REPORT OF THE
BOARD OF DIRECTORS FOR THE VIRGINIA
BIRTH-RELATED NEUROLOGICAL INJURY
COMPENSATION PROGRAM

STUDY TO INCREASE THE SCOPE AND MAGNITUDE OF THE VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 58

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COMMONWEALTH of VIRGINIA

Virginia Birth-Related Neurological Injury Compensation Program

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January 7, 1998

TO: The Honorable George Allen

and

The General Assembly of Virginia

The report contained herein is pursuant to House Joint Resolution 641 agreed to by the 1997 General Assembly which directed the Virginia Birth-Related Neurological Injury Compensation Program's Board to:

(1) identify the Program's strengths and weaknesses,

(2) assess the purposes for which the Program was created by the General Assembly, and

(3) develop recommendations that will result in the increased use of the Program in a manner beneficial to the Commonwealth.

The Board contracted with an entity outside the Program, the College of William and Mary's Center for Public Policy Research, to perform the study required by House Joint Resolution 641. The Board did not feel that it was appropriate for the Program to accomplish the study themselves. The Board also realized that its staff had insufficient resources to both administer the Program and perform the study. Moreover, insufficient expertise exists within the Program to conduct the study in a way which would fully accomplish the legislative goals.

After the Program has had an opportunity to review the study, consider the report, and formulate responses, we anticipate returning to the General Assembly in 1999 with suggested further action to address concerns that are raised and which need to be addressed.

Respectfully Submitted,

C. M. Kinloch Nelson, Chair
Board of Directors

Preface

This study has been conducted under the authority of House Joint Resolution (HJR) 641 of the 1997 General Assembly. HJR 641 directed the Board of Directors of the Birth-Related Neurological Injury Compensation Program "to study increasing the scope and magnitude of the Virginia Birth-Related Neurological Injury Compensation Program." As part of this effort, the General Assembly directed the Board to (1) identify the Program's strengths and weaknesses, (2) assess the purposes for which the Program was created by the General Assembly, and (3) develop recommendations that will result in the increased use of the Program in a manner beneficial to the Commonwealth.

In July 1997, the Board of Directors for the Virginia Birth-Related Neurological Injury Compensation Program contracted with the Center for Public Policy Research of the Thomas Jefferson Program in Public Policy at the College of William and Mary to conduct the study. The authors of this report are Leonard Schifrin, Ph.D. (Principal Investigator, Faculty Research Associate with the Center, and Chancellor Professor of Economics) and nine team members listed alphabetically: C. Lawrence Evans, Ph.D. (Faculty Research Associate and Associate Professor of Government), David Finifter, Ph.D. (Director of the Center and the Thomas Jefferson Program in Public Policy, and Professor of Economics), Charles Koch, J.D. (Faculty Research Associate and Woodbridge Professor at the School of Law), James Lee, Ph.D., M.D. (Research Associate and Adjunct Professor of Science and Public Policy), George Livingston, M.B.A. (Research Associate), J. Rosser Matthews, Ph.D. (Research Analyst), Kelly Metcalf-Meese, M.P.P. (Research Coordinator), Barbara Morgan, Ph.D. (Senior Research Analyst), and Paulette Parker, M.A. (Research Analyst). Ms. Caryn Grim, Ms. Margaret Mahoney, Ms. Elizabeth Stone, and Ms. Stacey Wilson, Research Assistants for the Center and graduate students in the Thomas Jefferson Program in Public Policy, also helped complete this project, as did Mr. Greg Westfall, an undergraduate at the College, Deborah Green, Ph.D. (Faculty Research Associate), and Ms. Karen Dolan (Assistant to the Director at the Thomas Jefferson Program).

The authors would like to express their sincere gratitude to several people in particular who contributed to the completion of this project. First, we would like to thank Ms. Elinor Pyles, Executive Director of the Virginia Birth-Related Neurological Injury Compensation Program, and Ms. Lisa Antis, Administrative Assistant. Ms. Pyles and Ms. Antis made themselves available to us at each progressive stage of our work and provided us with invaluable assistance throughout the project. In addition, we want to thank Mr. John Beall, Senior Assistant Attorney General assigned to the Program, who helped lay the groundwork for this study and provided us with helpful background information. Finally, we thank members of the Program's Board of Directors, who provided us with very helpful comments on early versions of this study.

The comprehensive nature of this study required us to collect data from many individuals, including the Program's beneficiaries, state legislators, insurers, hospitals, physicians, nurses, and attorneys. The suggestions offered by these individuals were integral in developing the recommendations provided in this study. In addition, we received helpful assistance from the Commonwealth's Clerks of the Court, Carolyn Colville from the Workers' Compensation Commission, and Brian Ostrom, Ph.D., Senior Research Associate of the National Center for State Courts.

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House Joint Resolution (HJR) 641 of the 1997 Session of the General Assembly directed the Board of Directors of the Birth-Related Neurological Injury Compensation Program "to study increasing the scope and magnitude of the Virginia Birth-Related Neurological Injury Compensation Program." As part of this effort, the General Assembly directed the Board to:

(1) identify the Program's strengths and weaknesses,

(2) assess the purposes for which the Program was created by the General Assembly, and

(3) develop recommendations that will result in the increased use of the Program in a manner beneficial to the Commonwealth.

In July 1997, the Board of Directors for the Virginia Birth-Related Neurological Injury Compensation Program contracted with the Center for Public Policy Research of the Thomas Jefferson Program in Public Policy at the College of William and Mary to conduct the study.

Findings and Recommendations

The first seven chapters of this Report on the Virginia Birth-Related Neurological Injury Compensation Program describe and analyze in detail the Program's origins and administrative processes; beneficiaries and participating obstetric service providers; financial structure, status, and management; and the views of beneficiaries, physicians, nurses, other health care professionals, hospitals, insurers and lawmakers on its strengths and weaknesses. Within or at the end of each chapter, observations and recommendations specific to that subject or from those sources have been offered. In the final chapter, we examine the broader objectives of this Report, which were requested by the General Assembly in HJR 641.

The main recommendations to increase the use of the Program and the major findings for each chapter are discussed in turn below:

Recommendations That Will Lead to the Increased Use of the Program in a Manner Beneficial to the Commonwealth

- Expansion of the Program should be sought, but within the present definition of qualifying birth injury.

- This expansion should focus on an improved and expanded informational system, with strong inducements for compliance by hospitals and obstetricians, pediatricians, pediatric neurologists, and other medical professionals who have contact with pregnant women, and with mothers and babies at the time of birth

and afterward. These informational systems and links should exist (1) within these various medical professions; (2) between them and the Program; and (3) between the providers of obstetric and pediatric health services, the Program, and the families of potentially Program-eligible children. In particular, hospitals should be required to report all cases of adverse birth outcomes that may be eligible for Program benefits to the Program or the Workers' Compensation Commission, for Program follow-up and outreach efforts.

- Increased participation by all obstetric service providers -- hospitals, physicians, and nurse-midwives -- should be a high priority, effected through broadening the dissemination of information about the Program, including to professional association leadership, and through financial incentives, such as malpractice insurance discounts.

- We do not recommend liberalizing the eligible-injury definition at this time.

Specific Recommendations Regarding Information:

- Information about the Program should be provided to each physician. In particular, the specialty organizations for obstetricians/gynecologists and pediatric neurologists should make it a policy to inform and educate members about the Program, and encourage participation.

- Information to nurse-midwives and other medical professionals involved in the delivery of newborns should be developed and disseminated, and their participation in the Program encouraged. The participation of nurse-midwives in medically underserved areas should be at reduced fees, based on an ability-to-pay formula, and consideration should be given to permitting nurse-midwives not in underserved areas to participate, also at reduced fees.

- Hospitals should be required to report to the Workers' Compensation Commission or the Program all cases of birth-injured babies who may possibly qualify for coverage under the Act. This reporting requirement might be extended as well to the insurance carriers which receive claims and to physicians and nurse-midwives who deliver babies who might qualify for the Program.

- Every provider of primary care services should be strongly encouraged or even required to give every pregnant patient a leaflet describing the Program. Every provider of obstetric services and every hospital with birthing capacity should be required to provide a leaflet describing the Program to every pregnant woman and every woman admitted to give birth. In the event that a severe injury occurs during the birth process, this should be followed up by a prompt, complete, and supportive information session about the Program, involving hospital personnel and the physician or nurse-midwife who delivered the baby, before the family leaves the hospital.

- Informational channels linking the various professional obstetric service providers, professional organizations, insurers, and others to each other and to the Program should be established and utilized.

Specific Recommendations Regarding Provider Participation:

- For the Program to work well, high levels of provider participation are needed. For it to work optimally, virtually 100% participation of physicians or hospitals is needed. One alternative is to make participation compulsory, which would remove inequities among equally injured babies, but not all of whom have participating obstetricians or hospitals. If all hospitals with birthing units were required to participate and the financial burdens of participation minimized through careful fee determination, virtually every injury-eligible child would be eligible for Program benefits. If all medical professionals who deliver babies in the Commonwealth were to participate, the same protection for injured babies would exist. Of the two alternatives, compulsory participation by hospitals appears less complicated to bring about. At first glance, the costs of participation would fall totally on hospitals, but these costs would largely be passed on to all direct or third party payers of hospital care, and, ultimately, broadly among the population. The end result would be broad social financial support for what essentially is a social problem, the incidence of severely birth-injured babies.

- Recognizing that compulsory participation may be politically infeasible, a second alternative is to create incentives strong enough to induce most physicians and hospitals to participate voluntarily. The cost of participation must be made lower than the savings on insurance to both physicians and hospitals. The best way to accomplish this is to negotiate specific lump sum insurance credits for the *fact* of participation, not credits pro-rated to the *costs* of participation. The Program can then structure participant fees to be lower than insurance credits, providing a financial incentive of sufficient power to generate more complete participation.

Specific Recommendations Regarding Housing, Income Loss, and "Pain and Suffering":

- The Program Board might consider a fixed set-aside, equal for all beneficiaries, in the name of the covered child and administered by the Program, to cover housing costs and, from the remainder, compensate families for other harms and losses, or, as an alternative, a variable, formula-determined set-aside, which takes into account the regional differences in housing and other costs.

Working from these recommendations, we believe the General Assembly and Program Board can enable the Virginia Birth-Related Neurological Injury Compensation Program to more

fully achieve the purposes for which it was created, and to more fully serve the children whom it was designed to assist. This can be accomplished by identifying all injury-eligible babies early in their lives and by increasing the number of Program-eligible babies by eliminating the possibility that they might be ineligible for benefits because they fail to meet the participating-Provider requirement.

Chapter Summaries

Chapter 1: Introduction

When the 1987 legislative session of the Virginia General Assembly ended, it won praise as "the most progressive session in modern times." One of its particularly notable accomplishments was the passage of the Virginia Birth-Related Neurological Injury Compensation Act. As the first "no-fault system" for adverse outcomes from medical procedures enacted anywhere in North America, it clearly was an historic legislative innovation. After nine years of Program operation, however, two observations have become clear.

(1) The beneficiary population is small, and, when compared with estimates made at the time of passage of the Act, considerably smaller than anticipated.

(2) Yearly total Fund income has exceeded yearly reserve set-asides for benefits plus expenditures for administration, and thus Fund financial assets have grown faster than the total estimated reserve for the payment of future claims for present beneficiaries.

Chapter 2: The Virginia Birth-Related Neurological Injury Compensation Program: Beneficiaries

From the outset, the Program has served fewer injured children than anticipated. When the Program was created in 1987, it was thought that as many as 40 children each year might be eligible to receive benefits by the nature of their birth outcomes. Later researchers reduced this number to no more than 10 children per year. If this expectation were correct, and all had entered the Program, today upwards of 90 children and their families would be receiving benefits. The actual beneficiary population -- just 31 -- obviously falls far below this maximum expectation.

Using two separate approaches to estimate the potential "beneficiary pool," we believe the present beneficiary population to be about 30% below its attainable level. In Chapter 4, we see that the Fund Balance (the amount in excess of the Claims Reserve) is about 42% of the Program's financial assets. The similarity between these numbers suggests that the injury-eligible infants not currently in the Program could be brought into it within the present financial structure.

Chapter 3: Participating Providers of Obstetric Services: Hospitals, Physicians, and Nurse-Midwives

To be eligible to receive benefits under the Program, an injured child must receive obstetric services from a hospital or physician (or nurse-midwife) who is a Program participant. Since 1988, of all hospitals having bassinets, 51 have participated for at least one year in the Program, and 20 never have. The highest rate of participation for such hospitals occurred in 1988, the first year the Program began collecting assessments from hospitals, when 43 hospitals participated. By 1991, this number had declined to only 27 hospitals, or 38% of those with birthing capacity. Since 1991, the number has remained fairly stable, dropping to a low of 24 in 1994, then increasing back to 29 at present. Since the Program's inception, participating hospitals have paid over $18 million in assessments. Given the Program's current statutory structure, in any given year no hospitals participate in the Program in at least five and in as many as 10 of the Commonwealth's 22 Health Planning Districts. In these cases, a newborn infant with a qualifying birth injury found his or her entry into the Program narrowed to one determinant: whether the attending obstetrician was or was not a Program participant.

Since the Program's inception, about 860 physicians have elected to participate in the Program, paying over $16.3 million in fees. Not surprisingly, the vast majority, 800, of these doctors are obstetricians and gynecologists. Family practice doctors, the second largest category of participating physicians, fall far behind at 17. Only six nurses have participated, all of whom were located in the Lynchburg area. Using the best information available to us, we estimate that during the Program's nine years of operation as a whole, the participation rate of obstetricians and gynecologists is approximately 61%.

As was the case with hospitals, not all geographic areas of the state have physicians who are participating, which results in decreased opportunities for children with neurological damage to enter the Program. In any given year, in at least four Health Planning Districts and in as many as seven, children born with severe neurological damage have no opportunity to participate in the Program, because no hospitals nor physicians in those Districts participate in the Program. In other Districts where less than 100% of hospitals or physicians participate in the Program, babies with Program-qualifying injuries may be ineligible for Program benefits, if neither the hospital nor obstetrician are participants.

Chapter 4: Fund Income and Management

The Virginia Birth-Related Neurological Injury Compensation Fund (the "Fund") was created to manage the financial resources which support Program benefits. Its two main functions are to serve as a repository for revenues coming from assessments on physicians and hospitals and to manage the investment of these funds to generate additional income. By 1994, investment income had grown to account for almost half of total Fund annual income, and, after the reduction in provider fees in 1995, it now represents about three-fourths of annual Fund income.

Our examination of the sources of income to the Fund and the management of the investment of that income concludes with these observations:

(1) The Fund is large relative to its obligations, and thus is sound.

(2) The Fund has been given broader investment parameters, which may well provide for even greater growth in its financial assets.

(3) To maximize Fund management and growth:

(a) a Financial Advisory Committee should be established to provide oversight of the actuaries, auditors, and investment managers.

(b) greater integration and cooperation among Fund managers, actuaries, and auditors should be fostered, perhaps by requiring that the actuary report be sent directly to the Board rather than the Virginia Bureau of Insurance, and the Board assess that report in relation to the strategic plans of its Financial Advisory Committee.

(4) The accounting practice of treating housing cost as non-liquid assets rather than expenses should be re-evaluated, particularly in view of the dominant role and potentially great growth in this expenditure category.

(5) To protect the independence of Fund resources, defining the Program as an independent state agency, and the Fund as a trust, should be considered.

(6) Finally, the Board might consider issuing a new RFP for management of the Fund because of the significant change in the investment authority.

Chapter 5: Strengths and Weaknesses of the Program: The Views of the Beneficiaries

Twenty-two beneficiary families agreed to be interviewed for this study. These families unanimously agreed that the Program is the pivotal source of funding for medical necessities not otherwise covered. The benefits provided through the Program were cited for having ameliorated or relieved financial duress, and having reduced the mental and emotional strain incurred by beneficiary families. Our major observations and findings for this Chapter are as follows:

(1) The Program's informational network is inadequate. Eight of the 22 beneficiary families with whom we spoke discovered the Program through an attorney, while two learned of it through the obstetrician who delivered their child. In none of the cases interviewed, were beneficiaries informed through hospital personnel. These data point to the question of how many children

born in the Commonwealth actually qualify for the Program but have not applied because their parents are unaware of its existence. The answer suggested by our interviews is that the informational problems are of a magnitude such that we cannot assume there to be no such cases.

(2) Based on our findings, it is our assessment that liberalizing the definition should be approached with a great deal of caution, and only *after* substantial efforts have been made to locate children who would qualify for the Program under existing criteria.

(3) To ensure a more user-friendly application process, the Program should develop a checklist, which itemizes the components of a complete application, that could be sent to those who wish to apply to the Program.

(4) With regard to the scope of benefits covered by the Program, 10 beneficiary families felt the scope of benefits to be adequate, while nine believed the scope of benefits to be inadequate. Among those in the latter category, the most likely area of additional coverage requested was a pain and suffering award, which would address the issue of lost income.

(5) When asked to cite the Program's two greatest strengths, eight beneficiary families cited Program staff. While Program personnel were strongly commended, there was also consensus among beneficiaries that the procedures associated with requesting and receiving benefits are complex and time-consuming.

(6) With regard to Program administration, 13 beneficiaries cited either the composition of the Board or the inaccessibility of the Board as one of the two weaknesses of the Program. Augmenting communication between Board members and beneficiary families was requested as a means of enhancing Program administration. Suggestions made by beneficiaries included requests for the Board to occasionally meet in cities around the State, and ideas on how to increase contact between Board members and beneficiary families.

Chapter 6: Strengths and Weaknesses of the Program: The Views of Physicians; Nurses, Nurse-Midwives, Nurses' Representatives; Physician Association Representatives; Residency Program Coordinators; and Former Board Members

Medical professionals who provide perinatal and pediatric care in the Commonwealth have a vital interest in the current status and future of the Virginia Birth-Related Neurological Injury Compensation Program. In order to obtain first hand perceptions and suggestions, a number of these health care providers were interviewed in conjunction with this study.

(1) The medical professionals interviewed expressed unanimous support for steps that will increase the number of participating physicians across the Commonwealth, in order to increase the success of the Program in achieving its objectives, as these objectives now stand.

(2) They unanimously agreed that the Program should either be made a trust, or in some way securely insulated from the political process.

(3) While there was some openness among them as to the prospect of amending the requirements for eligibility from the standpoint of the severity of the injury, over all, they felt that this should be approached cautiously, and only after efforts have been made to pursue other approaches, such as increasing provider participation rates.

(4) A dominant recommendation from the nurse-midwives and nursing representatives was that certified nurse-midwives across the Commonwealth should be permitted, and encouraged, to join the Program. Concern was expressed on the part of the nurse-midwives and nursing representatives regarding the ability of nurse-midwives to pay the current membership fees. Accordingly, they recommended that consideration be given to moderating the membership fees for nurse-midwives who wish to participate.

Chapter 7: Strength and Weaknesses of the Program: The Views of Hospitals, Insurers, and Lawmakers

To gather perspectives from individuals and organizations with strong interests in the Program's internal operations and overall effectiveness, we interviewed a sample of hospital officials, insurance company representatives, and members of the Virginia General Assembly. The following observations surfaced repeatedly:

(1) The Program has broad support. Even if, under current market conditions, it no longer is necessary to ensure adequate medical malpractice insurance in Virginia, informed observers believe that the Program continues to serve a worthy and needy beneficiary group.

(2) The small number of beneficiaries, combined with the large Fund balance, is perceived as an indicator of significant structural problems in the Program. Few of the people we interviewed argued that the solution is to further reduce the premiums paid by doctors and hospitals. Instead, the general preference was for relaxing the eligibility restrictions, although it also was generally recognized that all eligible babies probably had not become Program beneficiaries. The informational problem was cited, as well as low hospital (and, to a lesser extent, physician) participation, as the reasons for this.

(3) Because of the technical nature of these issues, there is little consensus about how the definition should be amended, if it were to be rewritten with the goal of increasing the number of beneficiaries in the Program. However, most observers feel that there is not an extremely large number of marginally ineligible babies, and thus a reasonably lower injury level would not flood the Program with new beneficiaries nor challenge the actuarial soundness of the Program.

(4) Based on these observations, the interviewees offer consensus that the Program is underutilized and should be expanded using three methods: (a) a modified injury definition; (b) an improved informational mechanism; and (c) steps that will augment the number and proportion of health-care providers who participate in the Program.

Chapter 8: How Well Does the Program Serve the Purposes For Which It Was Established?: Answers and Recommendations

In this final chapter, we examine the broader objectives of this Report, which were requested by the General Assembly in HJR 641. Below are the Program's main strengths and weaknesses and an assessment of how well the Program has fulfilled the purposes for which it was created. Our recommendations that will lead to the increased use of the Program in a manner beneficial to the Commonwealth are discussed earlier on pages i-iv of this Executive Summary.

(1) The Program's Main Strengths and Weaknesses

(a) Strengths in the "No-Fault" Conceptual Basis of the Program

- The Program avoids costly and time-consuming litigation.
- There is less uncertainty for victims, providers, and insurers. The outcomes of suits are problematic, often referred to as a "lottery." Program eligibility and "no-fault" awards are more objectively determined. Equitable treatment of victims is protected.
- In the event of a severe, birth-related neurological injury, the possibility of an adversarial relationship between patients and health-care providers is reduced.
- The incentives for "defensive medicine" are reduced.
- The supply of obstetric services is less threatened.

(b) Strengths of the Virginia Program

- Program administrators are responsive, qualitatively and quantitatively, to the needs of beneficiaries and their families.
- The Workers' Compensation Commission role is performed very capably. Deputy Commissioner Carolyn Colville is highly effective in her role in adjudicating claims.
- The Fund is sound, with a strong income base and responsible financial management.
- Widespread support exists for the Program, both in concept and in its operation, among beneficiaries, hospitals, physicians, nurses, insurers, and legislators.

(c) Weaknesses of the Virginia Program

- The greatest weakness of the Program is that it is underutilized, with a beneficiary population that is approximately 30% below our estimates of the injury-eligible children in the Commonwealth. The causes of this underutilization are to be found in the (1) inadequacies in the informational mechanisms and (2) the low participation rates, for reasons that go beyond lack of knowledge about the Program, that apparently leave injured babies in some Health Planning Districts unable to meet the participating-provider requirement, and in other Districts open to the possibility that this requirement might not be met.
- Administrative procedures in enrolling and obtaining benefits are time-consuming and complex.
- Board and internal mechanisms may not be optimally structured, particularly in regard to financial management.

It is the view of this Report that the strengths of the Program significantly outweigh its weaknesses; that the weaknesses -- particularly underutilization, the major one -- can be addressed successfully through the specific recommendations offered on pages i to iv of this Executive Summary.

(2) Assess the Role of the Program With Regard to the Purposes For Which It Was Created

(a) The Program's Effect on the Malpractice Insurance Crisis

- The supply of medical malpractice insurance is strong, as indicated by the presence of a large and growing number of insurers -- 10 with significant shares and as many as 34 others with small shares -- in the total market in the Commonwealth.

- The medical malpractice crisis was a national phenomenon, of a cyclical nature, and rose and fell in Virginia as in states that had not addressed the malpractice insurance issue at all. In view of the many factors at work, in our view, the Program has not removed enough cases from tort litigation to have made a significant contribution to the improved medical malpractice situation in Virginia. The effect of the 31 cases which were removed has been mitigated by the cap on medical malpractice awards, which has been a more powerful factor in easing the crisis of the 1980s.

- While the Act may not have played a large role in constraining premiums, passage of the Act itself was instrumental in bringing the major insurers back into the Virginia market and lifting the moratorium on new policies. This probably would have happened anyway, but it happened sooner because of the Act, and thus the crisis reached a turning point earlier.

(b) Promoting Quality Obstetric Services in the Commonwealth

- Between 1981 and 1995, the national supply of obstetricians increased steadily, as it did in Virginia. Further, the data show almost constant ratios for the supply of obstetricians/gynecologists relative to all physicians, and rising obstetrician/gynecologist-to-population ratios, both nationally and in Virginia. The obstetrician/gynecologist-to-population ratio in Virginia exceeds the national ratio by about one and a half percentage points, or 10% higher in Virginia in 1995, from equality in 1987.

Accordingly, while we are reluctant to offer a causal connection between the operation of the Program and the improvement in both the malpractice insurance crisis for obstetricians and their supply in the Commonwealth, the Program at least can be "associated" with the attainment of the objectives for which it was created.

Chapter 1

Introduction

Background to the Enactment of HB 1216

When the 1987 legislative session of the Virginia General Assembly ended, it won praise as "the most progressive session in modern times."[1] One of its particularly notable accomplishments was the passage of the Virginia Birth-Related Neurological Injury Compensation Act. As the first "no-fault" system for adverse outcomes from medical procedures enacted anywhere in the United States, it clearly was an historic legislative innovation. This Act addressed a concern that had troubled the medical community and lawmakers for almost two decades -- the so-called "medical malpractice crisis." Since 1970, nearly every state had attempted, in one way or another, to mitigate rising malpractice insurance costs, most notably for obstetric services. Serious concerns arose that, without reasonably priced and adequate insurance, the supply of medical services, especially obstetrics, would markedly decline, creating unacceptable risks to the well-being of mothers and children, particularly in areas, usually poor and rural, which were already medically underserved.

The concerns of Virginia were thus part of a larger national problem, and its legislative ?actions in the 1970s were similar to those in other states.[2] Initially, these reform efforts ?entered on such strategies as limiting the size of legal recoveries, decreasing the number of lawsuits, and constraining what economists call the "transactions costs" of litigation, through a variety of measures, including malpractice award caps, reduced statutes of limitations, and pre-trial screening. These different restraints shared the same conceptual approach of controlling medical malpractice costs by reducing the number and expenses of cases while maintaining the existing legal framework, that is, the exclusive jurisdiction of the courts over cases of injury due to medical negligence. Thus, injured parties continued to have recourse, though more restricted than before, to damages only through civil suits pursued in court.

By the 1980s, however, the effectiveness of these "first generation" reforms was in doubt. For example, in 1986 Virginia's malpractice cap of $1 million per plaintiff was held unconstitutional in Federal District Court on the grounds that the amount of tort damages was a fact issue to be determined by a jury.[3] This decision was reversed and other questions about

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[1] "'Progressive,' Observers Say," Richmond Times Dispatch (March 1, 1987), p. A1.

[2] U.S. General Accounting Office, Medical Malpractice: A Framework for Action, Report to Congressional Requesters 8 (1987).

[3] Boyd v. Bulala, 647 F. Supp. 781 (W.D.Va. 1986).

Virginia's malpractice award cap were clarified by the Circuit Court in 1989,[4] but three years of legal uncertainty had elapsed in the interim. Also, current data indicated that the number of malpractice cases, the sizes of awards, and insurance costs all were continuing to increase.[5] Admittedly, many factors were contributing to these trends and the legislative constraints addressed only a few, perhaps too few to have a major effect. But with legal clouds over caps and perceptions of only limited impacts from other restraints, there developed, in the latter-1980s, a new concept in tort reform. Unlike their first generation antecedents, which kept the tort system intact but sought to reduce compensation and transactions costs, the new "second generation" reforms set out to change the basic role of the tort system, but not reduce the severity or the frequency of claims filed, nor impair individuals' access to compensation.[6] Since Virginia's Birth-Related Neurological Injury Compensation Act re-routed severely, neurologically birth-injured infants from the courts to the Program administering the Act, and provided compensation for them through the Fund established by the Act, it represents a vivid example of this second-generation tort reform effort by offering an alternative to litigation, while addressing the needs of the injured children with compensation provided in a no-fault context.[7] (For a comparison of the conceptual differences in the "design elements" of malpractice tort litigation and no-fault compensation, see Table 1-1 on the following page.) Additionally, if the Act proved effective in reducing malpractice awards, then insurance costs and availability might be favorably influenced, alleviating, in turn, threats to the supply of quality obstetric services in the Commonwealth.

There are many reasons why malpractice reform efforts such as the Virginia Act have focused on a narrow class of obstetric injuries. According to the Institute of Medicine of the National Academy of Sciences, obstetric negligence claims in that period were "two to three times more numerous than (those) for all other physicians" and "more numerous and more severe than those in other specialties."[8] In a General Accounting Office (GAO) study of all malpractice claims filed in 1984, plaintiffs were successful in obstetric malpractice cases 45% of the time -- a figure about half again larger than the 31.8% success rate for the entire study sample of 17

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[4] Boyd v. Bulala, 877 F.2d 1191 (4th Circuit 1989).

[5] National Commission to Prevent Infant Mortality, Malpractice and Liability: An Obstetrical Crisis. (1988) pp. 4-5.

[6] For a survey of second-generation reforms, see Barrow R. Furrow, et al., Health Law: Cases, Materials, and Problems (St. Paul: West Publishing, Co., 1997), pp. 346-50.

[7] Other states debated similar legislation, but only Florida, in 1988, established a program essentially similar to that in Virginia, also to begin in 1989. The main differences between the Florida and Virginia Programs are described in Appendix 1-1.

[8] Quoted in Mary A. Cavanaugh, "Bad Cures for Bad Babies: Policy Considerations to the Statutory Removal of the Common Law Claim for Birth-Related Neurological Injuries," Case Western Reserve Law Review 43 (1993): 1311.

Table 1-1.
Relation of the Virginia Birth-Related Neurological Injury Compensation Program to Medical Malpractice Tort Litigation

Design Element	Tort System	Virginia No-Fault
"Trigger" for Compensable Event	Fault (establish that substandard care proximately caused the injury)	Cause (a panel of three medical experts establishes the existence of perinatal injury)
Measure of Compensation	Economic and punitive damage	Economic damages
Payment Mechanism	Providers (Third party insurance)	State fund (doctors, hospitals, insurers)
Forum for Resolving Dispute	Trial by jury (or settlement)	Administrative agency
Method of Implementation	Common law	Legislative statute

SOURCES: Abraham, Kenneth S., "Medical Liability Reform: A Conceptual Framework," Journal of the American Medical Association 260(1):July 1, 1988, pp. 68-72; Sieradzki, David L., "Throwing Out the Baby With the Bathwater: Reform in the System for Compensating Obstetric Accidents," Yale Law & Policy Review 7(538):1989, pp. 538-565.

specialty areas. Also, in large part because 31% of the claims against obstetricians were initiated on the basis of brain or spinal cord damage, the average indemnity payment by obstetricians found guilty of malpractice was $177,509, more than double the average indemnity for the study group as a whole.[9] As a consequence of more frequently lost cases and higher indemnity payments, obstetricians faced rapidly rising insurance premiums, reflecting both higher rates and the need for deeper coverage. To cite but one example, premiums rose from an average of $10,900 in 1982 to $18,800 in 1984, a 72% increase in only two years.[10] In view of this syndrome -- relatively more frequent suits, alleging more severe injuries, of which relatively more were successful, for larger awards, resulting in higher and more rapidly increasing insurance premiums -- it was not surprising to hear from the American College of Obstetricians and Gynecologists that the outflow of its members from obstetric practices not only had not abated after the "first generation" reforms, but had even increased, with perhaps more increases looming ahead.[11]

In 1986, concerns about the supply of obstetric services became especially compelling for Virginia when its three major malpractice insurers refused to issue new policies to obstetricians within the Commonwealth. St. Paul's Fire and Marine (a major national malpractice carrier)

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[9] Cited in David G. Duff, "Compensation for Neurologically Impaired Infants: Medical No-Fault in Virginia," Harvard Journal on Legislation 27 (1990): 398.

[10] Ibid., p. 398.

[11] Ibid., p. 400.

announced a *national* moratorium on new medical malpractice business, and Pennsylvania Hospital Insurance Company (PHICO) quickly followed with a refusal to renew most of its Virginia policies, leaving 1,100 Virginia physicians (including more than 140 obstetricians) without malpractice insurance. The Virginia Insurance Reciprocal then also followed, suspending the writing of new obstetrical malpractice coverage.[12] Obviously, the reduced availability of malpractice insurance seriously threatened to curtail essential obstetrical care across the state.

In the ensuing attempt to find a legislative solution to Virginia's insurance crisis, The Virginia Medical Society, through its Professional Liability Committee, took the lead. The Committee perceived that it could suggest three options to the legislature: (1) require any malpractice insurers still operating in the state to write coverage for obstetricians; (2) lure new malpractice carriers into the Virginia market; or (3) change the minds of the three major carriers threatening to leave the market. The Professional Liability Committee concluded (1) that any bill mandating coverage was not likely to pass the General Assembly, and (2) that the national nature of the malpractice crisis foreclosed the possibility that new carriers could be lured into the Virginia market. Accordingly, the Committee pursued the third option, by approaching the Virginia Insurance Reciprocal and asking what would have to be done legislatively for it to reenter the obstetrical insurance market. Virginia Insurance Reciprocal responded by saying: "Take the 'bad babies' out of the tort system. Reduce the uncertainty and unpredictability of the liability risk attached to the delivery of profoundly injured babies."[13] This response proved to be the catalyst that eventually led to the passage of the Virginia Birth-Related Neurological Injury Compensation Act.

Drafting the Virginia Birth-Related Neurological Injury Compensation Act

Many and complex substantive and procedural problems had to be confronted in the drafting of the legislation. Substantively, three issues had to be addressed: (1) how to give clear and precise statutory meaning to "birth-related neurological injury"; (2) whether the system should be made mandatory or voluntary; and (3) how to maintain quality of care within the context of a no-fault system. Procedurally, there were the twin issues of how the Program should be administered and financed. In the end, the drafters of the legislation agreed to focus on only the most severe forms of birth-related neurological injury; to make the Program voluntary (with incentives to encourage participation); to maintain quality of care by requiring that all claims automatically be referred to the Board of Medicine for review; to have administrative questions of eligibility decided by the Virginia Workers' Compensation Commission; and to finance the system by having those providers most affected by the Program (i.e., physicians and hospitals)

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[12] Lawrence H. Framme, III, "Cinderella: The Story of HB 1216," Virginia Medical 114 (May, 1987): 284.

[13] Ibid, pp. 286-8.

make annual payments into a compensation Fund that would be used to pay awards.[14]

Once the legislation was drafted, several more hurdles had to be overcome before it could become law. First, sponsors had to be chosen to steer it through the two houses of the legislature; for this task, Delegate Clifton A. "Chip" Woodrum and Senator William Parkerson were enlisted. When the legislation was officially introduced into the legislature on January 13, 1987, it quickly produced strong supporters (physicians) and opponents (The Virginia Trial Lawyers Association). Despite opposition, the steadfast support of The Medical Society of Virginia and various malpractice insurers proved decisive; on the day the legislation was introduced, The Virginia Insurance Reciprocal reaffirmed (in writing) that "if the legislature passes legislation which takes 'birth-related neurological injury' out of the tort system, we will lift the moratorium which the Reciprocal currently has on the writing of malpractice insurance for additional obstetricians."[15] With such strong support from Reciprocal (and the other insurers), the legislation was reported favorably out of the House Committee on Corporations, Insurance, and Banking. After modifications of its fee structure in both the House and Senate, the bill was signed into law by Governor Gerald L. Baliles in March 1987.[16]

The Key Provisions and Operational Procedures of the Act

In that law, the concept of "birth-related neurological injury" was given precise statutory meaning to define clearly which infants would be compensated by the Program. To become eligible for Program benefits, the injury had to meet four criteria: (1) *injury locality* ("brain or spinal cord"); (2) *causation* ("deprivation of oxygen or mechanical injury"); (3) *timing* ("labor, delivery, or . . . the immediate post-delivery period"); and (4) *consequence* ("permanently in need of assistance in all activities of daily living"). Additionally, both the attending physician (or nurse-midwife) and hospital where the birth occurred must be Program participants,[17] that is, they must have elected to participate by applying and paying the necessary fees. If these conditions of injury and participation are met, the Program becomes the exclusive remedy for these children. Even though the infants may still bring civil action against care providers for "intentional or willfully caused harm," such situations have proved to be rare. If injured babies are deemed not to qualify for the Program, their recourse is, as before the Act, tort litigation for medical malpractice.

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[14] Ibid., pp. 286-8.

[15] Gordon D. McLean, Executive Vice President for Virginia Professional Underwriters, Inc. to Ronald K. Davis, M.D., January 13, 1987; on file with the Virginia Birth-Related Neurological Injury Compensation Program.

[16] Ibid., pp.288-90.

[17] The requirement that both the physician *and* hospital be Program participants was changed by the Virginia State Legislature in 1990 to physician *or* hospital.

If eligible and brought under the Program's coverage, children qualify for two categories of benefits. First, they are entitled to compensation for "necessary and reasonable costs of [lifetime] care," which, in practice, have been rather broadly defined. Second, at the age of 18, they become eligible for monetary benefits to replace lost wages. It is particularly important to note that the Fund is the "payer of last resort" for Program beneficiaries. Private health insurance and public programs (usually Medicaid) provide the first sources of support: the Program covers only those costs not paid by other third-party payers.

As of October 16, 1997, petitions on behalf of 45 injured children have been filed with the Commission. Of these, 31 were approved, but the death of one of the approved claimants has left, for now, 30 beneficiaries in the Program. Five cases currently are pending before the Board.

A Brief Look at the Program's Financial Picture

To meet the expenses of the Program, fees are levied on health care providers. The legislated fee structure finally agreed upon was a compulsory fee of $250 per year for all licensed physicians (excluding retired physicians and medical residents), $5,000 per year for all obstetricians and nurse-midwives who elect to become "participants" in the Program, and a levy on hospitals who elect to participate of $50 per live birth during the previous year, up to a maximum of $150,000. Should income from these fees be insufficient to meet Program obligations, the Act provides for "fall back" authority to levy fees on malpractice insurers.

Because the Fund, in its initial years, had very few claimants, these revenues quickly accumulated, and earnings from the investment of these funds have now become the largest single source of yearly income. Consequently, over the years, with additional fee income plus increasing earnings on investments, the growth of the Fund's financial assets has exceeded the growth in the reserves necessary to meet the estimated lifetime costs for all current beneficiaries. As a result, the fee structure was substantially reduced beginning in 1995. Even with this reduction, by the end of that year, Fund financial assets totaled $64.4 million, well above the actuarially-determined "claims reserve" for future payments to current beneficiaries of $37.3 million, leaving a "Fund balance" at that time of $27.1 million, or 43% of the total Fund.

Questions About the Act and Program After Almost a Decade of Operation

The essential facts presented thus far relate to the objectives of the Act, the benefits provided by the Program, and the resources with which it meets these commitments. Bringing together the pertinent facts of each element of the Program elicits these observations and questions:

Observation 1: The beneficiary population is small, and, when compared with estimates made at the time of passage of the Act and subsequently, considerably smaller than anticipated.

Observation 2: Yearly total Fund income has exceeded yearly reserve set-asides for benefits plus expenditures for administration, and thus Fund financial assets have grown faster than the total estimated reserve for the payment of future claims for present beneficiaries.

Although these observations appear to represent two views of the same situation -- the shortfall in beneficiaries relative to resources -- their implications are quite different. The question that arises is whether the Program is *underutilized*, or whether it is *overfunded*. The answers to these questions -- and others posed below that follow from it -- will play a large role in determining and shaping the future of the Program.

Is the Program Underutilized :

(1) Does the size of the beneficiary population reflect the true incidence of babies with qualifying birth injuries, or can the beneficiary population be expanded within the present definition of the Act?

(2) If there are Program eligible babies who have not entered the Program, what are the reasons? Would strengthened and new approaches to the gathering and dissemination of information about birth outcomes and about the role of the Program bring these babies into the Program?

(3) Are there babies who have suffered qualifying birth injuries, but are not eligible for benefits because neither the hospital nor delivering physician were Program participants? If so, how can provider participation be expanded, so as to bring such injury-eligible babies under Program eligibility? What incentives might be implemented to induce increased provider participation?

(4) Or, are the criteria for eligible injury drawn too tightly, in that there are seriously damaged babies who are "marginally-ineligible" because they fall short, perhaps only by a little, in meeting one or more of the four criteria that define Program-eligible injury? If that is true, can the qualifying-injury definition be expanded unambiguously, equitably, and within the financial capabilities of the Program?

Is the Program Overfunded:

(1) Can we safely assume that the potential beneficiary population is totally enrolled in the Program, and reduce the financial base of the Program accordingly, while retaining its current mandate and structure?

(2) Are there just too few babies, with either Program-qualifying injuries or marginally close to that degree of severity, and so lacking in other sources of support, for a program of this scope to be cost-effective?

Other Questions Relating to the Goals of the Act and Program:

(1) What trends have occurred in the supply of obstetric services in the Commonwealth? Did the threats to the supply of obstetric services materialize? Has the Program had an influence on these trends?

(2) What is the status of the "medical malpractice insurance crisis"? What trends have occurred in malpractice insurance availability and costs and in malpractice suits since the inception of the Program? Has the Program had an effect on any such trends?

(3) And, in the final analysis, based on the answers to the above questions, was the fundamental assumption behind the passage of the Act -- that severely injured, high-cost babies were driving the malpractice crisis for obstetric services in Virginia -- correct or incorrect? If correct, it is a well-directed Program that may be meeting its objectives. If incorrect, does the Program nonetheless well-serve the Commonwealth?

The Objectives and Plan of this Report

In this light, the objectives of this Report are challenging but clear: to fully assess the operation of the Virginia Birth-Related Neurological Injury Compensation Program by addressing the questions posed above.

To accomplish this and satisfy the requirements set forth by the General Assembly in House Joint Resolution 641 (see Appendix 1-2), we first describe in pertinent detail the "real" operation of the Virginia Birth-Related Neurological Injury Compensation Program, in regard to both its beneficiaries and the benefits provided them under the Program (Chapter 2) and its participating obstetric service providers (Chapter 3). The study then turns, in Chapter 4, to an analysis of the Program's financial operation -- its fiscal capability, on the one hand, as depicted by the sources and amounts of Fund revenues and assets, and, on the other hand, demands on this capability, in the form of operational expenses and, primarily, compensation to beneficiaries. Special attention is paid here to the concepts and strategies used in managing the Program's resources, with evaluation and recommendations for that management.

After these discussions of the Program's operational and financial features, we turn to assessments of the Program's strengths and weaknesses. In Chapter 5, the strengths and weaknesses of the Program from the point of view of its beneficiaries are discussed, using information gained from our telephone surveys of this constituency. In Chapter 6, we provide similar surveys of opinions from physicians and nurses (including representatives of nurses' associations), coordinators of post-graduate medical residency programs, professional medical association representatives, and former Board members. In Chapter 7, we report on interviews

with hospital administrators, insurers, and lawmakers.[18] Chapter 8 provides conclusions about the operation of the Program to date and recommendations for the future, in the light of the two main reasons for which it was created: (1) addressing the needs of severely, neurologically birth-injured children and (2) protecting access to obstetric services in Virginia. As part of this first consideration, we provide our answers to the essential question of whether the full potential of the Program is being met, and, if not, ways in which its operations might be expanded to more fully meet both its mandate and its financial capability.

[18] In Chapters 5, 6, and 7, we report the views of these constituencies and interested groups on the "Program's strengths and weaknesses," as these views have been related to us. We consider these *perceptions* of the Program to be important to our evaluation of and recommendations for the Program, and therefore have refrained from qualifying them in any way.

Chapter 2

The Virginia Birth-Related Neurological Injury Compensation Program: Beneficiaries

It has been acutely observed that "disease is at once a biological event . . . [and] an occasion of and potential legitimation for public policy."[19] These dual facets of disease are vividly illustrated by the Virginia Birth-Related Neurological Injury Compensation Program. In Chapter 1, we pointed out that, for an infant to be included in the Program, there must first be the "biological event" (severe, birth-related neurological injury) and then criteria must be met that have been written into law (attending physician/midwife or hospital in which birth occurred must be a Program participant). As of October 16, 1997, applications for Program benefits have been pursued for just 45 children. Five of these were withdrawn before determination, five are pending, and of the 35 that have been decided, 31 were successful and four were not.[20] Table 2-1, on the next page, shows the number of applicants and decisions on their eligibility each year from 1988 to 1997. In the five years (1989-1993) after the first application was filed, a total of only six were submitted; however, in the next four years (1994-to date in 1997), 39 applications were entered.

This chapter focuses on these Program applicants, examining both the successful and unsuccessful; for unsuccessful applicants, why their petitions failed; for successful applicants, how they learned about the Program, the process by which they gained eligibility, and the benefits they receive. Importantly, we compare the current number of Program beneficiaries to our own calculations of the total eligible beneficiary population under the present injury definition.

