

Report to Address Assembly Bill 2342 (2006)
Prepared for the Medical Board of California

Contract No. 063-4666-7

Anna Orłowski, JD, Chief Health System Counsel

Kathleen M. Ayers, Psy.D., Staff Research Associate V

Mary Peters, Analyst III, Hospital Legal Affairs

UC Davis Health System

Submission Date: December 31, 2008

Introduction

Business & Professions Code Section 2023 mandates the Medical Board of California to study the options and cost of providing medical malpractice coverage or funding for malpractice coverage to individuals holding a physicians and surgeons certificate as defined in Business & Professions Code Section 2050 (hereinafter “physicians”) who volunteer their time to provide uncompensated medical services to patients. It has long been recognized by California state legislators that one of the challenges and potential barriers to physician volunteerism is the concern about medical malpractice liability associated with providing uncompensated care. The federal government and 43 states have determined that passing laws that protect health care professionals from individual liability promotes volunteerism. California is one of the seven remaining states in the U.S. that have no charitable immunity protection and/or malpractice insurance programs for physicians that provide unpaid, voluntary service. This report will provide an analysis of the programs that promote the provision of uncompensated care by creating specific protections for volunteer physicians.

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

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

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

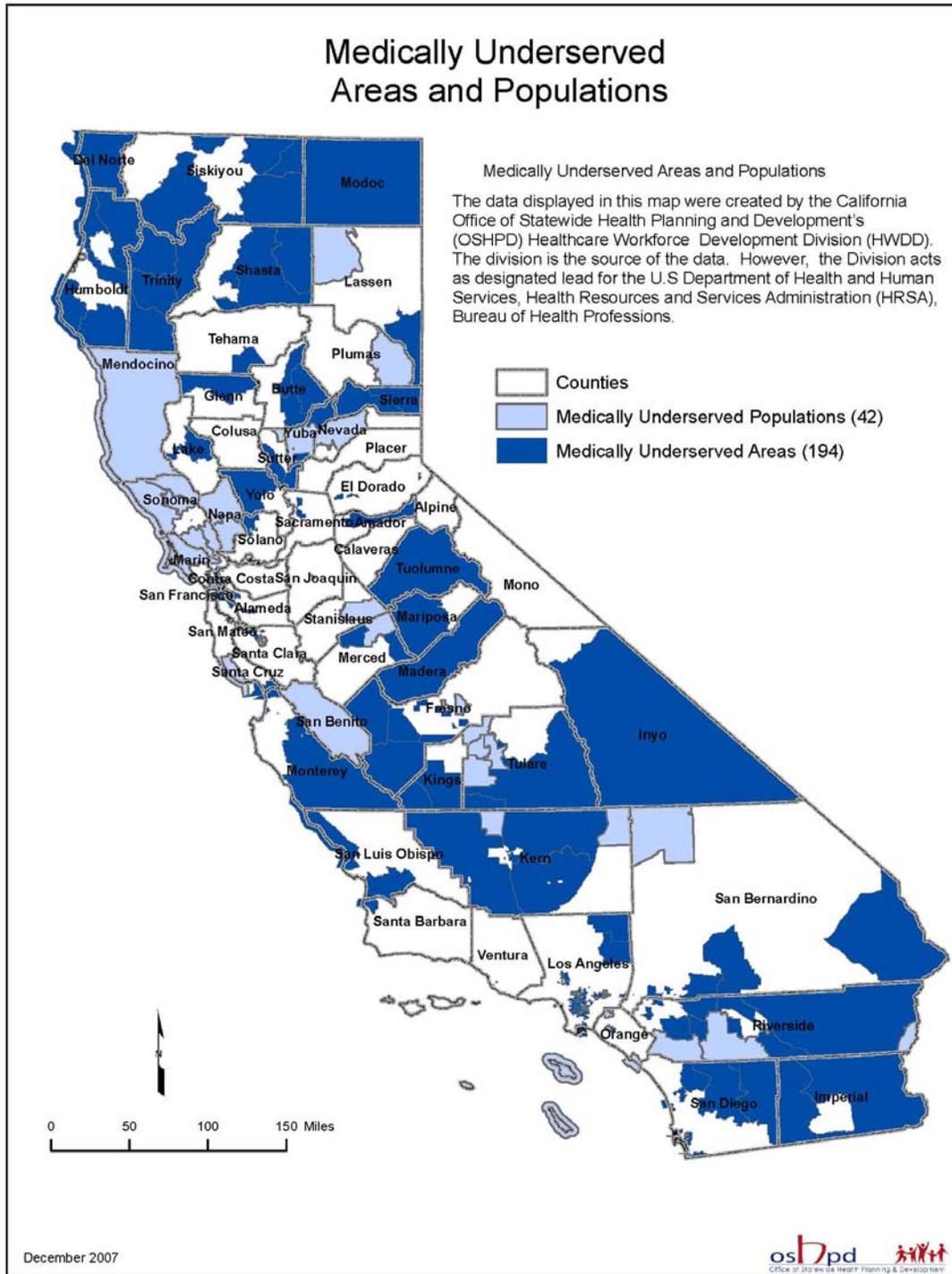
California Healthcare for Indigents Program (CHIP) funding is provided for the 24 largest counties through realignment and the Tobacco tax under Proposition 99 provisions. These funds reimburse providers for uncompensated services for individuals who cannot afford care and are ineligible for other programs. 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

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



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.

