No. 24-483

IN THE
Supreme Court of the United States

SANDHILLS MEDICAL FOUNDATION, INC.,
Petitioner,
v.
JOANN FORD, on behalf of herself and all others similarly situated,
Respondent,
and
UNITED STATES,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF PROFESSOR SARA ROSENBAUM AND PROFESSOR FEYGELE JACOBS AS *AMICI CURIAE* SUPPORTING PETITIONER

JESSICA L. ELLSWORTH
Counsel of Record
BAILY MARTIN
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5600
jessica.ellsworth@hoganlovells.com
baily.martin@hoganlovells.com

Counsel for Amici Curiae

TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

IN THE
Supreme Court of the United States

No. 24-483

SANDHILLS MEDICAL FOUNDATION, INC.,
Petitioner,
v.
JOANN FORD, on behalf of herself and all others similarly situated,
Respondent,
and
UNITED STATES,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF PROFESSOR SARA ROSENBAUM AND PROFESSOR FEYGELE JACOBS AS *AMICIS CURIAE* IN SUPPORT OF PETITIONER

STATEMENT OF INTEREST[1]

Amici are scholars with decades of experience in community health center policy. Amici are concerned that the Fourth Circuit's decision will undermine the financial viability of community health centers

[1] No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than amici curiae, its members, or counsel made any monetary contribution intended to fund the preparation or submission of this brief. All parties were notified of amici curiae's intent to submit this brief at least 10 days before it was due.

(CHCs), which provide essential health care to medically underserved communities, often at razor-thin margins. They write to underscore the importance of the question presented.

Professor Sara Rosenbaum is the Emerita Professor of Health Law and Policy, Milken Institute School of Public Health, at the George Washington University (GWU). She is one of the nation's leading experts on federal laws and policies related to CHCs and health care access in medically underserved communities. She has conducted extensive empirical research in her capacity as a professor of health law and policy, and also worked with CHCs and on federal health policymaking related to CHCs since 1977. She knows firsthand the critical role played by the Federal Tort Claims Act's (FTCA) protections for CHCs. Those protections ensure a workable remedy when someone experiences injury as a patient of a CHC without undermining CHC's financial stability. That stability is jeopardized by the decision below.

In her capacity as a member of the GWU faculty, she served for nearly a decade as the founding Chair of its Department of Health Policy, and during her tenure, founded the Geiger Gibson Program in community health, the only academic program devoted to CHC research, policy, and practice. She has focused throughout her 50-year career on health policies affecting access to primary health care in medically underserved urban and rural communities; during that time, Congress transformed CHCs from a small demonstration program into a core component of the Public Health Service Act. She worked closely on FTCA reforms that reflected a consensus view regarding the need for, and

value of, a comprehensive approach to liability coverage that would protect both CHCs and their patients while also protecting their scarce resources.

Professor Feygele Jacobs is the Professor of Health Policy and Management, Milken Institute School of Public Health, the GWU, where she directs the School's signature Geiger Gibson Program in community health, a leading program devoted to CHC scholarship, research and practice. She is a recognized expert on CHC history and practice.

Professor Jacobs had dedicated her career to advancing health care for underserved populations and communities. Prior to joining the GWU, she worked in the nation's largest public health and hospitals system, in CHC networks, in health center-controlled and operated managed care, and in health care philanthropy. Her work in CHC policy and practice on a nationwide scale grew out of her immersion in the development and operation of CHCs, CHC networks, and managed care plans owned and operated by CHCs. She has served on governing boards of CHCs and health center-related organizations and in senior management of the RCHN Community Health Foundation, a private nonprofit foundation devoted to supporting the work of CHCs nationally.

SUMMARY OF THE ARGUMENT

The question presented in this Petition is exceptionally important. CHCs serve more than 30 million children and adults—over 1 in 10 Americans—across rural and urban medically underserved communities. CHCs fulfill their mission to provide essential health care on incredibly thin operating margins; the decision below is not only inconsistent with law but

further complicates this mission by elevating operational costs. Since health centers work virtually without operating margins, these added costs must come directly at the expense of patient care.

