

United States General Accounting Office

GAO

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

September 1993

**MEDICAL
MALPRACTICE**

**Estimated Savings and
Costs of Federal
Insurance at Health
Centers**



150126

Human Resources Division

B-248435

September 24, 1993

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

With the assistance of federal grant funds, more than 500 community and migrant health centers provide access to health care for about 6 million people who live in areas of the country with shortages of physicians and other health care providers.¹ Facing growing financial pressures, the center grantees have searched for ways to continue to provide care. One area of potential savings is the grantees' cost of medical malpractice insurance. If malpractice insurance premiums can be reduced, grantees may be able to use the savings to provide more health care services.

To better understand the impact of medical malpractice on the grantees' ability to provide health care services, your Subcommittee requested that we examine the grantees' medical malpractice insurance costs and claims experience. To obtain these data, we surveyed 513 grantees located in the United States by sending them a questionnaire.² Appendix I provides the historical malpractice data we collected from 374 grantees that responded to our questionnaire and the estimates we developed for the 513 grantees' malpractice insurance costs and claims experience using these data.

After we began our survey, the Congress enacted the Federally Supported Health Centers Assistance Act of 1992—Public Law 102-501. This law, which was enacted on October 24, 1992, extended Federal Tort Claims Act (FTCA) coverage to the grantees and, primarily, their employees and full-time contractors to help reduce the grantees' insurance costs. Under FTCA, the government assumes responsibility for malpractice claims filed against its own health care facilities and providers. While the centers are

¹The Department of Health and Human Services (HHS) awards grants through sections 330 (community health centers) and 329 (migrant health centers) of the Public Health Service Act to public and nonprofit private entities to plan, develop, and operate health centers for medically underserved populations in the country. The Bureau of Primary Health Care, within the Health Resources and Services Administration in HHS' Public Health Service, administers the grant programs for the centers.

²Previously, we found that the medical malpractice claims data we needed were available only from the grantees. While several studies had surveyed the grantees to collect these data, either the surveys were unsuccessful or the data obtained were outdated.

funded only in part through HHS grants, the law made FTCA coverage available to the grantees for a 3-year period beginning January 1, 1993. Appendix II describes FTCA, Public Law 102-501, and the process followed by HHS to resolve claims under FTCA.

Scope and Methodology

Because FTCA coverage for the grantees will be up for reauthorization in 1995, your Subcommittee asked us to develop actuarial estimates of the savings to the grantees and the costs to the government during the 3 years when FTCA coverage is in effect. To make these estimates, we contracted with Tillinghast, a nationally recognized management and actuarial consulting firm that advises many of the medical malpractice insurers in the United States. Tillinghast developed the savings and cost estimates that are presented in this report using (1) the medical malpractice data we collected through our questionnaire to identify the grantees' malpractice claims and payments; and (2) industry trend data on malpractice insurance premiums, claims, and payment patterns.

When Tillinghast developed the savings and cost estimates, there were a number of unresolved issues concerning how FTCA coverage would be implemented for the grantees. Therefore, Tillinghast had to make assumptions about how these issues would be resolved. For example, it was not known which services provided by the grantees would be covered by FTCA and at what point in time all, or substantially all, the grantees would be covered. To develop the estimates, Tillinghast assumed that (1) all services provided by the grantees would be covered by FTCA and (2) FTCA would cover all the grantees for a 3-year period beginning January 1, 1993.

Decisions have subsequently been made by HHS that, in some cases, are counter to the Tillinghast assumptions. For example, between January and July 1993, HHS issued policies and procedures to the effect that not all the services provided by grantees and their health care providers may be covered under FTCA. Therefore, some grantees may have to continue to purchase some level of medical malpractice insurance. However, as of August 27, 1993, neither the number of grantees that may need to continue to purchase malpractice coverage nor the cost of that coverage is known. Further, as of August 27, 1993, only 65 of the more than 500 grantees had been deemed eligible for coverage under FTCA.

In addition, to develop cost estimates, Tillinghast had to deal with the uncertainty about how the lack of a coverage limit under FTCA would affect

the size of awards and settlements involving claims against the grantees. The historical claims experience of the grantees was based on malpractice coverage with per-claim limits. Therefore, Tillinghast included contingency margins when estimating the government's costs for 1993 through 1995—thereby increasing the government's estimated costs during this 3-year period. Tillinghast assumed that these amounts would be highest in the early years when the amount of the government's payments is most uncertain and a single large payment could easily distort the expected cost. Also, Tillinghast judgmentally determined that FTCA would provide coverage of slightly less than \$5 million for each claim filed. The estimates of the government's costs would have been lower if Tillinghast had assumed a smaller per-claim limit and higher if Tillinghast had assumed a larger per-claim limit.

The savings and cost estimates presented in this report represent those of a full, 3-year program in which all the grantees and all services are covered under FTCA. However, the results are subject to a significant range of uncertainty because they are based on assumptions. Further, they may be overstated because of the decisions that HHS has made that affect the services provided and the grantees covered.

Appendix III presents a more detailed description of our methodology and all the assumptions made by Tillinghast to develop actuarial savings and cost estimates of FTCA coverage. Appendix IV contains a copy of our questionnaire with a summary of the survey results, and appendix V contains a copy of the forms used to obtain malpractice claims and insurance policy data from the grantees.

We performed our review between June 1991 and August 1993 in accordance with generally accepted government auditing standards.

Results in Brief

The Federally Supported Health Centers Assistance Act of 1992 authorized the Public Health Service to assume responsibility for medical malpractice claims involving the grantees and certain of their health care providers under FTCA. During 3 years with a program in which all grantees and all services are covered under FTCA, grantees could save an estimated \$55 million in insurance costs. For the grantees' malpractice claims that are filed and closed between 1993 and 1995, the government's costs could total an estimated \$27 million—about \$19 million in claim payments and about \$8 million in contingency margins.

Because there can be a time lag between when an injury occurs and when a claim is filed and paid, it could take the government 10 or more years to pay for all the compensable injuries that occur at the grantees while FTCA coverage is authorized. Therefore, the government's estimated costs for claim payments could total about \$27 million, \$30 million, and \$33 million for coverage years 1993 through 1995, respectively. However, claims would be paid through the year 2006.

It could cost the government more money over time to resolve the grantees' malpractice claims under FTCA than it would have cost to resolve the grantees' claims if the private sector's insurance coverage had continued. Estimates of the government's costs are higher than the estimated private sector costs for two reasons. First, the estimates assume that because FTCA provides unlimited dollar coverage for each claim filed and paid—rather than the grantees' current private sector insurance with stated dollar coverage limits—losses could be about 50 percent greater. Second, FTCA provides a different type of insurance coverage from that which a majority of the grantees had purchased. This situation makes the government liable for a different set of injuries than private sector insurers would have been liable for if FTCA coverage had not been enacted.

Background

To assist in providing health care in medically needy areas of the country, HHS awarded about \$530 million in grants in fiscal year 1991 to community and migrant health centers—about \$478 million from section 330 (community health centers) and about \$52 million from section 329 (migrant health centers) to more than 500 grantees. In addition to section 330 and 329 grants, grantees received revenues from the Medicaid and Medicare programs, insurance companies, other federal grants, state and local governments, and out-of-pocket payments by the patients. Section 330 and 329 grant funds accounted for about 37 percent of the more than \$1.4 billion in total grantee revenues in fiscal year 1991.

Grantees must provide prevention-oriented primary health care to the people they serve.³ These services include physician services, diagnostic laboratory and radiology services, emergency medical services, and preventive dental care. In addition to primary care, such supplemental services as ambulatory surgery and mental health services can be provided

³Many of the people served by the center grantees are disadvantaged. For example, among those who receive center-based health care are poor pregnant women and infants enrolled in the Medicaid program, and migrant farm workers.

at the discretion of the grantees.⁴ Services are provided on a sliding fee scale based on the ability to pay.

Grantees and their health care providers are accountable for the quality of services they deliver. Patients or their representatives may file a claim for medical malpractice and seek compensation for economic losses (medical bills, rehabilitation costs, and lost income) and noneconomic losses (pain, suffering, and anguish) that result from treatment that does not meet an acceptable standard of care. If not resolved, these claims can be filed in state courts. Claims that reach the courts usually are based on tort law, with negligence being the most common tort that is the basis of a claim.⁵ Most claims are withdrawn or are settled before a judge or jury reaches a verdict.

To obtain protection against claims, most grantees purchased medical malpractice insurance from such sources as commercial and health care provider-owned companies, and joint underwriting associations.⁶ For a premium, an insurer investigates each claim, defends the provider, and pays for any successful claims, up to a stated policy limit, during the policy period. For example, a policy with coverage limits of \$1 million/\$3 million will pay up to \$1 million for each claim and no more than \$3 million for all claims annually. Higher levels of coverage will increase the cost of the malpractice insurance premiums. These premiums, which are influenced by the number of claims filed and the amounts paid on the claims, are based on the probability that an insurer will have to pay for a malpractice claim. Predicting the cost of future claims can be difficult because of the time that can pass between when an injury occurs and when a claim is filed and paid.

Medical malpractice insurance is sold on either an occurrence or claims-made basis. Occurrence policies cover any incident that occurs during the policy period, no matter when the claim is filed, within applicable statutes of limitation. These policies tend to be expensive; insurers try to establish premium levels that will be sufficient to create a

⁴Services are provided by (1) primary care physicians—doctors of medicine and osteopathy including internists, general and family practitioners, obstetricians/gynecologists, and pediatricians; (2) midlevel personnel—physician assistants, nurse practitioners, and nurse midwives; (3) dental services personnel; (4) ancillary services personnel, including laboratory and pharmacy personnel; (5) nurses; and (6) others.

⁵A tort is a wrongful act or omission (not based on a contract) that causes injury to another person. Tort law provides a legal framework for compensating an injured person for damages that result from medical malpractice.

⁶Several states have created nonprofit pooling arrangements—joint underwriting associations—to provide malpractice insurance to health care providers in their own states.

reserve for future losses because of the time lag and the unpredictability of claims. Claims-made policies, however, cover only claims that are filed while the policy is active; at first, this coverage is less expensive because claims resulting from injuries in the first year most likely will not be filed that year. However, the premiums increase to a "mature" level as time passes and the insured's exposure to claims stemming from prior years' injuries increases. The insurers' costs under claims-made policies are more predictable because claims experience does not have to be predicted as far into the future as with an occurrence policy. To cover claims that are filed after a claims-made policy is terminated, the health care provider can purchase "tail" coverage from the insurer.

With enactment of FTCA coverage, the federal government assumes responsibility for malpractice claims filed against grantees. Each grantee's coverage begins when the Secretary of HHS determines that the grantee has met several requirements specified in the law. For example, each grantee must implement policies and procedures to reduce the risk of malpractice that are consistent with the requirements for a quality assurance program, such as those addressing medical records and their periodic evaluation. In addition to the grantee, any officer, employee, or contractor who is a physician or other licensed or certified health care provider will be considered to be an employee of the Public Health Service and will be covered under FTCA. However, contracted health care providers must provide an average of 32-1/2 hours of service each week to be covered. Licensed providers of obstetrical services may receive FTCA coverage even if they work less than 32-1/2 hours per week for the grantee.

Federal malpractice claims are resolved according to a procedure that is different from the private sector. A patient or a patient's representative seeking to recover damages from the government must file an administrative claim first with the federal agency employing the person who committed the tort, which for community and migrant health centers will be HHS. These claims must be filed within 2 years after the patient has discovered or should have discovered the injury and its cause. When an administrative claim is filed, a precise dollar amount of damages claimed must be provided.

The government provides occurrence coverage. HHS has 6 months in which to act on an administrative claim. If the patient rejects the agency's settlement decision or the agency makes no decision within 6 months after

the claim is filed, the government can be sued in a federal district court.⁷ FTCA does not limit the amount for which the government can be sued. However, malpractice suits are tried under the law of the state where the tort occurred, and some states limit the amount that can be recovered for malpractice damages.

Grantees' Savings Associated With FTCA Coverage

With a full, 3-year program in which all grantees and all services are covered under FTCA, grantees' malpractice insurance premiums could be reduced or eliminated. The grantees could save about \$55 million during the 3 years FTCA coverage is provided. Initially, when all the grantees cancel their policies and begin coverage under FTCA, they could receive about \$13 million in premium rebates. Then, during the 3-year period, the grantees could save an additional \$76 million in premiums. However, because most grantees have claims-made policies, these grantees must also purchase "tail" coverage when converting to FTCA coverage—this requirement could cost about \$34 million during the 3 years. Table 1 shows the grantees' estimated net savings for each of the 3 calendar years.⁸

Table 1: Estimated Grantee Net Savings by Implementing FTCA Coverage for Calendar Years 1993 Through 1995

	Calendar year			Total
	1993	1994	1995	
Dollars in millions				
Estimated grantee savings				
Reduction in premiums	\$24.9	\$25.4	\$26.0	\$76.3
Premiums returned on canceled policies	12.5	0	0	12.5
Total grantee savings	\$37.4	\$25.4	\$26.0	\$88.8
Estimated grantee costs				
Tail coverage	25.5	5.1	3.4	34.0
Total grantee costs	\$25.5	\$5.1	\$3.4	\$34.0
Estimated grantee net savings	\$11.9	\$20.3	\$22.6	\$54.8

⁷A trial under FTCA is conducted without a jury. In addition, punitive damages cannot be awarded for malpractice claims resolved under FTCA.

⁸If FTCA coverage ends in 1995, grantees purchasing new claims-made insurance policies in 1996 should receive reduced premium rates for the first 3 to 5 years until the "mature" rate is reached, yielding additional savings not included in table 1.

