



MEDICAL BOARD OF CALIFORNIA
Executive Office



**MALPRACTICE STUDY
TASK FORCE MEETING**

MEMBERS OF THE TASK FORCE

Frank V. Zerunyan, J.D., Chair
Jorge Carreon, M.D.
Wendy Keegan, Esq.
Yvonne Choong
William Guertin

January 13, 2010

Sheraton Gateway-LA
Redondo Room
6101 W Century Blvd.
Los Angeles, CA
310-642-1111

*Action may be taken on any
item listed on the agenda.*

AGENDA

1:00 p.m. – 5:00 p.m.
(or until the conclusion of Business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1. Call to Order; Roll Call
2. Discussion of the Purpose and Objectives of the Task Force
3. Public Comment on Items Not on the Agenda
*Note: The Board may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide to place the matter on the agenda or a future meeting.
(Government Code Sections 11125, 11125.7(a))*
4. Review of Study Regarding the Provision of Medical Malpractice Insurance to Physicians Who Provide Voluntary, Unpaid Services (Assembly Bill 2324)
 - A. The Current Physician Volunteer Environment in California
 - B. Implementation Models; Other States' Programs
 - C. Program Costs, Policy Concerns and Potential Funding Sources
5. Discussion and Consideration of Options to Provide Malpractice Insurance; Potential Recommendation to Full Board
6. Next Steps of the Task Force
7. Adjournment



State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

Memorandum

Date: January 6, 2010

To: Malpractice Study Task Force Members

From: Abbie French

Subject: Review of the Malpractice Study

This memorandum provides a quick review of several areas within the Malpractice Study that may be helpful to the task force during our January 13, 2010 meeting. Full documents, from the Malpractice Study, have been provided to you.

AB 2342 (Nakanishi; Chap. 276, Stats. of 2006) added Business and Professions Code section 2023, requiring the Medical Board of California (Board) to study the issue of providing medical malpractice insurance for physicians and surgeons who provide voluntary unpaid services. The study was to include, but not be limited to, the cost and process of administering such a program, options for providing medical malpractice insurance and how the coverage could be funded.

The Current Physician Volunteer Environment in California:

The number of uninsured and underinsured Californians continues to grow. In 2001, the number of uninsured was estimated to be 6.3 million; this increased to 6.6 million by 2003. In 2007, approximately 7.6 million Californians relied on a "safety net" of community health centers, public hospitals and clinics for regular care.

Across all disciplines, California does not have a high percentage of individuals who volunteer their time. According to the website, www.volunteeringinamerica.gov, California has 6.7 million volunteers, who provided 896.4 million hours of service per year between the years 2005 and 2007. Even though this sounds like a great amount of hours and money, California's volunteer rate ranks 42nd among the 50 states and Washington, D.C.

The Medical Board of California reports there are 125,014 licensed physicians in California. Despite this number, there is an inadequate supply of physicians to care for the ever-increasing California population, especially those patients that have no insurance.

Implementation Models; Other States' Programs:

According to the malpractice insurance study, one of the below liability protection models would work best for the state of California:

- **Statutory Immunity: Change in the Standard of Care.** In this model the provider is not liable for common negligence, but only for gross negligence or willful misconduct. For an example of this model, refer to the state of Arizona handout (Arizona has approximately 20,300 licensed physicians).

Negligence: Generally, negligence is conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm. (Rest.2d, Torts, § 282.)

Gross Negligence: The want of even scant care or an extreme departure from the ordinary standard of conduct. (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941, [citation], quoting from *Van Meter v. Bent Cons. Co.* (1956) 46 Cal.2d 588, 594.)

- **Sovereign Immunity: Physicians are considered "State Actors"**. Under circumstances prescribed by the state, a physician volunteer would be considered a state employee when providing uncompensated care. For an example of this model, refer to the state of Florida handout (Florida has approximately 56,177 licensed physicians).
- **State-Run Liability Coverage Program or State-Purchased Insurance.** In this case, the state either purchases insurance for physician volunteers or establishes a self-insured pool. For an example of this model, refer to the state of Washington (Washington has approximately 19,000 licensed physicians).

Program Costs, Policy Concerns and Potential Funding Sources:

In the Arizona model, a physician would only be liable if he/she committed gross negligence. The cost of insuring the volunteer is substantially less than if the volunteer would be liable for common negligence. The Mutual Insurance Company of Arizona (MICA) offers volunteer insurance coverage to retired physicians who wish to continue providing medical care. The policy only provides coverage to the physician when he/she provides care on a voluntary basis with or without direct remuneration. Guidelines have been established to limit the scope of practice and liability exposure (see page 29 of the study for more information).

If California considered a model like Florida, the "State Actor" model, then the report suggests there would be no cost to the state, but the professional liability risk exposure would increase. Since California currently does not purchase medical malpractice insurance for its physician employees, nor does it maintain a risk pool for professional liability claims, it would be difficult to assess a cost of liability for the "state actor" model. The state of Florida does maintain good data about its claims

history. Florida reports that the Program's total patient visits for fiscal year 2006-07 was 290,026. In 2006-07, Florida reports nine claims were filed against the Volunteer Health Care Provider Program. Defense costs were just over \$550,000. Settlement costs were \$293,000 (see page 30 of the study for more information).

If California adopted legislation that would enable the state to purchase (or reimburse providers for) professional liability insurance premiums, similar to the state of Washington model, then there would be additional cost to the state. The state of Washington has an immunity statute. The cost for providing insurance to providers who rendered more than \$50,000 encounters was approximately \$145,000 for 2008.

A policy concern to take into consideration would be if a volunteer physician insurance program was developed in the state of California, who would it be administered by? If it were administered by the Board there may be a perceived conflict of interest if the Board must determine whether to take disciplinary action against a licensee to whom it has provided medical malpractice insurance

In conclusion, please take a look at the entire report for additional details on the above topics. This memorandum provides a brief summary of some of the documents that were passed out today in hopes to stir up some discussion on this important topic.

I. The Current California Climate



A. California's Population of Patients in Need and the Medical Facilities that Provide Care to the Uninsured or Underinsured

The number of uninsured and underinsured Californians continues to grow. In 2001, the number of uninsured was estimated to be 6.3 million; this increased to 6.6 million by 2003.¹ In 2007, approximately 7.6 million Californians relied on a "safety net" of community health centers, public hospitals and clinics for regular care.² It has also been estimated that in 2005 only one in five uninsured Californians were undocumented resident adults.³ The number of uninsured also varies widely among counties, from a low in Marin County at 11.0% to a high of 30.3% for Tehama, Glenn, and Colusa Counties.⁴

A range of health care settings make up the "safety net" that serves this population, including free and community clinics, hospitals, and other non-profit organizations and private providers. Clinics include Federally Qualified Health Centers (FQHC), FQHC Look-alike, Community, Free and Rural Health Clinics.⁵ Private providers also contribute to the provision of care for the poor and uninsured. There exists referral networks that enlist specialists to treat uninsured patients, such as Project Access or Operation Access.⁶

The uninsured are less likely to have a usual source of primary care.⁷ Approximately five million individuals received care at a community clinic/government clinic/community hospital in 2005, with 247,000 reporting emergency room/urgent care as their source of care; and 158,000 reporting "some other place" as their source of care.⁸

The number of enrollees in Medi-Cal who are not receiving other state financial assistance has climbed since 2000-2001 from just over five million to an estimated just under seven million in 2006-2007.⁹ However, due to low reimbursement rates, the number of providers who accept Medi-Cal is declining. An estimated 46 primary care

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providers are available for every 100,000 beneficiaries; the federal standard is 60-80 providers per 100,000.¹⁰

California counties have been given the responsibility for providing health care to uninsured individuals. Funding is from a mix of state and federal revenues. Part of this funding is from property taxes and realignment funds (from state sales taxes and vehicle license fees). Tobacco funds, safety net care pool, county match funds, and in some counties, tobacco litigation settlements make up other parts of funding. There are four county indigent health care programs: Medically Indigent Services Program (MISP), County Medical Services Program (CMSP), California Healthcare for Indigents Program (CHIP), and the Rural Health Services (RHS) Program. Although the specific services provided under indigent health care programs vary by county and region, all counties are required to provide health care to uninsured residents.¹¹ Counties are categorized as Provider, Payer, Hybrid, and CMSP, and they receive funding from different sources:

- Provider counties operate county hospitals and outpatient clinics. Approximately 15 counties operate 19 publicly owned hospitals.
- Payer counties contract with hospitals, community clinics and private physicians for outpatient services.
- Hybrid counties pay for hospital services and also operate public clinics; they may also pay private physicians and clinics.
- Small counties contract with CMSP, which is a centrally administered health coverage program; it is similar to Medi-Cal and covers 34 small counties.

Twenty-four large counties in California have Medically Indigent Service Programs (MISP) that operate under distinct eligibility requirements and spending guidelines (see Table 1).¹² Each program provides varying services based on funding, access to service, etc.

Table 1. Medically Indigent Service Program (MISP) Counties

Alameda	Placer	San Mateo
Contra Costa	Riverside	Santa Barbara
Fresno	Sacramento	Santa Clara

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Kern	San Bernardino	Santa Cruz
Los Angeles	San Diego	Stanislaus
Merced	San Francisco	Tulare
Monterey	San Joaquin	Ventura
Orange	San Luis Obispo	Yolo

California Medical Services Programs (CMSP) provide both inpatient and outpatient services to uninsured individuals in 34 small, rural counties (see Table 2 below).¹³ Both inpatient and outpatient services are provided. To qualify, individuals must be uninsured, medically indigent adults, earn less than 200% of the Federal Poverty Level (FPL), and not be eligible for Medi-Cal.

