No. 13-1075

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA,

Petitioner,

—v.—

MARLENE JUNE, CONSERVATOR,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICI CURIAE* OF THE NATIONAL CENTER FOR LAW AND ECONOMIC JUSTICE AND THE SARGENT SHRIVER NATIONAL CENTER ON POVERTY LAW IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae are the National Center for Law and Economic Justice ("NCLEJ") and the Sargent Shriver National Center on Poverty Law ("Shriver Center"). Each *amicus* has decades of experience in securing and maintaining legal protection for the least fortunate members of our society. The *amici* submit this brief in support of Respondent because the position taken by the Government would create a limitations trap in medical malpractice cases against federally funded Community Health Centers ("CHCs") that would adversely affect the low-income families and individuals *amici* serve.

NCLEJ.[2] For nearly half a century, the NCLEJ has litigated in state and federal courts nationwide to protect and promote the economic security of low-income families and individuals and as part of that advocacy has worked to protect access to the courts for these individuals.

Shriver Center.[3] For more than 40 years, the Shriver Center has provided national leadership in efforts to increase justice and opportunity for low-income people and to ensure that their voices are heard in the making of public decisions that affect them. Through policy development, advocacy, litiga-

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[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae* or their counsel made a monetary contribution to its preparation or submission. Counsel for the parties received timely notice of the intent to file this brief and have consented to its filing.

[2] http://www.nclej.org.

[3] http://www.povertylaw.org.

tion, consulting, training, and communications, it builds the nationwide capacity of low income communities by representing them directly and by supporting and enhancing the capacity of other public interest lawyers who serve them.

SUMMARY OF THE ARGUMENT

Since 1962, federally funded Community Health Centers have played a vital role in the delivery of health services to poorer Americans. Of the 21 million individuals who visited these CHCs in 2013, 71% were below the poverty line and fully 92% were below 200% of the poverty line.

Valuable and vital as CHCs are, they are not perfect. On occasion, malpractice happens. Prior to 1992, malpractice claims against CHCs and their staff were litigated under state law.

In 1992, however, Congress enacted the Federally Supported Health Centers Assistance Act of 1992 (the "FSCHAA"),[4] which made the Federal Tort Claims Act (the "FTCA") the *exclusive* vehicle for malpractice claims against federally funded Community Health Centers and their associated professionals. In doing so, Congress was not "waiving sovereign immunity" to permit a cause of action that had previously been barred, as in the construction of the FTCA urged by the Government. Rather, Congress was *replacing* an existing cause of action against private parties under state law with a new, exclusive federal cause of action against the United States.

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[4] Pub. L. No. 102-501, 106 Stat. 3268 (as amended and made permanent by the Federally Supported Health Centers Assistance Act of 1995, Pub. L. No. 104-73, 109 Stat. 777, codified principally at 42 U.S.C. § 233(g)).

The FSCHAA was enacted two years after this Court's decision in *Irwin* v. *Department of Veterans Affairs*, 498 U.S. 89 (1990), which explicitly recognized that the longstanding presumption in favor of equitable tolling applies to claims against the federal government. Even under the Government's "prospective only" reading of *Irwin*, Congress was creating a new federal claim that would be presumed subject to equitable tolling. Congress was doing so, moreover, against the backdrop of existing state law causes of action that were in many cases themselves subject to tolling doctrines of one form or another.

Nothing in either the text of the FSCHAA or the legislative history suggests that Congress thought the new claims would not be subject to equitable tolling in appropriate cases. Whether one views Congress's failure to bar equitable tolling in the post-*Irwin* adoption of the FSCHAA as legislative acquiescence in *Irwin*, or whether one sees it as simply confirming that the FTCA statute of limitations has *always* been subject to equitable tolling, the result is the same: the FTCA requirement that an administrative claim be filed within two years of the date of accrual is subject to equitable tolling in appropriate circumstances.

