REPORT OF THE
VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY
COMPENSATION BOARD

A Study to Establish an Economically Balanced Approach for Funding the Birth-Related Neurological Injury Compensation Fund

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 11

COMMONWEALTH OF VIRGINIA
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December 21, 2005

To: The Honorable Governor Mark R. Warner
The Honorable Members of the Virginia General Assembly

Subject: **Submission of Report of Virginia Birth Injury Program Required by HJR 646**

House Joint Resolution 646, which passed during the 2005 Session, requested "the Virginia Birth-Related Neurological Injury Compensation Program, with the assistance of the State Corporation Commission, the Office of the Attorney General, the State Workers' Compensation Commission and other state agencies, to develop recommendations for adequately funding the Birth-Related Neurological Injury Compensation Fund." The Resolution instructed the Program to submit to the Governor and the General Assembly an executive summary and a report of its findings and recommendations for publication as a House or Senate document.

Therefore, in accordance with the requirements of House Joint Resolution 646, and on behalf of the Board of Directors and Staff of the Virginia Birth-Related Neurological Injury Compensation Program, I am pleased to submit the enclosed report, which is entitled "A Study to Establish an Economically Balanced Approach for Funding the Birth-Related Neurological Injury Compensation Fund." This report contains an Executive Summary beginning on page 3. Legislative amendments consistent with the recommendations of the report are being prepared for submission to, and consideration by, the General Assembly during its 2006 session.

We look forward to upcoming opportunities to discuss this report and its recommendations.

With kindest regards,

Melina Perdue, RN, MBA, CNA, Chairperson

Board of Directors

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PART I: INTRODUCTION

Preface

In its 2005 session the Virginia General Assembly adopted House Joint Resolution 646 (HJR646) requiring the Virginia Birth-Related Neurological Injury Compensation Program (Program) Board of Directors (Board) to conduct a study to provide an economically balanced approach for adequately funding the Compensation Fund (Fund). A copy of this resolution is provided as Appendix A. The General Assembly directed that, "In conducting its study, the Virginia Birth-Related Neurological Injury Compensation Program shall":

- Identify the extent of Program deficit
- assess causes for such deficit
- review the program structure to determine the necessary amendments to stem deficit; and
- Assess the effect of such amendments on the number of beneficiaries projected to be assisted by the Program in subsequent years

The Executive Director, at the direction of the Board, engaged a professional to coordinate the study through the issuance of an RFP and selected C. Gary Burke to fill this role. Mr. Burke has over 25 years of financial and project management experience in Virginia State government. Mr. Burke was supported by a graduate student from Virginia Commonwealth University, Mr. Sam Ragsdale. Mr. Ragsdale assisted the project by conducting research, preparing analyses as required, and generally assisted the project coordinator with multiple project related tasks.

Additionally, such a study would, out of necessity, include actuarial projections to support its conclusions and recommendations. Accordingly, the Executive Director engaged the actuarial firm of Pinnacle Actuarial Resources, Inc. to conduct the actuarial analyses necessitated by the study. Pinnacle has extensive experience in the preparation of such analysis and has provided assistance to the Program in the past. Mr. Robert J. Walling, III, Principal and Consulting Actuary with the firm, was the primary contact on this project for Pinnacle. Mr. Walling and his firm is a good choice for this role as he has worked with other states and is recognized an "expert" in his field. Mr. Walling's Curriculum Vitae is provided in Attachment G.

As instructed by the House Joint Resolution 646 (HJR646) the Executive Director identified stakeholders that needed to participate in the completion of this study. The stakeholders so identified were contacted and informal interviews were conducted. Appendix B is a listing of those identified by the Executive Director as contacts and the organizations that they represent. Appendix C provides a copy of the questionnaire used in the interviews. Section III, Input from Stakeholders is a summary of the insight provided by the contacts on behalf of their constituents and their recommendations for this study.

The Board wishes to thank all of the participants of the study for their commitment to the task and for the time and effort all have provided to help continue the good work of the Program since its inception in 1987.

Executive Summary

The 2005 Virginia General Assembly House Joint Resolution 646 (HJR646) required the Virginia Birth-Related Neurological Injury Compensation Program Board of Directors to conduct a study to provide an economically balanced approach for adequately funding the Compensation Fund. Beginning in year 2000 and continuing through the 2005 Actuarial Report, issued September 2005, the Compensation Fund has been reported to be actuarially unsound. The 2005 Report issued by Mercer Oliver Wyman Actuarial Consulting, Inc. projects that the Fund would continue to be actuarially unsound through December 31, 2007, which was the time limit of its projections. According to the Mercer report, the Fund had a "Grand Total" deficit of $117.6 million. The Mercer report also states that the deficit is expected to grow to $137.1 by December 31, 2007. Although the Fund is not in immediate danger of defaulting on current obligations, it is clear to all that the Program must institute corrective policy action in order to avoid a continuing, and possibly more serious, adverse financial situation.

This study was structured to evaluate the causes of the current deficit and to recommend actions that would correct the current deficiencies, while at the same time identify opportunities to eliminate the deficit over the next several years. The proposed changes would allow for the continued service levels currently provided to our Program participants. Additionally, it should be noted that the study has presumed that the ongoing continuation of the Program is the only viable alternative and is in the best interest of the Commonwealth and the claimants we serve.

General Approach & Process

In conducting our research for this study we reviewed all of the previous legislatively mandated studies, conducted interviews with Program stakeholder organizations, researched the related programs of other states, and conducted independent actuarial assessments based on our preliminary findings and recommendations. We relied on and did not attempt to duplicate the previous works.

A review of the full study will reveal to the reader insight on how the Program has reached the point of requesting legislation for the sole purpose of eliminating the deficit. This is best provided in the Background section of the report. Further insight is provided in the Input from Stakeholders section of the report. This section reports on the diverse views of the major stakeholders of the Program. A review of the Review of other Patient Compensation Plans section of the full study shows how other states have approached the negative impact of medical malpractice insurance in their respective states. The section on Weighing Opportunities to Reduce Costs or Increase Assessments shows ways in which the Board has reduced costs in the face of the increasing deficit. This section is supported by our actuarial study, which illustrates alternative strategies for increasing or modifying current assessments and/or imposing an additional assessment.

Providing actuarial services for this report was Robert J. Walling, III, of Pinnacle Actuarial Services, Bloomington, Illinois. Mr. Walling was selected for his extensive experience with Patient Compensation Programs. Along with earlier work for the Virginia Birth-Injury Program, he has conducted actuarial research and reviews for Florida Neurological Injury Compensation Association, Ohio, and other states.

Use of Prior Legislative Studies

Since its creation in 1987, there have been several studies of the Program. None of the previous studies specifically focused on the funding of the Program. Therefore the HJR646 study is unique in that regard. The most significant of the previous studies with regard to funding issues was the 2003 JLARC Review. At the time of the JLARC study, the Program was reporting its first significant actuarial deficits. While the JLARC report concluded that the implementation of the Program had achieved its original legislative intent of reducing medical malpractices rate's for Virginia OB/GYN's, reduction of birth-injury lawsuits, and a reduction in subsequent claims costs, the Report said that it was less clear about the societal benefits of OB care in rural areas of the State. The report also found that the Program is more beneficial to the children served by the Program as compared to Virginia's capped tort system.

However, the JLARC study made what was possibly the most significant observation with regard to the Program financial issues. First, it noted flaws in the basic assessment structure and inadequate financial oversight by the Board. The General Assembly has since modified the Code of Virginia to address both of these fundamental issues. However, the JLARC Report goes on to note that due to these weaknesses the Program reduced its assessment income by over 65% between 1995 and 2000. Our conservative estimate of this lost income potential is $109 million. The Code of Virginia has been modified to prevent the Program and the State Corporation Commission from reducing assessments unless the annual actuarial study projects a positive fund balance.

Other changes since the issuance of the JLARC Review have had positive impact on the Program. For example, the 2003 JLARC Review found that the Board needed to place more of its focus on policy development and its fiduciary duties, and less effort on day-to-day operation of the Program. The Board membership has changed in recent years and Board attention has clearly been changed consistent with the JLARC recommendations. Another example of how the Board has adhered to the policy direction from the Commonwealth is in the way in which the housing benefit is now administered. Early on in the Program homes were purchased at great expense. In 2001, the Board changed the policy and will no longer purchase homes, but now provide a one time housing allowance of no more than $175,000.

During our interviews with stakeholder organizations, most agreed the care provided to the children was good. The JLARC Review also concluded that the benefits to the children exceeded the medical malpractice award cap in Virginia. The Program is not unduly burdensome for parents. The JLARC Review also concluded that the most parents believed that the program is a better choice than a medical malpractice lawsuit. With all of the above previous findings in mind, this current study focused on how the Program could be maintained at the current service levels, while increasing income to reduce the accumulated deficit. The Compensation Fund deficit accumulated over a period of time and, as this study demonstrates, a time-based response may be the best solution.

Birth-Injury Board of Directors Recommendations

Therefore, we sought ways to expand the Program's income base on a permanent and/or temporary basis. From this new research, past studies and from internal observations, it was concluded that there were several opportunities to grow our income base from existing sources and even by adding one additional source. This study identifies various options for increasing Program assessment income. All of these options are viable options and worthy of consideration. The actuarial evaluations portion of this study provides the impact for each option on Program revenue and expenses and therefore the impact on Fund balance. After careful consideration of these alternatives, the Birth-Injury Program Board of Directors recommends the following five alternatives for particular consideration by the General Assembly. The Board endorses any combination of approaches that would eliminate the actuarial deficit over a period of no more than15 years. Utilizing any one of, or combination of, the described alternatives would limit the fee or assessment increases for any one-stakeholder group, yet provide a concrete timeline for returning the Fund to a financially sound position.

Alternative 1: Amortize the current fund deficit of $117.6 million over ten years, beginning January 1, 2007, by:

1. Requiring mandatory participation for hospitals and OB/GYNs
2. Increasing the assessment fees for participating physicians by $200 a year for 5 years to a level maximum of $6,200
3. Increasing assessment fees for participating hospitals by$2.50 per live birth per year up to a $60 maximum (i.e. over four years, current amount is $50 per live birth)
4. Increasing the annual assessment for other physicians (non-OB/GYNs) by $10 per year up to a maximum of $370
5. Establishing a surcharge at a level necessary to amortize the current fund deficit over fifteen years, to be applied proportionately to all those who are currently assessed by the Program (physicians, hospitals, liability insurers)

Other Options

In addition, the study identified other options that include the following four alternatives. Please note that alternatives two, three, and four would require mandatory participation from hospitals and OB/GYN's.

Alternative 2:

- Extend the number of years during which the $117.6 million dollar current Fund deficit will be amortized from approximately 10 years to 15 years. This would lower the annual surcharges noted above to $1,723 per year for participating physicians, $16.81 per live birth for participating hospitals, and $93 per year for non-participating physicians. For liability insurers, the surcharge would be a fixed, flat percentage of net direct premiums written equal to .08%. Yearly increases beginning with 2011 and extending through 2021 would be held at $100 for participating physicians, and $10 for non-participating physicians. Hospital rates per live birth would be capped at $60 beginning in 2010.

Alternative 3:

- Eliminate the entire Fund deficit of $117.6 million dollars in approximately 7 years, or by 2013, principally by assessing a new fee on all health insurance providers of one quarter of one percent (.25%) on net direct premiums written. The annual increase of $100 to participating physicians, as provided under current legislation, would continue between years 2012 through 2021 up to a maximum of $7,200 in that final year. The annual increase of $10 to non-participating physicians, as provided under current legislation, would continue between 2012 through 2021 up to a maximum of $400 in that final year. Hospital rates per live birth would be capped at $50 in accordance with the current legislation.

Alternative 4:

- Eliminate the entire Fund deficit of $117.6 million dollars in approximately 15 years, or by 2021, principally by assessing a new fee on all health insurance providers of eleven one hundredths of one percent (.11%) on net direct premiums written. Other changes would be as described in Alternative 3 above.

Alternative 5:

- Provide approximately $7.*8 million from the General Fund of the Commonwealth each year for 15 years, beginning with 2007 fiscal year.* This would retire the $117.6 million deficit without necessitating any significant adjustments to the pattern of fees reflected in the current enabling legislation.

As confirmed by this study, the deficit of 117.6 million, as reported by the independent actuaries, has placed the Birth-Related Neurological Injury Compensation Fund in an unsound financial position. As recommended within this study, the Compensation Fund can only be returned to financial soundness through changes to the current legislation that authorizes and instructs the Program. While the Program is not in immediate danger of defaulting on its current obligations, the long-term viability of the Compensation Program, and the financial soundness of the Compensation Fund, depends greatly on the passage of corrective legislative changes. Such changes, when signed into law will protect the current and the future claimants of the Program.

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PART II: BACKGROUND

The Virginia Birth-Related Neurological Injury Compensation Act (the Act) was created by the Virginia General Assembly in 1987 with the signing of Chapter 540, 1987 Acts of Assembly. The Act was passed in response to "malpractice insurance availability problems for providers of obstetric services." in the mid 1980's. The "no fault" Program was created as an insurance alternative to the Virginia tort system available to injured parties. Additionally, it has been generally recognized that the creation of the Program, coupled with changes to the malpractice award cap, may have contributed to the improved market conditions for medical malpractice insurance companies in the 1990's. As a result, Virginia OB/GYN's were able to obtain malpractice insurance at lower rates than their counterparts in many other states.

With the creation of this Program, the Code of Virginia sets up the Virginia Birth-Related Neurological Injury Fund (Fund) to be controlled by the Board of the Directors of the Program. Out of the Fund would be paid the expenses associated with the three broad categories of Program benefits:

- Medically necessary and reasonable expense
- Loss of earnings from age 18 to age 65
- Reimbursement of reasonable expenses associated with the filing of a claim with the Program

The Fund has four primary sources of revenue. The following groups are assessed annually as established in the Code of Virginia:

- *P*articipating physicians
- *P*articipating hospitals
- *N*on-participating physicians
- *L*iability insurers

There have been numerous studies of the Program since its creation in 1987. See Appendix D for a complete list of these documents. Most notable of these studies is the 2003 Review of the Program conducted by the Judicial Legislative Audit and Review Commission (JLARC). A discussion of the recommendations from this Review is provided in the following section, "Historical Perspective."

A more recent document, though broader in scope than just the Birth-Related Neurological Injury Program, which needs to be considered by this study is the "Report of the Governor's Work Group on Rural Obstetrical Care" required by Governor Warner's Executive Directive 2 (ED2), issued in March 2004. The Work Group, chaired by Secretary of Health and Human Resources Jane Woods, has included in its 27 recommendations, four that directly affect the Program and its policies and procedures. A discussion of these four recommendations is provided in the following section, "Historical Perspective."

Additionally, the enabling legislation, Chapter 50 of § 38.2 of the Code of Virginia has been amended numerous times since 1987. See Appendix E for a complete listing of these amendments. As required by the Act, the State Corporation Commission is responsible for an actuarial valuation of the "Fund" at least each biennium. Table 1 provides a summary of the studies conducted by the SCC since the inception of the Program. Further discussion on these studies and the impact on the program will be provided in later sections of this report.

Table 1: SCC Actuarial Review of the Program

SCC Actuarial Review	
Year	**Finding**
1990	Unsound
1991	Sound
1992	Sound
1993	Sound
1994	Sound
1995	Sound
1996	No Study conducted
1997	Sound
1998	No Study conducted
1999	Sound
2000	Unsound
2001	Unsound
2002	Unsound
2003	Unsound
2004	Unsound
2005	Unsound
2006 Projected	Unsound
2007 Projected	Unsound

Additionally, the Program has from time to time engaged additional independent actuarial expertise to facilitate the management of the Program and to complement the work of the Bureau of Insurance within the State Corporation Commission.

In recent years, there have been changes in the leadership of the Program, both on the executive level and in the Board makeup. The most recent changes are having a positive impact and will continue into the foreseeable future. These changes are in direct response to the recommendations of the 2003 JLARC study recommendation number 41 in which it states "requiring… two citizen representatives with a minimum of five years professional investment experience."

Additionally, the Program is audited annually by an independent Certified Public Accounting firm and recent audits have confirmed the improved management and administration of the Program, notwithstanding the unfunded liability as reported in the most recent audit of the financial statements for the fiscal year ended December 31, 2004. As with all public service agencies, it is critical that the Program demonstrate effective management of its assets and minimizes liabilities.

It is critical to understand that the purpose of this study is not to repeat or in any way duplicate the studies of recent years, all of which had widespread participation and input from the public, stakeholders, Program's participants and others. It is, however, the intent of this study to rely greatly on these previous bodies of work to address the requirements of the HJR 646. Further, some of the supporting data in schedules and tables used in previous studies have been expanded and updated to reflect current information. The use of previous data provides a consistent basis for the ongoing analysis of the Program.

This study intentionally focused on the long-term financial viability of the Program. It is expected that this report will not only answer the questions required by the General Assembly in the HJR 646, but also provide a blueprint that the Program could use in planning for the future. It is expected that the recommendations contained herein, coupled with the management changes noted above, will have a long term positive impact on the bottom line without significantly reducing the services and support of the Program's participants. Although, given the size of the deficit, without the recommended significant increase in future revenue basis or without the investment from the State, reduction of services may be required to reduce the deficit and maintain the long-term viability of the Program.

As instructed by HJR646, the Executive Director identified stakeholders that needed to participate in the completion of this study. The stakeholders so identified were contacted and informal interviews were conducted. Appendix B is a listing of those identified by the Executive Director as Contacts and the organizations that they represent. Appendix C is an extract of questions that were posed in informal interviews. Section III, Input from Stakeholders is a summary of the insight provided by the contacts on behalf of their constituents and their recommendations for this study.

The remainder of this section of the study is intended to give the reader a historical perspective and to demonstrate how the actions taken in the past by the Program, the General Assembly, and others have set the stage for the recommendations for future action that will result in the long term financial viability of the Program.

Historical Perspective

As noted above, there have been several studies and/or reviews of the Program in its 18 years of existence. This section provides a discussion of the more significant of these studies, in an effort to provide the reader with a historical perspective and a sense of continuity of the ongoing direction of the Program. Additionally, this section will highlight the actions of a Board in transition that is moving forward consistent with its organizational mission and consistent with the direction provided by the policy makers within the Commonwealth of Virginia.

JLARC Review of the Virginia Birth-Related Neurological Injury Compensation Program (2003)

The following discussion of the 2003 JLARC Review of the Virginia Birth-Related Neurological Injury Compensation Program (Review) is provided to give a historical perspective for this study without duplicating the work of the JLARC review. It is the Board's belief that the direction, recommendations and the resulting legislation amendments from the JLARC Review are the preamble for the requirements of the HJR 646.

First, it should be noted that in the Preface of the Review document, Phillip A. Leone, JLARC Director noted that, "a number of concerns have been raised about the Program during its 15 year existence, including recent questions about the financial stability of the fund." Notwithstanding this statement, he goes on to say that the "Program appears largely beneficial to the children served by the Program…" With the above two statements in mind, the JLARC Review presents three policy options for the future of the birth injury Program as follows:

1. The basic structure of the Program could be maintained, including voluntary participation in the Program by obstetricians and hospitals.
2. Participation could be made mandatory for these groups.
3. The Program could be eliminated.

Mr. Leone goes on to say that if the General Assembly chooses to maintain the Program a number of changes will be needed. The Review report, without presumption of the preference of the General Assembly, provides 41 recommendations for improvements. The 41 recommendations do not seek to offer alternative funding sources for the Program, nor do they specifically provide recommendations that reduce mandatory expenditures for the Program. In fact, some of the recommendations, as a matter of public policy, will likely result in increased costs without identifying specific resources to support the increased requirements. In effect, the report does not offer recommendations to eliminate the funding deficit of the Program.

Table 2 provides a current status of the recommendations contained in the report, that in some measure, address either increased funding resources or reductions to mandated costs of the Program. A discussion of the most critical of these recommendations follows.

Table 2: Status of Selected Recommendations from the 2003 JLARC Review

Slected 2003 JLARC Report Recommendations		
Rec. #	**Recommendation Summary**	**Status***
1	Eliminate from the Code of Virginia the Board's power to reduce assessment	Implemented
18	Amend the Code to require hospitals to pay a fine where medical records are withheld or lost where the child is accepted in the Program	2003 Legislation passed
19	Amend the Code to allow the WCC to award reasonable attorney fees for petitions filed in good faith but not accepted into the Program	Implemented
28	The Program should develop a policy to address handicap accessible housing for children of non-homeowners	Implemented
30	Amend the Code to require claimants in the Program to purchase private health insurance or permit the Program to purchase insurance for them	Implemented
31	The Program should develop a consistent policy for payment of private health insurance premiums of families who cannot afford their own insurance	Implemented
32	The Program should begin planning for management of the lost wage benefit	Under Review
37	The Program should explore options to better address the needs of families in transporting their children	Implemented

In the following section each of the above recommendations in the JLARC Review are provided as they appeared in the JLARC Report and a discussion of the impact each has had on the Program.

JLARC 2003 Review Recommendation #1: The General Assembly may wish to consider amending the Code of Virginia to eliminate the sentence in §38.2-5016(F), which states, "The board shall also have the power to reduce for a stated period of time the annual participating physician assessment described in subsection A of §38.2-5020 and the annual participating hospital assessment described in subsection C of §38.2-5020 after the State Corporation Commission determines the Fund is actuarially sound in conjunction with actuarial investigations conducted pursuant to §38.2-5021."

Discussion of Recommendation #1: It is noteworthy that this is the first of the recommendations of this important study of the Program. The JLARC study states:

"If the board of directors and the SCC had never reduced assessment levels, it is estimated that the Program would have collected around $140 million in additional income. This additional income would have generated a fund balance of more than $200 million today, and would have secured a financially sound outlook well into the future (assuming assessments remain at maximum levels).

This change was made to the Code by the 2003 General Assembly and has already begun to have an impact on the Fund balance.

For historical perspective and accuracy, it should be noted that the reductions were only implemented by the Board after specific legislation by the Virginia General Assembly in 1994 (HB76) and, as stated in the legislation, after the State Corporation Commission determined the fund to be actuarially sound.

However, this single JLARC observation concerning reductions goes a long way in answering one of the questions raised by the General Assembly in its direction to the Board in conducting this study, "assess the causes for the deficit". It is clear that the reduction of assessments during the early years of the Program was, in hindsight, an unfortunate financial decision. The fact that the Board can no longer "close off" a significant revenue stream should be considered a positive change from the JLARC Review. The impact of this change is further explained in the Conclusions section of this document.

JLARC 2003 Review Recommendation #18: The General Assembly may wish to amend §38.2-5004 of the Code of Virginia to specify that the State Corporation Commission has the authority to require hospitals to pay a fine to the Virginia Birth-Related Neurological Injury Compensation Program in the event that a child whose records are withheld or lost is accepted into the Program. The amount of the fine should be determined by the Workers Compensation Commission and should be no more than the hospital's current participation assessment or the amount of the assessment had the hospital participated.

Discussion of Recommendation #18: This change has not been implemented as of the date of this report. It is not believed that this would have significant impact on the fund balance of the Fund. However, a 2003 change in the legislation did mandate a presumption for the claimant if certain hospital records were not provided by the hospital. While not used at this point, if utilized resulting in an admission into the Program without complete actual medical evidence, it would add substantial costs.

JLARC 2003 Review Recommendation #19: The General Assembly may wish to consider granting the Workers Compensation Commission discretion to award reasonable attorney's fees and expenses for cases filed in good faith, regardless of whether a child is accepted into the Virginia Birth-Related Neurological Injury Compensation Program.

Discussion of Recommendation #19: This provision was implemented in 2003 causing an immediate actuarial deficit increase of nearly $30 million. It was repealed by the General Assembly in 2004.

JLARC 2003 Review Recommendation #28: The Virginia Birth-Related Neurological Injury Compensation Program should develop a policy to address handicapped accessible housing for children on non-homeowners.

Discussion of Recommendation #28: This was completed in 2003. According to actuarial reports it has increased the deficit of the Program.

JLARC 2003 Review Recommendation #30: The General Assembly may wish to consider amending the Code of Virginia to require claimants in the Virginia Birth-Related Neurological Injury Compensation Program to purchase private health insurance premiums or for cases in which the claimant can not afford to pay the private health insurance premiums, to allow the Program to purchase the private health insurance for them.

JLARC 2003 Review Recommendation #31: The Virginia Birth-Related Neurological Injury Compensation Program should develop a consistent policy for payment of private health insurance premiums for those families who can not afford or do not have access to private health insurance.

Discussion of Recommendations #30 & 31: Recommendation 31 was implemented via legislation however it had little impact because it already was the practice. When a claimant is financially unable to afford health insurance, the Program generally (as an economic management tool) purchases insurance for the claimant. In some situations the Program may only partially pay for the insurance with the claimant paying the balance.

