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SENATE BILL NO. 687

Senate Amendments in [ ] — February 17, 2004

A BILL to amend and reenact §§ 38.2-5009, 38.2-5020, and 38.2-5021 of the Code of Virginia, relating to Virginia Birth-Related Neurological Injury Compensation Act.

Patron Prior to Engrossment—Senator Devolites

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-5009, 38.2-5020, and 38.2-5021 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-5009. Commission awards for birth-related neurological injuries; notice of award.

A. Upon determining (i) that an infant has sustained a birth-related neurological injury and (ii) that obstetrical services were delivered by a participating physician at the birth or that the birth occurred in a participating hospital, the Commission shall make an award providing compensation for the following items relative to such injury:

1. Actual medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel, such expenses to be paid as they are incurred. However, such expenses shall not include:

a. Expenses for items or services that the infant has received, or is entitled to receive, under the laws of any state or the federal government except to the extent prohibited by federal law;

b. Expenses for items or services that the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity;

c. Expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or federal government except to the extent prohibited by federal law; and

d. Expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

Expenses of medical and hospital services under this subdivision shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person.

In order to provide coverage for expenses of medical and hospital services under this subdivision, the Commission, in all cases where a comparative analysis of the costs, including the effects on the infant's family's health insurance coverage, and benefits indicates that such action is more cost-effective than awarding payment of medical and hospital expenses, shall (i) require the claimant to purchase private health insurance providing coverage for such expenses, provided that the premium or other costs of such coverage shall be paid by the Fund; (ii) require the claimant to participate in the State Medicaid Program, the Children's Health Insurance Program or other state or federal health insurance program for which the infant is eligible; or (iii) if the Commission determines that it would be unreasonably burdensome to require the claimant to purchase private health insurance and that the infant is ineligible for a health insurance program described in clause (ii), to make an award providing compensation for the cost of private accident and sickness insurance for the infant.

2. Loss of earnings from the age of 18 are to be paid in regular installments beginning on the eighteenth birthday of the infant. An infant found to have sustained a birth-related neurological injury shall be conclusively presumed to have been able to earn income from work from the age of 18 through the age of 65, if he had not been injured, in the amount of 50 percent of the average weekly wage in the Commonwealth of workers in the private, nonfarm sector. The provisions of § 65.2-531 shall apply to any benefits awarded under this subdivision.

3. Reasonable expenses incurred in connection with the filing of a claim under this chapter, including reasonable attorneys' fees, which shall be subject to the approval and award of the Commission.

A copy of the award shall be sent immediately by registered or certified mail to the parties.

B. If the Commission does not approve the award of compensation pursuant to subsection A, it may nonetheless, in its discretion, make an award providing compensation for reasonable expenses including reasonable attorneys' fees, which shall be subject to the approval and award of the Commission, incurred in connection with the filing of a claim in good faith under this chapter.

For purposes of this section, in determining whether the attorneys' fees are reasonable, the court shall take into account the following factors: (i) time and labor expended; (ii) skill required to properly

perform the legal service required; (iii) novelty and difficulty of the issue raised; (iv) preclusion of employment by the attorney due to acceptance of the case; (v) customary fee for like work; (vi) the nature of the fee (i.e., fixed, hourly or contingent); (vii) experience, reputation, and ability of the attorney; (viii) time limitations imposed by client or circumstances; (ix) amount involved and results obtained taking into account whether a party made a good faith offer of settlement in writing before commencement of an action or while an action is pending and whether the other party incurred additional attorneys' fees because of the failure to accept such good faith offer; (x) desirability of the case within the legal community in which the action arose; (xi) nature and length of professional relationship with client; (xii) attorneys' fee awarded in similar cases.

C. The amendments to this section enacted pursuant to Chapter 535 of the Acts of Assembly of 1990 shall be retroactively effective in all cases arising prior to July 1, 1990, that have been timely filed and are not yet final.

§ 38.2-5020. Assessments.

A. A physician who otherwise qualifies as a participating physician pursuant to this chapter may become a participating physician in the Program for a particular calendar year by paying an annual participating physician assessment to the Program in the amount of $5,000 on or before December 1 of the previous year, in the manner required by the plan of operation. *Effective January 1, 2005, the total annual assessment shall be $5,100, and shall increase by $100 each year thereafter, to a maximum of $5,500 per year.* The board may authorize a prorated participating physician or participating hospital assessment for a particular year in its plan of operation, but such prorated assessment shall not become effective until the physician or hospital has given at least ~~thirty~~ *30* days' notice to the Program of the request for a prorated assessment.

B. Notwithstanding the provisions of subsection A of this section, a participating hospital with a residency training program accredited to the American Council for Graduate Medical Education may pay an annual participating physician assessment to the Program for residency positions in the hospital's residency training program, in the manner provided by the plan of operation. However, any resident in a duly accredited family practice or obstetrics residency training program at a participating hospital shall be considered a participating physician in the Program and neither the resident nor the hospital shall be required to pay any assessment for such participation. No resident shall become a participating physician in the Program, however, until thirty days following notification by the hospital to the Program of the name of the resident or residents filling the particular position for which the annual participating physician assessment payment, if required, has been made.