Need to Continue to Provide Insurance Coverage Reduces Grantees' Savings

Although the grantees may save about \$55 million on medical malpractice insurance expenses, the savings are not as large as they could be. While grantees should no longer have to incur all the costs of medical malpractice insurance, some costs may remain because FTCA coverage does not apply to all health care providers. For example, grantees may have to provide insurance coverage for contractors working less than 32-1/2 hours—primarily part-time contracted physicians.

Generally, grantees can provide insurance coverage for part-time contracted physicians in two ways. First, grantees can purchase coverage directly from insurers. However, insurers tend to sell policies on a per-physician basis; the number of hours a physician works is not considered. Therefore, a grantee may have to purchase a full-cost policy for a part-time physician—an inefficient approach to providing malpractice insurance coverage. Also, grantees can provide malpractice coverage indirectly. A part-time contracted physician can purchase an insurance policy that provides coverage for services rendered while at the center and in other settings. In this case, the grantee can reimburse the contractor for a portion of the policy's premium, a more cost-effective approach than purchasing an individual policy. Reimbursing part-time contracted physicians for malpractice expenses could cost about \$15 million during the 3-year period.

Further, not all services provided by the grantees will be covered under FTCA. To be covered, the activity that caused a claim to be filed must be within the scope of the grantee's approved project supported with either grant or grant-related income and within the health care provider's scope of employment. Activities on behalf of and at locations other than the grantee, such as hospital call and emergency room coverage, usually will not be covered. However, activities within the health care provider's scope of employment may be covered even if undertaken outside of the grantee's facilities. Therefore, grantees may continue to purchase some insurance to ensure that all services are covered against malpractice claims.

HHS guidance states that the applicability of FTCA to each claim will depend upon the Attorney General's determination that the grantee or individual health care provider is covered under FTCA. Until a claim is filed, a grantee may not know if the health care provider or the service provided was considered to be covered under FTCA.

Government's Costs Associated With FTCA Coverage

During the 3 years the grantees receive FTCA coverage, the government could spend about \$27 million to pay for all the medical malpractice claims that are filed and closed. Table 2 shows the government's estimated costs for each of the 3 calendar years.

Table 2: Estimated Government Costs of Implementing FTCA Coverage for Calendar Years 1993 Through 1995

Dollars in millions

Government costs	Calendar year			Total
	1993	1994	1995	
Claim payments	\$1.3	\$5.5	\$12.3	\$19.1
Contingency margins	2.0	2.9	3.1	8.0
Total government costs^a	\$3.3	\$8.4	\$15.4	\$27.1

^aDoes not consider the cost of claims handling and loss prevention services provided by the federal government.

Government's FTCA Claim Payments Will Extend Into the Future

In addition to paying for medical malpractice claims that are filed and closed during 1993 through 1995, the government will pay for claims initiated after 1995. When expected future loss payments are considered—payments to be made for injuries that occurred during 1993 through 1995 while FTCA coverage was in effect but for which the claims were not filed or closed until after 1995—the government's additional estimated costs for claim payments could be about \$71 million, or a total of about \$90 million in claim payments through the year 2006, as shown in table 3. For FTCA coverage years 1993 through 1995, the government's estimated costs could be about \$27 million, \$30 million, and \$33 million, respectively.

Table 3: Estimated Government Costs for Claim Payments Under FTCA Coverage for Calendar Years 1993 Through 2006

Dollars in millions

Calendar year	Payments made for FTCA coverage year			Total payments made in calendar year ^a
	1993	1994	1995	
1993	\$1.3	\$0	\$0	\$1.3
1994	4.0	1.5	0	5.5
1995	6.2	4.4	1.7	12.3
1996	4.6	6.8	5.0	16.4
1997	3.2	5.1	7.6	15.9
1998	2.4	3.6	5.6	11.6
1999	1.6	2.7	4.0	8.3
2000	1.3	1.8	3.0	6.1
2001	0.8	1.5	2.0	4.3
2002	0.6	0.9	1.6	3.1
2003	0.6	0.6	1.0	2.2
2004	0.3	0.6	0.6	1.5
2005	0	0.3	0.7	1.0
2006	0	0	0.3	0.3
Total	\$26.9	\$29.8	\$33.1	\$89.8

^aPayments do not include any contingency margins.

FTCA Costs May Be Higher Than Private Sector Costs

While it could cost about \$90 million through 2006 to resolve the grantees' medical malpractice claims under FTCA, it would have cost about \$45 million to resolve the grantees' claims if the private sector's insurance coverage had been continued and FTCA coverage had not been enacted. Future loss payments may be more expensive under FTCA than the payments would have been in the private sector. This situation may occur for several reasons. First, private sector malpractice insurance limits the amount that can be paid on each claim during the policy period, typically an amount such as \$500,000 or \$1 million. The most frequent per-claim limit purchased by the grantees was \$1 million. However, under FTCA, there are no restrictions on the amount of money that can be paid in the case of very severe injuries.⁹ The unlimited coverage provided by FTCA could add about 50 percent to the loss amounts compared with coverage provided by the private sector.

⁹For HHS medical malpractice claims paid under FTCA in calendar years 1986 through 1991, the largest administrative settlement was \$975,000 (paid in 1989), and the largest federal court case payment was \$5.7 million (paid in 1986).

A second factor that contributes to the government's increased costs is that FTCA provides occurrence-based coverage rather than the mixture of occurrence and claims-made coverage that the grantees purchased in 1991. For grantees that had occurrence coverage from the private sector when FTCA coverage was implemented, there would be no appreciable difference in the cost of claims whether settled by the government or by the private sector, excluding any consideration of the effect of different coverage limits. That is, both would incur liability for all injuries occurring during the time that FTCA coverage was authorized, regardless of when the claim may be filed in the future. However, for grantees that had claims-made insurance policies when FTCA coverage was enacted, the government's cost for the injuries occurring during the 3 years becomes much greater by assuming liability on an occurrence basis. This larger cost occurs because the injuries that the government is assuming liability for during the 3-year period are not the same injuries as those for which the private sector would have been liable.

There is one source of liability and costs for the government—injuries that occur during the 3-year period, regardless of when the claims are filed, within the time permitted under the applicable statute of limitations. There is also one source of liability and costs for private sector claims-made policies—claims that are filed within the 3-year period. Some of the claims filed will result from injuries that occurred in prior years. Others will result from injuries that occur during the 3-year period for which claims are also filed during that time. What is not included in the private sector's costs is liability for injuries that occur during the 3-year period for which claims were not also filed during that period.

Conclusions

The Congress enacted Public Law 102-501—the Federally Supported Health Centers Assistance Act of 1992—to provide federal medical malpractice insurance coverage to the community and migrant health center grantees. During the 3 years when federal insurance coverage is authorized, the grantees may save money even though many may have to purchase “tail” coverage and may have to continue to purchase insurance for health care providers and services that are not covered by the law. However, the ultimate savings to the grantees and costs to the government will depend on several factors, including (1) the number of grantees that are eventually deemed eligible for federal coverage, (2) which of the services provided by the grantees are covered, and (3) how accurate the grantees' past malpractice claims and payments are as a predictor of future payments.

Although we did not obtain written comments on this report, we provided copies of our draft report to the Bureau of Primary Health Care within the Health Resources and Services Administration in HHS' Public Health Service. We discussed the report's contents with agency officials and incorporated their comments as appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 7 days after its issue date. At that time, we will send copies of this report to the Secretary of HHS, the Attorney General, the 513 health center grantees included in our review, and other interested parties. We will also make copies available to others on request.

If you or your staffs have any questions concerning this report, please call me on (202) 512-7117. Other major contributors to this report are listed in appendix VI.



Leslie G. Aronovitz
Associate Director,
Health Financing Issues

Contents

Letter		1
Appendix I		18
Historical Medical	Background	18
Malpractice	Grantees' Health Care Professionals Had Protection Against Malpractice Claims	18
Experience of the	Grantees Spent a Small Portion of Total Revenues on Medical Malpractice Insurance	23
Community and	Malpractice Claims Experience of Center Grantees and Providers	26
Migrant Health Center		
Grantees		
Appendix II		30
Community and	Law Authorizing FTCA Coverage for Health Center Grantees	30
Migrant Health Center	Medical Malpractice Claims Resolution in HHS	31
Grantee Protection		
Against Medical		
Malpractice Claims		
Under the Federal		
Tort Claims Act		
Appendix III		33
Methodology for	Mail Questionnaire	33
Developing GAO's	Telephone Survey	34
Database and	Tillinghast Savings and Cost Estimates	35
Actuarial		
Assumptions for		
Developing Savings		
and Cost Estimates		

Appendix IV Results of GAO's Survey of Medical Malpractice Insurance Costs and Claims at Community and Migrant Health Centers	40
Appendix V Medical Malpractice Claim and Insurance Policy Forms	55
Appendix VI Major Contributors to This Report	60
Tables	
Table 1: Estimated Grantee Net Savings by Implementing FTCA Coverage for Calendar Years 1993 Through 1995	7
Table 2: Estimated Government Costs of Implementing FTCA Coverage for Calendar Years 1993 Through 1995	9
Table 3: Estimated Government Costs for Claim Payments Under FTCA Coverage for Calendar Years 1993 Through 2006	10
Table I.1: Malpractice Insurance Coverage for FTE Physicians Who Provided Services Between 1989 and 1991	22
Table I.2: Number and Percent of Grantees by Number of Malpractice Insurance Policies Purchased in Fiscal Years Ending in 1991	23
Table I.3: Number and Percent of Paid Malpractice Claims by the Range of Payments During Calendar Years 1986 Through 1991	28
Table III.1: GAO Estimates of the Number of Insurance Policies Purchased and Total Premiums Paid During the Grantees' Fiscal Years Ending in 1991, and Related Sampling Errors	35

Table III.2: GAO Estimates of the Number of Claims Filed, Claims Paid, and Total Payments Made at the Grantees During Calendar Years 1986 Through 1991, and Related Sampling Errors	35
---	----

Figures

Figure I.1: Number of FTE Physicians, Dentists, and Midlevel Personnel Providing Services at the Grantees Between Calendar Years 1987 and 1991	19
Figure I.2: Number of Physicians, Dentists, and Midlevel Personnel Providing Services at the Grantees Between Calendar Years 1987 and 1991	20
Figure I.3: Range of Malpractice Insurance Premiums Paid by the Community and Migrant Health Center Grantees in Their Fiscal Years Ending in 1989 Through 1991	25
Figure I.4: Number of Malpractice Claims Filed by Percent of Grantees Between Calendar Years 1986 and 1991	27

Abbreviations

FTCA	Federal Tort Claims Act
FTE	full time equivalent
HHS	Department of Health and Human Services
NHSC	National Health Service Corps

Historical Medical Malpractice Experience of the Community and Migrant Health Center Grantees

Most U.S. community and migrant health center grantees have purchased medical malpractice insurance to cover malpractice claims that are filed against the grantees, the health care professionals providing services at the grantees, or both. Almost all of the health care professionals providing services at the grantees had some type of coverage against malpractice claims. During the past several years, medical malpractice claims have been filed against the grantees. The center grantees have spent millions of dollars to purchase medical malpractice insurance to protect against claims.¹

Background

Nearly three-quarters of the center grantees responded to our questionnaire. The responding grantees had revenues totaling about \$973 million during their fiscal years ending in 1991—revenues for each grantee averaged about \$2.6 million, with a median of about \$1.8 million.^{2,3} A majority (about 81 percent) received section 330 (community health centers) grants only. However, about 16 percent received grants under both sections—330 and 329 (migrant health centers). The median federal grant received by the grantees was about \$633,000 in fiscal year 1991. In addition, about two-thirds of the responding grantees were located in rural areas of the country.

Grantees' Health Care Professionals Had Protection Against Malpractice Claims

A malpractice claim can be filed by the patient or the patient's representative against the grantee's health care professionals, the grantee, or both to recover any damages if the services provided do not meet an acceptable standard of care.⁴ The grantees' exposure to medical malpractice claims is influenced by the number of health care

¹We mailed a questionnaire to 520 community and migrant health center grantees in the U.S. Seven grantees that did not operate health care facilities were eliminated from our original population, reducing the universe to 513. We developed estimates for five key medical malpractice data items for the 513 grantees. In this regard, for each grantee's fiscal year ending in 1991, we estimated the (1) malpractice insurance policies purchased and (2) premiums paid; for 1986 through 1991, we estimated the (3) malpractice claims filed, (4) claims closed with a payment, and (5) dollar amounts paid on closed claims. Sampling errors for these estimates are stated at the 95-percent confidence level and are shown in appendix III. Unless identified as an estimate, all data presented in this appendix represent the 374 grantees (73 percent) that returned our questionnaire and indicated that they were operating a center.

²Median is the value at which 50 percent of the responses fall above and 50 percent fall below.

³In addition to section 330 and 329 grants, revenue sources include the Medicaid and Medicare programs, insurance companies, other federal grants, state and local governments, and the patients.

⁴In this report, health care professionals include physicians, dentists, and midlevel personnel—nurse midwives, nurse practitioners, and physician assistants—who provided services that were funded by section 330 and 329 grants. The data include full-or part-time professionals who were salaried, contracted, or federally employed or who were volunteers.

