COMMUNITY HEALTH CENTERS AND RISING MALPRACTICE PREMIUMS: AN OVERVIEW OF THE COMMUNITY HEALTH CENTER PROGRAM AND PROPOSED SOLUTIONS TO THE MALPRACTICE INSURANCE RATE CRISIS

INTRODUCTION

For over a quarter of a century, the community health center program has provided primary care health services to low-income and uninsured patients throughout the United States.[1] Under the program, private non-profit health care centers carry out a unique mission to bring cost-effective and affordable health care to medically-underserved persons of remote rural communities and impoverished inner-city neighborhoods.[2] As federal grant recipients, these health centers fulfill an expressed federal purpose of treating communities and population groups that the government has designated as specially needy.[3]

Recently, the viability of the community health center program has been threatened by burdensome malpractice insurance costs.[4] Centers initially were staffed by federally-insured physicians of the National Health Service Corps (NHSC).[5] Budget cuts and policy changes in the NHSC, however, forced centers to hire former NHSC physicians as their own employees and supplement the clinical staff with private sector physicians. This change forced centers to purchase professional malpractice insurance coverage, the cost of which has increased dramatically for all health care providers in recent years.[6] These increasing insurance costs are forcing centers to decrease or eliminate services to the patients that centers are required to treat under federal law.[7]

Community health center representatives, Congress, and the Bush Administration agree that commercial malpractice premi-

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[1] *See infra* notes 3, 11 and accompanying text.

[2] *See* discussion *infra* part I.A.

[3] Public Health Service Act, 42 U.S.C. § 254c (1988). *See* discussion *infra* part I.A.

[4] *See* discussion *infra* part III.

[5] NHSC physicians, as federal employees, enjoy liability protection under the Federal Tort Claims Act, 28 U.S.C. §§ 1346, 2671-2680 (1988).

[6] *See infra* note 55.

[7] *See* discussion *infra* part III.D.

um costs place the centers in a precarious position and that a solution must be fashioned which will allow the centers to continue their mission of care to the indigent.[8] Policy-makers further agree that the federal government can no longer afford to divert vast sums of public health funding into commercial malpractice insurance.[9] Yet, they are divided over how to address the problem.

This article examines the role of community health centers and the mechanism by which the government-center partnership fulfills its stated mission. It explores factors contributing to escalating malpractice premium costs and the adverse consequences of these costs on center services. Finally, it evaluates three proposed solutions currently in the 102nd Congress.[10]

I. A UNIQUE AND SUCCESSFUL MISSION

A. COMMUNITY HEALTH CENTER PROGRAM GOALS AND SERVICES

The community health center program was created in the mid-1960's to facilitate the Johnson Administration's "War on Poverty."[11] From its inception, the program embodied notions of comprehensive health care, unhindered access, and community participation in the management of health care resources.[12] Its purpose is to provide financially accessible health care to

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[8] *See* Robert Pear, *Community Health Clinics Cut Back as Malpractice Insurance Costs Soar*, N.Y. TIMES, Aug. 21, 1991, at A18.

[9] *Hearings on H.R. 2239, The Federally Assisted Health Clinics Legal Protection Act of 1991 Before the Subcomm. on Admin. Law and Gov't Rel. of the House Comm. on the Judiciary*, 102d Cong., 1st Sess. 7-10, 35 (July 17, 1991) [hereinafter *H.R. 2239 Hearings*] (statements of Representative Ron Wyden and Representative Jim McDermott).

[10] The Federally Supported Health Centers Assistance Act of 1991, H.R. 3591, 102d Cong., 1st Sess. (1991); Ensuring Access Through Medical Liability Reform Act of 1991, S. 489, 102d Cong., 1st Sess. (1991); Community and Migrant Health Centers Self-Insurance Act of 1991, S. 815, 102d Cong., 1st Sess. (1991).

[11] The community health center program was initially funded by a 1966 amendment to the Economic Opportunity Act of 1964, Pub. L. No. 89-794, 80 Stat. 1451 (1966). Since 1975, the centers have received federal funding under tit. III, § 330 of the Public Health Service Act, 42 U.S.C. § 254c (1988).

[12] ALICE SARDELL, THE U.S. EXPERIMENT IN SOCIAL MEDICINE: THE COMMUNITY HEALTH CENTER PROGRAM, 1965-1986 3 (1988). For a comprehensive history of the community health center program, see *id.* at 3-233.

catchment areas identified by the U.S. Department of Health and Human Services (DHHS) as severely medically underserved. Specifically, centers target remote rural communities and economically depressed inner-city neighborhoods exhibiting elevated poverty rates, significantly above-average infant mortality rates, high concentrations of poor, elderly and minority residents, and low concentrations of physicians.[13] Today, 600 community health centers serve approximately six million patients each year at 1500 clinic sites located throughout the country.[14]

Title III § 330 of the Public Health Service Act requires each community health center to provide certain core services including primary health services,[15] health information,[16] ongoing case management,[17] and transportation services.[18] The Act further requires centers to offer, as appropriate, various supplemental health services such as rehabilitation, counseling, extended care, and ambulatory surgery or provide referrals to such services.[19] Federal guidelines also ensure that the cen-

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[13] NATIONAL ASS'N OF COMMUNITY HEALTH CTRS. INC., ACCESS TO COMMUNITY HEALTH CARE: A DATA BOOK 10 (1991) [hereinafter DATA BOOK]. A complementary federal initiative, the migrant health center program, addresses the health needs of migrant farm workers through rural-based and mobile health clinics. Migrant health centers are funded under tit. III, § 329 of the Public Health Service Act, 42 U.S.C. § 247d. While the program is smaller in scope than the community health center program, federal funding requirements are similar to those of community health centers. The malpractice insurance crisis discussed in this article has impacted migrant health centers with identical force.

[14] Pear, *supra* note 8, at A18.

[15] Primary health care services include diagnostic lab and x-ray services, emergency medicine, preventive dental services, pharmacy services and preventive care services such as childhood vision and hearing examinations, perinatal and family planning services. 42 U.S.C. 254c(b).

[16] 42 U.S.C. § 254c(a)(5).

[17] 42 U.S.C. § 254c(a)(6).

[18] 42 U.S.C. § 254c(b)(1)(E).

[19] 42 U.S.C. § 254c(a)(2)-(3), (b)(2). Centers engage in formal and informal arrangements with local health departments, other health clinics and hospitals to provide specialty care. Such services include mental health and substance abuse treatment, restorative dental care, and ambulatory surgery. *See* NATIONAL ASS'N OF COMMUNITY HEALTH CTRS. INC., COMMUNITY AND MIGRANT HEALTH CENTERS, A KEY COMPONENT OF THE U.S. HEALTH CARE SYSTEM: OVERVIEW AND STATUS REPORT 1991, 18-19 (1991) [hereinafter OVERVIEW AND STATUS REPORT].

ters tailor their services to the clinical, social and cultural needs of the immediate communities they serve.[20]

Community health centers address the varied health needs of a wide-ranging population. Nearly ten percent of all clinic patients seek care for serious disabilities, including AIDS, severe physical and medical illness and conditions, and alcohol or substance abuse problems.[21] Forty-four percent of all patients are children under age eighteen.[22] A crucial role of the centers is to provide obstetrical and maternity care. With the recent exodus of private obstetricians and family doctors from obstetrical practice, community health centers have inherited the burden of providing obstetrical care to many low income women who have no other source of care.[23] Centers provide prenatal care to approximately 12% of all high risk low income women in this country and approximately 30% of all U.S. women under age fifteen who give birth.[24]

Federal provisions require centers to dispense care on an ability-to-pay, sliding fee scale basis.[25] Patients whose family income falls below twice the federally-defined poverty level

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[20] DHHS requires centers to perform ongoing needs assessments of their service areas and target populations and to engage in community-based program planning. U.S. DEP'T OF HEALTH AND HUMAN SERVS., PROGRAM EXPECTATIONS FOR COMMUNITY AND MIGRANT HEALTH CENTERS 3 (1991) [hereinafter PROGRAM EXPECTATIONS]. Such planning efforts have led individual centers to develop special intervention programs for significant community health concerns such as teen pregnancy, substance abuse, infant mortality and AIDS. OVERVIEW AND STATUS REPORT *supra* note 19, at 3, 18. Furthermore, federal guidelines require that a majority of the board of directors of each center represent a cross-section of center patients. 42 U.S.C. § 254c(e)(3)(G). This ensures that clinics receive input from the immediate community about current and emerging health needs.

[21] DATA BOOK, *supra* note 13, at 11.

[22] DATA BOOK, *supra* note 13, at United States-4.

[23] Dana Hughes et al., *Obstetrical Care for Low-Income Women: The Effects of Medical Malpractice on Community Health Centers*, 2 MED. PROF. LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 59 (1989) (reporting that as many as 14% of private obstetricians have decreased the number of deliveries they perform and 23% have decreased the percentage of their practice time devoted to high-risk obstetrics).

[24] *Federal Tort Claims Act: Hearings Before the Subcomm. on Admin. Law and Gov't Rel. of the House Comm. on the Judiciary*, 101st Cong., 2d Sess. 34 (Sept. 25, 1990) [hereinafter *FTCA Hearings*] (statement of Daniel R. Hawkins, Jr., Director of Policy Analysis, National Association of Community Health Centers, Inc. (NACHC)).