Table 2. California Medical Services Program (CMSP) Counties

Alpine	Kings	Plumas
Amador	Lake	San Benito
Butte	Lassen	Shasta
Calaveras	Madera	Sierra
Colusa	Marin	Siskiyou
Del Norte	Mariposa	Solano
El Dorado	Mendocino	Sonoma
Glenn	Modoc	Sutter
Humboldt	Mono	Tehama
Imperial	Napa	Trinity
Inyo	Nevada	Tuolumne
		Yuba

California Healthcare for Indigents Program (CHIP) funding is provided for the 24 largest counties through realignment and the Tobacco tax under Proposition 99 provisions. These funds reimburse providers for uncompensated services for individuals who cannot afford care and are ineligible for other programs. The RHS is made up of 34 small counties, also with Proposition 99 funding. Indigent uninsured who are ineligible for any other program receive services under this program, and providers are reimbursed for covered services. Other programs are available for inpatient services, but that is beyond the scope of this report. Other outpatient programs provide services to a much

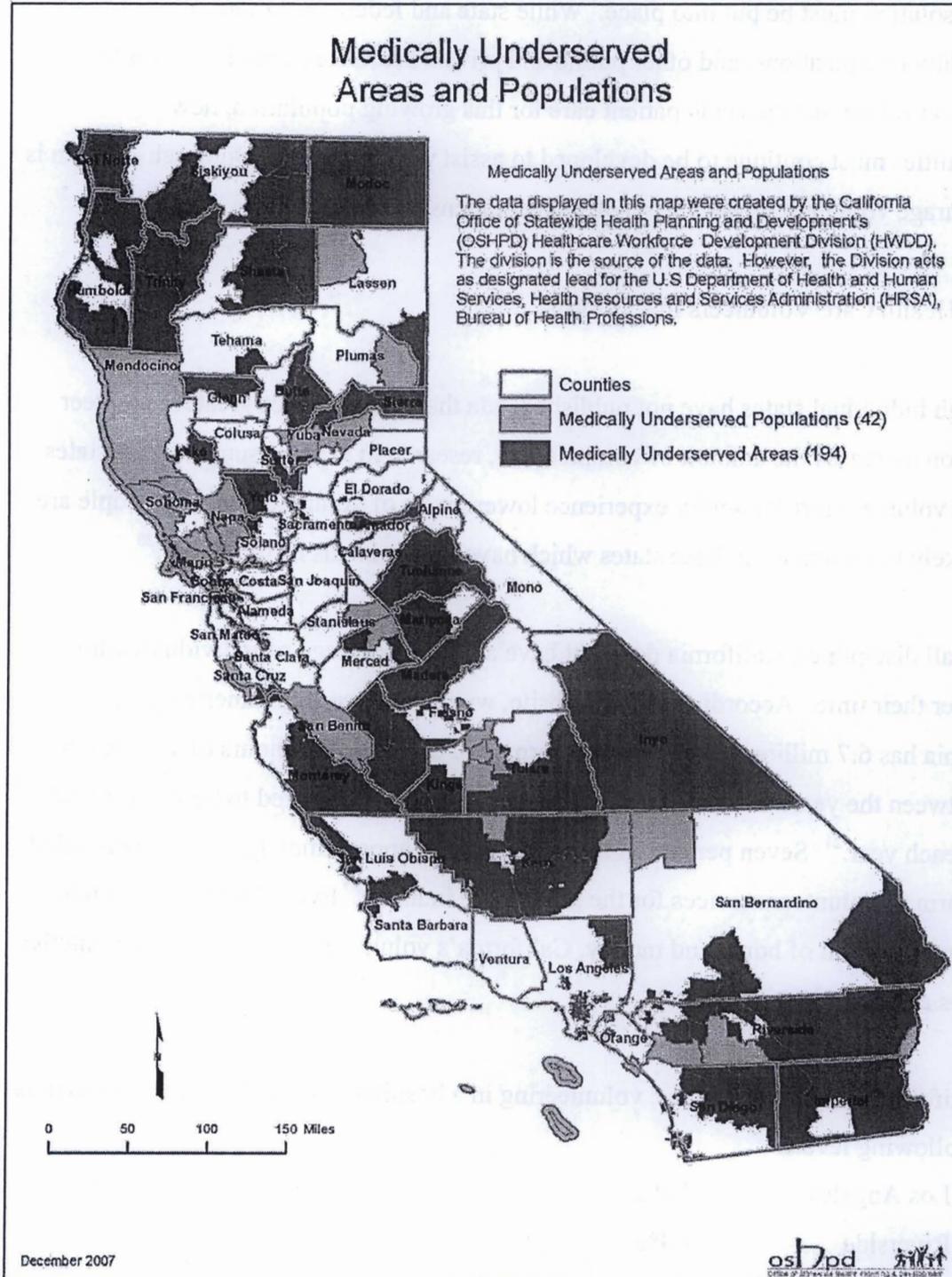
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smaller number of Californians: Cancer Control, Family PACT, Immunization and Tuberculosis Control, Children's Health and Disability Prevention Program, California Children's Services, and the Genetically Handicapped Persons Program.¹⁴

California has 850 licensed primary care clinics.¹⁵ In data from 2006, 379 of these clinics were Federally Qualified Health Centers (FQHS) and 76 were FQHS look-alikes. From 2005 data, 15% of all visits at primary care clinics were from patients who paid for care out of pocket or did not pay for care (1,297,539 patients were uninsured). When community and free clinics are considered, nearly 46% of patient visits were from the uninsured. Some counties receive reimbursement for these services while others do not. In 2005, uncompensated care in California was estimated to be \$421 million.¹⁶

Counties continue to be responsible for the uninsured population, but funds remain fixed or decline while need is increasing. California continues to have a high number of uninsured, despite coverage in existing programs.¹⁷ Indigent care programs are competing with other local spending programs. At the same time, realignment funds are decreasing as consumers spend less. Many county-run medical facilities experience fiscal difficulties and problems in managing costs. Some counties are using local managed care plans for administering and managing their indigent programs. Some counties have cut benefits or changed eligibility requirements.¹⁸ See Figure 1 for a map of areas and counties with medically underserved in California.

Figure 1. Medically Underserved Areas and Populations in California¹⁹



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To continue offering medical services to the indigent and uninsured population, a multi-faceted solution must be put into place. While state and federal programs, counties, community organizations, and other public and private healthcare entities are continuing to work on solutions to provide patient care for this growing population, new opportunities must continue to be developed to assist with this need. One such solution is to encourage volunteer physicians to offer uncompensated services.



B. Health Care Volunteers in California

Although individual states have not published data that demonstrates greater volunteer protection increases the amount of volunteerism, research in general suggests that states without volunteer tort immunity experience lower levels of volunteerism, and people are more likely to volunteer in those states which have higher levels of immunity.²⁰

Across all disciplines, California does not have a high percentage of individuals who volunteer their time. According to the website, www.volunteeringinamerica.gov, California has 6.7 million volunteers, who provided 896.4 million hours of service per year between the years 2005 and 2007. Those services are estimated to be worth \$17.5 billion each year.²¹ Seven percent of those volunteers (approximately 469,000) provided some form of volunteer services for the health care industry. Even though this sounds like a great amount of hours and money, California's volunteer rate ranks 42nd among the 50 states and Washington, D.C.

For California metropolitan areas, volunteering in a hospital or other health care system is at the following levels:²²

Los Angeles	7.0%
Riverside	7.4%
Sacramento	5.2%
San Diego	7.1%
San Francisco	7.4%
San Jose	6.7%

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These activities are not broken further down, so it is not possible to determine how many of those 469,000 volunteers providing health care related services are physicians. It is also not clear how many volunteer positions exist in California, much less the number of volunteer physician positions. A database search through the National Center for Charitable Statistics listed 4,148 nonprofit health care organizations in California as of June 6, 2008.

The Medical Board of California reports there are 125,014 licensed physicians in California.²³ Despite this number, there is an inadequate supply of physicians to care for the ever-increasing California population, especially those patients that have no insurance. Figure 2 shows areas of shortages, by both geographic designation and population designation.

