

**JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION
OF THE VIRGINIA GENERAL ASSEMBLY**

**Review of the
Virginia Birth-Related
Neurological Injury
Compensation Program**

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Preface

The Virginia Birth-Related Neurological Injury Compensation Program (birth injury program) pays for the medical and certain other expenses of children who have severe neurological injuries resulting from the birthing process. It is intended as an alternative to the tort system for obtaining compensation for injuries. A number of concerns have been raised about the program during its 15-year existence, including recent questions about the financial stability of the fund.

In January 2002, the Joint Legislative Audit and Review Commission (JLARC) directed staff to conduct a review of the birth injury program. In addition, staff were requested to examine the provisions of House Bill 714 (2002) as part of this study. Through this review, JLARC staff assessed the program's structure and operations, and examined the extent to which the program has served its intended purpose.


JLARC staff found that the birth injury program appears largely beneficial to the children served by the program, compared to Virginia's capped tort system. In addition, participating physicians, hospitals, and medical malpractice insurers have benefited by the program through reduced medical malpractice insurance rates, a reduction in birth-injury-related lawsuits, and a reduction in subsequent claims costs. However, it is less clear that the program has achieved the societal benefits intended, such as the availability of obstetrical care in rural areas of the State.

In addition, the most recent actuarial report on the program projected the fund would have an unfunded liability of more than \$88 million based on the fund balance at the end of 2002. Despite this long-term liability, there is no threat of a short-term deficit, as the fund's current balance is approximately \$84.7 million. This report identifies some of the decisions that have contributed to the fund's actuarially unsound status, including flaws in the basic assessment structure and inadequate financial oversight of the fund by the birth injury board.

Three policy options are presented concerning the future of the birth injury program. First, the basic structure of the program could be maintained, including voluntary participation in the program by obstetricians and hospitals. Second, participation in the program could be made mandatory for these groups. Third, the program could be eliminated. The body of the report discusses the strengths and weaknesses of each policy option.

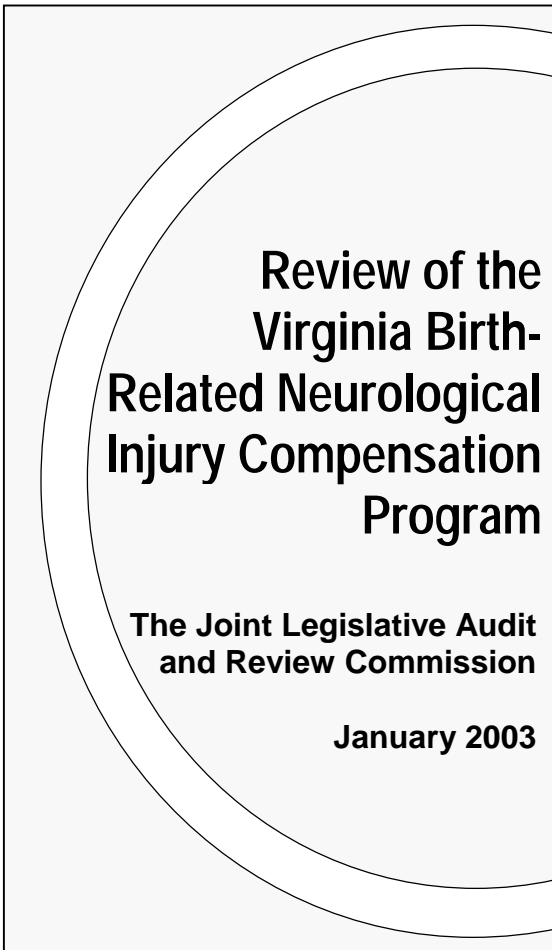
If the General Assembly chooses to maintain the program, a number of changes will be needed to the process for determining an infant's eligibility for the program, as well as to the structure and operation of the program. The report presents 41 specific recommendations for program improvements. Legislation has been introduced in the 2003 Session (House Bills 2048 and 2307) to implement many of the recommendations of this report.

On behalf of the JLARC staff, I would like to thank the staff and board of the Virginia Birth-Related Neurological Injury Compensation Program, the staffs of the State Corporation Commission and Workers' Compensation Commission, and the families involved in this program for their assistance with this review.


Philip A. Leone
Director

January 15, 2003

JLARC Report Summary



The Virginia Birth-Related Neurological Injury Compensation Act was passed by the General Assembly in 1987 in response to malpractice insurance availability problems for providers of obstetric services. The program pays for the medical and certain other expenses of children who have severe neurological injuries resulting from the birthing process. It is, therefore, intended as an alternative to the traditional tort system for obtaining compensation for injuries.

Because a number of concerns have been raised about this program during its 15-year existence, the Joint Legislative Audit and Review Commission (JLARC) directed its staff in January 2002 to conduct an evaluation of the

program. In the early years, the program built up a large fund, while very few children benefited from the program. In recent years, there has been a substantial increase in the number of children in the program, raising questions about the financial stability of the fund and the viability of the program's continued existence in its present form. Through this review, JLARC staff assessed the program's structure and operations, and examined the extent to which the program has served its intended purpose.

History of the Birth Injury Program

In the mid-1970s, Virginia along with the rest of the nation experienced its first medical malpractice crisis. As a result of this crisis, almost all states enacted some changes in their tort systems. Most notable among the changes in Virginia was a cap placed on the total amount recoverable in medical malpractice lawsuits.

By the mid-1980s, another medical malpractice crisis was looming, heightening interest in additional tort law changes. The early to mid-1980s saw increasing medical malpractice lawsuits, increasing malpractice insurance premiums, and decreasing insurance availability. This situation led to a "crisis" in obstetrics, in which physicians were reportedly eliminating obstetrical care from their practices. Rural areas of Virginia were reported to be particularly affected by this situation, with some counties having no obstetrical services available. Several changes in tort law were subsequently enacted, including the Virginia Birth-Related Neurological Injury Compensation Act. This act established a unique framework, separate from the court system, for addressing one of the most severe and costly types of medical injuries – birth injuries. Virginia was the

first state in the nation to develop a birth injury compensation plan completely removed from the tort system. The only other state to enact a birth injury program is Florida.

Purpose of the Virginia Birth-Related Neurological Injury Compensation Act

The goal of the birth injury act was to alleviate the medical malpractice insurance availability crisis for obstetricians. At its simplest description, the birth injury program was intended to remove malpractice lawsuits from the court system and provide for an alternative way of compensating the plaintiff for his or her medical-related injury. Infants severely injured at birth were singled out for this approach because lawsuits associated with these cases have a relatively high rate of success and the successful cases tend to result in large monetary awards.

To be eligible for the program, an infant must meet the definition in the act for a birth-related neurological injury, and the obstetrical services must have been performed by a physician or at a hospital that specifically participates in the birth injury program. The program was designed as a “no-fault” system of compensation, and therefore, decisions regarding acceptance into the program are not based on a finding of malpractice.

By delivering a baby in a participating hospital and/or through a participating physician, the baby’s family automatically waives the right to bring a medical malpractice lawsuit against the participating physician or hospital if the baby incurs a birth injury that meets the definition in the *Code*. The program was also intended to completely restructure the way injured infants are compensated for their injuries by eliminating the lump sum awards common in malpractice awards and instead, providing payment on a reimbursement basis, after collateral sources are used.

Around the same time as the medical malpractice crisis, the State was experiencing a problem regarding obstetric care for indigent women. To help alleviate this problem, language was included in the birth injury act to require doctors, as a requirement for participation in the program, to work with the Commissioner of Health in developing a program to provide obstetrical care to indigent women and to subsequently participate in its implementation.

Structure of the Birth Injury Program

Administration of the Birth-Related Neurological Injury Compensation Program (birth injury program) involves the program staff and two State agencies. The funding of benefits comes from assessments on physicians, hospitals, and insurers in Virginia.

Division of Responsibilities.

There are three main entities involved in the birth injury program and fund. The Workers’ Compensation Commission (WCC) conducts hearings and determines eligibility for claimants who seek entry into the program. The State Corporation Commission (SCC) has certain financial responsibilities vis-à-vis the fund. The birth injury board of directors administers the program and the fund.

Program Claimants. As of October 2002, 75 children have been accepted into the program. The children in the program currently range in age from one to 14 years old. By definition, all of the children in the program have severe physical and cognitive disabilities rendering them incapable of independently performing the basic activities of daily living.

Program Benefits. Section 38.2-5009 of the *Code of Virginia* identifies three broad categories of benefits that the program is to provide. First, it states that compensation will be provided for all “medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care

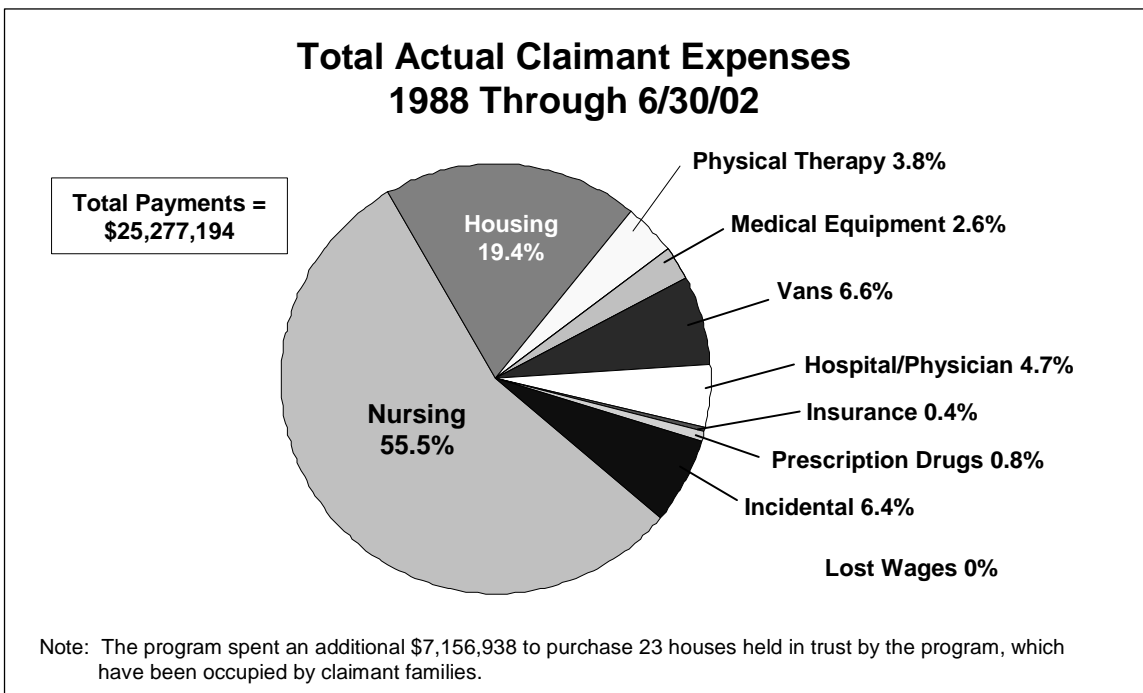
and service, special equipment or facilities, and related travel,” except those for which the claimant has already received reimbursement either under the laws of another government entity or the policy of another private insurance program. Second, it provides payment (in regular installments) for loss of earnings from the age of 18 until 65. Third, it allows for reimbursement of “reasonable expenses incurred in connection with the filing of a claim . . . including reasonable attorney fees.”

Although the program was established in 1987, the first payment to a claimant was not made until 1992. Since then, almost \$25.3 million in program assets have been distributed (see figure below) for claimant expenses through June 2002. (The program spent an additional \$7.2 million to purchase trust homes that remain assets of the program but are used by claimants for the duration of their lives. The trust home benefit was eliminated in January 2000.) On average, the dollar value of claimants’ benefits per year since 1992 is approximately \$62,000 (not including the value of the trust homes).

Funding the Birth Injury Program. The birth injury program is funded primarily through assessments on four sources. These sources are: participating physicians, participating hospitals, non-participating physicians, and liability insurers. Currently, the sources are assessed at the maximum levels allowed by law. As of July 2002, there were 500 participating physicians and 27 participating hospitals in the program. As of June 30, 2002, the fund was valued at \$83.6 million.

Impact of the Birth Injury Program Is Mixed

The birth injury program had an immediate impact on medical malpractice insurance availability in Virginia because, once the program was created by the General Assembly, one of the major malpractice insurers immediately lifted its moratorium on writing new policies for obstetricians/gynecologists (ob/gyns). This action helped ameliorate the lack of available insurance experienced prior to the program’s creation due to another insurer’s withdrawal from the Virginia market.



While this short-term impact is clear, the program's long-term impact is less clear. It appears that the program has had mixed success in meeting all of its objectives.

The Program Compares Favorably to Virginia's Capped Tort System for Birth-Injured Children. Overall, it appears that the benefits offered by the program are generally more advantageous to birth-injured children than a medical malpractice award in Virginia. In addition to serving more birth-injured children than the tort system, the program provides benefits that exceed the medical malpractice cap for the typical child. There are also major disadvantages to the families, however, including the inability of mothers to receive compensation for injuries caused by their physician during the birthing process. In addition, the program does not always meet the unique needs of individual children.

The Birth Injury Program Benefits Physicians, Hospitals, and Malpractice Insurers. Virginia's significant changes to the tort system (notably the malpractice award cap), along with a relatively low malpractice claims record, made the State an attractive market for medical malpractice insurance companies in the 1990s. It appears that the birth injury program played a role in creating this situation both by minimizing claims for severely birth-injured children and by helping to keep intact the medical malpractice award cap. As a result, ob/gyns in Virginia were able to obtain malpractice insurance at lower rates than their counterparts in many other states. To a lesser extent all physicians benefited from the lower level of indemnity incurred by malpractice insurers. Although malpractice premiums have increased significantly in the past few years, this does not negate the fact that the malpractice cap and birth injury program appear to have had a positive effect on claims costs and subsequent malpractice premiums.

At the same time, the birth injury program has directly benefited some participating physicians because they avoided medical malpractice lawsuits. Others have benefited from insurance discounts for participation that exceed the assessment paid for participating in the program. In other words, they benefit financially simply by participating in the program.

Societal Benefits from Program Are Less Clear. In the 1980s, ob/gyns were reportedly leaving the practice of obstetrics because of the rising malpractice insurance premiums and risk of lawsuits that they faced. Staff of the Medical Society of Virginia noted that a number of rural areas, in particular, had no obstetrics coverage. The rationale for the birth injury program was that by stabilizing medical malpractice premiums for obstetric providers and reducing their exposure to lawsuits, they would decide to continue practicing obstetrics in the State.

Definitive data are not available on the level of obstetric services throughout Virginia over time. However, review of available information suggests that while the program does help stabilize malpractice premiums, the program's existence does not appear to have a significant impact on the availability of obstetric services in the State.

Further, it appears that the annual program assessments are more than the potential awards and associated expenses of the tort system for addressing severe birth injuries, given Virginia's medical malpractice award cap. Total assessments for physicians, hospitals, and insurers in 2002 were almost \$15.2 million. In contrast, JLARC staff estimated that potential tort system awards and expenses for severe birth injury cases were about \$10.8 million – \$4.3 million less than the birth injury program assessments.

Finally, the impact of the program on obstetric services to indigent women is unclear. As directed in the birth injury

act, the Department of Health implemented plans in 1988 for ensuring indigent women had access to obstetric services. However, there is no indication that the plans have ever been updated or are currently in effect. Data from the Department of Medical Assistance Services suggests a generally increasing level of obstetric coverage for women with Medicaid coverage. However, this trend does not appear to be related to the provisions of the birth injury act, given that no action has been taken since the late 1980s regarding the birth injury act's indigent care provisions.

The Birth Injury Fund Is Actuarially Unsound, Although There Is No Threat of Short-Term Deficit

When the birth injury fund was established in 1988, the birth injury act mandated the Bureau of Insurance of the State Corporation Commission to undertake actuarial valuations of the assets and liabilities of the fund at least biennially. The most recent actuarial report, released in September 2002, projects the fund will have a balance of \$84.7 million as of December 31, 2002. However, it also projects an unfunded liability of more than \$88 million at that time.

While forecasts by the actuary point toward an \$88 million unfunded liability at the end of 2002, there appears to be no serious threat of a short-term deficit. In fact, according to the actuary, the current fund balance should be sufficient to meet claimant expenses for at least the next 25 years, provided current assessments are maintained. Nevertheless, this projection does not guarantee lifetime support for all current claimants, or for those born but not yet in the program.

The fund's current condition has resulted from a chain reaction of events, some of which were unavoidable. In the early years of the program, the actuary had little or no data on actual claimant expenses and other basic program pa-

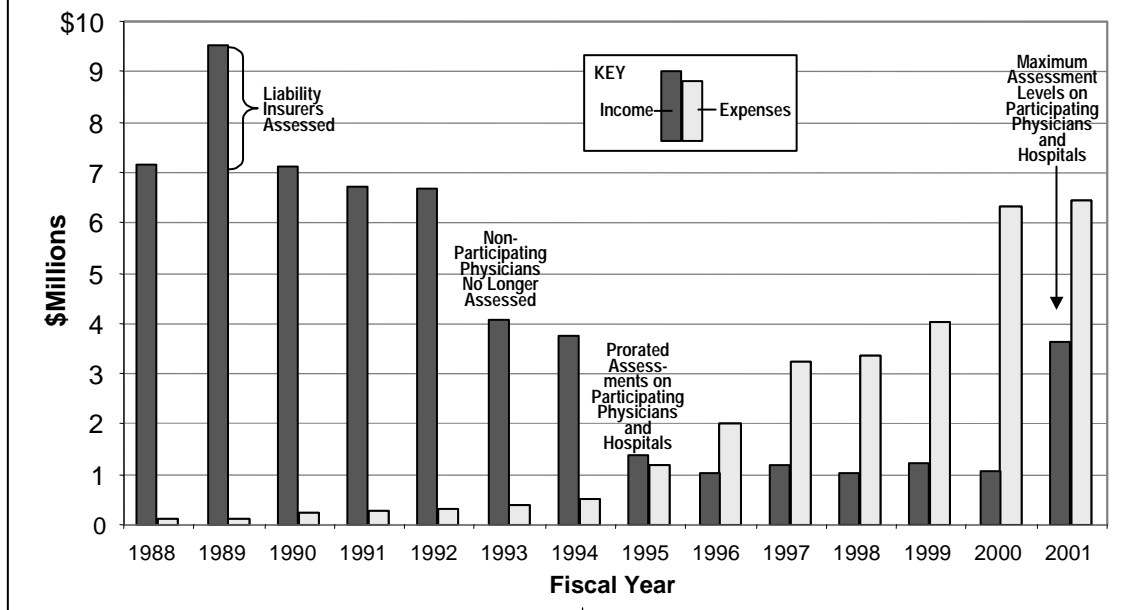
rameters on which to base its analyses. In hindsight, the parameters it chose to use underestimated the true cost to provide lifetime care to the birth injured children in the program. Only since 2001 has the actuary based its analyses on actual program expenses. The adjustments made to account for the claimant data indicate that the true cost to care for these children is more than double what was originally estimated. Because estimated costs were thought to be so much lower, the perception was that the fund had more than enough money to provide lifetime care for the children.

In addition, JLARC staff identified two main problems with the board's oversight of the fund. First, the board did not sufficiently scrutinize the actuarial assumptions and reports. Second, it failed to recognize an imbalance between fund income and expenses, and make appropriate financial decisions accordingly (see figure, next page). Historically, it appears that the board has been reactive rather than proactive regarding the conclusions of the actuarial reports. This management approach has negatively affected the fund's income and expenses.

In retrospect, it appears that to have funded the lifetime care for these children in an actuarially sound manner would have required that all of the possible assessment sources – participating physicians, participating hospitals, non-participating physicians, and liability insurers – be assessed for the duration of the program's existence. However, the current funding structure outlined in the birth injury act would not have allowed for maximum assessments, given the earlier actuarial findings that the fund was sound.

Recommendation (1). *The General Assembly may wish to consider amending the Code of Virginia to eliminate the sentence in §38.2-5016(F), which states, "The board shall also have the power to reduce for a stated period of time the annual participating physi-*

Assessment Income vs. Total Actual Expenses



cian assessment described in subsection A of §38.2-5020 and the annual participating hospital assessment described in subsection C of §38.2-5020 after the State Corporation Commission determines the Fund is actuarially sound in conjunction with actuarial investigations conducted pursuant to §38.2-5021.”

Recommendation (2). The board of directors should conduct annual evaluations of the actuarial assumptions, and communicate any concerns identified to the State Corporation Commission. To the extent that the program is unable to conduct such an investigation in-house, it should seek assistance from an independent consulting firm.

Options for the Future of the Birth Injury Program

As described previously, the value of the birth injury program varies on a group and individual basis. The data collected through this review suggests that the program is largely beneficial to Virginia’s ob/gyns and hospitals, and to a lesser extent all other physicians. In addition, most (but not all) of the children in the birth injury program fare better than they would have through the tort

system with a malpractice award cap in place. However, this program does not appear to have had a major impact in helping the Commonwealth attain its broader goal of maintaining an adequate supply of obstetric services, especially in the rural areas. In addition, annual program assessments are more than estimated awards and expenses associated with Virginia’s tort alternative.

There are three primary options that could be pursued depending on the primary goals sought to be attained through the birth injury program:

- maintain the current overall structure of the program,
- restructure the program to be mandatory for physician and hospital providers of obstetrics, or
- eliminate the program.

The body of this report explores the advantages and disadvantages of each approach.

These options suggest the difficult policy choices that must be made by the

General Assembly regarding the future of the birth injury program. Two of these options result in the continuation of the program. If the General Assembly wishes to continue the program, then significant improvements will be needed. The remainder of this summary outlines the findings and recommendations related to program eligibility and administration that would need to be addressed. The improvements recommended will help to ensure that the program is successful in serving birth-injured children as intended by the General Assembly.

Relatively Minor Changes to the Definition of Program Eligibility Are Needed

JLARC staff examined the appropriateness of the Virginia Birth-Related Neurological Injury Compensation Act's birth injury definition through interviews with medical professionals, a review of medical literature on birth injuries and cerebral palsy, and a review of WCC files for all birth injury petitions. Overall, the current definition in the act appears to meet the goals of the program by targeting the cases most likely to become the subject of a lawsuit. However, some refinements to the definition would make the eligibility criteria clearer, and may help reduce the contentiousness of the eligibility process. Specifically, the act should exclude children who die shortly after birth and explicitly define the timeframe of a qualifying injury.

Recommendation (3). *The General Assembly may wish to consider amending §38.2-5001 of the Code of Virginia to permit families of infants who die within 180 days of birth the option to file suit against a participating physician and/or hospital rather than require applications to the Virginia Birth-Related Neurological Injury Compensation Program.*

Recommendation (4). *The General Assembly may wish to consider amending §38.2-5001 of the Code of*

Virginia by replacing the language, "immediate post delivery period" with the more specific language, "within one hour of delivery."

Significant Improvements Needed to the Eligibility Determination Process

This review found that the WCC has done an adequate job in handling the birth injury claims, and should continue hearing these cases. However, a number of changes are needed to improve the eligibility process.

The Program's Role in the Eligibility Hearings Should Be Eliminated.

While there is no evidence that the program has inappropriately attempted to exclude cases from the program thus far, its involvement in the eligibility process increases the contentiousness of the proceedings and represents a conflict of interest. Therefore, the program should be removed from the eligibility process.

Recommendation (5). *The General Assembly may wish to consider amending §38.2-5004(D) of the Code of Virginia to eliminate the requirement that the Virginia Birth-Related Neurological Injury Compensation Program file a response to petitions and specifically state that the program shall not be a party to any hearing before the Workers' Compensation Commission.*

Medical Panel Reviews Need to Be Strengthened.

JLARC staff found that the medical panel reviews are not working as originally envisioned. However, with some modifications, it appears that the medical panels are still the appropriate mechanism for obtaining expert opinions in these cases and that many of these problems can be resolved through increased communication between the WCC and the panels.

Recommendation (6). *The General Assembly may wish to consider amending the Code of Virginia to require that the Workers' Compensation Commission and the medical panels meet on a yearly basis to discuss the eligibility*

process and any improvements that may be needed.

Recommendation (7). *The Workers' Compensation Commission should provide copies of all birth injury opinions to members of the medical panels.*

Recommendation (8). *The medical panels should develop a review form, in consultation with the Workers' Compensation Commission, that addresses each aspect of the eligibility definition. This form should be completed by the panels in each case they review for the Workers' Compensation Commission.*

Recommendation (9). *The deans of the medical schools should develop a plan to include both obstetrical and pediatric specialists who can evaluate whether applicants meet the entire definition in the Virginia Birth-Related Neurological Injury Compensation Act.*

Recommendation (10). *The General Assembly may wish to consider amending §38.2-5008(B) of the Code of Virginia to change the filing deadline for the medical panels from "at least ten days prior to the date set for hearing" to "30 days from the date the petition was filed at the Workers' Compensation Commission." The Workers' Compensation Commission should clearly communicate the deadline for the medical panel reports in all cases that are sent to the medical panels for review.*

Recommendation (11). *The General Assembly may wish to consider amending §38.2-5008 of the Code of Virginia to require the Workers' Compensation Commission to forward a copy of the medical panel report to all petitioners.*

Recommendation (12). *The Workers' Compensation Commission should begin to incorporate Eastern Virginia Medical School into the medical panel review process.*

Recommendation (13). *The Workers' Compensation Commission should assign cases to the medical panels for review on a continuous rotation basis*

instead of alternating on a three-year cycle.

Improvements Could Be Made to Assist Families Who Petition for Entry Into the Program. *JLARC staff found that some improvements could be made to better assist families during the application process. For example, to make the process more user-friendly for parents, the program could develop a hand-out that explains the hearing process in lay terms, including all deadlines and parties to the process. To encourage better record-keeping and the appropriate release of medical records, cases in which the fetal monitoring strips are withheld or lost should be given a rebuttable presumption that they showed fetal distress. This may result in some children being accepted into the program that would ordinarily be denied. To partially address this added cost, the WCC should be given the discretion to fine hospitals if they withhold a patient's records and the child is accepted into the program. Finally, the WCC should be given discretion to award reasonable attorney fees for all cases, regardless of whether or not the child is admitted into the program, to increase claimant access to legal representation during the process.*

Recommendation (14). *The Virginia Birth-Related Neurological Injury Compensation Program should develop an easy-to-understand hand-out that explains all aspects of the petition process. The program should also develop an application form for claimants who wish to apply to the program. Both documents should be sent to anyone who inquires about applying to the program. These documents should also be included on the program's website.*

Recommendation (15). *The General Assembly may wish to remove §38.2-5004(A)(i) and §38.2-5004(A)(j) of the Code of Virginia in order to streamline the process for submitting a petition to the Workers' Compensation Commission.*

Recommendation (16). *The General Assembly may wish to amend §38.2-5004 of the Code of Virginia to specify that hospitals are required to release all medical records, including fetal monitoring strips, to patients that plan to submit a petition to the Virginia Birth-Related Neurological Injury Compensation Program.*

Recommendation (17). *The General Assembly may wish to amend §38.2-5004 of the Code of Virginia to specify that claimants will have the rebuttable presumption of fetal distress in the event that fetal monitoring strips are not provided by the hospital.*

Recommendation (18). *The General Assembly may wish to amend §38.2-5004 of the Code of Virginia to specify that the Workers' Compensation Commission has the authority to require hospitals to pay a fine to the Virginia Birth-Related Neurological Injury Compensation Program in the event that a child whose records are withheld or lost is accepted into the program. This fine should not exceed the hospital's current participation assessment or the amount of the assessment if the hospital had participated.*

Recommendation (19). *The General Assembly may wish to consider granting the Workers' Compensation Commission discretion to award reasonable attorney fees and expenses for cases filed in good faith, regardless of whether a child is accepted into the Virginia Birth-Related Neurological Injury Compensation Program.*

Eligibility Hearings Should Remain at the Workers' Compensation Commission. The eligibility process at the WCC appears to be quite efficient. In addition, reversals of WCC decisions have been rare. Although the WCC should be more stringent in its enforcement of deadlines, it appears that the WCC has done an adequate job of handling the birth injury cases overall. Given the WCC's performance, there appears to be no need to change the venue for hearing birth injury cases.

Recommendation (20). *The Workers' Compensation Commission should enforce all deadlines for the birth injury cases.*

Medical Reviews of Physicians and Hospitals Should Be More Rigorous

Section 38.2-5004 of the Code of Virginia directs the Board of Medicine and the Virginia Department of Health (VDH) to review all birth injury petitions submitted to the WCC. The Board of Medicine is required to assess whether the physician(s) involved in the petitioner's birth provided substandard care that would warrant disciplinary action by the Board of Medicine. The VDH reviews the petition to determine whether the hospital and its staff provided inadequate medical care that should impact the hospital's license. JLARC staff reviewed the Board of Medicine and VDH records pertaining to birth injury petitions and found that minimal investigations of the circumstances surrounding the birth events were conducted. In the vast majority of cases, the agencies read the petitions but conducted no further investigation. Steps should be taken by the Board of Medicine and VDH to conduct more thorough investigations of these petitions and to communicate the results to all the affected parties.

Recommendation (21). *As part of their reviews of birth injury petitions, the Board of Medicine and Virginia Department of Health should routinely interview the claimant families on the events surrounding the births.*

Recommendation (22). *The Board of Medicine and Virginia Department of Health should routinely notify each claimant family concerning the outcome of the respective medical reviews.*

Recommendation (23). *The Workers' Compensation Commission should develop a plan for ensuring that all birth injury petitions, whether directly submitted by families of birth-injured children or transferred by the circuit court, are submitted to the Board of Medicine and*

Virginia Department of Health for review.

Informed Consent Process Needed for Obstetric Patients

The *Code of Virginia* requires the program to inform obstetrical patients about the program. However, it appears that the program has not been effective in its attempts to notify obstetrical patients. Although the program has supplied brochures to doctors and hospitals for them to distribute to patients, most of the claimant families indicated that they were not informed about the program through this mechanism. In fact, the most common source of information about the program was an attorney, which suggests that many families do not find out about the program unless they pursue a medical malpractice lawsuit. Further, the brochure developed by the program inadequately explains the patients' rights and limitations under the program.

To ensure that participating doctors and hospitals provide information about the program to their patients before they receive services, participating obstetrical providers should be mandated by the act to obtain informed consent regarding program participation from all obstetrical patients under their care. Given that past strategies of notifying obstetrical patients have been weak, the program should also pursue other ways of identifying children who may qualify for the program.

Recommendation (24). *The Virginia Birth-Related Neurological Injury Compensation Program should revise the current brochure to better explain the patients' rights and limitations under the program, especially the "exclusive remedy" provision.*

Recommendation (25). *The General Assembly may wish to amend the Code of Virginia to eliminate the exclusive remedy provision for participating physicians and hospitals that fail to obtain informed consent of obstetrical patients, except for cases in which the pa-*

tient has an emergency medical condition or when such notice is not practicable.

Recommendation (26). *The Virginia Birth-Related Neurological Injury Compensation Program should develop a strategy for informing pediatricians and other health care providers that come into contact with disabled children about the program so that they can make potential referrals and distribute program brochures.*

Benefits Have Not Been Well-Managed

One of the most contentious issues with the program is the administration of program benefits. Based on surveys of parents, interviews with program staff and board members, a review of board meeting minutes, and a review of the program guidelines, it appears that benefits have not been appropriately managed. For example, there were no written guidelines describing the benefits for the first nine years of the program. Even after benefit guidelines were developed, however, they were incomplete and inconsistently applied.

While it is understandable that in the early years of the program it would have been difficult to anticipate many of the types of benefits that families would request, the program now has 15 years of experience from which to draw in establishing program policies. Although the program cannot account for every possible request that may be reasonable, it should now be in a position to develop a set of comprehensive guidelines regarding benefits. Developing, maintaining, and implementing an updated and complete set of benefit guidelines would reduce the likelihood of inconsistent policy interpretation in benefit decision-making, which in turn would help to increase the credibility of program staff and board decisions among claimants requesting benefits.

In addition, a number of specific issues vis-à-vis program benefits need to be addressed. Although the current

housing renovation policy appears to be fair for homeowners and is a comparable benefit to that which could be obtained through a medical malpractice award, it does not address the needs of non-homeowners. Further, the program needs a consistent policy regarding the payment of primary health insurance premiums for claimants. The program also needs to re-examine its policies related to nursing care to ensure that its guidelines do not contribute to problems in obtaining reliable nursing care. In addition, the program should begin planning for the lost wage benefit. And finally, a codified process for appealing benefit decisions is needed.

Recommendation (27). *The Virginia Birth-Related Neurological Injury Compensation Program should develop an updated and comprehensive set of program guidelines. These guidelines should be provided to all families currently in the program and should also be posted on the program's website.*

Recommendation (28). *The Virginia Birth-Related Neurological Injury Compensation Program should develop a policy to address handicapped accessible housing for children of non-homeowners.*

Recommendation (29). *The General Assembly may wish to clarify §38.2-5009(A)(1) of the Code of Virginia to explicitly state that claimants in the Virginia Birth-Related Neurological Injury Compensation Program should receive reasonable accommodations for handicap accessible housing, not to include the purchase of a house.*

Recommendation (30). *The General Assembly may wish to consider amending the Code of Virginia to require claimants in the Virginia Birth-Related Neurological Injury Compensation Program to purchase private health insurance, or for cases in which a claimant cannot afford to pay private health insurance premiums, to allow the program to purchase private insurance for them.*

Recommendation (31). *The Virginia Birth-Related Neurological Injury Compensation Program should develop a consistent policy for payment of private health insurance premiums for those families who cannot afford or do not have access to their own health insurance.*

Recommendation (32). *The Virginia Birth-Related Neurological Injury Compensation Program should begin planning for management of the lost wage benefit for children who attain 18 years of age. In part, the program should consider reimbursing families for setting up special needs trusts for all children in the program to ensure eligibility for Medicaid and disability benefits.*

Recommendation (33). *The General Assembly may wish to consider amending the Code of Virginia to specify that claimants in the Virginia Birth-Related Neurological Injury Compensation Program may appeal benefit decisions by the program to the Workers' Compensation Commission.*

The Program Would Benefit from More Accountability

The Code of Virginia does not clearly define the program as a private or governmental organization. Based on interviews with staff from the Attorney General's Office, program staff, and staff from the Division of Legislative Services, it appears that the program does not fall into any particular category of State agency, nor is it a purely private entity. A lack of clarity on this issue has permitted the program to operate with little oversight. Changes to the Code of Virginia are necessary to increase accountability and oversight, including making the program subject to the Administrative Process Act, the Freedom of Information Act (FOIA), and the Public Procurement Act. In order to ensure the accuracy of the program's financial information, the Code of Virginia should also be changed to require an annual

audit by a Certified Public Accountant. Finally, the *Code of Virginia* should specify that the Office of the Attorney General provide legal counsel to the program.

Recommendation (34). *The General Assembly may wish to amend the Code of Virginia to require that the program be subject to the Freedom of Information Act, the Public Procurement Act, and the Administrative Process Act or another public rulemaking process. The Code of Virginia should also be amended so that the program is required to receive an annual audit by a CPA. Finally, the Code of Virginia should be amended so that the Office of the Attorney General is required to provide legal representation for the program.*

Program Services Generally Appear Adequate

JLARC staff assessed program services through surveys and interviews with families involved in the program, as well as interviews with program staff and board members. Overall, the program appears to provide adequate services to families in the program, and most families are satisfied with program services. The most frequent complaint about program services relates to the amount of paperwork needed to receive benefits. However, JLARC staff reviewed the required documentation, and found it to be an appropriate mechanism for ensuring that fund dollars are spent according to the intent of the act. Communication, on the other hand, has been a major shortcoming of the program and needs to be improved. In addition, the program needs to address two additional benefit process concerns.

Recommendation (35). *The Virginia Birth-Related Neurological Injury Compensation Program should follow existing procedures related to communication more closely to ensure that families in the program are aware of all program policies. The program should also follow through with the existing plan to*

hold group meetings across the State and obtain input from families on how they can improve communication and service provision. Finally, the program should improve its web site by including more features to help families access information needed to obtain benefits.

Recommendation (36). *The Virginia Birth-Related Neurological Injury Compensation Program should provide itemized reimbursement statements to families.*

Recommendation (37). *The Virginia Birth-Related Neurological Injury Compensation Program should explore options to better address the needs of families in transporting their children.*

Structure and Role of the Birth Injury Board Should Be Modified

JLARC staff found that the birth injury board has focused its efforts over the years on benefits and other administrative matters to the detriment of its fiduciary duties. Throughout most of the history of the program, it appears that the board received very little financial information from the fund manager and program staff that would have been necessary to properly oversee the fund. However, the current board has begun to focus more on the funding of the program, and has directed program staff to revise the benefit guidelines. Development of a more detailed benefit guidelines manual (as previously discussed) should enable program staff to make more decisions concerning claimant requests, and allow the board to focus more on its fiduciary duties. In addition, board representation should be changed so that it is less dominated by the interests of the medical community and more inclusive of individuals from the disabled community and those with financial expertise.

Recommendation (38). *The General Assembly may wish to consider amending the Code of Virginia to require the birth injury board of directors to obtain advice on the fund's investment strategy, including the asset allocations*

for its equities and fixed income portfolios, from the Chief Investment Officer of the Virginia Retirement System on a semi-annual basis.

Recommendation (39). *The Birth-Related Neurological Injury Compensation Board should direct the fund manager to supply an annual explanation of expected returns on the equities and fixed income portfolios.*

Recommendation (40). *The Birth-Related Neurological Injury Compensation Board should take steps to minimize its involvement in routine benefit decisions to allow for more focus on its fiduciary responsibilities. At a minimum, the board should set as a high priority the revision of the program's benefit guidelines.*

Recommendation (41). *The General Assembly may wish to consider*

amending the Code of Virginia to change the non-participating physician representative on the Birth-Related Neurological Injury Compensation Board to a citizen representative. In addition, the General Assembly may wish to consider requiring the appointment of two citizen representatives with a background in the disabled community, and two citizen representatives with a minimum of five years of professional investment experience. The General Assembly may also wish to consider specifying in the Code of Virginia that persons who have practiced as physicians or who have been representatives of the health care industry or the insurance industry may not be appointed to the board as citizen members.

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I. Introduction

The Virginia Birth-Related Neurological Injury Compensation Act was passed by the General Assembly in 1987 in response to medical malpractice insurance availability problems for providers of obstetric services. The program pays for the medical and certain other expenses of children who have severe neurologic injuries resulting from the birthing process. It is, therefore, intended as an alternative to the traditional tort system for obtaining compensation for injuries.

A number of concerns have been raised about the program during its 15-year existence, so the Joint Legislative Audit and Review Commission (JLARC) directed staff to conduct an evaluation of this program in January 2002. In the early years, the program built up a large fund, while very few children benefited from the program. In recent years, there has been a substantial increase in the number of children in the program, raising concerns about the financial stability of the fund. Some parties have questioned the appropriateness and viability of the program's continued existence in its present form. Through this review, JLARC staff assessed the program's structure and operations, and examined the extent to which the program has served its intended purpose. This chapter provides the history leading up to the birth injury act's passage, identifies the key features of the program, including the benefits, and concludes with an explanation of how the program is funded.

HISTORY AND PURPOSE OF THE BIRTH INJURY PROGRAM

In the mid-1970s, Virginia along with the rest of the nation experienced its first medical malpractice crisis. As a result of this crisis, almost all states enacted some change in tort laws. Most notable among the changes in Virginia was a cap placed on the total amount recoverable in medical malpractice lawsuits.

By the mid-1980s, another medical malpractice crisis was looming, heightening interest in additional changes in tort law. Legislative subcommittees studied the issues surrounding medical malpractice and liability insurance for several years, and ultimately proposed a series of changes. In the context of this effort to change the tort laws, the Medical Society of Virginia proposed to establish a unique framework, separate from the court system, for addressing one of the most severe and costly types of medical injuries – birth injuries. Virginia was the first state in the nation to develop a birth injury compensation plan completely removed from the tort system. The only other state to enact a birth injury program is Florida.

Medical Malpractice Situation in the 1980s

The early to mid-1980s can be characterized as a time of increasing malpractice lawsuits, increasing malpractice insurance premiums, and decreasing insurance availability. This situation led to a “crisis” in obstetrics, in which physicians were reportedly eliminating obstetrical care from their practices. Rural areas of Virginia were reported to be particularly affected by this situation, with some

counties having no obstetrical services available. Several changes in tort law were subsequently enacted, including the Virginia Birth-Related Neurological Injury Compensation Act.

Increase in Medical Malpractice Lawsuits. Much of the literature on medical malpractice discusses the increasing frequency of medical malpractice lawsuits beginning in the early 1980s. While malpractice lawsuits increased for all physicians, this increase was particularly acute for obstetrician/gynecologists (ob/gyns). In general, obstetrics has one of the highest rates of malpractice claims of all medical specialties, and this is one reason why the Medical Society of Virginia sought a specific malpractice remedy for obstetricians. According to an Institute of Medicine study, obstetricians are sued at two to three times the average rate of all other physicians.

This national trend appears to reflect the malpractice situation faced in Virginia. The Williamson Institute for Health Studies at the Medical College of Virginia conducted a study in 1989 on behalf of the Medical Society of Virginia to examine the frequency of malpractice claims for birth-injured infants in Virginia. This study reviewed the claims records of the major malpractice insurers in Virginia to identify the number of claims for severe neurological birth injuries – injuries that may meet the definition for eligibility in the birth injury program. This study found that the number of malpractice claims increased significantly between 1981 and 1987.

According to insurance representatives and the medical-legal literature, monetary awards for this subset of medical injury are among the highest of all medical malpractice awards. The Williamson Institute study found that of the 22 severe birth-injury cases in Virginia in which the child survived, the median settlement was \$504,673. The increase in the frequency of settlements, therefore, was of great concern to Virginia's obstetricians and the professional liability insurance industry. Adding to their concern was a 1986 federal district court decision, which ruled that Virginia's medical malpractice cap was unconstitutional on the grounds that the award amount was a fact issue to be determined by a jury. (This decision was overturned, but not before the birth injury act and other changes in tort law were enacted.)

Malpractice Insurance Cost and Availability. Reflective of the increase in malpractice claims that insurance companies were having to pay and a decline in insurance companies' investment income due to an economic downturn, the insurance premiums charged to obstetricians increased during the 1980s. According to a 1989 Institute of Medicine study, the average professional liability premiums for self-employed ob/gyns increased by 171 percent between 1982 and 1986 (Table 1). This increase far exceeded the medical care and consumer price indices of 32 and 14 percents, respectively.

Despite the premium increases, the major malpractice insurers were reportedly experiencing losses, and subsequently limited their coverage of ob/gyns. One insurer (PHICO) decided to leave the Virginia market entirely. The other two major insurers in Virginia were unwilling or unable to write new malpractice poli-

Table 1
Average Professional Liability Premiums for
Self-Employed Obstetrician/Gynecologists, 1982 – 1986

<u>Year</u>	<u>Average Premium</u>
1982	\$10,800
1983	14,000
1984	19,000
1985	23,500
1986	29,300

Source: Medical Professional Liability and the Delivery of Obstetrical Care, Institute of Medicine, 1989.

cies for ob/gyns. As a result, there were about 160 ob/gyns who were unable to obtain malpractice insurance at any price.

While the State Corporation Commission established a physician joint underwriting association, enabling some ob/gyns to obtain malpractice insurance, other ob/gyns reportedly stopped practicing obstetrics. Staff of the Medical Society of Virginia reported that there were some rural counties that had no obstetrical coverage; pregnant women from these counties had to drive substantial distances to get prenatal care and to deliver their babies. An Institute of Medicine study estimated that, nationwide, there was a 20 percent decline in the number of obstetrical providers in non-metropolitan areas between 1983 and 1987. Concern for the lack of obstetric care in rural areas was one of the reasons cited during the 1987 General Assembly Session as to the need for the birth injury act.

Changes to the Tort System Were Enacted During the 1980s

Against this backdrop of the medical malpractice crisis, the General Assembly enacted a number of changes to the tort system. These measures were intended to address the malpractice insurance situation broadly, as well as the particular problem faced by ob/gyns. First, the General Assembly capped punitive damage awards at \$350,000. These damages are included in the overall medical malpractice award cap, first enacted in 1976. (The cap was \$1 million in 1987 and is now \$1.65 million.) In addition, the Legislature authorized judges to impose penalties for the filing of “frivolous” claims. In another change to the tort system, the General Assembly removed many of the exemptions from jury duty. Most notably, physicians and dentists were no longer excluded from required jury duty. As noted in Senate Document 20 (1988), the argument for this change was that “making more people available for jury service would minimize the inconvenience, improve the knowledge and expertise brought into jury deliberations and ultimately improve the quality of justice” received.

The General Assembly also changed the statute of limitations for minors who are injured. Prior to the change, a minor who was injured could file a lawsuit until his or her 20th birthday, regardless of when the injury occurred. (For adults, there is a two-year statute of limitations.) Insurance companies argued that increasing premium costs were due, in part, to “their inability to predict with any degree of certainty the types and amount of claims involving minors and the difficulties they encounter when trying to defend such claims years after the event, when evidence is gone and memories have faded” (SD 20, 1988). The new law provided that if the child was less than eight years old at the time of the injury, a lawsuit could be filed until his or her tenth birthday. Children older than eight at the time of injury would have a two-year period of time in which to file a claim, identical to that for adults. (This change is the basis for the birth injury act’s ten-year limitation on filing an application for entry into the program.)

Two pieces of legislation were enacted that specifically addressed obstetric care. First, any physician who provides emergency obstetrical care to a woman in active labor and whom the physician had not treated during the pregnancy was granted immunity from a civil suit. This change allayed the fears of many obstetricians who thought that those types of births carried great risk and directly affected their liability insurance rates.

And second, a novel piece of legislation was introduced – the Birth-Related Neurological Injury Compensation Act, which created a separate administrative structure for compensating infants who were injured at birth, and thus removed these cases from the tort system altogether. This proposal was supported by the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia Society of Obstetricians and Gynecologists, and Virginia Insurance Reciprocal (a professional liability insurance carrier). It was opposed by the Virginia Trial Lawyers Association. Governor Baliles subsequently signed the birth injury bill into law, and the program became operational on January 1, 1988.

Purpose of the Virginia Birth-Related Neurological Injury Compensation Act

The ultimate goal of the birth injury act was to alleviate the medical malpractice insurance availability crisis for obstetricians. As previously stated, one of the three major malpractice insurers had dropped its malpractice line and the other two had suspended writing any new ob/gyn policies. One of these companies, Virginia Insurance Reciprocal, said that for it to reenter the market, the liability risks associated with the delivery of severely injured babies needed to be removed from the tort system. Passage of the birth injury act met this condition, and the company immediately began writing new ob/gyn policies. At the same time, the birth injury program provided the medical community an opportunity to modify some of the features of the tort system that it thought were unfair, and from its perspective, provide a more equitable way to compensate birth-injured children.

Program Was Intended to Remove Cases from the Tort System. At its simplest description, the birth injury program was intended to remove malpractice

lawsuits from the court system and provide for an alternative way of compensating the plaintiff for his or her medical-related injury. Infants severely injured at birth were singled out for this approach because lawsuits associated with these cases have a relatively high rate of success and the successful cases tend to result in large monetary awards.

An infant is eligible for inclusion in the program if his or her injury meets the definition contained in the *Code of Virginia*. Section 38.2-5001 states:

“Birth-related neurological injury” means injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled . . . such disability shall cause the infant to be permanently in need of assistance in all activities of daily living.

Children who have a congenital or genetic abnormality are ineligible for the program.

In addition, obstetrical services must have been performed by a participating physician or at a participating hospital. As will be described in more detail later in this chapter, participation by doctors and hospitals is voluntary, and requires payment of an annual assessment to the fund.

By delivering a baby in a participating hospital and/or through a participating physician, the baby’s family automatically waives its right to bring a medical malpractice claim against the participating physician or hospital if the baby incurs a birth injury that meets the definition in the *Code*. (If the child’s injury does not meet the definition in the *Code*, then the family can still file a lawsuit.) If either the physician or hospital did not participate in the program, the family can still choose to sue that non-participating party. However, this program is an exclusive remedy for the injury. Therefore, if the family chooses to sue the non-participating physician or hospital, the commencement of that suit results in the child’s ineligibility for the birth injury program, even if the family loses the lawsuit. Likewise, if the child petitions and is accepted into the program, the family’s right to sue the non-participating parties involved in the birth is also eliminated.

The program was designed as a “no-fault” system of compensation. To be accepted to the program, therefore, the claimant does not have to prove that the doctor’s action or inaction caused the injury, as would be necessary in a malpractice lawsuit. While the program’s intent was to remove malpractice cases from the court system, it was understood that the program would cover children with catastrophic birth injuries, regardless of whether or not the claimant planned to file a malpractice lawsuit against the doctor and/or hospital. Evidence must exist, however, that the injury occurred at birth.

The program was also envisioned as a more “user-friendly” and quicker process than the court system. The expectation was that the family would not need to hire a lawyer to gain entry into the program, as the application process would be straightforward and objective decisions would be made based solely on whether the child met the definition of birth-related neurological injury.

Program Fundamentally Restructured Compensation for Severe Birth Injuries. The program was also intended to completely restructure the way injured infants are compensated for their injuries. In a medical malpractice suit, a successful plaintiff may receive a large, lump sum award. This award can include a monetary amount for non-economic damages, commonly referred to as a “pain and suffering” award. Typically, at least one-third of the award is paid to the plaintiff’s lawyer as a contingency fee. Further, birth injury lawsuits are usually filed both by the mother and the infant, with separate awards potentially entered to each.

Finally, the collateral source rule applies in malpractice awards. This rule dictates that the plaintiff’s other sources of payment for injury-related expenses, such as third-party health insurance, cannot be taken into account in setting the amount of the award. This rule has been maintained based on the assumption that it is not fair to reduce the “penalty” paid by the defendant simply because the plaintiff had the foresight to acquire resources (for example, insurance) that could be used in the event of injury.

The birth injury program deviates substantially from a number of key features of malpractice awards. First, the program pays actual medical expenses on a reimbursement basis rather than providing a lump-sum award. Proponents of the program reported that this approach helps ensure that the money goes toward the child’s care, rather than being spent on other family members. It also eliminates issues surrounding life expectancy. When the child dies, the program stops making payments. In contrast, a malpractice award may be set high with the expectation of many years of medical expenses. However, the child may die shortly after the award; and therefore, the award would not accurately reflect the amount of medical expenses the child will incur.

Second, the program eliminates awards for non-economic damages (that is, pain and suffering awards) and awards to family members other than the child. Third, the large contingency fees awarded to lawyers are eliminated. The program only pays for “reasonable” attorney fees incurred in the process of applying for the program. In practice, attorneys are paid based on the number of hours worked on the case. Fourth, the program is a “payer of last resort,” thereby negating the collateral source rule. According to staff of the Medical Society of Virginia, this eliminates situations in which plaintiffs are essentially reimbursed twice for the same expenses. It was believed that this approach would also better meet the financial needs of more children.

While some of these changes appear to disadvantage the claimant, the trade-off is that the program provides a “lifetime of care” for the child. With malpractice awards, there is no guarantee that the award will cover the lifetime cost of the injured child’s medical needs.

Program Was Intended to Ensure Obstetric Care for Indigent Women. Around the same time as the medical malpractice crisis, the State was experiencing a problem regarding obstetric care for indigent women. Specifically, there were reports that some doctors were refusing to deliver babies of women on Medicaid whom they had not cared for during the pregnancy. For example, newspaper articles at the time reported that indigent women who came to hospital emergency rooms in Fredericksburg because they were in labor were being sent to Richmond to have their babies delivered. Supposedly, the doctors were fearful that the women did not receive proper prenatal care and might be more susceptible to an adverse birth outcome. The doctors reportedly feared that they would be subject to lawsuits due to the adverse outcomes, even if the outcomes were not a result of poor medical care during the delivery.

To help alleviate this problem, language was included in the birth injury bill to require doctors, as a requirement for participation in the program, to work with the Commissioner of Health in developing a program to provide obstetrical care to indigent women and to subsequently participate in its implementation. As previously mentioned, other legislation enacted during the same General Assembly Session granted immunity to obstetricians who provide emergency obstetrical care to a woman whom the physician had not treated during the pregnancy (a “Good Samaritan” law).

PROGRAM STRUCTURE

This section identifies the structure of the birth injury program. The role of each entity involved in the program is detailed according to its area of functional responsibility. Information about claimants in the program, including the number of claimants and their geographic distribution, is also provided. Additionally, this section outlines the types of benefits, as well as associated expenses, provided by the program. Finally, the assessment structure that funds the program is explained.

