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: HEALTH ACCESS OF CALIFORNIA, Applicant.	Application Tracking No. 1158954159203 (Filed September 23, 2006) Proceeding Control No. 2002-0019 For 28 CCR § 1300.67.24 (Re: Outpatient Prescription Drug Copayments, Coinsurance, Deductibles and Limitations)

OPINION GRANTING AWARD OF ADVOCACY AND WITNESS FEES TO HEALTH ACCESS OF CALIFORNIA FOR SUBSTANTIAL CONTRIBUTION TO PROCEEDING NO. 2002-0019

1. SUMMARY

This decision awards Health Access of California, a California corporation (HEALTH ACCESS), sometimes referred to as Health Access California, Advocacy and Witness Fees for its substantial contribution to Proceeding No. 2002-0019 of the Department of Managed Health Care (Department) regarding outpatient prescription drug copayments, coinsurance, deductibles, limitations and exclusions ("proposed outpatient prescription drug regulation"), which became final as set forth at 28 CCR §1300.67.24. 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, enacted in Health and Safety Code § 1348.9 (the Statute), required the Director (the Director) of the Department of Managed Health Care (the Department) to adopt regulations to establish the Consumer Participation 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 demonstrate 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, Consumer Participation Program (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

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.

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

3.1. APPLICATION TO PARTICIPATE

In August 11, 2004, HEALTH ACCESS 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 September 10, 2004, the Department Director (Director) ruled that HEALTH ACCESS was eligible to participate and to seek an award of compensation.

On October 1, 2004, HEALTH ACCESS submitted its Petition to Participate (Petition) with the Department in the outpatient prescription drug rulemaking proceeding. In its Petition, HEALTH ACCESS estimated its fees to be $25,000.

In its Petition, HEALTH ACCESS stated that, with respect to outpatient prescription drug issues that:

> Health Access strongly supported SB842 Speier and was intimately involved in the legislative negotiations leading to its enactment. We

> have offered testimony at several earlier DMHC proceedings regarding implementation of this legislation. Health Access was the sponsor of the HMO Patient Bill of Rights which resulted in the creation of the Department of Managed Health Care and which included more than 20 pieces of legislation related to managed care. Health Access also continued to participate in the various proceedings of the DMHC, including rulemaking and public hearings and meetings. Health Access also works on a range of health care issues, including the budget, access expansion, and health care cost control.

On October 29, 2004, the Director approved the Petition of HEALTH ACCESS to participate in the outpatient prescription drug rulemaking proceeding.

3.2. APPLICATION FOR AWARD OF ADVOCACY AND WITNESS FEES

The regulation (28 CCR § 1010) became final and effective on July 26, 2006. Within 60 days thereafter (on September 22, 2006), HEALTH ACCESS timely submitted its Application for an Award of Advocacy and Witness Fees (Application)), including a billing of the activities conducted and fees requested, together with biographies or resumes of the persons who provided services for which the fee award was sought. The total fees requested for work performed by Applicant HEALTH ACCESS is $12,750.00. However, the Application did not contain a description of how Market Rate was determined for the fees claimed.

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

By letter dated November 16, 2006, the Department requested additional information from HEALTH ACCESS, including a description of how HEALTH ACCESS determined the market rate for each staff member for whom fees were claimed.

By letter dated November 22, 2006, HEALTH ACCESS provided a summary of the data gathering and methodology followed in determining the hourly rate for the fees claimed. However, this response did not include the records and data used in the hourly rate determination.

By letter dated December 13, 2006, the Department requested copies of the records used by HEALTH ACCESS that reflected the hourly rates described by HEALTH ACCESS.

By letter dated January 2, 2007, HEALTH ACCESS submitted additional information, including copies of fee award records from the California Public Utilities Commission and private sector hourly rates for lawyers and consultants.

In response to a request by the Department, HEALTH ACCESS submitted additional information by e-mail dated January 30, 2007, regarding the experience of one of the experts.

4. PROCEDURAL HISTORY

On December 17, 2004, the Department issued a Notice of Proposed Rulemaking (Notice) proposing to adopt 28 CCR section 1300.42.7 (subsequently renumbered as section 1300.67.24), and establishing a 45-day comment period from December 17, 2004 to January 31, 2005.