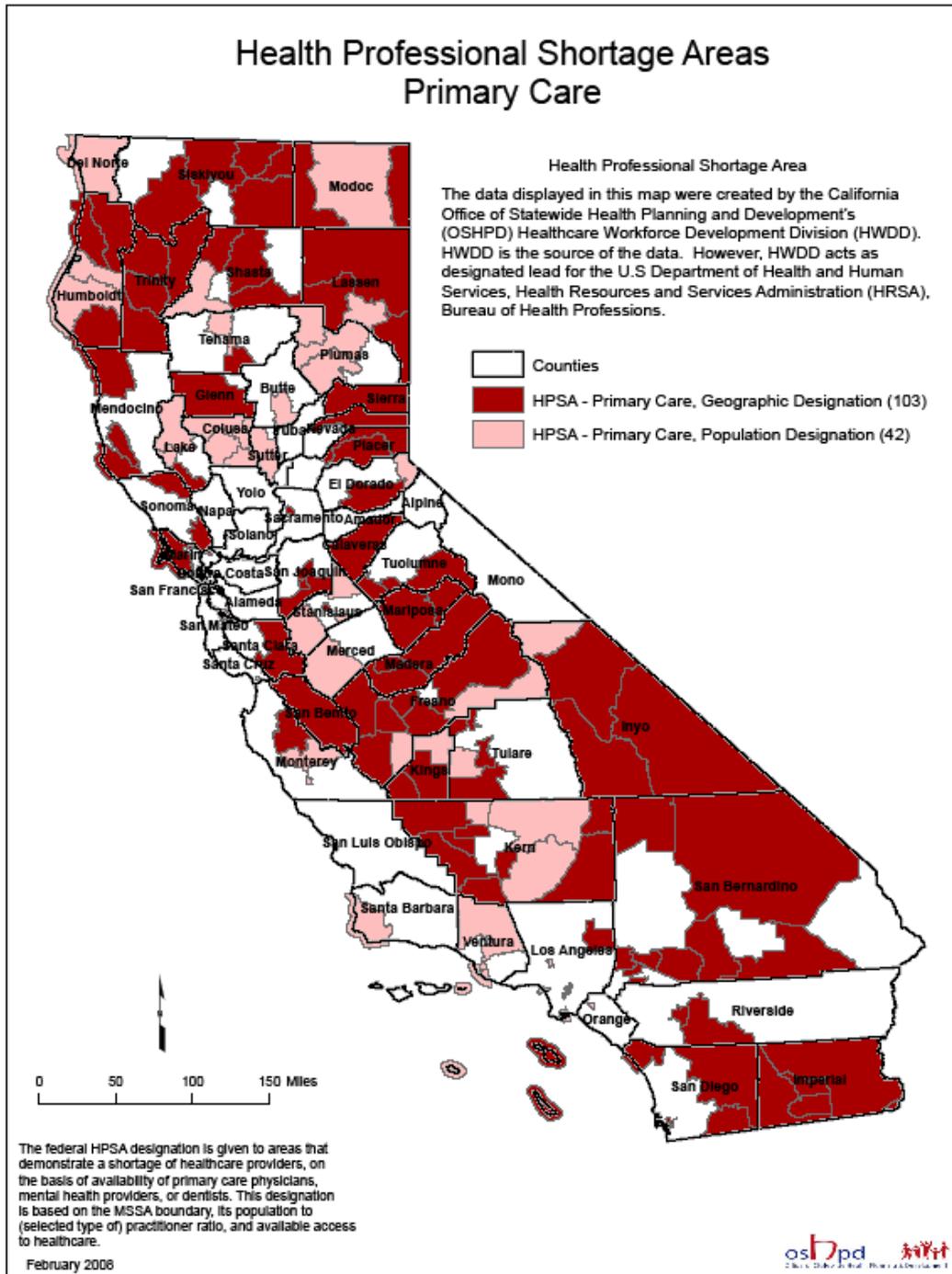
For California metropolitan areas, volunteering in a hospital or other health care system is at the following levels:²²

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

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



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

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.

II. Survey of Current Federal and State Laws Related to Volunteer Physician Malpractice Liability Protections

A. Summary of Federal Laws Providing Liability Protection to Volunteers

Since 1992, the Public Health Service Act has provided medical malpractice liability protection to employees of federally funded community health centers. In 1996, Congress amended the Public Health Service Act as part of the Health Insurance Portability and Accountability Act (HIPAA). This amendment, entitled the Volunteer Medical Act, provides that “a free clinic health professional shall in providing a qualifying health service to an individual to be deemed an employee of the Public Health Service.”²⁹ This 1996 amendment did not take effect until 2004, as a result of Congress failing to appropriate funds to cover the expense of the program. In 2004, Congress appropriated \$4.8 million to fund the extension of coverage to volunteers in free clinics. The appropriation established the Free Clinics Medical Malpractice judgment fund for the purpose of expanding “access to health care services to low-income individuals in medically underserved areas.”³⁰ Funding for the VMA must be periodically reviewed and re-approved. Each year, additional dollars have been appropriated as requested: In \$100,000 in 2005; \$44,000 in 2006; \$548,000 in 2007 and \$100,000 in 2008.

