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Subject: *Federal Tort Claims Act: Information Related to Implications of Extending Coverage to Volunteers at HRSA-Funded Health Centers*

The Federal Tort Claims Act (FTCA)[1] was enacted in 1946 and permits individuals injured by the wrongful or negligent acts or omissions of federal employees, including medical malpractice, to seek and receive compensation from the federal government through an administrative process and, ultimately, through the federal courts.[2] The FTCA, with few exceptions, provides the exclusive means by which individuals can seek compensation when injured by federal employees acting within the scope of their work for the federal government; in effect, the FTCA largely immunizes federal government employees from tort liability, including medical malpractice.[3] In 1993, medical malpractice coverage under FTCA was first extended to grantees of the Department of Health and Human Services' (HHS) Health Resources and Services Administration's (HRSA) Health Center Program.[4] The centers funded by this program, referred to in this report as Health Centers, are designed to increase access to primary care for medically underserved populations.[5] While FTCA coverage is available to the approximately 1,100 Health Centers and their employees nationwide, it does not extend to health care providers who volunteer services at the 78 Health Centers currently using volunteers.[6]

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[1]28 U.S.C. §§ 1346(b), 2671-2680.

[2]FTCA provides a limited waiver of the federal government's sovereign immunity—that is, the common law doctrine that a government cannot be sued in its own courts without its consent. By enacting FTCA, the Congress waived sovereign immunity for some tort suits.

[3]FTCA settlements and judgments in medical malpractice cases are paid by the federal government, which, in effect, becomes the primary source of providers' insurance for those claims.

[4]The Congress initially enacted the Federally Supported Health Centers Assistance Act of 1992 (Pub. L. No. 102-501, 106 Stat. 3268) to provide FTCA medical malpractice coverage to the Health Center Program for a 3-year period. This coverage was made permanent by the Federally Supported Health Centers Assistance Act of 1995 (Pub. L. No. 104-73, 109 Stat. 777, codified at 42 U.S.C. § 233(g)-(n)). FTCA coverage only applies to Health Centers that receive funding under Section 330 of the Public Health Service Act (codified at 42 U.S.C. § 254b) and to the employees, board members, and contactors who are deemed "employees" of the Public Health Service under the Federally Supported Health Centers Assistance Act. The Health Center Program includes community health centers, health centers for homeless and migrant populations, and health centers in public housing complexes.

[5]HRSA's Health Center Program (Section 330 of the Public Health Service Act) includes Health Centers supported by federal grants, centers that have been determined to meet the definition of a health center but do not receive funds under the Health Center Program, and outpatient health programs and facilities operated by tribal organizations. However, FTCA coverage is only available to Health Centers funded under the Health Center Program. Because of this, the scope of our work is limited to these funded Health Centers.

[6]FTCA coverage for Health Centers also applies to Health Center officers and board members, as well as certain licensed or certified health care providers who are contractors. 42 U.S.C. § 233(g)(5). For the purposes of this report, we use "employees" to refer to all Health Center individuals covered by FTCA. Volunteers are those who provide services without compensation and are not employees or contractors.

The Health Care Safety Net Act of 2008 requires that GAO study the implications of extending FTCA coverage to health care providers who volunteer services to patients at Health Centers.[7] As agreed with the committees of jurisdiction, for this report we describe (1) existing information on claims and lawsuits paid under current FTCA coverage for Health Centers, (2) existing information on the potential financial implications of extending FTCA coverage to volunteers in Health Centers, (3) how such an extension could have an impact on volunteerism at Health Centers, and (4) other selected federal and state efforts to protect health care volunteers. We briefed the committee staff on this work on April 6, 2009, and April 7, 2009.

To describe existing information on claims made under current FTCA coverage for Health Centers, we reviewed data on the number of Health Centers currently covered under FTCA, the number and amount of claims filed, the number of claims negotiated and resolved, the number of federal lawsuits filed, and the amount of paid claims and lawsuits. We also interviewed officials from HHS and the Department of Justice (DOJ) about the claims process for FTCA-covered Health Centers and about Health Centers' claims experience under FTCA. To describe existing information on the potential financial implications of extending FTCA coverage to volunteers in Health Centers, we interviewed officials from the Congressional Budget Office (CBO) about their estimate of the claims and lawsuits that might be paid in association with the expansion of FTCA to Health Center volunteers. To obtain information about the potential impact of an expansion of FTCA on volunteerism at Health Centers, including perceived barriers to provider volunteerism, we interviewed officials from HHS, DOJ, and provider and professional associations and experts. (See the enclosure for a full list of provider and professional associations that provided us with information.) Finally, to obtain information on other selected federal and state efforts to extend medical malpractice coverage to volunteer health care providers, which may include those volunteering at Health Centers, and the effect of these efforts on provider volunteerism, we interviewed experts, officials from provider and professional associations, and officials from state agencies. We identified these state agencies through interviews with experts and a review of relevant literature. We did not conduct a state-by-state review of all laws related to medical malpractice protections for volunteer health care providers. We conducted our work from January 2009 through June 2009 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions.

