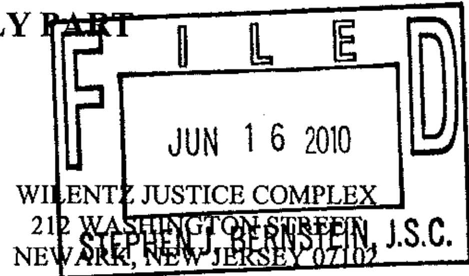
SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION, FAMILY PART
ESSEX VICINAGE

CHAMBERS OF
STEPHEN J. BERNSTEIN, J.S.C.

WILENTZ JUSTICE COMPLEX
212 WASHINGTON STREET
NEWARK, NEW JERSEY 07102



June 16, 2010

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RE: **Sutter v. Horizon Blue Cross Blue Shield of New Jersey**
Docket No. ESX-L-385-02

Dear Counsel:

Enclosed, please find my revised decision in the above referenced matter.

Hon. Stephen J. Bernstein, J.S.C.

Enclosures
CC: John M. Murdock, Esq.
Maxine H. Neuhauser, Esq.
Steven I. Kern, Esq.
Stephen L. Menaker, Esq.
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Neil L. Prupis, Esq.

RE: **Sutter v. Horizon Blue Cross Blue Shield of New Jersey**
Docket No. ESX-L-385-02

THE REVISED OPINION OF THE COURT IN THE ABOVE CAPTIONED MATTER

INTRODUCTION

Pursuant to the remand ordered by the Appellate Division, this Court conducted a testimonial fairness hearing (over the course of five days).[1] This testimonial fairness hearing was conducted after the Objectors were permitted to take discovery of the Settling Parties, involving depositions, the production of documents and the service of expert reports. Objectors were provided the opportunity to cross-examine witnesses presented by the Class and Horizon Blue Cross Blue Shield of New Jersey ("Horizon") and present their own witnesses regarding the value of the proposed Sutter settlement and Class Counsel's fee application.

In 2007, this Court approved the Sutter settlement, finding that it was "fair, reasonable and adequate" under the applicable nine-factor test set forth in Girsh v. Jepson, 521 F.2d 153 (3d Cir. 1975). The Appellate Division directly acknowledged this Court's "extensive review of the settlement." Sutter v. Horizon Blue Cross Blue Shield, 406 N.J. Super. 86, 102 (App. Div. 2009). As a result, this Court's prior review will not be revisited; except to the extent that new evidence has now supplemented the record, this Court's 2007 analysis and findings are incorporated herein.[2]

The Appellate Division ordered that this Court carry out two tasks on remand: (1) conduct a "testimonial hearing, particularly with respect to [Dr. Teresa] Waters"; and (2)

[1] The fairness hearing was conducted on February 2, 2010; February 3, 2010; March 23, 2010; March 26, 2010; and April 16, 2010.
[2] Specifically, this opinion incorporates the 2007 opinion's Facts and Procedural History (Section I), the Adequacy of the Notice (Section II), the Proposed Settlement Agreement (Section III), the Fairness of the Proposed Settlement (Section IV).

"reconsider" the "attorneys' fee award . . . in light of the court's reliance on Waters' valuation of the proposed settlement [and to] consider the reasonableness of the fee in light of the hourly rate." Id, at 102-09. The evidence presented during this remanded testimonial fairness hearing, in conjunction with the record previously developed, establishes that this settlement is "fair, reasonable and adequate" and should be granted final approval. Dr. Waters' conservative valuation credibly and reliably calculated the value of the settlement based on the scientific statistical random sample survey conducted by Mr. Sanderoff's firm, Research and Polling, Inc. ("RPI"). Furthermore, the evidence presented and analyzed under the applicable legal standards establishes that Class Counsel should be awarded attorneys' fees and disbursements of $4,685,285 and that the Class Representative, John I. Sutter, M.D., should be awarded an incentive award of $15,000 for his extensive work on behalf of the Class.

I. FINDINGS OF FACT

During the testimonial fairness hearing, Class Counsel presented the testimony of Teresa M. Waters, Ph.D. ("Dr. Waters"), who was accepted by this Court as an expert in health economics.[3] Dr. Waters testified regarding her valuation of the Sutter settlement; she was the only economist and valuation expert to testify at the hearing. Dr. Waters' valuation was contained in her report dated September 4, 2009. C-1. The Objector's provided no independent evaluation of their own.

[3] Dr. Waters' earned a Ph.D. in economics from Vanderbilt University in 1992 with concentrations in health economics and industrial organization. She was previously on the faculty of Northwestern University and is currently a tenured Associate Professor with the University of Tennessee Health Science Center. As part of her education she has taken numerous courses in statistics, including econometrics. She has previously worked on large projects in the healthcare field involving survey research and has prior experience working with survey research firms to design survey questions. She is well qualified given her educational background and training to value the settlement in this case.