If providing care in a free clinic, the volunteer is immune from liability for claims of medical malpractice. The Volunteer Medical Act (VMA) provides immunity to health care providers in limited circumstances: the care has to be provided in a non-profit entity; that entity can not accept reimbursement from any third-party payer, including Medicare and Medicaid; and the entity can not charge the patient for any care rendered. Therefore, volunteers do not have liability protection in all federally funded clinics, but only those clinics that are deemed “free clinics”. In order to have those liability protections, the free clinic has to first be approved as a Public Health Services free clinic by the Health Resources and Service Administration of HHS (HRSA). Then, the qualified free clinic must submit an application to the Department of Health and Human Services to have volunteer providers “deemed” and covered under the Free Clinics

Medical Malpractice program.³¹ Of the approximately 2000 free clinics established in the United States, as of March, 2007, only 75 of those free clinics were HRSA approved nation-wide.³²

The Volunteer Protection Act (VPA) of 1997 was enacted to provide immunity from tort claims for volunteers of government and nonprofit organizations.³³ This Act was intended to increase volunteerism by offering volunteers who may have otherwise been discouraged to contribute their services because of liability concerns, protections against civil action. The VPA provides all volunteers (not just clinical volunteers) of non-profit and governmental entities with limited protection from liability. The volunteers are immune from claims of negligence, but not for claims of gross negligence, willful or criminal misconduct, reckless misconduct, or conscious flagrant indifference to the rights or safety of the individual harmed by the volunteer.³⁴ In circumstances where the volunteer may be held liable (e.g., gross negligence), the VPA limits the amount of punitive damages that can be awarded against the volunteer. Punitive damages may be awarded only if the volunteer engaged in willful or criminal misconduct or conduct that showed a conscious, flagrant indifference to the rights or safety of the injured person. Additionally, there are restrictions on the amount of non-economic damages that can be awarded.

The VPA explicitly preempts any state law that is inconsistent with the VPA's provisions, except that it does not preempt any state law that provides additional protection.³⁵ A state may elect to avoid the provisions of the VPA in actions involving only citizens of the home state by passing specific legislation in accordance with the VPA.³⁶ In a non-citable 2006 case, one court of appeal concluded that California had not adopted any such legislation as of the decision date (*Galindo v. Board of Directors of Latin American* (2006) 2006 WL 93287.), and as of the date of this report, there does not appear to be any California statute that limits the VPA's application in California. As a result, it appears that the provisions of the VPA apply in California and preempt any California law that would otherwise impose liability for ordinary negligence on a volunteer.

It is important to note the VPA does not affect the liability of the nonprofit or governmental entity for any harm caused by a volunteer. Although volunteers may not face personal liability, if there is a basis for which the non-profit organization may be held to be vicariously liable for the volunteer, the VPA does not immunize the government or non-profit organization where the volunteer is working.

The VPA does not prevent claims from being brought against the individual physician, but merely limits the type of damages a plaintiff may seek. Therefore, in order to be completely covered, the individual physician or the non-profit organization in which he/she works still must pay for malpractice insurance for the physician.

In July, 2008, the Volunteer Healthcare Program Act of 2008 (Senate Bill 3354) was introduced in the Senate.³⁷ The purpose of the bill is to (1) promote access to quality health and dental care for the medically underserved and uninsured through the commitment of volunteers; and (2) encourage and enable health care providers to provide health services to eligible individuals by providing sovereign immunity protection for the provision of uncompensated services. If enacted, the Public Health Services Act (42 USC Section 280(g) et seq.) would be amended to establish a grant program for demonstration programs to enable states to develop volunteer healthcare programs.³⁸ Grants would be awarded to programs that serve individuals whose family income does not exceed 200% of the federal poverty level, are not covered by any insurance and are determined to be eligible for care by the State. The provider could not receive any compensation for the care provided and must be authorized by the state to provide services under the program. The grant would also require that the patients receive information about the provider's limitation of liability as a result of his/her sovereign immunity status. This bill has been referred to the Committee on Health, Education, Labor and Pensions for review.³⁹ No action has been taken on this bill as of the date of this report.

B. Summary of State Laws Providing Liability Protections for Physician Volunteers

There are currently 43 states and the District of Columbia with legislation that protects physicians from civil liability for administering health care in non-emergency circumstances. The ways in which physicians are protected from personal liability vary. There are three general models of state laws that provide professional liability protection to volunteer physician: 1) Statutory immunity in which the health care provider is immune from liability unless he/she commits gross negligence or engages in willful or wanton conduct; 2) Sovereign immunity in which the volunteer physician is considered a “state actor” when providing volunteer services; and 3) State-run professional liability programs in which the state purchases professional liability insurance for the volunteer physicians or reimburses providers for malpractice premiums. (See Appendix 1 for a summary of state laws that address physician volunteers.)⁴⁰ A summary of each professional liability protection model is more fully described, below.

1. Statutory Immunity: Change in the Standard of Care

a. Liability of the Provider

Many states have adopted models similar to the standard adopted by the federal Volunteer Protections Act (VPA) discussed above. In those states, physicians are immune from claims of common negligence. Some states provide immunity unless acts of gross negligence are committed, while other states protect health care givers at a higher level by only stripping them of their immunity when they engage in willful or wanton misconduct.

States that expressly protect health care providers from civil suit unless they commit acts of willful or wanton misconduct include: Alabama, Idaho, Illinois, Oregon, Pennsylvania, the District of Columbia, Rhode Island, Texas, Wyoming, and Nevada. In these states, providers are immune from liability for common negligence and gross negligence. States that provide immunity to health care providers unless they act grossly negligent include: Arizona, Arkansas, Delaware, Hawaii, Indiana, Illinois, Kentucky,

Louisiana, Maine, Maryland, Michigan, Montana, New Jersey, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Utah, Virginia, Wisconsin, Missouri, Colorado, and West Virginia.

b. Liability of the Organization

In many states where the volunteer physician may be immune, the organization/facility itself may be held liable for the volunteer's actions. In Arizona and Michigan, for instance, statutes specify that the organization may be held liable for the health care provider's actions when the health care provider is immune from civil action. Florida and Hawaii also allow for individuals to seek redress from the nonprofit organization itself when the volunteer is immune.

