortDir=descending

H. The 2007 Plan of Wellmark Defendants to Limit Visits to a Chiropractor and Impose a Precondition of the Need to Seek Approval of an Outside Agency in Order to Treat Their Chiropractic Patients, Requirements Not Imposed on Any Other Iowa Health Care Provider

Beginning in late 2006, the Wellmark defendants, for themselves and their self-funded co-conspirators, imposed or announced that they would impose a series of actions designed to impede the doctor-patient relationship of Iowa chiropractors. These actions were not applicable to any other class of health care providers. (Non-Conf. App., Vol. I, pp. 1117 to 1232 (chiropractic care needs preapproval).

Effective September 30, 2007, Wellmark Defendants announced a plan to unilaterally impose a "new Physical Medicine Program-Chiropractic Care Planning initiative that would apply to

services provided by Wellmark participating doctors of chiropractic (D.C.).” (*Id.*, pp. 1117-23). This unilaterally mandated condition on coverage and treatment required the completion and submission of a new, coding-based report for subscribers-patients of Wellmark Defendants who elect to seek chiropractic treatment, whether they are already being treated or are new patients as of the arbitrarily selected effective date. The decision whether to approve or deny a submitted plan would be made by a third-party entity, Triad Healthcare, based in Connecticut, using computerized statistical criteria not in conformity with Iowa Code, ch. 151. This decision is not made at the time of the patient’s visit. Instead, “[g]enerally, within two business days of receipt of each Care Plan, a medical necessity decision will be sent [to the doctor of chiropractic provider] via e-mail or fax, and a letter will be sent to [the subscriber-patient]. No coverage will be provided for treatment if the required “plan” is not submitted and approved. (*Id.*, pp. 1162, 1166-1232) .No such “plan” requirement was imposed upon other health care provider¬licensees. (*Id.*, pp. 1140-41 (¶ 32(e)).

In addition to purportedly determining “medical necessity,” the Triad program would calculate the number of additional treatment visits that will be covered for the subscribers-patients for whom the required “plan” is submitted, without regard to the particular subscriber-patient’s individual circumstances or condition. No similar or

comparable restrictions on the scope and extent of treatment decision-making is imposed upon other health care providers-licensees. (*Id.*, pp. 1141 (¶ 32(f)).

Also effective September 30, 2007, Wellmark Defendants required that "chiropractic clinical coaches" be assigned to each chiropractor provider, and to require communication with these "coaches," all of whom are selected and assigned by Wellmark Defendants. No comparable interference on the scope and extent of treatment decision-making is imposed upon other health care providers-licensees. (*Id.*, pp. 1141 (¶ 32(g)).

In late September 2007, counsel for the Iowa Chiropractic Association prepared a petition for injunctive relief and submitted the petition to Wellmark counsel as a courtesy before filing it. This resulted in a series of meeting between Wellmark Defendants and a committee of the Iowa Chiropractic Society about possible resolution of the matter, which meetings extended into spring of 2008 resulting in Wellmark Defendants stating that the preapproval plan would be postponed indefinitely, but not withdrawn. (*Id.*, pp. 1124-1232).

The First Amended Petition in the *Mueller* lawsuit was filed shortly thereafter. (*Id.*, pp. 1233).

I. Iowa Chiropractors and WHPI HMO

The terms of the Wellmark Practitioner Services Agreements are virtually identical for other health care providers with respect to the Wellmark BCBS and WHPI products to which the agreements apply, including HMOs. (Non-Conf. App., Vol. I, pp. 791-94, 795, 827, 837, 849 (¶ 13.2 non-exclusive)). By contrast, the chiropractors' Practitioner Services Agreements do not apply to HMO products. (*Id.*, p. 795, 1098-99). Wellmark BCBS and WHPI have an exclusive dealing agreement with Iowa Chiropractic Physicians Clinic ("ICPC") whereby Iowa chiropractic physicians are only paid for services to members of WHPI HMOs if the chiropractic physicians are members of ICPC. (Conf. App., Vol. II, pp. 83, 98 (¶ 13.2 exclusive)).

Some of the Representative Plaintiffs and the class of plaintiffs are chiropractic physician members of ICPC (membership is strictly limited by ICPC), whereas all others are excluded through the exclusive dealing agreement between the Wellmark defendants and ICPC. Within the network of non-chiropractic Iowa health care providers, there are more providers for WHPI HMO products (over 95% of all Iowa licensed active practitioners) than the Wellmark indemnity and HMO products networks. (Conf. App., Vol. II, pp. 151(95:5 to 153(107:25) (Fay), Evans Depo. (8-9-2013) pp. 42:17 to 44:20 & Ex. 33). By contrast, within the network of chiropractic providers, the number of chiropractors who participate through ICPC for WHPI

HMO products is less than 25% of the Wellmark chiropractor network for Wellmark indemnity and PPO products. (*Id.*).

When other health care providers in Iowa provide services to WHPI HMO products, their reimbursement rate from Wellmark is a small percentage lower than what they receive for services to Wellmark indemnity and PPO products. (Conf. App., Vol. II, pp. 173-76 (183:20 to 196:16) (Fay)). By contrast, when the already-limited ICPC member chiropractors provide services to WHPI HMO products, their reimbursement rate from Wellmark is less than 50% of what they receive for services to Wellmark indemnity and PPO products. (Conf. App., Vol. II, pp. 862:24 to 872:20, 2468-2474 (Rebarcak)).

