Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAL MALPRACTICE INSURANCE AND THE COMMUNITY HEALTH CENTERS

A MANAGEMENT ADVISORY REPORT

Richard P. Kusserow
INSPECTOR GENERAL

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INTRODUCTION

PURPOSE

The purpose of this report is to summarize current concerns and available information regarding the costs of medical malpractice insurance at federally funded community and migrant health centers.

BACKGROUND

This report was prepared in response to a request from Kevin E. Moley, Assistant Secretary for Management and Budget, for information on medical malpractice insurance costs at community and migrant health centers.

Five hundred and fifty community and migrant health center grantees receive funding through Sections 329 and 330 of the Public Health Service Act. These centers provide primary health services in medically underserved areas throughout the country.

Until the early 1980's, federally employed National Health Service Corps (NHSC) members comprised a significant portion of the centers' medical staffs. As Federal employees, members were covered for liability under the Federal Tort Claims Act.

Budget cuts and policy changes in the NHSC over the past decade have increased centers' malpractice insurance expenses in two ways. First, the number of corps providers available for service has been cut considerably. Consequently, centers have been forced to hire an increasing percentage of non-corps providers. Second, the Public Health Service has required that the majority of remaining corps members be employed directly by centers, rather than by the Federal government.[1] As a result, the cost of medical malpractice insurance--for both directly hired corps members and the increased number of non-corps providers--has been shifted to the centers.

At the same time, medical malpractice insurance costs nationwide have risen substantially. Premiums for obstetricians, for example, rose by as much as 300 percent between 1982 and 1987.[2] In FY 1989, centers spent approximately $50 million--10 percent of their total Federal grant funding, or 4.4 percent of total revenues--on malpractice insurance premiums.[3] Alternative insurance approaches might reduce costs, and thereby result in an increase in the amount of funding available for direct services to center clients.

METHODOLOGY

To gather information for this report, we spoke with staff at several congressional offices, national and regional primary care associations, Federal agencies, and advocacy groups. We reviewed published reports and proposed legislation from these offices, and examined data from a recent OIG survey (see appendix A).

FINDINGS

THE COST OF MEDICAL MALPRACTICE INSURANCE PREMIUMS LIMITS SERVICES AT CENTERS.

The rising cost of medical malpractice insurance--particularly for obstetrical care--has been identified as an increasingly serious financial burden, which limits the provision of services at community and migrant health centers.

In response to a June 1991 Office of Inspector General survey:

- 56 percent of centers cited the high cost of medical malpractice insurance as a factor that significantly limits their ability to provide pregnancy care;
- 27 percent of centers indicated that the cost of medical malpractice insurance has become a more serious limitation to care since 1988; and
- 9 rural centers reported that they have been forced to omit or discontinue obstetrical services entirely because of problems related to malpractice insurance.[4]

Research by the Institute of Medicine supports these findings.[5] Centers have found it increasingly difficult to recruit and retain staff, because the limited funds that might have been spent on salaries are being spent instead on insurance premiums. Centers that contract with providers for care have been unable to meet the rising hourly wages that are necessary to support these physicians' personal malpractice insurance premiums. Some centers have been unable to obtain coverage at any cost.

TO DATE, THE PUBLIC HEALTH SERVICE HAS NOT ROUTINELY COLLECTED DATA FROM CENTERS ON THE NUMBER AND DOLLAR VALUE OF MEDICAL MALPRACTICE CLAIMS AGAINST THEM.

While the Public Health Service (PHS) has required centers to report data on the costs of premiums as part of the annual center grant application process, it has not collected information on claims experience. Thus, it has not compiled comprehensive data on the centers' claims histories.

Beginning in fiscal year 1992, the PHS will require centers to report total claims paid in their annual applications. Only current year information will be collected.

The PHS and the General Accounting Office (GAO) have recently begun a comprehensive study of the premiums and claims experience of the centers over the past five years. They intend to survey all centers regarding their premiums and claims

histories. A GAO project update on this effort was published in May 1991; a final GAO report is expected in spring 1992.

MOST CENTERS FOR WHICH DATA HAVE BEEN COLLECTED ARE PAYING DISPROPORTIONATELY HIGH MEDICAL MALPRACTICE INSURANCE PREMIUMS.