Results in Brief

About $298 million has been paid for 639 resolved claims or lawsuits that arose from claims under Health Centers' existing FTCA coverage for the centers and their employees, from fiscal year 1993 through early fiscal year 2009. The number of claims and lawsuits filed has generally grown since the start of the program. As of March 2009, a total of 2,594 administrative claims and 890 federal lawsuits had been filed. Of these filed claims and lawsuits, HHS had settled 185 claims through the administrative process and DOJ had settled or tried 454 lawsuits filed in federal court—a total of 639 resolved claims and lawsuits. Of the remaining claims, 646 were disallowed during the administrative review process and the rest have not yet been resolved.

[7]Pub. L. No. 110-355, § 2(b)(5), 122 Stat. 3988, 3991-92.

CBO estimated that an additional $6 million would be paid in claims and lawsuits from fiscal years 2009 through 2013 if FTCA coverage were expanded to Health Center volunteers. CBO estimated that the expansion would result in claim and lawsuit costs of less than $500,000 in fiscal year 2009, $1 million in each of fiscal years 2010 and 2011, and $2 million in each of fiscal years 2012 and 2013.

Most provider association officials, federal officials, and experts we spoke with stated that expanding FTCA coverage to health care providers could increase the number of volunteers at Health Centers, noting that the lack of medical malpractice coverage is a somewhat significant barrier or very significant barrier to volunteerism. However, they could not estimate the actual number of providers who might volunteer or the volume of additional services that could be provided at Health Centers by these volunteers. Associations suggested that retired providers would be the most likely types of volunteers at Health Centers if FTCA coverage were extended. While experts agreed that the extension of FTCA coverage to Health Center volunteers would address the medical malpractice barrier to volunteerism in Health Centers, other barriers to volunteerism would remain that could limit the effect of FTCA coverage expansion on volunteerism. Provider and professional associations, experts, and federal agency officials identified additional barriers to provider volunteerism, including provider issues such as lack of time, licensure costs, and misperceptions about litigiousness. Other barriers included the capacity of Health Centers to recruit, retain, and effectively use volunteers.

While FTCA coverage for Health Centers currently does not extend to volunteer health care providers, there are multiple federal and state efforts intended to protect health care volunteers. However, information on the impact of these efforts is limited. Two federal efforts may protect volunteer health care providers. First, FTCA medical malpractice coverage has been extended to volunteers at free clinics, which are nonprofit volunteer-based health care organizations that are not part of the HRSA Health Center Program. Since 2004, just over 100 of the approximately 1,200 free clinics have pursued the option to apply to HRSA to have volunteers covered—or "deemed"—by FTCA and, as of April 2009, approximately 3,300 free clinic volunteers were covered under FTCA. As of April 2009, only one malpractice claim, for approximately $5 million, had been filed against a deemed free clinic volunteer. Second, the Volunteer Protection Act of 1997 (VPA) may also provide volunteers with some protection from liability. VPA generally provides liability protection from ordinary negligence to individuals who volunteer for government entities and nonprofit organizations—including Health Centers—for actions occurring during the course of their volunteer work. Additionally, at the federal level, because defenses available to private individuals are applicable under FTCA, VPA's protection against liability for ordinary negligence may be applicable for claims and suits involving volunteers at Health Centers. In addition to these federal efforts, experts and state officials we spoke with identified several efforts made by states and other entities to encourage the provision of health care services by volunteers. According to one 2007 analysis of state laws, 43 states had enacted laws granting volunteers some level of immunity from liability associated with their volunteer activities, and 35 of these states specifically referenced volunteer health care providers. Another review of state laws published in 2004 found that 10 states substitute the state as the defendant in place of the volunteer provider. States and other entities have also developed other mechanisms to assist health centers and clinics to secure medical malpractice coverage, such as allowing providers to purchase malpractice coverage for volunteers through the state or providing volunteers the option of purchasing discounted liability coverage.

HHS and DOJ reviewed a draft of this report and provided technical comments, which we incorporated as appropriate.

Background

Health Centers provide a range of health care services to underserved populations. Health Centers may opt for FTCA coverage for malpractice claims or private insurance. When Health Centers opt for FTCA coverage, claims against them for medical malpractice are resolved differently than when they opt for private malpractice insurance.

Health Center Services and Malpractice Coverage

Health Centers provide comprehensive primary health care to medically underserved populations and areas, including preventive, diagnostic, treatment, and emergency services as well as referrals to specialty care.[8] These services may include behavioral and oral health care as well as transportation and translation services designed to facilitate access to health care. In 2007, more than 100,000 Health Center employees—including clinical staff, such as physicians, nurses, dentists, and mental health providers—served more than 16 million patients. Like patients who receive care elsewhere, those receiving care from Health Centers may seek compensation for medical malpractice if they believe the treatment they receive does not meet an acceptable standard of care. Patients[9] may seek payment for economic losses, such as medical bills, rehabilitation costs, and lost income, and noneconomic losses, such as pain, suffering, and anguish. To obtain protection against malpractice claims before FTCA coverage became available, most Health Centers purchased private comprehensive malpractice insurance.[10]

