The Federal Tort Claims Act as a Precedent for the Future of Malpractice Reform

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Abstract

Malpractice reform in the United States has been a contentious, and largely avoided, topic in health care reform and among policymakers. The Federal Tort Claims Act (FTCA) provides a precedent by which malpractice reform might be considered. Under this Act, the federal government becomes the primary insurer, and only tries meritorious cases in court. Allowing the federal government to control these aspects of malpractice may save billions of dollars annually by minimizing the cost of malpractice insurance and preventing the practice of defensive medicine.

Issues relating to insurance against the consequences of medical malpractice continue to bedevil the American health care system. Because of the contentious nature of the issue, these issues have been repeatedly swept under the rug in discussions of health care reform over the last decade. Nevertheless, malpractice costs continue to have significant impacts on practicing physicians and on health care facilities. All must purchase private insurance as a safeguard against malpractice law suits. This emphasis on medical litigation creates distrust between patients and doctors and leads physicians to practice costly defensive medicine, frequently ordering unnecessary tests as proof that they are not negligent.

At present, federal and state governments are responsible for reimbursing doctors for all Medicaid and Medicare services they provide. These reimbursement rates must be sufficient to cover the cost of malpractice premiums physicians pay to purchase coverage. Reducing this cost to the government is one desirable goal that might be pursued in considering reform solutions. One solution that has been proposed exists in the form of the Federal Tort Claims Act (FTCA). This act enables the federal government to provide liability coverage to physicians and other health practitioners who practice under the authority of the federal government. It also provides coverage for some government-funded agencies such as community health centers. Insurance under this Act provides benefits to both physician and patient and appears to be far more cost-effective than the current private malpractice insurance system.

The Federal Tort Claims Act was passed in 1946 “to provide relief to plaintiffs

injured by government employees acting within the scope of their employment" (Kruppstadt, 1995). This legislation became the standard by which physicians working for the VA could protect themselves from liability. In 1976 Congress passed related legislation, the Medical Malpractice Immunity Act (Gonzales Act) to protect employees in "the armed forces, Department of Defense, Armed Forces Retirement Home, and Central Intelligence Agency, and medical employees engaged in training or duty in the National Guard" (Kruppstadt, 1995). If a case of malpractice were to be brought against a medical practitioner working under one of these aforementioned government agencies, the suit would be brought against the United States Government acting as defendant, which would bear all the costs of the suit. Although this may seem to lessen the degree of responsibility incurred by the physician, the malpractice suit is still listed in the physician's dossier in the National Practitioner Data Bank (NPDB), and thus a level of accountability remains (Kruppstadt, 1995).

Under the FTCA, the cost of liability insurance to the practitioner disappears. Insurance premiums for physicians have seen major increases in recent decades (Congressional Budget Office, 2004). Under the FTCA, the government incurs a cost only when a case has been deemed meritorious and brought to a court. Thus, if the federal government were to absorb the cost of malpractice coverage for all physicians, the cost of health care in the United States would be decreased and the federal government could decrease the amount it reimburses physicians for patients covered by Medicare and Medicaid.

When a claim is filed against the federal government under the FTCA, it first goes through an administrative process to determine whether the case is meritorious. The Program Support Center's Claims Office, in the Office of the General Counsel of the Department of Health and Human Services oversees all cases brought against practitioners employed through the Health Resources and Services Administration (HRSA), Indian Health Service (IHS) and National Institute of Health (NIH). If the injury is incurred under the Veterans Health Administration, the regional VA office handles the claim. The administrative process involves two steps. First, peer reviewers at the practitioner's agency review the case., If the case moves forward, medical staff at HRSA, IHS, NIH, or the VA create a Medical Claims Review Panel to examine the case and either deny the claim or offer an appropriate settlement (Office of the Inspector General, 2005). This type of administrative process weeds out non-meritorious cases, eliminating unnecessary costs of litigation while also sparing defendants the emotional trauma of trials. If denied, a patient or claimant can still file a suit in federal court.

In an effort to expand coverage under the FTCA to practitioners working in community health centers, the Office of the Inspector General released a report providing insight into a reform that would provide substantial cost savings for these federally-

subsidized agencies (Office of the Inspector General, 1991). The Federally Assisted Health Clinics Legal Protection Act of 1991 was introduced in the House by Representative Ron Wyden (D, OR). This legislation was strongly supported by the National Association of the Community Health Centers, the Children's Defense Fund, and the Institute of Medicine. It passed in 1992 as the Federally Supported Health Centers Act.