[25] 42 C.F.R. § 51c.303(f) (1991).

receive free care. This category represents a majority of clinic patients.[26] Forty-nine percent of health center patients are completely uninsured and 39% receive public insurance, primarily Medicaid. Only 12% of clinic patients carry some level of private insurance.[27]

Community health centers employ over 3000 board certified or board eligible physicians and numerous other health professionals. Center staff sizes vary widely depending on the size and characteristics of the target populations and available resources.[28] An average clinic employs about 50 persons,[29] but the sizes and types of staff vary widely depending on the size and characteristics of the target populations and available resources.[30] In addition to physicians, nurses, and clinical assistants, centers also typically employ social workers, health educators and outreach workers.[31] Centers may also contract with outside health personnel.[32]

Until the early 1980's, the centers' physician component was supplied predominantly by physicians of NHSC.[33] Under a Reagan Administration directive to reduce the cost of the NHSC field placement program, most NHSC physicians were assigned to the community health centers as center employees, rather

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[26] Over 60% of all health center users have family incomes below the federal poverty level. NATIONAL ASS'N OF COMMUNITY HEALTH CTRS. INC., COMMUNITY AND MIGRANT HEALTH CENTERS: TWO DECADES OF ACHIEVEMENT 3 (Sara Rosenbaum ed. 1987) [hereinafter TWO DECADES OF ACHIEVEMENT].

[27] A comparison to the health insurance profile in the general United States patient population (65% privately insured; 24% publicly insured; 11% uninsured) starkly demonstrates the insurance coverage deficiencies of the centers' patients. DATA BOOK, *supra* note 13, at United States-2.

[28] OVERVIEW AND STATUS REPORT, *supra* note 19, at 20.

[29] *FTCA Hearings*, *supra* note 24, at 38.

[30] OVERVIEW AND STATUS REPORT, *supra* note 19, at 20. A center's clinical team includes, on average, 5.87 full time equivalent (FTE) physicians (mostly family practitioners and general internists, with a smaller proportion of obstetricians and pediatricians), 2.21 FTE mid-level practitioners (nurse practitioners, nurse midwives and physician assistants) and 1.07 FTE dentists. *Id.*

[31] *Id.* at 20.

[32] 42 U.S.C. § 254c(a).

[33] OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., MEDICAL MALPRACTICE AND THE COMMUNITY HEALTH CENTERS 1 (1991) [hereinafter DHHS INSPECTOR GENERAL REPORT].

than employees of the federal government.[34] This change in employment status forced centers to assume responsibility for providing professional malpractice insurance coverage since the physicians could no longer enjoy liability protection under the Federal Tort Claims Act (FTCA).[35] As this article later addresses, the burden of purchasing commercial malpractice insurance has placed the centers in a precarious financial position, threatening the future of the program's mission.

B. PROGRAM SUCCESSES

Despite financial challenges, the community health center program, over its history, has achieved a positive impact on the health of the populations it serves.[36] For example, communities served by the centers exhibit infant mortality rates nearly ten percent lower than communities not served by such centers.[37] Center patients have over 50% higher immunization rates and considerably more prenatal care than community residents who do not use center services.[38]

The program also succeeds at providing cost-effective care. For example, community health centers' laboratory, medical, radiology and pharmacy costs are about two-thirds the national average for all health care providers.[39] Moreover, by emphasizing preventive care, the program limits overall health care expenditures. Since illnesses are diagnosed and treated at earlier stages, fewer expensive interventions (such as emergency care, inpatient or specialty care) are required. Community health center patients experience fewer hospital admissions, shorter inpatient stays, and fewer inappropriate uses of emergency rooms than persons living in comparable communities without such centers.[40]

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[34] *Id.* A small percentage of center physicians (about 10%) are still employed, paid and insured by the federal government because of special circumstances. *H.R. 2239 Hearings*, *supra* note 9, at 8 (statement of Representative Ron Wyden).

[35] DHHS INSPECTOR GENERAL REPORT, *supra* note 33, at 1. The Federal Tort Claims Act is codified at 28 U.S.C. §§ 1346, 2671-2680 (1988).

[36] *See generally* TWO DECADES OF ACHIEVEMENT, *supra* note 26.

[37] DATA BOOK, *supra* note 13, at 15.

[38] OVERVIEW AND STATUS REPORT, *supra* note 19, at 3.

[39] TWO DECADES OF ACHIEVEMENT, *supra* note 26, at 8.

[40] DATA BOOK, *supra* note 13, at 15. The cost effectiveness of the communi-

Despite the success of the program, current federal funding levels prohibit centers from addressing the health needs of all low-income persons in the center's communities. Indeed, 15 to 28% of center patient loads are placed on waiting lists because of limitations on financial and professional resources.[41] This access problem testifies, in part, to the need for expanded center resources and, one can argue, a greater number of centers in general.

II. A PARTNERSHIP WITH THE FEDERAL GOVERNMENT

Congress established the community health center program with the intent of using taxpayer funds to provide health services to underserved persons.[42] From the outset of the program, the federal government elected to develop a contractual relationship with the private sector for coordination of services, yet provided the majority of physicians through the NHSC. Now that the majority of center physicians are no longer federal employees,[43] the situation today represents an even purer federal-private partnership in which the federal partner predominately provides financing and general supervision.

The flow of grants from the federal government to the nonprofit community centers is the lifeblood of this partnership.[44] Through the grant procedure of the Public Health Service Act, the DHHS Secretary, using congressionally appropriated funds, provides seed money for clinic development and annual opera-

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ty health center program has prompted center advocates to argue that federal policy makers should view the clinic system as a model for any future coordinated national health care reform proposals. Telephone Interview with Daniel R. Hawkins, Jr., Policy Director, NACHC (Oct. 11, 1991). *See generally FTCA Hearings, supra* note 24, at 3 (statement of Daniel R. Hawkins, Jr. Policy Director, NACHC).

[41] 137 CONG. REC. S4364 (daily ed. April 11, 1991) (statement of Senator Hank Brown).

[42] *H.R. 2239 Hearings, supra* note 9, at 35 (statement of Representative Jim McDermott).

[43] *See supra* text accompanying note 34.

[44] Centers apply to the federal government for categorical grants every three years and follow-up with annual amendments. Centers' funding needs are calculated, in part, by projecting the number of physicians required to care for the target population. Telephone Interview with Dave Cavenaugh, Policy Research Specialist, NACHC (Feb. 18, 1992).

tional grants to support ongoing operations.[45] While the statute provides that the Secretary may issue grants to cover only the excess of costs over net receipts,[46] this amount, in fact, represents 44% of total clinic funding.[47] Medicaid reimbursement accounts for approximately 30% of clinic revenues.[48] The remaining 26% of funds is derived from state and local grants, private insurance, and a small number of self-paying patients.[49] By serving a largely poor patient population, 49% of which is completely uninsured, 39% of which is insured by Medicaid, and another 12% of which has minimal private insurance, the centers experience monumental bad debts and contractual allowance shortfalls.[50] Federal grant money inevitably makes up the deficit and, thus, is indispensable to the continuing viability of community health centers.

Federal funding is conditioned upon compliance by the grant recipients with certain federal grant management rules.[51] In addition to clinical, service area, and fiscal requirements, community health centers are expected to meet quality assurance, staffing and productivity standards.[52] These federal guidelines are an important mechanism to assure that the goals of the program are met.

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[45] 42 U.S.C. § 254c(c)-(d). The funds are administered by two offices within the DHHS: the Bureau of Health Care and Assistance of the Public Health Service. OVERVIEW AND STATUS REPORT, *supra* note 19, at 1.

[46] An annual operational grant to a center, "may not exceed the amount by which the costs of operation . . . exceed the total of—

(i) State, local and other operational funding, and

(ii) the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year." 42 U.S.C. 254c(d)(4)(A).

[47] *H.R. 2239 Hearings*, *supra* note 9, at 8 (statement of Representative Ron Wyden).

[48] Telephone Interview with Dave Cavenaugh, Policy Research Specialist, NACHC (Feb. 18, 1992).

[49] *Id.*

[50] Contractual allowances represent the difference between billed charges and contracted reimbursement rates.

[51] 42 U.S.C. § 254c(c)-(e); 42 C.F.R. § 51c.303 (1991).

[52] For example, centers are expected to define clinical experience and competence standards for staff privileges, ensure access to continuing professional education, maintain written policies regarding clinical protocols and risk management, and monitor clinical quality through ongoing quality assurance programs. PROGRAM EXPECTATIONS, *supra* note 20, at 22 (expanding upon federal grant management rules).

In recent years, annual appropriations for the community health center program have totaled about $478 million.[53] In addition, President Bush's 1993 budget proposes an additional $90 million to expand the scope of the community health center program.[54] Despite continued federal support, however, the survival of the program's mission has been jeopardized by high and escalating professional malpractice insurance costs.

III. THE MALPRACTICE INSURANCE RATE CRISIS AND ITS CONSEQUENCES

The rising cost of malpractice insurance threatens the continuing viability of all health care providers today.[55] While there is no indication that insurance premiums for community health centers and their doctors have risen considerably faster than for other medical personnel providing similar services,[56] the rate increases imposed on centers are sizeable and appear disproportionately large in relation to the centers' actual claims experience.

A. COMMUNITY HEALTH CENTER INSURANCE

Community health centers typically purchase a series of insurance policies, including general liability coverage,[57] professional malpractice, and corporate malpractice coverage. Professional malpractice insurance provides coverage for a center's physicians and other professional clinical staff. Corpo-

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[53] In fiscal years 1991 and 1992 Congress appropriated $478 million to the centers. *H.R. 2239 Hearings*, *supra* note 9, at 35 (statement of Representative Jim McDermott).

[54] Secretary Louis H. Sullivan, Remarks at DHHS Budget Briefing (Jan. 29, 1992) (transcript available through Federal News Service).

[55] The cost of professional liability insurance was the fastest growing component of physician costs in the 1980's and this trend has continued in the 1990's. Between 1983 and 1988, professional liability insurance rose by approximately 174%. 137 CONG. REC. S14907, S14915 (daily ed. Oct. 17, 1991) (statement of Senator John C. Danforth).

[56] Premiums for obstetricians nationwide, for example, rose by as much as 300% between 1982 and 1987. DHHS INSPECTOR GENERAL REPORT, *supra* note 33, at 1.

