

# CONTRA COSTA LAWYER

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## HEALTHCARE

Health Care Reform in 2011 **Katie Burch**

How to Pick the Right Health Insurance Plan **Colleen Callahan**

The Difficulty of Long Term Care Planning **Kathryn Korn**

Accountable Care Organizations **Brendan Sanchez**

Is There a Future for Nationwide Tort Reform? **Rashmi Nijagal**

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by Rashmi Nijagal



The federal appellate courts are now focused on the same question the lower courts faced: whether the choice not to buy health insurance should be defined as commercial activity that the Supreme Court has ruled can be regulated under the Commerce Clause or as inactivity which is beyond Congress' reach."

**O**n May 10, 2011, the Obama administration began defending its 2010 Patient Protection and Affordable Care Act (PPACA) in the federal appellate courts. The United States Court of Appeals for the Fourth Circuit was the first of the appellate courts to take up the constitutionality of the health care act. By the time this issue goes to press, the Court of Appeals for the Sixth Circuit and the Court of Appeals for the 11<sup>th</sup> Circuit will have heard arguments in defense of the health care act. The split of opinions in the lower courts thus far have fast-tracked the health care act to the U.S. Supreme Court, which many legal observers believe will take up the contentious law when its new term begins in October.

The May 10<sup>th</sup> hearing in Richmond, VA drew excitement from supporters of the health care act and administration when the three-judge panel was revealed the morning before arguments began. The three randomly selected judges are all Democratic appointees, one appointed by President Bill Clinton and the other two by President Barack Obama. On June 1<sup>st</sup>, the Sixth Circuit, after considering the plaintiffs' standing to sue (one plaintiff recently disclosed that she now has health insurance through her employer) heard arguments from both sides challenging the law's con-

stitutionality. The Sixth Circuit panel consisted of two Republican-appointed judges and one judge appointed by President Jimmy Carter. Accounts of the June 1<sup>st</sup> hearing reflected that the panel was arguably less friendly to the government than the Fourth Circuit panel.

The make-up of the Fourth Circuit and the Sixth Circuit three-judge panels is no guarantee of a ruling along "party lines." However, the lower courts' holdings have reflected divisions along party lines so the glimmer of hope seen by PPACA's advocates and supporters after the May 10<sup>th</sup> panel selection is not merely wishful thinking.

In the lower courts, three district judges appointed by Democratic presidents have upheld the law while two Republican-appointed judges have struck down all, or a part of, the health care act. In October 2010, Judge George Steeh, appointed to the U.S. District Court for the Eastern District of Michigan by President Clinton, deemed the individual mandate provision (requiring individuals who have not obtained health insurance by January 2014 to pay a penalty) constitutional and disagreed with the law's detractors who said that the health care act runs afoul of the Commerce Clause. U.S. District Court Judge for the Western District of Virginia, Norman K. Moon, also a Presi-

dent Clinton appointee, ruled similarly, declaring the individual mandate and the employer mandate constitutional. On February 22<sup>nd</sup> of this year, Judge Gladys Kessler of the U.S. District Court for the District of Columbia rejected a challenge to the health care act on the basis that it violates the Religious Freedom Restoration Act and the Commerce Clause. Rejecting as "pure semantics" that failing to acquire insurance was the regulation of inactivity, Judge Kessler noted that "those who do not purchase health insurance will ultimately get a 'free ride' on the backs of those Americans who have made responsible choices to provide for the illness we all must face at some point in our lives."<sup>1</sup>

Challengers to PPACA have found support in the lower courts as well. On December 12, 2010, U.S. District Judge Henry E. Hudson, appointed to the bench by President George W. Bush, became the first judge to rule against the health care act, stating that Congress does not have the authority under the Commerce Clause to impose the individual mandate provision. Judge Hudson said he could not find a precedent for extending the Commerce Clause to a person's decision to not buy a product.<sup>2</sup>

Judge Roger Vinson, appointed to the U.S. District Court for the Northern District of Florida by President Ronald Reagan, declared the individ-



ual mandate provision of the health care act unconstitutional because it exceeds the authority of Congress to regulate interstate commerce. By ruling that the provision is not severable from the PPACA as a whole, Judge Vinson struck down the entire act.<sup>3</sup>

The federal appellate courts are now focused on the same question the lower courts faced: whether the choice not to buy health insurance should be defined as commercial activity that the Supreme Court has ruled can be regulated under the Commerce Clause or as inactivity which is beyond Congress' reach.<sup>4</sup> According to observers of the May 10<sup>th</sup> hearing before the Fourth Circuit panel, the hearing lasted more than two hours during which the judges pressed both sides with pointed questions.<sup>5</sup> The government's strategy at that hearing was to focus the panel on activity instead of inactivity. Acting Solicitor General Neal K. Katyal tried to argue that the activity the health care law regulates "is merely the means of payment by Americans who will inevitably enter the health care market and who will shift costs onto others if they are not insured."<sup>6</sup> Matthew Staver, dean of Liberty University which is challenging the law, said that PPACA "forces inactive bystanders into the stream of commerce."

Given the deeply divided opinions and rulings regarding the health care act, it is now inevitable that the Supreme Court will take up the issue. Based on the rulings so far (at least at the time this issue went to press) and how support for the law appears to depend on whether the judge was a Democratic or Republican appointee, the question is whether the Supreme Court will fall along party lines as well, with Justice Kennedy being the swing vote.

Earlier this year, Harvard Law School professor Laurence Tribe asserted that predictions of a 5-4 split is an overly simplistic approach to assessing the Court's views of the legal issues presented by the health care law and reflects a "misunderstanding" of the Court and the Constitution.<sup>7</sup> Stating that the distinction between "activity" and "inactivity" is illusory, Tribe does not believe that the justices

will be "misled" by arguments that prompted Judge Hudson and Judge Vinson to declare the law unconstitutional. Tribe does not hide his disdain for the constitutional challenges to the health care act, calling it a "political objection in legal garb" but also derides efforts to pigeonhole the Court's more conservative jurists according to their politics versus their legal principles. Save for Justice Thomas who has publicly and repeatedly spoken against the Court's broad interpretation of Congress' Commerce Clause powers, Tribe does not think that the Court will buck against the post-1937 line of cases broadly interpreting Congress' commerce powers.

Time, and ultimately the Supreme Court, will tell if Tribe's predictions come true.\*

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*- Rashmi Nijagal is an attorney with the Ware Law Group, focusing primarily on healthcare law. A former medical malpractice litigator, she now practices regulatory and administrative law representing medical staffs at hospitals.*

<sup>1</sup> "Third Federal Judge Upholds Health Care Law; Score Now 3-2". (2011, February 22). ABC News: The Note.

<sup>2</sup> Schoenberg, Tom (2010, December 13). "Obama's Health-Care Law Ruled Unconstitutional Over Insurance Requirement". Bloomberg. Retrieved January 11. "The Obama administration's health-care overhaul unconstitutionally requires Americans to maintain a minimum level of health insurance, a federal judge ruled, striking down the linchpin of the plan."

<sup>3</sup> "Judge strikes down healthcare reform law". (2011, January 31). Reuters.com.

<sup>4</sup> "Appellate Court Hears Defense of Health Law". (2011, May 10). The New York Times.

<sup>5</sup> "Appellate Court Hears Defense of Health Law". (2011, May 10). The New York Times.

<sup>6</sup> "Appellate Court Hears Defense of Health Law". (2011, May 10). The New York Times.

<sup>7</sup> Tribe, Laurence (2011, February 7). "On Health Care Justice will Prevail". The New York Times

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# president's message



by Kathy Schofield

**H**ealth Insurance. Just thinking about it makes my blood pressure rise a few points. It probably does the same to you. Health insurance stresses out everyone, especially small businesses and their employees. Every year, the number one requested member benefit the CCCBA is asked for is a group health insurance policy. We would love to be able to provide health insurance, and every year we try. Crazy as it sounds, under the existing statutory scheme it will not happen. This month's Healthcare theme of the magazine seemed like a great backdrop to explain why health insurance is not among the many member benefits the CCCBA offers, as much as we want to provide it.\*

In short – we cannot offer health insurance as a member benefit because no carrier will provide it. Back in the 1990's, the state legislature passed AB1672 (Small Group Reform), which, for the most part, eliminated Association medical plans. In order to provide health insurance, the enrolled membership in the medical plan has to be at least 1,000 lives, excluding dependents. Although our entire membership is approximately 1,700, not all would enroll. Prior to AB1672, a carrier could deny coverage to a group at its discretion. Now, any carrier doing business in California has to cover a group with 2-49 employees no matter what health conditions any person in that group has. Solo practitioners are not required to be covered.

