BRIEFING PAPER REGARDING
FTCA ISSUES RAISED BY DOJ WHITE PAPER

The purpose of this paper is to provide background information on the extension of the Federal Tort Claims Act (FTCA) to Indian tribes and their tribal organizations (T/TO) who take over operation of Federal programs under the Indian Self-Determination and Education Assistance Act (ISDEAA), and to respond to the FTCA-related concerns raised in the DOJ White Paper about S. 1057, the Indian Health Care Improvement Act reauthorization bill.

Preliminary notes regarding the purpose of the IHCIA.

- The IHCIA is a health program authorization statute. It sets out the framework through which the Secretary of HHS -- through the Indian Health Service -- carries out the Federal government's trust responsibility to provide health care services to Indians.

- The IHCIA is not the law through which FTCA coverage is extended to Indian tribal contractors who take over operation of Federal programs for Indians; in fact, the IHCIA contains no reference to the FTCA. FTCA coverage for tribal contractors was provided through the ISDEAA and later through language in appropriations acts.[1] Thus, it is not appropriate to attempt to address FTCA issues through an IHCIA reauthorization bill.

- The primary policy objectives of S. 1057 are to update the IHCIA (its last comprehensive amendments were made in 1992), and to enable the Secretary of HHS to provide modern, more effective and more cost-efficient methods of health care delivery to Indian people, but without regressing from the benefits of current law. Achieving these objectives should be the paramount consideration of the legislative process.

- The new policies in S. 1057 must be judged on whether they achieve these programmatic objectives; their merits should not be viewed solely through the prism of the FTCA coverage Congress extended to tribally-operated programs some 16 years ago -- as the DOJ White Paper seeks to do. DOJ apparently retains its long-standing opposition to extension of FTCA coverage to tribal contractors, but an Indian health program bill is not the proper legislative vehicle for airing those concerns.

Why did Congress extend the FTCA to Indian tribes and tribal organizations who operate Federal programs under ISDEAA contracts?

- The ISDEAA allows a tribe to elect to operate a program that the Secretary of Interior or Secretary of HHS would otherwise be obligated to operate for the benefit of Indians.

- The ISDEAA requires the Secretary to provide to the tribal contractor the same amount of funds the Secretary would otherwise have to operate the program, AND to add additional funds (called "contract support costs") to cover reasonable costs that the tribe incurs to prudently carry out the contract, but which the Secretary does not normally incur in direct operation, or are provided to the Secretary from other resources.

- Since the U.S. self-insures, one of the costs the Secretary does not incur is the purchase of liability insurance.

- Congress initially required ISDEAA contractors to buy insurance with contract support cost funds, but later realized that premiums -- especially for malpractice insurance for health contracts -- were skyrocketing. Since contract support cost funds were insufficient to cover all indirect costs including insurance premiums, tribes had to dip into program funds to pay for insurance. Congress had two choices: either greatly increase annual appropriations to cover the costs of private insurance, or find another way to provide necessary liability coverage for tribal contractors.

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[1] *See* 25 USC §450f, note, for coverage language.

- Congress decided the best alternative was to extend FTCA coverage to tribal contractors. While not a perfect solution, Congress determined it was the best "insurance policy" available for tribal contractors.

- Policy considerations relevant to the FTCA extension decision:[2]

  - Since both Interior and HHS would be obligated to continue operation of a program if a tribe did not contract it, the U.S. would retain the risk of liability for the program, and the FTCA would be the exclusive remedy for claims arising from program operations.
  - Through ISDEAA contracts, tribes take over *Federal* obligations. Therefore, the Federal government should provide liability coverage in the same manner as such coverage is provided when the Federal government performs the program -- that is, apply the FTCA as the exclusive remedy for tort claims.
  - *The ISDEAA was not intended as a way for the Federal government to divest itself of the liability it would otherwise have for claims arising from Federal Indian program operations.*
  - Insufficient appropriations for contract support costs produced two negative results: (i) tribes had to use program funds to help pay for insurance, and thus were forced to reduce services to Indian beneficiaries; and (ii) this resulted in a "penalty" for exercising ISDEAA rights.
  - Extending FTCA to tribal contractors was determined to be preferable to greatly increasing appropriations to purchase of private insurance to cover tribal contractor liability.

