

On Your Behalf ...

Legislative and Practice Affairs Division

What the Election Results Mean for CSA

By William E. Barnaby, Sr., Esq., Legislative Counsel, and William E. Barnaby, Jr., Esq., CSA Legislative Advocate



Elections are over, we hope, for at least 18 months. When the polls closed on Tuesday, November 7, it marked the 8th California statewide election over the last five years, amidst virtually nonstop electioneering hoopla. Voter fatigue was evidenced by a near record low turnout. At the same time, California campaign spending hit record heights, more than \$650 million, and not all the reports are yet filed.

Despite record spending on campaign advertising and high voter interest nationally, registered California voters seemed disinterested, even with a celebrity hero on the ballot. Do incessant and increasingly nasty TV and radio spots, mailboxes stuffed with “hit pieces,” and “robo” telephone calls at dinner-time produce voter cynicism and apathy? Duh!?

The next regularly scheduled statewide election will take place on June 3, 2008. That should mean a respite from electioneering for the general public and CSA members, at least for awhile. In political circles, it simply starts a new campaign finance cycle so incumbents and candidates can start fundraising all over again.

With the votes counted, Governor Arnold Schwarzenegger coasted to an easy re-election, despite Republican registration being just 34 percent of statewide voters. Democrat Phil Angelides ran as the anti-Arnold and simply failed to connect with voters. Even so, Schwarzenegger’s coattails were not strong enough to pull other “down ticket” Republicans to victory.

Republican Steve Poizner reportedly spent \$11 million of his own money to win the Insurance Commissioner’s post, with only 51 percent of the vote. He defeated Lt. Governor Cruz Bustamante who had virtually no money and no visible campaign. Poizner has become well known and respected among Silicon Valley-area physicians, including CSA members, who have come to know him in recent years.

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Not a single State legislative seat changed parties. The most hotly contested legislative race (where more than \$7 million was spent) was in central Orange County's Senate District 34, which was not decided until two weeks after the election. Former Assemblyman and current County Supervisor Lou Correa finally edged out GOP Assemblywoman Lynn Daucher to retain the Democrats' 25 to 15 margin in the Senate.

The 48 to 32 Democratic advantage in the State Assembly remains unchanged, even though 35 brand-new lawmakers will take the seats of departing members of their same party.

Of 53 U.S. House of Representatives districts on the ballot, only one changed hands. Rep. Richard Pombo (R-Tracy) lost to Democrat Jerry McNerney, largely because he was targeted by national environmental groups. Democratic U.S. Senator Diane Feinstein hardly raised a finger in her landslide victory to a third six-year term.

Whether it was the lack of a competitive race for Governor and/or unhappiness with President Bush and the GOP-controlled Congress, registered Republican voters just did not go to the polls in expected numbers. Most independents voted for Democratic candidates—with the exception of Schwarzenegger, who not only was favored by independents, but also got 26 percent of registered Democrats.

Healthcare was not a major issue in any of these races. Perhaps the only race where healthcare was an issue related to Proposition 86, and even there it was muddled. This ballot measure was championed by the California Hospital Association and other health care groups that financed its campaign and whose pet programs stood to receive monies from the sharp increase in tobacco taxes it mandated. Although the largest share of the estimated \$2.1 billion in first-year receipts would have been allocated to emergency and trauma services, the proposed new law would have given hospital administrators added clout in negotiating payment for on-call physician services. This single provision in a lengthy and complex ballot initiative written by CHA resulted in opposition from many county and specialty medical societies. Prop. 86 lost 52 percent to 48 percent, with the \$50 million plus spent by tobacco interests as the biggest factor in its defeat.

Even before the election, Governor Schwarzenegger said 2007 would be the "Year of Health Care" for his new Administration. Exactly how this will play out remains to be seen. In the weeks following the election, the Governor has put in place a four-member team to develop a health reform agenda that will be the centerpiece of his "State of the State" address in January, with legislation

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to follow. Some of the goals and ideas being floated include expanding health insurance coverage but eliminating some mandated benefits; adding more health clinics in schools; reducing errors in surgeries, prescriptions and treatments by encouraging better technology and use of electronic records; addressing obesity rates by encouraging exercise; and calling for “shared responsibility” so that insurers, consumers, government, employers, and healthcare providers all contribute to the plan.

On behalf of CSA, we have met with Herb K. Schultz, the Governor’s Senior Health Policy Advisor, who is heading the reform effort. Our theme was that genuine, not illusory, patient access was the key to any meaningful reform. Pushing more patients on providers increasingly unwilling to accept discounted payments for medically necessary, oftentimes emergency, services is not a workable solution. This led to a discussion of current issues associated with non-contracted services that need to be resolved before a new program is superimposed on an already challenged system. Schultz expressed an interest in working with CSA. He cautioned against getting overly concerned about initial versions of the “plan,” since it will be a “work in progress” that develops over the course of its legislative consideration.