Program Processes, Applications, and Outcomes

Program Administration

The Virginia Birth-Related Neurological Injury Compensation Program is governed by a Board of seven directors. These directors are appointed by the Governor and serve for a period of three years. The Board consists of three citizen representatives, one participating physician representative, one participating hospital representative, one liability insurer representative, and one non-participating physician representative. It makes decisions based on majority votes with

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[19] Charles E. Rosenberg, "Introduction: Framing Disease: Illness, Society, and History," in Framing Disease: Studies in Cultural History, Charles E. Rosenberg and Janet Golden, eds. (New Brunswick: Rutgers University Press, 1992), p.xiii.

[20] One child admitted to the Program has died.

Table 2-1. Applications for Benefits in the Virginia Birth-Related Neurological Injury Compensation Program: Annual Totals and Outcomes, 1988-1997*

Year	Number of Families Seeking Services				
	Successful	Unsuccessful	Withdrew Application	Pending	Total
1988	0	0	0	0	0
1989	0	1	0	0	1
1990	1	0	0	0	1
1991	0	0	0	0	0
1992	2	0	0	0	2
1993	2	0	0	0	2
1994	5	2	0	0	7
1995	13	1	4	0	18
1996	3	0	0	0	3
1997	5	0	1	5	11
Total	31	4	5	5	45

As of October 16, 1997.

SOURCES: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997; Pyles, Elinor, Executive Director, Virginia Birth-Related Neurological Injury Compensation Program, personal communication, September 5 and October 16, 1997.

five members constituting a quorum. In its official capacity, the Board performs several functions. It administers the Program and the Birth-Related Neurological Injury Compensation Fund, appoints a service company to pay claims on behalf of the Program, directs the investment and reinvestment of Program funds, and reinsures the risks of the Fund.[21]

Procedure to Establish Eligibility

Administratively, eligibility is determined by the Virginia Workers' Compensation Commission.[22] After an applicant (the "claimant") petitions the Commission, the Program calls

[21] VA. Code § 38.2-5016(A)(B)(C)(D)(E)(F).

[22] A full description of the administrative process for qualifying for Program benefits is presented in Appendix 2-1, "Current Statutory Scheme, With Particular Reference to the Role of the Virginia Workers' Compensation Commission." The discussion here presents the most important features of that process.

on outside experts to evaluate the claim, and in a large number of cases the Program supports the claim and approval is granted by the Commission without the necessity of a hearing. (Throughout the entire process of determining eligibility, the presumption is that the injured child is eligible for benefits, and the Program bears the burden of proof if it challenges the petition.) If the petition is not supported by the Program, it is passed to the Commission, which reviews it and arranges for a hearing. On the basis of the evidence presented at this hearing, the Commission determines whether the two key prerequisites have been fulfilled: whether a birth-related neurological injury exists and whether the physician/midwife or hospital participated in the Program. In order to establish the existence of a birth-related neurological injury, the statute requires that "each claim filed with the Commission . . . [be] reviewed by a panel of three qualified and impartial physicians. This panel shall file its report and recommendations as to whether the injury alleged is a birth-related neurological injury . . . at least ten days prior to the date set for hearing." Also, at least one member of the panel must be available to testify at the hearing, and the Commission "must consider, but shall not be bound by, the recommendations of the panel."[23] The Commission then establishes whether the obstetrical services provided at the time of birth were delivered by a participating physician or whether the birth occurred in a participating hospital. If the Commission determines that the injury meets both the biological and the administrative criteria necessary for compensation, then an award is made, i.e., the claimant becomes eligible for benefits under the Program.[24] However, if the Commission determines that the injury is not a birth-related neurological injury (as defined by the statute) or that neither the physician nor the hospital participate, then it "shall dismiss the petition..."[25] When a claim is dismissed by the Commission, the family cannot re-apply, but is free to pursue a malpractice suit in the court system.

The Length of Time Elapsing Before Applications for Program Eligibility Are Entered

Under the Virginia Birth-Related Neurological Injury Compensation Act, a family has 10 years from the birth of a child to apply for entry into the Program. The lengths of time between the births of injured children and applications for eligibility taken by the 31 families currently[26] receiving benefits are shown in Table 2-2. Only 13% (four) of the families applied within one

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[23] VA. Code § 38.2-5008(B). The three physician panel are selected on a case-by-case basis from a predetermined list of medical experts in the field of high-risk obstetrics, neonatology, and pediatric neurology. On the mechanics of how the panel is established, see Robert M. Carey, M.D. and Stephen M. Ayres, M. D. to K. Marshall Cook, Senior Assistant Attorney General, Commonwealth of Virginia, 18 December 1987 and Cook to Carey and Ayres, 6 January 1988 on file with the Virginia Birth-Related Neurological Injury Compensation Program.

[24] VA. Code § 38.2-5009(1).

[25] VA. Code § 38.2-5008(A)(5).

[26] These 31 include the one child who has died.

Table 2-2. Time Interval Between Birth and Application by Successful Claimants, 1988-1997*

Length of Time in Years Before Applying**	Families Currently Receiving Services	
	Number	Percentage
0	4	12.9%
1	6	19.4%
2	3	9.7%
3	6	19.4%
4	4	12.9%
5	5	16.1%
6	2	6.5%
7	1	3.2%
8	0	0.0%
9	0	0.0%
10	0	0.0%
Total	31	100.0%

* As of October 16, 1997.
Length of time is the number of years between the year of the child's birth and the year the family applied for benefits through the Virginia Birth-Related Neurological Injury Compensation Program.

SOURCES: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997; and Pyles, Elinor, Executive Director, Virginia Birth-Related Neurological Injury Compensation Program, personal communication, October 1997.

year of their child's birth, while nearly 40% (12) did not apply until their child was four years of age or older.

According to Elinor Pyles, the Program's Executive Director, the primary reason most parents have not applied to the Program until at least one year after their infant's birth is that they learned about the Program only well afterward. Our analysis confirms this. Chapter 5, which presents the results of telephone interviews with beneficiary families, shows that information about the Program is neither readily nor routinely made available to the parents of injured infants.

Unsuccessful Applicants

Since the Program's inception, five families have withdrawn their applications for Program benefits, and four others were unsuccessful in gaining eligibility, as shown in Table 2-1

earlier in this chapter. Case information for withdrawn applications, provided in Table 2-3, indicates that four were withdrawn because they did not meet the required injury definition, and one because the application was not complete.[27] Similar information (Table 2-4) for the four failed applications shows that three failed because the injury definition was not met, and one because the participation requirement was not met.

Table 2-3. Withdrawn Applications for Program Benefits, 1988-1997

Location of Baby's Birth	Reason for Withdrawing Application
Mechanicsville	The baby did not fit the definition of a "birth-related neurological injury." Claimant's disabilities caused by prematurity and did not occur as a result of actions during labor or delivery. Provider participation requirement was not met.
Boones Mill	The baby did not fit the definition of a "birth-related neurological injury." Delayed development and seizure disorders did not result from any condition originating at the time of delivery. The hospital was participating in the Program.
Richmond	The baby did not fit the definition of a "birth-related neurological injury." Child received anoxic brain damage at birth, but it was not clear that child was in need of permanent assistance in all activities of daily living. The physician was participating, but the hospital was not.
Galax	Application was not complete. Hospital was participating, but the physician was not. Plans to reapply.
Falls Church	The baby did not fit the definition of a "birth-related neurological injury." Claimant qualifies as far as inability to care for himself, but it was not clear that the cause for injury occurred during birth. Both the hospital and physician were participating.

SOURCES: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, "Birth Injuries Filed," unpublished data, no date; letters to Carolyn Colville, Deputy Commissioner, Workers' Compensation Commission, various dates; Antis, Lisa, Virginia Birth-Related Neurological Injury Compensation Program, personal communication, September and October, 1997.

[27] This individual plans to reapply (see Table 2-3).

Table 2-4. Failed Applications for Program Benefits, 1988-1997

Location of Baby's Birth	Reason for Denial
Winchester	Provider participation requirement was not met. Baby is deceased.
Falls Church	The baby did not fit the definition of a "birth-related neurological injury." Claimant suffered from neurologic deficit, but was not determined to be "permanently, non-ambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living." The claim was referred to the Program by the Circuit Court.
Richmond	The baby did not fit the definition of a "birth-related neurological injury." Claimant developed herpes simplex encephalitis-meningitis, and there was no evidence that baby suffered from any deprivation of oxygen or mechanical injury. The hospital was participating in the Program, but the physician was not.
Norfolk	The baby did not fit the definition of a "birth-related neurological injury." Claimant's disabilities caused by prematurity and did not occur as a result of actions during labor or delivery. Both the hospital and the physician were participating in the Program.

SOURCES: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, "Birth Injuries Filed," unpublished data, no date; letters to Carolyn Colville, Deputy Commissioner, Workers' Compensation Commission, various dates.

Successful Applicants: Their Characteristics and the Benefits They Receive

Since 1987, as has been noted, 31 families, or a little over three-fourths of the 40 who have applied to the Program and whose cases have been decided, have succeeded in qualifying for benefits (see Table 2-1). We now look more closely at these 31 families, describing their geographic distribution within the Commonwealth, the benefits they receive, and Program expenditures for these benefits.

Geographic Distribution of Cases

Table 2-5 and Graph 2-1 shown on the following pages provide data on the geographic distribution of the families currently included in the Program. Table 2-5 shows that (1) they represent only 10 of the state's 22 Health Planning Districts, and (2) these districts accounted for just over three-fourths of the live births in Virginia over the past 10 years (78% of all live births by "place of occurrence," and 76% by "place of residence").[28] Graph 2-1 shows them to be in most regions of the State -- one in the southwest, three in the southeast, and six in an arc from the

[28] In the discussion that follows, we focus on place of occurrence in Table 2-5 rather than place of residence.

Table 2-5. Virginia Health Planning Districts Represented by Program Beneficiaries With Percentages of State Live Births by Occurrence and Place of Residence

Planning District***	Location of Baby's Birth*		Live Births			
			Place of Occurrence**		Place of Residence**	
	Number	% of Total	Number	% of all Live Births	Number	% of all Live Births
District 2 Buchanan, Dickenson, Russell, and Tazewell	1	3.2%	619	0.7%	1,345	1.4%
District 5 Alleghany, Botetourt, Craig, Roanoke, Clifton Forge, Covington, Roanoke City, Salem	6	19.4%	4,222	4.5%	3,189	3.4%
District 6 Augusta, Bath, Highland, Rockbridge, Rockingham, Buena Vista, Harrisonburg, Lexington, Staunton, Waynesboro	1	3.2%	2,802	3.0%	2,731	2.9%
District 7 Clarke, Frederick, Page, Shenandoah, Warren, Winchester	1	3.2%	2,179	2.3%	2,334	2.5%
District 8 Arlington, Fairfax, Loudoun, Prince William, Alexandria, Fairfax City, Falls Church, Manassas, Manassas Park	11	35.5%	24,767	26.7%	24,934	26.4%
District 11 Amherst, Appomattox, Bedford, Campbell, Bedford City, Lynchburg	1	3.2%	2,804	3.0%	2,831	3.0%
District 12 Franklin, Henry, Patrick, Pittsylvania, Danville, Martinsville	2	6.5%	2,197	2.4%	2,820	3.0%
District 15 Charles City County, Chesterfield, Goochland, Hanover, Henrico, New Kent, Powhatan, Richmond City	4	12.9%	12,726	13.7%	11,287	12.0%
District 19 Dinwiddie, Greensville, Prince George, Surry, Sussex, Colonial Heights, Emporia, Hopewell, Petersburg	1	3.2%	2,159	2.3%	2,244	2.4%
District 20 Isle of Wight, Southampton, Chesapeake, Franklin City, Norfolk, Portsmouth, Suffolk, Virginia Beach	3	9.7%	18,237	19.6%	17,681	18.7%
State of Virginia	31	100.0%	92,934	78.2%	94,355	75.7%

* 1988 through October 16, 1997.

** Data are for 1994, the latest year for which published information is available.

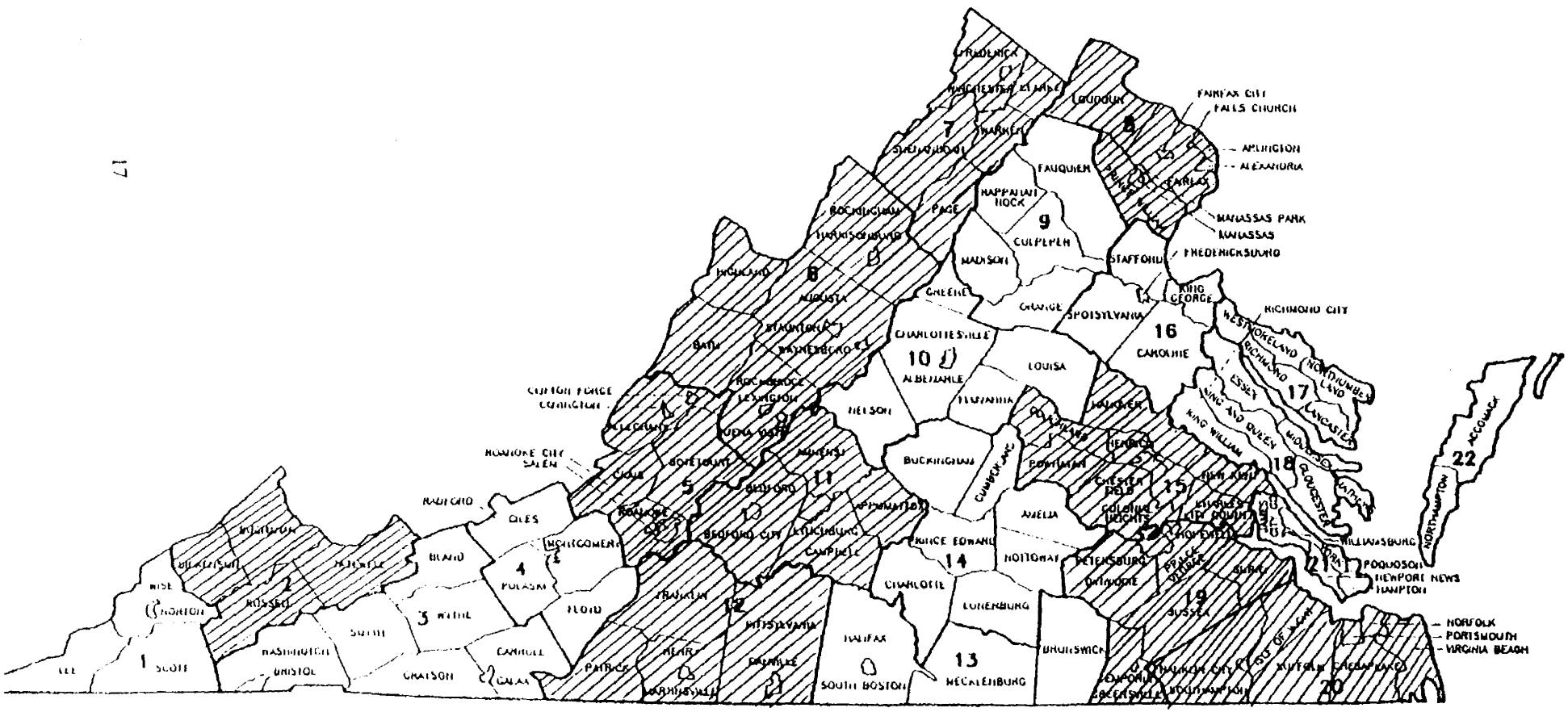
*** Excludes those planning districts where no claims were filed.

SOURCES:

Location -- Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished tables, August 1997.

Live Births -- Commonwealth of Virginia, Virginia Department of Health, Center for Health Statistics, Virginia Vital Statistics: Data Related to Maternal and Infant Health (Richmond, VA: December 1995).

Graph 2-1.
Geographic Distribution of Health Planning Districts Represented by Current Program Beneficiaries



SOURCES: Commonwealth of Virginia, Virginia Department of Health, Center for Health Statistics, Virginia Vital Statistics: Data Related to Maternal and Infant Health (Richmond, VA. December 1995); and Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished tables, 1997.

north to the south through the center of the state, but excluding the areas contiguous to the Chesapeake Bay.

The largest incidences of Program beneficiaries occur in Northern Virginia (District 8), with 11 cases and the Roanoke area (District 5) with six. Together, these two districts provide almost 55% of the cases, but represent only 31% of all live births. The next two most-represented Districts are the Richmond area (District 15) with four cases and Tidewater (District 20) with three cases. These two Districts together provide 23% of the beneficiaries, and 33% of all live births, a smaller and perhaps not significant difference; and 12 Districts, accounting for 22% of all live births, are not represented at all in the beneficiary population. The fact that some districts are represented in the Program at considerably higher rates than in the live-birth statistics, others about proportionally, and over half are not represented at all in the Program raises some interesting questions as to causation. Are these differences merely statistical, resulting from the small size of the beneficiary population, or are there systematic differences among Districts, in such important respects as health provider participation rates or informational mechanisms, that explain these disparities between percentages of live births and beneficiary representation in the Program? We will return to this important issue in Chapter 3, in which we present information about hospitals and physicians participating in the Program, and in Chapter 5, in which beneficiary families relate their experiences in learning about and entering the Program, as well as receiving benefits.

Benefits Provided

The Virginia Birth-Related Neurological Injury Compensation Act authorizes a wide range of benefits for eligible claimants. As listed in Table 2-6 (shown on the next page), these benefits include compensation for medical and hospital expenses, rehabilitation, residential and custodial care, special equipment, travel, loss of earnings beginning when the child reaches age 18, and reasonable legal expenses incurred in filing a claim. The Program is the "payer of last resort" for these benefits, only after any available private insurance and governmental programs, such as Medicaid, have been called upon. These expenses are paid as incurred, either through vendor billing or reimbursement to beneficiary families.

Although the Virginia Birth-Related Neurological Injury Compensation Program was created in 1987, the first payment to a beneficiary was not made until 1992. Since 1992, the Program has paid over $10.2 million, in total, to 30 beneficiaries, as indicated in Table 2-7A and Graph 2-2.[29] In the percentage distribution of benefit expenditures provided in Table 2-7B, by

[29] Full information for each beneficiary family is provided in Appendices 2-2 through 2-8 at the end of this chapter. Appendix 2-2 describes each beneficiary by year of birth, year of filing of claim, physician/hospital participation, and expenses paid, by category and in total, by the Program. Appendices 2-3 through 2-8 provide information on Program benefits year-by-year, by category, for each beneficiary in the Program at that time. These appendices do not include the last beneficiary entering the Program. This individual entered the Program after analysis of the Program's expenditures was completed.

Table 2-6. Benefits Authorized by the Virginia Birth-Related Neurological Injury Compensation Act

Benefits Authorized by Law*	Examples Provided by Program Guidelines
1. Actually medically necessary and reasonable expenses:	
A. Medical and hospital	Includes nursing care, dental care, and care provided by physicians and hospitals
B. Rehabilitative	Occupational, physical, and speech therapy
C. Residential and custodial care and service	Construction of a new home (not to exceed $500,000 and 3,300 square feet), modifications to an existing home, rental payments, housing moves
D. Special equipment or facilities	Van, oxygen concentrators, bipap machines, feeding pumps, gait trainers, wheelchairs, Wizard strollers, suction machines, apnea monitors, IV poles, pulse oximeters, Gorilla car seats, wheelchair lifts, and wheelchair tie-downs
E. Travel	Parking fees with receipts and mileage to and from appointments
2. Loss of earnings from the age of eighteen	Regular installments paid when child reaches 18 until he/she reaches age 65 in the amount of 50 percent of the average weekly wage in the Commonwealth of workers in the private, nonfarm sector
3. Reasonable expenses incurred in the filing of a claim, including attorneys' fees	Include reasonable fees incurred in a dispute that arises over the benefits, up to 3 hours to review the Trust and Occupancy Agreement if family receives a house
4. Other expenses provided under Program Guidelines (not mentioned in law)	Funeral expenses, postage for reimbursement expenses, telephone calls made to medical professionals, cellular phone if medically necessary, diapers once child reaches age 3, four therapeutic toys per year

* These are categories defined by law, and are not necessarily the categories used by the Program to track Program benefits (see Graph 2-2 and Appendices 2-2 to 2-8).

SOURCES:
Benefits Authorized by Law -- Virginia Birth-Related Neurological Injury Compensation Act, § 38.2-5009.

Examples Provided by Program Guidelines -- Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, "Guidelines for the Operation of the Virginia Birth-Related Neurological Injury Compensation Program," April 15, 1997.

Table 2-7A. Total Program Expenditures for Beneficiaries by Category, 1992-1997*

Year	Total Expenses Paid								
					Equipment				
	Incidental (a)	Nursing	Physicians/ Hospitals	Therapy	Medical (b)	Transportation (c)	Attorneys	Housing/ Additions	Total Paid
1992	$6,589.88	$6,745.75	$825.00	-	-	-	-	-	$14,160.63
1993	$17,797.18	$58,219.50	$8,670.43	$245.11	$155.00	-	$12,798.85	-	$97,886.07
1994	$23,895.10	$117,508.90	$7,285.35	$5,217.35	$12,582.44	$22,153.64	$25,483.78	$25,000.00	$239,126.56
1995	$94,147.80	$492,423.55	$52,226.27	$22,332.68	$37,459.72	$133,163.43	$32,943.08	$995,113.39	$1,859,809.92
1996	$127,267.50	$910,826.58	$38,225.79	$66,268.66	$59,156.96	$260,606.96	$67,361.42	$3,137,330.99	$4,667,044.86
1997	$122,793.25	$932,467.67	$19,845.62	$49,913.25	$38,444.43	$107,325.82	$56,269.57	$2,018,585.02	$3,345,644.63
Total	$392,490.71	$2,518,191.95	$127,078.46	$143,977.05	$147,798.55	$523,249.85	$194,856.70	$6,176,029.40	$10,223,672.67

* As of August 15, 1997.

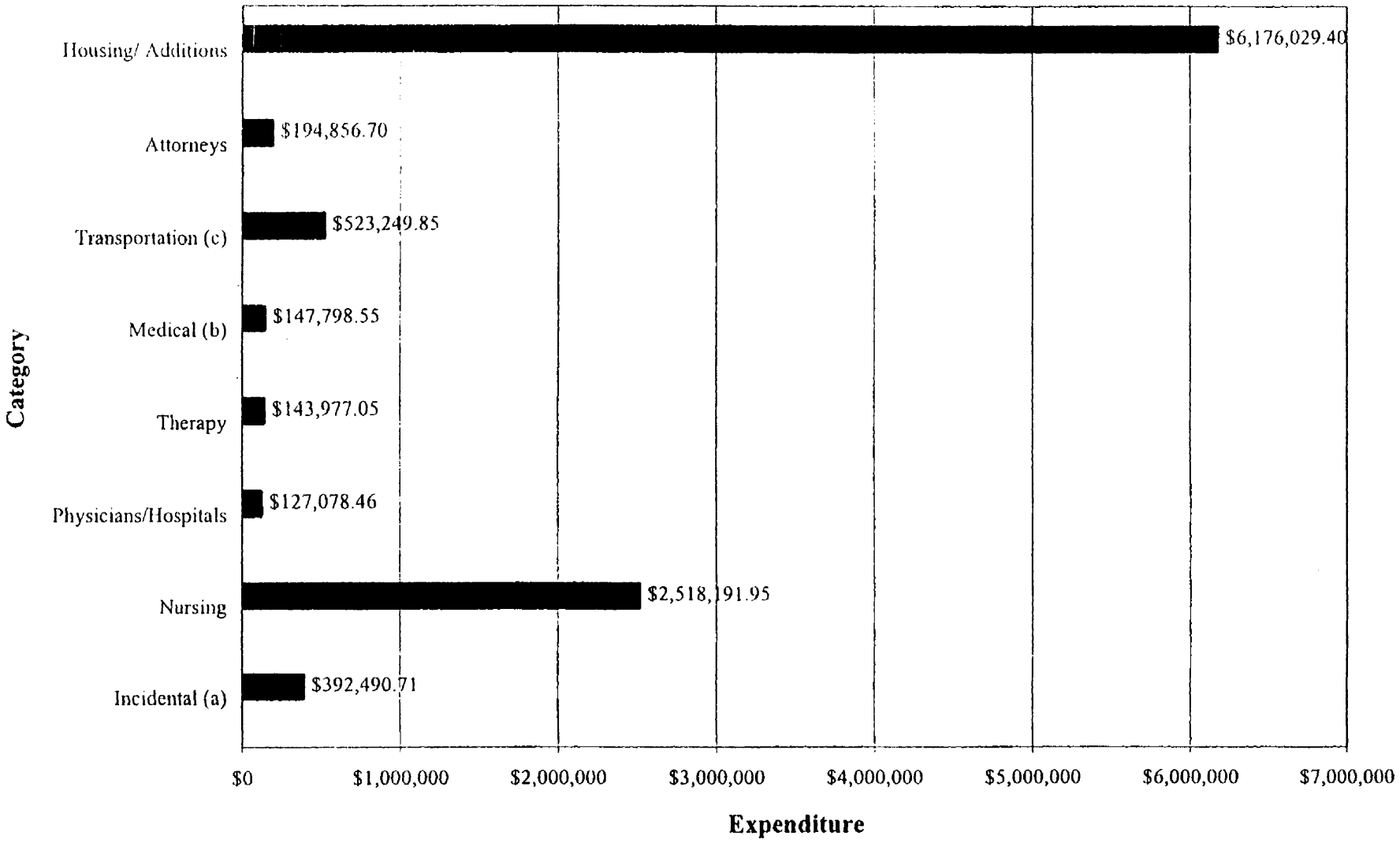
(a) Includes items such as diapers, medication, special formulas, and mileage.

(b) Includes items such as feeder seats, IV poles, oxygen concentrators, and beds.

(c) Includes items such as vans and lifts.

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997.

Graph 2-2. Total Program Expenditures for Beneficiaries by Category , 1992-1997



(a) Includes items such as diapers, medication, special formulas, and mileage.

(b) Includes items such as feeder seats, IV poles, oxygen concentrators, and beds.

(c) Includes items such as vans and lifts.

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished tables, 1997.

Table 2-7B. Total Program Expenditures for Beneficiaries by Category, Percentage Distribution, 1992-1997*

Year	Total Expenses Paid								
					Equipment				
	Incidental (a)	Nursing	Physicians/ Hospitals	Therapy	Medical (b)	Transportation (c)	Attorneys	Housing/ Additions	Total Paid
1992	46.5%	47.6%	5.8%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
1993	18.2%	59.5%	8.9%	0.3%	0.2%	0.0%	13.1%	0.0%	100.0%
1994	10.0%	49.1%	3.0%	2.2%	5.3%	9.3%	10.7%	10.5%	100.0%
1995	5.1%	26.5%	2.8%	1.2%	2.0%	7.2%	1.8%	53.5%	100.0%
1996	2.7%	19.5%	0.8%	1.4%	1.3%	5.6%	1.4%	67.2%	100.0%
1997	3.7%	27.9%	0.6%	1.5%	1.1%	3.2%	1.7%	60.3%	100.0%
Total	3.8%	24.6%	1.2%	1.4%	1.4%	5.1%	1.9%	60.4%	100.0%

* As of August 15, 1997.

(a) Includes items such as diapers, medication, special formulas, and mileage.

(b) Includes items such as feeder seats, IV poles, oxygen concentrators, and beds.

(c) Includes items such as vans and lifts.

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997.

far the largest component, representing over 60% of the total, is that for new houses or additions o existing houses, with nursing services the second largest category, accounting for 25% of all benefit outlays. In this period of not quite six years, the Program's annual benefit expenditures have increased from $14,161 in 1992 to $4.7 million in 1996 (the latest complete year,) as shown in Table 2-7A. It is instructive to compare benefit amounts paid from the Fund with costs of financial services provided for the Program and Program administration. In Table 2-8, we offer these comparisons for 1992-1995. The substantial growth in benefits since 1995, shown in Table 2-7A, very probably has increased the benefits share of total expenditures significantly, relative to both financial services and administration (for which 1996 and 1997 data are not yet available).

Table 2-8. Program Expenditures for Benefits, Financial Services, and Administration, Annually, 1992-1995

	Benefits		Financial Services		Administration	
Year	Amount	Percent	Amount	Percent	Amount	Percent
1992	$14,161	1.3%	$588,086	55.1%	$464,255	43.5%
1993	$97,886	6.3%	$794,196	51.2%	$660,324	42.5%
1994	$239,126	12.1%	$957,205	48.7%	$770,565	39.2%
1995	$1,859,810	48.5%	$1,080,099	28.2%	$894,133	23.3%

SOURCES:

enefits -- Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997.

Financial Services and Administration -- William Kuehl, Ltd., P.C., Independent Auditors' Report," August 18, 1994, August 22, 1994; Mitchell, Wiggins, & Company, "Independent Auditors' Report," December 22, 1995, June 25, 1995.

From the outset, the Program has served fewer injured children than anticipated. When the Program was created in 1987, it was thought that as many as 40 children each year might be eligible to receive benefits by the nature of their birth outcomes.[30] Later researchers reduced this number to no more than 10 children per year.[31] If this expectation were correct, and all had entered the Program, today upwards of 90 children and their families would be receiving benefits. The actual beneficiary population -- just 31 -- obviously falls far below this maximum expectation. Accordingly, this Report now turns to an analysis of the potential beneficiary pool.

[30] Lawrence H. Framme, III, "Cinderella: The Story of HB 1216," Virginia Medical 114(May 1987): 287.

[31] Barbara Brown, personal communication, December 8, 1997.

Methodological Alternatives and Choices

In brief, there are four possible approaches to determining Program-eligible babies who are not in the Program. These are (1) identifying through the legal system "real" cases (identities known) of children who belong in the Program but are going through the courts; (2) estimating "statistical" cases (how many, but identities unknown) in the legal system; (3) identifying "real" cases through information provided by the medical system; and (4) estimating "statistical" cases through epidemiological studies by the medical system. In Appendix 2-9, we discuss why approach 3 holds the most promise, but why we have had to use, as the next best alternative, approach 4.

Potentially Eligible Beneficiaries as Determined by Extrapolation from the Geographic Pattern of Current Beneficiaries

We have noted above that all 31 of the current Program beneficiaries were born in only 10 Health Planning Districts, and that, in total, these 10 Districts account for about 78% of all live births in the Commonwealth. Presumably, these Districts also would have 78% of the children who meet the injury level specified in the Act. Accordingly, if the 12 unrepresented Districts, which account for no fewer than 22% of all live births, were included in the beneficiary population, they would represent 22% of those children. By this simple projection, the total beneficiary population would be 40. Two points arise in applying this "geographic" projection: first, it assumes that the place of occurrence of birth has no bearing on the birth outcome, which seems to be a reasonable assumption given that Program-eligible injuries must have occurred at the time of birth or immediately afterward, and, second, that this broadening of the geographic representation in the beneficiary population makes each Health Planning District *proportionally* represented, but not necessarily *fully* represented. All may be (equally) underrepresented.

Potentially Eligible Beneficiaries as Determined from Epidemiological Studies

A second, complex, approach, based on epidemiological studies of birth injury, estimates the potential beneficiary population in a way that includes consideration of the underrepresentation question. In estimating the annual incidence of birth-related neurological injury, we are confronted with the problem that the statutory definition of this condition corresponds to a number of different clinical conditions, even though the statutory definition appears to be precise:

> "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. In order to constitute a "birth-related neurological injury" within the meaning of this chapter, such disability shall cause

> the infant to be permanently in need of assistance in all activities of daily living. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality, degenerative neurological disease, or maternal substance abuse.[32]

The clinical conditions actually falling within this injury definition include epilepsy, mental retardation, speech impairment, various learning disabilities, and cerebral palsy. As a result, birth-related neurological injury could potentially encompass a wide range of clinical conditions.[33]

However, some narrowing is possible. Of these conditions, severe cases of mental retardation or cerebral palsy would be most likely to produce sufficient impairment for an infant to be considered compensable by the Program. In determining whether a case of mental retardation is "severe," researchers use a readily available measuring stick -- a level of IQ less than 50.[34] Using this index, Nigel Paneth and Raymond I. Stark have reviewed epidemiological studies and estimated that the number of cases of severe mental retardation of perinatal origin to be three or four per 10,000 school children.[35] Based on these findings, it is possible to estimate the number of infants born in the Commonwealth of Virginia with severe mental retardation. These estimates are provided for the period 1988-1993 in Table 2-9 shown on the next page.

Since this table provides only an estimate of the number of mental retardation cases that might satisfy the *injury locality* criteria ("brain or spinal cord"), the actual number of potential beneficiaries of the Program is smaller than the annual figures suggested by these results, especially when one considers the other three criteria of *causation, timing, and consequence.* As to *causation*, the review of the literature conducted by Paneth and Stark indicates that "the evidence .. . does not support the conclusions . . . that perinatal asphyxia is *the* [italics in original] major cause of cerebral palsy and severe mental retardation."[36] If this observation is correct, then only a minority of all cases of severe mental retardation are associated with perinatal trauma. Yet, in the words of Paneth and Stark, this minority is "distinct." They assert:

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[32] VA. Code § 38.2-5001.

[33] David G. Duff, "Compensation for Neurologically Impaired Infants: Medical No-Fault in Virginia," Harvard Journal on Legislation 27 (1989): 394.

[34] For a normal population, the mean IQ is standardized to 100 with a standard deviation of 15.

[35] Nigel Paneth and Raymond I. Stark, "Cerebral Palsy and Mental Retardation in Relation to Indicators of Perinatal Asphyxia," American Journal of Obstetrics and Gynecology (December 15, 1983): 962.

[36] Ibid., p. 965.

Table 2-9. Estimated Annual Incidence of Severe Mental Retardation and Spastic Quadriplegia in Virginia, 1988-1993

Year	Number of Resident Births	Estimated Number of Cases of Severe Mental Retardation*	Estimated Number of Cases of Severe Mental Retardation Associated with Spastic Quadriplegia**
1988	92,816	28 to 37	4 to 6
1989	96,538	29 to 39	4 to 6
1990	96,752	29 to 39	4 to 6
1991	95,777	29 to 38	4 to 6
1992	96,725	29 to 39	4 to 6
1993	93,881	28 to 38	4 to 6

* Based on 3 to 4 per 10,000.
** Based on 2.5 per 1,000.

SOURCES: University of Virginia, Center for Public Services, Virginia Statistical Abstract, 1996-1997 edition, (Charlottesville, VA: 1996), and calculations using Paneth, Nigel, and Stark, Raymond I., "Cerebral Palsy and Mental Retardation in Relation to Indicators of Perinatal Asphyxia," American Journal of Obstetrics and Gynecology (December 15, 1983): 962.

> A distinct minority of depressed infants develop chronic brain impairment which appears to be the result of asphyxia. Three generalizations can be made about such infants: (1) Their asphyxia is likely to have been severe and prolonged. (2) They frequently show neurologic signs in neonatal period such as seizures, uncoordinated feeding and difficulties with respiratory control. (3) The subsequent handicap is generally severe, often multiple, and virtually always involves the motor system.[37]

The third condition, severe handicap to the motor system, implies that compensable cases most often involve some form of cerebral palsy. In that regard, there are three types of cerebral palsy: spastic diplegia, spastic hemiplegia, and spastic quadriplegia, and only the last category, spastic quadriplegia, affects the entire body, is characterized by extensive neurological damage, and is also commonly accompanied by mental retardation.[38] Thus, only cases of spastic quadriplegia caused by asphyxia come close to meeting *all* of the criteria necessary to be compensated by the Program. Since these most severe cases of cerebral palsy are "commonly

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[37] Ibid., p. 965.

[38] Richard P. Perkins, "Perspectives on Perinatal Brain Damage," Obstetrics & Gynecology 69 (1987): 808-9.

accompanied by mental retardation," Table 2-9 suggests that the "upper bound" of compensable cases annually (based solely on clinical criteria) will average approximately 38 or 39, if *all* severe mental retardation were associated with spastic quadriplegia. (This observation could be the basis of the initial estimates that the number of Program-eligible infants each year *might* be as many as 40.) The actual number of eligible babies most probably is considerably lower. Paneth and Stark estimate the "significant minority" of severely mentally retarded babies whose conditions are associated with spastic quadriplegia to be about 15%; if so, Program-eligible babies would average four to six per year (see Table 2-9), not comparable to the original estimates, but still larger than the average annual number of successful applicants since the establishment of the Program. If, on average, five children had entered the Program each year since 1989, the number of beneficiaries would be 45, less any attrition from death.

Comparing each estimate to the actual number of beneficiaries, 31, we can say that the first tells us that 9 children would be added if the 12 Health Planning Districts not currently providing any beneficiaries were represented in the same proportion, relative to live births, as the 10 Districts currently represented in the Program, and the second suggests that perhaps another five babies (the difference between the epidemiological result of five cases per year, for the nine years the Program has been operational, or 45, and the 40 cases who would be in the Program if all Health Planning Districts were proportionally represented at this moment) would be in the Program if no underrepresentation existed, i.e., *all* injury-eligible babies were included. This participation shortfall goes far in explaining why, as shown later in Chapter 4, the financial resources of the Fund have grown faster than its financial commitments to beneficiaries. By bringing those resources into this analysis of potential increases in beneficiaries, we can make an interesting comparison. Our two methods indicate that the present beneficiary population is approximately 14, or 30%, below its maximum attainable level; in Chapter 4 we see that the Fund Balance (the amount in excess of the Claims Reserve) is about 42% of the Program's financial assets. These numbers suggest that all injury-eligible infants not currently in the Program could be brought into it within the present financial structure. Further, the epidemiological approach indicates that, if all injury-eligible babies become beneficiaries, that population would grow by an average of five per year, less any deaths. The evidence in Chapter 4 also suggests that this growth could be accommodated within the present financial structure of the Birth-Injury Fund.

Some of the questions posed in the Introductory Chapter now are worth recalling. In essence, they ask why these beneficiary numbers are below original expectations, and the Fund excess over the claims reserve is substantial: that is, is the Program underutilized or is it overfunded? At this point in our analysis, it appears that the weight of evidence favors the view of underutilization. Why more of these children have not entered the Program now looms as the core question.

Chapter 3

Participating Providers of Obstetric Services: Hospitals, Physicians, and Nurse-Midwives

Hospitals

We have clearly defined the necessary conditions for eligibility in the Virginia Birth-Related Neurological Injury Compensation Program. The first is the requisite birth injury, discussed in detail in the preceding chapter. We now turn to the other necessary condition, that the injured child received obstetric services from a hospital or physician (or nurse-midwife) who is a Program participant. If the injury requirement is met but not the participation requirement, or vice versa, the injured child is not eligible for benefits from the Program, and the avenue of recourse is tort litigation. Assuming that the injury requirement is fulfilled, the available options on behalf of the injured child, which depend on provider participation, are spelled out in Table 3-1.

Table 3-1. Alternative Remedies Available to Children with Requisite Birth-Related Injury, According to Hospital Participation and/or Participation by the Physician or Nurse-Midwife

	Alternative Remedies Available to Children with Birth-Related Injui			
	Hospital		Physician	
Participation in the Program	Sue for Malpractice	Enter Program	Sue for Malpractice	Enter Program
Physician and Hospital Participate	No	Yes	No	Yes
Hospital Participates and Physician Does Not	No	Yes	Yes	No
Hospital Does Not Participate and Physician Does	Yes	No	No	Yes
Physician and Hospital Do Not Participate	Yes	No	Yes	No

SOURCE: Center for Public Policy Research, The Thomas Jefferson Program in Public Policy, College of William and Mary, 1997

The Virginia Birth-Related Neurological Injury Compensation Act defines "participating hospital" as

> a hospital licensed in Virginia which at the time of the injury (i) had in force an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the hospital 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, (ii) had in force an agreement with the State Department of Health whereby the hospital agreed to submit to review of its obstetrical service... and (iii) had paid the participating hospital assessment ...for the period of time in which the birth-related neurological injury occurred.[39]

This Report now focuses on those hospitals in the Commonwealth that have elected to be a part of the Program, with data on (1) the number and locations of participating hospitals and the percentages they represent of hospitals and hospital birthing capacity and (2) the fees they have paid into the Fund for their participation.

Number and Rates of Hospitals Participating in the Program

Of the more than 100 inpatient hospitals in the Commonwealth, 71 have "bassinets," the indicator of birthing-unit capacity.[40] Table 3-2, on the following five pages, spells out in detail the patterns of participation in the Program among Virginia's hospitals. They are organized by Health Planning District, identified by name and location, with data showing the years in which they participated and the fees they paid into the Fund. Since 1988, of all hospitals having bassinets, 51 have participated for at least one year in the Program, and 20 never have. The highest rate of participation for such hospitals occurred in 1988, the first year the Program began collecting assessments from hospitals, when 43 hospitals participated. In fact, only eight hospitals began their initial participation after 1988, and only one new participating hospital, John Randolph Medical Center in Hopewell, joined the Program in 1997.

There are several discernible patterns of year-to-year participation by the hospitals that have been in the Program.[41] Ten, for example, have participated every year since the Program began, and eight have been in the Program every year but one. In eight other cases, participation has been intermittently "in and out" with no general pattern; two examples are Allegheny Regional Hospital in Low Moor and Maryview Medical Center in Portsmouth, each of which participated for three years, stopped for six years, and then came back into the Program. (Table 3-3, which consolidates by Health Planning District the data presented on hospital participation in Table 3-2, follows Table 3-2.)

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[39] VA. Code § 38.2-5001

[40] The University of Virginia Medical Center and the Medical College of Virginia ("MCV") Hospitals are included, although no number of bassinets is provided for each.

[41] Four hospitals having no identified bassinet numbers as cited by the Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection are included here, because they participated at some point in the Program. These hospitals are: Buchanan General Hospital, Carilion Roanoke Memorial Hospital, King's Daughters Hospital, and Waynesboro Community Hospital.