Why do tribes continue to purchase private insurance?

- The FTCA does not cover all potential claims. Thus, it is necessary for tribes to protect themselves against risks that FTCA does not cover. They do this primarily by purchasing "gaps" insurance (at a lower premium) to cover non-FTCA covered events.

- It is sometimes difficult to identify precisely what is and what is not covered by FTCA, as DOJ decides on a case-by-case basis which claims it will agree to defend under the FTCA. This leaves gray areas of residual risk at the fringe. Sound risk management dictates that insurance coverage be purchased for these gray areas.

- FTCA coverage extends only to ISDEAA contract operations. Some tribes operate other programs that are not part of the ISDEAA contracts and must assure liability coverage for those operations.

The White Paper asserts that FTCA coverage is a bad idea because it makes the U.S. liable for torts committed by non-Federal entities where the Federal government does not supervise tribal contractor operations, and because tribes and tribal organizations "have no financial incentive to limit risk or to raise standards of care".

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[2] Congressional work on providing liability coverage for ISDEAA contractors spanned several years and the decision to permanently extend the FTCA to contractors was not made capriciously. In 1987, the ISDEAA was amended to extend FTCA coverage to tribal health contractors for medical claims due to the high cost of medical malpractice insurance. Pub.L. 100-202 (Dec. 22, 1987); *see also* H.Conf. Rep. 100-498, at 918, H.Rep. 100-171, at 95-96, and S.Rep. 100-165, at 112. In 1988, through Pub.L. 100-472 (Oct. 5, 1988), the ISDEAA was amended to make the Secretaries of HHS and Interior responsible for "obtaining or providing liability insurance or equivalent coverage on the most cost-effective basis". 25 USC 450f(c)(1). *See also* S.Rep. 100-274, at 26-28; *reprinted in* 1988 USCCAN at 2645-2647. In 1989, Congress extended FTCA for general liability claims against tribal contractors for one year only -- FY1990 -- as a stop-gap measure. Pub.L. 101-121 (Oct. 23, 1989). The Departments were directed to provide information on insurance alternatives for tribal contractors, but they did not do so. Thus, in 1990, FTCA extension to tribal contractors was made permanent in order to meet the liability insurance provisions in the ISDEAA. Pub.L. 101-512 (Nov. 5, 1990). This language was further amended in 1993 to assure that ISDEAA self-governance *compactors* were included in the coverage provided. Pub.L. 103-138 (Nov. 11, 1993).

- It is incorrect that the U.S. has no control over the program operations of tribal contractors. Indeed, the contrary is true. Every ISDEAA contract includes the standards applicable to the program(s) being performed and obligates the tribal contractor to comply with those standards. Often the standards recited in a contract are the standards the agency has established for its own direct operation of that program. Furthermore, tribal contractors are subject to reporting requirements and to on-site monitoring by the contracting agency such as the Indian Health Service.

- Of course, tribes have other incentives to maintain high program standards. They are serving *their own Indian people* and have a direct interest in assuring that the services they provide are of the highest possible quality and that their beneficiaries are exposed to the minimum level of risk.

- Indian health consumers themselves help assure maintenance of high standards. Like other consumers of health services, Indian patients would not tolerate lax program performance, especially when the programs in question are operated by their own elected tribal leaders.

- Since tribal contractors must purchase private insurance for FTCA gray areas and the non-ISDEAA programs they operate, they have a strong financial incentive to maintain high performance standards and to practice prudent risk management in order to obtain reasonable rates for this insurance coverage.

The White Paper asserts that tribal contractors lack any incentive to cooperate with the United States in defending litigation brought under the FTCA.

- This assertion does not bear scrutiny. Tribe not only have an incentive to cooperate, they have an obligation to do so under Federal regulations -- *See* 25 CFR Part 900, Subpart M.

- The cited regulations were developed jointly by Federal and tribal officials through the Negotiated Rulemaking process. They spell out precisely what tribal contractors must do when presented with an FTCA claim, and include a comprehensive description of the nature of cooperation the tribal contractor must provide.

- To the extent there may have been some isolated instances where a U.S. Attorney did not believe a tribe assisted to the desired degree with case development, such instances should not be ascribed to the entire tribal contracting community.

