

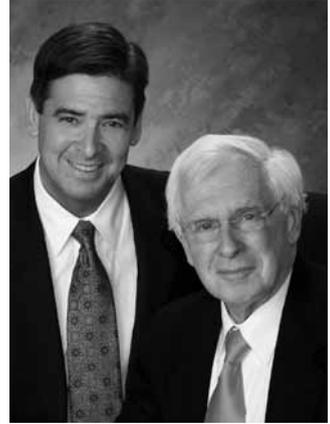
On Your Behalf ...

Legislative and Practice Affairs Division

Election Reform 2012—A New Political Environment?

By William E. Barnaby, Sr., and William E. Barnaby III, CSA Legislative Counsel

The 2012 election could be a seminal event in the evolution of California politics. Taking effect for the first time are two basic electoral reforms, and combined, they could calm the overheated partisanship that has paralyzed state government policy-making for the past several decades.



New Districts and New Ballots

Ending legislative gerrymandering has produced a number of competitive “swing” state legislative and congressional districts that can be won by either party. At the same time, allowing primary election voters to choose candidates without regard to party affiliation will encourage appeals to moderates and independents in the middle of the political spectrum, rather than to the party activists, at the two opposite ends. All candidates will be listed on the same ballot as there no longer will be a separate Democratic or Republican primary ballot. The two candidates receiving the most primary votes will face off in the November election regardless of their party membership. Taken together, citizen redistricting and the open “top two” primary *hopefully* would produce a new environment for cooperative bipartisan problem solving.

Both reforms were put in place by voter-approved ballot measures, and both have survived court challenges. Even so, the new State Senate districts being used for the 2012 election cycle will be the subject of a referendum in the November general election. The Citizen Redistricting Commission’s redrawn Senate maps were upheld by the California Supreme Court in late January before a sufficient number of voter signatures were tabulated to qualify the referendum. If voters were to reject the new Senate maps in November, then the Supreme Court might have to order a special master (an expert appointed by the Supreme Court to carry out an order or an action on behalf of the court, as has occurred in the past to carry out redistricting when legislative remapping was vetoed by a sitting governor) to produce yet another set of Senate

boundaries for future elections. However, some insiders question whether funding this referendum campaign will be possible.

Impact on 2012 Campaigns

The reforms delayed the start of many campaigns. Until all the new districts were confirmed by the January court ruling, many incumbents and other candidates were uncertain which office to seek or even whether to run. Campaign announcements were fast and furious right up to the deadline for filing official candidacy declarations.

One unexpected decision not to seek re-election came from Assembly Member Linda Halderman, M.D. (R–Fresno). Although finishing just her first term in elective office, she has been a forceful and effective voice for physicians. The CSA has been among Dr. Halderman’s strongest supporters and we are disappointed that she has chosen to exit the Legislature. Despite working on health policy as an elected legislator and, earlier as a Senate staff consultant, she felt compelled to return to medical practice.

New Faces in the State Legislature and Congress

The reforms will bring an unprecedented degree of change among state legislative and congressional officeholders. More than half of the 80-member State Assembly will be brand-new lawmakers. Of 40 State Senate seats, as many as 10 could have new occupants. Of the 53-member California congressional delegation, 10 or more incumbents could be gone due to retirements or defeats in newly aligned districts. Some of the departing congressional incumbents are longtime veterans whose seniority and clout will be missed.

Despite their importance to the Golden State, the potentially transformational California electoral changes might be overshadowed by 2012 being a presidential election year. Yet the electoral reforms could result in equally important alterations to the state’s political landscape, as did Proposition 13 (property tax limits) in 1978 and Proposition 20 (state elective office term limits) in 1990.

GASPAC

We interview candidates for state legislative offices. Some of the interviews are conducted independently, others in conjunction with the California Medical Association or the MICRA coalition, the Californians Allied for Patient Protection. The CSA traditionally has not “endorsed” candidates but has evidenced its support through GASPAC contributions. In that connection, CSA/GASPAC member recommendations are invited and are helpful.

Insurance and Indemnity: What Anesthesiologists Need to Know

By Phillip Goldberg, CSA Legal Counsel

Last year California Medical Association (CMA) chief executive Dustin Corcoran sent a letter to Catholic Health Care West (CHW) chief executive Lloyd Dean about troubling provisions CHW was including in its service contracts with hospital-based physicians. One of the provisions was a requirement that hospital-based groups' malpractice coverage limits be increased to \$2 million per claim and \$6 million annual aggregate. The other provision required the hospital-based groups to indemnify the hospital for claims brought against the hospital arising out of the group's conduct. Although the provision on higher malpractice limits is far less common than the contractual indemnity provision, this article will discuss both, and what anesthesia groups can do when presented with a contract that includes either.



Higher Malpractice Coverage Limits

The fact that CHW has even asked for limits of \$2 million/\$6 million indicates that not much thought has been given to the provision, because not all malpractice companies even offer these. The more common higher limits above the standard \$1 million/\$3 million usually are \$2 million/\$4 million. The reason that the hospital asks for the higher ones is obvious: It wants another deep pocket to share the cost of defending and resolving malpractice claims when both the hospital and the hospital-based group are named as defendants.