SUMMARY OF THE ARGUMENT

The district court's denial of class action certification was erroneously based on the district court's misinterpretation of what constitutes the essential elements of proof of a cause of action for violation of Section 553.4 of the Iowa Competition Act. The district court posits that it is an essential element of proof of "antitrust injury" to prove that each and all private and government self-fundeds would have offered each and all plaintiffs and proposed class members a uniform higher price for their chiropractic services absent the price fixing agreement with Wellmark defendants. The district court states: "The Plaintiffs' theory of antitrust injury is that, absent the unlawful Administrative Services Agreement between Wellmark and the self-funded employers, those employers would operate as competitors in the insurance market and, therefore, negotiate and pay the chiropractors directly, resulting in higher rates than those set by Wellmark." (Non-Conf. App., Vol. I, pp.1755, 1761 (1/18/23 Order p. 7)). This is not and has never been plaintiffs' theory of the case. It could not be a damage theory in Iowa because it violates the new business rule. Plaintiffs' theory of the case is that Wellmark and the Iowa self-fundeds entered into a written price fixing agreement that the price paid for health care provider services (including price paid for services of Iowa chiropractors) would be the price established by Wellmark through its annual provider fee schedules, and that the Wellmark pricing structure discriminates against

Iowa chiropractors by setting an unreasonable and anticompetitive radically lower relative price than for the corresponding pricing schedules for MD/DO, physicians assistants and advanced registered nurse practitioners, the other providers besides chiropractors with general health care diagnostic powers in Iowa. Furthermore, Wellmark Health Plan of Iowa, Inc. ("WHPI"), the HMO plan provider, and its self-funded conspirators discriminates solely against Iowa chiropractors by entering into an agreement with a servicing service middle person and setting the capitated fee for payment of chiropractic services at an unreasonably low level as to only allow approximately 25% of the Iowa chiropractors access to the WHPI and self-funded employers' Members, whereas all other Iowa primary health care providers have nearly 100% of their Iowa licensees having access to the WHPI and self-funded employers' Members and a payment rate less than 10% lower than the Wellmark PPO payment rate. The 25% are paid at about one-half of the Wellmark PPO rate, and the other 75% are paid nothing at all.

ARGUMENT SECTION

ISSUE I: THE DISTRICT COURT ABUSED ITS DISCRETION IN DENYING CLASS CERTIFICATION BY NOT FOLLOWING APPLICABLE LAW AND NOT STATING OR ACCEPTING PLAINTIFFS' PROOF OF THEORY SHOWING COMMON CLASS WIDE PROOF OF LIABILITY, PROXIMATE CAUSE AND ANTITRUST INJURY AND FACT OF ANTITRUST RELATED DAMAGES

Preservation of Error

Plaintiffs preserved error in the district court's Ruling Denying Class Certification by making direct appeal as a statutory matter of right by reason of Iowa R. Civ. P. 1.264(3) in a timely manner and by stating facts and law favorable to class certification in the briefs and oral hearings on the matter. (*See generally* Non-Conf. App., Vol. I, pp. 275, 300, (Motion for Class Determination and Statement of Facts) 422, 1464 (Hearing transcripts), 533-1387 (Non-Conf. Appendices); Conf. App., Vol. II, pp. 2248, 2258-2302 (Hearing Exhibits), 2248 (Reply), 32-940, 2303-2474 (Conf. Appendices).

Standard of Review

A ruling on a motion for class certification is reviewed for abuse of discretion. *Freeman v. Grain Processing Corp.*, 895 N.W.2d 105, 113 (Iowa 2017). "An abuse of discretion may be shown when it is exercised on untenable grounds or was clearly erroneous," *Annett*

Holdings, Inc. v. Pepple, 823 N.W.2d 418 (Iowa Ct. App. 2012) (citing *IBP, Inc. v. Al–Gharib*, 604 N.W.2d 621, 630 (Iowa 2000)), or on grounds that are clearly unreasonable. *Freeman* at 113 (quoting *Legg v. W. Bank*, 873 N.W.2d 756, 758 (Iowa 2016).

Argument

A. The District Court Abused Its Discretion in Denying Plaintiffs' Motion for Class Certification

In denying Plaintiffs' Motion for Class Certification in the January 19, 2022 Ruling, the District Court placed determining weight on the commonality requirement of Iowa R. Civ. P. 1.261(2) ("There is a question of law or fact common to the class.") and the predominance factor in Iowa R. Civ. P. 1.263(1)(e) ("Whether common questions of law or fact predominate over any questions affecting only individual members."). In fact, citing *Roland v. Annett Holdings, Inc.*, 940 N.W.2d 752 (Iowa 2020), and *Freeman v. Grain Processing Corp.*, 895 N.W.2d 105 (Iowa 2017), the District Court focused only on the "antitrust injury" factor in standing requirement of *Associated General Contractors of California, Inc. v. California State Council of Carpenters*, 459 U.S. 519, 537-44, 103 S. Ct. 897, 908-12 (1983) ("a causal connection between an antitrust violation and harm to the [plaintiff]", "whether [the injury] is of the type that the antitrust statute was intended to forestall", and "the directness or indirectness of the asserted injury").

The District Court's reliance on *Roland* was misplaced because of the peculiar proof needed to establish an element of the *Roland* plaintiffs' claim for an entire class with common proof of the claim. The representative plaintiff truck driver alleged bad faith refusal to process workers compensation claims. Roland himself had litigated the validity of the Memorandum of Understanding (MOU) required by the employer providing for short-term light duty and treatment in Des Moines for a work-related injury. Roland, a citizen of Alabama, challenged the MOU, asserting that treatment in Alabama was better for him. Roland took that claim to the Iowa Workers' Compensation Commissioner, who in due course ruled in Roland's favor. The Iowa Supreme Court had decided a factually similar case holding that suitable work during injury was a factual determination initially made by the Workers' Comp Commissioner and then subject to review by the courts under the Iowa Administrative Procedure Act for whether the Commissioner's ruling was supported by substantial evidence, a disputed fact determination. *Neal v. Annett Holdings, Inc.*, 814 N.W.2d 512, 518 (Iowa 2012). Since the determination of the validity depended upon factual findings by the Commissioner, only then reviewed by the courts for substantial evidence, each injured member of the absent class would need to go to the Commissioner first to get a ruling on the MOU before the claim could be adjudicated in the courts under a bad faith claim. So, Roland, the class representative, could not prove that common element of the claim for the entire class,

because it was subject to individual proof and agency determination which could vary from individual to individual. The commonality and predominance requirements under Iowa R. Civ. P. 1.261(2) and 1.263(1)(e) could not be met and class action certification must be denied. The Court differentiated the *Roland* case from *Freeman v. Grain Processing Corp.*, 895 N.W.2d 105, 108-09 (Iowa 2017), because *Freeman* was a nuisance case, and liability for nuisance is based on objective, class wide standards.