Division of Responsibilities

There are three main entities involved in the Birth-Related Neurological Injury Compensation Program and Fund. The Workers’ Compensation Commission (WCC) conducts hearings and determines eligibility for claimants who seek entry into the program. The State Corporation Commission (SCC) has certain financial responsibilities vis-à-vis the fund. The birth injury program, through its board of directors, administers the program and the fund. The specific responsibilities of these entities are discussed in this section.

Role of the Workers’ Compensation Commission. The WCC is responsible for determining a child’s eligibility for the program. A total of 118 birth injury claims have been filed at the WCC since the program’s inception. (While the program became operational on January 1, 1988, the first petition was not submitted until 1990 and the first claimant was not accepted until 1992.) One administrative law judge, a Deputy Commissioner at the WCC, handled all birth injury cases from the program’s inception until August 2001. Since that time, the Chief Deputy Com-

missioner has presided over all birth injury hearings. (A detailed discussion of the eligibility process is included in Chapter IV.)

The WCC also handles disputes over benefits once a child has been admitted into the program. Parents who disagree with a decision of the program's board of directors regarding a benefit may file an appeal with the Chief Deputy Commissioner, who may then schedule a hearing on the matter or handle the dispute on the record without a hearing. Examples of recent appeals include a request for an alternative van to the standard handicap-equipped van provided by the program and a request for a parent to be compensated for times in which missed home nursing shifts required the parent to miss work.

The Chief Deputy Commissioner's decisions in eligibility petitions and benefit appeals may be appealed to the full Workers' Compensation Commission and subsequently to the Court of Appeals. While historically there have been very few appeals to the WCC regarding benefits, benefit appeals have increased in frequency in the past year.

Role of the State Corporation Commission. The SCC has three primary duties with regard to the birth injury program: (1) to review and approve the program's plan of operation, (2) to provide a review of the actuarial soundness of the fund, and (3) if the fund is determined to be actuarially unsound, to impose assessments on liability insurers and physicians who do not participate in the program. (The specific assessments will be discussed later in this chapter.) Section 38.2-5021 of the *Code of Virginia* directs the SCC to have an actuarial review of the fund conducted at least biennially. The same private firm has conducted all actuarial reviews since the program's inception.

The actuarial review completed in the fall of 2001 concluded that the fund was actuarially unsound, with an unfunded liability of approximately \$88.4 million. Due to the financial position of the fund, the SCC has decided to have the actuarial review conducted on a yearly basis. Chapter III will discuss the actuarial findings and the fund's financial position in more detail.

Role of the Birth Injury Program. The birth injury program is governed by a board of directors. The board consists of seven non-paid members who are appointed by the Governor to serve staggered, three-year terms. The following representatives must be included in the Governor's appointments:

- one representative of participating physicians,
- one representative of participating hospitals,
- one representative of physicians other than participating physicians,
- one representative of liability insurers, and
- three citizen representatives.

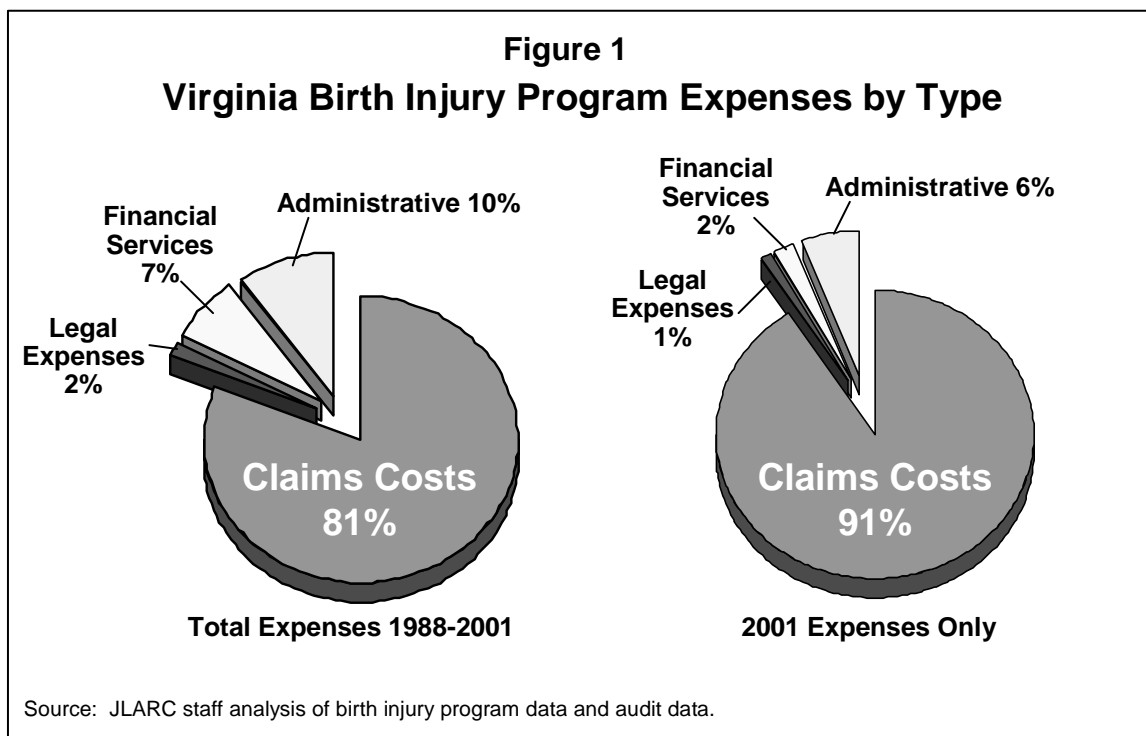
The primary duties of the board include directing the investment of the birth injury fund, deciding specific benefit requests from claimants, and overseeing the program director. In addition to these duties, the act was revised in 1994 to give

the board authority to reduce participating physician and hospital fees during years in which the SCC determined the fund to be actuarially sound. Decision-making powers are exercised through majority votes.

As required by the act, the board reports annually to the Speaker of the House of Delegates and the Chairman of the Senate Rules Committee regarding investment of the fund's assets by providing copies of the program's annual independent audit and the fund manager's yearly status report. It has also submitted its plan of operation to the SCC, as required.

The board hires staff to manage the daily operation of the program. Current staff positions include an executive director, an assistant executive director, a manager of accounting, an insurance administrator, a case manager, and an administrative assistant. For most of the program's history, it was staffed with only the executive director and an administrative assistant.

Since its inception in 1988, the program has expended more than \$28.5 million on claims costs, program administration, financial services, and legal expenses. (Claims costs are comprised of direct payments to service providers and reimbursements to families for medically necessary services and items.) In the beginning years of the program's operation, a large portion of expenses were directed toward costs associated with program administration and financial services. As evidenced by Figure 1, however, the largest portion (81 percent) of total fund revenues expended from 1988 to 2001 have been used to cover claims costs. In FY 2001, the program spent approximately 91 percent of fund revenues on direct payments to service providers and reimbursements to families.



Program Claimants

As of October 2002, 75 children have been accepted into the program. Table 2 shows the number of children admitted to the program each year from 1989 to the present. The number of cases accepted per year has ranged from a low of zero in each of the program's first four years to a high of 13 in 2000.

Year	Number of Children Enrolled in Program
1988	0
1989	0
1990	0
1991	0
1992	3
1993	1
1994	5
1995	11
1996	5
1997	8
1998	6
1999	11
2000	13
2001	5
2002	7
Total	75

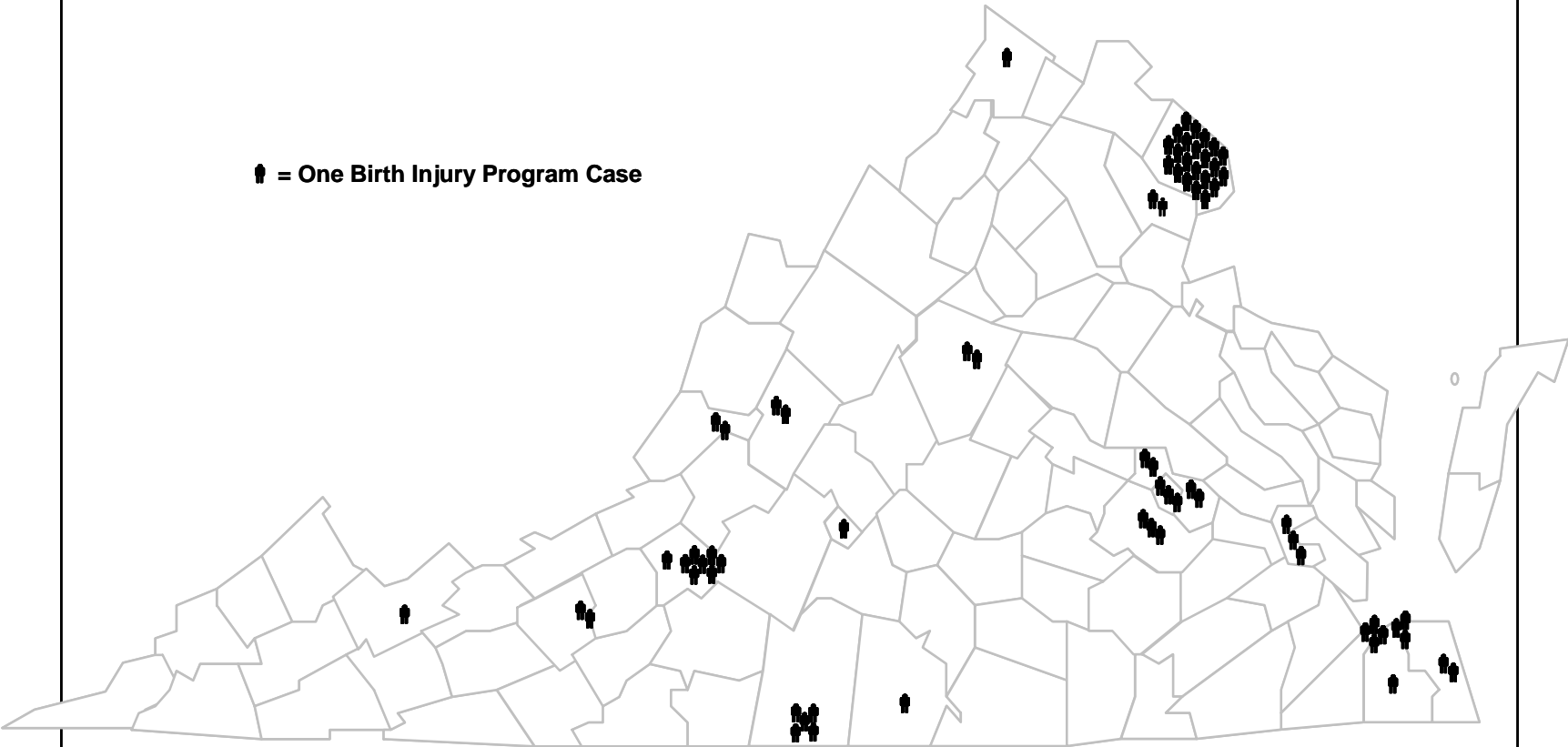
Source: JLARC staff review of WCC opinions and information from the birth injury program.

Figure 2 shows the location of claimants that have been accepted into the program from across the State. A large proportion of children in the program are from Northern Virginia (33 percent), the Richmond metropolitan area (14 percent), and Tidewater (14 percent). Very few children in the program are from the Shenandoah Valley, Southside Virginia, or far Southwest Virginia.

As previously described, for a child to be eligible for the program, he or she must have experienced oxygen deprivation or a mechanical injury during the birthing process. According to JLARC's review of WCC opinions, most of the cases accepted into the program involve babies who were oxygen deprived during the birthing process. Oxygen deprivation can be caused, for example, when an umbilical cord becomes tightly wrapped around a baby's neck, cutting off the blood supply, as the following case example describes.

Despite a healthy and uneventful pregnancy, one claimant was blue and motionless upon birth, and had an umbilical cord wrapped around her neck. Although her parents were warned that the oxygen deprivation experienced by their baby could result in long-

Figure 2
Current Distribution of Birth Injury Program Cases



Notes: Claimant locations are plotted according to the zip-code location of the hospital where delivery occurred. Location of cases is approximate; for example, the 22 cases shown in Fairfax County include cases in Arlington and Alexandria.

Source: JLARC staff analysis of birth injury petitions.

term health problems, the full extent of the damage was not clear until several months later when the baby began to exhibit infantile spasms and seizures. An MRI showed profuse brain damage. The child takes a daily dosage of anti-convulsants, but continues to experience seizures and neurological screaming every day. She has no voluntary movement and cannot speak. Her parents remain hopeful, but her long-term prognosis is unclear at best.

Mechanical injuries, which are much more rare among children in the program, generally are related to misuse of forceps or a vacuum extractor.

The children in the program currently range in age from one to 14 years old. By definition, all of the children in the program have severe physical and cognitive disabilities rendering them incapable of independently performing the basic activities of daily living. According to program staff and petition records, most of the children have cerebral palsy along with other problems. Of the 75 children admitted into the program, eight have since died.

Program Benefits

The *Code of Virginia* defines relatively broad categories of benefits that are to be provided to a child once he or she is accepted into the program. The birth injury program's board of directors interprets the *Code* provisions in determining the specific expenses for which the program will reimburse the claimants. Total claimant expenses have averaged approximately \$4.3 million per year for the past five years.

Benefits Provided. Section 38.2-5009 of the *Code of Virginia* identifies three broad categories of benefits that the program is to provide. First, it states that compensation will be provided for all "medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel," except those for which the claimant has already received reimbursement, either under the laws of another government entity or the policy of another private insurance program. Second, it provides payment (in regular installments) for loss of earnings from the age of 18 until 65. Third, it allows for reimbursement of "reasonable expenses incurred in connection with the filing of a claim . . . including reasonable attorney fees." Exhibit 1 provides examples of the benefits authorized by the act and the program's board of directors.

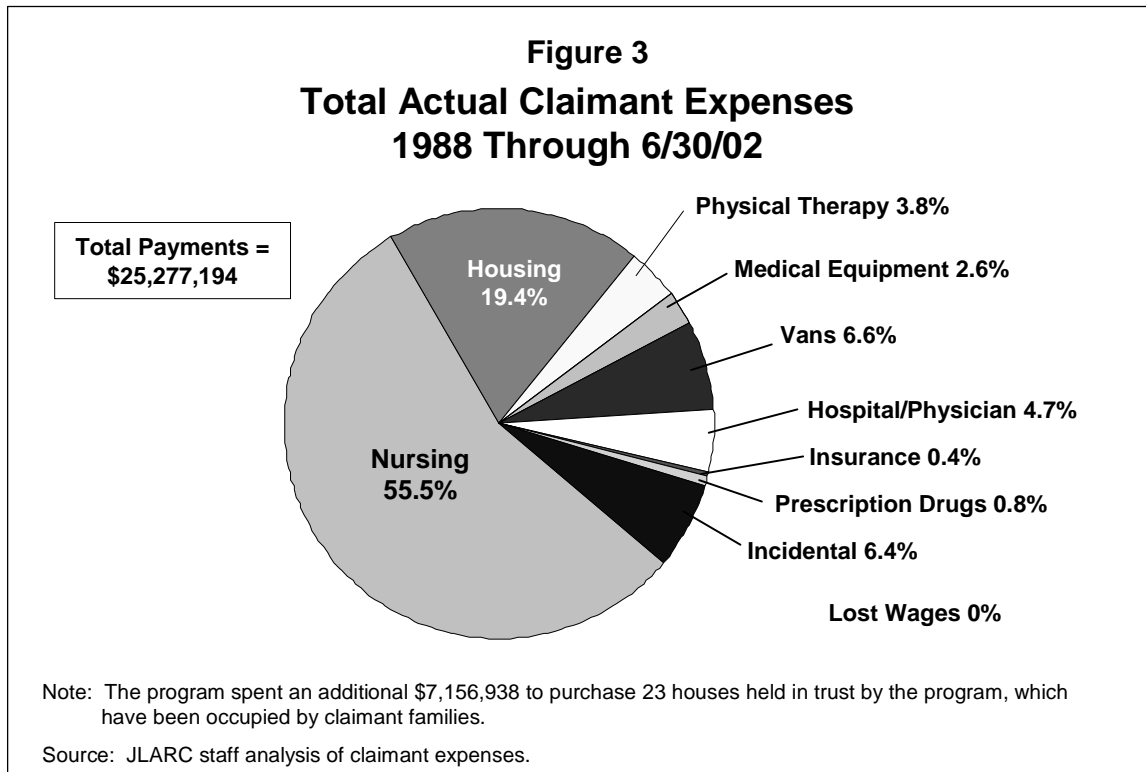
The only benefit that has not yet been paid is lost wages, because no claimant has attained the age of 18. Once this occurs, the amount to be paid to each claimant is fixed at 50 percent of the average weekly non-agricultural wage in Virginia, or approximately \$17,600 per year at 2000 cost levels.

Regardless of the child's age when he or she enters the program, the program will pay for medical and certain other expenses incurred since birth. However, the program will only pay for past expenses for which receipts are submitted.

Exhibit 1	
Examples of Benefits Authorized by the Board of Directors	
<ul style="list-style-type: none"> • Care provided by physicians, dentists and hospitals • Renovations to an existing home to make it handicapped-accessible • Medical equipment such as oxygen concentrators, feeding pumps, gait trainers, wheelchairs, suction machines, apnea monitors, IV poles, pulse oximeters, and Gorilla car seats • Funeral expenses 	<ul style="list-style-type: none"> • In-home nursing care • Occupational, physical, and speech therapy • Van with wheelchair lifts and wheelchair tie-downs • Parking fees and mileage to and from doctors' appointments • Diapers once child reaches age three • Therapeutic toys
Source: 2001 Birth Injury Program Guidelines.	

Claimant Expenses. Claimant expenses include the benefits authorized by the birth injury act and all reimbursements for medical-related expenses provided at the discretion of the board. Although the program was established in 1987, the first payment to a claimant was not made until 1992. Since then, almost \$25.3 million in program assets have been distributed for claimant expenses through June 2002. (In addition, the program spent an additional \$7.2 million to purchase trust homes that remain assets of the program but are used by claimants for the duration of their lives. The trust home benefit was eliminated in January 2000.) On average, the dollar value of benefits per year since 1992 is approximately \$62,000 per claimant (not including the value of the trust homes).

The birth injury program organizes claimant expenses into 12 categories, including: nursing, hospital/physician, incidental, housing, vans, lost wages, physical therapy, medical equipment, prescription drugs, legal, and insurance. As is illustrated in Figure 3, nursing and housing have been the most significant categories, comprising about 75 percent of the expenses throughout the life of the program. Nursing will likely continue to be the most expensive category, while housing is expected to gradually decrease since the program no longer provides housing grants. (Appendix A includes a table showing total claimant expenses paid by category by year.)



The program is only responsible for covering expense reimbursements not paid by other third-party payers such as private insurance and/or Medicaid. Hence, the fund becomes the “payer of last resort” for the program’s claimants. This has caused some disparity among claimants in the level of financial support provided by the program. The average yearly expenditure for benefits by claimant ranges from about \$8,400 to about \$247,000, depending largely on the extent of the claimant’s insurance and/or Medicaid coverage.

Funding the Birth Injury Program

The birth injury program is funded primarily through assessments on four sources. These sources are: participating physicians, participating hospitals, non-participating physicians, and liability insurers. Currently, the sources are assessed at the maximum levels allowed by law. As of June 30, 2002, the fund was valued at \$83.6 million.

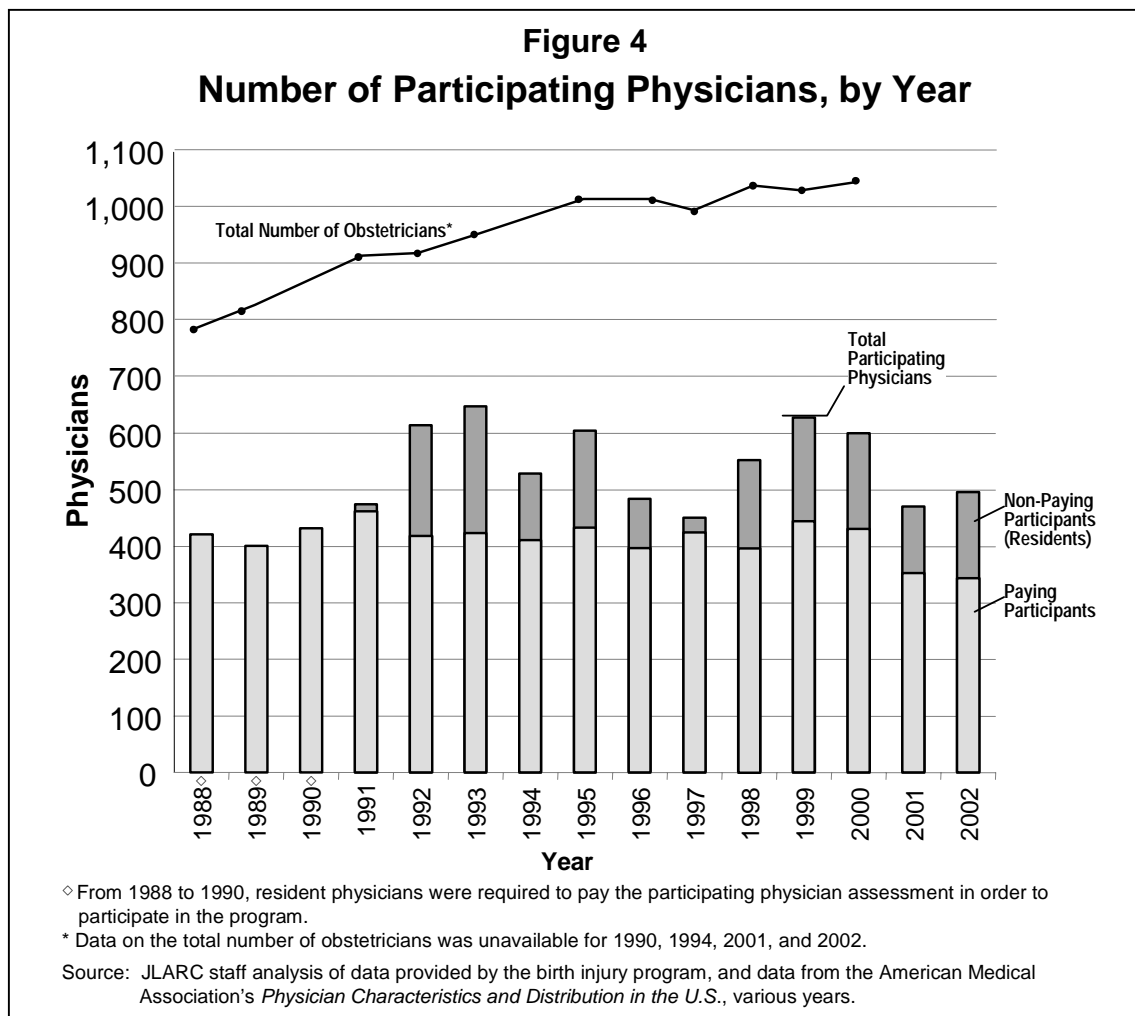
Participating Physicians. Certain conditions must be met to qualify for participation in the program. According to the birth injury act, the medical professional must:

- be licensed in Virginia as a physician or nurse-midwife,
- perform obstetric services (either as an ob/gyn, family practitioner, or nurse-midwife),

- have an agreement with the Health Department to provide obstetric care to indigent women,
- have an agreement with the Board of Medicine to submit to a review regarding whether appropriate standards of care were met when delivering children who are subsequently admitted into the program, and
- pay an assessment.

Residents in accredited family practice or obstetric residency training programs at participating hospitals are included as participating physicians. They do not have to pay the assessment. Upon meeting the aforementioned conditions for participation, the participant receives the benefit of the exclusive remedy provision of the law along with eligibility for a discount on his or her medical malpractice insurance premium.

As of July 2002, there were 500 participating physicians in the program. This reflects a participation rate among the State's ob/gyns of approximately 50 percent. Figure 4 shows the number of participating physicians each year of the program's existence. Participation has ranged from a low of 401 to a high of 648 physi-



cians and nurse-midwives. Of the current participating physicians, 319 are ob/gyns, 153 are residents, 12 are family practitioners, and five are certified nurse midwives. (The specialties of the remaining participants are unknown.) Appendix B shows the number of participating physicians in each planning district in the State.

The act sets the physician assessment at \$5,000 per year. However, the General Assembly enacted an amendment to §38.2-5016(F) of the *Code of Virginia* in 1994, which gave the board of directors the discretion to reduce the voluntary participating physician and hospital assessments for a stated period of time if and when the SCC determines the fund to be actuarially sound. In the first few years of the fund's existence, there were very few claims, revenues quickly accumulated from assessment income, and earnings from the investment of these funds became the largest source of yearly income. Due to the lack of claimants in the early 1990s (which were originally predicted to be 20 to 40 per year), the growth of the fund's financial assets exceeded the growth in the reserves that were estimated to be necessary to meet the lifetime costs for all the beneficiaries.

In response to this apparent over-funding situation, the board decided to implement a "sliding scale assessment," whereby participant fees would be prorated based on the number of years of participation in the fund. The board exercised this authority from program years 1995 through 2000, following the fee schedule shown in Table 3. Implementation of this assessment schedule reduced the program's assessment income from participating physicians and hospitals by approximately 65 percent.

Table 3		
Sliding Scale Annual Assessment Used by the Birth Injury Board, 1995 through 2000		
Number of Years in the Program	Physician Assessment	Hospital Assessment (Per Live Birth)
New	\$5,000	\$50.00
1	4,400	44.00
2	3,750	37.50
3	3,100	31.00
4	2,450	24.50
5	1,800	18.00
6	1,150	11.50
7+	500	5.00
Note: Under this fee schedule, the assessment of a participant was prorated based upon when the participant entered the program.		
Source: Virginia Birth-Related Neurological Injury Program.		

The assessment was restored to its maximum level for participating physicians (\$5,000) in 2001, after the 1999 actuarial report deemed the fund would be un-sound by 2001 unless the assessments were raised. In program year 2002, assessment fees collected from participating physicians totaled \$1,659,031. Table 4 shows the annual assessment income from participating physicians since the program's inception.

Participating Hospitals. In order for hospitals to acquire the same "no fault" exclusive remedy benefit as the participating physicians, they must meet similar conditions to those for participating physicians. Specifically, the hospital must:

Program Year	Participating Physicians	Participating Hospitals	Non-Participating Physicians	Liability Insurers	Total Annual Assessment
1988	\$ 2,039,167	\$ 3,028,458	\$ 2,100,777	-	\$ 7,168,402
1989	\$ 1,893,043	\$ 2,861,190	\$ 2,192,981	\$ 2,569,381	\$ 9,516,595
1990	\$ 2,025,913	\$ 2,838,000	\$ 2,269,362	-	\$ 7,133,275
1991	\$ 2,181,608	\$ 2,193,650	\$ 2,361,364	-	\$ 6,736,622
1992	\$ 1,864,583	\$ 2,183,800	\$ 2,637,372	-	\$ 6,685,755
1993	\$ 2,065,352	\$ 2,004,550	-	-	\$ 4,069,902
1994	\$ 1,870,555	\$ 1,866,039	-	-	\$ 3,736,594
1995	\$ 837,680	\$ 535,637	-	-	\$ 1,373,317
1996	\$ 658,623	\$ 367,169	-	-	\$ 1,025,792
1997	\$ 743,081	\$ 461,628	-	-	\$ 1,204,709
1998	\$ 622,250	\$ 399,003	-	-	\$ 1,021,253
1999	\$ 687,250	\$ 533,329	-	-	\$ 1,220,579
2000	\$ 709,900	\$ 374,902	-	-	\$ 1,084,802
2001	\$ 1,762,500	\$ 1,891,950	-	-	\$ 3,654,450
2002	\$ 1,659,031	\$ 2,256,000	\$ 3,223,200	\$ 8,042,558	\$15,180,789
Total	\$21,620,536	\$23,795,305	\$14,785,056	\$10,611,939	\$70,812,836

Notes:

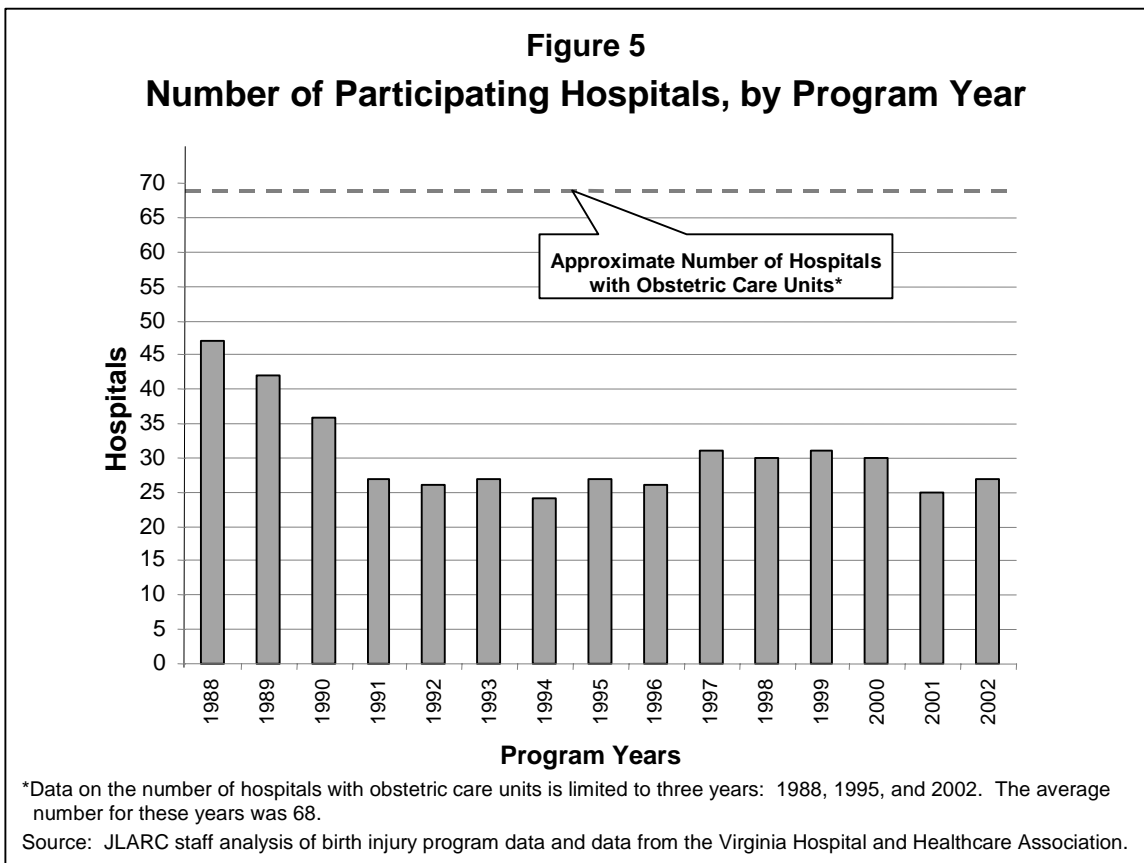
1. 1988-1994 includes \$5,000 per year from participating physicians, \$50 per live birth from participating hospitals (\$150,000 cap), and \$250 per year from all other non-participating physicians. Starting in 1993, assessments from non-participating physicians were eliminated.
2. 1989 includes an additional assessment of one tenth of one percent of net premiums written from liability insurers.
3. Assessments for 1995 through 2000 are pro-rated according to the length of time the participating physicians and hospitals have been in the program.
4. In 2001 and 2002, all participating physicians and hospitals were charged the maximum assessments allowed by the birth injury act, regardless of the length of time they have been in the program.
5. In 2002, liability insurers were assessed one quarter of one percent on net premiums written, and the \$250 assessment on non-participating physicians was restored.

Source: JLARC staff analysis of birth injury program audit information, 1988-2002.

- be licensed in Virginia,
- provide obstetric services to indigent women,
- agree to be reviewed by the Health Department regarding whether an appropriate standard of care was met, and
- pay the assessment.

Hospitals choosing to participate in the program pay an assessment in the amount of \$50 per live birth for the prior year, as reported to the Department of Health in the Annual Survey of Hospitals. For all participating hospitals, this fee is capped at \$150,000 per year. In program year 2002, the birth injury program received assessment income from 27 participating hospitals. Figure 5 shows the annual number of participating hospitals since the program's inception. As with physicians, hospitals were assessed on a sliding scale between 1995 and 2000. The maximum assessments for participating hospitals were restored in 2001, which increased hospital revenues from \$379,000 to almost \$1.9 million. (Appendix C shows the location of the participating hospitals.)

Non-Participating Physicians. A physician is classified as “non-participating” if either: (1) a licensed, otherwise qualified physician chooses not to pay the participating physician assessment and obtain the “no fault” benefit, or (2)



he or she is a licensed, non-obstetric physician practicing in the Commonwealth on September 30 of the previous year. In both cases, the act institutes a mandatory annual assessment of \$250 on all non-participating physicians. Unlike the participating physician and hospital assessments, this fee does not provide the exclusive remedy provision of the law, nor does it mandate a reduction in medical malpractice insurance premiums. The SCC is responsible for assessing this fee.

The act establishes fee exemptions for non-participating physicians in the following circumstances:

- a physician whose income from professional fees is less than an amount equal to ten percent of the annual salary of the physician;
- a physician who is enrolled in a full-time graduate medical education program accredited by the American Council for Graduate Medical Education;
- a physician who has retired from active clinical practice; or
- a physician whose active clinical practice is limited to the provision of services, voluntarily and without compensation, to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge.

Effective in 1993, the act was changed to require the SCC to eliminate the assessment of non-participating physicians if the actuarial review determines that the fund is actuarially sound. Based on projected funding estimates provided in the 1992 actuarial report, the SCC suspended the assessment of non-participating physicians beginning in program year 1993. Prior to suspending that fee, the fund received assessment income ranging from \$2.1 million to \$2.6 million annually (see Table 4). In response to the projected unfunded liability cited in the 2001 actuarial report, the SCC reinstated the \$250 assessment on all non-participating physicians, beginning with program year 2002. This year, assessments totaling just over \$3.2 million were received from approximately 12,893 non-participating physicians.

Liability Insurance Carriers. The birth injury act states that “all insurance carriers licensed to write and engaged in writing liability insurance in the Commonwealth of a particular year, shall pay into the fund an assessment for the following year, in an amount determined by the State Corporation Commission.” These assessments are to be based on the net direct liability premiums for the prior year ending December 31, and are not to exceed one quarter of one percent of the insurance carrier’s net direct premiums written. The SCC is to impose this assessment only when it is determined necessary to maintain the fund’s financial soundness, after all other maximum assessments have been imposed. Only a small portion of the insurance companies that are assessed this fee write medical malpractice policies.

The assessment on liability insurers has been imposed only twice in the program’s history. In program year 1990, the SCC assessed liability insurance carriers a total of 0.1 percent of their net liability premiums, or roughly \$2.6 million

(see Table 4). No assessment was imposed on this group for the remainder of the 1990s. Then, the 2001 actuarial report recommended that the insurer assessment be reinstated for 2002. In response to this recommendation, the SCC issued an order in October of 2001 reinstating the assessment for 2002 and beyond. A total of 423 liability insurers were assessed this fee, which was set at the maximum allowed by law – 0.25 percent of net direct liability premiums written in Virginia. Assessments collected from liability insurers for 2002 totaled just over \$8 million.

JLARC REVIEW

This review evaluates the effectiveness and viability of Virginia's birth injury program and fund. This section describes the specific issues addressed by the study and the research activities undertaken to arrive at the study's findings and recommendations.

Study Issues

JLARC staff identified six major issues designed to assess the birth injury program and fund:

- To what extent are births in Virginia covered by the program?
- What is the impact of the program on birth-injured children?
- What is the impact of the program on physicians, hospitals, and the insurance industry?
- Is the program's eligibility process sound?
- Is the program effectively structured and operated?
- Is the birth injury fund financially sound?

Research Activities

JLARC staff undertook a variety of research activities to address the study issues. These activities included structured interviews, mail and on-line surveys, a review of WCC opinions and case files, a review of financial and actuarial documents pertaining to the program, analysis of the Virginia Health Information births database, and document reviews.

Structured Interviews. JLARC staff conducted numerous structured interviews with representatives from the medical and hospital communities, personnel from liability insurance companies, and medical malpractice attorneys to ascertain perceived strengths and weaknesses of the program. These interviews were also used to gain their opinions about the impact of the program on physicians, hospitals, insurers, and the medical malpractice insurance market. Commissioners of ac-

counts from nine localities in Virginia were contacted to gain an understanding of award oversight in medical malpractice cases.

Interviews were also conducted with the program's board of directors. Current and past board members were interviewed individually to gain their perspectives on the board's role and the decision-making process through which benefit determinations are made. Each member of the program's staff was interviewed as well, in order to obtain information about how they perform their official duties, to determine how the program operates, and to assess the consistency with which various program policies and procedures are enforced, particularly those related to awarding benefits.

Comparative information on Florida's birth injury program was obtained through a telephone interview with that program's executive director. Telephone interviews were conducted with representatives from the New York and North Carolina chapters of the American College of Obstetricians and Gynecologists about proposed birth injury legislation in both of those states.

Additionally, the Chief Deputy Commissioner of the WCC and the medical panels from UVA and MCV were interviewed. The purpose of these interviews was (1) to gain their perspectives on potential changes to the birth injury definition, the degree of certainty with which they make decisions as to program eligibility, and perceived strengths and weaknesses of the program, and (2) to determine their roles in the eligibility process. The SCC was contacted, as well, to determine its role vis-a-vis the program and to obtain information about professional liability premiums in Virginia.

Survey of Claimant Families. JLARC staff sent a mail survey to each of the claimant families that had been accepted into the program as of April 2002 (Appendix D). Responses to these surveys were received from 51 (71 percent) of 72 claimant families. The survey was used to assess claimants' levels of satisfaction with services provided by the program staff and with the benefits provided by the program, and to gauge the difficulty of the application and hearing processes by which program eligibility is determined. An on-line discussion was conducted with claimant families to obtain supplemental information.

Survey of Participating Physicians. Each physician who had elected to participate in the program as of June 2002 was given the option to complete either an on-line survey or a paper-based survey (Appendix E). Responses were received from 130 (26 percent) of the 500 participating physicians. Responses to these surveys were used to obtain information about their decision to participate in the program, their views as to the appropriateness of participation assessments and the benefits provided by the program, as well as their perceptions of the program's impact on medical malpractice premiums.

Survey of Non-Participating Physicians. Using the Virginia Board of Medicine's Practitioner Database, JLARC staff identified all Virginia physicians who are board certified in obstetrics/gynecology and/or who have self-reported an obstetrics specialty, and who have not chosen to participate in the birth injury program.

Surveys were sent to 686 non-participating physicians, of which 106 physicians responded (Appendix F). This survey was used to determine why some physicians choose not to participate in the program and to gain an understanding of potential changes to the program that would encourage a greater number of physicians to participate.

Survey of Hospitals with Obstetrical Care Units. JLARC staff identified 66 hospitals in which there were deliveries in 2001. Twenty-seven of these hospitals participate in the program and 39 of them do not participate in the program. JLARC staff sent surveys to these hospitals and received responses from 23 (85 percent) of the participating hospitals and 23 (59 percent) of the non-participating hospitals (Appendix G). The surveys were used to gain knowledge about the factors hospitals consider in deciding whether or not to participate in the birth injury program, to obtain hospitals' views about perceived strengths and weaknesses of the program, and to obtain their views on the program's impact on medical malpractice premiums for hospitals.

Review of WCC Opinions and Case Files. JLARC staff conducted reviews of the formal opinions and case files for all of the birth injury petitions submitted to the WCC between 1988 and April 2002. These reviews were used to: assess the eligibility process at the WCC; determine the role of attorneys, the program, and the medical panels in the WCC eligibility process; to gain information on how benefit appeals have been administered; and address the impact of possible changes to the birth-injury definition.

Review of Financial Records. JLARC staff reviewed and analyzed all of the program's financial records, including balance sheets, profit and loss statements, and financial statements from the birth injury fund managers. These records were reviewed for yearly changes in net assets and claims reserve totals of the fund. The records were also reviewed to assess how the fund spends its money, the gains and/or losses on the sale of the fund's investments, the fees charged by the fund managers, and changes in investment strategies over time. The fund manager, the program auditor, and Virginia Retirement System (VRS) staff were also consulted throughout the study.

Review of Actuarial Studies. JLARC staff reviewed each of the 11 actuarial studies produced for the program since its inception. Through a review of the studies, JLARC staff tracked changes in the actuarial assumptions used over time. Data from these studies were also used by JLARC staff to estimate the impact of alternative assessment structures on the fund. Additional information about actuarial assumptions and various financial impacts on the fund was obtained through telephone interviews and electronic correspondence with the actuary.

Analysis of Virginia Health Information Data. Virginia Health Information (VHI) maintains a database on all patients admitted to hospitals in Virginia, including all births. Data provided in this database include the name of any attending and assisting physician(s) present at the delivery, the name of the admitting hospital, and diagnosis codes, from which the number of babies born to each mother

could be determined. JLARC staff analyzed the data for years 1996 through 2001 to determine how many births each year were attended or assisted by a participating physician, and/or that occurred in a participating hospital. Using this data, JLARC staff were also able to ascertain differences in the number of deliveries by participating and non-participating physicians, and in participating and non-participating hospitals.

Analysis of the National Practitioner Data Bank Public Use Data File. The Public Use Data File of the National Practitioner Data Bank contains information on all medical malpractice payments made since 1990, including the practice field of the practitioner against whom a claim is made (for example, obstetrics/gynecology), the state in which the malpractice took place, and the amount and number of awards and settlements. The NPDB Public Use File does not include information on the nature and severity of injuries that result in claims; however, JLARC staff used the database to identify malpractice acts resulting from the labor and delivery process (and thus, potential birth injuries), and to determine the volume and size of potential birth injury awards and settlements in Virginia. This information was used to compare the number and cost of potential birth injury claims in Virginia to those in nearby states.

Document Reviews. As part of the research process, JLARC staff reviewed numerous documents. Those reviewed included: relevant sections of the *Code of Virginia*; all versions of the birth injury program guidelines; all versions of the program's plan of operation; copies of the board meeting minutes for each board meeting since the program's inception; journal articles and books pertaining to medical malpractice, tort reform efforts, malpractice insurance, and birth injuries; relevant newspaper articles; relevant sections of the *Florida Annotated Statutes*; and no-fault injury legislation in other states.

REPORT ORGANIZATION

This chapter has provided an overview of the birth injury program. Chapter II examines the impact of the program on birth injured children, as well as physicians, hospitals, and insurers. It assesses the extent to which the goals of the program have been met. Chapter III examines the financial condition of the fund and presents options for the program's future that the General Assembly may wish to consider. Chapters IV and V discuss operational issues and provide recommendations for improvements in how the program is managed.

II. Impact of the Birth Injury Program

As described in Chapter I, the Virginia Birth-Related Neurological Injury Compensation Program (birth injury program) had an immediate impact on medical malpractice insurance availability in Virginia because, as promised, once the program was created by the General Assembly, one of the major insurers immediately lifted its moratorium on writing new policies for obstetrician/gynecologists (ob/gyns). This action helped ameliorate the lack of available insurance experienced prior to the program's creation due to another insurer's withdrawal from the Virginia market.

While this short-term impact is clear, the program's long-term impact is less clear. It appears that the program has had mixed success in meeting all of its objectives. This review found that the birth injury program is largely beneficial to the birth injured children accepted into the program. It also generally benefits Virginia's ob/gyns, hospitals, and malpractice insurers. However, the broader societal benefits that were expected to be attained – for example, retaining obstetric services in rural areas of the Commonwealth, as well as ensuring access to obstetric care for indigent women – do not appear to have come to fruition as a result of this program. Assessments for this program also appear to be more than the awards and expenses of the tort system it replaced. And, as will be discussed in Chapter III, the birth injury fund's long-term viability is questionable under the current assessment structure.

THE PROGRAM COMPARES FAVORABLY TO VIRGINIA'S CAPPED TORT SYSTEM FOR BIRTH INJURED CHILDREN

JLARC staff examined the relative benefits of the program and the capped tort system for birth-injured children in Virginia through a survey of claimants in the program, interviews with medical malpractice attorneys, a review of the medical malpractice literature, and a review of the program's financial records. Overall, it appears that the benefits offered by the program are generally more advantageous to birth-injured children than a medical malpractice award. In addition to serving more birth-injured children than the tort system, the program provides benefits for the typical child that exceed the medical malpractice cap. There are also major disadvantages of the program to the families, however, including the inability of mothers to receive compensation for injuries caused by their physicians during the birthing process. In addition, the program does not always meet the unique needs of individual children.

In General, Birth Injured Children Receive More Benefits from the Program than from Virginia's Capped Tort System

Although the main objective of the act was to stabilize medical malpractice insurance rates for obstetricians in order to ensure the availability of obstetrical services across the Commonwealth, the impact of the program on birth-injured children and their families is also of critical importance. To be fair to families, the pro-

gram needs to provide benefits that are at least comparable to what could be obtained through a medical malpractice suit.

JLARC staff found that, on average, birth injured children appear to receive more assistance from this program than they would have received through the tort system with a cap on malpractice awards. Further, the program appears to have met the goal of directing more of the money to meet the children's needs than the tort system does.

A Greater Number of Birth Injured Children Receive Benefits From the Program Than Through the Tort System. The program was set up as a no-fault system. Therefore, by definition, it can be expected that a portion of the birth injuries would not have involved malpractice issues and those families would not have pursued medical malpractice lawsuits through the court system. JLARC staff asked families in the program whether they believed their child's birth injury was a result of medical malpractice. Families were also asked whether they met with an attorney concerning a possible medical malpractice lawsuit against the physician or hospital involved in their child's delivery. Table 5 presents these survey findings. While most believe medical malpractice was the cause, almost one-fourth of the families who responded to the survey either did not think medical malpractice was involved or did not know. Furthermore, 17 percent of those who thought their child's injury was the result of medical malpractice never actually spoke to an attorney. Therefore, a substantial portion of these families would likely not have been served by the tort system.

In addition, data from the tort system show that many lawsuits are unsuccessful and do not result in any monetary compensation to the families. According to medical malpractice experts interviewed by JLARC staff, only about 20 percent of plaintiffs typically win medical malpractice suits. Of the subset of birth injury cases, estimates of the number of successful suits vary considerably from 47 percent

Table 5		
Families' Responses to Questions Related to Medical Malpractice Lawsuits		
	Yes	No/Don't Know
Do you believe your child's birth-related injury was the result of medical malpractice? <i>N=51</i>	78%	22%
<i>For respondents who answered "yes" to the question above:</i>		
Did you meet with at least one attorney concerning a possible medical malpractice lawsuit against your physician and/or the hospital in which your child was delivered? <i>N=40</i>	83%	17%
Source: JLARC staff survey of claimants in birth injury program.		

to 90 percent. Of the birth injury claims examined by the Williamson Institute study in 1989, 14 of the 47 claims (30 percent) that had been closed did not result in a payout by the defendant. Hence, even with the relatively high success rate of birth injury lawsuits, a significant portion of the children in the program would not likely have been compensated through the tort system.

While more severely birth injured children have been served by the program than through the tort system, many fewer have been served than were expected at the time the act was passed by the General Assembly. Initial estimates of the number of children that would be eligible for the program ranged from 20 to 40 children per year. Two years after the program's enactment, the Williamson Institute study and subsequent analyses concluded that the number of children born each year that would meet the birth injury definition was around ten.

Benefits Provided by the Program Are Estimated to Exceed the Medical Malpractice Award Cap in Virginia. Currently, Virginia has a cap on medical malpractice awards of \$1.65 million. (Until 1999, the cap was \$1 million.) However, based on actuarial analyses of the program, it is estimated that the average cost of care for these children is \$1.74 million in today's dollars (after all other sources of payment have been used). This assumes that \$1.74 million is invested and that money is taken out of that amount to cover the child's expenses as needed. The actual expected lifetime program expenditure for a child born in 2001 who enters the program averages \$4.4 million. Therefore, even considering that the program is the payer of last resort, the cost to care for a birth injured child is greater than the maximum amount that could be awarded through Virginia's tort system, given the current medical malpractice cap. (Under Virginia's tort system, collateral sources are not taken into account when deciding upon awards and settlements.)

Further, it appears rare that plaintiffs receive compensation at the amount of the medical malpractice award cap. Based on a review of obstetrics-related malpractice payments reported in the public use file of the National Practitioner Data Bank (NPDB), only three (five percent) of the 62 awards entered between 1998 and 2002 approached the medical malpractice cap at the time of the malpractice occurrence.

In addition, it should be noted that families would not receive the entire medical malpractice award. According to medical malpractice experts interviewed by JLARC staff, a total of 40 percent of a medical malpractice award is typically paid to the attorney for legal fees and expenses. Therefore, a claimant who receives an award equivalent to the medical malpractice cap would actually receive only about \$990,000 after such fees and expenses are paid. In addition, some health insurance companies require reimbursement for expenses paid when a malpractice award is received. (Medicaid always requires reimbursement.) For children in the program, on the other hand, legal fees average less than one percent of a claimant's expenses. Therefore, more money is spent directly on medical expenses for children in the program, rather than legal representation. Furthermore, if a child's expenses exceed the estimated average cost of \$1.74 million, the program is still obligated to pay those costs. There is no such option for children who deplete their medical malpractice awards. As one family in the program noted:

After our child was born, we considered a medical malpractice case against the obstetrician. We met with a team of attorneys and a medical expert, who advised us that we did indeed have a valid case. However, due to the laws in the state of Virginia at that time, the medical malpractice cap was at one million dollars. The lawyers would take 40%, the insurance company was going to put a lien on the award (they had paid over \$300,000 at that time), and we would wind up with little money that would have to last for the lifetime of our child. It was because of these facts that we applied to the Program.

Most Parents Believe the Program Is a Better Choice Than a Medical Malpractice Lawsuit. To obtain input from the parents on whether the program is an acceptable alternative to the tort system, JLARC staff asked parents the following question on the parent survey: “Based on your experience in the program and the current cap on medical malpractice awards in Virginia, if you were given the choice today, would you choose to be in the program or to file a medical malpractice lawsuit on behalf of your child?” In response, 69 percent of the families indicated that they would have chosen the program over a medical malpractice lawsuit. When asked to indicate why they would choose the program, most acknowledged that the current cap would not cover lifetime medical costs for their children.

The Program Is Not Unduly Burdensome for Parents

In addition to providing financial benefits that are comparable to or better than medical malpractice awards, it is also important that the program not be more difficult or taxing on parents than a medical malpractice lawsuit. To determine the timeliness of the eligibility process for acceptance into the program, JLARC staff reviewed files at the Workers’ Compensation Commission (WCC). In addition, JLARC staff conducted interviews with commissioners of accounts who monitor medical malpractice awards for minors to compare the process for receiving benefits from the program to the process required of parents to access funds from a child’s medical malpractice award. Through this review, JLARC staff found that the processes for entering the program and for accessing benefits once in the program are not overly cumbersome, as compared to the processes required in medical malpractice lawsuits.

The Eligibility Process at the WCC Is More Timely Than Medical Malpractice Lawsuits in Circuit Courts. Based on file reviews at the WCC, JLARC staff found that the median amount of time between a petition being filed at the WCC and the WCC’s final order was about 2.6 months. For cases not contested by the program (which was the majority of cases), the WCC issued its acceptance order in a median of 1.7 months after the date the petition was filed. On the other hand, it often takes several years to settle a medical malpractice lawsuit. For example, in the Williamson Institute study of birth injury cases, it took an average of three years to close a case. In addition to being more timely, most families who apply to the program do not have to go through the emotional stress of depositions and other legal requirements involved in lawsuits. Clearly, the process for entering the program is much more efficient than that of a typical medical malpractice lawsuit.

The Process for Obtaining Benefits from the Program Is Not Excessively Cumbersome. Although the program has a set of guidelines that enumerate the benefits available to children in the program, parents must obtain letters of medical necessity for any benefit they request. Once the letter of medical necessity has been provided, there are two processes parents may use to obtain benefits. Whenever possible, the program makes direct payments to suppliers and service providers to eliminate out-of-pocket expenses for parents. For out-of-pocket expenses, parents must turn in receipts to receive reimbursement from the program. As will be discussed in Chapter V, these processes are essential to ensuring that the fund only pays those expenses for which the fund was intended.