JLARC 2003 Review Recommendation #32: The Virginia Birth-Related Neurological Injury Compensation Program should begin planning for management of the lost wage benefit for children who attain 18 years of age. In part, the Program should consider reimbursing families for setting up special needs trusts for all children in the Program to ensure eligibility for Medicaid and disability benefits.

Discussion of Recommendation #32: The Program hired an outside legal consultant to conduct a study and evaluation of this issue. The resulting document is now under consideration by the Board of Directors. It's not expected there will be any major new financial impact since the actuaries have always included the wage benefit in their reports. Setting up trusts, if undertaken would have minimal impact.

JLARC 2003 Review Recommendation #37: The Virginia Birth-Related Neurological Injury Compensation Program should follow existing procedures related to communication more closely to ensure that families in the Program are aware of all Program policies. The Program should also follow through with the existing plan to hold group meetings across the state and obtain input from families on how they can improve communication and service provision. Finally, the Program should improve its web site by including more features to help families' access information needed to obtain benefits.

Discussion of Recommendation #37: These actions and more were implemented and/or underway prior to the JLARC study. The Program's web site was completely rebuilt to provide substantial information to all stakeholders including claimants, physicians, hospitals, lawyers, and prospective claimants. Sections include extensive background, appropriate forms, discussion of issues and benefits and frequently asked questions. Also posted on the site are all annual independent audits, actuarial reports, board meeting schedule and board meeting minutes.

Beginning in 2002, a printed Annual Report, outlining the Program's status, benefits and financial information was initiated and provided to all stakeholders including physicians, claimants, hospitals, state agencies, legislators and the general public. Quarterly newsletters to claimants were implemented to keep them abreast of key issues and concerns. This 2-3 page letter focuses on administrative issues for the claimants.

It was determined the Program's phone system and the number of lines was inadequate to handle the required volume. In response a new system was installed as well as an adequate number of phone lines. A toll-free number is available for claimants to call anytime. Staff training in communications- both written and oral- has been carried out on an ongoing basis from both external and internal sources to improve interaction with claimants, vendors and other stakeholders.

The Program's guidelines were reviewed and amended in 2003-2004 to provide more detail and greater clarity.

In most cases, the Program's nurse case manager visits each family annually to provide for an in-home, confidential opportunity for families to talk with a staff member. This is a continuation of a longtime practice.

The total cost for these changes is estimated at $30,000 to $50,000 per year.

More recently, the Program's Board utilized its 2004 annual meeting with participating parents from Northern Virginia to explore major areas where communications could be enhanced. Based on 10 specific recommendations received from the parents, the Board deliberated and conferred with the staff during 2005 on actions to be taken. Each parent recommendation was addressed through an amendment to the Program Guidelines, or required modifications to the Program communications. Further, commitments were formalized to increase the use of the Program's Web Site to communicate with parents. Finally, the Board formally established a Communications Committee, which will be responsible for facilitating the activities of the Parent's Committee, and the ensuring timely and meaningful communications with Program participating families.

A review of the above demonstrates that only 8 of the 41 recommendations of the Review by JLARC impact the funding position of the Program. Of course, the most significant of these is the first one regarding the assessment of all allowed revenue sources at the maximum levels allowed by law. A closer review of the others will show that none of them address the need for additional revenue, and most of them in fact create additional financial burden on the Program without identifying how these additional requirements would be funded.

Report of the Governor's Work Group on Rural Obstetrical Care (2004)

This report was not commissioned to address specific needs or issues with the Program. However, the basic requirements of the charge of the Governor in his Executive Directive 2, makes clear the relevance of the Governor's charge to the Work Group and the Virginia Birth-Related Neurological Injury Compensation Program. First, the common clientele served by the Program and Rural Obstetrical patients is a critical connection. Also, the common denominator of malpractice insurance between both is also important to note.

In addressing the four duties of the Work Group, the report notes that, "The challenges faced by babies born at very low birth weights (less than 3.3 pounds) often follow them throughout life". In its final report to the Governor, the Work Group includes a Chapter citing the both the past and more recent benefits of the Program. It also notes in four of its 27 recommendations, that changes are needed in the Program. Specifically, it makes the following four recommendations:

Recommendation # 19

A uniform data collection tool should be adopted by the workers' Compensation Commission for use by consultants evaluating medical records to determine whether children should be admitted to or denied access to the Virginia Birth-Related Neurological Injury Compensation Program. The form shall reflect criteria that are consistent with the existing provisions of the Virginia Birth-Related Neurological Injury Compensation Program and is intended to assist in assuring that decisions are as consistent as possible across the Commonwealth, recognizing that there are subtle differences in individual cases that require the exercise of medical judgment.

Recommendation # 20

VDH (Virginia Department of Health), the BOM (Virginia Board of Medicine), University of Virginia, Virginia Commonwealth University, Medical College of Virginia, and Eastern Virginia Medical School, in collaboration with stakeholder organizations, shall develop a process and mechanism to: 1) collect and analyze their findings from the Birth-Related Injury Compensation Program cases admitted on or after July 1, 2005, and 2) shall work with prenatal provider organizations to develop and disseminate reports on the factors in obstetrical care that contribute to the adverse birth outcomes.

Recommendation # 21

BOM and VDH should fully implement the recommendations from the Joint Legislative Audit and Review Commission (JLARC) in the "Review of the Birth-Related Injury Compensation Program" that call for routinely interviewing the claimant families about the events surrounding the births and notifying them about the outcome of the medical reviews.

Recommendation # 22

VDH, through its health districts, shall initiate, and update as needed, (but not less frequently than every three years), memoranda of agreement with appropriate local obstetrical providers as specified by the Birth-Related Injury Compensation Program.

The purpose of these agreements is to develop a plan to improve access for low income and uninsured women.

It is the position of the Board that only recommendation #19 has direct impact on the Program. A uniform data collection tool and evaluation format tool was developed in 2003 by a committee of clinical representatives from each of the medical schools providing panels. This tool has often been utilized by the panels. I was submitted to the WCC in 2003. Although there has been no formal action by the WCC to formally endorse this for evaluating submitted claims against the legislative requirements of the Program, it has been used as a basis for Medical Panel submission to the WCC. There is no direct financial impact from this recommendation.

The Report of the Governor's Work Group on Rural Obstetrical Care has mostly administrative implications for the Program. However, care should be taken to not inadvertently create unfunded mandates on a Program that already is operating in a deficit. If the recommendations of the Work Group are implemented, the State agencies charged with coordination should provide funding for additional support required by the Program. The Program does see the merit in the accumulation of data that will facilitate consistent application of decisions and approval of Program participation.

The Definition of Compensable Injury and the Funding Mechanism of the Virginia Birth-Related Neurological Injury Compensation Act (1990)

The creation of the Birth-Related Neurological Injury Compensation Program by the 1987 General Assembly was believed to have met one of its intended outcomes, to address the immediate medical malpractice insurance availability crisis. However, as of 1989 there had been no claims since the effective date of the Program. This caused the General Assembly to create a Joint Subcommittee asking the following questions:

1. Whether the definition of injury is meeting the intent of the Act
2. Whether any adjustment to the funding mechanism is needed.

The Joint Subcommittee concluded that the definition should be changed. However, the Joint Subcommittee held reservations that this change alone would resolve their concerns about the adequacy of the funding mechanism. It proposed that the study be continued for another year due to the fact that even though there had been no claims and the actuarial finding was that the fund was "under funded". It is significant to note that as early as 1990, the General Assembly was asking "whether any adjustment to the funding mechanism is needed" and that it had been reported that the Fund was under funded.

Study to Increase the Scope and Magnitude of the Virginia Birth-Related Neurological Injury Compensation Program (1998)

The purpose of this study was as follows:

1. Identify the Program's strengths and weaknesses
2. Assess the purpose for which the Program was created by the General Assembly
3. Develop recommendations that will result in the increased use of the Program in a manner beneficial to the Commonwealth

The Board of Directors engaged a project team from the Center for Public Policy Research at the College of William and Mary to conduct the study. In nearly 200 pages this team provided an exhaustive document that answered each of the above questions with great detail. The authors of this study utilized extensively the input from the medical profession including both participating and non-participating physicians, hospitals, Program participants, insurance industry and lawmakers. This study is most likely the second most important study of the Program since its inception, just behind the JLARC 2003 study. Unfortunately, it is another major study of the Program that focused much of its effort on the operational aspects of the Program. It did, in Chapter 4, discuss fund income and management. It also identified some changes included in the JLARC Review in later years, like the need for better fund management and coordination among those involved in the Fund and its investments to include actuaries, auditors, investment managers, administrators, and the Board. However, at the time of this study the latest financial prediction noted in the report, summarized in Table 4-2 of the report, and supported by independent audits for the fiscal year between 1987 and 1995, was that the fund was sound. It should be noted that this study did observe the need for greater oversight suggesting the creation of a Financial Advisory Committee.

As noted earlier, the 2003 JLARC Review noted 41 recommendations for improvement of the Program. Many of these recommendations suggested Code of Virginia changes. In the last three sessions of the Virginia General Assembly, 2 bills were passed to address some of these recommendations. The following is a summary of these changes.

- Chapter 931 (2004 Session) – This bill increases assessments for participating physicians and hospitals, and nonparticipating physicians on an incremental basis beginning in 2005, to maximums of $5,500, $200,000, and $300, respectively. The bill also eliminates the authority to pay attorney's fees to applicants who are not admitted into the birth injury fund program.
- Chapter 52 (2005 Session) - Establishes that the Birth-Related Neurological Injury Compensation Program's response to a claimant's petition is not due until 10 days after the three-physician panel's report is filed with the Workers' Compensation Commission. Upon the filing of the Program's response, the Commission shall set the hearing date, which shall be no sooner than 15 and no later than 90 days after the filing of the Program's response.

PART III: INPUT FROM STAKEHOLDERS

One of the methodologies used in this study was to contact representatives of key stakeholder groups that have an interest in the Program and its policies. The most significant of these stakeholder organizations are as follows:

- Virginia Medical Society
- Virginia Hospital and Healthcare Association
- Virginia Trial Lawyers Association
- Virginia Insurance Industry

As stated earlier, this study does not intend to duplicate the extensive interview, participation and involvement at so many levels of the earlier studies of the Program. Much of the information gathered in earlier studies is well documented and forms a basis for much of the information provided herein. However, there are several stakeholder organizations that had to be included in the study. In the interest of time, it was decided that informal interviews with representatives from these critical stakeholder organizations would be the best way to ensure their input.

Each of the above organizations was contacted and informal discussions were held with designees from each. The purpose of these discussions was to solicit their input on their experiences with the Program and their suggestions for the continuation of the Program. Their responses were as varied as the organizations themselves. It should be noted that all of the above organizations have an interest in the financial stability of the Program and to some degree all (except the Virginia Trial Lawyers Association) contribute to the Program through the fee assessments authorized in the Code of Virginia.

Most interviewees agreed that the Program has achieved the original goal to reduce the number of lawsuits resulting from birth injury through the “no-fault” insurance Program. However, most also were not sure if the Program is still a factor in reducing insurance premiums.

All interviewees agreed that the children and families affected by birth injury need and deserve the help and support. However, most all agreed that it is less clear that the Program is the best solution to help these families.

Among the observations common between the stakeholder organizations is that there is no consensus position within their organization in support or support against the Program. One of the interviewees noted that within their particular constituency group, one would not likely find consensus. That is to say, some within the membership are in favor of the Program and its continuation. However, some believe it should not continue to exist in any form. Another interviewee commented that the Program “is the worst Program in North America”. He went on to ask, “Why has no other state in the country, other than Florida, implemented such a program?”

Some of those interviewed, echoed previous reports of the JLARC study. It seems that many agree that the Program has met some of the needs of the Program participants but the Program has inherent weaknesses. It was suggested that a birth weight minimum for infants admitted to the Program should be imposed. It was noted that the gestation period, especially in multiple births be revised.

However, all agree that the Program must address the current under funding. It goes without saying, that none would expect that their constituency would voluntarily support increased assessments to alleviate the deficit. There is a perception that poor management of the Program in its earlier years was a contributor to its financial problems today. Example: Program had large reserves in the early years and when assessments were reduced and or curtailed then later in subsequent years fees were re-instituted they were naturally resisted.

Some interviewees questioned the mandatory vs. voluntary participation physicians and hospitals. With a voluntary system it becomes a business decision for both the physician and the hospitals. Though no one likes to have mandatory fees imposed, it may be the fairest way to distribute some of the burden of the cost of the Program.

It was noted that there is a need to improve the communications and simplify eligibility criteria. It has been suggested that the Program needs to develop a proactive approach to the public relations issues it has faced in recent years.

Most agree that public funds (i.e. General funds of the Commonwealth) could and should be used in support of the Program. However, some pointed out that there are other deserving public needs that are similar in nature to the participants of the Program.

Most agree that the Program should not provide for housing for participants, though they agree that some support for housing conditions such as handicapped accessibility should be approved costs of the Program.

All of the interviewees were open and candid with their responses and all were willing to participate in further efforts to improve the Program and its services. The following is a summary of the specific concerns and or issues as identified by the respective organizations.

Virginia Medical Society

- Program must eliminate the perception that it is a "scholarship Program"
- Program must eliminate the Deficit either by increasing revenues or by decreasing expenses…simple as that
- Change law to address birth weight issues
- Public Interest is protected by the Program
- Commonwealth should use public funds to support the Program

Virginia Hospital and Healthcare Association

- As an organization the VHHA supports the Program, but there are differing views among their constituency
- VHHA believes the Program must improve its outreach and public communications regarding the Program and its benefits
- Mandatory vs. Voluntary participation by Physicians needs to be addressed and resolved
- Need clarity between participation rates for hospitals and Physicians

Virginia Trial Lawyers Association

- Not sure the public interest is being protected
- Not sure Program is meeting original intent of legislation
- Removes the right to sue for damages of participants

Virginia Insurance Industry

- Why should Property and Casualty Insurers be assessed for this Program?
- Program is not adequately funded …but it is their own fault. Should not have reduced assessments early on in Program
- Not sure Public interest is protected by Program
- Why is Virginia only 1 of 2 states in the country with such a Program?
- Florida Program created same year as Virginia's but they have never assessed the Insurance carriers
- Cost of benefits under Tort system would have been less than deficit
- What is medical profession doing about doctors with excessive claimants in the Program

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PART IV: REVIEW OF OTHER PATIENT COMPENSATION PLANS (PCPS)

A Patient Compensation Fund (PCF) is a liability funding mechanism created by state governments. PCFs provide additional medical malpractice coverage for physicians in excess of their primary insurance coverage. In other words, by definition, "PCFs offer insurance for medical malpractice liability that exceeds the specified threshold amounts covered by the insured provider's primary insurance policy or qualified self-insured plan" (Sloan, Mathews, Conover, and Sage, 2005). All participants in these Programs must be qualified and licensed medical physicians. PCFs also limit or place a cap on the monetary awards received by claimants.

PCFs were created through tort reform and enabled by the (states) general assembly. Tort reform, "targets ways in which medical malpractice claims are processed through the court system and are aimed at reducing either the size of awards or the number of suits that make it to courts (Cornell, 2002).

Before the investigation into the components of specific state PCFs can occur it is important to understand the events which lead to their need and furthermore to their creation. PCF were created in response to the first medical malpractice insurance crisis in the 1970's and 1980's. The medical malpractice insurance crisis was dawned by the withdrawal of major medical insurers from the insurance market in several states.

Medical Malpractice or medical negligence occurs when it is believed a physician fails to properly treat a patient or identify a proper course of action in treating a medical condition and this negligence leads to a new or aggravated injury to the patient. As a result medical malpractice insurance was created to cover medical physicians in the event a liability claim from a patient arises. In 1988, the Journal of Medical Economics conducted a survey on malpractice claims filed against medical physicians. The study revealed that six out of ten practicing physicians had been sued during their career, the average malpractice settlement was approaching $81,000 in 1987, and the average malpractice premium rates were $17,000 while some specialty physicians had rates as high as $200,000 in 1988.

Over the last twenty-five years, several states have created PCFs in response to medical malpractice insurance crisis. Some of these Programs have been terminated as the liability crisis abated but today many states still have PCFs in place to provide additional coverage for physicians and to preempt future medical malpractice insurance crises.

Since their conception in the mid-1970s, PCFs have usually been funded from assessments on providers and invested returns, not from state subsidies (Sloan, Mathews, Conover, Sage, 2005). PCFs surcharges can either be charged to participating physicians and hospitals or primary insurance carriers (in most cases physicians and hospitals pay the surcharge). In most states surcharges are determined by the geographical area in which a physician or hospital is located, the specialty of the physician, whether surgery is performed, and the size of the hospital. Only two states have a flat rate for Program participation and these states require all health care providers to participate in the Program or fund. Some PCF, like Florida, were setup with a trust fund in order to help the Program if it ran into financial difficulties.

The following section is an investigation into state patient compensation funds. Information regarding funding approaches participation, primary coverage, and other key components of the patient compensation fund will be investigated.

Florida

In 1988 Florida legislation created the Birth-Related Neurological Compensation Association (NICA) as a result of the medical malpractice insurance crisis of the 1980's and from successful tort reform. This fund covers children who were brain-damaged during the birthing process from oxygen deprivation or mechanical injury. Participation in the Florida Program is mandatory for all Florida Hospitals but is voluntary for physicians.

The NICA receives funding from participating obstetricians/gynecologists ($5000 year), nurse midwives ($2,500 year), all other medical physicians ($250 year), and hospitals ($50 per live birth). "The compensation fund was initially capitalized with a $20 million appropriation from the legislature" (Spigel, 2003).The $20 million in appropriations was placed into an Insurance Regulatory Trust Fund that may be used if the Florida Programs assessments become insufficient in maintaining the Florida Program. As of June 30, 2002 the NICA has admitted 161 children into the Florida Program (approximately 1.85 million per claim). The NCIA has over $299 million in reserves claims and liabilities and $320 in various assets.

Indiana

The Indiana Malpractice Fund was created in 1975 and is operated by the Indiana Insurance Department. A variety of practitioners and institutions participate in the Indiana Program, which include physicians, nurses, blood banks, HMO's, hospitals, emergency medical technicians, and other health care providers and institutions. Participation in the Indiana Program is mandatory for all healthcare providers in the state. Practitioners in the Indiana Program are required to carry primary insurance of $250,000 per occurrence and $750,000 for the aggregate year. Indiana has a cap (total damages) on malpractice claims of 1.25 million dollars.

The Indiana Program funding comes from annual surcharges paid by participants. Surcharges range in price depending on the type of medical services being provided. For example, surcharges range from $2,334 for residents and specialties such as psychiatrists to $26,452 a year for OBs and GYNs. Also surcharges increase for doctors who perform surgery. For example, doctors who perform no surgery pay $3,112 a year. Family practitioners may pay between $5,602 and $9,336 a year depending on the amount of surgery performed (and risk involved). It is important to note, that as of August 2003 surcharge rates increased by 72.6%. The Indiana Malpractice Fund is well funded and actuarially sound (the Indiana State Law requires the Indiana Program to be actuarially sound).

Kansas

The Kansas Healthcare Stabilization Fund (KHSF) was created in 1976 through legislation formulated in the Health Care Provider Insurance Availability Act. The primary function of the KHSF is to provide excess professional liability coverage to healthcare providers. The KHSF requires (mandatory participation) all healthcare providers such as medical and osteopathic doctors, individuals in post graduate training, chiropractors, medical care facilities, hospitals, surgical centers, schools of medicine (such as the University of Kansas School of Medicine), dentists, and other health care providers to participate in the Kansas Program. The fund is governed by a ten-member board of governors, all of which are representatives of the healthcare community.

Healthcare providers must select a fund coverage limit from the following three options $100K/$300K, $300K/$900K, and $800K/2.4 million. The Kansas Program calculates a participant's yearly surcharge based on the coverage limit a participant selects and predetermined surcharge rate tables (which take into consideration a variety of factors. It is also important to note that Kansas has a non-economic damage cap of $25,000 but is does not limit total damages and only pays up to the amount of fund coverage selected by the participant (i.e. physicians or hospital).

Louisiana

The Louisiana Patient Compensation Fund (created in 1975) is a voluntary program that is run by the Fund's Oversight Board. The fund provides excess malpractice liability coverage up to $400,000 but participating physicians are required to carry a minimum of $100,000 in primary insurance. The Louisiana PCF has a damage cap of $500,000 but the cap does not include future medical costs. Annual surcharges for participation in the Louisiana Program are based on the level of coverage that is selected.

Currently approximately 7,000 doctors participate in the PCF. Doctors that do not participate in the fund cannot receive hospital privileges and as a result almost every doctor in the state participates in the Louisiana Program. The fund also covers any licensed healthcare provider including hospitals, EMS services, many physicians, and nursing homes, and nurses. Actuarial reports have found that the Program is financially sound and stable.

Nebraska

The Nebraska Medical Malpractice Fund was enacted in 1976 by the Nebraska Hospital-Medical Liability Act. The fund is a voluntary program and health care providers such as physicians, nurse anesthetists, medical facilities, and hospitals, and patients may participate in the Nebraska Program.

In order to be covered by the fund physicians must obtain basic liability coverage from a qualified insurance company in Nebraska ($200K/$600K); pay an annual surcharge to the fund in an amount determined by the insurance director (which may not exceed 50% of the premium for basic liability insurance coverage). It is important to note that as of 2003 surcharge rates for doctors, hospitals, and other health care providers will increase from 35% to 50%, the highest rate allowable.

The Nebraska PCF may not be actuarial sound or stable because of the volume of lawsuits filed in recent years (most cases involve one doctor, in connection with a Hepatitis C outbreak). Currently the fund has approximately $55 million but is expected to pay out $46 million in settling pending claims (this figure does not take into consideration the lawsuits from the Hepatitis C cases).

New Mexico

The New Mexico Patient Compensation Fund was established in 1976 and is operated by the New Mexico Insurance Division. The New Mexico PCF is open to all physicians, hospitals, clinics, and nurse anesthetists. Currently 2,300 doctors participate in the New Mexico Program that only constitutes a small portion of doctors in the state. Participation in this New Mexico Program is voluntary but participating physicians must carry primary insurance of $200,000 per occurrence and $600,000 per year. The New Mexico PCF has a cap on damages that is set at $600,000 but it is important to note that payments for future medical care and other related benefits are not subject to this limit. Surcharges vary by specialty, "from $2,061 for doctors in certain specialties who do not perform surgery, to $17,175 for doctors who perform surgery for cardiovascular disease, neurology, and obstetrics and gynecology" (Coppolo, Kasprak, Gelb, and McMarthy, 2003).

It is important to note that the surcharge rates have not increased since 1984. Even in light of this information the New Mexico PCF is financially sound and stable. According to a 2002 state report over the last seven years the New Mexico PCF has only spent $7,738,232 while New Mexico Program surcharges have brought in revenues of $8,851,625. On a down side many doctor participating in the New Mexico Program feel that they are paying too much for participation.

Pennsylvania

The Pennsylvania Medical Care Availability and Reduction of Error Fund (MCARE) were created in 1975 in order to address the medical malpractice insurance crisis (Pennsylvania was one of the hardest hit states). Participation in MCARE is mandatory for all physicians, nurse midwives, hospitals, nursing homes, and birth centers.

To be able to participate in the fund physicians must carry personal coverage of $500,000 per occurrence and $1.5 million in annual aggregate claims. Hospitals are required to carry $500,000 per occurrence and $2.5 million in annual aggregate coverage. The fund plans to increase these requirements to $750K/$2.25 million in 2006 for physicians and up to $750K/$3.75 million. The MCARE Pennsylvania Program does not cap liability claim limits at $1 million and as a result healthcare providers must purchase additional private healthcare insurance.

The Pennsylvania Program is funded by surcharges collected from participates in the Pennsylvania Program. Surcharge rates are determined by the region in which the physician practices, the physician's specialty, and whether the doctor performs surgery or not. In other words a family physician in a rural region of the state that does not perform surgery will have a much lower surcharge rate then a physician in an urban area that performs surgery. The higher the risk of the specialty the higher the surcharge payment will be, for example, OB/GYNs pay between $20,061 and $41,302 a year. As of 2000, insurance premiums for physicians had risen to levels 50% greater than the national average ($27,490) and over 100% for high-risk professions such as OB/GYNs.

The MCARE fund carries a very limited reserve. This is due to the fact the fund is scheduled to be terminated in 2010. The fund is currently operating on a "pay-as-you-go" system because surcharge rates can only handle current payouts.

South Carolina

The South Carolina Medical Malpractice Patient Compensation Fund was created in 1976. The South Carolina PCF is a voluntary South Carolina Program and currently the South Carolina Program has over 8,327 members (5,466 of which are physicians which comprises 79% of all physicians in South Carolina). Any healthcare provider (with personal insurance of at least $200K/$600K) in the state may participate in the South Carolina Program and this includes hospitals, physicians, dentists, nurses, and podiatrists. The PCF provides unlimited coverage for malpractice claims but also provides basic coverage of $200K/$600K. Over the last ten years the South Carolina Program has increased its membership by 67% and more then doubled the number of claims handled. The South Carolina PCF is funded by member fees (which the State Treasurer's Office invests).\

The South Carolina PCF appears to be financially sound and stable. As of 1999 the PCF had a cash balance of $19.3 million. South Carolina never had a full-blown medical malpractice insurance crisis but things in the state might be getting worse. It is important to note that annual surcharge rates for Neurosurgeons and OB/GYNs are increasing rapidly each year (by as much as 50%). The fund does not impose a damage cap, limit attorney fees, or require a pre-trial screening panel (which comes from tort reform measures, which many other states have done).