The Court cited *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 131 S. Ct. 2541 (2011) where a determination of commonality and predominance under Fed. R. Civ. P. 23 could not be made because there was no proof of a common pattern of discrimination from Wal-Mart itself, but rather individual instances of discrimination by many different supervisory employees of Wal-Mart on many different individual occasions. Thus, there was no common proof of the essential element of liability for the entire class at once.

The Court also cited *Comcast Corp. v. Behrend*, 569 U.S. 27, 133 S. Ct. 1428 (2012). *Comcast* was a case where class certification was asserted, contending that the fact of damages could be established by common class-wide proof by one class representative. The requirement of predominance over individual issues is a requirement of Fed. R. Civ. P. 23(b)(3). The damages problem was that the representative plaintiff posited four different proposed theories of antitrust

impact (fact that there was a common cause for plaintiff class damages), but the district court found only one of the four theoretical damages causes validly connected to a violation of the antitrust laws. Plaintiff class representative produced an expert econometrist's report calculating the combined impact of all four causes, including three invalid ones. *Comcast* held that common impact could not be proved for all of the absent class members across the entire class. *Comcast*, 133 S. Ct. at 1433-35. The flaw found in *Roland*, *Wal-Mart*, and *Comcast* is not present in this case because common class-wide proof of liability, proximate cause, impact and common measurable damages are present here for reasons stated as follows.

B. The Nature of the Conspiracy to Restrain of Trade and to Monopsonize

At this point, the exact nature of the violation of Section 553.4 of the Iowa Competition Act alleged in the Third Amended Petition must be established. The conspiracy between the Wellmark defendants and the Iowa private and governmental self-funded entities is found in (1) the Administrative Services Agreement of Wellmark Blue Cross and Blue Shield of Iowa effective January 1, 2009 ("2009 ASA"), (2) the Administrative Services Agreement between Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and 2012 Sample – Self Funded ERISA effective January 1, 2012 ("2012 ASA-SF"), and (3) the Administrative Services Agreement

between Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and 2012 Sample – Self-Funded Public Body effective January 1, 2012 ("2012 ASA-PB"). (Non-Conf., App., Vol. I, pp. 1024 (2009 ASA), 1044 (2012 ASA-SF), 1071 (2012 ASA-PB)). These ASAs are Wellmark mandatory forms to be signed by the self-fundeds, and the self-fundeds are all aware that all other self-fundeds sign the same forms. (Conf. App., Vol. II, pp. 255:5 to 256:10 (Druker); *See* Non-Conf. App., Vol. I, pp. 1024 (bottom of cover), 1044 (same), 1071 (same)).

At the outset, when the Iowa self-fundeds sign this agreement, they are purchasers of health care services for their employees and families in the same level of acquisition of health care services as are Wellmark and WHPI. If they weren't, they would have no reason to need an Administrative Services Agreement. The Iowa self-fundeds are competitors for the purchase of health care services, not mere potential competitors.

The 2009 ASA recites: "Account wishes to enter into a financial arrangement with Wellmark under which account is solely responsible for the claims paid for covered health services provided to its members." There is an identical recitation in 2012 ASA–ERISA and in 2012 ASA–PB. (Non-Conf. App., Vol. I, pp. 1025 (2009 ASA), 1045 (2012 ASA-SF), 1072 (2012 ASA-PB)).

Each of the ASAs are agreements of Wellmark defendants to provide administrative services for the self-fundeds. Administrative services are defined in article 1, section 1.2 of the ASA's. An administrative fee is charged for administrative services. (Art. 1, Sec. 1.1). Additionally, and separate from the agreement to provide Administrative Services is an agreement with respect to provider payment arrangements: "Wellmark has negotiated and entered into separate payment arrangements with health care providers and determined in its discretion the Maximum Allowable Fees to be paid for Incurred Claims. These provider payment arrangements and agreements apply to services for all persons entitled to benefits under the contract to which Wellmark is a party, *including Members under this Agreement*." (Art. 6, Sec. 6.1). "Member" is defined as the employee and family of the self-funded employer. (Art. 1, Sec. 1.15).

The self-fundeds agree to pay a separate "Network Access Fee," the amount charged to Account to gain the collective advantages of the network of providers with which Wellmark, any Host Blue, or any subcontractor has contracted for the provision of Covered Services. The Network Access Fee is a percentage of Network Savings, the amount saved due to contracts between Wellmark or another Blue Cross and Blue Shield plan and healthcare providers. It is calculated monthly and is "generally calculated as the difference between the

Covered Charge and the Maximum Allowable Fee." (Art. 1, Secs. 1.16 & 1.17) The Covered Charge is "the amount a health care provider bills a member or Wellmark for covered services." (Art. 1, Sec. 1.8).

Wellmark acknowledges that the agreement between it or them and the self-fundeds to set the price paid to healthcare providers at the price determined by Wellmark, is a separate agreement from the agreement to provide administrative services and a separate Network Access Fee is charged for that agreement. Each of the ASA's also states an agreement as to the Nature of Relationship: "Nothing contained in this agreement and no action taken or omitted to be taken by Account or Wellmark pursuant hereto shall be deemed to constitute Account and Wellmark a partnership, an association, a joint venture or other entity whatsoever. Wellmark shall at all times be acting as an independent contractor under this agreement." (Art. 10, Sec. 10.9)

All of these provisions are also in the 2012 ASA-ERISA and the 2012 ASA-PB, but additionally the 2012 ASA's are also an agreement by WHPI and contain additional agreement about Capitation payments and the fact that Non-Contracting Providers can charge the Member for the balance of the provider billing beyond Wellmark's payment. (Art. 1, Sec. 1.7; Art. 6, Secs. 6.1 &6.3)

It is noteworthy that the Practitioner Agreements do not mention the self-funded private and governmental entities as having employees or families covered by the Practitioner Agreements. Thus, the Plaintiffs and the Plaintiff Class have not agreed to service the self-fundeds' employees and families. Nevertheless, the self-fundeds' employees present a Wellmark card in identical to that of Wellmark insureds and all DC claims are processed without any indication that they are employees of self-fundeds, except that the WHPI HMO does not directly pay DCs, but pays an intermediary, ICPC, who pays some of the DCs for WHPI HMO covered patients. Most of the Iowa DCs, however, are not paid for patients covered by the WHPI HMO.