Dr. Waters monetarily valued three specific settlement benefits: (1) the disclosure of significant edits (Section 7.1); (2) the dedicated horizon capitation liaison (Section 7.4); and (3) the availability of fee schedules (Section 7.6).[4] Dr. Waters valued only the settlement agreement provisions to be instated, not what was already on the provider portal at the time of her evaluations. She valued the settlement at not less than $35.01 million, which would correspond to $1,741 per physician over a period of 5 years or $348 per physician per year. C-1.

This Court found that Dr. Waters' valuation and opinions were sufficiently reliable and are therefore admissible. Her valuations were based on surveys that clearly satisfy the criteria of trustworthiness and reliability; they were conducted in accordance with generally accepted survey principles and the results were used in a statistically correct way.

a. <u>Survey Methods Used</u>

In order to value the three aforementioned settlement benefits, Dr. Waters developed two survey questionnaires that were used to poll the most knowledgeable individuals about claims billing at randomly selected physician Class Members' offices. C-1. One survey was for fee for service physician Class Members and the second survey was for physician Class Members who paid a set fee each month for each patient assigned to their "panel," i.e., capitated physicians. C-1.

[4] Dr. Waters also testified that there were numerous other settlement benefits not expressly monetarily valued but that nonetheless were valuable to Class Members and their delivery of streamlined, quality healthcare, including the following: (1) greater notice of policy and procedure changes; (2) rights of Class Members to refuse to accept new Horizon members; (3) limited fee schedule changes; (4) binding nature of medical necessity certifications; (5) pledge not to use Most Favored Nation clauses in contracts; (6) pledge not to use gag clauses; and (7) investments and initiatives to improve provider relations. (H-2). Dr. Waters further testified, via permitted supplemental certification, that the value of the settlement would increase to over $55 million if she factored in that Clear Claim Connection would be in place for 5 years rather than 3 years 2 months.

Dr. Waters was the survey "content expert," preparing the substantive questions to be asked in the survey. The unrebutted testimony of Dr. Waters revealed that it is "perfectly common" for the party undertaking the research to draft the questions and have those questions vetted by the survey researcher (who also serves in a "data collection" capacity). In this matter, Dr. Waters' draft surveys were refined and tested with the assistance of the independent survey research firm, Research Polling, Inc. ("RPI"). This firm also conducted the actual survey over the telephone and collected the data. Once the data was compiled, Dr. Waters received the results, composed a database and developed her valuation. C-1.

Prior to going into the field, the survey questionnaires were reviewed by RPI through an intensive multi-step, pre-testing process designed to ensure that the questions were objectively neutral and understandable. The questionnaires were first scrutinized at an internal quality control meeting. At this meeting, RPI's staff[5] assessed both the understandability of the questions and the accuracy of the survey structure with respect to issues such as skip patterns and layout. Recommendations were also made to keep the language of the questions as neutral as possible and to increase and improve screening questions to ensure that RPI polled the most appropriate person when conducting the survey. Dr. Waters approved RPI's revisions. C-3.

Two pre-tests were then performed. C-3. During the first pre-test, cognitive interviews were conducted. RPI reviewed the draft questions with a number of potential respondents, knowledgeable about claims billing, and asked them whether the questions

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[5] The staff included expert research analysts, designers, statisticians and Brian Sanderoff (president of RPI). Mr. Sanderoff and RPI have over 25 years of survey research experience. RPI has represented major government and private clients and has also performed survey research for several healthcare providers. Based on his extensive background and experience, the Court accepted Mr. Sanderoff, without objection, as an expert in the field of survey research and methodology.

were clear and understandable and whether they accurately conveyed the objective of each question.[6] This informal procedure helped RPI to revise and adjust its screening questions. A second pre-test was then conducted, according to the survey design of a random sample of the population, to again resolve any potential issues with the questions. C-3. No further changes were required as a result of this second pre-test.

Eight experienced RPI professional telephone interviewers, each well trained in interviewing protocol, conducted the surveys. C-3. These individuals received a number of training sessions, which included reviewing and practicing the survey questions and participating in the pre-tests. C-3. During the surveys, the respondents were told that questions would be asked about the value of certain benefits associated with the settlement and that the results would be shared with the Court in determining the value of the settlement. C-1. The party on whose behalf the survey was conducted was not identified.

The survey questionnaires were carefully designed to include initial questioning to ensure that the individual most knowledgeable about billing practices would provide answers to the survey questions. C-3. As a result, when a physician's office was called the interviewer requested to speak to the representative most appropriate to answer questions regarding claims billing. C-1. In the event this representative was not available, RPI called back later. If it turned out that the designated person was incapable of answering the survey questions, RPI requested that the office refer RPI to the correct person and proceeded to question that individual. If the physician group outsourced its billing, the person at the billing company most knowledgeable about that physician group's billing was questioned.