Wisconsin

The Wisconsin Patient Compensation Fund was created in 1975 and participation is mandated by the state. The Wisconsin Program was created in response to the growing concern of availability and cost of medical malpractice insurance. The fund is managed by a thirteen-member board of governors. Each of the thirteen members represents a major stakeholder (for example the Wisconsin Hospital Association, the State Bar, Commissioner of Insurance, the Wisconsin Medical Society). Any healthcare provider in the state (who works more then 240 hours a year) must participate in the Wisconsin Program. Each of the participants is required to carry primary malpractice coverage of $1 million for each incident and $3 million per year. The fund insures physicians, nurses, nursing homes, ambulatory surgery centers, hospitals, and medical partnerships/cooperation.

Funding for the Wisconsin Program comes from surcharges paid by the participants. Surcharge rates range in price by specialty and increase with the amount of risk involved. The Wisconsin PCF appears to be stable. As of 2000 the fund is running a surplus of 27.2 million and is recording assets of $665 million.

The following table shows many states have taken differing approaches to the resolution of the medical malpractice crisis in the mid 1980's. The majority of the state's plans tend to require mandatory participation for their program.

Table 3: Summary of State Compensation Funds

State Patient Compensation Funds

State	Created	Eligible professions	Program Participation	Required Primary Insurance Coverage	Funding Source	Basic Benefits
Florida	1988	Physicians (obstetricians/gynecologists), Nurses, nurse midwifes, and hospitals	Physicians/Voluntary, Hospitals/Mandatory	$250K/claim, $500K/occurrence	hospitals, nurses, and physicians (assessments) and trust fund	-
Indiana**	1975	Any health care provider in the state	Mandatory	Phys: $250K/$750K Hosp: $250K/$5M or $7.5M	All healthacre providers in the state (assessments is based on specialties)	$500K in program cap coverage
Kansas	1976	All healthcare providers in the state	Mandatory	$200K/$600K	All healthacre providers in the state (assessments is based on specialties)	Has a non-economic damage cap of $25,000 but no economic damages cap
Louisiana	1975	Any licensed healthcare provider in the state	Voluntary	$100K/$300	Any participating healthacre providers in the state (assessments is based on specialties)	$400K in program cap coverage
Nebraska**	1976	Health Care provider such as physicians, nurse anesthetists, medical facilities, and hospitals are eligible to participate	Voluntary	Phys: $200K/$600K Hosp: $200K/$1M	Any participating healthacre providers in the state (assessments is based on specialties)	-
New Mexico	1976	Any healthcare provider in the state	Voluntary	$200K/$600K	Physicians, hospitals, clinics, and nurse anesthetists (assessments is based on specialties)	$400K in program cap coverage
Pennsylvania*	1975	physicians, nurse midwives, hospitals, nursing homes, and birth centers	Mandatory	Phys: $500K/$1.5M Hosp $500K/$2.5M	physicians, nurse midwives, hospitals, nursing homes, and birth centers	-
South Carolina*	1976	Any healthcare provider in the state	Voluntary	$200K/$600K	Any participating healthacre providers in the state (assessments is based on specialties)	-
Wisconsin	1975	All healthcare provider in the state (who works more then 240 hours a year)	Mandatory	$1M/$3M	Any healthcare provider in the state (who works more then 240 hours a year and is based on specialities	-

*(1)Pennsylvannia and South Carolina are the only two states with patient compensation funds that do not impose a damage cap of any kind
**(2)Indiana and Nebraska, impose a total damage cap that coves economic as well as non-economic damages

Additional Information

The final section of this paper will look at other insurance market intervention state Programs, such as State-Run, Stop-Gap Medical Malpractice Liability Coverage, State Patient Compensation Programs (already covered), State Subsidies to Providers, Joint Underwriting Associations, Physician Insurer Associations or Physician Mutual, and State Funded Indemnity for Specified Services.

State-Run, Stop-Gap Medical Malpractice Liability Coverage (SGMLC)

Under this scheme the state establishes its own insurance fund for doctors to purchase when there is no other insurance carrier on the market. These funds are used to provide immediate relief to insurance crises. In 2002 the state of Nevada and West Virginia both set up a SGMLC to relieve current shortages. These programs provide malpractice insurance when there is no other available source, however in many cases the insurance provided by the state is not very affordable. Price premiums are often very high which can be a burden on participants.

State Subsidies to Providers

Some states established a program that subsidizes all or a portion of private insurance premiums. This type of program can be used on a time limited basis or for extended periods (a few years) in order to help stabilize insurance premiums. These state subsidies can be used to help subsidize high-risk specialists (such as OB/GYNs) or medical providers in small/rural geographic areas. Arizona, Hawaii, Illinois, Louisiana, Maine, Nevada, New York, North Carolina, Texas, and Washington used such alternative programs during the 1980's malpractice insurance crises and have since cancelled the programs as insurance premiums stabilized.

Joint Underwriters Associations

A Joint Underwriters Associations (JUA) is a state sponsored association of insurance companies. The purpose of the Program is to provide certain types of insurance to the public when insurers are unwilling to provide coverage. This system spreads the risk of coverage over all those members participating in the plan coverage thus decreasing the overall risk to one company. One drawback to this system is it inflates the price of insurance, especially for high-risk specialties.

Physician Insurer Associations or Physician Mutual

Physician insurer associations are physician owned and operated insurance companies that provide medical liability coverage (Cornell, 2002). Physicians with the help of hospital associations contribute money to a fund that in turn creates several provider owned specialty carriers. Today physician owned companies insure 60% of all practicing physicians in the nation (Cornell, 2002).

State-Funded Indemnity for Specific Services

State-funded indemnity provides liability coverage for physicians who have a working relationship with the state (such as state university hospitals or pubic hospitals). A state indemnity program typically covers a claim against a physician when the physician is working directly for a city, county, or state (Cornell, 2002). The system provides coverage for specific services such as trauma or obstetrical services. This shifts liability/claim from the provider to the government. State-funded indemnity schemes protect physicians who serve low-income clients and physicians who are in high-risk specialties (such as OB/GYNs). It is important to note, that these programs place a great burden on the state by providing liability coverage for high-risk healthcare providers.

PART V: WEIGHING OPPORTUNITIES TO REDUCE COSTS OR INCREASE ASSESSMENTS

Early on in the project it was suggested that the dilemma facing the Program, while very complicated with many facets, is actually very simple. The Program must reduce benefit and administrative costs, or increase assessment revenue. The Board takes its fiduciary responsibility very seriously. It also recognizes the extraordinary need of the Program participants. Finding the balance necessary to sufficiently guide the Program from operating at a deficit to a Program with a sound financial base to provide services to its claimants well into the future is a high priority of this Board.

In 2001 the Board, upon recommendation by the actuaries, reduced the housing benefit. It should be noted that the housing benefit is a discretionary expense and not a legally mandated benefit. Since 2002 the Program has strenuously enforced the Birth-Injury Act's requirement to utilize all other non-program resources first. This change has reduced benefit costs considerably, with no additional cost to our claimants. Also beginning in 2002, the Program began negotiating contracts with providers, thereby reducing benefit costs. Most recently, the Board modified its investment policies allowing for greater return on investment dollars without increasing risk to the Program funds.

Additionally the Program realized that it would need to seek actuarial scenarios that would increase assessment revenue. A number of alternative modifications to the assessment models were considered. Eventually, we asked for actuarial projections based on the following changes.

- Mandatory participation for hospitals and OB/GYNs
- An increase in maximum assessment fees for participating physicians by $200 a year for five years
- An increase in the assessment fees for participating hospitals by $2.50 per live birth up to $60 maximum (i.e. over four years)
- A surcharge equivalent to amortizing the current fund deficit over a prescribed number of years
- Addition of group health insurance to the lines of insurance subject to the 0.25% premium assessment, and
- Introduction of a subsidy for participating rural health care providers

Additionally, two major policy differences between the Virginia Program and the Florida Program were explored. The Florida Program imposes a birth weight limit for eligibility of 1,500 or 2,000 grams, and requires the discontinuation of further Program admissions until he actuarial deficit has been eliminated. Therefore, an analysis of the impact of these Florida policies as they might bear on Virginia was prepared. The following is a summary of the results of the above scenarios and the results of the actuarial findings. As requested by the actuary, their entire report is provided as Appendix H.

The proposed increase in participating physician fees (continuing the voluntary participation plan) to a maximum of $6,200 per year, would produce additional revenue of $374K in 2006 and reach an increase of $1.3 million in 2010. However, the mandatory participation proposal would produce additional revenue of $483K in 2006 and reach $1.7 million in 2010.

The proposed increase of $2.50 per live birth per year up to a maximum of $60 would, under the optional participation plan, result in increase revenue of $110K in 2006 an increase to a maximum of $469K in 2009. Similarly, under the mandatory participation plan, assessment revenue would increase by $180K per year and peak in 2009 at an additional $747K per year.

The proposed addition of group health insurance to the lines of insurance subject to the 0.25% of premium assessment is projected to generate between $4.0 and $5.0 million per year. One approach that has been considered to reduce the deficit is to impose a surcharge that would amortize the deficit over a predetermined number of years

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PART VI: CONCLUSIONS AND RECOMMENDATIONS

In passing HJR646, the General Assembly stressed the need for the Board to address four areas of concern, as follows:

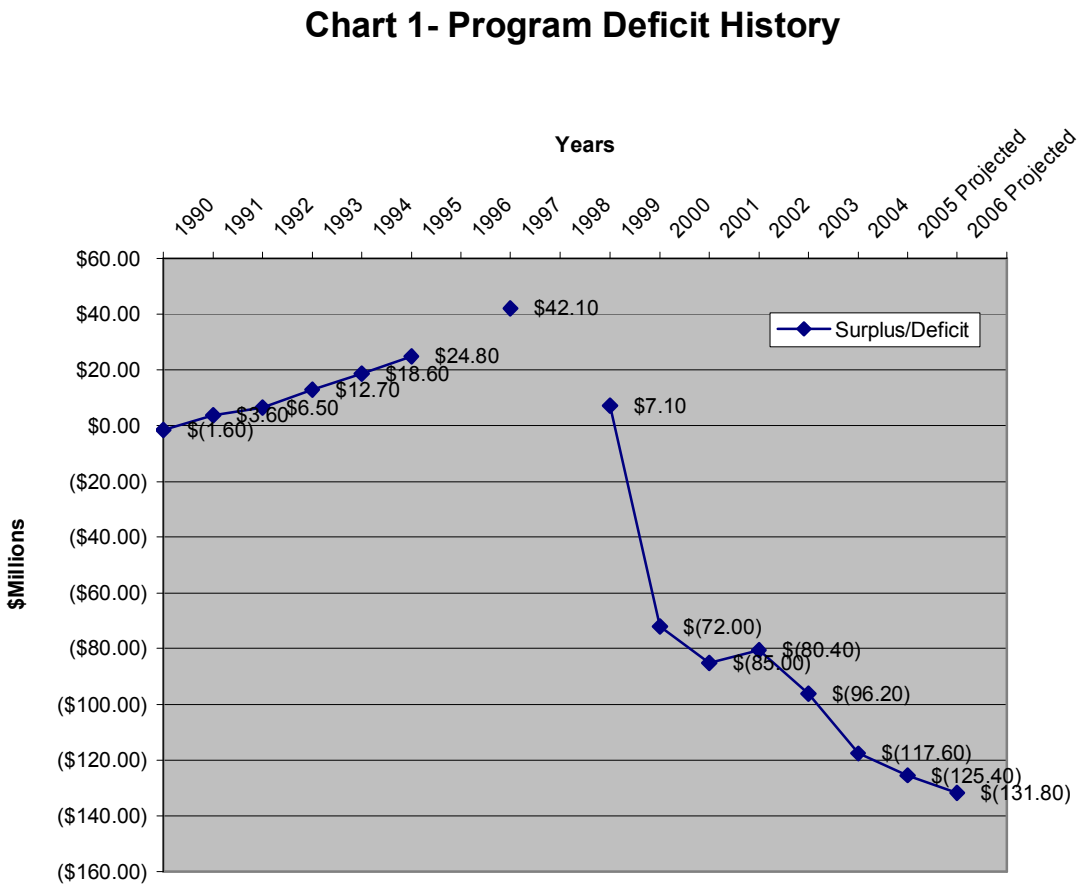
1. Identify the extent of the Program deficits
2. Assess causes for such deficits
3. Review Program structure to determine necessary amendments to stem deficits
4. Assess the effect of such amendments on the number of beneficiaries to be assisted by the Program in subsequent years

The following will provide the specific findings and recommendations in response to the above areas required by the HJR646.

1. Identify the Extent of the Program Deficits

It had been noted as early as 1990, only three short years after the Program's creation, that the Program was then under funded. More recently, as Chart 1 shows, the Program has reported a developing Fund Deficit, from a surplus condition of $42.1 million in 1997 to a deficit condition of $117.6 million in 2005. This decline in Fund balance represents an average deepening of the deficit of over 7 percent a year. Records indicate that the life expectancy of our Program participants grew from 17.5 years in 1999 to 23.4 years in 2004, according to the 2005 Mercer Actuarial study.

Chart 1: Time line of the Programs Deficit History



*Note: Studies were not completed for years 1996 and 1998

2. Assess Causes for Such Deficits

To isolate a single cause of the deficit is at best difficult, if not impossible. Many factors must be considered. There are many variables, as demonstrated in the actuarial data, and there are many cause-and-effect relationships throughout the Program's existence that contributed to the current deficit. However, the deficit has been in the making for many years and, as noted above, the Program was reported to be under funded in 1990 prior to having recorded its first claim. However, that being said, we believe that a fundamental cause of the deficit was the lack of diligence and consideration of the importance of accurate actuarial assumptions used early in the Program. This is, in part, explained by the fact that the Program was new and little, if any, actual historical data was available on which to base the assumptions. Therefore, it appears that only near term empirical data formed the basis of the actuarial assumptions of early years. Unfortunately a number of these earlier assumptions proved to be incorrect based on later evolving factual data.

This early lack of accurate and reliable data on which to base actuarial assumptions led past Boards, the SCC, and others to decisions that reduced possible assessment revenue by considerable amounts from 1990 until 2002. Tables 2, 3, 4, and 5 present a summary of the "lost opportunity" assessment revenue that was forgone as, at least, an indirect result of inaccurate

actuarial assumptions. These Tables show that considerable funds in historical dollars were never assessed, and therefore revenue during this period was "lost" to the Program. The JLARC Review in 2002, stated that the "sliding scale assessments", adopted by the Board from 1995-2000, "reduced the Program's assessment income from participating physicians and hospitals by approximately 65 percent".

For participating physicians, the Board reduced the assessment to 25 percent of the assessment allowed by law. At that time, the Board had the legislated authority to do so. However, as a result of one of the recommendations in the JLARC Review in 2003, the General Assembly amended the Code and removed this authority from the Board. Additionally, in 2001 the Board began to assess the full amount allowed under law. Even with a reduction in the number of participating physicians of approximately 19 percent in 2001, the assessment revenue was more than $1 million over 2000 year assessments. Table 4 is illustrative of the possible "lost opportunity" revenue to the Program from 1995 through 2000. Table 4 estimates that the "lost opportunity" could be as much as $9.5 million for participating physicians.

Table 4: Lost Opportunity Assessment Revenue from Participating Physicians

Lost Opportunity Assessment Revenue From Participating Physicians				
YEAR	**# of Participating Physicians**	**Reported Annual Revenue**	**Maximum Possible Annual Assessment Revenue**	**Lost Opportunity Assessment Revenue**
1995	426	$837,680	$2,130,000	$1,597,500
1996	403	$658,623	$2,015,000	$1,511,250
1997	420	$743,081	$2,100,000	$1,575,000
1998	402	$622,250	$2,010,000	$1,507,500
1999	444	$687,250	$2,220,000	$1,665,000
2000	433	$709,900	$2,165,000	$1,623,750
			Total Lost Revenue = $9,480,00	

For participating hospitals, the reduction in assessment revenue was the result of the Board placing a "cap" on the amount participating hospitals would have to pay. At the time the maximum amount allowed by law was $150,000 based on $50 for each live birth. However between 1995 and 2000, the Board, within its authority, reduced the cap from the above stated $150,000 to only $11,250 for those years. This policy change resulted in "lost opportunity" assessment revenue of approximately $17 million over the six-year period as shown in Table 5.

Table 5: Lost Opportunity Assessment Revenue from Participating Hospitals

Lost Opportunity Assessment Revenue from Participating Hospitals						
YEAR	**# of Participating Hospitals**	**Sliding Scale Assessment Rate**	**Reported Annual Revenue**	**Maximum Rate allowed by law**	**Possible Annual Revenue**	**Lost Opportunity Assessment Revenue**
1995	23	$50 per live birth up to $11250	$535,637	$50 per live birth up to $150,000	$3,450,000	$2,587,500
1996	23	$50 per live birth up to $11250	$367,169	$50 per live birth up to $150,000	$3,450,000	$2,587,500
1997	26	$50 per live birth up to $11250	$461,628	$50 per live birth up to $150,000	$3,900,000	$2,925,000
1998	25	$50 per live birth up to $11250	$399,003	$50 per live birth up to $150,000	$3,750,000	$2,812,500
1999	27	$50 per live birth up to $11250	$533,329	$50 per live birth up to $150,000	$4,050,000	$3,037,500
2000	27	$50 per live birth up to $11250	$374,902	$50 per live birth up to $150,000	$4,050,000	$3,037,500
Cumulative Total of Lost Opportunity Assessment Revenue = $16,987, 500						

For non-participating physicians, again based on assumptions that emanated from the 1992 actuarial report and a change in the law that in 1993, the SCC suspended the assessment of non-participating physicians of the $250 fee. The SCC reinstated the $250 assessment for all non-participating physicians beginning in 2002. Table 6 shows, using an estimate of non-participating physicians from 1993 until 2001, the "lost opportunity" assessment revenue of $22.3 million.

Table 6: Lost Opportunity Assessment Revenue from Non-Participating Physicians

Lost Opportunity Assessment Revenue from Non-Participating Physicians						
YEAR	# of Non-Participating Physicians	Estimated Possible # of Non-Participating Physicians	Sliding Scale Assessment Rate	Reported Annual Revenue	Maximum Rate allowed by law	Lost Opportunity Assessment Revenue
1993	0	9,917	-$250	-	$250	$2,479,250
1994	0	9,917	-$250	-	$250	$2,479,250
1995	0	9,917	-$250	-	$250	$2,479,250
1996	0	9,917	-$250	-	$250	$2,479,250
1997	0	9,917	-$250	-	$250	$2,479,250
1998	0	9,917	-$250	-	$250	$2,479,250
1999	0	9,917	-$250	-	$250	$2,479,250
2000	0	9,917	-$250	-	$250	$2,479,250
2001	0	9,917	-$250	-	$250	$2,479,250
Cumulative Total of Lost Opportunity Assessment Revenue = $22,313,250						

The last category of "lost opportunity" assessment revenue is from the liability insurance carriers. Also, as allowed by law, this assessment was not imposed due to the assumptions about the future participation and expenses of the Program. This assessment was not imposed from 1990 through 2001. Had it been assessed, an estimated $60.4 million would have been available to the Program as of December 31, 2001.

Table 7: Lost Opportunity Assessment Revenue from Liability Insurers

Lost Opportunity Assessment Revenue from Liability Insurers				
YEAR	Estimated* Possible # of Liability Insurers	Reported Annual Revenue **	Maximum Rate allowed by law	Lost Opportunity Assessment Revenue
1990	486	-	0.25%	$2,826,319
1991	486	-	0.25%	$3,108,951
1992	486	-	0.25%	$3,419,846
1993	486	-	0.25%	$3,761,831
1994	486	-	0.25%	$4,138,014
1995	486	-	0.25%	$4,551,815
1996	486	-	0.25%	$5,006,997
1997	486	-	0.25%	$5,507,696
1998	486	-	0.25%	$6,058,466
1999	486	-	0.25%	$6,664,313
2000	486	-	0.25%	$7,330,744
2001	486	-	0.25%	$8,063,818
Cumulative Total of Lost Opportunity Assessment Revenue = $60,438,810				

Changing Actuarial Assumptions Significantly Impacts Required Reserves

Significantly impacting the level of the Program's actuarial deficit were several revised underlying assumptions made by the SCC's consulting actuarial firm in 2001. The actuarial firm states:

- In October 2001, we provided estimates of funding for the program years 1988 through 2000, and projections for years 2001, 2002 and 2003. **In that report we made significant changes to the estimated number of claimants who would eventually be admitted to the program, to the mortality table underlying our forecasts, and to the estimated future average annual expenses for admitted claimants.** These changes all tended to increase our estimate of the Program's liabilities, and as a result we estimated that the Fund was not actuarially sound as of December 31, 2001... (page 75, MMC Enterprise Risk Consulting, Inc., September 2002)

Following these changes in the key underlying assumptions, the Program was suddenly considered actuarially unsound.

While it is entirely possible other factors may have contributed somewhat to the deficit, it is our conclusion that the single most significant factor was the lack of accurate and reliable actuarial assumptions that were made in the early years of the Program. In fairness, the financial difficulties facing many constituents during this time period, especially our stakeholders, makes it somewhat understandable why the practice was to error on the side of lower fund balance reserves. As is often the case, hindsight tells us that had the full assessments allowed by law during the 1990's been imposed the fund would be stronger today by as much as much as $109.2 million. Coincidentally, that is just slightly below the current reported deficit for the fiscal year ended December 31, 2004 of $117.6 million. It should be noted that our conservative estimate of $109.2 is approximately $31.0 million less than the JLARC estimate of $140.0 million.

3. Review Program Structure to Determine Necessary Amendments to Stem Deficits

It seems to some that the Program has been under continuous study and review since its inception in 1987. It also seems to some that the Program is in a constant state of change. In fact, there has been legislation affecting the Program in each session of the General Assembly since it inception, except for three years. As previously stated the most significant study of the Program in recent years was the JLARC Review in 2003. A number of Program changes came as a direct result of this review. Additionally, over the years several suggestions for new funding strategies have surfaced. A short list of current suggestions was provided to Pinnacle Actuarial Resources, Inc. in response to which they provided the report shown in Appendix H. The strategies they evaluated included:

1. Mandatory participation for hospitals and OB/GYNs
2. An increase to the maximum assessment fees for participating physicians by $200 a year for five years
3. An increase in the assessment fees for participating hospitals by $2.5 per live birth per year up to a $60 maximum (i.e. over four years)
4. Increase other physician (non-OB/GYN) annual assessment rates by $10 per year up to a maximum of $370
5. A surcharge equivalent to amortizing the current fund deficit over fifteen years would be assessed proportionately for all those who are currently assessed by the Program (physician, hospital, liability insurers)
6. Addition of group health insurance to the lines of insurance subject to the 0.25% premium assessment

The Consultant was also asked to assess the following policy options:

7. Imposition of a minimum birth weight eligibility of 1,500 or 2,000 grams. This eligibility feature would be similar to the provisions of the Florida Birth-Related Neurological Injury Compensation Association (NICA)
8. Discontinuation of further Program admissions until the actuarial deficit has been eliminated, which is also based on the Florida Program
9. Introduction of a subsidy for participating rural health care providers

4. Assess the Effect of Such Amendments on the Number of Beneficiaries to be Assisted by the Program in Subsequent Years

This section provides the impact of the above recommendations and the resulting impact on the Program and its beneficiaries. It also contains the Board's recommendations for the upcoming 2006 General Assembly session.

As previously stated it is a primary objective of the Board to continue to provide the same level of services to participants as we are currently providing, within the limits of our resources. Therefore, if the recommendations contained in this report are accepted fully, there will be no negative impact on the Program participants and the Program will expect to eliminate the current deficit as early as 2016. If the proposed mandatory participation or the proposed increased rates are not enacted, than it will take longer to reduce the deficit. Depending on choice(s) made to increase Program revenues the deficit could be eliminated anywhere from 7 to 15 years, or longer.

The following is a summary of the finding from the Pinnacle Actuarial Resources, Inc. Report, which is provided in its entirety as Appendix H. At the request of the Program, Pinnacle provided an Addendum to the original report, provided here as Appendix I.