There are very good economic reasons for declining to accept a higher-limits contract provision. The premium for \$2 million/\$4 million limits is likely to be 20 percent to 30 percent higher than the premium for \$1 million/\$3 million limits. This will hit the group's bottom line immediately. From discussions with underwriters at malpractice companies in California, I understand higher limits are offered but are not necessarily encouraged by the companies. Studies have shown that malpractice claims resulting in payments in excess of \$1 million are rare, although not unheard of. Thus, an anesthesia group may conclude that higher limits impose an additional cost without offering correspondingly greater benefits. On the rare occasion that a hospital contract has included a provision with higher malpractice limits, I have advised my

client to decline to accept the term. Anesthesia groups need to know they have the ability to negotiate hospital contract terms. Although I do not think it is necessary or appropriate to increase limits, an anesthesia group that wants to accommodate the hospital's proposal might agree to accept the higher limits on the condition that the hospital reimburse the additional premium.

Indemnifying the Hospital

Whereas, in my experience, the higher malpractice limits provision in hospital contracts is rare, contractual indemnity provisions are almost universal, and further, hospitals are less willing to eliminate indemnity provisions altogether. Although increased limits create an immediate and certain cost to the anesthesia group, the contractual indemnity provision creates only a potential cost, but one that could be significantly greater. The risk that the group assumes with the contractual indemnity provision is best explained by way of an example. Consider the situation where a bad outcome occurs, and a lawsuit ensues with both the group and the hospital as defendants. If the case proceeds to a judgment where the hospital is exonerated but the group is found liable, then the hospital may well have incurred costs of \$200,000 or more in successfully defending itself. If the anesthesia group has a contractual indemnity obligation to the hospital, it may find itself presented with a bill for the hospital's costs. If the group passes that bill to its own malpractice company, then the claim will be denied as a contractually assumed indemnity obligation. The exclusion for contractual indemnity is virtually universal in professional liability policies because it necessarily increases the risk insured. This means that the contractual indemnity provision makes the anesthesia group assume a potential liability against which it cannot effectively insure.

In my experience, contractually assumed indemnity provisions are often mutual. That is, the hospital agrees to defend, indemnify and hold the group harmless where the hospital is the cause of the claim, just as the group agrees to do so for the hospital when the situation is reversed. This does not make the provision more fair and even-handed. Most physician malpractice coverage is "first dollar" coverage, so that all costs of defense and indemnity payments within limits are paid by the insurance company, while the insured group pays nothing. By contrast, most hospitals have either self-insured programs, where they may pay most or all of the costs of defense and payments to claimants, or high deductibles or self-retention amounts. Accordingly, the hospital is much more likely to have an incentive to make the indemnity demand on the anesthesia group than the other way around. The anesthesia group, by contrast, has no practical benefit from the indemnity claim against the hospital. Anesthesia groups confronted with a contractually assumed indemnity provision might simply suggest that both parties rely on their

own insurance coverage to provide defense and indemnity for both valid and specious claims, and not look to each other to serve as insurance companies.

The leverage that an anesthesia group has with the hospital in contract negotiations varies significantly from contract to contract and hospital to hospital. There are a multitude of factors that need to be considered when increased limits or contractual indemnity are included in the contract the hospital presents to a group. Anesthesia groups need to understand they have the right to negotiate terms with the hospital and need to consider how important the insurance and indemnity provisions can be.

Report from the Legislative and Practice Affairs Division (LPAD)

By Paul Yost, M.D., Chair, Legislative and Practice Affairs Division

Federal Issues

The more things change, the more they stay the same: The Sustainable Growth Rate (SGR)—which has to be the greatest oxymoron, because it is neither sustainable nor a growth rate—remains in place. The U.S. Congress passed up another opportunity to permanently repeal the SGR in favor of passing another temporary 10-month “doc fix.” This latest act of kicking the can down the road averts the 27 percent cut to physician payments, for now. However, until Congress repeals the SGR, we will have to continue to discuss this issue.



On a related matter, the bill to repeal the Independent Payment Advisory Board (IPAB—a group of non-elected, unaccountable individuals who will decide upon future Medicare cuts, with minimal, if any Congressional oversight) portion of “Obamacare” passed out of the House of Representatives in late March on a highly partisan vote (seven Democrats voted with the Republicans), and almost certainly will not be approved by the Democratic-controlled Senate. The ASA has supported repeal of the IPAB and is a strong advocate for H.R. 452, “The Medicare Decisions Accountability Act.”

State Issues

U.S. District Court Judge Christina Snyder blocked the State of California from implementing a 10 percent MediCal reimbursement rate cut to physicians and

hospitals. The CMA successfully argued that decreasing the already abysmally low MediCal payments would further harm access to care for California's most vulnerable population.

LPAD Meetings

At a meeting in late 2011, we discussed a situation in which a national anesthesia provider replaced an existing anesthesia group. Dr. Keith Chamberlin has written an excellent article on this matter that appears in this *Bulletin* (see pages 28–32). In January, we discussed a disturbing trend of hospital systems requiring hospital-based physician groups to increase their medical malpractice coverage limits from the current standard of \$1 million/occurrence and \$3 million/year to \$2 million and \$6 million respectively (see the excellent piece on this matter by CSA Legal Counsel Phillip Goldberg, preceding).

Website Update

I hope you will visit the “Practice Resources” section of the website, which we continue to expand. Note that in addition to providing many useful documents, it has open groups containing discussions of key issues.

***CSA Bulletin* Cover for Volume 61, Number 2 “Bird and Blossoms”**

The cover photograph of this *Bulletin* issue was taken in the photographer's backyard in 2012. The birds were flying in and out of the the fruit tree for hours. The image was captured with a Canon 7D DSLR and processed in Photoshop and Silver Efex Pro.

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