[6] None of the participants in the first pre-test took part in the actual "live" survey.

The survey questions were designed to obtain responses regarding prospective time-savings, if any. C-1. Prospective estimates are regularly used in survey research, and both governmental and private entities rely on such surveys to undertake future planning and forecasting. Survey respondents were allowed to give "don't know" as a response if they could not answer a question. In addition, because some settlement provisions had already been implemented while others were not, neutral and uniform questions were used to avoid confusing the respondents.

The methods RPI used during all phases of its study were "scientifically sound and align[ed] with professional public opinion survey research approaches and practices." C-3. The Objectors introduced no evidence to contradict this conclusion.

b. Valuation of Significant Edits

In 2007, this Court expressly observed that as part of the implementation of Significant Edits Horizon agreed to "the posting of CPT and HCPCS level II codes that result in the reduction or denial of payment [that] will allow doctors to more easily determine whether they have been reimbursed properly and to decide how certain procedures they may be interested in performing will be reimbursed by Horizon." This is an important benefit to Class Members because understanding how claims are processed enables physicians and their offices to save time that would otherwise be spent chasing down payments from Horizon and to devote that time to more important matters involving patient care.[7] In addition, this settlement provision (as with most of the other provisions) was intended to make the claims handling process more transparent.

[7] It is not disputed that Clear Claim Connection will be the mechanism by which Class Members can plug in procedure code combinations in order to determine how their codes will be paid or denied and the reason for that claims processing, and is thus consistent with what Horizon agreed to implement as part of Significant Edits.

Based on the survey response data, Significant Edits will result in median clerical/office staff time-savings of 120 hours per practice per year. C-1. In order to value these savings, Dr. Waters applied wage and fringe benefit rates to convert the hourly savings into dollars. Dr. Waters also used the average New Jersey wage rate for a medical assistant based on data compiled by the Bureau of Labor Statistics because that was the job description that most closely matched the work performed by the physicians' office clerical personnel. C-1. Dr. Waters then used New Jersey specific data from the Bureau of Labor Statistics National Compensation Survey to obtain the appropriate fringe benefit rate. C-1. In order to determine the benefit for each individual physician, Dr. Waters had to ascertain the average number of physicians in each practice group. She determined that there are 4.2 physicians per group based on New Jersey estimates from 1998 American Medical Association ("AMA") data, which was the most recently available data for New Jersey. C-1. Moreover, to determine the Class-wide value of Significant Edits, Dr. Waters multiplied her calculation by 18,645, the total number of fee for service Class Members. C-1. Finally, because the benefit associated with Significant Edits would occur over an extended period of time, Dr. Waters had to calculate the present value of the benefit. She used the 30-year Treasury bill rate of 4.38 percent. C-1. The Objectors did not object to any of these calculations other than Dr. Waters' use of 4.2 physicians per New Jersey practice group. However, as discussed later, had Dr. Waters used more recent national averages, her valuation would only have increased.

Based on the foregoing information, Dr. Waters calculated that the implementation of Significant Edits had a value to the Class of $31.23 million. C-1.

Furthermore, because Significant Edits will be in place for at least 5 years once Clear Claim Connection is "live," the Class was allowed to submit, without any additional testimony, an adjusted value of Significant Edits. According to Dr. Waters, the adjusted calculation is $51.3 million.

c. Valuation of the Dedicated Capitation Liaison

Dr. Waters calculated the value of the Capitation Liaison using substantially the same methodology employed to determine the value of Significant Edits. She based the calculation on the number of capitated providers in the Class, totaling 1,464. Respondents were asked whether the liaison would save time and if so to estimate the time-savings. Respondents were also asked whether the liaison would increase Horizon capitation payments into the practice, the number of additional patients that would be added to the "panel" and the average dollar amount received per capitated patient per month. Based on the survey response data, Dr. Waters calculated median clerical/office time-savings of 87 hours per practice per year and an increase in capitation revenue of $720 per practice per year. C-1. Dr. Waters computed the total value of the Capitation Liaison to be $3.78 million. C-1.

d. Valuation of Disclosure of Fee Schedules

Dr. Waters calculated the value of the disclosure of complete fee schedules on the provider portal using substantially the same methodology employed to determine the value of the other benefits. Significantly, although 56.5% of the respondents believed that disclosure of complete fee schedules would save administrative time, ranging from 1.13 hours to over 400 hours for clerks annually, Dr. Waters conservatively valued this

provision at $0 because the median response for each category (i.e., clerical, nurses, physicians etc.) was 0. C-1.