In other states, the organization as well as the provider is immune from civil liability for common negligence. For instance, Delaware protects both the health care volunteer and the medical/dental clinic with which the volunteer is affiliated from being subject to suit directly unless there are acts of gross negligence. Other states have institutionalized liability ceilings. For example, in Massachusetts a charitable organization is only liable up to \$20,000.

2. Sovereign Immunity: Physicians are considered "State Actors"

In this model, the volunteer physician becomes a government employee when he/she is providing unpaid care in either a designated facility and/or to certain categories of patients. For example, in Wisconsin, volunteer health care professionals are "state agents of the department of health and family services and are therefore covered under the state tort claims act."⁴¹ In such models, the state usually sets certain conditions, such as the setting where health care is delivered, or the existence of a formal agreement between the health care professional and the state, before the provider will be deemed a state actor. Some states have enacted statutes applying only to specific health care professionals (such as physicians and dentists), and some states combine the two models.⁴² Thirteen

states specifically refer to retired physicians and three states have legislation for, more specifically, retired physician volunteers.⁴³ Seven states (Iowa, Louisiana, Missouri, Nevada, Oregon, Virginia and Wisconsin) have a statutory cap on total compensation that can be paid on a claim, ranging from \$250,000 to \$1,000,000.⁴⁴ Such statutes also exempt the state from punitive damages.

3. Qualifications for Immunity

The requirement common in most states that offer immunity protection is that the health care providers treat patients without compensation in a voluntary fashion. Other states such as Arkansas and Georgia provide immunity to those health practitioners that take only a nominal fee from those needing treatment. Some states limit immunity protections to physicians, while others expand immunity to an array of health care professionals. For example, the Arkansas statute broadly defines a health care professional to include an individual who is licensed or certified or is a student of a health care professional school. Any one of these individuals may be immune from civil liability when providing volunteers services.

Some states require that medical services must be provided at a free clinic. For example, South Dakota limits liability of a volunteer to that of a free clinic or organized hospital whereas South Carolina offers liability protection without specifying where the care must be administered. Montana also protects volunteers at any site, as long as the care is administered voluntarily and without compensation.

Some types of medical treatment are not protected by some states' immunity statutes. For instance, some states like Minnesota specify that the health care services protected under the statute are limited to health promotion, health monitoring, health education, diagnosis, treatment, minor surgical procedures, the administration of local anesthesia for the stitching of wounds, and primary dental services, including preventive, diagnostic, restorative, and emergency treatment. The types of services protected under the immunity statute do not include the administration of general anesthesia or surgical

procedures other than minor surgical procedures. Volunteers in Wyoming are not protected or immune from civil liability when they are involved in performing an operation or delivering a baby, unless the operation or delivery of a baby was necessary to preserve the life of a person in a medical emergency. Utah does not protect the use of general anesthesia or care that requires an overnight stay in a general acute or specialty hospital.

A number of states also require that health care centers and/or health care providers notify the patients receiving voluntary health care of the limitations for civil action that can be brought against the center/providers. Either a written notification is required (as in Arkansas, Alabama, Mississippi, Utah, the District of Columbia, and Texas), or an oral/unspecified form of notification of the limited liability is due to those receiving the volunteer's services (as in Colorado, South Carolina, Wyoming, Ohio, Georgia, Illinois, Louisiana, Montana).

4. State-Run Liability Coverage Programs or State-Purchased Insurance

Some states provide liability coverage to certain clinics and /or volunteer physicians through a state-run self insured risk pool. For instance, the state of Virginia offers a voluntary liability coverage to “any clinic that is organized in whole or primarily for the delivery of health care services without charge” and to health care practitioners who volunteer their services at facilities designated by the state as volunteer clinics.⁴⁵

Other states provide a mechanism to purchase malpractice insurance for volunteer health care professionals.⁴⁶ In Minnesota, the state licensing boards have a comprehensive program that will purchase malpractice insurance for uncovered volunteer physicians. The cost of professional liability premiums is paid through the revenues generated by health care professionals' licensing fees.⁴⁷ Kentucky's legislation makes funds available to free clinics so that the clinics may purchase professional liability insurance for the volunteer health care professionals at their facilities. The state reimburses the cost of the premium within monetary limits.⁴⁸ In Washington state, any provider participating in a

community based program who provides charity care to uninsured individuals is covered by the state for medical malpractice liability through a state purchased insurance program.⁴⁹

C. Model State Programs

The following is selected state legislation that enables and encourages physician volunteerism. (See full copy of state statutes in Appendix 3.)

Mississippi: Statutory Immunity-Change in the Standard of Care

A health care provider that voluntarily offers needed medical or health services to any person without the expectation of payment shall be immune from liability for any civil action arising out of the provision of such medical or health services provided in good faith on a charitable basis. The statute does not extend immunity to acts of willful or gross negligence. The voluntary health care provider is to notify the patient of the limited liability and obtain a written waiver that the services are provided without the expectation of payment and that the licensed physician or certified nurse practitioner shall be immune as provided in this subsection.⁵⁰

Arizona: Statutory Immunity-Change in the Standard of Care

A health care professional that provides uncompensated medical treatment is immune from medical malpractice action unless the health professional was grossly negligent. More broadly, Arizona law provides immunity to volunteers in general that act in good faith and within the scope of their duties for a government entity or nonprofit corporation, organization or hospital. Being able to prove the act or omission of a volunteer during the volunteer's official functions and duties is sufficient to establish the vicarious liability of an organization.^{51 52}

Oregon: Statutory Immunity-Change in the Standard of Care

A health care provider that voluntarily provides any assistance, services or advice for the purposes of a charitable organization is immune from civil liability. The immunity will not apply if the person receives compensation other than reimbursement for expenses incurred by the person providing such assistance, or if the volunteer acts in a grossly negligent manner.⁵³

Louisiana: Statutory Immunity-Change in the Standard of Care

A health care provider who in good faith renders health care services in a community health care clinic will be protected from civil action unless the damages were caused by the gross negligence or willful or wanton misconduct of the health care provider. The person receiving the health care services must receive prior notice from the community health clinic of the limitation of liability. Additionally, Louisiana has extended its volunteer health provider protection to include the provision of voluntary telemedicine services.^{54 55}

Florida: State Actor Model

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 Florida Statute Chapters 110 and 776.