[57] General liability insurance protects against many types of non-malpractice suits and, among other things, indemnifies directors and officers of an entity who can be sued in their capacity as fiduciaries of the centers.

rate malpractice insurance, providing "deep pocket" coverage, protects the institutional entity against claims arising out of the malpractice of its personnel. Approximately 85% of total malpractice premium dollars expended by the centers go to purchase professional malpractice coverage while the remainder buy corporate malpractice coverage.[58] Centers are experiencing the greatest cost increases for professional and corporate malpractice coverage relative to other types of coverage.

Community health centers, in total, purchased $58 million in professional and corporate malpractice insurance premiums in 1990,[59] representing more than 12% of the annual $478 million federal appropriation to the community health center program[60] and, on the average, over 4% of each center's total revenues.[61] Insurance costs for many individual centers have increased more than fourfold in the last decade.[62] Some centers have seen their insurance costs triple in the last three years alone.[63]

B. DISCREPANCY BETWEEN PREMIUM RATES AND ACTUAL CLAIMS EXPERIENCE

While aggregate data on successful malpractice claims brought against the centers and their doctors are not currently collected through standardized reporting,[64] various regional surveys and studies, when aggregated, suggest that the actual number of successful claims are small in comparison to premiums paid. Successful malpractice claims brought against centers (including litigation costs) total about $4 to $6 million annually.[65] At one-twelfth (8%) of premiums paid, the actual

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[58] Telephone Interview with Dave Cavenaugh, Policy Research Specialist, NACHC (Mar. 19, 1992).

[59] Pear, *supra* note 8, at A18.

[60] *See supra* note 53 and accompanying text.

[61] DHHS INSPECTOR GENERAL REPORT, *supra* note 33, at 1.

[62] Pear, *supra* note 8, at A18.

[63] *H.R. 2239 Hearings*, *supra* note 9, at 35 (statement of Representative Jim McDermott).

[64] 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. The Service will begin doing so in 1992. DHHS INSPECTOR GENERAL REPORT, *supra* note 33, at 2.

[65] The NACHC contends that this $4 to $6 million figure is an accurate

claims experience of clinics appears low to moderate as compared to the insurance costs.[66] The $52 to $54 million difference between premiums and successful claims represents federal dollars that could be utilized for direct patient care but are instead channeled to commercial insurance companies.

The 8% claims-to-premiums ratio of community health centers is considerably lower than that of other health care providers. The ratio for private practice physicians, for example, is approximately 65%.[67] Thus, community health centers believe that they are shouldering unwarranted insurance costs. That insurers demand high premiums in the face of low payouts seems to represent a failure of the market to respond realistically to the actual insurance risk represented by community health centers.

C. INSURANCE INDUSTRY RATIONALES FOR HIGH PREMIUM RATES

One may speculate that premium rates are set to contribute to excessive underwriting profits.[68] Indeed, the National Association of Community Health Centers (NACHC), the centers'

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portrayal of claims experience. The U.S. Department of Justice argues that current methodologies for collecting such data are unreliable. *H.R. 2239 Hearings*, *supra* note 9, at 18 (statement of Stuart M. Gerson, Assistant Attorney General, Civil Division, U.S. Dep't of Justice). A report of DHHS Inspector General, looking at all available data, estimates that malpractice claims represent roughly 10% of the cost of premiums. This would equal $5.8 million for 1990. DHHS INSPECTOR GENERAL REPORT, *supra* note 33, at 3.

[66] Center-specific examples are illustrative: the Peekskill Area Health Center in New York State reports its malpractice insurance premiums rose from $168,000 to $218,000 while the clinic has not paid any malpractice claims in 15 years. Pear, *supra* note 8. Malpractice rates for five community health centers in Providence, Rhode Island rose 39% last year even though the clinics have not paid out any malpractice claims in 24 years. *Id.* Centers in Virginia have spent over $900,000 in premiums during the last six years while paying out only $1,800 in claims, a ratio of two-tenths of one percent. *H.R. 2239 Hearings*, *supra* note 9, at 42 (statement of Daniel R. Hawkins, Jr., Director of Policy Analysis, NACHC).

[67] *H.R. 2239 Hearings*, *supra* note 9, at 35 (statement of Representative Jim McDermott).

[68] Only a relatively small number of insurers provide professional and corporate malpractice coverage to the centers. This market condition might enable these insurers to exact higher rates than would be expected in a market with a greater number of suppliers.

national advocacy group,[69] has suggested that the excess cost represents an insurance industry profit margin that goes beyond even the most liberal reserves requirement and, arguably, is far in excess of that necessary for good business practice.[70] Premium rates may also be set high in order to compensate for investment losses.[71] Finally, the disproportionately high premium costs borne by centers may help to subsidize higher risk insureds in the risk pool. Thus, community health centers may be subsidizing other insureds who are paying fewer premium dollars than their actual claims experience dictates they should.[72]

However, the insurance industry reports rate-making rationales which invoke notions of prudent risk protection and structural practicality.[73] Insurers cite adverse selection as a fundamental rationale for their rate-making scheme. They argue that the patients served by the centers, particularly the poor and, especially, indigent pregnant women, represent high insurance risks.[74] Thus insurers maintain that it is necessary to build sufficient reserves in anticipation of large payouts that may occur in the future.[75]

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[69] The mission of the NACHC is: "(1) to represent the interests of community and migrant health centers and homeless health care programs and (2) to serve as an information source concerning issues of health care for poor and medically underserved populations in the U.S." OVERVIEW AND STATUS REPORT, *supra* note 19, at back cover.

[70] The NACHC Director of Policy Analysis has testified that the profit margin afforded insurers is "far in excess of that necessary for good business practice, at the expense of prenatal care and other vital services for the poor and underserved in our communities." *H.R. 2239 Hearings*, *supra* note 9, at 39 (statement of Daniel R. Hawkins, Jr., Director of Policy Analysis, NACHC).

[71] This practice is known as cash-flow underwriting.

[72] This kind of cross-subsidization occurs when disparate risks are inappropriately pooled together.

[73] *See* Pear, *supra* note 8.

[74] *Id.*

[75] It is a common practice for insurance companies to build reserves in anticipation of large payouts that arise from high risk endeavors. There is a perception among underwriters that non-profit enterprises, in general, are engaged in exceptionally risky activities. Michael Pierce Singsen, Comment, *Charity Is No Defense: The Impact of the Insurance Crisis on Nonprofit Organizations and an Examination of Alternative Insurance Mechanisms*, 22 U.S.F. L. REV. 599, 608 (1988) (the "inability to predict loss, compounded by the random quality of claims made against nonprofits, may be the primary reason why nonprofits have been disproportionately affected by the insurance

Yet, the actual malpractice risks posed by community health centers and the clientele they serve may be less than expected. As a preliminary matter, indigent patients are much less able and, thus, less likely, to file malpractice suits than are persons of middle or upper incomes.[76] Data suggest, for example, that poor women are less likely to pursue a malpractice incident than are more affluent women.[77] Moreover, the risk-management and quality assurance guidelines which accompany federal grants[78] ensure standards of quality care and thus are designed to mitigate malpractice risk. In addition, the community participation element of the community health center program may promote more positive patient-doctor relationships and thus result in fewer malpractice claims.[79] Finally, the argument that community health center patients possess higher health risks and are, therefore, at a risk of poor outcomes, seems irrelevant to the question of whether doctors treating such patients will fall below a malpractice standard of care in treating such patients.

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crisis.").

[76] *See* Edmund G. Doherty & Carl O. Haven, *Medical Malpractice and Negligence: Sociodemographic Characteristics of Claimants and Nonclaimants*, 238 JAMA 1656, 1658 (1977) ("[P]atients who are more experienced with the health care provision system or who are of higher socio-economic status are more apt to recognize negative medical experiences and, therefore, make a claim or bring a suit."); *see also* DHHS INSPECTOR GENERAL REPORT, *supra* note 33, at C-1 ("[T]he 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." (quoting HEALTH RESOURCES AND SERVS. ADMIN., 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 (1987)); Molly McNulty, *Are Poor Patients Likely to Sue for Malpractice?*, 262 JAMA 1391 (1989) ("[C]urrent studies now universally demonstrate [that]...they [poor people] are less likely to sue than are middle-class or privately insured patients.").

[77] Hughes, *supra* note 23, at 61.

[78] 42 U.S.C. § 254c(c)-(e); 42 C.F.R. § 51c.303. *See supra* notes 51, 52 and accompanying text.

[79] "'The sense of community ownership,' one study noted, 'has made suits less likely.'" DHHS INSPECTOR GENERAL REPORT, *supra* note 33 at C-1 n.7, *quoting* ROBERT S. BURKE, CONNECTICUT PRIMARY CARE ASS'N, THE MALPRACTICE INSURANCE QUESTION FOR THE COMMUNITY HEALTH CENTERS OF CONNECTICUT 20 (1991).

Insurers further contend that implementing an insurance scheme based upon actual claims experience[80] would be impracticable. They assert that they do not possess the requisite detailed and comprehensive actuarial data that would be needed to construct proper experience-based rates.[81] Certainly, successful experience rating for the centers would require a comprehensive and time-tested data base of claims experience.[82] However, the composite of surveys on community health center claims,[83] while undoubtedly falling short of the exacting actuarial requirements of the insurance industry, would seem, at least, to suggest some rate-making guideposts to the insurers.

Whether the reasons advanced by insurers for high premiums are valid, the fact remains that community health centers are losing precious funds to costly commercial insurance premiums.

D. COMPROMISES IN PROGRAM SERVICES

The impact of increasingly high malpractice insurance premiums greatly compromises the integrity of the community health center mission. Indeed, community health centers could serve at least one-half million additional patients annually if the money spent on malpractice insurance were instead directed toward patient care.[84]

Other compromises in patient services resulting from high insurance costs are common. Since centers are unable to pass expenditure increases on to their patients, they are forced to reduce services or eliminate some programs. Some centers have had to discontinue obstetrical services entirely.[85] A 1991 survey conducted by the Department of Health and Human Services Office of the Inspector General found that 56% of centers

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[80] Experience rating uses the loss experience of the insured during one period to help set the premiums charged in the following period. *See generally* KENNETH S. ABRAHAM, DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY 64-100 (1986).