- Mandatory Participation for all hospitals and OB/GYNs - The impact of this change can be seen in Exhibit 1, Sheet 3 of the Pinnacle's report. Only minimal impact on the deficit fund balance is achieved as result of this change. However, the economic benefit of this change is that it results in greater access to benefits by potentially eligible children and greater overall protection to the physicians and hospitals than could be purchased through the commercial insurance market.
- Increase in Physicians fees – The most significant advantage of this is that OB/GYN physicians would have their fee increases offset against malpractice insurance costs.
- Amortization of Fund deficit – Pinnacle suggests that this, in conjunction with the proposed increase to premium assessments, is one of the two most practical ways to reduce the deficit. It should be noted that the savings to participating physicians and hospitals as a result of the reduced assessments during the 1990's, contributed to the rising deficit therefore there is a logic to having these the same groups be assessed at higher rate today to eliminate the deficit.
- Assessment of group health insurance premiums – Extension of the assessment mechanism to this category of insurance premiums is logical in that the coverage of an eligible birth event starts with the health insurer and continues through the coordination of subsequent benefits with the Program. It is estimated that the impact on the consumer is minimal, only one half of one percent. However, it may introduce an element to the proposed changes that would distract from passage of the other recommendations in the report.
- Introduction of a minimal birth weight – While the actuarial findings suggest that a birth weight provision would contribute to a reduction in a fund deficit, it is our recommendation that the Program continue allow the medical panels recommendations govern this aspect of eligibility.
- Discontinuation of New Claims Admission – At first glance, this alternative may seem appealing. However, the fact is that the injured party would need to be funded through insurance or other means. Under such a policy, it could be argued that the program was not full responsibility for the very issue they seek to cure.
- Rural Assessment Subsidy – Under this approach, there would be no contribution to fund balance, only a reallocation of assessment fees among rural and other OB/GYN physicians. Therefore, we do not recommend this option for inclusion in the proposed legislation.
- Appropriation from the Commonwealth of Virginia General Fund – The General Assembly may choose to provide a direct General Fund Appropriation to eliminate all or part of the deficit. This option would reduce the burden on smaller hospitals, self-insured, and physicians.

After reviewing the Pinnacle Report in Appendix H we determined the need for additional clarification of alternative funding options. Pinnacle was then requested to provide an addendum to their original report that is presented as Appendix I. In preparing this study we recognized the importance of providing the Members of the General Assembly with alternatives for consideration. These alternatives are presented in more detail in the Recommendations section of this Study.

Recommendations

Given the above information from Pinnacle and as reflected in the Study, the Board commends the following alternatives for use by the General Assembly in its deliberations as it relates to resolving the deficit of the Compensation Fund of the Program.

Alternative 1: Amortize the current fund deficit of $117.6 million over ten years, beginning January 1, 2007, by:

- Requiring mandatory participation in the Program by hospitals and OB/GYN's
- Increasing the fee assessed on participating physicians to $5,400, effective for the year beginning January 1, 2007, with annual increases of $200 per year, up to a maximum of $6,200 per year, which will occur in 2011.
- Increasing the fee assessed on participating hospitals to $52.50 per live birth, effective for the year beginning January 1, 2007, with annual increases of $2.50 per year, up to a maximum of $60 per year, which will occur in 2010.
- Increasing the fee assessed on all licensed, non-participating physicians to $290 per year, effective for the year beginning January 1, 2007, with annual increases of $20 per year, up to a maximum of $370 per year, which will occur in 2011.
- Imposing a temporary annual surcharge, effective for the year beginning January 1, 2007, of $2,275 per year for participating physicians, $22.12 per live birth for participating hospitals, and $122 per year for non-participating physicians. For liability insurers, the surcharge, effective for the year beginning January 1, 2007, is a fixed, flat percentage of net direct premiums written equal to .105%. All surcharges would terminate when the Fund is certified by the State Corporation Commission, Bureau of Insurance to be actuarially sound.
- Through the enactment of these above changes in assessment levels, it is estimated that the Birth Injury Compensation Fund would return to a sound and positive balance within approximately ten years or by 2015. ***Please see Appendix I, Exhibit 1, Sheet 5 for a full 15 year presentation of this significant alternative.***

One important aspect of alternative one would be that the stated changes would principally impact the above changes because it was the above-described parties who benefited financially from the reductions in assessments made in the 1990's. Our analysis indicates that those assessment reductions caused a loss of $109 million in revenues to the Fund, while the 2003 JLARC report estimated that $140 million in revenues to the Fund were lost due to these reductions.

Alternative 2:

- **Extend the number of years during which the $117.6 million dollar current Fund deficit will be amortized from approximately 10 years to 15 years.** This would lower the annual surcharges noted above to $1,723 per year for participating physicians, $16.81 per live birth for participating hospitals, and $93 per year for non-participating physicians. For liability insurers, the surcharge would be a fixed, flat percentage of net direct premiums written equal to .08%. Yearly increases beginning with 2011 and extending through 2021 would be held at $100 for participating physicians, and $10 for non-participating physicians. Hospital rates per live birth would be capped at $60 beginning in 2010. ***Please see Appendix I, Exhibit 1, Sheet 5A for a full 15 year presentation of this alternative.***

Alternative 3:

- **Eliminate the entire Fund deficit of $117.6 million dollars in approximately 7 years, or by 2013, principally by assessing a new fee on all health insurance providers of one quarter of one percent (.25%) on net direct premiums written.** The annual increase of $100 to participating physicians, as provided under current legislation, would continue between years 2012 through 2021 up to a maximum of $7,200 in that final year. The annual increase of $10 to non-participating physicians, as provided under current legislation, would continue between 2012 through 2021 up to a maximum of $400 in that final year. Hospital rates per live birth would be capped at $50 in accordance with the current legislation. ***Please see Appendix I, Exhibit 1, Sheet 1A for a full 15 year presentation of this alternative***.

Alternative 4:

- **Eliminate the entire Fund deficit of $117.6 million dollars in approximately 15 years, or by 2021, principally by assessing a new fee on all health insurance providers of eleven one hundredths of one percent (.11%) on net direct premiums written.** Other changes would be as described in Alternative 3 above**. *Please see Appendix I, Exhibit 1, Sheet 1B for a full 15 year presentation of this alternative.***

Alternative 5:

- **Provide approximately $7*.8 million from the General Fund of the Commonwealth each year for 15 years, beginning with 2007 fiscal year.*** This would retire the $117.6 million deficit without necessitating any significant adjustments to the pattern of fees reflected in the current enabling legislation.

As the General Assembly considers actions necessary for returning the Virginia Birth- Related Neurological Injury Compensation Fund to financial soundness, it is hoped that the various alternative funding mechanisms addressed in the report will give the General Assembly sufficient information and flexibility with which to develop legislative changes on which a majority of the Members can agree.

APPENDIX

A STUDY TO ESTABLISH
AN ECONOMICALLY BALANCED APPROACH
FOR FUNDING
THE BIRTH-RELATED NEUROLOGICAL INJURY
COMPENSATION FUND

Presented to
The Governor and
The Honorable Members of the General Assembly
of the Commonwealth of Virginia
In Compliance with the Requirements of
House Joint Resolution 646

December 21, 2005

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APPENDICES

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APPENDIX A

House Joint Resolution 646

2005 SESSION

ENROLLED

HOUSE JOINT RESOLUTION 646

Requesting the Virginia Birth-Related Neurological Injury Compensation Program, with the assistance of the State Corporation Commission, the Office of the Attorney General, the State Workers' Compensation Commission and other state agencies, to develop recommendations for adequately funding the Birth-Related Neurological Injury Compensation Fund. Report.

Agreed to by the House of Delegates, February 5, 2005
Agreed to by the Senate, February 24, 2005

ENROLLED

HJ646ER

WHEREAS, subsection A of § 38.2-5016 of the Code of Virginia cites that "the Birth-Related Neurological Injury Compensation Program shall be governed by a board of seven directors," to be hereafter referred to as the "Birth Injury Program"; and

WHEREAS, subsection F assigns to the Board the power to …"administer the Birth-Related Neurological Injury Compensation Fund", to be hereafter referred to as the "Compensation Fund"; and

WHEREAS, consistent with subsection B of § 38.2-5021 of the Code of Virginia, the Board of Directors of the Birth Injury Program have been notified by the State Corporation Commission through receipt of the *2004 Annual Report Including Projections for Programs Years 2004-2006*, dated September 2004, as submitted to the State Corporation Commission by Mercer Oliver Wyman Actuarial Consulting, Inc.; and

WHEREAS, that report stated "…that, as of December 31, 2003, the fund was not actuarially sound and had a "Grand Total" deficit of about $96.2 million", and further forecasted deficits as of December 31, 2004, 2005, and 2006, to be in amounts of $102.5 million, $106.9 million and $109.2 million, respectively; and

WHEREAS, parents of children who currently receive benefits from the Compensation Fund have expressed serious concerns to members of the Board of Directors with published reports that the Compensation Fund is not actuarially sound, in part out of fear that the future financial needs of their children may not adequately be met because of these reported deficits; and

WHEREAS, the State Corporation Commission has, in compliance with subsection B of § 38.2-5021 of the Code of Virginia, additionally notified the Speaker of the House of Delegates, the President of the Senate, and the Virginia Workers' Compensation Commission that the Neurological Birth-Related Injury Compensation Fund cannot be maintained on an actuarially sound basis subject to the maximum assessments listed in § 38.2-5020, as amended; and

WHEREAS, the Board wishes to advise the General Assembly of Virginia and the State Corporation Commission on an economically balanced approach for adequately funding the Compensation Fund; and

WHEREAS, it is the Board's intention to submit to the General Assembly of Virginia proposed amendments to the authorizing legislation for the Birth Injury Program, §§ 38.2-5000 through 38.2-5021 of the Code of Virginia, for consideration and action during its 2006 session; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Virginia Birth-Related Neurological Injury Compensation Program, with the assistance of the State Corporation Commission, the Office of the Attorney General, the State Workers' Compensation Commission and other state agencies be requested to develop recommendations for adequately funding the Birth-Related Neurological Injury Compensation Fund.

In conducting its study, the Virginia Birth-Related Neurological Injury Compensation Program shall (i) identify the extent of program deficits; (ii) assess causes for such deficits; (iii) review the Program structure to determine necessary amendments to stem deficits; and (iv) assess the effect of such amendments on the number of beneficiaries projected to be assisted by the Program in subsequent years.

The Program shall seek the assistance of the medical community, hospitals, insurance companies, and the legal profession in developing its recommendations. All agencies of the Commonwealth shall provide assistance to the Program for this purpose, upon request.

The Virginia Birth-Related Neurological Injury Compensation Program shall complete its meetings by November 30, 2005, and shall submit to the Governor and the General Assembly an executive summary and a report of its findings and recommendations for publication as a House or Senate document. The executive summary and report shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports no later than the first day of the 2006 Regular Session of the General Assembly and shall be posted on the General Assembly's website.

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APPENDIX B

Key Stakeholders and Organizations Involved

Contacts: Stakeholder Organizations		
Name	**Title**	**Organization**
Dr. Gil Siegal	-	Harvard School of Public Helath
Larry Tarr	Deputy Commissioner	VA Worker's Compensation Commission
Mary Bannister	-	State Corporation Commission
Susan Ward / Katherine Webb	-	Virginia Hospital Association
Ann Hughs	Lobbyist	Virginia Medical Society
Chris LaGow, Attorney Lobbyist	Property and Casualty Lobbyist	Nationwide Insurance
Dr. John Seeds	-	-
Ms. Kenney Shipley	Executive Director	Florida Program
Rob Walling	Actuary	Pinnacle Actuarial Resources, Inc.
Jack Harris	Exec Director	VA Trial Lawyers Association (VTLA)
Mark Ruben	Past Lobbyist for VTLA	Past Lobbyist for VTLA

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APPENDIX C

Virginia Birth-Related Neurological Injury Program Questionnaire

In its 2005 session, the Virginia General Assembly directed, through HJR 646, that the Virginia Birth-Related Neurological Injury Compensation Program (Program) conduct a study for the purpose of developing recommendations for adequately funding the Birth-Related Neurological Injury Compensation Fund (Fund). The Program management requests your input in this process through the completion of the following survey document.

1. Which of the following best describes your association with the Program?
    A. Program client / family member
    B. Health Care Professional / Provider
    C. Hospital Administrator/staff
    D. Legal Services Provider
    E. Financial, Insurance, or other Professional Services Provider
    F. Other _____

2. How many years have you been involved with the Program?
    A. Less than one year
    B. One to five years
    C. Five to ten years
    D. Ten to Fifteen years
    E. More than Fifteen

3. Are the Program Goals and Objectives clear to you?
    A. Goals and Objectives are not clear to me
    B. Goals and Objectives are somewhat clear to me
    C. Goals and Objectives are completely clear to me
    D. Not sure, no opinion, or not applicable

4. Do you agree with the Program Goals and Objectives?
    A. I agree with the Goals and Objectives of the Program
    B. I do not agree with the Goals and Objectives of the Program
    C. Not sure, no opinion, or not applicable

5. In your opinion, has the Program met its Goals and Objectives?
    A. Goals and Objectives are not met at all
    B. Goals and Objectives are somewhat met
    C. Goals and Objectives are completely met
    D. Not sure, no opinion, or not applicable

6. Are you aware of the financial position of the Fund?
    A. I am not aware of the Fund's financial position
    B. I am somewhat aware of the Fund's financial position
    C. I am completely aware of the Fund's financial position
    D. Not sure, no opinion, or not applicable

7. Would you be willing to serve on a voluntary advisory committee to facilitate improvements in services and operations of the Program?
    A. I am not willing to serve on an advisory committee of the Program
    B. I would be willing to serve on an advisory committee of the Program
    C. Not sure, no opinion, or not applicable

8. Do you believe the Program is adequately funded?
    A. Yes
    B. No
    C. Not sure, no opinion, or not applicable

9. Should the Program continue to operate as it is currently authorized by the Code of Virginia?
    A. Yes
    B. No
    C. Not sure, no opinion, or not applicable

10. If you answered "B. No" to Question 9, which of the following approaches would you suggest to address your concern?
    A. Abolish the Program completely
    B. Amend the Code of Virginia
    C. Allow private insurance companies to provide coverage as other states do
    D. Conduct a more comprehensive study

11. If you answered "B. Amend the Code of Virginia", in Question 10, describe briefly how you would change the Code.

12. Is the public interest adequately protected under the current legislation that governs the Program and its operation?
    A. Public Interest is not adequately protected
    B. Public Interest is adequately protected
    C. Not sure, no opinion, or not applicable

13. How often are you in contact with the Program staff, administrators, or management?
    A. Daily
    B. Weekly
    C. Monthly
    D. Quarterly
    E. Annually
    F. Only as needed
    G. Not at all

14. Please rate the timeliness of the responses of the Program staff, administrators, or management to your inquiries.
    A. Not very timely
    B. Somewhat timely
    C. Very timely
    D. Not sure, no opinion, or not applicable

15. Please rate the quality of the responses from the Program staff, administrators, or management to your inquiries.
    A. Not very good
    B. Adequate
    C. Very good
    D. Not sure, no opinion, or not applicable

16. Are the rules and regulations of the Program adequately communicated to you and to the Public?
    A. Not very well communicated
    B. Adequately communicated
    C. Very well communicated
    D. Not sure, no opinion, or not applicable

17. Does the Program make adequate use of technology in the delivery of services and information to clients, constituents, and others interested in the Program?
    A. Does not make adequate use of technology
    B. Makes adequate use of technology
    C. Makes excellent use of technology
    D. Not sure, no opinion, or not applicable

18. What is your understanding of the amount of annual allocation of Public resources, i.e. General Fund revenues that are allocated to the Program?
    A. None
    B. Less than $100,000
    C. Between $100,000 and $1,000,000
    D. More than $1,000,000
    E. Not sure, no opinion, or not applicable

19. In your opinion, should Public resources, i.e. General Fund revenues, be used to support or enhance the Program?
    A. Yes
    B. No
    C. Not sure, no opinion, or not applicable

20. Do you believe the cost reimbursement rates are fair and adequate to meet your needs?
    A. Reimbursement rates are not adequate
    B. Reimbursement rates are adequate
    C. Not sure, no opinion, or not applicable

21. In cases where you were to receive reimbursement of costs from the Program, please describe the timeliness of the reimbursement.
    A. Untimely … more than 90 days after you expected payment
    B. Slow Payment … more than 5 days but less than 90 days
    C. On schedule … within five days of expected payment date
    D. Fast payment more than five days before payment was expected
    E. Not sure, no opinion, or not applicable

22. How well do you believe the Program staff, administrators, and management understand the needs of you and your child?
    A. Not very well
    B. Understanding is adequate
    C. Understanding appears to exceed my expectations
    D. Not sure, no opinion, or not applicable

23. In the space provided below, please provide us with any additional information that you believe would be valuable to the Study.

24. Would you like the Study Coordinator to contact you for follow-up and further information?
    A. Yes
    B. No
    C. Not sure, no opinion, or not applicable

Thank you for your contribution to this study.

Questions, comments and / or concerns should be directed to:

HJR 646 Study Coordinator
C/O Virginia Birth-Related Neurological Injury Compensation Program
9100 Arboretum Parkway, Suite 365
Richmond, VA 23236

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APPENDIX D

Listing of Legislative Studies of or related to the Program

2005 RD66 -Annual report on the Investments and Assets of the Virginia Birth-Related Neurological Injury Compensation Fund - Years ending 12/312003 and 2002

2004 RD212 – Annual report on the Investments and Assets of the Virginia Birth Related Neurological Injury Compensation Fund - Year ending 12/312002 – 2001

2004 HD52 - Report of the Governor's Work Group on Rural Obstetrical Care

2003 Judicial Legislative Audit and Review Committee Review of the Virginia Birth-Related Neurological Injury Compensation Program

1998 HD58 - Study to Increase the Scope and Magnitude of the Virginia Birth-Related Neurological Injury Compensation Program

1990 HD63 - The Definition of Compensable Injury and the Funding Mechanism of the Virginia Birth-Related Neurological Injury Compensation Act

1990 SD12 - Creating A Liability Insurance Residual Market Facility and Joint Underwriting Association

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APPENDIX E

Chronology of the legislation amending the Code of Virginia enabling legislation 2005-1987

Chapter 52 March 20, 2005
An Act to amend and reenact §§ 38.2-5004 and 38.2-5006 of the Code of Virginia, relating to the Virginia Birth-Related Neurological Injury Compensation Program. Establishes that the Birth-Related Neurological Injury Compensation Program's response to a claimant's petition is not due until 10 days after the three-physician panel's report is filed with the Workers' Compensation Commission. Upon the filing of the Program's response, the Commission shall set the hearing date, which shall be no sooner than 15 and no later than 90 days after the filing of the Program's response.

Chapter 931 April 15, 2004
An Act to amend and reenact §§ 38.2-5001, 38.2-5009 and 38.2-5020 of the Code of Virginia, relating to the Virginia Birth-Related Neurological Injury Compensation Act; assessment of participating hospitals and participating physicians. Increases assessments for participating physicians and hospitals, and nonparticipating physicians on an incremental basis beginning in 2005, to maximums of $5,500, $200,000, and $300, respectively. The bill also eliminates the authority to pay attorney's fees to applicants who are not admitted into the birth injury fund program.

Chapter 897 March 22, 2003
An Act to amend and reenact §§ 2.2-3701, 2.2-3705, 38.2-5001, 38.2-5002, 38.2-5004, 38.2-5004.1, 38.2-5005, 38.2-5007, 38.2-5008, 38.2-5009, 38.2-5015, and 38.2-5016 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 38.2-5002.1, 38.2-5002.2, 38.2-5009.1, and 38.2-5016.1, relating to the Virginia Birth-Related Neurological Injury Compensation Act. Authorizes the Workers' Compensation Commission to award up to $100,000 to the parents or legal guardian of an injured infant covered under the Virginia Birth-Related Neurological Injury Program who dies within 180 days of birth. The Program is made subject to the Freedom of Information Act and is required to implement procedures consistent with the Public Procurement Act and the rulemaking provisions of the Administrative Process Act. The Virginia Birth-Related Neurological Injury Fund must be audited annually by a certified public accountant. The Office of the Attorney General is required to provide legal services for the Program. Other changes (i) clarify that a mother is not subject to the Program's exclusive remedy provision with respect to physical injuries she suffers during delivery; (ii) require hospitals to release fetal monitoring strips to the Program or injured infant's legal representative and provide that the failure to provide the information creates a rebuttable presumption of fetal distress; (iii) require the investigation and referral to the Board of Health Professions or Department of Health, as appropriate, of health care providers and participating hospitals if the conduct gives rise to disciplinary action; (iv) require physicians and nurse midwives to inform patients whether they are participants in the Program; (v) require all hospitals to provide a brochure on the Program with post-partum

materials if the infant was hospitalized in a neonatal intensive care unit; (vi) require the report of the reviewing panel of physicians to be mailed to the Program and all parties within 60 days after the filing of a petition; and (vii) provide that the Act's exclusive remedy provision applies with respect to claims by an infant's parents or other representative if the claim is derivative of the medical malpractice claim involving the infant's injury. The panel's report is required to confirm whether each element of the definition of a birth-related injury is satisfied, and the panel is to complete such documentation as the Program's board of directors requires. Physician review panel duties will rotate among Eastern Virginia Medical School, University of Virginia School of Medicine, and the Medical College of Virginia on a case-by-case basis. The Commission may require the claimant to procure health insurance for the injured infant, to be paid for from the Fund. The Commission may award unsuccessful petitioners reasonable attorneys' fees and other expenses incurred in filing a claim in good faith. The Program's board is required to consult semiannually with the chief investment officer of the Virginia Retirement System regarding fund management strategies and asset allocations, and the Program's investment advisor shall provide annual statements explaining the expected returns on its equities and fixed income portfolios. The Program's board is directed to (a) develop and implement a policy on handicapped-accessible housing, (b) study and develop options for revising fees for participating providers, and (c) maintain a list of Program participants and, with consent, make the list available to other claimants. The board of director's power to reduce the annual participating physician assessment and the annual participating hospital assessment is eliminated. The board's nonparticipating physician representative is replaced with a citizen member with professional experience working with the disabled community. Two of the other citizen members of the board are required to have a minimum of five years of professional investment experience, one is required to have professional experience working with the disabled community, and one shall be the parent of a disabled child.

Chapter 857 April 17, 2002

An Act to amend and reenact § 38.2-5016 of the Code of Virginia, relating to the Birth-Related Neurological Injury Compensation Program; reports by board of directors regarding investment of assets. Requires the board of directors of the Birth-Related Neurological Injury Compensation Program to report annually on the investment of the assets of the Birth-Related Neurological Injury Compensation Fund to the Governor, the Clerk of the House of Delegates and the Clerk of the Senate. Currently, such reports are made only to the Speaker of the House of Delegates and to the Chairman of the Senate Rules Committee.

Chapter 207 April 1, 2000
An Act to amend and reenact §§ 8.01-273.1 and 38.2-5001 of the Code of Virginia, relating to the Virginia Birth-Related Neurological Injury Compensation Act; referral to Workers' Compensation Commission. Clarifies that only parties to litigation who are either participating hospitals or physicians under the Virginia Birth-Related Neurological Injury Compensation Act may move the court to refer the action to the Workers' Compensation Commission for the purpose of determining whether the requirements of the Act are satisfied. The bill also requires that a motion to refer the action to the Commission be filed no later than 120 days after the date the party seeking the referral filed its grounds of defense. The bill specifies what constitutes a petition and certain filing and administrative requirements. The bill provides that the definition of participating physician includes a partnership, corporation, professional corporation, professional limited liability company or other entity through which the physician practices. The bill has an emergency clause.

Chapter 1038 April 19, 2000
An Act to amend and reenact §§ 38.2-5004.1 and 38.2-5009 of the Code of Virginia, relating to Birth-Related Neurological Injury Compensation Program. Limits the type of insurance companies required to notify possible beneficiaries under the Act to those providing medical malpractice liability insurance.

Chapter 822 March 29, 1999
An Act to amend and reenact § 38.2-5003 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 8.01-273.1, relating to the Virginia Birth-Related Neurological Injury Compensation Act; referral to Workers' Compensation Commission. Establishes procedures for referrals of civil actions from a circuit court to the Workers' Compensation Commission ("Commission") for the purpose of determining applicability of the Virginia Birth-Related Neurological Injury Compensation Act. When a party moves to refer a matter to the Commission for such a determination, the motion to refer and the motion for judgment are to be forwarded to the Commission. The circuit court must stay the proceeding pending notification by the Commission on the disposition of the motion to refer, which is communicated by the Commission in due course.

Chapter 823 March 29, 1999
An Act to amend and reenact § 38.2-5009 of the Code of Virginia, relating to the Birth-Related Neurological Injury Compensation Fund; disposition of benefits. Provides that benefits paid for loss of earnings from the Birth-Related Neurological Injury Fund are not assignable and may not be garnished or attached.

Chapter 824 March 29, 1999
An Act to amend and reenact § 38.2-5016 of the Code of Virginia, relating to the Birth-Related Neurological Injury Compensation Program; board of directors; quorum; board terms. Staggers the terms of the members of the board of directors for the Birth-Related Neurological Injury Compensation Program. The bill also reduces from five to four the number of board members required for a quorum.