In the Informative Digest/Policy Statement Overview contained within the Notice, the Department stated that:

> SB 842 added section 1342.7 and amended sections 1367.215, 1367.24, 1367.25, 1367.45, 1367.51 and 1374.72 of the Health and Safety Code specifying procedures for plans to request approval from the Department for a copayment, deductible, limitation, or exclusion to its prescription drug benefits and requires the Department to adopt regulations outlining the standards it uses in reviewing these requests. In addition SB 842 requires, subject to specified exceptions, that nonformulary prescription drugs include any drug for which an enrollees copayment or out of pocket costs are different than the copayment for a formulary prescription drug.

A Public Hearing on the proposed regulation was scheduled and noticed for January 25, 2005.

At the January 25, 2005 Public Hearing on the proposed adoption of the outpatient prescription drug regulation, a consultant/expert/policy analyst representing HEALTH ACCESS presented oral comments on the record.

On January 31, 2005, a consultant/expert/policy analyst representing HEALTH ACCESS presented written comments signed by the Executive Director of HEALTH ACCESS on the proposed outpatient prescription drug regulation. That submission contained Seven comments, all of which requested changes, requesting: (1) that the regulation not

authorize limiting prescription drug coverage to specified conditions or illnesses or specified classes of prescription drugs; (2) that the criteria for review for exclusions and limitations be separated from those for out-of-pocket costs, to add clarity; (3) and providing suggested revisions requiring that actual cost data for prescription drugs be the basis for pricing instead of "nationally recognized data sources;" (4) that any change in copayments, coinsurance or deductibles as well as tiers, method of computation or allocation of classes or drugs to particular tiers should be subject to review by the Department, and offering an amendment that requires that out-of-pocket costs, including the methodology for computing copayments, be included in the evidence of coverage and be made publicly available; (5) that the sequence and medications involved in each step therapy protocol be subject to review and approval by the Department, that each step therapy protocol take into account the prior medical history of the enrollee including portions of the step therapy protocol not medically appropriate for the enrollee, and requiring that step therapy protocols be subject to review annually; (6) that the regulations should prohibit plans from excluding a specific drug or class of drugs for which there is not a therapeutic equivalent; and (7) that benefit design proposals be reviewed by the Department with public notice and opportunity for public input and scrutiny.

Seven of the seven January 31, 2005, comments requesting changes were rejected in whole or in part by the Department as: (1) not appropriate because the statute specifically authorizes the Department to approve exclusions; (2) not appropriate because the Department considers all relevant factors may bear on copayments, coinsurance, deductibles, limitations and exclusions, and factors are not confusing as listed in the proposed regulation; (3) not reflecting the commentor's suggested revisions; (4) not reflecting the commentor's suggested revisions; (5) not appropriate because different clarifying language would be used; (6) inappropriate because the suggested language may limit the Department's ability to evaluate factors relevant to achieving flexibility of drug program designs; and (7) outside the scope of the proposed regulation because any person may request materials filed by a plan.

Three of the seven January 31, 2005, comments requesting changes were accepted in part and addressed by revisions which: (1) clarify the definition of "actual cost to the plan,"

eliminate inconsistent references, and clarify that a copayment must be reasonable; (2) add clarity, including to clarify that a copayment must be reasonable to allow access, as determined by the Department through consideration of specified factors; and (3) clarified the step therapy requirement to address the concerns of the commentor.

On August 26, 2005, the Department issued a notice of a second public comment period for 30 days from August 26, 2005 through September 26, 2005.

On September 26, 2005, the Executive Director of HEALTH ACCESS presented written comments on the proposed outpatient prescription drug regulation. That submission contained ten comments, seven of which requested changes: (1) that clarify or supplement the 50% of drug costs copayment limitation so as not to be affordability barriers to access; (2) that require plans seeking to establish limitations or exclusions on outpatient prescription drug benefits must do so in accordance with up-to-date evidence-based outcomes and current published, peer-reviewed medical and pharmaceutical literature and must review such limitations and exclusions no less than annually; (3) that require review by the Department of any change in copayments, coinsurance or deductibles, as well as tiers and method of computation or allocation of classes of drugs to particular tiers; (4) that place a limit on the absolute dollar amount of the copayment along with a limit on the ratio of lowest copayment to highest copayment; (5) that require step therapy to be based on the most current evidence-based outcomes and scientific literature as well as periodic review of step therapy protocols; (6) that require material modification filings for newly proposed types of copayments or other out-of-pocket costs; and (7) that quality assurance systems include "medical appropriateness" of prescription drugs.