Data from those centers that have been studied indicate that successful medical malpractice claims against them represent roughly 10 percent of the costs of premiums paid. By contrast, medical malpractice claims paid on behalf of all providers nationally represent 56 percent of premiums paid.[6] Explanations for the smaller amount paid on behalf of center providers might include:

- a smaller average number of claims brought against center providers than against non-center providers;[7] and/or

- a lower average amount paid in successful claims against center providers.

Current estimates of the number and dollar value of center claims are based, however, on limited information. In the past five years, several studies have attempted to collect claims data (see appendix B). These studies are limited by small sample sizes, low response rates, and limited focus. Their findings are outlined below.

▸ **Several regional primary care associations** have conducted studies during the past year. Although limited in geographic scope, these provide the most recent and most comprehensive data currently available on centers' premiums and claims histories. All of these studies have demonstrated that centers have paid high premiums relative to both the low number of claims filed against them and the small size of successful claims paid.

- **The Northwest Regional Primary Care Association** reported in July 1991 on survey responses from 28 of the 31 community and migrant health centers in Alaska, Oregon, Idaho, and Washington. Between 1988 and 1990, $4 million was spent on malpractice insurance premiums. Four claims had been paid in the total amount of $15,000, against initial claims of $55,000. Four claims were still pending for $215,500. If all pending claims were ultimately paid in full, total claims paid would represent 6 percent of annual premiums.

- **The Virginia Primary Care Association** has reported that the 17 centers in that state have paid approximately $1.1 million in professional liability premiums over the past 7 years. Four claims have been filed during that time, and none has been paid.[8]

- **The Association for Utah Community Health** has reported that the

5 community health centers in that state have spent approximately $100,000 on malpractice insurance premiums in 1991. No claims have ever been paid, and no claims are pending.

- o **The Rhode Island Health Center Association** has reported that the 4 community health centers in that state have spent $351,000 on malpractice premiums in 1991. In their entire history, the centers have paid less than $25,000 in claims. If the $25,000 had been paid in 1991, it would represent 7 percent of annual premiums. No claims are pending.

- o **The Connecticut Primary Care Association** has reported that 10 of the 14 centers in that state responded to a recent survey. These have paid $590,000 in premiums in 1991. In the history of the centers, only 5 claims have ever been filed; only one of these was paid, in the amount of $35,000. This claim represents 6 percent of 1991 premiums.

▸ **The National Association of Community Health Centers** released two reports in the mid-1980's on its members' medical malpractice premiums and claims experience. The data they present are both limited and dated.

The Medical Malpractice Claims Experience of Community and Migrant Health Centers, A Comparative Study, was released in 1986. This report was based on responses from 41 percent of all centers to a survey on claims experience, and responses from 32 percent of all centers to a survey on risk management/access to coverage.

- o A total of 95 claims had been brought against 67 (26 percent) of the respondents during their entire operating histories. Of the resolved cases, 46 percent had been found for the plaintiff. No dollar amounts for the claims paid were provided.

- o The study compared the rate of claims against center physicians, by specialty, to national averages obtained from physician organizations. The data suggested that claims were filed against center providers less frequently than against non-center providers.

Risk Financing Alternatives Study, prepared by Tillinghast, an independent actuarial consultant, was released in 1987. This report was based on survey responses from 18 percent of all centers.

- o In 1986, responding centers paid $3.5 million in professional liability premiums; their paid claims amounted to $71,000 (approximately 2 percent of premiums).

- o The study concluded that this ratio of claims to premiums was far lower than the industry average.[9]

▸ **The Health Resources and Services Administration** (HRSA) published *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*, in 1987. This study reviewed combined data on the claims against federally employed providers in both community health center and Indian Health Service settings. These data were available because these providers were covered for malpractice liability under the Federal Tort Claims Act. This study did not examine the claims histories of non-federally employed community health center providers.

- The report found that 374 claims had been brought against federally employed providers in both settings during the 7 year period. Of these, 12 percent had been approved and paid; 72 percent had been denied.[10] Suits had resulted from 59 percent of the denied claims. Forty-one percent of the suits were either settled or found for the plaintiff.

- Recorded payments for claims and suits totaled $6.8 million. The report did not offer any comparative or contextual background for understanding the significance of this sum.