With respect to conspiracy to monopsonize under Iowa Code § 553.4, Plaintiffs have shown the geographic market to be Iowa and the product market to be the purchase of services of Iowa health care providers having license to generally diagnose human ailments, being Iowa MDs, DOs, DCs, physician assistants, and advanced registered nurse practitioners, in a manner of payment grossly discriminatory to DCs. Wellmark's own evidence shows that in 2012 it had 49% of the Iowa statewide market for the purchase of such health care services in the PPO/HMO/POS market, with an HHI score of 3302 (highly concentrated. (Non-Conf. App., Vol. I, p. 967 (Ex. M)).

C. Plaintiffs' Antitrust Injury

In the first place, the District Court acknowledged that *Mueller I*, under the same set of facts, concluded that plaintiffs have stated an antitrust injury. Ruling p. 2; *Mueller I*, 818 N.W.2d at 265, *citing W. Penn Allegheny Health Sys., Inc. v. UPMC* 627 F.3d 85, 104-05 (3d Cir. 2010), *cert. denied* 565 U.S. 817 (2011) ((holding that a hospital had alleged antitrust injury based on its receipt of artificially depressed reimbursement rates from a dominant insurer and noting that "the defendants' argument reflects a basic misunderstanding of the antitrust laws").

The District Court cites to a recent antitrust case of the Second Circuit Court of Appeals, *IQ Dental Supply, Inc. v. Henry Schein, Inc.*, 924 F.3d 57, 62-63 (2d Cir. 2019), citing to *Gatt Commc'ns, Inc. v. PMC Assocs., L.L.C.*, 711 F.3d 68, 76 (2d Cir. 2013), which in turn cites to *Atl. Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 342, 110 S. Ct. 1884 (1990). The Second Circuit refers to this as the "*Gatt* test."

> (1) the court "must identify [ ] the practice complained of and the reasons such a practice is or might be anticompetitive . . . ," (2) the court "must identify the actual injury the plaintiff alleges . . . , [which] requires us to look to the ways in which the plaintiff claims it is in a 'worse position' as a consequence of the defendant's conduct," and (3) the court compares the "'anticompetitive effect of the specific practice at issue' to the 'actual injury the plaintiff alleges.' . . ."

IQ Dental Supply, 924 F.3d at 62-63 (citations omitted). Ruling p. 7. The District Court goes on to state: "The Plaintiffs' theory of antitrust injury is that, absent the unlawful Administrative Services Agreements between Wellmark and the self-funded employers, those employers would operate as competitors in the insurance market and, therefore, negotiate and pay the chiropractors directly, resulting in higher rates than those set by Wellmark." *Id.*

This "theory" is not found in Plaintiffs' Third Amended and Substituted Petition at Law (Revised) (Non-Conf. App., Vol. I, pp. 168-97), filed December 21, 2019 (*See* ¶¶ 59-64 set forth at pp. 62-64 below), but rather is found, when viewed in the light most favorable to *defendants*, in the class certification motion and oral presentations of plaintiffs' counsel at the hearings. The big problem with the theory is that no trial lawyer knowledgeable in Iowa civil damage law would posit such a theory because in violates the new business rule. *Harsha v. State Savings Bank*, 346 N.W.2d 791 (Iowa 1984), recites the new business rule of damages: "In Iowa we recognize the "new business rule" which deems "potential profits from an untried business" as too speculative to be recoverable. *Harsha* at 797. There are at least 20 cases from the Iowa Court of Appeals applying the new business rule. In all cases but the most compelling proof of an accountant's business projection and part performance by the new business, the Iowa courts deny admissibility of speculation on profitability of a new business.

To plaintiffs' counsel's knowledge, none of the self-fundeds have any record of performance in establishing a price for purchase of health care services for its employees. It would not be an acceptable method of proving antitrust damages under the "before-and-after" method recognized by the antitrust laws as a valid damages theory because there is no before and no after in the facts of this case. The before-and-after would be most highly speculative, and "even the most optimistic assessment of the before-and-after method of estimating damages must conclude that it yields only rough approximations of the price that would have prevailed had the conspiracy not occurred." H. Hovenkamp, Federal Antitrust Policy: The Law of Competition and Its Practice, § 17.5b2 at p. 729 (West Publishing, St. Paul, MN, 4th Ed. 2011); P. Areeda, H. Hovenkamp, & R. Blair, Antitrust Law ¶ 391e (Aspen Publishers, Frederick, MD, 2nd Ed. 2000).

The District Court correctly concluded that the appropriate method to find plaintiffs' theory of antitrust injury is to identify the elements of plaintiffs' alleged cause of action. Ruling p. 5, *citing Freeman v. Grain Processing Corp.*, 895 N.W.2d 105, 121-22 (Iowa 2017); *Roland v. Annett Holdings, Inc.*, 940 N.W.2d 752 (Iowa 2020); *Newton v. Merrill Lynch, Pierce, Fenner & Smith, Inc.*, 259 F.3d 154, 172 (3d Cir. 2001).