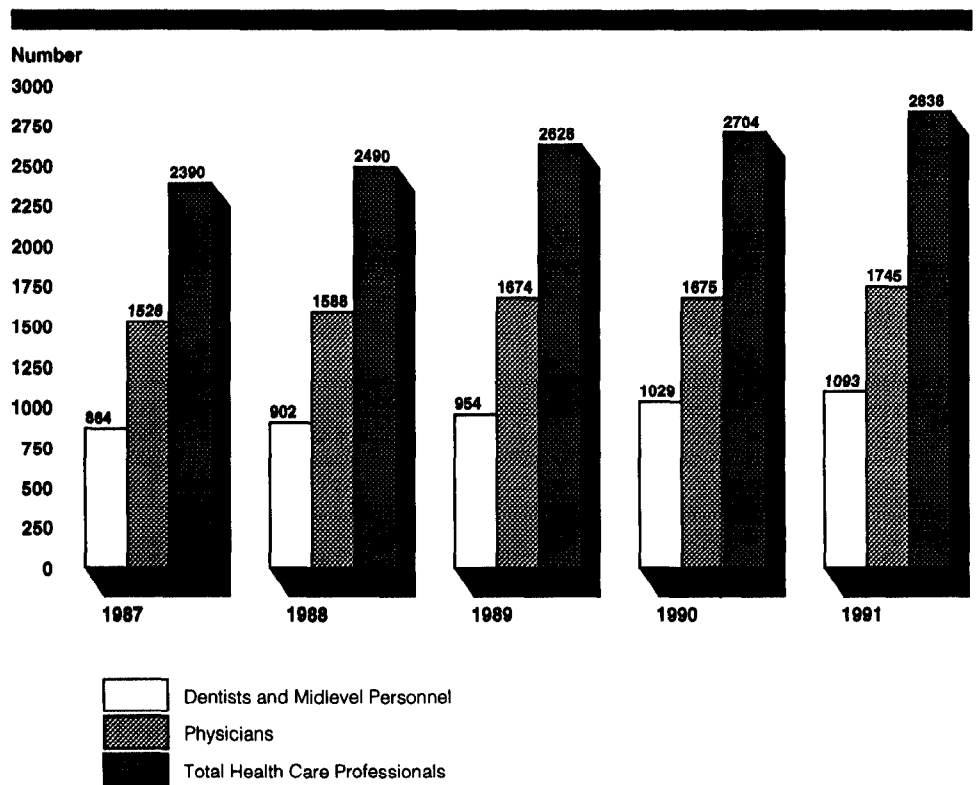
**Appendix I
Historical Medical Malpractice Experience
of the Community and Migrant Health
Center Grantees**

professionals who provide services and the type of services provided. However, the full time equivalent (FTE) number represents more closely the grantees' actual exposure.⁵

**More Physicians Than
Other Health Care
Professionals Provided
Services**

Physicians accounted for a majority of the FTE number of health care professionals providing services at the grantees. As shown in figure I.1, of the total FTE number of health care professionals providing services in 1991 (2,838), 1,745 were physicians. About 61 percent of the FTE number of health care professionals were physicians; the remaining 39 percent were dentists and midlevel personnel. The median number of FTE health care professionals providing services at the grantees in 1991 was five—about three FTE physicians and two FTE dentists and midlevels.

Figure I.1: Number of FTE Physicians, Dentists, and Midlevel Personnel Providing Services at the Grantees Between Calendar Years 1987 and 1991



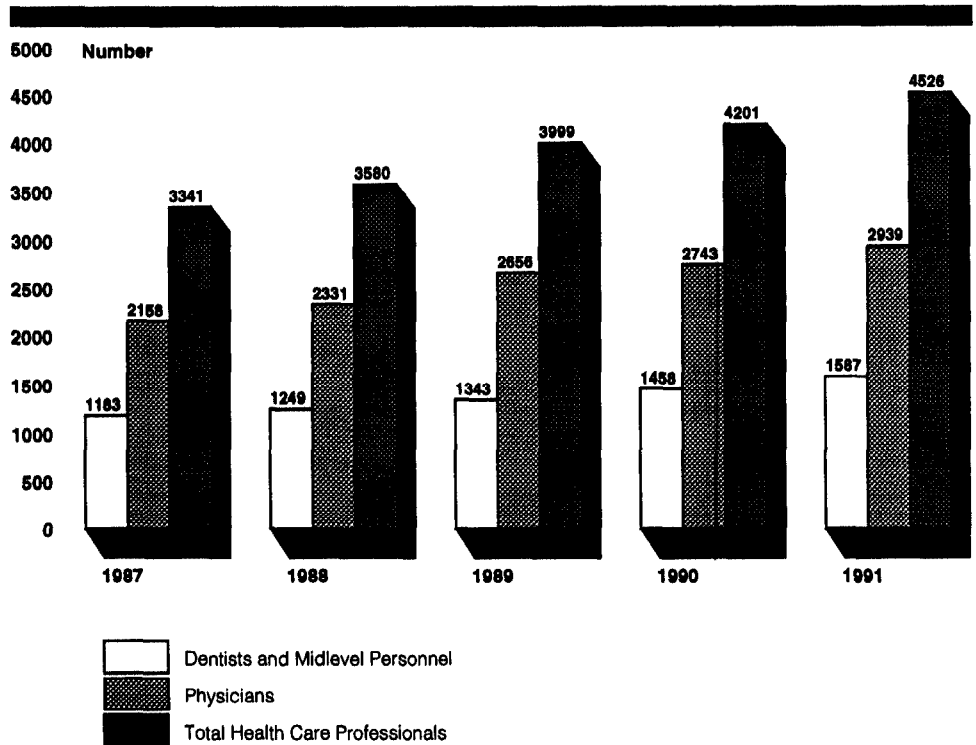
⁵FTEs represent the number of hours for which full-time and part-time health care professionals are compensated in terms of each grantee's definition of "full time." Therefore, the FTE number will be less than the actual number of health care professionals providing services at the grantees.

**Appendix I
Historical Medical Malpractice Experience
of the Community and Migrant Health
Center Grantees**

Overall, the FTE number of health care professionals grew by about 19 percent between 1987 and 1991. However, the increase was greater for dentists and midlevel personnel than it was for physicians. The number of FTE dentists and midlevel personnel increased about 26 percent, from 864 in 1987 to 1,093 in 1991. The number of FTE physicians increased by about 14 percent during this period.

While the FTE number of health care professionals increased, the number of professionals who actually provided services at the grantees, not considering the number of hours each professional worked, grew at a much greater rate—about 35 percent compared with 19 percent for the FTE number of health care professionals. The total number of health care professionals who provided services at the grantees increased from 3,341 in 1987 to 4,526 in 1991. Figure I.2 shows the increase in the number of health care professionals who provided services between 1987 and 1991.

Figure I.2: Number of Physicians, Dentists, and Midlevel Personnel Providing Services at the Grantees Between Calendar Years 1987 and 1991



**Appendix I
Historical Medical Malpractice Experience
of the Community and Migrant Health
Center Grantees**

Although we distinguished between neither the number of full- and part-time health care professionals nor the number of salaried and contracted professionals when we collected data on the questionnaire, it appears that part-time contracted physicians may be providing services at the grantees. For example, while the grantees reported 2,939 physicians providing services in 1991, the FTE number was 1,745, or about 59 percent of the physicians providing services.⁶

**Some Health Care
Professionals Provided
High-Risk Services**

Delivering babies or performing major surgery, for example, can expose health care professionals and the grantees to the possibility of more serious injuries and, therefore, more expensive malpractice claims.⁷ About 14 percent of the FTE number of health care professionals provided these services in 1991. About 19 percent of the FTE number of physicians either delivered babies or performed major surgery, while a smaller proportion of the FTE number of midlevel personnel (about 6 percent) delivered babies during 1991.

**Insurance Protection Was
Available for Health Care
Professionals**

Almost all of the FTE numbers of health care professionals providing services at the grantees were covered by some type of insurance to protect against medical malpractice claims.⁸ Therefore, availability of insurance protection did not appear to be a problem. However, coverage against incidents of malpractice was provided in several ways. For example, as shown in table I.1, during 1989 through 1991, more than 75 percent of the FTE number of physicians were covered by a medical malpractice insurance policy paid for by the grantees; about 10 percent were covered through their own policies. Compared with the number covered by a center policy, few of the FTE number of physicians at the grantees were

⁶In an earlier report, we found that, not counting volunteers, about 37 percent of the physicians practiced part time (less than 36 hours a week) at 446 grantees. See Health Care: Most Community and Migrant Health Center Physicians Have Hospital Privileges (GAO/HRD-92-98, July 16, 1992).

⁷As defined here, "major surgery" means surgery that has a high risk of complications or mortality and is performed at a hospital rather than at a center.

⁸The grantees indicated that only 0.06 FTE physicians were not covered by any insurance source in calendar year 1991; all FTE dentists and midlevel personnel had coverage.

**Appendix I
Historical Medical Malpractice Experience
of the Community and Migrant Health
Center Grantees**

covered by the Federal Tort Claims Act (FTCA).⁹ While a higher percentage of the FTE number of physicians who delivered babies or performed major surgery were covered by FTCA, these percentages decreased from a relatively small 12 percent in 1989 to an even smaller 3 percent in 1991.

Table I.1: Malpractice Insurance Coverage for FTE Physicians Who Provided Services Between 1989 and 1991

Type of FTE physician providing services	Coverage for FTE physicians (In percent)				
	Only by center policy	Only by own policy	By own policy and center policy	By FTCA	Other ^a
Calendar year 1989					
Delivered babies or performed major surgery	67	13	5	12	3
All others	80	10	4	1	5
Total	77	10	5	3	5
Calendar year 1990					
Delivered babies or performed major surgery	70	13	6	8	3
All others	80	9	5	1	5
Total	78	10	5	2	5
Calendar year 1991					
Delivered babies or performed major surgery	75	13	7	3	2
All others	79	10	4	1	6
Total	78	11	5	1	5

^aIncludes any other type of coverage—such as sovereign immunity, which prohibits an individual from bringing an action against the health care provider for damages—and those FTE physicians that were not covered by any source. In calendar years 1989, 1990, and 1991, 1.00, 0.40, and 0.06 FTE physicians, respectively, were not covered by any source.

⁹The National Health Service Corps (NHSC) scholarship program provides tuition assistance to students of medicine, dentistry, nursing, and other health professions in return for a commitment to practice in an underserved area for a period of time after completing training. Through the federal loan repayment program administered by NHSC, educational loans incurred by selected applicants in the health professions are repaid in exchange for practice in a designated underserved area. According to HHS data, there were 812 NHSC physicians working at the grantees in fiscal year 1991. Of the NHSC physicians working at the grantees, 39 were covered under FTCA in fiscal year 1991, prior to the passage of Public Law 102-501—the Federally Supported Health Centers Assistance Act of 1992.

Grantees Spent a Small Portion of Total Revenues on Medical Malpractice Insurance

Almost all of the 374 community and migrant health center grantees responding to our questionnaire purchased medical malpractice insurance. About 95 percent (355) of the grantees purchased over 1,700 medical malpractice insurance policies in their fiscal years ending in 1991.¹⁰ These grantees purchased policies to protect either the health care facility (center and supporting clinics), personnel, or both, against claims of medical malpractice.¹¹

Most Grantees Purchased More Than One Medical Malpractice Insurance Policy

The grantees were able to obtain medical malpractice insurance coverage. Each of the grantees purchased from 1 to 33 policies; the number averaged about 5, with a median of about 3 policies each. The policies were purchased from more than 100 commercial insurance companies and other sources. While about 34 percent of the grantees purchased one medical malpractice insurance policy, as shown in table I.2, about 11 percent purchased 11 to 33 policies. Many of the grantees purchased individual policies for each physician who provided health care services.

Table I.2: Number and Percent of Grantees by Number of Malpractice Insurance Policies Purchased in Fiscal Years Ending in 1991

Number of policies purchased	Grantees		Cumulative percent
	Number	Percent	
1	121	34	34
2 to 5	131	37	71
6 to 10	64	18	89
11 to 33	37	11	100
Total	353*	100	

*Number of policies purchased was unknown for two grantees.

¹⁰Eighteen grantees indicated that they did not purchase any medical malpractice insurance for reasons such as the grantee's being located in a jurisdiction covered by sovereign immunity or being part of a larger self-insured group. One grantee did not indicate whether medical malpractice insurance was purchased.

¹¹For the entire universe of center grantees, we estimate that the grantees purchased about 2,300 medical malpractice insurance policies in their fiscal years ending in 1991.