▸ **David Smith, Donna Denno, and Dana Hughes, of the Bureau of Health Care Delivery and Assistance; and Sara Rosenbaum of the Children's Defense Fund** have produced a draft report entitled *Community-Based Experience with the Federal Tort Claims Act and Malpractice*. This report presents a comparative analysis of the FY 1980-1986 data from the HRSA report on NHSC and IHS physician claims data; 1985 data from the American Medical Association on private physician premiums and claims; and data from a GAO report on the costs of private sector medical malpractice claims closed in 1984.

- The report estimates that the cost of commercial insurance for these federally employed providers would have been between five and ten times greater than was the cost incurred by covering them under the Federal Tort Claims Act.

▸ **The Institute of Medicine** (IOM) published "Obstetrical Care for Low-Income Women: The Effects of Medical Malpractice on Community Health Centers," as part of *Medical Professional Liability and the Delivery of Obstetrical Care*, in 1989. This report was based on a survey of approximately 10 percent of all centers.

- Fourteen percent of the respondents reported that claims had been filed against them at some point in their operating histories. No information was provided on either the number of claims paid or pending, or the dollar values of claims.

- The report concluded that medical malpractice costs adversely affected centers' provision of obstetrical services.[11]

These studies consistently indicate that responding centers have paid high malpractice premiums, that they have had few claims against them, and that the monetary values of these claims have been relatively small.

The data these studies present, however, may not be representative of premiums and claims experiences at all centers. The insurance industry requires comprehensive national data as a basis for setting premiums.

THREE ALTERNATIVE APPROACHES TO INSURING CENTER PROVIDERS ARE BEING PURSUED.

- Coverage under a risk-purchase group policy
- Establishment of a risk-retention group to self-insure
- Expanded coverage under the Federal Tort Claims Act (FTCA)

▸ COVERAGE UNDER A RISK-PURCHASE GROUP POLICY:

Centers would band together to obtain coverage at reduced rates from commercial insurers.

The National Association of Community Health Centers (NACHC) established a risk-purchase group, open to all centers nationally. This group has encountered several difficulties: No carriers will provide obstetrical coverage, premium reductions have been smaller than expected, and participation has required an increase in administrative work for the centers. Partially as a result of these limitations, few centers have participated.

The Virginia Primary Care Association also established a risk-purchase group for the 17 centers in that state in 1984. The Virginia group reports that its insurance carrier granted a 10.8 percent group premium discount, which saved the participating centers $15,412 in 1991.

▸ ESTABLISHMENT OF A RISK-RETENTION GROUP TO SELF-INSURE:

Centers would self-insure by developing a capital pool, out of which successful liability claims against the centers and their providers would be paid.

Two self-insurance proposals have been introduced during the 101st Congress.

One bill would establish a federally capitalized and administered risk retention group for the community and migrant health centers (S. 815, introduced by Senator Hank Brown [R-CO]). This pool would be capitalized at $80 million through the transfer of funds from the centers' Federal grant appropriations. Each center's contribution to

the capital pool would be based upon its risk exposure (including the numbers of patients served, types of providers, and types of care provided).

The Public Health Service would be required to review the pool at least once every two years. If claims payments were lower than expected, the excess funds would be returned to the centers as a supplement to their annual grant awards. If claims payments were high, and inadequate funds remained to cover potential claims, additional sums would be transferred to the pool from the centers' grant appropriations.

After five years, three independent evaluations of the fund and the centers' claims history would be made. If claims continued to be as low as anticipated, then the amount of capital in the fund would be reduced, and the excess sum would be returned to the centers as part of their grant appropriation.

A second bill calls upon the centers to form an independent national risk-retention group to provide professional liability coverage (S. 489; H.R. 1004, introduced by Senator Orrin Hatch and Representative Nancy Johnson).[12] Funds would be appropriated to establish this risk-retention group. If independent insurance experts determined that the operation of the group would result in an increase in the amount of funds available for use by the centers, then the Department of Health and Human Services would capitalize the group.

Advocates of self insurance argue that, by holding centers responsible for their malpractice claims, this approach gives centers a financial incentive to maintain the quality of their care. Further, it is anticipated that self-insurance would result in a substantial cost savings to the centers.

Centers have long claimed that a self-insurance program is not feasible because they cannot afford to capitalize the pool, and have been prohibited from using Federal grant funds for capitalization purposes.

