

On Your Behalf . . .

Legislative and Practice Affairs Division

Recap of 2004 Legislative Session

By William E. Barnaby, Esq., CSA Legislative Counsel

When the Assembly adjourned Saturday, August 28, at 3:32 a.m., the 2003-04 session of the California Legislature came to a close. Since the two-year session convened in early December 2002, the face of California state government had changed dramatically. Governor Arnold Schwarzenegger had replaced Gray Davis; Senator Don Perata (D-Oakland) had been elected to succeed Senate President Pro Tem John Burton (D-San Francisco); Assembly Speaker Fabian Nuñez (D-Los Angeles) had succeeded Assemblyman Herb Wesson (D-Culver City). Additional new faces will be present after the November election when at least 24 new Assembly Members and 10 new State Senators will be seated (which could include six moving from the Assembly if they all win their races).

Term limits are causing this mass exodus which will force out some of the most powerful and diligent legislators. Besides Burton, whose persuasion and guile made things happen, also gone will be such strong Republican leaders as Jim Brulte (R-Rancho Cucamonga) and Ross Johnson (R-Irvine).

Legislation of Interest to CSA

CSA was directly involved in the fate of a number of bills. A summary and status of several important 2004 legislative issues to CSA follows.

AB 2285 (Chu): Hospitals would have been required, commencing January 1, 2006, to share Medi-Cal eligibility information with hospital-based practitioners who render care to patients during their hospital stay. This would have enabled affected providers to avoid inappropriately billing patients whose care is covered by Medi-Cal and, instead, facilitate direct billing to Medi-Cal. CSA was the main physician organization that helped the Western Center on Law and Poverty gain legislative passage of the bill. Governor Schwarzenegger vetoed the bill, citing pending litigation “over some of the issues relevant to this legislation” and lack of budgeted funding to cover the estimated state cost of \$800,000 to implement the measure.

AB 2389 (Koretz): This CSA-opposed measure would have barred anesthesiologists, radiologists and pathologists from balance billing HMO and other managed care patients for services rendered in hospitals. A few patients who com-

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plained of receiving “surprise” billings mainly from anesthesiologists got the attention of the news media and legislators. The measure was sponsored by health insurance agents and brokers. The managed care industry was only too happy to vigorously support the effort. The goal of the author, Assembly Member Paul Koretz (D-West Hollywood), was to find a consensus solution. When he was finally convinced by the California Medical Association (CMA) and CSA that no consensus was possible, he dropped the bill before taking it to a hearing in the Senate. The issue will be back next year perhaps in legislation sponsored by the Governor’s Department of Managed Health Care (DMHC).

AB 2703 (Runner): Would have required a verbal and written informed consent by patients for elective surgery. The consent would have included a number of elements, such as cost, “known available efficacious alternative forms of treatment,” “expected amount and type of pain,” et cetera. After the impracticality of such requirements was explained, Assembly Member Sharon Runner (R-Lancaster) dropped the bill.

SB 494 (Escutia): Would have re-established a “Medi-Cal lien law.” This would have allowed physicians and other health providers to collect their fees from the judgments or settlements against the at-fault parties who were liable for causing the injuries to victims who happen to be Medi-Cal beneficiaries. Without an effective lien law, medical providers are forced to accept Medi-Cal payments as payment in full (at taxpayer expense), and give a “windfall” (the term used by the State Supreme Court) to auto and other insurers whose policy holders were at fault. In his veto message, the Governor said “this bill proposes a solution that provides for inflated medical and settlement costs.” He also referred to the “inflated cost to the insurance system for these overcharges will be borne by consumers, increasing the likelihood of growing the number of uninsured in this state.” The affected consumers, he should have recognized, are auto insurance policy holders. The term “uninsured” usually refers to people without health coverage, not people who drive without auto liability coverage.

SB 1325 (Kuehl): Will codify in law the rights and obligations of hospital medical staffs vis-à-vis hospital administrations. The bill largely stems from the litigation involving Ventura Community Hospital. As introduced, the bill would have deemed medical staff bylaws as a contractual relationship with the hospital governing body. The final compromise places in statute as duties of the medical staff such functions as the credentialing of practitioners and peer review. Once amended into this form, opposition was removed by the California Healthcare (Hospital) Association. CSA supported SB 1325 throughout the process. It was signed into law by the Governor.