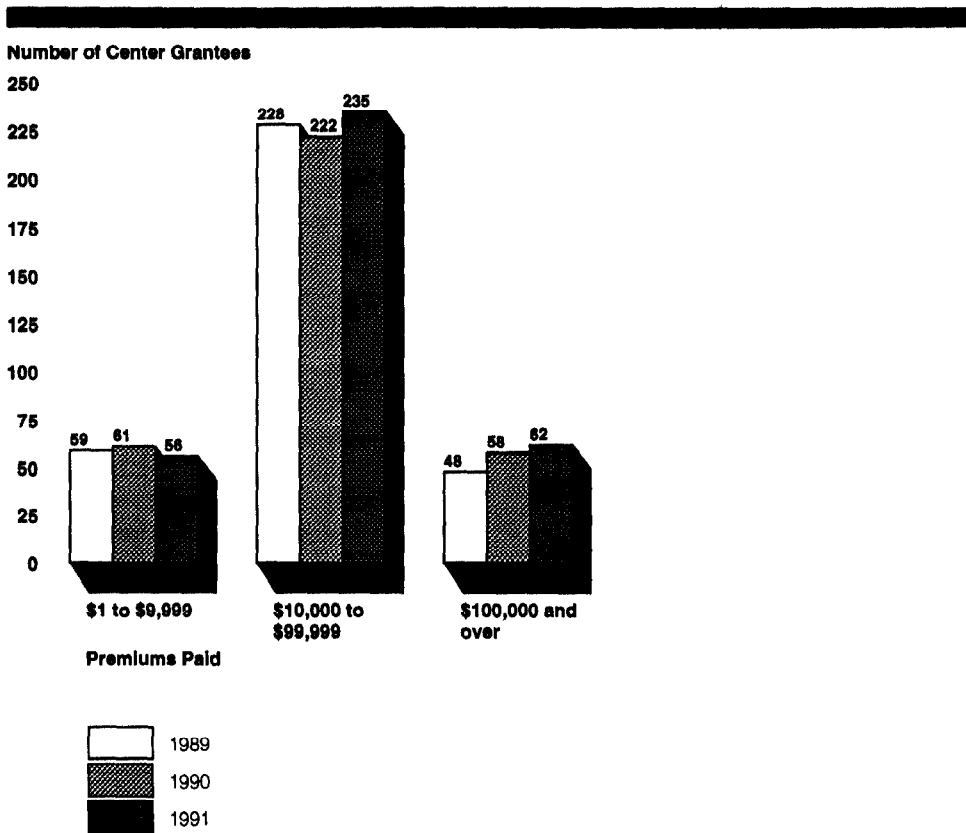
**Grantees Spent Millions of
Dollars on Medical
Malpractice Insurance
Policies**

The 374 grantees responding to our survey spent more than \$58 million for medical malpractice insurance as follows: about \$18.1 million, \$19.3 million, and \$20.8 million during their fiscal years ending in 1989, 1990, and 1991, respectively.¹² The grantees' insurance premiums, which increased by about 15 percent from 1989 to 1991, covered a wide range during each of the 3 fiscal years; they paid as little as \$525 to as much as \$437,026, for example, during their fiscal years ending in 1991. On average, the insurance premiums were \$58,806, with a median of \$35,262 in 1991. Figure I.3 shows the amounts paid by the grantees for malpractice insurance during the grantees' fiscal years ending in 1989 through 1991.

¹²We estimate that in their fiscal years ending in 1991, the 513 grantees spent about \$30 million for medical malpractice insurance. HHS data indicate that the grantees spent over \$50 million for malpractice insurance. HHS collects medical malpractice insurance premium data from the grantees, using provider profiles. The malpractice insurance data collected by HHS have certain limitations. For example, the data are self-reported, and the definitions of the data elements used to collect the data may not be clear to all grantees. An HHS official stated that as a result, when health care providers and the center are covered by one malpractice insurance policy, they may be reporting the same premium twice.

**Appendix I
Historical Medical Malpractice Experience
of the Community and Migrant Health
Center Grantees**

Figure I.3: Range of Malpractice Insurance Premiums Paid by the Community and Migrant Health Center Grantees in Their Fiscal Years Ending in 1989 Through 1991



Notes: Data were not provided by 11 grantees that indicated that they purchased insurance and had a fiscal year ending in 1989.

Data were not provided by eight grantees that indicated that they purchased insurance and had a fiscal year ending in 1990.

Data were not provided by two grantees that indicated that they purchased insurance and had a fiscal year ending in 1991.

Although the grantees collectively spent millions of dollars on malpractice insurance, this expense generally accounted for a small portion of each grantee's total revenues in a given year. For example, the grantees spent about 2 percent of their total revenues (about \$21 million out of \$973 million) for malpractice insurance to cover services funded by section 330 and 329 grants in their fiscal years ending in 1991; however, three grantees spent 10 percent or more for malpractice insurance.

**Claims-Made Policies and
\$1 Million Limits
Predominate**

Of the more than 1,700 malpractice insurance policies purchased by the grantees during their fiscal years ending in 1991, about 58 percent were claims-made, while about 42 percent were occurrence policies.¹³ Also, the malpractice insurance policies contained many different combinations of policy limits—the dollar amounts that would be paid on claims during the policy periods. More than one-half of the policies (about 57 percent) provided coverage of up to \$1 million for each paid medical malpractice claim and total coverage of up to \$3 million for all claims paid during the policy period.

**Malpractice Claims
Experience of Center
Grantees and
Providers**

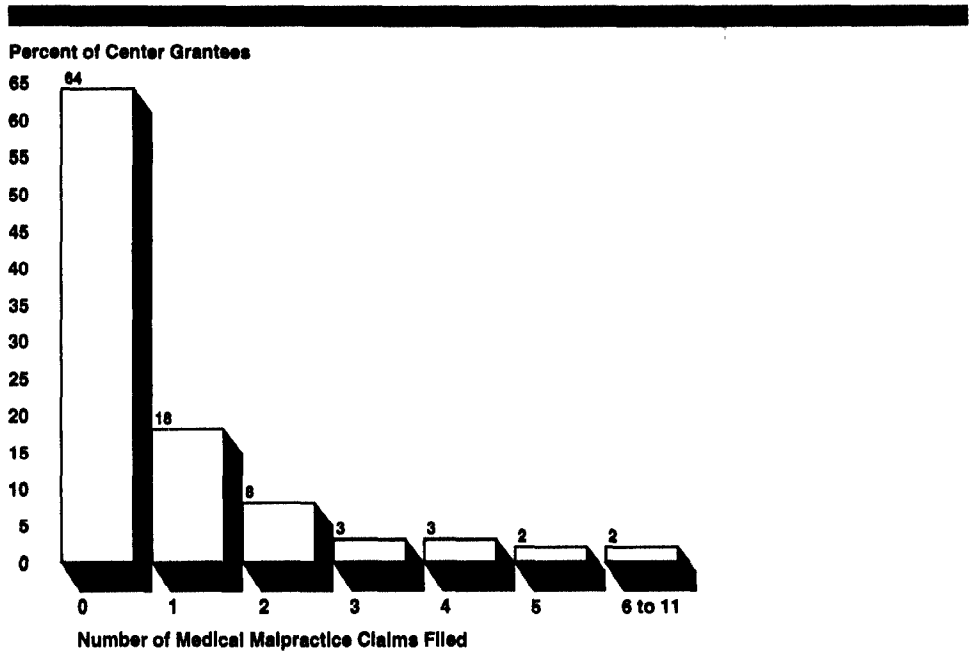
Medical malpractice claims were filed against some of the center grantees responding to the questionnaire, their personnel, or both, during 1986 through 1991. As shown in figure I.4, about two-thirds of the grantees (about 64 percent) reported that no malpractice claims were filed during this 6-year period. The remaining grantees reported 310 malpractice claims, and the number filed at these grantees ranged from 1 to 11, with an average of 2.¹⁴

¹³Claims-made policies provide coverage for malpractice claims that are reported to the insurer while the policy is in force. Occurrence policies provide coverage for any incident that occurs while the policy is in force, regardless of when a claim is filed.

¹⁴We estimate that a total of 424 medical malpractice claims were filed from 1986 through 1991. Because of the time lag that usually occurs between the injury and the claim filing, it is likely that the injuries for most of these claims occurred in the years prior to the year in which the claim was filed.

**Appendix I
Historical Medical Malpractice Experience
of the Community and Migrant Health
Center Grantees**

Figure I.4: Number of Malpractice Claims Filed by Percent of Grantees Between Calendar Years 1986 and 1991



More Than One-Third of the Claims Were Not Resolved

About 60 percent of the 310 claims filed between 1986 through 1991 were resolved and closed during that time. On average, it took about 17 months to close these claims. However, while one claim took 58 months (4.8 years) to close, the median resolution time was about 14 months. The remaining claims either were not closed (about 37 percent) or their status was unknown (about 3 percent).

Claimants in about 51 percent of the closed claims received no awards or settlements, while claimants in about 44 percent (81 claims) received either monetary payments, free services, or both. Grantees did not know whether any awards or settlements were made on about 5 percent of the closed claims. Insurers made the monetary payments at one time (lump sum), over time (structured settlements), or in a combination of the two procedures. The monetary payments made for the grantees' claims totaled at least \$5.2 million: insurers spent at least \$4.3 million on lump sum payments and more than \$800,000 to cover payments through structured

**Appendix I
Historical Medical Malpractice Experience
of the Community and Migrant Health
Center Grantees**

settlements.^{15,16} The smallest payment made was \$42 and, as shown in table I.3, payments ranged up to \$1 million. The average payment was \$74,100, and the median was \$10,000.¹⁷

Table I.3: Number and Percent of Paid Malpractice Claims by the Range of Payments During Calendar Years 1986 Through 1991

Range of payments (in dollars)	Paid claims		Cumulative percent
	Number	Percent	
\$1 to \$999	5	8	8
\$1,000 to \$9,999	23	37	45
\$10,000 to \$99,999	25	40	85
\$100,000 to \$999,999	8	13	98
\$1,000,000	1	2	100
Total	62^a	100	

^aPaid claims do not include the one claim that received free health care services only or the 18 claims for which the entire payment or part of the payment amounts were unknown.

Tillinghast's Assessment of Claims Experience

The medical malpractice claims experience reported by the responding grantees was extremely favorable, according to Tillinghast, a nationally recognized management and actuarial consulting firm that we used as a contractor for the actuarial estimates in this report. Relative to the medical malpractice insurance premiums paid, the malpractice claim payments were about 47 percent of what Tillinghast would have expected, the firm noted.

Tillinghast believed that there were several possible explanations for this favorable experience. First, the grantees' medical malpractice insurance premiums may include the cost of full-time coverage for part-time

¹⁵Total monetary payments include seven lump sum payments totaling about \$574,000 that either (1) included a structured settlement with an unknown amount or (2) lacked a grantee's knowledge of whether a structured settlement was included.

¹⁶We estimate that insurers paid about \$7 million for claims that were filed and closed with a payment during 1986 through 1991. However, this estimate may be understated because it (1) assumes that the respondents were aware of all claims and fully reported them, (2) does not account for claims where the respondents did not know if the claims were closed or if a payment was made, and (3) only includes claims that were filed and closed with a payment during the 6-year period—unresolved claims are not included. Previously, we found that the length of time to resolve malpractice claims ranged from less than 1 month to 11 years, with a median of 19 months and an average of 25 months. Generally, claims for more severe injuries are more costly and take longer to resolve. In addition, the estimate does not include those claims that were filed before 1986 but were paid during 1986 through 1991.

¹⁷The average and the median payments represent the 62 paid claims for which the entire payment amount was known. The amounts do not include the one claim that received free health care services only or the 18 paid claims for which the entire payment or part of the payment amounts were unknown.

**Appendix I
Historical Medical Malpractice Experience
of the Community and Migrant Health
Center Grantees**

physicians. Second, patients may have smaller or fewer claims because they have lower incomes or do not stay in an area long enough to sue. And third, the relatively low-risk procedures performed at the grantees may generate fewer malpractice claims than procedures of physicians in private practice.

Community and Migrant Health Center Grantee Protection Against Medical Malpractice Claims Under the Federal Tort Claims Act

Prior to 1946, the federal government had sovereign immunity that prohibited an individual from bringing a civil action against the government for any damages resulting from the negligent or other wrongful acts or omissions (torts) of its employees acting within the scope of their employment. The government waived its sovereign immunity for torts, including medical malpractice, by enacting FTCA.

Under FTCA, with certain exceptions, the government is substituted as the defendant in any civil suit filed to recover damages against federal employees. FTCA is the sole remedy available to a patient injured by a federal employee providing health care. A federal employee cannot be sued individually for medical malpractice if the incident occurred while the employee was performing official duties.

Law Authorizing FTCA Coverage for Health Center Grantees

Community and migrant health centers are financed in part by the federal government through grant funds. The majority of people working at the centers are not federal employees. However, under Public Law 102-501—the Federally Supported Health Centers Assistance Act of 1992, enacted on October 24, 1992—medical malpractice claims filed against the grantees and certain of their personnel may be resolved by the government under FTCA when various conditions are met.

As stated in the law, the Secretary of the Department of Health and Human Services (HHS), after consulting with the Attorney General, must determine that each entity (grantee)¹ has taken certain actions before the grantee can be covered under FTCA. For example, each grantee must assure that it (1) has implemented policies and procedures to reduce the risk of medical malpractice, (2) has reviewed the professional credentials of certain of its health care practitioners (providers), (3) will cooperate with the Department of Justice if any claims are filed, and (4) will cooperate in providing information on its historical claims experiences.

In addition to the grantee, any officer, employee, or contractor of the grantee who is a physician or other licensed or certified health care provider will be considered to be an employee of the Public Health Service and will be granted federal protection against medical malpractice claims. However, contracted health care providers must perform an average of

¹An entity is defined as a public or nonprofit private group receiving federal grant funds under any of the following four sections of the Public Health Service Act: (1) section 329—migrant health centers, (2) section 330—community health centers, (3) section 340—health services for the homeless, and (4) section 340A—health services for residents of public housing.

32-1/2 hours of service each week to be covered under FTCA. Licensed providers of obstetrical services receive special consideration.²

According to the law, grantees and health care providers that qualify will be covered under FTCA only for malpractice incidents that occur on or after January 1, 1993, through December 31, 1995. However, coverage under FTCA for a particular grantee begins only after the grantee has met the requirements of the law and has received a notice from HHS that it is deemed eligible. Coverage begins for actions or omissions occurring on or after that date. The Bureau of Primary Health Care in HHS has targeted all eligible grantees to participate in the deeming process by September 30, 1993.

The Attorney General must estimate the amount of all claims that are expected to arise for which payment may be made under FTCA. In making the estimate, at the beginning of fiscal years 1993,³ 1994, and 1995, the Attorney General must consult with the Secretary of HHS. The Secretary must establish a fund and transfer money to the Treasury to cover the medical malpractice claims that might be paid during these years. The amount of money set aside each fiscal year for this purpose cannot exceed \$30 million.