For cases in which a minor wins a medical malpractice award, parents must also go through a formal process to access funds for a child's expenses. After an award is received by a minor, it is placed in a trust and monitored by the court. In order to take money out of the trust, parents must be qualified as guardians and bonded. These safeguards are in place to ensure that the assets of the child's trust fund are protected. Although parents may sometimes seek approval for major expenses to ensure that they will be approved by the commissioner of accounts, parents have direct access to the funds and generally take money out to pay for expenses as needed. However, parents are required to submit all receipts and bank statements to a commissioner of accounts assigned to them by the court. On a periodic basis, the commissioner of accounts is then responsible for reviewing and approving the expenses paid from the account. There are no formal guidelines followed by commissioners of accounts in these types of cases, which probably results in some variability in the types of expenses that are permitted from one case to the next. Nevertheless, parents do not have complete discretion over their child's award, and must reimburse the trust fund for any expenses not approved by the commissioners of accounts. In the event that such expenses are not returned, a parent or guardian could be held criminally liable for misuse of the funds.

There Are Some Disadvantages to Being in the Program

Despite the significant benefits to the program, there are also benefits to the tort system that are not addressed by the program. For example, mothers who are injured during the birthing process would be permitted to receive compensation for any such injuries under the tort system. In addition, families who win a medical malpractice award may receive some satisfaction that negligent physicians are being held accountable. Finally, while parents do not have complete discretion over a medical malpractice award, the use of those funds is more flexible than that of program funds and may be spent in ways that better meet the specific needs of a particular child.

Mothers Who Are Injured During the Birthing Process Are Prohibited From Filing a Medical Malpractice Suit on Their Own Behalf. In addition to not being able to sue for injuries to their children, mothers are also prohibited from filing suit against a participating doctor in the program on their own behalf, even if they sustain a separate physical injury. The following language in §38.2-5002 of the act explicitly states:

The rights and remedies herein granted to an infant on account of a birth-related neurological injury shall exclude all other rights and remedies of such infant, his personal representative, parents, dependents or next of kin, at common law or otherwise arising out of or related to a medical malpractice claim with respect to such injury.

Because the program will only pay for expenses related to the child, mothers who are injured may incur out-of-pocket medical expenses that cannot be recovered. The following example illustrates such a case:

In one case a mother reported that the surgeon cut her bladder during a Caesarean-section. As a result, she had to wear catheters for a total of six weeks. She reports that her bladder and the nerves in her back are permanently injured. She has had out-of-pocket expenses for catheters and medications, which she still needs many years after the injury occurred.

Medical malpractice attorneys interviewed by JLARC staff have indicated that whenever there is an award for a child in a birth injury case, there is typically an award for the mother as well. Although the mother must show a separate injury than incurred by the child, this is reportedly not difficult to prove. Therefore, it is likely that many of the mothers who would have received an award in a medical malpractice lawsuit are not receiving any compensation if their child is in the program.

This problem could be addressed by allowing mothers to sue for economic damages in cases for which they can show a separate physical injury. However, even though such cases would likely involve much lower payouts, this would provide a disincentive for doctors and hospitals to participate in the program. Alternatively, the program could pay for any medical expenses incurred by mothers of children who are accepted into the program. This would likely require a separate hearing to determine whether the mother's injury was the result of the birth process. In addition, the program would have to develop separate guidelines for handling any such claims.

An additional issue related to the mother's inability to file suit relates to non-economic damages. Typically, a large portion of a mother's medical malpractice award is for "pain and suffering." There is no comparable award to families of birth-injured children in the program. This is a major source of complaints from the families in the program who believe their children's injuries are the result of malpractice. Foreclosing the mother's right to sue raises serious questions as to the fairness of this aspect of the program, which the General Assembly may wish to address.

Negligent Physicians Are Not Held Accountable. Because families in the program cannot sue their doctors for medical malpractice, many of the families who thought their child's birth injury was the result of medical malpractice felt that the doctors were not held accountable for their negligence. Although the Board of Medicine may still discipline a doctor in the program, many parents indicated a lack

of confidence in that process. For example, one parent had the following to say about the Board of Medicine's reviews of doctors with children in the program:

Just on the face of it, if after nearly 15 years and with 70 of the worst outcomes in a medical specialty, not a single disciplinary action has been taken, it is hard to take the process seriously.

Given the perception that the Board of Medicine does not handle these birth injury cases appropriately and that lawsuits are barred, parents are left with the impression that justice has not been served. (Issues surrounding the Board of Medicine's role in the birth injury program will be discussed further in Chapter IV.) Absent any action on the part of the Board of Medicine, families are left with no mechanism for venting their frustration at their physicians and/or hospitals.

The Program May Not Meet the Unique Needs of Each Child. The program has developed a set of guidelines that enumerate benefits in order to make them known to families and in an effort to enhance consistency in decision-making. While such guidelines are necessary, it has contributed to problems in some cases. For example:

In one case a family requested reimbursement for their child to attend a special needs camp (which was staffed with a nurse). However, the program turned down that request because it was not considered to be medically necessary. The parents in this case pointed out that the cost of the camp was significantly lower than the nursing costs the program would have incurred if the child had stayed home. Apparently, in an effort to be consistent in its application of the program's guidelines, the program denied this request.

In contrast, the use of medical malpractice awards are much more flexible in such cases. According to interviews with commissioners of accounts, decisions about how the money from a medical malpractice award is spent are made according to the court order and individual needs of each child. Decisions are reportedly not made with the intent of being consistent across all medical malpractice cases.

Some Families in the Program May Receive Less Compensation Than Through the Tort System. As would be expected with almost any compensation system, there are "winners" and "losers" in both the program and the tort system. As previously described, the families who would not have received any compensation under the tort system are clearly winners in the program. Under the tort system, families who have ample collateral sources, such as private health insurance, are better off than those without significant collateral sources. Those without collateral sources would need to spend more of the award on basic medical costs, while those for whom the basic medical costs are well-covered can spend the award on other, perhaps less urgent care for their children.

Not unlike the tort system, the amount received by each child in the program varies. However, this is because collateral sources are taken into account. In these cases, the families without collateral sources typically receive more benefits

than those with collateral sources. This is evident in examining the expenses paid by the program for individual claimants. For example, one family that has been in the program for seven years has received an average of over \$200,000 per year, but another family that has been in the program just as long has received less than \$10,000 per year on average. These variations in benefits are likely due to a combination of collateral sources as well as varying conditions of the children.

THE BIRTH INJURY PROGRAM BENEFITS PHYSICIANS, HOSPITALS, AND MALPRACTICE INSURERS

Virginia's significant tort system changes (notably the malpractice award cap), along with relatively low malpractice claims record, made the State an attractive market to medical malpractice insurance companies in the 1990s. It appears that the birth injury program played a role in creating this situation by both minimizing claims for severely birth-injured children and helping to keep intact the medical malpractice award cap. As a result, ob/gyns in Virginia were able to obtain malpractice insurance at lower rates than their counterparts in many other states. To a lesser extent all physicians benefited from the lower level of indemnity incurred by malpractice insurers. Although malpractice premiums have increased significantly in the past couple of years, it does not negate the fact that the malpractice cap and birth injury program appear to have had a positive effect on claims costs, and subsequent malpractice premiums.

At the same time, the birth injury program directly benefited some participating physicians because they avoided medical malpractice lawsuits. Others benefited from insurance discounts for participation that exceeded the assessment they paid for participating in the program. In other words, they earned money simply by participating in the program. Overall, JLARC staff found that the birth injury program has been beneficial to physicians, hospitals, and malpractice insurers as a group.

Program Removes Lawsuits from the Tort System

Most babies in Virginia are delivered by a participating physician and/or are delivered at a participating hospital and are, therefore, potentially covered by the birth injury program. Based on current participation levels, the actuarial reviews, and past medical research, it is estimated that approximately seven babies are born each year who would meet the birth injury definition for inclusion in the program. Therefore, up to seven cases per year are potentially removed from the tort system. While the number of cases is small, these children have a larger than average impact on insurance costs due to their typically large settlement amounts.

Participants Avoid Lawsuits. JLARC staff analysis of available data suggests that the program's existence does, in fact, result in the avoidance of lawsuits for the physicians involved in the claimants' births and the hospitals in which the births occurred. There have been 83 physicians involved in the births of the program's 72 claimants. As previously discussed in this chapter, more than three-fourths of the families who responded to the JLARC staff survey reported the belief

that their child's birth-related injury was the result of medical malpractice. Applying this percentage to the number of physicians involved in program cases suggests that as many as 62 physicians may have avoided lawsuits due to the program's existence.

These physicians, therefore, did not have to endure the professional and emotional expense involved in responding to a lawsuit. Further, since the birth injury program is a no-fault program, the physicians' names and case information are not reported to the National Practitioner Data Bank, which tracks all malpractice settlements. In addition, these cases are not counted as claims against the physicians when obtaining malpractice insurance, potentially enabling the physicians to obtain loss-free discounts on their insurance.

In addition to the impact on physicians, the hospitals in which these claimants were born also potentially avoid costly lawsuits. Since the program's inception, claimant births have occurred at 28 hospitals, with the number of births per hospital ranging from one to eight. Given that birth injury lawsuits typically name both the physician and hospital, it is reasonable to assume that the majority of these hospitals have avoided one or more lawsuits through their program participation.

While data are incomplete on the insurance companies that insure these physicians and hospitals, they were insured by at least 16 different malpractice insurers. Insurers clearly receive the most direct benefit from this program, as their total losses are reduced for each case in which an award does not have to be paid.

Virginia's Claims Costs Compare Favorably to Neighboring States.

In addition to relying on the views of the program claimants, JLARC staff examined data from the National Practitioner Data Bank (NPDB) on malpractice cases that have been closed with payments. Since 1990, insurers have been required to submit information to the NPDB on all claims closed with a monetary settlement or award. This database is used by hospitals, health maintenance organizations, and state licensing agencies for professional credentialing and licensing purposes. For example, a hospital may query a physician's record of malpractice awards in evaluating whether to give the physician privileges to work at the hospital.

JLARC staff used the public use file from this database to examine the volume and size of awards in birth-related cases in Virginia and other states. Although birth-related injuries are not specifically defined in the database, cases are coded according to a series of malpractice acts. JLARC staff focused its analysis on seven codes that most closely involve the labor and delivery process (for example, "ob: failure to identify/treat fetal distress" and "ob: delay in delivery: induction or surgery"). Since information on the nature and severity of the child's injury is not included in the database, JLARC staff were not able to identify specifically the total number of severe birth injury cases that have remained in the tort system rather than being diverted to the birth injury program. However, examination of the data did allow for some evaluation of whether the program appears to reduce claims costs.

Specifically, JLARC staff examined the average number of settlements per year, the average amount of the settlements, and the total dollar value of the set-

tlements for the past five years for Virginia and neighboring states. Table 6 presents the results of those comparisons. While Virginia does not have a particularly low number of settlements compared to most of the other states, its relatively low average settlement amount and total amount of settlements during the past five years suggest that Virginia has a favorable claims record compared to these other states. (Florida is the only other state that has a birth injury program.)

In examining the dollar amount of each award over the past five years, JLARC staff found that Virginia and Florida consistently have the lowest proportion of high cost awards compared to the other states (Table 7). Only five percent of Virginia's and Florida's awards exceeded \$950,000, while 27 percent of North Carolina's

State	Average Number of Settlements Per Year	Average Settle- ment Amount	Total Amount of Settlements
Pennsylvania	83	\$378,115	\$157,673,750
North Carolina	12	813,417	48,805,000
Maryland	19	470,914	43,795,000
Florida	27	308,204	42,224,000
Virginia	12	342,565	21,239,000
West Virginia	5	471,519	12,259,500

Source: JLARC staff analysis of data from the National Practitioner Data Bank Public Use Data File, April 2002, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Practitioner Data Banks.

State	Total Number of Settlements	Percentage of Settlements Exceeding \$500,000	Percentage of Settlements Exceeding \$750,000	Percentage of Settlements Exceeding \$950,000
North Carolina	60	37%	33%	27%
West Virginia	26	42	38	27
Maryland	93	26	20	15
Pennsylvania	417	23	17	12
Florida	137	9	7	5
Virginia	62	23	11	5

Source: JLARC staff analysis of data from the National Practitioner Data Bank Public Use Data File, April 2002, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Practitioner Data Banks.

and West Virginia's awards exceeded that amount. The maximum award in each state ranged from a low of approximately \$1 million in Virginia and West Virginia to a high of approximately \$4.75 million in North Carolina.

Finally, JLARC staff compared the number of malpractice settlements per year in Virginia that were for more than \$500,000 to the number of birth injury program claimants accepted per year (based on birth year). Since program claimants are by definition the most severely injured babies, insurance companies reported that comparably situated babies that were not diverted to the program generally receive settlements for \$500,000 or greater. In each birth year, there were more birth-injured claimants accepted into the program than there were malpractice settlements (Table 8). Across all years, there were an average of two tort settlements per year that exceeded \$500,000 compared to an average of six birth injury claimants accepted into the program per year. These results give further evidence that the birth injury program, in tandem with the State's medical malpractice award cap, help to eliminate the more costly awards from the tort system.

Birth Year	Birth Injury Program Claimants	Malpractice Settlements Greater than \$500,000
1988	2	2
1989	9	1
1990	3	2
1991	9	2
1992	8	1
1993	9	3
1994	4	0
1995	5	1
1996	8	3
1997	7	4
1998	6	3
1999	1	0
2000	1	0

Source: JLARC staff analysis of birth injury program claimant data and data from the National Practitioner Data Bank Public Use Data File, April 2002, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Practitioner Data Banks.

Physicians Experienced Low Medical Malpractice Insurance Premiums During the 1990s

As described in Chapter I, the medical malpractice insurance market "hardened" in the mid to late 1980s, and premiums rose substantially. However, by the early 1990s the market softened and competition increased considerably. This high

level of competition lasted for most of the 1990s. As a result, physicians saw little growth in insurance rates and in many cases experienced substantial declines from the rates they paid in the late 1980s.

As just described, it appears that the birth injury program reduces the number of malpractice claims against ob/gyns and hospitals in Virginia. This reduces insurance companies' exposure to losses. The fact that the program exists – with its potential to reduce indemnity payments by insurers – along with other changes in tort law, made Virginia attractive to insurers in the 1990s and many new insurers entered the insurance market as a result. As new companies entered the market, competition increased, resulting in reduced premiums for ob/gyns. The birth injury program's specific role in the reduction of malpractice premiums cannot be separated out, but given that it helped reduce claims losses, it reasonably can be considered one factor in encouraging insurers to bring their business to Virginia. It also appears that normal insurance industry cycles also played a role in ameliorating the insurance problems of the 1980s.

The favorable rates experienced by Virginia's ob/gyns are illustrated in the rates offered by St. Paul during this time period. (St. Paul was the largest insurer of physicians in Virginia until it withdrew from the malpractice insurance market nationally in late 2001.) Table 9 shows their rates at three points in time. The rates charged by St. Paul in 2001 (while the insurance market was already hardening) are still not as high as they were more than a decade prior.

According to an Urban Institute survey of average malpractice insurance premiums by state in 1992, Virginia's ob/gyns paid an average of \$25,298 across the State at that time. This average rate was the 11th lowest rate of all states, and was substantially below the national average of \$43,854.

JLARC staff also examined data from the Medical Liability Monitor (MLM), a trade publication for medical malpractice insurers. This publication annually surveys medical malpractice carriers to identify their base premium rates for selected specialties, including ob/gyns. Using these annual survey results, JLARC staff compared the rates charged in each state by one insurer with a national presence. Based on this comparison, the average base premiums charged in 1996 and 1997 by

Year	Territory I (Northern Virginia)	Territory II (Tidewater)	Territory III (Rest of State)	Territory IV (Richmond Area)
1988	\$46,500	\$43,100	\$34,500	\$29,400
1998	32,885	30,499	24,432	20,779
2001	39,985	36,703	31,918	28,726

* For policies with \$1 million/\$3 million limits.
Source: State Corporation Commission and Institute of Medicine study, 1989.

this insurer for ob/gyns in Virginia were the 5th and 6th lowest average rates, respectively, found in states where the insurer had a market presence. Furthermore, the average rate charged in 1996 and 1997 in Virginia by this insurer – \$25,286 – was substantially below the national average rates of \$34,967 and \$42,660 in those same years.

Current Medical Malpractice Insurance Market Reflects National Market Hardening

Although the intense competition in the 1990s was beneficial to physicians and hospitals, it negatively affected the financial condition of insurers by reducing rates below the amount necessary to cover their losses. According to interviews with insurance company executives and information from insurance trade journals, some insurers were writing policies for well below cost during the 1990s.

One insurance executive reported that companies were selling policies for a substantial loss during the 1990s. He noted that ob/gyn policies in the Richmond area were selling for as low as \$13,000 in the 1992-1993 time period. This “aggressive” competition caused his company to subsequently leave the Virginia market.

For a time these losses were recouped through gains in investment income. However, as investment income declined due to market conditions in the late 1990s, insurers have had to raise rates to more reasonable levels – rates that would be more in line with their loss experience. The current rate increases are essentially a market correction. As in the 1980s, they also are likely an outcome of the normal business cycle, and can be expected to moderate over time.

Data obtained from the State Corporation Commission and interviews with insurance company representatives reveal that, while not all companies in Virginia have increased their rates during the past year, a number of them have increased rates by 40 percent or more. Despite these increases, the rates for Virginia’s ob/gyns are still less than their counterparts in some other states. For example:

In Virginia’s most expensive rating territory (Northern Virginia), rates for companies currently writing new policies range from approximately \$39,000 to \$98,000 for \$2 million/\$6 million policies. The companies with the largest market share of ob/gyns in Virginia are charging premiums in the \$50,000 range for these policy limits. In contrast, the Medical Liability Monitor (MLM) cited premiums charged in some other states at more than twice those charged in Virginia, and at lower policy limits. MLM reported ob/gyn rates in Cleveland, Ohio as high as \$152,496, in Las Vegas, Nevada as high as \$141,760, and in Miami, Florida as high as \$210,576 for policies with \$1 million/\$3 million limits.

Also, there are several insurance companies that are currently writing new policies in Virginia. Thus, malpractice insurance is available to Virginia’s ob/gyns, albeit at a higher cost than in previous years.

Some physicians have stated that the increasing malpractice insurance rates of the past couple of years are an indication that the birth injury program is not effective. However, it is important to remember that the cases diverted by the program, while costly cases, are still the minority of cases for which malpractice claims are filed. The majority of obstetric claims remain in the tort system, as they do not meet all of the criteria required by the birth injury act. Therefore, although the rates have been reduced somewhat by the exclusion of these cases from insurers' losses, they are not the primary factor impacting rate levels. It would be unrealistic to assume that rates would never increase because of the program's existence since most cases are still litigated in the tort system.

One factor impacting the rate increases experienced by physicians is the fact that the medical malpractice cap is being raised incrementally each year. This fact in itself does not necessarily mean that the physicians have to increase the amount of insurance coverage they purchase. According to the State Corporation Commission, there is no State law or regulation that requires ob/gyns to purchase insurance at malpractice cap limits. However, in Virginia, hospitals typically require physicians, as a condition of obtaining hospital privileges, to obtain insurance policies with the cap limit per occurrence and an aggregate limit at triple the cap. While for most of the 1990s physicians purchased \$1 million/\$3 million policies, they are now required to purchase policies with at least \$1.67 million/\$4.95 million coverage limits. Some insurers only sell policies at \$1 million/\$3 million or \$2 million/\$6 million (or \$5 million depending on the company) limits, and therefore, physicians are required to purchase policies in excess of what they need. According to one insurance executive, this practice is unique to Virginia. He stated that the national standard is for physicians to obtain coverage limits at \$1 million/\$3 million, even in states that do not have a cap on malpractice awards. Therefore, the policy imposed by Virginia's hospitals has served to increase the costs physicians must incur to obtain insurance at a time when the rates are already increasing.

Some Physicians Receive Direct Financial Benefit from Program Participation

Section 38.2-5020.1 of the *Code of Virginia* requires insurance carriers that write medical malpractice insurance "to provide a credit on [participating physicians'] annual medical malpractice liability insurance premium." The State Corporation Commission maintains a listing of the premium discounts provided by every licensed insurance company that provides medical malpractice insurance in Virginia. The discount provided by insurers is not directly tied to the level of assessment paid by participating physicians. As a result, some ob/gyns receive more of a discount on their malpractice premiums than they pay to participate in the program. Discounts typically range from five to 16 percent of the rate of the insurance policy at maturity.

Assessments for Participating Physicians Historically Were Less than the Discounts Provided by Insurers. In 1995, the board lowered participation assessments for physicians based on the number of years each physician had participated in the program. From 1995 to 2000 (when assessments were based on a sliding scale), many physicians paid assessments at significantly reduced rates – as

low as \$500 per year, while receiving insurance discounts ranging from five to 16 percent of their malpractice insurance premiums. For example, in 1998, 64 percent of participating physicians (excluding non-paying resident physicians) paid assessments less than the minimum discount of \$1,709 on the average medical malpractice premium written by eight of Virginia's major medical malpractice insurance carriers in that year.

The participating assessment has now been reset at the maximum allowed by law (\$5,000). As premiums have risen in the past couple of years, the dollar value of the discount provided by insurers has also increased. Of ten insurance companies currently writing medical malpractice insurance in Virginia, the average discount given across the state of Virginia for participation ranges from \$4,873 to more than \$7,300, depending upon the region for which the policy is being written. This indicates that many physicians across the State still have the potential to earn money by choosing to participate in the birth injury program.

Amount of Discount Provided by Insurers Is Not Always Communicated to Participating Physicians and Hospitals. Concerns have been raised by some participating physicians and hospitals that they do not receive an insurance discount for participating in the program. All of the insurance companies contacted by JLARC staff were aware of the discount and reported providing it to participating physicians. However, insurers reported different means for determining which physicians participate in the program and for accounting for the premium discount. Most of the insurers reported that their applications contain a question as to whether or not the applicant participates in the program. However, one insurer stated that it is the responsibility of the applicant/policyholder to notify the insurer that he or she participates in the program.

In addition, insurers varied as to whether they explicitly show the discounted amount on the policyholder's statement. Some insurers itemize all discounts provided to the policyholder, including the birth injury program credit, on the statement, while others simply apply the discount to the final premium amount without itemizing discounts. Therefore, some physicians may simply be unaware that the program participation discount has been applied to their final premium amount. For informational purposes, the birth injury program may want to consider sending out the SCC's listing of insurance company discounts to participating physicians when it sends out the yearly assessment bill.

For hospitals, the discount provided by insurers for program participation is typically part of a complex calculation used to derive the hospital's insurance premium. As a result, it was not possible as part of this study to determine the dollar value of the discounts provided to hospitals. However, it is important to note that a number of hospitals in Virginia are self-insured and, therefore, do not receive a discount for participation.

Program Reduces Concerns About Medical Malpractice Award Cap

An important benefit of the program that has been recognized by the Medical Society of Virginia and others is the program's value in light of the medical mal-

practice award cap in Virginia. Since the cap constrains costs, all physicians, hospitals, and medical malpractice insurers benefit from the cap remaining in place.

As described previously, Virginia's medical malpractice cap is generally not sufficient to ensure that a severely birth-injured infant's medical needs are taken care of for his or her lifetime. This is especially true considering that Virginia's tort system is not supposed to take into consideration other resources that may be available, such as health insurance, to care for the child, when identifying an award amount. To the extent that these cases are excluded from the cap's provision by inclusion in the birth injury program, the cap becomes potentially more fair (although this study did not examine the costs associated with other types of malpractice-related injuries).

However, since this program is voluntary for ob/gyns and hospitals, some severely birth-injured children are presumably not eligible for the program and are, therefore, constrained in obtaining adequate compensation because of the cap. This problem could be alleviated if participation in the program were made mandatory. In contrast, if the program were eliminated, the General Assembly may want to reconsider the amount of the cap to ensure adequate compensation for severely birth-injured children. Chapter III discusses the advantages and disadvantages of various options regarding the program's future, including requiring participation by all ob/gyns and hospitals and the elimination of the program.

SOCIETAL BENEFITS FROM PROGRAM ARE LESS CLEAR

The direct purpose of the program is to help ob/gyns obtain malpractice insurance at a reasonable cost. The General Assembly's involvement in the issue of ob/gyn malpractice insurance coverage stems from concerns that ob/gyns were discontinuing their obstetric practices due to the rising cost of malpractice insurance and, in some cases, a lack of insurance availability. Clearly, it is in the best interest of the Commonwealth for its citizens to have access to obstetric services. A lack of adequate obstetric services was reportedly already a problem in the rural areas of the State, and there were fears that this problem would be exacerbated by the malpractice insurance "crisis." The expectation was that the general citizenry would ultimately benefit by enacting the alternative birth injury compensation approach sought by the medical community in Virginia.

No Direct Link Could Be Identified Between Program's Existence and Availability of Obstetric Services

In the 1980s, ob/gyns were reportedly leaving the practice of obstetrics because of the rising malpractice insurance premiums and risk of lawsuits that they faced. Staff of the Medical Society of Virginia noted that a number of rural areas, in particular, had no obstetrics coverage. The rationale for the birth injury program was that by stabilizing medical malpractice premiums for obstetric providers and reducing their exposure to lawsuits, they would decide to continue practicing obstetrics in the State.

Definitive data are not available on the level of obstetric services available throughout Virginia over time. However, review of available information suggests that while the program does help stabilize malpractice premiums, the program's existence does not appear to have a significant impact on the availability of obstetric services in the State.

To examine the level of obstetric services available in Virginia, JLARC staff analyzed a number of secondary sources of data, including data from the American Medical Association on the number of ob/gyns in each state, childbearing population data from the Census, and published reports on the proportion of family practitioners who perform obstetric services. As evidenced in Table 10, JLARC staff did not find significant differences in the ratio of ob/gyns to childbearing population in Virginia compared to neighboring states that could be attributed to the existence of the birth injury program. None of the other states except Florida have a birth injury program.

It is important to point out that the AMA data on ob/gyns does not separately account for physicians who perform obstetrics and gynecology from those who provide gynecology services only. It is likely that a portion of those physicians included under the specialty of ob/gyn do not perform obstetric work. Further, information was not available to JLARC staff regarding the distribution of ob/gyns by locality in Virginia over time. Thus, it is unclear whether the number of ob/gyns practicing in rural areas of Virginia has been impacted by the birth injury program.

In most rural areas, obstetric services are provided by family practitioners rather than ob/gyns. Therefore, to better examine the issue of rural obstetric services, JLARC staff examined annual state-by-state rankings of the proportion of family practitioners who perform obstetric services in each state. Based on a review of the rankings from 1996 and 1998 (the only years available), Virginia has consistently ranked in the last six of all states. In 1998, only 13 percent of Virginia's family practitioners were reported to offer obstetric services. In addition, JLARC staff identified 49 counties in Virginia in which there are currently no obstetric providers.

State	Ratio of Ob/Gyns to Childbearing Population
Maryland	0.756
Pennsylvania	0.579
North Carolina	0.567
Florida	0.564
Virginia	0.559
West Virginia	0.422

Source: JLARC staff analysis of data from the American Medical Association's *Physician Characteristics and Distribution in the U.S.*, 2001 and U.S. Census Bureau.

These findings are consistent with a 1996 report by the Joint Commission on Health Care (Senate Document 13). This report examined access to obstetric care in rural areas of the State and found that the supply of obstetric service providers – including obstetricians, family practitioners, and nurse midwives – was declining in rural areas, even after the establishment of the birth injury program. The report cited studies by the Virginia Academy of Family Practice and the Medical Society of Virginia, which noted that in addition to high medical malpractice costs, there are a number of other reasons for the lack of obstetrical services in rural areas, including the following:

Commercial insurers tend to reimburse rural areas less than urban areas of Virginia for the same services, even though rural practitioners claim that rural practice overhead is substantially higher than urban practice overhead.

* * *

Larger population areas are more likely to have larger numbers of obstetricians to provide backup.

* * *

Because of the relative lack of obstetrics providers in rural areas, family physicians who practice obstetrics face demanding schedules with little backup.

* * *

Stronger urban economies offer a more stable source of revenue due to a higher percentage of patients with health coverage.

These factors reflect the complexity of issues surrounding the lack of obstetrical care in rural areas. Indeed, the birth injury program was not intended to address most of these issues and cannot, therefore, be identified as having had any impact on the availability of obstetric providers in rural areas of the State.

Finally, despite the program's existence and impact on malpractice premiums, there is still a portion of ob/gyns who continue to report that malpractice issues – insurance rates and risk of being sued – are influencing their decisions to quit obstetric work. A small survey of ob/gyns in Florida and Virginia conducted in the mid 1990s found that, of the physicians who stopped their obstetrics practices after 1987, 39 percent did so, in part, because of the risk of being sued. An additional eight percent stopped because of medical malpractice insurance costs. Further, a poll conducted during the summer of 2002 by the American College of Obstetricians and Gynecologists (ACOG) found that some obstetricians in Virginia were leaving their obstetric practices due to malpractice insurance concerns. According to ACOG staff, 14 percent of the ob/gyn respondents who had stopped practicing obstetrics in the past 18 months had done so due to problems with availability and affordability of malpractice insurance. Taken together, these findings call into question the impact of the program on the level of obstetric services in Virginia.

Program Assessments Are More than Tort System Expenses, Given the Medical Malpractice Award Cap

Much of the literature on medical malpractice costs discusses the high cost of the U.S. tort system. To determine whether the birth injury program is a lower cost alternative to the tort system, JLARC staff compared the annual cash outlays of each compensation approach. The results of this analysis suggest that, overall, the birth injury program is more costly than the tort system, at least as the system currently exists with a medical malpractice award cap.

Exhibit 2 shows the 2002 annual assessments collected from each group that contributes to the birth injury program. Almost \$4.7 million was collected from the primary beneficiaries of the program – participating physicians, hospitals, and medical malpractice insurers. Non-participating physicians – indirect beneficiaries of the program – were required to pay an additional \$3.2 million, and \$7.3 million was collected from liability insurers that receive no benefit from the program. Total assessments in 2002 were almost \$15.2 million.

JLARC staff then compared the assessments to the estimated awards and expenses that may be incurred through the tort system. The estimated number of babies that are eligible for the birth injury program each year is seven, based on the program's actuarial report, past research by the Williamson Institute, and current participation levels by ob/gyns and hospitals. The JLARC staff analysis assumes that five of these seven children would enter the tort system (based on the program claimant survey results in which three-fourths of the claimants who responded to the survey thought that they had a malpractice case). To be conservative, JLARC staff also assumed that all of the infant claimants would receive an award at the current maximum allowed by law – \$1.65 million, although, based on past experience, it would be unlikely that all of the children would receive the maximum award. The additional assumptions used in this analysis are included in Exhibit 2. The total estimated awards and expenses from these cases in the tort system is \$10.8 million – \$4.3 million less than the annual assessments of the birth injury program.

While the annual birth injury program assessments are more than the estimated annual expenses of the capped tort system, the assessments are not borne exclusively by ob/gyns, hospitals and their insurers. Instead, the funding structure for the birth injury program is broader than the sources of funds for the tort system. A substantial portion of the future assessments for this program will be paid by liability insurers that do not sell medical malpractice insurance. The *Code of Virginia* allows these liability insurers to add this cost to their policyholders' premiums.

Therefore, these costs will eventually be paid for by anyone who purchases liability insurance policies, such as homeowners and automobile owners. Further, while there is an expected eventual funding shortage, it is unclear from what source this shortfall will be covered.

Exhibit 2**Comparison of Annual Assessments Associated with
Birth Injury Program and Tort System Expenses
for Physicians, Hospitals, and Insurers****Assessments of Physicians, Hospitals, and Insurers for the Birth Injury Program**

	<u>2002 Total Assessments</u>
Participating physicians	\$1,659,031
Participating hospitals	2,256,000
Medical malpractice insurers	772,159
Total for direct beneficiaries	\$4,687,190
Non-participating physicians	3,223,200
Other insurers	7,270,399
Total for non-direct beneficiaries	\$10,493,599
Total Annual Assessments	\$15,180,789

**Estimated Awards and Expenses Paid by Physicians, Hospitals, and Insurers
Through the Tort System**

		<u>Estimated Annual Expenses</u>
Infant's Award	5 awards X \$1.65 million	\$8,250,000
Mother's Award	5 awards X \$412,500	\$2,062,500
Defense Costs	5 plaintiffs X \$100,000	\$500,000
Physician's Time and Effort	5 weeks X \$3,800	\$19,000
	Estimated Expenses Incurred to Defend and Pay Out 5 Awards	\$10,831,500

Tort Cost Assumptions: Infant is awarded at the maximum cap as of 2002; Mother's award is one-fourth the infant's award (which may be greater than typical awards, based on information from insurers); Defense costs based on data provided by insurance companies; Physician's time and effort based on one week per case at the physician's average weekly pay, based on data from the American Medical Association.

Source: JLARC staff analysis and data from the birth injury program, medical malpractice insurers, and the AMA.

Despite the higher overall cost, the program appears to be a cost-effective approach for ob/gyns, hospitals, and medical malpractice insurers as a group. As shown in Exhibit 2, the annual assessments from these parties is substantially less than the likely maximum expenses that would be incurred through the tort system.

While the overall assessments of the birth injury program appear to be greater than the cost of Virginia's capped tort system, it is possible that the State would incur some costs if the program did not exist. Specifically, under the current program almost all of the claimant families care for their birth injured children at home instead of through an institutional setting. One of the major benefits of the program is the provision of home nursing care for the children who need such care. If the birth injury program did not exist, some of the families without the means to pay for home nursing care (especially families who do not receive medical malprac-

tice awards) may find it necessary to institutionalize their children. Typically, the cost to care for institutionalized children is borne by Medicaid.

Despite this possibility, annual data on the number of children in nursing care facilities paid for by Medicaid do not reflect a higher number of institutionalized children prior to the birth injury program's admittance of children. Therefore, any additional costs associated with institutionalized children may not have a particularly large impact on State Medicaid funds.

Impact of the Program on Obstetric Services to Indigent Women Is Unclear

As described in Chapter I, a provision was included in the birth injury act to ensure increased access to obstetric services by indigent women. At the time of the act's passage, there were reports that some ob/gyns were refusing to provide obstetric services to women they had not previously examined but who were in active labor. There were also broader concerns about a lack of obstetric services available to indigent women, and the high rate of low birth-weight babies born to mothers without prenatal care.

Section 38.1-5001 of the *Code of Virginia* states that, for a physician to be eligible to participate in the program, the physician must have:

an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the physician agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation.

In 1988, the Commissioner of Health notified all physicians who had elected to participate in the birth injury program that they were required to help develop local programs to provide obstetrical care to indigent women. Plans were developed for each health district and were approved by the State Health Commissioner in late 1988.

The Health Commissioner reported that the plans were subsequently implemented. However, Health Department staff were not aware of any ongoing efforts that occurred since the plans were first put in place. There is no indication that the plans have ever been updated or are currently in effect. In addition, they contain out-of-date listings of participating physicians.

The birth injury program requires participating physicians to sign a contract each year that includes the following language:

I hereby agree . . . to participate with the Commissioner of Health, or his designee, in the development of a program to provide obstetrical care, including prenatal care, labor and delivery services and

postpartum care, to patients eligible for Medical Assistance Services (“Medicaid”) and to patients who are indigent and, upon approval of this program by the Commissioner of Health, to participate in its implementation (this agreement does not require participation in the Medicaid program).

This contract is also signed each year by the Commissioner of Health. Program participants are not given a copy of the 1988 plan for their area, nor even notified that a plan exists (or at least existed at one time). In practice, this portion of the birth injury act is not operational.

Aside from the birth injury act, other measures have been taken since the mid-1980s that are also aimed at addressing this problem. For example, the State increased the Medicaid reimbursement rates for physicians who perform obstetric services in FY 1992. Further, Medicaid coverage was expanded in 1985, 1986, and 1991 to cover prenatal care for more pregnant women.

JLARC staff found that the number of ob/gyns who accept Medicaid patients has increased substantially since the mid 1980s. The Department of Medical Assistance Services reported that in 1985, 449 ob/gyns received reimbursements from Medicaid for patient care. In 2000, Medicaid reimbursements were made to 1,029 ob/gyns. This trend suggests a generally increasing level of obstetric coverage for women with Medicaid coverage. However, this trend does not appear to be related to the provisions of the birth injury act, given that no action has been taken since the late 1980s regarding the birth injury act’s indigent care provisions.

Program’s Voluntary Participation by Physicians and Hospitals Results in Regional Inconsistencies in Coverage

Under the current voluntary system, most babies in the State are potentially covered by the program (Figure 6). Over the past five years, 65 to 72 percent of all births each year are potentially eligible for the program, based on the participation of the delivering physician or that of the hospital. However, disparities exist in the number of covered births in various planning districts across the State, especially between urban and rural areas (Figure 7). In 2001, 85 percent of all births to mothers residing in Northern Virginia were covered by the birth injury program. In the same year, only four percent of births were potentially eligible for the program in the LENOWISCO district. While the babies ineligible for the program may sue their physician and hospital, the current malpractice cap precludes them from obtaining lifetime benefits such as they would receive through the birth injury program. This creates inequities in the treatment of Virginia’s citizens based on where they reside. A mandatory system would eliminate these disparities in access to the program.

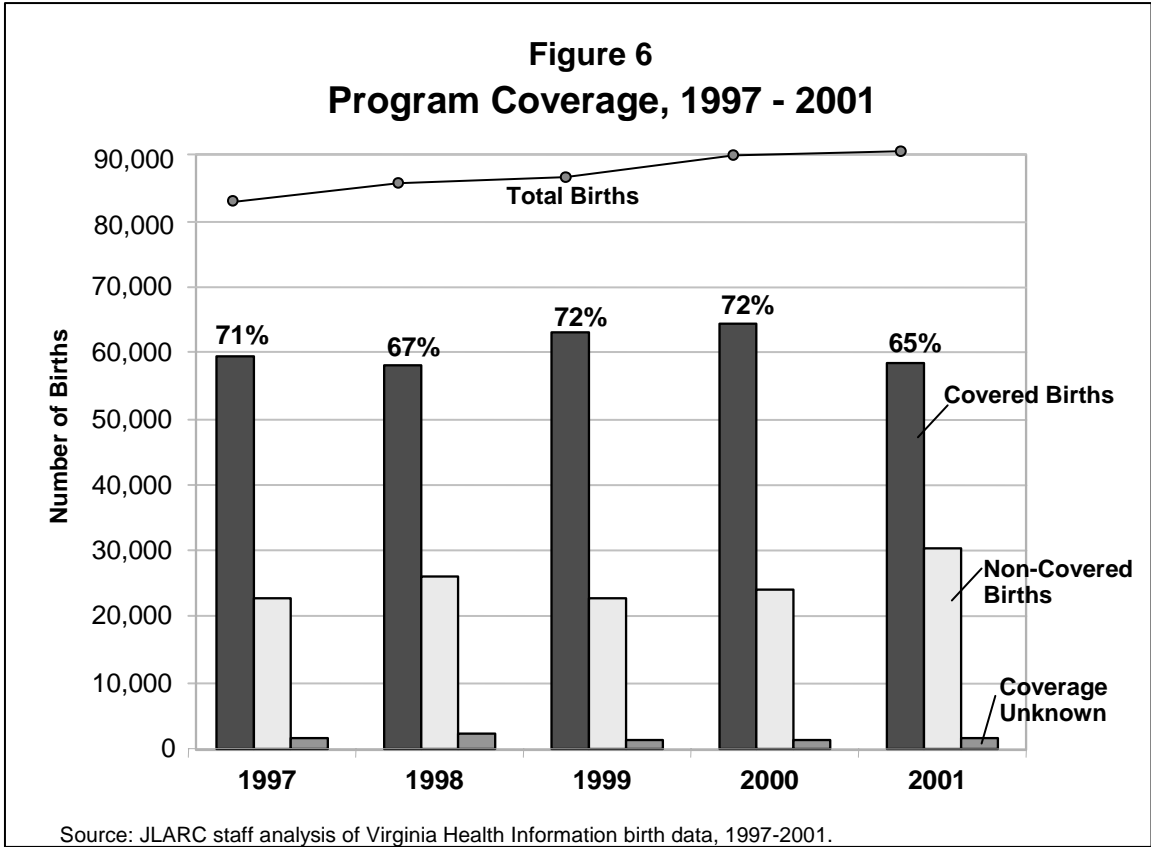
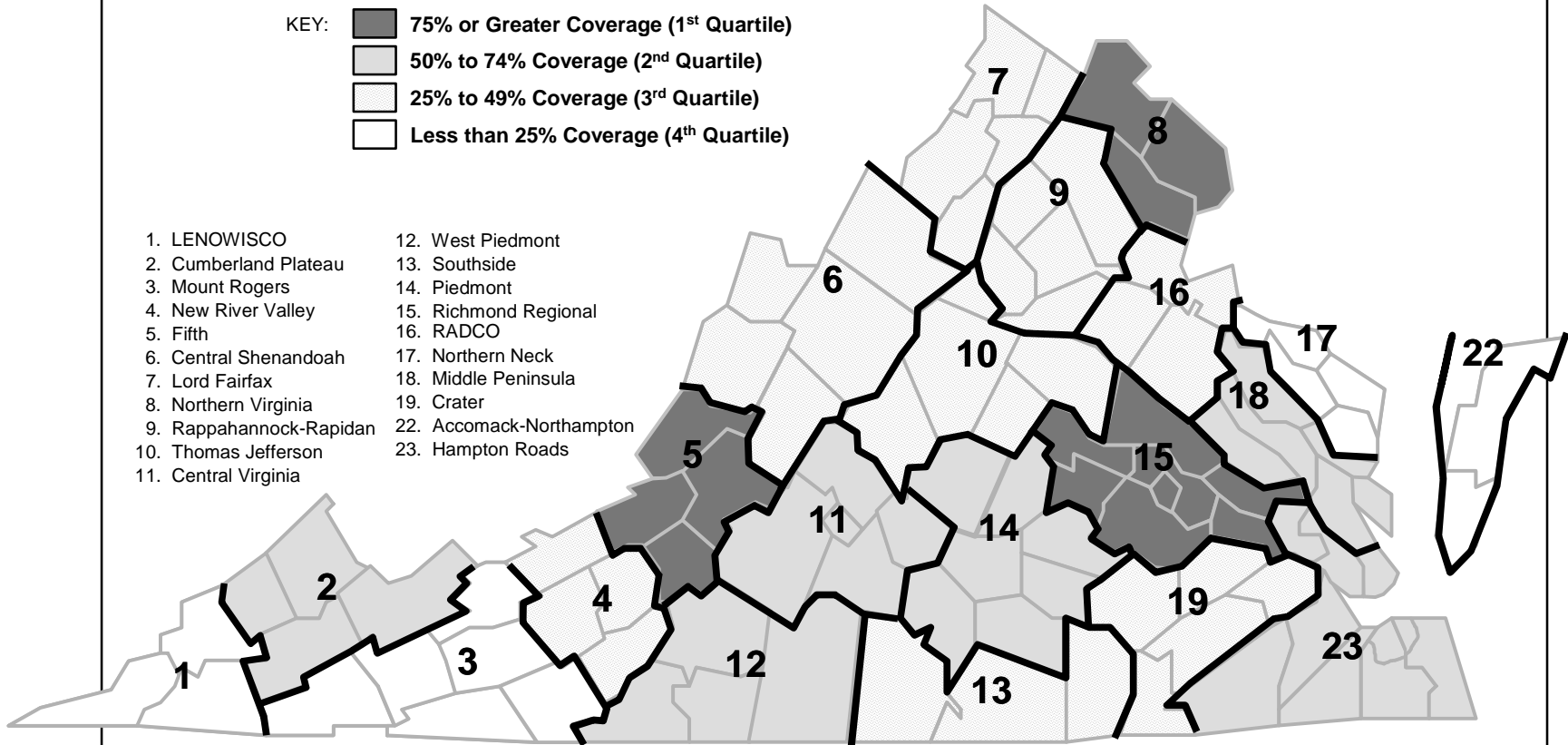


Figure 7
Proportion of Births Covered by the Birth Injury Program
by Planning District, 2001

KEY:  75% or Greater Coverage (1st Quartile)
 50% to 74% Coverage (2nd Quartile)
 25% to 49% Coverage (3rd Quartile)
 Less than 25% Coverage (4th Quartile)

- | | |
|-------------------------|--------------------------|
| 1. LENOWISCO | 12. West Piedmont |
| 2. Cumberland Plateau | 13. Southside |
| 3. Mount Rogers | 14. Piedmont |
| 4. New River Valley | 15. Richmond Regional |
| 5. Fifth | 16. RADCO |
| 6. Central Shenandoah | 17. Northern Neck |
| 7. Lord Fairfax | 18. Middle Peninsula |
| 8. Northern Virginia | 19. Crater |
| 9. Rappahannock-Rapidan | 22. Accomack-Northampton |
| 10. Thomas Jefferson | 23. Hampton Roads |
| 11. Central Virginia | |



Source: JLARC staff analysis of Virginia Health Information data on hospital births, 2001.

III. Status of the Birth Injury Program

This chapter explores the history of the birth injury program from a financial perspective, and identifies some of the decisions that have contributed to the fund's actuarially unsound status. Many of the problems stem from flaws in the basic assessment structure, as was originally established in the *Code of Virginia*. In addition, the birth injury board has historically provided inadequate financial oversight for the fund. More specifically, the board neglected both to identify major inconsistencies in actuarial assumptions and recognize an obvious imbalance between income and expenses in various years. It is projected that the fund will have an unfunded liability of more than \$88 million by the end of 2002.

At the conclusion of this chapter, JLARC staff present three options for the future of the birth injury program. The policy and funding implications of each option are discussed as well.

FINANCIAL STATUS OF THE BIRTH INJURY FUND

When the birth injury fund was established in 1988, the birth injury act mandated the Bureau of Insurance of the State Corporation Commission (SCC) to undertake actuarial evaluations of the assets and liabilities of the fund no less than biennially. Beginning in 1989, the SCC hired an independent consulting firm to report on the actuarial soundness of the program (hereafter referred to as "the actuary").

The actuary has consistently used a definition of actuarial soundness such that the fund is considered to be actuarially sound if its total assets exceed its estimated future payment obligations. In other words, actuarial soundness identifies whether the money paid to date is sufficient to cover the costs of the children with qualifying birth injuries expected to be born that year and admitted into the program, and those from previous years. It is measured as of a particular date and does not attempt to project the number of children that have not yet been born but may be admitted into the program in future years, nor does it consider future assessments.

The most recent actuarial report, released in September 2002, projects the fund will have a balance of \$84.7 million as of December 31, 2002. However, as indicated in Table 11, it also projects an unfunded liability of more than \$88 million at that time. This projection is based on 75 claimants admitted to the program, and an estimated 31 claimants born but not admitted to the program at the time of the analysis. Under the existing statute of limitations in this scenario, the last of the estimated 31 claimants who are born up to December 31, 2002, but not yet in the program, will have until 2012 to be admitted.

While forecasts by the actuary point toward an \$88 million unfunded liability at the end of 2002, there appears to be no serious threat of a short-term deficit. In fact, according to the actuary, the current fund balance should be sufficient to

Table 11	
Birth Injury Fund's Projected Financial Position as of 12/31/02	
Estimated Number of Claimants	106
Estimated Future Claim Payments	\$ (163.4 million)
+ Estimated Future Claims Administration Expenses	(9.7 million)
<u>- Value of Total Assets</u>	<u>84.7 million</u>
= Forecasted Unfunded Liability	<u>(88.4 million)</u>
Source: MMC Enterprise Risk Consulting, Inc.	

meet claimant expenses for at least the next 25 years, provided current assessment levels are maintained. Nevertheless, this projection does not guarantee lifetime support for all current claimants, or for those born but not yet in the program.

The fund's current condition has resulted from a chain reaction of events, some of which were unavoidable. In the early years of the program, the actuary had little or no data on actual claimant expenses and other basic program parameters from which to base its analyses. In hindsight, the parameters it chose to use underestimated the true cost to provide lifetime care to the birth-injured children in the program. Only since 2001 has the actuary based its analyses on actual program expenses. The adjustments made to account for the claimant data indicate that the true cost to care for these children is more than double what was originally estimated. Because estimated costs were thought to be so much lower, the perception was that the fund had more than enough money to provide lifetime care for the children. At the same time, the birth injury board made some inappropriate decisions concerning fund management that negatively affected the fund's income and expenses.

In hindsight, it now appears that to have funded the lifetime care for these children in an actuarially sound manner would have required that all of the possible assessment sources – participating physicians, participating hospitals, non-participating physicians, and liability insurers – be assessed for the duration of the program's existence. However, the current funding structure outlined in the birth injury act would not have allowed for maximum assessments, given the earlier actuarial findings.

Early Actuarial Reviews Underestimated Program Cost

There have been a total of 11 actuarial reports produced, three of which have been intermediate studies produced as a result of special requests due to statutory or policy changes. Beginning in 2002, the SCC has directed that the actuary conduct annual reviews. Table 12 summarizes the financial status and recommendations of each of the actuarial studies to date.

Table 12		
History of Actuarial Studies of the Birth Injury Fund		
Year	Status of Fund	Recommendations
1989	Unsound	Assessment on liability insurers for 1990 and continuation of all other assessment levels.
1990*	Sound	No change in current assessment levels.
1991	Sound	No assessment on liability insurers for 1991 and continuation of all other assessment levels.
1992*	Sound	No assessment on liability insurers for 1992 and 1993, no assessment on non-participating physicians for 1993, and continuation of all other assessment levels.
1993	Sound	No assessment on liability insurers for 1993, 1994, and 1995; no assessment on non-participating physicians for 1994 and 1995; and continuation of all other assessment levels.
1995	Sound	No assessments for liability insurers and non-participating physicians; continue the sliding scale assessments for participating physicians and hospitals based on the number of years of participation in the fund.
1997	Sound	No change in current assessment levels.
1999	Sound (but projected future unfunded liability)	Due to forecasted unfunded liability in 2001, restore assessments to full levels for participating hospitals, participating physicians, and non-participating physicians.
2000*	Sound	Forecasted unfunded liability deemed not material due to size of fund. Restore full level of assessments for participating physicians and hospitals for program year 2001; assess non-participating physicians for program year 2002 and both non-participating physicians and liability insurers for program year 2003. This is based on the fund discontinuing cash grants for housing.
2001	Unsound	Due to estimated unfunded liability of \$72 million, continue assessing participating physicians and hospitals at the maximum level; for program year 2002 and for future years as needed, assess non-participating physicians at the maximum level; conduct actuarial reviews annually until the program's experience stabilizes.
2002	Unsound	Due to estimated unfunded liability of \$85 million, continue applying maximum assessment levels for all funding sources, and conduct actuarial reviews of the Fund annually.
* Denotes interim or follow-up study.		
Source: JLARC staff analysis of periodic actuarial studies for birth injury program.		

The actuary most recently declared the fund to be actuarially unsound in its 2002 report, although it had previously forecasted unfunded liabilities in its 1989, 1999, and 2001 biennial reports. Since unfunded liabilities are estimates of the future based on current and past information, the status of the fund's "actuarial soundness" is dependent on the assumptions derived by the actuary. Actuarial assumptions are primarily used to forecast claimant expenses. For example, each of the expense categories is given an estimated annual inflation rate that is applied to future annual costs. These inflation rates are based on consumer price indices published by the Bureau of Labor Statistics, and are subject to change over time. Once future expenses are forecasted, the future costs are discounted to a present value using an assumed annual interest rate of 6.5 percent. This interest rate assumption is based primarily on the expected rate of return on invested assets as stated by the fund manager.

Other considerations the actuary makes in developing its assumptions include: quantity and type of insurance coverage of claimants, future claim administration payments, changes in utilization of benefits, the number of not-yet-admitted claimants, and the mortality and institutionalization of claimants. Some of the initial actuarial studies, which indicated that the fund was sound, were based primarily on theoretical assumptions about the number of claimants likely to be admitted to the program each year, the average payment made to each claimant in each year, and the average life expectancy of each claimant. Since the program is relatively young and had very few claimants admitted in the first seven years, there was very little program data on which to support many of the actuarial assumptions. The actuary makes adjustments to its forecasted lifetime costs annually as more extensive program data becomes available.

Since 1992, when the first child was admitted into the program, an average of around seven children have been admitted into the program annually, with as many as 13 and as few as two in a given year. With the recent availability of more extensive and complete program data, it has become clear that claimants in the program are living longer than originally assumed. This situation may be attributed in part, to the quality of care afforded by the program, especially the provision of nursing care. In fact, some claimants receive up to 24-hour nursing care at an average annual cost of up to \$200,000.