Since the carriers have to cover groups with 2 to 49 employees no matter what the risk is, no carrier is willing to take on the additional risk of offering Association plans if they don't have to. Adverse selection is built into Association plans. Understandably, those with medical conditions flock to Association plans, because decent coverage is not available to them in the market place. Big claims means big premiums, and then those that can obtain cheaper coverage in the marketplace leave the plan. The carriers reason that eventually only uninsurable individuals are left on the plan. The carrier can't make money on Association plans. Since carriers are not required to offer Association plans, they don't.

There are some associations out there that do provide health insurance to their membership, but that is either because of their size or because they were grandfathered in. The sad reality is that much like many individuals, when it comes to coverage, associations like the CCCBA are at the mercy of the health insurance industry.

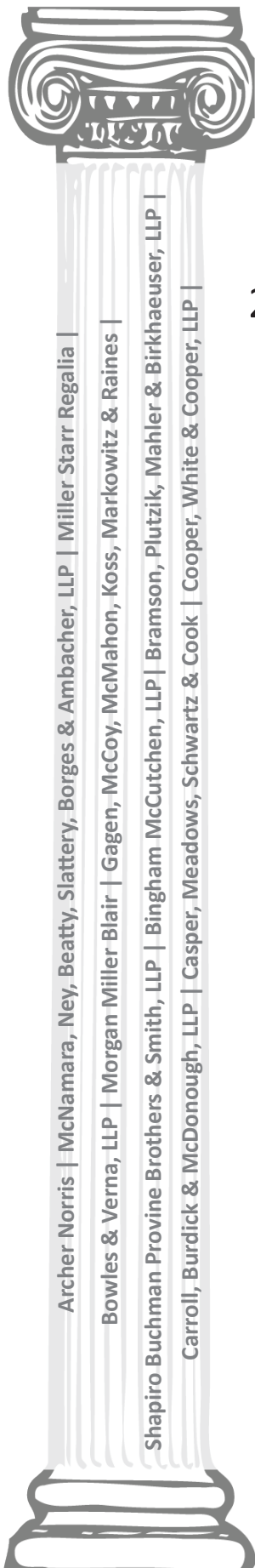
Rest assured, we are constantly reviewing this issue. The second we are able to offer health insurance to our membership, we will do it. ♦

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- Kathryn Schofield, owner of the Schofield Law Group, focuses her practice on Elder Law, Conservatorships, Estate Planning and Probate/Trust Administration - [www.schofieldlawgroup.com](http://www.schofieldlawgroup.com)

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# Health Care Reform in 2011

## New Initiatives under the Patient Protection & Affordable Care Act

by Katie Burch

After a contentious battle in Congress, President Obama signed the Patient Protection and Affordable Care Act ("PPACA") into law on March 23, 2010. Pub.L. 111-148, 124 Stat. 119. The Act aims to improve the private health insurance market and provide Americans with greater access to medical care. Since its enactment, the federal government has distributed substantial amounts of PPACA funds to various federal and state government entities in order to begin implementing the Act's provisions. Although many more changes will be implemented in 2014, below is a summary of changes currently in effect or being implemented in 2011 of which health care attorneys should be aware.



### **NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL**

Pursuant to Section 4001 of the PPACA, the National Prevention, Health Promotion and Public Health Council was established within the Department of Health and Human Services. With the Surgeon General serving as Chairperson, this Council was created to help develop a National Prevention and Health Promotion Strategy. The Council will provide summary and analysis to the President and Congress on federal health care policy. It will also recommend any changes that are necessary in order to achieve national wellness, health promotion, and public health goals. Executive Order 13544 (June 10, 2010).



### **LIFETIME AND ANNUAL DOLLAR LIMITS**

Insurance companies are prohibited from placing lifetime dollar limits on the individuals' benefits. The PPACA also restricts and phases out annual dollar limits and completely bans annual dollar limits by 2014. Lifetime dollar limits on most benefits are prohibited in any insurance policies issued after September 23, 2010. Annual dollar limits on insurance plans issued after March 23, 2010 are restricted by the PPACA provisions.



### **EMPLOYER TAX CREDITS**

Pursuant to PPACA provisions, some employers are entitled to business tax credits to help offset the cost of

their employees' health insurance coverage. To become a qualified employer, the employer must have less than 25 full-time employees, paying average annual wages of less than \$50,000. Additionally, the employer must cover at least 50% of its employees' health care coverage. If an employer does qualify for this tax credit, the tax credit could be worth up to 35% of a business' premium costs and up to 25% for tax-exempt employers. In 2014, the tax credit rate will increase to 50% for small businesses and 35% for tax-exempt organizations.



### **FLEXIBLE SPENDING ACCOUNTS AND HEALTH REIMBURSEMENT ACCOUNTS**

Section 9003 of the PPACA established a new uniform standard for medical expenses as of January 1, 2011. Under this provision, individuals cannot use their flexible spending accounts, health reimbursement accounts and health savings accounts to pay for over-the-counter drugs that are purchased without a prescription. However, insulin purchases are exempt from this new mandate.



### **COVERAGE FOR ADULT CHILDREN**

Under the PPACA, individuals who maintain health insurance plans that include coverage for children are now able to include their adult children on these plans as well. Adult children may remain on their parents' plan until the children reach the age of 26. Adult children can join their parents' insurance plan regardless of whether

they are married, living with their parents, a student, financially dependent, or eligible to enroll in their employer's plan.



### **PRE-EXISTING CONDITIONS**

The PPACA mandates that health plans cannot limit benefits or deny coverage for a child based on the child's "pre-existing condition." The PPACA also created the Pre-Existing Condition Insurance Plan, a plan that provides health insurance to those who have been denied coverage due to a pre-existing condition. Eligibility to this plan is not based on income. To qualify, an individual must have been uninsured for at least six months, have a pre-existing condition, and be a U.S. citizen or legal resident. This program will be available until 2014, when a new insurance system becomes effective. In 2014, individuals may purchase health insurance plans that offer certain benefits at varying cost standards in a new insurance "marketplace." This system will be known as "the Exchange."



### **"DONUT HOLE" REBATE CHECKS**

Prior to the PPACA, many Medicare drug plans had

a coverage gap after a certain amount of money was spent on covered brand-name drugs. Any drugs purchased after that point dollar limit were out-of-pocket costs to the Medicare beneficiaries. This is known as the "Donut Hole" in drug coverage. Under the PPACA, individuals affected by the "Donut Hole" gap will receive a \$250 rebate for the 2010 year. In 2011, "Donut Hole" brand-name prescription drug costs will receive a 50% discount.

## **THE PPACA IN CALIFORNIA**

Since the enactment of the PPACA, California has received over \$436 million in funding to provide employers and individuals with the new coverage options offered under the Act. This funding has helped implement the following initiatives:



### **"DONUT HOLE" REBATE CHECKS TO MEDICARE BENEFICIARIES**

In 2010, California Medicare beneficiaries received a tax-free \$250 rebate, totaling \$349,255, to help pay for prescriptions in the Medicare D coverage gap. This year, beneficiaries will receive a 50% discount for covered prescriptions.



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### **PRE-EXISTING CONDITION INSURANCE PLAN**

Over 1,500 uninsured California residents enrolled in the Pre-Existing Condition Insurance Plan, which provides health coverage for those uninsured for at least six months, who have a pre-existing condition or have been denied coverage because of their health condition, and are a U.S. citizen or legal resident.



### **CONSUMER ASSISTANCE PROGRAM**

The Consumer Assistance Program has helped individuals enroll in health coverage, file complaints and appeals against health plans and track consumer complaints to help identify problems and strengthen enforcement. The Office of the Patient Advocate in California received \$4.2 million to develop and promote this program by creating a consumer-friendly website and toll-free number for those with questions about health care coverage. These funds have also been used to conduct a statewide media campaign and evaluate the effectiveness of the new health care initiatives.



### **EARLY RETIREE REINSURANCE PROGRAM**

Since the enactment of the PPACA, hundreds of California employers have enrolled in the Early Retiree Rein-

surance Program, which provides financial relief to employers so that they may provide retirees who do not yet qualify for Medicare affordable health insurance coverage.