Plaintiffs' cause of action is stated at ¶¶ 59-64 of the Third Amended Petition (Revised):

59. Wellmark Defendants have contracted and conspired with their co-conspirators to engage in, and continue to engage in, a pattern of price fixing and other arbitrary and artificial price suppression against the Iowa Provider Plaintiffs. This price fixing and other arbitrary and artificial price suppression has occurred and is occurring in numerous ways, including:

(Listing nine specifications, (a) through (i))

60. In furtherance of that combination and conspiracy, in more recent times the Wellmark entities have established a scale of compensation for the same or similar diagnostic and treatment services to its members wherein Iowa Doctors of Medicine (M.D.'s) and Doctors of Osteopathy (D.O.'s) receive as much as 100% higher payment than chiropractors receive for the same or similar diagnostic and treatment services. The annual rate schedule for health care services which has been issued by Wellmark and which governs its payment of Iowa health care practitioners discriminates against those health care practitioners licensed under Chapter 151 of the Code of Iowa.

61. The plaintiffs and the plaintiff class have been damaged since at least May 20, 2004 and continue to be damaged presently (a) by receiving less than 50% for services to HMO members than Wellmark pays for Iowa chiropractic physicians in its PPOs; (b) by receiving much less or nothing for services to HMO members than what Wellmark defendants and their co-conspirators pay other health care practitioners in Iowa for the same or similar services to HMO members; and, (c) by receiving from 25% to 75% less from Wellmark defendants' implementation of the RBRVS system in a manner which discriminated against chiropractic services by establishing lesser rates for chiropractic diagnostic and treatment services than for the same or similar services provided by M.D.'s, D.O.'s, physicians assistants, and nurse practitioners.

62. This damage can be calculated through the examination of a schedule of fees prepared by the Wellmark defendants annually and comparing the compensation scheduled to be paid to plaintiffs and the plaintiff class to compensation scheduled to be paid to other Iowa health care practitioner for the same or similar services.

> 63. Plaintiffs and the Class they represent have been injured by conduct prohibited by Section 553.4, Code of Iowa (2007), the anticompetitive consequences of such contracts, tying arrangements, conspiracy or conspiracies outweigh any procompetitive benefits.
>
> 64. Plaintiffs and the other members of the Class have been damaged in their businesses and property by and as a proximate cause of the conduct of the Wellmark defendants and their co-conspirators.

Additionally, Plaintiffs filed 10 exhibits detailing their damage theory and calculations under the "yardstick" method of measuring damages from overcharge or underpayment from price-fixing restraint of trade and/or conspiracy to monopsonize. (Conf. App., Vol. II, pp. 2258-2301).

The antitrust law of private enforcement actions adopts the basic common law rule of compensatory damages that a plaintiff is entitled to an award of damages that will restore him to the position in which he would have been but for the violation. Furthermore, as the Supreme Court put it in *Story Parchment Co. v. Paterson Parchment Paper Co.*, 282 U.W. 555, 562, 51 S. Ct. 248, 250 (1931), "there is a clear distinction between the measure of proof necessary to establish the fact that petitioner has sustained some damages and the measure of proof necessary to enable the jury to fix the amount." The Supreme Court sets a relatively high standard for proof of the fact of an antitrust violation and resulting injury, but a lower standard for proof of amount of damages. L. Sullivan & W. Grimes, The Law of

Antitrust: An Integrated Handbook (Thomson West, St. Paul, MN, 2nd Ed. 2006) § 17.4, p. 723.

"The term 'overcharge injury' may also describe the injury suffered by a seller for whom the price was suppressed by a monopsonist or buyer's cartel . . . ." Hovenkamp, Federal Antitrust Policy § 17.51 p. 724; Sullivan, Law of Antitrust § 17.5a , p. 724. The U.S. Supreme Court adopted the "yardstick" method of computing antitrust damages in *Bigelow v. RKO Radio Pictures, Inc.,* 327 U.S. 251, 66 S. Ct. 574 (1946). Today the overcharge [or underpayment] method of computing damages is well established. Sullivan, Law of Antitrust p. 725. Under the "yardstick" method of proving the antitrust damages for restraint of trade conspiracy to price fix, "the price that prevails in a different market, similar to the cartelized market but presumed to be competitive, becomes the surrogate for the competitive price." "Under the yardstick method the plaintiff identifies some geography market that is as similar as possible to the cartelized market, but for the conspiracy." Hovenkamp, Federal Antitrust Policy § 17.5b p. 727.

This Court described such a competitive market in some detail in *Mueller I*. The similar "competitive market" is a nationwide market and covers approximately 25% of all health care services performed in the United States – the Medicare market.

Plaintiffs filed the 10 exhibits on January 28, 2021, for use at the hearing of January 29, 2021, to show how plaintiffs intended to

prove "impact" (that plaintiffs and the class were injured by the antitrust violation alleged) and how damages could be proven on a class wide basis for all class members. (Conf. App., Vol. II, pp. 2282-2301). This proof was discussed by Mr. Wandro for the plaintiffs in the hearing on class determination of January 29, 2021, before Judge Lauber on pp. 4:10 to 15:8 (Non-Conf. App., Vol. I, pp. 425:10 to 436:8) and particularly by visual slide 7. (Non-Conf. App., Vol. I, pp. 425:18 to 429:2; Conf. App., Vol. II, p. 2302 (Slide 7)). It is also discussed by Mr. Norris for plaintiffs at pp. 91:10 to 99:20 (Non-Conf. App., Vol. I, pp. 512:10 to 520:20) and also at pp. 108:4 to 109:10. (Non-Conf. App., Vol. I, pp. 529:4 to 530:10). It was set forth again by Mr. Norris for plaintiffs in the hearing before Judge Crane of November 19, 2021, at transcript pages 26:10 to 35:10 (Non-Conf. App., Vol. I, pp. 1489:10 to 1498:10) and at pages 47:5 to 49:15. (Non-Conf. App., Vol. I, pp. 1510:5 to 1512:15; Conf. App., Vol. II, p. 2302 (Slide 7)).