Furthermore, earlier actuarial reviews assumed that many claimants in the program would be institutionalized by the age of five, the cost of which would be borne by other programs. Instead, almost all of the claimants have been able to stay at home with the assistance of nursing or respite care. Just four claimants have been institutionalized, and the average age of the living claimants to date is almost nine. Many assumptions used in the earlier actuarial reports ultimately proved to be inaccurate according to more recent studies. Table 13 outlines examples of changes in actuarial assumptions that posed the largest impact on calculation of future financial soundness. Once these new assumptions were used, the projected costs of the program doubled, and the fund went from being actuarially sound to actuarially unsound, with an unfunded liability of \$88 million.

Table 13	
Major Changes in Actuarial Assumptions	
Original Assumption (Year)	Changed Assumption (Year)
1988: Fund investments will earn an annual return of approximately 8 percent.	2001: Fund investments will earn an annual return of approximately 6.5 percent.
1989: Around 20 claimants will enter program each year.	2001: Around 7 claimants will enter program each year.
1991: Around one out of four children with a birth injury will die within the first year of life.	2002: Underlying life expectancy of 18.2 years from birth, 20.4 years from the age of three.
1992: On average, claimants will be institutionalized by the age of five.	2001: Claimants will not be institutionalized.
1995: There is a 10 percent probability that a claim will include a request for a house.	2000: Almost 70 percent of claimants requested and received either a trust home or cash grant (as of 2000).
Source: JLARC staff analysis of birth injury program actuarial reports.	

Lack of Board and Program Oversight

In reviewing the actuarial reports and the records of the program, JLARC staff identified two main problems with the board's oversight of the fund. First, it did not sufficiently scrutinize the actuarial assumptions and reports. Second, it failed to recognize an imbalance between fund income and expenses, and make appropriate financial decisions accordingly. Historically, it appears that the board has acted reactively, rather than proactively, to the conclusions of the actuarial reports.

Board Lacks Understanding of Actuarial Assumptions and Methods. During the board meetings in 2002, board members expressed a concern that they did not understand the 2001 actuarial findings, which declared the fund actuarially unsound. They had sought answers to their questions after the 2001 report was released, but were unsatisfied with the actuary's explanation. While similar concerns have been voiced since the release of the 2002 actuarial report, it appears that no additional steps have yet been taken to better understand the findings.

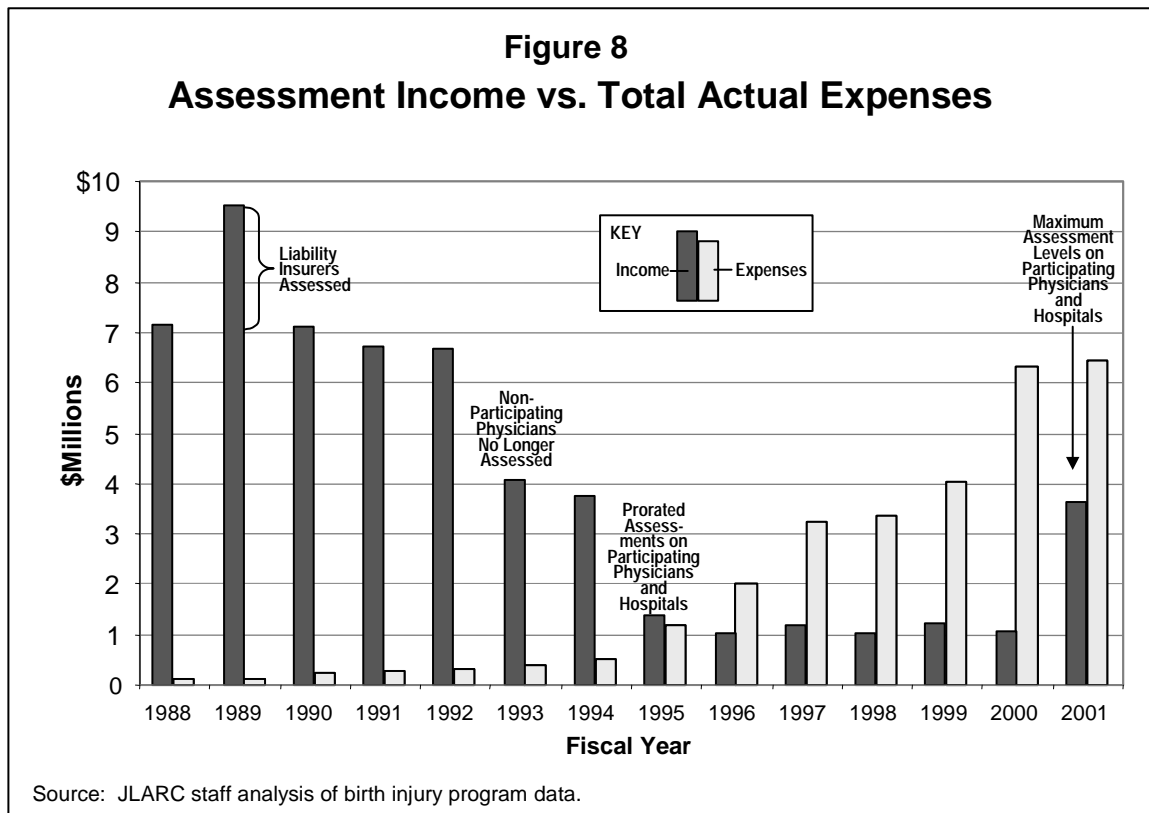
Prior to 2001, all but the first actuarial report indicated the fund was actuarially sound. During the initial years of the program, however, many of the assumptions used in the actuary's conclusions were inaccurate, and not based on actual claimant information. Based on JLARC staff's review of board meeting minutes, it appears that the board did not discuss the validity of these assumptions, and hence neglected to identify problems with the actuary's conclusions. Instead, it ap-

pears that the board simply accepted the assumptions in the actuarial reports, and based its funding decisions on the actuary's conclusions.

One of the assumptions used by the actuary in the early 1990s was the notion that claimants would be institutionalized by the age of five. Various parties involved in the program's creation have expressed surprise that the actuary made such an assumption, as these parties never expected that the children in the fund would be institutionalized. If this assumption was inappropriate, it was incumbent on the board to notify the actuary or the SCC that the assumption was wrong. Given the board's fiduciary responsibility, it is crucial that it understands the actuarial conclusions, and continues to delve into the findings and methodology of each report until any questions or concerns have been resolved.

Board Failed to Recognize Imbalance of Income and Expenses. The birth injury act gives the board authorization to prorate participating physician and participating hospital assessments for a particular year. From 1995 to 2000, in response to the actuary's conclusions that the fund was actuarially sound, the board decided to prorate both participating physician and hospital assessments according to the number of years of program participation. Figure 8 illustrates the difference between assessment income and total expenses since the program's inception. It is clear from this figure that the board's decision to reduce assessments occurred at the beginning of an ongoing trend of increasing expenses.

The board justified its decision to reduce assessments because of what had appeared to be an over-funded, underutilized program. At the time of the decision,



only nine claims had been awarded in the previous three years, while the fund balance had grown to over \$60 million. However, beginning in 1995, the number of claimants increased significantly, with 54 having been admitted to the program between 1995 and 2000. This claimant activity is reflected in the increasing program expenses illustrated in Figure 8.

Since 1995, the board missed several opportunities to recognize an imbalance in expenses and income. In fact, between 1995 and 1996, the claimant population doubled, while expenses were almost \$1 million greater than assessment income. The amount of assessments collected each year during this time was equal to less than \$30,000 per claimant. Yet, the board did not return assessment levels on participating physicians and hospitals to their maximum levels until 2001.

In addition to lowering assessment income while expenses were increasing due to the growing number of claimants in the program, the board also made the decision to add a significant benefit to the program. As mentioned earlier in this chapter, the board voted to begin providing trust homes for claimants' families in 1994. The average cost of the trust homes was around \$300,000. These homes are owned by the program and retained as assets of the fund.

In 1999, the board voted to eliminate the trust home benefit, and instead offer cash grants for housing. Not only was the average cost of cash grants greater than that of trust homes, at almost \$350,000, but homes built with cash grants became property of the claimant families and not the fund. The program spent almost \$4.5 million in housing grants between 1999 and 2000. While not the predominant reason for the fund's large unfunded liability, these decisions contributed to the eventual decline of the fund's financial projections, and perhaps could have been prevented had the board recognized sooner the inaccuracies of the actuarial assumptions and never reduced assessments.

Recommendation (1). The General Assembly may wish to consider amending the *Code of Virginia* to eliminate the sentence in §38.2-5016(F), which states, "The board shall also have the power to reduce for a stated period of time the annual participating physician assessment described in subsection A of §38.2-5020 and the annual participating hospital assessment described in subsection C of §38.2-5020 after the State Corporation Commission determines the Fund is actuarially sound in conjunction with actuarial investigations conducted pursuant to §38.2-5021."

Recommendation (2). The board of directors should conduct annual evaluations of the actuarial assumptions, and communicate any concerns to the Bureau of Insurance of the State Corporation Commission. To the extent that the program is unable to conduct such an investigation in-house, it should seek assistance from an independent consulting firm.

Basic Assessment Structure Is Inadequate

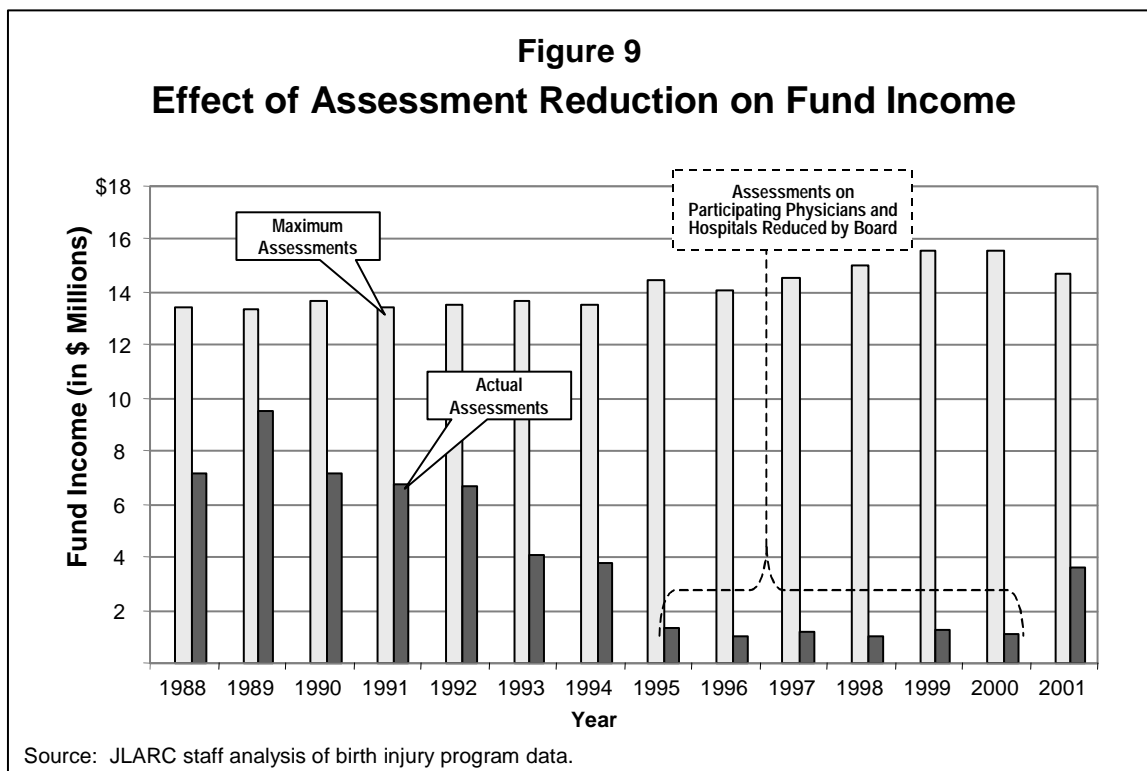
The assessment structure established in the *Code* (as modified over time) did not allow for adequate funding of the program. In addition to allowing the board

to reduce assessments on participating physicians and hospitals, the *Code* was changed in 1993, requiring the SCC to suspend non-participating physician fees when the fund is deemed actuarially sound. Only in 2002, after the release of the 2001 actuarial report that deemed the fund actuarially unsound, were assessments on non-participating physicians reinstated.

At the inception of the program, liability insurers were seen only as a “last resort” funding source. Many of the parties involved in the program’s creation never anticipated needing to assess liability insurers. However, in response to the 1989 actuarial report that projected assessment income for the following year was below the range of estimated claims costs, the SCC set an assessment rate for liability insurers at one tenth of one percent on net direct premiums written. It was not until after the 2001 actuarial report when the SCC again assessed liability insurers, this time however, changing the rate to one quarter of one percent on net direct premiums – the maximum allowed by law.

In 2002, assessment income more than quadrupled from the previous year, once all assessments were at their current maximum levels. In hindsight, it is clear that the fund needed all of the current funding sources assessed at or near their maximum levels in all years in order to remain actuarially sound. Figure 9 shows the estimated assessment income that could have been generated had liability insurers and non-participating physicians been assessed every year, and if all assessments were at maximum levels every year, including those on participating physicians and hospitals.

If the board of directors and the SCC had never reduced assessment levels, it is estimated that the program would have collected around \$140 million in additional income. This additional income would have generated a fund balance of more



than \$200 million today, and would have secured a financially sound outlook well into the future (assuming assessments remain at maximum levels).

OPTIONS FOR THE FUTURE OF THE BIRTH INJURY PROGRAM

As described in Chapter II, the value of the birth injury program varies on a group and individual basis. The data collected through this review suggests that the program is largely beneficial to Virginia's ob/gyns and hospitals, and to a lesser extent, all other physicians. In addition, most (but not all) of the children in the birth injury program fare better than they would through the tort system with a malpractice award cap in place. However, this program does not appear to have helped the Commonwealth attain its broader goals of maintaining an adequate supply of obstetric services, especially in the rural areas. In addition, based on its current financial situation, the primary source of funding for this program from now on is a source that does not even benefit from the program's existence – liability insurers that do not provide medical malpractice insurance. This source's status as the largest contributor to the fund raises questions about the fairness of this assessment.

Furthermore, the actuarial projections suggest that the current assessments are inadequate to fully meet the future liabilities of the fund. If the fund is depleted in the future, it is not clear what the obligation of the General Assembly will be. However, since the General Assembly established this program by law, and claimant families had to give up their rights to bring lawsuits in the tort system, it is possible that the State could be held liable for the shortfall. As required by the act, the SCC notified the General Assembly of the fund's unfunded liability. However, the *Code* is not clear regarding what the General Assembly's obligation is in response.

There are three primary options that could be pursued depending on the primary goals sought to be attained through the birth injury program – maintaining the current overall structure of the program, restructuring the program to be mandatory for physician and hospital providers of obstetrics, and eliminating the program. Each option has certain policy implications that are explored in this section. In particular, the financial impact of the various options is examined.

Option 1: Maintain the Current Structure of the Birth Injury Program

At 15 years old, the birth injury program is still a relatively young program, especially considering the population it serves. While the program does not appear to be addressing all of its original purposes, it does appear to be meeting some important goals. First, at this point it appears to more directly meet the costs associated with the medical needs of birth-injured children compared to the tort system, and certainly applies to more children than the tort system. Second, there is evidence that the program has helped stabilize medical malpractice premiums for participating ob/gyns and hospitals, and to a lesser extent, all physicians and hospitals providing obstetrical care services. (Additional strengths and weaknesses are included in the Option 1 Exhibit.)

OPTION 1 Exhibit: Maintain Current Structure of the Birth Injury Program		
	Advantages	Disadvantages
Overall	<ul style="list-style-type: none"> ▪ Cost-effective for obstetricians and medical malpractice insurers ▪ Does not disturb current medical malpractice situation in Virginia, which is better off than many other states ▪ Fund lasts longer than it would under mandatory participation scenario 	<ul style="list-style-type: none"> ▪ Not cost-effective overall, especially for non-medical malpractice insurers who are required to pay in, but receive no benefit ▪ Delaying decision to eliminate program or increase fees could increase the unfunded liability in the future ▪ Inconsistent participation levels make it difficult to plan and budget
Birth-Injured Children and Families	<ul style="list-style-type: none"> ▪ More birth injured children receive assistance through the program than through the tort system ▪ If appropriate informed consent process adopted, gives patients a choice as to whether to participate based on which physician they choose ▪ More timely than the tort system 	<ul style="list-style-type: none"> ▪ Mothers' rights to sue for economic damages as well as pain and suffering are abrogated ▪ For families with a strong medical malpractice case and significant resources, the program does not provide the flexibility of a medical malpractice award in providing for the needs of the children ▪ Inconsistent coverage of birth-injured babies, especially in rural localities
Medical Malpractice Insurers	<ul style="list-style-type: none"> ▪ Awards to severely birth-injured babies will remain low 	<ul style="list-style-type: none"> ▪ None
Other Insurance Companies	<ul style="list-style-type: none"> ▪ None 	<ul style="list-style-type: none"> ▪ Must pay into fund from which they receive no benefit

OPTION 1 Exhibit (Continued): Maintain Current Structure of the Birth Injury Program		
	Advantages	Disadvantages
OB/GYNs	<ul style="list-style-type: none"> ▪ Decrease in medical malpractice premiums, especially with discount ▪ Decrease in number of potential birth injury claims (Less amount of time and money expended than in a medical malpractice suit) ▪ Even if doctor does not participate, may receive “free ride” from participating hospital ▪ Doctors have a choice whether to participate ▪ Some obstetricians have received greater discounts than the participation assessment, thereby financially benefiting from participation 	<ul style="list-style-type: none"> ▪ For those who do not wish to participate, still have to pay non-participating physician fee ▪ Doctors who deliver small number of babies cannot afford to participate under current assessment structure
Hospitals	<ul style="list-style-type: none"> ▪ Decrease in number of birth injury claims (Less amount of time and money expended than in a medical malpractice suit) ▪ Decrease in medical malpractice premiums in some cases ▪ May receive “free ride” from doctors who participate, if the hospital does not participate ▪ Hospitals have a choice whether to participate 	<ul style="list-style-type: none"> ▪ None
Non-OB Physicians	<ul style="list-style-type: none"> ▪ Helps stabilize medical malpractice rates generally and helps keep cap intact 	<ul style="list-style-type: none"> ▪ Non-participating physicians have to pay a fee

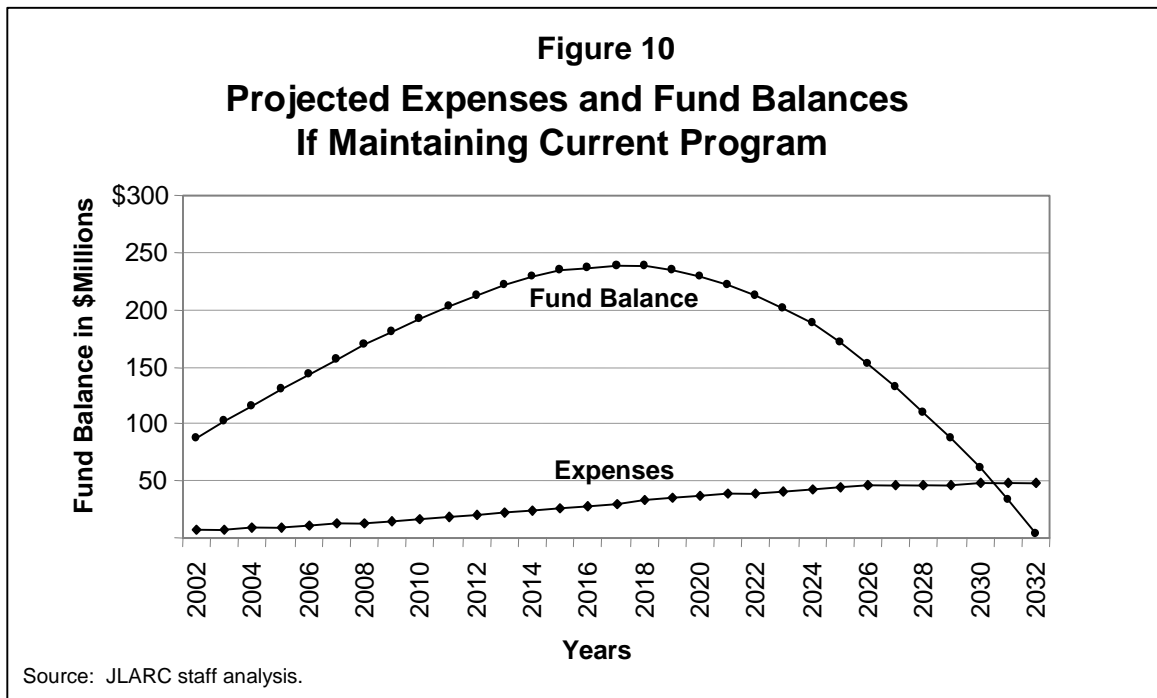
However, the true impact of the program may not be known for many years. Despite the actuary's conclusion that the fund is actuarially unsound, the actuary found that the fund is not in jeopardy of being depleted for at least 25 years if the funding structure remains intact and assessments are applied at the maximum level allowed by law. This conclusion is subject to the accuracy of the actuary's assumptions and the program data available to this point. While the actuary has begun to use program data that reflect the actual costs incurred by the claimants, these data are still incomplete because the program is relatively young. The oldest child in the program is only 14 years old, and thus, the program has not completed a full life cycle for the first claimants in the program. The children in the program have not even obtained all of the benefits prescribed by law since the lost wages benefit does not begin until the child turns 18 years old.

It is likely that additional modifications and refinements to the actuarial projections will occur as additional data are included in each subsequent actuarial review. As demonstrated by the 2001 actuarial review, changes in assumptions based on new data can have a major impact on projected fund solvency. It is possible that additional data gleaned from the program over time may show that the actuary's assumptions need further modification and that future costs may not be as great as currently projected.

Given these factors, the General Assembly may want to consider continuing the program, with periodic program reviews to assess the status of the program over time. At a minimum, the annual actuarial reviews should be closely tracked to determine if current projections are holding true. In addition to the annual actuarial reviews that the SCC directs, it also may be advisable to conduct more in-depth reviews at five-year intervals to determine the ongoing impact of the program on birth-injured children, physicians, hospitals, and insurers in Virginia. Chapters IV and V of this report identify a number of recommendations for improvements if the program is continued. Implementation of these changes may impact the program's ability to address its objectives and could be assessed in future studies.

JLARC staff developed illustrative projections to show the possible impact of keeping the program and maintaining the current funding structure at maximum levels. (These projections are not forecasts.) As shown in Figure 10, the fund balance is projected to increase substantially during the next 15 years, assuming all assessments are maintained at the maximum rates. At its peak, the fund may contain in excess of \$225 million, and thus will appear to be amply funded. However, based on current estimates of life expectancy and the potential eligible population, program expenses will also increase substantially each year, and after about 15 years will begin to deplete the fund balance. Based on JLARC staff's illustrative projection, the fund balance could be completely depleted in 30 years, when annual expenses could reach \$50 million.

With this option, the fund will remain viable only if all funding sources continue to be assessed at maximum levels. As previously mentioned, the fairness of assessing the non-medical malpractice insurers is questionable. However, if the General Assembly chooses to remove non-medical malpractice insurers as a funding



source for the birth injury program, an alternative funding source will need to be identified.

Because this option maintains the current voluntary participation approach, the ability of the General Assembly to modify the assessments is limited. However, one funding revision could be considered under this option. Since the act's creation, hospital assessments have been capped at \$150,000. Therefore, any hospital with more than 3,000 births per year essentially pays a lesser amount for coverage on a per birth basis than those hospitals with fewer than 3,000 births per year. In 2002, four hospitals paid assessments at the cap. To increase the equity of this assessment, the General Assembly may wish to consider raising this cap to \$200,000.

Periodic reviews of the program will help the General Assembly determine if these scenarios appear likely as time progresses. Over time, the General Assembly would have more information from which to decide whether to continue the program and what funding sources may be available to cover the claimant costs.

Option 2: Institute Mandatory Participation by Obstetric Providers and Hospitals

A second option the General Assembly may want to consider is to continue the program, but make participation by obstetric providers and hospitals mandatory. This option has a number of advantages over the current approach of voluntary participation, as noted in the Option 2 Exhibit. In particular, this approach would ensure that all babies with severe birth injuries (meeting the definition) would be covered by the program. In addition, a mandatory system would enable

OPTION 2 Exhibit: Mandatory Participation		
	Advantages	Disadvantages
Overall	<ul style="list-style-type: none"> ▪ Cost-effective for obstetricians and medical malpractice insurers ▪ Could enhance current medical malpractice situation in the State, even though Virginia is already better off than many other states ▪ Consistent participation levels would make it easier to plan and budget 	<ul style="list-style-type: none"> ▪ Not cost-effective overall, especially for non-medical malpractice insurers who are required to pay, but receive no benefit ▪ Delaying decision to eliminate program could increase the unfunded liability in the future ▪ The extra money collected through mandatory participation would not offset the increase in the number of children in the program and would deplete the fund sooner than the voluntary system ▪ Would be difficult to determine per live birth assessment fees
Birth-Injured Children and Families	<ul style="list-style-type: none"> ▪ More birth-injured children receive assistance through the program than through the tort system ▪ Would ensure that all similarly situated infants across the State are covered by the program ▪ More timely than the tort system 	<ul style="list-style-type: none"> ▪ Mothers' rights to sue for economic damages as well as pain and suffering are abrogated ▪ For families with a strong medical malpractice case and significant resources, this program does not provide the flexibility of a medical malpractice award in providing for the needs of the children ▪ Obstetrical patients would not be given the choice as to whether to participate
Medical Malpractice Insurers	<ul style="list-style-type: none"> ▪ Would have almost no awards for severely birth-injured babies 	<ul style="list-style-type: none"> ▪ None

OPTION 2 Exhibit (Continued): Mandatory Participation		
	Advantages	Disadvantages
Other Insurance Companies	<ul style="list-style-type: none"> ▪ None 	<ul style="list-style-type: none"> ▪ Must pay into fund from which they receive no benefit
OB/GYNs	<ul style="list-style-type: none"> ▪ Decrease in medical malpractice premiums, especially with discount ▪ Decrease in number of birth injury claims. (Less amount of time and money expended than in a medical malpractice suit) ▪ Some obstetricians have received greater discounts than the participation assessment, thereby financially benefiting from participation ▪ Doctors who deliver a smaller number of babies could afford assessment to participate under new assessment structure 	<ul style="list-style-type: none"> ▪ Doctors would have no choice regarding participation ▪ No “free rides” as a result of hospital participation
Hospitals	<ul style="list-style-type: none"> ▪ Decrease in number of birth injury claims (Less amount of time and money expended than in a medical malpractice suit) ▪ Decrease in medical malpractice premiums in some cases 	<ul style="list-style-type: none"> ▪ No “free rides” resulting from physician participation ▪ Hospitals would have no choice whether to participate ▪ Hospitals with ability to purchase additional insurance coverage at a lower rate than assessment would be forced to pay more for program coverage
Non-OB Physicians	<ul style="list-style-type: none"> ▪ Helps stabilize medical malpractice rates generally and helps maintain cap 	<ul style="list-style-type: none"> ▪ Non-OB physicians would have to pay non-participating fee

the State to institute a fairer assessment structure – one based on obstetric caseloads instead of a flat fee. On the other hand, JLARC staff analysis has shown that the mandatory approach is more costly than the voluntary approach, and therefore, it is likely that the fund would be depleted sooner.

An Alternative, Fairer Assessment Structure Could Be Implemented.

The program's flat assessment for participating physicians appears to have had the effect of including more births overall in the State because it is more cost-effective for the physicians who deliver large numbers of babies each year to participate. In contrast, the flat assessment has served to minimize participation by rural physicians, who tend to deliver fewer babies per year. As such, rural physicians benefit less from this program than their urban counterparts.

As described in Chapter I, a physician must pay \$5,000 per year to participate in the program. For a physician who delivers only 25 to 50 babies a year – a common delivery rate for rural physicians who provide obstetric services – the \$5,000 fee is viewed as unaffordable. Further, most of the physicians providing obstetric services in rural areas are family practitioners. While family practitioners who deliver babies generally pay less in premiums than ob/gyns, the premium discount they receive for participating in the program is also less. For example:

Under the current assessment structure, a family physician who delivers 40 babies per year pays the same \$5,000 assessment as an ob/gyn who delivers 125 babies per year. As such, the family physician pays \$125 per birth to participate while the ob/gyn pays \$40 per birth to participate. In addition, if the family practitioner's liability insurance premium was \$15,000 and his/her insurer provided a ten percent discount for participation, that physician would receive a \$1,500 discount. If the ob/gyn's premium was \$35,000, that same ten percent discount would yield a \$3,500 discount. The ob/gyn would essentially pay \$1,500 (\$5,000 minus the \$3,500 discount) to cover 125 babies while the rural family physician would pay \$3,500 to cover 40 babies.

If the program were mandatory, the State would have more flexibility to change the assessment structure without having to risk that physicians would choose to drop out of the program. One option would be to institute a modified per-birth assessment. Table 14 presents an example of such an approach. While this approach would require more administrative work because a mechanism would need to be developed to track the number of deliveries per physician, this approach would help ensure that instituting a mandatory system would not drive physicians out of the practice of obstetrics.

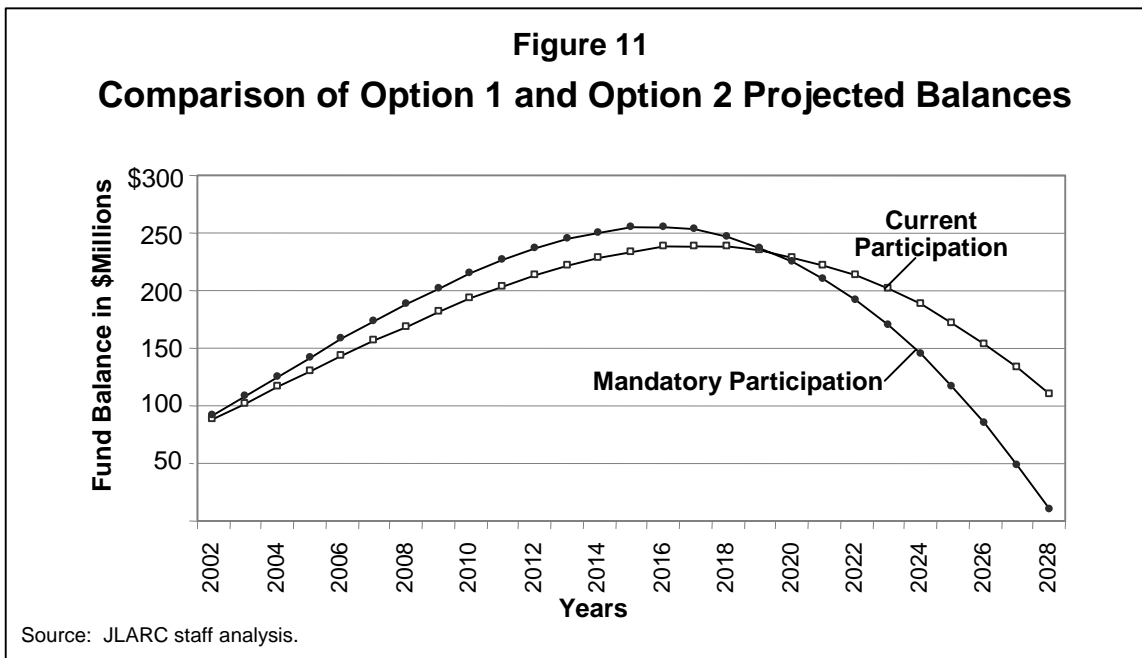
Mandatory Approach Would Be More Costly. The major drawback to this option is that it would be more costly than the current voluntary system. The program would collect more assessment income. However, additional children would become potentially eligible for the program. The costs associated with these children are estimated to be greater than the additional income that would be collected from increased participation. Figure 11 shows how a mandatory program would initially

Table 14

**Alternative Assessment Structure for Participating Physicians
Option 2: Mandatory Participation**

Number of Birth Events	Per Birth Event Assessment	Minimum Assessment	Maximum Assessment
Less than 70	\$80.00	\$250	\$3,850
70 to 120	\$55.00	\$3,850	\$5,445
121 to 170	\$45.00	\$5,445	\$6,840
171 to 200	\$40.00	\$6,840	\$7,000
More than 200	\$35.00	\$7,000	\$8,000

Source: JLARC staff analysis.



generate a greater fund balance, but that balance would start declining approximately five years sooner than under the current program, and would likewise be depleted sooner than the current program. While it is not clear what the General Assembly’s legal obligation is with regard to the fund’s unfunded liability, there is the potential that the financial liability could be judged an obligation of the State.

Option 3: Eliminate the Birth Injury Program

As previously described, the birth injury program appears to have helped birth-injured children, the medical community, and medical malpractice insurers. However, little impact has been identified regarding the broader benefits to the public. To the extent that the program has done little to address the broad societal goals originally envisioned for the program, and particularly considering the program is

more expensive than Virginia's capped tort system, the General Assembly may want to consider eliminating the program. Also, given the projected future financial liability of the program, eliminating the program now may help minimize the eventual fund deficit. The Option 3 Exhibit identifies additional advantages as well as disadvantages to dissolving the program.

If the General Assembly were to decide to eliminate the program, the issue of how to dissolve the fund would need to be addressed. Because eligibility for the program is based on birth year rather than the year a person applies to the program, the actuary estimates that there are 31 potential claimants who have been born, but are not yet in the program. The actual number of these potential claimants will not be known until 2012, at which time the statute of limitations would preclude additional claims (assuming the program is terminated in 2002).

To account for these future claimants, it may be appropriate to continue operation of the program until 2012. (The program would continue but no new assessments would be collected.) At that time, all of the children in the program could then be given a lump sum payment in lieu of the current benefit approach. In 2012, JLARC staff estimate that there would be approximately \$28 million remaining in the fund, which would not be enough to provide adequate payments to the potentially 90 children who would be living at that time (Figure 12). Therefore, dissolving the fund will require an additional source of funding. For illustrative purposes, if the children were given a payment equal to the current malpractice award cap (\$1.65 million), up to \$120 million in additional funding would be needed to close out the program in 2012.

Another issue that would need to be considered with this option is the appropriateness of the current medical malpractice award cap. Based on the actuarial analysis and program expenses, it is clear that Virginia's cap is not sufficient to meet the lifetime costs associated with a birth-injured child. This program provides a means to pay for the lifetime medical costs of these children. Without this program, the appropriate level for the malpractice award cap in birth injury cases would need to be reevaluated.

Conclusion

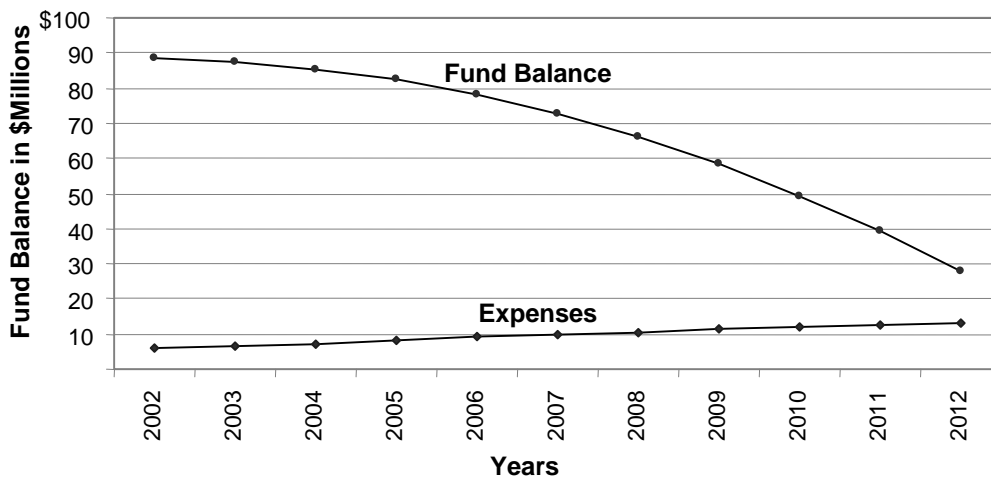
As the options presented suggest, there are difficult policy choices to be made by the General Assembly regarding the future of the birth injury program. Two options outlined in this chapter result in the continuation of the program. If the General Assembly wishes to continue the program, then significant improvements to the structure and management of the program will be needed. In chapters IV and V, JLARC staff outline the findings and recommendations related to program eligibility and administration that would specifically need to be addressed. The improvements recommended will help to ensure that the program is successful in serving birth-injured children as intended by the General Assembly.

OPTION 3 Exhibit: Dissolve the Program		
	Advantages	Disadvantages
Overall	<ul style="list-style-type: none"> ▪ Minimizes the future fund deficit 	<ul style="list-style-type: none"> ▪ Lack of an identified funding source to compensate current claimants in the fund ▪ Hard to determine appropriate compensation for families ▪ Have to find a place to house the program while it is being phased out ▪ Could potentially make the current medical malpractice situation much worse ▪ State could be subject to lawsuits
Birth-Injured Children and Families	<ul style="list-style-type: none"> ▪ Restores injured mothers' rights to sue for economic damages and pain and suffering ▪ For families with a strong medical malpractice case and significant resources, the receipt of a medical malpractice award would give more flexibility in providing for the needs of their children 	<ul style="list-style-type: none"> ▪ Birth injured children may receive no assistance. Those who receive assistance must rely on an award that is capped, which does not meet the medical needs of most children
Medical Malpractice Insurers	<ul style="list-style-type: none"> ▪ None 	<ul style="list-style-type: none"> ▪ Awards and settlements to birth injured children will increase
Other Insurance Companies	<ul style="list-style-type: none"> ▪ No longer have to pay into fund from which they receive no benefit 	<ul style="list-style-type: none"> ▪ None
OB/GYNs	<ul style="list-style-type: none"> ▪ No non-participating physician assessment for those who do not choose to participate 	<ul style="list-style-type: none"> ▪ Increase in the number of birth injury claims ▪ Increase in medical malpractice premiums ▪ No "free rides" resulting from hospital participation

OPTION 3 Exhibit (Continued): Dissolve the Program

	Advantages	Disadvantages
Hospitals	<ul style="list-style-type: none"> None compared to maintaining the program as it is currently structured 	<ul style="list-style-type: none"> Increase in number of birth injury claims Increase in medical malpractice premiums No “free rides” resulting from physician participation
Non-OB Physicians	<ul style="list-style-type: none"> No non-participating physician assessment 	<ul style="list-style-type: none"> More volatility in the medical malpractice insurance market and potential increase in medical malpractice insurance premiums

Figure 12
Projected Expenses and Fund Balances
If Dissolving Fund in 2012



Source: JLARC staff analysis.

IV. Eligibility for the Birth Injury Program

There are two elements related to eligibility for the Virginia Birth-Related Neurological Injury Compensation Program (birth injury program) that are addressed in this chapter. First is the birth injury definition that is required to be met to gain entry to the program. Second is the process by which the child is judged to meet that definition. In the 2002 General Assembly, House Bill 714 proposed a number of changes to the eligibility process, which are also considered in this chapter. While the birth injury definition has been criticized by different parties as either too restrictive or not restrictive enough, it appears that the basic components of the definition are well designed to meet the goal of the program vis-à-vis the tort system. Some relatively minor modifications have been recommended to help clarify the intent of the definition. These changes are not expected to have a significant impact on the number of children in the program.

With regard to the process for determining a child's eligibility for the program, JLARC staff identified a number of needed improvements. Most notable is the need to eliminate the program's role in the eligibility determination process. Its involvement in the process conflicts with its role as service provider to claimant families and serves to increase the contentiousness of the process. Without the program's involvement in eligibility determinations, the medical panels' role becomes more critical. As such, changes are needed to strengthen the medical panel reviews. In addition, the eligibility process needs to be more accessible for potential claimants of the program.

Finally, during the course of the eligibility process, petitions are sent to the Board of Medicine and Department of Health to determine whether the birth injuries resulted from substandard care that would warrant disciplinary action for the doctors or hospitals involved in the births. The reviews by the Board of Medicine have been inadequate thus far. The Board of Medicine should perform more rigorous reviews of these cases to ensure that physicians are held accountable if they provide substandard care.

PROGRAM ELIGIBILITY

JLARC staff examined the appropriateness of the Virginia Birth-Related Neurological Injury Compensation Act's birth injury definition through interviews with medical professionals, a review of medical literature on birth injuries and cerebral palsy, and a review of Workers' Compensation Commission (WCC) files for all birth injury petitions. Overall, the current definition in the act appears to meet the goals of the program by targeting the cases most likely to become the subject of a lawsuit. However, some refinements to the definition would make the eligibility criteria clearer, and may help reduce the contentiousness of the eligibility process. Specifically, the act should exclude children who die shortly after birth and explicitly define the timeframe of a qualifying injury.

The Basic Elements of the Definition Appear Sound

The definition that was initially adopted in the act specified three major conditions that had to be met for a birth-injured baby to be eligible for the program. The first component of the definition dealt with the cause of the injury and stated that the injury must be “caused by the deprivation of oxygen or mechanical injury.” The second component of the definition addressed the timing of the injury and stated that the injury must occur “in the course of labor, delivery or resuscitation in the immediate post-delivery period.” Finally, the third component of the definition focused on the degree of the disability and stated that the injury had to “render the infant permanently non-ambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living.”

This original definition was proposed based on anecdotal information that it would cover the types of birth injuries that were most costly for medical malpractice insurers. Stillborn births, as well as birth injuries that involve a congenital or genetic abnormality, were specifically excluded from the act based on the premise that these cases are unlikely to result in a claim. The resulting definition was intended to include events that occur during the birthing process that may reasonably be considered to be under the control of the obstetrician. The underlying premise in these cases is that the child would have been healthy except for an event that occurred during labor and delivery. Although not all such events can be prevented by an obstetrician, these are the types of incidents that are most likely to result in medical malpractice lawsuits.

In 1989, the Medical Society of Virginia (MSV) contracted with the Williamson Institute at MCV to conduct a study of birth injury claims in Virginia. This study examined whether the definition in the act captured the types of cases that were most likely to result in high payouts to claimants (see House Document No. 63, 1990 Session). Investigators reviewed actual medical malpractice claims data in Virginia between 1980 and 1988. The results indicated that one of the most significant factors that predicted payouts by a medical malpractice insurer was survival of the infant. In addition, claimants with multiple injuries (physical and mental) rather than a singular injury (mental or physical alone) were also more likely to receive compensation.

Researchers also found that babies who met the disability criteria of the definition in the act were very likely to die shortly after birth, and that the definition excluded a large number of infants who had more costly medical needs and who had obtained higher payouts from medical malpractice insurers.

Based on this information, researchers concluded that the extent of the disability required for the program was too restrictive. This third component of the definition was ultimately amended, so that in order to qualify for the program now, an infant must be “permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled” and “permanently in need of assistance in all activities of daily living.” The remaining components of the definition have not changed.

A review of the medical literature on birth injuries and cerebral palsy suggests that this definition is consistent with current medical research. In a 1999 issue of the *British Medical Journal*, the International Cerebral Palsy Task Force published an article stating that causes of cerebral palsy include developmental abnormalities, metabolic abnormalities, autoimmune and coagulation disorders, and infection. In addition, the article states that in a small number of cases, hypoxia (asphyxia) during labor results in adverse outcomes, such as the level of disability defined in the act.

While there are no perfect measures for determining when this has occurred, the International Cerebral Palsy Task Force concluded that there are specific indicators that should be used to identify an hypoxic event during labor. These criteria are shown in Table 15. The Task Force indicated that all of the elements in Table 15 should be present before an hypoxic event during labor may conclusively be tied to an adverse outcome. The blood cord gas results (criterion number one) are considered a key result.

The medical panels from the Commonwealth's medical schools largely reported using these same criteria in making their determinations. However, they pointed out that in practice, physicians do not always direct that blood cord gases be drawn and tested. They estimate that this important element of the identification

Table 15

Criteria to Define an Acute Intrapartum Hypoxic Event

Essential Criteria

1. Evidence of a metabolic acidosis in intrapartum fetal, umbilical arterial cord, or very early neonatal blood samples (pH<7.00 and base deficit \geq 12 mmol/l)
2. Early onset of severe or moderate neonatal encephalopathy in infants of \geq 34 weeks' gestation
3. Cerebral palsy of the spastic quadriplegic or dyskinetic type

Criteria that together suggest an intrapartum timing but by themselves are non-specific

4. A sentinel (signal) hypoxic event occurring immediately before or during labor
5. A sudden, rapid, and sustained deterioration of the fetal heart rate pattern usually after the hypoxic sentinel event where the pattern was previously normal
6. Apgar scores of 0-6 for longer than 5 minutes
7. Early evidence of multisystem involvement
8. Early imaging evidence of acute cerebral abnormality

Source: A template for defining a causal relation between acute intrapartum events and cerebral palsy: international consensus statement. *British Medical Journal* (1999).

process is missing in as many as 50 percent of the cases they review. But they also report that in such cases, they consider other criteria that, in combination, could point to an oxygen-depriving event. When such factors are present, the panels reportedly recommend inclusion of the child into the program.

The portion of the definition that requires that the injury be tied to oxygen deprivation during labor, delivery or the immediate post-delivery period has been the most frequently debated issue in determining eligibility. Of the 26 cases that were not accepted at the initial WCC hearing, a majority (73 percent) did not meet the first two parts of the definition, which specify how and when the injury must occur. In many of the cases contested by the program on that basis, petitioners submitted expert testimony that oxygen deprivation occurred during the statutory time period. Similar to a medical malpractice case, the WCC has had to consider conflicting testimony in deciding whether a child's injury fits the definition.

The contentiousness of the eligibility hearings has led some to conclude that the birth injury definition is flawed. But the link between oxygen deprivation and severe brain injuries is not disputed in the medical literature. In addition, the medical literature indicates that oxygen deprivation during labor and delivery only occurs in a small proportion of children who develop serious permanent disabilities such as cerebral palsy. Therefore, the fact that only a small number of cases have been accepted into the program is to be expected.

Given that the purpose of the act is to target those cases that will most likely end up in the tort system, and that the medical panels have criteria available for making such judgments, it does not appear that the basic structure of the definition needs major revision. However, there are some clarifications that appear warranted, as discussed in the next sections.

The Program Is Not Suitable for Infants Who Die Shortly After Birth

There has been some debate over the inclusion of babies in the program who die shortly after birth. Under the current definition, a baby must be born alive – that is, not stillborn – to be potentially eligible for the program. The *Code of Virginia* does not specify how long the child must be alive, but rather that he or she must meet the criteria of cause, timing and disability outcome.

Inclusion of these children in the program clearly benefits the doctors because it allows them to avoid a potential lawsuit, but the benefits to the parents and children are limited to the costs associated with the delivery itself and funeral expenses (up to \$5,000). The purpose of the program is to provide lifetime care for these children, with the expectation that caring for these children is very expensive. The child receives this care in exchange for giving up his or her constitutional right to sue. The fairness of admitting babies who die shortly after birth, therefore, is questionable.

It appears that there have been inconsistencies in how such cases have been handled by the courts and the WCC. Only one deceased baby has been admitted into the program thus far.

In this particular case, the baby lived for less than three hours. The baby's mother filed a wrongful death suit in a circuit court, but the case was transferred to the WCC on the motion of the hospital and doctor who were named in the suit and who participated in the program. Attorneys for the mother of this baby argued that even though the baby met the oxygen deprivation portion of the definition, he was not eligible for the program because he did not meet the disability requirement. But the WCC ruled that the baby did meet the disability requirement, citing case law that deceased babies may be considered developmentally disabled by virtue of their deaths. This case is currently on appeal by the mother.

In at least one circuit court case involving a deceased infant, the judge denied a motion to transfer jurisdiction to the WCC based on his finding that if the Legislature had intended to eliminate a wrongful death claim in that case, "it would have done so by defining birth-related neurological injury to mean an injury to the brain or spinal column resulting in permanent disability or death." This case was described in the June 1997 edition of *Virginia Lawyers Weekly*.

The fetal heart rate, as monitored by an external fetal heart rate monitor, dropped and the mother and her husband claimed that they were left alone without a physician or nurse for approximately one hour. During this time, the fetal heart rate strips indicated late and recurrent decelerations with a fetal heart rate in the 60s and 70s. The strips reflected sustained fetal bradycardia beginning 25 minutes prior to the baby's delivery. The infant's cord pH at delivery was 6.8, indicative of intrauterine asphyxia and hypoxia.

The infant had severely low apgar scores and was taken to intensive care with no spontaneous movement or response to stimuli. He developed tremulous movements to the upper and lower extremities and died two days after delivery.

The plaintiff's standard of care and causation expert testified that the infant should have been delivered much earlier in the evening and, if so delivered, would not have sustained substantial injuries.

It appears that this child would have been judged eligible for the program based on the fact that the child experienced severe oxygen deprivation during labor and delivery. However, given that the program is intended to provide a lifetime of care for children, it would be inconsistent with the spirit of the act to include deceased infants. HB 714 (2002) proposed that the program exclude "situations in which the infant died after birth," but did not include a specific timeframe. In addition, the language of HB 714 (2002) eliminates the possibility of a child being in the program, even if the surviving family wished to be included.

In identifying an appropriate time period for babies to live before being considered for eligibility in the program, it is important to consider the benefits that

reasonably can be expected from the program during the first few months of life. JLARC staff examined the expenses of the only three program claimants who were admitted within six months of their births. These children received an average of about \$300 in benefits for costs incurred during the first three months of their lives. By six months of life, they had received an average of about \$10,500 in benefits. However, benefits began to accrue more significantly between six months and twelve months of age. During this time period, they accumulated an average of \$15,000 in benefits per month. Based on these results, it appears that six months may be an appropriate cutoff timeframe, before which a child who dies would not be required to enter the program. However, it does seem appropriate to allow those parents who feel they might receive some benefit from the program to apply to the program before the child is six months old, if they wish to do so. But acceptance into the program should serve as an election of remedies, with a wrongful death suit prohibited, even if the child dies before he or she is six months old.

Given that there has only been one deceased infant admitted into the program during its 15 year existence, it does not appear that eliminating deceased infants from the program will have a significant impact on the number of babies in the program. Therefore such a change will not defeat the purpose of the act by permitting a large number of families to avoid the program and file suit.

Recommendation (3). The General Assembly may wish to consider amending §38.2-5001 of the *Code of Virginia* to permit families of infants who die within 180 days of birth the option to file suit against a participating physician and/or hospital rather than require applications to the Virginia Birth-Related Neurological Injury Compensation Program.

The Statutory Time Period of the Injury Should Be Clarified

Another area of concern is the portion of the definition which states that the injury must occur “in the course of labor, delivery or resuscitation in the immediate post-delivery period.” Because the term “immediate” has not been defined in the act, it has been interpreted differently by various parties at the eligibility hearings. While the definition of “immediate” has been an issue in only two cases thus far, the vagueness of this term has allowed for widely varying interpretations. The medical panels define “immediate” in a very limited fashion, and have suggested that only those injuries that occur within a few minutes of a delivery should be considered. The WCC, on the other hand, has accepted children into the program who were injured up to ten hours after delivery.

In one case, experts disagreed on whether an injury that occurred within ten hours of birth met the definition of immediate. In deciding that the infant was eligible, the Chief Deputy Commissioner noted that “there is not a unified perception within the medical profession” and that the term was not defined in the act by the General Assembly. In the absence of any such standard, the Chief Deputy Commissioner ultimately decided that the infant should be pro-

vided with the presumption that the injury occurred during the statutory time period.

Since the focus of the program is on obstetricians, the time period of the injury should center around the time in which an obstetrician is most likely to be involved. Typically, an obstetrician is not involved in a child's care after the birthing event when the child is taken to the nursery.

When asked how they interpret the term "immediate post delivery period", the medical panels reported that the term immediate is commonly considered to be the first few minutes after birth, for example when the Apgar scores are being assigned. (Apgar scores are used to quickly evaluate a newborn's condition after delivery.) While typically assigned at one and five minutes, Apgar scores can also be assigned up to 20 minutes after birth. Both panels reported that they do not typically consider the term immediate to include any event that occurs after the baby leaves the delivery room. One panel member indicated that the outer bounds for an event to be considered immediate would be 60 minutes.