FTCA Coverage for Health Centers

FTCA coverage, which is provided at no cost to Health Centers, is an alternative to private comprehensive malpractice insurance and is designed to allow centers to redirect the funds that would otherwise be spent on this insurance to the provision of health services. While centers opting for FTCA coverage may also decide to purchase a supplemental or "gap" policy to cover events not covered by FTCA, HRSA estimates that centers spend less on insurance than they would if they had continued to purchase comprehensive coverage, saving $203.6 million in 2008.[11]

Health Centers must apply to HRSA to be covered, or "deemed," as organizations that together with their employees, are recognized as federal employees under FTCA for the purposes of claims for medical malpractice. As part of this application process, Health Centers must demonstrate that they have policies and procedures in place to minimize the risk of malpractice. In addition, Health Centers must provide HRSA with information on the

[8]While referral to specialty services is a required service, in limited circumstances Health Centers may also directly provide specialty services.

[9]Throughout this report, we use "patient" to encompass both patients and claimants, that is, patients who have filed claims under FTCA or had claims filed on their behalf.

[10]Health Centers may use grant funds from HRSA's Health Center Program to purchase medical malpractice liability insurance coverage.

[11]Gap coverage may include services provided by a Health Center that are outside its scope of project. The scope of project defines the "approved service sites, services, providers, service area(s) and target populations(s) which are supported (wholly or in part)" by funds from HRSA's Health Center Program.

initial and most recent credentialing and privileging[12] dates of all licensed and certified employed health care providers. Health Centers must credential and privilege newly employed licensed and certified health care providers and then again every 2 years or sooner. FTCA coverage for Health Center providers covers only personal injury caused by negligent or wrongful acts or omissions within their scope of employment[13] and within a Health Center's scope of project. As of December 2008, 85 percent of all Health Centers (915 of 1,082) were deemed by HRSA for FTCA medical malpractice protection. According to HRSA, the remaining Health Centers include those Health Center grantees that have not yet applied for coverage or Health Centers that have other liability protections under state law.

Claims Process for FTCA-Covered Health Centers

Malpractice claims against FTCA-covered Health Centers are resolved differently from those filed against centers with private malpractice insurance. In a Health Center not covered by FTCA, patients or their representatives file a malpractice claim with the private carrier insuring the provider. Insurers are generally responsible for investigating claims, defending the provider, and paying any successful claims, up to a stated policy limit. If not resolved by the insurer, a claim could result in a lawsuit filed in state court.

For an entity or provider covered by FTCA, the claim is made against the United States rather than against the provider.[14] A patient of an FTCA-covered Health Centers must first file an administrative claim with HHS within 2 years after the patient has discovered, or reasonably should have discovered, the injury and its cause. (Fig. 1 provides details about the claims process.) After reviewing the claim, HHS may attempt to negotiate a financial settlement or, if it finds the case to be without merit, it may deny the claim. If HHS formally denies a claim or if HHS and the patient fail to reach a final settlement within 6 months of filing, claims may be filed in federal district court.[15] At this point, if a claim results in the filing of a medical malpractice suit, DOJ litigates the case and either settles or defends the case during a trial. At a trial, the case is heard in a federal district court without a jury; punitive damages cannot be awarded under FTCA.[16] Payments to patients either as part of an HHS or DOJ settlement or from a court judgment are paid out of the Health Center Judgment Fund, a fund that is financed by congressional appropriations. Appropriations for the Health Center Judgment Fund began in fiscal year 1993 with a $1 million appropriation, according to HRSA officials. During fiscal year 2008, approximately $44 million was appropriated to pay claims involving care provided by covered Health Center providers.

[12]According to HRSA, credentialing is the process of assessing and confirming the qualifications of a health care provider, while privileging is the process that health care organizations use to authorize health care providers to provide specific services to their patients.

