BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

In the Matter of the Application for an Award of Advocacy and Witness Fees of: Legal Services of Northern California, a California corporation dba Health Rights Hotline, Applicant.	**DMHC Decision 08-12-01 December 22, 2008** Application Received Date: October 16, 2008 Proceeding Control Nos. 2006-0777, 2006-0782, 2007-1253 and 2008-1536 For 28 CCR § 1300.71.39 (Re: Definition of Unfair Billing Patterns)

OPINION GRANTING AWARD OF ADVOCACY AND WITNESS FEES TO LEGAL SERVICES OF NORTHERN CALIFORNIA, A CALIFORNIA CORPORATION DBA HEALTH RIGHTS HOTLINE, FOR SUBSTANTIAL CONTRIBUTION TO PROCEEDING CONTROL NOS. 2006-0777, 2006-0782, 2007-1253 and 2008-1536

1. SUMMARY

This decision awards Legal Services of Northern California, a California corporation doing business as Health Rights Hotline ("Health Rights Hotline" or "APPLICANT"), Advocacy and Witness Fees for its substantial contribution to Proceeding Control Nos. 2006-0777, 2006-0782, 2007-1253 and 2008-1536 of the Department of Managed Health Care ("Department") regarding Unfair Billing Patterns ("proposed regulation"), which became final as set forth at 28 CCR §1300.71.39 (the "regulation"). The award represents a decrease from the amount requested for the reasons stated herein.

2. BACKGROUND OF CONSUMER PARTICIPATION PROGRAM

The Consumer Participation Program (the "Program"), enacted in Health and Safety Code § 1348.9 (the "Statute"), required the Director (the "Director") of the Department to adopt regulations

to establish the Program to allow for the award of reasonable advocacy and witness fees to any person or organization that (1) demonstrates that the person or organization represents the interests of consumers and (2) has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the Director if the order or decision has the potential to impact a significant number of enrollees.

The Statute requires the regulations adopted by the Director to include specifications for: (1) eligibility of participation, (2) rates of compensation, and (3) procedures for seeking compensation. The Statute specifies that the regulations shall require that the person or organization demonstrates a record of advocacy on behalf of health care consumers in administrative or legislative proceedings in order to determine whether the person or organization represents the interests of consumers.

Pursuant to the Statute, the Program regulations were adopted as section 1010 of Title 28 of the California Code of Regulations (the "Regulations"). The Regulations specified:

a. Definitions for the Program, including: "Advocacy Fee," "Compensation," "Market Rate," "Represents the Interests of Consumers," "Substantial Contribution," and "Witness Fees." (§ 1010, subsection (b)).

b. Procedure for a Request for Finding of Eligibility to Participate and Seek Compensation. (§ 1010, subsection (c)).

c. Procedure for Petition to Participate. (§ 1010, subsection (d)).

d. Procedure for Applying For An Award of Fees. (§ 1010, subsection (e)).

3. REQUIREMENTS FOR AWARDS OF ADVOCACY AND WITNESS FEES

3.1. PROCEDURAL REQUIREMENTS

All of the following procedures must be followed and criteria satisfied for a person or organization that represents the interests of consumers to obtain a compensation award:

a. To become a "Participant," the person or organization must satisfy the requirements of either or both of the following by:

(1) Submitting to the Director a Request for Finding of Eligibility to Participate and Seek Compensation in accordance with 28 CCR §1010(c), at any time independent of the pendency of a proceeding in which the person seeks to participate, or by having such a finding in effect by having a prior finding of eligibility in effect for the two-year period specified in 28 CCR § 1010(c)(3).

(2) Submitting to the Director a Petition to Participate in accordance with 28 CCR §1010(d), no later than the end of the public comment period or the date of the first public hearing in the proceeding in which the proposed Participant seeks to become involved, whichever is later (for

orders or decisions, the request must be submitted within ten working days after the order or decision becomes final).

b. The Participant must submit an "application for an award of advocacy and witness fees" in accordance with 28 CCR §1010(e), within 60 days after the issuance of a final regulation, order or decision in the proceeding.

c. The Participant must have made a Substantial Contribution to the proceeding. (Health & Saf. Code, § 1348.9, subd. (a); 28 CCR § 1010(b)(8)).

d. The claimed fees and costs must be reasonable (Health & Saf. Code, § 1348.9, subd. (a)) and not exceed market rates as defined in 28 CCR § 1010.

3.2. APPLICANT'S APPLICATION TO PARTICIPATE

On September 27, 2006, APPLICANT submitted its Request for Finding of Eligibility to Participate and Seek Compensation with the Department giving notice that it represents the interests of consumers and of its intent to claim compensation, updating APPLICANT's prior Finding of Eligibility.

On September 28, 2006, the Director ruled that APPLICANT was eligible to participate and to seek an award of compensation.

On September 8, 2006, APPLICANT submitted its Petition to Participate (Petition) with the Department in the Unfair Billing Patterns rulemaking proceeding. In its Petition, APPLICANT estimated its fees to be $17,000.00.

In its Petition, APPLICANT stated that, with respect to the Unfair Billing Patterns issues that:

> Billing problems consistently appear as one of the top five problems about which consumers contact the Hotline. Many of these issues involve emergency room services that should have been covered by a health plan but were not. Sometimes this is because the hospital is out of the health plan network and the plan is questioning whether it was a "true" emergency sometimes the bills are for physician or other ancillary services provided in the emergency room of a contracted hospital. As part of our mission to help make the health care system work better for consumers, the Health Rights Hotline is interested in ensuring that consumers are not caught in the middle of payment disputes between providers and health plans. By sharing the "real life" experiences of the consumers who contact the Hotline, we can help the Department understand how the regulation affects consumers and shed light on the impact unfair billing practices have on consumers.

On September 28, 2006, the Director approved APPLICANT's Petition to participate in the Unfair Billing Patterns rulemaking proceeding.

3.3. APPLICATION FOR AWARD OF ADVOCACY AND WITNESS FEES

The regulation became final and effective on October 15, 2008. By Application dated September 24, 2008, APPLICANT submitted its Application for an Award of Advocacy and Witness Fees ("Application"). Notwithstanding that the Application was submitted prematurely,[1] the Hearing Officer has deemed the Application as submitted on October 16, 2008 – i.e., within 60 days following issuance of the final regulation.

After the Application was publicly noticed, no objections to the Application were received.

The application for an award of compensation must include (as required by 28 CCR § 1010(e)(2) and (3)):

> "a. A detailed, itemized description of the advocacy and witness services for which the Participant seeks compensation;
> b. Legible time and/or billing records, created contemporaneously when the work was performed, which show the date and the exact amount of time spent[2] on each specific task[3]; and
> c. A description of the ways in which the Participant's involvement made a Substantial Contribution to the proceeding as defined in subpart (b)(8), supported by specific citations to the record, Participant's testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence." 28 CCR §1010 (e)(2).