[81] Pear, *supra* note 8, at A18.

[82] DHHS INSPECTOR GENERAL REPORT, *supra* note 33, at 6.

[83] *See supra* text accompanying note 64.

[84] *H.R. 2239 Hearings*, *supra* note 9, at 40 (statement of Daniel Hawkins, Jr., Director of Policy Analysis, NACHC).

[85] Pear, *supra* note 8, at A18.

have had to significantly limit their pregnancy care due to increased malpractice premiums.[86]

In addition to its effect on services, the high cost of insurance has also hurt the centers' ability to recruit and hire personnel, especially family practice physicians and obstetricians.[87] Some centers have been forced to reduce their staffs, thus frustrating patient access to timely services.[88] One study shows that some centers have been forced to replace experienced doctors with new graduates since, under the insurance industry rationale of accumulated exposure, more experienced physicians must carry more expensive insurance.[89]

In light of the community health centers' low claims experience and the insurance industry's unwillingness to charge accordingly, commercial insurance does not appear to be a cost effective way of insuring against malpractice losses for the program.

IV. IDENTIFYING POSSIBLE SOLUTIONS

The malpractice insurance cost crisis has prompted a search for solutions, both legislative and non-legislative.

A. AN ATTEMPT AT SELF-INSURANCE

Before seeking legislative solutions, the community health centers, through the NACHC, first pursued a self-help strategy by exploring the feasibility of forming a self-insuring or risk retention group.[90] However, federal requirements rendered the

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[86] DHHS INSPECTOR GENERAL REPORT, *supra* note 33, at 2.

[87] Hughes, *supra* note 23, at 68.

[88] *H.R. 2239 Hearings*, *supra* note 9, at 40 (statement of Daniel R. Hawkins, Jr., Policy Director of Policy Analysis, NACHC).

[89] Hughes, *supra* note 23, at 70.

[90] There are two types of self-insurance arrangements. In a "captive" arrangement, an entity or association of entities forms and owns its own insurance company. Like a commercial insurer, the self-insuring group collects premiums and maintains a capital fund, but it provides insurance only to its owner group. Under a generic self-insurance arrangement, an entity or association of entities insures itself without forming a separate insurance company. The self-insuring entity expects to cover losses up to a specified pooled amount (first-level coverage) and purchases reinsurance (second-level coverage) from a commercial carrier to cover losses beyond that amount. The NACHC explored this latter form of self-insurance. For a fuller explanation

endeavor impossible since grant management rules prohibit use of grant monies as capitalization for reserves.[91] Thus, the centers could not contribute federal money or funds from a non-federal source as capital to create an initial pool of reserves.[92] Furthermore, the community health centers discovered that no commercial carriers were willing to provide the necessary reinsurance (second-level insurance)[93] for the self-insuring group.[94] Even if a private carrier were willing, the costs of reinsurance would have been prohibitive to the centers.[95]

B. ANOTHER NON-LEGISLATIVE SOLUTION?

Perhaps another non-legislative solution lies in obtaining relief through state insurance commissioners or in the courts. Centers could argue that their malpractice rates are excessive, unfairly discriminatory, and not in accord with sound actuarial principles. Insurance regulation statutes and case law suggest that insureds may challenge insurers charging excessive premiums by showing that premiums are based upon dubious and unsupported evidence in light of data demonstrating that claims

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of self-insurance arrangements and their application in the context of midwifery malpractice, see Gail A. Robinson, *Midwifery and Malpractice Insurance: A Profession Fights for Survival*, 134 U. PA. L. REV. 1001, 1027-34 (1986).

[91] *FTCA Hearings*, *supra* note 24, at 35 (statement of Daniel R. Hawkins, Jr., Director of Policy Analysis, NACHC). *See also* 42 C.F.R. §§ 51c.201-204, 51c.301-305 (1991).

[92] Federal grant management rules apply to the entire budget of federal grant recipients. Thus, while the federal government funds only 44% of a center's budget, it has supervision over the entire budget. Federal grant restrictions, therefore, apply to the use of all funds in a center's budget. As a result, the centers were not allowed to contribute non-federal dollars for capitalization of reserves. *FTCA Hearings*, *supra* note 24, at 35 (statement of Daniel R. Hawkins, Jr., Director of Policy Analysis, NACHC).

[93] Insurance companies or self-insurers purchase reinsurance as additional protection. Reinsurance typically provides protection against the risk that primary insurance will be exhausted in paying catastrophic claims or an excessive number of claims.

[94] *FTCA Hearings*, *supra* note 24, at 35-36 (statement of Daniel R. Hawkins, Jr., Director of Policy Analysis, NACHC).

[95] The NACHC estimates that every $10 million of primary insurance requires approximately $6 million of reinsurance. Telephone Interview with Daniel R. Hawkins, Jr., Director of Policy Analysis, NACHC (Feb. 18, 1992).

experience warrants lower rates. An example of such a challenge is the Illinois case of *Anzinger v. O'Connor*[96].

In *Anzinger*, emergency room physicians argued that a rating scheme employed by defendant insurer, a physician-owned company, improperly placed them in a higher risk classification (and higher premium rate) than was warranted. The plaintiffs demonstrated that their specialty's actuarial risk level did not compare to that of general surgical specialties. Upon this showing, they contended that the rates charged violated a provision of the Illinois Insurance Code prohibiting "excessive" or "unfairly discriminatory" insurance rates. The Illinois Director of Insurance, following a hearing, found that the classification system was not unfairly discriminatory toward emergency room physicians and that the rates charged were not excessive. The *Anzinger* court reversed the Director's decision on the ground that the decision was contrary to the manifest weight of the evidence regarding the relative riskiness of the emergency room specialty.[97]

In reaching its decision, the court first noted that the Illinois code provision provided that a premium rate will not be deemed to be excessive unless "the rate is both 'unreasonably high for the insurance provided' and 'a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable.'"[98] The court then found that the insurer's data did not reliably lend itself to the classification used.[99] In light of the evidence that the insurance rate was so disproportionately large, the court deemed the Director's decision as contrary to the manifest weight of the evidence regard-

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[96] Anzinger v. O'Connor, 440 N.E.2d 1014 (Ill. 1982). *See also* Morgan v. Blue Cross and Blue Shield of Kentucky, 794 S.W.2d 629 (Ky. 1989) (Kentucky Commissioner of Insurance may refuse to approve a rate if "the benefits provided are not reasonable in relation to the premiums charged and loss ratios"); Medical Malpractice Joint Underwriting Ass'n of Massachusetts v. Comm'r of Ins., 478 N.E.2d 936 (Mass. 1985) (challenge of medical malpractice rates under Massachusetts insurance statute as not "adequate, just [and] reasonable," not "actuarially sound," and "unsupported by substantial evidence in the record"); Community Mut. Ins. Co. v. Fabe, 556 N.E.2d 1155 (Ohio 1990) (challenging Medicare complementary rate increase as "not calculated according to sound actuarial principles.").

[97] *Anzinger*, 440 N.E.2d at 1021.

[98] *Id.* at 1020.

[99] *Id.* at 1021.

ing the relative riskiness of the emergency medicine specialty.[100] Under the *Anzinger* holding and rationales, the community health centers could argue that their actual claims experience suggests they are inappropriately classified with providers who pose greater liability risks and, thus, centers bear disproportionately large premiums.

While the holding of *Anzinger* suggests some hope for a parallel community health center claim, bringing such a suit would prove difficult for the centers. Assuming the centers would want to fashion a program-wide solution, they would have to bring a claim based on each of the states' statutory prohibitions against unfairly discriminatory classification schemes and excessive rate-making (such as those provisions of the Illinois statute in *Anzinger*).[101] Centers would then have to present their arguments to the various state insurance commissioners. However, commissioners are known to take a wide variety of regulatory stances.[102] Some defer to market forces to define boundaries for private insurance activities. Others assume an eager regulatory posture. An inconsistency of commissioner findings would likely result. Such inconsistency would not be cured by court actions brought against adverse commissioner decisions, especially since courts give great deference to insurance commissioners' decisions.[103] An inconsistency of litigation results would be an undesirable solution for the community health center program as a whole.

Thus, the great variability in insurance regulation across the states presents a practical difficulty to any effort of coordinating a uniform solution.

V. LEGISLATIVE SOLUTIONS

Both Congress and the Bush Administration, acknowledging a concern for the survival of the community health center

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[100] *Id.*

[101] All states have statutes designed to prohibit excessive or unfairly discriminatory insurance rates.

[102] ABRAHAM, *supra* note 80, at 38-41.

[103] Typically, the standard of review for reviewing insurance commissioner decisions is whether the finding is supported by substantial evidence. *See, e.g.*, Massachusetts Auto Rating and Accident Prevention Bureau v. Comm'r of Ins., 453 N.E.2d 381, 385 (Mass. 1983); Nationwide Mut. Ins. Co. v. Ins. Comm'r, 509 A.2d 719, 723-24 (Md. 1986); State Comm'r of Ins. v. North Carolina Rate Bureau, 331 S.E.2d. 124, 131 (N.C. 1985).

program and its mission, have been willing to assist the centers through federal legislation. However, they dispute how much federal money and effort should be extended to alleviate the problem.