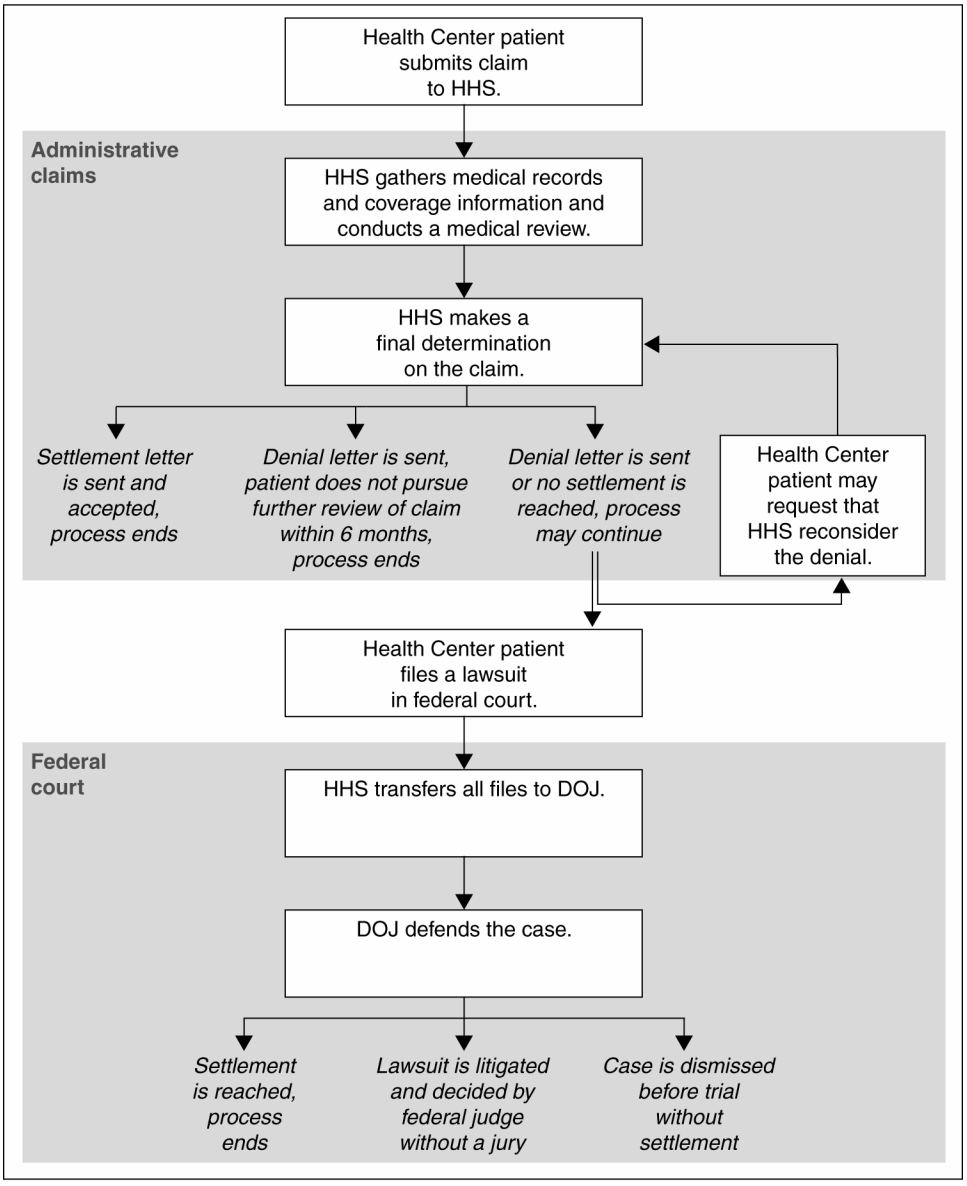
[13]Whether an act or omission falls within the scope of employment may be determined, in part, by evaluating whether the conduct was performed on behalf of the employer.

[14]Claims are first submitted to the relevant agency, in this case HHS. Once suit is filed, the defendant is the United States; if the suit incorrectly names the medical care provider, the United States will move to be substituted for the individual.

[15]Patients dissatisfied with HHS's denial have 6 months to file a lawsuit against the United States government in federal district court.

[16]Punitive damages, awarded in addition to the damages awarded for proven losses, are intended to punish reckless, malicious, or deceitful behavior.

Figure 1: Federal Tort Claims Process for Deemed HRSA-Funded Health Centers



Source: GAO analysis of HRSA and DOJ data.

Note: FTCA coverage only applies to Health Centers that receive funding under Section 330 of the Public Health Service Act (codified at 42 U.S.C. § 254b) and to the employees, board members, and contractors who are deemed "employees" of the Public Health Service under the Federally Supported Health Centers Assistance Act.

In prior work, we noted that while FTCA coverage may reduce Health Centers' insurance costs, it imposes a potentially significant liability on the federal government because FTCA, unlike private policies generally, does not limit the amount for which the government can be held liable.[17] At that time, at the recommendation of HHS's Office of Inspector General, HRSA developed a legislative proposal that would limit the federal government's liability to