With its request for fees, APPLICANT submitted a billing specifying the dates of services, a description of each specific task or each activity of advocacy and witness service, identification of the person providing each service, the elapsed time (exact amount of time spent) for each service in quarters (15 minutes) of an hour for attorney advocates and in 0.5 hour or 30 minute increments for non-attorney advocates, the hourly rate requested,[4] the total dollar amount billed for each task, biographies or resumes of the persons who provided the services for which the fee award is sought,

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[1] 28 CCR § 1010(e)(1) provides:
"(e) Procedure for Applying For An Award Of Fees.
(1) Following the issuance of a final regulation, order or decision by the Director in the proceeding, a Participant who has been found to be eligible for an award of compensation may submit within 60 days an application for an award of advocacy and witness fees...."

[2] "...the phrase 'exact amount of time spent' refers either to quarters (15 minutes) of an hour for attorneys, or to thirty (30) minute increments for non-attorney advocates." 22 CCR § 1010(e)(3).

[3] "The phrase 'each specific task,' refers to activities including, but not limited to:
a. Telephone calls or meetings/conferences, identifying the parties participating in the telephone call, meeting or conference and the subject matter discussed;
b. Legal pleadings or research, or other research, identifying the pleading or research and the subject matter;
c. Letters, correspondence or memoranda, identifying the parties and the subject matter; and
d. Attendance at hearings, specifying when the hearing occurred, subject matter of the hearing and the names of witnesses who appeared at the hearing , if any." 28 CCR § 1010(e)(3)a, b, c, and d.

[4] Under the PUC Intervenor Compensation Program, the intervenors submit time logs to support the hours claimed by their professionals. Those logs typically note the dates, the number of hours charged, and the issues and/or activities in which each was engaged. D.06-11-009 (November 9, 2006), p. 26.

and a description of how Market Rate was determined for the fees claimed. The total fees requested for work performed by APPLICANT is $17,508.45.

The Hearing Officer finds that the Application substantially complies with the technical requirements of 28 CCR § 1010(e)(2) and (3).

4. PROCEDURAL HISTORY

The evolution of the Definition of Unfair Billing Patterns proceeding consisted of four noticed proceedings[5] and four proceeding control numbers identified as follows.

4.1. PROCEEDING CONTROL NO. 2006-0777 -- Unfair Billing Patterns; Prohibition Against Billing Enrollees For Emergency Services; Independent Dispute Resolution Process

And

PROCEEDING CONTROL NO. 2006-0782 -- Claims Settlement Practices; Customary & Reasonable Criteria, revising section 1300.71 in title 28, California Code of Regulations

On August 18, 2006, the Department issued a Notice of Proposed Rulemaking Action (in "Proceeding Control No. 2006-0777") proposing to adopt 28 CCR section 1300.71.39 (relating to Unfair Billing Patterns), proposing to revise 28 CCR section 1300.71.38 (relating to a new Independent Dispute Resolution Process for non-contracting providers), and establishing a 46-day written comment period from August 18, 2006 to October 2, 2006.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2006-0777, the Department stated that:

> California Health and Safety Code section 1344 authorizes the Director to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Act, including rules governing applications and reports, and defining any terms, whether or not used in the Knox-Keene Act, insofar as the definitions are not inconsistent with the provisions of the Knox-Keene Act. Furthermore, the Director has the discretion to waive any requirement of any rule or form in situations where, such requirement is not necessary in the public interest or

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[5] The four proceedings are regarded as one "proceeding" for purposes of awarding advocacy fees and witness fees under the Program because they consist of an administrative decision-making process of the Department in the adoption of a regulation. The Statute specifies that it "... shall apply to all proceedings of the department...." Health and Safety Code section 1348.9, subdivision (c). The Regulation defines "proceeding" as follows:

> "'Proceeding' or 'Administrative Proceeding' mean an administrative decision-making process of the Department of Managed Health Care that results in the adoption of a regulation, or in an order or decision of the Director that has the potential to impact a significant number of enrollees. For purposes of this Article, 'order or decision made by the Director' shall include a decision not to adopt a regulation or take an action and shall not include resolution of individual grievances." 28 CCR § 1010(b)(5).

for the protection of the public, subscribers, enrollees, or persons or plans subject to the Knox-Keene Act.

These regulations are intended to implement, interpret, and/or make specific Health and Safety Code sections 1367(h), 1371, 1371.1, 1371.35, 1371.36, 1371.38, 1371.39, 1371.4 and 1379. This rulemaking action is intended to clarify unfair billing practices by non-contracting providers who provide emergency services to health plan enrollees, to prohibit balance billing of health plan enrollees by non-contracting emergency services providers, and to implement an independent claims payment dispute resolution process to provide non-contracting providers with a fast, fair and cost-effective process to resolve claims payment disputes with health plans, and to provide specific determinations for claims payment amounts, and to ensure that non-contracting providers are paid fairly and consistent with the health plans obligations to pay for covered services pursuant to Sections 1371, 1371.35 and 1371.4.

On August 18, 2006, the Department issued a Notice of Proposed Rulemaking Action (in "Proceeding Control No. 0782") proposing to revise 28 CCR section 1300.71 (relating to Claims Settlement Practices), and establishing a 46-day written comment period from August 18, 2006 to October 2, 2006.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2006-0782, the Department stated that:

California Health and Safety Code sections 1341.9, 1344, and 1346 vest the Director with the power to administer and enforce the provisions of the Knox-Keene Act.

California Health and Safety Code section 1344 authorizes the Director to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used in this chapter, insofar as the definitions are not inconsistent with the provisions of the Knox-Keene Act. Furthermore, the Director may waive any requirement of any rule or form in situations where in the Director's discretion, such requirement is not necessary in the public interest, or for the protection of the public, subscribers, enrollees, persons or plans subject to this chapter.

Existing law, enacted in 2000, through adoption of Assembly Bill 1455 (Stats. 2000, c. 827, §1 (AB 1455)) the California State Legislature enacted a comprehensive set of statutes intended to reform the claims submission and payment systems of California's health care industry. AB 1455 was enacted to refine the dispute resolution process between health plans and health care providers. The bill prohibited health care service plans from engaging in unfair payment patterns, and increased the penalties for doing so. The AB 1455 amendments to the Knox-Keene Act expressly authorize the Department to adopt regulations to implement and clarify the new statutes.

This proposed rulemaking action is intended to further implement, interpret, and/or make specific Health and Safety Code sections 1367(h), 1371, 1371.1, 1371.35, 1371.36, 1371.38, and 1371.39. The proposed revisions to section 1300.71 are to provide clarification regarding the requirements affecting claims settlement practices.

The subject matter of Proceeding Control No. 2006-0777 was related to the subject matter of Proceeding Control No. 2006-0782. Although a separate record was kept for each Proceeding, the written comment periods were established for identical time periods and the public hearings were held at the same times. The following reflects the combined comment periods and hearing dates.

Initially, no public hearing was scheduled on the proposed revisions and the proposed new regulation.

On August 23, 2006, the Department issued Notices of Public Hearings which scheduled and noticed two public hearings to be held on September 13, 2006 and on October 2, 2006.

On August 31, 2006, the Department issued Second Amended Notices of Proposed Rulemaking which extended the public written comment period for two days through October 4, 2006, re-noticed the public hearing to be held on September 13, 2006, and rescheduled the second public hearing to be held on October 4, 2006.