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, Chapter 776, 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's legislation also requires an annual report. The latest available indicates that in fiscal year 2006-2007, under Chapter 110 volunteer activities, 6,609 volunteers contributed 463,151 hours of their time for a total value of \$34.5 million in donated goods and services. Under Chapter 766, Volunteer Health Care Provider Program, 9,139 licensed health care professionals and 4,563 volunteers provided services for 290,026 patients, with a total value of \$112.9 million. This program is considered to be very successful.^{56 57}

Georgia: State Actor Model

The Georgia Volunteer Health Care Program authorizes the Georgia Department of Community Health (DCH) to offer sovereign immunity protection to uncompensated, licensed health care professionals when they provide donated services to eligible patients. Volunteer health care professionals enter into a contract with the state to provide voluntary services and are given the same legal protection as state employees receive. Georgia also completes an annual report, which is being drafted as this paper is written. Information provided by the program director, Yocasta Juliao, indicated that for the fiscal year 2007-2008, ending June 30, there are a total of 49 participating clinics, up from 10

when the Georgia Volunteer Health Care Program was begun. There were 62,521 patient visits with 1,251 health care providers participating in the program (it is not known how many were retired physicians). These health care providers volunteered 48,259 hours, at a value of \$6,950,335 (based on hourly rates for each type of service). The program also keeps track of volunteer hours donated by eligibility specialists and general administrative volunteers. The combined total dollar value of services provided through this program for the past fiscal year was \$15,715,021. Expenses were \$5,775,000.^{58 59}

Virginia: State –Administered Risk Pool

The state’s Risk Management Department administers the State Insurance Reserve Trust Fund, a pool of money held for the benefit of providing indemnity and defense for any malpractice claim asserted against a registered free clinic or a registered volunteer health care provider. Any claims or expenses related to these providers are paid by the state’s Department of Health Services. The program has been in existence since 1996. There have been up to 500 providers (clinics and individual physicians) covered under the program. The state does not keep statistics about the number of clinics and physicians registered in the program, or any data about claims history. The state reports a “miniscule number of claims” filed against the program in its history.⁶⁰

Minnesota: State –Purchased Insurance

The state has designated the administrative services unit for health-related licensing boards as the entity responsible for obtaining malpractice insurance for healthcare providers (physicians, nurses and dentists) who provide voluntary, uncompensated health care. A health care facility or organization that desires to participate in a program for voluntary health care must register with the unit. Similarly, a health care provider must register with the administrative services unit in order to be protected from civil liability when providing voluntary health care.⁶¹

Kentucky: State –Purchased Insurance

Kentucky provides sovereign immunity to volunteers of non profit and charitable organizations. Also, the state enforces that insurers offering medical professional liability insurance give the same coverage to volunteer based organizations as they do for the other entities it insures. The premiums for these policies are paid by the state from the general fund upon a written application for payment of the premium by a health care provider wishing to offer charitable services.⁶²

Washington: State –Purchased Insurance

Since 1992, the state of Washington has had some program in which the state purchases insurance for providers who volunteer their services at community clinics. The program began by covering retired volunteer providers, but grew to cover any volunteer provider and has expanded its coverage to care provided not only in community clinics but in private practice settings as well. Coverage is available to any licensed health care provider (physician, nurse, nurse practitioner, physician's assistant, dentist or dental hygienist) who is providing non-invasive care to low income patients and not receiving any remuneration from the patient or clinic for these services. In order to be covered, the clinic must be registered with the Volunteer/Retired Providers Program. A bi-annual survey must be completed by the clinic, as well as the providers rendering care at the clinic, in order for the program to track the types of services being provided and gather encounter data.⁶³ (See Appendix 5.) Services under this program are limited to non-invasive procedures. The services must be rendered to patients who do not have private insurance and who are unable to pay for care. (This includes Medicaid and Medicare patients.)⁶⁴

In 2004, the state of Washington amended its Good Samaritan laws and adopted a statutory immunity provision so that any provider who provides charity care to uninsured individuals is immune from liability unless he/she engaged in gross negligence or willful

misconduct. Since the adoption of the statutory immunity provision, the cost of insurance has significantly decreased.⁶⁵

Initially, the state purchased individual policies for volunteer physicians. For 2006-2007 (the last year that individual policies were purchased) the cost of an individual premium for a physician practicing less than 20 hours per week was \$1,242 per year. (The annual premium for dentists was \$860; for nurses and nurse practitioners, \$100; and for oral hygienists, \$88).⁶⁶