Medical Malpractice Claims Resolution in HHS

The grantees' malpractice claims will be resolved under FTCA by HHS according to established procedures. Every medical malpractice claim involving HHS facilities and personnel must be filed with the claims office in HHS for an administrative review and decision.⁴ The claims office begins the review process by arranging for a case review at the site where the incident occurred. Also, a specialist located at another site, with expertise in a relevant field of medicine, performs an independent review of the claim. Then, the Public Health Service Quality Review Panel, composed of a panel of members from each Public Health Service agency, makes a recommendation to the HHS Office of General Counsel as to the medical merits of the claim. The Office of General Counsel decides whether to make a settlement offer, and, if so, how much to offer, or whether to deny the claim. In addition, when appropriate, risk management

²Licensed or certified providers of obstetrical services may be covered under FTCA even if they work less than 32-1/2 hours per week for the grantee if (1) the provider's own malpractice insurance does not cover services performed for the grantee or (2) the Secretary of HHS determines that patients will be denied obstetrical services if the provider is not found eligible for FTCA coverage.

³The estimate for fiscal year 1993 had to be made by December 31, 1992, subject to an adjustment within 90 days. The fiscal year 1993 amount was \$1 million.

⁴The claims office is located in Rockville, Maryland.

**Appendix II
Community and Migrant Health Center
Grantee Protection Against Medical
Malpractice Claims Under the Federal Tort
Claims Act**

recommendations are formulated during the review process. HHS has 6 months from the time a claim is submitted in which to settle the claim.

The Secretary of HHS has authority to settle claims but needs approval from the Department of Justice for settlement amounts greater than \$25,000.⁵ An HHS official stated that the agency usually takes the entire 6 months to decide an administrative claim, regardless of merit. Patients injured at HHS facilities or by HHS personnel can file suit in a federal district court after the agency completes the administrative review or after 6 months have passed, whichever comes first.

⁵Some departments, including Defense, Transportation, and Veterans Affairs, have been granted independent settlement authority up to \$100,000.

Methodology for Developing GAO's Database and Actuarial Assumptions for Developing Savings and Cost Estimates

We developed a database containing information on the historical medical malpractice experiences of the community and migrant health center grantees. Our database includes such background information on the grantees as location, urban or rural status, and the amount of federal grant funds received through sections 330 and 329 of the Public Health Service Act. In addition, included are such medical malpractice-related data as the insurance purchased by the grantees to protect against malpractice claims; the claims filed; the settlements and awards made; and the grantees' exposure to claims, that is, health care professionals who are providing the services. We obtained the background data from HHS. Using a mail questionnaire, we gathered the malpractice data directly from 374 grantees.

Mail Questionnaire

We designed a three-part questionnaire to obtain information about the grantees' historical medical malpractice experiences. Part A collects information primarily pertaining to the grantees' exposure to claims during 1989 through 1991.¹ Part B collects information on each malpractice claim that was filed from 1986 through 1991. Part C collects information on (1) the malpractice insurance premiums paid during the grantees' fiscal years ending in 1989 through 1991 and (2) each malpractice insurance policy purchased during their fiscal years ending in 1991. A copy of the questionnaire and a summary of the questionnaire results are shown in appendix IV. Copies of the claim and policy forms are contained in appendix V.

Before we distributed the questionnaire, we pretested it in person with officials at eight center grantees located in both urban and rural areas.² Also, we provided the questionnaire to officials at (1) Tillinghast, (2) HHS, and (3) the National Association of Community Health Centers for review.³ Based on the pretest results and the reviewers' comments, we revised the questionnaire to ensure that the potential respondents could provide the information requested and that the questions were fair, relevant, and easy to understand and answer. In addition, we tested the questionnaire to

¹The health care professionals—physicians, dentists, and midlevel personnel (nurse midwives, nurse practitioners, and physician assistants)—who provided services that were funded by section 330 and 329 grants are exposed to medical malpractice claims. Included are full- or part-time professionals who were salaried, contracted, or federally employed or who were volunteers.

²These grantees were located in Florida, Maryland, Pennsylvania, and West Virginia.

³The National Association of Community Health Centers serves as the principal advocate to the Congress on behalf of the community and migrant health center grantees.

ensure that the task of completing it would not place too great a burden on the respondents.

In February 1992, we mailed the questionnaire to 520 recipients of section 330 and 329 grant funds located in the United States.⁴ To maximize our response rate, we conducted two follow-up mailings. These efforts resulted in a response rate of 73 percent (374 grantees).⁵

Telephone Survey

Although our objective was to obtain medical malpractice-related information from all the grantees, about one-quarter did not return the questionnaire. To be able to make estimates about these nonrespondents, we conducted a telephone survey of a random sample of 40 grantees that did not respond to our initial or follow-up mailings.⁶

During the telephone survey, we asked each grantee to provide data for five key items: for each grantee's fiscal year ending in 1991 we requested the (1) number of medical malpractice insurance policies purchased and (2) malpractice premiums paid on these policies; for 1986 through 1991 we requested the (3) number of medical malpractice claims filed, (4) number of claims closed with a payment, and (5) dollar amounts paid on the closed claims. We used the data from our sample to make estimates for the 144 grantees that had not responded to the initial or follow-up mailings.

We developed estimates for the five key data items for the universe of 513 grantees. These estimates were based on data provided by the grantees responding to our questionnaire as of the end of August 1992 combined with the estimates for the nonrespondents. Our estimates and associated sampling errors are shown in tables III.1 and III.2.⁷ The data we report for

⁴For the purposes of our study, we did not include the 21 grantees located outside of the United States. These grantees were located in the Commonwealth of the Northern Mariana Islands, Guam, the Republic of the Marshall Islands, Pohnpei, Puerto Rico, the Republic of Palau, and the Virgin Islands. Grantees were identified by the National Clearinghouse for Primary Care Information, a service of HHS.

⁵Seven grantees that did not operate center facilities were eliminated from our original universe of 520, thereby reducing the universe to 513. One was no longer an active grantee; the other six indicated that they either provided vouchers that patients could use to pay for services at other locations or arranged for services through subcontractors.

⁶The sample was selected from the 144 grantees that had not responded by the end of August 1992. Information was provided by 38 of the 40 grantees in the sample.

⁷The sampling errors are stated at the 95-percent confidence level. This statement means that the chances are 19 out of 20 that the true universe characteristic being estimated falls within the range defined by our estimate minus the sampling error and our estimate plus the sampling error.

**Appendix III
Methodology for Developing GAO's
Database and Actuarial Assumptions for
Developing Savings and Cost Estimates**

items not included in our nonrespondent survey represent the 374 grantees (73 percent of the universe) that returned the questionnaire.⁸

Table III.1: GAO Estimates of the Number of Insurance Policies Purchased and Total Premiums Paid During the Grantees' Fiscal Years Ending in 1991, and Related Sampling Errors

	Estimate ^a	Sampling error ^b
Number of policies purchased	2,270	+/- 181
Premiums paid (dollars in millions)	\$29	+/- 2.1

^aThe estimates combine data from the questionnaire respondents as of the end of August 1992 with weighted estimates from our nonrespondent sample telephone survey.

^bSampling errors are stated at the 95-percent confidence level. These sampling errors reflect the imprecision surrounding our estimates from the nonrespondent sample data only. The sampling errors do not reflect potential error associated with adjustments used to compensate for missing data among respondents.

Table III.2: GAO Estimates of the Number of Claims Filed, Claims Paid, and Total Payments Made at the Grantees During Calendar Years 1986 Through 1991, and Related Sampling Errors

	Estimate ^a	Sampling error ^b
Number filed	424	+/- 48
Number paid ^c	122	+/- 31
Payments made ^d (dollars in millions)	\$6.7	+/- 0.5

^aThe estimates combine data from the questionnaire respondents as of the end of August 1992 with weighted estimates from our nonrespondent sample telephone survey.

^bSampling errors are stated at the 95-percent confidence level. These sampling errors reflect the imprecision surrounding our estimates from the nonrespondent sample data only. The sampling errors do not reflect potential error associated with adjustments used to compensate for missing data among respondents.

^cFor 6 percent of the claims filed, questionnaire respondents did not report whether these claims were closed or, if closed, whether they were paid; we did not estimate payments for these claims.

^dQuestionnaire respondents did not provide settlement or award amounts for 14 percent of the claims closed with a payment. We estimated these amounts using the mean payment. In addition, we treated lump sum payments as the total payment where respondents reported a lump sum but did not report whether a structured settlement was included or, if included, the cost of such settlement (9 percent of the paid claims).

Tillinghast Savings and Cost Estimates

To develop savings and cost estimates, the actuaries at Tillinghast had to consider several different things. For example, Tillinghast had to estimate how much money the grantees would have spent for medical malpractice insurance (premiums) and how much money would have been paid for malpractice claims (losses) filed against the grantees, their health care

⁸Five of these grantees returned the questionnaire during September 1992, after we had selected the sample of 40 nonresponding grantees to be included in our telephone survey.

providers, or both if FTCA coverage had not been enacted.⁹ Then, as a comparison, Tillinghast had to estimate the savings and costs associated with implementing malpractice coverage for the grantees under Public Law 102-501 for the 3 years that this law authorized FTCA coverage.

When developing estimates, the actuaries had to determine how the malpractice premiums and losses would be distributed among the different types of health care providers for whom insurance was purchased at each center. Tillinghast had to estimate the difference in costs between the type of coverage provided by private sector insurers—a mixture of claims-made and occurrence policies—and FTCA—occurrence coverage. In developing payout patterns under FTCA, Tillinghast adjusted industry payment patterns to reflect the expected faster settlements under the federal administrative system. In addition, Tillinghast had to estimate how much money the grantees with claims-made insurance policies would have to spend on “tail” coverage when converting to FTCA coverage and the amount of premiums that would be returned to the grantees at the time of conversion.

Tillinghast had to rely on our questionnaire results to identify, among other things, claim counts and payments for a point in time when making savings and cost estimates.¹⁰ Tillinghast assisted us in developing our questionnaire to assure that we collected the data elements needed to develop the estimates. However, because we developed our questionnaire before Public Law 102-501 was enacted, questions specific to the legislation were not included. Also, Tillinghast relied on industry data showing trends in malpractice premiums and losses and other factors that seemed to be affecting malpractice premiums for the center grantees when making estimates.

Independently, Tillinghast verified a portion of the malpractice claims data provided by the grantees to assess the completeness of the grantees' reports of the claims filed. The grantees had provided the name of the insurance company and the policy number for each medical malpractice insurance policy they had purchased in their fiscal years ending in 1991 in part C of our questionnaire. Using these names and numbers, the actuaries

⁹To develop the expected medical malpractice premiums and losses in the absence of FTCA coverage, Tillinghast used the results of our survey, industry trends in premiums and losses, and factors that seemed to be affecting malpractice premiums for the grantees. Tillinghast developed the private sector losses replaced by FTCA to correspond to the private sector premiums replaced by FTCA. The private sector losses would have been paid over a period of years.

¹⁰We collected data on the medical malpractice claims that were filed against the grantees in calendar years 1986 through 1991. Payments represent payments made only on the claims filed during the 6-year period. Payments made during this period for claims filed prior to 1986 are not included.

contacted four medical malpractice insurance companies from which the grantees had purchased about one-quarter of their medical malpractice insurance policies.¹¹ The claims information reported by these companies was consistent with that indicated by the survey respondents.

Tillinghast Assumptions

To develop estimates, Tillinghast made a number of assumptions, which subject the results to a significant range of uncertainty. Overall, Tillinghast had to make assumptions about how the questionnaire results received would generalize to the total universe of 513 section 330 and 329 grantees.¹² In addition, Tillinghast assumed that the grantees' programs would remain at the 1991 levels in terms of the number of physicians and other health care providers insured. Tillinghast stated that the estimates that it developed would need to be adjusted to account for any growth that may occur in the program.

More specifically, for example, Tillinghast assumed that without FTCA coverage, the grantees' claim payment losses would have increased at the rate of 11 percent per year based on industry trend rates. In addition, the actuaries assumed that the grantees' insurance premiums would rise at a slower rate than the loss payments.

Because the coverage provided under FTCA has no policy limit, as is the case for private sector medical malpractice insurance policies (the most frequent limit purchased by the grantees was \$1 million per claim), Tillinghast assumed that FTCA would have the effect of raising the insured per-claim limit to slightly less than \$5 million of coverage per claim. This factor would add about 50 percent to the loss amounts compared with the loss amounts under private sector insurance.

Tillinghast judgmentally selected coverage limits of slightly less than \$5 million. If Tillinghast had assumed a per-claim limit of \$3 million, losses would have increased by about 40 percent relative to the private sector amount; if it had assumed a limit of \$20 million per claim, the loss factor would have been 81 percent. Tillinghast also included contingency

¹¹The four insurance companies contacted were (1) Clinic Mutual, (2) CNA, (3) Frontier, and (4) St. Paul.

¹²Public or nonprofit private groups receiving federal grant funds under any of the following four sections of the Public Health Service Act: (1) section 329—migrant health centers, (2) section 330—community health centers, (3) section 340—health services for the homeless, and (4) section 340A—health services for residents of public housing can be deemed eligible for FTCA coverage. We only sent questionnaires to section 329 and 330 grantees. The Tillinghast estimates would have to be increased to reflect any health care facilities that receive grants under sections 340 or 340A but not under sections 329 or 330.

**Appendix III
Methodology for Developing GAO's
Database and Actuarial Assumptions for
Developing Savings and Cost Estimates**

margins when estimating the government's costs for 1993 through 1995. Tillinghast assumed that these amounts would be highest in the early years when the amount of the government's payments is most uncertain and a single large payment could easily distort the expected cost.