Seven of the ten September 26, 2005, comments requesting changes were rejected in whole or in part by the Department as: (1) unnecessary because the regulation provides for additional factors the Department may consider in determining whether a copayment creates a barrier to access; (2) not appropriate because different clarifying language would be used; (3) unnecessary because the regulation is clear that any method that is different from the three methods described must have the Department's approval; (4) as inappropriate because to

permit flexibility in benefit design the regulation does not impose a particular dollar limit on a copayment, which is a determination to be made by the Department in review of a particular plan filing; (5) unnecessary because the concern is resolved through revision of a subsection regarding the clinical aspect of a prescription drug benefit; (6) inappropriate because the Department has determined not to include material modification filing requirements for copayments in this regulation; and (7) not appropriate because medical appropriateness of a drug for a particular patient is outside the scope of this regulation, and other provisions of Health and Safety Code § 1363.5 and this regulation address the concerns regarding establishing and revising formularies to eliminate medications determined to be unsafe for use.

Four of the ten September 26, 2005, comments requesting changes were accepted in part and addressed by revisions which: (1) clarify the requirement for periodic review to maintain consistency with professional standards; (2) clarify the manner in which a plan must file for the Department's prior approval of a cost methodology not listed in the regulation; (3) clarify copayment and coinsurance limits; and (4) clarify the requirements of review of the clinical aspects of step therapy and a prescription drug benefit.

On October 17, 2005, the Department issued a notice of a third public comment period for 15 days from October 17, 2005 through November 1, 2005.

On November 1, 2005, the Executive Director of HEALTH ACCESS presented written comments on the proposed outpatient prescription drug regulation. That submission contained twelve comments, nine of which requested changes: (1) that "self-administered" not be added to the definition of outpatient medications; (2) that the term "disposable" not be added; (3) that review by qualified medical and pharmacy professionals should not be limited to the "clinical" aspects of the prescription drug benefit but should be made in accordance with evidence-based outcomes and published peer-reviewed literature; (4) that review of limitations and exclusions should specify an interval of review or precipitating event for review; (5) that would limit the absolute dollar amount of copayments and place a limit on the ratio of lowest copayment to the highest; (6) that would delete a provision permitting prior authorization for prescription drug benefits due to lack of statutory basis in the authorizing

legislation; (7) that step therapy protocols should be subject to periodic review using evidence-based outcomes and peer-reviewed scientific literature; (8) that quality assurance systems include "medical appropriateness;" and (9) that material modification filing should be required for newly proposed types of copayments or other out-of-pocket costs.

Nine of the nine November 1, 2005, comments requesting changes were rejected in whole or in part by the Department as: (1) not appropriate to delete "self-administered;" (2) not appropriate to delete "disposable;" (3) not appropriate because the clinical aspects of a pharmacy benefit must be reviewed by qualified medical and pharmacy professionals; (4) not necessary to specify an interval or precipitating event for review of limitations or exclusions; (5) not appropriate to specify a dollar amount limit on outpatient prescription drug copayments in order to permit flexibility for innovative benefit designs and promote affordable health care coverage; (6) not appropriate to delete a provision authorizing prior authorization because the Knox-Keene Act permits prior authorization in compliance with the Act; (7) not necessary because step therapy protocols are subject to requirements of ongoing review by qualified medical and pharmacy professionals in accordance with available up-to-date evidence-based outcomes and current published, peer-reviewed medical and pharmaceutical literature; (8) not necessary to add "medical appropriateness" because the regulation requires ongoing review by qualified medical and pharmacy professionals of the clinical aspects of the prescription drug benefit, including the safety, efficacy, and utilization of outpatient prescription drugs; and (9) inappropriate because the Department has determined not to include material modification filing requirements for copayments in this regulation, and the public may request plan filings through Public Records Act requests.

Three of the nine November 1, 2005, comments requesting changes were accepted in part and addressed by revisions which: (1) clarified the meaning of the term "self-administered;" (2) clarified the meaning of the term "disposable;" and (3) retained the requirement that exclusions and limitations be determined in accordance with up-to-date clinical evidence.

On March 17, 2006, the Department issued a notice of a fourth public comment period for 15 days from March 17, 2006 through April 6, 2006.