On September 15, 2006, the Department issued Third Amended Notices of Proposed Rulemaking which scheduled and noticed a third public hearing for September 25, 2006.

On October 5, 2006, the Department issued Fourth Amended Notices of Proposed Rulemaking extending the public written comment period for nine days through October 13, 2006.

On August 7, 2007, the Department issued a Notice of Decision Not To Proceed and Intent to Refile, whereby the Department gave notice of its decision to withdraw the proposed adoption of Title 28 Section 1300.71.39 and the proposed amendment of Title 28 Section 1300.71.38, California Code of Regulations, and the Department gave notice of its intent to initiate, with the required notice, a new proposal to adopt and amend regulations pertaining to the same subject matter.

On August 7, 2007, the Department issued a Notice of Decision Not To Proceed and Intent to Refile, whereby the Department gave notice of its decision to withdraw the proposed revision of Title 28 Section 1300.71 regarding Claims Settlement Practices, Reasonable and Customary Criteria, and the Department gave notice of its intent to initiate, with the required notice, a new proposal to adopt and amend regulations pertaining to the same subject matter.

4.2. PROCEEDING CONTROL NO. 2007-1253 -- Plan and Provider Claims Settlement: Criteria for Determining Reasonable and Customary Value of Health Care Services; Expedited Payment Pending Claims Dispute Resolution; Definition of Unfair Billing Patterns; Independent Dispute Resolution Process

On August 17, 2007, the Department issued a Notice of Proposed Rulemaking (in "Proceeding Control No. 2007-1253") proposing to revise 28 CCR section 1300.71 (relating to Unfair Billing Patterns), proposing to revise 28 CCR section 1300.71.38 (relating to a new Independent Dispute Resolution Process for non-contracting providers), proposing to adopt a new 28 CCR section 1300.71.39, and establishing a 46-day written comment period from August 17, 2007 to October 1, 2007.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2007-1253, the Department stated that:

> California Health and Safety Code sections 1341.9, 1344, and 1346 vest the Director with the power to administer and enforce the provisions of the Act. California Health and Safety Code section 1344 authorizes the Director to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Act, including rules governing applications and reports, and defining any terms, whether or not used in the Knox-Keene Act, insofar as the definitions are not inconsistent with the provisions of the Knox-Keene Act. Furthermore, the Director has the discretion to waive any requirement of any rule or form in situations where, such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to the Knox-Keene Act.
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> These regulations are intended to implement, interpret, and/or make specific Health and Safety Code sections 1367(h), 1371, 1371.1, 1371.35, 1371.36, 1371.38, 1371.39, 1371.4 and 1379. More specifically, this rulemaking action will clarify the requirements for fair provider billing practices and fair health plan payment practices by: clarifying the criteria for health plans to consider in determining the reasonable and customary value of health care services rendered by providers who lack written contracts with the health plans; clarifying the nature of activities that constitute unfair billing practices by health care providers who render services to enrollees of health plans but lack written contracts with the health plans; establishing a fair and balanced approach to payment of providers pending resolution of a disputed provider claim; and implementing an independent claims payment dispute resolution process to provide health care providers with a fast, fair and cost-effective process to resolve claims payment disputes with health plans, which will provide specific determinations for claims payment amounts.

Initially, no public hearing was scheduled on the proposed revisions and the proposed new regulation. However, an interested stakeholder requested that a public hearing be held.

On September 20, 2007, the Department issued an Amended Notice of Rulemaking Action extending the public written comment period for forty-five additional days through November 15, 2007.

On October 12, 2007, the Department issued a Second Amended Notice of Rulemaking Action scheduling and noticing a public hearing for October 24, 2007.

On October 31, 2007, the Department issued a Third Amended Notice of Rulemaking Action scheduling and noticing a second public hearing for November 13, 2007, and a third public hearing for November 14, 2007, and extending the public written comment period for 15 days through November 30, 2007.

On March 12, 2008, the Department issued (and published on March 28, 2008) a Notice of Decision Not To Proceed and Intent to Refile, whereby the Department gave notice of its decision not to proceed with the rulemaking action entitled Plan and Provider Claims Settlement: Criteria for Determining Reasonable and Customary Value of Health Care Services; Expedited Payment Pending Claims Dispute Resolution; Definition of Unfair Billing Patterns; Independent Dispute Resolution Process (proposing the addition of Title 28, California Code of Regulations Section 1300.71.39 and the amendment of Title 28, California Code of Regulations Sections 1300.71 and 1300.71.38); and the Department gave notice of its intent to initiate, with the required notice, a new proposal to adopt and amend regulations pertaining to the same subject matter.

4.3. PROCEEDING CONTROL NO. 2008-1536 -- Definition of Unfair Billing Patterns, Adopting Section 1300.71.39 in title 28, California Code of Regulations

On March 28, 2008, the Department issued a Notice of Proposed Rulemaking (in "Proceeding Control No. 2008-1536") proposing to adopt 28 CCR section 1300.71.39, and establishing a 46-day written comment period from March 28, 2008 to May 12, 2008.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2008-1536, the Department stated that:

> Proposed adoption of section 1300.71.39
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> California Health and Safety Code sections 1341.9, 1344, and 1346 vest the Director with the power to administer and enforce the provisions of the Act. California Health and Safety Code section 1344 authorizes the Director to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Act, including rules governing applications and reports, and defining any terms, whether or not used in the Knox-Keene Act, insofar as the definitions are not inconsistent with the provisions of the Knox-Keene Act. Furthermore, the Director has the discretion to waive any requirement of any rule or

> form in situations where, such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to the Knox-Keene Act.
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> These regulations are intended to implement, interpret, and/or make specific Health and Safety Code sections 1367(h), 1371, 1371.35, 1371.39 and 1371.4. More specifically, this rulemaking action will protect enrollees from the harms of balance billing by providers by clarifying the nature of activities that constitute unfair billing practices by health care providers who render services to enrollees of health plans but lack written contracts with the health plans.

Initially, no public hearing was scheduled on the proposed regulation. However, a representative of the California Medical Association requested that a public hearing be held.

On May 2, 2008, the Department issued an Amended Notice of Rulemaking Action and Public Hearing Agenda scheduling and noticing a public hearing for May 14, 2008, and extending the public written comment period for two days through May 14, 2008.

On May 8, 2008, the Department issued a Second Amended Notice of Rulemaking Action and Public Hearing Agenda scheduling and noticing a second public hearing for May 19, 2008, and extending the public written comment period six days through May 20, 2008.

On May 9, 2008, the Department issued a Third Amended Notice of Rulemaking Action and Public Hearing Agenda scheduling and noticing a third public hearing for May 20, 2008.

On May 21, 2008, the Department issued a Fourth Amended Notice of Rulemaking Action extending the public written comment period 14 days through June 3, 2008.

On August 1, 2008, the final regulation package was submitted to the Office of Administrative Law (OAL). The regulation was approved by OAL on September 15, 2008[6] and filed with the Secretary of State. The regulation was effective on October 15, 2008.[7]

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[6] Office of Administrative Law, Notice of Approval of Regulatory Action, OAL File No. 2008-0801-01 S, September 15, 2008.