### **PREVENTION AND PUBLIC HEALTH FUND GRANTS**

The PPACA's Prevention and Public Health Fund, created to help prevent illness and promote health, awarded California \$42 million in grants to help support California programs, such as community and prevention clinics and training in improvements to primary care.

The Center for Consumer Information and Insurance Oversight (CCIIO), part of the Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services, has created an "Implementation Center" website to provide the public with a better understanding of the new health care reform bill and what it means for individuals and employers. The website also publishes materials regarding the implementation of the PPACA and provides information on the Act's provisions and regulations. For more information, please visit <http://www.healthcare.gov/center/>. ♦

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# HOW TO: Pick the Right Health Insurance Plan



by Colleen Callahan

Selecting health insurance for a solo practitioner, a new firm or a firm with an existing medical insurance plan evokes a range of emotions. It might evoke memories of Dustin Hoffman's dental procedure in *Marathon Man* or even Steve Carell's waxing in *The 40 Year-Old Virgin* (ouch!). The good news is that it doesn't have to be that way. With the proper approach and planning, selecting health insurance can be an educational and beneficial experience. The key is to follow these steps and go with the flow, like Nemo in the East Australian Current.

## 1 SELECT A PROFESSIONAL AGENT

First, select a professional agent specializing in group or individual health insurance. Two good places to start are [www.cahu.org](http://www.cahu.org) (California Association of Health Underwriters) and [www.nahu.org](http://www.nahu.org) (National Association of Health Underwriters). Both offer consumer information and a "Find an Agent" tool. If you have an agent, see if he or she is listed. These associations provide excellent information and training.

For maverick individuals, choosing to apply directly online, I have two words of advice: Be cautious. Those with health conditions or on medication could be denied or surprised by a hefty premium rating. That denial, now a permanent part of your history, could possibly have been avoided with proper man-

agement. An agent can submit an anonymous inquiry to nearly all of the insurance companies offering individual medical insurance. The health carriers respond with a "probable rating." Be honest and thorough in providing the information - it will make the process easier and more accurate. All of the carriers use a disclaimer that final rates are determined after full underwriting, but you will gain a better idea of what to expect and won't waste time applying to carriers that automatically decline due to certain health conditions or medications.

In the small group market - firms with less than 50 employees - there is no risk of being declined after meeting a few guidelines. California has had a small group "guarantee issue" since 1993. Insurance companies issue group coverage to groups with as few as two members, with only one person enrolling.

## 2 DEVELOP A PLAN

The second step is to have a planning meeting focusing on plan design, specific needs for employees, physician and hospital networks and budget. The decision maker or makers need to decide if the employees will contribute to the premium; it helps the employer and the employee to arrange for premiums to be paid on a pre-tax basis.

Armed with the information from the planning meeting, the agent can begin research. The agent collects quotes, reviews and summarizes them. Expect to see high, medium and low premium plans or the current top selling plans in the region (giving insight into what other employers are offering). In my experience law firms prefer more than one option for employees - in the past it was a PPO and HMO combina-

**HOW TO: PICK THE RIGHT  
HEALTH INSURANCE PLAN,**  
cont. from page 13

tion. As HMO premiums continue to climb, firms now often select one or two PPO options, including PPO plans called "HSA Compatible Plans." The HSA (Health Savings Account) plans require a high deductible. The HSA has a tax advantage, by establishing a separate account, those costs be paid on a pre-tax basis (for California residents it is only a Federal deduction), without regard for adjusted gross income. A participant may establish a separate account to pay the deductible and allowable medical expenses. The employer, employee or both may fund it. Unlike Flexible Spending Accounts (FSAs) there is not a "use it or lose it" concern for the money in the account.

### 3 ANALYZE AND DECIDE

The third step is to meet again with the agent, review the results of the research and make a decision. It is important to both analyze the benefits and the premiums. The least expensive plans are priced that way for a reason. Keep in mind that generally the key concerns of the employees are the office visit co-pay, the size of the network, the prescription drug coverage, as well as the annual maximum "out of

pocket" costs. Many PPO plans now have separate deductibles for brand name prescription drugs.

### 4 ANALYZE AND DECIDE

Once the plan selection has been made, the next step is implementation. The agent or a representative from the insurance company can conduct an employee educational meeting and handle the enrollment, which means the employer does not have to handle the questions!

### 5 REPEAT ANNUALLY

This process is normally repeated annually: meet, review, educate and enroll. It is valuable to have an annual employee meeting whether or not there is a change in insurance companies. It is an opportunity to remind employees about the availability of routine preventive care services and to discuss any changes to the plan.

How long will this take? The timeline is hard to pinpoint. The process for an individual application can take two to four weeks. For a small group it is a good idea to start the process 90 days before desiring to implement a new plan.

Employers whose plans were in

place prior to March 23, 2010, when The Patient Protection and Affordable Care Act became law might have "grandfathered" status. Essentially, those plans are not required to adopt the provisions of the new law. However, in some cases the insurance company has modified the plan adding provisions (100% coverage for preventive care, unlimited lifetime maximums) without jeopardizing grandfathered status. Choosing to maintain "grandfathered" plans could become financially challenging or the carriers could eliminate the plan and transfer groups to the closest similar plan. The value of maintaining "grandfathered" status needs to be reviewed on an individual basis.

The next major portion of the PPACA takes effect in 2014. As it stands now there will be individual and employer mandates. The regulations are being drafted by the various regulatory bodies involved. Ultimately it means the analysis and selection process for medical benefits will change. In the meantime, try following this process and imagine swimming with Nemo. ♦

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- Colleen has over 20 years of experience in the insurance industry. Her practice, based in Lafayette, focuses on individuals and small to mid-sized businesses, providing insurance and employee benefits. She is a current member of the board for the local health underwriters (GGAHU) and a member of the local insurance and financial advisors association (NAIFA).  
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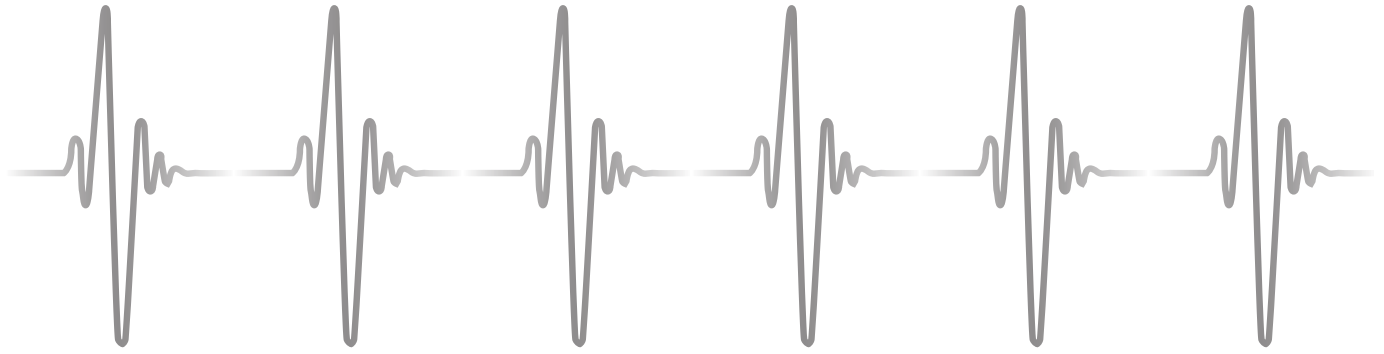
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# The Difficulty of Long Term Care Planning



by Kathryn S. Korn

**A** glaring omission in the health care reform is the fact that little thought has been given to providing long-term care benefits to our aging population which is growing at unprecedented rates. Historically, Medicare's support for long-term care has been quite limited and, in light of the impending budget cuts and shortfalls, it is unlikely that the Medicare program will ever provide meaningful long-term care benefits.

Many people assume that Medicare will provide for all their medical needs, including long-term care. In reality, the long term care support is nominal. Currently, long-term skilled nursing support in a skilled nursing facility is available to an individual who spends at least three days in an acute care hospital and then needs either skilled nursing or skilled rehabilitation services. Medicare will cover the cost for the first twenty days in the skilled nursing facility, but beginning on day twenty-one and continuing through day one hundred, there is a significant co-payment of \$141.50 per day.