ARGUMENT

THE FEDERALLY SUPPORTED HEALTH CENTERS ACT OF 1992 DEMONSTRATES THAT THE LIMITATIONS PROVISIONS OF THE FTCA ARE SUBJECT TO EQUITABLE TOLLING

1. The Health Center System

Six-year-old Mercy Santos had a swollen jaw and a fever when her mother took her to York Health Corporation's pediatric clinic in York, Pennsylvania. After at least seven visits to York's pediatric and dental clinics over the course of a month, Mercy ended up in the emergency room, where she was diagnosed with a deep neck-space infection extending into her spine. After 19 days in the hospital and months in a cervical collar, Mercy's top two vertebrae grew back fully fused together, permanently impairing her movement. She will likely suffer from an accelerated degenerative disc disease in her lower vertebrae.[5]

Mercy's mother hired counsel, who identified a doctor, two dentists, and a physician assistant whose negligence caused Mercy's injuries. Counsel performed a public records search on York Health, corresponded with York Health, obtained Mercy's medical records, visited the clinic, and reviewed records on-site. Two years and five months after the claim accrued, counsel filed a medical practice action in state court. While Pennsylvania typically applies a two-year statute of limitations in medical malprac-

[5] *Santos ex rel. Beato* v. *United States*, 559 F.3d 189 (3d Cir. 2009).

tice cases, counsel reasonably believed the action to be timely based on a statutory provision that tolls the statute of limitations in civil actions until the would-be plaintiff, a minor, turns 18. *See* 42 Pa. Cons. Stat. § 5533(b)(1)(i)-(ii).

Months later, the United States substituted itself as defendant and removed the case to federal court. Unbeknownst to counsel — and not revealed through his diligent investigation — York Health Corporation (and its employees) had been deemed federal government employees. *See* 42 U.S.C. § 233(g). Mercy's claims were thus governed by the Federal Tort Claims Act — and, most important, its two-year statute of limitations for filing administrative claims. Absent equitable tolling, Mercy could not recover for her injuries.

Mercy's case is not an outlier.[6] Instead, it is an inevitable — but unfortunate and almost certainly unintended — consequence of the system designed by the federal government to fund health providers that deliver medical services to the nation's poor. Pursuant to the Public Health Service Act, the federal government helps fund more than 1,300 public and nonprofit health organizations that serve "medically

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[6] *See, e.g.*, *Sanchez* v. *United States*, 740 F.3d 47 (1st Cir.), *cert. denied*, 135 S. Ct. 54 (2014); *Phillips* v. *Generations Family Health Center*, 723 F.3d 144 (2d Cir. 2013); *Arteaga* v. *United States*, 711 F.3d 828 (7th Cir. 2013); *A.Q.C. ex rel. Castillo v. United States*, 656 F.3d 135 (2d Cir. 2011); *Valdez ex rel. Donely* v. *United* States, 518 F.3d 173 (2d Cir. 2008); *Swift* v. *United States*, 2014 WL 2769141 (D. Mass. June 17, 2014); *Bazzo* v. *United States*, 2011 WL 2601009 (E.D. Mich. June 30, 2011); *Bohrer* v. *City Hosp., Inc.*, 681 F. Supp. 2d 657 (N.D. W. Va. 2010); *Jones* v. *United States*, 2007 WL 4557211 (M.D. Fla. Dec. 21, 2007).

underserved" rural and urban areas, as well as the homeless, migratory and seasonal agricultural workers, and residents of public housing. *See* 42 U.S.C. § 254b.[7] These federally qualified health centers served 21 million people last year, 71.9 percent of whom were at or below the poverty line.[8]

In order to alleviate the burden of purchasing private medical malpractice insurance and make funds spent on premiums available for additional health services,[9] Congress in 1992 extended to these centers protection from medical malpractice liability. Under 42 U.S.C. § 233(g), federally funded health centers can apply to be deemed federal agents and employees for purposes of the FTCA, making a claim against the federal government the exclusive remedy for malpractice. The provision today shields nearly 1,000 organizations[10] from liability under state law,

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[7] The history of these centers dates back to the 1962 enactment of the Migrant Health Act, which provided medical funding and support for migrant and seasonal agricultural workers. Subsequently, some neighborhood health centers began to receive federal funding under the Economic Opportunity Act of 1964. U.S. Department of Health and Human Services, *Health Centers America's Primary Care Safety Net Reflections on Success, 2002-2007*, 1-2, *available at* ftp://ftp.hrsa.gov/bphc/HRSA_HealthCenterProgramReport.pdf. Responsibility for funding these centers was later transferred to the Department of Health, Education, and Welfare, and, in 1975, Congress amended the Public Health Service Act to create a more formal system for funding them. *See* Pub. L. No. 94-63, § 501. *See also* S. Rep. No. 94-29, at 38-39 (1975).

