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Report to the Chairman, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, U.S. Senate

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MEDICAL MALPRACTICE

Data on Claims Needed to Evaluate Health Centers' Insurance Alternatives

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The Honorable Tom Harkin
Chairman, Subcommittee on Labor,
Health and Human Services, Education,
and Related Agencies
Committee on Appropriations
United States Senate

Dear Mr. Chairman:

Community and migrant health centers paid an estimated $50 million for medical malpractice insurance in fiscal year 1989. This accounted for about 10 percent of the total federal grant funds awarded to help these centers provide health care to vulnerable populations, such as poor pregnant women, HIV-infected people, and the homeless. If centers can reduce their malpractice insurance burden, access to health care for medically underserved populations could be increased without increasing federal grant expenditures. The Congress is considering alternate ways of providing insurance coverage for the centers. As agreed with Committee staff, this report identifies critical data elements needed to assess the alternatives and discusses their current availability.

Background

To help provide health care to millions of the most needy patients, the Bureau of Health Care Delivery and Assistance (BHCDA)[1] awards grants to public or nonprofit private entities to plan, develop, and operate community and migrant health centers. The centers provide prevention-oriented primary health care to medically underserved and disadvantaged populations living in areas with shortages of these services.[2] Services are provided to such groups as low-income minorities, substance abusers, HIV-infected people, migrant and seasonal farm workers, the homeless, the uninsured, and the elderly. The centers also give priority to women of child-bearing age and children living in poverty—those particularly at risk for premature deliveries and high rates of morbidity and mortality.

[1] Within the Department of Health and Human Services, BHCDA administers the federal grant programs for the community and migrant health centers. It is located within the Public Health Service's Health Resources and Services Administration (HRSA).

[2] The services all centers must provide include diagnostic laboratory and radiology services, preventive health services, emergency medical services, preventive dental care, and physician services. In addition, depending on the grantee, centers may provide supplemental services, such as home health care, extended care, mental health services, and ambulatory surgery.

Primarily, services are provided by health care providers who are either employed directly by the centers or assigned to the centers through the National Health Service Corps (NHSC).[3] Because the centers have difficulty recruiting private health care providers—they cannot always offer competitive salaries, working conditions may be poor, and many of the facilities are located in undesirable areas—they rely on NHSC as much as possible.[4] Usually, centers pay the salaries of the assigned NHSC providers.

In fiscal year 1990, the Congress appropriated about $506.2 million for 526 community and 109 migrant health center program grantees.[5] Some centers receive grant funds from both the community and the migrant health center programs—about 65 percent of the migrant center grantees also received funds from the community health center appropriation. These grants provided about 44 percent of the centers' total funding. The centers received another $514 million (45 percent) through Medicaid, Medicare, third party payers, and state, local, and other sources. Only about 11 percent of the centers' funding to meet the total operating expenses came from patient fees.

Included among community and migrant health centers' operating expenses is the cost of the medical malpractice insurance purchased to protect the centers and the associated health care providers against malpractice claims. The centers pay the malpractice expenses of all health care providers to be insured, including the NHSC providers for whom they pay the salaries. When the government pays the salaries of the NHSC health care providers assigned to the centers, the providers are

[3] The NHSC scholarship program provides tuition assistance to students of medicine, dentistry, nursing, and other health professions in return for a commitment to practice in an underserved area after completing training. Through the federal loan repayment program administered by NHSC, educational loans incurred by selected applicants in the health professions are repaid in exchange for practice in a designated underserved area.

[4] The National Association of Community Health Centers has stated that historically, the centers depended on NHSC for one-half of their physician staff. However, between 1985 and 1989, the number of NHSC scholars placed in centers decreased from 800 to 141. In 1990, an estimated 800 vacancies in the centers needed to be filled to reach full staffing of about 2,700 physicians.