After one hundred days, Medicare will not pay for any skilled nursing. The one hundred day "cap" is related to each separate illness. It is important to note that the limited benefits provided by Medicare are not guaranteed and can be difficult to receive. If, during any stay in a nursing home the Medicare-cov-

ered individual no longer requires skilled nursing care, reaches certain benchmarks in his or her physical and/or occupational rehabilitation, or is deemed to require only custodial care, Medicare coverage will immediately cease.

**Many people assume that Medicare will provide for all their medical needs, including long-term care. In reality, the long term care support is nominal.**

So, what alternatives are available for long-term skilled nursing? Some consumers purchase "Medigap" Supplemental Insurance policies in the belief that it will cover these costs. However, like a Medicare HMO, these policies usually cover a small amount of the costs, if at all, and, even if there was coverage, it would only cover the Medicare copayment amounts for days 21 through 100.

Other possibilities include: Long Term Care Insurance, (LTCI), Self-insuring, Public Benefits, Life Insurance with Long Term Care Riders, (LTC), and possibly, Community Living Assistance Services and Supports program, a product of the recent federal health care reform. This article does not include a detailed discussion of in-home support for seniors.

**LTCI:** Like many insurance products, long-term care insurance is not going to be the answer for everyone. Those individuals who are able to

both afford and qualify for a long-term care insurance policy pay premiums in the hope of minimizing future costs. Many TCI policies are not fixed and substantial premium increases, (some as high as fifty percent of the original premium) have

occurred. In light of the current economic conditions, it is likely premium increases will be seen in the future. Because of this uncertainty, retired people with fixed incomes may be at risk if premium increases result in an inability of the owner to make the premiums, resulting in either a reduction of insurance or a cancellation of the policy.

**Life Insurance:** A life insurance policy with a LTC rider is an option to LTCI. These policies have a provision allowing access to the policy's death benefit for the purpose of funding LTC. The policies usually require that the owner of the policy requires assistance with several of the 'activities of daily living' (ADLs). In addition, there are precondition waiting periods.

These policies contrast with LTCI-only policies in that they provide coverage for LTC if needed and a death benefit if the LTC is not required. However, in order to be a successful alternative for LTCI, the ►

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### LONG TERM CARE PLANNING, cont. from page 15

policy will not be available for any other purpose, i.e. retirement benefits. The policy needs to produce enough benefit to cover the cost of LTC if needed.

**Self-insuring:** While it seems a straightforward projection based on today's data for LTC multiplied by a factor for inflation would provide an estimate for self-insuring, it is a more complicated analysis. Some of the considerations include: 1) Estimating the cost of a long-term care stay for a certain period of time. The average nursing home stay is about 2 ½ years, but it is just an average; 2) Multiplying the contemplated stay by the current average cost of care in California, (currently slightly more than \$91,000 per year, exclusive of everything other than room and board); 3) If the amount of retirement income can be projected, some amount may be available to offset the monthly cost of long term care. The retirement income should be adjusted to reflect cost of living adjustments (COLAs); 4) The cost of the nursing home should also reflect COLAs, but it is more likely that the cost of the nursing home COLAs will exceed those of the retirement benefits; and 5) Estimating a rate of return on the funds and the period of time over which contributions will be made.

Self-insuring may be an option if the resources are available. One argument against federal funding of long-term health care is the fact that it could bankrupt the Treasury. Likewise, attempting to accumulate the funds for self-insurance will have a significant impact on individual funding.

**The CLASS Act:** This is a government run, voluntary long-term care insurance program, that is a part of the health reform bill. The benefits are legislated to average a minimum of \$50 per day in cash benefits, although there is discretion in offering higher benefit options. Pre-

miums have not been determined, although it is anticipated the premiums will increase with age. This option will not be available for sale through insurance agents, but instead will be available through employer payroll deductions. As of now, it has not been determined how self-employed people will enroll, or those whose employers do not offer the plan.

So, what is a person to do? A person with sufficient assets may decide to self-insure. Those with insufficient assets to self-insure may look to Medi-Cal. For those in between, some type of long-term care insurance may be the answer. But if a person is facing long-term care costs in the immediate future, the best answer might be to explore the ability to qualify for public benefits through California's Department of Health Services Long Term Care Program with a qualified attorney.

**Medi-Cal:** The Governor's proposed budget contemplates large reductions in home and community based services. However, there is

no proposed reduction in Medi-Cal benefits for skilled nursing home services.

The eligibility requirements for these long-term care services include the counting of resources and income. The requirements are based on similar eligibility rules in the federal Supplemental Security (SSI) program. However, Medi-Cal rules may be less restrictive than SSI rules; in general, this is the case as of today in California. The regulations promulgated by Department of Health Services currently allow for significant flexibility in planning to achieve eligibility for the long-term care program.

Moreover, for a couple facing long-term nursing home care costs, the rules to protect a spouse remaining at home from impoverishment when the "ill" spouse requires skilled nursing, are based on provisions in the Medicare Catastrophic Coverage Act of 1988. The provisions were implemented in California in 1990 and have had few changes since that time.

At some point in the future, it is anticipated that the State will adopt the Deficit Reduction Act of 2005. This will bring major changes to the ability to qualify for long-term care benefits through the DHCS Long Term Care Program. It is expected these new rules will only apply prospectively with the exception of long-term care for individuals with substantial home equity who became eligible due to application filed on or after January 1, 2006.

None of us have a crystal ball that allows us to know our future needs. It's hard to decide whether or not to spend \$50,000 or \$60,000 to protect several hundred thousand dollars of your hard-earned money that could be needed to care for your long-term care needs. Could you invest the amount of insurance premiums over thirty years and have more funds than needed for your care? It is worth some thoughtful analysis. ♦

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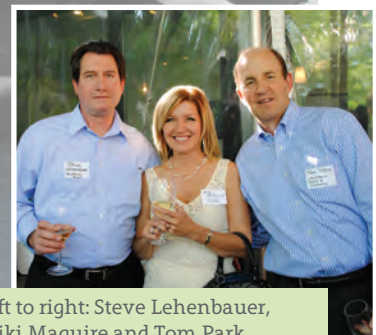
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# Induction of the Honorable **Christopher R. Bowen**

Superior Court of California | Contra Costa County | June 3, 2011



Presentation of the Gavel  
by **Kathryn Schofield**,  
President, Contra Costa  
County Bar Association

Speaker: **David E. Goldstein**,  
Deputy Public Defender,  
Contra Costa County



Closing Remarks by  
the Honorable  
**Christopher R. Bowen**



## Meet the Honorable Christopher R. Bowen



Right to left: Judge Christopher Bowen with CCCBA Ex-Officio President Ron Mullin and Board Secretary Jay Chafetz at Judge Bowen's Induction on June 3, 2011

by Stephen Steinberg

### BACKGROUND

Judge Bowen has been part of the East Bay community for his entire life. He grew up in Berkeley and attended Berkeley High School, where he regularly appeared on stage as a singer and actor. Among his most memorable performances was his portrayal of the Admiral in *H.M.S. Pinafore*. His connection to Contra Costa dates back to one of his first jobs as a teenager, doing yard work for a woman who lived in Orinda.

After high school, Judge Bowen attended Santa Clara University where he double-majored in Anthropology and French, in which he is fluent. He planned to continue on to a graduate program in history or French literature and pursue a career in teaching or academia. But his French relatives and some

of his professors encouraged him to become a lawyer, and he decided to apply to law school. It was also during Judge Bowen's undergraduate years that he became interested in public service, and he volunteered at a homeless shelter in San José.

Judge Bowen attended law school at the University of Virginia, though his commitment to the Bay Area and to public service led him to spend the summer after his first year working for the San Francisco City Attorney's office. The highlight of his summer was drafting and winning a motion for summary judgment that saved the city \$50,000. He spent his second summer working at the predecessor to Bay Area Legal Aid in Richmond, which was the beginning of his longtime love for the City of Richmond. Judge Bowen has lived in Richmond since 2001, and served on the city's Historic Preservation Advisory Committee from 2005-10.

### CAREER AS A LAWYER

After graduating from law school in 1993, Judge Bowen returned home to take the California bar exam. He scored a phone interview with David Coleman from the Contra Costa Public Defender's Office, but was told there was not enough work to hire him. A few weeks later, David called saying that another law clerk had bailed and they needed someone to start work the following Monday. Judge Bowen answered the call, and never looked back, spending the next seventeen years as a Contra Costa public defender.

