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: The Western Center On Law and Poverty, Inc., a California corporation, Applicant.	**DMHC Decision 09-04-02 April 27, 2009** Application Received Date: November 13, 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 THE WESTERN CENTER ON LAW AND POVERTY, INC., A CALIFORNIA CORPORATION, FOR SUBSTANTIAL CONTRIBUTION TO PROCEEDING CONTROL NOS. 2006-0777, 2006-0782, 2007-1253 and 2008-1536

1. SUMMARY

This decision awards The Western Center On Law And Poverty, Inc., a California corporation ("Western Center" 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 in order to not exceed Market Rate, 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 specified 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(a); 28 CCR § 1010(b)(8)).

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

3.2. APPLICANT'S APPLICATION TO PARTICIPATE

On October 12, 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.

On October 19, 2006, the Director ruled that APPLICANT was eligible to participate and to seek an award of compensation.

On October 12, 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 $10,000.

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

> Compounded with the rising cost of medical care, low-income people are facing medical debt at higher rates and more frequently than ever before. As a member of the Health Consumer Alliance HCA, a partnership of consumer assistance programs operated by community-based legal services organizations and two support centers, we are constantly confronted with the issues our clients face when they have medical bills they cannot pay. In 2004, together with our partners in the HCA, we published a report Sick and In Debt: Improper Practices that Cause Medical Debt for Low-Income Californians. This report documented how low-income Californians end up with significant debt due to bureaucratic barriers, improper billing practices and errors, failures to screen for available resources or government health coverage programs, and higher rates charged to the uninsured. The effects of such debt are most pronounced for low-income people who have little access to fair credit or other resources to manage medical bills that are often several times more than their annual income. With no way to manage such debt, low-income people face destroyed credit and destabilized housing, and do not seek treatment for ongoing or future health needs. Western Center will bring this vast experience and commitment in commenting on the proposed regulations regarding the balance billing of HMO consumers.

On October 19, 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. Within 60 days thereafter (on November 13, 2008), APPLICANT timely submitted its Application for an Award of Advocacy and Witness Fees (Application). 28 CCR § 1010(e)(1).

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[1] on each specific task[2]; 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 Application, 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 (or a more accurate tenths of an hour) for attorney advocates, the hourly rate requested,[3] and the total dollar amount billed for each task. The application did not include billing for non-attorney advocates. The Application included a brief summary of the data gathering and methodology followed in determining the hourly rates for the fees claimed, but did not include the records and data used in the hourly rate determination. The total fees requested for work performed by APPLICANT is $11,515.00.

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[1] "...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).

[2] "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.

[3] 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.

However, the Application did not contain: (1) biographies or resumes of the persons who provided the services for which the fee award is sought; and (2) in the case of attorneys, the date the attorney was admitted to the California State Bar Association.

By letter dated December 23, 2008, the Department requested additional information from APPLICANT, including: (1) biographies or resumes of the persons who provided the services for which the fee award is sought; and (2) in the case of attorneys, the date each attorney was admitted to the California State Bar Association.

By letter dated January 5, 2009, APPLICANT provided: (1) a resume or biography of each staff member for whom fees are claimed stating the name, job description, experience and skills of the staff member; and (2) the date each attorney was admitted to the California State Bar.

The Hearing Officer finds that the Application of APPLICANT , as supplemented, 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 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 Pro, 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 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, 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.
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> 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.
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> 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, 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 and Public Hearing Agenda scheduling and noticing a public hearing for October 24, 2007.

On October 31, 2007, the Department issued a Third Amended Notice of Rulemaking Action and Public Hearing Agenda 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, 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.

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[4] and filed with the Secretary of State. The regulation was effective on October 15, 2008.[5]

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[4] Office of Administrative Law, Notice of Approval of Regulatory Action, OAL File No. 2008-0801-01 S, September 15, 2008.
[5] *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.[6] 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 [7]…,

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[6] 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.

[7] 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.

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 information, 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 September 13, 2006, Public Hearing held in Burbank, California, APPLICANT's time records for APPLICANT'S Staff Attorney indicate "attended public hearing and reviewed provider and health plan arguments opposing regulations." The record of the hearing does not contain oral comments by APPLICANT's Staff Attorney or other representative of APPLICANT. However, APPLICANT's written comments dated October 4, 2006, and oral comments at the October 4, 2006, hearing indicate reference and response to opposing comments by others at the September 13, 2006, Public Hearing.