Table 3-2. Fees Paid by Hospitals Participating in the Virginia Birth-Related Neurological Injury Compensation Program by Health Planning District, 1988 - 1997

General Inpatient Hospital (number of bassinets in 1997) (a)	City or County	Participation Years										Total Assessments	
		1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	Amount	% of Total
DISTRICT 1													
Lee County Community Hospital, Inc. (4)	Pennington Gap						$5,000	$3,650	$4,875	$3,968	$3,847	$21,340	
Lonesome Pine Hospital (10)	Big Stone Gap											$0	
Norton Community Hospital (14)	Norton											$0	
St. Mary's Hospital, Inc. (12)	Norton											$0	
Wise Appalachian Regional Hospital (11)	Wise					$9,750	$5,050	$5,200	$2,449	$1,813	$234	$24,496	
TOTAL		$0	$0	$0	$0	$9,750	$10,050	$8,850	$7,324	$5,781	$4,081	$45,836	0.3%
DISTRICT 2													
Buchanan General Hospital (0)	Grundy	$5,450	$1,100	$0 (b)	$0 (b)	$0 (b)	$0 (b)	$0 (b)				$6,550	
Clinch Valley Medical Center (17)	Richlands	$31,350	$30,350	$34,150	$33,150	$35,150	$36,900	$34,100	$3,460	$3,035		$241,645	
Dickenson County Medical Center (0)	Clintwood											$0	
Russell County Medical Center (8)	Lebanon											$0	
Tazewell Community Hospital (0)	Tazewell											$0	
TOTAL		$36,800	$31,450	$34,150	$33,150	$35,150	$36,900	$34,100	$3,460	$3,035	$0	$248,195	1.4%
DISTRICT 3													
Johnston Memorial Hospital, Inc. (12)	Abingdon											$0	
Smyth County Community Hospital (21)	Marion											$0	
Twin County Regional Hospital (16)	Galax	$22,200	$25,750	$25,350	$26,050							$99,350	
Wythe County Community Hospital (8)	Wytheville	$6,750	$16,250									$23,000	
TOTAL		$28,950	$42,000	$25,350	$26,050	$0	$0	$0	$0	$0	$0	$122,350	0.7%
DISTRICT 4													
Carilion Giles Memorial Hospital (0)	Pearisburg											$0	
Columbia Pulaski Community Hospital (7)	Pulaski	$6,950	$200				$6,850	$4,400	$4,141	$5,096	$3,456	$31,093	
Montgomery Regional Hospital, Inc. (11)	Blacksburg											$0	
Radford Community Hospital (27)	Radford	$26,100										$26,100	
TOTAL		$33,050	$200	$0	$0	$0	$6,850	$4,400	$4,141	$5,096	$3,456	$57,193	0.3%
DISTRICT 5													
Alleghany Regional Hospital (14)	Low Moor	$16,000	$15,800	$17,700							$9,238	$58,738	
Carilion Roanoke Community Hospital (71)	Roanoke	$48,450	$47,000	$40,850	$38,650	$37,350	$89,150	$148,400	$15,290	$13,705	$13,730	$492,575	
Carilion Roanoke Memorial Hospitals (0)	Roanoke	$95,350	$101,050	$111,750	$122,550	$126,550						$557,250	
Lewis-Gale Medical Center (31)	Salem	$46,500	$45,300	$47,600					$27,807	$26,436	$17,334	$210,977	
TOTAL		$206,300	$209,150	$217,900	$161,200	$163,900	$89,150	$148,400	$43,097	$40,141	$40,302	$1,319,540	7.3%

Table 3-2. Fees Paid by Hospitals Participating in the Virginia Birth-Related Neurological Injury Compensation Program by Health Planning District, 1988 - 1997

General Inpatient Hospital (number of bassinets in 1997) (a)	City or County	Participation Years										Total Assessments	
		1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	Amount	% of Total
DISTRICT 6													
Augusta Medical Center (12)	Fishersville											$0	
Bath County Community Hospital (0)	Hot Springs											$0	
King's Daughters Hospitals	Staunton	$19,800										$19,800	
Rockingham Memorial Hospital, Inc (28)	Harrisonburg	$68,350	$73,250	$76,050								$217,650	
Stonewall Jackson Hospital, Inc (8)	Lexington	$14,200	$14,700	$14,450	$14,900			$11,900	$4,158	$4,302	$1,095	$79,705	
Waynesboro Community Hospital	Waynesboro	$17,667	$24,250									$41,917	
TOTAL		$120,017	$112,200	$90,500	$14,900	$0	$0	$11,900	$4,158	$4,302	$1,095	$359,072	2.0%
DISTRICT 7													
Page Memorial Hospital, Inc (0)	Luray											$0	
Shenandoah Memorial Hospital, Inc (17)	Woodstock	$12,900	$13,200	$12,100	$13,100	$14,600	$14,000					$79,900	
Warren Memorial Hospital, Inc (9)	Front Royal	$8,950	$9,267					$5,250				$23,467	
Winchester Medical Center, Inc (24)	Winchester	$80,950	$78,250	$79,450	$81,550							$320,200	
Winchester Rehabilitation Center (0)	Winchester											$0	
TOTAL		$102,800	$100,717	$91,550	$94,650	$14,600	$14,000	$5,250	$0	$0	$0	$423,567	2.3%
DISTRICT 8													
Alexandria Hospital, The (48)	Alexandria	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$16,455	$16,865	$17,415	$1,100,765	
Arlington Hospital, The (44)	Arlington	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$16,895	$15,930	$15,180	$1,098,105	
Fair Oaks Hospital (27)	Fairfax		$58,400	$58,650	$72,850	$87,150	$90,450	$94,750	$23,575	$24,403	$11,615	$521,843	
Fairfax Hospital (123)	Falls Church	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$45,000	$47,065	$17,085	$1,189,150	
Hospice of Northern Virginia, Inc (0)	Arlington											$0	
Loudoun Hospital Center (21)	Leesburg											$0	
Lynn House of Potomac Valley, Inc (0)	Alexandria											$0	
Mount Vernon Hospital (0)	Alexandria											$0	
National Hospital Medical Center (0)	Arlington											$0	
Potomac Hospital (16)	Woodbridge	$53,250	$66,250	$73,000	$85,100	$81,900	$80,900	$87,750	$8,955	$8,480	$9,350	$554,935	
Prince William Hospital (24)	Manassas											$0	
Reston Hospital Center (24)	Reston		$25,000	$23,000	$51,150	$63,850		$70,200	$23,994		$18,734	$275,928	
Vencor Hospital - Arlington (0)	Arlington											$0	
TOTAL		$503,250	$569,650	$604,650	$659,100	$682,900	$621,350	$702,700	$134,874	$112,743	$119,739	$4,710,956	25.9%
DISTRICT 9													
Culpeper Memorial Hospital, Inc (12)	Culpeper	$7,375	$12,500	$9,900	$8,500	$8,650	$13,800		$3,450	$1,715	$1,700	$67,590	
Fauquier Hospital, Inc (12)	Warrenton											$0	
Rappahannock General Hospital (8)	Kilmarnock											$0	
TOTAL		$7,375	$12,500	$9,900	$8,500	$8,650	$13,800	$0	$3,450	$1,715	$1,700	$67,590	0.4%
DISTRICT 10													
Martha Jefferson Hospital (24)	Charlottesville											$0	
University of Virginia Medical	Charlottesville	$93,300	$100,050	$116,150	$113,400	$112,400	$107,450		$20,252	$7,960	$7,415	$678,377	
TOTAL		$93,300	$100,050	$116,150	$113,400	$112,400	$107,450	$0	$20,252	$7,960	$7,415	$678,377	3.7%

Table 3-2. Fees Paid by Hospitals Participating in the Virginia Birth-Related Neurological Injury Compensation Program by Health Planning District, 1988 - 1997

General Inpatient Hospital (number of bassinets in 1997) (a)	City or County	Participation Years										Total Assessments	
		1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	Amount	% of Total
DISTRICT 11													
Carilion Bedford County Memorial Hospital (9)	Bedford											$0	
Lynchburg General Hospital Division, Centra Health (0)	Lynchburg											$0	
Virginia Baptist Hospital (39)	Lynchburg	$111,200	$115,350	$119,950	$130,650	$125,700	$118,700					$721,550	
TOTAL		$111,200	$115,350	$119,950	$130,650	$125,700	$118,700	$0	$0	$0	$0	$721,550	4.0%
DISTRICT 12													
Carilion Franklin Memorial Hospital (6)	Rocky Mount											$0	
Danville Regional Medical Center (26)	Danville	$61,450	$62,950	$61,950	$67,700	$68,450	$66,630	$62,900	$6,025	$5,840	$5,290	$469,205	
Memorial Hospital of Martinsville and Henry County (28)	Martinsville	$48,450	$35,500	$28,950	$25,800	$22,000	$21,500					$182,200	
R.J. Reynolds-Patrick County Memorial Hospital (10)	Stuart											$0	
TOTAL		$109,900	$98,450	$90,900	$93,500	$90,450	$88,150	$62,900	$6,025	$5,840	$5,290	$651,405	3.6%
DISTRICT 13													
Community Memorial Healthcare (16)	South Hill	$4,300	$8,300	$8,650	$9,150	$8,500	$10,250	$10,250	$955	$1,040	$1,025	$62,420	
Halifax Regional Hospital (20)	South Boston	$33,900	$34,400	$32,250	$35,550	$35,050	$34,950	$32,950	$3,290	$3,075		$245,415	
TOTAL		$38,200	$42,700	$40,900	$44,700	$43,550	$45,200	$43,200	$4,245	$4,115	$1,025	$307,835	1.7%
DISTRICT 14													
Southside Community Hospital (12)	Farmville											$0	
TOTAL		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
DISTRICT 15													
Bon Secours-Richmond Community Hospital, Inc (0)	Richmond											$0	
Bon Secours - Stuart Circle Hospital (0)	Richmond											$0	
Children's Hospital (0)	Richmond											$0	
Chippenham Medical Center (50)	Richmond	$106,000	$107,000	$111,750	$117,300	$116,200	$110,300	$95,650	$5,400	$5,500	$9,250	$784,350	
Columbia/HCA Retreat Hospital (0)	Richmond											$0	
Cumberland, Hospital for Children and Adolescents (0)	New Kent											$0	
Healthsouth Medical Center (0)	Richmond											$0	
Healthsouth Rehabilitation Hospital of Virginia (0)	Richmond											$0	
Henrico Doctors' Hospital (46)	Richmond	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$15,080	$15,245	$14,745	$1,095,070	
Johnston-Willis Hospital (33)	Richmond						$22,500	$45,000	$57,675	$55,275	$41,748	$222,198	
MCV Hospitals	Richmond	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000					$900,000	
Metropolitan Hospital, L.P. (0)	Richmond											$0	
Richmond Eye and Ear Hospital (0)	Richmond											$0	
Richmond Memorial Hospital (25)	Richmond	$45,950										$45,950	
Sheltering Arms Hospital (0)	Richmond											$0	
St. Mary's Hospital of Richmond, Inc. (42)	Richmond	$88,200	$85,000	$102,100	$114,200				$73,427		$60,174	$523,101	
TOTAL		$540,150	$492,000	$513,850	$531,500	$416,200	$432,800	$290,650	$151,582	$76,020	$125,917	$3,570,669	19.6%
DISTRICT 16													
Mary Washington Hospital, Inc. (40)	Fredericksburg	$70,150										$70,150	
TOTAL		$70,150	$0	$0	$0	$0	$0	$0	$0	$0	$0	$70,150	0.4%

Table 3-2. Fees Paid by Hospitals Participating in the Virginia Birth-Related Neurological Injury Compensation Program by Health Planning District, 1988 - 1997

General Inpatient Hospital (number of bassinets in 1997) (a)	City or County	Participation Years										Total Assessments	
		1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	Amount	% of Total
DISTRICT 17													
TOTAL		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
DISTRICT 18													
Riverside Tappahannock Hospital, Inc. (0)	Tappahannock											$0	
Riverside Walter Reed Hospital (0)	Gloucester											$0	
TOTAL		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
DISTRICT 19													
Greensville Memorial Hospital (13)	Emporia											$0	
John Randolph Medical Center (16)	Hopewell										$28,500	$28,500	
Southside Regional Medical Center (36)	Petersburg	$73,000										$73,000	
TOTAL		$73,000	$0	$0	$0	$0	$0	$0	$0	$0	$28,500	$101,500	0.6%
DISTRICT 20													
Chesapeake General Hospital (28)	Chesapeake	$76,050	$113,650	$111,200								$300,900	
Children's Hospital of the King's Daughters, Inc (0)	Norfolk											$0	
DePaul Medical Center (32)	Norfolk	$119,200	$122,250	$132,400		$121,500	$99,550	$84,100	$7,315	$5,495	$4,830	$696,640	
Lake Taylor Hospital (0)	Norfolk											$0	
Louise OBICI Memorial Hospital (20)	Suffolk	$37,300										$37,300	
Maryview Medical Center (20)	Portsmouth	$28,450	$36,800	$38,450							$23,312	$127,012	
Norfolk Community Hospital (22)	Norfolk	$24,300										$24,300	
Portsmouth General Hospital (34)	Portsmouth	$70,350	$66,320	$63,100		$63,500	$61,750	$54,850	$11,190	$10,925	$3,075	$405,060	
Sentara Bayside Hospital (20)	Virginia Beach									$68,750	$54,912	$123,662	
Sentara Leigh Hospital (20)	Norfolk				$1,050	$60,000	$31,300	$58,550	$32,095	$31,698	$19,435	$234,128	
Sentara Norfolk General Hospital (80)	Norfolk	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$150,000	$19,570	$12,470	$12,090	$1,094,130	
Southampton Memorial Hospital (14)	Franklin											$0	
Virginia Beach General Hospital (46)	Virginia Beach	$150,000	$150,000	$150,000								$450,000	
TOTAL		$655,650	$639,020	$645,150	$151,050	$395,000	$342,600	$347,500	$70,170	$129,338	$117,654	$3,493,132	19.2%
DISTRICT 21													
Mary Immaculate Hospital (24)	Newport News	$60,000	$44,703	$67,400								$172,103	
Newport News General Hospital (0)	Newport News											$0	
Riverside Regional Medical Center (43)	Newport News	$134,100	$133,900	$128,200								$396,200	
Riverside Rehabilitation Institute (0)	Newport News											$0	
Sentara Hampton General Hospital (37)	Hampton	$67,417	$81,550		$85,100	$85,550	$77,550	$69,700	$15,238	$13,237	$5,455	$500,796	
Williamsburg Community Hospital (15)	Williamsburg	$36,850	$35,600	$41,500	$47,250							$161,200	
TOTAL		$298,367	$295,753	$237,100	$132,350	$85,550	$77,550	$69,700	$15,238	$13,237	$5,455	$1,230,299	6.8%
DISTRICT 22													
Northampton-Accomack Memorial Hospital (14)	Nassawadox											$0	
TOTAL		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%

Table 3-2. Fees Paid by Hospitals Participating in the Virginia Birth-Related Neurological Injury Compensation Program by Health Planning District, 1988 - 1997

General Inpatient Hospital (number of bassinets in 1997) (a)	City or County	Participation Years										Total Assessments	
		1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	Amount	% of Total
SUMMARY													
Total Hospital Fees Paid		$3,028,458	$2,861,190	$2,838,000	$2,194,700	$2,183,800	$2,004,550	$1,729,550	$468,014	$409,322	$461,628	$18,179,212	100%
Number of Hospitals Participating		47	42	37	29	27	28	25	27	26	29		
Number of Hospitals with Birthing-Unit Capacity Participating in the Program		43	39	35	27	25	27	24	27	26	29		
Percentage of Hospitals with Birthing-Unit Capacity Participating in the Program		61%	55%	49%	38%	35%	38%	34%	38%	37%	41%		

(a) General inpatient hospitals and number of bassinets as listed in Commonwealth of Virginia, Virginia Department of Health Center for Quality Health Care Services and Acute Care Services Directory Consumer Protection, (Richmond, VA: November 20, 1996)

(b) Agreement signed. No babies delivered in the previous year

SOURCES: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished tables, 1988-1997, Commonwealth of Virginia, Virginia Department of Health, Center for Health Statistics, Virginia Vital Statistics: Data Related to Maternal and Infant Health: 1994 (Richmond, Virginia: December 1995); and Commonwealth of Virginia, Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection, Acute Care Services Directory (Richmond, VA: November 20, 1996)

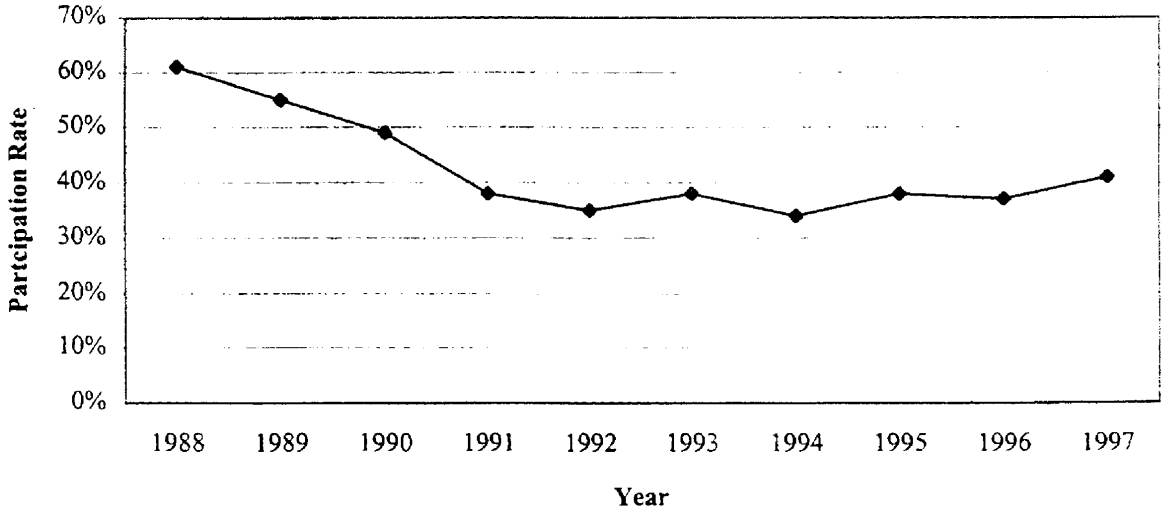
Table 3-3. Number of Hospitals Participating in the Program and the Fees They Paid by Health Planning District, 1988-1997

Health Planning District	Participation Years																				
	1988		1989		1990		1991		1992		1993		1994		1995		1996		1997		
	Total Fees Paid	# of Hosp.	Total Fees Paid	# of Hosp.	Total Fees Paid	# of Hosp.	Total Fees Paid	# of Hosp.	Total Fees Paid	# of Hosp.	Total Fees Paid	# of Hosp.	Total Fees Paid	# of Hosp.	Total Fees Paid	# of Hosp.	Total Fees Paid	# of Hosp.	Total Fees Paid	# of Hosp.	Total Fees Paid
District 1	$0	0	$0	0	$0	0	$0	0	$9,750	1	$10,050	2	$8,850	2	$7,324	2	$5,781	2	$4,081	2	$45,836
District 2	$36,800	2	$31,450	2	$34,150	2	$33,150	2	$35,150	2	$36,900	2	$34,100	2	$3,460	1	$3,035	1	$0	0	$248,195
District 3	$28,950	2	$42,000	2	$25,350	1	$26,050	1	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$122,350
District 4	$33,050	2	$200	1	$0	0	$0	0	$0	0	$6,850	1	$4,400	1	$4,141	1	$5,096	1	$3,456	1	$57,193
District 5	$206,300	4	$209,150	4	$217,900	4	$161,200	2	$163,900	2	$89,150	1	$148,400	1	$43,097	2	$40,141	2	$40,302	3	$1,319,540
District 6	$120,017	4	$112,200	3	$90,500	2	$14,900	1	$0	0	$0	0	$11,900	1	$4,158	1	$4,302	1	$1,095	1	$359,072
District 7	$102,800	3	$100,717	3	$91,550	2	$94,650	2	$14,600	1	$14,000	1	$5,250	1	$0	0	$0	0	$0	0	$123,567
District 8	$503,250	4	$569,650	6	$604,650	6	$659,100	6	$682,900	6	$621,350	5	$702,700	6	$134,874	6	$112,743	5	$119,739	6	$4,710,956
District 9	$7,375	1	$12,500	1	$9,900	1	$8,500	1	$8,650	1	$13,800	1	$0	0	$3,450	1	$1,715	1	$1,700	1	$67,590
District 10	$93,300	1	$100,050	1	$116,150	1	$113,400	1	$112,400	1	$107,450	1	$0	0	$20,252	1	$7,960	1	$7,415	1	$678,377
District 11	$111,200	1	$115,350	1	$119,950	1	$130,650	1	$125,700	1	$118,700	1	$0	0	$0	0	$0	0	$0	0	$721,550
District 12	$109,900	2	$98,450	2	$90,900	2	$93,500	2	$90,450	2	$88,150	2	$62,900	1	$6,025	1	$5,840	1	$5,290	1	$651,405
District 13	$38,200	2	$42,700	2	$40,900	2	$44,700	2	$43,550	2	$45,200	2	$43,200	2	$4,245	2	$4,115	2	$1,025	1	$307,835
District 14	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
District 15	$540,150	5	$492,000	4	$513,850	4	$531,500	4	$416,200	3	$432,800	4	$290,650	3	$151,582	4	$76,020	3	$125,917	4	$3,570,669
District 16	$70,150	1	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$70,150
District 17	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
District 18	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
District 19	$73,000	1	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$28,500	1	$101,500
District 20	$655,650	8	$639,020	6	$645,150	6	$151,050	2	$395,000	4	$342,600	4	$347,500	4	$70,170	4	$129,338	5	$117,654	6	$3,493,132
District 21	$298,367	4	$295,753	4	$237,100	3	$132,350	2	$85,550	1	$77,550	1	$69,700	1	$15,238	1	$13,237	1	$5,455	1	$1,230,299
District 22	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
Total	$3,028,458	47	$2,861,190	42	$2,838,000	37	$2,194,700	29	$2,183,800	27	$2,004,550	28	$1,729,550	25	$468,014	27	$409,322	26	$461,628	29	$18,179,212

SOURCES: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished tables, 1988-1997; and Commonwealth of Virginia, Virginia Department of Health, Center for Health Statistics, Virginia Vital Statistics: Data Related to Maternal and Infant Health: 1994 (Richmond, VA: December 1995).

Table 3-2 (and Graph 3-1 below) shows that in the last decade the number of hospitals participating in the Program has declined dramatically. In 1988, the first year in which participation occurred, 43 hospitals, 61% of those with birthing units, were in the Program. However, by 1991, this number had declined to only 27 hospitals, or 38% of those with birthing capacity. Since 1991, the number has remained fairly stable, dropping to a low of 24 in 1994, then increasing back to 29 at present. (Interestingly, the 1995 reduction in the assessment structure appears to have had little effect on the number of hospitals in the Program. Between 1994 and 1995, for example, the number of hospitals with birthing-unit capacity participating increased by only three, from 24 to 27. Four (Lewis-Gale Medical Center in Salem, Culpepper Memorial Hospital in Culpepper, University of Virginia in Charlottesville, and St. Mary's Hospital of Richmond) returned to the Program, possibly attracted back by the reduced assessments, while two (Buchanan General Hospital in Grundy and Warren Memorial Hospital in Front Royal) dropped out.

Graph 3-1. Rates of Participation in the Program by Hospitals, 1988-1997



SOURCES: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished tables, 1988-1997; Commonwealth of Virginia, Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection, Acute Care Services Directory (Richmond, VA: November 20, 1996); and Commonwealth of Virginia, Virginia Department of Health, Center for Health Statistics, Virginia Vital Statistics: Data Related to Maternal and Infant Health: 1994 (Richmond, VA: December 1995).

As shown in Graph 3-2, the hospitals participating in the Program have been located in almost every area of the Commonwealth. Since the beginning of the Program, only four of the 22 Health Planning Districts have never been represented. Three of these -- Districts 17, 18, and 22, covering the Northern Neck, Middle Peninsula, and Eastern Shore -- are clustered in the Chesapeake Bay area. The fourth, Health Planning District 14, lies in the south-central part of the state. In particular years, however, additional Districts have had no hospitals participating in the Program. Table 3-3 shows that in 1997, for example, nine Health Planning Districts had no participating hospitals. Thus, given the Program's current statutory structure, in any given year in at least five, and in as many as 10 of the State's 22 Health Planning Districts, a newborn infant with a qualifying birth injury found his or her entry into the Program narrowed to one determinant: whether the attending obstetrician was or was not a Program participant.

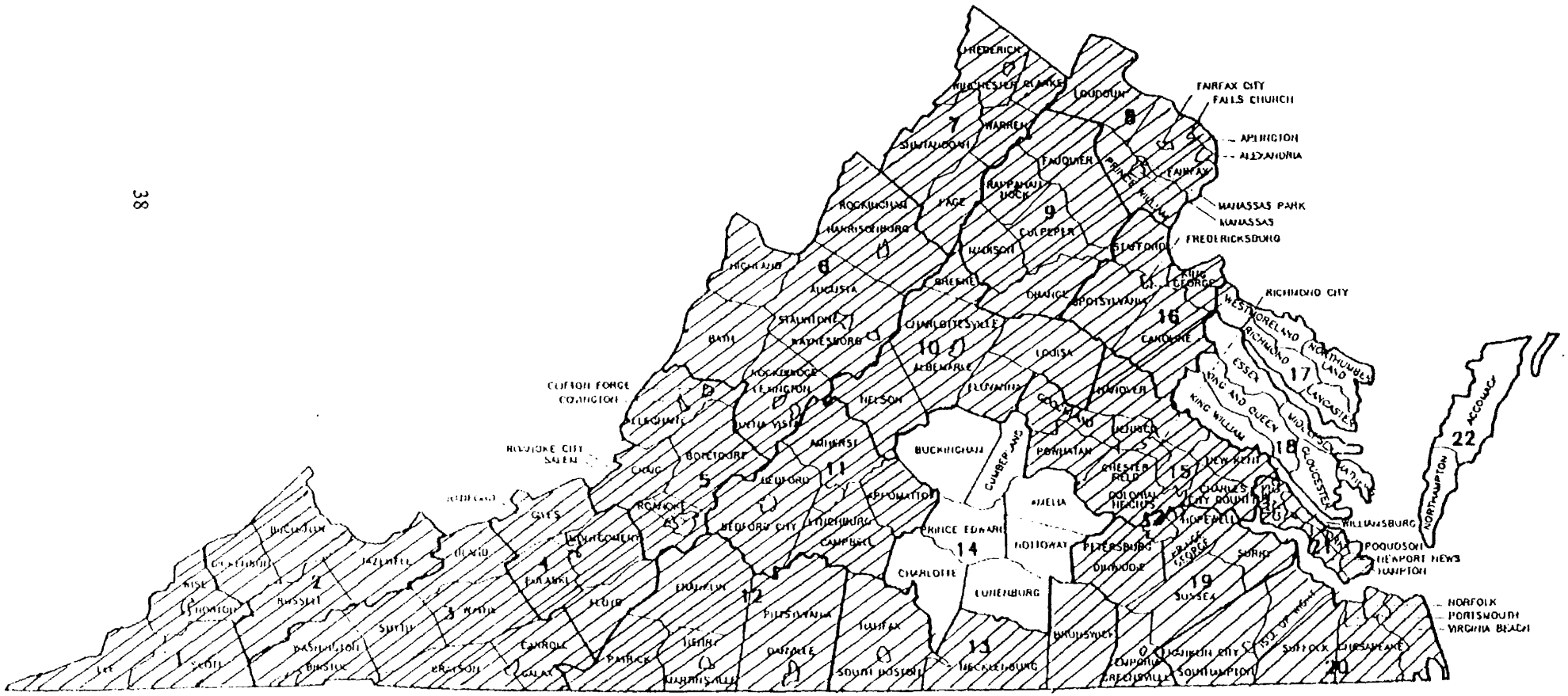
Assessments Paid by Hospitals

For the past decade, various combinations of assessments by participating hospitals, participating physicians, all licensed physicians, and liability insurance carriers have funded the Program (see Table 3-4). Until 1994, hospitals that chose to participate in the Program paid an annual assessment of $50 per live birth for the prior year as reported to the Department of Health in the Annual Survey of Hospitals, to a maximum of $150,000. In 1994, however, the General Assembly authorized the Program's Board of Directors to reduce and prorate the participating hospital assessment. Thus, beginning in 1995, hospitals that participated in the Program for more than one year did not pay $50 per live birth; instead, they paid lower assessments with each successive year in the Program. For example, a hospital that participated for six years pays an assessment of $11.50 per live birth.

Since the Program's inception, participating hospitals have paid over $18 million in assessments (see Table 3-2). Not surprisingly, the largest assessments were collected in 1988, the year of the highest hospital participation rate. Each year thereafter until the most current year, the assessments collected dropped, with the largest decrease occurring between 1994 and 1995 when the assessment structure was changed. In 1994, participating hospitals paid $1.7 million in assessments; in 1995, that amount dropped to $468,014. The only increase in hospital assessments collected occurred between 1996 and 1997.

Nearly 65% of the assessments collected came from participating hospitals located in only three areas of the Commonwealth -- the areas of Northern Virginia (District 8), Richmond (District 15), and Virginia Beach/Norfolk (District 20) (see Table 3-2). Of those beneficiaries currently in the Program, these areas represent 58% of the families in the Program and 60% of all live births in the state (see Table 2-5). While nearly 20% of the children currently in the Program come from the Roanoke area (District 5) (see Table 2-5), the hospitals in that area paid $1.3 million in total fees -- only 7% of all participating hospital assessments collected (see Table 3-2).

Graph 3-2.
Participation by Hospitals and Physicians in the Program by Health Planning District, 1988 - 1997



SOURCES: Commonwealth of Virginia, Virginia Department of Health, Center for Health Statistics, Virginia Vital Statistics: Data Related to Maternal and Infant Health (Richmond, VA: December 1995); Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished tables, 1997; and data obtained from Medical Society of Virginia, Directory of Virginia Physicians: 1997 (Richmond, Virginia: no date) and American Medical Association, Directory of Physicians in the United States, 33rd edition (Chicago, Illinois: 1993)

Table 3-4. Status of Assessments

Type of Assessment Required in the Authorizing Legislation	Status of Assessment
All Licensed Physicians Annual $250 assessment for all licensed physicians practicing in the Commonwealth as of September 30 of that year	Effective January 1, 1993, the mandatory assessment was suspended.
Participating Hospitals $50 per live birth, paid on or before December 1 of the previous year, up to a maximum of $150,000	During the 1994 legislative session, the General Assembly authorized the Program's Board of Directors to reduce the participating hospital assessment. Beginning in 1995, the participating hospital assessment was prorated. In 1997, the participating hospital assessments are as follows: New participating hospital--$50 per birth; Participating at least 1 year--$44 per birth; 2 years--$37.50 per birth; 3 years--$31 per birth; 4 years--$24.50 per birth; 5 years--$18 per birth; 6 years--$11.50 per birth; and 7 or more years--$5 per birth.
Participating Physicians Annual $5,000 participating physician assessment paid on or before December 1 of the previous year	During the 1994 legislative session, the General Assembly authorized the Program's Board of Directors to reduce the participating physician assessment. Beginning in 1995, the participating physician assessment was prorated. In 1997, the participating physician assessments are as follows: New participating physician--$5,000; Participating at least 1 year--$4,400; 2 years--$3,750; 3 years--$3,100; 4 years--$2,450; 5 years--$1,800; 6 years--$1,150; and 7 or more years--$500.
Liability Insurance Carriers Assessment set by the State Corporation Commission to maintain the actuarially sound basis of the Birth Injury Fund; all insurance carriers licensed to write and engaged in writing liability insurance in the Commonwealth of a particular year, shall pay the assessment	Occurred only in 1989.

SOURCES:

Type of Assessment -- Virginia Birth-Related Neurological Injury Compensation Act, 38.2-5020.

Status -- Pyles, Elinor, Executive Director, Virginia Birth-Related Neurological Injury Compensation Program, personal communication, September 25, 1997; Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, "1997 Physician Fee Schedule" and "1997 Hospital Fee Schedule," no dates.

This analysis of hospital participation rates in the Program has pointed out two important findings. First, participation has declined since the Program began, from 43 hospitals representing 61% of all those with birthing capacity in 1988 to 29 hospitals representing 41% of birthing capacity in 1997. Second, in any year from five to 10 Districts have had no Program-participating hospitals, and four of these have had none over the life of the Program to date.

We now turn to an analysis of obstetric physicians and nurse-midwives in the Program, to determine whether their participation rates and patterns compare closely with those for hospitals. If so, perhaps we have identified an important reason why a gap exists between the Program's actual and potential beneficiary populations.

Physicians and Nurse-Midwives

Under the Virginia Birth-Related Neurological Injury Compensation Act, both physicians and nurse-midwives may participate in the Program. The Act defines a participating physician and nurse-midwife as:

> a physician licensed in Virginia to practice medicine, who practices obstetrics or performs obstetrical services either full or part time or, as authorized in the plan of operation, a licensed nurse-midwife who performs obstetrical services, either full or part time, within the scope of such licensure and who at the time of the injury (i) had in force 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, (ii) had in force an agreement with the Board of Medicine whereby the physician agreed to submit to review by the Board of Medicine...and (iii) had paid the participating physician assessment...for the period of time in which the birth-related neurological injury occurred.

Number and Rates of Physicians and Nurses Participating in the Program

Since 1988, about 860 physicians have elected to participate in the Program. Not surprisingly, the vast majority of these doctors are obstetricians and gynecologists (see Table 3-5). Family practice doctors, the second largest category of participating physicians, fall far behind at 17. Since the Program's inception only six nurses have participated, all of whom were located in the Lynchburg area.

Like the hospitals participating in the Program, several distinct patterns of participation for physicians can be defined. For example, nearly 25% of participating physicians have participated every year or missed only one year, and 17% entered the Program after 1989 and have continued to participate. The largest group of physicians -- almost 50% -- among those ever in the Program participated for a period of time and then stopped (see Table 3-6).

Table 3-5. Number of Physicians by Specialty and Nurses Participating in the Program, 1988-1997

Physicians and Nurses	Number Participating
Physicians by Specialty:	
Obstetrics and Gynecology	800
Family Practice	17
Reproductive Endocrinology	5
Maternal and Fetal Medicine	3
Neonatal/Perinatal Medicine	1
No identified specialty	36
Total	**862**
Nurses	**6**

SOURCES: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished tables, 1988-1997; American Medical Association, Directory of Physicians in the United States, 33rd edition (Chicago, Illinois: 1992); Medical Society of Virginia, Directory of Virginia Physicians: 1997 (Richmond, Virginia: no date); Trigon Blue Cross Blue Shield, Key Advantage and Cost Alliance: Directory of Providers (August 1996); and Pyles, Elinor, Executive Director, Virginia Birth-Related Neurological Injury Compensation Program, November 1997.

Table 3-6. Patterns of Participation for Physicians and Nurses, 1988-1997

Participation Pattern	Participating Physicians/Nurses	
	Number	Percent
Physician/nurse participates every year or misses participating only one year	209	24%
Physician/nurse participates for some period of time and stops	420	48%
Physician/nurse begins participation sometime after 1989 and is still participating	151	17%
Physician/nurse participates some years and does not other years -- no distinct pattern	88	10%
Total participating physicians/nurses*	868	100%

* Of this total, only six are nurses. This total excludes Lynchburg Family Practice and Roanoke OB Residency Program.

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished tables, 1988-1997.

Unlike the case for hospitals, it is very difficult to determine what proportion of all physicians ever have participated or what that proportion may be participating in any given year. While the numbers of physicians participating in the Program are known for each year (see Table 3-7 on the following page), it is very difficult to estimate with high accuracy the numbers who are *not* participating. For example, we know that in 1988 just over 420 physicians participated in the Program, and that number has remained relatively stable since the Program's inception, with the highest number of participants (459) in 1991 and the lowest (399) in 1996. The difficulty in calculating a *rate* of participation lies in estimating the total numbers of obstetricians and all physicians in Virginia.

The only "census" data come from voluntary membership organizations, such as the American Medical Association (AMA), the Medical Society of Virginia (MSV), and the Virginia Obstetrical and Gynecological Society. We have used data from the AMA and MSV. If a physician is not a member of either organization, he or she is not included in our analysis. Unfortunately, there is no way to determine how many physicians are not members of these organizations, and, thus, it is likely that the participation rates we estimate below are somewhat exaggerated.

Using the best information available to us, we estimate that during the Program's nine years of operation as a whole, the participation rate of obstetricians and gynecologists is approximately 61% (see Table 3-8). As was the case with hospitals, however, in any one year, the participation rate is likely to be much lower. In 1992, for example, we estimate the rate at 38%, and in 1997, at 45%. Because these rates were calculated using two different data sources (American Medical Association for 1992 and the Medical Society of Virginia for 1997), we cannot say that the participation rate of physicians has increased between 1992 and 1997. Rather, we can simply note that the level of participation for obstetricians and gynecologists appears to be less than half in any year.

As was the case with hospitals, not all geographic areas of the state have physicians that are participating, which results in decreased opportunities for children with neurological damage to enter the Program. In fact, in four areas of Virginia already identified (Northern Neck, Middle Peninsula, Eastern Shore Districts [Districts 17, 18, and 22] and District 14), children born with severe neurological damage have no opportunity to participate in the Program, because no hospitals nor physicians in those areas participate in the Program (see Graph 3-2). The only way children in these areas could participate in the Program would be for their parents to have sought medical assistance in a Health Planning District other than their own. In any one year, however, children in other areas of the Commonwealth are likely to have the same foreclosed options. Our data show that, in any given year, injury-eligible children born in at least four and as many as seven of the State's 22 Health Planning Districts cannot qualify for benefits under the Program, because no hospitals and no physicians have elected to participate (see Tables 3-3 and 3-7).

Table 3-7. Number of Physicians Participating in the Program and the Assessments They Paid by Health Planning District, 1988-1997

Health Planning District	Participation Years																				Total Fees Paid
	1988		1989		1990		1991		1992		1993		1994		1995		1996		1997		
	Total Fees Paid	# of MDs	Total Fees Paid	# of MDs	Total Fees Paid	# of MDs	Total Fees Paid	# of MDs	Total Fees Paid	# of MDs	Total Fees Paid	# of MDs	Total Fees Paid	# of MDs	Total Fees Paid	# of MDs	Total Fees Paid	# of MDs	Total Fees Paid	# of MDs	
District 1	$5,000	1	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$4,587	1	$8,800	2	$18,387
District 2	$23,333	5	$10,000	2	$20,000	4	$25,000	5	$25,000	5	$10,000	2	$0	0	$0	0	$1,800	1	$5,500	2	$120,633
District 3	$21,667	5	$25,000	5	$10,000	2	$10,000	2	$5,000	1	$10,000	2	$10,000	2	$4,250	2	$8,600	3	$7,350	3	$111,867
District 4	$15,000	3	$20,000	4	$5,000	1	$51,253	11	$30,000	6	$30,000	6	$25,000	5	$14,000	6	$4,600	4	$0	0	$194,853
District 5	$137,917	28	$130,012	28	$141,305	27*	$148,755	33	$130,000	26	$140,000	28	$140,429	30	$41,200	30	$43,900	30	$36,100	28	$1,089,618
District 6	$93,333	20	$67,085	14	$40,000	8	$12,500	3	$10,000	2	$10,000	2	$10,000	2	$500	1	$500	1	$10,000	2	$253,918
District 7	$70,000	14	$71,251	15	$55,000	11	$59,585	13	$62,500	13	$57,500	12	$65,000	13	$16,250	13	$18,650	14	$15,600	13	$491,336
District 8	$575,417	121	$622,133	133	$730,848	154	$805,848	168	$855,844	175	$871,263	179	$893,344	184	$354,318	195	$256,971	177	$270,050	187	$6,236,036
District 9	$10,833	3	$5,000	1	$5,000	1	$10,000	2	$10,000	2	$10,000	2	$0	0	$4,250	2	$5,500	2	$2,950	2	$63,533
District 10	$80,000	16	$100,000	22	$110,000	24	$117,500	27	$45,000	9	$60,000	12	$7,500	2	$30,650	12	$12,300	9	$22,950	11	$585,900
District 11**	$55,000	11	$60,006	13	$102,086	15	$94,286	24	$72,505	10	$80,000	12	$70,000	11	$34,650	12	$13,950	10	$15,100	11	$597,580
District 12	$45,000	9	$38,753	8	$35,000	7	$45,000	9	$40,000	8	$40,000	8	$35,000	7	$6,250	6	$3,650	6	$6,100	7	$294,753
District 13	$25,000	5	$17,919	4	$25,000	5	$22,085	5	$20,000	4	$30,000	6	$30,000	6	$10,300	5	$7,700	5	$5,750	5	$193,754
District 14	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
District 15	$222,083	46	$189,585	39	$187,504	43	$135,714	28	$207,006	45	$218,753	45	$230,000	46	$114,985	49	$135,200	54	$115,300	54	$1,756,131
District 16	$22,917	5	$0	0	$5,000	1	$5,000	1	$5,000	1	$6,668	2	$10,000	2	$5,550	2	$6,150	2	$4,400	1	$70,685
District 17	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
District 18	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
District 19	$40,000	8	$0	0	$5,000	1	$10,000	2	$10,000	2	$5,000	1	$5,000	1	$3,100	1	$0	0	$9,400	2	$87,500
District 20	$437,917	90	$402,125	86	$420,000	89	$450,000	104	$445,044	90	$417,502	85	$420,000	88	$158,850	85	$102,235	65	$133,550	75	$3,387,183
District 21	$128,750	27	$115,421	24	$100,000	20	$70,000	14	$48,753	10	$30,000	6	$20,000	4	$12,600	7	$9,350	7	$4,300	7	$539,174
District 22	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
Other	$25,000	5	$18,753	4	$29,170	7	$40,000	8	$17,502	4	$35,834	8	$42,089	9	$16,050	6	$21,187	8	$15,850	7	$261,435
Total	$2,034,167	422	$1,893,043	402	$2,025,913	427	$2,112,526	459	$2,039,154	413	$2,062,520	418	$2,013,362	412	$827,753	434	$656,830	399	$689,050	419	$16,354,276

* Excludes one residency program.

** Excludes participating nurses in District 11: Six participate in 1990; five in 1991 and 1992; four in 1993; three in 1994 and 1995; and one in 1996 and 1997.

SOURCES: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished tables, 1988-1997; and Commonwealth of Virginia, Virginia Department of Health, Center for Health Statistics, Virginia Vital Statistics: Data Related to Maternal and Infant Health: 1994 (Richmond, VA: December 1995).

Table 3-8. Rates of Participation for Obstetricians and/or Gynecologists in 1992, 1997, and 1988-1997

Year(s)	Obstetricians and/or Gynecologists		Participation Rate
	Participating (a)	Total in Virginia (b)	
1992	402 (c)	1,068	38%
1997	398 (d)	881	45%
1988-1997	780 (e)	1,271	61%

(a) Numbers in this column were created using unpublished participation lists provided by the Virginia Birth-Related Neurological Injury Compensation Program.

(b) Numbers in this column were calculated using two sources: American Medical Association, Directory of Physicians in the United States, 33rd edition (Chicago, Illinois: 1992) and Medical Society of Virginia, Directory of Virginia Physicians: 1997 (Richmond, Virginia: no date). The American Medical Association directory was used for 1992, the Medical Society of Virginia directory for 1997, and both directories were used for 1988-1997. In certain cases, we used the following two sources to identify specialties for physicians: Elinor Pyles, Executive Director, Virginia Birth-Related Neurological Injury Compensation Program, personal communication, November 14, 1997 and Trigon Blue Cross Blue Shield, Key Advantage and Cost Alliance: Directory of Providers (August 1996).

(c) Excludes 11 individuals not identified specifically as an obstetrician and/or gynecologist participating in Virginia.

(d) Excludes 21 individuals not identified specifically as an obstetrician and/or gynecologist participating in Virginia.

(e) Excludes 89 individuals not identified specifically as an obstetrician and/or gynecologist participating in Virginia.

SOURCE: Center for Public Policy Research, The Thomas Jefferson Program in Public Policy, College of William and Mary, 1997.

Assessments Paid by Physicians

Until 1994, physicians who chose to participate in the Program paid an annual assessment of $5,000. Beginning in 1995, physicians, like hospitals, that participated for more than one year paid reduced assessments, scaled down in relation to their years of participation. Thus, a physician who has been in the Program for seven years or more pays the minimum assessment, $500 (see Table 3-4).

Since the Program's inception, participating physicians have paid over $16.3 million in fees (see Table 3-7). Not surprisingly, the largest assessments were collected in 1991, the year of the highest number of participating physicians. As with participating hospitals, the largest drop in assessments occurred between 1994 and 1995, when the General Assembly authorized the Program's Board of Directors to reduce and prorate the participating physician assessment. In

1994, physicians paid $2 million in fees; in 1995, the amount collected dropped to $827,753.

Looking at these assessments according to Districts, Table 3-7 shows a similar trend for physicians as it did for hospitals in that nearly 70% of assessments come from participating physicians located in only three areas of the Commonwealth -- the areas of Northern Virginia (District 8), Richmond (District 15), and Virginia Beach/Norfolk (District 20). These three areas' share of total physician payments to the Fund exceeds their nearly 60% share of Program beneficiaries and 60% share of all live births in the Commonwealth (see Table 2-5).

Hospital and Physician Participation Rates Considered Together

The question was posed earlier in the chapter as to whether the participation rates and patterns for physicians would compare closely with those for hospitals. The evidence we have examined indicates that, in both respects, they do: in 1997, we find that 41% of the hospitals with birthing units in the Commonwealth were Program participants, and we estimate that 45% of the obstetricians were. Further, four Districts have never had either a participating hospital or physician. In any given year, as many as five to 10 Districts had no participating hospitals, and as many as seven Districts had no participating physicians.

A second question asked whether these similar patterns supported the view that the Program was underutilized. At the least, we can say that, over the life of the Program, in four Health Planning Districts, babies suffering birth injuries that otherwise would qualify them for the Program most likely would fail to meet the participating provider requirement, and in any given year, in another one to three Districts, other injured babies also would fail that requirement. Additionally, in other Districts, where participation by hospitals and obstetricians is not 100%, it would be possible for an injured baby to have had neither a participating hospital nor obstetrician, and thus fall outside the bounds of the Program.

Accordingly, it is our view that incomplete participation by obstetric service providers, both hospitals and physicians, is a contributing cause to the shortfall of actual Program beneficiaries below the potential beneficiary pool estimated in Chapter 2.