The costs of cyber Insurance today are part and parcel of the cost of medical malpractice insurance that led Congress to extend FTCA protections to CHCs in the first place. By reading FTCA protections to extend only to direct clinical care, the Fourth Circuit has failed to adhere to both the letter and spirit of the law while, ironically, threatening the very revenue intended for patient care.

The Court should grant review and reverse the decision below.

ARGUMENT

I. THE QUESTION PRESENTED IS EXCEPTIONALLY IMPORTANT BECAUSE OF THE VITAL MISSION AND FRAGILE FINANCIAL POSITION OF COMMUNITY HEALTH CENTERS.

CHCs serve tens of millions of people every year and are now the nation's largest safety net primary health care system. In 2023, 1,363 health centers provided community-based care to more than 31 million Americans. Health Res. & Servs. Admin. (HRSA), *National Health Center Program Uniform Data System (UDS) Awardee Data* (*UDS Report*).[2] The decision below threatens their financial viability by limiting application of FTCA protections to their operations.

---

[2] *Available at* https://data.hrsa.gov/tools/data-reporting/program-data/national (last visited Nov. 26, 2024).

Since they were first statutorily established in 1975 as part of the Public Health Service Act, CHCs have carried out a unique mission. Their mission is to deliver comprehensive primary care regardless of ability to pay, and they operate under an enforceable legal duty to of care to reach community residents with essential cradle-to-grave primary care services. *See, e.g.*, Sara Rosenbaum & Daniel R. Hawkins, *The Good Doctor — Jack Geiger, Social Justice, and U.S. Health Policy*, 384 New Eng. J. Med. 983, 984 (2021). By law and mission, CHCs must focus exclusively on communities and populations designated as medically underserved by virtue of their poverty and the heightened health risks triggered by such poverty. Over 67 percent of patients they served in 2023 lived below the official federal poverty line, and almost 90 percent lived below twice poverty. *UDS Report*. The majority of CHC patients are enrolled in Medicaid or Medicare, but almost 1 in 6 are completely uninsured, including 1 million children. *Id.* 1 in 8 children received care from a CHC in 2023. HRSA, *2023 Uniform Data Systems Trends: Data Brief* (Aug. 2024).[3] As did 1.4 million people experiencing homelessness, 1 million agricultural workers, 405,000 veterans and 9.7 million rural residents. *Id.*

CHCs provide vital services. In 2023, that care consisted of 132.5 million patient visits for comprehensive primary and preventive care, prenatal care, chronic disease management, dental and vision care, and care for serious mental health and substance use disorder conditions. HRSA, *Impact of the Health*

[3] *Available at* https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2023-uds-trends-data-brief.pdf.

Center Program (Sept. 2024).[4] CHCs are on the front lines of the opioid epidemic, caring for millions of patients with mental health and addiction treatment and recovery services. *Id.* For millions of other patients, CHCs offer essential preventive care such as immunizations, well-child checkups, vision screenings, and cancer screenings. *Id.* And during the COVID-19 pandemic, they were the first line of care for many underserved communities, supporting the Department of Health and Human Services' testing and vaccination efforts by providing tens of millions of COVID-19 tests and vaccines, at-home tests, and N-95 masks. Bailey Spates, *Community Health Centers: A Vital Resource for COVID-19 Vaccination in the Era of Commercialization*, Nat'l Ass'n of CHCs (Oct. 5, 2023).[5] The impact: areas with CHCs experienced fewer COVID-19 infections and deaths compared to areas without them. *Id.*; *see also* Jessica Sharac et al., *Community Health Centers' Response to the COVID-19 Pandemic: Two-Year Findings from HRSA's Health Center COVID-19 Survey*, GWU Dep't of Health & Pol'y Mgmt. (May 3, 2022).[6]

CHCs are consistently recognized for the quality of care they provide. *See, e.g.*, Leighton Ku et al., *The Value Proposition: Evidence of the Health and Economic Contributions of Community Health Centers*,

---

[4] *Available at* https://bphc.hrsa.gov/about-health-center-program/impact-health-center-program.