Three distinct legislative solutions to the community health center insurance crisis currently occupy the attention of federal lawmakers.[104] The Federally Supported Health Centers Assistance Act of 1991 (H.R. 3591)[105] places the financial burden of solving the insurance crisis on the shoulders of the federal Treasury and Justice departments by extending liability protection of the FTCA[106] to center practitioners. The Ensuring Access Through Medical Liability Reform Act of 1991 (S. 489)[107] is a response by more conservative lawmakers. This bill addresses the malpractice crisis as one component of broad medical liability reform by advocating the formation of a nationwide risk retention group for the centers. The third bill, the Community and Migrant Health Centers Self-Insurance Act of 1991 (S. 815)[108] suggests a compromise by mandating a self-insurance approach that includes features more favorable to community health centers than S. 489.

A. H.R. 3591: THE FEDERALLY SUPPORTED HEALTH CENTERS ASSISTANCE ACT OF 1991

The sponsors[109] of H.R. 3591 adopt the notion that the federal government must bear responsibility for financing a solution to the crisis facing the community health centers. The bill shifts the duty of defending, settling, and paying malpractice claims brought against community health centers from the centers to the federal government.

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[104] Each of the three bills analyzed is currently receiving active attention and refinement in committee as of the date of this article. The final versions of the bills do not yet exist.

[105] H.R. 3591, 102d Cong., 1st Sess. (1991). Representative Ron Wyden originally introduced the bill during the 101st Congress as H.R. 2239.

[106] Federal Tort Claims Act, 28 U.S.C. §§ 1346, 2671-2680 (1988).

[107] S. 489, 102d Cong., 1st Sess. (1991).

[108] S. 815, 102d Cong., 1st Sess. (1991).

[109] H.R. 3591 sponsors include Representatives Wyden (D-Or), Waxman (D-CA), Frank (D-MA), English (D-OK), McDermott (D-WA), Rowland (D-GA), Skelton (D-MO) and Stenholm (D-TX).

1. *Extension of FTCA Protection*

H.R. 3591 shifts liability for medical malpractice from community health centers to the U.S. Treasury by extending coverage of the FTCA[110] to centers, their personnel, and their contractors. It accomplishes this by creating a fiction that the entity and its personnel are employees of the federal government for purposes of liability protection. Yet, the bill does not extend to the federal government direct supervisory control over center personnel.[111]

Under the bill's extension of the FTCA, plaintiffs could not bring civil claims against community health centers or their staff but instead would have to bring them directly against the United States.[112] The FTCA would place the burden of litigation costs upon the Justice Department while the Treasury would pay for successful claims or settlements.[113]

2. *Advantages and Disadvantages*

From the perspective of the community health centers, H.R. 3591 possesses positive features. Most importantly, through the application of FTCA liability protection, the centers would be freed from purchasing commercial corporate and professional malpractice insurance. Monies currently applied to commercial

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[110] Under the FTCA, the United States is liable for the "negligent or wrongful act or omission of any employee of the Government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred." 28 U.S.C. § 1346(b) (1988).

[111] H.R. 3591 states, in part,

> for purposes of this section, a public or non-profit private entity receiving Federal funds under section 329, 330, or 340, and any officer, employee, or contractor of such an entity who is a physician or other licensed health care practitioner *shall, . . . be deemed to be an employee* of the Public Health Service.

H.R. 3591 § (2)(a) (emphasis added) .

H.R. 3591 thus deems centers, their employees and contractors to be employees of the Public Health Service for purposes of FTCA protection only. Interestingly, the bill would reinstate FTCA protection to a number of practitioners -- former NHSC doctors -- who once enjoyed such protection. *See supra* text accompanying notes 33-35.

[112] 28 U.S.C. § 2674 (1988).

[113] 28 U.S.C. § 244 (1988).

insurance would be redirected toward needed clinic services. The NACHC and other proponents argue, therefore, that extension of FTCA liability protection redirects federal monies to better use.[114] Second, the bill provides FTCA protection to the centers as corporate entities,[115] a feature lacking in S. 815. Finally, H.R. 3591 shifts the burden of litigation costs[116] borne by the centers[117] to the federal government.

The Bush Administration and the Justice Department oppose H.R. 3591,[118] revealing a reluctance to bear the burden of a shift in tort liability coverage. The Administration has raised two related criticisms of H.R. 3591: (1) immunizing centers from tort liability without allowing the government to directly supervise the day-to-day activities and clinical quality of the center personnel violates a "control principle" policy of the FTCA,[119] and (2) H.R. 3591 would unavoidably reduce an institutional pecuniary incentive to provide high quality care.[120]

3. *The Control Principle Debate*

A central concern of the Bush Administration is that H.R. 3591 violates a fundamental precept of the FTCA – that its protection should not apply to individuals beyond the day-to-day supervision of the United States even if those persons operate under federal financial support.[121] The FTCA is not intended to immunize from liability those persons over whom the government has no supervisory control. Courts refer to this principle

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[114] *H.R. 2239 Hearings, supra* note 10, at 8 (statement of Rep. Ron Wyden).

[115] H.R. 3591 § 2(a).

[116] Litigation costs for medical malpractice claims generally equal or exceed 40% of total indemnity costs. *Study Finds Rising Defense Bills,* 24 BUS. INS. 2 (1990). Indeed, approximately $1.6 to 2.4 million of the $4 to $6 million claims paid by centers represents the costs of defending malpractice suits.

[117] Centers, as insureds, do not pay defense costs directly, as insurance companies bear the duty to defend. Yet, the cost of such defense is reflected in premium rates.

[118] *H.R. 2239 Hearings, supra* note 9, at 17 (statement of Stuart M. Gerson, Assistant Attorney General, Civil Division, U.S. Dep't of Justice).

[119] *Id.* at 22-24.

[120] *Id.* at 22.

[121] *Id.* at 22-24.

when deciding whether FTCA protection applies to persons or entities absent clear congressional mandate.[122]

The Supreme Court unanimously announced the control principle doctrine in *United States v. Orleans*.[123] The Court stated:

> Federal funding reaches myriad areas of activity of local and state governments and activities in the private sector as well. It is inconceivable that Congress intended to have waiver of sovereign immunity follow congressional largesse and cover countless unidentifiable classes of "beneficiaries." The Federal Government in no sense controls "the detailed physical performance" of all the programs and projects it finances by gifts, grants, contracts, or loans.[124]

In a number of other cases, courts have found the United States not liable for the acts or omissions of medical service contractors because the government did not have daily control over the contractor's activities.[125] Thus, the Bush Administration argues that extending FTCA protection to community health centers violates the policy underlying the control principle.

Of course, Congress is free to balance the policy behind the control principle against countervailing arguments for providing liability protection to non-federal employees and federal grant recipients. Indeed, Congress has extended FTCA protection to private individuals who perform services on behalf of the federal government even though the government does not supervise

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[122] Congress can, of course, statutorily extend FTCA protection by statute to any non-federal employee by deeming such person a federal employee for purposes of the FTCA. Where such congressional intent is not clear, however, the control principle guides court decisions.

[123] United States v. Orleans, 425 U.S. 807 (1976).

[124] *Orleans*, 425 U.S. at 816 (citation omitted).

[125] For example, in *Leone v. United States*, 910 F.2d 46 (2d Cir. 1990), the Second Circuit considered whether private physicians, designated by the Federal Aviation Administration (FAA) as aviation medical examiners, were employees of the government for purposes of the FTCA. The court found that although the FAA regulations referred to the private physician-contractors as representatives of the FAA, the federal government was under no obligation to extend liability protection to them under the FTCA. The court stated that while the FAA acted as a general overseer of the medical examiners, it did not manage the details of their work or perform daily supervision. Thus, the FAA did not maintain the type of control over the physicians required by the FTCA.

their daily activities. Most noteworthy is 25 U.S.C. § 1680c(d) which extends FTCA coverage to physicians who privately contract to provide care under the Indian Health Service.[126] Other examples include the extension of FTCA protection to civilians who provide voluntary services for a museum or a natural resources program operated by the U.S. military;[127] volunteers of the Youth Conservation Corps;[128] and President-designated science advisors of the federally administered Strategic Environmental Research and Development Program.[129] In these cases and others, Congress has deemed it important to create the federal employee fiction for purposes of liability protection. H.R. 3591 asserts such a rationale for the community health center program.

The Bush Administration could reasonably argue that in examples such as those above (except for the Indian Health Service application), the potential of liability risk assumed by the government does not compare to that posed by 1500 community health center clinics and thousands of health care personnel. However, the NACHC counters that extending FTCA coverage to community health centers and their personnel, given past claims experience, represents only a minute addition to the vast scope of FTCA coverage already provided by the federal government.[130]

The Bush Administration has maintained that extension of FTCA coverage to community health centers must be accompanied by greater federal supervisory control over center employees and their contractors.[131] H.R. 3591 proponents argue that the bill would not threaten the quality of care concerns underlying the control principle. First, federal grant management rules already provide adequate federal supervision through clinical

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[126] 25 U.S.C. § 1680c(d) (1988).

[127] 10 U.S.C. § 1588(b) (1988).

[128] 16 U.S.C. § 1703 (1988).

[129] 10 U.S.C.A. § 2904 (West Supp. 1991).

[130] *FTCA Hearings*, *supra* note 24, at 36 (statement of Daniel R. Hawkins, Jr., Director of Policy Analysis, NACHC).