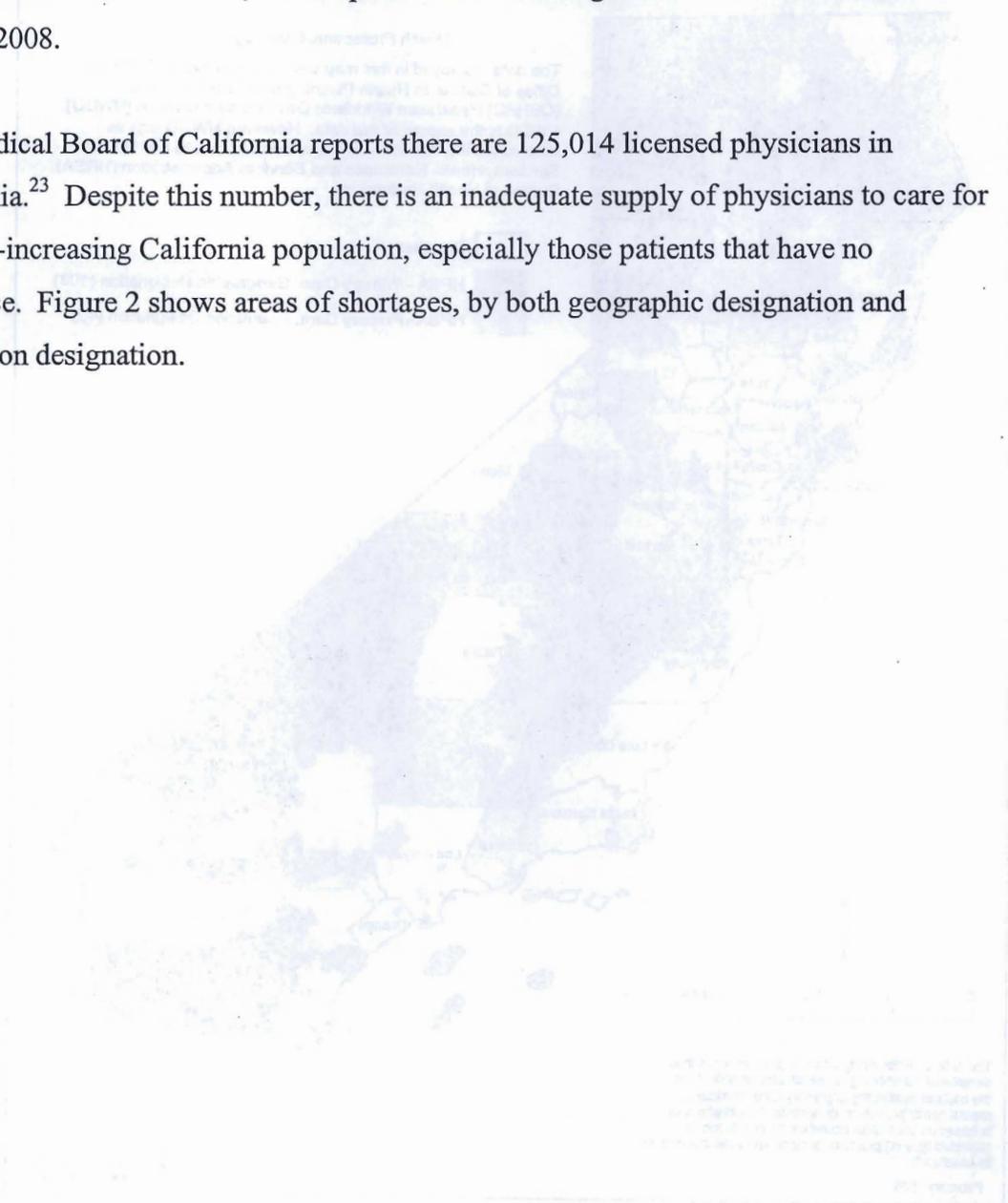
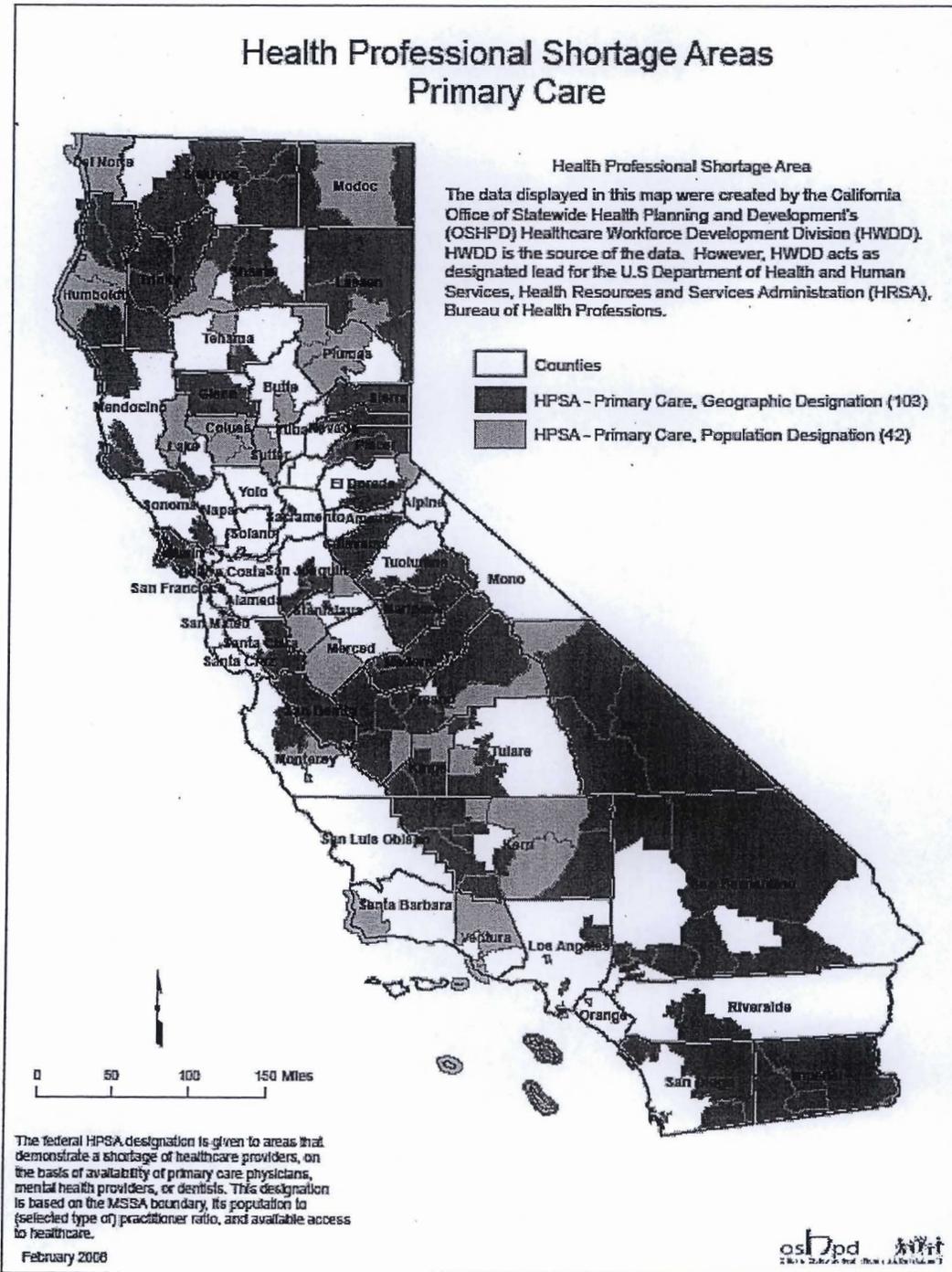


Figure 2. Primary Care Shortage Areas²⁴



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The Medical Board of California maintains a Physician Volunteer Registry, accessible through the Medical Board's website (www.publicdocs.medbd.ca.gov/volmd). The registry was created so that clinics and other health care entities may contact those physicians to provide volunteer services. The physicians listed in the registry have typically retired from private practice. The website explains that the registry was developed as a result of the Medical Board's Access to Care Committee's interest in increasing the availability of health care in California. The website advises clinics/health care entities that malpractice insurance will need to be provided to the volunteer. There are approximately 250 physicians in the registry. Specialties, along with city and county location, are listed. Therefore, this is a mechanism already established by the Medical Board to register volunteer physicians, but no mechanism in place to provide liability coverage to the physician who provides free care.



C. California Laws that Promote Physician Volunteerism

1. Immunity for emergency care

Although California does not have laws or regulations specific to reducing liability concerns of clinician volunteers in a non-emergency context, it does provide protections for physicians who render emergency care. Specifically, physicians who render care at the scene of an emergency or who provide volunteer on-call OB services to a hospital emergency room shall not be liable for his/her negligent acts. Additionally, immunity is provided for physicians rendering emergency care during college or high school athletic events.²⁵ Additionally, California Government Code Section 8659 provides immunity for physicians who provide medical services during a state of war or other state or local emergency.²⁶

2. Waiver of Licensing Fee

California is one of approximately 26 states in the U.S. that reduce or waive state licensing fees for certain physicians providing pro bono services. (See Appendix 1 for a summary of state licensure laws for volunteer physicians.)²⁷ Specifically, California

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Business & Professions Code Sections 2083(b) and 2442 state that the license fee shall be waived for a physician residing in California who certifies to the Medical Board of California that the issuance of the license or the renewal of the license is for the sole purpose of providing voluntary, unpaid service. There are currently 3,309 physicians residing in California whose license fees have been waived, but it is unlikely that any substantial percentage of those licentiates are providing voluntary medical service.²⁸ The physicians who want to provide free professional service still must pay malpractice premiums or work in entities that are willing to provide malpractice coverage to those volunteer physicians.

3. Telemedicine

California's comprehensive telemedicine legislation authorizes the practice of health care by telemedicine, in which a patient may be treated by a health care provider using interactive audio, video or data communication. Federal and state monies have been appropriated and used to enable providers throughout the state to establish telemedicine networks and links. Through telemedicine, a volunteer physician is able to electronically transport him or herself to a distant location, thus enabling the provider to serve patients in those geographically underserved areas without having to travel.

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Appendix 1: State Licensure and Liability Policies for Volunteer Physicians;

American Medical Association Publication, 2007

State	Volunteer/Limited License Offered	Liability Laws for Volunteer Physicians
Alabama	No provisions for volunteer or retired.	Medical professional who offers charitable services in established free medical clinic not liable for acts or omissions except for wanton misconduct. Requires notification of patients.
Alaska	No provisions for volunteer or retired.	No statute.
Arizona	Pro Bono license available for no fee. Must hold an active license from any state or territory or an active or inactive Arizona license. License is restricted to 60 days of practice per year.	Arizona law establishes immunity for volunteers acting in good faith and within the scope of volunteer duties for government entities or nonprofit corporations, organizations or hospitals. Vicarious liability of the organization can be established if the volunteer was working in the scope of official duties and functions.
Arkansas	No provisions for volunteer or retired.	Immunity for volunteers from civil liability unless gross negligence or willful misconduct. For immunity to apply, the patient must acknowledge the physician's immunity from civil suit. If the volunteer has liability insurance, liability is limited to the limit of the insurance policy. Statute references retired volunteer physicians

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California	Volunteer Service License, no fee. Retired license, no fee.	No statute.
Colorado	No provisions for volunteer or retired.	No civil liability except for wanton misconduct willful negligence. Patient must have notice of limited liability.
Connecticut	No provisions for volunteer or retired.	Charitable immunity for non-profit volunteer. Specifically references volunteer health care professional, retired physicians, certain health care settings, and limited to certain services.
Delaware	No provisions for volunteer or retired.	Charitable immunity for non-profit volunteer. Specifically references volunteer health care professional, retired physicians, certain health care settings, and limited to certain services.
District of Columbia	No provisions for volunteer or retired.	Licensed physicians who, in good faith, provide health care or treatment at or on behalf of a free health clinic without the expectation of receiving or intending to receive compensation shall not be liable in civil damages for any act or omission in the course of rendering the health care or treatment, unless the act or omission is an intentional wrong or manifests a willful or wanton disregard for the health or safety of others. In order to qualify for this immunity, physicians must require prospective patients to sign a written statement witnessed by two persons in which the parties agree to the rendering of the health care or treatment.

