The Federally Supported Health Centers Assistance Act of 1992: an Experiment in Malpractice Coverage

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Synopsis

Based on a claims experience that was extremely low and malpractice insurance rates that remained at "commercial" rates, the Congress concluded in 1992 that coverage of malpractice actions against these grantees and their health care practitioners would be more cost-effective under the Federal Tort Claims Act. This, in turn, would allow the grantees to apply the savings to providing health services to their beneficiaries. The lawmakers thereupon enacted a 3-year experiment in coverage of malpractice actions involving certain Public Health Service grantees.

This article describes the background, structure, and administration of this statutory experiment.

In the late 1980s and early 1990s, a malpractice insurance crisis faced many of the Public Health Service's grantees that provide services to medically underserved populations. In an era of fiscal austerity, the costs of malpractice insurance were consuming a disproportionate share of these grantees' operating budgets. This was especially a concern in the face of evidence that the malpractice premiums being paid by these grantees did not reflect the relatively low rate of malpractice claims and payments by these entities.

This article addresses the Congressional response to this crisis, the Federally Supported Health Centers Assistance Act of 1992 ("the Act"), Public Law 102-501, enacted in October 1992.

Background

The Public Health Service (PHS) supports several categories of health centers providing primary health services to medically underserved populations. The House of Representatives Committee report on this legislation notes as follows (*1*):

> In FY 92 [Federal fiscal year 1992], the Federal government will make $526.5 million in grants to nearly 1,500 community health center sites serving about 5.7 million people; $57.7 million in grants to 414 migrant health center sites providing services to about 500,000 migrant and seasonal farmworkers; $55.9 million in grants to 115 health care for the homeless projects delivering health care to about 425,000 homeless people; and $6.1 million in grants to 14 community-based organizations serving an estimated 60,000 public housing residents.

The Congress heard testimony from the National Association of Community Health Centers, representing many of these grantees, to the effect that community health centers spent in the range of $50 million for malpractice insurance premiums each year, while the amount of claims paid each year was less than 10 percent of the premiums paid (*1*). Assuming these data to be accurate, the results were that the insurance companies were reaping large profits on these premiums and that funds that might otherwise subsidize health care were being spent on malpractice insurance that was overpriced.

Efforts to negotiate lower premiums for these grantees, given their low claims rate, were not successful; malpractice insurers were unwilling to treat these centers as different from other health care providers, notwithstanding their different patient populations and their claims experience. Attempts by representatives of the grantees to set up alternative insurance mechanisms were also unsuccessful. A Federal legislative solution seemed necessary.

The model for a statutory solution was found in the manner in which commissioned officers and employees of the PHS are protected. Normally, under the doctrine of sovereign immunity, actions of Federal officials are not subject to challenge in court. The Federal Tort Claims Act (FTCA) was enacted in

1946 and provides a limited waiver of that sovereign immunity, under which the U.S. Government consented to be sued for personal injury or death caused by the negligence or wrongful act or omission of Federal employees acting within the scope of their employment.

Section 224 of the Public Health Service Act provides that the remedies under the FTCA constitute the exclusive remedy for "damage for personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions ... " by officers and employees of the PHS. The persons covered by the FTCA have a statutory immunity from personal liability.

Precedent existed for extending coverage of the FTCA, and the related personal immunity, to persons who are not Federal employees. Since 1988, incidents of medical malpractice and other negligent acts by health care contractors carrying out grants, contracts, or cooperative agreements under the Indian Self-Determination Act (Public Law 93-638) have been subject to FTCA coverage (*2*).

Statute

The Federally Supported Health Centers Assistance Act of 1992, Public Law 102-501, was signed into law on October 24, 1992. It provides a 3-year demonstration of an approach to protecting the identified grantees and their health care practitioners from malpractice claims, without the need for expensive insurance.

The statute covers grantees under the following programs:

- Community health centers, section 330 of the PHS Act.
- Migrant health centers, section 329 of the PHS Act.
- Health services for the homeless, section 340 of the PHS Act.
- Health services for residents of public housing, section 340A of the PHS Act.

Coverage is provided only after the Secretary of Health and Human Services, acting through the Bureau of Primary Health Care within the Health Resources and Services Administration, deems the grantee to meet certain requirements, including the implementation of policies and procedures to minimize the risk of malpractice and of lawsuits, and has reviewed and verified the professional credentials, claims history, and related matters for its health care practitioners (*3*). Program guidance has made clear that coverage for any entity under the Act will not be effective until this "deeming" process has been completed (*4*).

The Act provides that coverage is available for acts and omissions occurring on or after January 1, 1993, and before January 1, 1996 (*5*). As indicated previously, the deeming process must be successfully completed before a grantee may avail itself of the Act's protection.