[131] *H.R. 2239 Hearings*, *supra* note 9, at 24 (statement of Stuart M. Gerson, Assistant Attorney General, Civil Division, U.S. Dep't of Justice). The supervisory control the Bush Administration advocates includes the ability to make personnel decisions at individual clinics. Mr. Gerson has stated that the federal government would "like to be able to fire over-utilizers, underperformers and malpractitioners." Pear, *supra* note 8, at A18.

guidelines and quality assurance requirements.[132] Second, H.R. 3591 includes a quality safeguard provision which gives DHHS adequate supervisory authority over the centers. Section 2(b)(1) of H.R. 3591 amends the Public Health Service Act as follows:

> "(h) The Secretary may not make a grant to an entity . . . . unless the entity —
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> "(1) has implemented appropriate policies and procedures to assure against malpractice in all health or health-related functions performed by the entity;
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> "(2) has reviewed and verified the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians and other licensed health care practitioners, and, where necessary, has obtained the permission from these individuals to gain access to this information; and
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> "(3) has no history of claims having been filed against it pursuant to this section, or, if such a history exists, has fully cooperated with the Attorney General in defending against any such claims and either has taken, or will take, such corrective steps to assure against such claims in the future.[133]

In addition, the bill authorizes the U.S. Attorney General to remove FTCA protection[134] from any center physician or other licensed care-giver if the Attorney General finds that the person exposes the government to an "unreasonably high degree of risk of loss."[135] Finally, the centers argue that H.R. 3591 merely

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[132] *FTCA Hearings*, *supra* note 24, at 43 (statement of Daniel R. Hawkins, Jr., Director of Policy Analysis, NACHC).

[133] H.R. 3591, § 2(b)(1).

[134] Before removing FTCA protection, the Attorney General must consult with the Secretary of DHHS and provide notice and an opportunity for a hearing to the physician or other medical caregiver he wishes to remove. H.R. 3591 § 2(c).

[135] *Id.* Factors to be used in such a determination include: (1) the subject's claim history (must be outside the norm for a licensed practitioner), (2) the subject's prior disciplinary history, and (3) the subject's refusal to reasonably cooperate with the Attorney General in defending a claim. *Id.*

reinstates FTCA protection to many center physicians who for many years demonstrated satisfactory quality care while working for the NHSC.[136]

The Bush Administration is reluctant to acquiesce on the control principle debate despite these safeguards. H.R. 3591 sponsors continue to refine the bill to increase its acceptability to the Administration. In light of the Bush Administration's general reluctance to fashion a public solution when private or self-help solutions might be available, the Administration may never be satisfied with H.R. 3591.

4. *Perverse Economic Incentive?*

The Bush Administration also argues that H.R. 3591 eliminates institutionalized pecuniary incentives for quality care. The Administration, applying moral hazard reasoning, argues that FTCA protection would remove direct accountability for quality care from center caregivers and managers and thus provide an incentive to lower standards of care and to administer cost-saving changes in operations at the expense of quality assurance.[137] This reasoning belies a cynical view of the professionalism of center health practitioners and clinic administrators. While motivations to compromise quality of care are possible, the opportunity to achieve cost savings at the expense of quality care is not available to centers. As stated earlier, there are numerous quality safeguards accompanying federal grant management rules.[138] Furthermore, H.R. 3591 comple-

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[136] *FTCA Hearings*, *supra* note 24, at 43 (statement of Daniel R. Hawkins, Jr., Director of Policy Analysis, NACHC).

[137] *2239 Hearings*, *supra* note 9, at 22 (statement of Stuart M. Gerson, Assistant Attorney General, Civil Division, U.S. Dep't of Justice). Mr. Gerson stated:

> [H.R. 2239] would remove direct accountability from the providers and from the entities for whom they work because no government agency exercises day-to-day control over the activities of the Centers. . . . . As a result, the bill fails to establish an institutional pecuniary incentive to provide high quality care. This is particularly problematic where the Centers' patients have no real alternatives to the medical care provided by the Centers. . . . [The bill] would unavoidably reduce the incentive of the Centers to assure that quality of care provided [sic] to their patients.

Id.

[138] See *supra* note 52 and accompanying text.

ments federal grant provisions with its own risk management safeguards.[139]

5. *Other Concerns*

H.R. 3591 does, however, have weaknesses. First, it does not authorize federal monies for defending malpractice suits brought against the centers. The Justice Department must bear all litigation costs in professional and corporate malpractice claims brought against the centers and their personnel. Based on prior experience, this amount could total $1.6 to $2.4 million per year.[140] By shifting litigation duties to the Justice Department without providing accompanying funding to cover costs, H.R. 3591 seems to violate the budget neutral "pay-as-you-go" principle of the Omnibus Budget Reconciliation Act of 1990.[141] Second, federal government assumption of community health center liability risk creates a "deep pocket" which may encourage malpractice suits. Yet, it seems unlikely that greater litigation will occur as a result of this shift in liability. Community health center clients, largely indigent, are much less able and less likely to pursue claims in the courts than persons of middle and upper incomes.[142] In addition, while the federal government may be a "deep pocket," it is also an imposing litigation opponent.

Finally, litigation under the FTCA imposes limitations on patient-claimant rights. For example, the FTCA prohibits punitive damage awards against the government[143] and thus lowers potential awards for successful claimants. In addition, the FTCA imposes a two-year statute of limitations[144] which may bar claims earlier than applicable state statutes.[145] The

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[139] *See supra* text accompanying note 133. The cynical view also ignores other quality incentives motivating caregivers, including professional reputation, job security and personal notions of duty to the patient.

[140] *See supra* note 116.

[141] Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990).

[142] *See supra* notes 76-77 and accompanying text.

[143] 28 U.S.C. § 2674.

[144] 28 U.S.C. § 2401(b).

[145] Generally, an action for medical malpractice must be commenced within two to four years from the time the incident giving rise to the action occurred, or from the time the incident is discovered.

NACHC has admitted that its advocacy for FTCA protection has placed it in an uneasy position with respect to these claimant rights issues.[146]

Although the NACHC is concerned about H.R 3591's effect on patients' rights, it strongly supports this initiative as the best available solution to the crisis presently facing community health centers.[147] H.R. 3591 offers a complete solution to the crisis facing the community health centers. Fifty-eight million dollars of program funding is currently applied to commercial malpractice insurance. H.R. 3591 removes this entire burden from the centers, thereby allowing the $58 million to be directed toward the provision of patient services. As stated earlier, the program could serve an additional one-half million patients each year.[148] In addition, through their focus on preventive care, the centers could forestall more costly medical intervention.[149]

The transfer of liability risk from the centers to the federal government will increase federal government costs by a mere $4 to $6 million each year (assuming past claims and litigation cost experience of the program holds). This additional draw on the public fisc seems a small price to pay for the benefits in enhanced patient services that will accrue from freeing the centers from spiralling malpractice insurance costs.

B. S. 489: ENSURING ACCESS THROUGH MEDICAL LIABILITY REFORM ACT OF 1991

The "Ensuring Access Through Medical Liability Reform Act of 1991," introduced as a response to H.R. 3591,[150] proposes broad medical malpractice liability reforms. The bill: (1) provides grants to states to improve their systems for compensating individuals injured by medical malpractice, particularly through the development of alternative dispute resolution

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[146] *FTCA Hearings*, *supra* note 24, at 36 (statement of Daniel R. Hawkins, Jr., Policy Analysis Director, NACHC).

[147] The Children's Defense Fund and the Institute of Medicine also endorse H.R. 3591. DHHS INSPECTOR GENERAL REPORT *supra* note 33, at 8 (1991).

[148] *See supra* note 84 and accompanying text.

[149] *See* discussion *supra* part I.B.

[150] Senator Orrin Hatch (R-UT) is the primary sponsor of S. 489 in the Senate. H.R. 1004, introduced by Representative Nancy Johnson (R-CT), is the companion bill in the House of Representatives.

procedures;[151] (2) provides grants to states and to private non-profit organizations for research on health care procedure outcomes and the prevention of, and compensation for, malpractice-related injuries;[152] (3) establishes uniform criteria for awarding damages in most medical malpractice actions, including certain reductions in economic awards,[153] limitations on non-economic damages,[154] ceilings on attorneys fees,[155] and imposition of a two year statute of limitations;[156] and (4) provides grants to states to establish risk management programs and professional discipline reforms.[157] This article addresses only that portion of S. 489 related to resolving the insurance crisis facing the community health centers.

1. *Community Health Centers Risk Retention Group*

The provision of S. 489 addressing the malpractice insurance cost crisis faced by community health centers proposes a self-help strategy – the formation of an independent national risk retention group[158] to provide professional liability coverage. S. 489 states, in part:

"(b) Business Plan and Formation.
"(1) Development and establishment. –

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[151] S. 489 § 101(a).

[152] *Id.* § 111(a).

[153] *Id.* § 201(a)(3)(A).

[154] *Id.* § 201(a)(4).

[155] *Id.* § 201(a)(5)(A)-(C).

[156] *Id.* § 201(a)(6)(A).

[157] *Id.* § 112(a).

[158] *Id.* § 203(a). In effect, the bill circumvents federal grant management rules barring centers from using funds to establish a risk retention pool. *See supra* text accompanying notes 91-92. The provision requiring formation of a risk retention group has been replicated in bills introduced in Congress addressing systematic health care or medical liability reform. Health Equity and Access Improvement Act of 1992, S. 1936, 102d Cong. 2d Sess. (1992); Access to Health Care for All Americans Act of 1991, S. 2036, 102d Cong., 1st Sess. (1991); American Health Quality Act, S. 1836, 102d Cong., 1st Sess. (1991); Health Care Access and Security Act of 1991, H.R. 4054, 102d Cong., 1st Sess. (1991); Medical Injury Compensation Reform Act of 1991, H.R. 3516, 102d Cong., 1st Sess. (1991); Health Access and Affordability Today Act of 1991, H.R. 3410, 102d Cong., 1st Sess. (1991).