Judge Bowen's dedication to the Public Defender's Office was evident even in his early years, when he commuted for hours each day from Berkeley to Martinez and back on public transportation. After spending a year as a law clerk and becoming a Deputy Public Defender in October 1994, he was assigned to dependency cases for the next two years. He then spent just seven months handling misdemeanors before being promoted to felonies. He spent the next thirteen years as a felony trial lawyer in Martinez, Richmond, and at the Alternate Defender Office.

In a fitting conclusion to a long and distinguished career as a public defender, Judge Bowen spent his last year representing juveniles in delinquency proceedings. He appreciated the change of perspective, with more focus on rehabilitation. Judge Bowen says, "Those kids made me laugh and smile every day, and I always had hope that I might make a difference in someone's life and help them turn things around."



Besides his work as a lawyer, Judge Bowen has been an active member of the Contra Costa County Bar Association for his entire career, and served for two years on its board of directors. He is also a member of Bay Area Lawyers for Individual Freedom, Sacramento Lawyers for the Equality of Gays and Lesbians, and the Robert G. McGrath American Inn of Court.

Judge Bowen was appointed to the Contra Costa County Superior Court by former Governor Arnold Schwarzenegger and assumed his duties on December 6, 2010.

## JUDICIAL CAREER

Judge Bowen's chambers (Dept. 40) are in Room 203 in the Richmond courthouse. He primarily presides over misdemeanor jury trials, which start on Monday or Wednesday mornings at 9 a.m., and felony preliminary hearings. He also hears all petitions for domestic violence restraining orders filed in the Richmond courthouse on Mondays at 8:30 a.m. He occasionally handles small claims trials and appeals,

unlawful detainers, and traffic offenses.

Judge Bowen says that the transition to being a judge has not been particularly difficult, though it does require a different skillset. He feels a great responsibility to "get it right," and to ensure that all proceedings in his courtroom are fair and follow the rules. For example, while he occasionally asks his own questions of witnesses in order to clarify their testimony, he is careful not to ask a question that might "tip the scales" in either side's favor. When asked what aspects of the job he likes best, Judge Bowen said that he enjoys working with self-represented parties and ensuring that they have the opportunity to be heard. He also likes the jury selection process, because he gets to talk to members of the community and educate them about the importance of jury service. When asked what has most surprised him about being a judge, Judge Bowen said he has consistently been impressed by younger and/or new lawyers practicing in his courtroom.

## WHAT YOU NEED TO KNOW ABOUT PRACTICING IN JUDGE BOWEN'S COURTROOM

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**Clerk:** Jackie Espy

**Reporter:** Renée Smith

Judge Bowen greatly appreciates preparation. For example, if you intend to ask for a special jury instruction, you should draft and provide it to the Court and the other side in advance. Second, while Judge Bowen does not usually impose strict time limits on a party's case or particular elements of a trial (e.g. opening statements or closing arguments), he encourages all counsel to be reasonable in their use of the Court's and the jury's time and to avoid unnecessary repetition. Third, Judge Bowen insists that the parties exchange and show to the Court all exhibits and demonstratives in advance, before showing anything to the jury. ♦

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# Accountable Care Organizations



by Brendan Sanchez



Despite the intense focus upon the individual mandate, perhaps the most revolutionary aspect of the Patient Protection and Affordable Care Act ("Act") is the little-discussed establishment of Accountable Care Organizations ("ACOs").

Despite the intense focus upon the individual mandate, perhaps the most revolutionary aspect of the Patient Protection and Affordable Care Act ("Act") is the little-discussed establishment of Accountable Care Organizations ("ACOs").

Section 3022 of the Act obligates the Department of Health & Human Services to establish a Shared Savings Program.<sup>1</sup> Under this Program, doctors, hospitals and other health care providers can work together to manage and coordinate care for individuals enrolled in Medicare Parts A and B (i.e. traditional fee-for-service Medicare beneficiaries).<sup>2</sup> ACOs that meet quality standards established by the Centers for Medicare and Medicaid Services ("CMS") and achieve a specific level of savings are eligible to receive a share of those savings.<sup>3</sup>

The cost savings achieved by ACOs, if any, will be the result of integrating the various components required to care for a patient. At its most basic, an ACO is a network of doctors, hospitals, and other Medicare providers and suppliers that agree to manage the totality of health care needs for at least 5,000 Medicare patients. By integrating their clinical and administrative systems, ACOs arguably should run more efficiently and realize certain

costs savings as a result of those efficiencies. In addition, the quality standards established for ACOs, which emphasize preventative care and treatment for at-risk patient populations, arguably should improve patient health, thereby reducing overall expenditures.

## I. REQUIREMENTS FOR PARTICIPATION IN SHARED SAVINGS PROGRAM

On April 7, 2011, CMS issued a proposed rule that would implement the Shared Savings Program. The proposed rule defines an ACO in terms similar to those set forth in the Act. Specifically, an ACO is defined as a "legal entity that is recognized and authorized under applicable State law," comprised of an eligible group Medicare-enrolled providers and suppliers of services "that work together to manage and coordinate care" for Medicare Parts A and B patients.<sup>4</sup>

The Medicare-enrolled providers and suppliers eligible to form or join ACOs are identified in the Act and include:

(i) ACO professionals in group practice arrangements (ACO professionals include physicians, practitioners and hospitals, as de-

fined by sections 1861(r)(1), 1842(b)(18)(C)(i) and 1866(d)(1)(B) of the Social Security Act respectively);

(ii) Networks of individual practices of ACO professionals;

(iii) Partnerships or joint venture arrangements between hospitals and ACO professionals;

(iv) Hospitals employing ACO professionals; and

(v) Other providers and suppliers, as determined by the Secretary of the Department of Health and Human Services.<sup>5</sup>

Eligible providers and suppliers must submit an application to CMS requesting designation as an ACO<sup>6</sup> As part of the application process, ACOs must enter into an agreement to participate in the Shared Savings Program for at least three years and demonstrate their ability to serve at least 5,000 Medicare patients.<sup>7</sup> In addition, ACOs must establish "a leadership and management structure" that encompasses clinical and administrative systems.<sup>8</sup>

## II. QUALITY PERFORMANCE STANDARDS AND REPORTING

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## ACCOUNTABLE HEALTHCARE ORGANIZATIONS,

cont. from page 23

quality of care provided to their Medicare patients.<sup>9</sup> Under the Act, CMS is tasked with establishing quality performance standards designed to assess the quality of care furnished by ACOs.<sup>10</sup> CMS's proposed rule identifies 65 measures developed to promote better care for individuals and better health for populations.<sup>11</sup> These measures are categorized within five "quality domains," which include the patient/caregiver experience, care coordination, patient safety, preventative health, and at-risk population health.<sup>12</sup> (The at-risk population health quality domain focuses upon six categories of at-risk patients: patients suffering from diabetes, heart failure, coronary artery disease, hypertension and chronic obstructive pulmonary disease, and the frail elderly).<sup>13</sup>

To determine whether an ACO complies with the various quality measures, CMS must review relevant data gathered by ACOs. Consequently, the Act obligates ACOs to "submit data in a form and manner specified by the Secretary [of the Department of Health and Human Services]" regarding those measures deemed necessary to evaluate the quality of care furnished by the ACO.<sup>14</sup> According to CMS, much of data required to assess compliance with these quality measures is already gathered under the claims-based reporting systems already in place.<sup>15</sup> However, ACOs will be obligated to collect additional data (and perform surveys to collect such data) for certain quality measures.

CMS will assign a score rating to an ACO's compliance with each individual quality measure and tally these scores based upon quality domain.<sup>16</sup> The resulting five quality domain scores will be combined (using a weighted formula determined by CMS) to arrive at a total performance score.<sup>17</sup> This score will determine whether an ACO is eligible to share in any savings.<sup>18</sup> For the first year of

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Until there's a cure, people with the disease will need caregiving and legal advice. According to the Alzheimer's Association, approximately one in ten families has a relative with this disease. Of the four million people living in the U.S. with Alzheimer's disease, the majority live at home — often receiving care from family members.