The White Paper complains that tribes "oppose any efforts by the United States to seek coverage under insurance policies purchased by tribes that would otherwise cover [FTCA] claims".

- We believe the DOJ authors refer to their attempts to persuade tribes to list the United States as a co-beneficiary on the private insurance policies they purchase.

- It would make no sense whatsoever for tribal contractors to list the U.S. as a co-beneficiary on a privately purchased liability policy, as this would nullify any benefit from the FTCA coverage. A primary purpose of Congress's extension of FTCA coverage to tribal contractors was to reduce their insurance costs. No insurer would reduce the premium for a tribe's policy if the private insurance had to cover the United States' liability under the FTCA as well as "gaps" not covered by FTCA. Paying the full premium would defeat one of Congress's objectives -- that is, to enable tribes to have liability coverage without using scarce program resources to pay for private insurance.

The White Paper makes the unrealistic suggestion that Congress appropriate funds to purchase insurance for tribal contractors instead of covering contractor claims under the FTCA.

- In the late 1980's and early 1990's Congress sought alternatives from the Departments for providing liability coverage for tribal contractors, and expected the Departments to supply estimates on the cost involved with providing private insurance. No estimates were supplied.

- The White Paper make no effort to quantify the amount of appropriations that would be needed today to purchase liability insurance for all tribal contractors. The spiraling costs of malpractice insurance faced by medical practitioners throughout the country are a certain indication that a massive increase in appropriations would be needed to fund the White Paper's suggestion, making it wholly unrealistic from a budget perspective. With Congress and the Administration trying to curtail domestic spending, it is unlikely in the extreme that the President's budget request for either Department would seek the enormous increase in funds that would be needed to purchase liability insurance for ISDEAA contractors to replace FTCA coverage.

What was learned from the 2000 GAO report on issues affecting FTCA coverage for Indian Self-Determination contracts?[3]

- The DOJ White Paper makes reference to this report and indicates that it documents "some of the problems with application of the FTCA to tribes and tribal contractors." It is important to note, however, that the "problems" identified relate to some questions that have arisen in implementation of the FTCA coverage in a tribal context. GAO did not question Congress's decision to extend FTCA to tribal contractors.

- GAO's assignment was to describe the process for implementation of FTCA in a tribal contractor context; to provide some claims history for a 3-year period; and to identify any coverage issues.

- Tribes would agree with GAO that FTCA is not a "perfect fit", and that some gray areas of coverage uncertainty exist. But extension of FTCA to tribal contractors remains an important and positive policy decision because without that coverage, tribes would have to divert significant program funds to obtain medical malpractice and general liability insurance and thus reduce the direct services they can provide to their beneficiaries. One of the goals of Congress was to avoid such diversion of program funds.

- The full extent of cost savings from FTCA coverage were not immediately realized throughout the Indian health system, as tribal contractors had to become familiar with what was covered by FTCA and what was not, and they had to work with the insurance industry to design insurance products and establish fair premiums that took the existence of FTCA coverage into consideration. Now, 16 years after FTCA coverage was provided, tribes are in a better position to negotiate appropriate "gaps" policies and premiums with insurance companies.

- GAO advised that where private insurance has been purchased, the agencies check to see if that insurance covers a claim for which FTCA coverage is sought, and where it does, to assure the private insurer pays first. This is common sense.

- GAO said that it was understandable that uncertainty about the parameters of FTCA coverage had led some tribes to continue to purchase comprehensive liability coverage.

- The 2000 GAO report also identified some legal issues that arose in the course of FTCA implementation, such as the FTCA's silence on removal of FTCA claims from tribal to federal court. Congress has not addressed these issues in legislation.

- None of the uncertainties or questions surfaced by GAO are so insurmountable to lead one to conclude that extension of FTCA to tribal contractors was unwise. In fact, it is remarkable that so few implementation issues have arisen.

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[3] General Accounting Office, *Federal Tort Claims Act Issues Affecting Coverage for Tribal Self-Determination Contracts,* GAO/RCED-00-169 (July, 2000).

Sec. 213 of S. 1057: Authority for Provision of Other Services

- The White Paper raises strong objections to Sec. 213 solely because the authors believe it "dramatically expands" services that can be offered by IHS and tribal heath contractors, and, therefore, the potential FTCA liability. The Paper totally ignores the vital policy and programmatic objectives of this provision.