Currently, the state has approximately 300 volunteer providers, 120 of which are physicians. The state purchases “encounter based” insurance through Washington Casualty, in which premiums are set by the number of volunteer provider encounters with patients, rather than on a per-provider basis. The cost of the insurance for 2007-2008 was \$121,967. The number of encounters (the basis for the premium) was 21,657 encounters by primary care physicians, 12,963 encounters by nurses, nurse practitioners or physician assistants, 8,007 dental encounters and 240 mental health encounters. The cost of insurance for the 2008-2009 year is \$144,763, as calculated utilizing 2007-2008 encounter data. Last year, 270 licensed practitioners (approximately 120 of which were physicians) provided a total of 51,232 encounters of care: 25,494 encounters by primary care physicians, 19,533 encounters by nurses, nurse practitioners or physician assistants, 5,917 dental encounters and 288 mental health encounters. Therefore, the cost per physician encounter under this program is \$4.15 per encounter. (The cost for mid-level care by a nurse, nurse practitioner or physician assistant is \$1.48 per encounter; \$1.45 per dental encounter and \$3.81 per mental health encounter.)⁶⁷

The State of Washington Department of Health contracts with the Western Washington Health Education Center, a private non-profit organization, to administer the Volunteer/Retired Physicians Program. The state’s budgeted administrative cost for this program is approximately \$250,000 annually, which pays for an office manager, a contracts coordinator and a part-time program coordinator, however these positions

perform other state functions, so the actual cost for administering the Volunteer/Retired Physicians Program is thought to be significantly less.^{68 69}

D. Malpractice Experience for Volunteer Physicians

Overall, few states maintain any data or statistics about malpractice claims arising out of volunteer efforts. For those states that do maintain data, there are few reports of malpractice claims. Florida's Volunteer Health Care Provider Program, which provides immunity to health care providers by considering them state actors when they perform volunteer unpaid services at specified settings, maintains comprehensive data about its program. 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.

Minnesota's Voluntary Health Care Provider Program began in 1992. This program facilitates the provision of voluntary, unpaid health care services provided by physician, dentists and nurses by purchasing professional liability insurance for those health care providers. According to Robert Leach, Executive Director, Minnesota Medical Board of Licensing and Juli Vangsness, Accounting Director, Minnesota Administrative Services Unit, there has never been a claim, settlement or judgment related to malpractice claims against a volunteer in the Program since its inception.⁷⁰ Similarly, Washington state reports that there have been no malpractice claims issued against a volunteer provider since the program began over 15 years ago.⁷¹

III. Potential Models of Physician Liability Protection in California

Over the years, several attempts have been made in the California state assembly to enact legislation that would provide qualified immunity or malpractice insurance assistance for volunteer physicians, but have been unsuccessful. (See Appendix 2 for complete history.)

The American Medical Association's policies urge that all jurisdictions provide physicians with protection from liability for uncompensated care for the indigent.⁷² Additionally, the AMA "encourages state medical societies to support development of state assistance with malpractice premiums, caps on liability or immunity from liability for services provided to uninsured, indigent patients."⁷³

California has made significant strides in support of increased health care to underserved populations. The state has provided support to the University of California for its Programs in Medical Education (PRIME) initiative which is focused on training and developing leaders in medicine to address healthcare for the underserved. Telemedicine programs continue to develop with the help of proposition 1D monies, the FCC Telehealth Grant and other public and private initiatives, to connect patients in underserved areas with physicians across the state. This technology will further enhance and enable volunteer physicians to provide care in their own community or at distant sites. Yet without legislation that provides volunteer physicians with some sort of liability protection, the number of physicians willing to provide free care may not increase.

California remains one of only seven states that have yet to enact any meaningful legislation that relieves the providers who render voluntary, unpaid care to patients from paying the high cost of professional liability insurance. Lack of malpractice coverage is perceived as a serious impediment to attracting volunteers.⁷⁴ If California desires to promote physician volunteerism, then the legislation must address the following:

A. Adoption of one or more of the following liability protection models:

1. Immunity statute in which the provider is not liable for common negligence, but only for gross negligence or willful misconduct.

Positive aspects: Reduces liability exposure; minimizes cost of malpractice insurance. Negative aspects: Potential public perception that there is a different standard of care for the indigent; still requires purchase of professional liability insurance.

2. Immunity statute in which, under circumstances proscribed by the state, a physician volunteer would be considered a state employee when providing uncompensated care.

Positive aspects: The physician does not need to purchase insurance. Negative aspects: The state would bear the risk of any claims. The state's Attorney General would be responsible for the defense of any claims if insurance was not purchased.

3. State-established malpractice insurance program in which the state either purchases insurance for physician volunteers or establishes a self-insured pool.

Positive aspects: For purchased insurance, the state may be able to negotiate favorable rates for insurance. Negative aspects: The state would incur the cost of purchasing insurance for the physician or bear the risk of any claims with a state administered risk pool.

B. Determine setting where liability protection would apply:

The legislation would need to establish the settings (free clinics, non-profits, hospitals, private physician offices, etc.) in which services may be rendered for volunteer physicians to qualify under the program that is adopted. Certainly, if care could be rendered in private practice clinics, as well as non profit community organizations, (like the state of Washington program) there would be a greater likelihood for participation. The legislation should also not limit the ability to provide services via telemedicine.

- C. Determine whether there would be any limitation to the type of care that may be rendered:

The legislation would need to identify whether all services or only specified categories of services would be covered (surgical, anesthesia, minor procedures, primary care, etc.).

- D. Identify what patients would be covered under the program:

Determine if there are any limitations to the category of patients that could be treated (medically indigent, Medi-Cal, Medicare, etc).

- E. Establish a clinic and physician registration process:

Criteria would need to be developed to determine who could be a participating provider. An application form, similar to those utilized in Minnesota or Washington could be utilized. (See Appendix 4 and 5.) Since there is a mechanism already established by the Medical Board of California to register volunteer physicians, the Physician Volunteer Registry (www.publicdocs.medbd.ca.gov/volmd) could be the repository of names, information and insurance eligibility for those individuals who are approved as a participating provider.