▸ EXPANDED COVERAGE UNDER THE FEDERAL TORT CLAIMS ACT:

> **In case of litigation, *all* medical providers offering services at federally funded community and migrant health centers would be treated as Federal employees. They would be defended by the Department of Justice, and claims would be paid out of the U.S. Treasury.**

A bill to this effect has been introduced in the House (H.R. 2239, the Federally Assisted Health Clinics Legal Protection Act of 1991, sponsored by Representative Ron Wyden [D-OR]).[13]

Supporters contend that tort reform represents a return to the original program policy, under which a large percentage of center providers were federally employed National

Health Service Corps members, and thereby covered by the Federal Tort Claims Act. They further argue that, if the numbers and amounts of claims are as low as anticipated, tort reform would create a significant cost savings, not merely a cost shift. Federal tort reform is the preferred option of the National Association of Community Health Centers,[14] and has been supported by the Children's Defense Fund and the Institute of Medicine.[15]

Others have described tort reform as a poor strategy for both risk management and quality assurance. By shifting liability away from the centers, the measure would remove the centers' economic incentive to ensure quality of care. It is also argued that the data presently available are inadequate to demonstrate the need for--or economy of--this proposed reform in tort liability coverage.

The Department of Justice maintains that the Federal Government cannot accept liability for the actions of individuals who are not Federal employees and therefore are not subject to direct Federal supervision.[16] There are further concerns that this move would set a precedent whereby other Federal grant recipients might seek Federal coverage for their employees.

Congressional staffers have suggested that this plan is not in the best interests of either community health center providers or patients. Providers would object to being defended by assigned Justice Department attorneys, who might lack expertise in malpractice issues. Community health center patients who have suffered legitimate injury might be intimidated by the prospect of suing the Federal Government for damages.

APPENDIX A

METHODOLOGY

To gather information for this report, we spoke with representatives of the following offices and organizations: Senator Hank Brown (R-CO); Senator Tom Harkin (D-IA); Senator Orrin Hatch (R-UT); Senator Edward Kennedy (D-MA); Representative Barney Frank (D-MA); Representative Nancy Johnson (R-CT); Representative Ron Wyden (D-OR); Minority Counsel, House Energy and Commerce Committee; the General Accounting Office; the U.S. Department of Justice; the Bureau of Health Care Delivery and Assistance; the National Association of Community Health Centers; the New England Community Health Center Association; the Northwest Regional Primary Care Association; the Connecticut Primary Care Association; the Rhode Island Primary Care Association; the Utah Primary Care Association; the Virginia Primary Care Association; the American Insurance Association; and the Children's Defense Fund. We reviewed published reports and proposed legislation from these offices.

We also reviewed preliminary results of a June 1991 survey of all 330-grant recipients that was conducted as part of the Office of Inspector General study: "The Perinatal Service Capacity of the Community Health Centers" (OEI-01-90-02330). We received an 84 percent response rate, representing centers in every HHS region, and in every state and territory in which the Public Health Service funds centers, with the exceptions of the District of Columbia and the U.S. Virgin Islands. Two OIG inspection reports on perinatal services at urban and rural centers are forthcoming in winter 1991-92.

APPENDIX B

REPORTS ON MEDICAL MALPRACTICE PREMIUMS AND CLAIMS EXPERIENCE AT COMMUNITY HEALTH CENTERS

The Medical Malpractice Claims Experience of Community and Migrant Health Centers: A Comparative Study
National Association of Community and Migrant Health Centers, Washington, D.C., February 1986.

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
Health Resources and Services Administration, Rockville, MD, February 1987.

Risk Financing Alternatives Study
National Association of Community and Migrant Health Centers, Washington, D.C., June 1, 1987.

"Obstetrical Care for Low-Income Women: The Effects of Medical Malpractice on Community Health Centers," in *Medical Professional Liability and the Delivery of Obstetrical Care*
Dana Hughes, Sara Rosenbaum, David Smith, and Cynthia Fader,
Institute of Medicine, Washington, D.C., 1989.

Report on Malpractice
Rhode Island Health Center Association, March 1989.

Review of Legal Resolution Mechanisms for Claims against State and Local Public Employees
Children's Defense Fund, Washington, D.C., July 1989.

Statement on Statewide Malpractice Insurance Policy
Virginia Primary Care Association, 1991.