D. Plaintiffs Have Presented Common Proof of Liability, Proximate Cause, and Impact or Fact of Common Injury and Damages

Turning now to Plaintiffs' theory of common proof of (1) liability, (2) proximate cause of injury from the price fixing conspiracy, and (3) common damages of the type that the antitrust statute was intended to forestall, the first two items are inherent in the restraint of

trade alleged. Price fixing has been a restrain of trade since the earliest days of enforcement of the Sherman Act. The representative plaintiffs and members of the plaintiff class are direct sellers into the buyer price fixing conspiracy. There is no better private person to prosecute this action than the direct seller and no person more clearly injured as a proximate result of the price fixing conspiracy alleged. The leading treatise on antitrust monopsony is R. Blair & J. Harrison, Monopsony in Law and Economics, (Cambridge University Press 2010). As to the anticompetitive effects of a collusive monopsony (i.e., a conspiracy to fix price price to sellers), the authors summarize at page 157:

> "[I]n the case of sellers to a collusive monopsony, . . . the harm suffered is a direct result of a collusive activity that decrease competition among the buyers. Moreover, this injury is typically associated with decreases in the cartel's output and increases in consumer prices. It seems just as clear that the sellers to the collusive monopsony should be regarded as meeting the additional components necessary to establish antitrust standing. Clearly, there can be no more direct victim; the sellers to a monopsony hold a position that is directly analogous to the position of the buyers from a price-fixing cartel. . . [Furthermore,] a finding that sellers to the collusive monopsony have suffered antitrust injury does not create a risk of multiple liability."

This brings us to proof of common damages of the type that the antitrust statute was intended to forestall. The well-established "yardstick" method of measuring damages of underpayment from price-fixing restraint of trade and/or conspiracy to monopsonize is the common proof of "antitrust injury" or fact of damage from the price fixing alleged. Plaintiffs' theory of proof of damages is based, first of all, of

how Wellmark defendants and CMS and most major health insurers establish price for diagnostic and treatment services performed by licensed physician assistants and advanced registered nurse practitioners as 85% of the fee paid to MDs and DOs for any and all CPT codes. These practitioners, together with MDs, DOs, and DCs have licensing permission to perform differential diagnosis and diagnostic tests to determine if the patient has a human ailment which is subject to treatment. Exhibits H01 and H02 show that Wellmark defendants paid PAs and ARNPs 85% of the MD/DO non-facility (i.e., not in hospitals) fee rounded in the fiscal year beginning July 1, 2013. (Conf. App., Vol. II, pp. 2282-87) Exhibit H03 is a chart taken from the 2013 National Physician Fee Schedule Relative Value File, April Release, for the CPT codes Wellmark defendants pays to DCs, MDs, and DOs. This corresponds to similar exhibits prepared by Wellmark defendants. (*Id.*, pp. 2288-89).

Exhibit H04 shows how Wellmark defendants' conversion factors can be computed from the Wellmark defendant prices divided by the 2013 CMS RVUs. (*Id.*, p. 2290). Exhibit H05 is also Wellmark Exhibit I and states the Wellmark PPO conversion factors in 2013 for DCs and MD/DOs. (*Id.*, p. 2291). They correspond almost exactly to the computations in Exhibit H04.

Exhibit H06 is Wellmark defendants Exhibit K and shows the number of PPO procedures Wellmark paid for each CPT code for DCs, MD/DOs, and PTs in 2013. (*Id.*, pp. 2292-93).

Exhibit H07 is Wellmark defendants Exhibit L and shows the number of specialty providers in Wellmark's PPO provider network in 2013 and compares that with the total number of licensed providers of those specialties in 2013. (*Id.*, p. 2294). It shows over 95% of Iowa MD/DO specialists, PA, ARNPs, PTs, and Social Workers in the Wellmark PPO in 2013, and over 90% of DCs.

Exhibit H09 is a comparison of ratios between CMS RVUs for chiropractic vs osteopathic manipulation taken from CMS National physician fees schedule relative value files from 2004 to 2020. The last four columns (1) compare 98940 to 98925, (2) 98941 to 98926, (3) 98942 to 98927, and (4) 98943 to 98925. (*Id.*, pp. 2295-98). The average of the first three columns by year shows DCs manipulation RVUs being 89.01% of DO manipulation RVUs in 2004; 88.54% in 2005; 88.23% in 2006; 88.77% in 2007; 89.20% in 2008; 88.92% in 2009; 87.81% in 2010; 86.07% in 2011; 82.54% in 2012; 81.68% in 2013; 90.49% in 2014; 89.81% in 2015; 89.62% in 2016; 89.26% in 2017; 89.35% in 2018; 89.93% in 2019; and, 89.44% in 2020. In summary, it was approximately 88-89% in years 2004 to 2011, fell to approximately 82% in 2012 and 2013, the two years where DO codes

were adjusted which DC codes were not; and approximately 90% from 2014 to 2020.

Accordingly, plaintiffs' proof of common damages to all DCs in the years 2004 to 2020 is approximately 90% of the price Wellmark paid to MD/DOs for the same codes. That is how the "yardstick" measure of common damages from the common price-fixed under-payment may be computed from the data. Exhibit H10 takes the in-formation from Exhibit H04 and computes the "yardstick" measure of damages. (*Id.*, pp. 2299-2301). For example, for CPT code 99201in 2013, Wellmark paid DCs $30.00; Wellmark paid MD/DOs $63.00. 90% of $63.00 is $56.70 – the fair market price according to RBRVS data. The difference between what the DC received, $30.00, and what the fair market price should have been, $56.70, is $26.70. Hence, the underpayment for each 99201 a DC submitted to Wellmark in 2013 was $26.70. This figure was explicitly shown to the District Court in Mr. Wandro's argument using slide 7 in the January 29, 2021 hearing before Judge Lauber.