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SB 1569 (Dunn): Would have clarified the right of treating physicians to sue managed care plans for violation of Knox-Keene Act requirements for processing and payment of claims. A recent appellate court decision held that the sole remedy for Knox-Keene Act violations rests with the Department of Managed Health Care (DMHC). Yet DMHC denies it has authority to compel payment. The managed care industry vigorously fought CMA-sponsored SB 1569 at every turn. Nine separate Assembly floor roll calls over a three-day period were necessary to obtain the 41 votes needed for passage. The Senate passed the bill with only one vote to spare. The CSA-supported bill was vetoed. The veto message makes reference to recently adopted regulations of the Department of Managed Health Care (DMHC) which “should be given sufficient time to implement and evaluate them for effectiveness.” In the meantime, the Governor goes on to say “doctors currently have numerous remedies under existing law if plans fail to pay their claims on time, including using the health plans’ dispute resolution system and suing for breach of contract.” The statement seems to miss the point of the appellate court ruling that the exclusive remedy for claims disputes rests with DMHC and that DMHC insists it has no authority to compel payment.

SB 1782 (Aanestad): Expresses legislative intent that the California District Attorneys Association and interested parties, including CSA, develop protocols for interagency investigations related to prescription of pain medications. The CMA-sponsored measure is designed to facilitate communication between the medical and law enforcement communities and the timely return of any patient files seized during related investigations. CSA, among others, urged the Governor to approve the bill and he did.

Workers’ Compensation: After enactment of the “reform package” (SB 899-Poohigian) in April, no further legislation of consequence was actively considered. The issue of Workers’ Compensation Reform dominated legislative attention for much of 2003 and early 2004. Even though the issue lost its impetus after SB 899, it likely will be a hot topic next year. Segments of the medical community, especially CSA, will be active in seeking a physician reimbursement method other than 120 percent of Medicare RBRVS which could be implemented administratively next year. At the same time, the business community is complaining that the 2003-04 changes have not produced the premium reductions expected. Interested parties will be looking at data under “reform” for guidance in terms of 2005 legislation.

State Budget/Medi-Cal

CSA actively participated in the broad provider coalition led by CMA that blocked, through court order, a five percent provider rate cut scheduled to take

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effect January 1, 2004. Another 10 percent cut initially was proposed by Governor Schwarzenegger in the 2004-05 State Budget. This proposed cut was withdrawn by the Governor in May after heavy lobbying by the coalition and patient advocacy groups. He also announced plans for a “Medi-Cal Redesign” aimed at cutting costs by \$1 billion in fiscal 2005-06. Only vague hints of increased use of managed care in Medi-Cal have emerged to date as to what form the “Redesign” may take.

MICRA

No legislation to weaken MICRA surfaced during 2003-04 despite rumors that the Consumer Attorneys of California (CAOC) might try a last minute “sneak” attack. Perhaps the medical liability crisis throughout the nation discouraged CAOC aggression. The situation in crisis states served to highlight the effectiveness of MICRA in California in keeping medical malpractice available and affordable. There are strong indications, however, that an attack on MICRA will be a front-burner issue in 2005.

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Planning Ahead—and Staying in Fair Territory

By David E. Willett, Esq., CSA Legal Counsel

In her President's Page this month, Dr. Mason discusses the unreasonably low fees which will be paid to anesthesiologists if workers' compensation reform is implemented on January 1, 2006, without any change in the formula for reimbursing anesthesiologists. Fees calculated at 120 percent of Medicare are likely to be disastrous for those anesthesiologists who have a substantial workers' compensation case load.

Anesthesiologists, and physicians generally, are reluctant to close their doors to any patients. When this has occurred, the stimulus has usually been inadequate compensation for treating a patient category sufficiently large that providing care becomes unaffordable. Physicians who could routinely donate a day at the county hospital clinic could not survive the impact of an unrelenting flow of Medi-Cal patients, for example.

The scheduled cut in worker's compensation reimbursement may force anesthesiologists to review the economics of their practices. Those anesthesiologists who conclude they cannot afford cuts of this magnitude have the right to decide who they will serve. However, this painful decision making could invite difficult legal entanglements.

Anesthesiologists with a substantial workers' compensation practice, and those anesthesiologists likely to receive those cases if others now providing care withdraw, should review hospital exclusive contracts and contracts with medical groups and payer organizations, to be sure that there is no contractual impediment to implementing a decision to terminate or modify participation in workers' compensation.

Legal concerns arise even before the decision is made, if efforts to secure relief cause anesthesiologists to stray over the antitrust boundaries. That would be the charge if anesthesiologists were to join together in discontinuing, or threatening to discontinue, care for workers' compensation patients. Individual anesthesiologists, or integrated

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Lawyers complaining about legal fees established the law in this area. In 1983, private practice lawyers paid by the District of Columbia for representing indigent criminal defendants in Washington, D. C., agreed not to take any new cases until fees were increased. The plan was implemented, causing chaos in the court system, and fees were then increased. However, the FTC then brought a complaint, alleging an illegal boycott. The lawyers' response was that they were protected by the First Amendment, particularly because the impact of inadequate fees on the criminal justice system was a public concern. The U.S. Supreme Court disagreed, saying that a boycott to secure a civil rights objective, which is lawful, must be distinguished from a boycott to secure an economic advantage. The latter is a naked restraint on price and output, violating the antitrust laws. The lawyers lost.