[7] *Id.*

5. SUBSTANTIAL CONTRIBUTION

Health and Safety Code section 1348.9, subdivision (a) provides that:

> "[T]he director shall adopt regulations to establish the Consumer Participation Program, which shall allow for the director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation...." (Emphasis added).

The definition of "Substantial Contribution" provides the criteria for evaluating whether the consumer participant has made a substantial contribution.[8] 28 CCR § 1010(b)(8) defines "Substantial Contribution" as follows:

> "'Substantial Contribution' means that the Participant significantly assisted the Department in its deliberations by presenting relevant issues, evidence, or arguments which were helpful, and seriously considered, and the Participant's involvement resulted in more relevant, credible, and non-frivolous information being available to the Director."

5.1. APPLICATION MUST INCLUDE DESCRIPTION OF CONTRIBUTION

The application for an award of compensation must include "a description of the ways in which the Participant's involvement made a Substantial Contribution to the proceeding [9]...,

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[8] Further guidance is provided in PUC Decisions awarding intervenor compensation – for example:

"In evaluating whether ... [an intervenor] made a substantial contribution to a proceeding, we look at several things. First, did the ALJ or Commission adopt one or more of the factual or legal contentions, or specific policy or procedural recommendations put forward by the ... [intervenor]? ... Second, if the ...[intervenor's] contentions or recommendations paralleled those of another party, did the ...[intervenor's] participation materially supplement, complement, or contribute to the presentation of the other party or to the development of a fuller record that assisted the Commission in making its decision? ... [T]he assessment of whether the ...[intervenor] made a substantial contribution requires the exercise of judgment.

> "In assessing whether the ...[intervenor] meets this standard, the Commission typically reviews the record, ... and compares it to the findings, conclusions, and orders in the decision to which the ...[intervenor] asserts it contributed. It is then a matter of judgment as to whether the ..[intervenor's] presentation substantially assisted the Commission. [citing D.98-04-059, 79 CPUC2d 628, 653 (1998)].

Should the Commission not adopt any of the ...[intervenor's] recommendations, compensation may be awarded if, in the judgment of the Commission, the ...[intervenor's] participation substantially contributed to the decision or order. For example, if ...[an intervenor] provided a unique perspective that enriched the Commission's deliberations and the record, the Commission could find that the ...[intervenor] made a substantial contribution." PUC Decision D.06-11-031 (November 30, 2006), PP. 5 - 6; similarly, D.06-11-009 (November 9, 2006), pp. 7 - 8.

[9] Decisions under the PUC's Intervenor Compensation Program go further and require intervenor's to assign a reasonable dollar value to the benefits of the intervenor's participation.

"D.98-04-059 directed ...[intervenors] to demonstrate productivity by assigning a reasonable

supported by specific citations to the record, Participant's testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence." 28 CCR § 1010(e)(2)c.

5.2. APPLICANT'S DESCRIPTION OF ITS CONTRIBUTION

APPLICANT submitted the following documents and testimony in support of its position regarding the proposed adoption of the regulation and regulation changes:

Proceeding Control Nos. 2006-0777 and 2006-0782

Regarding the October 4, 2006, Public Hearing, APPLICANT's time records indicate "attending DMHC unfair billing hearing," identify the staff person attending as APPLICANT'S health policy analyst/law school graduate, and identify the name of a witness that appears to be the misspelled name of a person self-identified on the hearing record as "Supervising Attorney" for APPLICANT. The record of the hearing does not contain oral comments by APPLICANT's health policy analyst/law school graduate. However, the record contains oral comments by the person self-identified on the hearing record as "Supervising Attorney" for APPLICANT.

APPLICANT provided written comments dated October 4, 2006, on the proposed regulation and regulatory changes, in response to the first comment period which closed on October 13, 2006, after extensions, including factual descriptions of consumer-client experiences with unfair billing.

Proceeding Control No. 2007-1253

At the November 13, 2007, Public Hearing: Attendance and participation by APPLICANT's policy analyst/staff attorney.

APPLICANT provided written comments dated November 15, 2007, on the proposed regulation and regulation revisions, in response to the written comment period which closed on November 30, 2007, after extensions.

Proceeding Control No. 2008-1536

At the May 20, 2008, Public Hearing: Attendance and testimony of APPLICANT's policy analyst/staff attorney.

APPLICANT provided written comments dated May 20, 2008, on the proposed regulation and in response to the written comment period which closed on June 3, 2008, after extensions, focusing on clarifying what constituted amounts owed by enrollees, prohibiting reporting of balance billed amounts to collection agencies, and educating enrollees.

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dollar value to the benefits of their participation to ratepayers. The costs of ...[an intervenor's] participation should bear a reasonable relationship to the benefits realized through their participation. This showing assists us in determining the overall reasonableness of the request." D.06-11-031 (November 30, 2006), p. 11; D.06-11-009 (November 9, 2006), pp. 31 - 32.

5.3. PROCEDURAL VERIFICATION OF SUBSTANTIAL CONTRIBUTION

Proceeding Control Nos. 2006-0777 and 2006-0782

At the October 4, 2006, Public Hearing on the proposed adoption of the regulation and proposed regulation revisions, a person self-identified on the record as "Supervising Attorney" for APPLICANT presented oral comments on the record.

On October 4, 2006, APPLICANT's staff presented written comments signed by the Program Director of APPLICANT on the proposed regulation. That submission contained eight comments, including recommendations requesting changes (identified in the order presented in the comment letter):

(1) that the regulation should specify that non-contracted providers practicing in contracted hospitals are prohibited from balance billing enrollees for emergency services and non-emergency services; and APPLICANT suggested adoption of a provision similar to that of the Colorado Insurance Code to the effect that "Covered services or treatment rendered at a network facility, including covered ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at a network facility, shall be covered at no greater cost to the covered person than if the services or treatment were obtained from an in-network provider;"

(2) that the regulation language should provide that HMO enrollees who use network hospitals should be charged only for applicable co-payments, coinsurance, or deductibles, whether the services are performed by network or out-of-network providers;

(3) that the regulation should contain a definition of "emergency services" using the "prudent layperson criterion of "emergency" used elsewhere in the Knox-Keene Act, so as to give consumers a clear standard of what constitutes emergency services;

(4) that the language of the regulation – what constitutes "any amount due to the provider by the health plan" – should be made absolutely clear by stating that only co-payments, coinsurance, and deductibles not covered by the health plan may be billed to the enrollee;

(5) that the regulation should prohibit providers from sending to collection agencies the unpaid amounts the provider feels are due for services provided; and APPLICANT suggested using language similar to that used in Florida's Insurance Code which specifies: "A provider or any representative of a provider, regardless of whether the provider is under contract with the health insurer, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency an insured for payment of covered services for which the health insurer contested or denied the provider's claim;"

(6) that in the context of the regulation arbitration process for resolving non-contracting provider payment disputes with a health plan, the prohibition against balance billing should be reinforced by adding language to the effect: "Non-contracting provider claims payment disputes that have not been resolved by a plan to the provider's satisfaction may not be billed to the enrollee," so that providers are reminded that they may not directly bill the enrollee before, during, or after going through the dispute resolution process with the plan;

(7) that the regulation provide for consumer education by: requiring Evidence of Coverage documents to clearly explain what consumers should do if they receive a bill for services that should be covered by the health plan; and requiring bills sent by emergency services providers for co-payments, coinsurance and deductibles to clearly indicate the amount of the co-payment, coinsurance and/or deductible and list pertinent contact numbers if the consumer feels the amounts have been billed inappropriately; and

(8) that the regulation or the Department's practice should review data on balance billing reported by HMO enrollees and work with the Medical Board or other appropriate agencies to take action against those providers who engage in an unlawful pattern and practice of balance billing enrollees.