[5] Section 330 (Community Health Centers) and section 329 (Migrant Health Centers) of the Public Health Service Act authorize the grant funds. In fiscal year 1990, the Congress appropriated about $456.9 million for community health center grantees and about $49.3 million for migrant center grantees.

considered to be federal employees and the government assumes liability for malpractice claims under the Federal Tort Claims Act.[6]

As with other health care providers, centers sometimes face problems in purchasing medical malpractice insurance. Insurance can be unaffordable or unavailable. In addition, because centers cannot pass these expenses on to many of their patients, malpractice insurance costs reduce funds available for direct care services.

The centers have sought federal fiscal relief to help pay for the medical malpractice insurance. Alternatives for providing the centers' insurance may include (1) the federal government assuming liability under the Federal Tort Claims Act, (2) establishing a risk-retention group to self-insure the centers,[7] and (3) purchasing commercial insurance through a nationally formed risk-purchasing group.

Methodology

To identify critical data elements needed to assess alternatives for providing malpractice insurance coverage for the community and migrant health centers, we met with actuaries specializing in medical malpractice insurance at Tillinghast—an international consulting and actuarial firm providing services to medical malpractice insurers—in Atlanta.

To identify the data currently available, we met with officials at BHCDA in Rockville, Maryland; the National Association of Community Health Centers (NACHC) in Washington, D.C.; two rural health centers in Florida; and the Virginia Primary Care Association, which represents the 17 Virginia centers receiving BHCDA grants.

We also reviewed the methodologies and results of past efforts to obtain the data needed to assess alternatives. We did our work between February and April 1991.

[6] A private citizen who alleges injury as a result of medical care received from a federally employed health care provider or at a federal health care facility may sue the United States. The Federal Tort Claims Act waives sovereign immunity, with some exceptions, by making the government liable for civil damages in the same manner and to the same extent as a private individual in like circumstances.

[7] Under the Liability Risk Retention Act, groups may form their own insurance companies to provide insurance to their members. By forming an insurance company to deal with problems of a select group, the insurer should be able to provide insurance at reasonable rates and guarantee continued availability.

Historical Claims Experience Is Critical to Assessment of Alternatives

The medical malpractice actuaries at Tillinghast told us that to evaluate the potential liability costs to the centers and to estimate costs of alternatives, they would test the assumption that the malpractice claims experience[8] of physicians practicing in community and migrant health centers is lower than that of physicians in a typical family practice setting. If center physicians have a more favorable claims experience, proportionately lower malpractice insurance costs may be indicated. The actuaries also stated that the critical data needed to test this assumption are the number of physicians and other health care providers covered by the centers' (or their own) malpractice insurance and the associated number of claims and the dollar amount of claims of the centers over at least the past 5 years. Further, they emphasized that in actuarial terms the total number of physicians is small, making it important to maximize the adequacy of these data by maximizing the number of centers from which data are obtained.[9]

Available Claims Data Do Not Provide an Adequate Basis for a Current Assessment of the Alternatives

Data on the total number of medical malpractice claims filed against the community and migrant health centers and their associated health care providers are not available at a central source. Surveys to collect claims experience data have been largely unsuccessful or have provided data that are not current. Therefore, available claims data do not provide an adequate basis for a current assessment of insurance alternatives.

Data Not Collected on All Claims

As part of the grant application process, centers are required to provide information to BHCDA on their health care providers.[10] However, they are not required to report their claims experience. Neither BHCDA headquarters nor its regional offices collect any data from the centers on their total medical malpractice claims experience.

[8] Generally, this is the number of claims filed (frequency) multiplied by the amount paid per claim (severity) divided by the number of physicians insured (exposures).

[9] The use of historical statistics to predict future losses is based on the law of large numbers—as the number of exposure units increases, actual losses will more closely approach expected losses, assuming that there has been no change in the underlying factors that affect losses. But there is no number, however large, at which the actual losses will always equal the expected losses since there is always an element of chance in the occurrence of losses. The credibility of loss data—the extent to which there is confidence that the available statistics accurately indicate the losses to be anticipated in the future—increases as the number of exposure units increases. (See Bernard L. Webb and others, Insurance Company Operations - Volume II, American Institute for Property and Liability Underwriters, 1984, p. 37.)