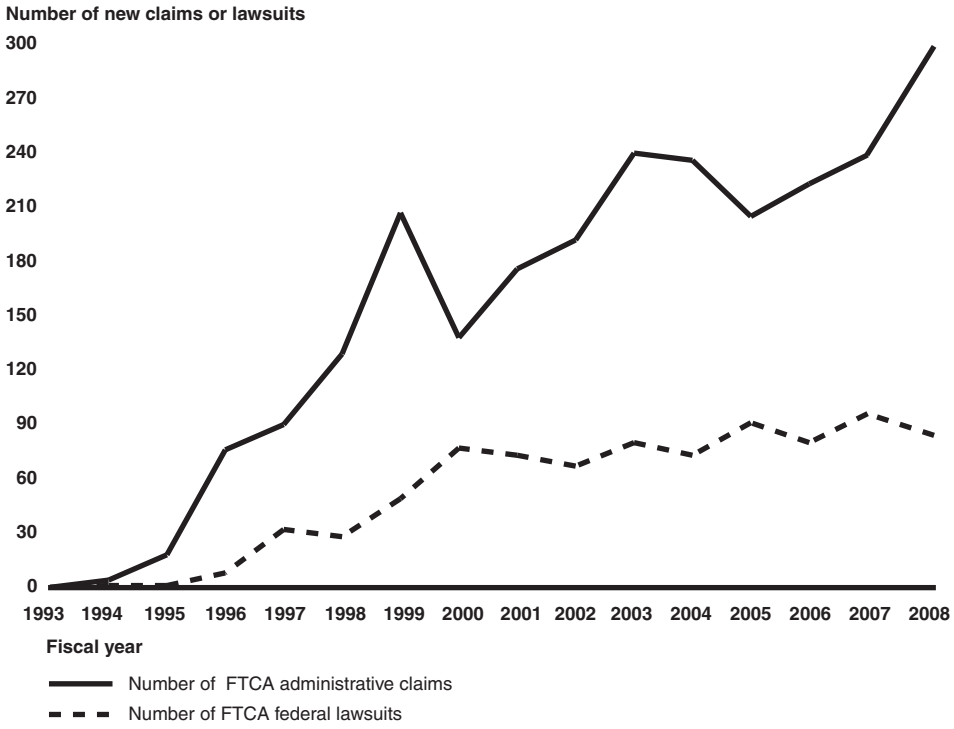
[17]See GAO, *Medical Malpractice: Federal Tort Claims Act Coverage Could Reduce Health Centers' Costs*, GAO/HEHS-97-57 (Washington, D.C.: Apr. 14, 1997).

$1 million for claims filed against FTCA-covered centers. According to current HRSA officials, this proposal was never reviewed outside the agency.

Claims and Lawsuits Paid under Current FTCA Coverage Totaled about $298 Million from Fiscal Year 1993 through Early Fiscal Year 2009

As of March 2009, about $298 million from 639 resolved claims and lawsuits that arose from claims has been paid since the extension of FTCA coverage to Health Centers and their employees in 1993. As of March 2009, 2,594 administrative claims have been filed, totaling approximately $66 billion.[18] In addition, 890 federal lawsuits totaling $8.9 billion were filed in federal court. The number of claims and lawsuits filed has generally grown since the start of the program.[19] (See fig. 2.)

Figure 2: Number of New Claims and Lawsuits, Fiscal Years 1993-2008



Source: GAO analysis of HHS and DOJ data.

Note: As of March 13, 2009, 122 administrative claims and 50 federal lawsuits have been filed for fiscal year 2009.

[18]HRSA officials stated that the claim amounts requested are higher than typically paid because generally the amount of the claim filed acts as a ceiling to the payment amount. In February 2009, two claims totaling $50 billion were filed for the same incident. According to HRSA officials, these claims are unprecedented, as the program has never had a claim that sought such a high damage amount.

[19]The program has also experienced significant growth in the number of providers and patients served since 1993.

Of the 639 resolved claims, HHS settled 185 claims through the administrative process, and DOJ settled or tried 454 lawsuits that are the result of claims filed in federal court after the administrative process. The remaining claims were either disallowed by HHS during the administrative review process (646 claims) or have not yet been resolved.

HRSA and DOJ do not have readily available information on Health Center–related FTCA claims that would allow the agencies to identify any common characteristics of Health Centers involved in FTCA claims, such as facility size, location, or types of Health Center providers most commonly cited in claims paid under FTCA.[20]

CBO Estimates the Costs for Claim and Lawsuit Payments for Expanding FTCA Coverage to Volunteers at $6 Million from Fiscal Year 2009 through Fiscal Year 2013

In 2008, CBO estimated that payments for claims and lawsuits associated with the expansion of FTCA to Health Center volunteers, if implemented, would be $6 million from fiscal years 2009 through 2013. CBO estimated that the expansion would result in claim and lawsuit costs of less than $500,000 in fiscal year 2009, $1 million in each of fiscal years 2010 and 2011, and $2 million in each of fiscal years 2012 and 2013. In its estimate, CBO assumed that Health Centers could use volunteers to fill unfilled positions and based its estimate on 2006 data[21] about such unfilled positions as well as expenditures for existing FTCA protections for Health Center employees. In addition, CBO assumed that funds would not be appropriated until later in the fiscal year and time would be needed for program implementation.

Extending FTCA Coverage Could Increase Volunteerism, but Barriers May Limit Its Effect

Most provider association officials, federal officials, and experts we spoke with stated that expanding FTCA coverage to health care providers could increase the number of volunteers at Health Centers, noting that the lack of medical malpractice coverage is a somewhat significant barrier or very significant barrier to volunteerism.[22] Based on Health Center applications, relatively few Health Centers currently have volunteers providing services—in fiscal year 2009, 78 of the approximately 1,100 Health Centers reported using about 126 full-time equivalent volunteers.[23] The provider associations could neither quantify the number of their members currently volunteering in Health Centers or other health care settings nor estimate the actual number of providers who might volunteer if FTCA coverage were

[20]HRSA's FTCA claims data set contains basic identifier information on health center organizations and providers, such as location (region, state, city) and provider specialty. Health center data related to broader demographic characteristics are collected through HRSA's Uniform Data System (UDS) and other grant-reporting requirements. FTCA claims data could be linked with the UDS data or other data for the purpose of identifying common characteristics, HRSA officials said. A DOJ official said that because DOJ does not manage the Health Center Program, the agency would not collect these data.