Imposing a specific time limit on the term immediate is somewhat arbitrary, regardless of how long that time period is defined to be. However, in the interest of clarifying eligibility criteria, particularly for potential claimants, and eliminating this area of debate for future cases, it would be helpful to define this term. Given the opinions of the medical experts at both MCV and UVA, it appears that the time period for immediate could be reasonably specified as one hour.

Recommendation (4). The General Assembly may wish to consider amending §38.2-5001 of the *Code of Virginia* by replacing the language, "immediate post delivery period" with the more specific language, "within one hour of delivery."

Excluding Premature Infants from the Program Would Appear to Lessen the Program's Impact on the Tort System

There has been much debate regarding whether premature infants, who are at high risk for complications, should be accepted into the program. Virginia's birth injury definition does not specifically exclude premature infants from the program. Arguments have been made that premature infants are predisposed to adverse outcomes not related to any specific birthing event, and therefore as a group should be excluded. In fact, Florida's birth-injury program has a minimum birth weight of 2,500 grams (approximately 5.5 pounds) for single births and 2,000 grams (approximately 4.4 pounds) for each infant in the case of multiple births.

According to a recent issue of *Contemporary OB/GYN*, 23 percent of those babies born before 26 weeks gestation are expected to have a severe disability, defined as the "expectation that a child will never be able to independently perform activities of daily living." There is also a perception that families with premature infants are less likely to file suit against their physician because they are more likely to view prematurity as an unpreventable act of nature.

Currently, 22 of the 72 children (31 percent) accepted into the program were less than 2500 grams (5.5 pounds) at birth and ranged from 23 to 41 weeks in gestation. (Thirty-eight weeks or more is considered a term birth.) Of these 22 cases, 12 were less than 1,500 grams (3.3 pounds). Sixteen of the 22 children under 2,500 grams were accepted by the program without a hearing or medical panel review. There have been an additional 24 petitions in which children less than 2,500 grams and/or less than 38 weeks of gestation were denied entry into the program.

According to the medical panels, regardless of gestational age it is possible to sustain a birth-related injury as defined in the act. They also pointed out that prematurity is difficult to define. Although birth weight and gestational age are typically used to define prematurity, there are some limitations to using these criteria to define eligibility. For example, gestational age is difficult to verify because it is often based on self-reported information from the mother as to when she experienced her last menstrual cycle. Birth weight is more easily verified, but is influenced by factors other than prematurity, such as race. (For example, full-term Asian babies typically weigh less than full-term Caucasian babies.) Overall, the medical experts felt that they could adequately decide which cases of prematurity fit the criteria for the program, and that premature babies should not be completely excluded by the act.

In addition, according to the Williamson Institute study (House Document 63, 1990 Session), 30 percent of the birth injury malpractice claims in Virginia from 1980 to 1988 involved premature infants. Based on this finding, the study recommended that premature infants not be excluded from the program, as it would increase the number of claimants in the tort system and defeat the purpose of the program.

As will be discussed later in this chapter, there is a lack of understanding as to how the medical panels decide whether a child meets the birth injury definition, which may partly impact how these cases involving prematurity are ultimately decided by the WCC. Clarifying how the medical panels reach their decisions may help to alleviate some concerns over the inclusion of premature infants.

Given that the inclusion of premature babies does appear to meet the purpose of the act and the panels' belief that they can make a distinction between premature babies who do or do not meet the definition, it seems appropriate to continue allowing premature infants to apply to the program.

ELIGIBILITY DETERMINATION PROCESS

JLARC staff examined the eligibility process through a review of WCC files and opinions, as well as interviews with representatives from all parties that participate in the eligibility hearings. It appears that the WCC has done an adequate job in handling the birth injury claims, and should continue hearing these cases. However, some structural changes are needed to improve the eligibility process. While there is no evidence that the program has inappropriately attempted to exclude cases from the program thus far, its involvement in the eligibility process increases the contentiousness of the proceedings and represents a conflict of interest.

Therefore, the program should be removed from the eligibility process. In addition, the medical panel reviews need to be strengthened to increase the effectiveness of that process. Finally, steps should be taken to make the application process more user-friendly for parents.

The Application Process Needs Modification

JLARC staff examined the application process by comparing the process followed by WCC to the eligibility process described in the *Code of Virginia*. In addition, the role of the program was evaluated by examining how it has responded to petitions filed at the WCC. Based on this review, it appears that the eligibility process has not been followed exactly as it is outlined in the *Code of Virginia*. Instead of making its own determination about program eligibility, the WCC has allowed the program to accept a majority of cases without an independent review by the medical panels. While there is no evidence to suggest the program has inappropriately accepted or denied cases, the program's participation in the hearings does present a potential conflict of interest. To promote fairness in the eligibility process, the program should be removed from the hearing process.

Codified Application Process. The application process at the WCC begins with a petition by a claimant, usually the parent of the injured baby, to the Clerk of the WCC. Pursuant to §38.2-5004 of the act, this petition must include the following information:

- the name and address of the legal representative and the basis for his representation of the injured infant;
- the name and address of the injured infant;
- the name and address of any physician providing obstetrical services who was present at the birth and the name and address of the hospital at which the birth occurred;
- a description of the disability for which claim is made;
- the time and place where the birth-related neurological injury occurred;
- a brief statement of the facts and circumstances surrounding the birth-related neurological injury and giving rise to the claim;
- all available relevant medical records relating to the person who allegedly suffered a birth-related neurological injury, and an identification of any unavailable records known to the claimant and the reasons for their unavailability;
- appropriate assessments, evaluations, and prognoses and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of a birth-related neurological injury;

- documentation of expenses and services incurred to date, which indicates whether such expenses and services have been paid for, and if so, by whom; and
- documentation of any applicable private or governmental source of services or reimbursement relative to the alleged impairments.

Families are required to submit at least ten copies of the petition to the WCC. (More than ten copies are required for cases in which multiple doctors are involved in a birth.) The WCC, in turn, distributes copies of the petition to the program, the participating physician(s), the participating hospital, the medical panel, the Board of Medicine, and the Department of Health.

The program is required to respond to the petition within 30 days of the filing date at the WCC. In the past, the WCC entered children into the program without any further proceedings if the program indicated in its 30-day response to the WCC that the child met the definition in the act. If the program indicated that the child did not meet the definition in the act, the WCC would obtain a medical panel report and hold a hearing. Beginning in May 2002, however, the WCC decided to require medical panel reports in all cases before entering awards, regardless of the program's response.

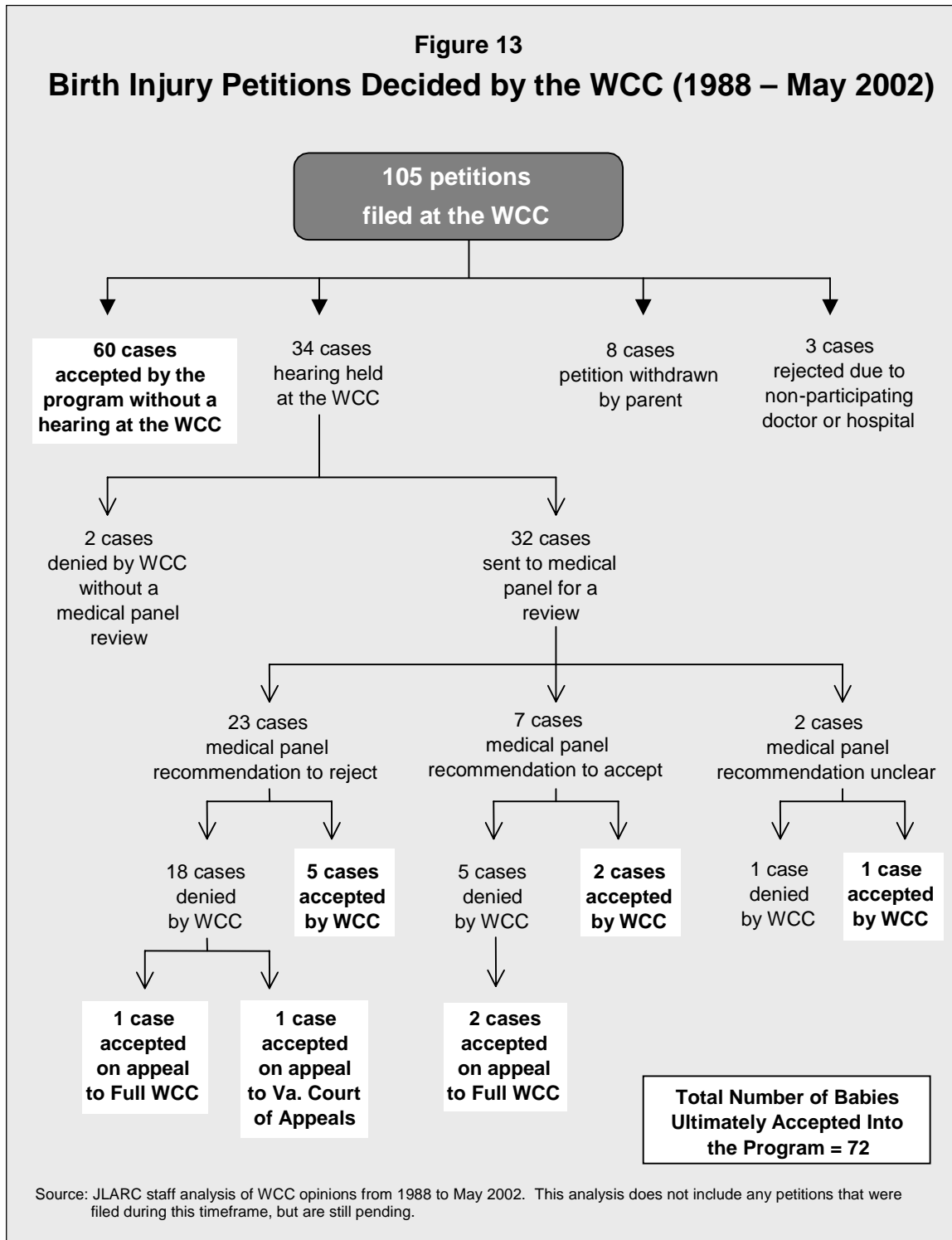
The medical panel consists of three impartial experts from one of the medical schools in the Commonwealth. Currently, the panel alternates each year between the medical schools at the University of Virginia and Virginia Commonwealth University. At least ten days before a hearing at the WCC, the panel is required to issue a report and recommendation as to whether the claimant's injury coincides with the definition in the act. Although the WCC must consider that report, it is not bound by its recommendations.

According to §38.2-5006 of the *Code of Virginia*, the hearing must be scheduled no sooner than 45 days and no later than 120 days after the petition has been filed. The parties required to be at the hearing are the claimant and the program. In practice, the WCC also allows the participating physician or hospital to be a party to the hearing.

At the hearing, the Chief Deputy Commissioner must determine whether the injury fits the definition of a birth-related injury as defined in the act. She must also determine whether the physician and hospital named in the petition were participants in the program at the time of the birth. After the hearing, it takes approximately one to two months for the Chief Deputy Commissioner to write an opinion stating whether the baby has been accepted into the program.

Either party, the claimant or the program, may appeal the decision of the Chief Deputy Commissioner to the full Workers' Compensation Commission. The decision of the full Commission may then be appealed to the Court of Appeals. These cases are placed on the privileged docket at the Court of Appeals, which provides for an expedited review. For cases in which the program is appealing a decision by the WCC to enter an award for the claimant, the appeal suspends payment of the award until the case has been resolved.

Most Petitions Have Been Accepted Without a Hearing at the WCC or a Review by the Medical Panels. As shown in Figure 13, a majority (77 percent)



of claimants who file a petition at the WCC are accepted into the program. Of the 72 petitioners who were accepted into the program as of May 2002, most (85 percent) were accepted without a hearing at the WCC. The remaining cases were accepted after a hearing at the WCC (ten percent) or after an appeal to the full Commission or the Virginia Court of Appeals (five percent).

Concerns have been raised that the program frequently opposes claimants to save money. However, there is no evidence to support this allegation. Thus far, in 61 of the 94 petitions (65 percent) filed at the WCC, the program accepted the case and no hearing was required. A review of opposition rates over time also shows that the rate at which the program has opposed cases has fluctuated over time, with no discernible pattern. In other words, that rate does not appear to have increased or decreased over the history of the program in response to the financial condition of the fund.

The Program's Role in the Eligibility Hearings Should Be Eliminated. Although the act mandates that the program respond to each birth injury petition filed at the WCC, this requirement presents significant problems. First, it is a conflict of interest for the program to respond to petitions because it has a financial incentive to minimize the number of claimants who are admitted into the program. Even though there is no evidence it has done so in the past, it is important to guard against that possibility in the future and to eliminate even the appearance of a conflict.

In addition to posing a conflict of interest, the program's participation in the hearings sets up an adversarial relationship between it and the parents when cases are contested. For cases in which the child is eventually admitted against the program's wishes, negative feelings may still remain between the two parties. The relationship between the program and the parents is an important one because it is long-term and will have an impact on the families' ultimate satisfaction with services and benefits. The program's role in the process has the potential to damage that relationship from the very beginning, and therefore should be eliminated.

To ensure that the fund is protected from inappropriate claims, the medical panel review process should be strengthened and used for every case. In addition to being "disinterested third-parties" to the process, the physicians who comprise the medical panels are the foremost experts on obstetrics in the State, and should be relied upon to a much greater degree than is currently the case. Although the program has indicated concerns that the medical panels may be less stringent in who they accept, it should be noted that the panels have agreed with the program in 84 percent of the cases that went to hearing thus far. Although the panels have not been significantly more lenient in their judgments of which cases are accepted, some changes will be needed to improve the effectiveness of these panels. These are discussed in the next section.

Finally, elimination of the program's response will result in some savings for the program because it will no longer have to pay for expert testimony. The only records on expert testimony available to JLARC staff for review from the program were those dating from 1999 to the first half of 2002. Based on those records, it ap-

pears that the program has spent approximately \$2,300 per case on expert testimony.

Recommendation (5). The General Assembly may wish to consider amending §38.2-5004(D) of the *Code of Virginia* to eliminate the requirement that the Virginia Birth-Related Neurological Injury Compensation Program file a response to petitions and specifically state that the Virginia Birth-Related Neurological Injury Compensation Program shall not be a party to any hearing before the Workers' Compensation Commission.

Medical Panel Reviews Need to Be Strengthened

Another concern about the eligibility process relates to the quality of the medical panel reviews. Some parties have criticized the panels as ineffective. In fact, HB 714 (2002) proposed that the panels be eliminated altogether. Through a review of WCC opinions and medical panel opinions, as well as interviews with WCC staff, medical panel members, and others, JLARC staff found that the medical panel reviews are not working as originally envisioned. However, with some modifications, it appears that the medical panels are still the appropriate mechanism for obtaining expert opinions in these cases and that many of these problems can be resolved through increased communication between the WCC and the panels. Enhanced communication should result in a strengthened role for the medical panels, consistent with what was originally intended by the act.

There Has Been a Lack of Communication Between the Parties Involved in Deciding Program Eligibility. It is imperative that each party at the eligibility hearing understand its role and the roles of other parties involved in the process. However, the medical panels have been far removed from the eligibility process since the beginning of the program, and are unaware of many aspects related to the eligibility process. The medical panels were simply given a copy of the act, and had to develop an understanding of their role without any outside input.

Specifically, the medical panels received no guidance from the WCC or the program when they started reviewing cases. For example, there was never any agreement between the WCC and the medical panels concerning the type of information that the WCC needs to help it make its determinations. Further, the WCC has not been given any information on the specific factors that the medical panels consider important when identifying whether a brain-injured infant experienced an hypoxic event during labor or delivery. Although the panels have criteria they use in reviewing the cases, those criteria have never been shared with the WCC.

The medical panel reports provided to the WCC typically state the panels' conclusions regarding whether the child meets the birth injury definition in very broad terms, without making clear their rationale for including or excluding a particular child. This may explain why some cases decided by the WCC did not follow opinions submitted by the medical panels. For example, in one case the only statement related to whether the child met the oxygen deprivation or mechanical injury portion of the definition was the following:

There is unanimous agreement that the disabilities described are likely the result of injury to the brain or spinal cord caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period.

During interviews with the panels, some members indicated that they did not fully understand the eligibility process and assumed that their opinion was followed in every case in which they rendered an opinion. Therefore, they may not have recognized the need to more fully explain their reasoning in the cases that they have reviewed. In addition, the panels have stated that they have never received a copy of a WCC opinion. Therefore, they have no idea how their reports are being interpreted or whether their reports have been misconstrued by the WCC. As a result, they have no information for determining whether they need to clarify their medical opinions.

The Chief Deputy Commissioner who currently handles the birth injury cases at the WCC has stated that she thinks the panels would benefit from receiving feedback from her, but she is not sure whether she has the authority to provide the panels such feedback. She explained further that she is currently considering whether to send them a copy of the Court of Appeals decision in a recent case, which states that in order to rebut the presumption specified in §38.2-5008(A)(1) of the *Code of Virginia*, the panel must prove “to a reasonable degree of medical certainty,” a specific, non-birth-related cause. Because the panels do not receive any legal guidance, they have not used this standard in writing their opinions. The Chief Deputy Commissioner explained that she would feel more comfortable communicating with the panels if the *Code of Virginia* granted her that authority.

The Chief Deputy Commissioner also indicated that it would be helpful if the panels addressed each aspect of the definition. Some of the medical panel members and others have suggested the use of a form. This form could identify the specific criteria considered by the panels, including the criteria established by the American College of Obstetricians and Gynecologists and the International Task Force on Cerebral Palsy, and the medical panels could identify whether each of the criteria were met. In addition, WCC staff would like the panels to specify the portion of the record they relied upon to reach their conclusions.

Another issue that has become apparent from the interviews with the panels at MCV and UVA is that the panels do not communicate with each other. Each has a separate process for handling cases, and have never contacted each other to determine whether there is consistency in what they are looking for or what types of injuries should be included.

A process for non-case-specific communication between the WCC and the medical panels is essential to maintaining the integrity of the eligibility hearings. To enhance the medical panels' understanding of the eligibility process, WCC staff should send copies of all birth injury case opinions to members of the medical panels. In addition, more explicit guidance from the commission should also be provided. The *Code of Virginia* should be amended to require that the WCC and the medical

panels meet on an annual basis to discuss the general process and any improvements that may be needed, without discussing specific cases that are pending at the commission. Initially, the panels and the WCC should work together to develop a form to be completed for each medical panel review. The adequacy of the form should then be reviewed on a yearly basis to determine whether any updates or revisions are needed. In addition, the WCC staff could discuss any perceived inconsistencies in medical panel reviews, as well as any new information in the medical literature that would impact how they decide these cases.

Recommendation (6). The General Assembly may wish to consider amending the *Code of Virginia* to require that the Workers' Compensation Commission and the medical panels meet on a yearly basis to discuss the eligibility process and any improvements that may be needed.

Recommendation (7). The Workers' Compensation Commission should provide copies of all birth injury opinions to members of the medical panels.

Recommendation (8). The medical panels should develop a review form, in consultation with the Workers' Compensation Commission, that addresses each aspect of the eligibility definition. This form should be completed by the panels in each case they review for the Workers' Compensation Commission.

Medical Panels Do Not Consider Every Aspect of the Definition When Deciding Eligibility. The lack of communication between medical panels and the WCC has resulted in a significant gap in determining whether each child meets the criteria in the birth injury definition. Although the *Code of Virginia* does not specify what medical specialties should be represented on the medical panels, both MCV and UVA have primarily included specialists in maternal-fetal medicine within the field of obstetrics/gynecology. Neither of the panels include a pediatric specialist. As a result, the panels have not been reviewing cases to determine whether they meet the portion of the definition involving the severity level of the injury. Due to a lack of guidance concerning the role of the medical panels, they have interpreted their role as not requiring an opinion regarding the degree of disability, even though this is one part of the birth injury definition that must be met for inclusion in the program. The members of one panel said that they make a global evaluation of whether the child needs constant care, but do not review specific areas of daily living in making that assessment. Members of the other medical panel reported that they do not provide any opinion concerning the child's disability level. Although the *Code of Virginia* does not specify that the medical panels should only review certain aspects of the definition, panel members do not believe it is their responsibility, nor do they have the expertise, to address the disability requirement. This discrepancy between expectations and practice has caused problems. For example:

In a case recently decided by the WCC, the program argued that the claimant did not meet the portion of the definition requiring her to be "permanently in need of assistance in all activities of daily living." Based on low Apgar scores, seizures, and other indicators, the

medical panel concluded that the child had experienced oxygen deprivation during the statutory time period. But only one sentence of the medical panel opinion addressed the component of the definition concerning the child's disability. This portion of the opinion simply stated that the claimant had "experienced numerous developmental delays." There was no mention of whether the child was permanently motorically disabled or whether the child needed assistance in all activities of daily living. The conclusion of the medical panel's report was that the child did meet the criteria for the program. Based in part on this recommendation, the WCC ordered that the child be accepted into the program. This case is currently on appeal by the program.

If the program is removed from the eligibility determination process, it will be critical for the medical panels to thoroughly examine and decide whether the cases they review meet the disability portion of the definition. To ensure that the medical panels can provide expert opinions on the entire birth injury definition, deans at each of the medical schools should appoint pediatric specialists to the medical panels.

Recommendation (9). The deans of the medical schools should develop a plan to include both obstetrical and pediatric specialists who can evaluate whether applicants meet the entire definition in the Virginia Birth-Related Neurological Injury Compensation Act.

The Medical Panel Reviews Have Not Been Timely. The medical panels are required by the *Code of Virginia* to submit opinions ten days before the hearing. In almost half (48 percent) of the cases that went to hearing, they did not meet this requirement. In seven of the 32 cases (22 percent) in which a panel report was requested, the panel reports were actually submitted after the hearing.

Without the medical panel reports in advance of the hearings, a claimant's opportunity for rebuttal is limited. Based on a survey of parents in the program, it appears that most of the parents (64 percent) whose cases went to hearing did not know that the panel was opposing them. Therefore, these claimants had no way to respond to the medical panel reviews at the hearing. The WCC should ensure that all claimants receive a copy of the medical panel report and permit a claimant ample time to prepare his or her case if the petition is being contested by the medical panel.

During interviews with the medical panels, it was noted that the deadlines are not always made clear to them. Part of this problem stems from how the medical panel review process evolved. Historically, the WCC accepted cases that were not disputed by the program before obtaining the medical panel opinion. As this practice became apparent, the medical panels began waiting to conduct their reviews until they heard from the WCC that a hearing date had been set. Instead of having a clear timeframe for completion at the time the panels received the petition, there would be no initial guidance from the WCC concerning when the panel's report was needed.

To eliminate confusion regarding deadlines, the medical panels should be required to submit their reports 30 days after receipt of the petition, rather than setting the date in reference to the hearing. Regardless of how the deadline is specified in the act, the WCC should communicate the deadlines to the medical panels as soon as possible to avoid future delays in getting those opinions to the WCC.

Recommendation (10). The General Assembly may wish to consider amending §38.2-5008(B) of the *Code of Virginia* to change the filing deadline for the medical panels from “at least ten days prior to the date set for hearing” to “30 days from the date the petition was filed at the Workers’ Compensation Commission.” The Workers’ Compensation Commission should clearly communicate the deadline for the medical panel reports in all cases that are sent to the medical panels for review.

Recommendation (11). The General Assembly may wish to consider amending §38.2-5008 of the *Code of Virginia* to require the Workers’ Compensation Commission to forward a copy of the medical panel report to all petitioners.

Changes Are Needed in the Process by Which Medical Schools Are Selected to Review Petitions. The *Code of Virginia* does not specify which medical schools should participate in the panel reviews. Rather, it says that all medical schools will participate in that process. However, the Eastern Virginia Medical School (EVMS) has not participated thus far. At a Medical Society of Virginia meeting attended by the current medical panels at MCV and UVA, as well as representatives from the Obstetrics/Gynecology Department at EVMS, EVMS indicated that they are willing to participate in the medical panel review process. Therefore, the WCC should begin to include them as soon as possible.

Currently, the panels alternate between MCV and UVA on a yearly basis. However, this may not be the most efficient way to rotate the cases, especially now that the WCC has indicated that medical panel opinions will be sought in all cases. In addition, now that EVMS will be participating in the reviews, there will be a three-year period between the reviews. This time lag could make it difficult for the panels to stay informed about the program and the logistics for handling these cases.

This problem could be corrected by alternating the medical panel reviews on a case-by-case basis instead of a yearly basis. In addition to preventing one panel from getting inundated with a large number of petitions in a particular year, this system will keep the panels in the practice of reviewing these cases and will ensure that they remain knowledgeable about the requirements of the process.

Recommendation (12). The Workers’ Compensation Commission should begin to incorporate Eastern Virginia Medical School into the medical panel review process.

Recommendation (13). The Workers' Compensation Commission should assign cases to the medical panels for review on a continuous rotation basis instead of alternating on a three-year cycle.

Consideration Should Be Given to Providing Compensation to the Medical Schools for Reviewing Petitions if the Number of Petitions Increases. A final issue relates to payment for the medical panel reviews. Based on historic rates of petition submissions, under the proposed process, each panel will be required to review three to four cases per year. If that number increases significantly, so that the panels are reviewing an average of one or more cases per month, for example, consideration should be given to compensating the obstetrics/gynecology department at each school for the time spent by their faculty reviewing these cases. This could be accomplished on a fee-per-case basis and could be paid from program funds or through a general fund appropriation.

Improvements Could Be Made to Assist Families Who Petition for Entry Into the Program

In addition to evaluating the role of the program and the medical panels during the eligibility process, JLARC staff assessed the remaining components of the eligibility process, in part, through surveys of parents and a review of WCC opinions. Based on this information, JLARC staff found that some improvements could be made to better assist families during the application process, as will be discussed in this section.

The Eligibility Process Could Be More User-Friendly for Parents. When asked to rate the difficulty level of the eligibility process at the WCC, about half (52 percent) of the families reported that the eligibility process was "somewhat difficult" or "very difficult." When asked to explain their ratings, several parents indicated that the process was confusing and the only guidance they received from the program was a copy of the act. Many of them did not seem to understand the role of each party involved in the process. For example, of those respondents who went through the hearing process, 73 percent did not know the program was opposing them. One parent commented:

It was not explained that the program would be against you with all of their medical experts. I felt totally humiliated and nervous to the point of not being able to represent our case. I was not prepared for this situation as it was not explained before hand.

In order to make the process more user-friendly for parents, the program could develop a basic hand-out that explains the hearing process in lay terms, including all deadlines and parties to the process. This hand-out could be supplied to all parties who inquire about the program. In addition, the program could also develop a fill-in-the-blank form for applicants, along with a checklist of the types of medical records the parent could attach to the form to ensure that a complete record of the case is submitted for review.

A review of the act by JLARC staff revealed two requirements of the petition process that could be eliminated altogether. Section 38.2-5004 of the *Code of Virginia* states that all claims filed at the WCC should include the following:

- i. Documentation of expenses and services incurred to date, which indicates whether such expenses and services have been paid for, and if so, by whom; and
- j. Documentation of any applicable private or governmental source of services or reimbursement relative to the alleged impairments.

Items i and j are clearly not needed to determine eligibility for the program. Further, this information has not been submitted to the WCC in many cases. Program guidelines give new claimants up to one year after being accepted into the program to submit requests for reimbursements of past expenses. Therefore, this language could be removed from the act to simplify that aspect of the petition process.

Recommendation (14). The Virginia Birth-Related Neurological Injury Compensation Program should develop an easy-to-understand hand-out that explains all aspects of the petition process. The Virginia Birth-Related Neurological Injury Compensation Program should also develop an application form for claimants who wish to apply to the program. Both documents should be sent to anyone who inquires about applying to the Virginia Birth-Related Neurological Injury Compensation Program. These documents should also be included on the program's website.

Recommendation (15). The General Assembly may wish to remove §38.2-5004(A)(i) and §38.2-5004(A)(j) of the *Code of Virginia* in order to streamline the process for submitting a petition to the Workers' Compensation Commission.

Hospitals and Physicians Should Be More Forthcoming in Supplying the Medical Records Needed to Apply to the Program. In addition to difficulties understanding the process and preparing the petition, most of the survey respondents reported that hospitals and physicians involved in their children's births were not helpful in providing information they needed to apply to the program. For example, one parent commented that getting the medical records from the hospital in which she gave birth "almost took an act of Congress." Several respondents indicated that hospitals would "lose" the patient records, especially the fetal monitoring strips, until a subpoena was served on the hospital. This problem is reflected in the following parents' comments:

The key evidence for our case was the fetal heart strip recordings. The hospital was not forthcoming with them. We had to have an attorney subpoena them.

* * *

[The] hospital tried to hide records. Would not release fetal monitoring strips until attorney threatened hospital administrator.

Because of the difficulty in proving oxygen deprivation without fetal monitoring strip documentation, it is essential that claimants have access to these records. To encourage better record-keeping and the appropriate release of medical records, cases in which the fetal monitoring strips are withheld or lost should be given a rebuttable presumption that they showed fetal distress. This may result in some cases being accepted into the program that would ordinarily be denied. To partially address this added cost, hospitals should be required to pay a fine to the program if they withhold a patient's records and the child is accepted into the program. The WCC could be given the authority to impose this fine for any case in which it finds that the child may not have been accepted, but for the presumption of fetal distress they received as a result of withheld records.

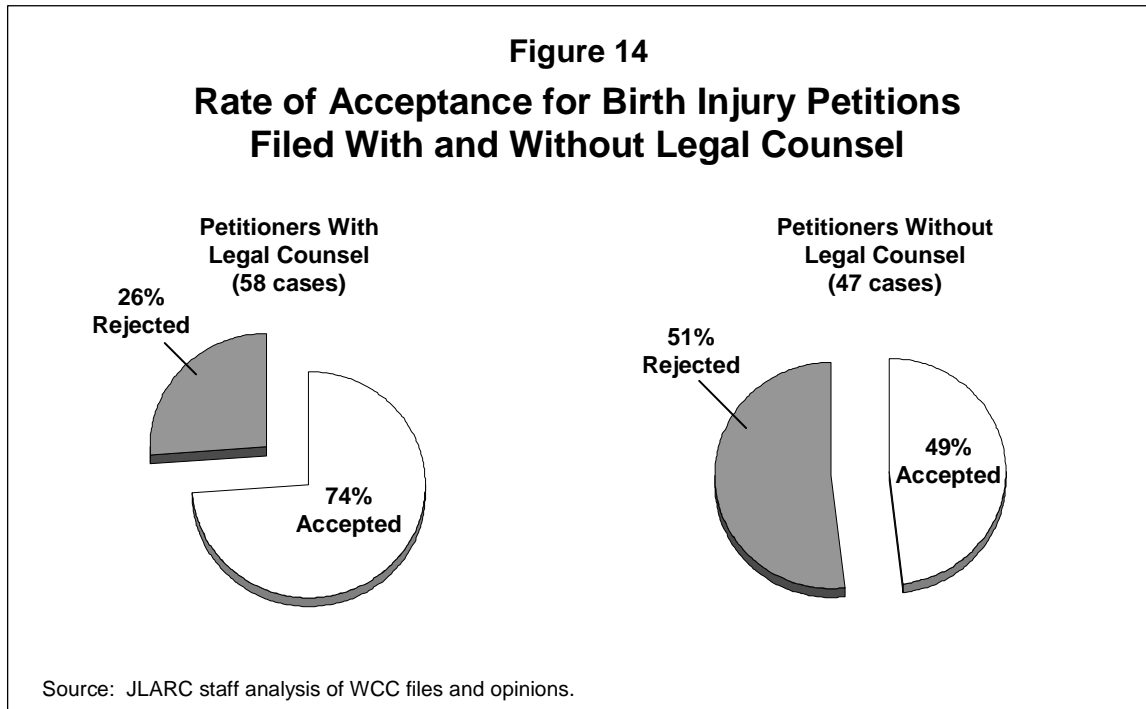
Recommendation (16). The General Assembly may wish to amend §38.2-5004 of the *Code of Virginia* to specify that hospitals are required to release all medical records, including fetal monitoring strips, to patients that plan to submit a petition to the Virginia Birth-Related Neurological Injury Compensation Program.

Recommendation (17). The General Assembly may wish to amend §38.2-5004 of the *Code of Virginia* to specify that claimants will have a rebuttable presumption of fetal distress in the event that fetal monitoring strips are not provided by the hospital.

Recommendation (18). The General Assembly may wish to amend §38.2-5004 of the *Code of Virginia* to specify that the Workers' Compensation Commission has the authority to require hospitals to pay a fine to the Virginia Birth-Related Neurological Injury Compensation Program in the event that a child whose records are withheld or lost is accepted into the program. The amount of the fine should be determined by the Workers' Compensation Commission and should be no more than the hospital's current participation assessment or the amount of the assessment if the hospital had participated.

Families Should Have Greater Access to Legal Representation During the Application Process. As shown in Figure 14, more than half of the applicants (55 percent) hired an attorney to represent them during the eligibility process. Of those applicants who hired an attorney, 74 percent were accepted into the program. However, of those applicants without attorneys, only 49 percent were accepted into the program.

One explanation for this finding is that applicants with stronger cases were more likely to find attorneys who would handle their cases. Legal fees are not paid when an applicant is rejected, which could make it difficult to find attorneys in more complex or weaker cases. On the other hand, it is possible that attorneys are better able to present these cases to the WCC and are more prepared to respond to arguments made by staff from the Attorney General's Office, which represents the program.



When asked whether attorneys are needed during the eligibility process, 76 percent of the parents responded that an attorney is needed. In addition to the belief that medical records are more easily obtained by an attorney, many of the respondents also indicated that they did not feel comfortable representing themselves without a legal background because of the economic stakes. As one parent noted:

I would not have attempted to construct a case to fit the narrow definition of a birth-related neurological injury. I would not have wanted to litigate against the Attorney General's Office without the benefit of counsel, had there been a dispute.

One reason for the lack of legal representation is that some families had a difficult time finding attorneys who would take their cases. One way to increase claimant access to legal counsel would be to permit the WCC discretion in awarding reasonable attorney fees for cases, regardless of whether or not the child is admitted into the program. To determine the financial impact of such a policy, JLARC staff examined orders for attorney fees in the WCC files for cases that were accepted into the program. This analysis revealed that the program has paid an average of \$4,000 in legal expenses for those cases. This figure includes an average of \$3,100 in fees and \$900 in expenses. If the program had paid for legal expenses in all 94 cases that were heard by the WCC, it would have cost them an additional \$88,000 or \$6,300 per year over the last 14 years. This is a relatively small amount of money to help ensure that families have adequate representation during the application process. To reduce the likelihood that frivolous petitions will be submitted, the General Assembly could direct the WCC to limit the award of legal fees so that only those cases that appear to be filed in good faith receive such compensation.

Recommendation (19). The General Assembly may wish to consider granting the Workers' Compensation Commission discretion to award rea-

sonable attorney fees and expenses for cases filed in good faith, regardless of whether a child is accepted into the Virginia Birth-Related Neurological Injury Compensation Program.

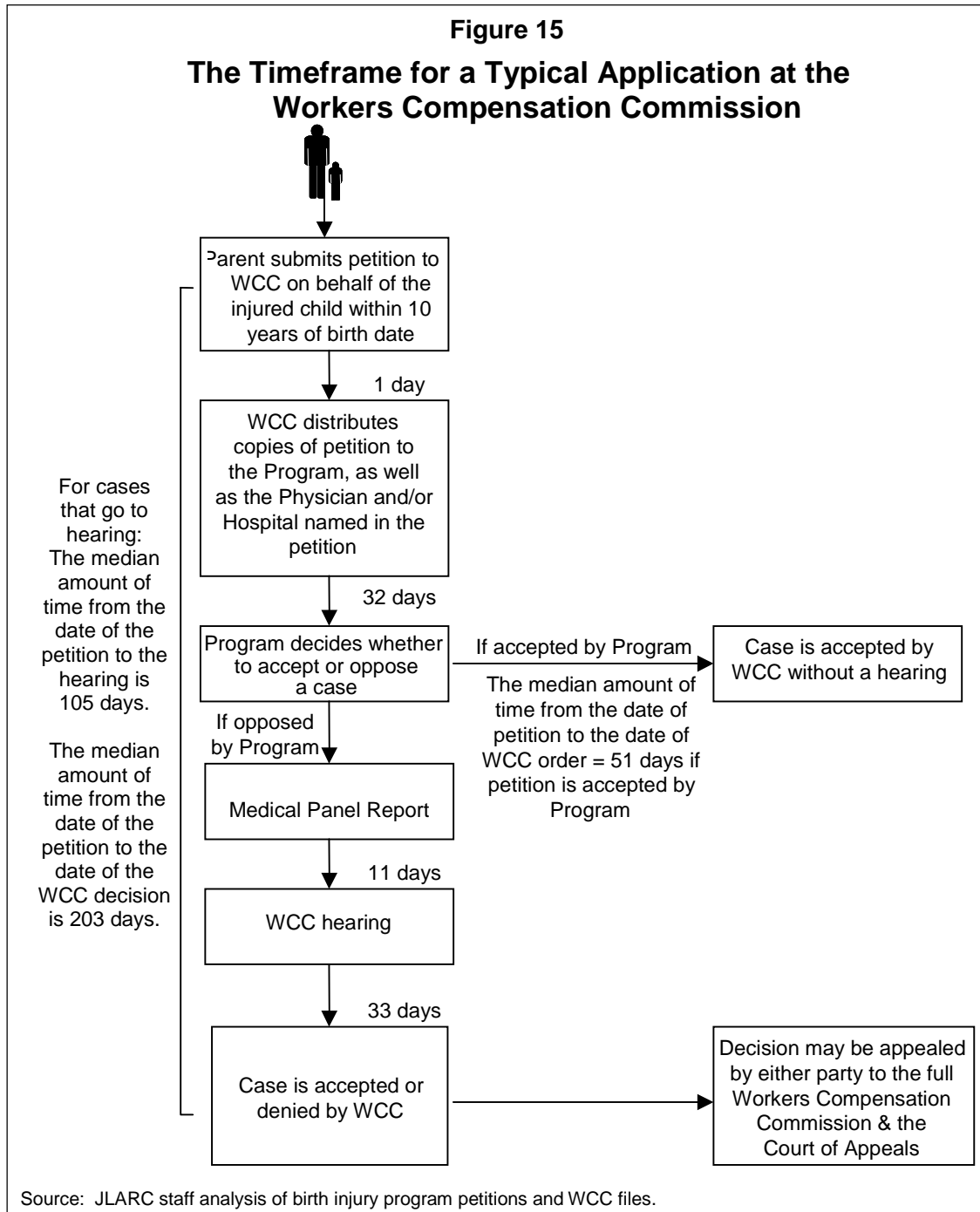
Eligibility Hearings Should Remain at the WCC

Some critics have argued that the WCC is not the appropriate venue for handling the birth injury cases. In fact, HB 714 (2002) proposed that the circuit courts hear these cases instead of the WCC. WCC staff have stated that the birth injury cases are different than the workers' compensation cases they typically hear, but they also point out that they are accustomed to reviewing the type of medical testimony that must be considered in the birth-injury cases. In addition, opponents of HB 714 (2002) contend that shifting the hearings to the circuit courts would contribute to inconsistent rulings, making it likely that similar cases would be handled differently across the Commonwealth.

To determine whether the WCC has handled the birth injury cases in an appropriate manner, JLARC staff reviewed WCC files and opinions. In addition, JLARC staff also examined cases that were appealed to the full Commission and the Virginia Court of Appeals. The results indicated that the WCC process generally has been quite efficient. In addition, reversals of WCC decisions have been rare. Although the WCC should be more stringent in its enforcement of deadlines, it appears that the WCC has done an adequate job of handling the birth injury cases overall. Given the WCC's performance, there appears to be no need to change the venue for hearing birth injury cases.

The Hearing Process Is Generally Timely. As shown in Figure 15, the median amount of time between the date the petition is filed and the date of the WCC decision is about 78 days or 2.6 months. However, there is a fairly large discrepancy between cases, depending on whether they go to hearing. Cases that do not go to hearing (69 percent of all petitions) are resolved in 51 days or 1.7 months, on average. Cases that do go to hearing (31 percent of all petitions) are resolved in an average of 203 days or 6.7 months. As mentioned in Chapter II, this process clearly results in families receiving assistance for their birth-injured infant sooner than if they pursued a medical malpractice lawsuit.

Despite the relatively short application process, problems were found regarding the extent to which the statutory deadlines were followed. First, the program did not meet its 30-day deadline for responding to petitions in a majority (66 percent) of the cases. While the median number of days by which the deadline was missed was only one day, when such deadlines are not enforced, it creates the perception that the program is receiving special consideration by the WCC and that the requirements in the *Code of Virginia* are unimportant. In addition, while some of these delays were due to legitimate problems in obtaining the necessary medical records for case reviews, many program responses were submitted late with little explanation.



The 120-day deadline for the hearing at the WCC was not met in 23 of the 34 cases (68 percent) in which there was a hearing. The median number of days in which the hearing deadline was missed was 25 days. When asked about these delays, the Chief Deputy Commissioner stated that the most common reason for delaying a hearing past the 120-day deadline was the inability to schedule a time when all parties could be present. While some such delays are to be expected, the WCC should take steps to ensure as speedy a process as possible.

Recommendation (20). The Workers' Compensation Commission should enforce all deadlines for the birth injury cases.

Reversals of WCC Opinions Have Been Rare. Of the 34 cases that went to hearing, seven (21 percent) were appealed to the full Commission and three (9 percent) were appealed to the Virginia Court of Appeals. Four of these cases (12 percent) were overturned on appeal, but one of the reversals was based on a change in the *Code of Virginia*. Therefore, only three decisions (9 percent) were overturned based on errors of law. In all three cases, a failure to rebut the presumption was cited as the reason for the reversal. This finding reflects positively on the soundness of the WCC decisions.

MEDICAL REVIEWS OF PHYSICIANS AND HOSPITALS

As required by §38.2-5004 of the Virginia Birth-Related Neurological Injury Compensation Act, the submission of a birth injury petition to the Workers' Compensation Commission triggers a review of the petition by the Board of Medicine and the Virginia Department of Health (VDH). The Board of Medicine is required to assess whether the physician(s) involved in the petitioner's birth provided substandard care that would warrant disciplinary action by the Board of Medicine. The VDH reviews the petition to determine whether the hospital and its staff provided inadequate medical care that should impact the hospital's license.

The Board of Medicine reviews are the only mechanism for identifying and disciplining physicians who have provided substandard care in these birth injury cases. While a physician who is found negligent through the tort system has at least been held accountable to the extent that he/she receives a claim against his record and the claim is reported to the National Practitioner Data Bank, no corresponding actions occur with birth injury program cases. As such, it is critical that the Board conduct thorough reviews of these cases. While the hospital reviews by VDH are also important, hospitals are subject to an extensive licensing review and other on-site evaluations at least biennially. Therefore, there are other avenues for identifying problems with the obstetric care performed by hospital staff.

JLARC staff reviewed the Board of Medicine and VDH records pertaining to birth injury petitions and found that minimal investigations of the circumstances surrounding the birth events were conducted. In the vast majority of cases, the agencies read the petitions but conducted no further investigation. Steps should be taken by the Board of Medicine and VDH to conduct more thorough investigations of these petitions and to communicate the results to all the affected parties.

Medical Reviews Need to Be Strengthened

When the provisions of the birth injury act were being considered in the mid-1980s, concerns were raised that physicians would not be held accountable for negligent acts occurring during the birthing process. While most of these cases may not involve medical malpractice, the act included the requirement that the Board of Medicine review all birth injury petitions as a way of identifying and disciplining

negligent physicians, in part to alleviate this concern. Specifically, §38.2-5004 of the *Code of Virginia* states that:

Upon receipt of the petition, the Board of Medicine shall evaluate the claim, and if it determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care on the part of the physician, it shall take any appropriate action consistent with the authority granted to the Board in sections 54.1-2911 through 54.1-2928.

Section 38.2-5004 also requires VDH to review the petitions to determine if there was substandard care provided by the hospitals. No physician or hospital has been sanctioned as a result of these reviews.

Most Reviews Are Limited to Reading the Petition. In most cases the reviews conducted by the Board of Medicine and VDH consist of reading the petitions, which include the medical records for each birth. According to staff at the Board of Medicine, the petition is first read by an enforcement case intake analyst. This staff person then identifies a recommended finding for consideration by the Board. The executive director and Board of Medicine chairperson also read the petition, and the Board chairperson makes the final determination regarding case closure.

In rare cases the Board may conduct a more detailed investigation of the petition. Of the 63 case files reviewed by JLARC staff, Board of Medicine staff conducted follow-up interviews related to four of the births. In one of these cases, however, the formal investigation was conducted only because a separate anonymous complaint had been filed about the same birth event.

One of the petitions reviewed by Board of Medicine staff was initially recommended for closure as “no violation” of the standard of care. However, when the chair of the Board of Medicine subsequently reviewed the petition, he asked the Board staff to check on a previous complaint that had been filed against the physician. Upon examining the other complaint, the staff person found that an anonymous complaint had been filed pertaining to the same birth event. For the anonymous complaint, Board staff had contacted four people involved in the birth, including the mother, and had prepared a formal investigative report. It is clear that the Board did not intend to conduct any interviews with parties involved in the petition had the anonymous complaint not been filed.

Based on the Board of Medicine reviews, all of the cases have been closed with a finding of either “no violation” or “undetermined.” According to Board staff, the finding of “undetermined” is used when a problem may be found but that one case alone is not enough to constitute a violation based on the Board’s standard for violations. “Undetermined” cases can be used in subsequent reviews in examining whether a pattern of substandard care exists that would warrant Board action. With a finding of “no violation,” the case cannot be examined again in conjunction with later cases to determine if any pattern of substandard care exists. Of all the

reviews conducted by the Board of Medicine, 13 cases have been closed as “undetermined.” The remaining cases were closed as “no violation.” JLARC staff examined eight of the “undetermined” cases and found that no additional follow-up investigation was conducted in any of these cases beyond the review of the petitions.

It was generally not possible to identify the reason for the Board’s findings in each case, based on the JLARC staff review of Board files. Of the 63 Board review files examined by JLARC staff, only 12 contained any indication of the intake analyst’s recommendation, and very few files contained any documentation supporting the conclusion of any of the reviewers. In addition, documentation was not included in most of the files to reflect that the intake staff routinely checked Board records for past cases that may have been filed against the physicians involved in the birth injury petitions.

In addition to the Board of Medicine reviews, a staff person within VDH’s Center for Quality Health Care Services and Consumer Protection reviews the birth injury petitions to determine whether there was substandard care on the part of the hospitals involved. Most of the records pertaining to birth injury petitions at VDH have been thrown away, and therefore, JLARC staff’s review of VDH’s petition review process was limited. However, VDH staff were able to provide some of the information from the birth injury files, including a log of the petitions they have reviewed, the findings of the reviews, and some miscellaneous correspondence related to individual petitions.

The documentation provided by VDH reflects that it conducted six site visits to hospitals and requested at least one written response from a hospital regarding the petitions it reviewed. However, in most cases the VDH staff person concludes her review after reading the petition, in consultation with another staff member who has a background as an obstetric nurse practitioner. VDH staff reported that most concerns they identify relate to the physician care given rather than the hospital care. No licensing actions have been taken by VDH based on these cases.

Gross Negligence Standard Limits Disciplinary Actions That May Be Taken by the Board of Medicine. One factor that may be limiting the Board of Medicine’s actions with regard to birth injury petitions is the standard used in determining whether a physician can be disciplined for providing substandard care. Based on §54.1-2914 of the *Code of Virginia*, the Board of Medicine can take disciplinary action against a physician when his actions are grossly negligent or a danger to the health and welfare of his patients. As previously cited in a 1999 JLARC staff report, *Final Report: Review of the Health Regulatory Boards*, the result of this high threshold for deciding standard of care cases is that almost all such cases are closed without a hearing. This report noted that no other health regulatory board in Virginia has such a high threshold for deciding standard of care cases.

According to the Board of Medicine staff, one way by which gross negligence can be established is if there is a pattern of negligent acts by a physician. However, as described in the 1999 JLARC study, a pattern is not likely to be established under the board’s current policies. The 1999 study found that the board closes most of the standard of care cases after investigation as having “no violation.” Cases closed with this designation cannot be used in the future to establish a pattern of negligent acts

even if additional complaints are received against that physician. As mentioned earlier, the current study found that the vast majority of birth injury petition reviews are likewise closed with a finding of “no violation.”

According to discussions with various physicians and review of medical literature, severe birth injuries as defined in the birth injury act are very rare and are typically perceived as a “once-in-a-lifetime” event for a physician. However, the current study found that there are six physicians who were each involved in delivering the babies named in two birth injury petitions. With each physician, the outcome of the first petition resulted in a finding of “no violation.” While, in fact, there may have been no negligence in these cases, because of the Board of Medicine policy, review of the subsequent petition could not even consider the first birth petition in determining whether there was a pattern of negligence.

In addition, there is one physician who has been named as the attending physician in three birth injury petitions, as the following case example describes.

One particular physician was never thoroughly investigated, even after a third birth injury petition in which he was the attending physician was submitted to the Workers’ Compensation Commission. In the first case, the Board of Medicine closed the case as “undetermined.” Therefore, based on Board policy this case could be considered in future cases involving the physician. However, there is no indication from the records in the second case that the Board of Medicine checked for previous cases filed against this physician. In the third case, the Board staff did check their records for past cases against this physician, but apparently erroneously recorded the first case as having found “no violation.” In each of these cases, the Board of Medicine’s review consisted of a reading of the petition only. No additional investigation was conducted, such as interviews with the patients involved. Based on the JLARC staff survey of claimant families, JLARC staff found that in the two most recent cases involving this physician, the claimant families believe that the events surrounding their babies’ deliveries involved malpractice on the part of the physician.

These cases raise concern regarding whether the Board of Medicine’s reviews are adequate for detecting negligent actions by the physicians involved in birth injury petitions. This is particularly disturbing since, as mentioned previously, these reviews are the only means for holding negligent physicians accountable in these cases, because remedy through the tort system is foreclosed.

At a Minimum, Families of Petitioners Should Be Interviewed As Part of the Medical Reviews. Staff of the Board of Medicine reported that review of the medical records contained in the petition is the appropriate means for determining whether the standard of care was met. Staff said that by examining the physician’s notes that are part of the medical records, Board staff can assess the steps taken by the physician in handling the birthing process and can determine whether those steps were appropriate. However, these records may not contain

relevant information on all the events that did or did not occur during the birthing process. For example:

One mother reported that during labor, she felt a sudden stabbing pain even though she had an epidural. According to medical literature this can be a sign of a placental abruption, after which the baby may be deprived of oxygen. She reported this intense pain to the nurses and her physician, but no action was taken. This mother reported that she begged her physician to have a c-section, as she had had with a previous birth; however, the physician wanted to continue with a vaginal birth. By the time a c-section was performed, the baby was stuck in the birth canal, further delaying the baby's delivery. These events were not recorded in the mother's medical records by the attending physician. However, they should have been considered by the Board of Medicine in determining whether the physician took adequate steps to safely deliver the baby.

The medical records typically contain notes from the attending physician and nurse(s) concerning the birth events. However, since the claimant families are not contacted as part of these reviews, potentially relevant information from the patient is not obtained. In contrast, with other medical complaints received by the Board of Medicine – those submitted directly from the public, the patient is routinely contacted.

Instead of relying solely on the petition, the medical reviews should, at a minimum, also consider information obtained from patient families involved in these petitions. Obtaining the firsthand accounts will provide a more complete picture of the events surrounding the birth from which to reach conclusions regarding any wrongdoing on the part of the physicians and hospitals. VDH staff specifically noted that discussions with the parties involved would be helpful in their reviews.

Currently, there is no coordination between the Board of Medicine and VDH concerning their reviews. To efficiently collect information from the patients in these reviews, Board of Medicine and VDH staff could work together to develop a process for interviewing claimant families and sharing that information between the agencies. However, a statutory change may be needed to allow the agencies to share this information. To the extent that the concerns raised by the claimant families are not addressed in the medical records, the physicians and other parties involved in the birth should also be interviewed.

Recommendation (21). As part of their reviews of birth injury petitions, the Board of Medicine and Virginia Department of Health should routinely interview the claimant families on the events surrounding the births.

Medical Review Findings Are Not Communicated to Birth Injury Program Petitioners

Both the Board of Medicine and VDH report the findings from their petition reviews to the executive director of the birth injury program. In addition, the Board of Medicine sends a letter of its findings to the physician(s) involved in each birth. Typically, these letters state that a review has been conducted and no violations have been found. Staff of these agencies reported that they perceive the birth injury program to be the source of the petition for investigation purposes.