Chapter 825 March 29, 1999

An Act to amend the Code of Virginia by adding in Chapter 50 of Title 38.2 a section numbered 38.2-5004.1, relating to Birth-Related Neurological Injury Compensation Program; notification of possible beneficiaries. Requires insurance companies and self-insured entities to report to the Birth-Related Neurological Injury Compensation Program any claims alleging a possible birth-related neurological injury or severe adverse outcome related to a birth. The program will inform the injured child's parents or guardians of the program and of the eligibility requirements. The report is not admissible in court and is not an inference of liability.

Chapter 826 March 29, 1999

An Act to amend and reenact § 38.2-5015 of the Code of Virginia, relating to the Birth-Related Neurological Injury Compensation Fund; assets of the Fund. Provides that the assets of the Fund are trust funds to be administered by the board of directors solely to award recipients and execute the Birth-Related Neurological Injury Compensation Program.

Chapter 806 March 29, 1999

An Act to amend and reenact §§ 38.2-5001, 38.2-5010, and 38.2-5013 of the Code of Virginia, relating to the Virginia Birth-Related Neurological Injury Compensation Act. Makes the definition of "birth-related neurological injury" as presently in effect retroactive in application to any child born on and after January 1, 1988, the date for the accruing of claims under the act. The definition included in the original statute was stringent and could not be met by some infants who were neurologically injured in a hospital at birth or immediately thereafter. The 1988 definition required an infant suffering a birth-related neurological injury to be rendered permanently non-ambulatory, aphasic, incontinent, and in need of assistance in all "phases" of daily living. In 1990, two bills were passed to revise the definition of "birth-related neurological injury" by striking the requirements to be permanently non-ambulatory, aphasic, and incontinent and inserting requirements for permanent motor disabilities and developmental disabilities or cognitive disability. The infant must require permanent assistance in all "activities" of daily living. This bill authorizes the legal representative of a child born between January 1, 1988, and July 1, 1990, to file an application for review by July 1, 2000, upon meeting the conditions that (i) a claim was timely filed for the child and was dismissed on the basis of a determination that although the child's injuries were caused by deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital, the injuries did not meet the earlier definition of non-ambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living and (ii) the medical panel's report provided pursuant to the dismissed claim stated that the child's injuries would meet the present definition, i.e., permanently motor disabled and developmentally disabled or cognitively disabled and permanently in need of assistance in all activities of daily living. The application for review may be filed regardless of whether or not the legal representative has previously obtained a review of the dismissed claim by the Commission. Such review can only be filed for live births and cannot be filed for claims dismissed as caused by genetic or congenital abnormalities,

degenerative neurological diseases, or maternal substance abuse. The full Commission will review the evidence and make a determination on the petition as though the definition in effect on July 1, 1990, had been in effect on the date of the child's birth and no previous review or dismissal had occurred. The statute of limitations on filing of claims is modified to allow for applications for review in these narrow circumstances to be filed by July 1, 2000, for any infant whose birth occurred more than ten years prior to the application, if the dismissed claim upon which the application is filed was filed before the infant's tenth birthday. This retroactive provision could result in two or more dismissed claims being reconsidered.

Chapter 399 April 15, 1997

An Act to amend and reenact § 38.2-5016 of the Code of Virginia, relating to the Virginia Birth-Related Neurological Injury Compensation Program; board of directors' standard of care; fund assets. Establishes a standard of care for the board of directors of the Virginia Birth-Related Neurological Injury Compensation Program. The board is required to invest the assets of the Fund with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. Any decisions regarding the investment of the assets of the Fund shall be based on the advice of one or more investment advisors retained by the board from a list provided by the chief investment officer of the Virginia Retirement System. The board must report annually to the Speaker of the House of Delegates and to the chairman of the Senate Rules Committee regarding the investment of the Fund's assets.

Chapter 232 March 16, 1996

An Act to amend and reenact § 38.2-5016 of the Code of Virginia, relating to the Birth-Related Neurological Injury Compensation Program; board authority. Clarifies the authority of the seven-member Birth-Related Neurological Injury Compensation Program board to purchase, hold, sell or transfer real or personal property and to place any such property in trust for the benefit of claimants who have received awards under the program's provisions.

Chapter 302 March 16, 1995

An Act to amend and reenact § 38.2-5001 of the Code of Virginia, relating to the Birth-Related Neurological Injury Compensation Act. Amends the Act's definition of participating hospital to include employees of such hospitals, excluding physicians and nurse-midwives who are eligible to qualify as participating physicians, acting within the course and scope of their employment.

Chapter 872 April 20, 1994
An Act to amend and reenact §§ 38.2-5001, 38.2-5016, 38.2-5017, and 38.2-5020 of the Code of Virginia, relating to the Birth-Related Neurological Injury Compensation Program. Amends the Virginia Birth-Related Neurological Injury Compensation Act to authorize the compensation fund's board of directors to (i) provide notice of the fund's existence to obstetrical patients, and (ii) reduce voluntary hospital and physician assessments whenever the State Corporation Commission determines that the fund is actuarially sound (the Act currently authorizes such reductions for involuntary assessments). The bill also authorizes hospitals and physicians to enter the program mid-year after a 30-day waiting period is established.

Chapter 414 March 23, 1992
An Act to amend and reenact §§ 38.2-5020, 54.1-106, 54.1-2901, and 54.1-2927 of the Code of Virginia, relating to liability and insurance protections, assessment exemptions, and temporary licensing for certain health care practitioners.

Chapter 767 April 5, 1992
An Act to amend and reenact §§ 38.2-5020 of the Code of Virginia, relating to suspension of certain assessments under the Birth-Related Neurological Injury Compensation Program.

Chapter 486 March 22, 1991
An Act to amend and reenact §§ 38.2-5020 of the Code of Virginia, relating to assessments under the Birth-Related Neurological Injury Compensation Program.

Chapter 234 March 24, 1990
An Act to amend and reenact § 38.2-5001 of the Code of Virginia, relating to the definition of injury under the Birth-Related Neurological Injury Compensation Program.

Chapter 498 April 4, 1990
An Act to amend and reenact § 38.2-5020 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered § 38.2-5020.1, relating to the Virginia Birth-Related Neurological Injury Compensation Act; assessment of participating hospitals and participating physicians. Amends the Code of Virginia to require credits against malpractice insurance premiums for participating physicians and hospitals

Chapter 534 April 5, 1990
An Act to amend and reenact §§ 38.2-5001 and 38.2-5008 of the Code of Virginia, relating to the definition of injury under the Birth-Related Neurological Injury Compensation Program.

Chapter 535 April 5, 1990
An Act to amend and reenact §§ 38.2-5001, 38.2-5008, and 38.2-5009 of the Code of Virginia, relating to coverage for physicians under the Birth-Related Neurological Injury Compensation Program

Chapter 361 March 20, 1989
An Act to amend and reenact § 38.2-5020 of the Code of Virginia, relating to the Birth-Related Neurological Injury Compensation Program. Amends the Code to allow for mid year entry into the Program for doctors who otherwise meet the eligibility criteria set out in the Code.

Chapter 463 March 22, 1989
An Act to extend the deadline for payment of assessments under the Virginia Birth-Related Neurological Injury Compensation Program for and hospitals for 1989 only to May 15, 1989. This allows for coverage under the program for the remainder of the year.

Chapter 523 March 23, 1989
An Act to amend and reenact §§ 38.2-5001, 38.2-5004 through 38.2-5009, 38.2-5011, 38.2-5016,38.2-5018, 38.2-5020, and 38.2-5021 of the Code of Virginia, and to repeal § 38.2-5019 of the Code of Virginia relating to the Birth-Related Neurological Injury Compensation Program

Chapter 540 March 27, 1987
The original legislation that created the Program.

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APPENDIX F

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Walter C. Wright, FCAS, MAAA, Mercer Oliver Wyman Actuarial Consulting, Inc., 2005 Annual Report including Projections for Program Years 2005-2007

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APPENDIX G

Background Information on Robert J. Walling III

NAME	Robert J. Walling, III	
BUSINESS ADDRESS	2817 Reed Road, Suite 2 Bloomington, Illinois 61704 Phone: (309) 665-5010 Fax: (309) 662-8116 e-mail: rwalling@pinnacleactuaries.com	
EDUCATION	MIAMI UNIVERSITY Bachelor of Science in Education – 1987 Certification in Secondary Mathematics Education	
CONTINUING EDUCATION	Estimated study time exceeding 3,000 hours necessary for completion of qualifying exams for membership in Casualty Actuarial Society (CAS) Participation as an attendee and on the faculty of the CAS Ratemaking Seminar, CAS annual meetings, CAS Dynamic Financial Analysis Seminar, and other educational seminars on special topics.	
MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS	Casualty Actuarial Society (CAS) Associate Member Fellow American Academy of Actuaries (AAA) Midwestern Actuarial Forum Casualty Actuaries of New England Central Illinois Actuarial Club	 1995 2001 1995
EMPLOYMENT HISTORY	Great American Insurance Group Providence Washington Insurance Companies Shelby Insurance Company / Anthem Casualty Miller, Herbers, Lehmann, & Associates, Inc. Pinnacle Actuarial Resources, Inc.	1989-1991 1991-1992 1992-1997 1997-2002 2003 – Present
PROFESSIONAL ACTIVITIES	CAS Committee on Health and Managed Care Issues CAS Ratemaking Seminar Committee Vice Chairperson for CAS Ratemaking Seminar Chairperson for CAS Ratemaking Seminar Vice Chairperson for CAS DFA Seminar Chairperson for the CAS DFA Seminar Faculty Member, CAS Limited Attendance Seminars on Dynamic Financial Analysis	1996-2001 1997-Present 2000-2001 2001-2002 2000 2000-2002 1998, 1999, 2001

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APPENDIX H

Pinnacle Actuarial Resources, Inc. Report - December 2005

*Please see attached document for full text version of "Analysis of Potential Program Changes"

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Virginia Birth-Related Neurological Injury Compensation Program

Analysis of Potential Program Changes

December 2005

Pinnacle Actuarial Resources, Inc.
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Paul A. Vendetti, FCAS, MAAA
John E. Wade, ACAS, MAAA
Gary C. Wang, FCAS, MAAA
Robert J. Walling, III, FCAS, AAA

December 12, 2005

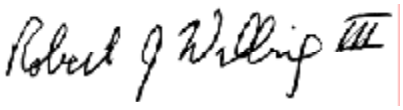
George Deebo
Va. Birth-Related Neurological Injury Compensation Program
9100 Arboretum Parkway, Suite 365
Richmond, VA 23236

Dear George:

Enclosed is our revised report reviewing the impact of several potential changes that would impact the expected revenues and/or covered losses of the Virginia Birth-Related Neurological Injury Compensation Program (the Program). Please destroy electronic and paper copies of previous drafts of this report as they do not reflect our current assumptions, analysis and findings.

We have enjoyed performing these services for the Program and remain available to answer any questions you may have. Should you have any questions or require any additional analysis, please feel free to contact me at your convenience.

Sincerely,



Robert J. Walling, FCAS, MAAA
Principal & Consulting Actuary

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Section

Virginia Birth-Related
Neurological Injury Compensation Program

Analysis of Potential Program Changes

Purpose & Scope

Pinnacle Actuarial Resources, Inc. (Pinnacle) has been retained by the Virginia Birth-Related Neurological Injury Compensation Program (the Program) to perform an analysis of the expected impact of several changes to the Program. This analysis is intended to assess the expected impact these changes may have on Program revenues and/or losses and ultimately the actuarial soundness of the Virginia Birth-Related Neurological Injury Compensation Fund (the Fund).

Distribution & Use

This report is intended solely for the use of the Program. We understand that the Program may wish to share a copy of this report with the Commonwealth of Virginia, State Corporation Commission, Bureau of Insurance as well as legislative officials and other policy makers in Virginia. This distribution is granted on the conditions that the entire report be distributed rather than excerpts and that all recipients be made aware that Pinnacle is available to answer any questions regarding the report. Third parties reading this report should recognize that the furnishing of this report is not a substitute for their own due diligence and should place no reliance on this report or the data contained herein that would result in the creation of any duty or liability by Pinnacle to the third party. Any further use or distribution is not authorized without prior written consent of Pinnacle.

Judgments as to conclusions, recommendations, methods, and data contained in this report should be made only after studying the report in its entirety. Furthermore, we are available to explain any matter presented herein, and it is assumed that the user of this report will seek such explanation as to any matter in question.

Background

The Virginia Birth-Related Neurological Injury Compensation Program was established in 1987 through legislation written by the Virginia General Assembly. The main purpose of the Program is to assure the payment of the financial costs for the lifetime care of infants born with birth-related neurological injuries. The Program is financed by the Virginia Birth-Related Neurological Injury Compensation Fund.

The Program was created with optional participation for both physicians and hospitals. In exchange for participating in the program, healthcare providers receive the benefits of 1) an exclusive remedy provision of the law, and 2) the opportunity for lower premiums for medical malpractice insurance.

Funding for the Program comes from four sources 1) participating physicians (currently $5,200 with annual increases of $100 up to $5,500), 2) participating hospitals (currently $50 per live birth up to a $170,000 annual maximum with $10,000 annual increases in maximum up to $200,000), 3) non-participating physicians (currently a $270 annual maximum with annual increases of $10 up to $300), and 4) insurers in Virginia (1/4 of 1% of net direct written premiums in Virginia for certain liability lines of business). The Program began collecting assessments in late 1987, and the compensation mechanism became effective for births as of January 1, 1988.

The Program has requested that we examine how several potential changes in the Program could impact the current and future actuarial soundness of the Fund. These changes are:

1. Mandatory participation for hospitals and OB/GYNs,
2. An increase in the maximum assessment fees for participating physicians by $200 a year for five years,
3. An increase in the assessment fees for participating hospitals by $2.50 per live birth per year up to a $60 maximum (i.e. over four years),
4. A surcharge equivalent to amortizing the current fund deficit over a prescribed number of years, and
5. Addition of group health insurance to the lines of insurance subject to the 0.25% premium assessment.

A brief comparison of the eligibility and funding similarities and differences between the Program and the Florida Birth-Related Neurological Injury Compensation Association (NICA) was also requested. In particular, analyses of the impacts of two elements of NICA program were performed:

1. Inclusion of a minimum birth weight eligibility of 1,500 or 2,000 grams, and
2. Discontinuation of further Program admissions until the actuarial deficit has been eliminated.

We have also provided some information and analysis of rural premium subsidy programs from other states and how a program like this could be applied to the Virginia program.

Discussion and Analysis

The approach used to compute the estimated impact of each of the proposed changes as well as the resulting finding will be discussed separately.

Mandatory Participation for Hospitals and OB/GYNs

There is currently a bit of an inconsistency between the premiums collected by the Program and the losses they cover. This is due to the provision in the Program's eligibility that covers a birth if either the physician or the hospital participates in the program. This means in some eligible births both the hospital and physician participate, and therefore pay participation assessments, while other eligible births have only one or the other party paying assessments. A move to mandatory participation would result in more consistency in that both health care provider and facility would both be paying participating assessments. A mandatory approach would produce additional losses only when both the physician and the hospital are not currently participants. However, this situation would also produce additional assessment revenues from both the hospital and the physician. The change to mandatory participation would increase revenues but not losses in the case where only the physician or the hospital is currently participating. Therefore, a move to mandatory coverage would produce proportionately more revenue than losses.

The impact of mandatory participation on eligible annual claim frequencies is shown in Exhibit 3, Sheet 1. Based on the Virginia birth data provided to us approximately 69% of all births in the state occur at participating hospitals. Just over half of all births in the state (53%) are performed by participating physicians. This suggests that approximately 15% of all births in Virginia occur with both a physician and hospital that are not participating (31% x 47% ≈ 15%). This means a move to mandatory participation would increase the number of eligible claims by approximately 17% ([1 / (1-15%)] – 1 ≈ 17%). Based on the current expected claim frequency of 10 eligible births annually, the Program would expect an average of 11.7 births annually with mandatory participation. We have selected a frequency of 12 claims to reflect a level of conservatism and the potential that a correlation could exist between non-participating physicians and non-participating hospitals.

The 2005 Annual Report on the Virginia Birth Related Neurological Injury Program produced for Commonwealth of Virginia, State Corporation Commission, Bureau of Insurance (SCC) by Mercer Oliver Wyman Actuarial Consulting, Inc., estimates the current present value of the forecasted lifetime costs of an average claim in the Birth-Injury Program at approximately $1,967,000. This is a significant increase from the previous year's report which is mainly due to significant increases in nursing costs. Pinnacle has produced estimates based on slightly different inflation and interest assumptions that estimate the average 2006 severity at approximately $2,094,000. This result is shown in Exhibit 4. Therefore, if two additional eligible claims are created due to mandatory participation about $4.2 million in losses will be incurred.

Exhibit 1, Sheet 1 shows the impact on the Fund balance due to a change to mandatory participation at current rates while Sheet 3 shows the impact of mandatory participation at proposed increased rates. The proportionately greater increase in revenues than losses (at the increased rate levels) results in an expected improvement in the Fund balance starting in 2008. Over the next five years this change continues to provide a benefit that reduces the Fund balance slightly. While the marginal reduction of the Fund deficit is certainly a positive, the consistency between premiums and losses is a clear advantage of moving to mandatory participation for OB/GYNs and Hospitals. If either hospitals or OB/GYNs are changed to mandatory participation the benefit is diminished.

Economic Benefits

It is also important to recognize the economic value of participation to OB/GYNs in the state. An important and often ignored aspect of the Program is the significantly greater benefits provided to eligible children than would be available through commercial insurance both in terms of the limits of coverage, the covered injuries and the types of benefits provided. It is also important to recognize the greater financial protection the Program provides to participating physicians and hospitals than could be purchased in the commercial insurance market. Health care providers run the risk of exhausting their coverage with commercial insurance, especially in

the case of the very severe injuries the Program is designed to handle. Beyond these benefits to both patient and provider, insurance costs to physicians are significantly lower for participating physicians than non-participating OB/GYNs. This is because of the other revenue sources that contribute to the Program, especially the liability insurance premium assessment. This results in coverage for the Program being provided at a subsidized rate. Exhibit 5 shows that participating physicians can save thousands of dollars on their overall insurance costs (in one case over $14,000), in spite of the broader coverage the Program offers. It is worth noting that medical malpractice liability rates vary significantly due to a variety of factors the specialty of the physician, his or her geographic location, the limits of coverage purchased, the deductible selected and other factors.

Impact on Self Insurance Programs

Some discussion of how mandatory participation would impact self insurance programs such as captive insurance companies ("captives") and risk retention groups (RRGs) is warranted at this point. Many hospitals and physician groups are large enough to retain a significant amount of the medical malpractice liability risk. Some of these insureds accomplish this through a large deductible on an insurance policy through a traditional insurer. Others use RRGs and captives due to regulatory and tax advantages these mechanisms can offer. RRGs are still subject to state insurance regulation in their state of domicile and therefore still subject to taxes and assessments in the states where they provide coverage. Captives often use a fronting insurance company licensed in the insured's state to meet regulatory requirements as well and thus can be assessed, through the fronting carrier, for state taxes, licenses and fees. Because of these continued regulatory controls, other states with mandatory government insurance programs for medical malpractice (e.g. patient compensation funds (PCFs) and joint underwriting associations (JUAs)) are often able to collect assessments and provide coverage to healthcare providers using captives and or RRGs. Most captive and RRG managers are familiar with coordinating claims and assessments between the captive or RRG and from these types of state programs.

Because of the large volume of claims that are typically involved in a captive or RRG, the traditional pricing approach of determining industrywide rates per physician or delivery are not

typically used for the programs. Rather, funding estimates based on historical experience are determined, sometimes augmented with industry experience for less frequent large losses. As a result of this experience-based approach to funding the impact of mandatory participation is somewhat less clear than in the traditional insurance example shown in Exhibit 5. However, to the extent that a health care provider had losses in their experience that would be covered by the Program, they would be removed from the data used to develop their funding estimate. Even if there were not any claims in the insured's own experience, a funding analysis will often make an explicit adjustment to their funding estimate to reflect the reduced future loss potential.

Increase in Physicians Fees

Exhibit 2, Sheet 1 examines the potential increase in revenues created by revising the assessment increases for participating physicians from the current annual increases of $100 up to $5,500, to a $200 annual increase for the next five years up to $6,200. Similarly, a $20 annual increase in non-participating fees is shown. The exhibit shows the current number of physicians participating in the Program as well as the current assessment income they generate. This information was provided in the September 2005 report produced by Mercer RFI. This report was produced by Mercer RFI on behalf of the Commonwealth of Virginia, State Corporation Commission, Bureau of Insurance (SCC). This increased revenue impacts five of the Fund balance scenarios shown in Exhibit 1.

In the voluntary participation scenario (Exhibit 1, Sheet 2), we have assumed that the number of participating physicians will remain unchanged for the next five years (July 2006 through July 2011). The proposed overall increase in assessments for each of the next five years is computed as $200 per participating physician times the current number of participating physicians. For the mandatory scenarios (Exhibit 1, Sheets 3, and 5-7), the corresponding number of physicians from Exhibit 1, Sheet 2 is used. In the voluntary scenario, revenues increase by $374K in 2006 and reach an increase of $1.3 million in 2010 partially due to the current cap on assessments of $5,500. The mandatory scenario (Sheet 3) produces additional revenue of $483K in 2006 and reach $1.7 million in 2010 as can be seen in Exhibit 2, Sheet 1.

This proposed change is not assumed to change the number of participating physicians or the expected number of admitted claims in the Program. An argument could be made that at some point the assessment increases in a voluntary participation climate would drive participants from the program. However, Exhibit 5 suggests that participating OB/GYNs still have much lower insurance costs than non-participating physicians at the increased rate levels.

Increase in Participating Hospital Fees

As one approach to increasing the assessment revenue from participating hospitals, we have estimated the impact of raising fees for participating hospitals by $2.50 per live birth per year up to a $60 maximum (i.e. over four years) without changing the current annual caps. Exhibit 2, Sheet 2 shows the current number of births at hospitals participating in the Program and the current assessment income these hospitals generate. This information was also provided in the September 2005 Mercer RFI report. In both the voluntary and mandatory scenarios, these proposed assessment rates produce increasing additional annual revenue that reach a maximum change of $468K in 2009 for the voluntary option and the mandatory scenario reaching $747K million of additional income during the same year. This analysis is shown in Exhibit 2, Sheet 2 and impacts five of the Fund balance scenarios shown in Exhibit 1 (Sheets 3, and 5-7).

We have assumed that the number of participating hospitals and the number of live births at these hospitals will remain unchanged for the next five years.

For the sheets in Exhibit 1 where the Fund deficit is being reduced by the end of the five year period, we have also estimated the number of years required to eliminate the deficit.

Exhibit 1, Sheet 3 shows that the combination of mandatory participation and the modest assessment increases proposed slow the growth of the deficit and then reduce it slightly. However, these two changes do not materially reduce the current deficit. Another revenue source, for example surcharges that amortize the deficit or adding assessments to group health insurance premiums will be necessary to meaningfully reduce the deficit.

Amortization of Fund Deficit

One approach to reducing the existing fund deficit is to apply a surcharge to each assessment (physicians, hospitals and insurance premiums) sufficient to amortize the deficit over a predetermined number of years. The additional surcharges required to fund the future payment for the claims occurring before 12/31/2004 are calculated assuming a level percentage of surcharge during the amortization period. The estimated additional surcharges, calculated based on 10 year, 15 year, 20 year and 25 year amortization schedules with a 4.27% interest rate, are shown in Exhibit 2, Sheet 4. For the financial models in Exhibit 1, Sheets 4, 5, and 7, the 15-year amortization of the deficit is shown. Based on the cost advantage of participation to OB/GYNs shown in Exhibit 5, we expect that the insurance costs for mandatory coverage for OB/GYNs, even with the additional amortization costs, can be kept lower than the current insurance costs for non-participants. Note that in scenarios with rate increases, mandatory participation and the amortization of the deficit, the deficit is also reduced by factors other than the amortization. As a result, the Program achieves a positive Fund balance in less than 15 years. This would suggest that assessments can be reduced once the positive Fund balance is achieved.

Assessment of Group Health Insurance Premium

A significant source of Program revenues is the current assessment of 1/4 of 1% of net direct premiums written in Virginia for liability lines of insurance in the state. This includes automobile liability, general liability, medical malpractice liability, workers compensation insurance, aircraft insurance, products liability, personal injury liability, property damage liability, and the liability portion of farmowners/homeowners insurance and commercial multiple peril insurance.

One possible extension of these assessments would be to include group health insurance premiums. There are logical connections between the Program's coverage and group health insurance that start with the involvement of the health insurer in the eligible birth event and continue on to the coordination of benefits between the Program and the health insurance of covered children. The extension of the 0.25% assessment to group health insurance also has the

benefit that a small percentage of assessment creates a significant revenue stream for the Program due to the much larger premium base of the group health insurance line of business.

