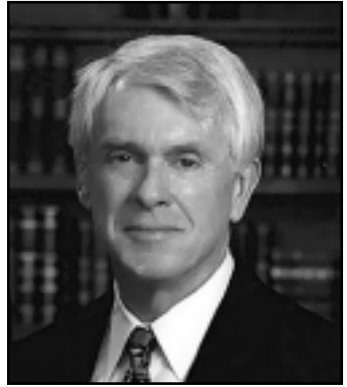


On Your Behalf ...

Legislative and Practice Affairs Division

Election Year Session: Bad Medicine for Legislation?

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



Conventional wisdom once dictated that legislative sessions during election years produce little lawmaking of significance. Too much political rhetoric, partisanship, and time devoted to campaigning. To some extent that remains true.

Here in California, however, a unique solution has taken hold. Every year is election year! California may not be the land of the endless summer, but it **is** the land of the endless campaign. For voters, there is no “off-year” any more. Nor for office holders and a seemingly endless supply of candidates, who solicit campaign donations incessantly. Nor for campaign managers, political consultants, professional fundraisers, petition circulators, opinion pollsters and public relations experts who drive and profit from the well-oiled government merry-go-round.

Voters will be besieged by statewide campaigning and beseeched to go to the polls for a fifth consecutive year in 2006. Following the Democratic sweep in 2002, the 2003 recall election replaced Gray Davis with Arnold Schwarzenegger as Governor; 2004 had “normal” primary and general elections for 100 state legislative and 54 U.S. Congressional seats plus 20 ballot propositions. 2005 will be remembered for the ill-fated “special election” burial of eight propositions under a \$300 million avalanche of campaign hoopla. The business of elections has been booming.

So what does this mean for the business of lawmaking? Funding competing programs and interests amid a continuing state budget deficit will be a challenge—especially because 2006 seems to be the Year of the Infrastructure. Competing interests in California’s diverse economy will be seeking, as always, to improve their standing. Healthcare issues abound. Ditto for the environment, education, criminal justice, disaster planning and a wide array of issues that demand annual legislative attention. Will the 2006 Legislature be able to cope?

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Crank into the equation the impact of legislative term limits. Of 80 Assembly seats, 36 will change hands (but not parties). Of these 36, 29 will be vacated due to the expiration of their terms. Another seven incumbent Assembly Members will leave early to run for the State Senate or Congress. None of the 36 “open” Assembly Districts is expected to be won by a candidate from the opposing party so the 48-to-32 Democratic majority likely will hold. For the Assembly, electoral competition essentially will be limited to party primary races.

Assembly primaries frequently attract multiple candidates, sometimes as many as six or seven wannabe legislators in each of several districts. Consequently, coveys of candidates flock to Sacramento to hunt for support. Candidate interviews, “meet and greets” and issue discussions must be sandwiched into calendars and still leave time for advocates, like us, to advance, protect and defend client interests, like yours, in the Capitol.

Similarly, 20 Senate seats are up for election with 12 being vacated by term limits. The two termed districts held by Republicans will be taken easily by incumbent GOP Assembly Members. The same will occur in two of the termed Democratic districts where two former Assembly members face little or no opposition. But the remaining eight seats have attracted 24 present or former Assembly Members in hotly contested primaries. Only two nonlegislators seem to have any chance of breaking into the Senate club. Since term limits took effect, Senate vacancies have been filled by “lower” house members moving up with only rare exceptions.

The one really competitive legislative race out of the 100 taking place is Senate District 34 in Orange County. Republican voter registration recently edged past a former Democratic advantage of 10 percent. A current Assembly Member, Tom Umberg, and a former Assembly Member (now county supervisor), Lou Correa, are vying for the Democratic nomination. Assembly Member Lynn Daucher will be the GOP nominee after her Assembly colleague, Van Tran, dropped (or was pushed) out of the primary. This race promises to be a campaign “money pit.” A GOP win would only trim the Democratic Senate majority to 24 to 16.

Leaving elected office must be hard. Of the 29 termed-out Assembly Members, 25 are running for other offices either in 2006 or 2008 elections. Of the 12 termed-out Senators, 10 are running for another elected office in 2006 or 2008.

Electoral politics have become almost as confusing as major league baseball under free agency. Who is playing for which team at what position? More than

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a scorecard is needed to keep track of the players—or the “electeds” as they’re sometimes called.

The impact of term limits goes even deeper. As legislative seats open, local elected officials—county supervisors, city council members, mayors, and school board trustees—try to move up. And then, if successful, they must be replaced in local elections. The government merry-go-round spins on.

“Democracy may be the worst form of government,” someone famous once said, “but there is none better.” After a late night hearing as a member of the Sacramento County Planning Commission, overheard was a pithy, yet profound, observation. “The trouble with democracy is that it takes too many evenings.” Both quotes are eminently true. Participation is the key to making democracy work.