> "(A) . . . the grantee shall develop a business plan . . . and have established a risk retention group that meets the requirements of . . . the Product Liability Risk Retention Act of 1981.
> . . .
>
> "(2) Business Plan. — The grantee shall develop a plan for the operation of the risk retention group that shall include all actuarial reports and studies conducted with respect to the formation, capitalization, and operation of the group.
> . . .
>
> "(3) Structure, rights, and duties of the risk retention group . . .
> "(E) Participants. —
> "(i) In general. — Except [for good cause or other exceptions], all community . . . health centers that receive assistance [under the Public Health Service Act] shall become members in the risk retention group . . . and shall purchase the professional liability insurance that is offered by such group for such centers and any health care staff or personnel employed by such centers or under contract with such centers. All professional staff members of such centers shall be eligible to obtain the insurance offered by such group.[159]

S. 489 thus mandates program-wide development of a business plan for a risk retention group.[160] The business plan must provide structure to the formation, capitalization, and continual operation of the risk retention group. The group's administrators are required to "take all steps . . . necessary to enable [the] group to be prepared to issue insurance . . ."[161]

Upon creation of a risk retention group and fund, a Board of Directors is to govern the fund through bylaws subject to the DHHS scrutiny.[162] The Directors may administer the risk

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[159] S. 489 § 203(a).

[160] *Id.* It is unclear how community health centers throughout the United States would coordinate efforts and resources to design a business plan, but, presumably, this could be accomplished with the NACHC assistance.

[161] *Id.*

[162] *Id.* The bill requires the board of directors to consist of twelve members

retention fund themselves or contract with commercial carriers for fund management.[163] Undoubtedly, the Directors would be allowed to negotiate with commercial reinsurance companies to provide second-level coverage of the risk retention fund.

A risk retention group requires adequate capitalization and reserves. S. 489 provides a one-time authorization of $1 million to establish a risk retention pool.[164] Any additional contributions to capitalization beyond this initial amount would be made available only upon, and to the extent of, a showing of financial need by independent auditors.[165] Upon a determination by these "experts" that the plan of operation is fiscally sound, the DHHS may appropriate, through Congress, additional reserves. However, this authorization extends to the Secretary only for the first two years following fund formation.[166]

The risk retention group would offer coverage to all center personnel and contractors as well as the corporate entity itself.[167] Thus, the bill provides deep pocket coverage in the event that the center is named as a defendant in a malpractice suit. As addressed later, the language of S. 815 does not provide such corporate malpractice coverage.

2. *Advantages and Disadvantages*

S. 489 has been praised by the Bush Administration and Justice Department as a pragmatic solution to the insurance crisis facing the community health center program.[168] From a conservative viewpoint, S. 489 is attractive because it does not invoke large or even moderate federal appropriations — tax dollars — to solve the insurance crisis faced by the community health centers. Instead, it mandates centers to implement a self-help strategy through risk retention. It expends few federal

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to be appointed by the insured's representative. The DHHS Secretary would approve the inaugural members of the board. *Id.*

[163] *Id.*

[164] *Id.*

[165] The auditors include "insurance, financing and business experts." *Id.*

[166] *Id.*

[167] *Id.* The bill states that centers "shall purchase the professional liability insurance that is offered by such group for such centers and any staff or personnel employed by such centers or under contract with such centers." *Id.*

[168] *H.R. 2239 Hearings*, *supra* note 9, at 26-27 (statement of Stuart M. Gerson, Assistant Attorney General, Civil Division, U.S. Dep't of Justice).

dollars to initiate and support the risk retention pool. Furthermore, by not guaranteeing continual congressional funding support, S. 489 does not portend future draws upon the public fisc.

Self-managed risk retention or self-insurance, as insuring mechanisms, possess many advantages.[169] The NACHC was aware of these advantages when it explored self-insurance as a solution to the insurance crisis. First, captive risk retention groups, by definition, are administered by the insured group. The group can construct and operate the fund to serve its own interests. Second, risk retention allows the insured to contain liability risk to one known cohort. The group does not bear the losses of other, more adversely selected, insureds. Finally, by supplying coverage through risk retention, insureds avoid the harsh effects of commercial insurance price setting and unstable market forces.[170]

S. 489, however, possesses more disadvantages than advantages. Its fundamental flaw is that it offers no guidance for determining the necessary size of the fund and makes no assurances that capitalization contributions will be provided by the government. Such lack of specificity and guidance raises the specter of highly discretionary appropriations determined by congressional and agency whim. Maintenance of capital reserves is paramount to the insuring function, yet S. 489 offers no source of capitalization other than discretionary federal funding for two years. Should capitalization appropriations prove insufficient, it is unclear whether federal grant management rules would then prohibit centers from using their annual appropriations to capitalize the risk retention fund.[171] It is possible that further funding would not exist.

In addition, by ignoring any provision for reinsurance, the bill seems to place the burden of purchasing such additional protection for first-level coverage on the health centers themselves. The NACHC has determined that purchasing reinsurance is cost prohibitive to the centers.[172] Moreover, commer-

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[169] For a comprehensive analysis of the advantages and disadvantages of self-insurance pools, see Victor E. Schwartz & Fred S. Souk, *Recent Developments in Self-Insurance: Is It Time to Stop Worrying and Love Risk Retention?*, 18 FORUM 636 (1983); *see also* Robinson, *supra* note 90, at 1027-34.

[170] *Id.* at 636.

[171] DHHS INSPECTOR GENERAL REPORT *supra* note 33, at 7.

[172] *See supra* note 95 and accompanying text.

cial reinsurers have expressed no interest in providing reinsurance to the centers.[173]

Furthermore, S. 489 does not explicitly guarantee that excess capitalization (should any ever exist) would be re-directed toward patient services. Instead, the Secretary of DHHS may presumably utilize excess funds for any purpose. The bill would more greatly advantage centers if it, like S. 815, explicitly channelled excess capitalization into center operational funding. Finally, S. 489 does not address investment of reserves. Presumably, fund managers would be allowed to invest group funds to build reserves, but conditions for such investment are nowhere specified.

S. 489, while purporting to address the insurance crisis facing the community health centers, seems to offer a non-solution and little solace to the community health center program. While the notion of assisting the centers through a self-insurance mechanism is appealing, S. 489 offers little financial assistance to create and maintain a risk-retention fund. Such a fund must be adequately capitalized if it is to provide true coverage for risk. S. 489 does not authorize adequate start-up capitalization and it conditions future contributions to the fund upon the determination of experts and at the discretion of Congress and the DHHS. Indeed, S. 489 cannot guarantee that an adequate risk retention pool will be created.

Certainly, S. 489 does not provide immediate relief to the centers since they would have to wait for fund formation and a determination by the government that the fund should be capitalized. Inevitably, S. 489 places the financial burden of solving the insurance rate crisis on the fragile budgets of the health centers themselves.

S. 489 receives minimal to no support from the NACHC. A recent DHHS Inspector General report reveals that Senators Hatch and Kennedy have discussed plans to build upon S. 489.[174] Senator Kennedy's involvement may significantly alter the content of S. 489, making it more acceptable to the community health centers.

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[173] *See supra* text accompanying note 94.

[174] DHHS INSPECTOR GENERAL REPORT *supra* note 33, at C-2 n.12.

C. S. 815: COMMUNITY AND MIGRANT HEALTH CENTERS SELF-INSURANCE ACT OF 1991

S. 815 appears to be a compromise between the two bills discussed above. It was introduced by Senate Republicans[175] and has been endorsed by the Bush Administration.[176] S. 815 also possesses features welcomed by the NACHC.[177] Like S. 489, S. 815 mandates self-insurance through a form of risk pooling.[178] S. 815 differs from S. 489 by specifying reserve and capitalization requirements and creating a federal entity to administer the self-insurance fund.

1. *A Federally Administered Self-Insurance Fund*

S. 815 establishes in the Treasury a self-insurance fund for community health centers.[179] It further creates an Office of Medical Insurance in the Public Health Service to administer the fund.[180] The fund would provide coverage for liability as follows:

"(4) Obligations from Fund.

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[175] Senators Brown (R-CO), Danforth (R-MO) and Hatch (R-UT).

[176] The Bush Administration supports S. 815 because the bill does not make the costs of center liability directly dependent on the public fisc and is budget neutral. *H.R. 2239 Hearings, supra* note 9, at 26-27 (statement of Stuart Gerson, Assistant Attorney General, Civil Division, U.S. Dep't of Justice).

[177] Telephone Interview with Dave Cavenaugh, Policy Research Specialist, NACHC (Feb. 23, 1992).

[178] As with S. 489, S. 815, in effect, circumvents federal grant management rules barring centers from using funds to establish a risk retention pool. *See supra* text accompanying notes 91-92.

[179] S. 815 § 2(b).

[180] *Id.* The Office of Medical Insurance will require minimal funding since its primary function is to dispense settlement checks to successful claimants. The DHHS Secretary's administrative budget, not Congressional appropriations for the community health center program will support the Office of Medical Insurance's operations. Telephone Interview with Paula McCann, Legislative Aide to Sen. Hank Brown (Feb. 25, 1992). According to S. 815, the Office of Medical Insurance may contract with "a public or non-profit private entity for the management of claims submitted to the self-insurance fund. . . ." S. 815 § 2(c).

> "(A) The Secretary [of DHHS], acting through the Office of Medical Insurance, is authorized to obligate such sums as are available in the self-insurance fund . . . to:
>
> "(i) Provide coverage for successful medical malpractice claims filed against health care providers utilized by community . . . centers . . . or their health care providers, if such claims arise from care provided by such providers pursuant to authority granted by such health centers; and
>
> "(ii) Provide coverage for successful claims filed against the Directors and officers of [centers] or their providers, if such claims arise from any acts, errors, or omissions of the duties of such Directors or officers . . . ."[181]

Therefore, the fund covers successful malpractice claims against caregivers and tort claims brought against center directors and officers.

The bill's language does not state that the fund would provide coverage for corporate malpractice.[182] Approximately 15% (or $8.7 million) of the program's annual malpractice expenditures purchase corporate, as opposed to professional, malpractice coverage.[183] By not explicitly providing fund coverage of corporate risk, S. 815 retains upon the centers this $8.7 million annual burden.

Under S. 815, the responsibility for litigation costs remains with the centers.[184] This feature is deliberate and presumably reflects a belief that the burden of litigation costs provides a financial incentive to centers to maintain quality of care.