Extending the 0.25% assessment to group health insurance would create between $15.5 and $19.5 million of additional revenue annually. This information is summarized on Exhibit 2, Sheet 3. This proposed additional revenue was included in the final two pro forma financial scenarios in Exhibit 1, Sheets 6 and 7. These additional revenues create even more annual revenue change than the 15 year amortization.

There are two important facts that need to be understood about these type of assessments. First, these types of assessments are common in most insurance lines. In Virginia, there are at least ten premium based assessments on property and casualty insurance premiums. These assessments include funding for programs such as the Bureau of Insurance, premium taxes, insurance fraud investigation units of the Virginia State Police, the Help Eliminate Auto Theft (HEAT) Fund, workers compensation funds for uninsured employers and second injury funds and several other programs. Assessments of this nature very greatly from state to state and insurance companies are experienced at implementing changes in these assessments.

The vast majority of state assessments of insurance companies are incorporated either explicitly or implicitly into the premiums they charge. Some assessments are legislated as "pass throughs" that are specifically reflected as a separate cost item on the insurance policy. These fees are charged to each insured and collected by the insurer on behalf of the state and passed on to the state authority. Other fees that are not pass throughs are typically loaded into rates using the ratemaking provision for the underwriting expense category known as "Taxes, Licenses and Fees". The important implication of this is that these state assessments have no impact on expected insurance company profitability and only a small amount of additional work is required of insurers to administer these assessments. Changes in these types of assessments typically impact insured premiums by less than 1%.

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION ISSUES AND REFORMS FROM OTHER STATESISSUES

Currently, the most comparable program in the country to the Program is the Florida Birth-Related Neurological Injury Compensation Association (NICA). NICA has many of the same funding elements (physician and hospital assessments as well as liability insurance premiums) and similar benefits. NICA has a few key differences that include:

1. access to as much as $20 million of state funds annually to maintain the actuarial soundness of NICA
2. a birth weight eligibility of 2,500, (or 2,000 grams if there are multiple births), and
3. the ability to discontinue admissions.

Introduction of a Minimum Eligible Birth Weight

Pinnacle has been asked to provide an estimate of the probable impact of legislation providing that "(w)here the infant weighs 2,000 or fewer grams at birth, or is equal to less than 32 weeks gestation, a rebutable presumption shall arise that the injury alleged is not a birth-related neurological injury but resulted from the premature birth" would have on the Fund's revenues and losses. An estimate with the weight eligibility at 1,500 grams was also desired.

To evaluate the impact of this proposed legislation, we have approached the problem using a frequency and severity approach. In other words, we have estimated how many currently qualifying claims are likely to be ineligible after enactment of this legislation and what is the average claim severity.

For the frequency analysis, we have relied on an analysis performed for the Florida Birth-Related Neurological Injury Compensation Association examining Florida Neonatal Intensive Care Unit (NICU) admission data from a University of Florida. The analysis examined neonatal intensive care unit (NICU) admissions by birth weight which we believe is as a reasonable proxy for the distribution of eligible Birth-Injury Program claimants by birth weight. This data suggests that approximately 30% of all NICU admissions are at birth weights below 2,000

grams. Similarly, approximately 9% of all NICU admissions are at birth weights below 1,500 grams.

Based on previous analyses performed for both the Virginia State Corporation Commission (SCC) and the Birth-Injury Program and Pinnacle's analysis of the impact of the mandatory option, we assume that the current expected number of eligible births annually is about 10 with voluntary participation and 12 if participation is mandatory for OB/GYNs and hospitals. The resulting number of eligible claims removed from the program are shown in Exhibit 6, Sheet 1.

While actuarial studies produced for the Florida Birth Related Neurological Injury Compensation Association (FBRNICA) suggest that the average claim severity for low birth weight claimants may be as much as 25% higher than overall eligible claim severities, we have made the conservative assumption that the claims eliminated by a minimum eligible birth weight have the same average severity as the Program overall. Based on all of this information, we expect that a birth weight eligibility of 1,500 grams would reduce average losses by about $1.9 million in 2006 with voluntary participation and $2.3 million with mandatory participation. The impacts of a birth weight eligibility of 2,000 grams in 2006 are $6.3 million and $7.5 million respectively for voluntary and mandatory participation respectively. The impact of these changes on the overall fund balance in both the voluntary and mandatory participation scenarios is shown in Exhibit 6, Sheet 2. The 1,500 gram eligibility option increases the expected Fund balance by between $1.9 and $2.2 million annually in the voluntary scenario and $2.3 and $2.7 million annually in the mandatory option. The 2,000 gram eligibility option increases the expected Fund balance by between $6.3 and $7.4 million annually in the voluntary scenario and $7.5 and $8.9 million annually in the mandatory option.

Discontinuation of New Claim Admissions

The Florida NICA has a provision that if unfunded claim liabilities exceed a specified limit, they are required to cease accepting new claimants. We were asked to evaluate the impact discontinuing the admission of new claims on the fund balance. In effect, this would mean that additional revenue would flow in but no new claims would be admitted. The results are shown

in Exhibit 6, Sheet 3. The additional revenues, without additional claims, produce a significant change in the Fund balance. However, if these new claims are no longer covered, they will need to be funded through insurance premiums or other means. From an actuarial perspective, this is problematic as future premiums would not be matched with future claims. If the future claims, will be admitted but at a future date, this is just delaying the timing of their impact on the Fund balance and creates no real savings. We see this change as potentially having a number of problems.

Rural Assessment Subsidy

A number of other states, including Oregon and Maine, have introduced rural premium subsidies of medical malpractice premiums for health care providers. The intent of these programs is to provide incentives to health care providers that work in underserved rural areas by reducing their medical malpractice premiums. Both the Oregon and Maine programs use state funds from other sources to fund the subsidy (e.g. in Oregon payments from SAIF Corporation). If this approach were taken in Virginia, it would have no impact on the Fund balance. Rather, it would result in a reallocation of revenue from the participating physicians and hospitals to the new revenue source. The voluntary option suggests that about $200K of additional funds would be needed annually to fund a 50% subsidy for rural OB/GYNs and a 25% subsidy for rural hospitals. The mandatory scenario of this subsidy would require about $500K of annual funding. One interesting possibility for funding this subsidy would be an assessment of physicians that maintain Virginia licenses but practice out of state.

We have also assessed a self-subsidizing approach where non-rural physician and hospital assessments would be increased to support the subsidy. This analysis is shown in Exhibit 7. Based on available physician and hospital demographic data in Virginia it appears that about 11% of births are performed by rural physicians and 7.5% of all births are in rural hospitals. If rural participating OB/GYNs receive a 50% subsidy in their Program assessments and rural hospitals receive a 25% subsidy, assessments for non-rural physicians would need to increase by about 6%, while non-rural hospital assessments would need to increase by about 2% to support

the subsidy. We believe this change serves to provide a significant means to support the availability of health care in traditionally underserved rural areas.

Findings

Based on the analysis included in the attached exhibits, the following table summarizes the various proposed changes to participating OB/GYN assessments including amortization of the $117.6 million deficit over fifteen years (for the applicable scenarios):

Participating OB/GYN Assessments

Change	7/06 - 7/07	7/07 - 7/08	7/08 - 7/09	7/09 - 7/10	7/10 - 7/11
Current Rates	5,200	5,300	5,400	5,500	5,500
Rate Increases Only	5,400	5,600	5,800	6,000	6,200
Current & Ammortization	7,452	7,552	7,652	7,752	7,752
Rate Increases & Amortization (No Group Health)	7,675	7,875	8,075	8,275	8,475
Rate Increases & Amortization (With Group Health)	6,817	7,017	7,217	7,417	7,617

The various proposals result in the following estimates of the Fund deficit for the next five years:

Expected Fund Balance

Change	7/06 - 7/07	7/07 - 7/08	7/08 - 7/09	7/09 - 7/10	7/10 - 7/11
Current Rates, Voluntary Participation (From Mercer)	(131,800)	(137,100)			
Current Rates, Mandatory Participation	(118,639)	(119,812)	(121,138)	(122,629)	(124,545)
Rate Increases, Voluntary Participation	(118,320)	(118,754)	(118,899)	(118,787)	(118,521)
Rate Increases, Mandatory Participation	(117,947)	(118,007)	(117,786)	(117,324)	(116,803)
Current Rates, Mandatory, Deficit Amortization	(107,864)	(97,951)	(87,864)	(77,604)	(67,411)
Rate Increases, Mandatory, Deficit Amortization	(107,172)	(96,165)	(84,566)	(72,411)	(59,849)
Rate Increases, Mandatory, Health Insurance	(102,459)	(86,102)	(68,479)	(49,571)	(29,497)
Rate Increases, Mandatory, Amortization, Health Insuran	(91,684)	(64,126)	(34,851)	(3,820)	-

We view expanding the premium assessments to include group health insurance premiums and a surcharge to produce a definite amortization of the Fund deficit as the two most practical ways to improve the current Fund balance and move toward actuarial soundness for the Program. We also believe a move to mandatory participation for OB/GYNs and hospitals to be in their best interest (from both a financial and risk management perspective), the best interest of their patients, and a move to greater Program equity

We also believe that a subsidy for rural health care providers would be a valuable enhancement to the Program from a public policy perspective. The decision to find an additional revenue source to support the subsidy (such as the additional fees for out of state physicians with Virginia licenses) or to increase non-rural assessments to offset the subsidy is a policy decision outside the scope of this report.

Reliances & Limitations

In developing this report, Pinnacle has relied upon data and information provided by the Program and Mercer RFI, as well as publicly available information regarding the Florida Birth-Related Neurological Injury Compensation Association (NICA). We have relied upon the accuracy of this data and information, without audit or verification. However, we did review certain elements of this data and information for reasonableness and consistency with our knowledge of the insurance industry. To the extent that any subsequent changes are noted that may have a material impact on our analysis, it is the responsibility of the Program to notify us of these changes so that they may be properly reflected.

As with all prospective funding estimates for the Birth-Injury Program, our estimates of the impact of legislative changes are subject to potential errors of estimation due to the fact that the ultimate liability for claims is subject to the outcome of events yet to occur, e.g., jury decisions and attitudes of claimants with respect to settlements. This is particularly true for an insurance program with frequencies as low and severities as high as the Fund. In this case, the effectiveness of the presumption language in eliminating claims, the appropriateness of the Florida data for this analysis, unexpected shifts in member participation and other unforeseen changes in the medical malpractice environment in Virginia, and the accuracy of the underlying frequency and severity assumptions are all sources of potential variability. We have not anticipated any extraordinary changes in the legal, social or economic environment, which might affect the cost and frequency of claims beyond those noted in the Mercer RFI report and the proposed legislation.

Future premium estimates are also subject to potential errors of estimation due to unexpected shifts in member participation and other unforeseen changes in the medical malpractice environment in Virginia.

Finally, the exhibits attached in support of our recommendations should be considered an integral part of this report.

INDEX OF EXHIBITS

Exhibit

Virginia Birth-Related Neurological Injury Compensation Fund
Mandatory Participation for Hospitals & OB/GYNS

Fund Balance with Current OB/GYNS and Hospital Fees

Contribution Category	Assessment Membership	Expected Live Births	Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Physicians							
OB/GYNS	1,102		5,732	5,842	5,952	6,062	6,062
Rate			*5,200*	*5,300*	*5,400*	*5,500*	*5,500*
All Other	13,115		3,541	3,672	3,803	3,934	3,934
Rate			*270*	*280*	*290*	*300*	*300*
Hospitals		90,364	4,101	4,131	4,149	4,159	4,159
Fee per Live Birth			*50.00*	*50.00*	*50.00*	*50.00*	*50.00*
Liability Insurers			11,510	12,201	12,933	13,709	14,532
Total Revenue			**24,884**	**25,846**	**26,837**	**27,865**	**28,687**

Compensation Fund Losses

	Claim Frequency		Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)
	(9)		(10)	(11)	(12)	(13)	(14)
Expected Losses	12.0		25,128	26,200	27,319	28,487	29,707
Expected Expenses			795.7	819.6	844.2	869.5	895.6
Total Loss & Expense			**25,923**	**27,019**	**28,163**	**29,357**	**30,602**
Change in Fund Balance			**(1,039)**	**(1,173)**	**(1,325)**	**(1,492)**	**(1,915)**
Fund Balance		**(117,600)**	**(118,639)**	**(119,812)**	**(121,138)**	**(122,629)**	**(124,545)**

Footnotes:

(2)	Provided by VABRNICP
(3)	Total from National Vital Statistics Report and VABRNICP
(4) - (8)	Based on current assessment levels and caps
(9)	Exhibit 3, Sheet 1
(10)-(14)	Mercer RFI September 2005 Report

Virginia Birth-Related Neurological Injury Compensation Fund

Voluntary Participation for Hospitals & OB/GYNS

Fund Balance with Raising OB/GYNS and Hospital Fees

Contribution Category	Current Membership	Expected Live Births	Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Physicians							
Participating	496		2,678	2,778	2,877	2,976	3,075
Rate			*5,400*	*5,600*	*5,800*	*6,000*	*6,200*
Non-Participating	13,721		3,979	4,254	4,528	4,802	5,077
Rate			*290*	*310*	*330*	*350*	*370*
OB/GYNS	606						
All Other	13,115						
Hospitals							
Participating		62,486	2,847	2,987	3,127	3,233	3,233
Fee per Live Birth			*52.50*	*55.00*	*57.50*	*60.00*	*60.00*
Non-Participating		27,878					
Liability Insurers			11,510	12,201	12,933	13,709	14,532
Total Revenue			**21,015**	**22,219**	**23,465**	**24,721**	**25,917**

Compensation Fund Losses

	Claim Frequency		Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)
	(9)		(10)	(11)	(12)	(13)	(14)
Expected Losses	10		20,940	21,833	22,766	23,739	24,756
Expected Expenses			795.7	819.6	844.2	869.5	895.6
Total Loss & Expense			**21,735**	**22,652**	**23,610**	**24,609**	**25,651**
Change in Fund Balance			**(720)**	**(433)**	**(145)**	**112**	**266**
Fund Balance		**(117,600)**	**(118,320)**	**(118,754)**	**(118,899)**	**(118,787)**	**(118,521)**

Footnotes:

(2)	Provided by VABRNICP (Liability assessment trended at 6% per annum)
(9)-(14)	Mercer RFI September 2005 Report
(3)	Total from National Vital Statistics Report and VABRNICP
(4) - (8)	Based on current assessment levels and caps

Virginia Birth-Related Neurological Injury Compensation Fund
Mandatory Participation for Hospitals & OB/GYNS

Fund Balance with Raising OB/GYNS and Hospital Fees

Contribution Category	Assessment Membership	Expected Live Births	Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Physicians							
OB/GYNS	1,102		5,952	6,172	6,393	6,613	6,834
Rate			*5,400*	*5,600*	*5,800*	*6,000*	*6,200*
All Other	13,115		3,803	4,066	4,328	4,590	4,852
Rate			*290*	*310*	*330*	*350*	*370*
Hospitals		90,364	4,311	4,520	4,730	4,906	4,906
Fee per Live Birth			*52.50*	*55.00*	*57.50*	*60.00*	*60.00*
Liability Insurers			11,510	12,201	12,933	13,709	14,532
Total Revenue			**25,576**	**26,959**	**28,384**	**29,819**	**31,124**

Compensation Fund Losses

	Claim Frequency		Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)
	(9)		(10)	(11)	(12)	(13)	(14)
Expected Losses	12.0		25,128	26,200	27,319	28,487	29,707
Expected Expenses			795.7	819.6	844.2	869.5	895.6
Total Loss & Expense			**25,923**	**27,019**	**28,163**	**29,357**	**30,602**
Change in Fund Balance			**(347)**	**(60)**	**221**	**462**	**521**
Fund Balance		**(117,600)**	**(117,947)**	**(118,007)**	**(117,786)**	**(117,324)**	**(116,803)**

Additional Years to Reach Positive Fund Balance 225

Footnotes:

(2)	Provided by VABRNICP
(3)	Total from National Vital Statistics Report and VABRNICP
(4) - (8)	Based on current assessment levels and caps
(9)	Exhibit 3, Sheet 1
(10)-(14)	Mercer RFI September 2005 Report

Virginia Birth-Related Neurological Injury Compensation Fund
Mandatory Participation for Hospitals & OB/GYNS

Fund Balance with Amortization of Fund Deficit

Contribution Category	Assessment Membership	Expected Live Births	Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Physicians							
OB/GYNS	1,102		8,213	8,324	8,434	8,544	8,544
Rate			*5,200*	*5,300*	*5,400*	*5,500*	*5,500*
Surcharge			*2,252*	*2,252*	*2,252*	*2,252*	*2,252*
All Other	13,115		5,074	5,205	5,337	5,468	5,468
Rate			*270*	*280*	*290*	*300*	*300*
Surcharge			*117*	*117*	*117*	*117*	*117*
Hospitals		90,364	5,877	5,920	5,946	5,960	5,960
			4,101	4,131	4,149	4,159	4,159
Fee per Live Birth			*50.00*	*50.00*	*50.00*	*50.00*	*50.00*
Surcharge			*21.65*	*21.65*	*21.65*	*21.65*	*21.65*
Liability Insurers			11,510	12,201	12,933	13,709	14,532
Surcharge			4,984	5,283	5,600	5,936	6,292
Total Revenue			**35,659**	**36,933**	**38,249**	**39,617**	**40,795**

Compensation Fund Losses

	Claim Frequency		Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)
	(9)		(10)	(11)	(12)	(13)	(14)
Expected Losses	12.0		25,128	26,200	27,319	28,487	29,707
Expected Expenses			795.7	819.6	844.2	869.5	895.6
Total Loss & Expense			**25,923**	**27,019**	**28,163**	**29,357**	**30,602**
Change in Fund Balance			**9,736**	**9,914**	**10,086**	**10,260**	**10,193**
Fund Balance		**(117,600)**	**(107,864)**	**(97,951)**	**(87,864)**	**(77,604)**	**(67,411)**

Additional Years to Reach Positive Fund Balance 7

Footnotes:

(2)	Provided by VABRNICP
(3)	Total from National Vital Statistics Report and VABRNICP
(4) - (8)	Based on current assessment levels and caps
(9)	Exhibit 3, Sheet 1
(10)-(14)	Mercer RFI September 2005 Report

Virginia Birth-Related Neurological Injury Compensation Fund
Mandatory Participation for Hospitals & OB/GYNS

Fund Balance with Raising OB/GYNS and Hospital Fees and Amortization of Fund Deficit

Contribution Category	Assessment Membership	Expected Live Births		Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)		(4)	(5)	(6)	(7)	(8)
Physicians								
OB/GYNS	1,102			8,459	8,680	8,900	9,121	9,341
Rate				*5,400*	*5,600*	*5,800*	*6,000*	*6,200*
Surcharge				*2,275*	*2,275*	*2,275*	*2,275*	*2,275*
All Other	13,115			5,406	5,668	5,930	6,192	6,455
Rate				*290*	*310*	*330*	*350*	*370*
Surcharge				*122*	*122*	*122*	*122*	*122*
Hospitals		90,364		6,127	6,338	6,549	6,715	6,715
				4,311	4,520	4,730	4,906	4,906
Fee per Live Birth				*52.50*	*55.00*	*57.50*	*60.00*	*60.00*
Surcharge				*22.12*	*22.12*	*22.12*	*22.12*	*22.12*
Liability Insurers				11,510	12,201	12,933	13,709	14,532
Surcharge				4,849	5,140	5,448	5,775	6,122
Total Revenue				**36,351**	**38,027**	**39,761**	**41,512**	**43,164**

Compensation Fund Losses

	Claim Frequency		Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)
	(9)		(10)	(11)	(12)	(13)	(14)
Expected Losses	12.0		25,128	26,200	27,319	28,487	29,707
Expected Expenses			795.7	819.6	844.2	869.5	895.6
Total Loss & Expense			**25,923**	**27,019**	**28,163**	**29,357**	**30,602**
Change in Fund Balance			**10,428**	**11,008**	**11,598**	**12,156**	**12,561**
Fund Balance		**(117,600)**	**(107,172)**	**(96,165)**	**(84,566)**	**(72,411)**	**(59,849)**

Additional Years to Reach Positive Fund Balance 5

Footnotes:

(2)	Provided by VABRNICP
(3)	Total from National Vital Statistics Report and VABRNICP
(4) - (8)	Based on current assessment levels and caps
(9)	Exhibit 3, Sheet 1
(10)-(14)	Mercer RFI September 2005 Report

Virginia Birth-Related Neurological Injury Compensation Fund
Mandatory Participation for Hospitals & OB/GYNS

Fund Balance with Raising OB/GYNS and Hospital Fees and Adding Group Health Insurance Assessments

Contribution Category	Assessment Membership	Expected Live Births	Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Physicians							
OB/GYNS	1,102		5,952	6,172	6,393	6,613	6,834
Rate			*5,400*	*5,600*	*5,800*	*6,000*	*6,200*
All Other	13,115		3,803	4,066	4,328	4,590	4,852
Rate			*290*	*310*	*330*	*350*	*370*
Hospitals		90,364	4,311	4,520	4,730	4,906	4,906
Fee per Live Birth			*52.50*	*55.00*	*57.50*	*60.00*	*60.00*
Liability Insurers			11,510	12,201	12,933	13,709	14,532
Group Health			15,488	16,417	17,402	18,446	19,553
Total Revenue			**41,064**	**43,376**	**45,786**	**48,265**	**50,677**

Compensation Fund Losses

	Claim Frequency		Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)
	(9)		(10)	(11)	(12)	(13)	(14)
Expected Losses	12.0		25,128	26,200	27,319	28,487	29,707
Expected Expenses			795.7	819.6	844.2	869.5	895.6
Total Loss & Expense			**25,923**	**27,019**	**28,163**	**29,357**	**30,602**
Change in Fund Balance			**15,141**	**16,357**	**17,623**	**18,908**	**20,074**
Fund Balance		**(117,600)**	**(102,459)**	**(86,102)**	**(68,479)**	**(49,571)**	**(29,497)**

Additional Years to Reach Positive Fund Balance 2

Footnotes:

(2)	Provided by VABRNICP
(3)	Total from National Vital Statistics Report and VABRNICP
(4) - (8)	Based on current assessment levels and caps
(9)	Exhibit 3, Sheet 1
(10)-(14)	Mercer RFI September 2005 Report

Virginia Birth-Related Neurological Injury Compensation Fund
Mandatory Participation for Hospitals & OB/GYNS

Fund Balance with Raising OB/GYNS and Hospital Fees and Adding Group Health Insurance Assessments and Amortization of Fund Deficit

Contribution Category	Assessment Membership	Expected Live Births		Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)		(4)	(5)	(6)	(7)	(8)
Physicians								
OB/GYNS	1,102			7,514	7,734	7,955	8,175	6,834
Rate				*5,400*	*5,600*	*5,800*	*6,000*	*6,200*
Surcharge				*1,417*	*1,417*	*1,417*	*1,417*	*0*
All Other	13,115			4,801	5,064	5,326	5,588	4,852
Rate				*290*	*310*	*330*	*350*	*370*
Surcharge				*76*	*76*	*76*	*76*	*0*
Hospitals		90,364		5,442	5,652	5,863	6,032	4,906
Fee per Live Birth				*52.50*	*55.00*	*57.50*	*60.00*	*60.00*
Surcharge				*13.78*	*13.78*	*13.78*	*13.78*	*0.00*
Liability Insurers				11,510	12,201	12,933	13,709	7,602
Surcharge				3,020	3,201	3,393	3,597	0
Group Health				15,488	16,417	17,402	18,446	10,228
Surcharge				4,064	4,308	4,566	4,840	0
Total Revenue				**51,839**	**54,577**	**57,438**	**60,388**	**34,422**

Compensation Fund Losses

	Claim Frequency		Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)
	(9)		(10)	(11)	(12)	(13)	(14)
Expected Losses	12.0		25,128	26,200	27,319	28,487	29,707
Expected Expenses			795.7	819.6	844.2	869.5	895.6
Total Loss & Expense			**25,923**	**27,019**	**28,163**	**29,357**	**30,602**
Change in Fund Balance			**25,916**	**27,558**	**29,275**	**31,031**	**3,820**
Fund Balance		**(117,600)**	**(91,684)**	**(64,126)**	**(34,851)**	**(3,820)**	**-**

Footnotes:

(2)	Provided by VABRNICP
(3)	Total from National Vital Statistics Report and VABRNICP
(4) - (8)	Based on current assessment levels and caps
(9)	Exhibit 3, Sheet 1
(10)-(14)	Mercer RFI September 2005 Report

Virginia Birth-Related Neurological Injury Compensation Fund
Impact of Raising OB/GYN Fees