Of the eight October 4, 2006, comments requesting changes, all were reviewed, but all were neither accepted nor declined because the Department issued notices of its decision not to proceed with the rulemaking actions of Proceeding Control Nos. 2006-0777 and 2006-0782.

Proceeding Control No. 2007-1253

At the November 13, 2007, Public Hearing on the proposed adoption of a regulation, a Staff Attorney of the APPLICANT presented oral comments on the record.

On November 15, 2007, APPLICANT's staff presented written comments signed by a Staff Attorney of APPLICANT on the proposed regulation, including a document showing proposed additions and deletions to the regulation. That submission contained eight comments, including recommendations requesting changes:

(1) that the regulation should prohibit balance billing by non-contracting providers practicing in contracting hospitals and hospital networks because enrollees should not be balance billed for any health care service that is a covered benefit and provided in a network hospital;

(2) that the regulation should make it absolutely clear that the only amounts that enrollees can be filled for by providers are co-payments, coinsurance and deductibles and that the definition of "unfair billing pattern" should include the practice of "reporting to a credit reporting agency, for any amount other than co-payments, coinsurance, or deductibles" for emergency services;

(3) that the regulation should require Evidence of Coverage documents to clearly explain what consumers should do if they receive a bill for services that should be covered by the health plan;
(4) that the regulation should require that bills sent by emergency services providers for co-payments, coinsurance, and/or deductibles should clearly indicate the amount of the co-payment, coinsurance, and/or deductible and list pertinent contact numbers if the consumer feels that she/he has been billed inappropriately;
(5) that the regulation should facilitate setting up a mechanism for enrollees to report balance billing problems, including reporting emergency providers who balance bill, to produce data on balance billing problems so that the Department may take action against those providers who engage in unlawful patterns and practices of billing enrollees; and
(6) that the regulations should outright prohibit balance billing, not contingently prohibit it, because providers should never have the option to balance bill.

Of the six November 15, 2007, comments requesting changes, all were reviewed, but all were neither accepted nor declined because the Department issued notice of its decision not to proceed with the rulemaking action of Proceeding Control No. 2007-1253.

Proceeding Control No. 2008-1536

At the May 20, 2008, Public Hearing on the proposed adoption of the regulation, a Staff Attorney representing APPLICANT presented oral comments on the record and provided helpful information and clarification in response to questions from the Director.

On May 20, 2008, APPLICANT's staff presented written comments signed by a Staff Attorney of APPLICANT on the proposed regulation. That submission contained six comments, including recommendations requesting changes:
(1) that the regulation should define "unfair billing pattern" by clarifying amounts for which enrollees cannot be billed by replacing "amounts owed to the provider" with "any amount that is not a co-payment, coinsurance, or deductible;"
(2) that the regulation should define "unfair billing pattern" to include "reporting to a collections agency, any amount that is not a co-payment, coinsurance, or deductible" for emergency services;
(3) that the regulation should define "unfair billing pattern" to include a bill for any health care service that is a covered benefit provided in a network hospital, including services provided by non-contracted physicians;
(4) that the regulation should require Evidence of Coverage documents to clearly explain exactly what costs a consumer would be responsible for in an emergency situation and what consumers should do if they receive a bill for services that should be covered by the health plan; and

5) that the regulation should require that bills sent by emergency services providers for co-payments, coinsurance and deductibles should clearly indicate the amount of the co-payment, coinsurance, and/or deductible and list pertinent contact numbers if the consumer feels that she/he has been billed inappropriately.

Of the five May 20, 2008, comments requesting changes, all were declined with explanation in the record as follows: (1) the suggested revision to expand the regulation to all non-contracted providers, and issues regarding the content of evidences of coverage and provider bills, are outside the intended scope of the rulemaking action; (2) the suggested revision regarding amounts owed by enrollees is not necessary to clarify application of the regulation because an enrollee's financial obligation is established by subscriber contract, and readily determined; (3) the amount that plans are obligated by law to pay non-contracted providers is already established by existing provisions of law as being the reasonable and customary value of the services rendered; (4) if there is a "balance" of a non-contracted provider's charges that is billed to an enrollee, then that is a result of either (a) the plan failing to pay reasonable and customary value of the services rendered or (b) the provider billing more than the reasonable and customary value; and (5) the suggested revision to impose a prohibition on reporting enrollees to collection agencies is outside the intended scope of this rulemaking action. Enrollees who are balance billed can submit a complaint to the Department's HMO Help Center.

5.4. FINDING OF SUBSTANTIAL CONTRIBUTION

The Hearing Officer finds that participation by APPLICANT: (1) significantly assisted the Department in its deliberations by presenting relevant issues, evidence, and arguments that were helpful and seriously considered, and (2) resulted in more relevant, credible, and non-frivolous information being available to the Director to make her decision regarding the proposed adoption of 28 CCR §1300.71.39 than would have been available to the Director had APPLICANT not participated.

The Hearing Officer hereby determines that by its participation APPLICANT made a substantial contribution on behalf of consumers to the proceedings, to the Department in its deliberations, and as a whole, to the adoption of 28 CCR §1300.71.39.

The Hearing Officer finds that APPLICANT has made a Substantial Contribution, pursuant to 28 CCR § 1010(b)(8), to the Unfair Billing Patterns rulemaking proceeding.

6. REASONABLENESS OF HOURS AND COSTS AND MARKET RATE

Health and Safety Code section 1348.9 allows the Director to award reasonable advocacy and

witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of a regulation.

6.1. FEES REQUESTED

APPLICANT billed the following time, hourly rates, and fees for its representatives.

Staff / Title	Hours	Rates	Fees
Program Director & Health Policy Expert			
-- Work in 2006	10.06	$210.00	$2,112.60
-- Work in 2007	0.0	---	$0.00
-- Work in 2008	0.0	---	$0.00
Health Policy Analyst & Staff Attorney			
-- Work in 2006 – Law School Graduate	66.0	$158.00	$10,428.00
-- Work in 2007 –Attorney & Policy Analyst	11.0	$200.00	$2,200.00
-- Work in 2008 –Attorney & Policy Analyst	13.5	$205.00	$2,767.50
TOTAL FEES	→		**$17,508.10**

The amount of fees claimed by APPLICANT is $17,508.45, which differs from the amount computed by using the hours claimed for the hourly rates claimed. The difference may be due to APPLICANT's computations using fractional hours of time spent (e.g., 0.32, 0.89, 0.61 and 0.24) or due to rounding or computational error. The Hearing Officer used the total of the number of hours claimed at the hourly rates claimed to reflect the total amount of APPLICANT's claim.