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

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

B. 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

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

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

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).

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

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.

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

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.

Conclusion

California is in a favorable position to take a step forward in introducing a program that would remove the professional liability insurance barrier to providing volunteer physician services. There are many outstanding models from various state statutes from which California may draw to develop its own program. There are many challenges to drafting legislation which supports volunteerism for health care providers. A climate must be created which encourages volunteerism, addresses the concerns of the health care providers regarding malpractice lawsuits, ensure that patients seen by volunteer health care providers retain their rights to compensation for acts of negligence, and avoids the perception that volunteer liability protection permits a lesser standard of care for the uninsured and underinsured.⁹²

In order to provide the most cost-effective liability protection model for physicians, some form of charitable immunity statute must be passed in this state, eliminating or reducing the likelihood that physicians providing voluntary, unpaid medical care would be susceptible to personal liability in a malpractice action. In the absence of such a statute, the cost to insure volunteer physicians is significant, but having a strong core of practitioners willing to provide free care to a growing population of uninsured Californians is invaluable. Providing health care services to the indigent patients of this state is the responsibility of state and local government. Those physicians that provide voluntary, unpaid medical care to indigent California are performing a service on behalf of the state. The state is in the best position to solicit the most competitive rates for insurance coverage for those volunteer physicians and establish programs that would provide coverage to these volunteer physicians at no cost to the practitioner.

¹ Kominski, Gerald F., Roby, Dylan H., and Kincheloe, Jennifer R. UCLA Health Policy Brief. *Cost of Insuring California's Uninsured* (May 2005).

² Gatchell, Melissa, Lavarreda, Shana Alex; and Ponce, Ninez. UCLA Health Policy Fact Sheet: *7.6 Million Californians Rely on the Safety Net of Health Care Providers for Regular Care* (September 2007).

-
- ³ Brown, Richard E., Pourat, Nadereh, and Wallace, Steven P. UCLA Health Policy Fact Sheet: *Undocumented Residents Make Up Small Share of California's Uninsured Population* (March 2007).
- ⁴ UCLA Health Policy Fact Sheet: *California County Uninsurance Rates Vary Greatly* (February 2007).
- ⁵ Fox, Brooke. Insure the Uninsured Project. *Where are the Uninsured Now? A Ten Year Overview* (January 2007).
- ⁶ Isaacs, Stephen L., and Jellinek, Paul. Health Affairs: The Policy Journal of the Health Sciences. *Is there a (Volunteer) Doctor in the House? Free clinics and Volunteer Physicians Referral Networks in the United States* (2007)
- ⁷ Roby, Kominski, and Cameron.
- ⁸ California Health Interview Survey, 2007. Chart created on July 24, 2008.
- ⁹ Botelho, Jamie and Wulsin, Jr., Lucien. Insure the Uninsured Project. *A Summary of Health Care Financing for Low-Income Individuals in California, 1998 to 2007* (August 2007).
- ¹⁰ Botelho and Wulsin.
- ¹¹ California HealthCare Foundation. Fact Sheet: *County Public Health Services* (July 2004).
- ¹² California HealthCare Foundation. Fact Sheet: *County Programs for the Medically Indigent in California* (August 2006).
- ¹³ California HealthCare Foundation. (August 2006).
- ¹⁴ Botelho and Wulsin.
- ¹⁵ Botelho and Wulsin.
- ¹⁶ Botelho and Wulsin.
- ¹⁷ Kelch, Deborah Reidy. California HealthCare Foundation. *Caring for Medically Indigent Adults in California: A History* (June 2005).
- ¹⁸ California HealthCare Foundation. Issue Brief: *County Innovations in Financing Care for California's Medically Indigent Adults* (November 2007).
- ¹⁹ California Office of Statewide Health Planning and Development's Healthcare Workforce Development Division. *Medically Underserved Areas* map (February 2008).
- ²⁰ Horwitz, J. R., and Mead, J. Journal of Empirical Legal Studies (in press). *Letting Good Deeds Go Unpunished: Volunteer Immunity Laws and Tort Deterrence* (Downloaded July 23, 2008).
- ²¹ Corporation for National & Community Services Office of Research and policy Development. *Volunteering in America: 2007 City Trends and Rankings* (2007).
- ²² Corporation for National & Community Services Office of Research and policy Development. (2007).
- ²³ Smith, Nancy. Staff Information Systems Analyst, Medical Board of California. Interview with Author (October 2008).
- ²⁴ California Office of Statewide Health Planning and Development's Healthcare Workforce Development Division. *Health Professional Shortage Areas Primary Care* map (February 2008).
- ²⁵ Business & Professions Code Sections 2395-2398.
- ²⁶ California Government Code Section 8659.