In that case (*FTC v Superior Court Trial Lawyers Assn.*, 493 U.S. 411, 1990), the lawyers also claimed that the Noerr Pennington privilege protected them. Noerr Pennington is the name of an antitrust case which concluded that otherwise illegal action can be permissible when the purpose of the action is to secure redress or otherwise influence government or political decisions. The Supreme Court refused to apply Noerr Pennington, saying that this protection is not available when the target of the action is higher prices from the government, even though political decisions would be made in making those price increases.

The dialogue which is likely to occur in 2005 about the need to increase intended fees for anesthesiology in workers' compensation is likely to be heated. The discussion will occur at the same time that numerous special interests, some with questionable fealty to these patients, seek to regain what they have lost, and business adamantly opposes any modification of the present formula. Anesthesiology has a legitimate, even compelling, justification for a change in the formula before it is implemented. However, in discussing the situation with employers, employees and the public generally, make it clear that each anesthesiology practice must decide what to do in 2006. Cite the circumstances confronting your own practice. Decisions in fact will vary, as circumstances vary, though the handwriting may be on the wall for many practices. There is a First Amendment right to tell the public, the legislature, and those who will be directly impacted if the system breaks down about the problem which needs fixing. However, it is important to recognize antitrust boundaries. Joint or concerted decisions are over the line. Individual decisions are fair.

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Dustin E. Corcoran, CMA's New VP of Government Relations: "The Torch Has Been Passed to a New Generation"

By William E. Barnaby III, Esq., CSA Legislative Advocate

To repeat an often used phrase from President Kennedy's inaugural speech, "the torch has been passed to a new generation . . ." seems appropriate with the naming of Dustin E. Corcoran as the new CMA Vice President of Government Relations.

In the six years that Dustin has been with CMA he has impressed us with his poise, articulate and agile speaking ability, quick learning of issues, knowledge, innate political sense and the most important asset a lobbyist (or most anyone) can possess—credibility. My father and I obviously are not the only ones to share this opinion as Dustin was voted the "Most Effective Lobbyist Under 40" by *AroundtheCapitol.com* a couple of months ago.

A graduate of American University in Washington, D.C., we noticed Dustin first in 1998 when he worked for CALPAC. Previously, he had lobbied for the Community College League of California.

Due to unexpected staff changes at CMA, Dustin became a lobbyist for CMA in 2000 and was thrust mid-session into the battle for higher Medi-Cal reimbursement rates for physicians. CSA had gained a 20 percent rate increase for OB anesthesia the year before, but CMA had the right person for the job just in, or, "Dustin," time. That year marked the first across-the-board Medi-Cal physician fee increase since 1985.

The first time I observed Dustin's "poise under fire" was during the 2000 Medi-Cal rate increase effort. Another medical specialty lobbyist had rushed to the witness table first and angered the Chair and staff of the Subcommittee with theatrics aimed to impress his client. Dustin was up next for the entire physician community and was able to calm the "ruffled feathers" quickly and coolly. Since that time we have worked well with Dustin and even had hopes to make him part of our business someday.

Steve Thompson was aware of this and continued to give Dustin the most challenging assignments, knowing full well that giving him tough challenges was the best way to keep his talent within CMA.

Unfortunately, Steve was diagnosed with his illness just last June. When Dustin called us to advise that he could not even think about leaving CMA due to Steve's

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condition, we told him our loss was CMA’s gain—not knowing at the time that Steve’s condition was irreversible.

As the 2004 session reached its hectic final stretch, we found ourselves working ever closer with Dustin on issues dealing with managed care, balance billing and medical staff independence.

Besides being well-known by legislators, administrative policy makers, and especially legislative staff, Dustin is respected and well-liked by the entire Capitol community. This includes campaign consultants, professional fundraisers, and fellow lobbyists.

December 6, 2004, was truly a day when the torch was passed. On that date, the last batch of legislators (with a few exceptions) in office when term limits were enacted were replaced by newly sworn legislators.

Steve and Bill Senior were consultants for the legislature at the same time and of the same generation. Dustin and I are of the same generation and have garnered our legislative experience without ever serving in the Capitol, although he is the polished speaker that I strive to become someday. We both desire to make our mentors proud. It will be a daunting task.

We look forward to working with Dustin and his lobbying staff for many years to come. He merits warm congratulations on the promotion, and we anticipate many years of the same close relationship CSA had with CMA when Steve was Chief Lobbyist.

Steve would have wanted to continue working toward an improved healthcare delivery system. We will have our work cut out for us next year and in the foreseeable future.