Why Hospitals and Physicians May Not Be Participants

Our interviews with hospitals and physicians about the Program, presented in Chapters 6 and 7, provided much useful information. At this point, some of that information helps explain why their rates of participation in the Program are not higher. In brief, we find that the main reason why hospitals do not participate is that they see -- throughout the state -- few Program-eligible birth injuries occurring, and thus choose to take the risks, through self insurance, rather than pay the Program hospital-participant fees. This may be especially true as more hospital systems and health care networks emerge, with greater size and financial strength for self insurance. In regard to physicians, we see two main reasons why they may not participate: lack

of knowledge about the Program and the cost of participation, the latter reason applying particularly to primary care physicians in the poorer areas of the Commonwealth who also provide obstetric services, and to some obstetricians in these areas also. Paradoxically, non-participating hospitals tell us that they can afford to opt out of the Program, while non-participating physicians often tell us that they cannot afford to opt into the Program.

Chapter 4

Fund Income and Management

Chapters 2 and 3 closely examined the operation of the Program in regard to its beneficiaries and obstetric service providers. Part of that analysis discussed the expenditures on behalf of the Program-eligible children and families, and the revenues into the Program from fees levied on participating hospitals and physicians. In this Chapter, these financial considerations are the focal point. Our goal is to describe and assess the financial structure of the Program and the management of its financial resources.

Fund Income

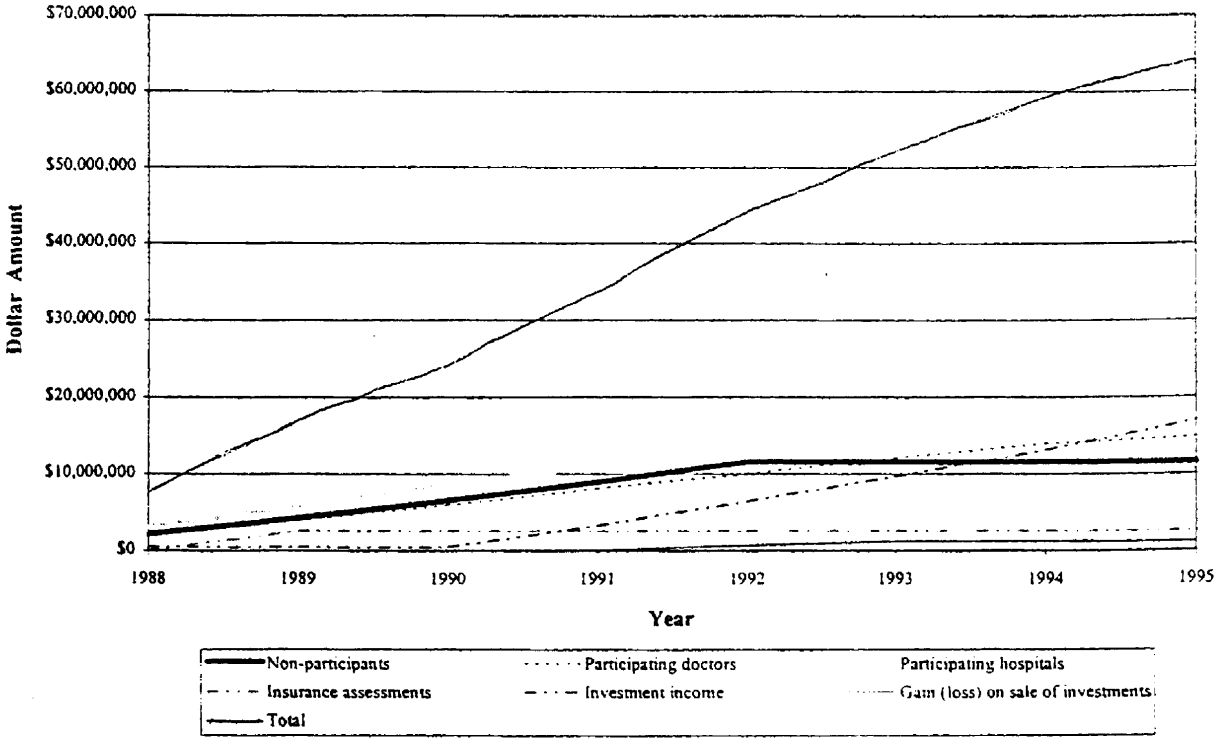
The Virginia Birth-Related Neurological Injury Compensation Fund was created to manage the financial resources which support Program benefits. Its two main functions are to serve as a repository for revenues coming from assessments on physicians and hospitals and to manage the investment of these funds to generate additional income. The annual assessment rates for physicians (both participating obstetricians and others), hospitals, and insurers since 1988 were shown in Table 3-4, in Chapter 3. Table 4-1, below, indicates the revenues to the Fund each year from these sources, as well as investment income and transaction gains or losses. Table 4-1 also shows that the Fund's monetary assets experienced large growth in the initial years, mainly from provider fees, but then increasingly were supplemented by robust investment earnings. By 1994, investment income had grown to account for almost half of total Fund annual income, and, after the reduction in provider fees in 1995, it now represents about three-fourths of Fund annual income. The cumulative growth of Fund monetary assets and the influences of each income component are pictured in Graph 4-1.

Table 4-1. Birth-Injury Fund Annual Income By Source, 1988-1995

Category	Year								
	1988	1989	1990	1991	1992	1993	1994	1995	Total
Non-participants	$2,100,777	$2,192,981	$2,269,362	$2,361,364	$2,637,372	-	-	-	$11,561,856
Participating physicians	$2,039,167	$1,893,043	$2,025,913	$2,181,608	$1,864,583	$2,065,352	$1,870,555	$837,680	$14,777,901
Participating hospitals	$3,028,458	$2,861,190	$2,838,000	$2,193,650	$2,183,800	$2,004,550	$1,866,039	$535,637	$17,511,324
Insurance assessments	-	$2,569,381	-	-	-	-	-	-	$2,569,381
Investment income	$465,885	-	-	$2,807,072	$3,146,699	$3,263,896	$3,414,321	$3,832,227	$16,930,100
Gain (loss) on sale of investments	($3,904)	-	-	$122,064	$588,594	$499,707	$5,165	($67,523)	$1,144,103
Total	$7,630,383	$9,516,595	$7,133,275	$9,665,758	$10,421,048	$7,833,505	$7,156,080	$5,138,021	$64,494,665

SOURCES: Charles M. Terry & Company, "Independent Auditor's Report," October 12, 1990, May 31, 1991, June 4, 1992; William Kuehl, Ltd., P.C., "Independent Auditors' Report," August 18, 1994, August 22, 1994; and Mitchell, Wiggins & Company, "Independent Auditors' Report," December 22, 1995, June 25, 1996.

Graph 4-1. Cumulative Birth-Injury Fund Income by Source, 1988-1995



SOURCES: Charles M. Terry & Company, "Independent Auditor's Report," October 12, 1990, May 31, 1991, June 4, 1992; William Kuehl, Ltd., P.C., "Independent Auditor's Report," August 18, 1994, August 22, 1994; and Mitchell, Wiggins & Company, "Independent Auditor's Report," December 22, 1995, June 25, 1996.

The Fund also has grown well ahead of the "claims reserve," the actuarial estimate of the present value of future claims against the Fund from all current beneficiaries. This relationship is shown in Table 4-2, where Fund financial assets (defined as total assets less current liabilities) are tracked against the estimated claims reserve, with the difference representing the "Fund balance." This balance was negative for the first three years of the Program (1988-1990), but had reached a positive value of over $27 million at the end of 1995.

Table 4-2. Birth-Injury Fund Assets Net of Current Liabilities, Estimated Claims Reserve, and Fund Balance, at Year's End, 1988-1995

Category	Year							
	1988	1989	1990	1991	1992	1993	1994	1995
Total assets - current liability	$7,526,323	$18,203,260	$27,305,612	$36,702,559	$46,799,474	$54,230,800	$60,870,362	$64,406,324
Estimated claims reserve	$9,900,000	$20,600,000	$32,600,000	$23,300,000	$32,600,000	$40,400,000	$38,800,000	$37,300,000
Fund balance	($2,373,677)	($2,396,740)	($5,294,388)	$13,402,559	$14,199,474	$13,830,800	$22,070,362	$27,106,324

SOURCES: Charles M. Terry & Company, "Independent Auditor's Report," October 12, 1990, May 31, 1991, June 4, 1992; William Kuehl, Ltd., P.C., "Independent Auditors' Report," August 18, 1994, August 22, 1994; and Mitchell, Wiggins & Company, "Independent Auditors' Report," December 22, 1995, June 25, 1996.

Fund Management

As stipulated in the Code of Virginia,[42] a board of seven Directors (the "Board") governs the Program. The Governor is responsible for appointing the Board which, as mentioned in Chapter 1, is made up of three citizen representatives, one representative of participating physicians, one representative of participating hospitals, one representative of liability insurers, and one representative of physicians other than participating physicians.[43]

Currently, the Governor's appointments are consistent with this mandate. The Board's broad authority includes decisions pertaining to the investment of Fund assets, but the Act does not call for any Directors to have professional investment experience, nor do any of the present Directors have this experience.

On June 4, 1993, the Board, in search of a Fund manager to manage and invest the Fund's monetary assets, issued a Request for Proposals (RFP). In the RFP, a "Statement of Needs" was articulated, calling on the contractor ("Fund Manager") to provide cash management/lockbox service and longer-term investment management for the Fund. Further stipulated in the RFP was that the contractor would designate an investment manager for the Fund. The investment manager's responsibilities, as stated by the RFP, include:

> Examining the investment market, making judgements on the relative value of various investment alternatives, determining which securities to hold for the Fund, and supervising the investment and reinvestment of the Fund's monetary assets.
>
> Investments must comply with the directives of the Board including the following:
>
> No single investment shall have a maturity date of more than five years.
> All corporate bonds purchased shall be rated at least AA.
> The Investment Manager shall establish a benchmark index, which will be subject to approval by the Board, and strive to outperform this index.[44]

These highly restrictive investment parameters make investment decisions more straightforward, when compared to less restrictive parameters. These restrictive parameters were substantially relaxed in September 1997. The consequences of this change are discussed later in this Chapter.

On September 16, 1993, a standard contract was issued by the Commonwealth of Virginia certifying Crestar Bank as the contractor of the Virginia Birth-Related Neurological

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[42] VA. Code § 38.2-5016 as amended January 30, 1997

[43] Ibid.

[44] REQUEST FOR PROPOSALS, RFP # 905-02, Commonwealth of Virginia, Department of General Services, June 4, 1993.

Injury Compensation Program. Crestar Bank has continually and, apparently, very capably fulfilled the obligations set forth in the RFP. Crestar Bank reports annually to the Board on the status and performance of the Fund, and also prepares monthly reports outlining current portfolio transactions and payments. This allows the Board to closely monitor the financial status of the Fund.

In addition to these investment services by Crestar, biennial actuarial studies and yearly audits are also prepared for the Fund. The Virginia Bureau of Insurance requires actuarial studies of the Fund, and is responsible for hiring an actuarial firm for that purpose. In turn, the actuary reports directly to the Virginia Bureau of Insurance and provides the Program with its analysis on an informational basis. William M. Mercer, Inc. has been responsible for these actuarial studies. The purpose of Mercer's studies is to determine if the Program is able to meet its current and future obligations. Their latest study, completed in October of 1997, found that the Program was able to meet its current and future obligations for the years 1997, 1998, and 1999. This study was made under the assumption that the Program's original investment parameters were to continue. With the recently highly liberalized investment parameters, this assumption may no longer be valid. Accordingly, a new study of the Fund's ability to meet its obligations in the next few years is needed.

Since the Program began, several different accounting firms have been retained by the Program to prepare yearly audits of the Fund. The latest audit was for the calendar year ending December 31, 1995. Recently, a new accounting firm was selected to prepare audits for the years 1996, 1997 and 1998; their report for 1996 had not yet been filed at the time of this writing.

From its inception, the Program's attention has been focused on providing the greatest possible service to its clients, those born with qualifying birth injuries. Because the Program's available funds quickly grew to exceed the reserve needed to support beneficiary claims, and earnings on Fund investments by themselves have been sufficient to meet all increases in claims reserves, the Board and Program administrators have been able to adhere to this objective. This financial strength has come from sizable fee income, productive -- if cautious -- investment parameters, and effective financial management, actuarial, and audit functions.

Need for Coordination in Financial Management and Reporting

Although the Fund managers, actuaries, and auditors have worked well individually, they have worked separately. Reports by each of them are submitted to the Program's Board and staff independently, without coordination. However, there are four factors that now require closer coordination among these functions. These factors are:

(1) The law regarding acceptable investments (the "investment parameters") has been changed.

(2) The Fund has experienced fairly rapid and sizable increases in claims, mostly for new housing construction or remodeling of existing housing.

(3) The Fund auditors have elected to treat these housing-related costs as non-liquid assets rather than as expenses.

(4) Changes may occur in the Program's future mission or funding structure.

In September 1997, the General Assembly radically changed the Program's investment powers by broadening the investment parameters. The new parameters greatly expand investment choices beyond high quality, short term bonds to now include a much broader array of bonds, including lesser grade paper, convertible and straight structures, as well as preferred and common stocks. These parameters introduce the potential for higher earnings, but at the same time increase credit quality risks and maturity risks. While studies have shown that, historically, equities over time provide higher rates of return than fixed-income securities, the risks associated with holding equities, in the forms of business risks and perpetual risk (no maturity), are greater. Further, lower grade bonds and longer maturity bonds also create increased business and maturity risks.

Prompted by this statutory change, the Board sought the advice of Crestar Bank and the Virginia Retirement System (VRS) in order to make an effective response to the expanded investment possibilities. The Board decided on September 16 to accept Crestar Bank's investment recommendations, which use a strategy similar to that employed by the VRS. It recommends that 30% of the funds be invested in stocks, 60% in bonds, and 10% held in cash equivalents.

These new, greatly broadened investment parameters now require a greater level of coordination between all parties involved with the Fund. To date, no coordination has occurred. Indeed, at the time of our recent contact, the Program's actuary, William M. Mercer, Inc., was unaware of the new investment authority. Because of the conceptual similarities between the Program and the VRS, the Program Board might be well advised to consider the high level of coordination currently existing within the VRS. For example, VRS' standard practice is to develop an investment plan and submit it to its actuaries. The actuaries then prepare a study incorporating the new investment plan and determine its impact. The new and broadened investment authority for the Birth-Related Injury Fund makes a well thought out investment plan by the Board, and a high level of coordination between the Board, the investment manager, and the actuary imperative. The Program is currently working on an upgrade of its internal accounting system. When accomplished, the Board should have access to more detailed data on the operating condition of the Fund. This should enable the Board to be well informed of the current status and any trends in the Fund's resources.

Investment Expertise at the Board Level

In regard to investment expertise at its Board level, the VRS has stipulated that four of the nine Board members must have a minimum of five years of professional investment experience. In addition, one other member must have at least five years experience in the administration of employee benefit plans. There are two additional subcommittees: a securities investment committee and a real estate investment committee. Each is responsible for insuring that sound investment strategies are developed and executed for each of these areas.

An essential similarity between the VRS and the Virginia Birth-Related Neurological Injury Compensation Program is that both receive funding from paid-in contributions and portfolio earnings. One major difference is that the VRS Directors are paid, while the Virginia Birth-Related Neurological Injury Compensation Program Board members are not. Accordingly, bringing to the Board directors with financial expertise and giving them the task of making financial decisions may be unduly burdensome. Instead, we suggest that a Financial Advisory Committee be appointed as an adjunct to the Board of Directors, to serve as a liaison between the Board and the paid managers of the Fund, and, on behalf of the Board, to provide oversight and recommendations to the managers.

Converting the Fund to Trust Status

Another important feature of the VRS is that it is an independent state agency accountable only to the beneficiaries of the plan. This protects the assets from being diverted to any use other than that of honoring obligations to participants. We recommend that the Virginia Birth-Related Neurological Injury Compensation Program be defined in a similar vein -- as a separate agency accountable only to its beneficiaries. There is a strong feeling among all of the Program's constituencies that the Fund should be fully protected for its intended beneficiaries, with trust status. (These views are to be found in Chapters 5, 6, and 7)

Concluding Observations

This examination of the sources of income to the Fund and the management of the investment of that income concludes with these observations:

(1) The Fund is large relative to its obligations, and thus is sound.

(2) The Fund has been given broader investment parameters, which may well provide for even greater growth in its financial assets.

(3) To maximize Fund management and growth:

   (a) a Financial Advisory Committee should be established to provide oversight of the actuaries, auditors, and investment managers.

(b) greater integration and cooperation among Fund managers, actuaries, and auditors should be fostered, perhaps by requiring that the actuary report be sent directly to the Board rather than the Virginia Bureau of Insurance, and the Board assess that report in relation to the strategic plans of its Finanical Advisory Committee.

(4) The accounting practice of treating housing cost as non-liquid assets rather than expenses should be re-evaluated, particularly in view of the dominant role and potentially great growth in this expenditure category. The rationale for this change is that these properties, although owned by the Program, cannot readily be sold or devoted to income earning uses.

(5) To protect the independence of Fund resources, defining the Program as an independent state agency, and the Fund as a trust, should be considered.

(6) Useful examples for guiding these changes in the management structure and legal status of the Program, its financial planning, managing, and reporting, and perhaps future questions, are provided by the Virginia Retirement System.

(7) Finally, the Board might consider issuing a new RFP for management of the Fund because of the significant change in the investment authority. Under the terms of the current contract, the Program or Crestar Bank can end the contractual agreement with 90 days notice. Because every component of the investment authority has been or may be changed, it would be appropriate for the Program to prepare a new RFP stating the updated investment guidelines and procedures, and to invite qualified fund managers to bid for the newly defined contract.

Chapter 5

Strengths and Weaknesses of the Program: The Views of the Beneficiaries[45]

At the time of these interviews, there were 29 children receiving benefits from the Virginia Birth-Related Neurological Injury Compensation Program. Twenty-two of the beneficiary families agreed to be interviewed for this study. In six of the 22 beneficiary homes, both parents wanted to speak with us. Consequently, we interviewed a total of 28 beneficiary parents. Although the same survey instrument was used for each interview, conversations varied in length from 20 to 90 minutes, due to individual differences in the amount of information that the beneficiaries conveyed. The beneficiary interviews were conducted by phone, and on a not-for-attribution basis in order to elicit comments that would be as candid as possible. (The survey instrument used to conduct these interviews appears in Appendix 5-1.) In deference to the confidentiality of the beneficiaries, comments from beneficiaries on the Program's strengths and weaknesses have been topically arranged, and edited to remove identifying information; they appear in Appendix 5-2.

Interviews of beneficiary families were the primary means of determining the views of those people for whom the Program exists. This chapter outlines the beneficiaries' perspectives on (1) the role of their doctors, hospitals, and other sources, in informing them of the Program; (2) the application process and eligibility standards; (3) the benefits provided by the Program, particularly the appropriateness of the scope of coverage, and the procedures by which benefits are requested and obtained; and (4) administration of the Program. Each subsection includes a synopsis of suggestions made by beneficiaries.

The Role of Doctors, Hospitals, and Others in Informing Beneficiaries of the Program

Of the 22 beneficiary families interviewed, exactly half, 11, first learned of the Program through either a medical professional, or someone involved with social services for special needs children. Of these 11, two were informed of the Program by the obstetrician who delivered their child. Three were informed by an obstetrician other than the one who performed the delivery, and one by a physician of another specialty. Two beneficiary families first learned of the Program through a physical therapist working with their child. One family heard of the Program through a labor room nurse, another through a worker in an Early Intervention Program, and still another from an Easter Seals worker.

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[45] We repeat here footnote 18, Chapter 1: "In Chapters 5, 6, and 7 we report the views of these constituencies and interested groups on the 'Program's strengths and weaknesses,' as these views have been related to us. We consider these *perceptions* of the Program to be important to our evaluation of and recommendations for the Program, and therefore have refrained from qualifying them in any way."

Of the other 11, three first heard of the Program through a friend. In two of these cases, a neighbor noticed a newspaper article on the Program and passed it along to the beneficiary family. The most likely source of information to beneficiary families was attorneys. Eight of the current beneficiary families first heard of the Program through an attorney. In one case, a relative referred a family to a malpractice attorney in another state, who subsequently assisted the Virginia family in making contact with the Program office. In another instance, the attorney who informed the beneficiary family of the Program's existence was the third attorney they had seen.

It is particularly noteworthy that the 22 beneficiary babies were delivered at 16 different hospitals, and of these, at least 14 have participated in the Program, yet in not one case did the beneficiary family learn of the Program through their hospital. The ages of beneficiaries when their parents first learned of the Program further underscores concerns regarding the effectiveness of current methods of informing potential beneficiary families. Of the 22 interviewed families, only four were informed of the Program when their children were less than three months of age. Three learned of the Program when their children were three to six months old; one family learned about the Program when their child was one year old; six families when their children were two years old; two families with three year olds; two families with four year olds; three with five year olds; and one with a six year old child. The family who learned of the Program when their child was six years old was informed when a relative picked up a brochure on the Program in her obstetrician's office. This beneficiary family commented, "We will never understand why *our* doctors didn't let us know about this."

The beneficiary families whose children were of toddler age or older when they learned of, applied to, and were admitted to the Program, unanimously cited the problems they experienced prior to their admittance due to the demands associated with taking care of a severely handicapped child in the face of grossly inadequate assistance. These difficulties were most often reported in terms of extreme emotional stress and financial hardship. Once accepted into the Program, beneficiary families were able to submit their otherwise uncovered previous medical bills for reimbursement. In one case, the Program's retroactive assistance involved dealing with collection agencies. The family on whose behalf this was done expressed its sincere gratitude.

As indicated, 11 families learned of the Program through sources outside the medical community. Having learned of the Program, several then spoke personally to their doctors, nurses, social workers, and hospital administrators, in an effort to obtain more information. In one of these instances, the delivering obstetrician acknowledged awareness of the Program, but indicated that s/he thought the family "already had adequate insurance coverage." In another case, the parents reported that the "doctor seemed very irritated that we might be pursuing legal action," and in a third instance, the doctor became "incredibly apologetic" and acknowledged knowing of the Program. On approaching the hospital where their child was delivered to obtain the medical records necessary for applying, one family reported being told several times that the "birth records and the fetal monitor records had been lost." When the President of this hospital was subsequently contacted by the family's attorney, the records were successfully retrieved.

Based on the information gathered from beneficiary families regarding the channels through which they learned of the Program and the timing of becoming informed relative to the ages of their children, a strong case is made that the Program's current informational network is either inadequate, functioning ineffectively, or, probably, both. As noted above, the role played by the attending obstetricians in informing potential beneficiaries is minimal, and the contribution of the hospitals where beneficiaries were born has been nil. The sources through which beneficiary families have received information all too often were circuitous and serendipitous. Three beneficiary families used the word "fluke" when describing how they first learned of the Program. These data relate to the question raised earlier in the Report about the possibility that there are birth-injured children who qualify for the Program but have not applied for coverage because their families are unaware of its existence. Yet, despite the total failure of hospitals and partial failure of physicians as sources of information about the Program, an optimistic note is to be found in these responses from beneficiary families: nurses, social service workers, and attorneys have been valuable sources of information. In one light, they may be viewed as substitutes for the limited informational effectiveness of physicians and hospitals; in another light, however, they may be viewed as extensions of the informational network, not replacing the central roles of physicians and hospitals but supplementing them. A highly effective informational system involves all sources, and thus new and stronger efforts are called for to render physicians and hospitals more effective in connecting families of injury-eligible babies with the Program.

The Application Process and Eligibility Standards

The consensus of the beneficiary families interviewed is that applying to the Program is quite daunting. Of the 22 families with whom we spoke, 19 had consulted with an attorney about legal recourse at some point since their child's birth. Of these 19, 14 used the services of an attorney to assist them with the application process. In three cases, the families neither consulted nor required the assistance of an attorney for the submission of their application. In two of the cases where the family saw an attorney but did not use one for the application process, the parents cited the significant assistance offered to them by Elinor Pyles. In one of these cases, the family had been referred to the Program by an out-of-state malpractice attorney; in the other, the family's initial application was denied because one of the physicians in attendance at their child's birth refused to testify regarding another attending physician. In the latter case, Ms. Pyles referred the family to a consulting physician who examined their child, their child's medical records, and then submitted his assessment as part of the reapplication. With the documentation provided by the consulting physician, the applicant was subsequently deemed eligible and admitted to the Program.

One beneficiary parent commented that he "believes it would be possible for claimants to go through the application process without a lawyer if the application itself were more straightforward." When beneficiaries' attorneys, or potential beneficiaries themselves contact the Program requesting written information on applying, they are sent a copy of the statute under

which the Program was established. For several of the beneficiaries, receiving the pertinent section of the Code of Virginia was, in itself, quite intimidating. These families quickly decided that they needed legal assistance in order to prepare their application. As cited above, there were also cases in which the families' requests for medical records obtained a successful response only after the relevant hospitals were contacted by their attorney. Suggestions from the families who used the services of an attorney in the application process included recommendations that the Program develop a check list of items that comprise the application. The sheer volume of medical records needed, combined with the requirement of sending 12 copies of everything was also intimidating to a number of families. One beneficiary parent told us that just one copy of his child's medical records was "four or five inches high" at the time they applied. Reproducing this 12 times, writing a cover letter, and making it all presentable was a challenge that several beneficiaries felt they could not meet.

Along with these experiences, we spoke with beneficiaries who felt capable of deciphering the application requirements based on the statute. In one instance, the beneficiary family obtained the Code citation from their attorney, went to the public library, copied that section, and began studying it. This level of initiative was not unusual among the families who applied on their own. As noted above, eight of the 22 beneficiary families we spoke with applied to the Program without the assistance of an attorney. Notwithstanding, we believe that the data collected through beneficiary interviews indicates that the Program would do well to consider supplying applicants with a check list that would clearly identify all the necessary components of an application.

As one would expect, when views on the eligibility standards were expressed, the opinions of those with whom we spoke were skewed in support of maintaining existing criteria. Only one respondent suggested changing the current definitions in a way that would increase the number of beneficiaries. This parent expressed concern about the number of children who suffer from severe disabilities, but "are left out in the cold." Each interviewee was asked to cite the Program's "two greatest strengths" and "two greatest weaknesses." One respondent stated that the Program's greatest weakness is that "nobody knows about it." This parent cited the length of time during which the Program has been operating, and emphasized that the current number of beneficiaries is "ridiculously low." Continuing, the respondent suggested that the "Program needs to be publicized. The doctors and hospitals need to talk about it." And, there are "definitely more than 29 children in the State of Virginia who need it!"

The Scope of Benefits and Obtaining Benefits

With regard to benefits, the beneficiary interviews focused on the procedures for obtaining benefits, and solicited opinions on the appropriateness of the scope of benefits covered by the Program. The first questions in this section of the survey instrument address the issues of how reimbursement for expenditures is acquired in the event that prior approval is, or is not, obtained through Program staff. Two families, recently admitted to the Program, explained that they feel they are still learning about what the Program covers. Others indicated that, even with

the guidelines developed over the past two years, there are still "grey areas" with many items being considered on a "case by case basis."

Families who have been in the Program for two or more years noted that when they were accepted, the Program had very little printed information on what would be covered. Moreover, because the Program serves as a secondary insurer, beneficiaries must first apply to their primary insurer, even when a denial is virtually certain. For example, in order to obtain a piece of medical equipment, the primary insurer's letter of denial, along with a doctor's letter of support, or a prescription, must be submitted to the Program. If approved, the Program shops for the best price, makes the purchase, and delivers the equipment to the beneficiary's home.

The survey instrument used for these interviews does not ask if beneficiary families believe it is difficult to receive benefits through the Program. However, in nine of the interviews, beneficiaries offered unsolicited complaints, often vehement, regarding "red tape," "cumbersome procedures," or "dealing with bureaucracies." It should also be noted that 10 interviewees commended Program staff while discussing obtaining benefits. Those who stated that the complexity of procedures makes receiving benefits long and arduous, made several suggestions regarding ways to expedite this facet of the Program. Beneficiaries receive benefits in the form of reimbursements for out-of-pocket expenses, as well as for various medical supplies and equipment. For this reason, recommendations include ideas for streamlining the reimbursement process, as well as for more quickly obtaining items purchased by the Program.

Beneficiaries' recommendations included the suggestions to "give more authority to the Program staff, so that fewer requests go to the Board," and "eliminate the requirement of supplying receipts for legitimate expenditures which can be cited, but are less than $25." Two families have made arrangements with their pharmacy whereby their otherwise uninsured prescription expenses are billed directly to the Program. Each of the beneficiaries who cited the procedures associated with obtaining benefits as a problem, alluded in some way to the volume of paperwork, and the time that must be devoted to submitting their claims.

Each of the interviewees were asked his/her opinion of whether the coverage provided by the Program is appropriate. Of the 22 families interviewed, 19 chose to respond to this question. Of the 19, 10 expressed their satisfaction with the scope of benefits. Nine felt the benefits to be inadequate, and cited various bases for this. The reasons most frequently given were, first, the loss of income that the family has experienced due to the severity of their child's disabilities, and, second, that the Program should offer a pain and suffering award as part of its coverage. With regard to the first reason, the loss of income is due to the inability of one spouse (always the mother) to work full-time outside the home. Four beneficiaries felt the mother's presence in the home to be necessary in order to help take care of their disabled child, and expressed the conviction that their child's care would suffer if the mother were to pursue a full-time career position. Other related activities that were cited as being time-consuming and had become the mother's responsibility, included completing the Program's paperwork, taking the child to doctor and therapy appointments, and being available to stay with the child during hospital stays.

Three of those who felt the Program's coverage to be inadequate explicitly cited the benefits, such as a pain and suffering award, offered through the comparable program in Florida. In four cases where the beneficiaries felt the Program's coverage to be inadequate, but where they did not cite the Florida program, the interviewees alluded to uncovered expenses associated with the difficulties faced by the entire family and/or other children due to the disabilities of their impaired child. Reasons here included the frequency of their need for child care for siblings when the parent(s) take the disabled child to out-of-town doctor's appointments or when the disabled child is hospitalized. Four of the beneficiary parents with whom we spoke are single mothers. Of these, two are living in rural areas. They explained that, due to the severity of their child's disabilities, they would qualify for in-home nursing assistance under the Program's current standards. However, until now, their rural location has made it impossible for the Program to provide them with such care. In these two cases, this was the substantiation for the loss of income for their household. The two single mothers living in urban areas reported that the disabilities of their child has caused significant financial hardship for them, but that this was being ameliorated by their admittance to the Program.

Each of the interviewees was asked whether or not the household had experienced a decline in income since the birth of the child. Of the 22 beneficiary families with whom we spoke, 16 responded affirmatively to this question. As above, the most likely basis given for this was the inability of one parent to pursue a career outside the home. In addition to the two rural single mothers unable to work due to the inaccessibility of nursing care, eight two-parent households reported that mothers have either been out of work for a period of years, able to work only part-time, or unable to work at all. One household reported that, due to the impact of the mental and emotional stress of their child's disabilities, the father has lost two jobs since their child's birth and is now working at the rate of $7 per hour. One father explained that the stress of his child's disability and the practical need for him to spend more time at home (both to help care for the disabled child and the siblings) have resulted in a $2,000 per month reduction in his income. In these 11 cases, the families described their losses of income as continuing circumstances that the Program has addressed, but not alleviated.

The two single mothers who work full-time feel that the coverage provided by the Program has reduced the negative financial impact of their children's disabilities, and that the benefits of the Program, particularly in the form of nursing care, have made it possible for them to return to work. In short, of the 16 families who cited loss of income as one result of their child's disabilities, five described situations in which this impact was evident until their acceptance into the Program, while 11 believe the negative impact on their household income to be ongoing.

Program Administration and Staffing

The views of beneficiary families on the administration of the Program were solicited at several points during each interview. First, in the section regarding application to the Program, interviewees were asked to describe their contact with Program staff after their child was

determined eligible for the Program. Second, in the section on overall experience with the Program, respondents were asked to cite what they saw as the Program's two greatest strengths and two greatest weaknesses. In regard to "strengths," Program administration and staff were often mentioned. Third, also in the section on overall experiences, we asked for a quantitative description of perceptions of Program staff. Fourth, a high proportion of the unsolicited comments we received had to do, in some way, with administration of the Program.

The first opportunity offered in the survey instrument for respondents to express their views on Program administration and staff appears in the section on application to the Program. The item is phrased, "Please describe your contact with Program staff after your child was determined eligible for the Program." Of the 22 families, 13 responded by recounting the sequence of events they recalled after receiving notification of their admittance. Of these 13, three told us that at the time of their acceptance they had requested written guidelines from the Program on what would be covered and were told that such guidelines were not available. Each of these three went on to explain that this has been rectified to a large extent, and, over the past two years, the Program has developed two successive iterations of benefits which will be covered.

In response to the question regarding initial contact with Program staff, nine families offered unsolicited positive comments on the staff. In each of these cases, the respondents further elaborated on their affirmations of Program staff later in the interview, when questions on this topic were more direct. These unsolicited comments reflected strongly held opinions, including the following: "We are very happy with the staff;" "The staff are very supportive. Elinor gave us her home phone number when we first talked to her, and encouraged us to call her at home;" "Elinor and Lisa have been great to work with;" and, perhaps the most effusive, "They are excellent. I have nothing but good to say about Elinor. She is very kind, very patient, and incredibly helpful. I love both Elinor and Lisa; they couldn't be nicer; they're like angels."

Second, the topics of Program administration and staff frequently came up in responses to the questions, "What do you think are the Program's two greatest strengths?" and, "What do you think are the Program's two greatest weaknesses?" With regard to Program administration, five respondents felt that the amount of red tape and paperwork involved with receiving benefits is a weakness. One respondent believes there is a need for additional staff. On the topic of the staff, eight respondents cited staff as one of the Program's two greatest strengths. In the majority of cases, those who cited unwieldy procedures as a weakness, as well as those who cited Program staff as a strength, appeared to hold their opinions quite strongly. (We encourage the reader to see the transcripts of the interviews in Appendix 5-2. Other comments which were elicited by asking families to cite strengths and weaknesses are more fully discussed in the next section of this Chapter.)

Third, we asked the respondents to give quantitative overall assessments of the Program. We offered the interviewees a scale from one to five, with one being "poor," and five being "excellent." Using this scale, we asked the families to "describe your experience with Program

staff." The average score given by respondents on their experience with the staff is 4.04. Of the 22 responses to this question, two gave a score of 2, and no one gave a score of 1. Using the same scale, we requested that families ascribe a score on the question, "How do you rate this Program overall?" The average score given to the Program is 4.14. Of the 22 responses to this question, there was one respondent who rated the Program a 1, while the remaining answers were 3 or above.

Fourth, we received a variety of comments regarding administration of the Program. These observations were unsolicited in that they were offered in response to the questions on the Program's two greatest strengths and weaknesses. In addition, following these questions, we asked, "Are there any other strengths or weaknesses that come to mind?" This question also elicited a number of comments on Program administration. A synopsis of the comments on Program administration includes the following: When asked to cite the Program's two greatest weaknesses, five families told us they could not think of any weaknesses.

Thirteen comments cited either the composition of the Board or its inaccessibility as a weakness. Of these, two specifically addressed the credentials of the individuals on the Board. These comments focused on the need for a pediatric neurologist and a physical therapist, and indicated that the Board should include members who are not only medical professionals, but who are skilled in working with children who have neurologically-related disabilities. In general, opinions on the credentials of Board members and composition of the Board were held strongly, and suggested that the Board should be made up of individuals whose areas of expertise are appropriate to the needs of beneficiaries.

The 11 comments regarding accessibility of the Board included several topics. One was the suggestion that the Program generate a newsletter of some sort. In four cases, the need for a newsletter was associated with the need for the Program to institute a network of communication among the beneficiary families. One parent suggested the Program send out a release form, whereby beneficiary families could give consent for their names to be released to each other. In this manner, a newsletter could become a forum for communication between the families.

Several comments regarding the Board suggested ways in which the Board could become more available and in-touch. One form of this recommendation was that beneficiary families should have a representative on the Board. Descriptions of how this would benefit administration of the Program included requests for an "ombudsman," an "advocate" for the families, and "a parent representative that could serve ex officio." A second idea advanced by three respondents was that the Board should occasionally meet in locations other than Richmond. A number of families indicated, at some point in our conversations, that they would like to attend a Board meeting, but have never been able to do so. The three who suggested alternative meeting locations felt that meetings in other cities around the State could be held a few times each year and publicized among the beneficiaries well in advance. A third recommendation on making the Board more accessible was that Elinor Pyles should take photos of the families and children (with their consent) when she makes home visits. These photos should then be shown to

the Board. One respondent would like the Board to see copies of the medical report on each beneficiary's annual physical examination. The proponent of this idea felt that the information would assist the Board in their understanding of the condition of each child.

What appears here is a representative summary of comments and suggestions regarding Program staff and administration. As noted, the full range of observations and recommendations made by beneficiary families appears in Appendix 5-2.

Diverse Strengths and Weaknesses of the Program as Viewed by the Beneficiaries

Additional topics cited as the Program's strengths included endorsement of the Program's coverage of various items not covered by the beneficiaries' primary insurers. Items mentioned by two or more beneficiaries include: a van with a lift, housing, nursing assistance and/or respite care, and medical equipment. Other strengths of the Program mentioned by two or more beneficiary families include: (1) the alleviation of financial distress, (2) the security of knowing that the Program will provide care for their disabled child throughout his/her lifetime, (3) the Program avoids the stress that would be caused for families due to malpractice lawsuits, and (4) the Program makes it possible for the families to have their child at home with them rather than the child being institutionalized. A weakness of the Program raised by more than two beneficiaries is the lack of impact on the doctors and/or hospitals who were responsible for the neurological injuries now covered by the Program. When cited, this factor was described as a weakness of the Program because doctors, in particular, do not face any disciplinary action. In addition, current and prospective patients of these doctors have no means of discovering which doctors have been involved in such incidents, other than by word of mouth. Two beneficiaries questioned the constitutionality under State law of a potential litigant foregoing his/her right to sue in a case involving personal injury, even when other compensatory provision is made through the State.

Concluding Comments and Beneficiaries' Recommendations

The first topic addressed in this Chapter is the role played by doctors, hospitals, and other sources in informing beneficiary families of the Virginia Birth-Related Neurological Injury Compensation Program. As mentioned, the most likely source for information regarding the Program has been attorneys. Eight of the 22 beneficiary families with whom we spoke discovered the Program through an attorney, while two learned of it through the obstetrician who delivered their child. Sources within the medical community include one nurse, obstetricians (delivering or otherwise), physical therapists, and social workers. In none of the cases interviewed were beneficiaries informed through hospital personnel. These data illustrate the inadequacy of the Program's current informational network. Our interviews made it possible to gain an overview in this area. The findings on informational sources, combined with the ages of the children when parents were informed, substantiate our recommendation for measures which will remedy the current situation. Further, these data point to the question of how many children

born in the Commonwealth actually qualify for the Program but have not applied because their parents are unaware of its existence. The answer suggested by our interviews is that the informational problems are of a magnitude such that we cannot assume there to be no such cases.

The second topic addressed in this Chapter is the application process by which beneficiaries are admitted to the Program. On this issue, there was a specific recommendation offered by beneficiary families, with which we concur. This recommendation was that the Program develop a checklist that could be sent to those who wish to apply. Such a document could accompany the section of the statutory Code that is currently sent, and would supply an itemized list of each of the components of a complete application.

The third topic addressed in this Chapter is the procedures associated with applying for, and obtaining benefits through the Program. As noted above, five of the beneficiary families cited the volume of paperwork associated with requesting and receiving benefits as a weakness of the Program. In addition, four others noted the amount of time that must be devoted to these procedures, although they did not cite it as a weakness, nor did they suggest a means of streamlining the process. On the basis of beneficiary interviews, we do not have sufficient information to recommend specific ways in which the acquisition of benefits could be expedited. Further, because the Program serves as a secondary source of coverage, obtaining approval for requested items, making purchases, and delivering the items becomes a complex process. Suffice it to say that nine of the beneficiaries interviewed commented on the time required to request and receive benefits. The concerns expressed by beneficiaries regarding the complexity of the process of obtaining benefits did not include comments citing problems with the dispute resolution procedures.

With regard to the scope of benefits covered by the Program, the beneficiaries who responded to this question were almost evenly divided in their opinions. Of the 19 who addressed this question, 10 felt the scope of benefits to be adequate, while nine believed the scope of benefits to be inadequate. Among those in the latter category, the most likely area of additional coverage requested was a pain and suffering award that would address the issue of lost income.

The fourth topic addressed in this Chapter is beneficiary views on the strengths and weaknesses of administration of the Program, including staff. Nine respondents offered unsolicited positive comments regarding Program staff before this topic was explicitly raised. When asked to cite the Program's two greatest strengths, eight beneficiary families cited Program staff. In short, the preponderance of comments regarding Program staff reflected strong endorsements of the responsiveness and professionalism of Elinor Pyles and Lisa Antis. While Program personnel were strongly commended, it should be noted that there was also consensus among beneficiaries that the procedures associated with requesting and receiving benefits is complex and time-consuming. Five cited paperwork and red tape when asked to name the Program's two greatest weaknesses, and six mentioned this topic when asked about receiving benefits. In short, the beneficiaries do not attribute the challenges of obtaining benefits to

Program staff. Rather, the procedures for making requests, the need for documentation from doctors, making initial claims to primary insurers, waiting for the Program to make a purchase and deliver an item, and the occasional need for a decision or dispute resolution to go the Board, were cited as the reasons for the lengthiness of the process.

With regard to Program administration, 13 beneficiaries cited either the composition of the Board, or the inaccessibility of the Board, as one of the two weaknesses of the Program. Augmenting communication between Board members and beneficiary families was requested as a means of enhancing Program administration. Suggestions made by beneficiaries included requests for the Board to occasionally meet in cities around the State, and ideas on how to increase contact between Board members and beneficiary families. In addition, four beneficiaries suggested that the Program offer an additional service by becoming the vehicle for a network of communication among them. Specifically, these respondents asked that the Program print a newsletter, and, with the beneficiaries consent, their names, addresses and phone numbers, be released to each other. If implemented, this suggestion would utilize the Program's administrative capacity to set up a forum for mutual support, and the sharing of ideas and information. Alternatively, if information on the beneficiaries were released to all who chose to participate, the initiative as to how this communication would function could be left to the beneficiary families themselves. In other words, if the Program disseminates this information, the beneficiaries could institute their own means of communicating, independently of the Program itself.

Interviews with beneficiaries gathered significant information from those whom the Program serves. The beneficiaries' contact with the Program is frequent and substantive. Indeed, the beneficiary families unanimously articulated that the Program is the pivotal source of funding for medical necessities not otherwise covered. The benefits provided through the Program were cited for having ameliorated or relieved financial duress, and having reduced the mental and emotional strain incurred by beneficiary families. Because the Program is a secondary provider, the proportion of need on the part of each beneficiary varies relative to the breadth of coverage available through their primary insurer. This is one factor which accounts for variance in the benefits provided to individual beneficiaries.

In the interviews, care was taken to convey the nature of the study and the impartiality of the Center for Public Policy Research. The beneficiaries, in turn, gave generously of their time and viewpoints. Their contribution to this Report is greatly appreciated.

Chapter 6
Strengths and Weaknesses of the Program: The Views of Physicians; Nurses, Nurse-Midwives, Nurses' Representatives; Physician Association Representatives; Residency Program Coordinators; and Former Board Members

Medical professionals who provide perinatal and pediatric care in the Commonwealth have a vital interest in the current status and future of the Virginia Birth-Related Neurological Injury Compensation Program. In order to obtain first hand perceptions and suggestions, a number of these health care providers were interviewed in conjunction with this study. The interviews reported in this Chapter were conducted by phone and varied in length from 10 to 40 minutes, based on individual differences in the information which each person wished to convey. Each of the medical professionals and representatives of professional medical associations spoke openly and agreed to be identified by name with the opinions they articulated.

The questions addressed to medical professionals focused on seven facets of the Program. First, the interviewees were asked to comment on levels of participation and the requirements for participation by the various health care providers whom the Program covers, including physicians, nurses, nurse-midwives, and hospitals. Second, we solicited ideas on how the proportion of health care providers and hospitals that participate in the Program might be increased. Third, in connection with the previous question, we asked about the fees which support the Program. Fourth, we asked the health care professionals for opinions on why the number of beneficiaries in the Program is lower than anticipated. In the case of the physicians, we further inquired about their contact with the Program in terms of reviewing cases, informing patients of the Program, and treating beneficiaries. Fifth, those interviewed were asked to comment on the current structure of the Program, as well as on Program finances. Sixth, we asked for suggestions on how to augment the Program's current informational network, including the possibility of initiating a newsletter. Seventh, the interviewees were asked whether they had any further comments on the strengths and weaknesses of the Program, and whether they would like to make specific recommendations. (The questions posed to these medical professionals are listed in Appendix 6-1.)