C. A hospital that otherwise qualifies as a participating hospital pursuant to this chapter may become a participating hospital in the Program for a particular year by paying an annual participating hospital assessment to the Program, on or before December 1 of the previous year, amounting to ~~fifty dollars~~ *$50* per live birth for the prior year, as reported to the Department of Health in the Annual Survey of Hospitals. The participating hospital assessment shall not exceed $150,000 for any participating hospital in any ~~twelve~~*12*-month period *until January 1, 2005. Effective January 1, 2005, the total annual assessment shall be $160,000, and shall increase by $10,000 each year thereafter, to a maximum of $200,000 in any 12-month period.*

D. All licensed physicians practicing in the Commonwealth on September 30 of a particular year, other than participating physicians, shall pay to the Program an annual assessment of $250 for the following year, in the manner required by the plan of operation. *Effective January 1, 2005, the total annual assessment shall be $260, and shall increase by $10 each year thereafter, to a maximum of $300 per year.*

Upon proper certification to the Program, the following physicians shall be exempt from the payment of the annual [~~$250~~] assessment [*under this subsection*] :

1. A physician who is employed by the Commonwealth or federal government and whose income from professional fees is less than an amount equal to ~~ten~~ *10* percent of the annual salary of the physician.

2. A physician who is enrolled in a full-time graduate medical education program accredited by the American Council for Graduate Medical Education.

3. A physician who has retired from active clinical practice.

4. A physician whose active clinical practice is limited to the provision of services, voluntarily and without compensation, to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106.

E. Taking into account the assessments collected pursuant to subsections A through D of this section, if required to maintain the Fund on an actuarially sound basis, all insurance carriers licensed to write and engaged in writing liability insurance in the Commonwealth of a particular year, shall pay into the Fund an assessment for the following year, in an amount determined by the State Corporation Commission pursuant to subsection A of § 38.2-5021, in the manner required by the plan of operation. Liability insurance for the purposes of this provision shall include the classes of insurance defined in

§§ 38.2-117 through 38.2-119 and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125 and 38.2-130 through 38.2-132.

1. All annual assessments against liability insurance carriers shall be made on the basis of net direct premiums written for the business activity which forms the basis for each such entity's inclusion as a funding source for the Program in the Commonwealth during the prior year ending December 31, as reported to the State Corporation Commission, and shall be in the proportion that the net direct premiums written by each on account of the business activity forming the basis for their inclusion in the Program bears to the aggregate net direct premiums for all such business activity written in this Commonwealth by all such entities. For purposes of this chapter "net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of liability insurance less (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance.

2. The entities listed in this subsection shall not be individually liable for an annual assessment in excess of one quarter of one percent of that entity's net direct premiums written.

3. Liability insurance carriers shall be entitled to recover their initial and annual assessments through (i) a surcharge on future policies, (ii) a rate increase applicable prospectively, or (iii) a combination of the two, at the discretion of the State Corporation Commission.

F. On and after January 1, 1989, a participating physician covered under the provisions of this section who has paid an annual assessment for a particular calendar year to the Program and who retires from the practice of medicine during that particular calendar year shall be entitled to a refund of one-half of his or her annual assessment for the calendar year if he or she retires on or before July 1 of that year.

G. Whenever the State Corporation Commission determines the Fund is actuarially sound in conjunction with actuarial investigations conducted pursuant to § 38.2-5021, it shall enter an order suspending the assessment required under subsection D. [~~An~~ *The*] annual assessment [~~up to $250~~] shall be reinstated whenever the State Corporation Commission determines that such assessment is required to maintain the Fund's actuarial soundness.

§ 38.2-5021. Actuarial investigation, valuations, gain/loss analysis; notice if assessments prove insufficient.

A. The Bureau of Insurance of the State Corporation Commission shall undertake an actuarial investigation of the requirements of the Fund based on the Fund's experience in the first year of operation, including without limitation the assets and liabilities of the Fund. Pursuant to such investigation, the State Corporation Commission shall establish the rate of contribution of the entities listed in subsection E of § 38.2-5020 for the tax year beginning January 1, 1989.

Following the initial valuation, the State Corporation Commission shall cause an actuarial valuation to be made of the assets and liabilities of the Fund no less frequently than biennially. *However, if the results of any valuation indicate that the Fund is not actuarially sound, then an actuarial valuation shall be made of the assets and liabilities of the Fund on an annual basis until the Fund is deemed actuarially sound.* Pursuant to the results of such valuations, the State Corporation Commission shall prepare a statement as to the contribution rate applicable to contributors listed in subsection E of § 38.2-5020. However, at no time shall the rate be greater than one quarter of one percent of net direct premiums written.

B. In the event that the State Corporation Commission finds that the Fund cannot be maintained on an actuarially sound basis subject to the maximum assessments listed in § 38.2-5020, the Commission shall promptly notify the Speaker of the House of Delegates, the President of the Senate, the board of directors of the Program, and the Virginia Workers' Compensation Commission.