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the Program, ACOs will be considered to have met all individual quality measures if they have satisfied their reporting requirement.<sup>19</sup>

### III. SHARED SAVINGS AND LOSSES

Under the Shared Savings Program, providers and suppliers who have joined an ACO will continue to receive fees for services and items as contemplated by the current Medicare payment system.<sup>20</sup> But to share in any savings realized by the Medicare program, the ACO must, on a yearly basis, (1) meet the quality standards established by CMS and (2) achieve total per capita costs for Medicare patients participating in the ACO that are a certain percentage less than a benchmark established by CMS.<sup>21</sup> (This certain percentage of savings has been termed the “minimum savings rate” by CMS and will be adjusted for variations in health care spending.<sup>22</sup>)

CMS has proposed two “risk” models for participation in the Shared Savings Program that would impact the total percentage of savings that could be achieved by an ACO. The one-sided risk model allows an ACO to share in savings for the first two years of program participation and share in savings and losses in the third year; ACOs participating in the one-sided model can share up to 50 percent of any savings realized.<sup>23</sup> The two-sided risk model allows an ACO to share in savings and losses for all three years of Program participation; ACOs who adopt this model can share up to 60 percent of savings.<sup>24</sup> According to CMS, ACOs may choose which risk model to follow.<sup>25</sup>

As the risk models suggest, ACOs not only share in savings but losses too. Where the per capita cost per Medicare patient is more than two percent higher than the benchmark set by CMS, ACOs will be liable for a share of the losses.<sup>26</sup> Under the proposed rule, the amount of losses to be shared per year would be capped (although variable based upon

the whether the loss occurs in the first, second or third year of Program participation) and depend, in part, upon the ACO’s overall performance score.<sup>27</sup>

To proponents of the Shared Savings Program, ACOs represent a rare opportunity to improve patient care while lowering costs. Although shared savings incentivize ACOs to cut costs, quality performance metrics and other requirements placed upon ACOs—including obligations to promote evidence-based medicine and patient engagement—arguably prevent saving from being achieved by limiting access to care.<sup>28</sup>

It is not, however, altogether clear whether ACOs will be able to achieve demonstrable savings while meeting the benchmarks for quality established by CMS. Given that the quality benchmarks limit the opportunities for ACOs to cut costs, savings will have to be achieved, in the main, through efficiencies gained via integration and preventative medicine.

In addition, the prospect of substantial integration resulting from ACO formation has the perverse potential to undercut savings. By accelerating hospital mergers and provider consolidation, many critics of ACOs argue that ACOs could reduce competition and drive up health costs.<sup>29</sup> Indeed, significant concerns have been raised as to whether ACOs might violate antitrust law.<sup>30</sup>

It thus remains to be seen whether ACOs permanently alter the health care delivery model or are simply remembered as yet another failed experiment. ♦

*- Brendan Sanchez is an associate attorney at the Ware Law Group. Brendan represents hospital medical staffs in a broad array of health law issues including credentialing and peer review, by-laws matters, medical staff policies and procedures, physician hearings and appeals, mandated reporting, disabled and impaired physicians, and patient care issues.*

<sup>1</sup> 42 U.S.C. §1395jjj(a)(1).

<sup>2</sup> *Id.*

<sup>3</sup> 42 U.S.C. §1395jjj(d). See also Centers for Medicare and Medicaid Services, Fact Sheet – What Providers Need to Know: Accountable Care Organizations (April 2011), p. 3 ([http://www.cms.gov/MLNProducts/downloads/ACO\\_Providers\\_Factsheet\\_ICN903693.pdf](http://www.cms.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf))

<sup>4</sup> Federal Register Vol. 76, No. 67 (April 7, 2011), 19537.

<sup>5</sup> 42 U.S.C. §1395jjj(b)(1). Note that the proposed rule developed by CMS would permit the participation of Critical Access Hospitals in certain circumstances. Please see Federal Register Vol. 76, No. 67 (April 7, 2011), 19539.

<sup>6</sup> Centers for Medicare and Medicaid Services, Fact Sheet – What Providers Need to Know: Accountable Care Organizations (April 2011), p. 2 ([http://www.cms.gov/MLNProducts/downloads/ACO\\_Providers\\_Factsheet\\_ICN903693.pdf](http://www.cms.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf))

<sup>7</sup> 42 U.S.C. §1395jjj(b)(2).

<sup>8</sup> *Id.*

<sup>9</sup> 42 U.S.C. §1395jjj(b)(2).

<sup>10</sup> 42 U.S.C. §1395jjj(b)(3)(C).

<sup>11</sup> Federal Register Vol. 76, No. 67 (April 7, 2011), 19569-19586.

<sup>12</sup> Federal Register Vol. 76, No. 67 (April 7, 2011), 19594.

<sup>13</sup> Federal Register Vol. 76, No. 67 (April 7, 2011), 19569.

<sup>14</sup> 42 U.S.C. §1395jjj(b)(3)(B).

<sup>15</sup> Federal Register Vol. 76, No. 67 (April 7, 2011), 19592.

<sup>16</sup> Federal Register Vol. 76, No. 67 (April 7, 2011), 19593.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> Federal Register Vol. 76, No. 67 (April 7, 2011), 19569.

<sup>20</sup> Centers for Medicare and Medicaid Services, Fact Sheet – What Providers Need to Know: Accountable Care Organizations (April 2011), p. 2 ([http://www.cms.gov/MLNProducts/downloads/ACO\\_Providers\\_Factsheet\\_ICN903693.pdf](http://www.cms.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf))

<sup>21</sup> 42 U.S.C. §1395jjj(d)(1)(B)(i).

<sup>22</sup> Federal Register Vol. 76, No. 67 (April 7, 2011), 19611-19613. See also Centers for Medicare and Medicaid Services, Fact Sheet – What Providers Need to Know: Accountable Care Organizations (April 2011), p. 3 ([http://www.cms.gov/MLNProducts/downloads/ACO\\_Providers\\_Factsheet\\_ICN903693.pdf](http://www.cms.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf))

<sup>23</sup> Federal Register Vol. 76, No. 67 (April 7, 2011), 19603.

<sup>24</sup> Federal Register Vol. 76, No. 67 (April 7, 2011), 19616-19619.

<sup>25</sup> Centers for Medicare and Medicaid Services, Fact Sheet – What Providers Need to Know: Accountable Care Organizations (April 2011), p. 3 ([http://www.cms.gov/MLNProducts/downloads/ACO\\_Providers\\_Factsheet\\_ICN903693.pdf](http://www.cms.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf))

<sup>26</sup> *Id.*

<sup>27</sup> *Id.* at 3-4.

<sup>28</sup> 42 U.S.C. §1395jjj(b)(2)(G).

<sup>29</sup> Jenny Gold, “Accountable Care Organizations, Explained,” National Public Radio (January 18, 2011) (<http://www.npr.org/2011/04/01/132937232/accountable-care-organizations-explained>).

<sup>30</sup> Jenny Gold and Phil Galewitz, “Health Care Providers, Insurers: Accountable Care Organizations Bring Legal Worries,” Kaiser Health News (October 5, 2010) (<http://www.kaiserhealthnews.org/Stories/2010/October/05/accountable-care-organizations.aspx?p=1>)

# Is There a Future for Nationwide Tort Reform?

by Rashmi Nijagal

A clear victory for trial lawyers, tort reform never saw its way into the Patient Protection and Affordability Plan (PPACA) signed into law last year. Proponents of tort reform wanted to see the usual talking points appear in the bill: caps on the amount of money juries can award a patient, letting jurors

consider a patient's other sources of income when making an award and assigning damages based on how much a physician and/or hospital contributed to an injury. These principles of traditional tort reform did not make it into the law.