The physicians with whom we spoke represent several specialties: obstetrics, family practice, pediatrics, and pediatric neurology. As a consequence, there was some variance in the facets of the Program in which they have the greatest interest. The obstetricians with whom we spoke included both those who participate in the Program, and those who do not. In the case of the nurses, nurse-midwives, and representatives of nurses, there was also some diversity accounted for by the differing areas of expertise of each individual. No interviewee responded to every question.

The physicians we interviewed are:

- Dr. Vaughn Arey, Galax, Family Practice
- Dr. Camilla M. Buchanan, Williamsburg, Obstetrics and Gynecology
- Dr. Michael A. Filak, Centreville, Family Practice
- Dr. Judith Goettert, Lebanon, Doctor of Osteopathy
- Dr. Roger W. Jones, Williamsburg, Obstetrics and Gynecology
- Dr. Jay Lavigne, Abingdon, Obstetrics and Gynecology
- Dr. Robert Lazo, Galax, Family Practice
- Dr. Duncan C. MacIvor, Richmond, Obstetrics and Gynecology
- Dr. Patricia D. Mulreany, Midlothian, Pediatrics
- Dr. John R. Partridge, Richmond, Obstetrics and Gynecology;
- Dr. Philip L. Pearl, Alexandria, Pediatric Neurology;
- Dr. Donald A. Taylor, Richmond, Pediatric Neurology;
- Dr. Jean-Gilles Tchabo, Arlington, Obstetrics and Gynecology
- Dr. Joseph Terry, Abingdon, Obstetrics and Gynecology
- Dr. Robert Vermillion, Roanoke, Obstetrics and Gynecology
- Dr. Gayle S. Vest, Norton, Obstetrics and Gynecology
- Dr. Charles Zimmerman, Hampton, Obstetrics and Gynecology

We made numerous unsuccessful attempts to contact additional physicians, some of whom were unwilling to discuss the Program.

The nurses, nurse-midwives, and nurses' representatives with whom we spoke are:

- Judy Castleman, RN, CNP, Legislative Liaison for, (among others) The Virginia Chapter of the American College of Certified Nurse Midwives, and the Virginia Perinatal Association
- Joan Corder-Mabe, RN, MS, WHNP, of the Division of Women's and Infant's Health at the Virginia Department of Health
- Jan Johnson, RN, Executive Director of the Virginia Nurses Association
- Jessica Jordan, RN, CNM, a practicing nurse-midwife
- Rebecca Rice, Ed.D., President of the Virginia Nurses Association

The representatives of physicians' associations with whom we spoke are:

- Madeline Wade-Abbitt, Director of Legislative Affairs for the Medical Society of Virginia
- Melanie Gerheart, Executive Director and Director of Government Relations for the Virginia Obstetrical and Gynecological Society

The coordinators of residency programs with whom we spoke are:

- Dr. Linda Archer, Ed.D., Assistant Dean for Graduate Medical Education at Eastern Virginia Medical School
- Dr. John Seeds, M.D., Director of the residency program for obstetrics at the Medical College of Virginia of the Virginia Commonwealth University
- Eileen Hardigan, Administrator for the Department of Obstetrics and Gynecology at the Medical College of Virginia of the Virginia Commonwealth University
- Dr. James Kitchen, M.D., Director of the residency program for obstetrics at the University of Virginia Hospital

The former members of the Program's Board with whom we spoke are:

- Malea J. Kiblan, Esq., who served on the Board from 1990 to 1996
- Leslie Barnes Hagan who served on the Board from 1990 to 1996

We would like to express our gratitude to these individuals. Each took their time to articulately and candidly give opinions and suggestions. These health care professionals, residency program coordinators, representatives of professional medical associations, and former Board members provided insights which are both knowledgeable and focused. For the purpose of clarity, we first discuss the findings of the interviews with the physicians as a group, followed by a discussion of the findings of the interviews with the nurses, nurse-midwives, and nursing representatives, then, the residency program coordinators, the lobbyists and the former Board members.

The Views of Physicians

It should be noted at the outset that the physicians with whom we spoke are supporters of the Program. Most of them offered suggestions to refine or adjust the Program, but each strongly supported it. Of the obstetricians with whom we spoke, six are participants in the Program, and four are not. In addition, we interviewed two family practice doctors who deliver babies, who are not participants. Most of the physicians linked the existence of the Program and its provisions to the level of malpractice insurance premiums, but others did not think that this link was significant. However, differing views on this question were not a barrier to unanimous support for the Program.

Each of the physicians interviewed felt that efforts should be made to increase the participation of obstetricians in the Program. Similarly, the family practice doctors we interviewed who deliver babies expressed their support for increasing participation among physicians in this category. Doctors offered various rationales for the benefits of increasing

physician participation, as well as suggestions on how this might be accomplished. Dr. Partridge recommended that the Program send a letter to all non-participating obstetricians in the State. Such a letter should inform physicians of the objectives and activities of the Program and encourage them to become participants. Dr. Partridge believes that there still are a number of obstetricians practicing in Virginia who are unaware of the Program; he would like to see the Program "get the word out." Dr. Partridge suggested making contact through each of the professional associations to which obstetricians belong, since the membership in these organizations varies from one to the other. In addition to contacting obstetricians through the Medical Society of Virginia, Dr. Partridge recommended the Richmond Academy of Medicine and the Virginia Chapter of the American College of Obstetricians and Gynecologists. Dr. Partridge commented that he "could not understand why any obstetrician would not want to join if he/she were aware of the Program."

Dr. Filak, a family practice physician, offered observations that reinforce the concern of obstetricians regarding a lack of information in the medical community. In Dr. Filak's view, many health care providers simply do not know about the Program. Dr. Filak suggested that the Program take steps to publicize its existence to health care professionals. As a family practice physician, Dr. Filak would like to see a greater level of awareness among physicians in specialties such as family practice, pediatrics, and pediatric neurology, since these are the physicians that may treat children who are potential beneficiaries, but are unaware of the Program. Dr. Filak treats two children who are current beneficiaries. He believes that there may be a number of children in the Commonwealth who would be eligible under current requirements, but have not applied to the Program because their parents have heard nothing about it.

Dr. Jean-Gilles Tchabo felt that increasing the proportion of obstetricians who participate in the Program "would be the best way to cover more babies." This comment from Dr. Tchabo addresses an issue which was a recurring, major theme in our interviews with physicians. One of our questions had to do with "expanding the Program," and we received responses focusing on all three possibilities: (1) expanding the program by locating children who are eligible under current requirements, (2) increasing the number of obstetricians and hospitals who are participants, and (3) liberalizing the definitional injury requirements. Dr. Tchabo's recommendation pinpoints the way to bring the largest number of babies into the Program within the current statutory requirements. This approach would have the added benefit of augmenting the flow of information from the medical community to the community at large, including new parents of birth-injured babies. We believe that significantly increasing the number of health care providers who are participants in the Program will yield a direct and substantial increase in the number of eligible beneficiaries.

Dr. MacIvor, Dr. Jones, and Dr. Buchanan each suggested ways of increasing participation among obstetricians by offering additional incentives, and/or removing disincentives, for membership in the Program. Dr. MacIvor felt that the high cost of participating in the Program is a disincentive to many physicians. Younger physicians,

physicians in solo practice, and family practice physicians in underserved areas who deliver babies, are all categories of physicians who may want to join the Program but are deterred from doing so by the cost of membership. On this point, Dr. Partridge mentioned that his office initially covers the fees for younger physicians when they join the practice.

Dr. Jones advised emphasizing the connection between participation fees and malpractice insurance premiums as a means of offering incentives for participation. For example, Dr. Jones' malpractice carrier gives a dollar-for-dollar discount to subscriber obstetricians who participate in the Program. Dr. Jones and Dr. Vermillion recommended that State officials encourage malpractice insurance carriers to give this type of discount and to help publicize the Program. Dr. Jones felt that efforts from the General Assembly in this direction may yield positive results. On the topic of increasing participation by obstetricians, Dr. Buchanan and Dr. Vermillion indicated that the Program should make a renewed effort to publicize its objectives and what it provides to the medical community. In particular, Dr. Buchanan felt that the Program should emphasize the benefit of participation by focusing on the fact that membership will reduce the possibility of malpractice suits against individual physicians.

The physicians we interviewed were unanimous in their support of increasing participation among hospitals. Even though the Program now requires that only the delivering obstetrician or the hospital be a participant in order for a baby to become eligible, the physicians maintain that the membership of hospitals in the Program is important and worthwhile. Indeed, each of the physicians emphasized this point in some way. Dr. Partridge, Dr. Tchabo, and Dr. Mulreany all felt that participation on the part of hospitals with birthing capacity should be mandatory. Dr. Buchanan and Dr. MacIvor also stressed the importance of hospital participation. The physicians felt that the hospitals, in many instances, are better able to afford Program participation than are individual physicians, or even group practices. Two physicians asked whether the cost of participation, per birth, for most hospitals is lower than for physicians. Once again, the goal of increasing Program participation dovetails with the objective of expanding the Program by increasing the number of potential beneficiaries. If the participation of hospitals with birthing capacity were to rise dramatically, the physicians firmly believed that the number of actual beneficiaries also would rise.

With regard to broadening the participation of health care professionals, Dr. MacIvor, Dr. Tchabo, Dr. Partridge, Dr. Arey, Dr. Goettert and Dr. Vest expressed strong support for permitting all certified nurse-midwives in the Commonwealth to become Program participants. Dr. Lavigne added that licensed nurse midwives should be permitted to join, but that lay midwives are not appropriate candidates for participation. Each of the physicians responded positively on the point of making membership available to all certified midwives in the State. At this time, only those certified nurse-midwives practicing in underserved areas of the State are permitted to join the Program. The consensus among the physicians was that all health care professionals in the Commonwealth who deliver babies should be eligible to participate in the Program. As we will see, the nurses and nurse-midwives also endorsed opening membership to all certified nurse-midwives, but expressed concern about the expense of membership fees

relative to their income.

Recently, the study concluded under House Joint Resolution 617, "Improving Access to Perinatal Care in Rural and Under Served Areas," recommended that "legislation...allow the Board of Directors of the Birth-Related Neurological Injury Compensation Program to reduce the participation fee for all providers practicing in the perinatal underserved areas due to manpower deficiencies." While expressing his support for increasing the number of participants in the Program, Dr. Partridge commented on this recommendation. He felt that it would be beneficial to encourage participation in the Program on the part of family practice physicians in rural areas who deliver babies. However, if the State chooses to pursue the possibility of reduced fees for such areas, Dr. Partridge suggested that this not be done as an income transfer. In other words, if the General Assembly opts to lower the fees for practitioners in underserved areas, the "legislature should also put up the funds to equal the ante," so that those in urban areas are not compensating for the difference in participation fees.

The family practice doctors with whom we spoke who deliver babies are Dr. Lazo and Dr. Arey. They are partners in a practice in Galax which delivers approximately 50 to 60 babies per year. Both doctors were interviewed, and expressed their desire to join the Program. However, they feel that the membership fees are prohibitively expensive for them given that they practice in a rural area and perform 50 to 60 deliveries per year. Dr. Judith Goettert, Doctor of Osteopathy in Lebanon, and Dr. Gayle Vest, an obstetrician practicing in Norton, expressed similar concerns. Dr. Vest and Dr. Goettert expressed support for the Program and a desire to become participants, but see the membership fees as very high relative to their incomes. Dr. Vest is in practice with two other obstetricians; the practice delivers 450 to 500 babies per year. According to Dr. Vest, she and her partners "have discussed [membership] a number of times, but we can't afford it." Dr. Vest's practice delivers at three hospitals, all of which are not participants in the Program.

Dr. Arey recommended that the membership fees for obstetricians and family practice doctors who deliver babies in underserved areas be prorated based on the average number of babies delivered each year. Dr. Arey advocated this method of setting fees on the basis that it would be fairer for doctors with smaller practices in rural areas, and because such an arrangement would assist in maintaining the supply of obstetric care in underserved sections of the Commonwealth.

One approach to expanding the Program by increasing the number of beneficiaries would be to amend the current definition of birth-related neurological injury, and reduce the requisite severity level of resulting injuries, in a manner that would increase the number of children who would meet the Program's standards for eligibility. In an illustrative comment, Dr. MacIvor pointed out that "it would be very difficult to change the existing definition, and still maintain the actuarial soundness of the Program." This concern was voiced by both the physicians who felt it best not to alter to definition, and those who were open to doing so. Dr. MacIvor stated that care should be taken not to liberalize the definitional requisites in a way which would

include children who have cerebral palsy that has been caused by congenital factors, and believes that if this were to be done, "it would drain the Fund."

Dr. Vest endorsed expanding the Program by increasing participation among doctors and hospitals, and thereby including more potential beneficiaries. Further, Dr. Vest stated that in order to achieve this expansion of participation, membership fees will have to be reduced. Dr. Vest feels that this approach to expansion is preferable to the prospect of changing the current injury requirements. Dr. Zimmerman feels that because the Program fund has built up, "people are anxious to spend the money." Dr. Zimmerman believes that expansion of the Program should be undertaken after study, and under advisement, and with a view toward protecting the actuarial soundness of the Fund.

Dr. Jones, Dr. Vermillion, Dr. Filak, Dr. Buchanan, Dr. Tchabo, and Dr. Partridge each expressed a cautious openness to amending the requirements for qualifying in order to admit additional beneficiaries. Dr. Tchabo and Dr. Jones advised that those undertaking such discussions should begin by carefully re-examining Program goals, and what the Program is expected to accomplish. This should be followed by an examination of precisely how altering the definition could be executed in order to admit more beneficiaries while maintaining the stated objectives. Each of the physicians we interviewed felt that such a discussion should take place in close consultation with medical professionals, and providers of medical services who are well versed in the needs of babies and children with neurological injuries. Like Dr. Vest, Dr. Mulreany, a pediatrician, felt that the Program should be not be expanded by amending the injury definition, but by increasing the participation of physicians and hospitals.

Dr. Taylor, a pediatric neurologist, was involved with the writing of the current definition of a qualifying birth-related neurological injury. Nonetheless, he was cautiously open to changes in the requirements, but endorsed doing so in a way that would make only minor changes in the prospective number of beneficiaries. Babies and children who are now marginally ineligible may be the only ones whom the Program should consider for inclusion. Dr. Taylor believes that those with oversight of the Program should think about "how to use the Fund to help those with neurological problems who are in need," and that attempting to amend the definition could be quite "awkward." Dr. Pearl, a pediatric neurologist, felt that changing the definitional standards for eligibility is not indicated, and would be prohibitively problematic. Dr. Pearl believes that the "eligibility criteria are appropriate," and that in order to qualify, "a child should be severely and permanently impaired." Dr. Pearl advocated expanding the Program by augmenting the informational network in a manner that will deliver information on the Program to those who would qualify under current standards, but who have not applied because they are unaware of its existence.

Dr. Taylor, Dr. Pearl, and Dr. Filak conveyed their concern with the level of benefits currently available to the beneficiaries of the Program. Dr. Filak suggested that since the number of beneficiaries is quite low, perhaps the Board of the Program feels pressured to be overly generous. Dr. Pearl also voiced questions regarding the current allocation of Program funds,

relative to the number of beneficiaries. Dr. Pearl observed that "the Program has a small number of beneficiaries, and a very large amount of dollars being spent. The appropriation per beneficiary is excessive." Dr. Zimmerman expressed concern that because the number of current beneficiaries relative to the size of the Fund is quite small, there is now inordinate pressure to find ways to spend the Fund balance. Dr. Vermillion pointed out that if one looks at the trend in allocations relative to the size of the Fund, the proportion of the Fund being expended is increasing. Further reinforcing concerns about the level of awareness of the Program, Dr. Pearl advised that the "Program needs to find all the children who should be beneficiaries of the Program." In the view of Dr. Pearl and Dr. Filak, publicizing the Program would raise the number of beneficiaries, which in turn would moderate the amount being spent on each individual beneficiary.

A third topic we discussed with health care professionals was Program fees and assessments. The participating obstetricians who have been members of the Program since the late 1980s pointed out that they have paid higher fees over a longer period of time than those who have more recently opted to become participants. This seemed to be one factor in the opinions of these physicians regarding the reduction of fees, as well as discussion of the possible future uses of the Fund. The consensus among the participating obstetricians was that the size of the Program's assets at this time is the direct result of the membership fees which they have paid. In their view, the Program Fund consists of money that was contributed by medical professionals and hospitals for a specific purpose. For this reason, funds should be utilized to fulfill the objectives for which the Program was founded. Further, the linkage between the membership fees and the need to insulate the Fund from the political process was made clear by the physicians. Current and future decisions regarding the Fund should be carefully circumscribed, so that the Board, with consultation from medical professionals, is the body which decides how the Program funds will be utilized. Dr. MacIvor pointed out that during the previous administration there was talk of using the Fund to cover Medicaid shortfalls. The prospect of entertaining such possibilities was clearly unacceptable to the physicians we interviewed.

A fourth issue on which we solicited the opinions of physicians was the question of why the Program has so few beneficiaries -- considerably fewer than were originally anticipated. A number of the responses reported above have dealt in some way with this. To repeat, the physicians felt that the most logical and available means of increasing the number of beneficiaries in the Program is to increase participation by health care providers. As additional obstetricians and hospitals become members, the number of potential and actual beneficiaries will correspondingly increase. This method of expanding the Program would broaden those whom the Program serves in terms of geographic distribution, and probably also in depth. Furthermore, this method would expand the Program without altering it in terms of original intent and objectives.

A requisite of increasing participation among health care professionals is taking steps to publicize the Program to potential members, as discussed above. A related issue which we

discussed with the physicians was the importance of distributing information to potential applicants. Dr. Vermillion, Dr. Tchabo and Dr. Partridge indicated that they routinely distribute a brochure on the Program to all their new obstetric patients. Each of the obstetricians told us that they would give information to any patient whom they felt may be a candidate for the Program. Dr. Mulreany, a pediatrician, believes there to be a need to improve the communication mechanisms between the obstetric and pediatric communities in a way which will channel more potential beneficiaries to the Program.

In addition, Dr. Mulreany made several practical recommendations for identifying the most effective means of finding possible applicants. She suggested that each Newborn Intensive Care Unit (NICU) in the Commonwealth periodically be sent information on the Program. In all cases where there has been birth asphyxia and/or low Apgar scores, information should be given or sent to the family. Second, Dr. Mulreany recommended that Program information be sent to the Nursing Directors of each of the NICUs. In order to directly reach potential beneficiaries, Dr. Mulreany suggested sending information on the Program to the families of all newborns who go home with Cardia Apnea Monitors, and to the parents of babies with cerebral palsy who have been referred to Infant Stimulation and Early Intervention Programs. Dr. Mulreany believes that these steps would distribute information in a focused manner which would have a good likelihood of reaching those who may be eligible for the Program.

A fifth theme of our conversations with physicians was Program structure and finances. We asked physicians whether they felt the Program should become a Trust, and/or whether it should be clearly identified as an independent State agency similarly to the Virginia Retirement System. We also solicited their opinions on Program staff, the functions of the Program, and whether distribution of literature on the Program to obstetric patients should be mandated by law. Related to the issue of Program finances, we discussed how the existence of the Program has influenced malpractice insurance premiums, and the current and prospective actuarial soundness of the Fund.

As a group, the physicians felt that the Program should either become a Trust, or in some way be legally set aside in a manner which will preclude the possibility of appropriation or reallocation of its funds by the General Assembly. Since the Program's finances have been built upon the fees and assessments made within the medical community, the physicians feel that the direction of the Program should be determined by, and restricted to, the medical needs which the Program was created to meet. Moreover, the physicians feel that the objective of avoiding malpractice suits is a constructive goal which has met its expectation of providing a solution to the insurance crisis of the early 1980s while maintaining the supply of obstetrical services in Virginia.

Several physicians expressed concerns regarding the intentions of the General Assembly vis a vis Program funds. In a comment reflective of apprehensions shared by physicians, Dr. Taylor felt that the "legislature wants to use the Fund's money for other purposes, but politicians should have no access to the Fund." In a similar vein, Dr. Partridge recommended that

"whatever is necessary" should be done "to make the Fund sacrosanct on a permanent basis." Dr. Partridge stated that giving the Program Trust status would protect it from "political incursions," and believes that the Program should also remain a separate agency. Dr. Jones believes that the Program should be "insulated from the political process," and that the General Assembly "should not be permitted to take money from the Fund." Dr. Tchabo stated that, "the Fund should become a Trust because it should not be subject to any tampering by politicians." Dr. MacIvor commented that the integrity of the Program should be protected and that the purposes for which its funds are distributed should be limited to the original goals. Dr. Vermillion endorsed the idea of the Program becoming a Trust, and being "protected as well as possible." Dr. Vermillion also believes that it is appropriate to expand the base of financial support for the Program, and in particular, that insurance companies should be assessed. Dr. Lavigne, an obstetrician who is not a Program participant, and Dr. Lazo, a family practice doctor who delivers babies, and is also not a participant voiced concern for insulating the Fund from the political process. Dr. Lavigne believes there to be "a need to safeguard the money." Dr. Lazo emphasized that the Program fund should be made a Trust, or an independent agency, that the Program needs "excellent financial management," and the State should be careful "not to chip away" at the Fund because the medical care for severely neurologically injured children is so expensive.

With regard to the Program's informational network and the prospect of initiating a newsletter, the physicians expressed strong and unanimous support. A number of these comments have been cited above in the process of discussing how to increase participation in the Program by health care providers, and how to expand the Program by increasing the number of beneficiaries. Suggestions on this topic included publishing newsletters which are targeted toward various segments of the medical community, one that would circulate among beneficiary families, and also distributing general information which will raise awareness of the Program among families of child-bearing age. Each of these ideas was endorsed as a relatively inexpensive yet potentially effective means of better informing Virginia citizens and health care providers of what the Program has to offer.

The Views of Nurses, Nurse-Midwives and Nurses' Representatives

The interviews conducted with nurses, nurse-midwives, and nurses' representatives focused on two central themes. The first was the participation of certified nurse-midwives in the Program. Since certified nurse-midwives are among the medical professionals offering perinatal care, including delivering babies, both physicians and nurses expressed opinions regarding the validity of including midwives. The second theme was the current debate between the medical community and the legal community regarding the future of the Program. This topic has to do with the legal aspects of the Program, such as the cap on malpractice awards, and the implications of beneficiaries giving up their right to litigate when they are found eligible for the Program. Other subjects under discussion in the interviews with nurses, nurse-midwives and nurses' representatives included evaluations of the adequacy of the Program's informational network both among health care providers and for potential beneficiaries, as well as the provision

of perinatal health services in underserved areas of the State.

Joan Corder-Mabe, Jessica Jordan, and Judy Castleman, strongly endorsed the idea that all certified nurse-midwives in the State be permitted to join the Program. Ms. Jordan stated that, "anyone who delivers babies in the Commonwealth should be allowed to participate." Ms. Corder-Mabe and Ms. Castleman echoed the same view. Ms. Castleman expressed concern regarding the expense of membership fees, and conveyed that it is unlikely that certified nurse-midwives would be capable of affording these fees at their present rates. In the interest of increasing the number of participants in the Program and expanding the coverage to areas which are currently underserved, Ms. Castleman suggested that the Board of the Program consider what the appropriate rate of membership fees for certified nurse-midwives should be.

Ms. Castleman represents the Virginia Chapter of the American College of Certified Nurse Midwives in Richmond, and articulated strong support among the members of that organization for such a proposal. Moreover, Ms. Castleman feels that the certified nurse-midwives can make a strong case for their inclusion in the Program on the basis that augmenting the membership of midwives will bring broader coverage under the Program to health professionals who deliver babies. Ms. Jordan and Ms. Corder-Mabe similarly endorsed the importance and potential benefits of offering Program membership to all certified nurse-midwives in Virginia, while requesting that the Board consider ability-to-pay when the membership fees for midwives are established.

Ms. Johnson, Executive Director of the Virginia Nurses Association, informed us of the dialogue that is currently taking place between the Virginia Trial Lawyers Association and various coalitions of the State's health care providers. According to Ms. Johnson and corroborated by Dr. Rebecca Rice, President of the Virginia Nurses Association, and Ms. Corder-Mabe (cited above), this debate has ramifications for the Birth-Related Neurological Injury Compensation Fund because it focuses on the cap on the awards that may result from medical malpractice cases. In order to have a voice in this discourse, the Legislative Coalition of Virginia Nurses has been formed. The Coalition represents over 20 nursing organizations in the State, according to Ms. Johnson, and is monitoring the progress of the dialogue. Ms. Castleman confirmed that mediation between the Virginia Trial Lawyers Association and the health care providers, including physicians, is underway.

Ms. Castleman explained that the Virginia Trial Lawyers Association has informed the medical community that they plan to introduce legislation that will end the $1 million cap on malpractice awards. The health care providers are represented by organizations such as the Virginia Hospital and Health Care Association (VHHA) and the Medical Society of Virginia. The health care groups have circulated draft legislation entitled, "The Catastrophic Injury Insurance Coverage Act." This proposed Act offers a compromise solution in that it would raise the malpractice cap rather than abolish it.

From the standpoint of the Birth-Related Neurological Injury Compensation Program,

this debate could have repercussions. For example, based on what they have learned after conferring with malpractice attorneys, Program beneficiaries have questioned the constitutionality of individuals forsaking their right to litigate in cases that involve personal injury. In addition, physicians expressed to us the importance of this pre-requisite for the viability of the Program, and the value of the Program in terms of providing a no-fault resolution of potential cases and removing them entirely from the tort system.

The interviews with nurses, certified nurse-midwives and nurses' representatives yielded additional suggestions on improving the efficiency of the Program's informational network. Specifically, these sources recommended that the Program consider the nursing community a potential source of information, and develop strategies for utilizing nurses organizations and nurse administrators in hospitals as channels for communicating with nurses. Ms. Jordan felt that certified nurse-midwives could enhance the level of awareness about the Program by incorporating information on it into their educational materials. Moreover, this type of collaboration seems logical in view of the emphasis among certified nurse-midwives on educating women of child-bearing age.

Ms. Jordan and Ms. Corder-Mabe also emphasized the benefits of coordinated action on the part of the Program and groups such as the Regional Perinatal Coordinating Councils, which are vehicles for disseminating information to Health Departments across the State. Ms. Jordan, Ms. Castleman, and Ms. Corder-Mabe encouraged the Program to make efforts to broaden the participation among family practice physicians, particularly those in underserved areas of the State. Increasing membership in the Program by non-obstetricians who deliver babies would, according to these interviewees, have the benefit of making more children eligible for the Program, while providing an incentive for these physicians to offer obstetric services. Those from the nursing community were unanimous in pointing out that it is extremely difficult to motivate obstetricians to move to underserved areas. Therefore, the interviewees advised incentives that would encourage family practice physicians in all parts of the State to deliver babies, and to provide these physicians, as well as midwives, with reasonably priced membership in the Program.

The Views of Representatives of Physicians' Associations

We spoke with representatives of two professional associations whose membership includes physicians who are participants in, or knowledgeable about, the Program. They were Madeline Wade-Abbitt, Director of Legislative Affairs for the Medical Society of Virginia, and Melanie Gerheart of the Virginia Obstetrical and Gynecological Society. Both lobbyists explained that they stay informed on issues that may be pertinent to the Virginia Birth-Related Neurological Injury Compensation Program. We asked for their opinions on how best to expand the Program, the impact of the Program on the medical profession and on the cost and supply of malpractice insurance, and what they feel are the Program's greatest strengths.

Ms. Wade-Abbitt believes that the first approach to expansion of the Program should be augmenting the informational network whereby medical professionals and women of child-bearing age find out about the Program's benefits. Specifically, Ms. Wade-Abbitt endorses the distribution of Program information to all pregnant women by their obstetricians, early in pre-natal care. Ms. Wade-Abbitt feels that if this information is presented, this factor may become a variable in women's choices of doctors; that is, if informed of the Program, women will be more likely to choose doctors who are participants. Moreover, Ms. Wade-Abbitt is aware that the current requirement that Program information be dispensed by obstetricians is neither being followed nor enforced. Ms. Wade-Abbitt indicated that "the Medical Society of Virginia would not be opposed to the strengthening of the law which requires obstetricians to disseminate the brochure on the Program." As a further means of locating babies who may be eligible for the Program, Ms. Wade-Abbitt suggested that the Executive Director of the Program could be given the prerogative to search the records of all hospitals in order to find potential beneficiaries.

In her remarks, Ms. Wade-Abbitt established a linkage between the current informational network of the Program, and her recommendations for expanding the Program. Ms. Wade-Abbitt explained that she would not be opposed to the possibility of investigating opening up the Program to additional children by amending the definitional requirements, but she cautioned that this should be done in a manner which will ensure the continuing actuarial soundness of the Fund. Ms. Wade-Abbitt is of the opinion, that to this point, "we are not finding all the eligible patients," and that for this reason, "the Board must be very proactive in finding these children."

With regard to underserved areas, Ms. Wade-Abbitt believes that maintaining the supply of obstetric services in rural areas is a "delicate balance," and that targeted incentives are needed which will encourage doctors to practice in all parts of Virginia. Ms. Wade-Abbitt feels that the existence of the Birth-Related Neurological Injury Compensation Program is assisting in maintaining obstetric care in underserved areas because of its capacity to provide a no-fault means of settling potential malpractice suits, and because of the Program's provision of excellent lifetime medical care. Ms. Wade-Abbitt explained that she is in contact with doctors in rural parts of the Commonwealth who receive 50 to 90% of their compensation for obstetric services in the form of public assistance funds. For these doctors, and their patients, the Program can provide significant benefits. Therefore, the Program and the State should do all they can to encourage participation by obstetricians and family practice doctors who deliver babies in underserved segments of the Commonwealth.

Ms. Wade-Abbitt feels that the discussion now taking place between the medical community and the legal community regarding the cap on malpractice awards has some implications for the Birth-Related Neurological Injury Compensation Program. Ms. Wade Abbitt feels that the supply of malpractice insurance in Virginia is excellent at this point, and is likely to remain so. Even if the cap on malpractice awards is raised or abolished, Ms. Wade-Abbitt believes there would be no direct effect on the Program. Ms. Wade-Abbitt sees the Program as being statutorily insulated from direct assault by the legal community, although she stated clearly that the Virginia Trial Lawyers Association would be likely to oppose any efforts to improve the

Program, or to open it up to an increased number of beneficiaries.

When asked about the greatest strengths of the Program, Ms. Wade-Abbitt explained that the current statutory requirements direct potential beneficiaries to apply for Program coverage through channels other than the circuit courts. In so doing, the State is providing injured parties with "lawyerless access" to significant benefits. Ms. Wade-Abbitt believes this to be an optimal arrangement because it "expedites these cases, and offers the best possibility for fair decisions."

The second representative of a physicians' association with whom we spoke was Melanie Gerheart. Ms. Gerheart is Executive Director of the Virginia Obstetrical and Gynecological Society, and is also responsible for the Society's activities in the sphere of government relations. We asked Ms. Gerheart what she views as the most pressing current issues for the Program; she responded by affirming, "...it's a great Program, but it needs more beneficiaries." On this point, Ms. Gerheart made several recommendations. First, those responsible for the Virginia Birth-Related Neurological Injury Compensation Program should take a look at the comparable program in Florida. Ms. Gerheart points out that the Florida program "does a lot of outreach, and has a larger program with more beneficiaries." Second, the Program should focus on broader education regarding the Program's existence and its benefits, and focus these efforts toward patients and physicians. Third, the Program should make sure that there is "a steady stream of information going to everyone in the State." Fourth, in order to implement these recommendations, Program staff will need to be increased. Fifth, at least one additional person on Program staff should have the responsibility of coordinating a "concerted information outreach which will extend to physicians, nurses, hospitals administrators, and insurance companies." In each case, the information going to each of these audiences must be appropriately targeted and delivered.

Ms. Gerheart believes that the Program should promote itself to insurance companies by showing them that it can save money. As a means of increasing participation among physicians, insurance companies should also be encouraged to offer incentives to their subscribing doctors to become members of the Program. Echoing the opinions of several of the obstetricians interviewed, Ms. Gerheart endorsed the idea that the insurance companies offer a discount to doctors who are Program members, which will at least offset the fees being paid by physicians for membership. Ms. Gerheart feels that family practice doctors who deliver babies should be one of the focal points for increasing physician participation, and that all obstetricians "should be strongly encouraged to join."

The Views of Coordinators of Residency Programs

In order to ascertain the membership status of resident doctors, and the opinions of those associated with residency programs, we spoke to individuals from Virginia's three medical schools. From Eastern Virginia Medical School (EVMS), we interviewed Dr. Linda Archer, Ph.D., Assistant Dean for Graduate Medical Education. From the Medical College of Virginia of Virginia Commonwealth University (MCV/VCU), we spoke to Dr. John Seeds, M.D., Chair of

the Department of Obstetrics, and Director of the Residency Program for Obstetrics and Gynecology. From the University of Virginia Hospital, we spoke to Dr. James Kitchen, M.D., Director of the Residency Program in Obstetrics and Gynecology.

Dr. Archer explained that the circumstances for the resident doctors of EVMS are substantively different from those of the other two medical schools because EVMS does not have its own hospital. The EVMS obstetric residents do their deliveries in one of three hospitals: Maryview and DePaul, both of which are Bon Secours, and Sentara Norfolk General. Moreover, in any year, a particular resident may be in all three hospitals. As a result, each of these hospitals participates in the Program, and does so in order that the EVMS residents may be covered. Because the EVMS residents use three different hospitals, and the hospitals are Program participants, it is not necessary for all of the supervising physicians to be participants as well, in order for the residents to receive coverage. However, Dr. Archer feels that coverage for the residents under a supervising physicians would be preferable to coverage through the hospital. The reason is that such an arrangement would offer greater flexibility to EVMS obstetric residents to deliver babies in additional hospitals such as Chesapeake General, which EVMS does not use for its obstetrics residents because it is not a Program participant.

At the beginning of our interview, Dr. Seeds explained that the views he was relating are those which were articulated recently in a letter from the Medical College of Virginia Hospital to the Program. In recounting the position of MCV Hospital, Dr. Seeds indicated that after discussion with their legal counsel, the Hospital has elected not to maintain its membership in the Virginia Birth-Related Neurological Injury Compensation Program since 1993 because of the narrowness of the scope of the injuries which are covered under the Program. Dr. Seeds explained that MCV has decided that the current eligibility criteria of the Program with regard to the severity of the injury, and the tightly defined period of injury, would exclude too many infants, and would not impact the Hospital's liability exposure one way or the other. Dr. Seeds offered the opinion that if the definition of "birth-related neurological injury" were expanded to increase eligibility, the Program could become more beneficial. When asked about how the definition should be altered, Dr. Seeds responded that this should only be undertaken with great care.

Dr. Kitchen mentioned at the beginning of our interview that, before speaking with us, he had conferred with several colleagues who are also involved with the obstetric residency from at the University of Virginia Hospital. Dr. Kitchen explained that the Hospital participates in the Program, and therefore, the obstetric residents receive Program coverage. Dr. Kitchen expressed the opinion that those involved with the residency program at the University of Virginia Hospital would prefer to see the residents covered, as they are now, by the Hospital, rather than through the supervising physician. Further, Dr. Kitchen indicated that he serves on the Professional Liability Committee of the Medical Society of Virginia, and is a proponent of the Society's view that expansion of the Program should be sought through improvement of the Program's informational network.

The question of the participation fees for medical residents has been raised. Currently, these fees are waived for residents in participating hospitals, but not in non-participating hospitals. The issue is whether, for residents in these non-participating hospitals, fees should be waived if the resident is functioning under the supervision of a participating physician. In our view, since the participation requirement for potential beneficiaries is now met by either the hospital or physician being a Program participant, it is consistent that residents' fees be waived if either the hospital or the supervising physician is a Program participant.

The Views of Former Board Members

In the process of this study, we interviewed two former members of the Board of Directors of the Virginia Birth-Related Neurological Injury Compensation Program. These two members served as citizen representatives from 1990 to 1996. They are: Mrs. Leslie Barnes Hagan and Ms. Malea J. Kiblan.

Mrs. Hagan began by informing us that, during her tenure on the Board, she was the only person on the Board with a child who had suffered severe birth-related neurological injuries. Mrs. Hagan's child was born before 1987, and is not disabled to the point that he would be likely to qualify for the Program. Mrs. Hagan has also served on the Alexandria School Board for eight years, as well as on the Special Education Advisory Committee in Alexandria. Mrs. Hagan's strongest recommendation for the Program had to do with the composition of the Board. She endorsed the idea that the Board should include a person who is a parent of a special needs child. Mrs. Hagan explained that while serving on the Board she was occasionally able to explain the validity of requests being made of the Board by beneficiaries. As Mrs. Hagan pointed out, "having a special needs child is not something you can learn about by reading a report or a book." Further, Mrs. Hagan feels that, hypothetically, the parent of a special needs child on the Board should not be the parent of a beneficiary. Mrs. Hagan indicated that the Board of the Program and the General Assembly may want to consider having a parent of a beneficiary as a representative to the Board, but that this should be considered as an issue separate from appointing the parent of a special needs child as a Board member.

With regard to expansion of the Program, Mrs. Hagan offered several recommendations. First, Mrs. Hagan feels that "it is ridiculous that there aren't more children in the Program. Parents of potential beneficiaries need to be informed of the Program by their pediatricians. In order to accomplish this, the Program needs additional budget and staffing." Second, Mrs. Hagan recommended that the Program communicate with all public school systems in the State. Through various school census initiatives, the public school systems are usually aware of the special needs children in their districts. Third, and more specifically, Mrs. Hagan would like to see the Program make contact with all the special education programs in Virginia. In short, Mrs. Hagan believes that if the public school systems were aware of the Program, they would be an excellent source of referrals of potential beneficiaries. Fourth, Mrs. Hagan endorsed a concerted and professional public relations outreach by the Program. As above, pediatricians should be considered an important source of information to potential beneficiaries since obstetricians and

hospitals are often not comfortable talking about the Program for various reasons. Mrs. Hagan would support the Program putting out an RFP for a public relations company. Fifth, Mrs. Hagan suggested that the Program do outreach to all local government offices, and provide such offices with appropriate literature on the Program. In short, Mrs. Hagan feels that implementation of these recommendations would save money in the long-run, and most important, contribute to increased utilization of the Program.

When asked about changing the definition of "birth-related neurological injury" in order to expand the Program, Mrs. Hagan felt that the "definition could be loosened a little." Perhaps the definition could be rewritten to provide for the eligibility of children who are semi-ambulatory. Mrs. Hagan pointed out that children in this condition often require as much or more care than a child in a vegetative state.

With regard to protecting the actuarial soundness of the Program, Mrs. Hagan believes that the "Fund should be actuarially protected for the long-term." Similarly to the majority of the physicians interviewed, Mrs. Hagan linked this point to the possibility of changing the definition, and stated, "I am very leery of loosening it up too much because then the Program funding and the Program's mission could be corrupted. The Program is a wonderful idea, and it must be continued. The Program has to be financially independent and cannot become enmeshed in politics. It should be made a Trust, or otherwise protected."

Ms. Kiblan sees the impact of the benefits which the Program provides to beneficiaries as a crucial source of quality care for babies and children with severe neurological disabilities. Ms. Kiblan strongly endorses the capacity of the Program to provide for the beneficiaries through channels established by the Act, rather than through the court system and litigation procedures. She does not agree with the current cap of $1 million on malpractice awards, and pointed out that in the cases of those served by the Program, even an award in excess of $1 million would not be able to provide the breadth and quality of care which is made available through the Virginia Birth-Related Neurological Injury Compensation Program.

When asked about the current number of beneficiaries and how the Program might be expanded, Ms. Kiblan referred to the informational booklet which the Program developed with guidance from the Board. Ms. Kiblan indicated that distribution of this booklet should be encouraged in order to publicize the Program as broadly as possible. In particular, obstetricians and hospitals who participate in the Program should make the booklet available to all obstetric patients. We asked Ms. Kiblan whether she feels the Program might be constructively expanded by amending the current definition for the degree of disability. According to Ms. Kiblan, if this is being considered, the matter should be referred to medical experts who could give advice on rewriting the definition, and the potential ramifications for the Program.

Concluding Comments and Recommendations

A primary conclusion that emerges from the interviews detailed in this Chapter is the

importance of the participation of physicians and nurses to achieving the goals of the Virginia Birth-Related Neurological Injury Compensation Act. Membership in the Program on the part of the delivering physician constitutes a sufficient condition making it possible for an infant who has experienced a severe birth-related neurological injury to become an eligible applicant to the Program. As such, the physicians' knowledge about the Program and their motivation to disseminate information can be key factors in raising public awareness of the benefits of the Program and bringing more injury-eligible babies under its coverage. As noted early in this Chapter, the physicians interviewed for this study expressed unanimous support for steps which will increase the number of participating physicians across the Commonwealth, in order to increase the success of the Program in achieving its objectives, as these objectives now stand.

The physicians interviewed for this study unanimously agreed that the Program should either be made a Trust, or in some way securely insulated from the political process. As this Chapter has delineated, the physicians' strong preferences for increasing the scope of the Program are to bring in fully eligible babies whose families are uninformed about the Program, and, with probably greater impact on the beneficiary population, expand coverage by increasing the physician and nurse-midwife participation rates. Various recommendations have been offered as to how these objectives might best be accomplished.

While it was the position of the physicians we interviewed that children with severe birth-related neurological injuries should remain the target group which the Program serves, there was some openness among them as to the prospect of amending the requirements for eligibility from the standpoint of the severity of the injury. However, over all, the physicians, nurses, and former Board members felt that this should be approached cautiously, and only after efforts have been made to pursue the other approaches.

From the nursing community, we interviewed nurses, nurse-midwives, and nursing representatives. A dominant recommendation from the physicians, nurse-midwives and nursing representatives was that certified nurse-midwives across the Commonwealth should be permitted, and encouraged, to join the Program. Certified nurse-midwives in underserved areas of Virginia are now able to become members, and the interviewees endorsed broadening the membership among this segment of health care professionals. Three of the obstetricians interviewed voiced the same suggestion. Concern was expressed on the part of the nurse-midwives and nursing representatives regarding the ability of nurse-midwives to pay the current membership fees. Accordingly, nurse-midwives recommended that consideration be given to moderating the membership fees for nurse-midwives who wish to participate.

The opinions offered by members of the medical community in this Chapter confirm those gathered in interviews with beneficiaries, and together they highlight the importance of improving the informational channels regarding birth outcomes and the Program. The perspective gained from the cumulative experience of 21 beneficiary families (Chapter 5) with regard to when and how they were first informed of the Program indicates that the Program's current informational network is not functioning effectively. The data collected through the

interviews, which appear in Chapter 6, confirm those conclusions and provide additional understanding of the inefficiencies in this network. An effective informational system has two requirements: first, that those hospitals and physicians providing obstetric and pediatric services generate complete and accurate information about severe adverse birth injuries, and that this information be disseminated to the Program to enable it to locate and contact all potential Program beneficiaries; and, second, that information about the Program be distributed effectively to those who provide services to mothers and infants before, at the time of, and after birth, and that they, in turn, also provide this information routinely and pointedly to all expectant parents.

Several forums in which information transfers occur have been mentioned: Information regarding a negative birth outcome first comes to the attention of the parents, the delivering doctor, and the attending medical staff. On the basis of the initial medical assessment that takes place in this context, we have raised the possibility of requiring hospitals to report such outcomes. We also have observed the need for augmenting the dissemination of information within the medical system. For example, we have cited the potential benefit of strengthening communication between obstetricians, on one hand, and pediatricians and pediatric neurologists, on the other. Third, the channels by which information flows from health care practitioners to the families of possible beneficiaries should be targeted as an area requiring additional attention. Examples here include pediatricians, pediatric neurologists, physical therapists, and social workers. In short, the interviews with individuals in the medical community corroborate the findings from the beneficiary interviews by indicating that all of these informational channels must become focal points for specific improvement. If all of these informational channels were functioning effectively, the Program would be notified of the needs and condition of potential beneficiaries with much greater efficiency, and would then be able to contact their families; and these families would have become knowledgeable about the Program, making for a two-way link between the Program and the families and children it is designed to assist. Implementation of these recommendations will directly address the current underutilization of the Program.