Regarding the September 25, 2006, Public Hearing held in San Diego, California, APPLICANT's Application indicates services in preparation for testimony of a Health Consumer Alliance representative. However, the Application does not, and the record of the hearing does not, indicate that a representative of APPLICANT entered an appearance or provided oral comments at the hearing.

At the October 4, 2006, Public Hearing held in Sacramento, California: Attendance, presentation of oral comments, and introduction of a consumer witness by APPLICANT's Staff Attorney/Legislative Advocate.

APPLICANT, together with other consumer advocates of the Health Consumer Alliance, 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 statistics and studies that documented the results of balance billing practices on low-income consumers, data and factual descriptions of consumer-client experiences with unfair billing, proposed definition of emergency services, inclusion of all providers of emergency services at contracting and non-contracting hospitals by pointing out the myriad of bills received by consumers and the confusion this causes, other consumer protections, and comments and suggested amendments to the proposed regulation.

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

Proceeding Control No. 2007-1253

At the October 24, 2007, Public Hearing held in Burbank, California: Attendance and presentation of oral comments by APPLICANT's Staff Attorney.

APPLICANT, together with other consumer advocates of the Health Consumer Alliance, provided written comments dated November 26, 2007, on the proposed regulation and regulation revisions, in response to the written comment period which closed on November 30, 2007, after extensions, focusing on legal argument why an outright prohibition against balance billing was well within the Department's authority, urging that the prohibition not be conditioned on the providers participation in a dispute resolution process, requesting that the proposed regulation cross-reference other statutes and regulations that broadly define "emergency services," and seeking other consumer protections.

Proceeding Control No. 2008-1536

At the May 20, 2008, Public Hearing held in Sacramento, California: Attendance and presentation of oral comments by APPLICANT's Staff Attorney/Legislative Advocate. Although APPLICANT's time records indicate "prepared testimony, attended and testified at hearing" on May 19, 2008, the record of the May 19, 2008, Public Hearing held in San Diego, California, does not contain oral comments by APPLICANT's representative. The Hearing Officer assumed that the time records simply contained an erroneous reference to May 19 instead of May 20.

APPLICANT, together with other consumer advocates of the Health Consumer Alliance, provided written comments dated May 15, 2008, on the proposed regulation and regulation revisions, in response to the written comment period which closed on June 3, 2008, after extensions, focusing on requests for clarifying changes and urging the Department to adopt the proposed regulation quickly so that more consumers would not be harmed.

5.3 PROCEDURAL VERIFICATION OF SUBSTANTIAL CONTRIBUTION

Proceeding Control Nos. 2006-0777 and 2006-0782

At the October 4, 2006, Public Hearing held in Sacramento, California, APPLICANT's Staff Attorney/Legislative Advocate presented oral comments on the record.

By letter dated October 4, 2006, APPLICANT presented written comments on the proposed regulation, over the signature blocks of APPLICANT and three other consumer center advocates as partners of The Health Consumer Alliance. Initially, the letter provided support for refuting statements made on the record at the Public Hearings in Los Angeles and San Diego (referred to as

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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.

misrepresentations), to the effect that "a patient suffers no harm when she is billed by the provider, that no one avoids the emergency room because she still owes a hospital money for a previous visit, that patients do not suffer negative credit effects when they are balance billed and cannot pay, and that balance billing is not a problem in general." The letter presented data from a prior report which analyzed data collected from cases involving consumers who sought services at consumer assistance programs regarding balance billing problems. In addition, the letter contained six comments, including recommendations requesting changes (identified in the order presented in the comment letter), plus an attachment containing APPLICANT's proposed changes to the regulations highlighted in underlined and strike out format. The comments included the following:

(1) that the proposed regulation should reference existing definitions of "emergency services" in existing law or contain a definition of "emergency services" based upon the enrollee's belief that an emergency medical condition exists, to avoid provider billing because, in hindsight, an emergency did not exist;

(2) that the proposed regulation (in Section 1300.71.39(b)(2)), in addition to prohibiting a provider of emergency services from collecting or attempting to collect from a health plan enrollee, should also prohibit reporting to a credit reporting agency, any amount as an enrollee obligation that is due to the provider from the health plan, in order to protect consumers from unfair collection practices;

(3) that the proposed regulation should not only prohibit a provider of emergency services from collecting or attempting to collect from an enrollee any amount due to the provider from the health plan, but also any amount <u>allegedly due</u> to the provider from the health plan;