6.2. CONSIDERATIONS USED IN PUC'S INTERVENOR COMPENSATION PROGRAM

Reference to the intervenor compensation program of the California Public Utilities Commission ("PUC") seems appropriate because it is similar to the Department's Consumer Participation Program[10] and has an extensive history of awarding intervenor compensation and updating hourly rates used in computing awards of compensation to intervenors who make substantial contributions to PUC decisions.

In each proceeding before the PUC in which intervenors participate, the PUC issues a written opinion setting forth the decision regarding award of intervenor compensation. Therefore, the many PUC written decisions granting intervenor compensation provide a valuable source of guidelines to

[10] The Legislative history behind the Department's Consumer Participation Program specifically referred to the PUC's program.

> "The Legislature finds and declares that consumer participation programs at the Public Utilities Commission and the Department of Insurance have been a cost-effective and successful means of encouraging consumer protection, expertise, and participation...." Stats 2002 C. 792 § 1 (SB 1092).

determine reasonableness and market value. Some of the common threads of the PUC decisions are summarized as follows.

In considering an intervenor organization's request for compensation, the PUC opinions:

a. Separately consider and approve the individual hourly rate of compensation for each of the intervenor's experts and advocates.[11]

b. Have awarded the same rate for an individual expert that was approved in a prior proceeding in the same year,[12] and have declined to approve a requested increase in hourly rate for an expert over the rate approved in a prior proceeding in the same year.[13]

c. Have awarded increases of three percent (3%) rounded to the nearest $5 over the prior year when increase in hourly rates is requested by the intervenor organization or where the hourly rate for an individual expert or advocate was approved in the prior year and an increase is considered warranted for the current year.[14] The PUC has consistently rejected requests for increase over 3%.[15]

d. Have stated that documentation of claimed hours by presenting a daily breakdown of hours accompanied by a brief description of each activity, reasonably supported the claim for total hours.[16]

e. Have approved compensation for travel time at one-half the normal hourly rate.[17]

f. Have approved compensation for preparation of the intervenor organization's compensation request or compensation claim at one-half the normal hourly rate.[18] However, administrative costs are considered non-compensable overheads, and therefore, the PUC has disallowed time charged by an intervenor's office manager for gathering expense data for the compensation claim.[19]

g. Have approved compensation for efforts that made a substantial contribution even where the PUC did not wholly adopt the intervenor's recommendations.[20]

h. Have approved payment of itemized direct expenses where the request shows "the miscellaneous expenses to be commensurate with the work performed," including costs for photocopying, FAX, Lexis research, postage, courier, overnight delivery, travel, and parking.[21]

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[11] PUC Decision (D.) 06-11-031 (November 30, 2006).
[12] D.06-11-031 (November 30, 2006).
[13] D.06-11-032 (November 30, 2006), pp. 10 – 11.
[14] D.06-11-031 (November 30, 2006), p. 11.
[15] D.06-11-031 (November 30, 2006), p. 11.
[16] D.06-11-031 (November 30, 2006), p. 10.
[17] D.06-11-031 (November 30, 2006); D.06-11-032 (November 30, 2006), p. 8, fn. 4.
[18] D.06-11-031 (November 30, 2006), p. 9, fn. 2; D.06-11-032 (November 30, 2006), p. 8, fn. 4.
[19] D.06-11-009 (November 9, 2006), p. 27.
[20] D.06-11-031 (November 30, 2006), p. 10.

i. Have reminded intervenors of the requirements for records and claim support, and that PUC staff may audit the records – for example:

> "We remind all intervenors that Commission staff may audit their records related to the award and that intervenors must make and retain adequate accounting and other documentation to support all claims for intervenor compensation. [Intervenor's]... records should identify specific issues for which it requested compensation, the actual time spent by each employee or consultant, the applicable hourly rate, fees paid to consultants, and any other costs for which compensation was claimed."[22]

j. Have disallowed time where the "hours seem excessive" or the "proposal is not persuasive,"[23] and have changed or disallowed compensation amounts requested for the following reasons:[24] "Excessive hourly rate; arithmetic errors; failure to discount comp prep time [and travel time]; hours claimed after decision issued; ...administrative time not compensable; unproductive effort."

6.3. REASONABLENESS OF TIME BILLED

We must assess whether the hours claimed for the consumers' efforts that resulted in substantial contributions to the proceedings are reasonable by determining to what degree the hours and costs (if any costs are claimed) are related to the work performed and necessary for the substantial contribution.[25]

a. Billed Activities. APPLICANT billed for six activities summarized as follows:

(1) Review and analysis of the text of the proposed regulation and regulation modifications, research and review of APPLICANT's cases to identify client cases with unfair billing issues and useful factual circumstances, including clients with Medi-Cal HMO and emergency services billing issues, research other states' laws on balance billing, prepare proposed revisions and changes to proposed regulation language, and draft and edit written comments for submission in the first written comment period ending October 13, 2006, in Proceeding Control Nos. 2006-0777 and 2006-0782, for a total of 63.31 hours.

(2) Preparation for, attendance and providing testimony at the Public Hearing held on October 4, 2006, in Proceeding Control Nos. 2006-0777 and 2006-0782, for a total of 12.75 hours.

(3) Review and analysis of revised proposed regulation and regulation modifications,

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[21] D.06-11-031 (November 30, 2006), p. 12; D.06-11-032 (November 30, 2006), pp. 14 – 15; D.06-11-009 (November 9, 2006), p. 32.

[22] D.06-11-031 (November 30, 2006), pp. 14 -15.

[23] D.06-11-032 (November 30, 2006), pp. 9 - 10.

[24] D.06-11-009 (November 9, 2006), Appendix p. 1.

[25] See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 9; D.06-11-009 (November 9, 2006), p. 26.

research and prepare written comments submitted in the extended written comment period ending November 30, 2007, in Proceeding Control No. 2007-1253, for a total of 6.5 hours.

(4) Preparation for, attendance and providing testimony at the Public Hearing held on November 13, 2007, in Proceeding Control No. 2007-1253, for a total of 4.5 hours.

(5) Analysis of revised text of the proposed regulation, and preparation of written comments submitted in the extended written comment period ending June 3, 2008, in Proceeding Control No. 2008-1536, for a total of 8.5 hours.

(6) Preparation for, attendance and providing testimony at the Public Hearing held on May 20, 2008, in Proceeding Control No. 2008-1536, for a total of 5.0 hours.

b. Adjustments. The time billed appears reasonable except for the following:

(1) APPLICANT billed 3.0 hours for services described as "Attending DMHC unfair billing hearing" on October 4, 2006, by APPLICANT's health policy analyst/law school graduate. However, the record of the Public Hearing held October 4, 2006, does not identify APPLICANT's health policy analyst/law school graduate as testifying or being present therein, and merely attending a hearing (without testifying or otherwise contributing) does not evidence a substantial contribution to the proceeding. The record of the October 4, 2006, Public Hearing contains comments by a person self-identified on the record as "Supervising Attorney" for APPLICANT. However, APPLICANT's Application does not contain claim for time or fees for such Supervising Attorney and does not contain any information regarding the experience or credentials of such Supervising Attorney. Inasmuch as no fees were claimed for a Supervising Attorney, no fees can be awarded for services by such Supervising Attorney. Accordingly, the 3.0 hours of time billed for services on October 4, 2006, are disallowed.

c. Finding. The Hearing Officer hereby finds that, as adjusted, the time billed is related to the work performed, necessary for the substantial contributions made, and reasonable for the advocacy and witness services performed and work product produced.