[10] Data on each provider include specialty, full-time equivalency, malpractice insurance coverage limits, and insurance costs.

Limited data are available only on those claims filed under the Federal Tort Claims Act. As part of its efforts to strengthen risk management, HRSA reviewed claims involving Indian Health Service facilities and NHSC federally employed health care providers working in community health centers. Claims included in the study were filed during fiscal years 1980 through 1986. The study did not provide a complete picture in that it contained no information on the claims experience of the centers as an entity or of the private and nonfederally employed NHSC health care providers at the centers. Appendix I presents a brief description of the methodology and results of the HRSA study.

Claims Data From Surveys Are Limited or Not Current

The first of three surveys we identified that attempted to quantify the medical malpractice claims experience of the centers was conducted by NACHC in the fall of 1985. NACHC surveyed 641 community and migrant health centers to determine, among other things, their medical malpractice claims experience and compare their claims history with that of other health care providers. The survey sought to collect longitudinal claims data reflecting each center's claims history for all operating years. In February 1986, NACHC reported that 95 claims were filed at the 261 centers responding to the survey.[11] Compared to other health care providers, at that time the claims experience of the centers was found to be lower. The report also stated that the survey findings could not be accepted with the same confidence as if all the centers had responded.

The second survey was done in 1986. NACHC surveyed 493 centers and retained Tillinghast of Los Angeles to evaluate alternate risk-financing strategies, including group-purchasing plans and risk-sharing groups. Tillinghast reported in June 1987 that from 1982 through 1986, the 89 centers responding to the survey experienced between four and eight claims each year with the associated dollar amount of claims ranging from $7,500 to $58,815.[12] While the centers reported few claims, the report noted that only 18 percent of the centers responded to the survey. As a result, Tillinghast could not project the final results to assess all of the alternatives for financing medical malpractice insurance expenses.

[11] The National Association of Community Health Centers, The Medical Malpractice Claims Experience of Community and Migrant Health Centers—A Comparative Study, February 1986.

[12] Tillinghast, National Association of Community Health Centers Risk Financing Alternatives Study, June 1, 1987.

The third survey was commissioned by the Institute of Medicine in 1988 as part of a larger study on the effects of medical malpractice on maternal and child health care.[13] A sample of 139 community and migrant health centers were surveyed to obtain, among other things, centers' malpractice claims experience. Only 8 of the 58 responding centers ever had a claim filed against them. However, the report stated that these results may be limited by selection bias because centers that had claims may not have completed the survey.

Appendix II presents a brief description of the methodologies for the three surveys discussed above. Because the claims experience data are outdated and there are no data available at a central location, we will be conducting a survey to collect the critical data needed for a current assessment of alternatives for providing medical malpractice insurance coverage.

As agreed with your office, we did not obtain comments on this report. We will send copies of the report to BHCDA, NACHC, and other interested parties, and we will make copies available to others on request.

Please call me on (202) 275-5451 if you or your staff have any questions about this report. Other major contributors are listed in appendix III.

Sincerely yours,

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

[13] Institute of Medicine, Medical Professional Liability and the Delivery of Obstetrical Care, Volumes I and II, 1989.

Contents

Abbreviations

BHCDA	Bureau of Health Care Delivery and Assistance
HRSA	Health Resources and Services Administration
NACHC	National Association of Community Health Centers
NHSC	National Health Service Corps

Methodology and Results of HRSA's Study of Medical Injury Claims Filed Under the Federal Tort Claims Act

HRSA reviewed claims filed under the Federal Tort Claims Act that stemmed from medical care provided at Indian Health Service facilities and by federally employed NHSC health care providers working at community and migrant health centers from October 1, 1979, through September 30, 1986. Study data were obtained from card files maintained by the Division of Public Health Service Claims. In most cases, cards for claims against the Indian Health Service listed only the facility at which the alleged incident occurred and not the providers. The providers at the Indian Health Service facilities could have been Commissioned Officers of the Public Health Service, private practitioners under contract to the Indian Health Service, or additional federally employed NHSC providers assigned to the facilities.