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		Free clinics that cannot afford liability insurance and their volunteers can be part of a federal indemnity program and are considered District employees for indemnification purposes.
Florida	Limited license is available for retired physicians wishing to volunteer services, no fee. Must practice in a government or 501c(3) organization in an area to be determined to be an area of critical need by the board.	Volunteer for a non-profit is not liable except for gross or negligent misconduct. Patients must receive prior notice of limited liability.
Georgia	Volunteer in Medicine license, no fee.	Volunteer for a non-profit or government organization such as a physician who renders care without the expectation of compensation, is granted civil immunity except for gross or negligent misconduct. Patients must receive prior notice of limited liability.
Hawaii	No provisions for volunteer or retired.	Not liable unless wanton misconduct or willful negligence IF the organization carries liability insurance of no less than 200K for single occurrence OR if the organization has less than 50K in assets.
Idaho	No provisions for volunteer or retired.	Health care provider at charitable clinic is immune from liability – if liability insurance exists, person is liable to the extent of the policy. Patients must

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		receive prior notice of limited liability.
Illinois	No provisions for volunteer or retired.	A physician who volunteers services at a free medical clinic to the indigent is exempt from civil liability except for wanton misconduct or gross negligence. Patients must receive prior notice of limited liability.
Indiana	Retired inactive status – can practice with no restrictions as long as there is no compensation. Fee of \$100 every 2 years. Must be fully licensed in Indiana prior to application. Physicians from other states wishing to volunteer in Indiana are limited to 30 days of practice per year with a Limited Scope license.	A health care provider, including a retired physician, who voluntarily provides health care at a medical clinic or health care facility is immune from civil liability arising from the care provided, unless in delivering care the provider's acts or omissions constitute a criminal act, gross negligence, or willful or wanton misconduct.
Iowa	No provisions for volunteer or retired.	Iowa legislators established a volunteer physician program within the Iowa Department of Public Health which provides for immunity from liability in certain circumstances. These circumstances include instances when a physician, registered with the Department as being part of the program, provides free medical care at specified hospitals and clinics. While delivering free care under the program, a physician is considered an employee of

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		the state and receive certain immunity from liability.
Kansas	Exempt status for retired physicians to provide direct patient care gratuitously. Reduced fee.	Volunteer of a non-profit is not liable if the organization has liability insurance, health care not specifically named.
Kentucky	No provisions for volunteer or retired.	Volunteer for a non-profit is not liable except for wanton misconduct or gross negligence.
Louisiana	No provisions for volunteer or retired.	Health care worker providing free care in a community health clinic is not liable for acts or omission in rendering care or for an act or failure to act in providing or arranging for further services. This immunity from liability is valid only if the patient was notified of the limited liability.
Maine	Retired physician license for those doing volunteer work.. Fee is \$75.	Maine grants civil liability immunity for physicians (including retired) who voluntarily render uncompensated medical care for a nonprofit organization or agency of the state, except in the case of wanton misconduct or willful negligence.

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<p>Maryland</p>	<p>Special volunteer license with no fee. Must submit the form to the volunteer agency and attest to the fact that the license will be used only in volunteer capacity.</p>	<p>Maryland provides civil immunity from personal liability to volunteers who render certain services under specified circumstances.</p> <p>Circumstances include health care providers or physicians who render health care services voluntarily and without compensation to any person seeking health care through a charitable organization chartered to provide health care services to homeless and indigent patients.</p> <p>Such volunteers are not liable for any amount in excess of any applicable limit of insurance coverage in any suit for civil damages for any act or omission resulting from the rendering of such services, unless the act or omission constitutes: a) willful or wanton misconduct, b) gross negligence, or c) intentionally tortuous conduct.</p>
<p>Massachusetts</p>	<p>No provisions for volunteer or retired.</p>	<p>Limit on liability to 20K for a charitable organization. Healthcare worker not liable for volunteer care.</p>
<p>Michigan</p>	<p>No provisions for volunteer or retired.</p>	<p>Law protects physicians from liability for care provided at a free clinic, or care provided as a result of a referral from a free clinic. Patients must receive prior notice of limited liability.</p>

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Minnesota	No provisions for volunteer or retired.	Physicians in certain charitable health care settings performing limited services are immune.
Mississippi	License for retired physicians who wish to volunteer services. Valid for one year, No fee.	Mississippi grants immunity from liability for any civil action to a licensed physician who, in good faith on a charitable basis, voluntarily provides medical or health services to any person without the expectation of payment. Immunity will only be extended if the physician and patient execute a written waiver in advance of the rendering of medical services, specifying that such services are provided without the expectation of payment and that the physician shall be immune from liability, unless the act or omission is the result of the physician's gross negligence or willful misconduct.
Missouri	Limited license for retired physicians who have practiced for at least 10 years. Some restrictions on services physician can offer – e.g. no controlled substances. Fee not to exceed \$25.	Volunteer at a non-profit is immune to liability with the exception of willful or wanton misconduct or gross negligence. Physicians specifically mentioned.
Montana	No provisions for volunteer or retired.	A healthcare practitioner who provides free service is not liable for civil damages with the exception of wanton misconduct, so long as patients receive

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		prior notice of limited liability
Nebraska	No provisions for volunteer or retired.	Directors, officers and trustees of non-profit organization are immune from liability, no specific mention on physicians or volunteers in the organizations. No charitable immunity for volunteer health care providers.
Nevada	Special volunteer license, requires acknowledgement of no compensation and care only for indigent. No fee. Renewable annually. New legislation.	Civil immunity for physicians, including retired physicians, who offer free care and/or provide emergency obstetrical services except for willful or wanton misconduct.
New Hampshire	No provisions for volunteer or retired.	A volunteer in a non-profit organization is immune from civil liability as long as the volunteer is documented by the organization. Exception for wanton misconduct. Additionally, New Hampshire grants certain retired physicians immunity from civil liability for volunteer health education services.
New Jersey	Special volunteer license, but must practice under the supervision of a fully-licensed physician. No fee.	Volunteer health care providers are not personally liable for damages caused except if there is gross negligence or wanton misconduct.
New Mexico	No provisions for volunteer or retired.	No statutes for charitable immunity. Grants immunity only to public employees including physicians, psychologists or dentists providing services to the corrections dept and children, youth and families dep't. Only

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		mention of immunity for directors of a charitable organization.
New York	No registration renewal fee for non-compensated physicians. Must file affidavit of non-compensation. Some restrictions on practice.	No statutes for volunteers of a non-profit or volunteer organization.
North Carolina	Limited Volunteer License to serve indigent. Reduced fee.	Volunteers for charitable organizations are not liable for loss or damages or death except in cases of willful misconduct and wanton negligence.
North Dakota	No provision for volunteer. Offer retired Emeritus status for \$150 per year, but cannot practice or prescribe (more honorary).	A health care provider who renders services at a free clinic is not liable in a personal injury civil action, except for willful or wanton misconduct.
Ohio	Volunteer certificate for those who are retired and have practiced for at least 10 years. No fee. Some restrictions on services e.g. cannot deliver babies, perform surgery. Valid for 3 years.	Ohio provides physicians, retired physicians, other health care professionals, and shelters or health care facilities with qualified immunities from civil liability for providing free diagnoses, care, and treatment to indigent or uninsured patients at certain facilities. Patients must receive prior notice of limited liability.
Oklahoma	Volunteer license – new statute to go into effect November 1, 2003.	A volunteer of a charitable or non-profit organization is not liable but in cases of willful misconduct, however, the organization is liable. Oklahoma enacted a provision which relieves volunteers of

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		liability for punitive damages when providing services to nonprofit organizations unless those volunteers are currently offering the same service for profit.
Oregon	Emeritus status license for retired volunteers. Must first have active full license. \$50 per year.	A physician who volunteers services to a charitable organization is not liable for damages with the exception of gross negligence.
Pennsylvania	Volunteer license for retired physicians. No liability insurance requirement. Can be renewed every 2 years. Requires verification from the director of the approved clinic that the physician has been authorized to provide volunteer services.	A physician who holds a volunteer license under the volunteer health services act (retired physician) is not liable for damages with the exception of sub-standard care. This immunity is valid only if such a statement of immunity is posted in a conspicuous place in the clinic. This immunity does not apply to institutional healthcare organizations who hold vicarious liability for the volunteer license holder.
Rhode Island	Active Emeritus status for physicians who are 70+ and who have practiced for 15+ years in RI. Reduced fee of \$25 for license.	A person who volunteers without compensation in a non-profit or charitable organization is not liable with the exception of gross negligence.
South Carolina	Volunteer limited license for practice in underserved areas. Renewable annually. No fee. Must practice under a supervisory physician.	South Carolina law provides that no licensed health care provider, who provides voluntary medical services without compensation, is liable for any civil damages arising out of acts or omissions resulting from the services

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		rendered, unless due to gross negligence or willful misconduct. Immunity extends only if the agreement to provide voluntary, uncompensated services is made before the rendering of services by the provider.
South Dakota	No provisions for volunteer or retired.	South Dakota provides immunity from civil liability for health care professionals volunteering health care services at free clinics. The immunity extends to damages or injuries arising from care provided in good faith and within the scope of the provider's official function. Immunity does not apply to gross negligence and willful misconduct.
Tennessee	Volunteer license is available for those who practice in a not-for-profit clinic. No fee.	Liability insurance companies for healthcare providers may not exclude those who volunteer their services. No specific language for non-profit or charitable volunteer immunity, only directors.
Texas	Voluntary Charity Care license – must sign affidavit that care will be given for free. Renewable annually, no fee. No restrictions of practice.	The Act provides physician volunteers immunity for performing non-emergency care for certain charitable organizations. volunteer is a person rendering services for a charitable organization who does not receive compensation in excess of reimbursement for expenses incurred. This includes a person serving as a director, officer, trustee, or direct service

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		<p>volunteer, including a volunteer health care provider. “A volunteer health care provider is an individual who voluntarily provides health care services without compensation or expectation of compensation and who meets one of the ten types of health care providers included in the law. The first option is that the volunteer health care provider is an individual licensed to practice medicine under the Medical Practice Act. A second alternative is that the volunteer health care provider is a retired physician who is eligible to provide health care services, including a retired physician who is licensed but exempt from paying the required annual registration fee. Patients must receive prior notice of limited liability.”</p>
Utah	No provisions for volunteer or retired.	A health care provider who volunteers services at a health care facility and a facility that sponsors uncompensated health treatment is not liable in a malpractice suit.
Vermont	No provisions for volunteer or retired.	No specific mention of charitable immunity or volunteer health care providers in particular.
Virginia	No provisions for volunteer or retired.	Virginia law grants immunity from liability to health care providers who provide health care services to patients of a clinic which is organized for the

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		delivery of health care services without charge and allows such providers, hospitals, and clinics to charge a reasonable minimum fee and still be afforded immunity, except for gross negligence.
Washington	Retired Active status license. Can be used for uncompensated practice of up to 90 days per year. Reduced fee, 2 year license.	Limited liability for physicians in certain settings; Charitable immunity exists for retired physicians.
West Virginia	A volunteer license to work in a volunteer clinic can be applied for if the physician holds an active license. No fee. Renewable annually.	A physician with a volunteer license (retired physician) who renders service to needy people is immune from civil liability. Exception for gross negligence.
Wisconsin	No provisions for retired or volunteer. If practice is less than 240 hours/year, does not have to pay into Patient's Compensation Fund.	Volunteers of non-profit corporations are not liable, no specific mention of physicians other than in emergency and athletic circumstances.
Wyoming	New retired volunteer license statute effective 7/1/03. Must show proof of license in good standing immediately prior to retirement in any jurisdiction for minimum of 10 years. No fee, but must sign affidavit that they are not being compensated each year. Renewable annually.	Non-profit is liable for negligence of its volunteers. The volunteer is not individually liable unless gross misconduct or negligence. No specific mention of volunteer healthcare providers.