[5] *Available at* https://www.nachc.org/chcs-a-vital-resource-for-covid-19-vaccination-in-the-era-of-commercialization/.

[6] *Available at* https://hpmmatters.publichealth.gwu.edu/community-health-centers-response-covid-19-pandemic-two-year-findings-hrsas-health-center-covid-19.

Geiger Gibson/RHN Cmty. Health Found. (Aug. 2022);[7] HRSA, *2022 Health Center Patient Survey Dashboard* (Mar. 31, 2022).[8] The decision below, if not reviewed by this Court, creates risks to CHCs' ability to provide this high-quality care in the many medically underserved communities where they operate.

This risk to care itself is driven by the fact that CHCs operate under highly stressed economic conditions and with very tight operating margins—which have grown tighter with increased demand for services. Costs have outpaced revenue in recent years. *See* Kristine Namhee Kwon et al., *Community Health Centers Grew Through 2023, But Serious Hazards Are on the Horizon*, Geiger Gibson Program in Cmty. Health (Sept. 17, 2024).[9] As a result, CHCs' net margins have fallen by about two-thirds, from 5.3 percent in 2021 to 1.6 percent in 2023. *Id*. Nearly half of CHCs actually had *negative* financial margins in 2023, and even among health centers with positive margins in 2023, more than 10 percent had margins below 3 percent. *Id*.

---

[7] *Available at* https://geigergibson.publichealth.gwu.edu/68-value-proposition-evidence-health-and-economic-contributions-community-health-centers.

[8] *Available at* https://data.hrsa.gov/topics/health-centers/hcps/dashboard-2022#/topic.

[9] *Available at* https://geigergibson.publichealth.gwu.edu/72-community-health-centers-grew-through-2023-serious-hazards-are-horizon.

II. THE FOURTH CIRCUIT'S DECISION IS CONTRARY TO THE PURPOSE AND HISTORY OF FTCA AMENDMENTS FOR COMMUNITY HEALTH CENTERS.

The FTCA was enacted in 1946 to protect federal employees and certain entities from lawsuits arising out of their official duties, providing immunity where it serves the public interest. *See* FTCA, 60 Stat. 842 (1946). Since 1992, FTCA coverage has been extended to CHCs which, since their initial creation in 1965, have provided comprehensive healthcare, unrestricted access, and community involvement in managing healthcare resources. *See* Alice Sardell, The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1986 3 (1st ed. 1988). Congress made FTCA coverage permanent in 1995 in order to ensure that CHCs would not need to spend limited resources on medical liability insurance, while also ensuring that clinics and their patients are protected in the event of a health care-related injury. In light of both the text and the law's underlying purpose, it is clear FTCA protections were intended to operate expansively, safeguarding the interests of CHCs and patients alike without the need to divert resources meant for their communities into the commercial medical liability market.

The history of FTCA amendments offers critical insight into why Congress designed the Act's immunity protections to be comprehensive. Prior to 1992, CHCs faced overwhelming costs—to the tune of tens of millions of dollars—in malpractice premiums. In 1990, for example, malpractice insurance premiums cost CHCs $58 million—over 12 percent of their total

federal grant funding and 4 percent of their total revenues. John T. Hammarlund, *Community Health Centers and Rising Malpractice Premiums: An Overview of the Community Health Center Program and Proposed Solutions to the Malpractice Insurance Rate Crisis*, 1 Cornell J. L. & Pub. Pol'y 135, 144 (1992). The next year, malpractice insurance costs for some CHCs rose 30 percent to 40 percent. Robert Pear, *Community Health Clinics Cut Back As Malpractice Insurance Costs Soar*, N.Y. Times (Aug. 21, 1991).[10]