On the whole, the physicians, nurses, nurse-midwives, and nursing representatives with whom we spoke expressed strong support for both the goals and implementation of the Virginia Birth-Related Neurological Injury Compensation Program. The Director of Legislative Affairs for the Medical Society of Virginia, the Executive Director of the Obstetric and Gynecological Society, the former Program Board members, as well as various health care practitioners, endorsed the Program undertaking a concerted and appropriately targeted public relations and informational campaign. As we have reported, several suggestions were made that, in the view of the interviewees, would refine and improve the Program. However, the capacity of the Program to obviate malpractice suits, to prevent malpractice insurance premiums from becoming prohibitive, to help guarantee the availability of malpractice insurance, and indeed, to maintain the supply of quality obstetric care in the Commonwealth, were recurrent themes that frequently arose in the course of these health care professionals explaining their support for the Program.

Chapter 7
Strengths and Weaknesses of the Program: The Views of Hospitals, Insurers, and Lawmakers

In addition to the views on the Virginia Birth-Related Neurological Injury Compensation Program held by beneficiary families (Chapter 5) and physicians, nurses, nurse-midwives, and other health care professionals (Chapter 6), those of others directly or indirectly affected by it, or with strong interests in its internal operations and overall effectiveness, are important to this assessment of the Program. To gather these perspectives, interviews were conducted with a sample of hospital officials, insurance company representatives, and members of the Virginia General Assembly. Their viewpoints for the most part reinforce the points that emerge from the quantitative evidence presented in Chapters 2 and 3, and the subjective evidence in Chapters 5 and 6. These interviews also generated additional insights that, beforehand, had not been apparent.

Most of the individuals contacted provided helpful views -- often at considerable length -- about the Program. Our hope was that these conversations be as candid as possible and, as a result, the interviews were conducted on a "not-for-attribution" basis. Hence, in this Chapter we summarize what we learned from the interviews, using verbatim quotations when useful, but no specific remarks are attributed to interviewees by name. For most of the questions asked, there was not significant disagreement *within* the relevant constituencies. Thus, any specificity lost by not directly quoting individuals is more than compensated, we believe, by the frank and open nature of the conversations. On average, the interviews lasted from 45 minutes to one hour. The questions used for these interviews and related information about the interviews are provided in Appendix 7-1 and Appendix 7-2.

Although the contents of the interviews with different constituencies overlap, we summarize their perspectives sequentially, beginning with the hospital officials, and then proceeding with the insurance company executives, and the lawmakers. This Chapter closes with recommendations for changes in the Program offered in these interviews.

The Views of Hospital Officials

The hospital officials with whom we spoke tend to view the Program favorably overall, but still believe that there is substantial room for improvement. The following comments are representative: "I think that the Program is working pretty well, and it appears to be managed well. I hear concerns about eligibility, but for infants admitted into the Program, it is very effective." "It's a good program, even though it may not be fulfilling all the goals that were envisioned for it."

Many of the hospital officials suggested that the low number of beneficiaries, combined

with the size of the Fund, indicates that the definition of "birth-related neurological injury" should be expanded somewhat. Asked one, "Why should hospitals and doctors continue paying into the Fund when such a large surplus exists?" They suggested that the eligibility definition be expanded. As one hospital official observed, "in my time here, we've had maybe three or four infants with cerebral palsy. The severity of those cases was not even close to meeting the definition. Not even close. The requirement is for total impairment. A baby can be severely impaired and not meet that definition." According to another official, "the hospitals have been putting money in but there's not been much access. The criteria are too stringent, although some changes have been made to open it up." For the most part, the hospital officials we interviewed thought that expanding the definition would be a desirable way of increasing the effectiveness of the Program.

One individual also suggested that a revised eligibility definition should permit partial benefits for less severely-impaired children, but with conditions that might become more severe over time. She recalled one child who did not meet the existing definition, but who was profoundly impaired. The parents lacked the resources or knowledge to provide a sufficiently high standard of care and the child's condition deteriorated. The level of developmental impairment often is not apparent for three or four years. Thus, providing selected benefits to a broader class of injured infants early in life might prevent more serious impairments later on.

The hospital officials also mentioned that another reason for the low number of beneficiaries may be informational. Families are provided with a short brochure about the Program during pregnancy, but it is just a small part of the reading material they receive. More important, few parents-to-be are likely to give serious attention to a program for fundamentally impaired infants, given the natural expectation for a healthy baby. As a result, information provided to parents prior to the birth is unlikely to make an effective impression.

The hospital officials were asked whether or not the relevant obstetrician can be relied upon to inform parents about the Program following the delivery of a potentially eligible baby. The comments of one individual are particularly instructive. "Special skill is necessary to confidently and competently talk about unexpected outcomes. Physicians take these births very personally. Society deals poorly with failure and death. When a severely compromised infant is born, physicians know they are a potential target. It's hard for them to sit down and talk about the matter with the parents. To talk about cause comes close to talking about fault." Another hospital official observed that parents are more likely to learn about the Program from a pediatrician or other physician who treats the child after birth, than from the obstetrician. These respondents offered the opinion that, perhaps because of the imperfect informational channels between physicians and families, most families appear to learn about the Program from their contact with the tort litigation system. Moreover, as we shall see, there are specific economic factors that can account for why plaintiff's attorneys may not be inclined to give potential beneficiaries a positive initial explanation of the Program.

Little consensus emerged in our interviews about how to best reach potential beneficiaries. One individual suggested the use of extensive public service announcements about the Program, and perhaps greater reliance on the existing network of child health care advocates in Virginia. But another hospital official argued that strict reporting requirements may be the only adequate solution to this problem. Perhaps hospitals should be required to inform the State and the Program, when children are born with impairments potentially covered by the definition. The hospital officials we spoke with complained that they already are awash in reporting requirements, but as one commented, "one more probably wouldn't make much of a difference."

According to the hospital executives, decisions on whether or not to participate are mostly based on the benefits and costs to their organization. The benefits are the monetary gain of reduced medical malpractice insurance premiums, and the psychic gain in helping the families of birth-injured children cope financially. The costs are in terms of the assessment fee. Most hospitals calculate that the probability of delivering a child that fits the current eligibility definition is so low that the benefits of participation fall well below the costs. The hospitals that do participate are likely to be (1) facilities that deliver a large number of infants, and also are characterized by a relatively high levels of acuity -- that is, the risk factors associated with delivering a severely impaired baby are particularly prominent in their patient population; (2) hospitals that participate as a service to obstetricians, eliminating their need to participate in order for injured babies to be Program eligible; and (3) hospitals that derive a large, if intangible, "psychic" benefit from the practical and altruistic purposes of the Program on behalf of others.

Interestingly, prior changes in the Statute aimed at opening up the Program to more infants may have reduced incentives for hospitals to participate. Early in the Program's existence, when both the hospital and the attending obstetrician were required to be participants for a child to be eligible, some hospitals joined the Program because such participation was necessary for their physicians, as well as the injured babies, to be covered. However, after the Statute was amended in 1990, hospitals or obstetricians could be "free riders" in the Program if the other were a participating provider. As a result, the pressure from physicians for hospitals to participate apparently has declined markedly, with the result that hospitals -- particularly those whose participation occurred in response to this pressure -- are now less likely to join in the Program.

The hospital officials did not express firm views about issues relating to the administrative design of the Program, for instance, whether or not it should be transformed into a Trust, or be identified as an independent State agency akin to the Virginia Retirement System. For the most part, they perceive that the Program is well-intentioned and efficiently managed. Their primary concern is the restrictive definition. In their view, for the Program to achieve maximum effectiveness, the number of infants receiving benefits needs to be significantly increased, and they see modification of the injury definition as the most logical and available means of achieving this objective.

The Views of Insurance Company Executives

Overall, the insurance company representatives we interviewed spoke highly of the Program. Interestingly, there was some disagreement here about whether it should be substantially expanded through a more relaxed definition.

As we have described, the Program was created in the late-1980s as part of efforts to induce the Virginia Reciprocal Group to resume writing new medical malpractice insurance policies for obstetricians. The position of the Reciprocal was that offering such policies only would be worthwhile to them if the worst birth-related neurological injuries were removed from the tort system. At the time, the St. Paul Fire & Marine Company viewed the issuance of such new policies as profitable, even without the existence of the Program. One individual's view was that the company was then unable to write new policies in this area because of the "press of other business."

Is the Program still necessary to ensure adequate medical malpractice insurance access in Virginia? There is some disagreement here. Most of the representatives of the insurance industry we spoke with view it as a valuable device for avoiding a recurrence of the malpractice insurance crisis of the 1980s. However, certain of the officials did state that, absent a return to such market conditions, Virginia obstetricians would have access to liability insurance with or without the Program. The supply side of medical malpractice coverage in the Commonwealth is now relatively strong. In addition, the $1 million per plaintiff cap places a ceiling on liability that the companies can handle. One individual commented, "In the early 1980s, the insurance carriers saw heavy losses and some left the market. By the mid-1980s, there was a real availability problem. Those who stuck it out and took the heat made money in the 1990s. And now those who left have reentered the market. It's a cyclical business, moving from soft to hard markets every 10 to 15 years. In the current soft market, the Program doesn't have that much of an impact on availability, but it might in a hard market."

Other insurance company officials echoed these points, "The Fund is not irrelevant to the supply of insurance in Virginia. It has had an impact on the insurance industry, by making companies more willing to write medical malpractice policies. The Fund has not been a failure." However, one interviewee emphasized that his Company views the possibility of damages due to birth-related neurological injury cases as "...part of the business of writing insurance." The Company is willing to deal with such risks, and does so in the states where a birth-related neurological injury compensation program is not in existence. Further, this individual did not believe that the reduction in medical malpractice rates that occurred in Virginia following creation of the Program was due to passage of the Virginia Birth-Related Neurological Injury Compensation Act. According to this insurance executive, similar reductions concurrently occurred nation-wide.

Under the current statutory provisions for the Program, insurance carriers in Virginia may be asked to pay an assessment into the Fund should this be necessary to maintaining the Fund on

an actuarially sound basis. We asked the insurance company executives with whom we spoke for perspectives regarding the appropriateness of the State having "fallback authority" to assess insurance companies if this should become necessary. One insurance company representative was of the opinion that insurance companies could live with the provision as it now stands, but would be equally happy without it. This person indicated that the provision was hammered out after extensive debate with insurance companies. As the Act currently stands, all insurance companies, not only those involved in medical malpractice, can be assessed a fee. This individual believes this to be fair because the issue of a birth-related injury is largely a social one, not a problem or fault of the medical community. Further, this person expressed concern regarding the potential for increases in physician insurance rates if only those insurance companies writing medical malpractice insurance were assessed. A second insurance company executive expressed similar views, and pointed out that the main opposition to the current fallback provision comes from insurance companies who write little or no medical malpractice insurance. With regard to the appropriatenesss of the provision, this second person affirmed the belief that the risk of future assessment on insurance companies being made is quite slim, but that the provision affords a necessary degree of protection to the Fund. An executive of a third insurance company offered the view that the provision could be removed from the statute, since the size of the Fund's assets make such a provision totally unnecessary at this time.

One official argued that the primary public policy rationale for the Program's continued existence is equity for the affected families. Reliance on the tort system would compensate a few families at a high level, but many more would receive highly limited, or even no, compensation for the injuries to their children. Under the Program, there is an increase in the number of families who receive benefits. In addition, the Program provides medically-necessary benefits throughout the life of the child, and, combined with income-loss benefits beginning at age 18, the total compensation is likely to be far in excess of the $1 million cap on medical malpractice tort awards in Virginia. However, under the Program, the costs of this compensation are primarily borne by physicians (non-participating and participating) and participating hospitals, regardless of fault, rather than targeted on the individuals and facilities responsible for the injury.

Concerns were raised by insurance company respondents about the process through which potential cases are admitted to the Program. Beneficiaries, more often than not, enter the Program as a byproduct of the tort system. A family decides to sue the doctor and/or hospital, because they believe their child was unnecessarily and avoidably injured during the birth process. Attorneys for the affected insurance company respond by arguing that the case may fit the definition of the Program and that, before litigation proceeds, it should be forwarded to the Program to settle the issue of eligibility. If a child fits the definition, the parents cannot pursue action via the tort system.

Insurance representatives have argued that the reference of a case to the Program for consideration of eligibility should be automatic, and not subject to the discretion of the presiding judge. A representative of the insurance industry contends that there are half a dozen or so pending cases that may qualify for the Fund, but are going to Court (see Appendix 2-9, part 1,

paragraph 2). The representative continues: "There has to be a judgement that the trial court is an improper jurisdiction, and courts can be reluctant to dismiss these cases. The process (referring potentially eligible cases to the Program for consideration) needs more teeth. If a case involves a birth-related injury, it should go to the Fund first and automatically for a decision (about eligibility)."

As mentioned, there was some disagreement among the insurance company respondents about whether there should be an expansion of the definition for acceptance into the Program. Most of these individuals did argue that such an expansion is necessary. One commented, "When the Fund was created, the thought was that the numbers (of beneficiaries) would be much higher. As the Fund commenced, people were naturally hesitant to rewrite the definition. There's a learning curve. People were concerned about the 'flood to come.' Over the past three years, it's apparent that there is no flood. So now let's take some aggressive, pro-active steps."

It has been argued at several points in this Report that there are injury-eligible children who are not in the Program, and that the Fund balance probably is sufficient to provide benefits for these children. A related question, highlighted by the findings of the interviews with insurance company representatives, is how many marginally-ineligible children there are, that is, those who are severely injured but not to a degree which would qualify them for the Program under the current injury definition. According to these anecdotal data, a relatively small number of babies fall into this latter category. As one insurance representative observed, "[My company] insures about one-third of the hospitals and one-third of the doctors. Based on medical malpractice actions, we should see about one-third of the cases that come close to the definition, but don't make it for whatever reason. The changes in the definition we're talking about -- I think that they might pick up five or six babies per year."

Other insurance company officials agreed with this estimation. Injuries even close to the magnitude covered by the existing definition are very rare, and incremental relaxations of the definition should not lead to an avalanche of new beneficiaries. Still, one of the insurance company officials emphasized that the Commonwealth should be very cautious about making major changes in the definition. In his view, there is no way to know for sure what the impact of such alterations will be.

The insurance company representatives also observed that the decisions of doctors and hospitals regarding whether or not to participate are largely based on benefit-cost criteria. Remarked one person, "It's a financial issue for them. The chief financial officer is going to ask 'What am I getting by participating?' It's a monetary issue. What's the chance of a law suit? You need to demonstrate to hospitals that there are real benefits from participating." In this view, another advantage of expanding the definition would be to make participation beneficial for more hospitals, potentially increasing the participation rate and the flow of money into the Fund.

As with the hospital officials we interviewed, the insurance company representatives felt

that potential beneficiaries often lack information about the Program and that disincentives may exist for the attending obstetrician to adequately inform parents about the Program. One attorney observed that discussing the Program with a family could weaken a physician's defense during future litigation. Suggesting that the parents contact the Program can be portrayed as evidence that the obstetrician views the injury to the child as birth-related. If the request is then turned down by the Program because the child does not fit the definition for other reasons, the case may end up in the tort system. At that point, the physician's act of informing the family about the Program may preclude defense attorneys from arguing that the injury was congenital, rather than birth-related. If the injury was congenital, plaintiff's attorneys may ask, why did the physician refer the case to the Program to begin with? These and related disincentives make it difficult to rely on physicians to forward cases directly to the Program. According to an attorney, one partial remedy might be to make such referrals inadmissible as evidence in a law suit. Of course, trial lawyers clearly would have concerns about immunizing these doctor-patient discussions.

The insurance company representatives believe that the Program is efficiently administered. However, one individual we interviewed suggested that the Program needed additional staff assistance, primarily to more aggressively seek out potential beneficiaries. This person urged that "anything to capture more of these children should be done," including adding staff.

The Views of Lawmakers

Members of the Virginia General Assembly have a valuable perspective on the Virginia Birth-Related Neurological Injury Compensation Program. Lawmakers played a key role in creating the Program, as well as in implementing reforms in 1990 and 1994. Certain legislators hear from important Program constituencies -- insurers, health care providers, and beneficiaries -- about problems they perceive with the Program. Because the General Assembly has oversight responsibilities, lawmakers who follow the Program are a significant source of information regarding Program design and operations. And, of course, any meaningful restructuring of the Program must pass muster with the Legislature.

Members of the General Assembly are mostly favorable in their comments about the Program and its administrators. None of the legislators we spoke with favored abolishing the Program, or even mentioned abolition as a viable option. The information lawmakers receive about the Program tends to come from the insurance and hospital industries and the Medical Society of Virginia. Legislators are likely to learn about the Program when it becomes part of the overall legislative agenda. Remarked one Senator, "about 90% of the contacts I receive (about the Program) are from one of three groups -- trial lawyers and the insurance and medical industries. Every now and then I might hear about it from a local doctor or lawyer." For the most part, the legislators are familiar with the events that led to the creation of the Program, are familiar with the concerns of the key constituency groups, know about the large Fund balance, and believe that more steps should be taken to inform potential beneficiaries about the Program.

Among legislators, there also is a general sense that the definition could be expanded somewhat. The following comments are representative. "I try to think about how I would feel if I had a child who was born with severe impairments -- if the child was almost a vegetable -- and I had no place to turn. These children require 24 hour a day care. The costs are huge. If we can help these families, we should do it." Another lawmaker remarked that "Concerns have been raised because the Fund has grown to a high level and very few babies qualify for compensation. I've heard complaints that the qualification requirements are too narrowly drawn.... They should be loosened." One Senator observed that "the definition is still too restrictive. Many injuries are slipping through the cracks that were intended to be covered. The Fund is more than actuarially sound now. The criteria need to be opened up."

Other legislators commented that the low participation rate for hospitals was largely due to the restrictive eligibility definition: "If some changes aren't made [in the definition], this thing may go belly up. When it started, a lot more hospitals participated. But the participants are starting to see problems with the Fund and they're dropping out. People believe in this Program, but it's not working properly. Open it up and more hospitals will participate."

One lawmaker asked why participation is not mandatory: "I don't understand why not participating is even an option. If it's a good program, participation should be required. Make it mandatory and lower the fees. That would simplify the program and make it iron clad." However, there was not general support among the lawmakers we interviewed for requiring participation, either for hospitals or physicians, and one delegate urged against further reductions in the assessment fees: "I would be reluctant to significantly lower the payments. We can always broaden the definition as the money accumulates. But I fear lowering the payments because it would be a fight to get them back up if necessary."

A number of the legislators expressed concerns that attorneys were discouraging the families of potential beneficiaries from applying for benefits. These lawmakers spoke in blunt terms about the disincentives that attorneys face: "In a lot of these cases, the parents go to an attorney. The attorney's interests are not served with a no-fault system in which they get paid on an hourly basis. If a tort case settles, they get 35 to 45% of the award. There's a tremendous economic motivation for attorneys to steer their clients away from the no-fault system." Remarked one Delegate, "talk about medical malpractice, well, I'm aware of instances of almost legal malpractice -- attorneys all but discouraging families from contacting the Fund."

According to the legislators with whom we spoke, formal oversight of Program administration by the General Assembly is minimal. Legislators mostly are willing to delegate that function to the Program Board. One lawmaker remarked that it might be useful for the Program to report more systematically to the General Assembly, but there appears to be little desire among lawmakers for substantially more information about Program functions. For the most part, they view it as a secondary state Program that serves a deserving group of people. They feel that it *may* still be necessary to ensure adequate access to medical malpractice insurance for obstetricians in the Commonwealth. Lawmakers want the Program to be run as

efficiently as possible, and they view the size of the Fund balance as an indicator that the flows of money into and out of the Program need to be better aligned.

As mentioned, for most lawmakers, most constituent contacts tend to be from doctors or hospitals. However, one of the legislators did report hearing from a number of beneficiary families, who expressed complaints about certain specific benefits requests that had been turned down by Program administrators: "I've had some complaints [about Program administrators] from parents, who are under extreme stress. It may be that the Program needs to show a little more empathy toward the families." Overall, such contacts between beneficiaries and legislators are rare. Although this particular lawmaker raised concerns about the "bedside manner" of Program administrators, the legislators we spoke with generally believe that the Program is being run in a manner consistent with the Statute.

Not surprisingly, the legislators were sensitive to the views of the major interests and constituencies directly affected by the Program. They noted that the plaintiff's bar dislikes the Program, and that many trial lawyers would like to see it dismantled. And lawmakers recognize that a primary beneficiary is the insurance industry, because the Fund removes potentially costly legal cases from the tort system. One lawmaker objected to what he views as the insurance industry too often getting its way on these issues. Two other legislators raised concerns about the provision in the Statute providing that all insurance carriers be assessed if the fees collected from physicians and hospitals are too low to maintain the actuarial soundness of the Birth-Injury Compensation Fund. Asked one lawmaker, "why should every citizen in the state with casualty insurance have to pay for coverage for some doctor who has made a mistake?"

Still, all of the legislators with whom we spoke -- whether supportive or unfriendly to the interests of the various constituency groups -- expressed strong support for the Program's continued existence.

Concluding Comments and Recommendations

For the most part, our interviews with hospital officials, insurance company representatives, and state legislators generated qualitative, anecdotal information. Nonetheless, the perspectives of these individuals shed further light on the effectiveness of the Program. More concretely, the following observations surfaced repeatedly:

First, the Program has broad support. Even if, under current market conditions, it no longer is necessary to ensure adequate medical malpractice insurance in Virginia, informed observers believe that the Program continues to serve a worthy and needy beneficiary group.

Second, the small number of beneficiaries, combined with the large Fund balance, is widely perceived as an indicator of significant structural problems in the Program. Few of the people we interviewed argued that the solution is to further reduce the premiums paid by doctors and hospitals. Instead, the general preference was for relaxing the eligibility restrictions,

although it also was generally recognized that all eligible babies probably had not become 'rogram beneficiaries. The informational problem was cited, as well as low hospital (and, to a lesser extent, physician) participation as the reasons for this.

Third, because of the technical nature of these issues, there is little consensus about how the definition should be amended, if it were to be rewritten with the goal of increasing the number of beneficiaries in the Program. However, most observers feel that there is not an extremely large number of marginally ineligible babies, and thus a reasonably lower injury level would not flood the Program with new beneficiaries nor challenge the actuarial soundness of the Program.

Fourth, based on these three observations, the interviews offer consensus that the Program is underutilized and should be expanded. Based on the findings of the interviews with hospital administrators, insurance company representatives, and lawmakers, three means of accomplishing this are offered: (1) a modified injury definition; (2) an improved informational mechanism; and (3) steps that will augment the number and proportion of health-care providers who participate in the Program.

Chapter 8
How Well Does the Program Serve the Purposes For Which It was Established? Answers and Recommendations

The first seven chapters of this Report on the Virginia Birth-Related Neurological Injury Compensation Program have described and analyzed in detail the Program's origins and administrative processes; beneficiaries and participating obstetric service providers; financial structure, status, and management; and the views of beneficiaries, health professionals, hospitals, insurers, and lawmakers on its strengths and weaknesses. Within each chapter and/or at its end, observations and recommendations specific to that subject or from those sources have been offered. The observations and recommendations together apply to every aspect of the Program, and range from details to its conceptual philosophy. Rather than reiterate this very long list, we refer the reader to the specific chapters and the conclusions and recommendations therein.

In this final chapter, we examine the broader objectives of this Report:

(1) To identify the Program's (main) strengths and weaknesses;

(2) To assess the role of the Program in regard to the purposes for which it was created by the General Assembly, namely, resolving the malpractice insurance crisis and promoting quality obstetric services in the Commonwealth; and

(3) To develop recommendations that will result in the increased use of the Program in a manner beneficial to the Commonwealth.

OBJECTIVE 1: The Program's Main Strengths and Weaknesses

Strengths in the "No-Fault" Conceptual Basis of the Program

The Program avoids costly and time-consuming litigation.

There is less uncertainty for victims, providers, and insurers. The outcomes of suits are problematic, often referred to as a "lottery." Program eligibility and no-fault awards are more objectively determined. Equitable treatment of victims is protected.

In the event of a severe, birth-related neurological injury, the possibility of an adversarial relationship between patients and health-care providers is reduced.

The incentives for "defensive medicine" are reduced.

The supply of obstetric services is less threatened.

Strengths of the Virginia Program

Program administrators are responsive, qualitatively and quantitatively, to the needs of beneficiaries and families.

The Workers' Compensation Commission role is performed very capably. Ms. Colville is highly effective in her role in adjudicating claims.

The Fund is sound, with a strong income base and responsible financial management.

Widespread support exists for the Program, both in concept and in its operation, among beneficiaries, hospitals, physicians, nurses, insurers, and legislators.

Weaknesses of the Virginia Program

The greatest weakness of the Program is that it is underutilized, with a beneficiary population that is approximately 30% below our estimates of the injury-eligible children in the Commonwealth. The causes of this underutilization are to be found in the (1) inadequacies in the informational mechanisms and (2) the low participation rates, for reasons that go beyond lack of knowledge about the Program, that apparently leave injured babies in some Health Planning Districts unable to meet the participating-provider requirement, and in other Districts open to the possibility that this requirement might not be met.

Improved informational mechanisms (a) within the health care professions, notably hospitals, obstetricians, pediatric neurologists, pediatricians and other primary care physicians, nurses, and support service agencies, would enhance the identification of birth-injured babies who are likely candidates for Program benefits; (b) between the medical system (particularly, but not only, hospitals and early intervention services) and the Program, would enable potential beneficiaries to be identified for Program outreach efforts; and (c) between the health care system and the families of birth-injured babies would inform these families about the existence of the Program, the benefits it provides, and the likelihood of their babies qualifying for these benefits.

Increased participation in the Program by the providers of obstetric services (obstetricians, hospitals, and primary care physicians and nurse/midwives who deliver babies) would make more, and perhaps all, of the injury-eligible babies Program-eligible.

Other weaknesses include:

Administrative procedures in enrolling and obtaining benefits are time-consuming and complex.

Board and internal mechanisms may not be optimally structured, in regard to financial management and medical expertise in pediatric neurology.

Perceptions exist among some beneficiaries that some families receive better treatment, largely in housing benefits, than others.

It is the view of this Report that the strengths of the Program significantly outweigh its weaknesses; that the weaknesses -- particularly underutilization, the major one -- can be addressed successfully through the specific recommendations offered at the end of this Chapter.

OBJECTIVE 2: Assess the Role of the Program With Regard to the Purposes for Which It Was Created

The Program was created for two purposes, to resolve the malpractice insurance crisis and to promote quality obstetric services in the Commonwealth. We now turn our attention to these specific issues.

The Program's Effect on the Malpractice Insurance Crisis

When the Virginia Birth-Related Neurological Injury Compensation Act was enacted into law in 1987, it was believed that the Act would significantly improve the availability and cost of medical malpractice insurance for obstetric service providers and hospitals. In the ensuing years the "medical malpractice crisis" for obstetrics has at least "leveled off," and seems to have eased. The supply of medical malpractice insurance is strong, as indicated by the presence of a large and growing number of insurers -- 10 with significant shares and as many as 34 others with small shares -- in the total market in the Commonwealth (see Table 8-1 shown on the next page). Mean premium payments (reflecting the product of premium rates and coverage depth) have stabilized in recent years for all physicians and for ob/gyns, throughout the United States and in the South Atlantic region (see Table 8-2). Tables 8-3A, 8-3B, and 8-3C make some strong points about the improving picture for ob/gyns in Virginia since the program began: for two commonly purchased levels of coverage ($100,000/$300,000 and $1 million/$3 million), the worsening cost situation that peaked in the late 1980s had significantly improved by 1994, in absolute dollars (see Table 8-3A), and, in relation to other medical specialties, in all but one case (7/5A: Major Surgery -- Anesthesiology") for both levels of coverage (see Tables 8-3B and 8-3C).

Table 8-1. Market Shares in the Medical Malpractice Insurance Market in Virginia

	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
St. Paul Fire and Marine	45.7	40.2	35.6	48.5	45.9	49.4	42.1	50.0	47.8	43.5	45.3	29.8
Medical Protective Co.	0.0	0.1	2.1	2.0	3.0	4.5	7.1	7.5	8.7	11.7	11.8	14.1
Virginia Insurance Reciprocal	25.0	30.4	35.3	30.8	40.4	34.3	31.5	20.8	19.0	16.2	12.3	10.5
Contintental Casualty Co.	1.9	2.6	3.0	2.1	2.6	0.0	4.6	5.6	5.0	5.2	7.6	5.8
Mid-Atlantic Medical	0.0	0.0	0.0	0.0	0.0	0.0	0.5	2.3	4.0	4.5	4.3	5.8
Transportation Co.												5.5
American Casualty Co.	0.6	0.4	0.6	0.5	0.5	0.7	1.1	1.0	1.5	1.7	1.4	4.5
American Continental	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	4.3
Doctors Co.	0.0	0.0	0.0	0.0	0.2	0.4	1.0	1.6	2.3	4.5	3.7	4.1
Phico Insurance Co.	22.9	22.1	19.1	12.2	2.5	2.6	4.0	3.1	3.5	3.7	2.6	2.9
CR4	95.5	95.3	93.0	93.6	91.9	90.8	89.3	83.9	80.5	76.6	77.0	60.2
CR8	97.6	97.2	97.6	97.7	96.7	94.3	96.6	92.1	91.8	91.1	89.7	80.3
Share of remaining firms	2.4	2.8	2.4	2.3	3.3	5.7	3.4	7.9	8.2	8.9	10.3	19.7
Total number of firms	33	32	33	39	34	34	40	39	44	45	46	44

SOURCE: Calculated from data supplied by the Bureau of Insurance, Richmond, VA.

Table 8-2. Mean Liability Insurance Premium Payments, Annual Liability Claims Per 100 Physicians, and Percent of Physicians Incurring Claims

Year	Mean Liability Insurance Premiums Per Physician ($000's)						Annual Liability Claims Per 100 Physicians			Percent of Physicians Incurring Claims		
	U.S.			South Atlantic			U.S.		South Atlantic	U.S.		South Atlantic
	Ob/Gyn	Total	Ratio	Ob/Gyn	Total	Ratio	Ob/Gyn	Total	Total	Ob/Gyn	Total	Total
1976-81(avg.)							14.0	6.2				
1981-84(avg.)							20.6	8.2				
1982	10.8	5.8	1.9		5.6							
1983	14.0	6.9	2.0		6.1							
1984	19.0	8.4	2.3		8.6							
1985	23.5	10.5	2.2		11.3		25.8	10.2	7.0	20.0%	8.5%	6.3%
1986	29.3*	12.8*	2.3		14.4		13.0*	9.2	7.5	10.9%*	7.6%	6.2%
1987	35.3*	15.0*	2.4		15.5		8.0	6.7*	5.6	6.7%	6.0%*	5.2%
1988	35.3	15.9	2.2		18.4		15.1*	6.4	4.7	14.1%*	5.8%	4.5%
1989	37.0	15.5	2.4		15.6		13.5	7.4	4.8	13.2%	6.6%	4.6%
1990	34.3	14.5	2.4	39.3	15.4	2.6	11.9	7.7	5.7	9.3%	6.6%	4.8%
1991	34.9	14.9	2.3	30.7	13.9	2.2	11.6	8.2	5.4	11.1%	7.5%	4.6%
1992	34.0	13.8	2.5	35.7	13.4	2.7	15.6	9.1	5.6	11.5%	7.9%	5.3%
1993	33.7	14.4	2.3	29.7	13.4	2.2	22.5	9.8	5.8	17.2%	7.8%	5.3%
1994	37.4	15.1	2.5		14.4		19.2	9.5	6.9	14.0%	8.0%	6.1%
1995	38.6	15.0	2.6	33.4	14.6	2.3	20.9	9.0*	8.0	15.7%	7.9%	6.3%
1985-95(chg.)	6.4%*	4.6%*					-2.6%	-1.6%	1.7%	-3.0%	-0.9%	0.0%

SOURCE: Socioeconomic Characteristics of Medical Practice, various years, American Medical Association.

Note: Premiums are not adjusted for inflation.

* Change significant at the 5% level

Table 8-3A. Medical Liability Rates ($'s) for Obstetricians/Gynecologists in Virginia, 1983-1994

	$100,000/$300,000 limits					$1mill/$3mill.limits				
Year	Area1	Area2	Area3	Area4	%ch.	Area1	Area2	Area3	Area4	%ch.
1983	8,822	7,764	5,999	5,999		18,173	15,994	12,358	12,358	
7/1/84	10,559	9,782	7,822	6,648	21.7	23,441	21,716	17,365	14,759	31.2
9/12/85	14,048	13,014	10,407	8,845	33.05	31,187	28,891	23,104	19,636	33.05
7/24/86	15,946	14,773	11,821	10,042	13.53	37,473	34,717	27,779	23,599	20.18
10/1/87	19,472	18,039	14,434	12,262	22.11	45,759	42,392	33,920	28,816	22.11
7/1/88	21,346	19,775	15,824	13,443	9.631	52,084	48,251	38,611	32,801	13.83
7/1/89	16,361	15,158	12,130	10,305	-23.34	39,921	36,986	29,597	25,144	-23.34
7/1/92	17,310	16,036	12,832	10,901	5.784	36,870	34,157	27,332	23,219	-7.656
7/1/94	17,310	16,036	12,832	10,901	0	36,870	34,157	27,332	23,219	0

SOURCE: Bureau of Insurance

Table 8-3B. Ratio of Obstetricians'/Gynecologists' Rates to Other Rating Classes ($100,000/$300,000), 1983-1994

Year	'7/1A	'7/1	'7/2	'7/3	'7/4	'7/5A	7/5	7/6	'7/8
1983		6.61	3.42	2.75	2.30		1.39	1.16	0.67
7/1/84		6.61	3.42	2.75	2.30		1.39	1.16	0.67
9/12/85		7.17	4.86	3.68	2.74	1.86	1.66	1.25	0.79
7/24/86		7.08	4.82	3.66	2.73	1.86	1.66	1.25	0.79
10/1/87		7.05	4.81	3.65	2.73	1.86	1.66	1.25	0.79
7/1/88	8.01	6.49	4.41	3.33	2.68	1.96	1.72	1.25	0.79
7/1/89	7.83	6.38	4.36	3.31	2.67	1.95	1.71	1.25	0.79
7/1/92	7.02	5.70	3.88	3.00	2.41	2.71	1.54	1.19	0.73
7/1/94	7.02	5.70	3.88	3.00	2.41	2.87	1.54	1.19	0.73

SOURCE: Bureau of Insurance

Table 8-3C. Ratio of Obstetricians'/Gynecologists' Rates to Other Rating Classes ($1 million/$3 million), 1983-1994

Year	'7/1A	'7/1	'7/2	'7/3	'7/4	'7/5A	7/5	7/6	'7/8
1983		7.44	3.85	3.10	2.59		1.39	1.16	0.67
7/1/84		7.52	3.89	3.13	2.62		1.39	1.16	0.67
9/12/85		8.16	5.54	4.19	3.12	1.86	1.66	1.25	0.79
7/24/86		7.36	5.01	3.80	2.84	1.86	1.66	1.25	0.79
10/1/87		7.33	5.00	3.80	2.84	1.86	1.66	1.25	0.79
7/1/88	9.31	7.55	5.12	3.87	3.12	1.96	1.72	1.25	0.79
7/1/89	9.10	7.41	5.06	3.84	3.10	1.95	1.71	1.25	0.79
7/1/92	7.05	5.73	3.90	3.01	2.42	2.71	1.54	1.19	0.73
7/1/94	7.05	5.73	3.90	3.01	2.42	2.87	1.54	1.19	0.73

SOURCE: Bureau of Insurance
Based on rates for St. Paul Fire and Marine Insurance Co.

It was mentioned with little elaboration in Chapter 1 that the malpractice insurance crisis probably was the result of many factors, among which suits brought on behalf of babies with severe, birth-related neurological injuries was but one. Other cited contributing causes were suits brought for other degrees or types of obstetric-related injury and relatively high plaintiff success rates and large damage awards in these suits. Additional factors were also thought to be at work: some have suggested that insurers themselves contributed heavily to the increases in premiums through their management practices.[46] The crisis was a national phenomenon, of a cyclical nature, and rose and fell in Virginia as in states that had not addressed the malpractice insurance issue at all. In view of the many factors at work, in our judgment, the Program has not removed enough cases from tort litigation to have made a significant contribution to the improved medical malpractice situation in Virginia. The effect of the 31 cases which were removed seems not to have been a large one. Further, even if all potential injury-eligible beneficiaries were enrolled in the Program, it is doubtful whether there would a discernible effect on state-wide suits, awards, and insurance costs. If there was any special role of the Virginia General Assembly in easing the crisis, it was more through the award limitation on all medical malpractice liability suits -- the so-called "cap" -- than the Program's effect on severe, birth-related, neurological injury suits.

While the Act may not have played a large role in constraining premiums, passage of the Act itself was instrumental in bringing the major insurers back into the Virginia market and lifting the moratorium on new policies. This probably would have happened anyway, but it happened sooner because of the Act, and thus the crisis reached its turning point earlier.

Promoting Quality Obstetric Services in the Commonwealth

The supply of quality obstetric services in the Commonwealth is dependent on the availability of affordable medical malpractice insurance, since physicians cannot be expected to participate in risk-taking activity without adequate risk-pooling. While it may be assumed that improvement in the insurance scene alleviated threats to the supply of obstetric services, it is instructive to examine that supply directly.

Table 8-4 shown on the next page answers many questions about the supply of obstetricians in the Commonwealth. Between 1981 and 1995, the national supply of obstetricians increased steadily, as it did in Virginia. Further, the data show almost constant ratios for the supply of OB/GYNs relative to all physicians, and rising OBG-to-population ratios, both nationally and in Virginia. A last point in these data, a telling one, is that the OBG-to-population ratio in Virginia exceeds the national ratio by about one and a half percentage points, or 10% higher in Virginia in 1995, from equality in 1987.

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[46] Institute of Medicine, Division of Health Promotion and Disease Prevention, Committee to Study Medical Professional Liability and the Delivery of Obstetrical Care, "Summary of Conclusions and Recommendations," Medical Professional Liability and the Delivery of Obstetrical Care (National Academy Press: Washington, D.C., 1989).

Table 8-4. Supply of Non-Federal Physicians, 1981-1995

	U.S.					Virginia				
Year	OBG	Total	Population (000's)	OBG/Total	OBG/Pop	OBG	Total	Population (000's)	OBG/Total	OBG/Pop
1981	25,637	443,502	229,637	0.058	0.112	631	9,682	5,442	0.065	0.116
1982	26,461	460,128	231,996	0.058	0.114	625	10,021	5,489	0.062	0.114
1983	27,602	479,157	234,284	0.058	0.118	651	10,482	5,558	0.062	0.117
1984	28,564	496,947	235,825	0.057	0.121	678	10,848	5,644	0.063	0.120
1986	30,093	528,169	240,133	0.057	0.125	723	11,875	5,812	0.061	0.124
1987	30,571	544,308	242,289	0.056	0.126	748	12,311	5,932	0.061	0.126
1989	32,354	577,605	246,819	0.056	0.131	820	13,299	6,120	0.062	0.134
1990	32,956	592,166	248,718	0.056	0.133	853	13,795	6,189	0.062	0.138
1992	34,602	631,137	255,039	0.055	0.136	932	14,638	6,389	0.064	0.146
1993	34,908	647,008	257,800	0.054	0.135	943	15,008	6,475	0.063	0.146
1994	35,881	660,582	260,350	0.054	0.138	988	15,350	6,551	0.064	0.151
1995	36,962	697,269	262,755	0.053	0.141	1,034	16,362	6,618	0.063	0.156

SOURCES:

For physician numbers, Physician Characteristics and Distribution in the U.S., various years, American Medical Association, Chicago, IL.
For population, Statistical Abstract of the U.S., various years, Bureau of the Census Washington, D.C.

Accordingly, while we are reluctant to offer a causal connection between the operation of the Program and the improvement in both the malpractice insurance crisis for obstetricians and the supply of obstetric services in the Commonwealth, the program at least can be "associated" with the attainment of these objectives for which it was created.

OBJECTIVE 3: Recommendations That Will Lead to the Increased Use of the Program in a Manner Beneficial to the Commonwealth

(1) Expansion of the Program should be sought, but within the present definition of qualifying birth injury.
(2) This expansion should focus on an improved and expanded informational system, and
(3) Increased participation by all obstetric service providers should be sought.
(4) We do not recommend liberalizing the eligible-injury definition at this time.
(5) The issues of housing, income loss, and pain and suffering should be reexamined.

Recommendations Regarding Information

Gathering and disseminating information by the health care professions about birth outcomes that may qualify for the Program, and informing the health care professions and

potential beneficiary families about the Program do not involve separate informational networks. Birth-injured babies, the Program, and the health care professions are inextricably bound together in these cases of severely injured infants. Accordingly, the needed informational instruments are best viewed as components of one integrated system, serving these multiple, but closely related, purposes.

Information about the Program should be provided to each physician. In particular, the specialty organizations for obstetrician/gynecologists and pediatric neurologists should make it a policy to inform and educate members about the Program, and encourage participation.

Information to nurse-midwives and other medical professionals involved in the delivery of newborns should be developed and disseminated, and their participation in the Program encouraged. The participation of nurse-midwives in medically underserved areas should be at reduced fees, based on an ability-to-pay formula, and consideration should be given to permitting nurse-midwives not in underserved areas to participate, also at reduced fees.

Hospitals should be required to report to the Workers' Compensation Commission or the Program all cases of birth-injured babies who may possibly qualify for coverage under the Act. This reporting requirement might be extended as well to the insurance carriers which receive claims and to physicians and nurse-midwives who deliver babies who might qualify.

The reporting of severe, adverse birth outcomes should be strongly encouraged by physicians' and nurses' professional organizations, especially those for obstetricians, pediatric neurologists, and pediatricians, so that potential Program beneficiaries can be fully identified by these health care providers. This information, channeled to the Program, together with that from hospitals, would enable the Program administration to reach out to potential claimants. Receiving and acting upon this information may necessitate increasing the Program staff, which we consider to be a cost-effective administrative expansion. Initial contacts from the Program to families may lead to more babies receiving benefits, and would set a tone of *support* and *mutuality of goals* in regard to the injured children that would make for a strong, trusting relationship over the long term.

Every provider of primary care and obstetric services should be encouraged or even required to give every pregnant patient a leaflet describing the Program. Every provider of obstetric services and every hospital with birthing capacity should be required to provide a leaflet describing the Program to every woman admitted to give birth. In the event that a severe injury occurs during the birth process, this should be followed up by a prompt, complete, and supportive information session about the Program, involving hospital personnel and the physician or nurse-midwife who delivered the baby, before the family leaves the hospital. Some proof (e.g., signature) of the leaflet having been provided is needed. Failure to provide this information might be deemed sufficient to allow a medical malpractice suit in regard to the birth injury, which would provide compelling incentives for insurers to play a major role in the dissemination of information about the Program. (Provision of such information, however,

should be immune from any evidentiary case against physicians and hospitals in medical malpractice suits.) Information might also be made available at other agencies with which the families might be expected to come into contact, such as Medicaid, social services, early intervention programs, and others.

We believe that there must be consistency in the determination of whether birth injury cases fall within the Program's boundaries, and that consistency will best be accomplished if such determination is made by one instrument or process rather than many. Moreover, the designated instrument or process should be one that has extensive experience and perspective in this matter. Accordingly, it is our view that malpractice actions filed in court which may reasonably be viewed as falling within the scope of the Act be routed first to the Workers' Compensation Commission for determination of Program eligibility in the same manner as if the case had been filed first with the Commission. Cases found by the Commission not to qualify for the Program would then be rerouted to the courts.

Recommendations Regarding Provider Participation

For the Program to work well, high levels of provider participation are needed. For it to work optimally, virtually 100% participation of physicians or hospitals is needed. One alternative is to make participation compulsory, which would remove inequities among equally injured babies, but not all of whom have participating obstetricians or hospitals. If all hospitals with birthing units were required to participate and the financial burdens of participation minimized through careful fee determination, virtually every injury-eligible child would be eligible for Program benefits. If all medical professionals who deliver babies in the Commonwealth were to participate, the same protection for injured babies would exist. Of the two alternatives, compulsory participation by hospitals appears less complicated to bring about. At first glance, the costs of participation would fall totally on hospitals, but these costs would largely be passed on to all direct or third party payers of hospital care, and, ultimately, broadly among the population. The end result would be broad social financial support for what essentially is a social problem, the incidence of severely birth-injured babies.