MODEL TYPE: Statutory Immunity - Change in the Standard of Care

ARIZONA

A.R.S. § 12-982

12-982. Qualified immunity; insurance coverage

A. A volunteer is immune from civil liability in any action based on an act or omission of a volunteer resulting in damage or injury if:

1. The volunteer acted in good faith and within the scope of the volunteer's official functions and duties for a nonprofit corporation or nonprofit organization, hospital or governmental entity.
2. The damage or injury was not caused by willful, wanton or grossly negligent misconduct by the volunteer.

B. Notwithstanding subsection A of this section, in any suit against a nonprofit corporation or nonprofit organization, hospital or governmental entity for civil damages based on the negligent act or omission of a volunteer, proof that the act or omission was within the scope of the volunteer's official functions and duties is sufficient to establish the vicarious liability, if any, of the organization.

C. A motor vehicle liability policy, as defined in § 28-4001, which provides coverage to the operator of a motor vehicle is subject to the following provisions which need not be contained in the policy. The liability of the insurance carrier with respect to the insured and any other person using the vehicle with the express or implied permission of the insured shall extend to provide excess coverage for a nonprofit corporation or nonprofit organization for the acts of the operator in operating a motor vehicle at all times when the operator is acting as a volunteer for that nonprofit corporation or nonprofit organization.

A.R.S. § 12-571

12-571. Qualified immunity; health professionals; nonprofit clinics; previously owned prescription eyeglasses

A. A health professional, as defined in § 32-3201, who provides medical or dental treatment within the scope of the health professional's certificate or license at a nonprofit clinic where neither the professional nor the clinic receives compensation for any treatment provided at the clinic is not liable in a medical malpractice action, unless such health professional was grossly negligent.

B. A health professional who, within the professional's scope of practice, provides previously owned prescription eyeglasses free of charge through a charitable, nonprofit or fraternal organization is not liable for an injury to the recipient if the recipient or the recipient's parent or legal guardian has signed a medical malpractice release form and the injury is not a direct result of the health professional's intentional misconduct or gross

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negligence. For purposes of this subsection, "medical malpractice release form" means a document that the recipient or the recipient's parent or legal guardian signs before the recipient receives eyeglasses pursuant to this subsection to acknowledge that the eyeglasses were not made specifically for the recipient and to accept full responsibility for the recipient's eye safety.

MODEL TYPE: Sovereign Immunity: "State Actor"

FLORIDA

Florida Department of Health: Volunteer Health Services Program

The Florida Department of Health (DOH) administers the Volunteer Health Services Program in the Division of Health Access and Tobacco. The program supports the department's volunteer efforts in eleven regions throughout the state. A DOH volunteer coordinator is assigned to each region. Regional coordinators work with DOH entities, community, and faith based health care providers to promote access to quality health care for the medically underserved and uninsured residents of Florida through the commitment of volunteers.

The Volunteer Health Services Program accomplishes its mission through two volunteer programs authorized by Chapters 110 and 776, Florida Statutes.

The Chapter 110 volunteer program, an internal state agency program, provides opportunities for anyone who wants to donate goods and/or their services to those in need under the supervision of the Department of Health. A variety of volunteer opportunities are available in many DOH facilities to individuals with clerical, administrative, technical and professional skills.

The Volunteer Health Care Provider Program, s. 766.1115, F.S., allows private licensed health care providers to volunteer their services to the medically indigent residents of Florida with incomes at or below 200% of the Federal Poverty Level and be under the state's sovereign immunity. Through a contract, a provider can be designated an "agent of the state" and have sovereign immunity for uncompensated services rendered to clients determined eligible and referred by DOH. Under this program, providers have the option to volunteer in freestanding clinics or to see eligible clients in their private offices or corporate facilities.

Florida Statute Chapter 110.501-110.504

110.501 Definitions.--As used in this act:

(1) "Volunteer" means any person who, of his or her own free will, provides goods or services, or conveys an interest in or otherwise consents to the use of real property pursuant to chapter 260, to any state department or agency, or nonprofit organization, with no monetary or material compensation. A person registered and serving in Older American Volunteer Programs authorized by the Domestic Volunteer Service Act of 1973, as amended (Pub. L. No. 93-113), shall also be defined as a volunteer and shall incur no civil liability as provided by s. 768.1355. A volunteer shall be eligible for payment of volunteer benefits as specified in Pub. L. No. 93-113, this section, and s. 430.204.

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(2) "Regular-service volunteer" means any person engaged in specific voluntary service activities on an ongoing or continuous basis.

(3) "Occasional-service volunteer" means any person who offers to provide a one-time or occasional voluntary service.

(4) "Material donor" means any person who provides funds, materials, employment, or opportunities for clients of state departments or agencies, without monetary or material compensation.

110.502 Scope of act; status of volunteers.--

(1) Every state department or state agency, through the head of the department or agency, secretary of the department, or executive director of the department, is authorized to recruit, train, and accept, without regard to requirements of the State Career Service System as set forth in part II of this chapter, the services of volunteers, including regular service volunteers, occasional-service volunteers, or material donors, to assist in programs administered by the department or agency.

(2) Volunteers recruited, trained, or accepted by any state department or agency shall not be subject to any provisions of law relating to state employment, to any collective bargaining agreement between the state and any employees' association or union, or to any laws relating to hours of work, rates of compensation, leave time, and employee benefits, except those consistent with s. 110.504. However, all volunteers shall comply with applicable department or agency rules.

(3) Every department or agency utilizing the services of volunteers is hereby authorized to provide such incidental reimbursement or benefit consistent with the provisions of s. 110.504, including transportation costs, lodging, and subsistence, recognition, and other accommodations as the department or agency deems necessary to assist, recognize, reward, or encourage volunteers in performing their functions. No department or agency shall expend or authorize an expenditure therefor in excess of the amount provided for to the department or agency by appropriation in any fiscal year.

(4) Persons working with state agencies pursuant to this part shall be considered as unpaid independent volunteers and shall not be entitled to unemployment compensation.

110.503 Responsibilities of departments and agencies.--Each department or agency utilizing the services of volunteers shall:

(1) Take such actions as are necessary and appropriate to develop meaningful opportunities for volunteers involved in state-administered programs.

(2) Comply with the uniform rules adopted by the Department of Management Services governing the recruitment, screening, training, responsibility, use, and supervision of volunteers.

(3) Take such actions as are necessary to ensure that volunteers understand their duties

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and responsibilities.

- (4) Take such actions as are necessary and appropriate to ensure a receptive climate for citizen volunteers.
- (5) Provide for the recognition of volunteers who have offered continuous and outstanding service to state-administered programs. Each department or agency using the services of volunteers is authorized to incur expenditures not to exceed \$100 each plus applicable taxes for suitable framed certificates, plaques, or other tokens of recognition to honor, reward, or encourage volunteers for their service.
- (6) Recognize prior volunteer service as partial fulfillment of state employment requirements for training and experience pursuant to rules adopted by the Department of Management Services.

110.504 Volunteer benefits.--

- (1) Meals may be furnished without charge to regular-service volunteers serving state departments, provided the scheduled assignment extends over an established meal period, and to occasional-service volunteers at the discretion of the department head. No department shall expend or authorize any expenditure in excess of the amount provided for by appropriation in any fiscal year.
- (2) Lodging, if available, may be furnished temporarily, in case of a department emergency, at no charge to regular-service volunteers.
- (3) Transportation reimbursement may be furnished those volunteers whose presence is determined to be necessary to the department. Volunteers may utilize state vehicles in the performance of department-related duties. No department shall expend or authorize an expenditure in excess of the amount appropriated in any fiscal year.
- (4) Volunteers shall be covered by state liability protection in accordance with the definition of a volunteer and the provisions of s. 768.28.
- (5) Volunteers shall be covered by workers' compensation in accordance with chapter 440.
- (6) Incidental recognition benefits or incidental nonmonetary awards may be furnished to volunteers serving in state departments to award, recognize, or encourage volunteers for their service. The awards may not cost in excess of \$100 each plus applicable taxes.
- (7) Volunteers, including volunteers receiving a stipend as provided by the Domestic Service Volunteer Act of 1973, as amended (Pub. L. No. 93-113), shall be covered by s. 768.1355, the Florida Volunteer Protection Act.

Florida Statute 766.1115

766.1115 Health care providers; creation of agency relationship with governmental contractors.--

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(1) SHORT TITLE.--This section may be cited as the "Access to Health Care Act."