Government plays a huge role in all our lives. The impact of all these laws, rules and regulations demands participation in the democratic process if only in self-defense. Improving matters calls for a higher level of participation and proactively seizing upon opportunities. It requires diligence and vigilance on our part, backed by an organized and interested CSA membership.

The interests and concerns of CSA members are conveyed to us by the CSA leadership, the district directors, the Legislative and Practice Affairs Division, contacts through the central office and from members directly. This direction guides our activities on issues of interest. Also essential is the political visibility of CSA through the Greater Anesthesia Service Political Action Committee (GASPAC). Blessed with a catchy and memorable name, GASPAC is not one of the bigger PACs, but its careful use of limited funds has earned GASPAC a very visible role on the Sacramento scene. It gives CSA a seat at the table, a voice, in legislative issues of concern.

Will campaign pressures hinder legislative responses to some of the pressing issues facing California this year? Because almost every legislator will be running or planning to run for something, campaign pressures are bound to be a distraction.

Will electioneering partisanship block the bipartisan cooperation essential to effective problem solving? While the outlook for legislative business is uncertain, there has been welcome talk about working together and toning down confrontations.

Yet the election business seems ready for more growth. Governor Schwarzenegger plans a \$120 million reelection campaign with his two Democratic challengers each with starting cash on hand in the \$20 million to

\$25 million range. Most of the big bucks will go to the top spots on the statewide ticket, but large sums will be spent on “down ticket” races and in trying to pick up a legislative seat or two. Or just making the other side spend money on races they would prefer to forego.

Maybe Las Vegas oddsmakers will make book on whether 2006 California campaign spending will top the \$300 million record of 2005. On the “over and under,” my bet is on the over.

Stay tuned. The gains and losses will be tallied in future reports. Finally, be sure to exercise your right to vote. If unsure of what your schedule will be on June 6 or November 7, request an absentee ballot. Voting absentee is easier than ever these days. And by mailing in your ballot up to two weeks before election day, you can ignore all those ubiquitous political TV spots and junk mail.

Anesthesiologist Investment in Surgery Centers

By Phillip Goldberg, Esq., CSA Legal Counsel

Over the last several years there has been a proliferation of ambulatory surgery centers owned by referring physicians. There are a number of explanations for this proliferation, including the fact that surgery centers present an opportunity for physicians to capture facility fees as a supplemental source of income. The financial motivation is enhanced by declining reimbursement for professional services.



Many of the newer surgery centers are developed by companies that specialize in this area. These “promoters” often identify an opportunity for a surgery center venture, scout out a location for the facility, identify the key physician investors, prepare and distribute promotional materials to physician investors, and even offer to manage (or insist on managing) the surgery center once it has been developed, licensed and certified. Many promoters operate nationally and have significant experience in the development and operation of ambulatory surgery centers. By contrast, most physician investors have limited experience in this aspect of the health care delivery system and, for that reason, give great deference to the promoters in matters ranging from the general structure of the surgery center to the details of its organizational documents.

A common provision in the organizational documents of ambulatory surgery centers is one that requires each physician investor to comply with the federal Anti-Fraud and Abuse Statute which prohibits payment or receipt of any consideration in exchange for referring patients covered under federal health care program. (See 42 U.S.C. Section 1320a 7b(b).) Many physicians have some understanding of the Anti-Fraud and Abuse Statute, although confusion and uncertainty about its details and application are common, even among health care attorneys. The potentially broad sweep of the Anti-Fraud and Abuse Statute, coupled with the significant penalties that can be imposed for its violation, led to the adoption of a number of regulatory "safe harbors." Arrangements that fall within these safe harbors will, absent extraordinary circumstances, be deemed to comply with the Anti-Fraud and Abuse Statute. In November of 1999, safe harbor regulations were adopted for physician investment in ambulatory surgery centers.

The specific requirements for fitting within the surgery center safe harbors vary slightly, depending upon whether the surgery center physician investors are in various specialties or a single specialty. Among the requirements for surgery centers owned by physicians in different surgical specialties to fit within the safe harbor, each physician investor must generate at least one-third of his or her medical practice income from outpatient surgical procedures and at least one-third of all outpatient procedures performed by the physician must be performed at the surgery center in which the physician has the ownership interest. (42 C.F.R. Sections 1001.952(r)(3)(ii)-(iii).) The reasoning behind this requirement is that physicians who routinely use the surgery center treat it as an extension of their office practice. (Fed.Reg. at p. 63534; Nov. 19, 1999.)

Safe harbors which **require** referrals are a significant departure from past practices when enforcement authorities frowned upon physician owners referring patients to affiliated ancillary providers. This inconsistency is more easily understood and appreciated when you consider the economics of procedures performed in surgery centers. The cost to federal health care programs for procedures in surgery centers is significantly less than the cost of the same procedures in many other settings. The government does not want to discourage physicians from utilizing the more cost-effective venue for these procedures. This economic policy is evident in the safe harbor requirements that mandate minimum referrals by physician investors to their surgery centers.