(4) that the proposed regulation should make clear that an emergency services provider may not attempt to collect from an enrollee any amount other than co-payments, coinsurance, or deductibles, as appropriate, and instead must seek payment from the health plan;

(5) that the proposed regulation should be clarified to assure that non-contracted provider claims payment disputes that have not been resolved by a the health plan may not be billed to the enrollee, so that the enrollee is not mistakenly billed by the provider while disputes are being resolved; and

(6) that the proposed regulation should be amended to protect enrollees from being billed for services provided by <u>all</u> providers (not only emergency department physicians) at plan network hospitals, including for post-stabilization services and post-emergency care, by prohibiting non-contracted providers from collecting or attempting to collect from the enrollee, or reporting to a credit reporting agency, any amount (other than co-payments, coinsurance or deductibles) claimed due for services and must seek payment directly from the health plan.

Of the six October 4, 2006, comments requesting changes, all were reviewed, but none were accepted or rejected because the Department withdrew the proposed regulation by issuing a Notice of Decision Not To Proceed (with the rulemaking action of Proceeding Control Nos. 2006-0777 and 2006-0782) and Intent to Refile.

Proceeding Control No. 2007-1253

At the October 24, 2007, Public Hearing held in Burbank, California, a Staff Attorney of APPLICANT presented oral comments on the record.

By letter dated November 26, 2007, APPLICANT presented written comments on the proposed regulation, over the signature blocks of APPLICANT and three other consumer center advocates as partners of The Health Consumer Alliance, including proposed additions and deletions to the regulation. That submission contained three categories of comments, including recommendations requesting changes:

(1) that:

- the Department has authority to regulate pradftic3s that place patient5s in the middle of provider-health plan disputes; and adoption of a balance billing regulation is vital to realizing the legislature's intent that the DMHC act in order to protect consumers from this unnecessary medical debt;
- the proposed regulation should prohibit balance billing, and reporting to a credit reporting agency, by non-contracting providers providing services in contracting hospitals because enrollees should not be balance billed (other than for co-payments, coinsurance, or deductibles) for any health care service that is a covered benefit and provided in a network hospital;

(2) that:

- the proposed regulation should prohibit providers from forwarding patient bills to credit reporting agencies or commencing a debt collection lawsuit while awaiting payment from a health plan;
- the proposed regulation should acknowledge that amounts billed by the provider are still in controversy;
- the proposed regulation should make it absolutely clear that the only amounts that enrollees can be billed for by providers are co-payments, coinsurance and deductibles;
- the definition of "billing an enrollee" should include reporting an amount due or allegedly due to a credit reporting agency or collection department or agency;

(3) that:

- the proposed regulation should prohibit balance billing and not just condition the prohibition on whether the provider accepts an expedited payment as in proposed section 1300.71(a)(3)(B)(iii) so as to prevent attempts by providers to bill or collect from patients during the Independent Dispute Resolution Process; and
- emergency services providers without a written contract may not collect or attempt to collect from the enrollee, or report to a credit reporting agency, any amount due or allegedly due to the provider from the health care services plan.

Of the three categories of comments submitted by date of November 26, 2007, 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 held in Sacramento, California, APPLICANT's Staff Attorney/Legislative Advocate presented oral comments on the record.

By letter dated May 15, 2008, APPLICANT presented written comments on the proposed regulation, over the signature blocks of APPLICANT and three other consumer center advocates as partners of The Health Consumer Alliance, including proposed amendments to the proposed regulation. That letter contained five comments, including recommendations requesting changes:
(1) that subsection (b)(1) of the proposed regulation contain a reference to 42 U.S.C.A. §§ 1395cc and 1395dd (the EMTALA law) and to California Health and Safety Code §§ 1317 et seq. to ensure that physicians do not deny medically necessary care;
(2) that the proposed regulation should define "billing an enrollee" to include "assigning or reporting amounts due or allegedly due to a collection or credit reporting agency or other party that could negatively affect an enrollee's credit rating or report, by amending subsection (b)(4);
(3) that the proposed regulation should define "unfair billing pattern" to include billing for amounts "allegedly owed," because the amount that the provider should be paid is in controversy until the health plan and the provider have agreed on compensation;
(4) that the proposed regulation should include in the definition of "unfair billing pattern" a clarification that both pre- and post-stabilization care that is required to be covered by the health plan shall not be balance-billed to the consumer; and
5) that the proposed regulation be amended to protect consumers from billing for covered services provided by all providers at network hospitals, including providers not contracted to the health plan; and health plans should be required to include information in evidence of coverage documents to

explain the right to be free of unfair billing practices and provide information on where a consumer may make a complaint when inappropriately or illegally billed.