-
- ²⁷ American Medical Association. *Report of the Board of the Trustees* (2007).
Downloaded on July 31, 2007.
- ²⁸ Smith (October, 2008).
- ²⁹ 42 USC Section 233.
- ³⁰ Health Resources Services Administration (HRSA), *Fiscal Year 2008 Justification of Estimates for Appropriations Committee* (2008).
- ³¹ HRSA (2008).
- ³² Isaacs, Stephen L., and Jellinek, Paul. (2007).
- ³³ 42 USC Section 14501-14505.
- ³⁴ 42 USC Section 14503.
- ³⁵ 42 USC Section 14502.
- ³⁶ 42 USC Section 14502.
- ³⁷ US Senate Bill 3354 .
- ³⁸ 42 USC Section 280(g) et seq.
- ³⁹ US Senate Bill 3354.
- ⁴⁰ American Medical Association.
- ⁴¹ Hattis, Paul A., Walton, Janet, and Staton, Sonya. *Understanding Charitable Immunity Legislation_ A Volunteers in Health Care Guide* (November, 2004).
- ⁴² Shapiro, Howard B. Family Practice Management. *Providing Charity Care: A Primer on Liability Risk* (January 2003). Downloaded July 31, 2008.
- ⁴³ Hattis, Walton, and Staton.
- ⁴⁴ Hattis, Paul A. University of Illinois Law Review, Vol. 2004, 167-182. *Overcoming Barriers to Physician Volunteerism: Summary of State Laws Providing Reduced Malpractice Liability Exposure for Clinician Volunteers* (2004). Downloaded on July 31, 2008.
- ⁴⁵ Commonwealth of Virginia. Department of the Treasury. Liability for Free Clinics.
- ⁴⁶ Shapiro.
- ⁴⁷ Hattis.
- ⁴⁸ Hattis.
- ⁴⁹ RCW 4.24.300 Immunity for certain types of medical care.
- ⁵⁰ Mississippi Code Ann. § 95-9-1. Qualified volunteers, immunity and exemptions (2008).
- ⁵¹ Arizona A.R.S. § 12-982: Qualified Immunity; Insurance Coverage (2008).
- ⁵² Arizona A.R.S. § 12-571: Qualified immunity; health professionals; nonprofit clinics; previously owned prescription eyeglasses (2008).
- ⁵³ Oregon O.R.S. § 30.792. Health care provider; liability for volunteer services to charitable corporations (2008).
- ⁵⁴ Louisiana LSA-R.S. 9:2799.5: Limitation of liability for gratuitous service by a health care provider in a community health care clinic or community pharmacy (2008).
- ⁵⁵ State of Louisiana, Department of Health and Hospitals. Medical Malpractice HB 193 (2008).
- ⁵⁶ Florida Department of Health. *Volunteer Health Services Program Annual Reports* http://www.doh.state.fl.us/tobacco/VHS/archive/Volunteer/Annual_Reports.html (2007).
- ⁵⁷ Florida Statute 766.1115 Health care providers; creation of agency relationship with governmental contractors (2008).

-
- ⁵⁸ Juliao, Yocasta. E-mail to author (September 2008).
- ⁵⁹ Georgia Code - Torts - Title 51, Section 51-1-20 (2008).
- ⁶⁰ Commonwealth of Virginia. Department of the Treasury. Free Clinic Volunteer Health Care Practitioners.
- ⁶¹ Minnesota Statute 214.40 Volunteer Health Care Provider Program (2008).
- ⁶² Kentucky KRS § 304.40-075 Medical malpractice insurance for charitable health care providers; scope of coverage; premiums; registration of providers; review; availability of information (2008).
- ⁶³ Christine Lindquist, Program Administrator for the State of Washington Volunteer/Retired Providers Program. Interview with author (December, 2008).
- ⁶⁴ Washington RCW 43.70.470. Retired health care provider liability malpractice insurance — Conditions (2008).
- ⁶⁵ Kohel, Frank. Office Manager, Washington Western Area Health Education Program (October, 2008).
- ⁶⁶ Lindquist (December, 2008).
- ⁶⁷ Washington Casualty Company Schedule of Insurance for the Volunteer/Retired Physicians Program, 2008-2009 (2008).
- ⁶⁸ Kohel, (October, 2008).
- ⁶⁹ Lindquist, (December, 2008).
- ⁷⁰ Vangsness, Juli. Interview with author (October 2008).
- ⁷¹ Kohel, (October, 2008).
- ⁷² AMA Policy H-160.965. Voluntary Medical Care for the Indigent (2008).
- ⁷³ AMA Policy H-160.922 Physician and Health Plan Provision of Uncompensated Care (2008).
- ⁷⁴ Isaacs, Stephen L., and Jellinek, Paul. (2007).
- ⁷⁵ Charles, Robin. E-mail to author (2008).
- ⁷⁶ Wisconsin Department of Administration, Division of Executive Budget and Finance. Fiscal Estimate (2007).
- ⁷⁷ Bianchini, Karen. Insurance Services Manager, State of California Risk and Insurance Management Office. Interview with author (October, 2008).
- ⁷⁸ Bianchini.(2008).
- ⁷⁹ Vangsness.(2008).
- ⁸⁰ Minnesota Health Licensing Board. Administrative Services Unit. Voluntary Health Care Provider Program (2008).
- ⁸¹ Commonwealth of Kentucky. Office of Insurance, Property and Casualty Division. Medical Professional Liability Insurance. *Annual Call for Data* (February 2008).
- ⁸² Kohel, (October, 2008).
- ⁸³ Lindquist. (December, 2008).
- ⁸⁴ Bain, Scott. AB 621—Bill Analysis (May, 2003).
- ⁸⁵ Harrington, Mike. Bickmore Risk Services and Consulting. Annual Premium Rates Report (2008).
- ⁸⁶ The Doctors Company, Medical Malpractice Rates (2008).
- ⁸⁷ Southern California Physician Insurance Exchange, Medical Malpractice Rates (2008).
- ⁸⁸ Sam, Lucy. Director of Underwriting, NORCAL Mutual Insurance Company. Interview with Author (November, 2008).

⁸⁹ Sam, Lucy (November, 2008).

⁹⁰ Minnesota Health Licensing Board. Administrative Services Unit. *Voluntary Health Care Provider Program* (2008).

⁹¹ Western Washington Area Health Education Center, Volunteer/Retired Providers Program Site Application (2008).

⁹² Hattis (2004).