(2) FINDINGS AND INTENT.--The Legislature finds that a significant proportion of the residents of this state who are uninsured or Medicaid recipients are unable to access needed health care because health care providers fear the increased risk of medical negligence liability. It is the intent of the Legislature that access to medical care for indigent residents be improved by providing governmental protection to health care providers who offer free quality medical services to underserved populations of the state. Therefore, it is the intent of the Legislature to ensure that health care professionals who contract to provide such services as agents of the state are provided sovereign immunity.

(3) DEFINITIONS.--As used in this section, the term:

(a) "Contract" means an agreement executed in compliance with this section between a health care provider and a governmental contractor. This contract shall allow the health care provider to deliver health care services to low-income recipients as an agent of the governmental contractor. The contract must be for volunteer, uncompensated services. For services to qualify as volunteer, uncompensated services under this section, the health care provider must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient, or any public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract.

(b) "Department" means the Department of Health.

(c) "Governmental contractor" means the department, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.
2. An ambulatory surgical center licensed under chapter 395.
3. A hospital licensed under chapter 395.
4. A physician or physician assistant licensed under chapter 458.
5. An osteopathic physician or osteopathic physician assistant licensed under chapter 459.
6. A chiropractic physician licensed under chapter 460.
7. A podiatric physician licensed under chapter 461.
8. A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this

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section.

9. A midwife licensed under chapter 467.
10. A health maintenance organization certificated under part I of chapter 641.
11. A health care professional association and its employees or a corporate medical group and its employees.
12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.
13. A dentist or dental hygienist licensed under chapter 466.
14. A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.
15. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9. The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

(e) "Low-income" means:

1. A person who is Medicaid-eligible under Florida law;
2. A person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or
3. Any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.

(4) CONTRACT REQUIREMENTS.--A health care provider that executes a contract with a governmental contractor to deliver health care services on or after April 17, 1992, as an agent of the governmental contractor is an agent for purposes of s. 768.28(9), while acting within the scope of duties under the contract, if the contract complies with the

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requirements of this section and regardless of whether the individual treated is later found to be ineligible. A health care provider under contract with the state may not be named as a defendant in any action arising out of medical care or treatment provided on or after April 17, 1992, under contracts entered into under this section. The contract must provide that:

- (a) The right of dismissal or termination of any health care provider delivering services under the contract is retained by the governmental contractor.
 - (b) The governmental contractor has access to the patient records of any health care provider delivering services under the contract.
 - (c) Adverse incidents and information on treatment outcomes must be reported by any health care provider to the governmental contractor if the incidents and information pertain to a patient treated under the contract. The health care provider shall submit the reports required by s. 395.0197. If an incident involves a professional licensed by the Department of Health or a facility licensed by the Agency for Health Care Administration, the governmental contractor shall submit such incident reports to the appropriate department or agency, which shall review each incident and determine whether it involves conduct by the licensee that is subject to disciplinary action. All patient medical records and any identifying information contained in adverse incident reports and treatment outcomes which are obtained by governmental entities under this paragraph are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
 - (d) Patient selection and initial referral must be made solely by the governmental contractor, and the provider must accept all referred patients. However, the number of patients that must be accepted may be limited by the contract, and patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or chapter 395.
 - (e) If emergency care is required, the patient need not be referred before receiving treatment, but must be referred within 48 hours after treatment is commenced or within 48 hours after the patient has the mental capacity to consent to treatment, whichever occurs later.
 - (f) Patient care, including any followup or hospital care, is subject to approval by the governmental contractor.
 - (g) The provider is subject to supervision and regular inspection by the governmental contractor.
- A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

(5) NOTICE OF AGENCY RELATIONSHIP.--The governmental contractor must

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provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of s. 768.28. With respect to any federally funded community health center, the notice requirements may be met by posting in a place conspicuous to all persons a notice that the federally funded community health center is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of s. 768.28.

(6) QUALITY ASSURANCE PROGRAM REQUIRED.--The governmental contractor shall establish a quality assurance program to monitor services delivered under any contract between an agency and a health care provider pursuant to this section.

(7) RISK MANAGEMENT REPORT.--The Division of Risk Management of the Department of Financial Services shall annually compile a report of all claims statistics for all entities participating in the risk management program administered by the division, which shall include the number and total of all claims pending and paid, and defense and handling costs associated with all claims brought against contract providers under this section. This report shall be forwarded to the department and included in the annual report submitted to the Legislature pursuant to this section.

(8) REPORT TO THE LEGISLATURE.--Annually, the department shall report to the President of the Senate, the Speaker of the House of Representatives, and the minority leaders and relevant substantive committee chairpersons of both houses, summarizing the efficacy of access and treatment outcomes with respect to providing health care services for low-income persons pursuant to this section.

(9) MALPRACTICE LITIGATION COSTS.--Governmental contractors other than the department are responsible for their own costs and attorney's fees for malpractice litigation arising out of health care services delivered pursuant to this section.

(10) RULES.--The department shall adopt rules to administer this section in a manner consistent with its purpose to provide and facilitate access to appropriate, safe, and cost-effective health care services and to maintain health care quality. The rules may include services to be provided and authorized procedures. Notwithstanding the requirements of paragraph (4)(d), the department shall adopt rules that specify required methods for determination and approval of patient eligibility and referral and the contractual conditions under which a health care provider may perform the patient eligibility and referral process on behalf of the department. These rules shall include, but not be limited to, the following requirements:

(a) The provider must accept all patients referred by the department. However, the

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number of patients that must be accepted may be limited by the contract.

(b) The provider shall comply with departmental rules regarding the determination and approval of patient eligibility and referral.

(c) The provider shall complete training conducted by the department regarding compliance with the approved methods for determination and approval of patient eligibility and referral.

(d) The department shall retain review and oversight authority of the patient eligibility and referral determination.

(11) APPLICABILITY.--This section applies to incidents occurring on or after April 17, 1992. This section does not apply to any health care contract entered into by the Department of Corrections which is subject to s. 768.28(10)(a). Nothing in this section in any way reduces or limits the rights of the state or any of its agencies or subdivisions to any benefit currently provided under s. 768.28.

MODEL TYPE: State-Purchased Liability Insurance

WASHINGTON STATE

Washington 43.70.460. Retired primary and specialty care provider liability malpractice insurance—Program Authorized

(1) The department may establish a program to purchase and maintain liability malpractice insurance for retired primary and specialty care providers who provide health care services to low-income patients. The following conditions apply to the program:

(a) Health care services shall be provided at clinics serving low-income patients that are public or private taxexempt corporations or other established practice settings as defined by the department;

(b) Health care services provided at the clinics shall be offered to low-income patients based on their ability to pay;

(c) Retired health care providers providing health care services shall not receive compensation for their services; and

(d) The department shall contract only with a liability insurer authorized to offer liability malpractice insurance in the state.

(e) Specialists in this program will be limited to those whose malpractice insurance premiums are comparable to primary care providers.

(2) This section and RCW 43.70.470 shall not be interpreted to require a liability insurer to provide coverage to a health care provider should the insurer determine that coverage should not be offered to a health care provider because of past claims experience or for other appropriate reasons.

(3) The state and its employees who operate the program shall be immune from any civil or criminal action involving claims against clinics or health care providers that provided health care services under this section and RCW 43.70.470. This protection of immunity shall not extend to any clinic or health care provider participating in the program.

(4) The department may monitor the claims experience of retired health care providers covered by liability insurers contracting with the department.

(5) The department may provide liability insurance under chapter 113, Laws of 1992 only to the extent funds are provided for this purpose by the legislature. If there are insufficient funds to support all applications for liability insurance coverage, priority shall be given to those retired health care providers working at clinics operated by

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public or private tax-exempt corporations rather than clinics operated by for-profit corporations.

Washington RCW 4.24.300

Immunity from liability for certain types of medical care.

(1) Any person, including but not limited to a volunteer provider of emergency or medical services, who without compensation or the expectation of compensation renders emergency care at the scene of an emergency or who participates in transporting, not for compensation, therefrom an injured person or persons for emergency medical treatment shall not be liable for civil damages resulting from any act or omission in the rendering of such emergency care or in transporting such persons, other than acts or omissions constituting gross negligence or willful or wanton misconduct. Any person rendering emergency care during the course of regular employment and receiving compensation or expecting to receive compensation for rendering such care is excluded from the protection of this subsection.

(2) Any licensed health care provider regulated by a disciplining authority under RCW 18.130.040 in the state of Washington who, without compensation or the expectation of compensation, provides health care services at a community health care setting is not liable for civil damages resulting from any act or omission in the rendering of such care, other than acts or omissions constituting gross negligence or willful or wanton misconduct.

(3) For purposes of subsection (2) of this section, "community health care setting" means an entity that provides health care services and:

(a) Is a clinic operated by a public entity or private tax exempt corporation, except clinic that is owned, operated, or controlled by a hospital licensed under chapter 70.41 RCW unless the hospital-based clinic either:

(i) Maintains and holds itself out to the public as having established hours on a regular basis for providing free health care services to members of the public to the extent that care is provided without compensation or expectation of compensation during those established hours; or

(ii) Is participating, through a written agreement, in a community-based program to provide access to health care services for uninsured persons, to the extent that:

(A) Care is provided without compensation or expectation of compensation to individuals who have been referred for care through that community-based program; and

(B) The health care provider's participation in the community-based program is conditioned upon his or her agreement to provide health services without expectation of compensation;

(b) Is a for-profit corporation that maintains and holds itself out to the public as having established hours on a regular basis for providing free health care services to members of

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the public to the extent that care is provided without compensation or expectation of compensation during those established hours; or

(c) Is a for-profit corporation that is participating, through a written agreement, in a community-based program to provide access to health care services for uninsured persons, to the extent that:

(i) Care is provided without compensation or expectation of compensation to individuals who have been referred for care through that community-based program; and

(ii) The health care provider's participation in the community-based program is conditioned upon his or her agreement to provide health services without expectation of compensation.

IV. The Cost of Providing Malpractice Coverage

The cost of insurance or the funding of a state-run risk pool would vary substantially based on the statutory protections (if any) the State of California would adopt.

A. Statutory Immunity- Change in the Standard of Care

If state law made volunteer physicians immune for common negligence similar to the model adopted by Arizona, Oregon, Virginia, Washington and Wisconsin, then the cost of purchased insurance would be significantly less.