Recognizing that compulsory participation may be politically infeasible, a second alternative is to create incentives strong enough to induce most physicians and hospitals to participate voluntarily.[47] The cost of participation must be made lower than the savings on

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[47] Malpractice insurance discounts for participating physicians range from 10% (St. Paul, Medical Protective) to 12% (Virginia Reciprocal). These discounts have not changed over time. We can apply these discounts to average insurance rates calculated from information supplied by the Bureau of Insurance (Table 8-3A). At a discount of 10%, and assuming $1 million/$3 million limits, insurance premiums for OB/GYNs would be reduced by amounts ranging from $2,320 to $3,690, depending on region. At a discount of 12%, premiums would be reduced by amounts ranging from $2,780 to $4,430, depending on region. Clearly, at least until 1995, there was little financial incentive for a physician to participate in the Program, and since 1995, there remains a strong disincentive for a physician to begin to participate.

insurance to both physicians and hospitals. The best way to accomplish this is to negotiate specific lump sum insurance credits for the *fact* of participation, not credits pro-rated to the *costs* of participation. The Program can then structure participant fees to be lower than insurance credits, providing a financial incentive of sufficient power to generate more complete participation.

Recommendations Regarding Housing, Income Loss, and "Pain and Suffering"

In regard to the linked issues of benefits for housing, loss of income, and pain and suffering, solutions are not easy to formulate. Housing expenses dominate the total benefit cost of the Program, and are a source of contention among beneficiaries. So, too, are loss of income and the lack of payment for pain and suffering.

One can argue, correctly, that the Program is not intended to alleviate all economic effects on beneficiary *families,* but to provide assistance to injured *children.* The interests of these two groups do not fully coincide, and housing meets the needs of the children, while benefits for income loss and pain and suffering are not as easily related to the children's needs. Nonetheless, the Program's Board might consider emulating the Florida Program in this regard, by providing a fixed set-aside, equal for all beneficiaries, in the name of the covered child and administered by the Program, to cover housing costs and, from the remainder, compensate families for other harms and losses, or, as an alternative, a variable, formula-determined set-aside, which takes into account the regional differences in housing and other costs.

Working from these recommendations, we believe the General Assembly can enable the Virginia Birth-Related Neurological Injury Compensation Program to more fully achieve the purposes for which it was created, and to more fully serve the children whom it was designed to assist.

Appendix 1-1.

The Florida Birth-Related Neurological Compensation Program[1]

Legislative Intent: The Legislature determined that "recent increases in.... (medical malpractice) premiums have been greater for ....physicians (practicing obstetrics) than for other physicians." and resolved "to provide a plan designed to result in the stabilization and reduction of malpractice insurance premiums for providers of such services in Florida." (Section 766.301)

Date of commencement of Program: January 1, 1989

Definition: (words in italics indicate differences between the two states with respect to definition):

Florida: "'Birth-related neurological injury' means injury to the brain or spinal cord of a *live* infant *weighing at least 2,500 grams at birth* caused by oxygen deprivation 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 and substantially mentally and physically impaired.* This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality." (Section 766.302)

Virginia: "'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. In order to constitute a 'birth-related neurological injury' within the meaning of this chapter, such disability shall cause the infant to be permanently in need of assistance in all activities of daily living.* This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality, *degenerative neurological disease, or maternal substance abuse."* (Section 38.2-5001)

Thus, the Florida definition is stricter in terms of having a weight restriction but less strict in not requiring the child to be permanently in need of assistance in all activities of daily living -- for example, in the Florida Program, there are one or two children who can walk or eat independently.

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[1] This information is based on conversations with Lynn B. Dickinson, Executive Director of the Florida Birth-Related Neurological Injury Compensation Association and the Florida and Virginia statutes. The focus is on areas where there are substantive differences between the Virginia and Florida programs.

Procedure for filing claims:

In Florida, claims are filed with the Division of Administrative Hearings of the Department of Management Services, which appoints a Judge to make the final determination. (In Virginia, this role is performed by the Workers' Compensation Commission and its representative, Carolyn Colville.) The same Judge is assigned to all of these types of cases.

Each claim is evaluated for substandard care on the part of the physician or hospital (by the Division of Medical Quality Assurance and the Department of Health and Rehabilitative Services) and appropriate disciplinary action taken. The Program is administered by the Florida Birth-Related Neurological Injury Compensation Association. Any claim that the Association deems compensable may be accepted for compensation provided the acceptance is approved by the Judge.

In Florida, each claim filed is reviewed by medical consultants for the Association. The law allows that the medical panel be made up of one pediatric neurologist or neurosurgeon, one obstetrician, and one neonatologist or pediatrician. (In Virginia, the medical advisory panel is appointed by the deans of the medical schools and consists of three "qualified and impartial physicians." The Program and the petitioners typically also present reports from obstetricians, pediatric neurologists, and neonatologists.) In each case the Commission/Judge considers, but is not bound by, the recommendations of the panel. In Florida, if a claimant or the attorney requests this review, the claim is sent to the panel.

Awards:

In Florida and Virginia, all medical expenses and attorney fees are covered with the Program being the payer of last resort. One major difference is that there is no loss of earnings provision in Florida. A second difference is that, in Florida, although the Program has paid for housing modifications it has not (to date) provided new housing. A third difference is that, under the Florida statute, there is an additional provision for "periodic payments of an award to the parents or legal guardians of the infant, which award shall not exceed $100,000. However, at the discretion of the Judge, such award shall be made in a lump sum." (Section 766.31) The purchase of housing is often facilitated by monies from this discretionary award.

Limitations on claim:

In Florida, claims could originally be filed up to seven years after birth. A change in the law in July 1993 reduced the time in which a claim could be filed to five years after birth (10 years in Virginia).

Assessments:

Assessments are administered by the Florida Birth-Related Neurological Injury Compensation Association. The assessment on hospitals in Florida is $50 per live birth. All physicians pay $250; participating physicians $5,000; nurse-midwives $2,500. Assessments have not changed over time. If funds are insufficient, an additional amount up to $20 million can be transferred from the Insurance Commissioner's Regulatory Trust Fund. There is also provision for an assessment of up to 0.25% of the prior year's net premiums written by casualty insurers in the event the Fund is determined to be actuarially unsound.

Participating physicians are frequently given a dollar-for-dollar credit on their malpractice premiums, although this is not a universal practice. As of October 1997, 728 physicians and 85 nurse-midwives participate in the Program. Participation has increased somewhat over the life of the Program.

Approximately 61% of all live births were covered by assessments in 1996.

Management of the Program:

The Florida Birth-Related Neurological Injury Compensation Association consists of a Board of five directors. The directors are appointed by the Insurance Commissioner for staggered terms of three years. They include one citizen representative, one representative of participating physicians, one representative of hospitals, one representative of casualty insurers, and one representative of physicians other than participating physicians. The Board oversees the administrative and financial aspects of the Program in a very broad sense, meeting approximately two or three times a year, or as often as necessary on specific issues.

The administrative office consists of a staff of five full-time and two part-time persons. This staff deals with the collection of funds, and administration and payment of claims. Most decisions relating to payment of medical and other expenses are made by the administrative staff, board consulting physicians, and attorneys representing the Association. Determinations on controversial items are made by the Judge. The Board does not make individual claim decisions or adjudicate on matters related to day-by-day expenses, but makes policy decisions.

Current administrative costs are $600,000 to $800,000 per annum. Funds used to be invested by the Florida Treasury (for a fee). On November 20, 1997, the Board transferred funds to financial managers to oversee the fund.

The Association must estimate the present value of the total cost of a claim within 60 days after a claim is filed (including the maximum for noneconomic damages) and revise these estimates quarterly based on actual costs incurred. In the event the total of all current estimates equals 80% of the funds on hand and the funds that will become available within the next 12 months, the Association is forbidden by statute to accept any new claims without express

authority from the Legislature.

Actuarial reviews are ongoing on a quarterly basis. Recent actuarial reviews have indicated that the Program may be underfunded. There is a great deal of concern abut the increasing cost of claims as claimants age; first, because many young parents of claimants are initially on Medicaid and then become ineligible for Medicaid as they enter the labor force leaving the Program to pick up the tab; second, because as claimants get older and heavier the cost of their nursing care tends to increase; third, because as parents themselves age and face their own health problems they are less capable of taking care of their children and need additional nursing resources.

There have been 241 claims of which 85 have been deemed compensable. Thirty of these infants are now deceased, although awards were made to them or their parents. Cases that were determined not to fall within the Program's jurisdiction were because the problem was not labor and delivery related (42%), because there was not substantial mental and/or physical impairment (36%), because the physician/hospital involved was a non-participant (13%), or because of low birth weight (9%). The use of the Program as exclusive remedy is controversial and is a topic in the current legislative session.

Requirement to inform obstetric patients:

Each hospital with a participating physician on its staff and each participating physician "shall provide notice to the obstetrical patients thereof as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan."

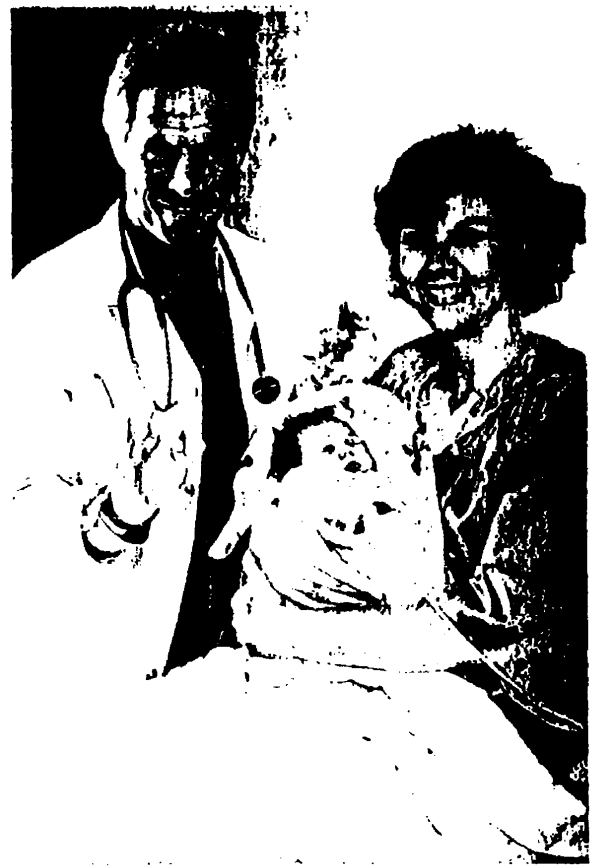
The Program produces a brochure and makes it available to doctors and hospitals to provide to all women about to give birth. (Two Florida brochures, "A Unique Partnership" and "Peace of Mind" [this one is available in several languages] are reproduced at the end of this Appendix, with a copy of the Virginia brochure.) If doctors do not notify the patient about the brochure, then the Program is no longer the exclusive remedy. Most doctors ask their patients to sign the brochure as evidence that they have received it.

Deterrence:

Lynn Dickinson sees no lowering of incentives for doctors to provide quality care under a no-fault system. Since all claims filed are reviewed by qualified representatives of the Department of Health, appropriate discipline or corrective action may be taken to protect patients.

Brochures for the Florida Birth-Related Neurological Injury Compensation Program

A Unique Partnership



Florida Birth-Related Neurological Injury Compensation Association

Florida Birth-Related Neurological Injury Compensation Association

The hopes and expectations of today's patients and their families are commonly heightened to unrealistic levels because of our technologically-oriented society.

We move faster - live longer - and sue more.

Sadly, the trade-off for technological advances achieved is the voluminous amount of litigation filed and the huge judgments awarded, all resulting in rapidly escalating malpractice premiums for physicians. Preoccupation with this problem by physicians and hospitals has the potential to divert medical attention away from providing optimal patient care.

This is why the Florida Legislature created a Plan to address an especially high risk group for malpractice, birth-related neurological injuries. The Plan is administered by the Florida Birth-Related Neurological Injury Compensation Association with funds from the State of Florida and hospitals, as well as physicians.

If you would like more information or have any questions, please call or write:

Florida Birth-Related Neurological Injury Compensation Association

Post Office Box 14567
Tallahassee, Florida 32317-4567
Attn: Lynn Dickinson,
Executive Director
Telephone: (904) 488-8191

BENEFITS

The primary advantage for the family practitioner, the obstetrician and the delivery team, is the freedom to concentrate on patient care, rather than direct involvement with costly and lengthy litigation. In addition, the Plan allows for a faster resolution of claims than can be achieved through malpractice lawsuits.

The medical community has campaigned for tort reform and this Plan is a first step in that direction. In the event there is a claim, the patient is protected and there is no need to prove fault.

PROFESSIONAL LIABILITY

The law provides that awards under the Plan are exclusive. This means that if an injury is covered by the Plan, the child and its family are not entitled to compensation through malpractice lawsuits.*

Participation in the Plan provides physicians with unlimited* coverage for catastrophic claims resulting from birth-related neurological injuries. Claims are resolved in a timely manner without assessment of fault.

In order to participate, physicians must:

- ❑ be licensed to practice medicine in Florida;
- ❑ practice obstetrics or perform obstetrical services on a full or part-time basis; and
- ❑ have paid, or been exempted from paying, the required assessment when the incident occurred.

FUNDING

The Plan is funded by a combination of state funds, physician fees, and hospital assessments.

If you wish to have your births covered, you are required to pay a $5,000 fee each year, for coverage which runs January 1st through December 31st. There is no provision for a prorated fee; if payment is made after January 1st, coverage begins the day the payment is received. You may wish to send the payment by certified mail.

A mandatory fee of $250 is paid by all licensed Florida physicians, regardless of specialty. Hospitals pay $50 for each live birth during the previous calendar year. Certain exemptions apply to all these categories including resident physicians, retired physicians, and government physicians and facilities. In the future, casualty insurers may also provide a source of funding assessments.

CRITERIA FOR COVERAGE

Birth-related neurological injuries have been defined as an injury to the spinal cord or brain of a live-born infant weighing at least 2500 grams at birth. The injury must have been caused by oxygen deprivation or mechanical injury, and must have occurred in the course of labor, delivery or resuscitation in the immediate post delivery period in a hospital. Only hospital births are covered.

The injury must have rendered the infant permanently and substantially mentally and physically impaired. The legislation does not apply to genetic or congenital abnormalities. Only injuries to infants delivered by participating physicians are covered by the Plan.

COMPENSATION

Compensation may be provided for the following:

- ❑ Actual expenses for necessary and reasonable care, services, drugs, equipment, facilities and travel, excluding expenses that can be compensated by state or federal government or by private insurers.
- ❑ In addition, an award, not to exceed $100,000 to the infant's parents or guardians.
- ❑ Reasonable expenses for filing the claim, including reasonable attorney's fees.

(* See S766.314 (9) (c) for Claims Limitation.)

Peace of Mind
for An Unexpected Problem

The birth of a baby is an exciting and happy time. You have every reason to expect that the birth will be normal and that both mother and child will go home healthy and happy.

Unfortunately, despite the skill and dedication of doctors and hospitals, complications during birth sometime occur. Perhaps the worst complication is one which results in damage to the newborn's nervous system - called a "neurological injury." Such an injury may be catastrophic, physically, financially and emotionally.

In an effort to deal with this serious problem, the Florida Legislature, in 1988, passed a law which creates a Plan that offers an alternative to lengthy malpractice litigation processes brought about when a child suffers a qualifying neurological injury at birth. The law created the Florida Birth-Related Neurological Injury Compensation Association.

EXCLUSIVE REMEDY

The law provides that awards under the Plan are exclusive. This means that if an injury is covered by the Plan, the child and its family are not entitled to compensation through malpractice lawsuits.

CRITERIA AND COVERAGE

Birth-related neurological injuries have been defined as an injury to the spinal cord or brain of a live-born infant weighing at least 2500 grams at birth. The injury must have been caused by oxygen deprivation or mechanical injury, and must have occurred in the course of labor, delivery or resuscitation in the immediate post delivery period in a hospital. Only hospital births are covered.

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COMPENSATION

Compensation may be provided for the following:

- ❑ Actual expenses for necessary and reasonable care, services, drugs, equipment, facilities and travel, excluding expenses that can be compensated by state or federal government or by private insurers.
- ❑ In addition, an award, not to exceed $100,000 to the infant's parents or guardians.
- ❑ Reasonable expenses for filing the claim, including reasonable attorney's fees.

The Association is one of only two (2) such programs in the nation, and is devoted to managing a fund that provides compensation to parents whose child may suffer a qualifying birth-related neurological injury. The Plan takes the "No-Fault" approach for all parties involved. This means that no costly litigation is permitted, and the parents of a child qualifying under the law who file a claim with the Division of Administrative Hearings may have all actual expenses for medical and hospital care paid by the Association.

You are eligible for this protection if your doctor is a participating physician in the Association. Membership means that your doctor has purchased this benefit for you in the event that your child should suffer a birth-related neurological injury, which qualifies under the law.

ou would like more information or would like to receive a copy of Florida Statute 766.301 which details the provisions of the Neurological Compensation Act, please call or write:

Florida Birth-Related
Neurological Injury
Compensation Association
Post Office Box 14567
Tallahassee, Florida 32317-4567
Attn: Lynn Dickinson
Executive Director
Telephone: (850) 488-8191
Toll Free: 1-800-398-2129

§766.301, et seq., Florida Statutes, provides rights and remedies for certain birth-related neurological injuries and is an exclusive remedy. This brochure is prepared in accordance with the mandate of §766.316, Florida Statutes, a copy of which is available free of charge to completely inform patients of their rights and limitations under the application provisions of Florida law.

Brochure for the Virginia Birth-Related Neurological Injury Compensation Program

A lifetime of help

Every year a small number of babies are born with serious birth-related neurological injuries.

Virginia has a program to help parents take care of these babies for life.

The program covers what insurance and other programs don't – necessary medical expenses, hospital expenses, rehabilitation expenses, residential and custodial care and service expenses, special equipment or facilities expenses, and related travel expenses for eligible babies.

Through infancy, through childhood, through adulthood, for a lifetime.

It pays compensation for lost earnings between ages 18 and 65.

It reimburses costs of filing a claim, including reasonable attorneys' fees.

It works quickly, privately, confidentially. It's an exclusive remedy. And it's no-fault.

We hope your family never needs this program. But we also hope you'll find it reassuring to know that, if you ever should, it's there.

The Program At A Glance

Repays Necessary

- Medical expenses
- Hospital expenses
- Rehabilitation expenses
- Residential and custodial care and service expenses
- Compensation for lost earnings, ages 18 to 65
- Special equipment or facilities expenses
- Reasonable claim-filing expenses
- Reasonable attorneys' fees
- Related travel expenses
- For all awarded claims

Doesn't Repay

- Expenses covered by other government programs
- Expenses covered by prepaid health plans or HMOs
- Expenses covered by private insurance

Eligibility

- Babies delivered by a participating doctor
- Or at a participating hospital
- With serious birth-related neurological injury, as defined by Virginia law

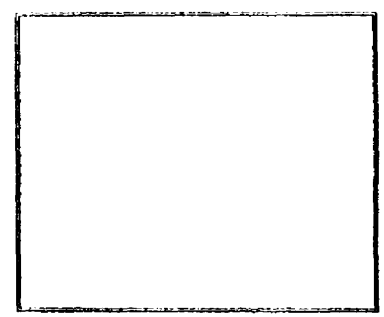
Procedure

- Quick
- Private
- Confidential
- Exclusive remedy
- No-fault

For More Information

Elinor J. Pyles, R.N.
Executive Director
Virginia Birth-Related Neurological Injury Compensation Program
700 East Main Street, Suite 1635
Richmond, Virginia 23219
1-800-260-5352

Virginia Birth-Related Neurological Injury Compensation Program



Participating in
Virginia Birth-Related Neurological
Injury Compensation Program

Appendix 1-2.
House Joint Resolution 641

HOUSE JOINT RESOLUTION NO. 641

Requesting the Board of Directors of the Birth-Related Neurological Injury Compensation Program to study increasing the scope and magnitude of the Virginia Birth-Related Neurological Injury Compensation Program.

Agreed to by the House of Delegates, February 20, 1997
Agreed to by the Senate, February 19, 1997

WHEREAS, the Virginia Birth-Related Neurological Injury Compensation Program was created by the General Assembly in 1987 to assure that physicians who deliver babies in the Commonwealth would have access to affordable medical malpractice insurance, to increase access to obstetrical care, and to assist neurologically-impaired infants, all as described in the Program's enabling legislation; and

WHEREAS, since enactment of the legislation, the General Assembly has approved amendments to the statutes designed to enable the Program to respond to more claims from injured infants; and

WHEREAS, despite these initiatives, the Program has provided compensation for only 23 injured infants in its nine years of existence, and has amassed a fund balance of $63 million; and

WHEREAS, the current Program is not providing the amount or scope of assistance to those injured during birth as intended by the General Assembly; and

WHEREAS, an increase in the Program's response to claims would result in greater resources being provided to those who suffer, during their birth, permanent disabilities of such a magnitude that they will require assistance in all activities of daily living for the remainder of their lives; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Board of Directors of the Birth-Related Neurological Injury Compensation Program be requested to study increasing the scope and magnitude of the Virginia Birth-Related Neurological Injury Compensation Program. The Board shall examine in detail all aspects of the Program's current operation, assess the Program's strengths and weaknesses, and develop recommendations that will result in increased assistance to those in the Commonwealth suffering neurological injuries during birth.

In conducting its study, the Board shall examine the Program and (i) identify its strengths and weaknesses, (ii) assess the purposes for which the Program was created by the General Assembly, and (iii) develop recommendations that will result in the increased use of the Program in a manner beneficial to the Commonwealth.

All agencies of the Commonwealth, including the Office of the Attorney General and the Division of Legislative Services, shall provide assistance to the Board for this study, upon request.

The Board shall complete its work in time to submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Go to (General Assembly Home)

Appendix 2-1.
Current Statutory Scheme, With Particular Reference to the Role of the Virginia Workers' Compensation Commission

(This appendix is based on the Plan of Operation of the Virginia Birth-Related Neurological Injury Compensation Program and on conversations with Deputy Commissioner Carolyn Colville, who is the member of the Workers' Compensation Commission dealing exclusively with cases from the Program. Several of Deputy Commissioner Colville's views are included.)

The Virginia Workers' Compensation Commission is authorized by the Virginia Birth-Related Neurological Injury Compensation Act to hear and process all claims arising under its provisions. The claimant files a petition ("claim") in the Richmond office of the Commission: the claimant can be a parent, legal guardian, or legal representative of the child. Claims must be filed within 10 years after the birth of the injured infant. There is a filing fee of $15. The initial petition should include the following information:

- name and address of legal representative;
- name and address of infant;
- name and address of the physician present at birth providing obstetric services and of the hospital;
- description of the disability for which claim is made;
- time and place the injury occurred;
- brief statement of the facts and circumstances surrounding injury;
- all relevant medical records, identification of unavailable records;
- valuation, prognoses and other records for determination of compensation;
- documentation of expenses and services incurred to date; and
- documentation of other sources of reimbursement.

After the petition is recei . ed, the Deputy Commissioner sets a date for a hearing, to be held no sooner than 45 and no later than 120 days after the filing of the petition. The key parties (claimant and the Program) are notified, and copies of the petition are sent to other interested parties (the physician and hospital involved, the Board of Medicine, and the Department of Health). The Program is required to file a response to the petition within 30 days, and to submit information as to whether the injury is a birth-related neurological injury. The Board of Medicine evaluates a claim for substandard care on the part of the physician. The Department of Health evaluates a claim for substandard care on the part of the hospital.

The Commission must make a determination on the following issues:

(1) whether the injury claimed is a birth-related neurological injury;
(2) whether obstetric services were delivered by a participating physician at birth;

(3) whether the birth occurred in a participating hospital; and
(4) in the event that the above apply, how much compensation is awardable.

In practice, the Program's own physician, who is an expert hired by the Program, makes the initial determination as to whether the injury is a birth-related neurological injury. In the vast majority of cases, this determination is accepted by Deputy Commissioner Colville. If there is some dispute, the claim is reviewed by a medical panel of three physicians 10 days prior to the hearing. The Commission considers, but is not bound by, the recommendations of the panel. The finding of the Commission with respect to whether the injury is a birth-related neurological one is binding on all parties.

According to statute, any formal hearing must be conducted pursuant to the Commission's rules of practice and procedure. Parties may cause depositions of witnesses to be taken. In practice, formal hearings rarely occur,[1] and Deputy Commissioner Colville usually makes a determination based on written records submitted to her.

If the claim falls under the provisions of the Act, the Commission makes an award including:

- actual medical expenses incurred and all other necessary and reasonable medical expenses and expenses for hospital, rehabilitative, residential and custodial care and service, special equipment and travel
- reasonable expenses in connection with the filing of the claim and attorney's fees

Services provided by private insurance or any other governmental program are excluded. Were an infant to reach the age of 18, he or she would also be entitled to loss of earnings paid in regular installments at a rate equivalent to one-half of the average weekly wage in the private non-farm sector in Virginia.

The claimant may make application within 20 days from the date of a determination or an award for a review of evidence (or a rehearing) by the full Commission (excluding any member who made the initial determination or award). Although one in three claims is not accepted, apparently such reviews occur extremely rarely -- there has been no such review in at least four years.

If the claimant is dissatisfied after the review, an appeal can be made to the Court of Appeals. Notice of appeal should be filed within 30 days from the date of determination or award. Cases so appealed are placed upon the "privileged docket" of the Court. This procedure provides quick access to the court system for claimants that have been denied compensation or who dispute compensation. We believe that no appeals have occurred in the history of the

[1] Only two have occurred so far.

Program.

According to Deputy Commissioner Colville, in the early days of the Program, Circuit Court judges often redirected questionable malpractice claims to the Workers' Compensation Commission, leading to lengthy delays for some claimants. Over time, judges have become more adept at recognizing cases that fall outside the Program's jurisdiction, to the benefit of all parties involved.

Although the advice of the medical panel is generally accepted, Deputy Commissioner Colville does recall one occasion on which she did not accept the medical panel's recommendation. The medical panel determined that the oxygen deprivation suffered by a particular infant was only minimally caused by the birth process itself and largely due to the smoking habits of the mother and recommended that the claim be rejected. Deputy Commissioner Colville agreed with the panel as to the evidence, but concluded that the fact that oxygen deprivation had occurred during the birth process at all meant that the claim fell under the definition of the Act.

Once the Commission determines that a particular infant fits the definition, there are relatively few disputes over payments or services. Occasionally, disputes occur over the amount of attorney fees to be awarded or such issues as renovating an existing house versus building a new one. Where disagreements over compensation arise that cannot be resolved by the Program's Board of Directors, a petition for resolution may be filed with the Commission.

Deputy Commissioner Colville is very supportive of the Program and pointed out several of its strengths. She believes that the Program better serves the injured child in the long run, because the child is reimbursed directly for all medical expenses. Under the tort system, the full value of awards do not always go directly to the injured child, but to the parents and legal representatives of the child. Moreover, awards in the tort system are currently capped at $1 million, but this is not true of the Program. She pointed out that some claims have been awarded in as little as 45 days, and never more than 120 days, whereas the most severe tort cases can take more than 4 years to resolve.

Deputy Commissioner Colville also points out that the current system is not adversarial, despite the fact that two-thirds of the parties hire attorneys. She attributes this to the attitude of Program administrators. For example, if parents do not have all the necessary information to support their claim, the Program points this out and even works with them to help provide it. The Program also operates very efficiently, almost routinely, with few delays or disputes. Deputy Commissioner Colville stressed that she uses up very little time on Program issues. Although there is a limited amount of traveling, most of her involvement consists of relatively routine paperwork, with a case-load of eight last year and 17 this year.

If the Program injury-level definition were to expand, Ms. Colville predicts that there will probably initially be a greater role for the Commission in determining eligibility, and an initial

flurry of disputes, until guidelines are established and, as before, Circuit Court judges feel more comfortable about making such decisions. If the definition of impairment were to change, Deputy Commissioner Colville suspects that she would be involved in considerably more travel to visit injured children and their families and to listen to testimony. A substantial increase in workload would necessitate her reducing her attendance at Workers' Compensation hearings.

Appendix 2-2. Program Beneficiaries by Year of Birth, Year of Filing of Claim, Physician/Hospital Participation, and Program Payments by Category and Total, 1992-1997*

Workers' Compensation Claim Number	Year of Beneficiary's Birth	Year Claim Filed	Location of Baby's Birth	Participation in Program		Total Expenses Paid								
										Equipment				
				Physician	Hospital	Incidental (a)	Nursing	Physicians/ Hospitals	Therapy	Medical (b)	Transportation (c)	Attorneys	Housing/ Additions	Total Paid
B 90-2 (d)	1989	1990	Tidewater (e)	Yes	Yes	-	-	-	-	-	-	-	-	$0
B 92	1989	1992	Northern Virginia	Yes	Yes	$28,091.66	$374,281.90	$5,200.35	$11,242.60	$5,422.30	$18,120.00	$10,676.99	$258,575.37	$711,611.17
B 92-2 (f)	1992	1992	Richmond	No	Yes	-	-	$5,825	-	-	-	$2,121.86	-	$7,946.86
B 93-1	1989	1993	Lexington	Yes	Yes	$16,301.25	$16,256.47	$4,225.38	$10,088.95	$4,134.98	$24,788.11	-	-	$75,795.14
B 93-2	1991	1993	Northern Virginia	Yes	Yes	$34,777.97	$218,767.51	$11,101.85	$5,580.89	$14,702.93	$24,001.14	$4,660.50	$515,261.23	$828,854.02
B 94-2	1993	1994	Northern Virginia	Yes	Yes	$48,957.97	$518,589.95	$38,541.92	$14,039.00	$30,097.90	-	$28,108.26	$511,878.61	$1,190,213.61
B 94-3 (g)	1993	1994	Northern Virginia	Yes	Yes	$17,707.44	$164,864.25	$2,457.17	$23,887.14	$2,201.83	$24,213.94	$4,950.50	$526,008.83	$766,291.10
B 94-5	1993	1994	Norfolk	Two of the four physicians	Yes	$1,724.80	-	$2,711.36	$55.00	$6,092.07	$28,644.96	$4,221.00	$11,050.00	$54,499.19
B 94-6	1989	1994	Winchester	Yes	Yes	$10,035.79	$5,490.00	$3,289.94	$72.00	$558.69	$14,506.19	$6,301.04	$236,872.17	$277,125.82
B 94-7	1993	1994	Blue Ridge	Yes	No	$16,235.21	$6,347.69	$2,077.66	$32,618.00	$2,420.11	$21,691.87	$11,830.64	$509,972.09	$603,193.27
B 95-1	1991	1995	Chesapeake	Yes	No	$17,421.48	$27,875.08	$2,575.81	$2,066.41	$18,480.49	$35,269.16	-	$281,101.93	$384,790.36
B 95-2	1992	1995	Roanoke	Yes	Yes	$11,881.39	$79,076.26	$9,246.66	$13,232.00	$3,624.60	$20,172.00	$1,454.83	$66,588.38	$205,276.12
B 95-3	1995	1995	Richmond	Yes	Yes	$99,921.61	$382,087.95	$3,477.78	$11,249.55	$29,336.08	$28,698.93	-	$48,658.32	$603,430.22
B 95-5	1992	1995	Fairfax	Yes	Yes	$7,699.86	$23,062.75	$5,756.72	$2,355.09	$680.00	-	$44,474.05	$532,988.63	$617,017.10
B 95-7	1993	1995	Roanoke	Yes	Yes	$6,234.89	$228,923.81	-	-	$210.00	$35,160.19	$2,006.45	$199,037.36	$471,572.70
B 95-8	1994	1995	Garden City	Yes	Yes	$10,406.19	$30,574.84	-	-	$1,138.50	$19,712.01	$1,068.78	$287,115.19	$350,015.51
B 95-9	1992	1995	Springfield	Yes	Yes	$6,831.84	-	$2,428.38	$420.05	$2,304.75	$28,327.42	-	$364,108.36	$404,420.80

Appendix 2-2. Program Beneficiaries by Year of Birth, Year of Filing of Claim, Physician/Hospital Participation, and Program Payments by Category and Total, 1992-1997*

Workers' Compensation Claim Number	Year of Beneficiary's Birth	Year Claim Filed	Location of Baby's Birth	Participation in Program		Total Expenses Paid								
										Equipment				
				Physician	Hospital	Incidental (d)	Nursing	Physicians/ Hospitals	Therapy	Medical (e)	Transportation (f)	Attorneys	Housing/ Additions	Total Paid
B 95-10	1989	1995	Chantilly	Yes	Yes	$15,050.52	$102,470.78	$1,254.00	$2,854.48	$13,304.93	$18,647.58	-	$401,202.95	$554,785.24
B 95-11	1989	1995	Annandale	Yes	Yes	$12,374.57	$49,774.00	$4,444.56	$2,647.55	-	$33,644.92	$1,205.01	$340,073.36	$444,163.97
B 95-12	1995	1995	Salem	Yes	Yes	$4,719.57	$109,424.06	-	$175.00	$409.50	$28,868.15	$1,219.86	$200,257.23	$345,073.37
B 95-14	1990	1995	Arlington	Yes	Yes	$7,673.32	$156,752.75	$9,540.21	$5,241.70	$5,015.40	$21,980.06	$21,524.87	$504,630.22	$732,358.53
B 95-15	1988	1995	Danville	Yes	Yes	$171.91	-	-	-	-	$24,313.42	$4,295.05	$192,169.72	$220,950.10
B 95-17	1991	1995	Richlands	Yes	Yes	$2,208.37	$130.00	-	-	-	$24,474.10	$11,431.00	$186,049.45	$224,292.92
B 96-1	1992	1996	Richmond	No	Yes	$7,427.55	$4,589.40	$3,625.36	$4,151.64	$6,870.00	$24,092.75	-	$1,275.00	$52,031.70
B 96-2	1991	1996	Greenville	Yes	Yes	$1,385.86	$2,438.50	$9,298.35	$2,000.00	$793.49	$23,371.63	-	$768.75	$40,056.58
B 96-3	1991	1996	Brookneal	Yes	Yes	$2,497.66	-	-	-	-	$551.31	$18,209.82	$86.25	$21,345.05
B 97-1	1994	1997	Richmond	Yes	Yes	$384.66	-	-	-	-	-	$6,708.29	-	$7,092.95
B 97-3	1997	1997	Falls Church	Yes	No	$2,194.68	$16,414.00	-	-	-	-	$3,491.49	$300.00	$22,400.17
B 97-4	1992	1997	Roanoke	Yes	Yes	$1,669.69	-	-	-	-	-	$4,896.41	-	$6,566.10
B 97-5	1994	1997	Arlington	No	Yes	$503.00	-	-	-	-	-	-	-	$503.00
Total Expenditures						$392,490.71	$2,518,191.95	$127,078.46	$143,977.05	$147,798.55	$523,249.84	$194,856.70	$6,176,029.40	$10,223,672.67

* As of August 15, 1997.

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997.

(a) Includes items such as diapers, medication, special formulas, and mileage.
(b) Includes items such as feeder seats, IV poles, oxygen concentrators, and beds.
(c) Includes items such as vans and lifts.
(d) Claim was initially denied, but was appealed to the Full Industrial Commission in Richmond after which an award was made.
(e) Baby was born in Virginia Beach (Elinor Pyles, Executive Director, Virginia Birth-Related Neurological Injury Compensation Program, October 21, 1997).
(f) The baby died in May 1993.
(g) Family was advised of Program by the participating physician.

Appendix 2-3. Program Expenditures for Beneficiaries, 1992

Workers' Compensation Claim Number	Total Expenses Paid								
					Equipment				
	Incidental (a)	Nursing	Physicians/ Hospitals	Therapy	Medical (b)	Transportation (c)	Attorneys	Housing/ Additions	Total Paid
B 90-2 (d)	-	-	-	-	-	-	-	-	-
B 92	$6,589.88	$6,745.75	$825.00	-	-	-	-	-	$14,160.63
Total	$6,589.88	$6,745.75	$825.00	$0.00	$0.00	$0.00	$0.00	$0.00	$14,160.63

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997.

(a) Includes items such as diapers, medication, special formulas, and mileage.
(b) Includes items such as feeder seats, IV poles, oxygen concentrators, and beds.
(c) Includes items such as vans and lifts.
(d) Claim was initially denied, but was appealed to the Full Industrial Commission in Richmond after which an award was made.

Appendix 2-4. Program Expenditures for Beneficiaries, 1993

Workers' Compensation Claim Number	Total Expenses Paid								
					Equipment				
	Incidental (a)	Nursing	Physicians/ Hospitals	Therapy	Medical (b)	Transportation (c)	Attorneys	Housing/ Additions	Total Paid
B 90-2 (d)	-	-	-	-	-	-	-	-	-
B 92	$12,266.00	$58,219.50	$1,071.39	$245.11	$155.00	-	$10,676.99	-	$82,633.99
B 92-2 (e)	-	-	$5,825	-	-	-	$2,121.86	-	$7,946.86
B 93-1	$5,447.70	-	$1,774.04	-	-	-	-	-	$7,221.74
B 93-2	$83.48	-	-	-	-	-	-	-	$83.48
Total	$17,797.18	$58,219.50	$8,670.43	$245.11	$155.00	$0.00	$12,798.85	$0.00	$97,886.07

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997.

(a) Includes items such as diapers, medication, special formulas, and mileage.
(b) Includes items such as feeder seats, IV poles, oxygen concentrators, and beds.
(c) Includes items such as vans and lifts.
(d) Claim was initially denied, but was appealed to the Full Industrial Commission in Richmond after which an award was made.
(e) The baby died in May 1993.

Appendix 2-5. Program Expenditures for Beneficiaries, 1994

Workers' Compensation Claim Number	Total Expenses Paid								
					Equipment				
	Incidental (a)	Nursing	Physicians/ Hospitals	Therapy	Medical (b)	Transportation (c)	Attorneys	Housing/ Additions	Total Paid
B 90-2 (d)	-	-	-	-	-	-	-	-	-
B 92	$1,772.46	$91,348.40	$1,738.29	$417.81	$1,773.10	-	-	-	$97,050.06
B 92-2 (e)	-	-	-	-	-	-	-	-	-
B 93-1	$1,967.42	-	$1,211.25	$718.40	$3,161.49	-	-	-	$7,058.56
B 93-2	$7,771.44	$13,216.75	$250.51	$3,030.89	$5,138.92	$22,153.64	-	-	$51,562.15
B 94-2	$5,783.56	$8,303.25	$3,244.40	$225.00	$1,613.90	-	$15,752.25	$25,000.00	$59,922.36
B 94-3 (f)	$4,393.98	$4,640.50	$840.90	$825.25	$895.03	-	-	-	$11,595.66
B 94-5	$833.80	-	-	-	-	-	$4,221.00	-	$5,054.80
B 94-6	$1,372.44	-	-	-	-	-	$5,510.53	-	$6,882.97
Total	$23,895.10	$117,508.90	$7,285.35	$5,217.35	$12,582.44	$22,153.64	$25,483.78	$25,000.00	$239,126.56

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997.

(a) Includes items such as diapers, medication, special formulas, and mileage.
(b) Includes items such as feeder seats, IV poles, oxygen concentrators, and beds.
(c) Includes items such as vans and lifts.
(d) Claim was initially denied, but was appealed to the Full Industrial Commission in Richmond after which an award was made.
(e) The baby died in May 1993.
(f) Family was advised of Program by the participating physician.

Appendix 2-6. Program Expenditures for Beneficiaries, 1995

Workers' Compensation Claim Number	Total Expenses Paid								
					Equipment				
	Incidental (a)	Nursing	Physicians/ Hospitals	Therapy	Medical (b)	Transportation (c)	Attorneys	Housing/ Additions	Total Paid
B 90-2 (d)	-	-	-	-	-	-	-	-	-
B 92	$1,210.48	$86,876.25	$658.05	$1,482.88	$1,445.20	$18,120.00	-	$57,332.28	$167,125.14
B 92-2 (e)	-	-	-	-	-	-	-	-	-
B 93-1	$715.37	$1,781.84	$1,021.60	$850.00	$771.55	-	-	-	$5,140.36
B 93-2	$8,890.11	$52,494.03	$10,764.46	$1,884.00	$138.54	-	-	$477,421.58	$551,592.69
B 94-2	$13,420.14	$168,521.00	$19,701.02	$5,040.00	$8,381.63	-	$12,356.01	$454,260.93	$681,680.73
B 94-3 (f)	$5,173.97	$43,925.75	$1,201.20	$9,458.80	$327.25	-	-	$2,081.42	$62,168.39
B 94-5	$378.00	-	$2,397.07	$55.00	$4,868.07	-	-	-	$7,698.14
B 94-6	$5,502.38	$3,588.00	$2,360.01	-	$558.69	$14,506.19	-	-	$26,515.27
B 94-7	$6,762.24	$1,027.00	$821.50	$2,246.60	$2,264.59	-	$11,830.64	-	$24,952.57
B 95-1	$6,098.63	$234.88	$715.06	$1,158.31	$1,084.90	$22,580.26	-	-	$31,872.04
B 95-2	$6,573.70	$13,460.00	$5,924.51	-	$1,181.20	$20,172.00	$1,454.83	-	$48,766.24
B 95-3	$21,994.43	$99,152.58	$1,011.07	-	$13,046.17	-	-	-	$135,204.25
B 95-5	$2,258.14	$4,248.50	$5,650.72	$157.09	$324.00	-	$2,275.00	$126.18	$15,039.63
B 95-7	$1,896.72	$15,735.62	-	-	-	$19,647.21	$1,532.95	$3,806.00	$42,618.50
B 95-8	$1,945.64	-	-	-	$1,007.93	$19,490.19	$1,068.78	-	$23,512.54
B 95-9	$618.50	-	-	-	-	-	-	-	$618.50
B 95-10	$7,522.42	-	-	-	$2,060.00	$18,647.58	-	-	$28,230.00
B 95-11	$1,062.50	$1,378.13	-	-	-	-	$1,205.01	$85.00	$3,730.64
B 95-12	$666.81	-	-	-	-	-	$1,219.86	-	$1,886.67
B 95-14	-	-	-	-	-	-	-	-	-
B 95-15	-	-	-	-	-	-	-	-	-
B 95-17	$1,457.62	-	-	-	-	-	-	-	$1,457.62
Total	$94,147.80	$492,423.55	$52,226.27	$22,332.68	$37,459.72	$133,163.43	$32,943.08	$995,113.39	$1,859,809.92

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997.

(a) Includes items such as diapers, medication, special formulas, and mileage.
(b) Includes items such as feeder seats, IV poles, oxygen concentrators, and beds.
(c) Includes items such as vans and lifts.
(d) Claim was initially denied, but was appealed to the Full Industrial Commission in Richmond after which an award was made.
(e) The baby died in May 1993.
(f) Family was advised of Program by the participating physician.