Neither agency reports its findings to the families of the birth-injured children. As a result, a number of the claimant families were unsure whether a medical review had been conducted. As reported by one claimant family:

In our case, if the records were referred to the Board of Medicine and even a casual investigation conducted, we weren't informed of it.

Staff of the birth injury program have stated that they are not involved in issues surrounding the adequacy of the medical care received by the claimants, and therefore, do not need to be notified about the findings of the medical reviews. In contrast, many of the claimant families are very interested in the medical review findings pertaining to their own birth events. Since claimant families submit the petitions to the WCC, for distribution to the Board of Medicine and VDH, it is the claimants' actions that precipitate the Board and VDH reviews. Accordingly, the Board of Medicine and VDH should immediately begin notifying claimant families concerning the outcome of the medical reviews.

Recommendation (22). The Board of Medicine and Virginia Department of Health should routinely notify each claimant family concerning the outcome of the respective medical reviews.

Board of Medicine and VDH Do Not Receive All Birth Injury Petitions for Review

While the Board of Medicine and VDH have reviewed most of the birth injury petitions, there are some cases for which reviews were not conducted. In a few cases there is a record at the WCC that petition copies were sent to the Board of Medicine and/or VDH, but there is no record of these agencies having received the petitions. In other cases, it appears that the petitions were not submitted to the Board of Medicine and VDH for review. For example, there have been five petitions since 2000 that the Board of Medicine and VDH never received. In addition, VDH does not have a record of having received one additional petition that the Board of Medicine did receive. Four of these petitions involved cases that were transferred from circuit court.

Because of the contentiousness of court proceedings, the WCC often has difficulty obtaining complete petitions in cases transferred from court. Since the transfer of cases is typically sought by the physicians and/or hospitals, the families of the

birth injured children have no interest in ensuring that a formal petition is submitted, and therefore, it becomes the responsibility of the physicians and hospitals to gather the medical records for submission to the WCC. In these cases it appears that the WCC has not required enough copies of the medical records be submitted in order to provide copies to the Board of Medicine and VDH.

By virtue of these cases originating in court, the families in these cases clearly believe that there are malpractice issues involved in the birth of their children. Therefore, it is important that the Board of Medicine and VDH conduct reviews of these cases.

Steps need to be taken by the WCC to ensure that the Board of Medicine and VDH receive all petitions so that the proper reviews can be conducted. One option would be for the WCC to provide electronic mail notification that a petition is being sent to the Board of Medicine and VDH. These agencies should then be responsible for notifying the WCC if they do not receive the petition within a week of being mailed.

Recommendation (23). **The Workers' Compensation Commission should develop a plan for ensuring that all birth injury petitions, whether directly submitted by families of birth-injured children or transferred by the circuit court, are submitted to the Board of Medicine and Virginia Department of Health for review.**

V. Program Administration

As part of its review of the Virginia Birth-Related Neurological Injury Compensation Act, JLARC staff examined the basic administration of the program. One of the important responsibilities of the program is to notify obstetric patients about the program. The program has attempted to carry out this mandated obligation by providing brochures to participating doctors and hospitals for distribution to patients, but such efforts have not been effective thus far. An informed consent process may be needed to ensure that obstetric patients are aware of the program before they receive care from participating physicians or hospitals.

JLARC staff also assessed a number of other issues related to program management and services. While basic service provision to families in the program has been adequate in many respects, a lack of detailed written policies and procedures has resulted in the appearance of, if not actual, inconsistencies in the provision of benefits. Policies and procedures in other areas of the program, including personnel issues, have also been lacking. Furthermore, the program has operated with very little oversight since its inception. The program was created by the General Assembly and it serves a public purpose. As such, it should operate under the normal practices of other public operations – that is, in the “sunshine” – and should be subject to the Freedom of Information Act (FOIA) and other regulations that would enhance accountability.

NOTIFICATION OF OBSTETRIC PATIENTS

The *Code of Virginia* requires the program to inform obstetrical patients about the program. In order to determine whether the program is meeting its mandated obligation, JLARC staff interviewed board members and program staff to identify current strategies for making the program known to potential claimants. In addition, parents in the program were asked to specify how and when they found out about the program to see which methods of notification were most common. Parents were also asked to assess the adequacy of written material they received before they were accepted into the program. Finally, participating physicians and hospitals were surveyed to find out whether they notify their patients about the program.

It appears that the program has not been effective in its attempts to notify obstetrical patients about its existence. Although the program has supplied brochures to doctors and hospitals for them to distribute to patients, most of the parents indicated that they were not informed about the program through this mechanism. In fact, the most common source of information about the program was an attorney, which suggests that many families do not find out about the program unless they pursue a medical malpractice lawsuit. To ensure that participating doctors and hospitals provide information about the program to their patients before they receive services, participating obstetrical providers should be mandated by the act to obtain informed consent regarding program participation from all obstetrical patients under their care.

The Program Has Not Met Its Obligation to Inform Obstetrical Patients of Its Existence

In 1994, the following language requiring the board to inform obstetrical patients about the program was added to the act:

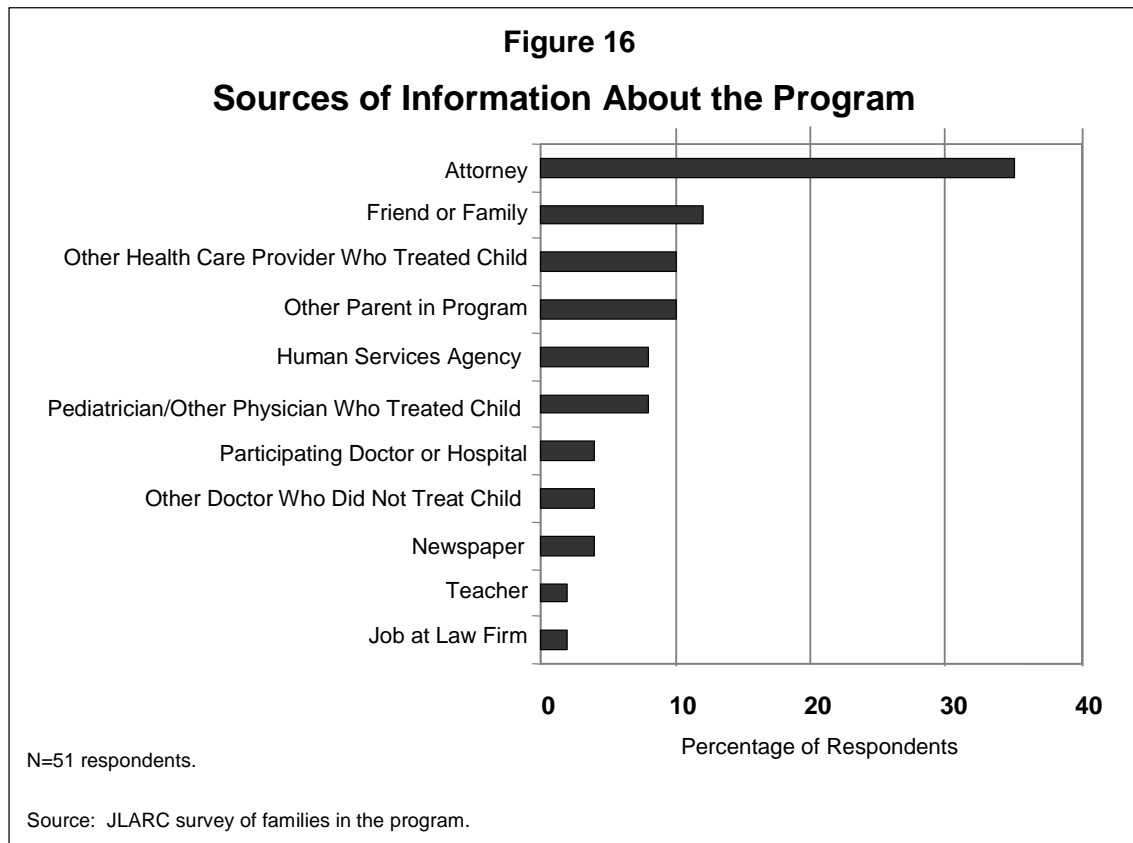
No later than October 1, 1994, the board shall establish a procedure in the plan of operation for notice to be given to obstetrical patients concerning the no-fault alternative for birth-related neurological injuries provided in this chapter, such notice to include a clear and concise explanation of a patient's rights and limitations under the program.

To address this mandate, the program developed a brochure which briefly explains the program. Historically, the program has sent a small supply of these brochures to participating doctors and hospitals to be distributed to obstetric patients. Although some of these doctors and hospitals reportedly contacted the program to obtain additional brochures, it appears that many stopped distributing them once they ran out, perhaps because there was no clear mechanism in place for them to obtain a new supply. In September 2002, brochures were again sent out to all participating physicians and hospitals. However, this year the brochures were accompanied by a letter stating that it is the physician's responsibility to order new brochures as needed, as well as a fax form for ease of ordering.

Despite the program's efforts to notify patients through participating doctors and hospitals, it appears that very few families in the program were notified through that process. For example, when parents were asked to specify on the JLARC survey how and when they found out about the program, only one of the 50 families who responded to the survey indicated that they knew about the birth injury program before their child's birth. Of the remaining parents, the age of the children at the time they found out about the program ranged from one month to over nine years. On average, families did not learn about the program until their child was two years old.

In addition, as shown in Figure 16, the most frequent source of information about the program was an attorney. This finding suggests that many families did not find out about the program until they pursued a medical malpractice case. Notably, very few families in the program were notified of its existence from the physician who delivered the child or staff from the hospital in which the child was delivered.

Based on these findings, it appears that the program's efforts to notify parents through participating obstetricians and hospitals have been ineffective. Further, the brochure developed by the program inadequately explains the patients' rights and limitations under the program. Of the 23 parents who reported on the JLARC survey that they received the brochure before applying, many (61 percent) stated that it did not adequately explain the program. A review of the brochure revealed that it provides only a brief statement that the program is an "exclusive remedy," which may not be fully understood by all obstetrical patients who read it.



Patients need enough information to make an informed decision about whether they want their infants covered by the program. The brochure should be revised to ensure that patients are provided with an adequate description of the program. Revisions should include a more detailed explanation about the no-fault nature of the program and the fact that patients give up their right to sue their doctors in the event of a qualifying birth injury in exchange for participation in the program. The brochure should also provide explicit directions for finding out whether a specific physician and hospital participate in the program.

Recommendation (24). The Virginia Birth-Related Neurological Injury Compensation Program should revise the current brochure to better explain the patients' rights and limitations under the program, especially the "exclusive remedy" provision.

Participating Doctors and Hospitals That Do Not Obtain Informed Consent Should Lose Protection from Lawsuits

According to JLARC's survey of participating doctors, most (77 percent) indicate that they do not routinely notify patients about the program. When asked to explain why they do not discuss the program with patients, many of the physicians indicated that they do not want to unnecessarily alarm their patients. Other physicians noted that a discussion of the program is simply inappropriate because they view the program as a form of medical malpractice insurance. Physician comments from the survey include the following:

I have not found a simple way to notify my patients about the fund without completely terrorizing them.

* * *

...there is no need to unnecessarily scare patients about possible, but rare adverse outcomes.

* * *

I believe it is inappropriate to discuss resolutions to “bad outcomes” routinely. I generally propose good outcomes and want the patient to feel I am confident. If a “bad” outcome arises I will discuss the use of the Birth Injury Program.

* * *

Topic not discussed unless indicated by outcome or clinical course. Nor do I discuss malpractice coverage, premiums, or their views on retribution if outcome is less than expected.

Concerns that patients may be unnecessarily alarmed by a discussion of the program are understandable, but the basic fact remains that through the physician’s and/or hospital’s participation in the program, patients automatically give up their basic right to sue in the limited circumstances covered by the program. Fundamental fairness dictates that the patient be informed of this fact ahead of time. It is also reasonable and appropriate for the patient to be informed of the benefits or advantages of the program that would be available in the unlikely event that a negative outcome arises.

Given that the current system has proven ineffective for notifying obstetrical patients about the program, a requirement for informed consent is needed to strengthen this process. In addition to providing patients with the opportunity to opt out by seeking non-participating providers, an informed consent process would guarantee that those claimants who choose to remain with a participating doctor or hospital do not circumvent the program based on the argument that their right to file a lawsuit was abrogated without their knowledge. In Florida, cases based on this argument were successful. This prompted a change to the Florida statute in 1998 requiring that physicians provide notice of program participation to all obstetrical patients. Staff from the Attorney General’s Office are not aware of any such claims thus far in Virginia, but it is always possible that a family will make this argument in the future to avoid the program in favor of a lawsuit. Obviously this would defeat the purpose of the program. In addition, based on discussions with participating physicians who do notify their patients about the program on a routine basis, it appears that this type of disclosure has not caused the anticipated problems noted above.

An informed consent process could simply involve each patient of a participating hospital or doctor signing a form that acknowledges their receipt of the revised program brochure. For participating hospitals, obstetrical patients should be informed about the program when they pre-register. The informed consent process by participating doctors should take place at the first prenatal visit. For doctors who

do not wish to be involved, this procedure could be handled entirely by administrative staff who process other routine paperwork for patients, such as verification of insurance information. Patients with questions about the program could be directed to call the program to remove the burden on doctors and hospitals to become familiar with specific details of the program. The consent form should include the effective dates of program coverage since doctors and hospitals may change their participation status from year to year.

Although this process should be effective in notifying most affected patients, it will not ensure that all obstetrical patients are notified about the program in advance. For example, some patients do not receive regular prenatal care. In addition, those patients who do receive prenatal care may not be seen by their regular obstetrician when they go into labor because a different doctor in the practice may be on-call at the time. Finally, some obstetrical patients do not pre-register at a hospital, especially if they go into labor prematurely. Despite these limitations, this process is a better mechanism than the current one for ensuring that most obstetrical patients are notified about the program in advance.

To encourage compliance, doctors and hospitals that do not obtain informed consent should lose protection from lawsuits covered by the act. For cases in which informed consent is not possible, however, a participating physician should not be penalized and should receive immunity from lawsuits, as written in the act. (For example, this might include cases in which a patient must have an immediate c-section, and is treated by a physician other than her regular ob/gyn.) Non-participating doctors and hospitals should not be required to notify patients about the program because the usual remedy of a lawsuit is still available in the event of a birth injury.

Recommendation (25). The General Assembly may wish to consider amending the *Code of Virginia* to eliminate the exclusive remedy provision for participating physicians and hospitals that fail to notify obstetrical patients about the Virginia Birth-Related Neurological Injury Compensation Program, except for cases in which the patient has an emergency medical condition or when such notice is not practicable.

Additional Steps Could Be Taken to Identify Birth-Injured Children

Because current strategies of notifying obstetrical patients about the program are weak, there are likely to be a number of birth-injured children born over the past ten years whose families still do not know of its existence. Therefore, even if the informed consent process becomes a requirement for participating doctors and hospitals, the program should pursue other ways of identifying children who may qualify for the program.

One approach the program could take is to provide information to pediatricians and other health care providers that specialize in treating children with disabilities, such as the Kluge Center in Charlottesville and the Children's Hospital of the King's Daughters in Norfolk. In addition to making potential referrals to the

program, these providers could also help to advertise the program by placing brochures in their waiting rooms.

Participating hospitals could also increase awareness of the program by making sure that staff in Newborn Intensive Care Units (NICU) and other areas of the hospitals that treat children are informed of the program. Currently, not all of these staff members are even aware of the program. For example, when participating hospitals were surveyed regarding their participation in the program, one NICU nurse who was asked to complete the survey did not know the program existed. Clearly, hospital staff are a valuable source of referrals and should be informed about the program so they can make families aware of its existence.

Recommendation (26). The Virginia Birth-Related Neurological Injury Compensation Program should develop a strategy for informing pediatricians and other health care providers that come into contact with disabled children about the program so that they can make potential referrals and distribute program brochures.

PROGRAM MANAGEMENT

JLARC staff examined issues related to general management of the program through a review of program policies, surveys of families in the program, interviews with staff from the Attorney General's Office, and interviews with program staff and board members. This review revealed a number of management problems. One issue has been poor administration of program benefits. The housing benefit, for example, has been particularly problematic due to the inconsistent manner in which it has been defined by the board.

To address problems related to management of benefits, the program should revise the guidelines to make the benefits as specific as possible, and then ensure that these guidelines are applied consistently to all claimants in the program. The program also needs to plan ahead for the lost wage benefit to ensure that it does not impact eligibility for other government benefits that would be advantageous to the program and the families. Finally, to increase accountability, the program should be subject to governmental regulations that enhance public disclosure.

Benefits Have Not Been Well-Managed

One of the most contentious issues with the program is the administration of program benefits. Based on surveys of parents, interviews with program staff and board members, a review of board meeting minutes, and a review of the program guidelines, it appears that benefits have not been appropriately managed. First, there were no written guidelines describing the benefits for the first nine years of the program's operation. Even after benefit guidelines were developed, however, they were incomplete and inconsistently applied. The housing benefit, especially, has resulted in large benefit disparities between claimants, depending on when they entered the program, and is inequitable to non-homeowners. Finally, the lost wage benefit offered to claimants once they turn 18 years old also has the potential to be problematic for the program if it does not plan ahead.

Benefit Guidelines Are Incomplete. Three basic problems with the program's benefit guidelines were identified. First, the guidelines changed frequently without adequate notice to claimants. Second, there is a lack of specificity with the guidelines. Third, there appears to be a lack of consistency in administering the benefits.

Based on results of the parents' survey, it appears that many claimants in the program do not have a current set of benefit guidelines. Of those parents who responded to the JLARC survey, almost half are still referring to guidelines dating back to 2000 and prior. Thus, it is not surprising that over half of the claimant families who responded to the survey do not feel that they are adequately informed of changes in program policies, procedures, and other relevant program issues. The perception among families is that benefits change frequently, and that the program does not update them on these changes in a timely manner. The following quotations taken from the survey responses illustrate this concern.

Policies are changed by the board and families are not sent new guidelines to reflect these changes. Families are not notified when board members change, office staff members replaced.

* * *

If there were guidelines as to what is covered maybe we wouldn't have to redo paperwork or we would not be sending in for reimbursement for things not allowed. For example, for two months I had no nursing available so I was told to find anyone that was not a family member and did not live in the household and they could be paid. I could not find anyone so I asked my close friend who does not live in the household nor is a family member, paid them, and then was told they weren't allowed to be reimbursed as they were a close friend. I have had many situations where one person at the program tells you one thing and then the other tells you a different answer. They need to all have a meeting and discuss what is allowed so they will all be giving the correct answer.

* * *

...families have not been apprised of current and ever evolving policies. In this climate of policy du jour, large inequities have been created among families, thereby fostering a climate of frustration, cynicism, and anger. Examples of inequities we have witnessed include: earlier vans were inadequate; some families have trust homes, some have house modifications; therapeutic toy allowance was \$1000, then \$0, and now \$300 (Or last correspondence is \$0). Expenses for nurses to go on trips or vacations were paid for some families and not others. We were told that no expenses would be paid.

* * *

Rather than the Fund openly sharing all the benefits with you, they wait until you find out or ask for a particular benefit. Policies

and procedures were at the Fund interpretation, not always what they said.

* * *

We were accepted into the Program in 1994 and we received Program guidelines in April 1997.

Some benefit policies that had been approved by program staff or the board in the past were never incorporated into the guidelines manual distributed to families.

A case in point is vacation expenses for nurses who go on vacation with claimant families. In previous years, the program paid all expenses for nurses that went on vacations with families. This has included hotel accommodations, food, transportation, and tickets to amusement parks or other family activities. The current policy is that the program will pay for the nurse's hourly wage only. Additional expenses related to the trip are no longer covered. The program has developed a form letter to address this type of request, but is only sending it out if a claimant submits a request instead of notifying all claimants about the policy. This is the type of specificity that is needed in the guidelines.

The majority of families in the program also do not believe benefits are provided in a consistent manner. For example, when asked whether they agreed or disagreed with the statement, "The program exercises consistent decision-making regarding benefits while considering the individual needs of each child," only 29 percent of the families who responded to the JLARC survey indicated agreement.

As discussed earlier in this report, the board of directors historically has spent a large portion of its time at board meetings making benefit decisions, many of which have been deferred by program staff due to lack of policy or precedent. The reason for the board's focus on this responsibility may be that the existing benefit guidelines offer only a broad policy description of the various benefit categories.

While it is understandable that in the early years of the program, it would have been difficult to anticipate many of the types of benefits that families would request, the program now has 15 years of experience from which to draw in establishing program policies. Although the program cannot account for every possible request that may be reasonable, they should now be in a position to develop a set of comprehensive guidelines regarding benefits. Developing, maintaining, and implementing an updated and complete set of benefit guidelines would provide a useful tool that the program could use in managing its budget with regard to claimant benefit distribution. Also, it would reduce the likelihood of inconsistent policy interpretation in benefit decision-making, which in turn would help to increase the credibility of program staff and board decisions among claimants requesting benefits. Program staff are reportedly in the process of drafting updated guidelines, and expect to present them to the board for approval sometime in 2003. During this process, program staff and the board should strive to develop guidelines that are more

comprehensive than those issued in the past to minimize the level of confusion that currently exists vis-à-vis program benefits.

Recommendation (27). The Virginia Birth-Related Neurological Injury Compensation Program should develop an updated and comprehensive set of program guidelines. These guidelines should be provided to all families currently in the program and should also be posted on the program's website.

The Program's Policy on Housing Needs Modification. Perhaps the most inconsistently defined benefit of the program has been the housing provision. In §38.2-5009 of the *Code of Virginia*, it states that claimants are entitled to the following benefits:

Actual medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel, such expenses to be paid as they are incurred.

The "residential and custodial care" portion of the act has been interpreted by some to mean that the program should provide a housing benefit.

The program has, in fact, offered a housing benefit to many of the families in the program. As shown in Exhibit 3, the housing policy has undergone major revisions since the program's inception. According to program staff, housing was originally offered during a time when very few children were seeking admission to the program, and when the board was coming under increased pressure to do something with the rapidly accruing funds. At first, the board offered the new housing benefit by providing funding for medically-related renovations to claimants' homes. Then, in 1994, the board began providing trust homes for claimant families, to be occupied until the claimant died or was permanently institutionalized. (It was not until a change in the *Code of Virginia* in 1996 that the program was given the authority to purchase and hold real estate – two years after the trust home benefit was instituted.)

During the time that trust homes were being offered, the program provided 23 homes to claimants, of which 20 are still being occupied by families. The initial cost of existing trust homes ranged in value from slightly less than \$100,000 to almost \$600,000. As previously mentioned, the program spent a total of \$7.2 million to acquire the 23 trust homes. When the actuary first included the cost of this benefit in actuarial projections in 1995, it assumed that only about ten percent of the claimants would avail themselves of this benefit. In fact, the majority of claimants sought and received the trust home benefit.

Due in part to the administrative difficulties in managing the trust homes, the board voted in 1998 to discontinue granting trust homes, and instead, award a housing allowance, or cash grant, that claimant families could use to renovate or build a home. Unlike the trust homes, homes that were built with a housing grant the designs," and on a few houses, "construction started before handicap accessibility

Exhibit 3	
Key Dates Related to Changes in the Program's Housing Policy	
Beginning in 1992	Claimants began being admitted into the program, and the board decided to provide funding for medically accommodating renovations to claimants' homes.
1994	The board voted to provide trust homes for claimant families, to be occupied until the claimant deceased or was permanently institutionalized. The program provided 23 homes to claimants, ranging in value from around \$100,000 to almost \$600,000.
1995	The board voted to offer \$100,000 cash grant for claimants to purchase homes. This option was discontinued as of March 1996. In addition, the board voted to "outfit the home for handicapped accessibility."
1996	Legislation was officially enacted authorizing the fund to purchase and hold real estate.
November 1998	The board voted to discontinue granting trust homes, and instead award housing allowances, or cash grants, that claimant families could use to renovate or build a new home. These cash grants, ranging in value between \$300,000 to over \$400,000, became property of the claimant's family – not the fund.
January 2000	The 1999 actuarial report projected future unfunded liability for the fund. The board decided to suspend cash grants, pending the findings from the 2000 actuarial report. Handicapped modifications to existing homes became the only housing benefit authorized by the program.
March 2000	In response to 2000 actuarial report, the board terminated all benefits for cash grants, and instituted the current housing renovation policy. The board also hired an independent consultant to evaluate further the future impact of implementing a one-time cash grant to all new claimants for housing. Based on the consultant's conclusions, the board decided such a benefit was not feasible.
Source: JLARC staff analysis of birth injury program documents and interviews with program staff.	

became property of the claimant's family – not the fund. A total of 13 housing grants have been issued by the program, ranging in value from around \$300,000 to over \$400,000, depending upon the family's location. The grant money was paid out over time to cover incremental construction costs and other related expenses, such as rental costs until the homes were completed. According to the program's construction manager, there were occasions when "nobody was brought in to monitor was determined." Since the purpose of the home was to provide adequate hand-

capped accessible accommodations, the program should have approved all housing plans prior to construction. Although there is no indication that any inappropriate housing construction costs were paid by the program, this lack of oversight allowed for possible abuse of this benefit.

When the 2000 actuarial study declared the fund unsound, the board decided to eliminate cash grants for housing, and establish what is currently the program's housing renovation policy. This policy covers renovations to the claimant's existing house (if the claimant's family owns a home) to make it handicap-accessible, including the possibility of an addition of one bedroom and one bathroom. The values of housing renovations have ranged from less than \$50,000 to around \$160,000. The program's construction manager indicated that Americans with Disabilities Act (ADA) standards are typically used as guidelines for renovations.

To determine whether the current housing policy is appropriate, JLARC staff conducted a review of the act, surveys of families, and interviews with the parties involved in the act's development. In addition, JLARC staff also conducted telephone surveys with commissioners of accounts. As noted in Chapter II, for any case in which a minor receives a medical malpractice award or settlement, the money is placed in a trust. A parent may be qualified as the guardian of the child's trust, but a commissioner of accounts is responsible for auditing and approving the account. Because commissioners of accounts are aware of the types of expenses permitted with medical malpractice awards and settlements, JLARC staff obtained their input on the types of housing accommodations generally approved in these situations.

Based on interviews with parties involved in this program's creation, the purchasing of homes was never anticipated to be a benefit of this program. As previously mentioned, the act does not specifically state that the program should provide housing for the children in the program. Furthermore, based on interviews with commissioners of accounts, it appears that housing allowances for children who win medical malpractice awards or settlements are typically limited to renovations to make homes handicap-accessible. Because commissioners of accounts are not authorized to approve expenses that exceed \$3,000 in a given year, families would have to obtain a court order to purchase a home with a child's medical malpractice award. Commissioners of accounts would be aware of any such orders because expenses related to the purchase of a house would be included on the child's account. However, none of the commissioners of accounts were aware of any family receiving a court order allowing them to make such a purchase with a child's medical malpractice award or settlement.

Although it appears that the program's current policy on housing renovations is appropriate, this issue has been a source of contention among families recently admitted into the program who were expecting a cash grant or a trust home. This may be due, in part, to the language used in the program's guidelines, which stated that housing was "Suspended Pending Results of Actuarial Study." In doing so, the program implied that cash grants and trust homes were no longer being offered due to the program's financial problems, whereas JLARC's review of the housing policy suggests that those benefits should not have been offered in the first place.

The current housing renovation policy does appear to be fair for homeowners and is a comparable benefit to that which could be obtained through a medical malpractice award, but it does not address the needs of non-homeowners. Currently, there are four claimant families who do not own homes and reside in rental properties. The housing renovation benefit precludes these families, and all future families who rent housing, from receiving this benefit – a benefit that is supposed to provide medically necessary accommodations for claimants, according to the board's interpretation of the act.

Since all claimants are essentially eligible to receive the housing renovation benefit providing their current accommodations are not medically acceptable for day-to-day functioning and communal mobility, one possible solution for a more equitable distribution of the housing benefit may be to offer renters a cash grant equivalent to housing renovation. According to the program's construction manager, the standard specifications for housing renovations provided by the program account for approximately 583 square feet of construction.

If average regional rates for handicap-accessible construction across Virginia could be determined, and then applied to the program's standard square footage for a housing renovation, it would produce a reasonable amount that could be granted to claimant families who rent housing. This cash grant equivalent to a housing renovation would give the program the opportunity to assist these families in obtaining medically necessary accommodations for their children, while remaining relatively consistent to what is currently available to homeowners. The program should also be responsible for playing a larger role in helping families that rent housing find better accommodations for their children, rather than simply stating that there is nothing that can be done.

Recommendation (28). The Virginia Birth-Related Neurological Injury Compensation Program should develop a policy to address handicapped accessible housing for children of non-homeowners.

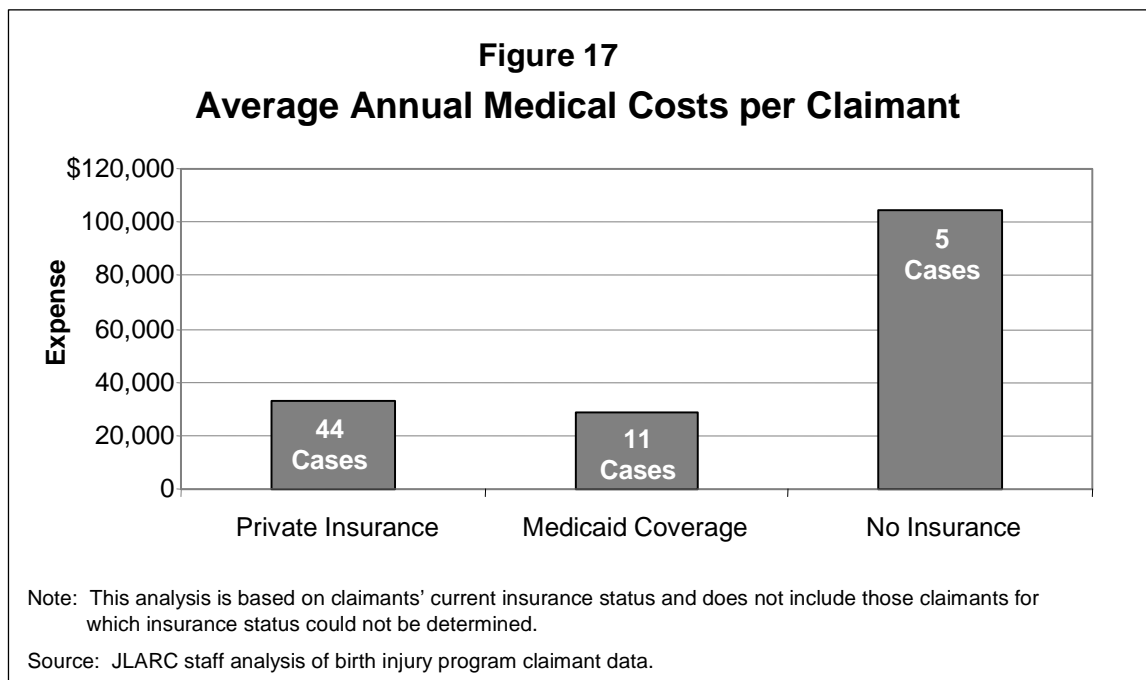
Recommendation (29). The General Assembly may wish to clarify §38.2-5009(A)(1) of the *Code of Virginia* to explicitly state that claimants in the Virginia Birth-Related Neurological Injury Compensation Program should receive reasonable accommodations for handicap-accessible housing, not to include the purchase of a house.

The Program Should Develop a Consistent Policy for Payment of Primary Health Insurance Premiums. Another issue related to administration of program benefits is the program's payment of private health insurance premiums for some of the claimants in the program. Although the program does not have an official policy for paying insurance costs, the program began paying health insurance premiums in 1999 for claimant families ineligible for Medicaid and without private insurance. Currently, the program is paying for all or a portion of health insurance costs for seven claimants. The total cost incurred by the program for this insurance in 2002 was just over \$9,000 – a minimal cost, considering the thousands of dollars per claimant that would otherwise have to be spent by the program for medically related expenses.

The medical expenses that are impacted by health insurance coverage include nursing, physician/hospital bills, therapy, medical equipment, and prescriptions. Taken together, these costs are significantly higher for uninsured claimants. As illustrated in Figure 17 these medical expenses cost the program an average of \$104,000 per year for uninsured claimants, as opposed to around \$33,000 and \$29,000 per year for claimants covered by private insurance and Medicaid, respectively.

The act does not stipulate a requirement that all claimants in the program either obtain private insurance or apply for Medicaid eligibility. According to program staff, some of the families of uninsured claimants have refused to apply for private insurance or Medicaid eligibility and turned down any offers the program has made to pay for private insurance, stating that they do not want to be restricted by a particular physician or practice. It appears that it was originally assumed that families would have primary health insurance, as the program was established as the “payer of last resort.” Currently, there is nothing in the *Code of Virginia* that would prevent all of the families from dropping their primary insurance on their child and having the program pay the full cost of all medical bills. However, this is an abuse of the program and families who can afford health insurance should be required to provide such coverage. Clearly, this is a normal and reasonable expense, regardless of their child’s disability. Even if a child had won a medical malpractice award, it is likely the family would continue to purchase health insurance to ensure the award was not depleted too quickly.

Although it is cost-effective for the program to pay private health insurance premiums for families who cannot afford them on their own, the program should develop a policy for deciding when they will offer this benefit. For example, they could adopt a standard similar to the one used by FAMIS, which is Medicaid’s program for uninsured children. (FAMIS guidelines state that in order to be eligible, a family’s



income must be at or below 200 percent of the federal poverty line.) Since private insurance for these children may be unusually expensive given their condition, it would seem appropriate to take into account this cost as well. For example, the guidelines could state that the program will pay for the portion of the insurance cost that exceeds a certain proportion of the family's income. In addition, an amendment to the act is needed to ensure that those families who do not meet the program's criteria purchase their own insurance.

Recommendation (30). The General Assembly may wish to consider amending the *Code of Virginia* to require claimants in the Virginia Birth-Related Neurological Injury Compensation Program to purchase private health insurance, or for cases in which a claimant cannot afford to pay private health insurance premiums, to allow the program to purchase private health insurance for them.

Recommendation (31). The Virginia Birth-Related Neurological Injury Compensation Program should develop a consistent policy for payment of private health insurance premiums for those families who cannot afford or do not have access to their own health insurance.

The Program Should Re-Examine Policies Related to Nursing Care to Ensure That the Current Guidelines Do Not Contribute to Problems in Obtaining Reliable Nursing Care. Administration of program benefits related to home health nursing care has also been a concern. As mentioned in Chapter III, the home health nursing benefit accounts for over half of the total amount paid to claimants on average, including all other benefits offered by the program. This benefit allows many of the claimant families to keep their birth-injured children at home when they would otherwise have to institutionalize them.

Because nursing is such a critical benefit from the standpoint of the claimant, and an expensive one from the standpoint of the fund, it is important that it be carefully managed. The program utilizes nursing agencies, when available, to provide up to 24-hour nursing services. The average rates paid by the program to these agencies for licensed practical nurses and registered nurses exceed Medicaid rates from about one dollar per hour to six dollars per hour.

Of the claimant families who responded to the JLARC survey, 50 percent indicated that their child receives nursing care. Of the 20 families who provided information on the amount of nursing care authorized by the program, the average number of hours per month was 120. The families also pointed out that typically an average of 14 hours of nursing care authorized by the program each month are not provided because a nurse is unavailable.

It should be noted that six families reported a significant number of missed nursing shifts per month, ranging from 32 hours per month to 190 hours per month. These missed nursing shifts pose an inconvenience to claimant families, requiring them to either hire someone on their own, or take off work to remain at home with their children. The program will reimburse families who hire their own nurse or caretaker up to the amount that would have been paid to a nursing agency. How-

ever, the program's policy is not to compensate family members who stay at home with the claimants.

Given the current shortage of nursing care nationwide, it is unrealistic to expect the program to ensure complete nursing care coverage for all families at all times. However, the program has a codified responsibility to provide medically necessary services, and therefore should make sure that its policies related to nursing care do not serve as additional impediments to obtaining such care. Although the program already exceeds the Medicaid rate in most cases, this may require that the program increase the rate at which they pay nurses in areas where there are nursing shortages. Overtime pay for nurses should also be considered for cases in which adequate nursing coverage has been a problem.

The Program Should Begin Planning for the Lost Wage Benefit.

Once claimants reach the age of 18, they will begin to receive a lost wage benefit from the program. According to the *Code of Virginia*, the amount to be paid is fixed at 50 percent of the average weekly non-agricultural wage in Virginia. At 2000 cost levels, this benefit would amount to approximately \$17,600 per year.

The program needs to plan ahead to ensure that this benefit does not have unintended consequences. For example, allowing for some variation and depending on claimants' current primary insurance policies, it would be expected that most of the children in the program would seek eligibility for Medicaid once they turn 18 or are no longer eligible to be covered under their parents' policies. However, the program's current lost wage benefit has the potential to make the children ineligible for Medicaid once they are 18 due to Medicaid income guidelines. The alternative would likely be to go without any insurance – a costly alternative for the program.

The lost wage benefit could also make the children ineligible for Title XVI benefits (Supplemental Security Income). Although the claimants would likely qualify based on their disability, they may only hold \$2,000 in resources to meet SSI income requirements. In addition, any additional income they receive counts against them dollar for dollar. For example, the current SSI benefit is approximately \$500 per month. However, if a claimant received \$1,000 per month from the program as part of the lost wage benefit, he would lose the entire benefit because his income would exceed the amount of the SSI payment. Because it appears that many of the claimants in the program will live beyond the age of 18, it will be important for the program and its board to consider the impact of the lost wages benefit in managing the fund and making future funding decisions.

One suggestion that has been made by several claimant families with regard to lost wages is for the program to set up special needs trusts for the claimants, which would essentially preserve eligibility for Medicaid and SSI benefits, while securing the assets that will meet the supplemental needs of the claimants – those that go beyond food, shelter, and clothing. With special needs trusts, a family member could become the trustee, who would be responsible for managing the claimant's assets by distributing money to pay for necessary goods and services. The program should explore the feasibility and cost implications of special needs trusts, and consider reimbursing families for setting up special needs trusts if it appears to be cost-effective.

Recommendation (32). The Virginia Birth-Related Neurological Injury Compensation Program should begin planning for management of the lost wage benefit for children who attain 18 years of age. In part, the program should consider reimbursing families for setting up special needs trusts for all children in the program to ensure eligibility for Medicaid and disability benefits.

A Codified Process for Appealing Benefit Decisions Is Needed. Currently, claimants who are denied a particular benefit by the program file an appeal with the WCC. Although the *Code of Virginia* does not specifically provide for appeals of benefit decisions in birth injury cases, the WCC began hearing such appeals in 2000. These cases are treated as the equivalent of a “change in condition” claim in workers’ compensation cases, which provides claimants an opportunity for due process if they disagree with the program’s response to a benefit request.

For example, one claimant family appealed the program’s decision not to provide them compensation for caring for their child during missed nursing shifts. This parent was awarded partial compensation by the WCC. As another example, one family who was living in a trust home wanted to keep the trust home after their child died, even though they had signed a contract with the program stating that they would vacate the trust house once their child was deceased. This same family also requested payment of the lost wage benefit their child would have received between the ages of 18 and 65. However, in this case, the WCC denied both claims.

The program’s mandate to provide for the medical needs of the children is necessarily broad and open to wide interpretation. Therefore, conflicts between the program and the families regarding benefits decisions are to be expected. The current process for appealing benefit decisions appears to be working well, but should be codified to ensure that future claimants are afforded the same right to due process. In addition, deadlines for filing notices of appeal, briefs, and replies should also be specified to formalize this process.

Recommendation (33). The General Assembly may wish to consider amending the *Code of Virginia* to specify that claimants in the Virginia Birth-Related Neurological Injury Compensation Program may appeal decisions by the program to the Workers’ Compensation Commission.

The Program Would Benefit from More Accountability

The *Code of Virginia* does not clearly define the program as a private or governmental organization. Based on interviews with staff from the Attorney General’s Office, program staff, and staff from the Division of Legislative Services, it appears that the program does not fall into any particular category of State agency, nor is it a purely private entity. A lack of clarity on this issue has permitted the program to operate with little oversight. Changes to the *Code of Virginia* are necessary to increase accountability and oversight, including making the program subject to the Administrative Process Act, the Freedom of Information Act (FOIA), and the Public Procurement Act.

The Program's Status as a State or Private Entity Is Unclear. The program was created by the General Assembly as an alternative to the tort system (a government-controlled system), is managed by a board appointed by the Governor, and is represented by the Attorney General's Office. As such, some have argued that the program is a State agency. However, the board believes the program is not a State agency because it is not funded by State dollars and program staff are not State employees. In addition, the Attorney General's Office argued successfully in the 2002 General Assembly session that the Legislature does not have control over the program's fund because it is not a State agency. This discouraged the General Assembly from appropriating program money to a parent who requested a trust home (HB 617, 2002). The Attorney General's Office has said that the program is not required to follow FOIA and APA, but because of the wording of the Public Procurement Act, it may be subject to that act.

The Program Should Be Subject to the Key Regulations that Govern Public Business. The only agency that provides any oversight for the program is the SCC. One responsibility of the SCC is to obtain an actuarial review of the program every two years. According to the SCC, however, its role in the actuarial review process is limited to procurement of the actuarial study, and it does not provide any guidance or recommendations to the program based on study results. The act also directs the SCC to approve the program's Plan of Operation, as well as any changes to that plan, but this document is simply a restatement of the general guidelines established by the act. The fact that the SCC has no real oversight role and the program is not governed by any "sunshine laws" at a minimum presents the appearance that the program and board do not have to account for their actions.

It appears that in order to maintain the independence of the fund, the program should not be given status as a State agency. However, it should be made subject to the Public Procurement Act and the Freedom of Information Act (FOIA). FOIA exemptions would need to be made, however, to ensure that the medical records in the petitions and specific requests that relate to medical conditions remain confidential.

In addition, the Act should be amended to require the program to follow a more public rule-making process before making changes to benefits. At times, such changes appear to have been frequent and haphazard. For example:

In one set of guidelines dated September 2000, the therapeutic toy benefit was \$1,000. In an undated addendum to the guidelines, this benefit was eliminated. However, in a set of guidelines dated 2000 and currently posted on the program's website, it appears that the benefit was reinstated at a maximum amount of \$300.

To eliminate the program's ability to change benefits without public notice or participation and to discourage frequent and confusing benefit changes in the future, the program could be required to follow the rulemaking portion of the Administrative Process Act. This would entail that the program file both proposed and adopted regulations with the Virginia Registrar, and includes a process for interested parties to provide oral or written input on any such changes. Proposed regula-

tions are also filed with the Department of Planning and Budget (DPB), as well as the Governor's Office. If the program adopts the proposed regulation, the agency then files the adopted regulation with the Registrar and it is published in the Virginia Register. Alternatively, the Act could be amended to include a public disclosure process specifically for the program.

Steps should also be taken to protect the integrity of the program's financial information, which is essential to the accuracy of the actuarial report and should be a priority for the program. In order to ensure the accuracy of the program's financial information, the *Code of Virginia* should be changed to require an annual audit by a Certified Public Accountant. Although the program is routinely obtaining an annual audit, a change to the *Code of Virginia* will ensure that this practice continues.

Finally, the *Code of Virginia* should specify that the Office of the Attorney General provide legal counsel to the program. Staff from the AG's Office have acquired expertise in this area, and should be used to represent the program, which was designed to protect the interests of the Commonwealth. This arrangement maximizes the fund's use for claimant benefits since the Attorney General's Office has not charged the program for its services, and even if fees were instituted, they would likely be lower than fees charged by a private law firm. It should be noted that if the program is removed from the eligibility process, there will be less need for legal counsel, and some of the demands on the Attorney General's Office will be alleviated.

Recommendation (34). The General Assembly may wish to amend the *Code of Virginia* to require that the program be subject to the Freedom of Information Act, the Public Procurement Act, and the Administrative Process Act or another public rulemaking process. The *Code of Virginia* should also be amended so that the Virginia Birth-Related Neurological Injury Compensation Program is required to receive an annual audit by a CPA. Finally, the *Code of Virginia* should be amended so that the Office of the Attorney General is required to provide legal representation for the Virginia Birth-Related Neurological Injury Compensation Program.

PROGRAM SERVICES

JLARC staff assessed program services through surveys and interviews with families involved in the program, as well as interviews with program staff and board members. Overall, the program appears to provide adequate services to families in the program. The most frequent complaint about the program relates to the amount of paperwork needed to receive benefits. However, JLARC staff reviewed the required documentation, and found it to be an appropriate mechanism for ensuring that fund dollars are spent according to the intent of the Act. Communication, on the other hand, has been a major shortcoming of the program and needs to be improved.

The Program Appears to Provide Adequate Services to Families

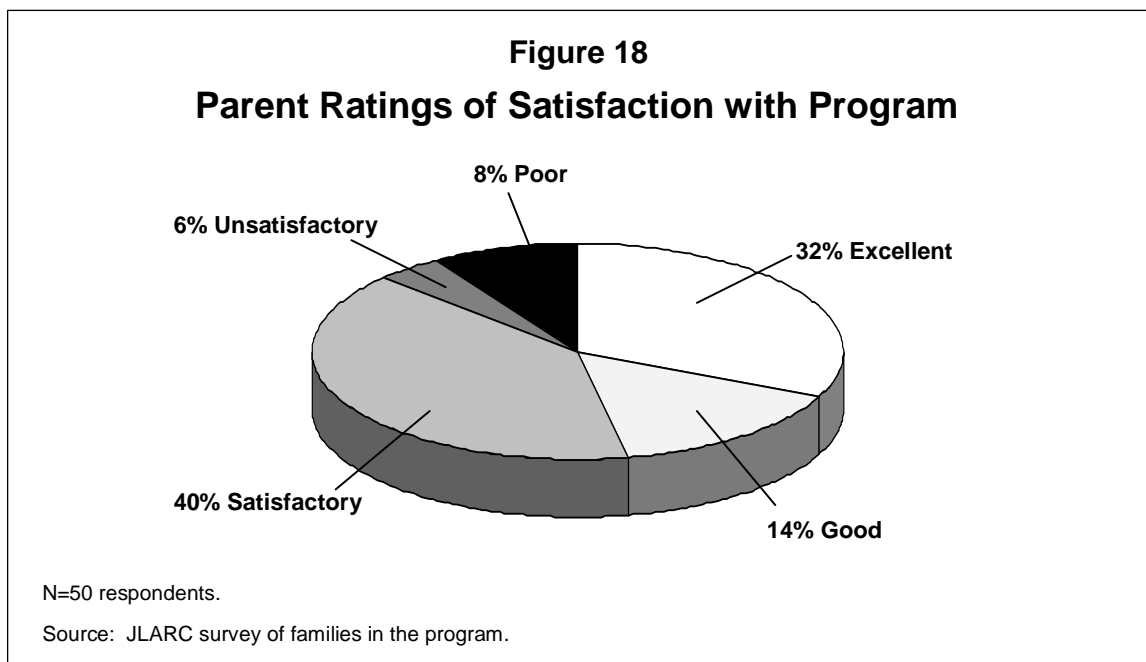
A majority of families who responded to the JLARC survey reported satisfaction with program services. In addition, most families also reported that program benefits are processed in an efficient and timely manner. Although some families complained about the documentation required to receive benefits, JLARC staff found this component of the process to be appropriate. One aspect of the process that should be addressed, however, is the lack of itemized reimbursement statements.

Most Families Are Satisfied with Overall Program Services. Currently, there are six staff who manage the daily operation of the program and provide direct services to families in the program. These services include orientations for new families who enter the program, answering questions about benefits, developing plans for housing renovations, ordering vans, processing reimbursements, and making direct payments to service providers and suppliers.

To determine whether the current level of service provision has been sufficient to meet the needs of the families, JLARC staff asked parents to evaluate the services they receive from the program. As shown in Figure 18, when asked “How do you rate the program overall?”, most of the families rated the program as “excellent,” “good,” or “satisfactory.” In addition, when asked to rate the helpfulness of program staff, a majority of respondents (82 percent) indicated that staff were “somewhat helpful” or “very helpful,” as opposed to “not very helpful” or “not at all helpful.”

Some of the comments JLARC received from parents included the following:

The program isn't overloaded with red tape and bureaucratic regulations that would make it difficult to access the child's benefits.



* * *

It is far superior to capped [medical malpractice] suits in meeting long term needs for my child.

* * *

It's a relief to not worry about how to pay for all the expensive medical care the children need.

* * *

Providing my son with his needs (nursing and respite care, equipment, meds, diapers) has lifted a burden from my family and improved the quality of life for all of us.

The Process for Obtaining Benefits Is Efficient and Timely. As noted in Chapter II, there are two methods used by the program to provide benefits to clients. To the extent possible, the program pays service providers and medical suppliers directly for expenses not covered by the child's primary health insurance plan. This arrangement is particularly helpful to families because they never even see the bill in some cases. When this arrangement is not possible, the families must pay for expenses out-of-pocket and submit receipts for reimbursement. Both of these methods were designed to ensure that the program pays for costs directly related to the child's medical care, and that the parents are not given lump sums of money to spend at their own discretion.

To determine whether access to benefits is unnecessarily difficult or cumbersome, JLARC staff asked parents to evaluate the process for obtaining benefits. Many of the parents who responded to the JLARC survey (54 percent) indicated that obtaining benefits from the program is "somewhat easy" or "very easy." Some of the comments included the following:

Reimbursements are extremely timely and easy. I fax information and receive them within the week consistently. This is wonderful.

* * *

I feel that staff have always been clear regarding reimbursements and helpful.

However, a sizeable minority (46 percent) rated the process as "somewhat difficult" or "very difficult." Those who rated the process negatively complained about having to provide letters of medical necessity and proof of payment in order to receive benefits. For example:

[The] Program investigates needs for services, medical items by calling Doctor. Indicates lack of trust toward parents.

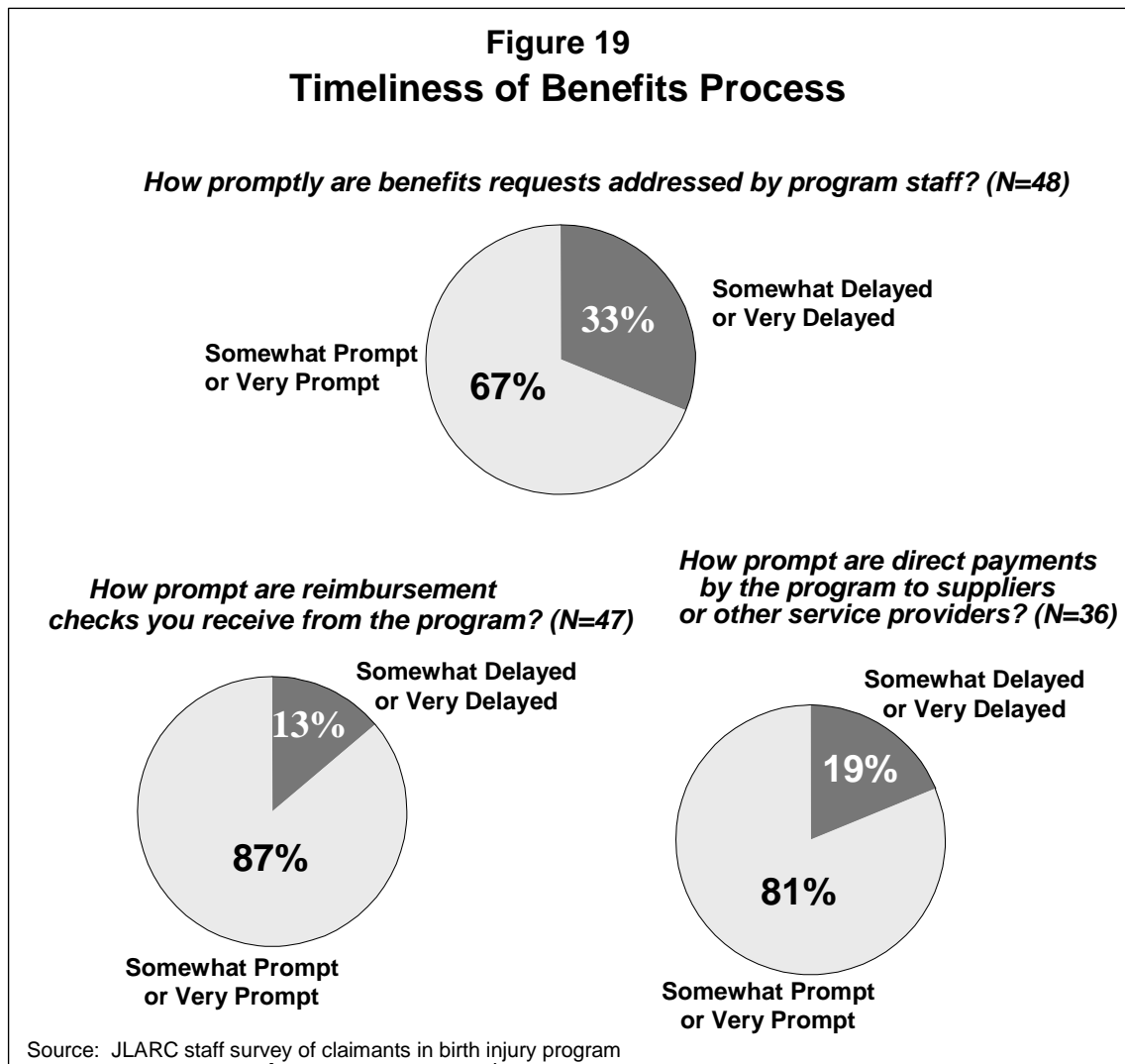
* * *

The management of the program is distrustful of families and non-communicative. The management of the program is structured like an insurance company- i.e., to limit and define benefits.