The Act covers the grantees themselves, but also covers persons associated with them. Included are " ... any officer, employee, or contractor ... of such an entity who is a physician or other licensed or certified health care practitioner ... " (*6*). A contractor may be covered if he or she normally performs on average 32½ hours of service per week for the grantee, or for those providing less hours of service, if (*a*) they are licensed or certified providers of obstetrical services, and (*b*) either their individual malpractice insurance does not extend to services provided for the grantee, or the Secretary finds that the grantee's patients will be deprived of services should coverage under the Act not extend to them (*7*).

FTCA claims are handled initially as administrative claims. Claimants must file within 2 years of the alleged incident (subject to certain exceptions based on the patient not having reason to suspect negligence at the time of the incident) with the PHS Claims Officer. If no action is taken within 6 months, or if a satisfactory settlement is not reached within that time, the claimant may then deem the claim denied and file a civil suit in the appropriate Federal district court.

Grantees and their health care practitioners may find that civil suits have been filed in State or Federal courts before an FTCA claim has been filed. If so, they should contact the PHS to obtain a determination whether the conduct involved is protected by the Act. If it is so determined, a motion would be filed to remove any action from State court to Federal court, to substitute the Federal Government as the proper defendant, and to dismiss the action against the grantee and the individual.

The determination that the conduct at issue is subject to FTCA coverage requires action by both PHS and the Department of Justice. The PHS will determine whether the act or omission occurred after a "deeming" determination has been made and whether the action was within the scope of the grant-supported activity. The Justice Department will consider these issues and will also certify whether the activity was within the scope of employment, in the case of individual health care practitioners. Coverage may be denied an individual by the Department of Justice for an inadequate compliance with the grantee's risk reduction policies, for an excessive history of claims, or for failure to cooperate in the

defense of claims. Such denial of coverage would apply only after the appropriate grantee receives notice of such a decision by the Department of Justice (*8*).

Issue Arising Under the Act

Funding. The Act provides that the Attorney General is to estimate the likely costs associated with coverage of grantees and persons under the Program and to send the PHS a "bill" for such amounts for each of Federal fiscal years 1993, 1994, and 1995. The amounts are not to exceed $30 million per year and are to be transferred to an account in the U.S. Treasury (*9*). A question arose whether funds for this purpose would be derived from the appropriation for each of the grant programs. Congress resolved any question about this by amending the Act in 1993 to state explicitly that funds were to be obtained from a separate appropriation from that for grants (*10*).

Furthermore, in the event of a large estimate from the Attorney General for the "bill" to pay claims, the PHS is limited to the amounts specified in each fiscal year's appropriation. Thus, for example, the fiscal year 1995 appropriation for the Department of Health and Human Services limits to no more than $5 million the amount that may be paid in that fiscal year into the claims account in the Treasury (*11*).

Need for insurance. The Act provides "event" coverage during the time it applies to a grantee and its providers. That is, if the act or omission under challenge occurred while the entity was deemed covered and before the expiration of the Act's provisions, coverage will be available, regardless of when the suit or claim is filed. However, for grantees whose prior insurance coverage was on the basis of "claims made," the cancellation of their malpractice insurance would leave open the possibility of malpractice actions based on events that occurred prior to the Act's applicability. These grantees have been advised to purchase "tail" insurance, under which coverage of prior acts and omissions is insured, regardless of when the legal action is filed.

Gaps in coverage. In many cases, coverage for individual health care practitioners is not going to be certain in advance. A major area of discussion between the PHS and the Justice Department has been related to coverage for treatment of persons who are not patients of the grantee. Three examples have been identified in a regulation to address this issue:

1. A proper grant-supported activity is the provision of services in a school-based health care program.
2. As a condition of a grantee's physician obtaining staff privileges at a community hospital, he or she must agree to provide occasional coverage at the hospital's emergency room.
3. A grantee's physician is required by his or her employment contract to provide periodic cross-coverage with a community physician, who in turn will cover the grantee's patients after hours.

In the regulation, the Department of Health and Human Services provided a procedure for determinations by the PHS that coverage would be available in such situations, subject to certain safeguards (*12*). The preamble to the regulation makes clear that moonlighting activities are not covered and that the Justice Department must still certify each claim as being within the scope of employment. Still, it is hoped that the rule, when implemented, will resolve most cases of uncertainty regarding coverage.

Many grantees have felt the need to purchase "gap" insurance, under which acts and omissions not covered by the FTCA will still be insured. For example, contract providers working less than 32 1/2 hours per week for the grantee (other than providers of obstetrical services, as discussed above) would need either their own insurance or coverage under a policy from the grantee. The cost of such gap insurance has been difficult to calculate due to the uncertainties regarding scope of coverage. It is expected that the greater certainty provided by the regulation will make the cost of gap insurance easier to calculate and, indeed, lower.