Raising OB fees with Voluntary Participation

Contribution Category	Assessment Membership	Expected Change in 7/06 - 7/07 Assessment Income $(000)	Expected Change in 7/07 - 7/08 Assessment Income $(000)	Expected Change in 7/08 - 7/09 Assessment Income $(000)	Expected Change in 7/09 - 7/10 Assessment Income $(000)	Expected Change in 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Current Income		6,284	6,471	6,657	6,844	6,844
OB/GYN Rate	496	*5,200*	*5,300*	*5,400*	*5,500*	*5,500*
Other Physician Rate	13,721	*270*	*280*	*290*	*300*	*300*
Proposed Rates		6,657	7,031	7,405	7,778	8,152
OB/GYN Rate	496	*5,400*	*5,600*	*5,800*	*6,000*	*6,200*
Other Physician Rate	13,721	*290*	*310*	*330*	*350*	*370*
Total Change in Yearly Assesment		**374**	**560**	**747**	**934**	**1,308**

Raising OB fees with Mandatory Participation

Contribution Category	Assessment Membership	Expected Change in 7/06 - 7/07 Assessment Income $(000)	Expected Change in 7/07 - 7/08 Assessment Income $(000)	Expected Change in 7/08 - 7/09 Assessment Income $(000)	Expected Change in 7/09 - 7/10 Assessment Income $(000)	Expected Change in 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Current Income		9,273	9,514	9,755	9,997	9,997
OB/GYN Rate	1,102	*5,200*	*5,300*	*5,400*	*5,500*	*5,500*
Other Physician Rate	13,115	*270*	*280*	*290*	*300*	*300*
Proposed Rates		9,755	10,238	10,721	11,204	11,686
OB/GYN Rate	1,102	*5,400*	*5,600*	*5,800*	*6,000*	*6,200*
Other Physician Rate	13,115	*290*	*310*	*330*	*350*	*370*
Total Change in Yearly Assesment		**483**	**724**	**965**	**1,207**	**1,690**

(2) Exhibit 1, Sheet 1&2 Respectively
(3) - (7) Participating Physicians Increase $200 per year for five years
Non-Participating Physicians Increase $20 per year for five years

Virginia Birth-Related Neurological Injury Compensation Fund
Impact of Raising Hospital Fees

Raising Hospital Fees with Voluntary Participation

Contribution Category	Expected Live Births	Change in Expected 7/06 - 7/07 Assessment Income $(000)	Change in Expected 7/07 - 7/08 Assessment Income $(000)	Change in Expected 7/08 - 7/09 Assessment Income $(000)	Change in Expected 7/09 - 7/10 Assessment Income $(000)	Change in Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Current Assesment	62,486	2,737	2,755	2,765	2,765	2,765
Rate		*50.00*	*50.00*	*50.00*	*50.00*	*50.00*
Proposed Assesment		2,847	2,987	3,127	3,233	3,233
Rate		*52.50*	*55.00*	*57.50*	*60.00*	*60.00*
Total Change in Yearly Assesment		**110**	**232**	**362**	**468**	**468**

Raising Hospital Fees with Mandatory Participation

Contribution Category	Expected Live Births	Change in Expected 7/06 - 7/07 Assessment Income $(000)	Change in Expected 7/07 - 7/08 Assessment Income $(000)	Change in Expected 7/08 - 7/09 Assessment Income $(000)	Change in Expected 7/09 - 7/10 Assessment Income $(000)	Change in Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Current Assesment	90,364	4,131	4,149	4,159	4,159	4,159
Rate		*50.00*	*50.00*	*50.00*	*50.00*	*50.00*
Proposed Assesment		4,311	4,520	4,730	4,906	4,906
Rate		*52.50*	*55.00*	*57.50*	*60.00*	*60.00*
Total Change in Yearly Assesment		**180**	**371**	**571**	**747**	**747**

Footnotes:

(2) Total from National Vital Statistics Report and VABRNICP

(3) - (7) (2) x Fee per Live Birth Subject to Maximum Cap per Hospital

Virginia Birth-Related Neurological Injury Compensation Fund
Impact of Assessing Group Health Insurance Premium

Compensation Fund Income with Voluntary Participation

Contribution Category	2004 Virginia Group Health Earned Premiums $(000)	Assessment Percentage	Group Health Premium Trend	Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Group Health Assessment	5,676,582	0.25%	6.00%	15,488	16,417	17,402	18,446	19,553

Compensation Fund Income with Mandatory Participation

Contribution Category	2004 Virginia Group Health Earned Premiums $(000)	Assessment Percentage	Group Health Premium Trend	Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Group Health Assessment	5,676,582	0.25%	6.00%	15,488	16,417	17,402	18,446	19,553

Footnotes:

(2)	From Annual Statement data supplied by Virginia SCC
(4)	From Pinnacle Analysis of AM Best Data for Group Health premiums earned in VA
(5) - (9)	(2) x (3) Trended at 6%

Virginia Birth-Related Neurological Injury Compensation Fund
Amortization of Fund Deficit

Amortization of Fund Deficit

Amortization Time Period	Current Deficit (in $000's)	Interest Rate	Level Annual Fund Contribution	% Increase in Annual Revenue Needed W/ Current Rates & Mand. Part.	% Increase in Annual Revenue Needed W/ Incr. Rates & Mand. Part.	% Increase in Annual Revenue Needed W/ Incr. Rates, Mand. Part. & Group Health
(1)	(2)	(3)	(4)	(5a)	(5b)	(5c)
10 - Years	(117,600)	4.27%	14,692	59%	57%	36%
15 - Years	(117,600)	4.27%	10,775	43%	42%	26%
20 - Years	(117,600)	4.27%	8,858	36%	35%	22%
25 - Years	(117,600)	4.27%	7,741	31%	30%	19%

Development of Surcharge Rate

		Current Rate	Proposed surcharges for deficit amortized over 10 - Years	15 - Years	20 - Years	25 - Years
		(6)	(7)	(8)	(9)	(10)
OB/GYNS	(a)	5,200.00	3,070	2,252	1,851	1,618
	(b)	5,400.00	3,102	2,275	1,870	1,634
	(c)	5,400.00	1,932	1,417	1,165	1,018
All Other Physician	(a)	270	159	117	96	84
	(b)	290	167	122	100	88
	(c)	290	104	76	63	55
Hospitals	(a)	50.00	29.52	21.65	17.80	15.55
	(b)	52.50	30.16	22.12	18.18	15.89
	(c)	52.50	18.78	13.78	11.33	9.90
Liability Insurers	(a)	0.25%	0.148%	0.108%	0.089%	0.078%
	(b)	0.25%	0.144%	0.105%	0.087%	0.076%
	(c)	0.25%	0.089%	0.066%	0.054%	0.047%
Group Health	(a)	0.00%	0.000%	0.000%	0.000%	0.000%
	(b)	0.00%	0.000%	0.000%	0.000%	0.000%
	(c)	0.25%	0.089%	0.066%	0.054%	0.047%

Footnotes:

(2) Mercer RFI September 2005 Report
(3) Exhibit 4
(4) Ammortization of (2)
(5) (4) / Corresponding Annual Revenue
(a) Columns & Rows denoted with (a) use Revenue and Rates from Exhibit 1, Sheet 1(Current Rates & Mandatory Participation)
(b) Columns & Rows denoted with (a) use Revenue and Rates from Exhibit 1, Sheet 3(Increased Rates & Mandatory Participation)
(c) Columns & Rows denoted with (a) use Revenue and Rates from Exhibit 1, Sheet 6(Increased Rates, Mandatory Participation & Group Health)

Virginia Birth-Related Neurological Injury Compensation Fund

Impact on Claim Frequency due to Mandatory Participation

Estimate of Claim Frequency with Additional Exposure

1.	Current Percent of Births in Non-Participating Hospitals	31%
2.	Current Percent of Births by Non-Participating Physicians	47%
3.	Current Percent of Births not Covered	15%
4.	Current Percent of Births Covered	85%
5.	Current Claim Frequency	10
6.	Expected Claim Frequency with Additional Exposure	11.7
7.	Selected Claim Frequency with Additional Exposure	12

Footnotes:

(1) From November 2003 report by E.A. Brown Consulting
(2) From November 2003 report by E.A. Brown Consulting
(3) (1) * (2)
(4) 1 - (3)
(5) Mercer RFI September 2005 Report
(6) (5) / (4)
(7) Judgmental Selection

Virginia Birth-Related Neurological Injury Compensation Fund
Mandatory Participation for Hospitals & OB/GYNS

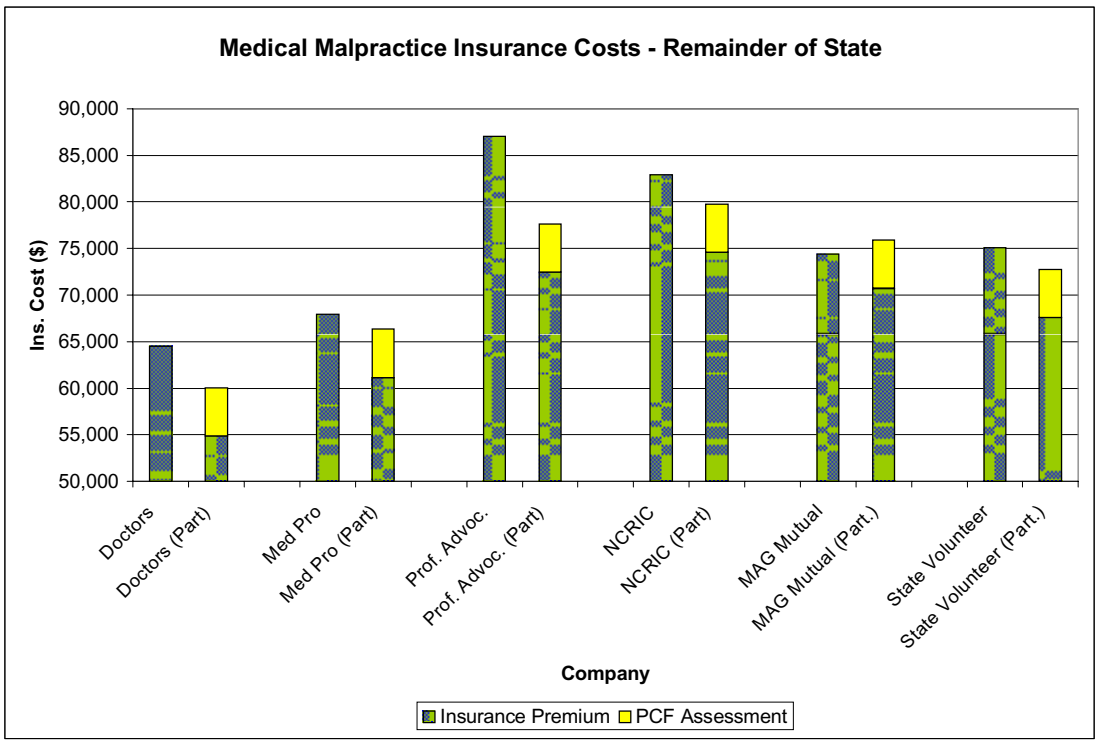
Estimated 2004 Lifetime Claim Cost (at 12/31/2004 Present Value)

Expense Category	Forecasted Lifetime Costs per Claimant @12/31/2004	Estimated Annual Inflation Rate	Forecasted Lifetime Costs per Claimant @6/30/2006	Forecasted Lifetime Costs per Claimant @6/30/2007	Forecasted Lifetime Costs per Claimant @6/30/2008	Forecasted Lifetime Costs per Claimant @6/30/2009	Forecasted Lifetime Costs per Claimant @6/30/2010	Inflation based on CPI Urban Index for:
Nursing	1,414,842	4.5%	1,511,410	1,579,424	1,650,498	1,724,770	1,802,385	Other Professional Services
Hospital/Physician	83,628	5.1%	90,145	94,769	99,631	104,742	110,115	Medical Care Services
Incidental	61,543	3.3%	64,624	66,763	68,973	71,256	73,614	General Inflation
Housing	113,342	3.5%	119,413	123,641	128,018	132,549	137,242	Housing
Vans	72,704	1.0%	73,797	74,535	75,281	76,033	76,794	New & Used Motor Vehicles
Lost Wages	86,130	3.3%	90,442	93,435	96,528	99,723	103,024	General Inflation
Physical Therapy	30,103	4.5%	32,158	33,605	35,117	36,697	38,349	Other Professional Services
Medical Equipment	47,398	4.8%	50,844	53,279	55,832	58,506	61,308	Prescription Drugs & Medical Supplies
Prescription Drugs	25,333	4.8%	27,175	28,476	29,840	31,270	32,768	Prescription Drugs & Medical Supplies
Legal	12,969	5.4%	14,024	14,774	15,564	16,397	17,274	Legal Services
Insurance	17,992	3.3%	18,893	19,518	20,164	20,831	21,521	General Inflation
Medical Review/Intake	989	3.3%	1,039	1,073	1,108	1,145	1,183	General Inflation
TOTAL	1,966,973	4.3%	2,093,962	2,183,292	2,276,553	2,373,920	2,475,576	

Virginia Birth-Related Neurological Injury Compensation Fund
Economics of Mandatory Participation - Physicians
Current Rates

Examples of Overall Insurance Costs For OB/GYNS

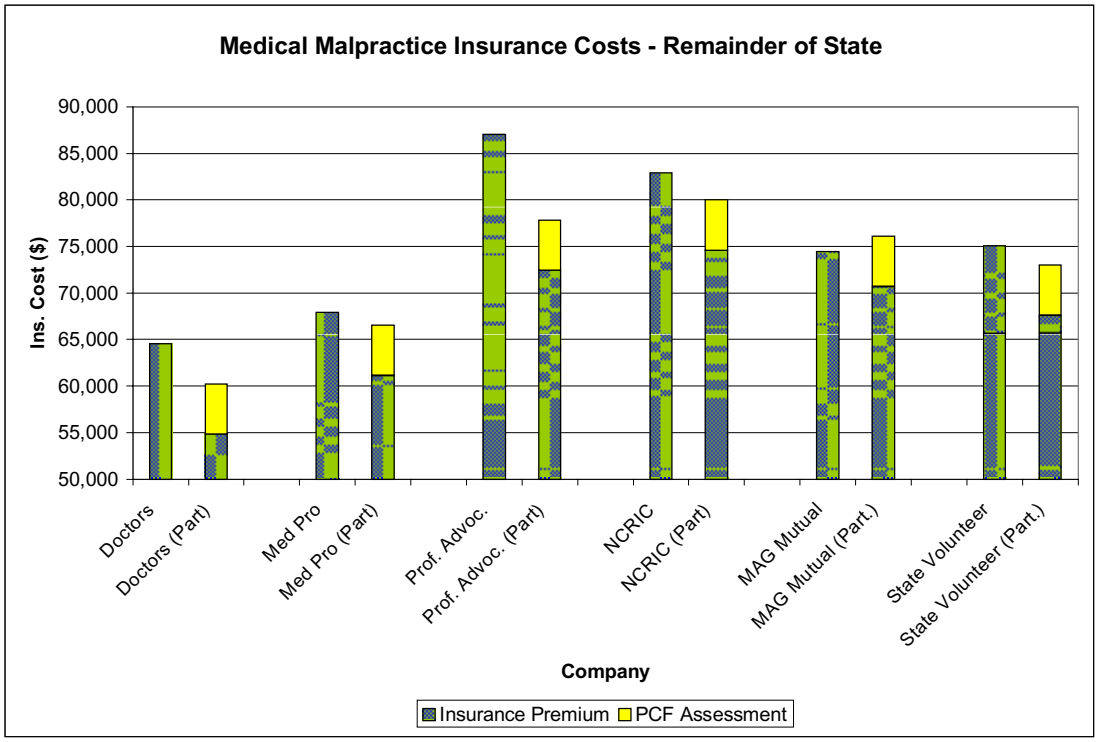
Company	Region	Non-Participating Rate	Credit for Participation	Rate after Credit	VA BRNIC Assessment	Total Costs for Participating	Change in Costs from Participating
The Doctors Company	Northern VA	89,150	15.0%	75,778	5,200	80,978	-8,173
(11.8% Market Share)	Tidewater Region	79,165	15.0%	67,290	5,200	72,490	-6,675
	Remainder of State	64,517	15.0%	54,839	5,200	60,039	-4,478
	Richmond Area	57,109	15.0%	48,543	5,200	53,743	-3,366
	Fauquier & Loudoun Cos.	64,517	15.0%	54,839	5,200	60,039	-4,478
Medical Protective	Northern VA	81,491	10.0%	73,342	5,200	78,542	-2,949
(11.8% Market Share)	Tidewater Region	75,462	10.0%	67,916	5,200	73,116	-2,346
	Remainder of State	67,919	10.0%	61,127	5,200	66,327	-1,592
	Richmond Area	57,851	10.0%	52,066	5,200	57,266	-585
	Fauquier & Loudoun Cos.	67,919	10.0%	61,127	5,200	66,327	-1,592
Professionals Advocate	Northern VA	117,618	16.8%	97,884	5,200	103,084	-14,534
(11.8% Market Share)	Tidewater Region	109,385	16.8%	91,032	5,200	96,232	-13,153
	Remainder of State	87,037	16.8%	72,434	5,200	77,634	-9,403
	Richmond Area	74,100	16.8%	61,668	5,200	66,868	-7,232
	Fauquier & Loudoun Cos.	87,037	16.8%	72,434	5,200	77,634	-9,403
NCRIC Inc.	Northern VA	110,442	10.0%	99,398	5,200	104,598	-5,844
(10.5% Market Share)	Tidewater Region	102,565	10.0%	92,309	5,200	97,509	-5,057
	Remainder of State	82,874	10.0%	74,587	5,200	79,787	-3,087
	Richmond Area	71,061	10.0%	63,955	5,200	69,155	-1,906
	Fauquier & Loudoun Cos.	82,874	10.0%	74,587	5,200	79,787	-3,087
MAG Mutual	Northern VA	92,735	5.0%	88,098	5,200	93,298	563
(4.7% Market Share)	Tidewater Region	85,413	5.0%	81,142	5,200	86,342	929
	Remainder of State	74,430	5.0%	70,709	5,200	75,909	1,479
	Richmond Area	67,107	5.0%	63,752	5,200	68,952	1,845
	Fauquier & Loudoun Cos.	92,735	5.0%	88,098	5,200	93,298	563
State Volunteer Mutual	Northern VA	102,108	10.0%	91,897	5,200	97,097	-5,011
(5.4% Market Share)	Tidewater Region	95,437	10.0%	85,893	5,200	91,093	-4,344
	Remainder of State	75,085	10.0%	67,577	5,200	72,777	-2,309
	Richmond Area	67,148	10.0%	60,433	5,200	65,633	-1,515
	Fauquier & Loudoun Cos.	102,108	10.0%	91,897	5,200	97,097	-5,011



Virginia Birth-Related Neurological Injury Compensation Fund
Economics of Mandatory Participation - Physicians
Increased Rates

Examples of Overall Insurance Costs For OB/GYNS

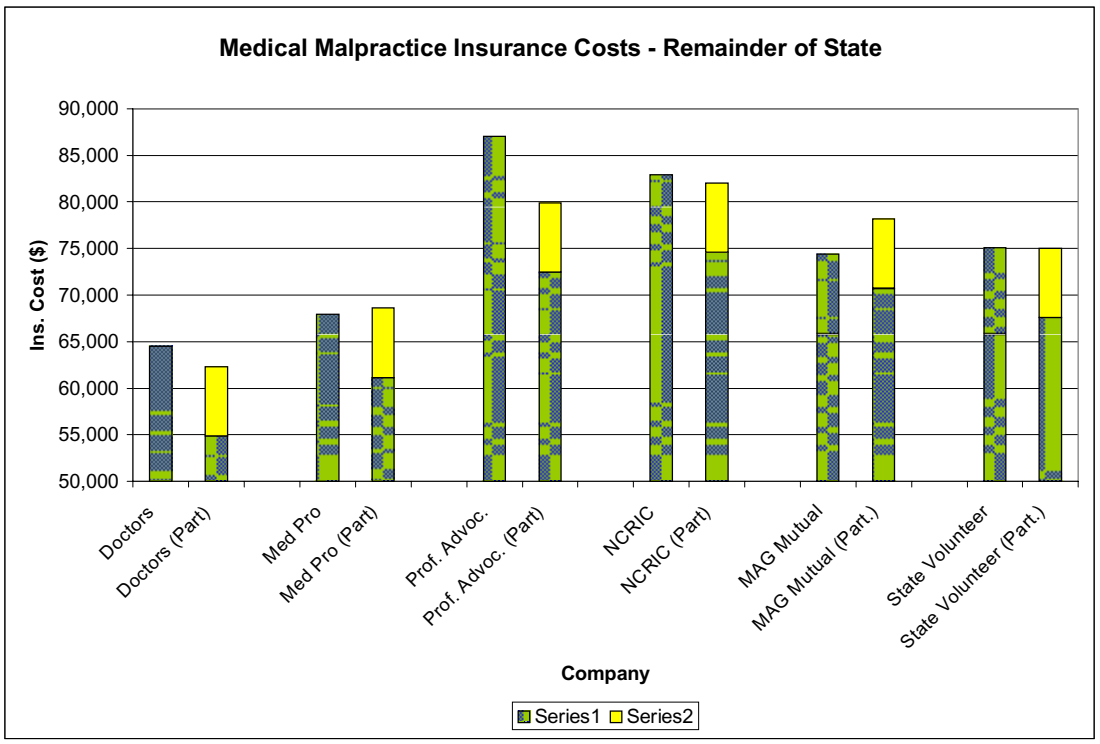
Company	Region	Non-Participating Rate	Credit for Participation	Rate after Credit	VA BRNIC Assessment	Total Costs for Participating	Change in Costs from Participating
The Doctors Company	Northern VA	89,150	15.0%	75,778	5,400	81,178	-7,973
(11.8% Market Share)	Tidewater Region	79,165	15.0%	67,290	5,400	72,690	-6,475
	Remainder of State	64,517	15.0%	54,839	5,400	60,239	-4,278
	Richmond Area	57,109	15.0%	48,543	5,400	53,943	-3,166
	Fauquier & Loudoun Cos.	64,517	15.0%	54,839	5,400	60,239	-4,278
Medical Protective	Northern VA	81,491	10.0%	73,342	5,400	78,742	-2,749
(11.8% Market Share)	Tidewater Region	75,462	10.0%	67,916	5,400	73,316	-2,146
	Remainder of State	67,919	10.0%	61,127	5,400	66,527	-1,392
	Richmond Area	57,851	10.0%	52,066	5,400	57,466	-385
	Fauquier & Loudoun Cos.	67,919	10.0%	61,127	5,400	66,527	-1,392
Professionals Advocate	Northern VA	117,618	16.8%	97,884	5,400	103,284	-14,334
(11.8% Market Share)	Tidewater Region	109,385	16.8%	91,032	5,400	96,432	-12,953
	Remainder of State	87,037	16.8%	72,434	5,400	77,834	-9,203
	Richmond Area	74,100	16.8%	61,668	5,400	67,068	-7,032
	Fauquier & Loudoun Cos.	87,037	16.8%	72,434	5,400	77,834	-9,203
NCRIC Inc.	Northern VA	110,442	10.0%	99,398	5,400	104,798	-5,644
(10.5% Market Share)	Tidewater Region	102,565	10.0%	92,309	5,400	97,709	-4,857
	Remainder of State	82,874	10.0%	74,587	5,400	79,987	-2,887
	Richmond Area	71,061	10.0%	63,955	5,400	69,355	-1,706
	Fauquier & Loudoun Cos.	82,874	10.0%	74,587	5,400	79,987	-2,887
MAG Mutual	Northern VA	92,735	5.0%	88,098	5,400	93,498	763
(4.7% Market Share)	Tidewater Region	85,413	5.0%	81,142	5,400	86,542	1,129
	Remainder of State	74,430	5.0%	70,709	5,400	76,109	1,679
	Richmond Area	67,107	5.0%	63,752	5,400	69,152	2,045
	Fauquier & Loudoun Cos.	92,735	5.0%	88,098	5,400	93,498	763
State Volunteer Mutual	Northern VA	102,108	10.0%	91,897	5,400	97,297	-4,811
(5.4% Market Share)	Tidewater Region	95,437	10.0%	85,893	5,400	91,293	-4,144
	Remainder of State	75,085	10.0%	67,577	5,400	72,977	-2,109
	Richmond Area	67,148	10.0%	60,433	5,400	65,833	-1,315
	Fauquier & Loudoun Cos.	102,108	10.0%	91,897	5,400	97,297	-4,811



Virginia Birth-Related Neurological Injury Compensation Fund
Economics of Mandatory Participation - Physicians
Increased Rates With Ammortization