According to the language in the act, the program was designed to pay for “medically necessary” items only. As the payer of last resort, it was intended to operate much like a final layer of insurance for the children under its care. Because it is the program’s responsibility to ensure that fund dollars are spent in a manner consistent with the intent of the act, JLARC staff found that the level of required documentation is appropriate. In fact, it would be improper for the program to pay for items without such proof.

As shown in Figure 19, parents’ ratings of the timeliness of the benefits process were also mostly positive. A majority of the respondents indicated that benefit decisions, reimbursements for out-of-pocket expenses, and direct payments to service providers and suppliers are all addressed by the program in a prompt manner.

One complaint about the benefits process noted by several families is that the program does not itemize reimbursements. Therefore, the families do not know which items are included in reimbursement checks. According to one staff member, a lack of staff time has prevented the program from providing itemized statements. However, without a clear understanding of what will and will not be reimbursed, the



claimant will likely turn in erroneous claims again, causing inefficiency and wasted time for both the claimant and the program. This practice is confusing to parents and should be corrected, even if this results in a slight delay of those reimbursements.

A final issue related to the process of receiving benefits is the program's procedure for ordering vans. Currently, the program purchases a handicapped accessible club van for most of the families in the program so that they may transport their children safely. However, they reportedly order these vans from the manufacturer without input from families. Families have consistently noted various problems with the vans, including complaints that the six-cylinder engine makes it hard to accelerate and navigate hills in certain areas of the State. These vans are medically necessary for the safe transport of these children to doctors' appointments and

other daily activities. As such, the program should work with families to address their concerns regarding the vans.

***Recommendation (35).* The Virginia Birth-Related Neurological Injury Compensation Program should provide itemized reimbursement statements to families.**

***Recommendation (36).* The Virginia Birth-Related Neurological Injury Compensation Program should explore options to better address the needs of families in transporting their children.**

Claimants Have Voiced Concerns Regarding Inadequate Communication from the Program

According to the current case manager for the program, communication with families that are new to the program begins with an introductory letter and a copy of the guidelines. She then calls the families to schedule a home visit within two weeks of their acceptance into the program. During this visit, she reviews the guidelines and answers any questions they may have about benefits. In addition, she also reviews the policies about prior approval, the need for nursing orders in applicable cases, the documentation necessary to receive reimbursement for non-nursing caregivers, forms for reimbursements, and the list of acceptable forms of proof of payment. The van benefit and the housing benefit are also discussed in detail at this time.

When parents were asked on the JLARC survey about their initial communication with the program, only about half of the families (56 percent) reported that they were contacted by the program within 30 days of acceptance into the program. In addition, only about half (46 percent) indicated that they received program guidelines within 30 days. Many of the respondents (41 percent) indicated that staff did not adequately explain the program after they were accepted.

Also, according to parents who responded to the survey, communication with the program continues to be an issue long after the initial orientation period.

The program reportedly maintains communication through a newsletter every two to three months, occasional letters to families to announce policy changes, and yearly home visits with families. However, only about half of the respondents (53 percent) indicated that they are adequately informed of changes in policies, procedures, and other relevant program issues.

Some of the parents' comments regarding communication include the following:

Historically this has been one of the great weaknesses of the program: families have not been apprised of current and ever evolving policies.

* * *

I feel completely out of touch. [There is] no communication from fund unless I generate it.

* * *

There have been occasions when procedures were changed without advance notice. While I understood the rationale behind the changes, it would have been helpful to receive advance notice.

* * *

A home visit by this case manager, or another member of the Program staff, should occur yearly, with phone calls made by the case manager to each family every other month. I cannot speak for other families in the program, but in our case, it would be greatly appreciated if this case manager would get to know our child, and then follow up on the health and welfare of our child.

Although the program has established appropriate mechanisms for communicating with claimants, it appears that they have not been entirely effective. There are several factors that may account for this finding. Many of these factors have been discussed previously in this chapter, including the lack of detail in the benefit guidelines. In addition, there are many different versions of the guidelines and some claimants may not have the most recent version. Finally, even though there is a procedure in place to update claimants on changes to benefits, these procedures are not always followed.

By implementing the recommendations noted earlier in this chapter and following more closely the existing procedures related to yearly home visits and notification of policy changes, the program may be able to enhance communication with the families. In addition, the current chair of the board has stated that he would like to hold group meetings with the families around the State to establish a dialogue between the board, the program, and the claimants. The program should follow through with this plan and solicit feedback from families on how the program can do a better job communicating and providing services. Finally, the program should continue development of its web site and incorporate additional features, such as examples of reimbursement forms and blank reimbursement forms that may be downloaded by parents.

Recommendation (37). The Virginia Birth-Related Neurological Injury Compensation Program should follow existing procedures related to communication more closely to ensure that families in the program are aware of all program policies. The program should also follow through with the existing plan to hold group meetings across the State and obtain input from families on how they can improve communication and service provision. Finally, the program should improve its web site by including more features to help families access information needed to obtain benefits.

STRUCTURE AND ROLE OF THE BIRTH INJURY BOARD

JLARC staff examined the appropriateness of the birth injury board's representation and function through interviews with board members, a review of the board meeting minutes, and a review of the program claimant survey responses. The board clearly lacks representation from the disabled community, and has historically been deficient with regard to financial expertise. However, with adjustments to its current makeup, along with some periodic assistance from staff at the Virginia Retirement System (VRS), the board should become more focused on its fiduciary responsibilities, while also meeting the goal of the program to provide medically necessary benefits to birth injured claimants.

Role of Board Needs to Be Refocused on Financial Management of Fund

The birth injury act gives the board of directors responsibility over the following five general functions: (1) to administer the birth injury program, (2) to manage the fund, (3) to appoint a service company to administer the payment of claims, (4) to direct the investment and reinvestment of the fund's balance, and (5) to reinsure the risks of the fund in whole or in part. Of these functions, the board has exercised all of them except for reinsuring the risks of the fund in whole or in part – something that Florida's birth injury program has done since its inception. Based on JLARC staff's review of board meeting minutes, historically Virginia's birth injury board spent most of its time administering the program through policy changes and responding to specific benefit requests to the detriment of its fiduciary responsibility.

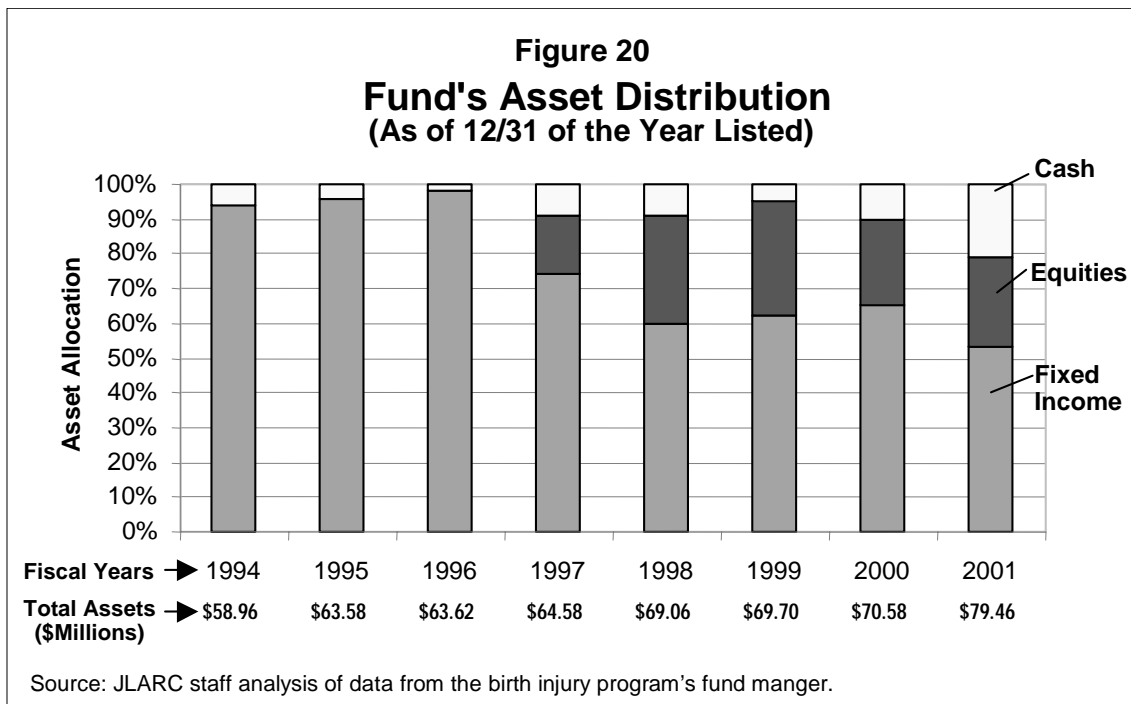
Board Has Neglected Fiduciary Duties Historically. The board has focused its efforts over the years on benefits and other administrative matters, rather than its fiduciary duties. Throughout most of the history of the program, it appears that the board received very little financial information from the fund manager and program staff that would have been necessary to properly oversee the fund. For example, it was not until 2001 that financial statements and investment reports detailing the activity of the fund manager were regularly distributed to board members at meetings. Further, 2002 has been the first year that the board has directed program staff to provide monthly and quarterly profit and loss statements, which

have helped inform the board about regular operational and claimant costs paid by the program.

In 1988, the board contracted with an investment bank to manage the program's monetary assets, initially only to be invested in money markets and other interest bearing accounts. In November of 1989, according to JLARC staff's review of board meeting minutes, the board approved recommended changes in the investment guidelines to take on a slight increase in risk through other short-term investments. A new fund manager was hired in 1993 to manage and invest the fund in fixed income bonds. The investment parameters established with this fund manager remained highly restrictive, but ensured steady, low-risk growth.

In 1997, the birth injury act was amended to broaden the investment authority over the fund. This change granted the board authorization to seek advice on longer-term investments from the fund manager and the VRS, another fund administrator that establishes investment parameters according to actuarial conclusions. With its expanded investment powers, the board consulted the fund manager and decided to accept its recommendation to model the investment strategy in a manner similar to that of VRS. This strategy entails generally targeting equities, fixed income, and cash equivalent allocations to 30 percent, 65 percent, and five percent, respectively. Figure 20 shows the historical distribution of assets from 1994 through 2001. If the board had invested in equities prior to 1997 when the market was doing well, it is presumed that there would have been a much higher potential for return on investment during those years.

The current fund manager took control of the fund in November of 2000, and has been managing the fund as an active, large cap, value manager, according to the parameters established in its contract. Since that time, the total portfolio has grown 13.59 percent. Specifically, the rate of return on fixed income was 15.68 percent, which is slightly below its fixed income benchmark index, the Lehman Intermediate Aggregate Bond Index. But equities have grown 12.55 percent. This is sig-



nificantly higher than returns obtained by both the Russell 1000 Value Index (-9.09 percent) and the S&P 500 Index (-29.19 percent.)

The current investment portfolio spreads the fund's assets among equities (common stocks), fixed income investments (corporate bonds and government securities), and cash equivalents (cash, obligations, certificates of deposit, and money market funds). Since the fund is allocated heavily in bonds, the investment portfolio appears to be conservative, as all of the current board members pointed out to JLARC staff. However, the equities portion of the portfolio, comprising roughly 30 percent of the investments, is not considered to be a conservative strategy according to VRS. With the equities, the fund manager is holding a small number of only around 36 stocks, which presents the potential for high volatility.

VRS indicated that an indexed fund would likely be less risky, although the returns may be higher using this large cap, value style strategy. This type of concentrated approach can be risky if the market declines, and the fund's equity portfolio could experience heavy losses at any given point in time. Since it is practically impossible to predict the expenses the program may incur in the future, the board needs to take this volatility into consideration. On the other hand, without this volatility, there is less potential for higher returns.

The board's fiduciary responsibility assumes a clear understanding of the fund's investment portfolio, style, and risk, along with its expected returns over time. However, the fund manager has not kept the board regularly informed about the monetary changes in annual rates of return, and has not provided the board with future projected returns on the equities and fixed income portfolios. One of the biggest disadvantages of the board in managing the fund has been its lack of significant financial and investment experience. Prior to the current board, no members had worked in the financial industry. Currently, one board member has past professional investment experience.

In order to evaluate the level of volatility appropriate for the fund over the long term, it is important that the board obtain the best available financial information. VRS suggested that the board direct its fund manager to supply future expected returns, and seek further explanation on the ramifications of the existing investment strategy and other possible investment approaches that might ensure sufficient future returns. Periodically, it would also be prudent for the board to obtain input from VRS regarding the risk profile of the fund. These steps would help the board better meet its fiduciary responsibilities.

Recommendation (38). The General Assembly may wish to consider amending the *Code of Virginia* to require the Birth-Related Neurological Injury Compensation Board to obtain advice on the fund's investment strategy, including the asset allocations for its equities and fixed income portfolios, from the Chief Investment Officer of the Virginia Retirement System on a semi-annual basis.

Recommendation (39). The Birth-Related Neurological Injury Compensation Board should direct the fund manager to supply an annual explanation of expected returns on the equities and fixed income portfolios.

Board's Focus Has Been on Making Detailed Benefit Decisions. Instead of fund management, the board's focus has been on benefit requests that have been deferred by program staff as being outside the purview of the benefit guidelines. Since the board's practice has been to be heavily involved in benefit decisions, many of the claimant families have indicated that it takes too much time to obtain some benefits. In fact, of the claimant families who have submitted a benefit request to the board and responded to the JLARC survey, more than one-half indicated either a somewhat or very delayed response from the board for benefit decisions. The following quotations, taken from responses to the JLARC survey, reflect concerns about the board's current role in the process.

The Board needs to provide more autonomy to the office staff. Processes should be established using predetermined guidelines. The Board is micromanaging resources. The Board also has no understanding of the children, families, and their needs.

* * *

Have some way to resolve simple issues without having to wait for a monthly Board meeting. The Board usually takes at least two to three meetings to resolve one issue. The first meeting they discuss it. The second meeting they see how everyone felt now that they had a month to think it over. Sometimes a third meeting to resolve issues they didn't think of the first meeting.

The problem of timeliness in the board's actions was exacerbated in the past as many of the monthly board meetings were cancelled. This added to the length of time it normally took for claimant families to obtain certain benefits.

The current board has made an effort to ensure more of the monthly meetings are held. In addition, the current board has begun to focus more on the funding of the program, and has directed program staff to revise the benefit guidelines. Development of a more detailed benefit guidelines manual (as previously discussed) should enable the program to make more decisions concerning claimant requests, and allow the board to focus more on its fiduciary duties. This effort should be made a high priority for the board and program staff.

Recommendation (40). **The Birth-Related Neurological Injury Compensation Board should take steps to minimize its involvement in routine benefit decisions to allow for more focus on its fiduciary responsibilities. At a minimum, the board should set as a high priority the revision of the program's benefit guidelines.**

Changes Needed in Board Representation

The birth injury board is made up of seven individuals appointed by the Governor, who serve staggered, three-year terms. One board member represents each of the four contributing fund sources, along with three "citizen representatives." The "citizen representatives" appointed to the board have often been associ-

ated with the industries represented on the board. In fact, two of the three current citizen representatives have affiliations with the health industry, one being a doctor.

Given this representation on the board, there is a perception that the program's focus is solely on benefiting doctors and insurance companies, while its members have no direct familiarity with the needs of disabled children and the challenges of raising a disabled child. Many claimant families have expressed concern that the board's current makeup poses a conflict of interest because the majority of members represent either the insurance or health care industries.

It is questionable whether claimant interests are being appropriately represented when the majority of board members currently pay assessments into the fund, while also making decisions about benefits to be paid from the fund. Past actions of the board highlight problems regarding the board membership's conflict of interest. Of significant concern is that the *Code of Virginia* gives the board authority to reduce assessment levels on the very industries they represent. This presents a direct conflict of interest, especially since the board has also exercised the power to change, and in some cases, reduce benefits to protect the integrity of the fund. An example of this occurred in 1999 and 2000, when the board voted to eliminate the trust home and cash grant housing benefits. The following excerpt was taken from a letter written by a former board chairperson, and sent to participating physicians and hospitals in 2000.

The Board has studied this situation very carefully and has explored other actions to ensure the financial integrity of the Fund in order to avoid returning to the maximum statutory assessment level. The Board has eliminated the housing benefit that provided medically necessary homes in trust. A housing allowance that had been adopted in lieu of trust homes has also been eliminated.

In this passage, the former chairperson explicitly states that the board eliminated a benefit to avoid requiring doctors and hospitals from paying up to – and not more than – the assessment amount mandated in the *Code*. As described in Chapter III, JLARC staff recommend that the board's authority to reduce assessments be eliminated.

Another problematic aspect of board membership is that, until very recently, there were no board members who could provide perspectives on the needs of the disabled children, such as physical therapists and parents with disabled children. The *Code* includes the following language regarding the citizen representatives:

In selecting citizen representatives, consideration shall be given to (i) persons who have experience in finance and investment; (ii) parents; and (iii) persons who have worked closely with persons who might qualify as claimants. Citizen representatives shall not have children or relatives who are claimants or who have been awarded benefits under the Act.

In practice, there have only been two citizen representatives with involvement in the disabled community during the board's history, and only one member with a background in financial and investment management. The *Code's* permissive language has been insufficient to ensure representation from these parties.

To alleviate the inequity in board representation, changes are needed to broaden representation on the board. First, it does not appear necessary to have a representative for the non-participating physician population on the board since individually, non-participating physicians contribute such a small amount to the fund. Instead, this board position should be converted to a citizen representative member, bringing to four the number of citizen representatives on the board. To ensure a better understanding of the needs of disabled children, two of the citizen representatives should be persons who work with disabled children, such as physical therapists, special education teachers, or parents of disabled children. They should not include any person who has practiced as a physician or been a representative of the health care or insurance industries. The other two additional citizen representatives should be individuals with a background in investment management so as to provide the board some financial expertise.

Recommendation (41). The General Assembly may wish to consider amending the *Code of Virginia* to change the non-participating physician representative on the Birth-Related Neurological Injury Compensation Board to a citizen representative. In addition, the General Assembly may wish to consider requiring the appointment of two citizen representatives with a background in the disabled community, and two citizen representatives with a minimum of five years of professional investment experience. The General Assembly may also wish to consider specifying in the *Code of Virginia* that persons who have practiced as physicians or who have been representatives of the health care industry or the insurance industry may not be appointed to the board as citizen members.

Appendixes

The body of this report makes reference to several appendixes as sources of additional detailed information regarding the birth injury program. They include the following:

- Appendix A: Birth Injury Program Claimant Expenses, by Category and Year**
- Appendix B: Number of Participating Physicians, by Planning District, 2002**
- Appendix C: Location of Participating and Non-Participating Hospitals**
- Appendix D: JLARC Staff Survey of Clients in the Birth Injury Program**
- Appendix E: JLARC Staff Survey of Participating Physicians**
- Appendix F: JLARC Staff Survey of Non-Participating Physicians**
- Appendix G: JLARC Staff Surveys of Participating and Non-Participating Hospitals**
- Appendix H: Agency Responses to This Study**

Appendix A

Birth Injury Program Claimant Expenses by Category by Year

Year	Incidental	Hosp/Phys	Nursing	Therapy	Med Equip	Vans	Housing	Insurance	Prescrip.	TOTAL
1988	0	0	0	0	0	0	0	0	0	0
1989	0	0	0	0	0	0	0	0	0	0
1990	0	0	0	0	0	0	0	0	0	0
1991	0	0	0	0	0	0	0	0	0	0
1992	6,590	825	6,746	0	0	0	0	0	0	14,161
1993	17,797	8,670	58,220	245	155	0	0	0	0	85,087
1994	23,894	7,285	117,509	5,216	12,582	22,154	25,000	0	0	213,640
1995	94,848	52,227	492,425	22,333	37,461	133,163	65,641	0	0	898,098
1996	127,266	38,225	910,828	66,269	59,157	260,606	176,999	0	0	1,639,350
1997	211,786	26,199	1,737,579	107,533	75,136	149,573	357,995	0	0	2,665,801
1998	203,862	50,507	2,123,278	156,345	49,449	227,249	76,816	0	0	2,887,506
1999	231,245	175,104	2,270,844	124,429	92,016	213,175	299,069	2,260	0	3,408,142
2000	300,168	282,521	2,659,413	188,354	99,866	211,158	1,660,494	19,540	46,428	5,467,942
2001	282,125	250,002	2,609,605	215,794	167,541	325,588	1,873,765	44,078	91,482	5,859,979
2002	124,822	288,955	1,029,954	73,005	60,647	114,880	357,108	27,684	60,583	2,137,638
Total	1,624,403	1,180,520	14,016,400	959,523	654,010	1,657,546	4,892,887	93,562	198,493	25,277,344

Appendix B

Number of Participating Physicians by Planning District, 2002		
Planning District	Number of Participating Physicians	Percentage of Total
1	1	0.2%
2	3	0.6
3	4	0.8
4	3	0.6
5	43	8.7
6	8	1.6
7	13	2.6
8*	156	31.5
9	1	0.2
10	43	8.7
11	17	3.4
12	10	2.0
13	5	1.0
14	2	0.4
15	21	4.2
16	3	0.6
17	0	0.0
18	0	0.0
19	6	1.2
22	0	0.0
23	23	30.0

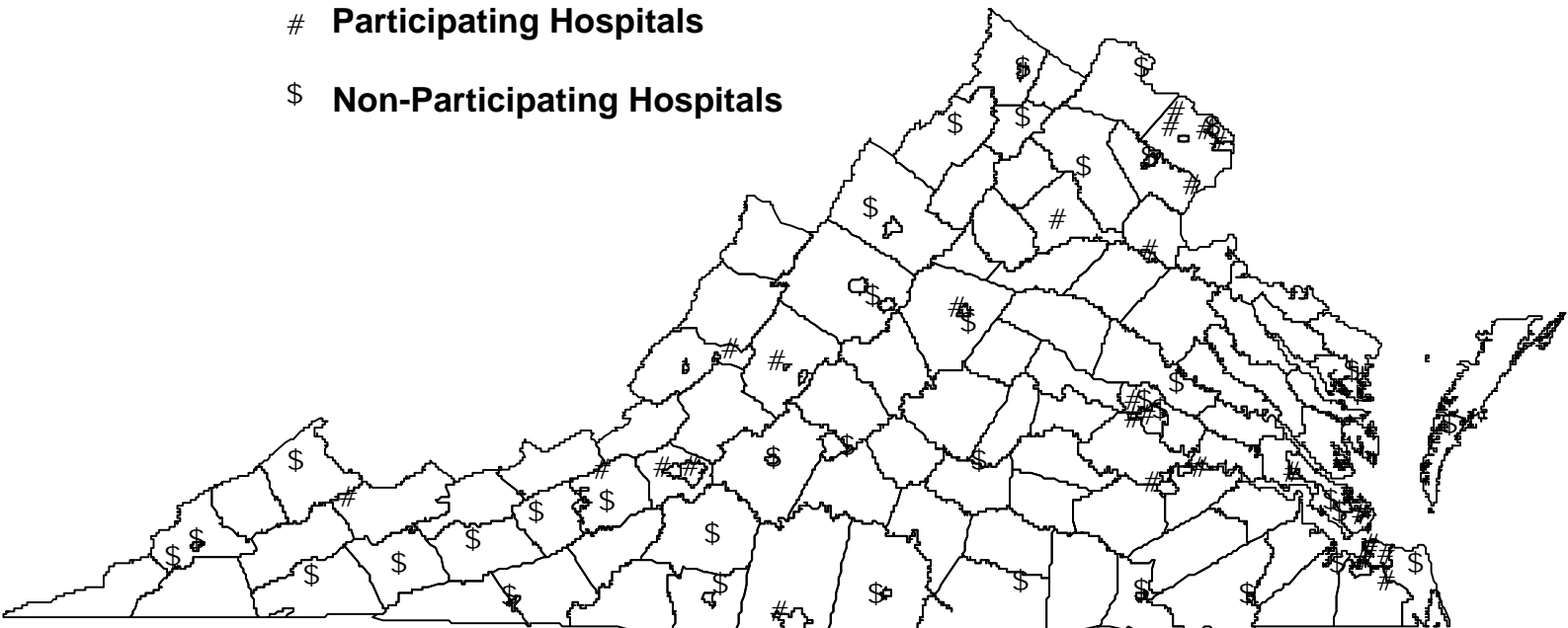
Note: Participating physicians with Washington, D.C. addresses are included in Planning District 8. An additional eight participating physicians have addresses located outside of Virginia and Washington, D.C.

Source: JLARC staff analysis of birth injury program data.

Appendix C

Location of Participating and Non-Participating Hospitals

Participating Hospitals
\$ Non-Participating Hospitals



Appendix D



Commonwealth of Virginia Joint Legislative Audit and Review Commission

Survey of Clients in the Virginia Birth-Related Neurological Injury Compensation Program

In January of 2002, the Joint Legislative Audit and Review Commission (JLARC) directed staff to conduct a review of the Virginia Birth-Related Neurological Injury Compensation Program and Fund. As part of this study, JLARC staff are conducting a survey of parents whose children have been admitted into the Program.

The purpose of this survey is to obtain your perceptions on various aspects of the program, including the eligibility process for acceptance into the Program, services offered by the Program, and benefits provided by the Program. Your answers to the following questions will help us provide valuable information about the Program to the Governor and General Assembly. If you need additional space in providing any responses, please attach additional sheets.

We hope that you will be candid in your responses. Information collected in these surveys will be reported primarily in aggregate form and **no identifying information will be given or shared with anyone outside of our agency.** Your input is essential for our study of the Birth Injury Program, and we appreciate your time and effort. Please return the completed survey in the attached, postage-paid envelope to JLARC by **Wednesday, July 24, 2002.**

If you have questions about the survey, please direct them to Sandra Wright (swright@leg.state.va.us or 804-819-4578) or Linda Ford (lford@leg.state.va.us or 804-819-4568).

Please complete the information below before returning the survey.

Phone number: _____

E-mail address: _____

Knowledge About the Birth Injury Program

1. Who first informed you about the Program? (Check only one box.) (n=51)

- 1 The physician who delivered my child
- 1 Staff from the hospital where my child was delivered
- 18 Attorney
- 0 Birth injury program staff
- 4 Pediatrician, neonatologist, or other physician who treated my child
- 6 Other health care professional who treated my child (e.g., physical therapist)
- 21 Other (Please specify: _____)

2. Were you aware of the Program before your child's birth? (n=51)

- 1 Yes
- 50 No If no: Please specify how old your child was when you first learned about the Program: _____ average: 22 months

3. How old was your child when you first applied to the Program? (n=49)

Child's Age: _____ average: 39 months

If you did not initiate an application before your child's first birthday, please indicate the reason why. (Check all that apply.) (n=49)

- 31 Did not know about the Program until after my child's first birthday
- 4 Did not realize the extent of the injury until after my child's first birthday
- 4 Could not find an attorney to prepare my application until after my child's first birthday
- 10 Other (Please specify: _____)

4. Were you provided with any written material about the Program before you applied? **(n=51)**

28 No *If no: Please skip to question 6.*

23 Yes *If yes: Who provided the material? (Check all that apply.)*

- 1 The physician who delivered my child
- 2 Staff from the hospital where my child was delivered
- 4 Attorney
- 3 Birth injury program staff
- 3 Pediatrician, neonatologist, or other physician who treated my child
- 2 Other health care professional who treated my child (e.g., physical therapist)
- 6 Other (*Please specify:*) _____

5. Do you feel that the written material provided before you applied to the Program adequately described the benefits and limitations of the Program? **(n=23)**

9 Yes

14 No

6. Please use the space below to provide suggestions for how the Program could best make itself known to potential clients.

Medical Malpractice Cases

7. Did you meet with at least one attorney concerning a possible medical malpractice lawsuit against your physician and/or the hospital in which your child was delivered? **(n=51)**

36 Yes

15 No

8. Do you believe your child's birth-related injury was the result of medical malpractice? **(n=51)**

40 Yes

3 No *If no: Please skip to question 13.*

8 Don't Know

9. Did you file a medical malpractice lawsuit against your physician and/or the hospital in which your child was delivered? **(n=51)**

16 Yes

35 No

10. Based on your experience in the Program and the current cap on medical malpractice awards in Virginia, if you were given the choice today, would you choose to be in the Program or to file a medical malpractice lawsuit on behalf of your child? **(n=45)**

31 Birth injury program

14 Medical malpractice lawsuit

11. In your opinion, what are the advantages of being in the Program, rather than filing a medical malpractice lawsuit on behalf of your child?

12. In your opinion, what are the disadvantages of being in the Program, rather than filing a medical malpractice lawsuit on behalf of your child?

The Eligibility Process for Acceptance into the Program

13. How difficult was the eligibility process for your child's acceptance into the Program? **(n=50)**

- 16 Very difficult
- 10 Somewhat difficult
- 13 Somewhat easy
- 11 Very easy

If you checked "Very difficult" or "Somewhat difficult": Please explain which aspects of the process were difficult.

14. Please rate the helpfulness of the physician who delivered your baby in providing the information needed to apply to the Program. **(n=51)**

- 5 Very helpful
- 5 Somewhat helpful
- 1 Not very helpful
- 27 Not at all helpful
- 13 Not applicable

15. Please rate the helpfulness of the hospital where you delivered your baby in providing the information needed to apply to the Program. **(n=51)**

- 6 Very helpful
- 10 Somewhat helpful
- 4 Not very helpful
- 23 Not at all helpful
- 8 Not applicable

16. Did you hire your own medical expert to provide an opinion on your child's eligibility for the Program during the eligibility process? **(n=51)**

- 16 Yes
- 35 No

17. Did you have an eligibility hearing at the Workers' Compensation Commission? **(n=51)**

11 Yes

40 No *If no: Please skip to question 20.*

18. Did you know whether the Program supported your child's acceptance into the Program prior to the hearing? **(n=11)**

3 Yes

8 No

19. Did you know whether the medical panel from the University of Virginia or the Medical College of Virginia supported your child's acceptance into the Program prior to the hearing? **(n=11)**

4 Yes

7 No

20. Did an attorney help you through the eligibility process? **(n=51)**

30 Yes

21 No

21. In your opinion, do applicants need attorneys during the eligibility process? **(n=51)**

38 Yes

13 No

Please explain why you believe applicants do or do not need attorneys in the space below:

22. Did you or the Program appeal the initial decision at the Workers' Compensation Commission to the full Workers' Compensation Commission? **(n=39)**

- 1 The Program appealed the decision.
- 2 I appealed the decision.
- 36 No Appeal. *(If no appeal, skip to question 24.)*

23. Did you or the Program appeal the decision of the full Workers' Compensation Commission to the Virginia Court of Appeals? **(n=4)**

- 2 The Program appealed the decision.
- 2 I appealed the decision.
- No Appeal.

24. Please use the space below to provide suggestions for improving the eligibility process.

Services Provided by Staff

25. How long did it take for Program staff to contact you after the Workers' Compensation Commission made a decision to accept your child into the Program? **(n=48)**

- 27 Less than 30 days
- 12 30 to 60 days
- 6 More than 60 days
- 1 Never (I have not had any contact with the Program thus far.)
- 2 I contacted them approximately _____ days after acceptance into the Program. *(Please fill in the blank.)*

26. Did Program staff adequately explain the Program to you after your child was accepted? **(n=51)**

- 30 Yes
- 21 No

27. About how long after your child was accepted into the Program did you receive written Program Guidelines? **(n=48)**

- 0 I received the Program Guidelines prior to my child's acceptance into the Program.
- 22 Less than 30 days
- 14 30 to 60 days
- 11 More than 60 days
- 1 Never

28. What year did you receive your most recent copy of the written Program Guidelines?

Year: _____

29. Do you feel that you are adequately informed of changes in Program policies and procedures and other relevant Program issues? **(n=51)**

- 24 Yes
- 27 No *If no: Please provide examples of policies or procedures that were not adequately communicated to you.*

30. Please rate the overall helpfulness of Program staff in providing services. *(For example, this would include answering questions, approving benefit requests, distributing reimbursement checks, and communicating program information.)* **(n=49)**

- 22 Very helpful
- 18 Somewhat helpful
- 8 Not very helpful
- 1 Not at all helpful

31. Please identify any services you would like the Program staff to provide that are not currently provided. *(This does not include specific benefits you would like to receive.)*

Program Benefits

32. Please rate the difficulty level of the process by which you obtain benefits from the Program. *(For example, this would include submitting requests to the Board, submitting receipts for reimbursement, and setting up direct payments to service providers.) (n=50)*

- 6 Very difficult
- 17 Somewhat difficult
- 21 Somewhat easy
- 6 Very easy

33. Based on the needs of your child and family, please rate the overall appropriateness of the benefits offered by the Program. **(n=49)**

- 14 Very appropriate
- 28 Somewhat appropriate
- 2 Somewhat inappropriate
- 5 Very inappropriate

34. In your opinion, what benefits does the Program not provide for your child and/or family that perhaps it should provide?

35. In your opinion, what benefits does the Program provide that perhaps it should not provide?

36. Please indicate how strongly you agree or disagree with the following statement: **(n=51)**

The Program exercises consistent decision-making regarding benefits while considering the individual needs of each child.

- 4 Strongly agree
- 10 Agree
- 8 Disagree
- 16 Strongly disagree
- 10 Don't know/No opinion

37. Typically, how promptly are your benefit requests addressed by Program staff? **(n=48)**

- 10 Very promptly
- 22 Somewhat promptly
- 11 Somewhat delayed
- 5 Very delayed

38. Typically, how promptly are your benefit requests addressed by the Board? **(n=50)**

- 5 Very promptly
- 12 Somewhat promptly
- 10 Somewhat delayed
- 11 Very delayed
- 12 I have never submitted a request to the Board.

39. Typically, how prompt are reimbursement checks you receive from the Program once approval is granted? **(n=47)**

- 17 Very prompt
- 24 Somewhat prompt
- 5 Somewhat delayed
- 1 Very delayed

40. Typically, how prompt are direct payments by the Program to suppliers or other service providers that you use? **(n=50)**

- 12 Very prompt
- 17 Somewhat prompt
- 6 Somewhat delayed
- 1 Very delayed
- 12 Don't know/No opinion
- 2 The Program does not make any direct payments to suppliers or other service providers for my child.

41. Please use the space below to provide suggestions for how the Program can improve the process of obtaining benefits. (*Include comments related to the approval of benefits as well as the reimbursement of expenses.*)

42. Does your child receive nursing care? **(n=51)**

- 25 Yes
- 26 No *If no: Please skip to question 47.*

43. How many hours of nursing care are authorized by the Program each month?
_____ (*If "0": Please skip to question 45.*) **(n=21) average: 120**

44. How many hours of nursing care authorized by the Program each month are typically not provided because a nurse is unavailable? _____ **(n=21) average: 14**

45. How many hours of nursing care are authorized by private insurance or a source other than the Program each month? _____ (If "0": Please skip to question 47.) **(n=2) average: 528**
46. How many hours of nursing care authorized by private insurance or a source other than the Program each month are typically not provided because a nurse is unavailable? _____ **(n=2) average: 91**
47. Do you receive a respite childcare benefit (not including home health nursing care) from the Program? **(n=50)**
- 40 No
- 11 Yes *If yes: Please specify how many hours of respite care are authorized by the Program each month: _____* **average: 10**
48. Which of the following best describes your current housing situation? **(n=50)**
- 4 I rent and have received no housing benefit from the Program.
- 21 I live in a trust home.
- 3 I own my home and have received a cash grant for housing.
- 9 I own my home and have received a housing renovation.
- 8 I own my home and have received no housing benefit from the Program.
- 5 Other *(Please specify): _____*
49. How satisfied are you with how the Program has accommodated your child's housing needs? **(n=49)**
- 18 Very satisfied
- 11 Somewhat satisfied
- 6 Somewhat dissatisfied
- 10 Very dissatisfied
- 4 Did not need a housing benefit from the Program.
50. If your child received a housing benefit, how satisfied are you with how this benefit has accommodated your family's housing needs? **(n=49)**
- 18 Very satisfied
- 10 Somewhat satisfied
- 2 Somewhat dissatisfied
- 3 Very dissatisfied
- 16 Did not receive any housing benefit from the Program.

Overall Experience with the Program

51. How do you rate the Program overall? **(n=50)**

- 16 Excellent
- 7 Good
- 20 Satisfactory
- 3 Unsatisfactory
- 4 Poor

52. What do you think are the Program's greatest strengths?

53. What do you think are the Program's greatest weaknesses?

54. Would you advise expectant mothers to deliver their babies with a participating doctor or at a participating hospital? **(n=51)**

- 34 Yes
- 17 No

Please explain your response in the space below.

Please use the space below for any additional comments related to the Program that you would like to make.

Note: JLARC will host an on-line discussion with BIF parents in September 2002. For those of you who may not have access to the internet at home, we will attempt to coordinate with local libraries to arrange for your access to the on-line discussion. Please indicate below whether you will need JLARC's assistance to participate in the on-line discussion.

- I have internet access at home or elsewhere and do not need JLARC's assistance.
- I do not have internet access at home and would need JLARC's assistance in acquiring access at my local library. (Please indicate the name of your local library:_____)

**Thank you for your time and cooperation.
Please return the completed survey by July 24, 2002
(using the enclosed, postage paid envelope) to:**

**Sandra Wright
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, Virginia 23219**



Appendix E

Commonwealth of Virginia Joint Legislative Audit and Review Commission

Confidential Survey of Physicians Who Participate in the Virginia Birth-Related Neurological Injury Compensation Program

This brief survey, containing only 14 questions, requests information about your participation in the Virginia Birth-Related Neurological Injury Compensation Program (Birth Injury Program). We hope that you will be candid in your responses. Information collected in this survey will be reported primarily in aggregate form and **no identifying information will be given or shared with anyone outside of our agency.** Your answers to the following questions will help us provide valuable information about this program to the Governor and General Assembly, and we appreciate your time and effort.

Please complete this two-sided survey, and return it in the enclosed stamped envelope by July 22, 2002. If you have questions about the survey, please direct them to Scott Demharter (sdemharter@leg.state.va.us or 804-819-4569) or Linda Ford (lford@leg.state.va.us or 804-819-4568).

ID Number: _____ *(Please provide the number included in the JLARC letter you received.)*

1. In what year did you begin practicing obstetrics in Virginia? *(If you first practiced obstetrics in a residency program in Virginia, please indicate the year you began that program.)*

2. Do you routinely notify your obstetric patients about the Birth Injury Program?
(n=127)

29 Yes

98 No *If no: Please specify in the space below why you do not routinely notify your patients about the Program; then skip to question 5.*

3. What method do you **usually** use to notify your patients about the Birth Injury Program? *(Please select all that apply.) (n=55)*

- 29 Provide a program brochure/pamphlet
 - 31 Provide a verbal explanation of the program
 - 5 Other *(please specify):*
-

4. When do you **usually** notify your patients about the Birth Injury Program? *(Please select only one box.) (n=54)*

- 27 During pregnancy
 - 1 Immediately after the birth
 - 23 Upon detection of a birth-related injury
 - 3 Other *(please specify):*
-

5. In your opinion, are the benefits currently provided to the children in the Birth Injury Program reasonable? **(n=127)**

- 46 Don't know what benefits are provided to the children
- 71 Yes
- 10 No *If no: Please explain in the space below why you think the benefits are not reasonable.*

6. Based on your experience with the Birth Injury Program, what are the advantages of the Birth Injury Program for physicians who perform obstetric services? *(Please select all that apply.) (n=125)*

- 15 No advantages
- 61 Participation is cost-effective (in relation to medical malpractice premium credits)
- 55 Participation helps avoid lawsuits
- 75 Program's existence helps stabilize malpractice insurance premiums
- 78 Participation provides peace of mind that birth-injured child is taken care of during his/her lifetime
- 12 Other *(please specify):* _____

7. Based on your experience with the Birth Injury Program, what are the disadvantages of the Birth Injury Program for physicians who perform obstetric services? (*Please select all that apply.*) **(n=84)**

- 15 No disadvantages
- 30 Participation is not cost-effective (in relation to medical malpractice premium credits)
- 44 Participation does not help avoid lawsuits
- 30 Program's existence does not help stabilize malpractice insurance premiums
- 24 Program pays for unnecessary expenses of birth-injured children (inappropriate benefits)
- 16 Other (*please specify*): _____

8. Would you say the assessment you pay for participation in the Birth Injury Program is: **(n=125)**

- 64 Too high
- 1 Too low
- 38 About right / Reasonable
- 22 Do not know / No opinion

9. In the space below, please explain why **you** participate in the Birth Injury Program.

If you did not participate in the Birth Injury Program in at least one of the past three years, answer question 10. Otherwise, skip to question 11.

10. Please identify the reason(s) why you elected not to participate in the Birth Injury Program in at least one of the past three years. *(Please select all that apply.)* **(n=18)**

- 6 Did not know about the Birth Injury Program
- 2 Did not practice obstetrics in Virginia during that time period
- 5 Thought that the Program was not cost-effective (in relation to medical malpractice premium credits)
- 4 Thought that the Program was not properly managed
- 0 Thought that the Program was not beneficial for birth-injured children
- 0 The hospital where I provided obstetric services was a participant in the Birth Injury Program
- 5 Other *(please specify)*: _____

11. What changes, if any, do you think are needed to the Birth Injury Program? *(In providing your response, please explain why you think the change(s) is/are needed.)*

12. Are you a member of a group practice? **(n=126)**

- 31 No *If no, skip to question 14.*
- 95 Yes *If yes: Please specify the name of your group practice:*

13. Does your practice decide as a group whether or not to participate in the Birth Injury Program, or do the physicians in the practice make individual decisions as to whether or not to participate? *(Please select only one box.)* **(n=92)**

- 82 Group decides as a whole
- 10 Each physician decides individually

14. Does your professional liability insurance company require you to participate in the Birth Injury Program? **(n=105)**

37 Yes

68 No

ADDITIONAL COMMENTS

Please use the space below for providing any additional comments you would like to make about the Birth Injury Program. (Attach additional sheets as necessary.)

Thank you for your time and cooperation. JLARC staff will be conducting its review of the Birth Injury Program through the Fall, with a final report expected in November 2002. This report will be available on our web site <http://jlarc.state.va.us>, or by contacting our office.

Appendix F



Commonwealth of Virginia Joint Legislative Audit and Review Commission

Confidential Survey of Physicians Who Do Not Participate in the Virginia Birth-Related Neurological Injury Compensation Program

This brief survey, containing only six questions, requests information about your decision not to participate in the Virginia Birth-Related Neurological Injury Compensation Program (Birth Injury Program). We hope that you will be candid in your responses. Information collected in this survey will be reported primarily in aggregate form and **no identifying information will be given or shared with anyone outside of our agency.** Your answers to the following questions will help us provide valuable information about this program to the Governor and General Assembly, and we appreciate your time and effort.

Please complete this two-sided survey, and return it in the enclosed stamped envelope by July 22, 2002. If you have questions about the survey, please direct them to Scott Demharter (sdemharter@leg.state.va.us or 804-819-4569) or Linda Ford (lford@leg.state.va.us or 804-819-4568).

ID Number: _____ (Please provide the number included in the JLARC letter you received.)

1. In what year did you begin practicing obstetrics in Virginia? (If you first practiced obstetrics in a residency program in Virginia, please indicate the year you began that program.)

_____ If you do not deliver babies as part of the obstetric services you provide in Virginia, please check the box and return the survey in the enclosed envelope.

2. Do you routinely notify your obstetric patients during their pregnancies that you do not participate in the Birth Injury Program? (**n=96**)

3 Yes

93 No *If no:* Why have you decided not to notify your patients about your participation status? (Please specify in the space below.)

3. Why have you elected not to participate in the Birth Injury Program? (*Please select all that apply.*) **(n=80)**

- 57 \$5,000 assessment is too high
- 8 I have not been informed about the Birth Injury Program
- 12 The hospital where I provide obstetric services is a participant in the Birth Injury Program
- 57 Participation is not cost-effective (in relation to medical malpractice premium credits)
- 40 Participation does not help avoid lawsuits
- 33 Participation does not help me get malpractice insurance
- 20 Program is not properly managed
- 11 Program pays for unnecessary expenses of birth-injured children
- 7 Program does not provide adequate benefits for birth-injured children
- 0 I am a resident and the hospital where I provide obstetric services does not participate
- 29 Other (*please specify*): _____

4. If the Birth Injury Program is continued, what changes could be made to the Program that might persuade you to participate? (*In providing your response, please explain why you think the change(s) is/are needed.*)

5. Are you a member of a group practice? **(n=98)**

- 27 No *If no, Skip to "ADDITIONAL COMMENTS."*
- 71 Yes *If yes: Please specify the name of your group practice:*

6. Does your practice decide as a group whether or not to participate in the Birth Injury Program, or do the physicians in the practice make individual decisions as to whether or not to participate? (*Please select only one.*) **(n=65)**

- 60 Group decides as a whole
- 5 Each physician decides individually

ADDITIONAL COMMENTS

Please use the space below for providing any additional comments you would like to make about the Birth Injury Program.

Thank you for your time and cooperation. JLARC staff will be conducting its review of the Birth Injury Program through the Fall, with a final report expected in November 2002. This report will be available on our web site <http://jlarc.state.va.us>, or by contacting our office.



Appendix G

Commonwealth of Virginia Joint Legislative Audit and Review Commission

Survey of Hospitals That Participate in the Virginia Birth-Related Neurological Injury Compensation Program

In January of 2002, the Joint Legislative Audit and Review Commission (JLARC) directed staff to conduct a review of the Virginia Birth-Related Neurological Injury Compensation Program and Fund. As part of this study, JLARC staff are conducting a survey of hospitals that participate in this Program.

Your answers to the following questions will help us provide valuable information about the Birth Injury Program to the Governor and General Assembly. We hope that you will be candid in your responses. Information collected in this survey will be reported primarily in aggregate form and **no identifying information will be given or shared with anyone outside of our agency.** We appreciate your time and effort in filling out the survey. If you need additional space in providing any responses, please attach additional sheets.

Please complete this two-sided survey, and return it in the enclosed stamped envelope by August 20, 2002. Alternatively, you may fax the completed survey to the attention of Linda Ford at 804-371-0101. If you have questions about the survey, please direct them to Linda Ford (804-819-4568) or Wendy Thomas (804-819-4579).

Please complete the information below before returning the survey.

Contact Person for Survey: _____

Position Title: _____

Phone number: _____

E-mail address: _____

1. Does your hospital routinely notify your obstetric patients about the Birth Injury Program? **(n=22)**
- 6 Yes
- 16 No *If no: Please specify in the space below why your hospital does not routinely notify obstetric patients about the Program; then skip to question 4.*
2. What method does your hospital **usually** use to notify your obstetric patients about the Birth Injury Program? *(Please select all that apply.)* **(n=7)**
- 4 Provide a program brochure/pamphlet
- 1 Provide a verbal explanation of the program
- 2 Other *(please specify):* _____
3. When does your hospital **usually** notify your obstetric patients about the Birth Injury Program? *(Please select only one box.)* **(n=7)**
- 1 When obstetric patient registers at or is admitted to the hospital
- 1 Immediately after the birth
- 3 Upon detection of a birth-related injury
- 2 Other *(please specify):* _____
4. Based on your hospital's experience with the Birth Injury Program, what are the advantages of the Birth Injury Program for hospitals that provide obstetric services? *(Please select all that apply.)* **(n=16)**
- 2 No advantages
- 9 Participation is cost-effective (in relation to medical malpractice premium credits)
- 6 Participation helps avoid lawsuits
- 10 Program's existence helps stabilize malpractice insurance premiums
- 14 Participation provides peace of mind that birth-injured child is taken care of during his/her lifetime
- 3 Other *(please specify):* _____

5. Based on your hospital's experience with the Birth Injury Program, what are the disadvantages of the Birth Injury Program for hospitals that provide obstetric services? *(Please select all that apply.) (n=23)*

- 9 No disadvantages
- 5 Participation is not cost-effective (in relation to medical malpractice premium credits)
- 6 Participation does not help avoid lawsuits
- 6 Program's existence does not help stabilize malpractice insurance premiums)
- 3 Program pays for unnecessary expenses of birth-injured children inappropriate benefits
- 4 Other *(please specify)*: _____

6. Would you say the assessment your hospital pays for participation in the Birth Injury Program is: **(n=22)**

- 7 Too high
- 0 Too low
- 12 About right / Reasonable
- 3 Do not know / No opinion

Comments:

7. Is the decision whether or not the hospital will participate in the Birth Injury Program made by personnel at your hospital? **(n=22)**

- 16 Yes
- 6 No *If no: Please identify in the space below the name and contact information for the entity that makes this decision. (For example, if the decision is made by an official of the corporation that owns the hospital, please identify the corporation name and a contact name and phone number of the decision-maker at the corporation.)*

If you answered "No" to question 7, please skip to question 12. Otherwise, proceed to question 8.

8. In the space below, please explain why **your hospital** participates in the Birth Injury Program. In answering this question, please identify the factors your hospital considers in making the decision whether or not to participate.

If your hospital did not participate in the Birth Injury Program in at least one of the past three years, answer question 9. Otherwise, skip to question 10.

9. Please identify the reason(s) why your hospital elected not to participate in the Birth Injury Program in at least one of the past three years. *(Please select all that apply.)* **(n=0)**

- Did not know about the Birth Injury Program
- Did not provide obstetric services during that time period
- Thought that the Program was not cost-effective (in relation to medical malpractice premium credits)
- Thought that participation did not help avoid lawsuits
- Thought that the Program was not properly managed
- Thought that the Program was not beneficial for birth-injured children
- Other *(please specify)*: _____

10. Does your hospital's professional liability insurance company require your hospital to participate in the Birth Injury Program? **(n=23)**

- 1 Yes
22 No

11. To what extent does the premium discount/credit provided to your hospital by its professional liability insurance company for Program participation cover the hospital's cost of participation? **(n=13)**
- 1 The insurance company's discount/credit covers 100 percent of the cost of the hospital's participation in the Program
 - 0 The insurance company's discount/credit covers 50 to 99 percent of the cost of participation in the Program
 - 3 The insurance company's discount/credit covers 1 to 49 percent of the cost of the hospital's participation in the Program
 - 7 The hospital does not receive a discount/credit from its professional liability insurance company for Program participation
 - 2 Other (*please specify*): _____
12. Does your hospital **require the physicians** who deliver babies at your hospital to participate in the Birth Injury Program? **(n=22)**
- 1 Yes
 - 21 No
13. What changes, if any, do you think are needed to the Birth Injury Program? (*In providing your response, please explain why you think the change(s) is/are needed.*)

ADDITIONAL COMMENTS

Please use the space below for providing any additional comments you would like to make about the Birth Injury Program. (*Attach additional sheets as necessary.*)

Thank you for your time and cooperation. JLARC staff will be conducting its review of the Birth Injury Program through the Fall, with a final report expected in November 2002. This report will be available on our web site, <http://jlarc.state.va.us>, or by contacting our office.



**Commonwealth of Virginia
Joint Legislative Audit and Review Commission**

**Survey of Hospitals That Do Not Participate in the
Virginia Birth-Related Neurological Injury Compensation Program**

In January of 2002, the Joint Legislative Audit and Review Commission (JLARC) directed staff to conduct a review of the Virginia Birth-Related Neurological Injury Compensation Program and Fund. As part of this study, JLARC staff are conducting this brief survey of hospitals that do not participate in this Program.