HRSA reported in February 1987 that during the 7-year period, 374 claims were filed under the Federal Tort Claims Act—195 at Indian Health Service facilities, and 179 against federal providers at community health centers. Of these claims, 108 were open at the time of the study, 41 had received payments totaling $417,837 (21 claims totaling $137,436 were paid against NHSC health care providers at the centers), and 225 were denied. In addition, 154 plaintiffs (65 with claims against the health care providers at the centers) pursued denied claims by filing suits in federal court. Of these suits, 46 were settled with payment to the plaintiff[1] (14 dealing with the NHSC health care providers totaling $989,030), and 1 was judged in the plaintiff's favor for a total of about $4.2 million. The outcome of 50 suits was unknown.

However, the study also stated that because of the many variables that influence claim initiation by patients and the absence of uniform standards and definitions of appropriateness of a medical action, no conclusions could or should be made about the quality of care or the frequency of malpractice in Indian Health Service facilities or by NHSC federal health care providers. The report, Claims of Medical Injury, Filed Under the Federal Tort Claims Act Against the Indian Health Service and the National Health Service Corps, Between FY 1980 and FY 1986, was published in February 1987.

[1] The amount paid for three of the settlements was unknown.

Claims Survey Methodologies

The Medical Malpractice Claims Experience of Community and Migrant Health Centers

NACHC reported that it mailed a claims survey instrument to 641 federally funded community and migrant health centers in September 1985. The instrument was designed to gather such data as (1) the number of full-time equivalent physicians by specialty, (2) the number of claims filed by specialty of physician, (3) the claims' status, (4) the number of claims involving NHSC physicians, and (5) insurance coverage carried by the centers. By January 15, 1986, NACHC received 261 (41 percent) completed questionnaires.

In February 1986, to obtain additional data, NACHC called a random sample of 10 percent of the nonrespondents. Its report stated that this group was similar to the respondents in terms of location, number of full-time equivalent physicians, area served, and federal funding and that therefore the findings from the claims survey represented the malpractice claims of all health centers in general.[1]

Risk Financing Alternatives Study

Retained by NACHC, Tillinghast developed a comprehensive questionnaire addressing all aspects of the centers' insurance profile and experiences, including those pertaining to medical malpractice, general liability, automobile operations, workers' compensation, umbrella coverages, and directors' and officers' liabilities. NACHC's Washington, D.C., office mailed the questionnaires to 493 centers in October 1986. Eighty-nine centers (18 percent) returned the questionnaire. Tillinghast analyzed the survey results and reported its findings in a June 1987 report, National Association of Community Health Centers Risk Financing Alternatives Study.

Medical Professional Liability and the Delivery of Obstetrical Care

To examine the effects of medical professional liability on the delivery of maternal and child health care, the Institute of Medicine assembled an interdisciplinary committee. For the study, it commissioned more than 20 papers by experts in various fields, reviewed more than 50 surveys dealing with the medical malpractice problem in obstetrics, and commissioned three surveys to gather new data—including a survey of the community and migrant health centers.

To obtain data, the commissioned researchers surveyed a random sample of 208 community and migrant health centers (about 37 percent of all centers) between April and May 1988. Of the 208 questionnaires in

[1] The Medical Malpractice Claims Experience of Community and Migrant Health Centers—A Comparative Study, February 1986.

the original sample, 69 were excluded because the respondents were not community and migrant health centers.[2] The researchers received 58 completed questionnaires from the remaining 139 centers. The 58 centers represented about 10 percent of all the federally funded centers. The Institute of Medicine reported its findings in a 1989 report, Medical Professional Liability and the Delivery of Obstetrical Care.

[2] The sample was selected from NACHC's membership list, which, according to the study, included nonproviders, such as individual members and state associations.

Major Contributors to This Report

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