During the course of the lengthy campaign, we met with numerous candidates for open seats, including most of the winners. As part of these “meet and greets,” we explained the interests and concerns of CSA. Returning incumbents already have become acquainted with these matters and with us. CSA and its issues will be widely known as the new 2007-08 Legislature’s members take their oath of office on December 4, 2006.

Perhaps equally as important as the election results to CSA are changes in key legislative posts resulting from term limits. The new chair of the Assembly Health Committee, for example, will be Mervyn Dymally (D-Compton). As a member of the Committee for the past two years, he supported the position of CSA and the California Medical Association on the “balance billing” issue. Another ally on the issue has been Assemblyman Hector De La Torre (D-South Gate) whose role as Assembly Rules Committee Chair makes him part of the top leadership.

Every legislative session takes on a character of its own that reflects its dominant issue. Last year was the “Year of Infrastructure.” Prior sessions have been tagged as the “Year of Reform,” “Year of the Budget,” “Year of Education,” “Year of the Energy Crisis,” etc. The Governor has declared 2007 will be the “Year of Health Care.” Will it stick? Only time will tell. You can read about it in our future *Bulletin* columns.

Employees and Independent Contractors

By Phillip Goldberg, CSA Legal Counsel



Introduction

I have previously written in these pages about anesthesia groups holding exclusive contracts with a hospital, surgery center or other facility under which the group acts as the exclusive provider of anesthesia services at the facility. Exclusive contracts are more common as these facilities shift to the anesthesia group the burden and risk of finding and keeping qualified anesthesiologists. The anesthesia group usually engages anesthesiologists as either employees or independent contractors, and many groups have both. It is important to understand why one person should be treated as an employee and another as an independent contractor. I will discuss the particulars of these types of relationships, the benefits and burdens of each, and when one or the other should be used.

In this discussion I assume the group is organized as a medical corporation, so the principals of the group are both shareholders and employees. For those anesthesia groups organized as partnerships (which is a small minority of anesthesia groups in my experience), the principals of the group provide services as partners, which is distinct from either an employee or an independent contractor. Partnerships may still engage anesthesiologists who are not principals as either employees or independent contractors, so the discussion that follows is also relevant for anesthesia group partnerships.

Employees

The most common relationship between individual anesthesiologists and the anesthesia group holding an exclusive contract is that of employee and employer. The same basic rules and concerns apply, whether or not the anesthesiologist is a shareholder of the medical corporation. (It is unusual, however, for a shareholder of a medical corporation to be engaged as an independent contractor.)

Medical corporations have statutory obligations to withhold and pay over income taxes, to pay employment taxes, and to provide state disability insurance, unemployment, and workers' compensation insurance (with limited exceptions). Employees may receive tax-favored retirement and other benefits

from the medical corporation, and, to be fully tax compliant, the medical corporation is sometimes required to offer these benefits to the nonshareholders. Employers are also subject to various Labor Code provisions addressing details of the employment relationship, including reimbursement of expenses and the timing and frequency of compensation payments. Also, employers are vicariously (i.e., automatically) liable for the negligence of their employees during the scope of their duties.

Independent Contractors

It is less common, but often more desirable, for an anesthesia group to engage anesthesiologists as independent contractors. In contrast to employees, anesthesia groups have few statutory obligations to independent contractors. The groups do not have to provide benefits and do not incur the cost of employment taxes and statutorily mandated coverages, such as workers' compensation. Additionally, anesthesia groups are not automatically liable for the negligence of their independent contractors.

Anesthesia groups often prefer to engage anesthesiologists as independent contractors to avoid the burdens and expenses associated with the employment relationship. However, anesthesia groups are not free to designate all anesthesiologists they engage as independent contractors because the true relationship of the parties is not determined solely by the understanding and agreement of the group and the anesthesiologist. Even where the group and the independent contractor both desire an independent contractor relationship and have signed a contract that clarifies this relationship of the parties, the Internal Revenue Service, other governmental agencies, and even injured patients pursuing malpractice claims, may challenge the relationship for which the group and anesthesiologist have contracted.

Distinguishing Employees and Independent Contractors

Although the rules applied to determine whether an anesthesiologist should be considered an employee or an independent contractor vary slightly, depending on who is making the determination (e.g., the analysis applied for income tax purposes is not identical to that used for workers' compensation purposes, which may be different from that used to determine vicarious liability), the rules employed by the IRS are the most commonly applied because the tax ramifications of the classification are so important. In January of this year, the IRS issued Publication 15-A, which simplified and clarified the analysis involved in classifying workers as employees or independent contractors. Under the recent publication, the IRS examines "evidence of the degree of control and independence [that] fall into three categories: *behavioral control*, *financial control*, and the *type of relationship* of the parties."

Behavioral Control. The instructions and training provided by the anesthesia group to the anesthesiologist are examined to determine the extent of behavioral control. Most anesthesia groups provide little training, expecting the anesthesiologist to be fully trained when engaged. Some aspects of instruction favor the employment relationship, while others weigh in favor of an independent contractor relationship. Although the group may not instruct the anesthesiologist on what tools or equipment to use, or the sequence to follow in providing anesthesia services, the group will tell the anesthesiologist when and where to work.