The final January 29, 2021 hearing exhibit is Exhibit H11. It takes the data from defendants' Exhibit K (Plaintiffs' Exhibit H06) and computes the total number of claims DCs made to Wellmark PPO in 2013 for each CPT code and computes the 90% of MD/DO fee schedule times that number. (*Id.*, p. 2301). For example, the total claims DCs made in 2013 for CPT 99201 times the $26.70

underpayment is $179,317.20. Exhibit H11 shows the total Wellmark PPO underpayment damages to be $20,601,405.80. This is common proof for all class members of common damages proximately resulting from the antitrust price fix in 2013 with respect to Wellmark PPO underpayment, the type of damages that the antitrust statute was intended to forestall. As *Mueller I* concluded in 2012, Plaintiffs have established "antitrust injury." Thus, the only two factors the District Court relied upon in denying class certification, actually showed that the commonality requirement of Iowa R. Civ. P. 1.261(2) ("There is a question of law or fact common to the class.") and the predominance factor in Iowa R. Civ. P. 1.263(1)(e) ("Whether common questions of law or fact predominate over any questions affecting only individual members.") was established. The District Court erred in ignoring Plaintiffs" theory of proof of the case and rather focusing on Defendants' theory of proof of the case not found in the Third Amended and Substituted Petition at Law (Revised) filed December 21, 2019. This error was an abuse of discretion. *Roland v. Annett Holdings, Inc.*, 940 N.W.2d 752 (Iowa 2020); *Freeman v. Grain Processing Corp.*, 895 N.W.2d 105 (Iowa 2017): *Comcast Corp. v. Behrend*, 133 S. Ct. 1426 (U.S. 2013); and, *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541 (U.S. 2011), are all in accord with this conclusion.

ISSUE II: THE DISTRICT COURT ABUSED ITS DISCRETION IN DENYING CLASS CERTIFICATION BY NOT STATING OR ACCEPTING PLAINTIFFS' PROOF OF THEORY SHOWING COMMON CLASS WIDE PROOF OF LIABILITY, PROXIMATE CAUSE AND ANTITRUST INJURY AND FACT OF DAMAGES WITH RESPECT TO THE CONSPIRACY TO PRICE FIX AND PARTIAL BOYCOTT LED BY WHPI HMO

Preservation of Error

Plaintiffs preserved error in the district court's Ruling Denying Class Certification by making direct appeal as a statutory matter of right by reason of Iowa R. Civ. P. 1.264(3) in a timely manner and by stating facts and law favorable to class certification in the briefs and oral hearings on the matter. (*See generally* Non-Conf. App., Vol. I, pp. 275, 300, (Motion for Class Determination and Statement of Facts) 422, 1464 (Hearing transcripts), 533-1387 (Non-Conf. Appendices); Conf. App., Vol. II, pp. 2248, 2258-2302 (Hearing Exhibits), 2248 (Reply), 32-940, 2303-2474 (Conf. Appendices).

Standard of Review

A ruling on a motion for class certification is reviewed for abuse of discretion. *Freeman v. Grain Processing Corp.*, 895 N.W.2d 105, 113 (Iowa 2017). "An abuse of discretion may be shown when it is exercised on untenable grounds or was clearly erroneous," *Annett*

Holdings, Inc. v. Pepple, 823 N.W.2d 418 (Iowa Ct. App. 2012) (citing *IBP, Inc. v. Al–Gharib*, 604 N.W.2d 621, 630 (Iowa 2000)), or on grounds that are clearly unreasonable. *Freeman* at 113 (quoting *Legg v. W. Bank*, 873 N.W.2d 756, 758 (Iowa 2016).

Argument

A. WHPI and the Self-fundeds Discriminate Only Against Chiropractors in WHPI's HMO Network Through the WHPI contract with Iowa Chiropractic Physicians Clinic ("ICPC")

1. Two separate subclasses are needed

There are two subclasses of chiropractor plaintiffs with respect to the discrimination by WHPI and the self-fundeds against chiropractic providers. The first subclass, represented by Plaintiff Rod Rebarcak, D.C., is the approximately 25% of Iowa chiropractors who have access to WHPI HMO Covered Persons in Iowa through membership in Iowa Chiropractic Physicians Clinic ("ICPC"). The other subclass, represented by Drs. Chicoine and Niles, is the 75% of Iowa chiropractors who have no access to WHPI HMO Covered Persons at all because of the conspiracy to boycott.

2. Common Questions of Fact and Law Predominate on This Sub-issue

In the past five years, over half of the self-funded purchases of services of Iowa health care services providers have been through the

HMO provider network maintained by Wellmark Health Plan of Iowa, Inc. ("WHPI"). But WHPI requires that chiropractors participate in its HMO networks and the Hawk-I HMO network only through an affiliation with the Iowa Chiropractic Physicians Clinic ("ICPC"). (Non-Conf. App., Vol. I, p. 795 (Ex. 39.52)) ICPC is owned by Ronald Evans, D.C. and his family. ICPC's relationship with WHPI started in 1994 at the time WHPI was incorporated. [Conf. App., Vol. II, p. 674:13 to 675:18 (Evans)).

The unique WHPI Provider Organization Services Agreement with ICPC is for chiropractic services only, and WHPI agrees that "[d]uring the term of this Agreement, [WHPI] will not contract with chiropractic providers (other than [ICPC and its member chiropractors]) with respect to [WHPI's HMO products]." (Ex. 41C, § 13.2, Conf. App., Vol. II, pp. 83, 98). The WHPI Provider Organization Services HMO Agreement for all other non-chiropractic practitioner organizations states that "[n]othing herein shall preclude HMO from contracting with other providers and provider organizations to provide Covered Services to Covered Persons . . . ." (Ex. 41B, § 13.2, Non-Conf. App., Vol. I, p. 826, 837, 849).

The non-chiropractor WHPI Provider Organization Services HMO Agreement does not require a capitated rate payment, but rather states the standard fee for services payment for claims. (*Id.*, § A-1, p. 854). The WHPI HMO fee schedules for MD/DO, PA, ARNP,

and PT use a small discount[12] from the PPO rate in the same fee schedules. (Conf. App., Vol. II., pp. 501:1—508:10 (Fay)). WHPI requires none of these providers to participate in a capitated payment plan. (*Id.*, pp. 684:2—686:14(Evans)).