Examples of Overall Insurance Costs For OB/GYNS

Company	Region	Non-Participating Rate	Credit for Participation	Rate after Credit	VA BRNIC Assessment	Total Costs for Participating	Change in Costs from Participating
The Doctors Company	Northern VA	89,150	15.0%	75,778	7,452	83,229	-5,921
(11.8% Market Share)	Tidewater Region	79,165	15.0%	67,290	7,452	74,742	-4,423
	Remainder of State	64,517	15.0%	54,839	7,452	62,291	-2,226
	Richmond Area	57,109	15.0%	48,543	7,452	55,994	-1,115
	Fauquier & Loudoun Cos.	64,517	15.0%	54,839	7,452	62,291	-2,226
Medical Protective	Northern VA	81,491	10.0%	73,342	7,452	80,794	-697
(11.8% Market Share)	Tidewater Region	75,462	10.0%	67,916	7,452	75,367	-95
	Remainder of State	67,919	10.0%	61,127	7,452	68,579	660
	Richmond Area	57,851	10.0%	52,066	7,452	59,518	1,667
	Fauquier & Loudoun Cos.	67,919	10.0%	61,127	7,452	68,579	660
Professionals Advocate	Northern VA	117,618	16.8%	97,884	7,452	105,336	-12,282
(11.8% Market Share)	Tidewater Region	109,385	16.8%	91,032	7,452	98,484	-10,901
	Remainder of State	87,037	16.8%	72,434	7,452	79,886	-7,151
	Richmond Area	74,100	16.8%	61,668	7,452	69,119	-4,981
	Fauquier & Loudoun Cos.	87,037	16.8%	72,434	7,452	79,886	-7,151
NCRIC Inc.	Northern VA	110,442	10.0%	99,398	7,452	106,849	-3,593
(10.5% Market Share)	Tidewater Region	102,565	10.0%	92,309	7,452	99,760	-2,805
	Remainder of State	82,874	10.0%	74,587	7,452	82,038	-836
	Richmond Area	71,061	10.0%	63,955	7,452	71,407	346
	Fauquier & Loudoun Cos.	82,874	10.0%	74,587	7,452	82,038	-836
MAG Mutual	Northern VA	92,735	5.0%	88,098	7,452	95,550	2,815
(4.7% Market Share)	Tidewater Region	85,413	5.0%	81,142	7,452	88,594	3,181
	Remainder of State	74,430	5.0%	70,709	7,452	78,160	3,730
	Richmond Area	67,107	5.0%	63,752	7,452	71,203	4,096
	Fauquier & Loudoun Cos.	92,735	5.0%	88,098	7,452	95,550	2,815
State Volunteer Mutual	Northern VA	102,108	10.0%	91,897	7,452	99,349	-2,759
(5.4% Market Share)	Tidewater Region	95,437	10.0%	85,893	7,452	93,345	-2,092
	Remainder of State	75,085	10.0%	67,577	7,452	75,028	-57
	Richmond Area	67,148	10.0%	60,433	7,452	67,885	737
	Fauquier & Loudoun Cos.	102,108	10.0%	91,897	7,452	99,349	-2,759



Virginia Birth-Related Neurological Injury Compensation Fund

Impact of Limit on Eligible Birth Weight to Greater than 1,500 grams

	Voluntary Participation	Mandatory Participation
1. Estimated Annual Claim Frequency	10	12.0
2. Estimated % Claims Below 1,500 grams	9%	9%
3. Estimated Number of Claims Eliminated	0.9	1.1
4. Estimated 2006 Claim Severity	2,093,962	2,093,962
5. Estimated Annual Loss Reduction due to introduction of 1,500 birth weight limit	1,884,566	2,261,479

Impact of Limit on Eligible Birth Weight to Greater than 2,000 grams

	Voluntary Participation	Mandatory Participation
1. Estimated Annual Claim Frequency	10	12.0
2. Estimated % Claims Below 2,000 grams	30%	30%
3. Estimated Number of Claims Eliminated	3.0	3.6
4. Estimated 2006 Claim Severity	2,093,962	2,093,962
5. Estimated Annual Loss Reduction due to introduction of 2,000 birth weight limit	6,281,887	7,538,265

Footnotes:

(1) Exhibit 1, Sheet 1 & 2 respectively
(2) Based on Florida BRNICA analysis of neonatal intensive care admissions.
(3) (1) * (2)
(4) Exhibit 4
(5) (3) * (4)

Virginia Birth-Related Neurological Injury Compensation Fund
Impact of Birth Weight Restrictions

Birth Weight Restriction with Voluntary Participation

	Current Claim Frequency	% Change in Frequency	Frequency	Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Losses w/ Current Eligibility	10			20,940	21,833	22,766	23,739	24,756
Losses w/ 1500g Eligibility	10	9%	9.1	19,055	19,868	20,717	21,603	22,528
Losses w/ 2000g Eligibility	10	30%	7.0	14,658	15,283	15,936	16,617	17,329
Change in Expected losses w/1500g Eligibility				(1,885)	(1,965)	(2,049)	(2,137)	(2,228)
Change in Expected losses w/2000g Eligibility				(6,282)	(6,550)	(6,830)	(7,122)	(7,427)
Change in Fund Balance w/ 1500g Eligibility				**1,960**	**2,351**	**2,748**	**3,118**	**3,389**
Change in Fund Balance w/ 2000g Eligibility				**6,357**	**6,936**	**7,529**	**8,103**	**8,588**

Birth Weight Restriction with Mandatory Participation

	Current Claim Frequency	% Change in Frequency	Frequency	Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Losses w/ Current Eligibility	12.0			25,128	26,200	27,319	28,487	29,707
Losses w/ 1500g Eligibility	12.0	9%	10.9	22,866	23,842	24,860	25,923	27,033
Losses w/ 2000g Eligibility	12.0	30%	8.4	17,589	18,340	19,123	19,941	20,795
Change in Expected losses w/1500g Eligibility				(2,261)	(2,358)	(2,459)	(2,564)	(2,674)
Change in Expected losses w/2000g Eligibility				(7,538)	(7,860)	(8,196)	(8,546)	(8,912)
Change in Fund Balance w/ 1500g Eligibility				**2,710**	**3,118**	**3,524**	**3,895**	**4,091**
Change in Fund Balance w/ 2000g Eligibility				**7,987**	**8,620**	**9,261**	**9,878**	**10,329**

Footnotes:

(1)	Mercer RFI September 2005 Report & Exhibit 3, Sheet 1 Respectively
(2)	Exhibit 6, Sheet 1
(3)	(2) x [1-(3)]
(4) - (9)	(3) x Severity from Exhibit 4

Virginia Birth-Related Neurological Injury Compensation Fund
impact of Closing Fund to New Claims

Voluntary Participation

Contribution Category	Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
	(1)	(2)	(3)	(4)	(5)
Income	21,015	22,219	23,465	24,721	25,917
Expenses	795.7	819.6	844.2	869.5	895.6
Losses	0	0	0	0	0
Change in Fund Balance	20,219	21,399	22,620	23,851	25,021

Mandatory Participation

Contribution Category	Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)
	(6)	(7)	(8)	(9)	(10)
Income	25,576	26,959	28,384	29,819	31,124
Expenses	795.7	819.6	844.2	869.5	895.6
Losses	0	0	0	0	0
Change in Fund Balance	24,781	26,140	27,539	28,949	30,228

Footnotes:

(1) - (5) From Exhibit 1, Sheet 1
(6) - (10) From Exhibit 1, Sheet 2

Virginia Birth-Related Neurological Injury Compensation Fund
Analysis of Subsidy for Rural Doctors & Hospitals

Rural Doctors

(1)	% of OB/GYNS in Rural Area	10.9%
(2)	% of Subsidy	50.0%
(3)	% of Annual Assessment [(1) x (2)]	5.47%
(4)	% of Docs in Non-Rural area [1.0 - (1)]	89.1%
(5)	% of increase in Non-Rural Docs Assessment [(3) / (4)]	6.15%

Current 06/07 rate	5,200
Rural 06/07 rate	2,600
Non Rural 06/07 rate	5,520

Rural Hospitals

(1)	% of Births in Rural Areas	7.43%
(2)	% of Subsidy	25.0%
(3)	% of annual Assessment [(1) x (2)]	1.86%
(4)	% of births in Non-Rural Areas [1.0 - (1)]	92.6%
(5)	% of increase in Rate for Non Rural Hospitals [(3) / (4)]	2.01%

Current 06/07 rate	50.00
Rural 06/07 rate	37.50
Non Rural 06/07 rate	51.00

APPENDIX I

Pinnacle Actuarial Resources, Inc. Addendum Letter December 2005

*Please see attached document for full text version of "Addendum Letter and related attachments dated December 19, 2005"

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PINNACLE
ACTUARIAL RESOURCES, INC.
Consulting Actuaries

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Gary C. Wang, FCAS, MAAA
Robert J. Walling, III, FCAS, AAA

December 19, 2005

George Deebo
Virginia Birth-Related Neurological Injury Compensation Program
9100 Arboretum Parkway, Suite 365
Richmond, VA 23236

Dear George:

This letter is an addendum to our December 2005 report for the Virginia Birth-Related Neurological Injury Compensation Program (VABRNICP or the Program) entitled "Analysis of Potential Program Changes". This letter and the attached exhibits should be viewed as an extension of that report and subject to the limitations on distribution and use as well as the reliances and limitations and other elements of the original report. Per the request of the VABRNICP, we have created three more exhibits demonstrating possible future pro forma financials based on various approaches to future revenue assessments and claims conditions.

Exhibit 1, Sheet 1A assumes current participant assessment levels followed by a moderate level of assessment increases in years 6-15, mandatory participation and the use of the group health insurance premium assessments to eliminate the current fund deficit and then to maintain a fund balance of $0. The full 0.25% assessment of group health insurance premiums is needed through approximately July, 2013 to eliminate the deficit. After that a 0.03% assessment of group health insurance premiums is needed to avoid a fund deficit.

Exhibit 1, Sheet 1B assumes current participant assessment levels followed by the same moderate level of assessment increases in years 6-15 as 1A, mandatory participation and the use of the group health insurance premium assessments to eliminate the current fund deficit evenly over fifteen years. Instead of the full 0.25% assessment of group health insurance premiums shown initially in 1A, a 0.11% assessment of group health insurance premiums over the fifteen year period appears to be sufficient to eliminate the deficit in fifteen years.

Exhibit 1, Sheet 5A assumes the increased participant assessment levels from Exhibit 1, Sheet 5 followed by a moderate level of assessment increases in years 6-15, mandatory participation, surcharges intended to eliminate the current fund deficit and no group health insurance premium assessments. The surcharges shown are fixed dollar amount per year per participating physicians and per live birth for hospitals and a fixed percentage of premium per year for liability insurers in Virginia. Surcharges of $1,723 per OB/GYN, $93 per other participating physician, $16.81 per live birth and 0.08% of liability premium are sufficient to produce an expected fund balance of $0 after fifteen years.

We have enjoyed performing these services for the Program and remain available to answer any questions you may have. Should you have any questions or require any additional analysis, please feel free to contact me at your convenience.

Sincerely,

Robert J Willis III

Virginia Birth-Related Neurological Injury Compensation Fund
Mandatory Participation for Hospitals & OB/GYNS

Fund Balance with Current OB/GYNS and Hospital Fees and Group Health Assesment

Contribution Category	Assessment Membership	Expected Live Births		Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)	Expected 7/11 - 7/12 Assessment Income $(000)	Expected 7/12 - 7/13 Assessment Income $(000)	Expected 7/13 - 7/14 Assessment Income $(000)	Expected 7/14 - 7/15 Assessment Income $(000)	Expected 7/15 - 7/16 Assessment Income $(000)	Expected 7/16 - 7/17 Assessment Income $(000)	Expected 7/17 - 7/18 Assessment Income $(000)	Expected 7/18 - 7/19 Assessment Income $(000)	Expected 7/19 - 7/20 Assessment Income $(000)	Expected 7/20 - 7/21 Assessment Income $(000)
(1)	(2)	(3)		(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
Physicians																		
OB/GYNS	1,102			5,732	5,842	5,952	6,062	6,062	6,172	6,283	6,393	6,503	6,613	6,724	6,834	6,944	7,054	7,164
Rate			*5,200*	*5,300*	*5,400*	*5,500*	*5,500*	*5,600*	*5,700*	*5,800*	*5,900*	*6,000*	*6,100*	*6,200*	*6,300*	*6,400*	*6,500*	
All Other	13,115			3,541	3,672	3,803	3,934	3,934	4,066	4,197	4,328	4,459	4,590	4,721	4,852	4,984	5,115	5,246
Rate			*270*	*280*	*290*	*300*	*300*	*310*	*320*	*330*	*340*	*350*	*360*	*370*	*380*	*390*	*400*	
Hospitals		90,364		4,101	4,131	4,149	4,159	4,159	4,159	4,159	4,159	4,159	4,159	4,159	4,159	4,159	4,159	4,159
Fee per Live Birth			*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	
Liability Insurers				11,510	12,201	12,933	13,709	14,532	15,403	16,328	17,307	18,346	19,446	20,613	21,850	23,161	24,551	26,024
Group Health				15,488	16,417	17,402	18,446	19,553	20,726	20,910	2,490	2,690	2,892	3,095	3,300	3,504	3,707	3,907
Group Health Assesment			0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.24%	0.03%	0.03%	0.03%	0.03%	0.03%	0.03%	0.03%	0.03%	
Total Revenue				**40,372**	**42,263**	**44,239**	**46,311**	**48,240**	**50,527**	**51,876**	**34,677**	**36,157**	**37,701**	**39,313**	**40,995**	**42,752**	**44,586**	**46,500**

Compensation Fund Losses

	Claim Frequency		Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)	Expected 7/11 - 7/12 Losses $(000)	Expected 7/12 - 7/13 Losses $(000)	Expected 7/13 - 7/14 Losses $(000)	Expected 7/14 - 7/15 Losses $(000)	Expected 7/15 - 7/16 Losses $(000)	Expected 7/16 - 7/17 Losses $(000)	Expected 7/17 - 7/18 Losses $(000)	Expected 7/18 - 7/19 Losses $(000)	Expected 7/19 - 7/20 Losses $(000)	Expected 7/20 - 7/21 Losses $(000)
	(19)		(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)
Expected Losses	12.0		25,128	26,200	27,319	28,487	29,707	30,981	32,310	33,699	35,149	36,662	38,243	39,894	41,617	43,417	45,297
Expected Expenses			795.7	819.6	844.2	869.5	895.6	922.4	950.1	978.6	1,008.0	1,038.2	1,069.4	1,101.4	1,134.5	1,168.5	1,203.6
Total Loss & Expense			**25,923**	**27,019**	**28,163**	**29,357**	**30,602**	**31,903**	**33,260**	**34,677**	**36,157**	**37,701**	**39,313**	**40,995**	**42,752**	**44,586**	**46,500**
Change in Fund Balance			**14,448**	**15,244**	**16,077**	**16,954**	**17,638**	**18,624**	**18,616**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Fund Balance		**(117,600)**	**(103,152)**	**(87,908)**	**(71,831)**	**(54,877)**	**(37,239)**	**(18,616)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Footnotes:

(2) Provided by VABRNICP
(3) Total from National Vital Statistics Report and VABRNICP
(4) - (18) Based on current assessment levels and cap
(19) Exhibit 3, Sheet 1
(20)-(34) Mercer RFI September 2005 Report

Virginia Birth-Related Neurological Injury Compensation Fund
Mandatory Participation for Hospitals & OB/GYNS

Fund Balance with Current OB/GYNS and Hospital Fees and Group Health Assesment

Contribution Category	Assessment Membership	Expected Live Births		Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)	Expected 7/11 - 7/12 Assessment Income $(000)	Expected 7/12 - 7/13 Assessment Income $(000)	Expected 7/13 - 7/14 Assessment Income $(000)	Expected 7/14 - 7/15 Assessment Income $(000)	Expected 7/15 - 7/16 Assessment Income $(000)	Expected 7/16 - 7/17 Assessment Income $(000)	Expected 7/17 - 7/18 Assessment Income $(000)	Expected 7/18 - 7/19 Assessment Income $(000)	Expected 7/19 - 7/20 Assessment Income $(000)	Expected 7/20 - 7/21 Assessment Income $(000)
(1)	(2)	(3)		(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
Physicians																		
OB/GYNS	1,102			5,732	5,842	5,952	6,062	6,062	6,172	6,283	6,393	6,503	6,613	6,724	6,834	6,944	7,054	7,164
Rate				*5,200*	*5,300*	*5,400*	*5,500*	*5,500*	*5,600*	*5,700*	*5,800*	*5,900*	*6,000*	*6,100*	*6,200*	*6,300*	*6,400*	*6,500*
All Other	13,115			3,541	3,672	3,803	3,934	3,934	4,066	4,197	4,328	4,459	4,590	4,721	4,852	4,984	5,115	5,246
Rate				*270*	*280*	*290*	*300*	*300*	*310*	*320*	*330*	*340*	*350*	*360*	*370*	*380*	*390*	*400*
Hospitals		90,364		4,101	4,131	4,149	4,159	4,159	4,159	4,159	4,159	4,159	4,159	4,159	4,159	4,159	4,159	4,159
Fee per Live Birth				*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*	*50.00*
Liability Insurers				11,510	12,201	12,933	13,709	14,532	15,403	16,328	17,307	18,346	19,446	20,613	21,850	23,161	24,551	26,024
Group Health				6,639	7,037	7,459	7,907	8,381	8,884	9,417	9,982	10,581	11,216	11,889	12,603	13,359	14,160	15,010
Group Health Assesment				0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%
Total Revenue				**31,523**	**32,883**	**34,297**	**35,772**	**37,069**	**38,685**	**40,384**	**42,170**	**44,048**	**46,025**	**48,106**	**50,298**	**52,606**	**55,039**	**57,603**

Compensation Fund Losses

	Claim Frequency		Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)	Expected 7/11 - 7/12 Losses $(000)	Expected 7/12 - 7/13 Losses $(000)	Expected 7/13 - 7/14 Losses $(000)	Expected 7/14 - 7/15 Losses $(000)	Expected 7/15 - 7/16 Losses $(000)	Expected 7/16 - 7/17 Losses $(000)	Expected 7/17 - 7/18 Losses $(000)	Expected 7/18 - 7/19 Losses $(000)	Expected 7/19 - 7/20 Losses $(000)	Expected 7/20 - 7/21 Losses $(000)
	(19)		(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)
Expected Losses	12.0		25,128	26,200	27,319	28,487	29,707	30,981	32,310	33,699	35,149	36,662	38,243	39,894	41,617	43,417	45,297
Expected Expenses			795.7	819.6	844.2	869.5	895.6	922.4	950.1	978.6	1,008.0	1,038.2	1,069.4	1,101.4	1,134.5	1,168.5	1,203.6
Total Loss & Expense			**25,923**	**27,019**	**28,163**	**29,357**	**30,602**	**31,903**	**33,260**	**34,677**	**36,157**	**37,701**	**39,313**	**40,995**	**42,752**	**44,586**	**46,500**
Change in Fund Balance			**5,600**	**5,864**	**6,134**	**6,415**	**6,466**	**6,782**	**7,123**	**7,492**	**7,892**	**8,325**	**8,794**	**9,303**	**9,855**	**10,453**	**11,103**
Fund Balance		**(117,600)**	**(112,000)**	**(106,136)**	**(100,002)**	**(93,587)**	**(87,121)**	**(80,339)**	**(73,216)**	**(65,724)**	**(57,832)**	**(49,507)**	**(40,713)**	**(31,411)**	**(21,556)**	**(11,103)**	**0**

Footnotes:

(2) Provided by VABRNICP
(3) Total from National Vital Statistics Report and VABRNICP
(4) - (18) Based on current assessment levels and cap
(19) Exhibit 3, Sheet 1
(20)-(34) Mercer RFI September 2005 Report

Virginia Birth-Related Neurological Injury Compensation Fund
Mandatory Participation for Hospitals & OB/GYNS

Fund Balance with Raising OB/GYNS and Hospital Fees and Amortization of Fund Deficit

Contribution Category	Assessment Membership	Expected Live Births		Expected 7/06 - 7/07 Assessment Income $(000)	Expected 7/07 - 7/08 Assessment Income $(000)	Expected 7/08 - 7/09 Assessment Income $(000)	Expected 7/09 - 7/10 Assessment Income $(000)	Expected 7/10 - 7/11 Assessment Income $(000)	Expected 7/11 - 7/12 Assessment Income $(000)	Expected 7/12 - 7/13 Assessment Income $(000)	Expected 7/13 - 7/14 Assessment Income $(000)	Expected 7/14 - 7/15 Assessment Income $(000)	Expected 7/15 - 7/16 Assessment Income $(000)	Expected 7/16 - 7/17 Assessment Income $(000)	Expected 7/17 - 7/18 Assessment Income $(000)	Expected 7/18 - 7/19 Assessment Income $(000)	Expected 7/19 - 7/20 Assessment Income $(000)	Expected 7/20 - 7/21 Assessment Income $(000)
(1)	(2)	(3)		(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	
Physicians																			
OB/GYNS	1,102			7,851	8,072	8,292	8,513	8,733	8,843	8,953	9,064	9,174	9,284	9,394	9,505	9,615	9,725	9,835	
Rate				*5,400*	*5,600*	*5,800*	*6,000*	*6,200*	*6,300*	*6,400*	*6,500*	*6,600*	*6,700*	*6,800*	*6,900*	*7,000*	*7,100*	*7,200*	
Surcharge				*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	*1,723*	
All Other	13,115			5,017	5,279	5,541	5,804	6,066	6,197	6,328	6,460	6,591	6,722	6,853	6,984	7,115	7,246	7,378	
Rate				*290*	*310*	*330*	*350*	*370*	*380*	*390*	*400*	*410*	*420*	*430*	*440*	*450*	*460*	*470*	
Surcharge				*93*	*93*	*93*	*93*	*93*	*93*	*93*	*93*	*93*	*93*	*93*	*93*	*93*	*93*	*93*	
Hospitals		90,364		5,691	5,901	6,112	6,280	6,280	6,280	6,280	6,280	6,280	6,280	6,280	6,280	6,280	6,280	6,280	
Fee per Live Birth				*52.50*	*55.00*	*57.50*	*60.00*	*60.00*	*60.00*	*60.00*	*60.00*	*60.00*	*60.00*	*60.00*	*60.00*	*60.00*	*60.00*	*60.00*	
Surcharge				*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	*16.81*	
Liability Insurers				11,510	12,201	12,933	13,709	14,532	15,403	16,328	17,307	18,346	19,446	20,613	21,850	23,161	24,551	26,024	
Surcharge				3,673	3,673	3,673	3,673	3,673	3,673	3,673	3,673	3,673	3,673	3,673	3,673	3,673	3,673	3,673	
% Surcharge				0.08%	0.08%	0.08%	0.08%	0.08%	0.08%	0.08%	0.08%	0.08%	0.08%	0.08%	0.08%	0.08%	0.08%	0.08%	
Total Revenue				**33,742**	**35,126**	**36,552**	**37,978**	**39,284**	**40,397**	**41,563**	**42,784**	**44,063**	**45,405**	**46,814**	**48,292**	**49,844**	**51,475**	**53,190**	

Compensation Fund Losses

	Claim Frequency		Expected 7/06 - 7/07 Losses $(000)	Expected 7/07 - 7/08 Losses $(000)	Expected 7/08 - 7/09 Losses $(000)	Expected 7/09 - 7/10 Losses $(000)	Expected 7/10 - 7/11 Losses $(000)	Expected 7/11 - 7/12 Losses $(000)	Expected 7/12 - 7/13 Losses $(000)	Expected 7/13 - 7/14 Losses $(000)	Expected 7/14 - 7/15 Losses $(000)	Expected 7/15 - 7/16 Losses $(000)	Expected 7/16 - 7/17 Losses $(000)	Expected 7/17 - 7/18 Losses $(000)	Expected 7/18 - 7/19 Losses $(000)	Expected 7/19 - 7/20 Losses $(000)	Expected 7/20 - 7/21 Losses $(000)
	(19)		(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	
Expected Losses	12.0		25,128	26,200	27,319	28,487	29,707	30,981	32,310	33,699	35,149	36,662	38,243	39,894	41,617	43,417	45,297	
Expected Expenses			795.7	819.6	844.2	869.5	895.6	922.4	950.1	978.6	1,008.0	1,038.2	1,069.4	1,101.4	1,134.5	1,168.5	1,203.6	
Total Loss & Expense			**25,923**	**27,019**	**28,163**	**29,357**	**30,602**	**31,903**	**33,260**	**34,677**	**36,157**	**37,701**	**39,313**	**40,995**	**42,752**	**44,586**	**46,500**	
Change in Fund Balance			**7,819**	**8,107**	**8,389**	**8,622**	**8,681**	**8,494**	**8,302**	**8,106**	**7,907**	**7,705**	**7,501**	**7,297**	**7,092**	**6,889**	**6,689**	
Fund Balance		**(117,600)**	**(109,781)**	**(101,674)**	**(93,285)**	**(84,663)**	**(75,982)**	**(67,488)**	**(59,186)**	**(51,080)**	**(43,173)**	**(35,469)**	**(27,968)**	**(20,671)**	**(13,579)**	**(6,689)**	**0**	

Footnotes:

(2)	Provided by VABRNICP
(3)	Total from National Vital Statistics Report and VABRNICP
(4) - (18)	Based on current assessment levels and caps
(19)	Exhibit 3, Sheet 1
(20)-(34)	Mercer RFI September 2005 Report