Financial Control. Many of the details of the financial control category have little application to anesthesia services, including consideration of the anesthesiologist's investment in his or her practice and whether the anesthesiologist can realize a profit or loss. However, unreimbursed expenses, the time and manner of payment, and making services available to others are details that can be important and can vary from one anesthesiologist to another. Typically, a group will not pay any expenses for an independent contractor, and independent contractors often work for more than one group. This is very true of locum tenens who often are engaged as independent contractors for good reason. As mentioned above, employees must be paid at prescribed times and frequency. To the extent independent contractors are paid per job—whether for taking call or staffing a room for a day, as is often the case with locums services—this supports the independent contractor classification.

Type of Relationship. This category includes examination of the terms of any written contract between the parties, whether benefits are provided, and the permanency of the relationship. I mentioned above that the terms of the written contract do not control the true relationship that exists between the group and the anesthesiologist, but it does enter into the analysis. It should be easy enough for the group to offer a contract to the independent contractor that does not include benefits, but sometimes the group needs to offer malpractice insurance coverage for the sake of efficiency and simplicity. Even so, it is in the type of relationship category that the group and the anesthesiologist have the greatest opportunity of establishing and reinforcing the independent contractor relationship.

Practical Considerations

Although it is possible for the group and the anesthesiologist to misidentify an independent contractor relationship as an employment relationship, the much greater concern is misidentifying an employee as an independent contractor. This is because groups may be inclined to try to avoid the burdens and costs of the employment relationship. Moreover, there are far fewer negative consequences to the group from treating an independent contractor as an

employee. The failure to provide statutorily mandated benefits to an anesthesiologist misclassified as an independent contractor can lead to fines and other penalties. The favorable tax treatment of benefits provided to anesthesia group employees may be lost if technical rules for coverage and nondiscrimination are not met because the misclassified anesthesiologist was not included in the benefit plans.

Many of the specific factors the IRS considers seem to have little application to anesthesia groups, while others tend to weigh in favor of an employment relationship without much opportunity to avoid that implication. For this and other reasons, it is almost always safer when in doubt to assume the relationship is an employment relationship. If this is not possible, there are some important practical considerations in establishing and proving that the relationship is that of independent contractor and not employee.

Although not determinative, the written contract between the parties is one of the factors to examine to determine the true relationship. Accordingly, it is always important to have a written independent contractor agreement signed by both parties. The agreement should include a provision that clearly and unequivocally states that the parties intend an independent contractor relationship. It should have as many other provisions as possible to support that relationship. For instance, it should make clear that the group is not providing any benefits, not paying employment taxes or withholding income taxes, and not providing workers' compensation or other insurance coverages required for employees. Since control is the single most important factor in determining the worker's status, the agreement should also include a provision that the group does not, and cannot, control the details of the services the anesthesiologist provides. Of course, there may be tension between the control the group wants to assert when the independent contractor is scheduled in the operating room or taking call and its desire to have an agreement consistent with an independent contractor relationship.

It is important to avoid treating an anesthesiologist as an independent contractor when there is no practical difference between the services and relationship of an employee anesthesiologist working for the same group. Typically, independent contractors are working part-time and often are working for other groups. Sometimes former full-time and exclusive employees convert to part-time independent contractor status. This should not occur without some justification and a change in the written contract between the parties. Additionally, the change should not occur during the calendar year. This avoids the group having to file an IRS form W-2 for the payments to the employee and an IRS form 1099 for the payments to the independent contractor for the same year and same person. This could raise an audit flag with the IRS. The group

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certainly wants to have some explanation as to why the nature of the relationship changed.

Although not a true safe harbor, it is difficult for the IRS to assert an anesthesiologist is an employee instead of an independent contractor, when that anesthesiologist is engaged through another medical corporation. Anytime an anesthesia group wants to engage an independent contractor that has his or her own single shareholder corporation, the contract should identify that single shareholder corporation as the independent contractor and not the individual shareholder. It is a practical impossibility for a corporation to be an employee. The contract should include a provision that only the single shareholder can provide services for the group.

Conclusion

Anesthesia groups looking to ensure that they have enough personnel to fulfill their obligations under exclusive contracts may look to alternatives to the traditional and more common employment relationship. They should not engage an anesthesiologist as an independent contractor unless they can justify and substantiate that is the true relationship. The agreement with the independent contractor should always be in writing and signed by both parties.

Greater Anesthesia Service Political Action Committee

Imagine a scenario where the profession is powerless to protect the public from those who endeavor to limit patient access to an anesthesiologist's care. Then envision a world where, without impunity, patient safety can be compromised with cost-cutting measures designed by those who stand to profit most.

**CSA legislative advocacy is your voice in Sacramento.
We urge you to join your fellow anesthesiologists in
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