Even though they were rarely sued,[11] high malpractice insurance costs prevented CHCs from providing care, and yet forgoing liability insurance meant that their clinicians could not obtain staff admitting privileges at nearby hospitals. Some clinics reduced services, particularly for pregnant women, and many struggled to recruit and keep doctors due to the inability to afford insurance. *See, e.g.*, U.S. Dep't of Health & Human Servs., OIG, *Medical Malpractice Insurance and the Community Health Centers* 2 (Nov. 1991).[12] Attempts to secure lower premiums for CHCs, despite their low claims rates, were unsuccessful. Malpractice insurers were unwilling to

---

[10] *Available at* https://www.nytimes.com/1991/08/21/us/community-health-clinics-cut-back-as-malpractice-insurance-costs-soar.html.

[11] H.R. Rep. No. 104-398, pt. 1 (1995) ("The number of medical malpractice claims against health centers under FTCA has been very low. [Between 1992 and 1995,] only 15 claims ha[d] been approved for FTCA coverage. This low number is consistent with the low rate of claims filed against health centers under private insurance.").

[12] *Available at* https://oig.hhs.gov/oei/reports/oei-01-91-01550.pdf.

distinguish CHCs from other healthcare providers, despite their unique patient populations and claims history. While the frequency of suits was extremely low, insurers effectively punished CHCs financially because of the high health risks experienced by their patients. *See, e.g.*, David Benor, *The Federally Supported Health Centers Assistance Act of 1992: An Experiment in Malpractice Coverage*, 110 Pub. Health Rep. 357, 357-360 (1995). Efforts to create alternative insurance options also failed, making a federal legislative solution necessary. *See id* at 357.

A. Congress amended the FTCA to address CHCs' rising malpractice costs.

In 1992, Congress amended the FTCA to address increasing liability costs faced by CHCs. *See* Federally Supported Health Centers Assistance Act of 1992, Pub. L. No. 102-501, 106 Stat. 3268. The amendment extended FTCA protections to employees of federally funded CHCs, effectively deeming them federal employees when acting within the scope of their work at the centers. *See* Michael A. Dowell & Carol D. Scott, *Federally Qualified Health Center Federal Tort Claims Act Insurance Coverage*, 27 Health Lawyer 31, 31 (Feb. 2015). By doing so, Congress sought to eliminate CHCs' need to purchase costly medical malpractice insurance so that their resources could be directed toward healthcare services. *See id.*

The 1992 amendment established a three-year pilot project to determine the impact of FTCA coverage on CHC expenses. *Id.* By one estimate, the 1992 amendment had resulted in sufficient savings to enable care to an additional 75,000 additional patients by 1995. H.R. Rep. No. 104-398 at 6. Congress then approved

a permanent extension of the coverage in 1995. *See* Federally Supported Health Centers Assistance Act of 1995, Pub. L. No. 104-73, 109 Stat. 777.[13] This amendment also clarified eligibility for immunity, ensuring that additional staff and volunteers were covered. *See* H.R. Rep. No. 104-398 at 5, 7, 9, 11. Like the 1992 amendment, the 1995 amendment was also largely in response to continued challenges CHCs faced in obtaining affordable liability insurance. *Id.* at 5.

B. The Expansion of FTCA Protections Reflect Congressional Intent to Protect Key Health Care Resources for Underserved Communities.

Congress' 1992 and 1995 amendments to the FTCA sought to adapt the statute's immunity provisions to contemporary risks faced by entities performing essential services. Those changes were part of a continued expansion of protection. The first expansions of FTCA protections to non-federal entities came with 1989 and 1991 amendments. Bureau of Land Management Appropriations Act, Pub. L. No. 101-121, § 315, 103 Stat. 701, 744 (1989); Department of the Interior and Related Agencies Appropriations Act, 1991, Pub. L. No. 101-512, § 314, 104 Stat. 1915, 1959-60 (referencing to appropriations for the Indian Self-Determination and Education Assistance Act

---

[13] FTCA coverage was impactful for CHCs. *See, e.g.*, U.S. Dep't of Health & Human Servs., OIG, *Cost to the Government for Providing Medical Malpractice Coverage to Community and Migrant Health Centers*, 3 (1996), *available at* https://oig.hhs.gov/documents/audit/4366/A-04-95-05018-Complete%20Report.pdf.