Your answers to the following questions will help us provide valuable information about the Birth Injury Program to the Governor and General Assembly. We hope that you will be candid in your responses. Information collected in this survey will be reported primarily in aggregate form and **no identifying information will be given or shared with anyone outside of our agency.** We appreciate your time and effort in filling out the survey. If you need additional space in providing any responses, please attach additional sheets.

Please complete this two-sided survey, and return it in the enclosed stamped envelope by August 20, 2002. Alternatively, you may fax the completed survey to the attention of Linda Ford at 804-371-0101. If you have questions about the survey, please direct them to Linda Ford (804-819-4568) or Wendy Thomas (804-819-4579).

Please complete the information below before returning the survey.

Contact Person for Survey: _____

Position Title: _____

Phone number: _____

E-mail address: _____

1. Does your hospital routinely notify your obstetric patients that the hospital does not participate in the Birth Injury Program? **(n=23)**

0 Yes

23 No *If no:* Please specify in the space below why your hospital does not routinely notify your obstetric patients about the hospital's participation status.

2. Is the decision whether to participate in the Birth Injury Program made by personnel at your hospital? **(n=23)**

22 Yes

1 No *If no:* Please identify in the space below the name and contact information for the entity that makes this decision. *(For example, if the decision is made by an official of the corporation that owns the hospital, please identify the corporation name and a contact name and phone number of the decision-maker at the corporation.)*

If you answered "No" to question 2, please skip to question 5. Otherwise, proceed to question 3.

3. In the space below, please explain why your hospital has decided not to participate in the Birth Injury Program. In answering this question, please identify the factors your hospital considers in making the decision whether or not to participate.

4. If the Birth Injury Program is continued, what changes could be made to the Program that might persuade your hospital to participate? In providing your response, please explain why you think the change(s) is/are needed.

5. Does your hospital **require the physicians** who deliver babies at your hospital to participate in the Birth Injury Program? **(n=23)**

0 Yes

23 No

ADDITIONAL COMMENTS

Please use the space below for providing any additional comments you would like to make about the Birth Injury Program. (*Attach additional sheets as necessary.*)

Thank you for your time and cooperation. JLARC staff will be conducting its review of the Birth Injury Program through the Fall, with a final report expected in November 2002. This report will be available on our web site, <http://jlarc.state.va.us>, or by contacting our office.

Appendix H

As part of an extensive data validation process, the major entities involved in a JLARC assessment effort are given an opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from the written comments have been made in this revision of the report.

This appendix contains the written responses of the Virginia Birth-Related Neurological Injury Compensation Program, the Workers' Compensation Commission, the State Corporation Commission, the Board of Medicine, and the Virginia Department of Health.

NOV 6 - 2002



VIRGINIA BIRTH-RELATED
NEUROLOGICAL INJURY
COMPENSATION PROGRAM

November 5, 2002

Mr. Philip Leone
Director, Joint Legislative Audit and Review Commission
Suite 1100
General Assembly Building, Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

Please find enclosed the Virginia Birth-Related Neurological Injury Compensation Program's response to the Commission's recently completed review. The Board of Directors would like to express their appreciation for the thorough work of your staff and the opportunity to provide this response.

A lifetime of help

Phone: 804-330-2471

Fax: 804-330-3054


9100 Arboretum Pkwy

Suite 365

Richmond, VA 23236

www.vabirthinjury.com

Sincerely,


George Deebo
Executive Director

**Virginia Birth-Related Neurological Injury Compensation Program's
Response To The Joint Legislative Audit & Review Commission
November 5, 2002**

The Board of Directors of the Virginia Birth-Related Neurological Injury Compensation Program commends JLARC on their exhaustive efforts in reviewing the Program. The review bears out that several purposes of the Birth-Injury Program clearly have been obtained. These include improving the lives of severely birth-injured children and improving the ability of obstetricians and other physicians to obtain affordable malpractice liability coverage.

On improving the lives of the involved children the review notes:

This review found that the birth injury program is largely beneficial to the birth injured children accepted into the program. (Page 25)

Overall, it appears the benefits offered by the program are generally more advantageous to birth-injured children than a medical malpractice award. (Page 25)

Further, the program appears to have met the goal of directing more of the money to meet the children's needs than the tort system does. (Page 26)

On holding down the cost of malpractice premiums the review notes:

...it [Birth-Injury Program] reasonably can be considered one factor in encouraging insurers to bring their business to Virginia. (Page 36)

Based on this comparison, the average base premiums charged in 1996 and 1997 by this insurer for ob/gyns in Virginia were the 5th and 6th lowest average rates, respectively. (Page 37)

The Birth-Injury Program's Board also agrees with the JLARC review that while the Program has been successful in many areas, other original purposes of this first-of-its-kind program may be less clear at this point. However, it's notable that the Program continues to receive inquiries from other states and even the Chief Medical Officer's Office of the United Kingdom concerning setting up similar programs. Along with displaying interest in the Birth-Injury Program by other governments, these inquiries demonstrate the current universal struggle in dealing with the problem of runaway medical liability coverage costs and access to obstetrical care.

Comments On Three Overarching Options

JLARC's review also stipulates three overall options for the future of the Program. The first, maintaining the current general structure, provides the best scenario for citizens of

the Commonwealth, and especially for the current and future participants of the Program. The Board recognizes the need for some minor revisions to meet the changes in the healthcare environment since the Program's inception in 1987. The Board also notes that it has required 15 years to gain enough programmatic and actuarial experience to reasonably evaluate many aspects of the Program. This emphasizes the uniqueness of this legislation.

The second option, requiring mandatory participation by obstetricians, is a viable possibility and even has a precedent in Florida law, however it merits additional study before a decision is reached.

The third option is regressive. The elimination of this program might well return Virginia's healthcare environment, including its liability insurance situation, back to a volatile climate that once threatened access to healthcare services in Virginia. That turmoil currently is being experienced in many other states. In fact, at least three states have had to hold emergency legislative sessions in the past year to deal with a malpractice crisis, in sharp contrast to the reasonably stable condition that exists in Virginia. As noted in JLARC's review, abandoning this program would not be in the best interests of the children eligible for this program as they would have fewer overall benefits and would lack the provisions that do not exist in any other public programs. Additionally, for some eligible children, other state resources would undoubtedly be required for their support and care.

Overall, the Birth-Injury Program, as noted in this JLARC report, continues to successfully meet its primary goals. In many ways it even may be considered one of the General Assembly's most innovative efforts. However, a key need is to obtain more data on the long-term funding needs. While the current actuarial reports note possible shortfalls, the actuarial assumptions continue to be based on limited experience. The Board believes that only additional years of Program experience will provide the data needed for accurate projections.

We agree with the illustration provided in chapter one that the concomitant severe reduction in revenue and the significant increase in expenses had a negative impact. However, we hope that JLARC does agree that the current Board has taken appropriate available remedies. Due to the nature of the legislation, little leeway is provided for the Board to take actions to secure the financial future of the Program and therefore the Board requests that the General Assembly carefully consider and address the financial issues.

In the introduction to the recommendations the report states that this program is "...more costly than Virginia's tort alternative." The basis for this assertion apparently is Exhibit 2, page 44. We ask that these data be re-examined as they do not seem to provide an appropriate comparison. For example, the analysis of tort performance is a one-year, one time analysis for 5 clients. Furthermore, it does not account for the expense of the plaintiff's lawyer, often quoted as 40 percent or more of the award. On the other hand, the analysis of the Fund does not give recognition to the fact that it addresses the needs of

about 70 clients. Furthermore, the provisions are not “one time” but for a lifetime and that fund growth for future needs (for example, lost income) must be incorporated.

Response To Individual Recommendations

JLARC has stated 41 specific recommendations. Following are the Board’s specific responses to each these recommendations.

Recommendation 1.

The board concurs but notes there will be no practical impact in the foreseeable future.

Recommendation 2.

This recommendation has been practiced on occasion in the past and the Board believes it is useful. However, the cost of conducting such studies is in the tens of thousands range, which impacts the overall financial situation of the Fund.

Recommendation 3.

The Board would suggest this recommendation receive further study due to the fact it may well discourage participation in the Program by obstetricians by circumventing the Program’s purpose, which is to take such cases out of the tort system.

Recommendation 4.

A more specific and defined time period would be a positive step and would help remove some of the variables in the legislation.

Following is a response to discussion concerning a birth-weight limit on pages 77 & 78 of the JLARC review.

The Board respectfully requests that the JLARC reconsider its position regarding the issue of prematurity as now stated on pages 77 and 78. We base our request on the following considerations. First, we quote from page 72 of your document on which you correctly state: “The resulting definition was intended to include events that occur during the birthing process that may reasonably be considered to be under the control of the obstetrician. The underlying premise in these cases is that the child would have been healthy except for an event that occurred during labor and delivery.” Indeed, it was made clear in the act that causes for disability beyond the reach of medical intervention, such as genetic disorders, were not to be included. It was also made clear that events remote from the processes of labor, delivery and immediate resuscitation also were not intended to be included.

Second, your document, on page 77, illustrates that babies born prematurely have severe disabilities as a group. Indeed, these disabilities include neurological disorders that increase both in frequency and severity as birth-weight decreases. Although more research is needed, current knowledge indicates that the human brain is not fully developed at these early times of pregnancy and, unfortunately, birth before full development often causes lifetime disability. Additionally, there is increasing evidence that unknown intrauterine infections cause both brain injury such as periventricular leukomalacia (PVL) and cause early delivery. The following are quotations from a document soon to be published in the US that is a sequel to the British Medical Journal article quoted in your text.

- "...preterm or low-birth weight (<2500 g) infants suffer at least eight-fold greater risks of cerebral palsy than term infants..."
- "Intrauterine infection and inflammation are similarly linked to intraventricular leukomalacia, bronchopulmonary dysplasia, and cerebral palsy in the fetus and newborn."
- "Chorioamnionitis in very-low-weight infants is significantly associated with an increase in periventricular leukomalacia."
- "Intrauterine infection may precede pregnancy or be established very early in pregnancy. Endometrial or decidual infection may remain clinically unrecognized and may even persist from one pregnancy to the next."
- "Infection/inflammation is the most commonly identified cause of preterm birth at the lowest viable gestational ages."

You have made specific mention that the Florida program, in its legislation establishing a similar program, deliberately excluded premature babies, and defined them by weight. Undoubtedly, they were influenced by data similar to those that you have now reviewed. We agree with your discussion regarding the imprecision in defining prematurity. However, this problem is not new. The birth weight of <2500 g is the most widely accepted standard and is the most reliably documented measure in clinical use. Birth weight is an objective measure and not subject to legal dispute. We ask that you seriously reconsider your position and make a recommendation that prematurity, defined by weight, be added to the exclusions. Indeed, a mother may have concern regarding the medical management of her pregnancy or the delivery of her premature child, or of her genetically affected child, or of her congenitally abnormal child. However, those concerns should not be included in this program and can be pursued by other legal means.

We wish to add, for information, that there are important but less publicized issues than prematurity that soon may require your attention. Please consider the following quote from the document mentioned above: "Another group of investigators reported the risk of producing at least one child with cerebral palsy from one pregnancy to be 15 per 1,000 for twins, 80 per 1,000 for triplets, and 429 per 1,000 for quadruplets." In other words, multiple pregnancies are another important cause of cerebral palsy. Multiple pregnancy is on the rise nationwide because women are delaying childbirth and because of in-vitro fertilization, both of which increase the incidence. This is further complicated

by the fact that if one of the fetuses in a multiple pregnancy dies in-utero it may cause neurological damage to the remaining fetus(es). Consider these data: "...series in which one twin had died in utero, the incidence of mental retardation was 40% and that of seizures was 20%." "A series of 79 sets of triplets noted seven cases in which one fetus died in utero and found a prevalence of cerebral palsy of 154 per 1,000 among those who survived to 1 year, compared with 29 per 1,000 when all the triplets were born alive..." The numbers here are small and are suggestive rather than statistically conclusive. However, it appears that even more issues must be faced in the future. It would seem prudent to adjust the entry criteria to exclude premature infants now and consider other issues when the data are more certain.

Recommendation 5.

Removing the ability of the Program to provide uniquely available insight and information would be of concern to the Birth-Injury Program. There is a legitimate need for the interests of the Birth-Injury Program to be represented. It's vital to assure an appropriate system of checks and balances is maintained.

Recommendation 6.

We concur with this recommendation.

Recommendation 7:

No comments on the specific recommendation, however the Program highly encourages increased communication, information exchange and coordination between the Worker's Compensation Commission and medical review panels.

Recommendation 8.

We concur with this recommendation and would note that a draft of such a document has already been completed.

Recommendation 9.

The Board concurs with this recommendation.

Recommendation 10.

The Board concurs with this recommendation.

Recommendations 11, 12, 13

No comments.

Recommendation 14.

The Board concurs with this recommendation.

Recommendation 15.

The Board concurs with the recommendation but would suggest that these requirements be included elsewhere in the legislation.

Recommendation 16.

No comments.

Recommendation 17

The Birth-Injury Board recommends appropriate medical experts review this item. It should be noted that fetal monitoring strips are only one of several key indicators. If such an assumption is made which leads to increased numbers of children in the Program, then additional funding will be required.

Recommendation 18.

Such fines may discourage participation in the Programs by hospitals. Additionally, any such fines would be unlikely to offset the increased costs to the Birth-Injury Program.

Recommendation 19.

Such a provision will obviously increase the administrative costs of the Birth-Injury Program and appear to be contrary to usual and customary practices.

Recommendation 20.

The Board concurs with this recommendation.

Recommendation 21, 22, 23.

No comments.

Recommendation 24.

The Board concurs with this recommendation.

Recommendation 25.

Implementing such a provision would surely discourage participation by physicians in the Birth-Injury Program due to the additional administrative burden and the potential elimination of the very reason the physicians enter the Program.

Recommendation 26.

The Board concurs with this recommendation. Over the years the Birth-Injury Program has distributed tens of thousands of brochures, plus television commercials, print advertisements, meeting presentations and other methods to disseminate information about the Program. The Program agrees with the need to continually develop and implement public information campaigns to accomplish this goal.

Because the Board takes very seriously its fiduciary responsibility to the Program and its claimants, the benefits of conducting broad information campaigns must always be weighed against the cost to the Program and ultimately, its beneficiaries before undertaking such an effort.

Recommendation 27.

The Birth-Injury Program's guidelines are provided to all new claimants and upon request by current claimants. Current guidelines were made available on-line in June 2002.

The process of developing an updated set of guidelines has been underway since early 2002. Due to the fact that every child's situation truly is unique because of specific medical needs, it's a demanding process to develop flexible yet well defined guidelines. The Program expects to have the new guidelines available early in 2003.

Recommendation 28.

While a reasonable suggestion that is fully supported by the Board, there are many challenges in fulfilling this need in a manner responsible to all Program concerns and Program stakeholders. The Program will continue to seek an appropriate and financially feasible solution.

Recommendation 29.

As indicated, a housing benefit (providing a house) is not a part of the current legislation. Early in the program it was apparent that average homes might not provide well for the needs of those who are severely handicapped. Due to the availability of funds in the early years of the Program, housing was provided to claimants through various methods. Building Trust Homes was pursued but proved unaffordable and difficult to manage. Several other methodologies have been tried. Currently the Program continues to provide housing modifications (usually including the addition of a bedroom and bath) to make

homes handicapped accessible. The Birth-Injury Board recognizes the valuable role handicapped accessible housing can play in the life of claimants, as well as the fact no other assistance program offers such a benefit. The Board cautions that should a housing requirement be added to the legislation, additional funding should also be provided to pay for the increased benefit

Recommendation 30.

This is a very complex issue that the Birth-Injury Program continually examines. The Board highly recommends that this issue be carefully studied before any mandates are implemented which may cause claimants to discontinue their participation in private insurance programs which are the primary payment source for their children. Should the Program be mandated to pay for all of these insurances, additional funding would need to be provided.

Recommendation 31.

The Program agrees that this issue needs continued review. Currently, by evaluating each situation individually, the Program has been able to utilize this flexibility to maintain insurance coverage for virtually all claimants.

Recommendation 32.

The Board concurs with this recommendation.

Recommendation 33.

This process has been in place for many years, is regularly utilized by claimants and appears to meet current needs.

Recommendation 34.

Privacy of claimants is and must be a primary concern of the Board and could be jeopardized by subjecting the Program to the FOIA, PPA and APA. Additionally, the Board believes that placing the Program under these acts would severely hamper the ability of the Birth-Injury Program to complete its day-to-day functions in a cost effective manner. As a small organization of a half-dozen employees, meeting the demands of these Acts would detrimentally impact service to claimants and/or require hiring additional staff and thereby expend funds better utilized in providing claimant benefits.

Since the Program's inception the Attorney General's office has provided capable legal representation that is sincerely appreciated. The Board agrees it would be advantageous to require the Attorney General's office to represent the Program. However, experience has shown that there are instances in which both the Attorney General's office and the Program agree it's in the best interest for all parties to have outside counsel. We highly recommend that this latitude in specific circumstances be maintained.

Recommendation 35.

The Program concurs with the ongoing need to improve communication. As noted, regional group meetings are planned (underway) and will be completed on November 13, 2002. Over the past six months several upgrades to the website have been made and others are in process.

Recommendation 36.

This is a regular practice of the Program.

Recommendation 37.

The Program concurs this is an ongoing need and continues to work with claimants on a family-by-family basis to meet individual needs.

Recommendation 38.

The Program welcomes financial planning assistance. However it seems fair that it be clear that this recommendation is not in response to some deficiency. The Board would note that during the 2001-2002 state fiscal year, the Birth-Injury Program's financial reserves earned a 5.14 yield. In comparison, the Commonwealth of Virginia's retirement system lost about 8 percent of its total assets and the Standard & Poor 500 showed a 20 percent loss.

Recommendation 39.

This is currently the Birth-Injury Board's practice.

Recommendation 40.

The Board recognizes this need and has taken steps towards this goal.

Recommendation 41.

Concerning changing the non-participating board member to a citizen representative.
In the past, the Board and Program claimants have benefited tremendously from pediatrician and other specialty board members who have been able to lend their expertise so that the Board could make the most appropriate and effective decisions pertaining to the care of children participating in the Program.

Also, assessments of non-participating physicians provide a key portion of the Program's funding. Eliminating the non-participating physician representative while continuing to

assess them for the support of the Program would most likely not be well received. It would make non-participating physicians the only group providing funding but without a board seat. It would be a violation of the well-tested American principal of “no-taxation without representation.”

Concerning adding Board members:

The Program is supportive of having Board members with experience and expertise salient to the organization’s purpose and function.

Concerning disqualifying physicians or those with health care experience from being citizen board members:

This recommendation presumes an adversarial relationship between health care entities and claimants that does not and should not exist. Citizen representatives with expertise in health policy can offer important insight and guidance that benefits the program and its claimants. It would appear equally effective to direct the Governor’s office, which makes all Program board appointments, to provide for a diverse and appropriate mix of Board members during the selection process.



NOV - 1 2002

COMMONWEALTH of VIRGINIA

WORKERS' COMPENSATION COMMISSION

1000 DMV DRIVE

RICHMOND, VIRGINIA 23220

WILLIAM L. DUDLEY, JR., CHAIRMAN
LAWRENCE D. TARR, COMMISSIONER
VIRGINIA R. DIAMOND, COMMISSIONER

MARY ANN LINK, CHIEF
DEPUTY COMMISSIONER
LOU-ANN D. JOYNER, CLERK

November 1, 2002

Philip A. Leone, Director
Joint Legislative Audit
and Review Committee
Suite 100
General Assembly Building
Capitol Square
Richmond, Virginia 23219

Re: Review of the Birth-Related Neurological Injury Compensation Program

Dear Mr. Leone:

Thank you for the opportunity to review the exposure draft of the referenced document. I have only a few very minor suggestions.

Page 79 – Codified Application Process
The petition is actually filed with the Clerk of the Workers' Compensation Commission.

Page 80 – Second Full Paragraph, Last Sentence

- Delete "to hold hearings in all cases,"
- Substitute with "to require medical panel reports in all cases before entering awards,"

A representative of this agency will be present on November 12, 2002, in Senate Room A, but we do not wish to reserve time to speak.

Sincerely yours,

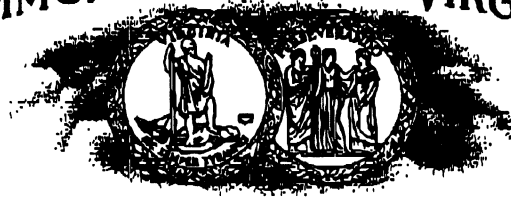
A handwritten signature in cursive script that reads "Mary Ann Link".

Mary Ann Link
Chief Deputy Commissioner

MAL/kld

COMMONWEALTH OF VIRGINIA

NOV 4 - 2002

ALFRED W. GROSS
COMMISSIONER OF INSURANCEP.O. BOX 1157
RICHMOND, VIRGINIA 23218
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<http://www.state.va.us/scc>STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

November 4, 2002

VIA FAX: 371-0101

Ms. Linda Ford
Chief Legislative Analyst
Joint Legislative Audit and Review Commission
General Assembly Building, Suite 1100
Capitol Square
Richmond, Virginia 23219

RE: Review of the Virginia Birth-Related Neurological Injury Compensation Program

Dear Ms. Ford:

We have reviewed the exposure draft of the Joint Legislative Audit and Review Commission and have the following comments.

1. Recommendation #2 states that the board of directors should conduct annual evaluations of the actuarial assumptions and communicate its findings to the State Corporation Commission. We would suggest that the recommendation state that the board's annual evaluations of the actuarial assumptions *shall be made available* to the State Corporation Commission and its actuaries *upon their request*, rather than require the annual evaluations to be reported to the Commission.
2. We would also like to point out that the annual cost to the State Corporation Commission in actuarial fees incurred pursuant to § 38.2-5021 has averaged \$83,321 for the past two years. This does not include in-house staff costs. You may wish to include this information in the report.

Thank you for the opportunity to provide these comments. If you have any questions, please feel free to contact us.

Sincerely,

Mary M. Bannister
Deputy Commissioner
Property and Casualty Division



NOV 6 - 2002

COMMONWEALTH of VIRGINIA

Robert A. Nebiker
Director of the Department

William L. Harp, M.D.
Executive Director of the Board

medbd@dhp.state.va.us

Department of Health Professions
Board of Medicine

November 6, 2002

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Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, VA 23219

Dear Mr. Leone:

Thank you for the opportunity to review the section of JLARC's exposure draft that pertains to the Board of Medicine's review process in relation to the Virginia Birth-Related Neurological Injury Compensation Program. In preparing these comments, I have reviewed the exposure draft, Section 38.2-5000 et seq. of the Code of Virginia, abstracts of the literature on asphyxia neonatorum identified by the OVID medical search engine and current textbook recommendations for fetal monitoring in labor and delivery. Within the Department of Health Professions, I have coordinated with the Director, the Director of the Enforcement Division and the President of the Board of Medicine. External to DHP, I have had brief conversations with the Executive Director for the Center for Quality Health Care Services and Consumer Protection, the Executive Director for the Birth Injury Fund, OAG counsel to the Program and have obtained the national malpractice experience data on neurological deficit and other birth related injuries compiled by Physician Insurers Association of America. The Board notes that the policy analyst for this matter did not choose to speak with the Executive Director for the Board of Medicine, or with the President of the Board, who is board-certified in obstetrics and gynecology. Arguably, the greatest amount of technical and clinical expertise regarding the Board's handling of these matters rests with these two individuals.

As a preface to further comment, several points should be made. The Board of Medicine labors under specific confidentiality statutes, the violation of which is a crime. In certain circumstances, these statutes limit the Board in its ability to communicate with interested parties regarding disciplinary matters. Also, it should be noted that the review process for standard of care cases,

including birth injury program petitions, has metamorphosed over the years. More standard of care cases that do not rise to the level of a violation are now closed in an “undetermined” status, which allows the Board to revisit the case in light of new information or the filing of a similar case. And as a final prefacing comment, implementation of any new recommendations by the Board will most likely necessitate additional resources.

The exposure draft characterizes the Board’s current review process as being less than thorough in both the investigative and administrative realms. The reader of the draft is led to believe that, as a result of the current process, physician wrongdoing has gone undetected and unpunished. The criticism of the current process appears to be based on several points: 1) the lack of physician discipline by the Board in these cases, 2) the absence of a brief identifying the reason for the Board’s determination to close a particular case, and 3) the lack of interviews of individuals involved in the cases. The draft cites a single example in which the president of the Board asked to look at a previous complaint against a physician and found that it concerned the same birth. The case was then investigated more fully. This example indicates that the checks and balances, indeed the serial reviews, built into the system work as they should.

The Board’s process has been to review the petition of the claimant submitted to the Program and to the Workmen’s Compensation Commission on behalf of an injured infant. The petition includes the statement of the claimant and the medical records pertinent to the case. Section 38.2-5001 of the Code of Virginia defines a birth-related neurological injury as “an injury to the brain or spinal cord caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate postdelivery period in a hospital.” The statement of the claimant along with the mother’s and infant’s medical records sent to the Board document this phase of the physician’s care. Unless there is information of a complaint nature concerning other care by the physician or documentation that raises concerns in the petition, the focus of the review of the physician’s care is the period of labor and delivery. The records for labor and delivery that accompany the petition document the period of concern. On occasion, fetal monitoring strips have not been included in the petition, and the Board has had to ask for them. After review of the petition and any additional material, the Board may seek further investigation about the care rendered, close the case for lack of evidence of a violation or bring the physician in for an administrative hearing. The Board’s practice has been to have these cases reviewed by the Executive Director for the Board and an OB/GYN member of the Board. Staff may not close a case; only a Board member may close a case. Only the President of the Board may send a case forward to an administrative proceeding.

There is no prohibition on the claimant in regards to filing an expanded complaint against the physician with the Board of Medicine along with the petition to the Program. It is significant that this has not occurred. Also, Section 38.2-

5007 of the Code of Virginia states that any party to a petition may serve interrogatories and take depositions. This mechanism also serves to collect data about a case that may be beyond the scope of the eligibility issue that should be made available to the Board.

As stated above, the reader may be led to think that not only is the Board's review process flawed, but that there may be frequent negligence on the part of physicians. A review of the literature would not suggest this to be the case. In fact, the issue of physician wrongdoing becomes even less certain when attending to the details of science in these unfortunate situations. Perinatal asphyxia is a problem worldwide. The exact incidence is difficult to determine, but studies estimate 2% or greater of all births may involve hypoxic episodes. Hypoxic events can be difficult to anticipate and difficult to detect. Algorithms have been developed to deal with indications of fetal distress. At every step, it is the responsibility of the physician to assess the data and make his/her best decision. Contrary to popular belief, a Cesarean section is not always the answer to fetal distress. A Swedish study found that an increase in the C-section rate does not lower the rate of perinatal asphyxia. Abnormal fetal heart rate patterns, meconium staining and breech presentation are not automatic indicators for C-section, which can have significant morbidity for the mother. The current state of the science and art of obstetrics is that despite any given physician's highest suspicion, greatest vigilance and application of a systematic approach in any given delivery, perinatal asphyxia can, and at a rate of 2% or more, will occur. Some of these events will result in neurological injury. Given the foregoing, it cannot be said with any degree of confidence that a significant number of infants with neurological sequelae are mishandled during labor and delivery. Nor is it surprising, in light of the science, that there have been no actions taken by the Board of Medicine, which must provide affirmative evidence of wrongdoing. In administrative process, it is the responsibility of the Commonwealth to prove by evidence, at a clear and convincing level, that not only was substandard care rendered, but that it rose to the level of a violation of law.

National malpractice experience data from January 1985 to June 2001 compiled by PIAA, which has statistics for approximately 60 % of US physicians, yield an average of 189 paid claims per year. Extrapolating for the other 40% not included in this data set, the number of paid claims per year for neurological birth injury may be approximately 315. Based on population, these numbers equate to 7-8 paid claims per year for the Commonwealth. A finding of a breach of the standard of care that is simply negligent suffices in these cases, and in some, paid claims may occur with no evidence of any wrongdoing by the physician.

The gross negligence standard is also mentioned as an impediment to discipline in these cases. Again, based upon the infinitely variable process that is labor and delivery, it would be very difficult to find gross negligence, except in

those circumstances in which it is clear that the physician's conduct was recklessly negligent relative to clear-cut data in the record.

The draft indicates that one way in which gross negligence can be determined is by repeated acts of negligence. This historically has been the Board's avenue to find a physician in violation of the law by conducting his/her practice in a manner to be a danger to patients and the public, rather than making the determination of gross. The Board can take action when it determines that a physician is dangerous, just as it can with the determination of gross. However, to make the determination of dangerousness based on a pattern of simple negligence, there must be evidence to support the allegations in more than one case. A previously closed undetermined case is only reviewed if there is potential probable cause in the current case, to which data from the previous case can be added. If probable cause does not exist in the current case, then the previous case becomes moot. In essence, with a determination of no violation in a current case, the Board has no foundation to which it can add information from a previously closed undetermined case. The Board considers two cases sufficient to establish a pattern. This allows a physician to be noticed for danger to patients if there is probable cause of a violation in two cases. At this time, the Virginia Board does not have the authority to notice a physician for a single incident of simple negligence.

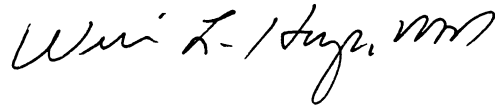
It is very understandable that families would have great curiosity about the events surrounding the birth of an injured infant. The public generally has expectations of the Board beyond its authority, and it would be expected that at least some of the families would experience disappointment and anger upon being informed that the Board determined that no law was violated. When informing a family of a determination, there can be, by law, no explanation of the events of the birth, no explanation of how the Board reached its determination, just the determination. This is not settling to those citizens who expect more. The possible emotional toll exacted by family involvement needs to be weighed against the benefit to the process of the Board's mission to protect the public.

It is recommended in the draft that the Board of Medicine immediately begin notifying all affected parties in these cases. Section 38.2-5004(A)(2) of the Code of Virginia requires that the Workmen's Compensation Commission forward a copy of the petition to the Board of Medicine. The Board has routinely notified the Program of its determination in these cases. Section 54.1-2400.2 of the Code of Virginia requires that information relative to a possible disciplinary proceeding be held in strict confidence. If current law prohibits the release of information to any affected parties, then legislation might be in order. Further, there is no statutory mechanism, other than by court order, for the Board to share confidential information with the Center for Quality Health Care Services and Consumer Protection.

I do hope these comments will be helpful in your agency's quest to understand the Board's processes. The Board strives, within its current authority, to protect the public and does its best to insure the integrity of its work. Suggestions that might improve the processes of the Board are welcomed. The Board appreciates the analysis and insights of the exposure draft and therefore, lends its support to Recommendations (21) and (22).

I have attached several abstracts that are supportive of the above clinical information. Again, on behalf of the Board, thank you for the opportunity to comment at this time on this very important piece of work.

With kindest regards,

A handwritten signature in black ink, appearing to read "William L. Harp, M.D.", with a stylized flourish at the end.

William L. Harp, M.D.
Executive Director

Wlh/dao

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Heinonen S. Saarikoski S.

Institution

Department of Obstetrics and Gynecology, Kuopio University Hospital, Finland.
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Title

Reproductive risk factors of fetal **asphyxia** at delivery: a population based analysis.

Source

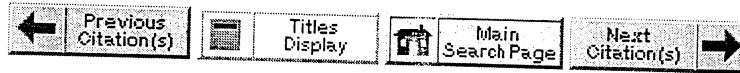
Journal of Clinical Epidemiology. 54(4):407-10, 2001 Apr.

Abstract

To investigate reproductive maternal risk factors of intrapartum fetal **asphyxia**, we analyzed 556 women with singleton pregnancies complicated by intrapartum fetal **asphyxia** who gave birth at Kuopio University Hospital from January 1990 to December 1998. The general obstetric population (N=21746) was selected as the reference group and logistic regression analysis was used to identify independent reproductive risk factors. The incidence of intrapartum fetal **asphyxia** was 2.5%. Placental abruption, primiparity, alcohol use during pregnancy, low birth weight, preeclampsia, male fetuses, and small-for-gestational age births were independent risk factors of intrapartum **asphyxia**, with adjusted relative risks of 3.74, 3.10, 1.75, 1.57, 1.49, 1.48 and 1.33, respectively. Most cases of intrapartum fetal **asphyxia** occur in low-risk pregnancies and, therefore, risk screening in antenatal care cannot accurately predict which women will eventually need emergency care for fetal **asphyxia**.

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Kolatat T. Vanprapar N. Thitadilok W.

Institution

Department of Pediatrics, Siriraj Hospital, Mahidol University, Bangkok, Thailand.

Title

Perinatal **asphyxia**: multivariate analysis of risk factors.

Source

Journal of the Medical Association of Thailand. 83(9):1039-44, 2000 Sep.

Abstract

Perinatal **asphyxia** contributes greatly to neonatal mortality and morbidity. In developing countries, the need for risk assessment in perinatal **asphyxia** is obvious because of the high birth rate and limited perinatal resources. **OBJECTIVE:** To determine the incidence and risk factors of perinatal **asphyxia** in infants who were delivered from mothers with high-risk conditions. **STUDY DESIGN:** A prospective study over a 5-year period from 1993 to 1997 was performed at a tertiary level, referral hospital. **PATIENTS AND METHOD:** Nine hundred and sixty-one infants who were delivered from 878 high-risk mothers were recruited. All of the risk factors that might have contributed to **asphyxia** were identified and recorded. Univariate and stepwise multiple logistic regression analysis was performed to identify significant factors that might have contributed to **asphyxia**, the odds ratios and 95 per cent confidence interval were computed. **RESULTS:** Abnormal fetal heart rate pattern, thick meconium stained amniotic fluid, and premature delivery, were three common risk factors for **asphyxia**. The mean gestational age was 37.6 +/- 3.5 weeks, 10.5 per cent (101/961) were infants less than 33 weeks. The incidence of **asphyxia** was 9.7 per cent and was highest (26.7%) in infants less than 1000 g. By univariate analysis, significant relationships between perinatal factors and **asphyxia** were found among birth weight, gestational age, premature and breech delivery but stepwise multiple logistic regression analysis revealed that only birth weight was significantly associated with perinatal **asphyxia**. **CONCLUSION:** In countries where resources are limited, a neonatal resuscitation team should be available for very low birth weight infants, premature and breech delivery.



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M.Ellis@bristol.ac.uk

Title

Stillbirths and neonatal encephalopathy in Kathmandu, Nepal: an estimate of the contribution of birth **asphyxia** to perinatal mortality in a low-income urban population.

Source

Paediatric and Perinatal Epidemiology. 14(1):39-52, 2000 Jan.

Abstract

We describe a prospective cross-sectional survey over a 12-month period in the principal maternity hospital of Kathmandu, Nepal, where over 50% of the local population deliver. The study aim was to estimate the contribution of birth **asphyxia** to perinatal mortality in this setting. During 1995, there were 14,371 livebirths and 400 stillbirths, a total stillbirth rate of 27 per 1000 total births. The fresh term (2000 g or more) stillbirth rate was 8.5 per 1000 total births [95% CI 7.1, 10.1]. Ninety-two cases of neonatal encephalopathy (NE) affecting term infants were detected (excluding those due to congenital malformations, hypoglycaemia and early neonatal sepsis). The birth prevalence of NE was 6.4 per 1000 livebirths [95% CI 5.2, 7.8]. There was evidence of intrapartum compromise in 63 (68%) of the cases of NE and 65 (76%) of the stillbirths, but only in 12 (12%) of controls. The cause-specific early neonatal mortality rate for NE was 2.1 per 1000 livebirths [95% CI 1.4, 3.0]. Combining the NE deaths and fresh stillbirths gives an upper estimate for term birth **asphyxia** perinatal mortality rate of 10.8 per 1000 total births [95% CI 9.2, 12.6], 24% of all perinatal deaths before hospital discharge. This study suggests that birth **asphyxia** remains an important cause of perinatal mortality in developing countries. The paper discusses the pros and cons of different strategies to reduce birth **asphyxia** in low-income countries.



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Authors

[Eckerlund I.](#) [Gerdtham U.G.](#)

Institution

Stockholm School of Economics.

Title

Estimating the effect of cesarean section rate on health outcome. Evidence from Swedish hospital data.

Source

International Journal of Technology Assessment in Health Care. 15(1):123-35, 1999 Winter.

Abstract

This paper tests the null hypothesis of a zero effect of cesarean section rate on health outcome against the alternative of a positive effect. Using data from 59 hospitals in Sweden from 1988-92, we specify two separate linear regression models for health outcome, one with perinatal mortality, and the other with rate of **asphyxia**, as dependent variable. We estimate the models by single-year cross-section regressions and as pooled data systems. The null hypothesis cannot be rejected, i.e., we do not find any significant positive effect of cesarean section rate on health outcome. Thus, we conclude that an increase in cesarean section rate does not imply lower perinatal mortality or lower rate of **asphyxia**. This in turn indicates that the minimum cesarean section rate is optimal.

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Citation 19.

[Link to...](#) Complete Reference

Unique Identifier

9890213

Medline Identifier

99105219

Authors

Dite GS. Bell R. Reddihough DS. Bessell C. Brennecke S. Sheedy M.

Institution

Department of Child Development and Rehabilitation, Royal Children's Hospital, Melbourne, Victoria, Australia.

Title

Antenatal and perinatal antecedents of moderate and severe spastic cerebral palsy.

Source

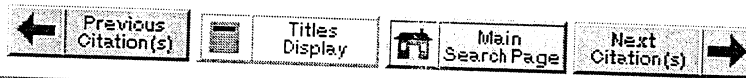
Australian & New Zealand Journal of Obstetrics & Gynaecology. 38(4):377-83, 1998 Nov.

Abstract

Routinely collected perinatal morbidity data were abstracted for 204 cases of moderate and severe spastic cerebral palsy and 816 matched controls. Separate analyses were conducted for cases with birth-weight > or = 2,500 g and birth-weight < 2,500 g. The presence of a congenital abnormality was an important risk factor for cerebral palsy in both groups and further analyses were conducted after dividing the groups according to presence or absence of a congenital abnormality. In the < 2,500 g group, resuscitation needed was clearly identified as a risk factor for cerebral palsy in the group with no congenital abnormalities (adjusted OR=3.4; 95% CI=1.6-7.5) while in the group with congenital abnormalities, none of the risk factors were clearly associated with an increased risk of cerebral palsy. Among the cases with birth-weight > or = 2,500 g, intrauterine hypoxia/birth **asphyxia** was clearly associated with an increased risk of cerebral palsy (adjusted OR=18.1; 95% CI=1.8-186) in the group with no congenital abnormalities while in the group with congenital abnormalities, none of the factors were clearly associated with an increased risk of cerebral palsy.



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Citation 93.

[Link to...](#) Complete Reference

Unique Identifier

1937632

Medline Identifier

92039891

Authors

[Chaturvedi P. Shah N.](#)

Institution

Department of Pediatrics, M.G. Institute of Medical Sciences, Sevagram, Wardha.

Title

Foetal co-relates and mode of delivery in **asphyxia neonatorum**.

Source

Indian Journal of Pediatrics. 58(1):63-7, 1991 Jan-Feb.

Abstract

A prospective study was conducted on consecutively born live births for determining the role of certain foetal factors and mode of delivery on **asphyxia neonatorum**. The difference in the incidence of neonatal asphyxia in 1208 singleton births (8.5%) and in the 66 multiple births (9.7%) was statistically significantly (p less than 0.01). Among the singleton live births a significantly increased incidence of **asphyxia** was recorded in preterms when compared to term and post term babies collectively (p less than 0.001). Small for date babies were at a greater risk for asphyxia **neonatorum** when compared to babies weighing appropriate for gestational age (p less than 0.001). An inverse relationship was observed between birth weight and **asphyxia neonatorum**. A significant difference was seen in the occurrence of neonatal **asphyxia** between babies weighing less than 2000 g. and those weighing more than 2000 g. (p less than 0.001). The incidence was significantly influenced by mode of delivery, being highest in vaginal breech delivery followed in decreasing frequency by forceps and normal vaginal delivery. Among vaginal breech delivered neonates those weighing greater than or equal to 2500 g were at the highest risk. Evidence of foetal distress and meconium stained amniotic fluid had a low predictability of **asphyxia** being 35.0% and 40.0% respectively though both were statistically significant (p less than 0.001).



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Citation 95.

[Link to...](#) Complete Reference

Unique Identifier

1874058

Medline Identifier

91339542

Authors

Gu BM, Tao HQ.

Institution

Hospital of Maternal and Child Hygiene, Suzhou.

Title

[Clinical analysis of 1704 cases of fetal distress]. [Chinese]

Source

Chung-Hua Fu Chan Ko Tsa Chih [Chinese Journal of Obstetrics & Gynecology]. 26(3):153-4, 187-8, 1991 May.

Abstract

From Oct 1985 through Sept 1986 and from Oct 1988 through Sept 1989, a total of 1,704 cases were clinically diagnosed as having fetal distress. The results of analysis showed no significant differences (P greater than 0.05) between fetal distress and fetal sex, and age of pregnancy women respectively (P greater than 0.05), but there was a significant difference between fetal distress and gestational weeks. (P less than 0.01) and birth weight (P less than 0.05). The highest incidence occurred in postterm pregnancy. The number of neonatal **asphyxia** cases with fetal distress accounted for 61.08% of the total of neonatal **asphyxia**. The more indexes of the fetal distress, the higher is the incidence rate of **asphyxia neonatorum**. Among the complications of pregnancy, the fetal distress rate due to pregnancy induced hypertension is the highest. The results suggested that by using multiple item examinations, early diagnosis of fetal distress and prompt management are possible to decrease the **asphyxia** rate and the prevention of complications of pregnancy is important to reduce the fetal distress.

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Citation 101.

[Link to...](#) Complete Reference

Unique Identifier

2309819

Medline Identifier

90178264

Authors

[Low JA.](#) [Wood SL.](#) [Killen HL.](#) [Pater EA.](#) [Karchmar E.](#)

Institution

Department of Obstetrics and Gynecology, Queen's University, Kingston, Ontario, Canada.

Title

Intrapartum **asphyxia** in the preterm fetus less than 2000 gm.

Source

American Journal of Obstetrics & Gynecology. 162(2):378-82, 1990 Feb.

Abstract

The incidence of intrapartum **asphyxia** in the preterm fetus less than 2000 gm (6%) is greater than that in the mature fetus (2%). Severe antepartum hemorrhage is the only clinical marker predictive of **asphyxia** in the preterm fetus. Marked deceleration patterns and particularly late decelerations may be of predictive value for **asphyxia**. However, many intrapartum **asphyxial** episodes are not identified on the basis of clinical observations. Consistent diagnosis of intrapartum **asphyxia** in the preterm fetus requires routine umbilical cord blood gas and acid-base assessment at delivery.

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Citation 119.

[Link to...](#) Complete Reference

Unique Identifier
3514392

Medline Identifier
86166026

Authors
[Nielsen TF.](#)

Title
Cesarean section: a controversial feature of modern obstetric practice. [Review] [42 refs]

Source
Gynecologic & Obstetric Investigation. 21(2):57-63, 1986.

Abstract
Cesarean section (CS) has been an integral part of modern obstetrics during the last decades. As safety has increased, so too has the range of problems that CS is used to solve, to a degree that it must cause medical concern. There is a great danger in the blind faith that CS is the only way out in every difficult obstetric situation. The problem can always be easily solved by CS in an acute difficult obstetrical situation. However, CS is a major abdominal surgery and it may present any complication that besets major surgery including severe intraoperative and postoperative complications, a much greater risk for maternal death compared to vaginal delivery and also late complications, i.e. secondary involuntary infertility. Therefore, CS should never be undertaken lightly and without serious consideration of the justifications, preparations and all ancillary support. [References: 42]



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✓ Citation 121.

[Link to... Complete Reference](#)

Unique Identifier

4096448

Medline Identifier

86157192

Authors

Esque MT. Baraibar R. Figueras J. Mauri E. Moretones MG. Padula C. Posa J. Zuasnabar MA.

Title

[Multicenter study of **asphyxia neonatorum**]. [Spanish]

Source

Anales Espanoles de Pediatria. 23(8):542-50, 1985 Dec.

Abstract

Out of 14,673 term infants born at seven neonatal centers in the Barcelona area, 215 newborns were identified as being at risk of developing hypoxic-ischemic encephalopathy. They had shown one or more of the following criteria: fetal pH less than or equal to 7.20, abnormal fetal heart rate patterns, umbilical artery pH less than or equal to 7.20, 5 minute Apgar score less than or equal to 6, or the need for immediate neonatal resuscitation. 135 items were investigated in relation to epidemiological, clinical and laboratory parameters. The incidence of HIE was 6.39% and the mortality was 0.55%. Abnormal neurologic examination was present in 43.7% of 215 term infants at risk, and in 1/10 of them the symptoms were severe. The predictive accuracy of the criteria used in the study was: the most sensitive criteria were the fetal distress and umbilical artery pH, the most specific criteria were the need for immediate neonatal resuscitation and a 5 minute Apgar score less than or equal to 6, and the most efficient criteria were the need for immediate neonatal resuscitation and fetal pH less than or equal to 7.20.

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Citation 134.

[Link to...](#) Complete Reference

Unique Identifier

7365599

Medline Identifier

80162338

Authors

MacDonald HM. Mulligan JC. Allen AC. Taylor PM.

Title

Neonatal **asphyxia**. I. Relationship of obstetric and neonatal complications to neonatal mortality in 38,405 consecutive deliveries.

Source

Journal of Pediatrics. 96(5):898-902, 1980 May.

Abstract

The requirement of greater than one minute of positive pressure ventilation was prospectively used to identify infants suffering from **asphyxia** at birth in 38,405 consecutive deliveries. Multivariate analysis of high-risk factors associated with increased risk of **asphyxia** showed the prematurity was the most significant predictor of **asphyxia**. **Asphyxia** occurred in 62.3% of infants less than 27 weeks' gestation and decreased to 0.4% in infants greater than 38 weeks' gestation. Presence of **asphyxia** was associated with significant increase in neonatal mortality of infants greater than 36 weeks' gestation. Of the **asphyxiated** neonates, growth retardation, hypothermia, hyaline membrane disease, and seizures were significantly associated with an increased risk of death.

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Citation 147.

[Link to...](#) Complete Reference

Unique Identifier

1146872

Medline Identifier

75202298

Authors

Low JA. Pancham SR. Worthington D. Boston RW.

Title

The incidence of fetal **asphyxia** in six hundred high-risk monitored pregnancies.

Source

American Journal of Obstetrics & Gynecology. 121(4):456-9, 1975 Feb 15.

Abstract

Six hundred high-risk monitored obstetric patients were reviewed for evidence of fetal **asphyxia** at delivery. The over-all incidence was 20 per cent, i.e., 8 times the incidence in a normal obstetric population. Highly significant indicators of risk for **asphyxia** were severe toxemia (79 per cent), prematurity with further medical or obstetric complications (36 per cent), and clinical fetal distress, particularly meconium staining with fetal heart rate abnormality (33 per cent). All obstetric, medical, or gestational complications in this review were associated with an increased risk for fetal **asphyxia** when compared to that in a normal obstetric population.

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NOV 5 - 2002

COMMONWEALTH of VIRGINIA

Department of Health

ROBERT B. STROUBE, M.D., M.P.H.
STATE HEALTH COMMISSIONER

P O BOX 2448
RICHMOND, VA 23218
November 4, 2002

TTY 7-1-1 OR
1-800-828-1120

Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, VA. 23219

Dear Phil:

Thank you for the opportunity to review excerpts from the exposure draft *Review of the Virginia Birth-Related Neurological Injury Compensation Program*. The comments of the Virginia Department of Health are attached. Representatives from the Department of Health will attend the Commission meeting on November 12. Please let me know if you require any additional information.

Sincerely,

A handwritten signature in black ink that reads "Robert B. Stroube" followed by a stylized set of initials.

Robert B. Stroube, M.D., M.P.H.
State Health Commissioner

Enclosure

VIRGINIA DEPARTMENT OF HEALTH COMMENTS ON JLARC EXPOSURE DRAFT

Page 45, Section titled “Impact of the Program on Obstetrical Services to Indigent Women Is Unclear”

This section appears to be factual in content. Because of the expansion of the Medicaid coverage and increase in provider reimbursement rates, the need for local plans to address access to care for the indigent population has become unnecessary. The increased level of obstetric coverage is the reason no recent action has been taken on the indigent care provision.

Page 96, first paragraph – “During the past year a new staff person at VDH accidentally threw away most of VDH’s records concerning these petitions, and therefore, JLARC staff’s review of VDH’s petition review process was limited.”

This is not an accurate description of the records’ loss. VDH staff, based on their understanding of records retention policies and requirements, discarded the oldest neurological birth injury records.

Page 96, second paragraph – “None of the VDH reviews have resulted in any licensing action being taken against a hospital.”

It is incorrect to assert that no reviews have resulted in licensing actions. In a small number of cases, VDH’s reviews of the petitions and medical records have extended to on-site investigations of the hospital involved. Staff have cited regulatory violations and required the hospital to submit and follow a plan of correction. This is consistent with practices used for addressing serious complaints of any type. VDH’s objective is to guide the deficient facility in identifying and implementing corrective actions to avoid recurrence of the problem that spurred the complaint. A “licensing action” is not intended to shut down facilities except as an extreme last resort.

Aside from the emphasis on a preventive rather than strictly punitive licensure program, several variables can hinder the finding of concrete deficiencies in the investigation of a neurological birth injury. By the time claims are presented to VDH for review, as much as ten years may have elapsed since the incident occurred. In the interim the policies and procedures existing at the hospital at the time of birth may have changed significantly and/or been corrected. Additionally, the hospital staff involved in the birth may no longer be employed at the hospital or otherwise available to be interviewed.

Page 98, Recommendation (21) – “As part of their reviews of the birth injury petitions, the Board of Medicine and Virginia Department of Health should routinely interview the claimant families on the events surrounding the births.”

The petition and its amplifying information (e.g. the patient’s medical records) thoroughly present the claimant’s position and allegations. Interviews are conducted with hospital staff if the medical records do not provide all information required to perform a thorough investigation. However, VDH agrees that interviewing the claimant family may provide a valuable added perspective in investigating the subject incident.

Page 99, Recommendation (22) – “The Board of Medicine and Virginia Department of Health should routinely notify each claimant family concerning the outcome of the respective medical reviews.”

VDH is most willing to notify each claimant family of the outcome of its review. It should be noted, however, that in the interests of maintaining neutrality the hospital must be notified concurrently.

JLARC Staff

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DEPUTY DIRECTOR: R. KIRK JONAS

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DIVISION II CHIEF: ROBERT B. ROTZ

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JOHN W. LONG, PUBLICATIONS AND GRAPHICS

GREGORY J. REST, RESEARCH METHODS

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● WENDY THOMAS, *INTERN*

FORMER JLARC STAFF WHO CONTRIBUTED TO THIS STUDY:

● SCOTT F. DEMHARTER

● Indicates JLARC staff with primary assignment to this project

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Special Report: Status of Automation Initiatives of the Department of Social Services, February 1998
Review of the Virginia Fair Housing Office, February 1998
Review of the Department of Conservation and Recreation, February 1998
State Oversight of Commercial Driver-Training Schools in Virginia, September 1998
The Feasibility of Converting Camp Pendleton to a State Park, November 1998
Review of the Use of Consultants by the Virginia Department of Transportation, November 1998
Review of the State Board of Elections, December 1998
Review of the Virginia Department for the Aging, January 1999
Review of Regional Criminal Justice Training Academies, January 1999
Interim Report: Review of the Health Regulatory Boards, January 1999
Interim Report: Review of the Functional Area of Health and Human Resources, January 1999
Virginia's Welfare Reform Initiative: Implementation and Participant Outcomes, January 1999
Legislator's Guide to the Virginia Retirement System, 2nd Edition, May 1999
VRS Oversight Report No. 12: Semi-Annual VRS Investment Report, July 1999
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Interim Report: Child Support Enforcement, January 2000
Interim Special Report: Revolutionary War Veteran Gravesites in Virginia, February 2000
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Review of Selected Programs in the Department of Medical Assistance Services, January 2002
Review of Secondary and Elementary School Funding, February 2002
Review of State Spending: June 2002 Update
VRS Oversight Report No. 18: VRS Biennial Status and Semi-Annual Investment Report, July 2002
The Future of the Chesapeake Bay Bridge-Tunnel, January 2003
Review of Information Technology Systems Development, January 2003
Review of the Virginia Birth-Related Neurological Injury Compensation Program, January 2003

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