There were many unresolved questions about how Public Law 102-501 would be interpreted and eventually administered when Tillinghast began to develop the savings and cost estimates at the end of 1992, shortly after the law was enacted. Therefore, Tillinghast had to make certain assumptions about the law.

The assumptions made by Tillinghast relating to the law include the following:

- Because the law did not appear to exclude any services provided by the grantees from FTCA coverage, Tillinghast assumed that if the center received grant funds, any and all services provided would be covered under FTCA, whether or not the services were supported by section 330 or 329 grant funds. We did not collect information through our questionnaire on the services provided by the grantees that were not supported by section 330 and 329 grants. Therefore, Tillinghast increased the grantees' estimated medical malpractice insurance premium amounts by 5 percent to account for the cost of malpractice protection for services that were not included in our database because they were not eligible for funding.¹³
- Because the law does not cover contracted health care providers who work less than 32-1/2 hours per week—with certain exceptions for providers of obstetrical services—Tillinghast assumed that FTCA coverage would extend to part-time providers of obstetrical services for whom the grantees directly purchased insurance.¹⁴ Tillinghast assumed that if the grantee reimbursed part of the malpractice premiums for part-time

¹³As stated in the Bureau of Primary Health Care's policies and procedures for implementing FTCA coverage under Public Law 102-501 dated July 2, 1993, covered activities are those activities conducted within the approved federal project supported with either grant or grant-related income.

¹⁴According to the law, licensed or certified providers of obstetrical services may be covered under FTCA even if they work less than 32-1/2 hours per week for the grantee if (1) the provider's own malpractice insurance does not cover services performed for the grantee or (2) the Secretary of HHS determines that patients will be denied obstetrical service if the provider is not found eligible for FTCA coverage.

**Appendix III
Methodology for Developing GAO's
Database and Actuarial Assumptions for
Developing Savings and Cost Estimates**

providers of obstetrical services, rather than purchasing a policy for them, these obstetrical providers would not be covered under FTCA.¹⁵

- Although the law seems to suggest that the section 330 and 329 grant funds might be reduced to pay for the cost of services provided under FTCA, Tillinghast assumed that grant funds would not be reduced to pay for the claims filed under FTCA.
- Although the law states that the grantees must meet several requirements before each grantee can be deemed eligible for FTCA coverage, Tillinghast assumed that these requirements would not be enforced in such a way as to significantly reduce the number of individuals or grantees that will be eligible for coverage under the law.

¹⁵Tillinghast indicated that if literally interpreted, most part-time obstetrical service providers who purchase their own policies that are then reimbursed by the grantees could be excluded from FTCA coverage because policies for these providers (1) appear to be available almost everywhere; and (2) are nearly always in force at any location where the individual provides services, including the center grantees.

Results of GAO's Survey of Medical Malpractice Insurance Costs and Claims at Community and Migrant Health Centers

PART A

CENTER'S REVENUES AND HEALTH CARE PROFESSIONALS

This Part Includes

- instructions for completing Parts A, B, and C.

- questions about your center's Section 330 and 329 grants.

- questions about your center's revenues and health care professionals.

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

INTRODUCTION

At the request of the Congress, the U.S. General Accounting Office is evaluating options for providing medical malpractice insurance coverage to community and migrant health centers. As part of our evaluation, we are sending this questionnaire to all centers.

This questionnaire is divided into three parts. This part, Part A, contains questions on your center's revenues and medical malpractice insurance coverage of your center's health care professionals--physicians, dentists, and mid-level professionals. Part B asks about medical malpractice claims that have been filed against your center since January 1, 1986. In addition, Part B contains a 3-page form to be completed for each claim, if any, filed since 1986. We have included 6 copies of this form for your use, if needed. Part C contains general questions on (1) your center's medical malpractice insurance policies and (2) the health care personnel covered. Also included in Part C is a 2-page form to be completed for each medical malpractice insurance policy your center purchased during your center's fiscal year that ended in calendar year 1991. We have included 15 copies of this form for your use, if needed.

INSTRUCTIONS

Please complete all three parts of this questionnaire. If you would like to comment on any medical malpractice issues or any questions asked in this questionnaire, please use the space provided in question A-10, at the end of Part A, to do so.

This questionnaire should be completed by the person(s) most familiar with your center's revenues, staffing, and insurance policies, and with medical malpractice claims filed against your center or its health care personnel. For questions about medical malpractice claims and insurance policies, you may want to consult with your center's insurance broker or agent.

Please provide the name, title, and telephone number of the person mainly responsible for completing the questionnaire so that we may consult him or her, if necessary, for clarification of your responses or additional information.

Name of person: _____

Title: _____

Telephone number: () _____

If you have any questions about this questionnaire, please call Joseph Petko collect at (202) 512-7154. Please return the completed questionnaire within 3 weeks of receipt, in the enclosed preaddressed business reply envelope. If the envelope is misplaced, please send your questionnaire to the U.S. General Accounting Office

Mr. Joseph Petko
Room 6846
441 G Street NW
Washington DC 20548

Thank you for your help.

CENTER PROFILE

A-1. Does your center currently receive a section 330 Public Health Service Act grant, a section 329 Public Health Service Act grant, or both? (Check one) (N=373)^a

1. 302 Only a section 330 grant (Community Health Center program)
2. 11 Only a section 329 grant (Migrant Health Center program)
3. 60 Both section 330 and 329 grants

A-2. Are any funds from either of these grants also used to provide services at your center's clinics? (Check one) (N=373)

1. 337 Yes --> (Go to question A-3)
2. 6 No --> (Go to question A-4)
3. 30 Not applicable, the center has no clinics --> (Go to question A-4)

^aFor Parts A and C of the questionnaire, 373 centers responded; for Part B of the questionnaire, 374.

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

A-3. How many of your center's clinics are funded by either of these grants? (Enter number) (N=337)

Range Median
1-13 2 clinic(s) ---->

In this question, the term "center" refers to the section 330 or 329 grantee and all clinics funded by the grantee's section 330 or 329 grant. If the grantee has other non-330 or 329 grant-funded clinics, you should indicate those clinics when asked questions about the grantee's other clinics.

A-4. Since January 1, 1986, has your center continuously received section 330 or 329 grant funding under either the center's current name, another name, current organizational structure, or another structure? (Check one) (N=372)

1. 353 Yes
2. 19 No --> For what period(s) of time did your center not receive grant funds? (Enter starting and ending dates--months and years. If more than one period of time, provide each starting and ending date.)
 1. Starting date /___/___/ Ending date /___/___/
 2. Starting date /___/___/ Ending date /___/___/
 3. Starting date /___/___/ Ending date /___/___/
 4. Starting date /___/___/ Ending date /___/___/
 5. Starting date /___/___/ Ending date /___/___/

A-5. Now we would like to focus on your center's revenues. Consider the total revenues received during your center's fiscal years that ended in calendar years 1989, 1990, and 1991; include revenues from section 330 grants, section 329 grants, other federal grants, the Medicare and Medicaid programs, third-party payers, patients' out-of-pocket payments, and state and local governments. For each of your center's fiscal years listed below, complete Parts A and B.

Part A: Enter the starting and ending dates for your center's fiscal years that ended in calendar years 1989, 1990, and 1991.
Part B: Enter the total revenues received during your center's fiscal years that ended in 1989, 1990, and 1991.

Center's fiscal year ending in	Part A Center's fiscal year (Months and years)	Part B Center's total revenues (Enter amount)
1. 1989	Start date: /___/___/ (N=355) ^b End date: /___/ 89/	(N=349) <u>Median</u> <u>Range</u> \$1,394,692 \$73,225-\$25,036,115
2. 1990	Start date: /___/___/ (N=354) ^c End date: /___/ 90/	(N=351) <u>Median</u> <u>Range</u> \$1,524,000 \$60,095-\$32,495,993
3. 1991	Start date: /___/___/ (N=371) End date: /___/ 91/	(N=370) <u>Median</u> <u>Range</u> \$1,781,020 \$50,345-\$34,731,724

^aTen centers' fiscal years did not end in 1989, 5 centers did not receive grant funds in 1989, and 3 centers did not respond.
^bTwelve centers' fiscal years did not end in 1990, 4 centers did not receive grant funds in 1990, and 3 centers did not respond.

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

HEALTH CARE PROFESSIONALS

Centers might be providing services that are funded by section 330 or 329 grants and services not funded by section 330 or 329 grants. Here in Part A, we are asking for information on the malpractice insurance coverage of full-time equivalent (FTE) health care professionals who provided services funded by section 330 or 329 grants. First, we will focus on physicians who, when working for your center, provided services funded by section 330 or 329 grants.

Physicians

A-6. Complete Parts A through C for your center's physicians who, in each calendar year listed below, either (1) delivered babies or performed major surgery funded by section 330 or 329 grants or (2) provided other services funded by section 330 or 329 grants. (As defined here, major surgery, as opposed to minor surgery, means surgery that has a high risk of complications or mortality and is performed at a hospital rather than at the center.)

Part A: For each type of physician listed below, enter the number of physicians who provided services funded by section 330 or 329 grants at your center either full- or part-time. Include all physicians who were salaried, contracted, or federally employed or who were volunteers. Use physician data reported for BHCDA's BCRR system. (If none, enter "0")

Part B: For the physicians identified in Part A, enter the number of FTEs. Use physician data reported for BHCDA's BCRR system. (If none, enter "0")

Part C: For the FTE physicians identified in Part B, enter the FTE number who were covered (1) only by a medical malpractice insurance policy purchased by your center, (2) only by a medical malpractice insurance policy purchased by the physician, (3) by the physician's own policy and by residual coverage provided by your center (residual policy pays only if physician's own policy does not pay), (4) by the Federal Tort Claims Act, (5) in some other way (for example, physician had sovereign immunity), and (6) by neither an insurance source nor sovereign immunity--physician was without any coverage.

Physicians by calendar year (Jan. 1-Dec. 31)	Part A Number of physicians	Part B Number of FTE physicians	Part C Coverage for FTE physicians (Enter number of FTE physicians for each column below)					
			(1) Covered only by center policy	(2) Covered only by own policy	(3) Covered by own policy and center's residual policy	(4) Covered by Federal Tort Claims Act	(5) Other	(6) Not covered by any source or immunity
Calendar year 1989								
1. Physicians who delivered babies or performed major surgery								
2. All other physicians								
Calendar year 1990			<i>(See next page for summary of responses.)</i>					
1. Physicians who delivered babies or performed major surgery								
2. All other physicians								
Calendar year 1991								
1. Physicians who delivered babies or performed major surgery								
2. All other physicians								

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

Physicians by calendar year (Jan. 1-Dec. 31)	Part A Number of physicians	Part B Number of FTE physicians	Part C Coverage for FTE physicians (Enter number of FTE physicians for each column below)						
			(1)	(2)	(3)	(4)	(5)	(6)	
			Covered only by center policy	Covered only by own policy	Covered by own policy and center's residual policy	Covered by Federal Tort Claims Act	Other	Not covered by any source or immunity	
Calendar year 1989 ^a	(N=365)	(N=364)							
1. Physicians who delivered babies or performed major surgery	<u>Range</u> 0-18 <u>Median</u> 1	<u>Range</u> 0-11.06 <u>Median</u> .02	<u>Range</u> .20-11.06 <u>Median</u> 1.30	<u>Range</u> .04-3.69 <u>Median</u> .50	<u>Range</u> .12-4.00 <u>Median</u> .50	<u>Range</u> .10-4.00 <u>Median</u> 1.25	<u>Range</u> .25-3.00 <u>Median</u> 1.60	<u>Range</u> NA ^b <u>Median</u> 1.00	
2. All other physicians	<u>Range</u> 0-45 <u>Median</u> 4	<u>Range</u> 0-29.56 <u>Median</u> 2.80	<u>Range</u> .05-21.70 <u>Median</u> 2.90	<u>Range</u> .02-10.66 <u>Median</u> .70	<u>Range</u> .04-5.00 <u>Median</u> 1.32	<u>Range</u> .11-3.00 <u>Median</u> 1.61	<u>Range</u> .06-17.00 <u>Median</u> 1.09		
Calendar year 1990 ^a	(N=370)	(N=369)							
1. Physicians who delivered babies or performed major surgery	<u>Range</u> 0-17 <u>Median</u> 0	<u>Range</u> 0-11.00 <u>Median</u> 0	<u>Range</u> .05-8.83 <u>Median</u> 1.49	<u>Range</u> .04-3.87 <u>Median</u> .47	<u>Range</u> .20-5.90 <u>Median</u> .74	<u>Range</u> .50-2.44 <u>Median</u> 1.67	<u>Range</u> .12-3.20 <u>Median</u> 1.00	<u>Range</u> NA ^b <u>Median</u> .40	
2. All other physicians	<u>Range</u> 0-32 <u>Median</u> 4	<u>Range</u> 0-26.38 <u>Median</u> 2.80	<u>Range</u> .04-23.40 <u>Median</u> 2.99	<u>Range</u> .02-9.29 <u>Median</u> .70	<u>Range</u> .03-5.00 <u>Median</u> 1.00	<u>Range</u> .20-3.00 <u>Median</u> .80	<u>Range</u> .07-19.60 <u>Median</u> 1.20		
Calendar year 1991 ^a	(N=370)	(N=369)							
1. Physicians who delivered babies or performed major surgery	<u>Range</u> 0-17 <u>Median</u> 0	<u>Range</u> 0-8.98 <u>Median</u> 0	<u>Range</u> .06-8.98 <u>Median</u> 1.73	<u>Range</u> .04-3.67 <u>Median</u> .40	<u>Range</u> .10-8.05 <u>Median</u> .56	<u>Range</u> .10-2.00 <u>Median</u> .80	<u>Range</u> .07-3.30 <u>Median</u> .42		
2. All other physicians	<u>Range</u> 0-50 <u>Median</u> 4	<u>Range</u> 0-30.66 <u>Median</u> 2.94	<u>Range</u> .09-25.60 <u>Median</u> 3.00	<u>Range</u> .01-8.05 <u>Median</u> 1.00	<u>Range</u> .03-4.88 <u>Median</u> 1.45	<u>Range</u> .15-3.00 <u>Median</u> 1.00	<u>Range</u> .05-22.30 <u>Median</u> 1.22	<u>Range</u> NA ^b <u>Median</u> .06	

^aDuring calendar year 1989, 367 centers indicated that they had received grant funding; during 1990, 372, and during 1991, 372.
^bNot applicable. Only one center indicated that its FTE physicians were not covered by any source or immunity.