Arizona, for example, is a state that has statutory immunity for physician volunteers in which the physician would only be liable if he/she committed gross negligence. Therefore, the cost of insuring the volunteer is substantially less than if the volunteer would be liable for common negligence. The Mutual Insurance Company of Arizona (MICA) offers volunteer insurance coverage to retired physicians who wish to continue providing medical care.⁷⁵ According to Robin Charles of MICA, the policy only provides coverage to the physician when he/she provides care on a voluntary basis with or without direct remuneration. Guidelines have been established to limit the scope of practice and liability exposure: the volunteer retired physician must have a valid medical license or permit from the appropriate licensing board; services must be rendered on a volunteer basis with no financial compensation; services must be provided at an approved facility with liability coverage acceptable to MICA; the volunteer retired physician must have been a prior MICA insured physician before applying for this limited coverage policy and was issued a MICA extended reporting endorsement (tail coverage); and the applicant must have retired while insured with MICA. The physician is insured for \$1,000,000 per occurrence; \$3,000,000 aggregate. The cost of the insurance per year is

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\$100. Since the inception of the MICA program, there have been no losses or claims involving the retired physicians.

B₂ State Actor Immunity

If California considered volunteer physicians as “state actors” similar to the model adopted by Florida or Georgia, then there would be no cost to the state, but the professional liability risk exposure would increase. Since California currently does not purchase medical malpractice insurance for its physician employees, nor does it maintain a risk pool for professional liability claims, it would be difficult to assess a cost of liability for the “state actor” model.

Limited data is available from other states that have adopted the “state actor” model for physician volunteers. From our extensive research, we could find no evidence that those “state actor” immunity states maintain a self-insured risk pool for potential claims. As referenced earlier in this report, the state of Florida does maintain good data about its claims history. Florida reports that the Program’s total patient visits for fiscal year 2006-07 was 290,026. In 2006-07, Florida reports nine claims were filed against the Volunteer Health Care Provider Program. Defense costs were just over \$550,000. Settlement costs were \$293,000.

In April, 2007, the State of Wisconsin proposed legislation that would make volunteer health care providers “state actors” when providing health care free of charge to patients of non-profit entities. In its fiscal analysis of the bill, the state’s Division of Executive Budget and Finance concluded the fiscal effect of this bill is “Indeterminate”. The financial analysis concluded, “If these volunteer health care providers were added to the department for liability purposes, and claims were made against them, the department’s liability premiums would also increase. However, the amount by which the premiums will increase as a result of the bill cannot be estimated.”⁷⁶

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There does not appear to be an identified methodology to determine the fiscal impact of a sovereign immunity model. Currently, the State of California maintains no data about the number of clinical physicians it employs in the state or the number of claims, or dollars expended in the defense/settlement/judgment of those claims.⁷⁷ The State of California does not maintain a risk pool/self insurance program for professional liability; nor does it purchase umbrella coverage for medical malpractice. The state's Attorney General is responsible for the defense of any claim brought by the state, and all costs, settlements or judgments associated with the claim are paid by the state agency or by the General Fund.⁷⁸ Therefore, it is not possible to determine what the additional cost to the state would be if physician volunteers would be deemed state actors when providing voluntary, uncompensated care.

C. Purchased Insurance

If California adopted legislation that would enable the state to purchase (or reimburse providers for) professional liability insurance premiums, similar to the model adopted by Washington, Minnesota and Kentucky, then there would be additional cost to the state.

Minnesota's Voluntary Health Care Provider Program has been summarized earlier in this report. As of 2008, \$65,000 is appropriated annually to purchase malpractice insurance for the volunteer health care providers (nurses, dentists and physicians) enrolled in the program. The \$65,000 premium payments are paid out of the revenue generated from health care providers' licensing fees. (The state's physician license fee is \$192). There are 18,797 licensed physicians in Minnesota. In 2002, The Minnesota Joint Underwriting Association, on behalf of the state, contracted with a local medical malpractice carrier to provide \$1,000,000 per occurrence/\$3,000,000 aggregate coverage for volunteer physicians. The cost of a policy for each volunteer physician is \$5,000 per year (the cost for dental malpractice insurance is \$1,500 per year; nursing practice liability coverage is \$500). There are currently 26 providers enrolled in the program.⁷⁹ (See Appendix 4.)⁸⁰

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In Kentucky, the state maintains a professional liability reimbursement program for volunteer physicians. Since Kentucky law provides immunity from civil liability to uncompensated volunteers that provide services to non-profit organizations unless the volunteer engages in willful or wanton conduct, the cost of professional liability insurance would be substantially less than in a state that does not have an immunity statute. For registered charitable health care providers approved by the state, premiums for the professional liability insurance policies are paid out of the state's General Fund. There are 25 clinics registered as Charitable Health Care Providers with the state. Professional liability premium reimbursement for those providers for fiscal year 2006-07 was just over \$100,000. For the 2007-08 fiscal year, to date, the state has reimbursed the charitable providers \$42,000.⁸¹

Similarly, state of Washington has an immunity statute. The cost for providing insurance to providers who have rendered more than 50,000 encounters will be approximately \$145,000 this year.^{82 83}

Insurance plans and programs vary from state to state. In California, there appears to be several options for purchased liability insurance for volunteer physicians.

The first option is the individual physician policy where the state would either purchase liability insurance for the volunteer physician or reimburse the volunteer physician for the cost of his/her insurance premiums.

In 2003, an amended bill was introduced by Assembly Member Nakanishi proposing to create the Physicians and Surgeons Liability Insurance Pilot Program (PSLIPP), to be administered by the State Department of Health Services. (See Appendix 2.) Under the proposed legislation, up to 100 physicians and surgeons would be covered through the pilot program, which would purchase liability insurance for health care professionals volunteering in specific public or not-for-profit agencies. The volunteer physicians and surgeons would be eligible for waivers of license renewal fees, and the bill would be contingent on receiving sufficient private funding to pay the costs of both administering

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the program and purchasing liability insurance. An analysis of the bill indicated that, depending on the number, location, specialty, and whether the physician is considered to be low or high risk by liability insurers, the cost of liability insurance would be \$1.1 to \$1.9 million.⁸⁴ The 100 physicians proposed to comprise this pilot program were 40 family and general practice physicians, 50 internal medicine physicians, and 10 obstetrics/gynecologist physicians. There is no other data maintained by the state or Assemblyman Nakanishi's office that provide information about how this estimate was derived. By all accounts, it appears that the then-current estimate of insurance costs was based on individual medical professional liability premiums for full time physicians.

Rates for malpractice premiums are determined utilizing a complex actuarial calculation. Rates are derived by an aggregate rate analysis that evaluates historical loss ratios (losses/premiums) to determine how much rates need to be charged overall to achieve a target loss ratio. The second part of the equation involves rate relativities. These are derived for each specialty based upon historical experience.⁸⁵ Data from two of the major malpractice carriers in California identify that insurance premiums in Southern California are significantly greater than Northern California premiums. Ranges for malpractice insurance premiums for coverage with limits of \$1,000,000 per occurrence/\$3,000,000 aggregate are as follows: Annual premiums for primary care range from \$6,300 to \$16,000 for Family Practice and \$8,100 to \$16,100 for Internal Medicine. Rates for specialty care (non-surgical) range from \$7,000 to 16,100 for Infectious Disease and \$8,100 to \$25,500 for Ophthalmology. Rates for high risk specialties such as Obstetrics/Gynecology range from \$35,000 to \$77,000. General surgery rates range from \$29,000 to \$54,500. Commercial carriers do adjust for part-time status, which would reduce an individual premium up to 50%.^{86 87 88}

Utilizing the range of professional liability premiums in the primary care and subspecialty areas, we estimate that individual malpractice premiums for physician volunteers providing low to mid risk medical care (non-surgical) on a part-time basis (less than 20 hours per week) would be in the range of \$3,000 to \$6,500 for primary care and \$5,000 to \$10,500 per physician per year for specialty care (non-surgical).

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The second option to provide malpractice coverage for volunteer physicians is where the state would purchase or reimburse a clinic for the cost of purchasing a clinic professional liability policy. At least one major professional liability carrier in California, NORCAL Mutual Insurance Company, has a specialized policy for non-profit clinics. This program is managed through an exclusive broker arrangement. The program has specific eligibility requirements in order to be considered for evaluation of coverage. Premiums are based on numerous elements including: the type of visits and services being performed at the clinic, geographical location, retroactive date of coverage, limits of liability, etc.

The policyholder for this type of insurance is the non-profit clinic and the physicians providing care at the clinic are added to the clinic's policy. The policy has a single, shared per occurrence/aggregate limit. According to NORCAL, the minimum premium per clinic begins at \$5,000, but annual premiums are generally in the \$15,000-\$20,000 range.⁸⁹ This clinic policy model is likely more cost effective than the individual physician model.

Many clinics in California that serve the medically indigent are FQHC or other non-profit clinics so that physicians who volunteer their services are immune from certain liability by the Federal Tort Claims Act (see discussion in Section II A, above). Professional liability carriers such as NORCAL also offer "wrap" coverage for professional and general liability claims not immune under the FTCA, provided coverage for such claims is not excluded.

There may be other types of professional liability insurance programs available to California volunteer physicians, such as the "encounter based" model offered in the state of Washington (see page 24, above). In order to arrive at an accurate dollar amount for the true cost of purchasing medical professional liability insurance for volunteer physicians, a formal request for proposal should be issued by the state that should specify the following: 1) the scope of practice volunteer physicians could provide under the

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proposed state program; 2) the type of services provided by the volunteer physicians; 3) the type of settings volunteer physicians may practice (e.g., hospitals, non-profit clinics, private offices) and 4) specifications for coverage including: the amount of coverage requested (e.g., \$1,000,00/\$3,000,000), type of coverage requested (professional / general liability,) etc.

Given the restrictions placed on public entities pursuant to the California Public Contracts Code Section 10515(a), we did not retain the expertise of a commercial medical professional liability insurer to provide data for premium rates or specific malpractice insurance programs.* It would be better if the Medical Board would issue a formal Request for Information or Request for Proposal through its standard procurement processes. If professional liability premiums were competitively bid, the state would be in the best position to obtain the most favorable rates for coverage for volunteer physicians.