[8] National Program Grantee Data, http://www.bphc.hrsa.gov/uds/datacenter.aspx?year=2013 (last visited Nov. 10, 2014; data are for 1,201 reporting grantees).

[9] *See* H. R. Rep. No. 102-823 (Part 1), at 3-5 (1992).

[10] Based on search of deemed health centers on the Health Resources and Services Administration's website. *See* http://

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including groups such as Jewish Renaissance Medical Center of Perth Amboy, N.J., Presbyterian Medical Services of Santa Fe, N.M., and Valley Health Team, Inc., of San Joaquin, Calif.

2. The Statute of Limitations Trap

With names like these, it is not surprising that even experienced medical malpractice lawyers who engage in extensive investigation of their clients' claims fail to discover that those claims are governed by the FTCA. Indeed, courts have recognized that plaintiffs and their counsel may have no reason even to ask the question. In the case of Mercy Santos, the Third Circuit reversed the district court's refusal to apply equitable tolling for precisely this reason. Even if publicly available sources could have shown that York was covered by the FTCA, the court held, the government had not shown "what circumstances should have led her to inquire into York Health's federal status for purposes of FTCA." *Santos ex rel. Beato* v. *United States*, 559 F.3d 189, 203 (3rd Cir. 2009). Nor did statements on York's website that it was a federally qualified health center and that it received federal funding reveal "to a reasonably diligent plaintiff" that its doctors would be covered by the FTCA. *Id.* at 201.

The Second Circuit has likewise recognized that equitable tolling may be appropriate where counsel, despite investigating diligently, fails to discover a health provider's FTCA status. In *Phillips* v. *Generations Family Health Center*, 723 F.3d 144 (2d Cir. 2013), plaintiff's counsel tried to determine Genera-

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www/bphc.hrsa.gov/ftca/healthcenters/ftcahcdeemedentitysearch.html (last visited Nov. 10, 2014).

tions' ownership and funding structure by visiting its website, looking at medical records, and having a paralegal perform a corporate search. *Id.* at 146. The court remanded because the district court had applied an erroneous *per se* rule that lawyers at top malpractice firms always lack diligence if they fail to investigate an apparently private health center's federal status. *Id.* at 148-49. Instead, it held, a case-by-case consideration of all relevant facts is required.[11] Again, the availability of a health center's FTCA status was not dispositive. "Although HHS has created a publicly accessible online database of all its deemed employees and established a toll-free phone hotline that prospective plaintiffs can call to determine if a particular provider is a federal employee, Nielsen was apparently unaware of these resources and, in any event, did not suspect that Generations might be a federal employee." *Id.* at 147.

The trap in *Santos* and *Phillips* is not an anomaly. *See Valdez ex rel. Donely* v. *United* States, 518 F.3d 173, 183 (2d Cir. 2008). It follows from the absence of national uniformity with regard to statutes of limitations. Under the FTCA (and absent tolling), a claim expires two years after the plaintiff knows "both the existence and the cause of his injury." *United States* v. *Kubrick*, 444 U.S. 111, 113 (1979). State causes of action, though, may accrue at different times,[12] expire after a greater number of years,[13]

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[11] The court noted that "[t]he government could probably avoid such a case-by-case inquiry by requiring . . . that all deemed employees provide notice to patients about their federal status." 723 F.3d at 153.