(ISDEAA)). The ISDEAA extended coverage to certain negligent acts by tribal contractors when acting within the scope of their duties. *Id.* FTCA protections became part of a broader effort to expand and strengthen health care resources for medically underserved communities. For example, in 1996, the Health Centers Consolidation Act of 1996 built on the 1995 reform by consolidating and streamlining into a unified federal legislative framework a series of health programs all of which shared the aim of providing primary care to underserved populations. *See* Federally Supported Health Centers Assistance Act of 1995, Pub. L. No. 104-73, 109 Stat. 777; Health Centers Consolidation Act of 1996, Pub. L. No. 104-299, 110 Stat. 3662. The consolidation was designed to improve access to care by simplifying the management of federal funding and operational oversight as part of a broader effort to enhance the focus and coordination of health services for vulnerable groups, particularly in underserved areas.

In 2002, Congress again broadened the FTCA to include additional staff at CHCs. *See* Health Care Safety Net Amendments of 2002, Pub. L. No. 107-251, 116 Stat. 1621. Recognizing the evolving needs of CHCs in reaching community residents in need of care, in 2022, Congress permanently extended FTCA coverage, as codified in the 21st Century Cures Act of 2016, for health professionals who volunteer in CHCs. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016), *amended by* Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, 136 Stat. 997, 1005. The 2022 amendment allowed CHCs to provide essential care to remote and vulnerable populations without incurring additional liability costs. Although

the Consolidated Appropriations Act of 2024 did not include new FTCA-related provisions, it allocated significant funding to address mental health and substance use issues to providing clinics, many of which are CHCs. *See* Dylan Stafford & Eli Rosen, *BILL SUMMARY: Labor, Health and Human Services, Education, and Related Agencies Fiscal Year 2024 Appropriations Bill*, S. Comm. on Appropriations (Mar. 21, 2024).[14] The funding support reflected ongoing efforts to strengthen the healthcare infrastructure, improve access to care, and address public health challenges, including the growing need for mental health services.

Just as the original 1992 and 1995 amendments were essential in shielding health centers from crippling malpractice costs, the 1996, 2002, 2022, and 2024 changes underscore the importance of broad, evolving protections that safeguard both patients and CHCs—especially as the landscape of healthcare delivery continues to change, including the expanded use of telemedicine and electronic transmission of patient and health information. The extension of FTCA coverage reflects the continuing need for comprehensive immunity protections that adapt to the challenges of both traditional and emerging risks, ensuring that CHCs can continue their vital mission without the burden of financial ruin from premiums or lawsuits. At the same time, FTCA protections also ensure that patients who do suffer injury have legal recourse without having to sap communities and their health centers of needed health care resources. Given the reach of CHCs, which serve over 30 million of the

[14] *Available at* https://www.appropriations.senate.gov/imo/media/doc/fy24_lhhs_bill_summary.pdf.

most vulnerable Americans, *UDS Report*, these legal protections play a vital role. To address liability risks, the FTCA must remain robust and flexible, adapting its scope as healthcare-related services evolve and preserving resources designated for healthcare.

C. Community Health Centers Face Increased Demand for Care, Rising Costs, and Cyber Concerns.

At the same time Congress was expanding legal protections for CHCs, the number of CHCs was quickly growing. In 1991, 600 CHCs served approximately six million patients at 1,500 clinics. Pear, *supra*. By 2023, nearly 1,400 CHCs served over 31 million patients annually, meaning CHCs now serve 1 in 10 people across the United States. *UDS Report.* At the same time, demand for care among uninsured patients has surged. *See, e.g.*, *Kwon* et al., *supra.* The Congressional Budget Office projects that the proportion of uninsured Americans will rise in 2024 and continue increasing in subsequent years. Because CHCs must serve all patients regardless of insurance status, CHCs will likely treat a growing proportion of uninsured patients. *See, e.g.*, *id.* Operational costs, however, may force CHCs to limit the total number of patients they can serve, potentially reducing access for both insured and uninsured patients. *See, e.g.*, *id.*