D. Revenue Generation

In order for the state to purchase malpractice liability, revenues could be generated by increased physician license fees. Several states (e.g., Minnesota) have utilized physician licensing fees to fund their purchased professional liability program for volunteers. California has one the highest medical license fee in the country at \$805, so the easiest route to generating revenue for volunteer physician malpractice insurance may be the most difficult to implement.** Certainly, if every licensed physician was assessed an additional \$50 to the biennial fee, over \$3 million could be generated annually, which could easily pay for malpractice coverage for 150-200 clinics, utilizing the NORCAL non-profit clinic insurance data (see estimated costs on page 34, above) or provide

* California Public Contracts Code 10515. (a) No person, firm, or subsidiary thereof who has been awarded a consulting services contract may submit a bid for, nor be awarded a contract on or after July 1, 2003, for the provision of services, procurement of goods or supplies, or any other related action that is required, suggested, or otherwise deemed appropriate in the end product of the consulting services contract.

** The biennial fee will increase to \$830 on January 1, 2009.

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revenue to pay for approximately 450 individual physician premiums (see estimated costs on page 33, above).

Additional revenues could be generated by requiring those health care entities that register with the state in order to be an eligible site to receive volunteer physicians who are covered through the state program to pay a nominal annual fee, e.g. \$200. Although this would be a limited source of revenue, it could generate some additional dollars. Similarly, the volunteer physicians could be required to pay a nominal fee (e.g., \$200) toward their malpractice insurance benefit.

It is questionable whether assessing physician licensing fees is the most appropriate avenue to generate funds for this program. Most states pay for volunteer professional liability coverage out of their General Fund. In California, there may be current state program funding that could pay for an insurance coverage program for volunteer physicians. Health and Safety Code 12855, the Medically Underserved Account for Physicians, was established within the Health Professionals Education Fund for two purposes: 1) to provide funding for the ongoing operations of the Steven M. Thompson Physician Corps Loan Repayment Program and 2) to provide funding for the Physician Volunteer Program. In 2008, SB 1379 appropriated additional \$1 million of revenue to the Medically Underserved Account for Physicians to be used specifically for the Loan Repayment Program (and not for the Volunteer Physician Program). Nonetheless, this additional revenue to the loan repayment program may free up funds that could be used to pay for the professional liability coverage program for volunteer physicians consistent with the missions of the Physician Volunteer Program. Additionally, SB 1379 appropriated \$10 million to be transferred to the Major Risk Medical Insurance Fund to be used to further that program. It may be appropriate for other revenue generated from health care service plan fines and administrative penalties (currently in the Managed Care Fund) be used to pay for a volunteer physician liability insurance program.

Grant opportunities, through organizations like the California Endowment, or other healthcare non profit organizations, could also present potential avenues for revenue

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generation to pilot this program. Additionally, it may take a combination of funding sources from licensing assessments, state monies and granting opportunities to pay for professional liability coverage and program administration.

E. Program Administration

If a volunteer physician insurance program was developed in the state of California, it should not be administered by the Medical Board of California but by another branch of the state. (If administered by the Medical Board, there may be a perceived conflict of interest if the Board must determine whether to take disciplinary action against a licensee to whom it has provided medical malpractice insurance.) The Board could develop criteria for eligible health care entities and eligible health care providers and create a registration process that can be used to process insurance as well as to track statistical information. The best example of such a registration process (for the purchased insurance model) has been found in Minnesota and Washington states that request detailed information from the health care entity and the providers and requires annual or bi-annual information back from the health care entities about the quantity and type of free health care that is provided under the program. (See Appendix 4 and 5.)^{90 91} There would be some additional costs associated with administering such a program by the state. Once insurance rates are secured, and a registration process is established for clinics and physicians to participate in the program, administrative costs for the program should be relatively low.

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Appendix 2: History of Prior California Legislation Related to Liability Protections for Volunteer Physicians

The following information was obtained from interviews with California Assembly staff regarding the successes, challenges, and lessons learned from previous bills.

Assembly Bill 621, first introduced on February 19, 2003, concerned a special license to qualifying retired health care professionals to practice in public agencies or institutions, at not-for-profit organizations, agencies, institutions, corporations or associations that provide health care to indigent patients in medically under-served or critical-need populations. This bill also would have exempted “those health care providers from liability for professional negligence or malpractice or any other civil damages for any act or omission resulting from the rendering of those services, with certain exceptions.” This bill was amended (March 24, 2003) to cover only physicians and surgeons, and would exempt them from liability for “professional negligence or malpractice or any other civil damages for any act or omission resulting from those services, with certain exceptions.”

An April 8 analysis (Pacheco, 2003) raises questions about who would bear the liability should negligence occur—the non-profit facility, the public health facility or other practitioners? How would the higher standard of liability be justified? Would this bill create two levels of medical care? Current laws authorize local government to insure and self-insure for tort claims against volunteer health professionals. The bill received support from the Civil Justice Association of California and the California Primary Care Association. Groups opposing this bill were the American Nurses Association of California, the Congress of California Seniors, and the Consumer Attorneys of California.

On April 21, 2003, the amended bill was introduced again by Assembly Member Nakanishi. This bill would create the Physicians and Surgeons Liability Insurance Pilot Program (PSLIPP), to be administered by the State Department of Health Services. Up to 100 physicians and surgeons would be covered through the program, which would

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purchase liability insurance for these health care professionals volunteering in specific public or not-for-profit agencies. The bill would need to receive funding in the annual Budget Act. This bill was amended on April 24, 2003, to be funded privately. The program would also remain in effect until January 1, 2009. In a bill analysis (Gilman, 2003), it was noted that Washington State had a similar program. The bill was supported by the California Congress of Seniors and the California Primary Care Association. No opposition groups were on file.

The bill was amended in Assembly on May 6, 2003. The volunteer physicians and surgeons would be eligible for waivers of license renewal fees, and the bill would be contingent on receiving sufficient private funding to pay the costs of both administering the program and purchasing liability insurance. An analysis of the bill (Bain, 2003) indicated that, depending on the number, location, specialty, and whether the physician is considered to be low or high risk by liability insurers, the cost would range from \$1.1 to \$1.9 million. Through this program, 40 family and general practice physicians, 50 internal medicine, and 10 OB/GYNs would receive coverage. This analysis called for an amendment to require an evaluation of the PSLIPP.

The bill was amended on June 4, 2003, requiring the Department of Health Services to contract for an evaluation of the program, with the evaluation submitted to the Legislature by January 1, 2009. An analysis of the bill (Gilman, 2003) did not list any groups supporting or opposed to the bill. The bill was amended again on June 9, 2004. This text is listed below:

Division 3.4 CALIFORNIA ACCESS TO HEALTH CARE ACT

600. This division shall be known and may be cited as the California Access to Health Care Act.

601. The Legislature finds and declares that a significant portion of the residents of this state who are uninsured or Medicaid recipients are unable to access needed health care. It is the intent of the Legislature that access to medical care for indigent residents be

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improved by providing governmental protection to health care providers who offer free quality medical services to underserved populations of this state.

602. As used in this division, the following terms have the following meanings:

(a) "Contract" means an agreement executed under this division between a health care provider and a governmental contractor that authorizes the health care provider to deliver health care services to low-income recipients as an agent of the governmental contractor on a volunteer, uncompensated basis.

(b) "Governmental contractor" means a county health department, a hospital district, or a hospital owned and operated by a governmental entity.

(c) "Health care provider" or "provider" means any of the following:

(1) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(2) An entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(3) An employee or contractor of an entity under paragraphs (1) and (2) who is acting within the scope of employment or contract.

(d) "Low-income" means any of the following:

(1) A person who is eligible for Medi-Cal benefits under California law.

(2) A person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level, as defined by the federal Office of Management and Budget.

(3) A patient or client of the governmental contractor who voluntarily chooses to participate in a program.

603. (a) A provider that executes a contract with a governmental contractor to deliver health care services on or after January 1, 2005, as an agent of the governmental contractor, is an agent for purposes of Division 3.6 (commencing with Section 810) while acting within the scope of duties pursuant to the contract, if the contract complies with the requirements of this division, regardless of whether the

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individual treated is later found to be ineligible to receive health care services under the contract.

(b) A provider may not be named as a defendant in an action arising out of medical care or treatment provided on or after January 1, 2005, pursuant to the terms of a contract entered into under this division. The exclusive remedy for injury or damage suffered as a result of an action or omission of the provider or any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to Division 3.6 (commencing with Section 810).

(c) (1) Initial referral or assignment shall be made solely by the governmental contractor, and the provider shall accept all referred patients. However, the number of patients that a provider is required to accept may be limited by the contract, or when, in the provider's reasonable judgment accepting additional patients could endanger patient access or continuity of care.

(2) Patients may not be transferred to a provider based on a violation of subsection (c) of the federal Emergency Medical Treatment and Active Labor Act (42 U.S.C. Sec. 1395dd).

(3) Any follow up patient care or hospital care, shall be subject to approval by the governmental contractor.

(4) The provider shall be subject to regular inspection by the governmental contractor.

(d) A governmental contractor that is also a health care provider is not required to enter into a contract under this division with respect to the health care services delivered by its employees.

604. A governmental contractor shall provide written notice to each patient, or the patient's legal representative, receipt of which shall be acknowledged in writing, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to Division 3.6 (commencing with Section 810).

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605. A governmental contractor engaging in a contract under this article shall establish a quality assurance program to monitor services delivered under contracts between the governmental contractor and a health care provider under this article.

606. This article applies only to act or omissions occurring on or after January 1, 2005.

At an Appropriations Committee Fiscal Summary (Cate, 2008), it was noted that the bill met the criteria to be placed on the Suspense file. The cost of purchasing liability insurance and conducting an evaluation during the duration of the pilot would be between \$1.1 and 1.9 million in private funds. Assembly Member Nakanishi's office indicated that this private funding would be sought from the insurance industry and private foundations. A follow up summary from August 28 indicates that the bill does not give authority to expend funds once they are obtained. A history of the bill indicates that on November 30, "From Senate committee without further action."