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

Dentists and Mid-Level Health Care Professionals

Next we need information on the malpractice insurance coverage of your center's dentists and mid-level health care professionals (mid-levels)--including physician assistants, nurse practitioners, and nurse midwives--who when working for your center provided services funded by section 330 or 329 grants.

A-7. Complete Parts A through C for your center's dentists and mid-levels. For each calendar year listed below, consider (1) mid-levels who delivered babies funded by section 330 or 329 grants or (2) dentists and mid-levels who provided other services funded by section 330 or 329 grants.

Part A: For each type of professional listed below, enter the number of dentists and mid-levels who provided services funded by section 330 or 329 grants at your center either full- or part-time. Include all dentists and mid-levels who were salaried, contracted, or federally employed or who were volunteers. Use data reported for BHCDA's BCRR system. *(If none, enter "0")*

Part B: For the dentists and mid-levels identified in Part A, enter the number of FTEs. Use data reported for BHCDA's BCRR system. *(If none, enter "0")*

Part C: For the FTE dentists and mid-levels identified in Part B, enter the FTE number who were covered (1) only by a medical malpractice insurance policy purchased by your center, (2) only by a medical malpractice insurance policy purchased by the dentist or mid-level, (3) by the dentist's or mid-level's own policy and by residual coverage provided by your center (residual policy pays only if dentist's or mid-level's own policy does not pay), (4) by the Federal Tort Claims Act, (5) in some other way (for example, dentist or mid-level had sovereign immunity), and (6) by neither an insurance source nor sovereign immunity--dentist or mid-level was without any coverage.

Dentists and mid-levels by calendar year (Jan. 1-Dec. 31)	Part A Number of dentists and mid- levels	Part B Number of FTE dentists and mid- levels	Part C Coverage for FTE dentists and mid-levels (Enter number of FTE dentists and mid-levels for each column below)					
			(1) Covered only by center policy	(2) Covered only by own policy	(3) Covered by own policy and center's residual policy	(4) Covered by Federal Tort Claims Act	(5) Other	(6) Not covered by any source or immunity
Calendar year 1989								
1. Mid-levels who delivered babies								
2. Dentists and all other mid-levels								
Calendar year 1990			<i>(See next page for summary of responses.)</i>					
1. Mid-levels who delivered babies								
2. Dentists and all other mid-levels								
Calendar year 1991								
1. Mid-levels who delivered babies								
2. Dentists and all other mid-levels								

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

	Part A Number of dentists and mid-levels	Part B Number of FTE dentists and mid-levels	Part C Coverage for FTE dentists and mid-levels (Enter number of FTE dentists and mid-levels for each column below)						
			(1)	(2)	(3)	(4)	(5)	(6)	
			Covered only by center policy	Covered only by own policy	Covered by own policy and center's residual policy	Covered by Federal Tort Claims Act	Other	Not covered by any source or immunity ¹	
Calendar year 1989²	(N=366)	(N=366)							
1. Mid-levels who delivered babies	<u>Range</u> 0-7 <u>Median</u> 0	<u>Range</u> 0-5.39 <u>Median</u> 0	<u>Range</u> .25-5.39 <u>Median</u> 1.00	<u>Range</u> .07-5.25 <u>Median</u> .58	<u>Range</u> NA ³ <u>Median</u> .48	<u>Range</u> NA ³ <u>Median</u> 1.00	<u>Range</u> .40-1.00 <u>Median</u> .70		
2. Dentists and all other mid-levels	<u>Range</u> 0-27 <u>Median</u> 2	<u>Range</u> 0-20.50 <u>Median</u> 1.73	<u>Range</u> .07-15.52 <u>Median</u> 2.03	<u>Range</u> .01-13.10 <u>Median</u> 1.00	<u>Range</u> .49-5.00 <u>Median</u> 1.15	<u>Range</u> .07-3.96 <u>Median</u> 1.00	<u>Range</u> .05-20.50 <u>Median</u> 1.00		
Calendar year 1990²	(N=371)	(N=371)							
1. Mid-levels who delivered babies	<u>Range</u> 0-8 <u>Median</u> 0	<u>Range</u> 0-5.20 <u>Median</u> 0	<u>Range</u> .10-5.14 <u>Median</u> 1.00	<u>Range</u> .05-5.20 <u>Median</u> 1.00	<u>Range</u> .38-.50 <u>Median</u> .44	<u>Range</u> NA ³ <u>Median</u> 1.00	<u>Range</u> .30-3.01 <u>Median</u> .32		
2. Dentists and all other mid-levels	<u>Range</u> 0-30 <u>Median</u> 2	<u>Range</u> 0-25.90 <u>Median</u> 1.91	<u>Range</u> .15-15.70 <u>Median</u> 2.10	<u>Range</u> .03-12.50 <u>Median</u> .90	<u>Range</u> .30-6.00 <u>Median</u> 1.20	<u>Range</u> .30-2.80 <u>Median</u> 1.00	<u>Range</u> .18-25.90 <u>Median</u> 1.18		
Calendar year 1991²	(N=371)	(N=371)							
1. Mid-levels who delivered babies	<u>Range</u> 0-7 <u>Median</u> 0	<u>Range</u> 0-6.00 <u>Median</u> 0	<u>Range</u> .30-4.88 <u>Median</u> 1.25	<u>Range</u> .05-5.34 <u>Median</u> 1.50	<u>Range</u> .23-6.00 <u>Median</u> 3.12	<u>Range</u> .67-1.00 <u>Median</u> .84	<u>Range</u> .25-3.40 <u>Median</u> .40		
2. Dentists and all other mid-levels	<u>Range</u> 0-34 <u>Median</u> 3	<u>Range</u> 0-19.03 <u>Median</u> 2.00	<u>Range</u> .05-17.30 <u>Median</u> 2.04	<u>Range</u> .01-14.60 <u>Median</u> 1.00	<u>Range</u> .10-6.21 <u>Median</u> 1.20	<u>Range</u> .25-2.80 <u>Median</u> 1.00	<u>Range</u> .04-17.81 <u>Median</u> 1.00		

²During calendar year 1989, 367 centers indicated that they had received grant funding; during 1990, 372, and during 1991, 372.

³Not applicable. Only one center indicated that its FTE dentists and mid-levels were covered by their own policy and the center's residual policy.

⁴Not applicable. Only one center indicated that its FTE dentists and mid-levels were covered by the Federal Tort Claims Act.

¹All centers indicated that their FTE dentists and mid-levels had coverage.

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

A-8. The next two questions will complete the information we need in Part A on health care professionals.

For calendar years 1987 and 1988, please enter (1) the total number of physicians who provided services funded by section 330 or 329 grants and (2) their related number of FTEs. (Enter number in columns 1 and 2 for each calendar year. If none, enter "0.")

Calendar year	(1) Number of physicians		(2) Number of FTE physicians	
	<i>Range</i>	<i>Median</i>	<i>Range</i>	<i>Median</i>
1. 1987 ¹	(N=346)		(N=351)	
	0-36	4	0-31.90	3.00
2. 1988 ¹	(N=353)		(N=357)	
	0-43	5	0-29.90	3.11

A-9. Now enter for calendar years 1987 and 1988 (1) the total number of dentists and mid-levels who provided services funded by section 330 or 329 grants and (2) their related number of FTEs. (Enter number in columns 1 and 2 for each calendar year. If none, enter "0.")

Calendar year	(1) Number of dentists and mid-levels		(2) Number of FTE dentists and mid-levels	
	<i>Range</i>	<i>Median</i>	<i>Range</i>	<i>Median</i>
1. 1987 ¹	(N=350)		(N=351)	
	0-33	2	0-19.70	1.53
2. 1988 ¹	(N=355)		(N=356)	
	0-32	2	0-23.60	1.81

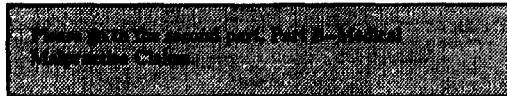
¹During calendar year 1987, 364 centers indicated that they had received grant funding; during 1988, 365.

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

A-10. If you have any comments about medical malpractice insurance issues or any questions asked in this questionnaire, please write them in the space provided below. (N=373)

(Provided comments) - 28

(No comments) - 345



HRD/BLS/2-92
(101210)

**PART B
MEDICAL MALPRACTICE CLAIMS**

This Part Includes

- questions about your center's history of medical malpractice claims.

- 6 copies of a 3-page Medical Malpractice Claim form (blue form). The number to be completed will depend on the number of claims your center had.

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

INTRODUCTION

As discussed in Part A, the Congress requested that the U.S. General Accounting Office evaluate options for providing medical malpractice insurance coverage to community and migrant health centers. This is Part B of a 3-part questionnaire designed to collect information for our evaluation. This part focuses on any medical malpractice claims that might have been filed against either your center or your center's health care personnel in which the alleged incident involved a service funded by section 330 or 329 grants. In addition, this part contains a 3-page form to be completed for each medical malpractice claim filed against your center or its health care personnel from 1986 through 1991.

Definition of the term "claim"

For purposes of this questionnaire, when identifying claims, include incidents in which an injured center patient or his or her representative believed substandard care had been provided by the center or any of its health care personnel and an insurer eventually became involved--that is, opened a claim file. An insurer might become involved as a result of different events that might have occurred, such as

- the injured center patient or his or her representative filed a suit for damages;
- the injured center patient or his or her representative, either orally or in writing, charged your center, or its health care personnel, or both, with malpractice and demanded an investigation or explanation;
- an attorney sent a letter of representation (other than a request for records); or
- your center contacted the insurer because it believed substandard care had been provided.

In addition, include all claims in which claim files were opened, including claims that were (1) handled by your center's medical malpractice insurers, (2) handled under the Federal Tort Claims Act, (3) against health care personnel providing medical care at your center who had purchased their own malpractice insurance, and (4) against personnel who were no longer at your center.

- B-1. During calendar years 1986 through 1991, were any medical malpractice claims filed against your center or any of its health care personnel (for example, physicians, dentists, mid-levels, nurse-RNs, LPNs, nursing assistants, technicians) in which the alleged incident involved a service funded by section 330 or 329 grants? (Check one) (N=374)

1. 133 Yes
2. 241 No --> (Go to Part C -- Medical Malpractice Insurance Cost Information)

- B-2. How many medical malpractice claims involving services funded by section 330 or 329 grants were filed against your center or its health care personnel during calendar years 1986 through 1991? (Enter number) (N=133)

<u>Range</u>	<u>Median</u>	
<u>1-11</u>	<u>2</u>	claims filed during calendar years 1986 through 1991

- B-3. For each claim you counted in responding to question B-2, please complete one of the 3-page forms printed on the following pages. (For example, if two claims were identified in question B-2, then complete two of the forms--one form for each claim filed during calendar years 1986 through 1991.)

(See appendix V for a copy of the claim form.)

If you need any assistance in completing the form, please call Joseph Petko collect at (202) 512-7154. If you need any additional forms, you may call Mr. Petko or photocopy the form.

PART C

**MEDICAL MALPRACTICE INSURANCE
COST INFORMATION**

This Part Includes

- questions about your center's medical malpractice insurance premiums and policies.

- 15 copies of a 2-page Medical Malpractice Insurance Policy form (green form). The number to be completed will depend on the number of policies your center had.

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

INTRODUCTION

As discussed in Part A, the Congress requested that the U.S. General Accounting Office evaluate options for providing medical malpractice insurance coverage to community and migrant health centers. This is Part C of a 3-part questionnaire. This part focuses on your center's medical malpractice insurance policies and the health care personnel covered. In addition, this part contains a 2-page form to be completed for each medical malpractice insurance policy your center purchased during your center's fiscal year that ended during calendar year 1991.

C-1. During your center's fiscal years ending in 1989, 1990, or 1991 did your center purchase any medical malpractice insurance policies, that is a policy covering the facility, its health care personnel (for example, physicians, dentists, mid-levels, nurse-RNs, LPNs, nursing assistants, technicians) or both the facility and its health care personnel? (Check one) (N=373)

1. 355 Yes
2. 18 No --> (STOP. This concludes Part C. Please return Parts A, B, and C in the enclosed business reply envelope. Thank you for all your help!)

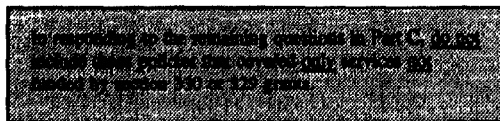
C-2. Consider all the medical malpractice insurance policies your center purchased during your center's fiscal years ending in 1989, 1990, and 1991. Any single policy might cover (1) only services funded by section 330 or 329 grants, (2) only services not funded by these grants, or (3) both services funded and services not funded by these grants.