CHCs also face new risks in today's health care digital landscape. Safeguarding patient data is inextricably linked to their mission. As patient information and healthcare operations increasingly rely on electronic health records and digital systems, CHCs are more vulnerable to cyber threats, including data breaches, ransomware attacks, and phishing

schemes. Micky Tripathi, *Getting Real about Information Blocking and APIs*, HealthITbuzz.com (Oct. 8, 2024).[15] Like other health care providers, CHCs are obligated to protect all individually identifiable patient information, both under the duty of confidentiality that binds health centers by law, 42 U.S.C. § 254b, and as a result of other advances in federal law, most centrally, the Health Insurance Portability and Accountability Act. Incidents that threaten information security not only jeopardize the confidentiality of sensitive health information but can also disrupt critical healthcare services, putting patients' safety and privacy at risk. *See, e.g.*, Kesang Tashi Ukyab & Filipe Beato, *Healthcare pays the highest price of any sector for cyberattacks — that's why cyber resilience is key*, World Econ. Forum (Feb. 1, 2024).[16] Given the volume of patient data they manage and the resource limitations they often face, CHCs require robust cybersecurity measures and financial protections to respond effectively to potential cyber incidents. Mike Elgan, *Cost of a data breach: The healthcare industry*,

---

[15] *Available at* https://www.healthit.gov/buzz-blog/electronic-health-and-medical-records/interoperability-electronic-health-and-medical-records/getting-real-about-information-blocking-and-apis (As of October 2024, "[m]ore than 96% of hospitals and 78% of physician offices now use electronic health records" certified through the Office of the National Coordinator for Health Information Technology's voluntary Health IT Certification Program.).

[16] *Available at* https://www.weforum.org/stories/2024/02/healthcare-pays-the-highest-price-of-any-sector-for-cyberattacks-that-why-cyber-resilience-is-key/.

SecurityIntelligence.com (Aug. 6, 2024).[17] Unlike medical malpractice, cyber insurance premiums are not explicitly covered under FTCA protections, potentially posing a significant financial burden for CHCs as they strive to safeguard patient data and health records.

Cyber incidents, such as data breaches and ransomware attacks, introduce costly liabilities that can detract from CHCs' capacity to serve their communities. Given the high cost of cyber insurance and the budgetary limitations of many CHCs, these liabilities can pose devastating risk to their operations, similar to the threats that prompted the FTCA's initial malpractice protections. The history and purpose of FTCA amendments reflect a consistent commitment to protecting essential services provided by CHCs. By expanding immunity, Congress sought to ensure that CHCs could focus on providing needed healthcare services without the debilitating risk of liability. As such, applying FTCA immunity to cyber liability furthers the Act's objective of reducing financial burdens that jeopardize CHCs' provision of patient care.

D. FTCA Immunity Should Cover Cyber Liability Like It Does Other CHC Liability.

FTCA amendments reflect a clear intent to provide robust legal protections to patients and CHCs, underscoring Congress's recognition of the essential role that the CHCs play in providing accessible care to

[17] *Available at* https://securityintelligence.com/articles/cost-of-a-data-breach-healthcare-industry/ (In 2023, the healthcare industry suffered the highest average breach costs at $10.93 million.).

underserved populations. By establishing and later strengthening FTCA immunity provisions, Congress acted to reduce the financial and legal burdens on CHCs, enabling them to focus their resources on patient care rather than costly litigation. The legislative history supports a broad and comprehensive interpretation of FTCA immunity, aiming to preserve the viability and effectiveness of CHCs while safeguarding patient access to affordable healthcare services.