- Sec. 213 authorizes the Secretary of HHS and tribal contractors to offer modern methods of health care delivery including *hospice care; assisted living, long-term care; and home- and community-based care.*

- These are all proven methods of alternative health care delivery utilized throughout the United States. The purpose of Sec. 213 is to assure that Indian health programs can achieve the programmatic benefits and cost-savings presented by these alternatives to far more expensive facility-based care.

- Making alternative forms of care, particularly home- and community-based care, available to health consumers is a key goal of the Bush Administration's health policy. For example, under his New Freedom Initiative, the President strongly endorsed the notion of providing Medicaid beneficiaries with greater choices in obtaining the care they need in the form of funding for self-directed and home and community based services as viable alternatives to institutional care. Congress agreed and included such policies in the Medicaid provisions of the Deficit Reduction Act of 2005.

- Former CMS Director McClellan observed that "the evidence supporting such [self-directed and home and community based services] reforms is stronger than ever -- evidence that personal control leads to much better beneficiary satisfaction, better health outcomes, and lower costs per person served."[4]

- Because of high rates of unemployment in Indian Country, a high percentage of Indian people are eligible for Medicaid. In order for Indian Medicaid beneficiaries to access the DRA's home and community based care reforms, IHS and tribal programs must be able to offer those services in their communities. Sec. 213 is intended to assure they can do so.

- The White Paper objects to care being provided in "a domestic setting, rather than a health care facility" based *solely* on its fear of tort claims. This narrow focus ignores the policy goals of this Administration and of Sec. 213 to *encourage* care to be provided in homes and communities where appropriate rather than deliver care only in an institutional setting. While cost seems to be the basis for the DOJ objection, the proven economies of alternatives to facility-based care were not factored into their cost analysis.

- Sec. 213 has already been revised by Committee staff in an effort to respond to DOJ's concerns about possible tort liability. Apparently, however, DOJ continues to press for provision to be stricken -- a position that is at odds with sound health policy espoused by the Administration.

- DOJ's fear that Sec. 213 would "dramatically expand" categories of treatment that could be provided is also misplaced. In fact, IHS's Community Health Representatives program has been operated by both IHS and tribal contractors in tribal communities since it was authorized in 1988. Furthermore, some IHS- and tribally-operated programs already offer home care, community-based services, end--of-life services, aftercare and skilled nursing care services.

"Traditional Health Care Practices"

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[4] Remarks of Mark B. McClellan, M.D., Ph.D., to National Council on Independent Living Annual Conference, Keynote Address, May 23, 2006.

- The White Paper objects that the definition of "traditional health care practices" will raise constitutional and tort liability issues. This concern is misplaced, as the definition of this term and all but one new use of that term have been removed from S. 1057 -- directly as a result of DOJ's objections.

- The White Paper's constitutional concern is that somehow the now-deleted definition or one/more of the five references to traditional health care in the bill could be viewed by a court as having a religious component. This is highly improbable, as no entry even remotely refers to religion.

- Four references to traditional health care are retained from *current law;* these have been in the law since at least 1992,[5] and none of them has ever been the subject of a malpractice lawsuit. They are retained in S. 1057 based on the principle that there should be no regression from current law authorities in the reauthorization legislation.

- The one new reference to traditional health care appears in Sec. 708 which authorizes a new demonstration project to address the critical need for Indian youth suicide prevention and intervention programs.

- *All five references to traditional health are based on the sound policy goal of making treatment programs relevant and effective for the Indian population being served.* This is particularly important in the context of behavioral health programs where traditional cultural concepts of Indian communities can be usefully employed to obtain beneficial patient outcomes. It would be misguided policy, indeed, to disallow use of these concepts in programs where they can help produce effective results merely because of vague and unfounded fears of malpractice claims.

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[5] Bill Sec. 109(b)(6) is in current law Sec. 107(b)(6) [Community Health Representatives]
Bill Sec. 704(d) is in current law Sec. 209(g) [Comprehensive Behavioral Health Prevention and Treatment]
Bill Sec. 711(b)(5) is in current law Sec. 209(k)(1)(E) [Behavioral Health Program]
Bill Sec. 712(a)(2)(A)(v) is in current law 708(a)(2)(E) [Fetal Alcohol Disorder Programs]