Instead, PPACA includes two small provisions related to tort reform. The "Sense of Senate" in Section 6801 sets forth the hope that health care reform can usher in tort reform by stating that "health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance." The health care act encourages states "to develop and test alternatives to the civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to li-

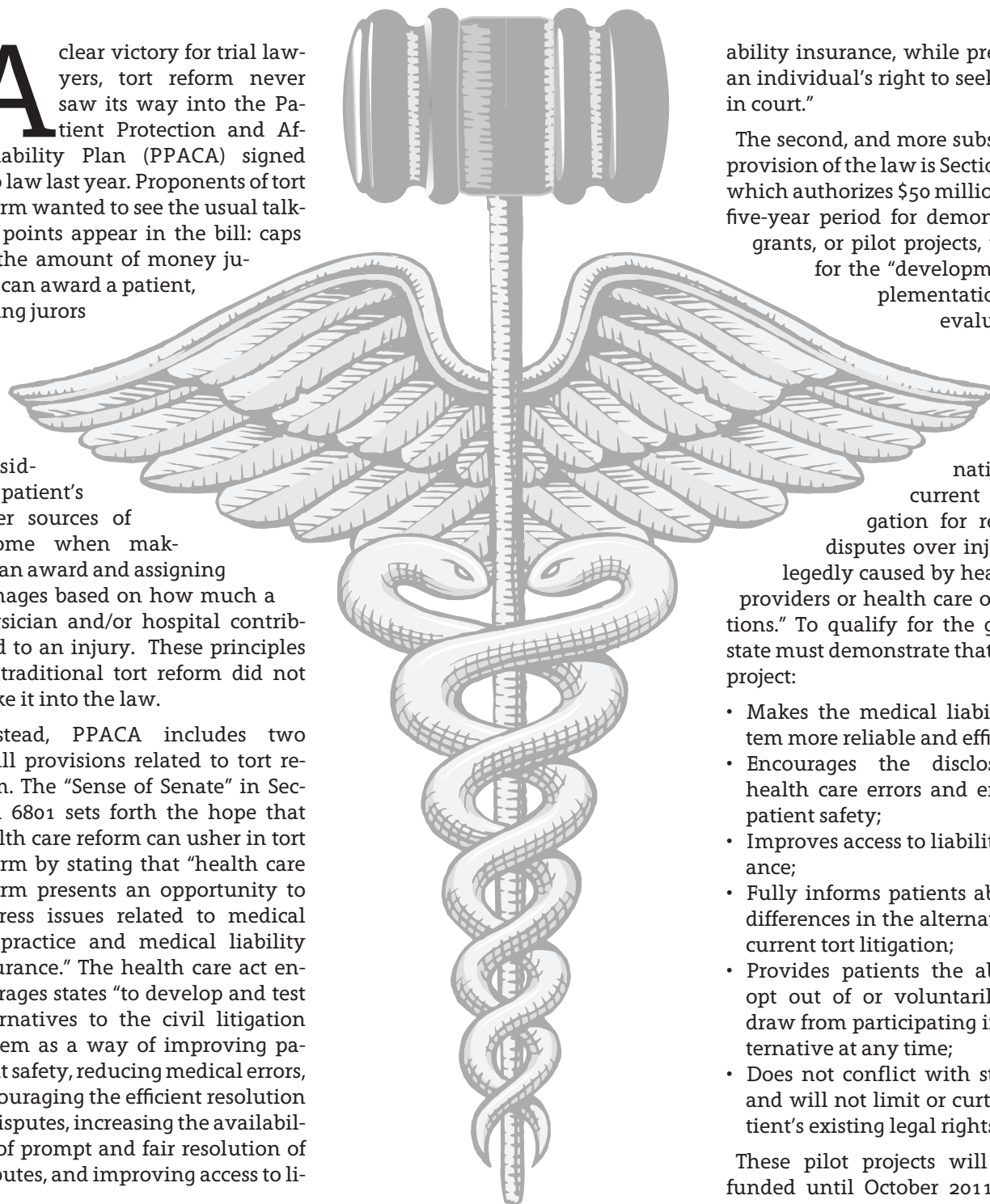
ability insurance, while preserving an individual's right to seek redress in court."

The second, and more substantive, provision of the law is Section 10607 which authorizes \$50 million over a five-year period for demonstration grants, or pilot projects, to states for the "development, implementation and evaluation of

alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations." To qualify for the grants, a state must demonstrate that its pilot project:

- Makes the medical liability system more reliable and efficient;
- Encourages the disclosure of health care errors and enhances patient safety;
- Improves access to liability insurance;
- Fully informs patients about the differences in the alternative and current tort litigation;
- Provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time;
- Does not conflict with state law and will not limit or curtail a patient's existing legal rights.<sup>1</sup>

These pilot projects will not be funded until October 2011.<sup>2</sup> How-



ever, there are a significant number of states that have already implemented, or have tried to implement, some form of tort reform. Since 1975, about 30 states have adopted caps on noneconomic or total damages in medical malpractice cases.<sup>3</sup> California's cap of \$250,000 on noneconomic damages (not adjusted for inflation) is, for many tort reform advocates, the gold standard. Former President George W. Bush proposed capping plaintiffs' damages in medical malpractice cases along the lines of California's cap but was obviously unable to succeed in those efforts. Other states, like Illinois and Wisconsin, have attempted to implement caps on damages in medical malpractice cases as well but their courts overturned the tort reform laws they passed.

For reasons that are evident and understandable, physicians have aggressively pushed for tort reform as their medical malpractice insurance premiums have risen astronomically over the years. Yet the American Medical Association (AMA) backed President Obama's health care law last year, despite the act's lack of meaningful tort reform. Although certainly the AMA has not given up on tort reform as a top priority, a recent article in *The New York Times* offers insight on a trend that has been growing over the years. More physicians have been giving up their traditional private practices for employed, salaried positions with hospitals, particularly

in the North and increasingly in the South.

This trend is not visible in California where, with few exceptions, it is against the law for hospitals to employ physicians. However, in states where hospitals can employ physicians (which are most of the states in this country), salaried positions often come with medical malpractice coverage, removing concerns amongst these salaried physicians about the cost of their medical malpractice premiums. "That change," the article states, "could have a profound effect on the nation's health care debate."<sup>4</sup>

The *Times* article points to the situation in Maine as a case study where "doctors have abandoned the ownership of practices en masse, and their politics and points of view have shifted dramatically." The change in doctors' attitudes in Maine was apparent in February this year when Republican State Senator Lois A. Snowe-Mello introduced a bill in the Republican-controlled state legislature to limit doctors' liability. To Ms. Snowe-Mello's surprise, the doctors' lobby asked her to shelve the bill. The article observes that as the doctors in Maine abandon their private practices for salaried positions, the policies that they have supported are now less focused on tort reform to and more on public health and safety concerns.

Although the AMA's apparent re-

treat from insisting on tort reform in PPACA cannot be completely explained by the trend seen in Maine, as more doctors abandon private practice for salaried position, the age-old fight between doctors and lawyers may continue to wane. However, it remains to be seen what role, if any, PPACA's Section 10607 pilot programs will have on reigniting the push for nationwide tort reforms in the health care arena. These recent developments make one thing clear: PPACA's distilled efforts at addressing tort reform, coupled with a gradual, but perceptible, shift in direction for many physicians' lobbying groups, means that tort reform on the federal level faces an uphill battle. ♦

- *Rashmi Nijagal is an attorney with the Ware Law Group, focusing primarily on healthcare law. A former medical malpractice litigator, she now practices regulatory and administrative law representing medical staffs at hospitals.*

<sup>1</sup> David A. Hyman and William M. Sage, "Do Health Reform and Malpractice Reform Fit Together?" *The American Enterprise Institute*, April 1, 2011.

<sup>2</sup> Andrew Cohen, "Funding Opportunities in the Affordable Care Act" Center for Health Law and Economics, University of Massachusetts Medical School, October 2010.

<sup>3</sup> David Hyman et al., "Estimating the Effect of Damage Caps in Medical Malpractice Cases: Evidence from Texas," *Journal of Legal Analysis* 1, no. 1 (2009): 355.

<sup>4</sup> "As Physicians' Jobs Change, So Do Their Politics" *The New York Times*, May 30, 2011.

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by Carol Langford



## CASH FOR CONVICTIONS:

A reward for a job well done  
or an unlawful stake in the outcome of the case?"

Stephen McCrohan, a public defender in Colorado, recently filed a motion claiming that the District Attorney's Office policy of paying bonuses for convictions gave the prosecutor in his case an improper financial interest in the outcome of the matter. District Attorney Carol Chambers had paid bonuses to her felony prosecutors who won convictions in at least 70 percent of their cases. In order to get the average \$1,100 award, they had to try at least five cases - plea bargains and mistrials don't count. Judge Carlos Samour Jr. allowed McCrohan to subpoena documents about the bonuses and at the time of submitting this article all the documents have not yet been turned over.

Chambers is now backpedaling, saying that she will not offer bonuses in 2011 because of budgetary concerns. But the questions remain - does a bonus amount to an unlawful contingency fee in a criminal matter? Should the court force the District Attorney's Office to abandon the cash for convictions policy?

The job of prosecutors comes with special responsibilities. Prosecutors have what many consider a quasi-judicial function, in that they are the ones who decide what to investigate, whom to charge and what to charge. They must balance their advocacy with their other role - "to

seek justice, not merely to convict," according to the ABA Standards Relating to the Administration of Criminal Justice, 3-1.2 (c). With this dual role come some special responsibilities, both of constitutional and ethical dimensions, such as ABA Model Rule 3.8, which enumerates a series of special requirements for prosecutors. But as any prosecutor will tell you, the criminal justice system often relies on the personal integrity of the district attorney. This is most irrevocably true in death penalty cases.