The origins, history, and integration of FTCA amendments, with other reforms aimed at broadening and deepening the reach of federally supported health care services to underserved populations, demands a comprehensive approach in interpreting the concept of a health care related activity, as specified under the FTCA statute. Immunity against cyber breaches aligns with the original intent to protect CHCs from crippling financial exposure for liabilities arising from health care and its necessarily related activities in the modern era. A proper reading of the FTCA is critical to ensuring that CHCs remain a stable, accessible resource for communities in need. The rise of cyber risks today underscores the importance of the question presented: whether FTCA immunity covers patient data breaches and cyber liability.

III. THE DECISION BELOW RISKS DEVASTATING CONSEQUENCES FOR COMMUNITY HEALTH CENTERS AND THEIR PATIENTS AND COMMUNITIES.

The Fourth Circuit held that FTCA protections do not cover liability claims for patient data breaches. *See Ford v. Sandhills Med. Found.*, 97 F.4th 252, 262-263 (4th Cir. 2024). This decision will have

profoundly detrimental effects on CHCs and their patients. The exclusion of FTCA protections leaves CHCs exposed to significant legal and financial risks in the event of a data breach, potentially diverting scarce resources away from patient care and threatening their ability to continue serving low-income and marginalized populations.

1. The decision below has devastating financial consequences for CHCs. The court held that liability for data privacy violations is not covered under the FTCA because the term "related functions" in 42 U.S.C. § 233(a) does not include collecting and protecting personally identifying information and protected health information; it only includes "health care" functions. *See* Pet. App. 17a-19a. But that reasoning ignores the reality that collecting data from patients is an inherent part of furnishing quality and appropriate healthcare. CHCs cannot stop collecting this data without compromising the level of care they provide patients. They must collect it, they have a duty to protect it, and they face massive liability if they fail to do so. Cyber liability has the potential to shutter CHCs across the nation.

2. Health care organizations are particularly susceptible to cyberattacks because of the sensitivity of the data they store and their inability to halt operations while systems are compromised, making them the "most vulnerable" industry. Alexis Kayser, *Hospitals Are Hacked, Then Sued. Is It Fair?*, Newsweek (June 10, 2024).[18] And protecting against cybersecurity

[18] *Available at* https://www.newsweek.com/hospitals-are-hacked-then-sued-it-fair-1910523.

attacks is expensive and outside the "core competency" for most health care entities. *Id.* When a cyberattack does occur, the resulting lawsuits and settlements are difficult for financially fragile organizations like CHCs to bear. In 2023, the average health care data breach cost $10.93 million, including expenses for detection, post-breach responses, and lost business, nearly double the cost of breaches in the second-most-expensive sector, finance. *Id.*

For CHCs today, the costs of cyber insurance, *see* Dan Garcia-Diaz, *Rising Cyberthreats Increase Cyber Insurance Premiums While Reducing Availability*, GAO (July 19, 2022),[19] present the 21st-century version of the enormous stress caused by the medical liability insurance crises of decades past, *see* Hammarlund, *supra* at 143-145. If cyber claims fall outside FTCA protection, CHCs are faced with choosing between absorbing the high costs of cyber insurance, or limiting or shutting down their services.

Nationally, median CHC margins are razor thin. *See, e.g.*, Peter Shin et al., *Community Health Centers in Financial Jeopardy Without Sufficient Federal Funding*, Geiger Gibson Program in Cmty. Health (Jan. 17, 2024).[20] But operating margins are crucial to maintaining programs and services and to investing in strengthening and expanding care. In 2022, more than half of all CHCs operated with margins below 5 percent. *See id.* In 2023, it was even lower. The

---

[19] *Available at* https://www.gao.gov/blog/rising-cyberthreats-increase-cyber-insurance-premiums-while-reducing-availability.

[20] *Available at* https://geigergibson.publichealth.gwu.edu/community-health-centers-financial-jeopardy-without-sufficient-federal-funding.

average margin of a CHC was about 1.6 percent—or $535,000—and median margins are projected to be negative in 2024. *Id.* *See Kwon* et al., *supra.* If CHCs must absorb an additional $20,000 to $100,000 in cyber insurance costs per center, *see, e.g.*, *Cyber Liability Insurance*, Koop Techs,[21] it is a significant financial burden on their operations.