Of the five May 15, 2008, comments requesting changes, all were declined with explanation in the record as follows: (1)"The issues regarding possible provider incentive to deny care, provider collection actions and the content of evidences of coverage, are outside the intended scope of this rulemaking action, and are already addressed by other provisions of existing law"; and (2) "The suggested revision to include post-stabilization care within the meaning of emergency services is not consistent with the requirements of the Knox-Keene Act, and is outside the intended scope of this rulemaking action."

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
Staff Attorney & Legislative Advocate	17.6	$400.00	$7,040.00
Staff Attorney	17.9	$250.00	$4,475.00
TOTAL FEES	**→**		**$11,515.00**

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[8] 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 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.[9]

b. Have awarded the same rate for an individual expert that was approved in a prior proceeding in the same year,[10] 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.[11]

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.[12] The PUC has consistently rejected requests for increase over 3%.[13]

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.[14]

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[8] 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).

[9] PUC Decision (D.) 06-11-031 (November 30, 2006).

[10] D.06-11-031 (November 30, 2006).

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

[12] D.06-11-031 (November 30, 2006), p. 11.

[13] D.06-11-031 (November 30, 2006), p. 11.

[14] D.06-11-031 (November 30, 2006), p. 10.

e. Have approved compensation for travel time at one-half the normal hourly rate.[15]

f. Have approved compensation for preparation of the intervenor organization's compensation request or compensation claim at one-half the normal hourly rate.[16] 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.[17]

g. Have approved compensation for efforts that made a substantial contribution even where the PUC did not wholly adopt the intervenor's recommendations.[18]

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.[19]

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."[20]

j. Have disallowed time where the "hours seem excessive" or the "proposal is not persuasive,"[21] and have changed or disallowed compensation amounts requested for the following reasons:[22] "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

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[15] D.06-11-031 (November 30, 2006); D.06-11-032 (November 30, 2006), p. 8, fn. 4.
[16] D.06-11-031 (November 30, 2006), p. 9, fn. 2; D.06-11-032 (November 30, 2006), p. 8, fn. 4.
[17] D.06-11-009 (November 9, 2006), p. 27.
[18] D.06-11-031 (November 30, 2006), p. 10.
[19] 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.
[20] D.06-11-031 (November 30, 2006), pp. 14 -15.
[21] D.06-11-032 (November 30, 2006), pp. 9 - 10.
[22] D.06-11-009 (November 9, 2006), Appendix p. 1.

and costs (if any costs are claimed) are related to the work performed and necessary for the substantial contribution.[23]

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 impact of proposed regulation on Medi-Cal plans, prepare proposed revisions and changes to proposed regulation language, coordinate with other consumer advocates of the Health Consumer Alliance regarding positions to take in the written comments, 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 5.2 hours.

(2) Attendance at Public Hearing held on September 13, 2006, in order to identify health plan arguments opposing the proposed regulation and develop arguments and testimony countering those arguments to present at the October 4, 2006, Public Hearing, coordinate with the Health Consumer Alliance workgroup regarding positions and arguments to present at the Public Hearing, coordinate with Health Consumer Alliance workgroup members regarding client stories and positions for comments on the proposed regulation; draft, review and edit testimony for the Public Hearing, and 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 15.7 hours.

(3) Review and legal analysis of revised proposed regulation and regulation modifications against the backdrop of existing law and client experience, discussion with Department staff to ascertain reasons for changes in the proposed regulation, research and prepare written comments, coordinate with other consumer advocates of the Health Consumer Alliance regarding comments on the proposed regulation, revise and edit written comments, submit written comments in the extended written comment period ending November 30, 2007, in Proceeding Control No. 2007-1253, for a total of 3.9 hours.

(4) Research and draft testimony, edit and finalize testimony, preparation for, attendance and providing testimony at the Public Hearing held on October 24, 2007, in Proceeding Control No. 2007-1253, for a total of 3.1 hours.

(5) Legal analysis of revised text of the proposed regulation, and preparation of written comments, review and revise co-authors' draft written comments, revise and edit written comments, finalize and submit written comments in the extended written comment period ending June 3, 2008, in Proceeding Control No. 2008-1536, for a total of 3.9 hours.

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[23] 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.