During your center's fiscal years ending in 1989, 1990, or 1991, did any of the malpractice insurance policies purchased by your center cover any services funded by section 330 or 329 grants? (Check one) (N=354)

1. 354 Yes
2. 0 No --> (STOP. This concludes Part C. Please return Parts A, B, and C in the enclosed business reply envelope. Thank you for all your help!)

C-3. Did any of those malpractice insurance policies purchased during your center's fiscal years ending in 1989, 1990, or 1991 cover only services not funded by section 330 or 329 grants? (Check one) (N=354)

1. 14 Yes -->



2. 340 No

C-4. Did any of those policies that provided coverage of services funded by section 330 or 329 grants also cover some services not funded by section 330 or 329 grants? (Check one) (N=353)

1. 68 Yes
2. 285 No --> (Go to question C-6)

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

C-5. Now thinking only of those insurance policies that to any extent covered services funded by section 330 or 329 grants, we would like you to estimate what proportion of all full-time equivalent (FTE) health care professionals covered by those policies provided services that were not funded by section 330 or 329 grants.

Please consider the total number of FTEs covered by all the insurance policies that to any extent covered services funded by section 330 or 329 grants. Of the total number of FTEs, please enter your best estimate of the percentage of those FTEs who provided services that were not funded by section 330 or 329 grants. For example, if in 1990 the total number of physician FTEs covered by these policies had been 8, and 2 of the FTE's had been spent in providing services not funded by section 330 or 329 grants, you would enter 25% for 1990. (Please provide estimates for each of your center's fiscal years listed below and for each category of health care professionals. Enter percentages for each year and category of health care professionals. If none, enter "0.")

Health care professionals	Percentage of all FTEs covered in policies (that covered any services funded by section 330 or 329 grants) who provided services <u>not</u> funded by section 330 or 329 grants		
	Center's fiscal year ending in 1989	Center's fiscal year ending in 1990	Center's fiscal year ending in 1991
1. Physicians who delivered babies or performed major surgery (Major surgery, as opposed to minor surgery, means surgery that has a high risk of complications or mortality and is usually performed at a hospital rather than at the center.) (N=68)	<u>Range</u> 0-100% <u>Median</u> 0%	<u>Range</u> 0-100% <u>Median</u> 0%	<u>Range</u> 0-100% <u>Median</u> 0%
2. All other physicians (N=67)	<u>Range</u> 0-100% <u>Median</u> 0%	<u>Range</u> 0-100% <u>Median</u> 0%	<u>Range</u> 0-100% <u>Median</u> 1%
3. Mid-levels (physician assistants, nurse practitioners, and nurse midwives) who delivered babies (N=68)	<u>Range</u> 0-100% <u>Median</u> 0%	<u>Range</u> 0-100% <u>Median</u> 0%	<u>Range</u> 0-100% <u>Median</u> 0%
4. Dentists and all other mid-levels (N=67)	<u>Range</u> 0-100% <u>Median</u> 0%	<u>Range</u> 0-100% <u>Median</u> 0%	<u>Range</u> 0-100% <u>Median</u> 0%

C-6. Next consider the medical malpractice insurance premiums paid for every policy purchased by your center that solely or to any extent covered services funded by section 330 or 329 grants. For your center's fiscal years ending in 1989, 1990, and 1991, enter the total amount of medical malpractice insurance premiums paid by your center under all of these policies—include premiums paid for coverage of your center and any of its health care personnel. (Enter amount)

Center's fiscal year ending in	Total medical malpractice insurance premiums paid (Include only premiums paid for professional liability.)	
1. 1989	(N=335) ^h <u>Range</u> \$706-\$521,878 <u>Median</u> \$31,560	
2. 1990	(N=341) ⁱ <u>Range</u> \$706-\$411,492 <u>Median</u> \$31,086	
3. 1991	(N=353) <u>Range</u> \$525-\$437,026 <u>Median</u> \$35,262	

^hOf those centers that purchased malpractice insurance, 3 did not have a fiscal year ending in 1989, 4 did not receive grant funds in 1989, and 13 did not respond.

ⁱOf those centers that purchased malpractice insurance, 2 did not have a fiscal year ending in 1990, 2 did not receive grant funds in 1990, and 10 did not respond.

**Appendix IV
Results of GAO's Survey of Medical
Malpractice Insurance Costs and Claims at
Community and Migrant Health Centers**

C-7. For your center's fiscal year that ended in 1991, consider every medical malpractice insurance policy your center purchased that solely or to any extent covered services funded by section 330 or 329 grants. How many of these policies did your center purchase? (Enter number. If none, check the box below.) (N=353)

<u>Range</u>	<u>Median</u>	
<u>1-33</u>	<u>3</u>	policies purchased during your center's fiscal year ending in 1991

No policies purchased during your center's fiscal year that ended in 1991--> (STOP. This concludes Part C. Please return Parts A, B, and C in the enclosed business reply envelope. Thank you for all your help!)

C-8. For each policy you counted in responding to question C-7, please complete one of the 2-page forms printed on the following pages. For example, if you identified three policies in question C-7, then complete three of the forms--one form for each policy your center purchased during the fiscal year that ended in 1991.

(See appendix V for a copy of the policy form.)

If you need any assistance in completing the form, please call Joseph Petko collect at (202) 512-7154. If you need any additional forms, you may call Mr. Petko or photocopy the form.

Medical Malpractice Claim and Insurance Policy Forms

MEDICAL MALPRACTICE CLAIM FORM

CLAIM # 1

Please complete this form for each claim filed since January 1, 1986, against your center or its health care personnel in which the alleged incident involved a service funded by section 330 or 329 grants.

1. Please briefly describe the alleged incident that led to this claim.

2. When did the alleged incident occur? (If the incident occurred on a specific date, enter the month and year. If the incident was over a period of time, enter the month and year when the period started and ended. If unknown, check the box below.)

____/____/____ or (started) ____/____/____ (ended) ____/____/____
month year month year month year

Unknown

3. When was the medical malpractice claim filed? (Enter month and year. If unknown, check the box below.)

____/____/____
month year

Unknown

4. Did the claim name your center only, one or more of your center's health care personnel only, or both your center and one or more of your center's health care personnel? (Check one)

1. This center only --> (Go to question 6)
2. This center's health care personnel only
3. Both this center and its health care personnel

**Appendix V
Medical Malpractice Claim and Insurance
Policy Forms**

5. Answer Parts A through D for only your center's health care personnel named in this claim who allegedly provided substandard care that had been funded by section 330 or 329 grants. (Do not include personnel who allegedly provided substandard care not funded by these grants.)

Part A: The type of health care personnel (for example, physician, dentist, nurse practitioner, nurse-RN, LPN, nursing assistant, technician).

Part B: The person's specialty area of practice (for example, internal medicine, pediatrics, obstetrics, family practice). (If none, enter NA for not applicable)

Part C: The person's source of medical malpractice insurance coverage, such as (1) coverage by a medical malpractice insurance policy purchased by your center, (2) coverage by a medical malpractice insurance policy purchased by the person, (3) the Federal Tort Claims Act, (4) any other source (for example, the person had sovereign immunity) or (5) none, no insurance coverage from any source. (Check all that apply)

Part D: Whether or not the person was in the National Health Service Corps (NHSC) at the time the incident occurred.

Part A Type of health care personnel (If more than five, please photocopy this page and complete for additional personnel.)	Part B Person's specialty area of practice	Part C Source of person's malpractice insurance coverage (Check all that apply)					Part D Was the person in the NHSC? (Check one)	
		(1)	(2)	(3)	(4)	(5)	Yes	No
		Center pays	Person pays	Federal government	Other (e.g. sovereign immunity)	None		
1.								
2.								
3.								
4.								
5.								

6. Consider the insurance source(s) that covered your center or your center's health care personnel named in this claim. Indicate the insurer(s) that was responsible for investigating, defending, or if applicable, paying on this claim. (Check all that apply)

1. Insurer from which your center purchased the insurance (Complete below. If more than one company involved, please attach information.)

Name of company: _____

2. Insurer from which your center's health care personnel purchased the insurance (Complete below. If more than one company involved, please attach information.)

Name of company: _____

3. Federal government under the Federal Tort Claims Act

4. Other (Please explain) _____

**Appendix V
Medical Malpractice Claim and Insurance
Policy Forms**

7. Has this claim been closed by all the involved insurance source(s) that covered your center or your center's health care personnel? (Check one)

- 1. Yes --> (Go to question 8)
- 2. No --> (Go to question 14)
- 3. Unknown --> (Go to question 14)

CLOSED CLAIMS

8. As of what date had all the involved insurance source(s) that covered your center or your center's health care personnel closed this claim? (Enter month and year. If unknown, check the box below.)

/____/____/
month year

Unknown

9. Was a settlement or award made on this claim by the involved insurance source(s) that covered your center or your center's health care personnel? (Check one)

- 1. Yes
- 2. No --> (Go to question 14)
- 3. Unknown --> (Go to question 14)

10. Did the settlement or award include a lump sum payment?

- 1. Yes --> Enter the amount \$_____.00
 Amount unknown.
- 2. No
- 3. Unknown

11. Did the settlement or award include structured payments to be made over time?

1. Yes --> Enter the total amount the insurance source(s) spent to cover the payments to be made over time.

\$_____.00

Amount unknown.

- 2. No
- 3. Unknown

12. Did the settlement or award include the provision of any type of free health care services? (Check one)

- 1. Yes
- 2. No
- 3. Unknown

13. What amount, if any, did the involved insurance source(s) that covered your center or your center's health care personnel pay for attorney fees related to this claim? (Enter amount. If none, enter "0.")

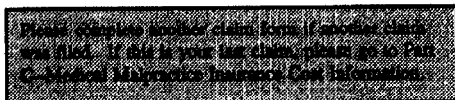
\$_____.00

Unknown

PATIENT INFORMATION

14. At the time of the incident, how was this patient's care primarily paid for at your center? (Check one)

- 1. Private (commercial) insurance
- 2. Out of patient's own pocket
- 3. Medicare
- 4. Medicaid
- 5. Other (Please specify) _____
- 6. Unknown



**Appendix V
Medical Malpractice Claim and Insurance
Policy Forms**

MEDICAL MALPRACTICE INSURANCE POLICY FORM

POLICY # 1

Please complete this form for each policy your center purchased during your center's fiscal year ending in calendar year 1991 that solely or to any extent covered services funded by section 330 or 329 grants.

Insurer's name _____ Policy number _____

Policy period: From /____/____/ To /____/____/
month year month year

1. Is this an occurrence policy or a claims-made policy? *(Check one)*

1. Occurrence policy --> *(Go to question 4)*

2. Claims-made policy

2. For this claims-made policy, what is the effective date of the original policy, that is, retroactive date?

/____/____/
month year

3. Does this policy provide tail coverage, that is, insurance purchased to cover claims filed after a claims-made policy has expired? *(Check one)*

1. Yes --> For how many health care personnel does this policy provide tail coverage? *(Enter number)*

2. No

4. For this policy, please provide the following: *(If none, enter "0")*

1. Per claim policy limit \$ _____00

2. Aggregate limit \$ _____00

3. Amount of deductible \$ _____00

4. Total premium amount \$ _____00

5. Does this policy cover your center, specific health care personnel, or both? *(Check one)*

1. This center only --> *(Go to question 7)*

2. This center's health care personnel only

3. Both this center and its health care personnel

**Appendix V
Medical Malpractice Claim and Insurance
Policy Forms**

6. Complete Parts A, B, and C.

Part A: Indicate whether or not each type of personnel listed below was covered by this policy.

Part B: For each type of personnel covered by this policy, enter the number, if any, who provided services funded by section 330 or 329 grants.

Part C: For each type of personnel covered by this policy, enter the number, if any, who provided services not funded by these grants.

	PART A Personnel covered by this policy (Check one)			PART B Number covered who provided services funded by section 330 or 329 grants (Enter number. If none, enter "0.")	PART C Number covered who provided services <u>not funded</u> by these grants (Enter number. If none, enter "0.")
	Yes	No			
1. Physician			If yes -->		
2. Dentist			If yes -->		
3. Mid-level			If yes -->		
4. Other health care personnel			If yes -->		
5. Other (Specify) _____			If yes -->		

7. Does this policy provide excess coverage above another policy? That is, is this a second policy which acts to increase the per claim and aggregate limits provided by another policy? (Check one)

1. Yes

2. No

8. Does this policy provide residual coverage? That is, is this a policy that your center purchased to cover claims not covered by the individual policies purchased by your center's health care personnel? (Check one)

1. Yes

2. No

9. If any aspect of this policy requires additional explanation, please provide it in the space below.

Do not complete this Medical Malpractice Insurance Policy form if your center purchased another policy that provides excess coverage above another policy or provides residual coverage. Please enter Part A, B, and C in the space below.

Major Contributors to This Report

**Human Resources
Division,
Washington, D.C.**

Sarah F. Jaggar, Director, Health Financing and Policy Issues
Susan D. Kladiva, Assistant Director, (202) 512-7106
Joseph A. Petko, Evaluator-in-Charge
Sheila R. Nicholson, Staff Evaluator
Greta M. Tate, Staff Evaluator
Susan L. Sullivan, Senior Social Science Analyst
Elsie A.M. Picyk, Senior Evaluator (Computer Science)

**Office of the General
Counsel,
Washington, D.C.**

Susan A. Poling, Senior Attorney

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are \$2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1000
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000
or by using fax number (301) 258-4066.

United States
General Accounting Office
Washington, D.C. 20548

Official Business
Penalty for Private Use \$300

First-Class Mail
Postage & Fees Paid
GAO
Permit No. G100