Consequently, among today's primary beneficiaries of the FTCA are community health centers (CHCs) and their patients. Until the passage of this act, CHCs had to purchase private insurance to cover their doctors' liability. This was a costly investment for them. However, included in this act was a provision that assigned a portion of the CHC budget to coverage under a Judgment Fund maintained by HRSA (Taylor, 2004). After this expansion, the FTCA helped save an estimated $1.05 billion on malpractice premiums between 1993 and 2003 (Taylor, 2004). This had a significant beneficial impact on both the government and CHCs. Prior to FTCA coverage, in the fiscal year of 1989, CHCs spent more than 40 million dollars in insurance premiums, while less than 10 percent of that had been paid in claims on their behalf (Nair, 2010). If this coverage was expanded to include all practicing physicians, the cost to the nation of malpractice would be greatly reduced.

It has been estimated that approximately $55 billion is spent each year on the liability system. Included in that estimate are indemnity payments, administrative expenses, and defensive medicine costs, as well as lost clinician work time. Indemnity payments, which include economic, non-economic, and punitive damages, account for $5.72 billion of the total accounting (Mello, Chandra, Gawande, & Studdert, 2010). Therefore, these costs only represent 10.3% of the total cost of the liability system. Malpractice insurance premium costs are not included because part of the premium cost goes to insurer profit, and much of the data on premium costs does not include entities such as self-insured hospitals. If most other costs are eliminated under this type of tort reform, potentially $50 billion can be saved per year.

Although this kind of coverage presents many advantages over the current commercial insurance system, some argue that it shifts professional accountability away from individual physicians, gives greater leeway to medical error, and reflects a poor risk management strategy (Office of the Inspector General, 1991). By moving away from the current mode of malpractice coverage, the economic incentive is therefore removed. This is the incentive that arises from having to purchase private malpractice insurance and keep costs and premiums low. Once removed, this may lower physicians' standard of care. On the other hand, some Congressional staffers have argued that health care providers would object to being defended by a government-appointed attorney who might have little experience in malpractice cases (Office of the Inspector General, 1991). Similarly, a patient who experienced a medical error at the hands of a physician acting under the authority of the

government may not have the resources or abilities to pursue his case and may be discouraged by the prospect of having to sue the federal government for damages (Office of the Inspector General, 1991).

Despite these arguments, the advantages of such a comprehensive method of dealing with the malpractice issue certainly make it worth considering. The current approach erodes the doctor-patient relationship and reduces patients' trust in the health care system (Kohn, Corrigan, & Donaldson, 2000). Each year, between 44,000 and 98,000 people die from medical errors, and an efficient system is needed to reduce this epidemic of bad care and properly compensate injured patients or their families (Kohn, Corrigan, & Donaldson, 2000). In our litigious society, trials to award patients their rightful compensation can take many years and be a costly investment. Deeming physicians and other health care practitioners employees of the government for the purposes of malpractice coverage may offer a more effective system to handle such cases, allowing for consistency and fairness while minimizing the cost to the society.

References

Congressional Budget Office. (2004). *Limiting Tort Liability For Medical Malpractice.* Economic and Budget Issue Brief.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (2000). *To Err Is Human: Building a Safer Health System.* Washington D.C.: National Academy Press.

Kruppstadt, T. K. (1995). Determining whether a Physician Is a United States Employee or an Independent Contractor in a Medical Malpractice Action Under the Federal Tort Claims Act. *Baylor Law Review, 47*(223).

Mello, M. M., Chandra, A., Gawande, A. A., & Studdert, D. M. (2010, September). National Costs of the Medical Liability System. *Health Affairs, 29*(9), 1569-1577.

Nair, S. (2010). *Federal Tort Claim Act Medical Malpractice Program: Update on Federal Policies and Implications for Health Centers.* HRSA. Rockville, MD: NACHC Community Health Institute.

Office of the Inspector General. (1991). *Medical Malpractice Insurance and the Community Health Centers.* Management Advisory, Office of the Inspector General, Department of Health and Human Services, Boston.

Office of the Inspector General. (2005). *HHS Agencies' Compliance With the National Practitioner Data Bank Malpractice Reporting Policy.* Office of the Inspector General, Department of Health and Human Services, Washington D.C.

Taylor, J. (2004). The Fundamentals of Community Health Centers. *National Health Policy Forum.* Washington D.C.: The George Washington University.