On April 2, 2006, the Executive Director of HEALTH ACCESS presented written comments on the proposed outpatient prescription drug regulation. That submission contained nine comments, four of which requested changes, requesting: (1) that the term "disposable" not be used in regard to devices necessary to administer medications; (2) to add interval of review or precipitating event for review of limitations or exclusions; (3) to delete provision for prior authorization for prescription drug benefits; and (4) to base step therapy on the most current evidence-based outcomes and scientific literature as well as periodic review, and subject step therapy protocols to review to assure that they are consistent with regulation requirements regarding clinical efficacy and clinical effect. Three of the four comments requesting changes were rejected by the Department as: (1) not necessary because the stated concerns regarding the term "disposable" were addressed by the language added to clarify the meaning of the term for purposes of the regulation; (2) not consistent with the Department's intent to include the requested specific detail in the regulation, but instead to provide appropriate flexibility for variations in plan operations; and (3) not appropriate because the regulation clarifies that prior authorization processes are permissible limitations for prescription drug benefits when established in compliance with the Act and regulations. One of the four comments requesting changes was accepted in part and addressed by revisions which reflect that the development of all clinical aspects of pharmacy benefits by clinical professionals must be consistent with good professional practice.

On May 1, 2006, the Department issued a notice of a fifth public comment period for 15 days from May 1, 2006 through May 16, 2006.

On May 16, 2006, a consultant/expert/policy analyst representing HEALTH ACCESS presented written comments signed by the Executive Director of HEALTH ACCESS on the proposed outpatient prescription drug regulation. This submission contained four comments requesting changes: (1) requesting that plan's be required to demonstrate how consumers and purchasers would benefit from cost reductions due to discounts, rebates and other

pricing arrangements; (2) requesting that outpatient prescription drug benefits expressly comply with section 1374.33(b); (3) requesting that further consumer protections be added, including basing step therapy on the most current evidence-based outcomes and scientific literature and requiring periodic review to assure that step therapy protocols are consistent with the regulations in regard to clinical efficacy and clinical effect; and (4) requesting that plans not be allowed to seek prior approval via material modification for exclusion of a class of prescription drugs when one drug within the class becomes available over-the-counter but instead that approval for such exclusions be obtained only after an open, public process. Each of the four comments was rejected by the Department as: (1) not being necessary to specify the information that plans must file to demonstrate cost to the plan because such review will be handled in the normal course of the Department's licensing function, which may take into consideration the variations in plan operations and contractual arrangements in evaluating whether the plan has submitted sufficient information; (2) not necessary because the regulation specifies that the plan's outpatient prescription drug benefits must comply with the Act and Rules; (3) not necessary because the regulation provides for periodic review of limitations including step therapy; and (4) not necessary because the statute establishes a notice of material modification as the process for requesting a determination regarding a proposed limitation or exclusion.

On May 24, 2006, the final regulation package was submitted to the Office of Administrative Law (OAL). The regulation was approved by OAL and filed with the Secretary of State on June 26, 2006. The regulation was effective on July 26, 2006.

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).

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."

The definition of "Substantial Contribution" provides the criteria for evaluating whether the consumer participant has made a substantial contribution.[1]

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 [2]...,

---

[1] 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.

[2] 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. With this guidance in mind, we turn to the claimed contributions HEALTH ACCESS made to the proceeding.

HEALTH ACCESS submitted the following documents and testimony in support of its position regarding the proposed adoption of 28 CCR § 1300.67.24:

a. Testimony of a consultant/expert/policy analyst representing HEALTH ACCESS at the January 25, 2005 Public Hearing.

b. Written comments by a consultant/expert/policy analyst representing HEALTH ACCESS on, and in response to the first comment period that closed on, January 31, 2005, including three of seven comments requesting changes that were accepted in part and addressed by revisions.

c. Written comments by the Executive Director of HEALTH ACCESS on, and in response to the second comment period that closed on, September 26, 2005, including four of ten comments requesting changes that were accepted in part and addressed by revisions.

d. Written comments by the Executive Director of HEALTH ACCESS on, and in response to the third comment period that closed on, November 1, 2005, including three of nine comments requesting changes that were accepted in part and addressed by revisions.

e. Written comments by the Executive Director of HEALTH ACCESS on April 2, 2006, in response to the fourth comment period that closed on April 6, 2006, including one of four comments requesting changes that was accepted in part and addressed by revisions.