Other Colorado District Attorney's offices say they don't typically award bonuses or tie performance evaluations to convictions. That sounds disingenuous; of course an attorney's conviction rate would be important to their progression in a District Attorney's Office. Public defenders say that they worry that a prosecutor just shy of making her five convictions might be tempted to drive a harder plea bargain to force a case to trial rather than consider whether a trial is in the interests of justice.

In my view, prosecutors are no different than attorneys in private practice, at least as far as their incentive to grab a financial brass ring are concerned. Have you ever noticed how associate hours in a private firm seem to go up - sometimes way up - right before the year ends? Who

knows how many of their hours are exaggerated to fall within bonus guidelines, because no one is going to talk about it. Prosecutors understand this incentive, and have expressed unease over the bonus. "Our job is not to directly tie the conviction rate, trials or plea bargains to a monetary figure. That would be like working on a commission or something, and that is not what we do" said Colorado District Attorney Scott Storey. It also may not reward the right people; the toughest cases - the ones most likely to result in an acquittal or mistrial - are given to the best people in the office. Therefore the bonus may end up rewarding the people with less talent and ability.

Word on the street is that this is not the first time Ms. Chambers has been the subject of ethics allegations and controversy. She was said to have put judges on a stopwatch to see who was swifter in managing their case load.

Hopefully her bonus system will not be picked up by other states as an idea whose time has come. ♦

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-Carol M. Langford ([clangford.com](http://clangford.com)) is an attorney in Walnut Creek specializing in ethics matters and attorney conduct matters. She is also a lecturer in professional responsibility at U.C. Berkeley this semester.



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# THE SIDE BAR

by Dana Santos

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## "ObamaCare." Discuss.



Health care is too important and too complicated for "democratic" decision. Few of us understand much about it. That is why we are a

republic. Our elected representatives need to work it out. I don't like hostile attacks on Congress for this reason.

*Thomas W. Cain*

Law Office of Thomas W. Cain



Sometimes something that is done quickly but not perfectly is better than nothing at all. I was around for the Hillary Clinton Healthcare

initiative, for the Bush Healthcare initiative, and now we have this. As Churchill said, "the Americans will try everything until they figure it out."

*James R. Arnold*

The Arnold Law Practice



Anything that increases health coverage available to Americans is better than what we have, but the only really just system is single-payer, universal care

that does not tie health coverage to employment (unemployed people get sick, too). Requiring people to buy insurance is the opposite direction of where we should be going; that just helps the insurance companies and burdens the people even more. I am ashamed that the U.S. is so stingy about taking care of its own people (leaving out the question of caring for OTHERS).

*Paula Aiello*

Law Office of Paula Aiello



"Death Panels." "Socialized Medicine." "Medicare Vouchers." Do they really think we are that stupid?

*Dana L. Santos*

Certified Family Law Specialist



The Obama health care plan is Obama's in name alone. The plan was written by the health care industry and its lobbyists to serve its financial goals,

not patients or providers. It provides a trillion dollar gift to that industry over the next decade, on a level with the Obama bailout of the banks and insurance companies. In light of this grotesque travesty, it is up to us, individually, to bring enough pressure from the bottom up to force our political institutions to do the decent thing for all Americans and implement a true single payer health care plan. Please support SB 810 which has just passed the California Senate and is on its way to Governor Brown's desk for signature.

*David Baker*

It's difficult to comment on a piece of legislation that is over 2000 pages long and which no one - not even the lawmakers urging its passage and that it not to be tampered with - has read.

*Brian M. Sanders, Esq.*

Bricksen Arbuthnot

# HEALTH QUIZ

by Dana Santos



**Do you get at least 30 minutes of moderate exercise every day? <sup>1</sup>**

If yes, give yourself 1 point.



**Do you smoke or ingest other forms of tobacco? <sup>2</sup>**

If not, give yourself 1 point.



**Are you a "low risk" drinker: If you are a woman, do you limit your daily alcohol consumption to 3 beverages, and your weekly limit to 7 beverages? If you are a man, do you limit your daily alcohol consumption to 4 beverages, and your weekly limit to 14 beverages? <sup>3</sup>**

If so, give yourself 1 point.



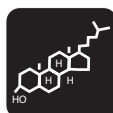
**Do you wear UVA/UVB sunscreen, skin-covering clothing, a hat and sunglasses when you are out in the sun? <sup>4</sup>**

If so, give yourself 1 point.



**Do you maintain a healthy body weight? <sup>5</sup>**

If yes, give yourself 1 point.



**Is your total cholesterol level less than 200mg/dl? <sup>6</sup>**

If yes, give yourself 1 point.



**Do you get 2-3 cups of fruit and 2-3 cups of vegetables everyday? <sup>7</sup>**

If yes, give yourself 1 point.



**Do you have sex at least once per week? <sup>8</sup>**

If yes, give yourself 1 point.



**Do you have a pet? <sup>9</sup>**

If yes, give yourself 1 point.



**Do you take vacations at least twice per year? <sup>10</sup>**

If yes, give yourself 1 point.



**Do you get 6 to 8 hours of sleep each night? <sup>11</sup>**

If yes, give yourself 1 point.

## FIND YOUR SCORE ON PAGE 33

**1** Surgeon General's Report on Physical Activity and Health recommends that all adults should accumulate 30 minutes of moderate-intensity activity on most, if not all days of the week.

**2** CDC reports smoking causes coronary heart disease, the leading cause of death in the United States. Cigarette smokers are 2-4 times more likely to develop coronary heart disease than non-smokers. Additionally, smoking approximately doubles a person's risk for stroke.

**3** "Low risk" is not "no risk." Even within these limits, drinkers can have problems if they drink too quickly, have health problems, or are older (both men and women over 65 are generally advised to have no more than 3 drinks on any day and 7 per week). Based on your health and how alcohol

affects you, you may need to drink less or not at all. National Institutes of Health.

**4** Skin cancer is the most common form of cancer in the United States. CDC.

**5** Research has shown that being overweight or obese substantially raises a person's risk of getting endometrial (uterine), breast, prostate, and colorectal cancers. Overweight is defined as a body mass index (BMI) of 25 to 29, and obesity is defined as a BMI of 30 or higher. CDC.

**6** Per the Mayo Clinic, it is desirable to maintain a total cholesterol level of 200mg/dl or less, and to pay particular attention to the specific types of cholesterol and their respective levels in your bloodstream.

**7** Check out the fruit and vegeta-

ble calculator at the CDC website for your personalized calculation for daily fruit and vegetable consumption.

**8** Researchers at Wilkes University in Pennsylvania have found that having sexual intercourse once or twice a week raises the body's level of the immune-boosting antibody immunoglobulin A by a third, which in turn lowers your risk of getting colds and the flu.

**9** Writing in the British Journal of Health Psychology, Dr Deborah Wells said pet owners tended in general to be healthier than the average person.

**10** Information harvested from the 20-year Framingham Heart Study shows that women who take at least two annual vacations are eight times less likely to develop heart disease or have

a heart attack than those who vacation once every six years or less.

**11** Everyone's individual sleep needs vary. In general, most healthy adults are built for 16 hours of wakefulness and need an average of eight hours of sleep a night. However, some individuals are able to function without sleepiness or drowsiness after as little as six hours of sleep. Others can't perform at their peak unless they've slept ten hours. Sleep is essential for a person's health and wellbeing, according to the National Sleep Foundation (NSF). In addition, more than 40 percent of adults experience daytime sleepiness severe enough to interfere with their daily activities at least a few days each month - with 20 percent reporting problem sleepiness a few days a week or more.



## HEALTH QUIZ - Scores

**10 - 11 points:** You are a wellness guru, why not just retire and go live on an island and meditate?

**9 points:** You are hot, you must be in high demand, you will live forever.

**8 points:** Not bad, you can afford to sit on your laurels.

**7 points:** Probably should hit the gym a little more, eat a little less meat.

**6 points:** Hmm, getting slightly concerned you will die earlier than is absolutely necessary.

**5 points:** Can you say intervention?

**4 points:** Really?

**3 points:** Maybe modeling your lifestyle choices after John Belushi is not such a good idea.

**2 points:** Throw in the towel, what's the point?

**1 - zero points:** Do you have a pulse?

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