(6) Review revised text of the proposed regulation, 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 3.7 hours.

b. Finding. The Hearing Officer hereby finds that 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.[24] 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.

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

a. Hourly fees awarded by the Department in prior proceedings – specifically: For services provided by APPLICANT's Staff Attorney/Legislative Advocate in a proceeding in 2004-2005 on behalf of Health Rights Hotline, an award was made at $325.00 per hour.

b. Hourly fees awarded by the California Department of Social Services "in early 2008 for work done for the most part in 2007," the California Department of Social Services "agreed to compensate ... [APPLICANT's Staff Attorney] at the rate of $250 an hour."

c. Rates in prior litigation – In developing the rates requested, APPLICANT "relied on fees awarded in the past to ... [APPLICANT] in litigation with state and county agencies through its litigation and prevailing market rates for attorney time." However, those rates were not provided with APPLICANT's Application, and APPLICANT did not provide case citations or copies of fees awarded in such litigation cases.

6.7. HOURLY RATE DETERMINATIONS UNDER THE PUC PROGRAM

Until PUC Decision R.04-10-010 in 2004, the PUC "set hourly rates piecemeal"[25] 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."[26] 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.[27] 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.[28]

In an Interim Opinion on Updating Hourly Rates,[29] 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.[30] 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

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

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.[31] (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.

Hourly Intervenor Rate Ranges for 2006, 2007 and 2008[32]

(2006 rates = rates adopted in D.05-11-031 x 3%, rounded to nearest $5)
(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	2006 Range	2007 Range	2008 Range
Attorneys:			
0 - 2	$140 - $195	$145 - $200	$150 - $205
3 - 4	$190 - $225	$195 - $230	$200 - $235
5 - 7	$260 - $280	$270 - $290	$280 - $300
8 - 12	$280 - $335	$290 - $345	$300 - $355
13+	$280 - $505	$290 - $520	$300 - $535
Experts:			
0 - 6		$120 - $180	$125 - $185
7 - 12		$150 - $260	$155 - $270
13+		$150 - $380	$155 - $390
All years	$115 - $370		

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.[33] The PUC based its 3% COLA adjustments on the Social Security Administration's COLA, which is

[31] *Id.* at p. 5.
[32] D.08-04-010 (April 10, 2008) (part of Rulemaking 06-08-019) at p. 5.
[33] D.07-01-009 (January 11, 2007) at p. 9.

released annually in late fall, and reliance thereon would be consistent with a calendar year adjustment of hourly rates.[34]

In 2008, the PUC found it reasonable to adopt another 3% COLA for intervenor rates for work performed in 2008.[35] 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 consumer prices and wages.[36] 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.[37]

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 Staff Attorney/Legislative Advocate and one Staff Attorney.

For work performed by APPLICANT's Staff Attorney/Legislative Advocate, APPLICANT claims advocacy and witness fees at the hourly rate of $400.00 for 2006 and 2008 (there were no services reported or claimed for 2007 for APPLICANT's Staff Attorney/Legislative Advocate). The PUC's adopted hourly intervenor rate range for 2006 for attorneys with 8 – 12 years of experience is $280 - $335. For 2008, the PUC's adopted hourly intervenor rate range for attorneys with 8 – 12 years of experience is $300 - $355 (see ¶ 6.7, supra). At the time of the work for which claim is made (2006 and 2008), APPLICANT's Staff Attorney/Legislative Advocate had approximately 8 -10 years of experience. APPLICANT submitted justification for the rate claimed by reference to: "the number of years experience for each staff member for whom fees are claimed;" an award by the Department for services of APPLICANT's Staff Attorney/Legislative Advocate at the hourly rate of $325.00 for services in late 2004 and 2005 in connection with a Consumer Participation Program matter for participation by Health Rights Hotline; and APPLICANT's reliance on "fees awarded in the past to ... [APPLICANT] in litigation with state and county agencies through its litigation and prevailing market rates for attorney time," but those rates were not provided and APPLICANT did not provide case citations or copies of fees awarded in such litigation cases. The highest of the PUC's rates for attorneys with 8 - 12 years of experience is $335.00 for

[34] *Id.* at pp. 4 and 11.
[35] D.08-04-010 (April 10, 2008) at pp. 4 and 24.
[36] *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.
[37] D.08-04-010 (April 10, 2008) at pp. 24 -25.