Statement on Utah Community Health Center Malpractice Information
Association for Utah Community Health, 1991.

The Malpractice Insurance Question for the Community Health Centers of Connecticut
Robert S. Burke, available from the Connecticut Primary Care Association, May 1991.

Medical Malpractice: Data on Claims Needed to Evaluate Health Centers' Insurance Alternatives (HRD-91-98)
U.S. General Accounting Office, May 1991.

Statement of Thomas Trompeter, Executive Director, Northwest Regional Primary Care Association, before the House Judiciary Subcommittee on Administrative Law and Governmental Relations
July 17, 1991.

Community-Based Experience with the Federal Tort Claims Act and Malpractice (Draft)
David Smith, Donna Denno, Dana Hughes, Bureau of Health Care Delivery and Assistance; Sara Rosenbaum, Children's Defense Fund

APPENDIX C

NOTES

1. The average annual field strength of federally employed corps providers fell from 1,696 in 1980 to 412 in 1986. *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*; Health Resources and Services Administration (HRSA), p. 43. A small percentage of corps providers are still employed, paid, and insured by the Federal government because of special circumstances. These include the providers' original employment status, and specific center difficulties in provider recruitment.

2. National Association of Community Health Centers, *Mothers, Infants, and Community and Migrant Health Centers*, 1989; p. 9.

3. General Accounting Office, *Medical Malpractice: Data on Claims Needed to Evaluate Health Centers' Insurance Alternatives* (HRD-91-98), May 1991, p. 1.

4. *Survey of Perinatal Services*, Office of Inspector General, June 1991. "Significant" responses are a combination of "Moderate" and "Substantial" responses. Numbers indicate the percentage of responding Section 330 grantees. Ten urban and 45 rural centers reported that they have discontinued or omitted obstetrical services for other reasons.

5. Institute of Medicine, *Medical Professional Liability and the Delivery of Obstetrical Care*, 1989.

6. This is the average adjusted loss ratio for all medical malpractice carriers for 1990. "Best's Insurance Management Reports," A.M. Best Company; obtained through the American Insurance Association.

7. Although insurance companies view community health center patients as medically high risk, these clients may in fact be less likely than private-practice patients to bring suit in case of injury. The 1987 HRSA report notes that "the socio-economic and educational levels of patients served by community health centers . . . may constitute barriers to awareness that the care provided or the outcome achieved does not meet acceptable medical standards. Reduced access to alternative sources of care may also mitigate against aggressive redress of injury." Moreover, strict Federal risk-management and community involvement requirements may promote more positive patient-doctor relationships. "The sense of community ownership," one study noted, "has made suits less likely" (Robert S. Burke, *The Malpractice Insurance Question for the Community Health Centers of Connecticut*, 1991, p. 20).

8. All 17 centers in Virginia formed a risk purchase group in 1984 to obtain insurance at reduced rates (see p. 7 of this report).

9. Tillinghast recommended that the National Association of Community Health Centers establish an insurance risk-purchasing group, and that it evaluate the feasibility of establishing an insurance risk-retention group at some future point.

10. In the remaining 16 percent of cases, either the claim was still pending or no record of the claim could be found.

11. The authors recommended extension of coverage under the Federal Tort Claims Act to all center obstetrical health care providers (not only federally employed National Health Service Corps members).

12. Senator Hatch's and Senator Kennedy's offices have discussed plans for legislation that would build upon the current Hatch and Brown bills.

13. Representative Nancy Johnson (R-CT) has introduced a similar bill (H.R. 1565).

14. Daniel Hawkins, Director of Policy Analysis, NACHC; Letter to Congressman Ron Wyden, April 26, 1991.

15. Sara Rosenbaum, Director, Health Division, Children's Defense Fund; Testimony before the U.S. House Small Business Subcommittee on Regulation, Business Opportunities, and Energy, October 12, 1989. The Children's Defense Fund has conducted a survey of 33 State policies regarding the liability of State-employed medical providers. Thirty-one of the 33 States cover State-employed medical providers under their respective State tort claims acts.

16. Stuart Gerson, Assistant Attorney General, U.S. Department of Justice, Civil Division, Testimony before the U.S. House Judiciary Subcommittee on Administrative Law and Governmental Relations, July 17, 1991.