e. Savings to Third-Party Billing Companies "Pass Through" to Class Members

Dr. Waters' valuation is solidly grounded in established fundamental economic theory, demonstrating that in a competitive industry a business is compelled to pass along its savings to its customers. Dr. Waters' unchallenged testimony was that the billing company industry is very competitive in New Jersey and numerous such enetited are available for customers. Dr. Waters explained that if a physician's office used an outside billing company, the benefit of the savings to the billing company would be passed onto the physician Class Member's office. The Objectors' own expert, Ruth Harris, an owner of a third-party billing company, corroborated Dr. Waters' opinion that billing company savings would "pass through" to physician Class Member clients.

f. Realization of Savings to Class Members

Dr. Waters explained that, as a result of Significant Edits, if a physician's practice saved 10 hours per month (120 hours per year) in clerical time, that physician's office would realize an economic benefit in different ways. For example, if its clerks were paid hourly, the practice could reduce the number of hours worked by the clerks. Alternatively, the practice could assign its clerks to other tasks that were valuable to the practice. The value of these tasks would be appropriately measured by the amount the practice paid its clerks for the amount of time involved.

Testimony of survey respondents, proffered by the Objectors as witnesses, corroborated Dr. Waters' economic analysis. One witness testified that time savings would enable her office to ". . . increase our revenues because we can work on other

claims from Horizon that are not being processed." Another testified that saving time could enable him to devote personnel to other resources and that, given current budget issues, if there was less work to do, the amount of employees he had on staff could be reduced. A third witness likewise acknowledged that if there were time savings their office would save on staff because less people would be needed to deal with Horizon on billing issues.

g. **Objectors' Expert**

The Objectors' sole expert, Ruth Harris,[8] testified that Horizon failed to adequately communicate the Sutter settlement business reforms to the physician community. This conclusion was based only on her companies experience and answers to the survey questions. Despite her impressions regarding Horizon's communication of specific reforms, Ms. Harris acknowledged that she has never read the settlement agreement and unaware of all the reforms it encompasses. In fact, of all the business reforms proposed by the settlement agreement, she only rendered an opinion as to Horizon communicating code combinations, capitation and fee scheduling.

Ms. Harris' ultimately agreed that the Significant Edits and Capitation Liaison are valuable and would result in administrative time-savings to physicians dealing with Horizon billing problems. The fact that Ms. Harris' testimony only dealt with a limited number of business reforms undercut her testimony's persuasiveness. If anything, Ms. Harris' testimony supported the proposition that this settlement has value.

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[8] Ms. Harris works as the Managing Partner of Source One Medical Management (SOMM), which is a full service Practice Management, Revenue Management, Billing, Consulting and Staffing firm. Ms. Harris actively works with physician and hospital based groups of all sizes as well as a wide range off specialties. Her roll is to assist clients in day to day operation to improve workflow, cash flow, and the overall operations of a practice. Ms. Harris has been in the healthcare field for more than 20 years and affiliated with SOMM since 1997, when she founded the company.

h. Effect of Dr. Waters' Conservative Methodology on Her Overall Valuation

Dr. Waters employed a highly conservative methodology in valuing the settlement. Most significantly, to eliminate the influence of high and low outliers, she used arithmetic medians instead of means, even though the latter method would have been an acceptable methodology. This is significant because had means been used, the time-savings would have jumped considerably in each personnel category (i.e., clerical, nurses, physicians, etc.) and there would have been more personnel categories included in the valuation. Thus, the overall monetary valuation would have substantially increased. In addition, Dr. Waters could have computed a still higher value if she had assumed that certain benefits would have remained open for an infinite time as Horizon indicated it had no intention of terminating the benefits after the expiration of the Settlement Agreement. Dr. Waters also conservatively assumed there were 4.2 physicians per practice group based on the most recent AMA data for New Jersey. Dr. Waters could have used more recent national data, as Objectors advocated. However, the data urged by the Objectors would have resulted in doubling the value of Significant Edits. Finally, Dr. Waters valued the settlement at the group practice rather than the physician level. Had she calculated value at the physician level, the monetary valuation would have been still even greater.