6.4. MARKET RATE

Public interest attorneys are entitled to request the prevailing market rates of private attorneys of comparable skill, qualifications and experience. (*Serrano v. Unruh* ("*Serrano IV*") (1982) 32 Cal.3d 621.). APPLICANT is entitled to be compensated for Advocacy Fees and Witness Fees at hourly rates that reflect Market Rate for services. Advocacy Fees and Witness Fees cannot exceed Market Rate, as defined in the Regulation. 28 CCR §§ 1010(b)(1), (3) and (10). "Market Rate" is defined at 28 CCR section 1010(b)(3) as follows:

> "'Market Rate' means, with respect to advocacy and witness fees, the prevailing rate for comparable services in the private sector in the Los Angeles and San Francisco Bay Areas at the time of the Director's decision awarding compensation for attorney advocates, non-attorney advocates, or experts with similar experience, skill and ability."

6.5. HOURLY RATES THAT REFLECT "MARKET RATE"

The Hearing Officer finds that hourly rates for services provided in a statewide proceeding or proceeding of a state agency having statewide jurisdiction and effect (such as proceedings of the PUC, see *infra*) are essentially equivalent to "comparable services in the private sector in the Los Angeles and San Francisco Bay Areas," as required by 28 CCR § 1010, subsection (b)(3).

Accordingly, we must take into consideration whether the claimed fees and costs (if any) are comparable to the market rates paid to experts and advocates having comparable training and experience and offering similar services.[26] In order to determine Market Rate, we must look to available data inside and outside the Department.

6.6. APPLICANT'S JUSTIFICATION FOR RATES BILLED

In support of the hourly fee rates requested, APPLICANT submitted experience and biographical information regarding the persons providing services and the following justification for the hourly rates requested.

a. Hourly rates awarded by the Department in prior proceedings – specifically:

(1) The hourly rate claimed ($210) for Program Director & Health Policy Expert services for 2006 is the same rate awarded ($210) for services provided in the Language Assistance Programs regulation proceeding in 2006.

(2) The hourly rate claimed ($158) for Law School Graduate & Health Policy Analyst services for 2006 is approximately five percent more than the rate awarded ($150) for services provided in the Block Transfer Filings regulation proceeding in 2004.

b. Hourly rates awarded by the PUC for Intervenors, for attorney advocacy services for 2007 and 2008 for attorneys with 0 – 2 years of experience:

In 2007: $145 - $200.

In 2008: $150 - $205.

[26] See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 10.

6.7. HOURLY RATE DETERMINATIONS UNDER THE PUC PROGRAM

Until PUC Decision R.04-10-010 in 2004, the PUC "set hourly rates piecemeal"[27] for intervenors – i.e., "... for each proceeding, each intervenor, and indeed each appearance by a particular representative of an intervenor, ... [the PUC] might revisit the reasonableness of that representative's hourly rate."[28] The PUC recognized the need for coordination by establishing, through periodic rulemakings, the rates to be paid to all intervenors' representatives for work done in specified time periods.[29] The first such rulemaking was R.04-10-010, D.05-11-031, which set certain guidelines, recognized that hourly rates had stabilized, and determined that the PUC would not authorize a general increase to intervenor hourly rates for work performed in 2005.[30]

In an Interim Opinion on Updating Hourly Rates,[31] the PUC adopted a three percent (3%) cost-of-living adjustment (COLA) for work performed in calendar year 2006, adopted an additional 3% COLA for work performed in 2007, and established effective with 2007 work three rate ranges for non-attorney experts based on levels of experience, similar to the five levels already established for attorneys.[32] The three levels for non-attorney experts are: 0-6 years; 7-12 years; and 13-plus years. In so doing, the PUC found that:

> "...basing expert rates on levels of experience, similar to the levels established for attorneys, will better ensure that an expert's given rate is within the market rates paid to persons of comparable training and experience. However, in no event should the rate requested by an intervenor exceed the rate billed to that intervenor by any outside consultant it hires, even if the consultant's billed rate is below the floor for a given experience level. ...[I]ntervenors must disclose the credentials of their representatives in order to justify the requested rates.[33] (Emphasis added).

The following table shows the PUC's adopted ranges for work performed by intervenor representatives in 2007 and 2008. The rate ranges for attorneys and non-attorney experts are based on levels of applicable experience.

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[27] PUC Order Instituting Rulemaking R.06-08-019 (August 24, 2006), p. 2.
[28] *Id.*
[29] *Id.*
[30] *Id.* at pp. 2-3.
[31] D.07-01-009 (January 11, 2007) (part of Rulemaking R.06-08-019).
[32] *Id.* at pp. 1, 3-4.
[33] *Id.* at p. 5.

Hourly Intervenor Rate Ranges for 2007 and 2008[34]

(2007 rates = rates adopted for 2006 in D.07-01-009 x 3%, rounded to nearest $5)
(2008 rates = rates adopted for 2007 x 3%, rounded to nearest $5)

Years of Experience	2007 Range	2008 Range
Attorneys:		
0 - 2	$145 - $200	$150 - $205
3 - 4	$195 - $230	$200 - $235
5 - 7	$270 - $290	$280 - $300
8 - 12	$290 - $345	$300 - $355
13+	$290 - $520	$300 - $535
Experts:		
0 - 6	$120 - $180	$125 - $185
7 - 12	$150 - $260	$155 - $270
13+	$150 - $380	$155 - $390

Note: The rates intervenors request for the use of outside consultants may not exceed the rates billed to the intervenors by the consultants, even if the consultants' rates are below the floor for any given experience level.

The PUC decided to continue to update hourly rates annually on a calendar year basis.[35] The PUC based its 3% COLA adjustments on the Social Security Administration's COLA, which is released annually in late fall, and reliance thereon would be consistent with a calendar year adjustment of hourly rates.[36]

In 2008, the PUC found it reasonable to adopt another 3% COLA for intervenor rates for work performed in 2008.[37] That increase is primarily based on various federal inflation indexes, such as the Social Security Administration's COLA and Bureau of Labor Statistics data for

[34] D.08-04-010 (April 10, 2008) (part of Rulemaking 06-08-019) at p. 5.
[35] D.07-01-009 (January 11, 2007) at p. 9.
[36] *Id.* at pp. 4 and 11.
[37] D.08-04-010 (April 10, 2008) at pp. 4 and 24.

consumer prices and wages.[38] In its 2008 Decision and for future reference, the PUC found that a COLA adjustment should be authorized, by future PUC Resolution, for work performed in 2009, and in subsequent years in the absence of a market rate study, to be effective on January 1 of each year.[39]

6.8. DETERMINATION OF MARKET VALUE HOURLY RATE

Fees claimed may be adjusted to reflect Market Rate. "The hearing officer shall issue a written decision that ... shall determine the amount of compensation to be paid, which may be all or part of the amount claimed." 28 CCR § 1010(e)(7). APPLICANT claims advocacy and witness fees for one non-attorney Program Director & Health Policy Expert and one Health Policy Analyst & Law School Graduate/Staff Attorney.