Hospital admitting privileges. Section 3 of the Act further amended section 224 of the PHS Act by adding a new subsection (*j*), which provides that hospitals may not deny staff privileges to officers, employees, and contractors of covered grantees if they meet the appropriate professional qualifications and agree to abide by the hospital's bylaws. Thus, the lack of malpractice insurance may not be used as a basis to deny staff privileges; failure to comply may result in losing Medicare and Medicaid reimbursement (*13*).

Need for reauthorization. As noted previously, this is a 3-year demonstration. Because, under the initial Act, coverage expires for acts and omissions occurring after December 31, 1995, Congress will need to consider whether to reauthorize the program. To help in its deliberations, Congress mandated that the

Department of Justice report by April 1, 1995, on the malpractice liability claims experience of covered entities and on the risk exposure associated with such entities (*14*).

The data available to date may be insufficient to allow a thorough analysis of the potential cost of this program. Claims experience may be incomplete for several reasons:

- The different dates that grantees were "deemed" covered.
- The time lag between the acts and omissions alleged to constitute malpractice and the deadline for filing claims.
- The uncertainty about double coverage, based on some grantees carrying malpractice insurance after being "deemed" covered, and the uncertainty about which claims will be covered by the FTCA and which by "gap" insurance.

In fact, an analysis of the potential cost of the program was undertaken by the U.S. General Accounting Office (GAO) in 1993. In September 1993, the GAO issued a report speculating that (*15*):

> It could cost the government more money over time to resolve the grantees' malpractice claims under FTCA than it would have cost to resolve the grantees' claims if the private sector's insurance coverage had continued.

The GAO report acknowledges, however, that this conclusion is based on assumptions that losses under FTCA will be higher than under malpractice insurance, for two reasons.

1. FTCA provides unlimited dollar coverage. For example, the consulting firm under contract to the GAO estimated "coverage of slightly less than $5 million for each claim filed," and the report notes that "estimates of the government's costs would have been lower if ... [the consulting firm] had assumed a smaller per-claim limit.... " (*15a*).

2. FTCA coverage "makes the Government liable for a different set of injuries than private sector insurers would have been liable for if FTCA coverage had not been enacted" (*15b*). Furthermore, the report admits that its cost estimates under the FTCA are not based on the grantees' traditionally low claims experience and indicates that these estimates assume the FTCA coverage will have been in effect for the full 3-year period authorized, rather than a shorter period based on the dates of the "deeming" process (*15a*).

While the authors of the GAO report met informally with PHS officials prior to issuing the report, the GAO did not obtain written comments from the agency (*15c*). However, the Bureau of Primary Health Care, the unit within PHS responsible for implementing the Act, has advised Congress of its disagreement with the "assessment and conclusions offered by the GAO report ... ", citing the issues described previously (letter of December 8, 1993, to Congressman Ron Wyden from Marilyn H. Gaston, MD, Assistant Surgeon General and Director, Bureau of Primary Health Care).

Conclusion

This program represents an experiment in providing malpractice coverage for a category of Federal grantees whose needs the private insurance market had failed to meet. While it will take some years to determine whether it proves to be cost-effective, in the short term, it has enabled the PHS to support increased funding for health care services.

References

1. H.R.Rep. No. 823, Part 2, p. 5, 102nd Cong. 2nd Sess.
2. Public Laws 100-202 and 101-121.
3. Section 224(h) of the PHS Act, 42 U.S.C. 233(h).
4. Proposed 42 CFR § 6.5 as set forth in 59 Federal Register 42792, Aug. 19, 1994.
5. Section 224(g)(3) of the PHS Act, 42 U.S.C. 233(g)(3).
6. Section 224(g)(1) of the PHS Act, 42 U.S.C. 233(g)(1).
7. Section 224(g)(5) of the PHS Act, 42 U.S.C. 233(g)(5).
8. Section 224(i) of the PHS Act, 42 U.S.C. 233(i).
9. Section 4 of the Act, adding a new subsection (k) to Section 224 of the PHS Act, 42 U.S.C. 233(k).
10. Section 706(a) of Public Law 103-183, Dec. 14, 1993.
11. Title II of Public Law 103-333, Oct. 4, 1994.
12. 60 Federal Register 22530-32, May 8, 1995.
13. 57 Federal Register 62349 at 62350, ¶ V, Dec. 30, 1992.
14. Section 5 of Public Law 102-501, Oct. 24, 1992.
15. Medical malpractice: estimated savings and costs of federal insurance at health centers. Report of the GAO to the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, U.S. Senate, No. GAO/HRD-93-130. (*a*) p. 3; (*b*) p. 4; (*c*) p. 14.