It should be noted that on the last day of this hearing, Objector counsel introduced into evidence 400+ survey responses to determine the typical physician practice size in New Jersey. The Objectors' contention that average practice size could be based on the responses to this survey is rejected for several reasons. First, the incontrovertible testimony from the Class' experts was that the survey questionnaire was designed and

tested solely to ensure that it obtained accurate information from respondents about their evaluation of certain settlement benefits and the time-savings associated with those benefits; the survey was not designed to determine practice size. Although some demographic information was obtained in the course of the survey, the Objectors presented no expert to opine that the average New Jersey group practice size could be determined by examining limited data that was incidental to the survey's designed and tested purpose. Mr. Sanderoff, the survey researcher, even testified that the average practice size could not be determined from the survey. He testified that any inquiry on this issue should have been directed to Dr. Waters; the Objectors never questioned Dr. Waters on this issue.

i. <u>Health Economists Regularly Rely on Survey Research Data</u>

Dr. Waters testified that survey research data is the type of data that health economists regularly rely upon to do their professional work. Moreover, health economists regularly undertake survey research to estimate time-savings by physicians' offices dealing with health claims. Dr. Waters also cited to an article published by Casalino in <u>Health Affairs</u>, an important health policy journal that, like this case, used surveys of physicians and physicians' administrators to estimate interactions with health plans and the costs involved.

j. <u>Statistically Significant Random Samples Were Used in the Surveys</u>

The surveys utilized to value the settlement were scientifically and statistically valid. For fee for service physicians, the New Jersey Board of Medical Examiners' list of licensed physicians was used to obtain a sampling frame. C-1. For capitated physicians, information from Horizon's HMO directory was used to obtain a sampling frame. C-1.

RPI then utilized computerized random number generators to draw the random samples from the sampling frames for each of the two categories of physicians. C-1. A sample size of at least 200 was chosen for each survey, which is a sufficient number to provide statistically reliable information. C-1. RPI ultimately completed 216 fee for service and 212 capitation surveys. C-3. A survey was completed for any physician that was randomly selected even if two or more randomly selected physicians were part of the same group practice.[9]

A sample size of 200 generates a maximum margin of error of approximately +/- 6.8% at a 95% confidence level. This means that in 95 out of 100 cases the results from the sample of 200 are within 6.8% of the results that would have been obtained if the entire population had been surveyed. C-3. Thus, the results are "generalizable" over the entire population to a "high degree of certainty." C-3. A 95% confidence level is "very standard" and +/- 6.8% margin of error is a "very acceptable level of tolerance of risk error" in survey research. C-3.

Conversely, the evidence presented by the Objectors challenging the Class' valuation was not compelling. First, the Objectors did not undertake any survey of their own; nor did they present any survey research expert. Rather they presented anecdotal testimony from only 6 individuals (despite the Court's granting leave to the Objectors to present at least 10 and perhaps more survey respondents). Four of these witnesses addressed the Capitation Liaison and two addressed Significant Edits. One of these individuals was not even a survey respondent. Significantly, all 6 witnesses testified on cross examination that the Capitation Liaison and Significant Edits provisions were

[9] Accordingly, if a practice location was contacted more than once a "replicate" survey was completed based on the answers provided to the original survey conducted with the practice location. C-3.

valuable. Regardless, the testimony presented by the Objectors, even if accepted in a light most favorable to them, is statistically insignificant and cannot be "generalized" over the entire population.[10]

II. Conclusions of Law

As previously stated, this Court approved the Sutter settlement in 2007, finding that it was "fair, reasonable and adequate" under the applicable nine-factor test set forth in Girsh v. Jepson, 521 F.2d 153 (3d Cir. 1975). The Appellate Division directly acknowledged this Court's "extensive" review of Sutter settlement matter and maintained this Courts' approval. Sutter v. Horizon Blue Cross Blue Shield, 406 N.J. Super. 86, 102, 109 (App. Div. 2009). Therefore, this opinion incorporates herein the February 2007 opinion and focuses on the issues of concern to the Appellate Division.

a. The Settlement is Fair and Reasonable

The Sutter settlement entails real changes to Horizon's business practices, requiring an investment of money, personnel and resources. From disclosing fee schedules to providing a capitation liaison, the testimony presented was that those two features of the settlement had a value of at least $35.01 million. C-1. While Objectors contend that the business reforms stipulated in this settlement have no value because they are already mandated by statute, this Court find that the settlement's significant reforms are not adequately provided for in any existing law.

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[10] See Schering Corp. v. Pfizer, Inc., 189 F.3d 218, 237 (2d Cir. 1999). In this matter, the Second Circuit held,

> "[t]he alternatives of having a much smaller section of the public testify . . . or using expert witnesses to testify . . . are clearly not as valuable [as a scientific sample] because the inferences which can be drawn from such testimony to [the statistical facts sought to be proven] are not as strong or as direct as the justifiable inferences from a scientific survey."

Id.

1. Disclosure of Significant Edits

This provision in the Settlement Agreement requires Horizon to post on its provider website, and to update annually, all Significant Edits that result in a denial or reduction of payment for any such codes where such an adjustment is made more than 250 times per year. When Horizon edits a claim, it becomes very difficult for physicians to reconcile the payments they receive with the claims they have submitted and to determine whether or not an appropriate payment has been made. This provision will save significant administrative time because physicians' office staff will no longer spend time "chasing down" payment on edited claims and will be in a position to simplify or streamline the services provided to, and the claims involving, Horizon patients.