"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 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.

f. Written comments presented by a consultant/expert/policy analyst representing HEALTH ACCESS and signed by the Executive Director of HEALTH ACCESS on, and in response to the third comment period that closed on, May 16, 2006.

5.2. FINDING OF SUBSTANTIAL CONTRIBUTION

The Hearing Officer finds that participation by HEALTH ACCESS: (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 §1300.67.24 than would have been available to the Director had HEALTH ACCESS not participated.

The Hearing Officer hereby determines that by its participation HEALTH ACCESS 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 §1300.67.24.

The Hearing Officer finds that HEALTH ACCESS has made a Substantial Contribution, pursuant to 28 CCR section 1010(b)(8), to the outpatient prescription drug 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 fess 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. REASONABLENESS OF TIME BILLED

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[3] on each specific task[4]; 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, HEALTH ACCESS submitted a billing specifying the dates of service, the time spent and time of day of each service, a description of each activity of advocacy and witness service, the elapsed time (exact amount of time spent) for each service in 0.5 hour or 30 minute increments for non-attorney advocates, and the hourly rate requested.[5] The application did not include billing for attorney advocates.

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

Next, 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.[6]

HEALTH ACCESS billed for six activities summarized as follows:

1. Preparation for and attendance and providing testimony at the Public Hearing held on January 25, 2005, for a total of 4.5 hours.

2. Preparation of written comments submitted in the first written comment period ending January 31, 2005, for a total of 7 hours.

---

[3] "...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).

[4] "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.

[5] 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.

[6] 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.

3. Preparation of written comments submitted in the second written comment period ending September 26, 2005, for a total of one hour.

4. Preparation of written comments submitted in the third written comment period ending November 1, 2005, for a total of 3.5 hours.

5. Preparation of written comments submitted in the fourth written comment period ending April 6, 2006, for a total of one hour.

6. Preparation of written comments submitted in the fifth written comment period ending May 16, 2005, for a total of 8.5 hours.

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.

6.2. 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.). HEALTH ACCESS 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."

6.3. 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 California Public Utilities Commission, 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.[7] In order to determine Market Rate, we must look to available data inside and outside the Department.

6.4. FEES REQUESTED

HEALTH ACCESS billed the following hourly rates and fees for its representatives.

Staff / Title	Hours	Rates	Fees
Policy Consultant Health Care Policy Expert	17.5	$500.00	$8,750.00
Project Coordinator Health Care Policy Expert	8.0	$500.00	$4,000.00
TOTAL FEES	**25.5**		**$12,750.00**

6.5. HEALTH ACCESS' JUSTIFICATION FOR RATES BILLED

In support of the hourly fee rate requested ($500.00 per hour), HEALTH ACCESS submitted the following:

a. Hourly fees awarded by the California Public Utilities Commission (PUC) for Intervenors, for advocacy services in two categories -- (a) attorneys and (b) non-attorney policy experts – submitted by HEALTH ACCESS[8] as follows:

For attorneys, the hourly fees awarded by the PUC ranged as follows:

In 1999: $290 - $413.
In 2001: $255 - $310.
In 2002: $235 - $435.

For non-attorney policy experts, the hourly fees awarded by the PUC ranged as follows:

In 1999: $290 - $290.
In 2001: $290 - $310.

HEALTH ACCESS increased the PUC fees by five percent (5%) for each year since the award date. However, using the highest PUC rate submitted by HEALTH ACCESS for non-attorney policy experts ($310 in 2001) and increasing by five percent (5%) per year

[7] See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 10.
[8] Obtained from California Public Utilities Commission Intervenor Compensation Decisions Annotated Bibliography 2003, pages 55, 66, 82 and 83.

compounded for five years to 2006, the result would be approximately $395.64, which is below the $500 per hour rate claimed by HEALTH ACCESS for its policy experts.

b. Hourly rates charged by experts in the private sector (which HEALTH ACCESS "pulled from the Internet") – as follows:

Chief Operating Officer of a 450 bed community based, major medical school teaching affiliation, with M.B.A. degree: $650.00 per hour for non-testimonial (i.e., not testifying as a witness in court or deposition and not subject to cross-examination).

Physician, M.D., board certified in emergency medicine; consultant re quality assurance and utilization review: $500.00 per hour for non-testimonial.