[21]R.A. Rosenblatt, C.H.A. Andrilla, T. Curtin, and L.G. Hart, "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion," *Journal of the American Medical Association*, vol. 295, no. 9 (2006).

[22]Some provider associations noted that the lack of medical malpractice may be less of a barrier for some providers, such as nurses, who have not traditionally been the focus of medical malpractice cases.

[23]For the purposes of the Health Center Program, HRSA defines a "full-time equivalent" (FTE) of 1.0 to mean that a person worked full-time for 1 year. For example, if a physician is hired full-time and works 40 hours per week, that physician is a 1.0 FTE while a physician who works 20 hours per week in that Health Center would be considered a 0.5 FTE. Each Health Center defines the number of hours for full-time work.

extended. As a result, the volume of additional services that could be provided at Health Centers also could not be estimated.

While associations could not quantify the number of providers who might volunteer, certain providers were identified as being more likely to volunteer if FTCA coverage were extended to Health Center volunteers. Retired providers were identified as the provider type most likely to volunteer at Health Centers if FTCA coverage were extended. However, experts and associations noted that while retirees often have the time to volunteer, they may be inhibited from volunteering because they may not maintain medical malpractice coverage, may not be willing to pay for this coverage, and are not currently covered by FTCA. Provider and professional associations also identified other potential volunteers, such as actively employed practitioners whose malpractice would not extend to volunteer activities or providers who work part-time. Extending FTCA coverage may reduce the barrier for these providers who would have to purchase their own malpractice coverage to volunteer.

One professional association and an expert we spoke with noted that providers in private practice who have their own medical malpractice insurance, which may cover their activities regardless of the setting, may be more willing to provide volunteer services. However, associations and an expert noted that even providers with their own medical malpractice insurance may be cautious about possible risk to their personal malpractice coverage, such as an increase in premiums, from a medical malpractice claim resulting from their volunteer activities.

While experts agreed that the extension of FTCA coverage to Health Center volunteers would address the medical malpractice barrier to volunteerism in Health Centers, other barriers to volunteerism would remain that could limit the effect of FTCA coverage expansion on volunteerism. Provider and professional associations, experts, and federal agency officials identified additional barriers to provider volunteerism, including provider issues such as lack of time, provider costs, lack of awareness of Health Center need for volunteers, location, and misperceptions about litigiousness. Other barriers are related to Health Centers, including their capacity to recruit, retain, and effectively use volunteers and limited resources and ability to use specialists.

Lack of time. According to experts and association officials, many providers do not have time to volunteer their services at Health Centers. For example, provider associations noted that employed nurses often work significant amounts of overtime, limiting the time they have available to volunteer, while obstetricians typically have unpredictable schedules that make it hard to coordinate volunteerism with the schedule of a Health Center. According to an American Academy of Pediatrics 2007 survey of its members, almost 83 percent of pediatricians identified lack of time as a reason for not volunteering, making it the most frequently identified barrier to their participation in volunteer opportunities in community-based settings.

Provider costs. According to federal officials, as well as a provider association and an expert, the costs of providing care, such as licensure or required continuing medical education requirements, can also be a barrier to health care volunteers. This may be particularly true for providers who no longer maintain their licensure, such as retirees.

Lack of awareness of Health Center need for volunteers. Provider and professional associations reported that providers interested in volunteering may not be aware of Health Centers as a possible volunteer location. Because Health Centers receive federal funding and may be considered an integrated part of a community's health delivery system, providers may believe that the centers do not need volunteers as much as other locations, such as free clinics.

Location. Experts and provider associations reported that providers may have concerns about their safety in some areas in which Health Centers are located. Other Health Centers may be in locations where, according to experts, there simply may not be enough providers available to act as volunteers. One expert noted that in rural areas facilities may have a hard time recruiting staff—volunteer or permanent—because finding housing for providers is a problem.[24]

Misperceptions about litigiousness. Two associations reported that many providers believe that patients served in Health Centers or similar settings are more likely to sue than other patients. Both associations noted that their experience indicated that this was an incorrect perception, but providers still may need to be reassured.

Capacity to recruit, retain, and effectively use volunteers. According to provider associations, Health Centers may still have difficulty recruiting and retaining volunteers. Experts and professional associations noted that effectively recruiting and using volunteers can be difficult and time and labor intensive. They expressed concern that Health Centers would have to address their capacity to recruit, retain, and recognize volunteers—all key elements to a successful volunteer program. Officials from one association stated that Health Centers would need to develop a system that can accommodate the constantly changing population of volunteers, building in rewards and recognition for ongoing involvement, in an effort to maintain volunteerism, which these officials said represented a different organizational dynamic than that currently used by Health Centers. They also noted that Health Centers would still need to address their organizational capacity to use volunteers, such as developing scheduling systems to effectively combine volunteers, who may have irregular hours with varied frequency, with regular full- and part-time staff.