The Objectors contend that Horizon is already required to post Significant Edits pursuant to the Health Claims Authorization Processing and Payment Act ("HCAPPA"), codified in N.J.S.A. § 17B:30-51(a). The Objectors are incorrect. In pertinent part, HCAPPA requires Horizon to provide,

> the following information concerning utilization management and the processing and payment of claims . . . : (1) "a description of the source of all commercially produced clinical criteria guidelines . . . ; (2) a list of the material, documents or other information required to be submitted . . . with a claim; (3) a description of claims for which the submission of additional documentation or information is required for the adjudication of a claim . . . ; and (4) the payer's policy or procedure for reducing the payment for a duplicate or subsequent service provided by a health care provider on the same date of service . . . .

N.J.S.A. § 17B:30-51(a).

Subsections (1) through (3) are irrelevant to the posting of Significant Edits; such edits are not used to determine "medical necessity," nor are they used to determine

"clinical criteria guidelines." Rather, Significant Edits are used by Horizon to reduce or deny payment to doctors in order to save the carrier money.

The only subsection of the law that may have any bearing on this business reform is subsection (4). However, even a cursory plain reading of that subsection makes it perfectly clear that all that Horizon would be required to disclose under HCAPPA is its macro-level "policy or procedure for reducing the payment for a duplicate or subsequent service" provided on the same day. The law does not require Horizon to disclose the actual edits themselves that are included in such "policy or procedure." Further, HCAPPA would require, at the very most, the disclosure of only a small number of policies (again, not the edits themselves), where payment is reduced when a duplicate or subsequent service was provided on the same date of service. In contrast, this settlement requires Horizon to disclose to doctors thousands of very specific automated adjustments the carrier makes on their claims, particularly when multiple medical procedures were conducted, to reduce or deny payment (HCAPPA only makes reference to "reducing the payment") by allowing Class Members to query these code edits in Horizon's provider portal database.

Furthermore this law became effective on July 11, 2006. There are no adopted regulations implementing it, and the law has not been interpreted by any court or regulatory body. Given the infancy of the HCAPPA, what business reforms that statute directly mandates is unclear. However, as a result of the comprehensive and specific provisions that have been incorporated into this settlement agreement, this uncertainty has been removed; there is no ambiguity as to what Horizon must do and how it should do it. It should be noted that absent this settlement agreement, there is no clear

enforcement mechanism to ensure that Horizon discloses their Significant Edits nor any interpretation that there was to be a private right of action to enforce a violation of the regulation.

This Court finds that the Significant Edits settlement provision has real value, exceeding any vague statutory mandates.

2. Capitation Reporting and Dedicated Horizon Capitation Liaison

Horizon is required under Section 7.3 of the Settlement Agreement to provide detailed capitation reports that will enable physicians that receive capitation (i.e., a set dollar figure per month for each patient) to ensure that they are getting the money that is due to them and reconcile such payments each month. Section 7.4 requires that Horizon establish an e-mail address for physicians to communicate with a dedicated Horizon capitation professional who will be directly responsible for resolving common capitation issues and payment inquiries. Section 7.4 also requires Horizon to fully respond to at least 90% of such inquiries within 10 business days and the liaison must make best efforts to facilitate the prompt payment of any capitation payments due and owing to physicians.

In approving this settlement in 2007, the Court recognized the value of the Dedicated Capitation Liaison. In addition, the Objectors' expert, Ms. Harris, conceded that the Dedicated Capitation Liaison is valuable to Class Members. There are no existing statutory or regulatory requirements as to either capitation reporting or the dedicated capitation liaison. There is also no existing Horizon policy or provision in any of its provider agreements requiring the institution of the dedicated capitation liaison. Therefore this Court finds that this new business practice is valuable to the Class. The

major criticism of this provision was more in line with promoting the available of the liaison to handle problems.

3. Availability of Fee Schedules

Under this settlement provision, Horizon shall provide participating physicians "complete fee information showing the applicable fee schedule amounts" for typical CPT and HCPCS Level II codes billed by that physicians' specialty within 15 days of such a request. Furthermore, this provision allows a physician to request as many as 100 other codes each year that the physician actually bills or anticipates billing Horizon. The "complete fee information" will be provided to the doctor on paper or electronically. Moreover, in accordance with the agreement, Horizon has now posted the fee schedules on its provider website.