Appendix 2-7. Program Expenditures for Beneficiaries, 1996

Workers' Compensation Claim Number	Total Expenses Paid								
					Equipment				
	Incidental (a)	Nursing	Physicians/ Hospitals	Therapy	Medical (b)	Transportation (c)	Attorneys	Housing/ Additions	Total Paid
B 90-2 (d)	-	-	-	-	-	-	-	-	-
B 92	$1,812.88	$68,067.00	$310.58	$4,268.20	$2,049.00	-	-	-	$76,507.66
B 92-2 (e)	-	-	-	-	-	-	-	-	-
B 93-1	$3,855.28	$10,548.47	$80.40	$2,628.24	$201.94	$24,788.11	-	-	$42,102.44
B 93-2	$6,466.73	$57,330.31	$73.88	$122.00	$1,487.77	-	$1,095.00	$34,766.59	$101,342.28
B 94-2	$16,465.07	$217,539.00	$9,496.00	$5,100.00	$17,157.52	-	-	$19,042.07	$284,799.66
B 94-3 (f)	$4,959.13	$71,701.50	$365.07	$8,710.26	$515.00	$24,213.94	$1,385.00	$513,912.17	$625,762.07
B 94-5	$513.00	-	$225.23	-	$1,224.00	$28,743.21	-	$11,050.00	$41,755.44
B 94-6	$1,389.20	$1,522.00	$791.38	$72.00	-	-	-	$10,793.40	$14,567.98
B 94-7	$5,928.74	$3,549.00	$261.00	$20,677.60	$135.32	-	-	$55,000.00	$85,551.66
B 95-1	$6,771.26	$11,404.95	$1,050.30	$908.10	$8,644.59	-	-	$279,753.08	$308,532.28
B 95-2	$3,175.15	$29,684.80	$3,075.15	$8,465.00	$1,895.00	-	-	$4,204.24	$50,499.34
B 95-3	$40,855.97	$167,769.84	$857.56	$7,922.55	$13,350.36	$28,391.21	-	-	$259,147.49
B 95-5	$3,018.22	$5,173.25	$106.00	$1,608.00	$356.00	-	$27,157.00	$515,398.99	$552,817.46
B 95-7	$3,248.06	$97,048.63	-	-	-	-	$473.50	$184,676.73	$285,446.92
B 95-8	$2,344.85	$12,926.83	-	-	$130.57	-	-	$237,369.82	$252,772.07
B 95-9	$5,221.51	-	$2,406.73	$420.05	-	$23,734.35	-	$3,455.14	$35,237.78
B 95-10	$4,143.61	$31,411.78	$1,254.00	$1,506.66	$335.00	-	-	$390,377.32	$429,028.37
B 95-11	$6,855.29	$19,061.87	$1,695.92	$500.00	-	$33,644.92	-	$329,918.55	$391,676.55
B 95-12	$1,463.96	$44,060.60	-	-	-	-	-	$180,243.32	$225,767.88
B 95-14	$5,909.24	$62,026.75	$8,860.21	$1,360.00	$4,040.40	-	$21,524.87	$1,465.12	$105,186.59
B 95-15	$151.04	-	-	-	-	$24,313.42	$4,295.05	$187,942.22	$216,701.73
B 95-17	$616.29	-	-	-	-	$24,313.42	$11,431.00	$177,380.98	$213,741.69
B 96-1	$1,872.24	-	$3,625.36	-	$6,870.00	$25,092.75	-	$581.25	$38,041.60
B 96-2	$230.78	-	$3,691.02	$2,000.00	$764.49	$23,371.63	-	-	$30,057.92
B 96-3	-	-	-	-	-	-	-	-	-
Total	$127,267.50	$910,826.58	$38,225.79	$66,268.66	$59,156.96	$260,606.96	$67,361.42	$3,137,330.99	$4,667,044.86

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997.

(a) Includes items such as diapers, medication, special formulas, and mileage.
(b) Includes items such as feeder seats, IV poles, oxygen concentrators, and beds.
(c) Includes items such as vans and lifts.
(d) Claim was initially denied, but was appealed to the Full Industrial Commission in Richmond after which an award was made.
(e) The baby died in May 1993.
(f) Family was advised of Program by the participating physician.

Appendix 2-8. Program Expenditures for Beneficiaries, 1997

Workers' Compensation Claim Number	Total Expenses Paid								
					Equipment				
	Incidental (a)	Nursing	Physicians/ Hospitals	Therapy	Medical (b)	Transportation (c)	Attorneys	Housing/ Additions	Total Paid
B 90-2 (d)	-	-	-	-	-	-	-	-	-
B 92	$4,439.96	$63,025.00	$597.04	$4,828.60	-	-	-	$201,243.09	$274,133.69
B 92-2 (e)	-	-	-	-	-	-	-	-	-
B 93-1	$4,315.48	$3,926.16	$138.09	$5,892.31	-	-	-	-	$14,272.04
B 93-2	$11,566.21	$95,726.45	$13.00	$544.00	$7,937.70	$1,847.50	$3,565.50	$3,073.06	$124,273.42
B 94-2	$13,289.20	$124,226.70	$6,100.50	$3,674.00	$2,944.85	-	-	$13,575.61	$163,810.86
B 94-3 (f)	$3,180.36	$44,596.50	$50.00	$4,892.83	$464.55	-	$3,565.50	$10,015.24	$66,764.98
B 94-5	-	-	$89.06	-	-	($98.25)	-	-	($9.19)
B 94-6	$1,771.77	$380.00	$138.55	-	-	-	$790.51	$226,078.77	$229,159.60
B 94-7	$3,544.23	$1,771.69	$995.16	$9,693.80	$20.20	$21,691.87	-	$454,972.09	$492,689.04
B 95-1	$4,551.59	$16,235.25	$810.45	-	$8,751.00	$12,688.90	-	$1,348.85	$44,386.04
B 95-2	$2,132.54	$35,931.46	$247.00	$4,767.00	$548.40	-	-	$62,384.14	$106,010.54
B 95-3	$37,071.21	$115,165.53	$1,609.15	$3,327.00	$2,939.55	$307.72	-	$48,658.32	$209,078.48
B 95-5	$2,423.50	$13,641.00	-	$590.00	-	-	$15,042.05	$17,463.46	$49,160.01
B 95-7	$1,090.11	$116,139.56	-	-	$210.00	$15,512.98	-	$10,554.63	$143,507.28
B 95-8	$6,115.70	$17,648.01	-	-	-	$221.82	-	$49,745.37	$73,730.90
B 95-9	$991.83	-	$21.65	-	$2,304.75	$4,593.07	-	$360,653.22	$368,564.52
B 95-10	$3,384.49	$71,059.00	-	$1,347.82	$10,909.93	-	-	$10,825.63	$97,526.87
B 95-11	$4,456.78	$29,334.00	$2,748.64	$2,147.55	-	-	-	$10,069.81	$48,756.78
B 95-12	$2,588.80	$65,363.46	-	$175.00	$409.50	$28,868.15	-	$20,013.91	$117,418.82
B 95-14	$1,764.08	$94,726.00	$680.00	$3,881.70	$975.00	$21,980.06	-	$503,165.10	$627,171.94
B 95-15	$20.87	-	-	-	-	-	-	$4,227.50	$4,248.37
B 95-17	$134.46	$130.00	-	-	-	$160.68	-	$8,668.47	$9,093.61
B 96-1	$5,555.31	$4,589.40	-	$4,151.64	-	-$1,000.00	-	$693.75	$13,990.10
B 96-2	$1,155.08	$2,438.50	$5,607.33	-	$29.00	-	-	$768.75	$9,998.66
B 96-3	$2,497.66	-	-	-	-	$551.32	$18,209.82	$86.25	$21,345.05
B 97-1	$384.66	-	-	-	-	-	$6,708.29	-	$7,092.95
B 97-3	$2,194.68	$16,414.00	-	-	-	-	$3,491.49	$300.00	$22,400.17
B 97-4	$1,669.69	-	-	-	-	-	$4,896.41	-	$6,566.10
B 97-5	$503.00	-	-	-	-	-	-	-	$503.00
Total	$122,793.25	$932,467.67	$19,845.62	$49,913.25	$38,444.43	$107,325.82	$56,269.57	$2,018,585.02	$3,345,644.63

Appendix 2-8. Program Expenditures for Beneficiaries, 1997

SOURCE: Commonwealth of Virginia, Virginia Birth-Related Neurological Injury Compensation Program, unpublished data, 1997.

(a) Includes items such as diapers, medication, special formulas, and mileage.
(b) Includes items such as feeder seats, IV poles, oxygen concentrators, and beds.
(c) Includes items such as vans and lifts.
(d) Claim was initially denied, but was appealed to the Full Industrial Commission in Richmond after which an award was made.
(e) The baby died in May 1993.
(f) Family was advised of Program by the participating physician.

Appendix 2-9.
Methods for Determining Program-Eligible Babies in the Commonwealth

The task of identifying Program-eligible babies (those with severe, neurological birth injuries) who are not in the Program involves two alternative sources (legal and medical systems) and two types of data ("real" or actual cases, and "statistical" or estimated cases) for these sources. The combination of these sources and types of data provides four possibilities for identifying Program-eligible babies: (1) identifying through the legal system "real" cases (identities known) of children who belong in the Program but are not in it; (2) estimating "statistical" cases (how many, but identities unknown) through the legal system; (3) identifying "real" cases through the medical system; and (4) estimating "statistical" cases through the medical system.

In the course of our work, we have found approaches #1 and #2 through the legal system highly problematic. The reasons are two-fold:

(1) Current case documentation practices in the legal system do not provide the systematic, useful information on medical malpractice suits needed to provide a reliable data base for finding cases in litigation that should be considered for Program-eligibility. Our contacts with the National Center for State Courts, the Administrative Office of the Courts (of Virginia), and 71 Circuit Courts in the Commonwealth lead us to conclude that information on litigation is not codified in ways that enable us (or anyone else) to identify precisely (or even roughly) specific cases involving injuries that are Program-eligible or have a high probability of eligibility.

We also contacted representatives of the three medical malpractice insurance firms in Virginia. Their responses to our question "Do you have any information on claims (currently being pursued in court) that might be potentially eligible for the Program?" Peter Thrane (St. Paul) indicated that his company currently has no claims that are or potentially could be eligible for the Program or that could be more appropriately handled by the Program. Robert Herald (Medical Protective) also said he was unaware of any cases currently in the courts that are potentially eligible for the Program. Scott Johnson (Virginia Reciprocal) has provided materials relating to four court cases where efforts have been made on the part of infants who "may" be eligible for Fund benefits. We found these responses informative, but not useful for the specific goal at hand.

(2) Even if we could identify specific tort cases for qualifying birth injuries, this list is likely to provide unreliable estimates of the potential beneficiaries not in the Program.

(a) Injured babies may not appear in the legal system if the family does not pursue litigation, which may occur for a variety of reasons. The number of suits may thus understate the number of Program-eligible babies.

(b) Suits on behalf of babies meeting the biological definition may not meet the causal definition. In fact, the purpose of the suit is to establish cause (and by implication, fault). Thus, legal cases involving severely, neurologically injured babies may overstate the Program-eligibility of these babies.

(c) There are incentives bearing on plaintiff attorneys to shift Program-eligible cases into the court system by defining them as non-Program-eligible.

(d) There are incentives bearing on insurers to shift non-Program-eligible cases out of the court system by defining them as Program-eligible.

Despite the problems associated with the two legal approaches, Center staff not only tried to identify medical malpractice cases through the Clerks of the Courts, but Center and Program staff contacted the National Practitioner Data Bank, which is a combined legal/medical program to promote quality of medical services. Unfortunately, the Data Bank does not provide appropriate data for identifying specific Program-eligible babies who have pursued medical malpractice suits. For example, the Data Bank does not include data specific to ob/gyns or to cause (i.e., "birth-related neurological injury"). Another problem is that by focusing only on medical malpractice payments and adverse actions taken against all medical practitioners, the Data Bank excludes injured babies who are Program-eligible but for whom litigation has not been pursued or has resulted in no monetary compensation. Conversely, the Data Bank may include cases that result in monetary compensation but that may not be fully Program-eligible.

Given the difficulties associated with the legal approaches for identifying Program-eligible babies, we believe the third approach -- finding "real" cases of Program-eligible babies through the medical system (viewing birth injury as a medical event, rather than as a legal event) -- is a more analytically sound approach. Unfortunately, there are again problems associated with this approach.

Current informational mechanisms do not provide information on "real" cases of Program-eligible babies. No systematic reporting of babies with birth injuries that might qualify them for the Program is made by hospitals, obstetricians, pediatricians and other primary care physicians, or social service agencies. While such mechanisms currently are inadequate for identifying the babies who belong in the Program, our recommendations emphasize developing these sources as the probably most cost-effective informational system for this purpose.

By default, we have taken approach #4 -- estimating the number of "statistical" cases of

Program-eligible babies through geographic extrapolation of the current beneficiary population and epidemiological estimates of the annual number of newborn eligible babies. We believe our methodology to be sound and the results to agree with opinions from informed sources that have been offered to us on this question. These approaches and results are presented in Chapter 2.

We conclude that highly specific information about potential Program beneficiaries is lacking at this time. However, reasonable statistical estimates can be derived more easily from medical perspectives than from the legal system, and this is the approach we have chosen. For the future, we find that in creating effective specific information about injured babies, fewer new rules and new mechanisms would be required if this function is fulfilled by the medical system rather than the legal system. We believe that both the costs and benefits of obtaining this information favor methods that rely upon the medical professions rather than legal practitioners and courts.

Appendix 5-1.
Survey Instrument Used for Interviews with Beneficiaries

Hi, my name is _____. Could I please speak with _____?

I'm calling from the Center for Public Policy Research at the College of William and Mary. I received your name and phone number from Elinor Pyles at the Virginia Birth-Related Neurological Injury Compensation Program. Elinor mentioned that you agreed to speak with us about your experience with the Program. As you know, we have been asked by the General Assembly and the Board for the Virginia Birth-Related Neurological Injury Compensation Program to evaluate the Program. To do this properly, we thought it was necessary to talk with current beneficiaries of the Program. We believe that the individuals currently involved in the Program have a unique perspective and one that the General Assembly and the Board would benefit from hearing. I was wondering if you would mind answering a few questions about your and your child's experience with the Program? None of your answers will be attributed to you. This should take about 15 to 30 minutes of your time -- if this is an inconvenient time I can certainly call back later.

I. General Questions

A. How are you related to the child?

B. Where was your child born?

C. When was your child born?

D. What sorts of difficulties was your child born with?

II. Application to the Program

A. How old was your child when you applied to the Program?

B. How and when did you first learn about the Program?

1. After the birth of your child, how helpful was your physician and/or hospital in linking you to the Program?

2. Were you provided with any written material? If so, who provided the material?

3. Did anybody else explain the Program to you?

C. Did you ever consider taking your child's case to court?

1. If you didn't, why didn't you?

2. If you did go to court, what happened?

D. Please describe your experience in having your child determined eligible for the Program.

1. Did you have a lawyer help you through the process? If so, did you feel that he/she was adequately prepared to negotiate on your behalf?

2. Please tell me about your experiences when you went before the Workers' Compensation Commission? Did the Workers' Compensation Commission representative(s) seem as though they wanted your child to be in the Program?

E. Please describe your contact with Program staff after your child was determined eligible for the Program.

III. Obtaining Benefits

A. Please describe the typical process by which you obtain benefits?

1. How often do you obtain prior approval from Program staff before obtaining benefits, for which the Program later reimburses you?

____ Always ____ Most of the time ____ Some of the time ____ Never

2. When you don't obtain prior approval, does the Program reimburse you for the full amount?

____ Always ____ Most of the time ____ Some of the time ____ Never

B. Generally speaking, do you think the coverage in terms of benefits is appropriate?

1. What does the Program not cover that perhaps it ought to?

2. In your mind, are there things that the Program covers that it ought not to?

IV. Overall Experience with the Program

A. What do you think are the Program's two greatest strengths?

1. _____

2. _____

B. What do you think are the Program's two greatest weaknesses?

1. _____

2. _____

C. Are there any other strengths/weaknesses that come to mind?

D. On a scale of 1 to 5 with 1 being poor and 5 being excellent, how do you describe your experience with Program staff?

____ 1 (Poor) ____ 2 ____ 3 ____ 4 ____ 5 (Excellent)

Do you have any comments related to your rating?

E. On a scale of 1 to 5 with 1 being poor and 5 being excellent, how do you rate this Program overall?

____ 1 (Poor) ____ 2 ____ 3 ____ 4 ____ 5 (Excellent)

Do you have any comments related to your rating?

V. Background Information

Now, I would like to get some background information from you, if you don't mind. Again, none of the information that you provide will be attributed to you in any way.

A. Who is/are the legal guardians for the child?

B. How much formal schooling have you completed?

____ Grade School or Less/0-8 years
____ Some high school/9-11 years
____ Graduated high school/13-15 years
____ Some college/13-15 years
____ College graduate
____ Graduate school

C. How much formal schooling has your spouse (or ex-) completed? (Ask only if two legal guardians.)

____ Grade School or Less/0-8 years
____ Some high school/9-11 years
____ Graduated high school/13-15 years
____ Some college/13-15 years
____ College graduate
____ Graduate school

D. What was your approximate family income last year -- before taxes?

____ Under $20,000
____ $20,000 - $39,999
____ $40,000 - $59,999
____ $60,000 - $79,999
____ $80,000 - $99,999
____ Over $100,000

E. Is this a significant change from the time previous to your baby's birth?

Appendix 5-2.
Comments on Strengths and Weaknesses from Interviews with Beneficiaries[1]

Comments Made in Response to the Following Questions:
"What Do You Think Are the Program's Two Greatest Strengths?" and
"Are There Any Other Strengths that Come to Mind?"
(See Survey in Appendix 5-1)

- The greatest strength of the Program is that it covers the child, the home medical needs, and the major necessities for the rest of her life. This takes stress off the parents. Prior to the family's admittance into the Virginia Birth-Related Neurological Injury Compensation Program, the parents had been thinking of refinancing their home in order to meet all their expenses.

- The Program is "a definite plus. It has taken the financial strain off of having a child with special needs."

- The greatest strength is the "ability for me to keep my child at home with me. I have the help that I need, so that I can keep him in good health, and keep him with me."

- The Program has taken the monetary stress off of us, and made it possible to provide our son's needs beyond what we could have done on our own, or through our primary insurance.

- So far, the people they have dealt with have been "pleasant and willing to help." The Program helps people who need help. One family needed a van, and they got it. They needed a house, and they got it.

- The best strength of the Program is the help that they give people. Especially helpful is the assistance the Program has provided with getting around. A van with a lift was needed, and the Program provided it.

- The people in the Program are pleasant to work with.

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[1] Some of the comments in this Appendix involve direct quotes, and others do not. We have identified the quoted statements with the use of quotations marks. Other statements are given in the "third person," because we were not able to transcribe the statements exactly as they were made. Nonetheless, we believe that we have reported accurately the content of these responses to our questions.

- Financially their son is taken care of. The family knows that his medicine, hospitalization, and nursing care are covered.

- The extent of the things that the Program pays for. This includes the 24 hour per day nursing care. Having this care is quite intrusive, but the Program has paid for an addition to their house. This has been a help in making the nursing care less intrusive.

- The financial assistance. There are so many medical expenses associated with having a disabled child, and many of them are unforeseen. The Program "provides some security." For example, if the father in the family changes jobs, he would not be able to get new health insurance due to the child's disabilities.

- The nursing care makes it possible for the family to take care of their son and to take care of their house.

- The Program covers the medical necessities of children who have suffered brain injuries. By doing this, the Program spares the families from suing the physicians and hospitals.

- The people who run the Program.

- The greatest strength is the "people who work there." The people in the Program respond very promptly. If the beneficiaries call with a question or concern, they are called back quickly.

- The biggest strength of the Program is how much they support families. "You feel like you really have an advocate." Elinor and Lisa have both been to their house, and met their son; this has been a real advantage because it makes them feel that they have a relationship with them. Elinor and Lisa are not just people they speak to on the phone.

- All the medical bills are covered, and they will be covered for all of their son's life.

- Because of the Program, they are "able to get needed medical equipment that would otherwise by impossible or extremely difficult to get."

- The two greatest strengths are "Elinor Pyles and Lisa Antis." A father has stopped by the office in Richmond when he has been in the area. If there are things the family is requesting that "they cannot authorize on their own, they go to the Board and then get back to us as soon as possible. They are extremely helpful."

- The Program's greatest strength is that there is no cap on the assistance available. This is good because it is "impossible to say how much (our son's) medical expenses will be. [We have] no idea how long he will live, and how high his medical expenses will go."

- The Program has recently become more flexible in terms of working with, and listening to, the beneficiaries.

- Lisa and Elinor are always receptive. The people at the Program are easy to communicate with. The family talks to Elinor or Lisa about things and is often able to get information on what will be approved.

- The Program is "reaching out and touching children, and helping they, and their families, to be more comfortable."

- The house that they have through the Fund is much better for taking care of their son. They have more space and are better equipped to help him. They also have a lift on their van.

- The greatest strength is the accessibility of Program staff and getting quick responses from them. They respond in a reasonable time. If the Program becomes "more bureaucratic, this will be bad."

- "The Program covers a lot of things for the child."

- The Program provides equipment, nursing, and medical supplies. The Program has a good funding mechanism and is appropriately funded through assessments on doctors and insurance companies.

- The general concept of the Program is a good idea; it provides a special type of assistance. The requirement that a child must permanently require assistance with all activities of daily living is an important pre-requisite.

- The greatest strength is getting a vehicle and a home.

- "The Program has made it possible for me to keep my son with me, rather than him having to be institutionalized. When he was born, we were living in a one bedroom basement apartment that was very moldy. Everything that we receive through the Program is in trust in my child's name."

- Being in the Program eliminated a malpractice suit. "Also, my child is receiving a lot of therapeutic treatments and equipment, which he really needs, and which help him a lot."

- There has been a dramatic improvement in one mother's health due to the respite care the family receives through the Program. The mother was working so hard to take care of her son by herself before the Program, that her "immune system crashed," and she became diabetic.

- Through the Fund, they have received a van, and their son's medical equipment, including his wheelchair. "Before getting into the Program, we were thousands of dollars in debt, because of the things we needed to buy to take care of our child."

- "They take absolutely wonderful care of the kids. If you have a reasonable and justified request, they follow through with it."

- "I don't know what we would have done if we had not been accepted into the Program. They offer support in all sorts of ways."

- "My daughter receives around the clock nursing care. Certified Nurse Assistants stay with her 24 hours a day. Her nurse goes to school with her. Through the Program, we have a van with a lift."

- The greatest strength of the Program is that "my son will receive his needs throughout his life. The Program assures that he will have adequate medical care."

- The provision of benefits, such as the van, has made it easier to transport her son, since he has become too large to transport in a car.

- This is a unique Program. Other families with special needs children do not receive the same type of benefits. The Program does now have new guidelines, which is an improvement.

- A good point of the Program is that it helps with child care while the mother works. Parents of children in the Program are reimbursed for after school child care, and have a number of additional hours allotted for child care. In order to utilize this, they call an agency, and obtain child care for the allotted time per month; this is then billed directly to the Program. This respite care is something which they really appreciate.

- "Considering the choices available, this is a good Program for my son. It covers his medical needs, and helps him to meet his fullest potential."

- The "Fund is a big relief to us, because we know that if we die, our son will still be taken care of."

- The people at the Program are "truly helpful. They offer services and tell us about services that we wouldn't have realized were covered."

- "Elinor and Lisa are really good."

- The Program has made it possible for me to keep my child with me, and reassured me that when I needed something that was a medical necessity, I could get it for him."

- "I want to emphasize that the Program is wonderful; these kids need everything we can do for them."

Comments Made in Response to the Questions:
"What Do You Think Are the Program's Two Greatest Weaknesses?" and
"Are There Any Other Weaknesses that Come to Mind?"
(See Survey in Appendix 5-1)

- There are "too many processes and procedures. The Program is too bureaucratic." Dealing with bureaucracy causes difficulties. It is a wealthy Fund with few beneficiaries. This is probably no one's fault, but it should be streamlined, legally if necessary. The way the laws are set up now, it is too restrictive.

- People at the Program office need more authority. They should be able to make decisions on small items. Elinor should be able to make a determination on purchases under $25. The Program should have more of a relationship with the people who are in the Program, and this would help them to see that the participants are not trying to milk it.

- The Program needs to include an allocation to deal with other expenses. In this family's view, there may be other expenses which are related to the neurological injury, but in the view of the Program they are not related. The child's injury and disability has affected the whole family and the other children.

- Loss of income is not reimbursed by the Program.

- There are additional items that the Program should cover. Also, communication between the Program and the beneficiaries could be better. Beneficiaries have to take a lot of initiative. The Program assistant sometimes forgets the insurance checks and needs to be reminded.

- The only problem is that they wish they would have found out about the Program sooner. Before getting into the Program, they went through "a lot of stress, and very heavy bills." Having so much worry impacts the whole family.

- The Program's greatest weakness is that "nobody knows about the Program." The

Program has been in existence since about 1987 or 1988. The number of beneficiaries in the Program is "ridiculously low." The Program "needs to be publicized. The doctors and hospitals need to talk about the Program." There are "definitely more than the 28 to 32 children currently in the Program in the state of Virginia, who need it."

- The second weakness of the Program is that the Board does not have a parent member. Also, the head of the Board is a urologist. There needs to be a change in the make-up of the Board. The Board needs a parent representative, maybe not someone in the Program, but the parent of a special needs child. On the Board, there should also be a speech therapist, or a physical therapist, or some type of therapist. The Board also needs a pediatrician who specializes in special needs and a special education teacher. With the present make-up of the Board, the people on the Board do not really understand the needs of the beneficiaries. The Board needs to be composed of people who will have more understanding, and a "more sympathetic ear." Both parents emphasized their hope that the composition of the Board will be altered or augmented in order to include someone who is a parent of a disabled child, or some person who can speak from the beneficiaries' point of view.

- They received appropriate housing through the Program. They were formerly in a three level townhouse. However, there was "a two year fight" over the housing they would receive.

- The Program does not have enough staff. The same people answer the phone each time they call, and sometimes the Director answers the phone. There will be a greater need for this Program in the future, especially in the areas of administration and the making of decisions. More beneficiaries will move out of the State. For these reasons, the Program will need more staff.

- Some things are still being ironed out regarding policies and procedures. The Program is working on this now. Things can be confusing, even with good policies and procedures, so that is why the people at the Program are so needed. It's important to have someone to speak to at these times.

- Regarding the ability for beneficiaries to purchase some larger items, Elinor's office is hindered by the Board due to some procedures that are now in place.

- Sometimes it is frustrating to deal with the processes involved with receiving benefits, but they understand that it is a necessity. The Program has become more organized over the past year because they have grown. When the house they received through the Program was under construction, there were some misunderstandings, because this was during the period when the Program was still rather unorganized. However, all of this was worked out; they now feel that they have a good relationship with Program staff, and that the previous problems with organization have been rectified.

- Earlier in their contact with the Program, when they would call and ask for things, sometimes the Program staff made them feel as though they didn't think that their request should be covered.

- The weakness is that the scope of the Program is so narrowly limited with regard to the children who are covered. There are other children with disabilities who are "left out in the cold." There are other disabled children who also need these types of services.

- The Program is not very open or very accessible. The Program needs to have a newsletter to beneficiary families. A newsletter like this would be a way of sharing information on things like therapists; for example, they discovered that using a vibrator on their son helps him to calm down. Also, the Board of the Program should periodically meet in locations other than Richmond, so that families can go to the Board meetings. This way the Board would have faces of people to associate with their names and with various requests. This would help them to see the needs.

- The Program has not covered the monetary loss which they have experienced. Their son's condition has reduced the potential for income earning in the household. Through the Program, they have 56 hours per week of nursing care. However, some of the nurses are better than others, so the nurses have to be watched over; this is the main reason that the mother stays at home.

- The Program "can be too picky." For example, this family requested a cell phone. Recently, the coverage through the Program is better, because the Program has become more consistent in what they will cover.

- The Program does a poor job of program management. The person in charge does not have program management skills. It is not so critical for this person to know about medical needs, even though the Program sent Elinor to get her RN degree. Elinor needs some business courses. For example, one family received a van through the Program. In addition to the van which the Program provided, the family paid for many upgrades to the van. They would like to be reimbursed for these upgrades, and have asked Elinor about this. When she doesn't know something, she says, "That's a Board matter." At this point, the Board oversees all major questions. When the Program gets bigger and there are more families, the Program will have to deal with a lot more information, and the Program is not adequate to this.

- The Program does a poor job of communicating with the families, and a family network also needs to be set up. A family network would permit the sharing of helpful ideas. This family knows two other families personally who are beneficiaries, and know the names of several more.

- The Program needs to stop lowering the amount that doctors have to pay, and make them pay.

- The composition of the Board needs to be changed so that there is someone on the Board who will be an advocate for the beneficiaries. One family has been to a couple of Board meetings. "The current composition of the Board does not provide for the representation of the needs."

- A weak point is the administration of the Program. This is not just that it is bureaucratic, (i.e., the requirements for documentation), but also the lack of knowledge on the part of the staff and Board regarding needs and alternatives of how to meet these needs. It is up to the beneficiaries to find out what types of resources might be available for their children.

- There is a lack of any advocate to the Program for the parents/beneficiaries. If a beneficiary has to fight the Program, they have to pay for their attorney, and because they are paying taxes, they are also paying for the State's attorney. This could become difficult and expensive. There is a need for new legislation to add to the existing statute. Provision needs to be made for an ombudsman who could be an advocate for the parents with the Board and the Executive Director. At this point, the parents have no representative on the Board. Beneficiaries would have to go to all of the Board's meetings in order to be fully informed; the Board provides no transcripts of their deliberations.

- "The families need to have more choices in determining what the needs are."

- "If anything happens to my son, everything goes back to the Fund, plus my child is gone too." Parents in the Program put their careers on hold, then, if their child dies, they are left with nothing.

- There are constant changes going on in the Program that make it hard to get benefits.

- "There's a lot of red tape involved."

- "The laws [pertaining to the Program] change a lot."

- "Parents should have some say in the decisions of the Board, and parents should have a representative on the Board."

- A weakness is having to go through the processes to get benefits. Getting the doctor's approval for requests to the Program is not a problem, but having to go through Medicaid first is a problem. This mother wishes that Medicaid had a list of things that it approves,

and does not approve. Also, if the Program could call Medicaid to check on specific items, this would be a big help to her. There are long delays with Medicaid, but the Program is prompt about getting things.

- "The worst part of the Fund is that it protects doctors who have made mistakes which deserve malpractice suits." The Fund is "a huge benefit" for doctors.

- The greatest weakness is that the beneficiaries have no representation on the Board. No one on the Board knows about the day to day activities of the beneficiaries. Having a very disabled child is extremely stressful. No one on the Board really understands the reality of this. The medical profession is represented on the Board; there are two slots for members of the general public, but these members are not familiar with what this life is like.

- "Having a child with the needs that my son has makes it impossible for my wife to work. If she were to work, his care would suffer. In this sense the Program has little focus on the family and the needs of the family."

- In sum, there is too much paperwork, dealing with receipts, and concerns about reimbursement.

- In general, the Program should have more direct contact with the beneficiaries. They would also like to see a meeting with all the beneficiaries. They feel that the beneficiaries would benefit from being able to talk to one another. The Program does not offer a lot of emotional support, although that is not their mission.

- The "amount of paperwork" associated with receiving benefits through the Program is "very difficult."

- When new families enter the Program, a very poor job is done of explaining what the Program provides. Also, the Program is not good at communicating with the families. Now, after 12 years, the Program has a brochure that goes over the guidelines of what is covered.

- There is a need for a network of communication outside the purview of the Board and the Program, i.e. not under the control or influence of the Program. One family knows "a fair number of people in the Fund, because, we have looked for them."

- The composition of the Board needs to be re-evaluated. "No one on the Board walks or talks this life." The Board needs to include a pediatric neurologist and a physical therapist. The people currently on the Board have never seen a child who is a beneficiary, or any child with similar needs. Currently on the Board, four of seven members are from either the medical or insurance communities. Of the other three, one is

a nurse, and two positions are open. However, the medical people currently on the Board "have no experience working with these kids."

- The Program needs to go further. "It is an idea that can work, but implementation is poor." The Program needs a new staff and a new Board. At one point, one board member accused a father of being a "gold digger." This board member asked him why he was fighting for a house when his child would die by the age of seven.

- In the Program, you never know what you can get, and what you can't. You "have to play it" in order to get benefits. There are a lot of things you need, but you have to have a doctor's approval for everything. Families have personal needs too, and not everything can fall under medical necessity.

- The beneficiaries of the Virginia Program should receive a pain and suffering award, as do the beneficiaries in Florida. This mother is a single parent, and for the first two years of her son's life, he was constantly in and out of the hospital. He had seven or eight surgeries. During this period, they were not in the Program, and it was impossible for her to work, as she had to be with her son. She feels that under these circumstances a pain and suffering award would have helped her get back on her feet more quickly.

- The Program needs to have a release form which would permit beneficiaries to set up a network of communication amongst themselves. This is one way in which the families would "be able to offer more information which would improve the Program." After releases were signed, the Program could put names into this network.

- Also, the Board should have meetings in cities other than Richmond, as it is very hard for some people to get to Richmond. The Board should meet in other cities once or twice per year, and publicize this well ahead of time. This would make the Board more accessible. Right now, the only ones who know how the Fund works overall is the staff; because they are the only ones who are in contact with everybody. The Board is not in contact with the families. Another idea would be for Elinor and Lisa to take photos when they visit families, and show them to the Board. The Board should also look at the records of the yearly physicals of the children in the Program, because this would give them an idea of the children's needs and how they are progressing as they get older.

Comments Made in Response to the Question:
"Do You Have Any Additional Comments?"
(See Survey in Appendix 5-1)

- The Chairman of the Board is Mr. Nelson, who has the authority to approve items. This helps avoid delays. Mr. Nelson has granted approval on some things which have been requested.

- One family is still concerned about having given up their right to legal action.

- The current employees of the Program are "caring, but don't give the impression that" as a beneficiary, "you can get anything you want." The staff are very open to dialogue and discussing needs. They "have a very good grasp of what's involved in caring for a child with severe disabilities."

- One family is concerned because they have heard that the Program is starting to admit children who are disabled because of premature births. They feel that this is "not the same as genuine malpractice." They believe that those who are in the Program who have grounds for malpractice, should be permitted to sue the doctors at fault, and that new laws should be passed to provide for this. "A premature birth is an act of God," and when this happens, the "doctors do the best they can." This needs to be differentiated from instances where the "doctor is blatantly at fault." A doctor who is at fault in a case should also have to do community service. These persons are "not in the same category" with a situation where there is a premature birth, or where the mother is hemorrhaging.

- There is a lot of "grief and turmoil" with having a severely disabled child. The Program really can't "compensate for that. We can't complain; the Program has come a long way in the last couple of years. It is a big mental strain" to have a child in our son's condition. People from the Program came to the house after they were accepted. They "did the best they could to explain" the Program. "The people are genuine about wanting to work with you." During the past few years, the Fund has become "more defined, and there are more beneficiaries. All in all, [the Program] has worked with us, and has a responsive ear." To the family, it seems as though, in their case, the state is being billed twice for their expenses. Because Medicaid is their primary insurance, Medicaid is billed first, then the Program.

- One family is extremely concerned that for the doctors whose mistakes are responsible for the injuries, there are no reprimands, and no form of punishment. "There is no accountability for the doctors, and that really distresses me." At first, under the Program, the doctors paid higher premiums, but now they have been reduced. Now the doctors "are not paying much, but are still getting the coverage." The Program is actuarially sound, so the doctor's payments have been reduced to about $500 -- this is minimal relative to the coverage they receive.

- No one finds out about the mistakes of the doctors that have resulted in these very severe disabilities. The doctors involved have had "major screw-ups," and the Board has the responsibility to investigate this. In one case, the doctor's errors were blatant. According to statute, the Medical Society of Virginia requires that a doctor involved in a case like this be investigated, but this is not done. Two weeks after their son was born, the delivering obstetrician did a delivery where she once again injured the baby. In the second case, forceps were used, and the forceps damaged the baby to the point that the

child is paralyzed on the right side. Less than one year after these two incidents, the doctor became Board certified. The doctor is still practicing, and according to the Medical Society of Virginia, has a perfect record.

- "All the families in the Program have found out that there are two states that have this type of Program, Virginia and Florida. I found this out from a friend who is also in the Program. In Florida, the families receive an award for pain and suffering. I think they receive $25,000 in a cash bonus to cover pain and suffering, and lost work. I have a friend who is also in the Program, but we don't discuss our benefits anymore."

- "We would like to see a newsletter about the families in the Program. Each child has different needs and requires different services, but the families should be able to get in touch. We need to have access to each other." This family knows several other people in the Program; some of these, they have met because they have been looking for similar types of help.

- "Many beneficiaries are bitter and not thinking straight. What if there was no Fund?"

- "The Program is micro-managed."

- "This Program should be no fault, as a part of tort reform, but in our experience, the Program is more advantageous to the medical professionals than to the beneficiaries and claimants. The Program needs a better mechanism for adequate representation on the Board, without each beneficiary having to go and fight for individual issues." Obtaining benefits takes "a lot of time and effort, and is very stressful. What we are looking for from the Program is a fairer situation."

Appendix 6-1.
Survey Instrument Used for Interviews with Physicians, Nurses, Nurse-Midwives, and Nursing Representatives

I. Assessment and Participation

A. Are you currently participating in the Program? If so, why did you decide to participate? If you're not participating, why not? Current criteria require that either the physician or hospital be participating. Do you deliver in a participating hospital? If so, do you feel that through this Program, you are covered?

If physician or nurse-midwife is participating:

1. Are you part of the informational network of the Program?

2. How do you go about providing information regarding the Program?

3. How would you suggest encouraging more OB/Gyns to join the Program?

4. What has happened to your malpractice insurance premiums, and do you see any relationship between the Program and these premiums?

If physician or nurse-midwife is not participating:

1. Why? Finances; knowledge of the Program; practicality, i.e. lack of incentives?

2. What would it take for you to become a participant? Do you have some sort of threshold?

B. Why do you think physicians decide to join or not join the Program?

C. Should the participation of physicians be mandatory? Why or why not?

D. Should the participation of hospitals be mandatory? Why or why not?

E. Should all licensed nurse-midwives be allowed to participate in the Program, or should licensed nurse-midwives participate only in those areas that otherwise would not have access to obstetrical care? Why or why not?

F. Should participating assessments for resident physicians be waived if they are

supervised by attending participating physicians in non-participating hospitals, in addition to the current situation where there is no resident physician assessment for participating when delivering obstetrical services in a participating hospital?

G. Should assessments for practitioners who deliver obstetrical services in underserved areas of the Commonwealth be permitted to pay a lesser assessment? How would you define underserved area?

II. Eligibility and Procedure

A. How many children have you seen that fit the definition of a "birth-related neurological injury" under the law? Should the definition of a "birth-related neurological injury" be revised? If the definition were changed, how many children would you anticipate seeing that would fit the revised definition?

B. When you see a child that might be eligible for the Program, what do you do?

C. Should current legal procedures be changed with respect to disputes over benefits once an infant is accepted by the Program? Should malpractice legal actions where the potential defendants are either a participating hospital or a participating physician involving a possible "birth-related neurological injury" be referred to the Program and the Workers' Compensation Commission for a determination that the injury is a "birth-related neurological injury" as a condition precedent to maintaining the malpractice action?

D. Why do you think that there are so few children currently receiving benefits under the Program?

E. Have you ever served on a medical panel that made a determination as to "birth-related neurological injury?"

III. Program Structure and Operation

A. Is the current Program structure sufficient? Should the Program become a Trust? Should the Program be clearly identified as an independent State agency akin to the Virginia Retirement System? Should there be an increase in staff or function?

B. The law creating the Program allows insurance carriers to be assessed a fee if the fees collected from physicians and hospitals are too low to maintain the actuarially soundness of the Birth Injury Fund. Should this provision of the law be changed? In the current fee structure, there is a lot of forgiveness; if the Program is expanded there will be a need to enforce the original fee structure more stringently. How would this affect physicians?

C. Do you think a periodic publication that publicized the shared experiences of the Program's beneficiaries would be useful?

D. Should hospitals and physicians be required under the law to distribute information about the Program to all pregnant women?

IV. General Questions

A. What are the strengths and weaknesses of the Program?

B. Do you think the Program is worth having? If so, why? If not, why not?

Appendix 7-1.
The Hospital Administrators, Insurance Company Representatives, and Lawmakers Interviewed for this Chapter

As mentioned in the text of Chapter 7, our interviews with hospital officials, insurers, and lawmakers were informal and semi-structured. They were conducted on a not-for-attribution basis to facilitate candid comments. On average, the discussions lasted from 45 minutes to one hour. We spoke with the following individuals from these Program constituencies:

Members of the Virginia General Assembly
Senator William T. Bolling*
Senator John S. Edwards
Senator Thomas K. Norment, Jr.
Senator Jackson E. Reasor, Jr.
Delegate Robert Tata
Delegate Clifton A. Woodrum

Insurance Company Representatives
Robert Herald, The Medical Protective Company
W. Scott Johnson, Crews and Hancock, P.L.C.
Peter Thrane, St. Paul Fire and Marine Insurance Company
Senator William T. Bolling, The Virginia Reciprocal Group*

Hospital Administrators
Jessica Greco, Bon Secours DePaul Medical Center
Melina Purdue, Community Hospital of Roanoke Valley
Betsy Snow, Winchester Medical Center
James Thweatt, Clinch Valley Medical Center

* In addition to being in the Legislature, Senator Bolling is Second Vice President of The Virginia Reciprocal Group.

Appendix 7-2.
Questions Asked in Interviews with Hospital Administrators, Insurance Company Representatives, and Lawmakers

A core set of questions was used in all of the interviews. However, in keeping with our aim and intent, the conversations were semi-structured in nature. That is, if the individual being interviewed brought up a relevant topic "out of order," we proceeded with that topic. The people we spoke with also raised useful new questions that were not initially included on our list. We were open to such new lines of inquiry. In short, although a common set of questions formed the core of the interviews, we tried to keep the conversations as free-flowing as possible. The core questions included the following.

(1) Overall, what are the strengths and weaknesses of the Program? Do you think the Program is worth having? Please explain.

(2) Why are there so few infants and children currently in the Program?

(3) Is the definition of a "birth-related neurological injury" appropriate? Should it be revised and, if so, how? What do you think would be the impact of such changes on the number of beneficiaries?

(4) How well is the Program being administered? How about the role of the Workers' Compensation Commission in the Program? Is that role being fulfilled effectively?

(5) Is the current Program structure sufficient? Should the Program become a Trust? Should the Program be clearly identified as an independent State agency akin to the Virginia Retirement System? Should there be an increase in staff or function?

(6) Are the relevant people sufficiently informed about the Program? Please explain. What might be done to increase the quantity and quality of the information these individuals have about the Program?

(7) Should hospitals be required to report to the Program about any children born in their facilities with injuries approximating the eligibility definition?

(8) The law creating the Program allows insurance carriers to be assessed a fee if the fees collected from physicians and hospitals are too low to maintain the actuarial soundness of the Fund. Should this provision be changed?

(9) Should participation in the Program by hospitals and obstetricians be mandatory?

Questions Addressed to Specific Groups

In addition to the above questions, we also asked certain questions tailored for particular constituencies and observers of the Program. Included here were the following:

Members of the Virginia General Assembly

(1) How interested are lawmakers in the Program? Typically, how much do they know about it? How much oversight does the General Assembly exercise in this area?

(2) About how often does someone contact you about the Program, or about an issue related to the Program's functions? What sorts of people -- physicians, hospitals, attorneys, insurers, potential beneficiaries -- tend to contact you about the Program?

(3) Are the people who contact you about the Program generally satisfied with its internal operations, structure, and performance? Please explain.

(4) Do you believe that the design of the Program adequately protects the rights of families with injured children, or does it tilt excessively toward the interests of physicians, hospitals, or insurers? Please explain.

(5) Are your colleagues in the General Assembly generally satisfied with the Program? Please explain.

Insurance Company Representatives

(1) What has been the impact of the Program on malpractice insurance rates for obstetricians in Virginia?

(2) More specifically, how are malpractice insurance rates for obstetricians in Virginia determined? What is the insurance pool?

(3) Is the Program now necessary to ensure adequate malpractice insurance accessibility in the Commonwealth? If not, is it likely that the Program will become necessary in this way at some future time? Please explain.

(4) In the late-1980s, there was concern that insurance companies might not provide adequate malpractice insurance for obstetricians in Virginia. Is there similar concern in other states? What was the response?

(5) Why do so many physicians and hospitals choose not to participate in the Program? Please explain.

(6) In your view, about how many babies are born every year who might fall just short of the eligibility definition? That is, about how many infants are "marginally ineligible" for the Program, and thus might be picked up by an incremental expansion of the definition?

(7) Should malpractice legal actions where the potential defendants are Program participants be referred to the Program and the Workers' Compensation Commission to see if the child is eligible as a condition precedent to maintaining the malpractice action?

Hospital Administrators

(1) In your view, about how many babies are born every year who might fall just short of the eligibility definition? That is, about how many infants are "marginally ineligible" for the Program, and thus might be picked up by an incremental expansion of the definition?

(2) What factors has your facility considered in deciding whether or not to participate in the Program? More generally, why is the participation rate among hospitals so low? What factors do doctors consider in deciding whether or not to participate?

(3) Should the participation rate for hospitals (and for physicians) be increased? If so, then how might that goal be accomplished?

(4) How do the families with potentially eligible children typically find out about the Program? Do hospital officials or the relevant physicians usually inform the parents about it? Please explain why or why not.

(5) Would systematic reporting requirements -- in which hospitals must inform the Program and the State about potentially eligible children -- be workable?

(6) Is the Program now necessary to ensure adequate malpractice insurance accessibility in the Commonwealth? If not, is it likely that the Program will become necessary in this way at some future time? Please explain.

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