Physician, M.D., board certified in neurology, prior Professor of Neurology, UC Davis and UCSGF: $575 per hour for non-testimonial.

Registered Nurse, R.N., MSN, BSN: $175.00 - $200.00 per hour.

Physician, M.D., board certified in internal medicine, Certified Medical Review Officer, Certified Independent Medical Examiner: $325.00 per hour for non-testimonial.

Attorney, Walnut Creek, CA: $375.00 per hour for expert employment.

Attorney, Walnut Creek, CA: $400.00 per hour for expert employment.

Although somewhat similar in certain experiences, it is difficult to find these experts from the private sector directly comparable to the HEALTH ACCESS policy experts, and therefore, difficult to base Market Rate on these experts' hourly rates.

6.6. CONSIDERATIONS USED IN PUC'S INTERVENOR COMPENSATION PROGRAM

Reference to the PUC's intervenor compensation program seems appropriate because it is similar to the Department's Consumer Participation Program[9] 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

[9] 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).

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.[10]

b. Have awarded the same rate for an individual expert that was approved in a prior proceeding in the same year,[11] 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.[12]

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.[13] The PUC has consistently rejected requests for increase over 3%.[14]

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.[15]

e. Have approved compensation for travel time at one-half the normal hourly rate.[16]

f. Have approved compensation for preparation of the intervenor organization's compensation request or compensation claim at one-half the normal hourly rate.[17] 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.[18]

---

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

g. Have approved compensation for efforts that made a substantial contribution even where the PUC did not wholly adopt the intervenor's recommendations.[19]

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.[20]

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."[21]

j. Have disallowed time where the "hours seem excessive" or the "proposal is not persuasive,"[22] and have changed or disallowed compensation amounts requested for the following reasons:[23] "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."

6.7. HOURLY RATE DETERMINATIONS UNDER THE PUC PROGRAM

A recent PUC Decision[24] approved and adopted hourly rates within the following ranges for 2006:

For attorneys: $170, $175, $190, $210, $250, $260, $285, $310, $325, $335, $360, $375, $400, $405, $425, $435, and $505.

For non-attorney, policy experts: $110, $150, $340, and $360.

Another PUC Decision[25] provided the following examples of "recently adopted non-attorney rates and years of professional experience (as provided by an expert seeking a rate increase).

---

[19] D.06-11-031 (November 30, 2006), p. 10.
[20] 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.
[21] D.06-11-031 (November 30, 2006), pp. 14 -15.
[22] D.06-11-032 (November 30, 2006), pp. 9 - 10.
[23] D.06-11-009 (November 9, 2006), Appendix p. 1.
[24] Id. at pp. 30-31.

Non-attorney Hourly Rates

Experience (years)	Year Work Performed	Hourly Rate
16	2003	$215
12	2005	$130
12	2003-2005	$180
5	2005	$120
7	2005	$120
12	2005	$150
8	2005-2006	$150

Until PUC Decision R.04-10-010 in 2004, the PUC set hourly rates for intervenors in a piecemeal manner –i.e., for each proceeding, the PUC might revisit the reasonableness of the hourly rate for each intervenor and each appearance by a particular representative of an intervenor. 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.[26] 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.[27]

In an Interim Opinion on Updating Hourly Rates,[28] 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.[29] 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

[25] D.06-11-032 (November 30, 2006), pp. 11 – 12.
[26] PUC Order Instituting Rulemaking R.06-08-019 (August 24, 2006), p. 2.
[27] Id. at pp. 2-3.
[28] D.07-01-009 (January 11, 2007)(part of Rulemaking R.06-08-019).
[29] Id. at pp. 1, 3-4.

of their representatives in order to justify the requested rates.[30] (Emphasis added).

The following table shows the PUC's adopted ranges for work performed by intervenor representatives in 2006 and 2007. The rate ranges for attorneys and non-attorney experts are based on levels of applicable experience.