Limited resources and ability to use specialists. Provider and professional associations reported that providers may be used to providing care in settings with more resources and may find it difficult to provide care in settings with limited resources, such as less laboratory testing capacity or limited ability to refer patients for specialty care. There may be barriers related to equipment used by some providers. For example, one expert noted that a dentist may not be able to volunteer to provide services unless specialized equipment is available at volunteer locations. In addition, federal officials and experts also noted that Health Centers, which focus on providing preventive and primary care, may not be able to use some specialists in their areas of expertise.

[24]Other reasons rural communities have difficulty in attracting and retaining providers include concerns about isolation, limited health facilities, or a lack of employment and educational opportunities for their families. See the Institute of Medicine of the National Academies, Committee on the Future of Rural Health Care, Board on Health Care Services, "Quality Through Collaboration: The Future of Rural Health Care" (Washington, D.C., 2005).

Multiple Federal and State Efforts Aim to Protect Health Care Volunteers, but Information on the Impact of These Efforts Is Limited

Two federal efforts may protect volunteer health care providers. The first effort is the extension of FTCA medical malpractice coverage to volunteers at free clinics. This coverage protects volunteer health providers providing certain services at free clinics.[25] Free clinics are nonprofit volunteer-based health care organizations—typically with annual budgets of less than $250,000—that do not accept reimbursement from third-party payers and typically do not charge individuals to whom they provide care or charge a nominal fee.[26] Unlike Health Centers, free clinics are not part of the HRSA Health Center Program. While the application to be covered under FTCA and the claims process is similar to that of Health Centers, only the actual volunteer is covered under FTCA, not the free clinic itself. However, for a provider to be deemed under FTCA, the free clinic must submit an application on behalf of that provider. The volunteer provider must be licensed or certified in accordance with applicable law and patients must be provided with notice that FTCA limits the provider's liability. Once deemed, the requirements related to credentialing and privileging free clinic volunteers covered by FTCA are similar to those of employees at Health Centers. For example, like Health Centers, free clinics must, among other things, verify volunteer providers' licensure, certification, and registration; review prior malpractice claims; and obtain evidence of providers' ability to perform the requested duties.

Since 2004, just over 100 of the approximately 1,200 free clinics have pursued the option to sponsor volunteers for FTCA deeming and, as of April 2009, approximately 3,300 free clinic volunteers were covered under FTCA. As of April 2009, only one malpractice claim, for $5 million, had been filed against a deemed free clinic volunteer. According to officials there may be several reasons why so few free clinics have chosen to sponsor volunteers for FTCA deeming. Officials noted that because free clinic employees are not eligible for FTCA coverage, free clinics may choose to simply extend the coverage purchased for employees to their volunteers, avoiding the FTCA deeming application process. In addition, free clinics have historically been more informally structured, without formal policies and processes and with limited administrative support. Because of this, experts stated that the initial FTCA application process may be difficult for free clinics.

A second federal statute—VPA—may also provide volunteers with some protection from liability.[27] VPA generally protects individuals who volunteer for government entities and nonprofit organizations—including Health Centers—from liability for ordinary negligence[28] occurring during the course of their volunteer work, with some exceptions.[29] VPA does not

[25]The Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, title I § 194, 110 Stat. 1936, 1988-91) amended Section 224 of the Public Health Service Act (codified at 42 U.S.C. § 233) by adding a provision extending FTCA coverage to free clinic volunteers effective upon the date appropriations were first made for the provision. The Consolidated Appropriations Act, 2004 (Pub. L. No. 108-199, div. E, title II, 118 Stat. 3, 237) made the first appropriation for FTCA coverage of free clinic volunteers. FTCA coverage for volunteers at free clinics is for limited medical assistance services, such as preventive services, dental services, or prescription drugs, and is limited to medical malpractice. In addition, unlike coverage at Health Centers, coverage at free clinics does not include employees or the free clinics themselves.

[26]To obtain FTCA coverage for their volunteers through HRSA, free clinics cannot accept reimbursement from third-party payers and cannot impose any charges on individuals to whom they provide care, including charges on a sliding scale.

[27]Pub. L. No. 105-19, 111 Stat. 218 (codified at 42 U.S.C. §§ 14501-05).

[28]Generally, ordinary negligence may be defined as failure to exercise ordinary care, and gross negligence may be defined as failure to take the simplest precautions against harm. What acts or omissions constitute gross or ordinary negligence vary across states.

[29]Exceptions would include a volunteer acting under the influence of alcohol, among other things.

affect the liability of the organization for the actions of its volunteers or an organization's ability to file an action against its volunteers. VPA requires that volunteers be appropriately licensed in accordance with state law and does not protect volunteers from liability for acts that constitute "willful or criminal conduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by the volunteer." Additionally, VPA preempts existing state laws to the extent that they are inconsistent with VPA, but state law may provide additional protections to volunteers. Also, VPA permits states to make laws declaring VPA inapplicable in state court cases in which all parties to the case are citizens of the same state. As of May 2009, only New Hampshire has taken this step. According to a DOJ official, at the federal level, because defenses available to private individuals are applicable under FTCA, VPA's protection against liability for ordinary negligence may be applicable in claims and suits against volunteers at Health Centers.