[12] New York and Michigan, for instance, both use a form of the continuous treatment rule. N.Y. C.P.L.R. § 214-a; Mich. Comp. Laws Ann. §§ 600.5805, 600.5838.

or be subject, as in *Santos*, to bright-line rules of statutory tolling.

This patchwork of state medical malpractice laws becomes problematic when plaintiffs have no reason to suspect that generous state limitations or accrual rules might not apply. And although differing statutes of limitation alone may not justify equitable tolling, courts have recognized that diligent counsel's failure to discover that plaintiffs' claims are covered by the FTCA may be the kind of "extraordinary circumstances" that merit relief. This is so even apart from any affirmative misconduct on the part of these health centers. *See Valdez ex rel. Donely*, 518 F.3d at 184 (remanding because of "a special circumstance that may warrant equitable tolling even absent fraudulent concealment").

3. The Case for Equitable Tolling

Now, take the complex legal landscape described to this point — a landscape that seasoned legal practitioners have trouble navigating — and consider the difficulty the typical health center client might face in attempting to assert a legal claim. The 21 million people who visited these centers last year are among the country's most impoverished. In fact, more than 92 percent of patients were at or below 200% of the poverty line (compared to 34.2% of the U.S. population), and more than 71 percent were at or below 100% of the poverty line (compared to 15.0% of the U.S. population).[14] Low-income individuals may not

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[13] In Maryland, for example, actions must be brought within the earlier of five years of the time of injury or three years of discovery of the injury. Md. Code, Cts. & Jud. Proc. § 5-109.

[14] As set forth in HRSA's National Program Grantee Data, *su-*

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realize that they have a legal claim or that legal help is available and thus may not seek legal assistance — or seek it late. Legal Services Corporation, *Documenting the Justice Gap in America* (2009). They are also significantly less likely to bring a medical malpractice suit. Mark A. Rothstein, *Health Care Reform and Medical Malpractice Claims*, 38 J. Law, Medicine & Ethics 871-74 (2010). These clients, who already face significant obstacles in accessing legal services, can hardly be expected to avoid the statute of limitations trap that ensnares so many experienced lawyers.

In taking away existing state-law remedies for medical malpractice by CHCs and substituting for them claims against the United States under the FTCA, Congress could not have intended to create limitations traps for the very individuals CHCs were created to serve. The FSHCAA was enacted against the backdrop of presumed equitable tolling that was expressly recognized by this Court in *Irwin*. *Irwin* pre-dated the FSCHAA by two years; even under the Government's "prospective only" reading of *Irwin*, malpractice claims involving CHCs are clearly new causes of action against the United States that were created after *Irwin* was handed down.

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pra, the centers served 1.1 million homeless people, 861,000 agricultural workers, and 227,000 people who live in public housing in 2013. In addition 22.9% of health center patients were best served in a language other than English. Health centers also treat significant numbers of people with mental health problems or disabilities: 1.1 million patients received mental health services, 105,000 received substance abuse services, and 2 million received enabling services.

The legislative history of the FSCHAA reflects Congressional awareness that malpractice claimants against CHCs would no longer have jury trials or punitive damages available.[15] It likewise reflects that Congress knew that malpractice claims involving a CHC would now be subject to a uniform federal statute of limitations.[16] Nowhere in either the legislative history or the text of the FSCHAA, however, is there the slightest suggestion that Congress intended to preclude relief from the FTCA limitations periods for individuals who, through no fault of their own, did not timely perceive that their only claim was against the United States.

The rule advocated by the Government turns the presumption against which Congress legislated on its head. It does so at the expense of our nation's most vulnerable individuals. Whether one views the enactment of the FSCHAA in 1992 and its re-enactment in 1995 as legislative acquiescence in *Irwin* in the context of the FTCA, or whether one sees them simply as confirmation that the FTCA limitations periods have *always* been subject to equitable tolling, the result is the same: the limitations periods of the FTCA are subject to equitable tolling in appropriate cases.

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[15] *See* H. R. Rep. No. 102-823 (Part 2), at 4 (1992).

[16] *Id.* at 6.

CONCLUSION

The judgment below should be affirmed.

November 11, 2014

Respectfully submitted,

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