Current New Jersey law, on the other hand, offers significantly less. Pursuant to the HCQA, Horizon is only obligated to provide physicians the fees for 40 commonly used CPT codes (and not HCPCS Level II codes) as determined solely by Horizon. The law does not require Horizon to provide complete fee information for all codes typically billed -- including both CPT and HCPCS Level II codes. Nor does the law require that Horizon honor additional individual requests for other codes, including codes that were never billed by the physician or which the physician anticipates he or she may bill in the future. Moreover, the law does not require that fee schedules be posted on the carrier's website. Because Horizon has now posted complete fee information on its physician website, Class Members have immediate access to their reimbursement rates and can download those reimbursement rates into their practice's management systems for ease of use and reference. These important benefits will enable these Class Members to quickly

determine expected payment for specific services, and when such payment is not made allow these doctors to swiftly track down the missing amounts.

Finally, evidence in this case did not uncover any systemic practice by Horizon to provide complete fee information to physicians. While it is true that there are times when Horizon will provide certain fee information to some physicians, that is not defendant's usual practice, nor is the carrier obligated to do so.

In approving this settlement in 2007, the Court recognized the value of posting on-line fee schedule information. Ms. Harris, Objector's expert, conceded that the on-line posting of fee schedules was valuable to the Class. There is no question that the posting of fee schedule information on the provider portal is a significant benefit to the Class, and is something totally new as a result of the settlement of the Sutter class action.

4. The Love Settlement[11]

Objectors argue that in determining the fairness of this settlement, this Court must take into consideration the Love settlement. At the initial fairness proceedings, all parties recognized that if Sutter had not settled first, a Love settlement could extinguish the Sutter cause of action. However, when the Sutter settlement was approved, a settlement in Love was still uncertain. Objectors now assert that because Love settled (with a settlement agreement encompassing many of the same terms as the Sutter settlement), they are receiving nothing of value in this matter.

[11] On May 22, 2003, the Love lawsuit (in the United States District Court) was initiated against virtually every Blue Cross Blue Shield insurance company, including Horizon. This suit raised largely the same allegations as in this case. A settlement agreement was reached and a Final Order approving the Love settlement, including a bar order, was entered on April 20, 2008, after the Final Order approving the Sutter settlement was issued and Objectors filed their appeal. Objectors did not object to, or opt-out of, the Love settlement.

This court finds Objector's argument unpersuasive. The Love settlement did not exist at the time the Class and Horizon negotiated this settlement, it would be improper to allow Objectors to argue in hindsight that they have received nothing of value because of a subsequent settlement. The interplay between the Sutter settlement and Love settlement is nothing new to the parties and was a risk anticipated during the Sutter settlement negotiation. Furthermore, it could be equally argued that the Love settlement may not have been as valuable had they not copied provisions from the Sutter settlement.

It should be noted that the Love settlement was not a factor that the Appellate Division directed this Court to consider on remand; no party raised this concern before the Appellate Division despite the fact that the Love settlement occurred while the appeal was going on. Nevertheless, if this Court considers any impact of the Love settlement, it would be that the Class is likely to be without any cause of action if this settlement agreement is not approved, because Love potentially extinguishes the Sutter cause of action.

Ultimately, the Love settlement falls outside the parameters of the Appellate Division's remand and does not undercut the fairness of this settlement agreement.

b. Attorney's Fees

Two methods exist for determining class action fees: the lodestar method and the percentage of recovery method. In re Gen. Motors Corp. Pick-Up Truck Fuel Tank Prods. Liab. Litg., 55 F.3d 768, 820-21 (3d Cir.), cert. denied sub nom, GMC v. French, 516 U.S. 824, 116 S. Ct. 88 (1995). Due to the fact that the negotiated relief is business reform and not money, the Appellate Division expressed concern that this case is more akin to a civil rights class action, where a lodestar method is traditionally applied.

Accordingly, this Court has reexamined the application for attorney's fees under the lodestar method. While this court finds that the methodology used in evaluating the dollar value of the business practices to be instituted by Horizon to be valid and reasonable, the court is also mindful of the limitations in these prospective evaluations as opposed to class actions where there is a monetary fund for the class members. Prospective estimates based on survey results are not the type of fixed hard numbers that are available under a negotiated fund settlement.

The fact that the Clear Claim Connection system has not yet been implemented and the exact date of installation has not been provided, clearly adds an element of variability to the equation. While Horizon's counsel has represented that the system would remain in place for no less than 5 years, factors such as start date can affect the present value. Questions also remain as to the methods for making these programs known to all potential users and the extent of utilization. The objectors also argue even if there were a potential for savings in billing, that many of the class members utilize third party billing services and there are questions as to whether those savings will be passed on to the physicians. Contrary to the argument of Dr. Waters, there is probably no such thing as a perfect free-market system and while these savings may result in less expensive third party billing costs one could argue that at least some of these savings will go to the third parties as opposed to all being passed on to the physicians. One could also argue that by making the billing process more transparent and easier to use that more physicians would go back to doing their own billing.