For work performed by APPLICANT's Program Director & Health Policy Expert, APPLICANT claims advocacy and witness fees at an hourly rate of $210.00 (for 2006). The PUC's adopted hourly non-attorney intervenor rate range for 2006 is $115 - $370 without breakdown by years of experience. At the time of the work for which the claim is made and according to the biographical information submitted, APPLICANT's Program Director had a B.A. degree in Social Work from Rutgers University, was a 2005 Leadership Fellow at the Sierra Health Foundation Health Leadership Program, and had approximately 25 years of experience in program direction, policy development, health and human services advocacy, managed care consulting, provider network operations and management, and legislative advocacy. The highest of the PUC's rates for 2006 is $380. Therefore, it appears that the $210.00 hourly rate claimed by APPLICANT does not exceed "Market Rate" as defined in 28 CCR § 1010(b). Regarding services provided by APPLICANT's Program Director & Health Policy Expert, the Hearing Officer finds that $210.00 per hour does not exceed Market Rate for the services provided in 2006.

For work performed by APPLICANT's Law School Graduate & Policy Analyst, APPLICANT claims advocacy and witness fees at an hourly rate of $158.00 (for 2006). The PUC's adopted hourly non-attorney intervenor rate range for 2006 is $115 - $370 without breakdown by years of experience. At the time of the work for which claim is made and according to the biographical information submitted, APPLICANT's Law School Graduate & Policy Analyst had a B.A. degree in English with a minor in History from the University of Massachusetts, a J.D. degree from the University of California, Berkeley School of Law (Boalt Hall), and approximately two years of experience as a law clerk and legal intern in three positions. The highest of the PUC's rates

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[38] *Id.* In reviewing available data, the PUC found no index that specifically targets rates for services by regulatory professionals (attorneys, engineers, economists, scientists, etc.), and the PUC's "findings are weighted heavily to SSA COLA and similar data." *Id.* at p. 4.

[39] D.08-04-010 (April 10, 2008) at pp. 24 -25.

for 2006 is $370. Therefore, it appears that the $158.00 hourly rate claimed by APPLICANT does not exceed "Market Rate" as defined in 28 CCR § 1010(b). Regarding services provided by APPLICANT's Law School Graduate & Policy Analyst, the Hearing Officer finds that $158.00 per hour does not exceed Market Rate for the services provided in 2006.

For work performed by APPLICANT's Staff Attorney & Health Policy Analyst,[40] APPLICANT claims advocacy and witness fees at the hourly rates of $200.00 (for 2007) and $205 (for 2008). For 2007, the PUC's adopted hourly intervenor rate range for attorneys with 0 – 2 years of experience is $145 - $200. For 2008, the PUC's adopted hourly intervenor rate range for attorneys with 0 – 2 years of experience is $150 - $205. At the time of the work for which claim is made and according to the biographical information submitted, APPLICANT's Staff Attorney had a B.A. degree in English with a minor in History from the University of Massachusetts, a J.D. degree from the University of California, Berkeley School of Law (Boalt Hall), approximately two years of experience as a law clerk and legal intern in three positions, and approximately 0 - 2 years of experience as an attorney who was admitted to the California State Bar Association in December 2006. For attorneys with 0 - 2 years of experience, the highest of the PUC's rates for 2007 is $200.00 and the highest of the PUC's rates for 2008 is $205.00. Therefore, it appears that the $200.00 hourly rate claimed by APPLICANT for 2007 services and the $205.00 hourly rate claimed by APPLICANT for 2008 services do not exceed "Market Rate" as defined in 28 CCR § 1010(b). Regarding services provided by APPLICANT's Staff Attorney & Policy Analyst, the Hearing Officer finds that $200.00 per hour does not exceed Market Rate for the services provided in 2007 and $205 per hour does not exceed Market Rate for the services provided in 2008.

Based on the information and documentation provided by APPLICANT, the Hearing Officer did not consider it necessary to audit the records and books of the APPLICANT to verify the basis for the amounts claimed in seeking the award. 28 CCR § 1010(e)(6).

[40] It appears that a person self-identified at the October 4, 2006, Public Hearing as "Supervising Attorney" of APPLICANT provided advocacy and/or witness services which could have been considered for compensation. However, APPLICANT did not claim any fees for those services, and therefore, such compensation cannot be considered or awarded.

7. AWARD

APPLICANT is awarded Advocacy and Witness Fees as follows:

Staff / Title	Hours	Rates	Fees
Program Director & Health Policy Expert			
-- Work in 2006	10.06	$210.00	$2,112.60
-- Work in 2007	0.0	---	$0.00
-- Work in 2008	0.0	---	$0.00
Health Policy Analyst & Staff Attorney			
-- Work in 2006 – Law School Graduate	63.0[41]	$158.00	$9,954.00
-- Work in 2007 –Attorney & Policy Analyst	11.0	$200.00	$2,200.00
-- Work in 2008 –Attorney & Policy Analyst	13.5	$205.00	$2,767.50
TOTAL FEES	→		**$17,034.10**

8. ASSIGNMENT OF PROCEEDING

This proceeding was and is assigned to Stephen A. Hansen, Staff Counsel III, as Hearing Officer.

FINDINGS OF FACT

1. APPLICANT has satisfied all the procedural requirements necessary to claim compensation in this proceeding.

2. APPLICANT made substantial contributions to Proceeding Control Nos. 2006-0777, 2006-0782, 2007-1253 and 2008-1536 as described herein.

3. APPLICANT requested hourly rates for its representatives that, as adjusted herein, are reasonable when compared to market rates for persons with similar training and experience.

4. The total reasonable compensation for APPLICANT is $17,034.10.

CONCLUSIONS OF LAW

1. APPLICANT has fulfilled the requirements of Health and Safety Code § 1348.9 and 28 CCR § 1010, which govern awards of advocacy and witness compensation, and is entitled to such compensation, as adjusted herein, incurred in making substantial contributions to Proceeding Control Nos. 2006-0777, 2006-0782, 2007-1253 and 2008-1536 and 28 CCR § 1300. 71.39.

[41] Adjusted as specified in paragraph 6.3, *supra*.

2. APPLICANT should be awarded $17,034.10 for its contribution to Proceeding Control Nos. 2006-0777, 2006-0782, 2007-1253 and 2008-1536 and 28 CCR § 1300. 71.39.

AWARD ORDER

1. Legal Services of Northern California, a California corporation dba Health Rights Hotline is hereby awarded $17,034.10 as compensation for its substantial contribution to the Unfair Billing Patterns regulatory Proceeding Control Nos. 2006-0777, 2006-0782, 2007-1253 and 2008-1536, and 28 CCR § 1300. 71.39.

2. Payment shall be made within thirty (30) days of the effective date of this decision.

3. This decision is effective thirty (30) days after posting of this decision on the Department's website. 28 CCR § 1010(e)(7) and (8).

Dated: December 22, 2008.

Original Signed by:

STEPHEN A. HANSEN
Hearing Officer
Department of Managed Health Care