While VPA may provide some protection to volunteer health care providers, provider associations and experts stated that relatively few providers or clinics, including Health Centers, were aware of VPA and the protections it offers to volunteers. In addition, groups noted that because of providers' legal expenses of proving in court that an action was not gross negligence—which is not covered by VPA—VPA may not be sufficient to encourage volunteerism. Agency officials and an expert also reported that because providers see VPA as largely untested in the courts, which means that there is little case law related to VPA and medical malpractice, they are not willing to rely on it as a source of protection.

In addition to these federal efforts, multiple state efforts are intended to protect volunteer health care providers. Experts and state officials we spoke with identified several efforts made by states and other entities to encourage the provision of health care services by volunteers, though limited data are available on the effect of these efforts.

Grant immunity from liability. According to a 2007 review of state laws conducted by the American Medical Association, 43 states have enacted laws granting volunteers some level of immunity from liability associated with their volunteer activities, and 35 of these states specifically reference volunteer health care providers.[30] Some states, such as Arizona and Arkansas, grant providers immunity from claims of ordinary negligence, but hold them responsible for claims of gross negligence.

Substitute state as defendant. A 2004 review of state laws found that 10 states substitute the state as the defendant in place of the volunteer provider.[31] For example, through the Florida Department of Health's Chapter 110 Volunteer Program, licensed providers approved by the department may be eligible for coverage under the state's sovereign immunity. Limited data are available on the effect of the states' efforts though Florida has collected data on both the number of overall volunteers participating in its program and the value of goods and services donated. From July 2007 to June 2008, 9,278 volunteers participated in the program. Florida officials estimate that the value of donated goods and services totaled $41.15 million.

[30]American Medical Association, "Table of State Licensing and Liability Laws for Volunteer Physicians," http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/senior-physicians-group/physician-volunteers.shtml (accessed Feb. 26, 2009).

[31]P.A. Hattis, "Overcoming Barriers to Physician Volunteerism: Summary of State Laws Providing Reduced Malpractice Liability Exposure for Clinician Volunteers," *University of Illinois Law Review*, vol. 2004, no. 1 (2004).

Other state-level efforts. States and other entities have also developed other mechanisms to assist health centers and clinics to secure medical malpractice coverage, such as allowing providers to purchase malpractice coverage for volunteers through the state or providing volunteers the option of purchasing discounted liability coverage. For example, Virginia offers free or low-cost liability coverage through a state-run self-insured risk pool that includes clinics that provide free health care and health care practitioners who volunteer their services at facilities that the state designates as volunteer or free clinics. Medical Mutual Insurance Company of North Carolina, a professional liability company owned and operated by physicians, offers discounted medical malpractice coverage—$100 per year—for retired health care providers interested in providing volunteer health care services.

Many states require certain conditions to be met in order for clinics and providers to receive coverage under state programs. These conditions may include restrictions on the setting in which the health care can be delivered, restrictions on the type of care provided, patient notification of liability limitations, or limits on the amount that can be recovered by a patient through a lawsuit.

Agency Comments

HHS and DOJ reviewed a draft of this report and provided technical comments, which we incorporated as appropriate.

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We are sending copies of this report to the Secretary of Health and Human Services, the Attorney General, and other interested parties. The report also is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or bascettac@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributions to this report were made by Karen Doran, Assistant Director; Emily Gamble Gardiner; Dawn D. Nelson; Timothy Walker; and Jennifer Whitworth.

Cynthia A. Bascetta
Director, Health Care

Enclosure

The Honorable Edward M. Kennedy
Chairman
The Honorable Michael B. Enzi
Ranking Member
Committee on Health, Education, Labor, and Pensions
United States Senate

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

The Honorable Henry A. Waxman
Chairman
The Honorable Joe Barton
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable David R. Obey
Chairman
The Honorable Todd Tiahrt
Ranking Member
Subcommittee on Labor, Health and Human Services,
Education, and Related Agencies
Committee on Appropriations
House of Representatives

Enclosure

Associations from Which Information Was Obtained for This Report

American Academy of Nurse Practitioners

American Academy of Pediatrics

American Dental Association

American Medical Association

American Nurses Association

National Association of Community Health Centers

National Association of Free Clinics

National Association of Social Workers

Additional associations were contacted but either did not respond or declined to participate, in some cases because they had no information on the implications of extending Federal Tort Claims Act (FTCA) coverage to volunteers at Health Centers. We identified professional associations to contact regarding expanding FTCA coverage to Health Centers using research that provided information on unfilled medical personnel positions at Health Centers.[32] We used these data to identify volunteer provider types Health Centers might use to fill unfilled positions.

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[32]R.A. Rosenblatt, C.H.A. Andrilla, T. Curtin, and L.G. Hart, "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion," *Journal of the American Medical Association*, vol. 295, no. 9 (2006).