WHPI has more MD/DOs, PAs, ARNPs, and PTs in its HMO provider network than Wellmark has in its PPO provider network. (Non-Conf. App., Vol. I, App. 760-94 (Ex. 39.49); Conf. App., Vol. II, 505:5—508:10 (Fay)). On the other hand, although Wellmark includes over 90% of all Iowa chiropractic physicians (approximately 1,322) in its PPO participating provider network, less than 25% of that number (approximately 248) are selected as participating providers for the WHPI HMO plans, and those chiropractic physicians are paid less than 50% of the PPO *chiropractor* payment schedule (which is already substantially less than the MD/DO schedule for the same CPT codes) through ICPC. (Conf. App., Vol. II, pp. 684:2—686:14, 691:24—695:7 (Evans), 865:11—872:20 (Rebarcak); p. 795 (Ex. 39.52)). WHPI self-administers its HMO provider network for MD/DOs, PAs, ARNPs, and does not charge an additional

[12] Testimony of Mike Fay indicates that the WHPI fee schedule for MD/DO, PA, ARNP, and PT employ an average discount of less than 10% in 2012 and 2013 from the Wellmark PPO rate in the various fee schedules. (Conf. App., Vol. II, pp. 503:20 to 504:16 (Fay)) Further, WHPI does not use a capitated rate and does not charge an additional administrative fee for MD/DO, PA, ARNP, and PT providers of its HMO network.

administrative fee for so doing. ICPC, on the other hand, charges a huge[13] administrative fee, which goes to Dr. Evans and his sons. (Conf. App.. Vol. II, pp. 501:1—508:10 (Fay), 700:5—701:4(Evans)).

There can be no doubt that Wellmark is aware of the huge fee ICPC is taking. In addition to hearing counsel for Wellmark, Mike Fay, the Wellmark Vice President for Health Networks, and Michel Druker, Wellmark Vice President and Associate General Counsel, were present during Dr. Evans' testimony as Wellmark representatives. (*Abbas* administrative hearing, Conf. App., Vol. II, p. 454).

Testimony of Rod Rebarcak, DC, based upon the past years' actual disbursements from Iowa Chiropractic Physicians Clinic, shows that a chiropractor member of ICPC receives approximately 47.92% of the Wellmark PPO *chiropractic* fee schedule for services to the members of the HMO's of Wellmark Health Plan of Iowa, Inc. (Conf. App., Vol. II, pp. 867:13—872:20, 2468-74 (Rebarcak)).

Dr. Evans testified that he has had discussions with WHPI "that have always centered on WHPI asking or seeking to have all the [DC] providers, but not changing the subscriber base." (*Id.*, pp. 696:25—701:4 (Evans)). Dr. Evans told WHPI, "It's economically impossible to do that unless they change something from their side of the

[13] Actual percentage charged and payment taken by ICPC is found in the Confidential Appendix, Vol. II, pp. 35-38.

formula or increase the subscriber base, it was undoable." That, Dr. Evans testified, was because the chiropractor could not afford to do the service. (*Id.*).

In summary, Dr. Evans testified that the capitated payment rate of Wellmark to ICPC permits only a limited number of chiropractors in the ICPC network – 248 in ICPC as opposed to 1,300 to 1,500 Iowa chiropractors in the Wellmark PPO network. Mike. Fay testified that the PPO and HMO networks of Wellmark's and WHPI's MD/DO, PA, ARNP, and PT providers are similar in size and comprise more than 95% of the active Iowa licensed MD/DO, PA, ARNP, and PT practitioners.

The measure of damages for the subclass of chiropractic physician members of ICPC would be the difference between the PPO schedule for the various CPT codes for services performed for WHPI patient members, discounted by the standard less than 10 per cent discount from the PPO schedule given for other health care providers services to WHPI patient members, and what was actually received by the ICPC physician members from ICPC from the various CPT services codes.

The measure of damages for the subclass of non-members of ICPC for WHPI discrimination would have to be lost profits from the inability to be compensated for services to WHPI patient members, determined by expert testimony. Of course, This subclass would be

entitled to injunctive relief from the WHPI for the refusal to include the subclass members as providers in the WHPI network. In short, the foregoing demonstrates that the methodology for calculation of class wide damages is susceptible to common proof. Proof of liability, proximate cause, antitrust impact, and measure of damages would all be by common class wide proof. There would be no individual issues.

The common questions of law on this sub-issue are essentially the same as discussed for the price fix with the Iowa self-fundeds regarding Wellmark's PPO which sets a discriminatory underprice solely against Iowa chiropractors. The District Court did not even mention the WHPI HMO issues addressed here. The District Court does not posit any theory of common proof contrary to the theory which plaintiffs posit. The District Court abused its discretion in not addressing this cause of action of the two subclasses.

III. Conclusion

For each and all of the above-stated reasons, this Court should reverse, for abuse of discretion, the District Court's Order Denying Class Certification filed January 19, 2022, and remand the matter back to the District Court for determination by the District Court under the correct legal principles governing commonality and predominance relating to common impact and fact of damages of the type that the antitrust statute was intended to forestall.

Request for Oral Argument

Plaintiffs/Appellants respectfully request to be heard in oral argument in this appeal.

Dated: April 14, 2023.

Respectfully submitted,

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1. This Appellants' Opening Proof Brief complies with the type-volume limitation of Iowa R. App. P. 6.903(1)(g)(1) or (2) because this brief contains 13,808 words, excluding the parts of the application/motion exempted by Iowa R. App. P. 6.903(1)(g)(1).

2. This Appellants' Opening Proof Brief complies with the typeface requirements of Iowa R. App. P. 6.903(1)(e) and the type-style requirements of Iowa R. App. P. 5.903(1)(f) because this brief has been prepared in a proportionally spaced typeface using MS Word in Georgia Pro 14 pt.

/s/ Glenn L Norris Dated: April 14, 2023

CERTIFICATE OF SERVICE

The undersigned certifies that the foregoing instrument was filed on the 14th day of April, 2023 with the Clerk of Court using the EDMS system, which will send notification of such filing to the counsel below: */s/ Glenn L Norris AT0005907*

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