3. By excluding liability claims related to patient data breaches from FTCA immunity, the decision below hurts CHCs in multiple ways. For one, it exposes CHCs to significant financial risks from lawsuits and legal battles far beyond the financial capacity of many CHCs. *See, e.g.*, Emily Olsen, *Average cost of healthcare data breach nearly $10M in 2024: report*, HealthcareDive.com (Aug. 1, 2024).[22] The need to redirect funds from patient care to legal defenses is not hypothetical: one loss calculator estimated that an entity with 50,000 records would incur nearly $1.1 billion in costs (excluding regulatory fines and penalties) due to a data breach. *See NetDiligence® Data Breach Cost Calculator*, Lockton.[23]

In addition, cyber incidents and the cost of cyber insurance likely will force many CHCs to scale back or eliminate essential services, reduce staff, limit operating hours, or cut vital programs crucial for patient

---

[21] *Available at* https://www.koop.ai/commercial-cyber-liability (last visited Nov. 26, 2024) ("Enterprises or companies in high-risk industries can expect significantly higher costs, with annual premiums ranging from $20,000 to $100,000 or more.").

[22] *Available at* https://www.healthcaredive.com/news/healthcare-data-breach-costs-2024-ibm-ponemon-institute/722958/.

[23] *Available at* https://eriskhub.com/mini-calc-usli (accounting for 50,000 records and PHI for type of data exposed).

care. As a result, the operational stability of these centers would be compromised, impacting their ability to serve the vulnerable populations who rely upon them for accessible and affordable healthcare.

Additional concerns exist too. Patients may be hesitant to seek care without adequate assurance that their data is secure and insured against breach. *See, e.g.*, Ukyab & Beato, *supra*. Forcing CHCs to limit or forgo offering care because of the cost of cyber insurance would detrimentally effect health outcomes given CHCs' critical role as a healthcare safety net for underserved communities. Reduced primary care access is associated with escalated costs for avoidable emergency care, which in turn not only adds stress to community hospitals but also heightens serious health disparities and worsens health outcomes. *See, e.g.*, Daniel Weisz et al., *Emergency Department Use: A Reflection of Poor Primary Care Access?*, 21 Am. J. Managed Care 152 (2015). The effects would be felt most acutely by the low-income and rural communities that rely on CHCs for primary care.

When CHCs must limit their operations, it also threatens the employment for healthcare professionals, administrative staff, and support personnel who work at those entities. In 2021, CHCs supported over 500,000 direct and indirect jobs, nearly $85 million in economic output, and more than $37 billion in labor income. *Economic Impact of Community Health Centers in the United States*, Matrix Glob. Advisors 1 (Mar. 2023).[24] The loss of jobs and career

[24] *Available at* https://www.nachc.org/wp-content/uploads/2023/06/Economic-Impact-of-Community-Health-Centers-US_2023_final.pdf.

development programs would more broadly impact the local communities which depend on these centers for employment. Data shows that CHCs bolster employment and economic growth by attracting significant federal funding to their areas, in addition to generating an "economic multiplier" effect. Ku et al., *supra*.

***

FTCA protection from cyber liability is essential for CHCs as it ensures they can continue to provide vital healthcare services without the burden of costly cybersecurity-related lawsuits. As healthcare systems become more reliant on digital infrastructure, these centers are increasingly vulnerable to cyber threats. FTCA protection not only shields CHCs from financial risks but also fosters trust in the healthcare system, allowing these centers to focus on improving patient care, reducing healthcare costs, and strengthening the economic vitality of their communities.

CONCLUSION

For the forgoing reasons, and those discussed in the Petition, the Petition for Writ of Certiorari should be granted.

Respectfully submitted,

JESSICA L. ELLSWORTH
Counsel of Record
BAILY MARTIN
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5600
jessica.ellsworth@hoganlovells.com
baily.martin@hoganlovells.com

Counsel for Amici Curiae

NOVEMBER 26, 2024