Surgery center promoters will sometimes assert that the need to comply with the safe harbors will prevent the surgery center from accepting anesthesiologists as investors. (Sometimes, the aversion to anesthesiologist investors is alleviated to the extent that the anesthesiologist also performs pain procedures and is in a position to help make maximum utilization of the surgery center's

facilities.) Although the anesthesiologist may spend most or all of his or her time providing services at the surgery center, the anesthesiologist will not be engaged in the performance of “procedures,” as that term is defined in the regulations, but in the provision of anesthesia associated with the surgical procedures. This characterization of the anesthesiologist’s services may be correct, but this misses the point.

A detail often omitted from surgery center investment offerings (if not flatly misrepresented) is that **compliance with the safe harbors is not required to comply with applicable law**. The preamble to the safe harbor regulations makes clear that failure to comply strictly with the safe harbors does not mean referrals are illegal. (See Fed. Reg. at p. 63520, Nov. 19, 1999.) The idea that enforcement authorities would investigate or prosecute a physician for making too few referrals is an absurd proposition. Indeed, if an anesthesiologist does not have a pain practice and is not in a position to refer any patients to the surgery center, it is not possible for the anesthesiologist to violate the Anti-Fraud and Abuse Statute since a patient referral is an essential element of the law.

The fact that there are internally inconsistent requirements to meet the regulatory safe harbor for surgery centers also reduces their credibility as a strict requirement. For instance, the terms on which an interest is offered to an investor cannot be tied to previous or expected referrals. (42 C.F.R. Section 1001.951(r)(3)(i).) At the same time, all physician investors must make a certain threshold of referrals to fit within the safe harbor and perform a certain level of outpatient surgical procedures somewhere (whether at your surgery center or somewhere else). Given these contradictory requirements, it would appear you could only meet **all** of the safe harbor requirements by accident.

It is not surprising to find that promoters, indeed other physician investors, hope and expect that physician investors will cooperate in making the surgery center venture successful for everyone. I suspect many promoters welcomed the safe harbors as a basis to insist that only referring physician investors be allowed to invest in the first place and that only those who continue to refer be allowed to hold on to their investments. There is obviously a strong business incentive for promoters to mandate strict compliance with the safe harbor requirements. Accordingly, even if you can convince the promoters and other investors that anesthesiologists, even those who do not perform pain procedures, are not disqualified from investing in the surgery center, this does not mean investment must be offered to anesthesiologists. For those anesthesiologists who do not perform pain procedures and consequently do not refer, the point to be made to the promoter and, more important, to the other physician investors, is that **anesthesiologists are critical to the success of the surgery center**. The point should be made that the promoters will not be making any

patient referrals either. While there continues to be a shortage of anesthesiologists, helping ensure the availability, support and cooperation of well-qualified anesthesiologists should be viewed as very desirable by both the promoters and the surgeon investors.

In summary, anesthesiologists are **not** precluded from investing in surgery centers by the safe harbor regulations, and no other law imposes a flat prohibition on anesthesiologist investment. This is true of surgery centers that are owned exclusively by physicians, those partially owned by promoters, and even those partially owned by hospitals. The anesthesiologists who may legally invest include those who work at the surgery center exclusively, those that work there part time, and even those who do not work at the surgery center at all. Of course, the fact that anesthesiologists may invest does not mean that they must be offered an investment opportunity, or if offered the opportunity, they should take it without hesitation. Every surgery center is different and every surgery center investment is different. If presented with a surgery center investment opportunity, the terms should be examined very carefully, but anesthesiologists **need not be concerned** that the very nature of their medical specialty raises legal issues.

GASPAC—The Greater Anesthesia Service Political Action Committee

By William Barnaby III, Esq., CSA Legislative Advocate

As the late, great Jesse Marvin Unruh, former Speaker of the California State Assembly, once said, “Money is the mother’s milk of politics.” The reason is fairly obvious. In a state the size of California, the only means for a candidate to get his/her message to the voters is through extensive advertising—whether it be TV, radio, print, slate mailers, et cetera. All these media cost money, and lots of it. That is why making political contributions is often referred to as—participating in the “democratic process.”



To effectively advocate, an interest group needs to be respected, have its facts straight and be a part of the “democratic process.” To this end, CSA has GASPAC—the Greater Anesthesia Service Political Action Committee. While one of the smaller PACs in California, it is still very well known due to its

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catchy name and adroit use of its limited funds. Candidates/office holders know that GASPAC is the political action arm of the CSA, not affiliated with Exxon/Mobile, PG&E, or some other petroleum provider. In other words, without GASPAC it would be much harder for CSA to have “a seat at the policy-making table.”

Every anesthesiologist in California owes a “thank you” to the GASPAC donors listed below for assisting CSA’s participation in the “democratic process.” We also thank those listed below and invite every CSA member to become a GASPAC member. If we can do it, so can you!

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