Hourly Intervenor Rate Ranges for 2006 and 2007[31]

(For 2006, rates adopted in D.05-11-031 x 3%, rounded to nearest $5)
(For 2007, rates adopted for 2006 x 3%, rounded to nearest $5)

Years of Experience	2006 Range	2007 Range
Attorneys:		
0 - 2	$140 - $195	$145 - $200
3 - 4	$190 - $225	$195 - $230
5 - 7	$260 - $280	$270 - $290
8 - 12	$280 - $335	$290 - $345
13+	$280 - $505	$290 - $520
Experts:		
All	$115 - $370	
0 - 6		$120 - $180
7 - 12		$150 - $260
13+		$150 - $380

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.[32] The PUC based its 3% COLA adjustments on the Social Security Administration's

[30] Id. at p. 5.
[31] Id. at pp. 8 - 9.

COLA, which is released annually in late fall, and reliance thereon would be consistent with a calendar year adjustment of hourly rates.[33]

6.8. DETERMINATION OF MARKET VALUE HOURLY RATE

HEALTH ACCESS claims advocacy and witness fees for two non-attorney experts,[34] both at the hourly rate of $500.00. Compared to the PUC's adopted hourly intervenor rate ranges for 2006 and 2007, the highest rate for non-attorney experts for 2006 is $370 and for 2007 is $380. Therefore, it appears that the $500.00 hourly rate claimed by HEALTH ACCESS exceeds "Market Rate" as defined in 28 CCR § 1010(b), discussed above.

Fees claimed may be adjusted to reflect Market Rate. "The hearing officer shall issue a written decision that ... shall determine the amount if compensation to be paid, which may be all or part of the amount claimed." 28 CCR § 1010(e)(7).

Each of the experts for which fees are claimed is described by HEALTH ACCESS as a "Health Care Policy Expert." The credentials provided indicate that: one expert has a Ph.D. in political science from the University of California at Berkeley and has approximately 30 years of experience working in the California Legislature, California Administrations, and for various interest groups; and the other expert has a B.A. from the University of Redlands, has approximately 10 years (7/22/93 – 1/3/06) of experience with the Centers for Medicare and Medicaid Services (CMS), including 8 years (8/20/95 – 1/3/03) as the Region IX Administrator for CMS, has approximately 8 years of administrative experience with the Social Security Administration, including 4 years as a District Manager for the Social Security Administration, and one year (1/13/06 – present) of experience representing consumers as Project Director with HEALTH ACCESS.

The PUC adopted 2006 rate range for experts is $115 - $370. Based on their experience, it appears that both experts are in the third tier (13+ years of experience) of the PUC adopted 2007 rate ranges, where the range is $150 - $380 per hour.

The Hearing Officer finds that the hourly rates requested by HEALTH ACCESS exceed Market Rates and therefore will be adjusted. For the expert providing 17.5 hours of services, the Hearing Officer finds that $370 per hour is consistent with Market Rate for the

---

[32] Id. at p. 9.

[33] Id. at pp. 4 and 11.

[34] It appears that the Executive Director of HEALTH ACCESS provided advocacy and/or witness services which could have been considered for compensation. However, HEALTH ACCESS did not claim any fees for those services, and therefore, such compensation cannot be considered or awarded.

services provided in 2006. For the expert providing 8 hours of services, the Hearing Officer finds that $370 per hour is consistent with Market Rate for the services provided in 2006.

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

7. AWARD

HEALTH ACCESS is awarded Advocacy and Witness Fees as follows:

Professional Expert Fees

First Expert .....17.5 hours @ $370 per hour	=	$6,475.00
Second Expert..... 8.0 hours @ $370 per hour	=	2, 960.00
Total.....	=	**$9,435.00**

8. ASSIGNMENT OF PROCEEDING

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

FINDINGS OF FACT

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

2. HEALTH ACCESS made substantial contributions to Proceeding No. 2002-0019 as described herein.

3. HEALTH ACCESS 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 HEALTH ACCESS is $9,435.00.

CONCLUSIONS OF LAW

1. HEALTH ACCESS 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 for its claimed compensation, as adjusted herein, incurred in making substantial contributions to Proceeding No. 2002-0019 and 28 CCR § 1300.67.24.

2. HEALTH ACCESS should be awarded $9,435.00 for its contribution to Proceeding No. 2002-0019 and 28 CCR § 1300.67.24.

AWARD ORDER

1. HEALTH ACCESS is hereby awarded $9,435.00 as compensation for its substantial contribution to the outpatient prescription drug regulatory Proceeding No. 2002-0019, 28 CCR § 1300.67.24.

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: February 6, 2007

Original Signed by:

STEPHEN A. HANSEN
Hearing Officer
Department of Managed Health Care