The self-insurance fund would be established through a direct charge against the centers' appropriations.[185] Thus, the bill would redirect monies from congressional appropriations to

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[181] S. 815 § 2(b).

[182] The risk retention group proposed by S. 489, on the other hand, would provide coverage for the corporate entity. *See supra* text accompanying note 167.

[183] *See supra* text accompanying note 58.

[184] As mentioned earlier, of the program's annual $4 to $6 million claims experience, the litigation costs (at about 40% of claims) are approximately $1.6 to $2.4 million per year.

[185] S. 815 § 2.

the Treasury. S. 815 does not detail the methodology for determining each center's pro-rata contribution to the fund, but conference report language accompanying the bill will suggest a formula guideline.[186] Each center's contribution to the trust fund presumably would depend on factors that distinguish one center from another. These might include the size of a center's operating budget and staff, a center's access to non-federal funding, and, perhaps, the prior claims experience of a center and its personnel.

S. 815 authorizes $80 million to establish the trust fund over three years: $30 million for the first year of operation and $25 million for each of years two and three.[187] After these initial transfers, the Office of Medical Insurance can mandate additional contributions if necessary to "maintain the actuarial soundness of the Self-Insurance Fund."[188] Thus, the bill requires capitalization above $80 million only if the actual claims experience during the first three years of operation indicates the need for additional protection.

The capitalization amount is expected to grow through investments in United States-backed securities.[189] S. 815 sponsors believe the $80 million capitalization and investment returns on that principal will be more than adequate to cover all future claims in light of the program's past claims experience[190] and even if more catastrophic claims occur.[191]

S. 815 includes other provisions designed to ensure the financial adequacy of the self-insurance fund. The bill requires the Office of Medical Insurance to ask the President to submit a budget request for supplemental monies if the trust amount is insufficient to cover a claim.[192] In addition, S. 815 requires

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[186] An aide to Senator Brown explains that such formulas are best left to the discretion of DHHS. Telephone Interview with Paula McCann, Legislative Assistant to Senator Hank Brown, United States Senate (Feb. 25, 1992).

[187] S. 815 § 2.

[188] *Id.*

[189] *Id.* "It shall be the duty of the Secretary of the Treasury to invest such portion of the Self-Insurance Fund as is not, in the judgment of such Secretary, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." *Id.*

[190] *See supra* note 65 and accompanying text.

[191] Telephone Interview with Paula McCann, Legislative Assistant to Senator Hank Brown, United States Senate (Feb. 25, 1992).

[192] S. 815 § 2. "If the Office of Medical Insurance determines that insuffi-

the Office of Medical Insurance to initiate a program-wide data collection of claims experience no later than one year after enactment of the bill.[193] This would allow the Office to build a comprehensive national data base portraying the community health centers' actual claims experience. The data will assist in an actuarial analysis of the fund which the bill requires no later than five years from its enactment.[194]

Finally, S. 815 provides that any moneys in the fund that are deemed excessive will be transferred to the community health centers for operational use. The bill states:

> [I]f the Office of Medical Insurance determines that excess monies are building up in the Self-Insurance Fund as a result of investment returns or lower than expected anticipated claims against the Fund, such Office shall direct the Secretary of the Treasury to transfer such excess from the Fund to the appropriate accounts for the funding of [community health centers under the Public Health Service Act].[195]

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cient amounts are contained in the Self-Insurance Fund, the Office shall request that the President submit a budget request, either as part of the annual Budget of the United States government . . . or for a supplemental appropriation, for additional funds." *Id.*

[193] *Id.*

[194] *Id.* Three independent actuarial analyses are to be performed by the Health Care Financing Administration, the Congressional Budget Office, and an independent evaluator selected by the Office through a competitive bid process. The bill states:

> "[T]he analyses ... shall be based on the claims history of the Self-Insurance Fund for at least a 36-month period and shall contain --
> "(A) recommendations on the manner in which the Fund should be managed during the 4-year period beginning with [year five of operation];"
> "(B) a description of whether the Fund contains sufficient or excessive amounts of capital; and
> "(C) a description of the actions that are or may be needed to ensure that the administration and capitalization of the Fund is in compliance with [this section of the bill].

Id.

[195] *Id.*

2. Advantages of S. 815

The advantages of S. 815 are most apparent when the bill is compared to S. 489. Both bills attempt to relieve the centers' insurance premium burden by offering a self-insurance solution. S. 815, by authorizing $80 million for the establishment of a self-insurance fund, extends significantly greater financial assistance toward liability coverage. S. 489, on the other hand, provides minimal support toward the organization of a risk retention group. S. 489's $1 million start-up commitment leaves centers without adequate protection and would impose upon them the necessity to purchase costly second-level insurance. The $80 million initial contribution provided by S. 815 is also guaranteed, not conditioned upon later findings by independent auditors or congressional and agency whim.

In addition, S. 815, unlike S. 489, offers some protection to the fiscal and actuarial integrity of the self-insurance fund. While the supplemental appropriations and actuarial analysis provisions of S. 815 may be less than vigorous protections, they are nevertheless offered in the spirit of fund maintenance not found in the language of S. 489. S. 815 is also more advantageous than S. 489 because it creates an independent governmental agency to administer the self-insurance fund. This demonstrates a congressional commitment to engage the Administration and DHHS in a meaningful and active partnership in resolving the insurance rate crisis. S. 489, on the other hand, places all responsibility for fund administration on the centers. S. 815 further differs demonstrably from S. 489 in its treatment of excess reserves. Whereas S. 489 does not provide that excess reserves must be channelled back into community health center operations, S. 815 makes this requirement explicit.

While both S. 489 and S. 815 purport to emancipate the centers from the purchase of costly commercial insurance, only S. 815 can practicably accomplish this. S. 489 does not offer timely coverage and is vague on how such protection will be financed. S. 815, on the other hand, offers tangible protection almost immediately. By so doing, it infuses the program with more federal dollars for clinic operations than are currently available. S. 815 allows centers to discontinue the annual purchase of approximately $49.3 million of commercial professional malpractice coverage.[196] Of this $49.3 million savings,

[196] Eighty-five percent (or $49.3 million) of the total $58 million premiums

$30 million must be transferred to the Treasury, under S. 815, for the first year capitalization of the self-insurance fund. This leaves $19.3 million -- not currently available to the centers -- to be expended on direct patient services as consistent with the program's mission.[197]

A similar benefit would accrue to the centers during years two and three of the trust fund's capitalization. After the fund has reached its $80 million capitalization goal, no more funds need be diverted from community health center appropriations to the Treasury unless the actuarial soundness of the fund is threatened.

3. *Disadvantages of S. 815*

While the financial consequences of S. 815 are promising for the future of the community health centers' mission, the bill is clearly less advantageous to the centers than H.R. 3591.

First, while the set-away feature of S. 815 is only designed to re-channel appropriations for only the first three years of the self-insurance fund, it nevertheless creates a precedent that, in times of federal budget cuts, would make any federal grant recipient uneasy. Certainly, the set-aways allow a solution that is financially more advantageous than the purchase of commercial insurance. Once a portion of grant money is removed from direct control of the recipients, however, such control may be difficult to regain in the future.

Second, whereas H.R. 3591 extends corporate liability coverage to the centers, the S. 815 self-insurance fund does not extend such coverage. Under S. 815, the burden of purchasing corporate malpractice insurance rests with the centers. Third, S. 815, unlike H.R. 3591, places the burden of litigation costs (approximately $1.6 to $2.4 million annually) on the shoulders of the community health centers. H.R. 3591, by invoking FTCA liability protection, redirects litigation costs to the Department of Justice.

While S. 815 offers a practical and beneficial solution to the insurance cost crisis faced by the centers, it clearly does not offer

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purchases professional malpractice coverage. *See supra* text accompanying note 58.

[197] As noted earlier, since S. 815 relieves centers from the costs of defending malpractice claims, a portion of the $19.3 million windfall (approximately $1.6 to $2.4 million) would be expended on litigation costs.

a comprehensive solution. For this reason, S. 815 falls short of H.R. 3591.

H.R. 3591 does offer a complete solution. It removes all financial implications of malpractice liability risk from the centers. The $58 million currently spent on malpractice premiums would be re-directed toward patient services. The cost of H.R. 3591 to the federal government is merely the cost that would be incurred to defend, settle and pay out malpractice claims. The $4 to $6 million additional draw on the public fisc would allow the community health centers to serve an additional one half million patients each year.[198] Given the community health center program's demonstrated ability to provide cost effective care and, through early prevention, avoid more costly health services in the future, this additional $4 to $6 million investment of federal moneys is a bargain.

The Bush Administration has embraced the community health center program's goals through its call for an additional $90 million of federal support.[199] Investing a few more million dollars in federal liability protection would bolster the mission of this valuable program.

CONCLUSION

The future viability of the federal-private community health center program is in jeopardy due to rising malpractice insurance premiums. The health centers and the federal government are searching for solutions that will preserve and, perhaps, enhance the delivery of basic health care services to millions of medically underserved and needy persons. Congressional initiatives offer some promise of solving the present crisis.

S. 489 offers the least relief to community health centers. Its vagueness and lack of adequate financial support betray a level of commitment to the centers that pales in comparison to the other legislative initiatives. S. 815 offers meaningful relief to the community health centers. Yet, while it mitigates the burden of much of the commercial insurance costs, thereby releasing money for use on patient care, it requires centers to finance their own solution. S. 815 would be more advantageous to the program if it financed the cost of defending claims and provided coverage for corporate malpractice.

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[198] *See supra* note 84 and accompanying text.

[199] *See supra* text accompanying note 54.

H.R. 3591 provides the most generous support to the centers. It allows health centers to direct $58 million currently spent on commercial insurance to better use – the provision of services to the needy populations for whom the program was created. H.R. 3591 recognizes that the federal government is a vital partner of the community health center program and must bear additional responsibility for protecting the program's important mission.

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