All of these factors make any attempt to assign a reasonably exact number to the value of these business practice changes difficult at best, and suggests to this court that

the lodestar method as opposed to trying to take a percentage of the estimated value is a more appropriate method.

When calculating fees to be awarded under the lodestar method, a "court typically begins its calculation of fees by multiplying the number of hours reasonably spent on the litigation by a reasonable hourly rate." McCown v. City of Fontana, 550 F.3d 918, 922 (9th Cir. 2008). The resulting number is commonly referred to as the "lodestar" amount. City of Riverside v. Rivera, 477 U.S. 561, 568 (1986). The lodestar amount "provides an objective basis on which to make an initial estimate of the value of a lawyer's services. The party seeking an award of fees should submit evidence supporting the hours worked and rates claimed. Where the documentation of hours is inadequate, the district court may reduce the award accordingly." Hensley v. Eckerhart, 461 U.S. 424, 433 (1983). In this case the plaintiff's counsel has presented a reasonably detailed list of hours expended by each participating attorney in the firm. This court having had the benefit of handling the case for many years was aware of the nature and extent of the contested litigation both before the settlement between the original parties and after the settlement with the objectors. With almost 10 years of litigation, this court finds that the detailed number of hours and nature of the services appears reasonable and the court will approve the 5,528 hours as detailed in the certification submitted by class counsel.

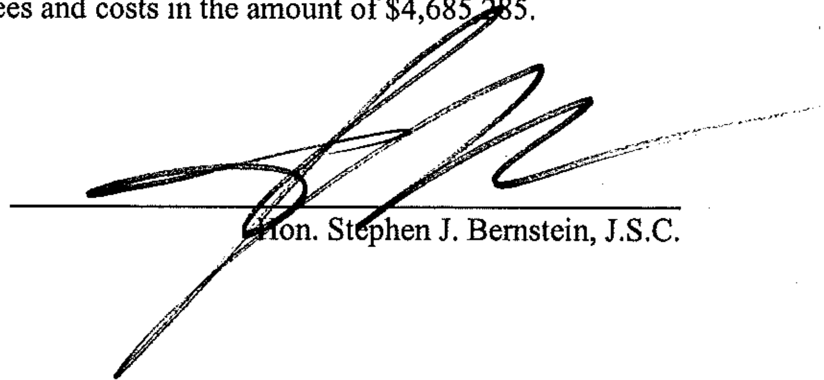
The more difficult task is the assignment of a reasonable hourly rate and determining whether a multiplier is appropriate. Neither party provided comprehensive information in support of what the appropriate lodestar rate should be. However, this court has experience in fee applications and is also familiar with the rates awarded in similar situations by other courts such as the decision in In RE Schering-Plough/Merck

Merger Litigation, which was recently decided. 2010 U.S. Dist. LEXIS 29121 (D.N.J. Mar. 25, 2010). This court took into account the complicated nature of this litigation and the experience and reputation of class counsel's firm and finds that a blended rate of $550 per hour to be appropriate. This court rejects the use of effective rates as argued by class counsel, since these are artificially high rates based on the success of the firm on contingency cases as opposed to usual hourly billing rates. I selected the blended rate since there were a number of attorneys who worked on this matter, but over 75% of the work was done by Mr. Katz and Mr. Mazie who would have commanded rates of at least this level. I did not however assign this rate to the work done by law clerks and allowed $100 per hour for their 117 hours. Using the blended rate of $550 for 5,411 hours and $100 for 117 hours the lodestar becomes $2,987,750.

In this state the case law has suggested that multipliers, when used, should generally be in the 25-35% range. See Rendine v. Pantzer, 141 N.J. 292, 343-344 (N.J. 1995); Hughes v. AT&T Corp., No. A-1166-06T2, 2008 N.J. Super. Unpub. LEXIS 321, at 37-38 (2008); Education Station Day Care Center v. Yellow Book, No. A-1653-05T1, 2007 N.J. Super. Unpub. LEXIS 1607 at 30 (2006); Colon v. City of Newark, No. A-3260-30T2, 2006 N.J. Super Unpub. LEXIS 1094 at 30-31 (2006). Considering that this litigation was contingent, the length of time that class counsel has been involved, and the fact that they expended over $600,000 in out of pocket costs that they risked not recovering, this court believes that a multiplier to enhance the fee is appropriate and that the higher end should be used. Using an enhancement of 35% equates to an adjusted fee of $4,033,463 plus net out-of-pocket expenses which this court approves in the amount of $651,822 for a total of $4,685,285.

CONCLUSION

For the foregoing reasons, Court grants final approval of the settlement and approves Class Counsel attorney's fees and costs in the amount of $4,685,285.



Hon. Stephen J. Bernstein, J.S.C.