2006 and $355.00 for 2008. Therefore, it appears that the $400.00 hourly rate claimed for 2006 and 2008 by APPLICANT exceeds "Market Rate" as defined in 28 CCR § 1010(b). The Hearing Officer finds that the hourly rate requested by APPLICANT exceeds Market Rate and therefore will be adjusted. Regarding services provided by APPLICANT's Staff Attorney/Legislative Advocate, the Hearing Officer finds that $335.00 per hour is consistent with Market Rate for the services provided in 2006 and $355.00 per hour is consistent with Market Rate for the services provided in 2008.

For work performed by APPLICANT's Staff Attorney, APPLICANT claims advocacy and witness fees at the hourly rate of $250.00 for 2006, 2007 and 2008. The PUC's adopted hourly intervenor rate range for attorneys with 0 – 2 years of experience is $140 - $195 for 2006 and $145 - $200 for 2007. For 2008, the PUC's adopted hourly intervenor rate range for attorneys with 3 – 4 years of experience is $200 - $235 (see ¶ 6.7, supra). At the time of the work for which claim is made, APPLICANT's Staff Attorney had approximately 1 -2 years of experience for 2006 and 2007, and approximately 3 – 4 years of experience for 2008. APPLICANT submitted justification for the rate claimed by reference to: "the number of years experience for each staff member for whom fees are claimed;" APPLICANT's reliance on "fees awarded in the past to … [APPLICANT] in litigation with state and county agencies through its litigation and prevailing market rates for attorney time," but those rates were not provided and APPLICANT did not provide case citations or copies of fees awarded in such litigation cases; and a settlement with the California Department of Social Services in early 2008 for work done for the most part in 2007, wherein the Department of Social Services agreed to compensate APPLICANT's Staff Attorney at the hourly rate of $250. The highest of the PUC's rates for attorneys with 0 - 2 years of experience is $195.00 for 2006 and $200.00 for 2007. The highest of the PUC's rates for attorneys with 3 - 4 years of experience is $235.00 for 2008. Therefore, it appears that the $250.00 hourly rate claimed for 2006, 2007 and 2008 by APPLICANT exceeds "Market Rate" as defined in 28 CCR § 1010(b). The Hearing Officer finds that the hourly rate requested by APPLICANT exceeds Market Rate and therefore will be adjusted. Regarding services provided by APPLICANT's Staff Attorney, the Hearing Officer finds that $195.00 per hour is consistent with Market Rate for the services provided in 2006, $200.00 per hour is consistent with Market Rate for the services provided in 2007, and $235.00 per hour is consistent with Market Rate for the services provided in 2008.

Additional information and documentation was considered necessary by the Hearing Officer. The additional information and documentation was provided by APPLICANT, and therefore, the Hearing Officer did not consider it necessary to audit the records and books of the APPLICANT to verify the basis for the amount claimed in seeking the award. 28 CCR § 1010(e)(6).

7. AWARD

APPLICANT is awarded Advocacy and Witness Fees as follows:

Staff / Title	Hours	Rates	Fees
Staff Attorney/Legislative Advocate			
-- Work in 2006	12.7	$335.00	$4,254.50
-- Work in 2007	0.0	NA	$0.00
-- Work in 2008	4.9	$355.00	$1,739.50
Staff Attorney -- Work in 2006	8.2	$195.00	$1,599.00
-- Work in 2007	7.0	$200.00	$1,400.00
-- Work in 2008	2.7	$235.00	$634.50
TOTAL FEES	→		**$9,627.50**

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 $9,627.50.

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.

2. APPLICANT should be awarded $9,627.50 for its contribution to Proceeding Control Nos. 2006-0777, 2006-0782, 2007-1253 and 2008-1536, and 28 CCR § 1300. 71.39.

AWARD ORDER

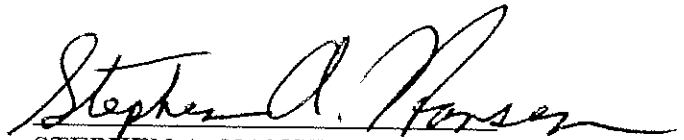
1. The Western Center On Law And Poverty, Inc., a California corporation, is hereby awarded $9,627.50 as compensation for its substantial contribution to the Unfair Billing Patterns regulatory Proceeding Control Nos. 2006-0777, 2006-0782, 2007-1253 and 2008-1536, and 28 CCR § 1300. 71.39.

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: April 27, 2009

Original Signed by:



STEPHEN A. HANSEN
Hearing Officer
Department of Managed Health Care