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HOUSE BILL NO. 1306

Offered January 9, 2008
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A BILL to amend and reenact §§ 38.2-5004, 38.2-5008, 38.2-5009, 38.2-5016, 38.2-5020, and 38.2-5021 of the Code of Virginia, relating to the Virginia Birth-Related Neurological Injury Compensation Program.

Patron—Morgan

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-5004, 38.2-5008, 38.2-5009, 38.2-5016, 38.2-5020, and 38.2-5021 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-5004. Filing of claims; review by Board of Medicine; review by Department of Health; filing of responses; medical records.

A. 1. In all claims filed under this chapter, the claimant shall file with the Commission a petition, setting forth the following information:

a. The name and address of the legal representative and the basis for his representation of the injured infant;

b. The name and address of the injured infant;

c. The name and address of any physician providing obstetrical services who was present at the birth and the name and address of the hospital at which the birth occurred;

d. A description of the disability for which claim is made;

e. The time and place where the birth-related neurological injury occurred;

f. A brief statement of the facts and circumstances surrounding the birth-related neurological injury and giving rise to the claim;

g. All available relevant medical records relating to the person who allegedly suffered a birth-related neurological injury and an identification of any unavailable records known to the claimant and the reasons for their unavailability;

h. Appropriate assessments, evaluations, and prognoses and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of a birth-related neurological injury;

i. Documentation of expenses and services incurred to date, which indicates whether such expenses and services have been paid for, and if so, by whom; and

j. Documentation of any applicable private or governmental source of services or reimbursement relative to the alleged impairments.

2. The claimant shall furnish the Commission with as many copies of the petition as required for service upon the Program, any physician and hospital named in the petition, the Board of Medicine and the Department of Health, along with a $15 filing fee. Upon receipt of the petition the Commission shall immediately serve the Program by service upon the agent designated to accept service on behalf of the Program in the plan of operation by registered or certified mail, and shall mail copies of the petition to any physician and hospital named in the petition, the Board of Medicine and the Department of Health.

B. Upon receipt of the petition or the filing of a claim relating to the conduct of a participating physician, the Department of Health Professions shall investigate the petition or claim, utilizing the same process as it does in investigating complaints filed under any provision contained in Title 54.1. Conduct of health care providers giving rise to disciplinary action shall be referred to the Board of Medicine for action consistent with the authority granted to the Board in §§ 54.1-2911 through 54.1-2928. If a notice or order is issued by the Board of Medicine, a copy shall be mailed to the petitioner or claimant.

C. Upon receipt of the petition or the filing of a claim relating to the conduct of a participating hospital, the Department of Health shall investigate the petition or claim, utilizing the same process as it does in investigating complaints filed under any provision of Title 32.1. If it determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care on the part of the hospital at which the birth occurred, it shall take any appropriate action consistent with the authority granted to the Department of Health in Title 32.1.

D. The Program shall file a response to the petition and submit relevant written information relating to the issue of whether the injury alleged is a birth-related neurological injury within the meaning of this chapter within 10 days after the date the panel report prepared pursuant to subsection C of § 38.2-5008 is filed with the Commission, *unless the panel files its report prior to the filing deadline established by*

the Commission for the filing of the panel report. If the panel files its report prior to such deadline, the Program's response shall be filed by the date originally established by the Commission as the date for the filing of the panel report.

E. Any hospital at which a birth occurred, upon receipt of written notice from the legal representative of an injured infant that he intends to file a petition under this chapter, shall promptly deliver to such person all available medical records relating to the infant who allegedly suffered a birth-related neurological injury.

F. As used in this chapter, fetal monitoring strips, whether printed or in electronic format, shall be deemed to constitute part of the medical records relating to an infant who allegedly suffered a birth-related neurological injury.

§ 38.2-5008. Determination of claims; presumption; finding of Virginia Workers' Compensation Commission binding on participants; medical advisory panel.

A. The Commission shall determine, on the basis of the evidence presented to it, the following issues:

1. Whether the injury claimed is a birth-related neurological injury as defined in § 38.2-5001.

a. A rebuttable presumption shall arise that the injury alleged is a birth-related neurological injury where it has been demonstrated, to the satisfaction of the Virginia Workers' Compensation Commission, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury, and that the infant was thereby rendered permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled.

If either party disagrees with such presumption, that party shall have the burden of proving that the injuries alleged are not birth-related neurological injuries within the meaning of the chapter.

b. A rebuttable presumption of fetal distress, an element of a birth-related injury, shall arise if the hospital fails to provide the fetal heart monitor tape to the claimant, as required by subsection E of § 38.2-5004.

2. Whether obstetrical services were delivered by a participating physician at the birth.

3. Whether the birth occurred in a participating hospital.

4. How much compensation, if any, is awardable pursuant to § 38.2-5009.

5. If the Commission determines (i) that the injury alleged is not a birth-related neurological injury as defined in § 38.2-5001, or (ii) that obstetrical services were not delivered by a participating physician at the birth and that the birth did not occur in a participating hospital, it shall dismiss the petition and cause a copy of its order of dismissal to be sent immediately to the parties by registered or certified mail.

6. All parties are bound for all purposes including any suit at law against a participating physician or participating hospital, by the finding of the Virginia Workers' Compensation Commission (or any appeal therefrom) with respect to whether such injury is a birth-related neurological injury.

B. The deans *of the schools of medicine* of the Eastern Virginia Medical School, *the* University of Virginia School of Medicine, and Medical College of Virginia of Virginia Commonwealth University shall develop a plan ~~whereby each claim filed with the Commission is reviewed by a panel of three qualified and impartial physicians~~ *for reviewing cases pursuant to this chapter*. Such plan shall provide that each of the three aforementioned medical schools shall maintain a review panel of physicians to review claims, with responsibility for reviewing claims rotating among each medical school's panel on a case-by-case basis *at the direction of that school's dean. Each claim filed with the Commission shall be reviewed by a panel of three board-certified and impartial physicians, consisting of an obstetrician, a neonatologist, and a neurologist. The chair of the panel shall be determined by the school's dean. The Commission shall receive a report in conformity with this provision and shall then direct the Program to pay to the medical school that performed the assessment and prepared the report the sum of $3,000.*

C. The panel created pursuant to subsection B shall prepare a report that provides a detailed statement of the opinion of the panel's members regarding whether the infant's injury does or does not satisfy each of the criteria of a birth-related neurological injury enumerated in such term's definition in § 38.2-5001. The report shall include the panel's basis for its determination of whether each such criteria was or was not satisfied. In addition, the report shall include such supporting documentation as the board of directors of the program may reasonably request. The panel shall file its report with the Commission 60 days from the date the petition was filed with the Commission. At the same time that the panel files its report with the Commission, the panel shall send copies thereof to the Program and all parties in the proceeding. At the request of the Commission, at least one member of the panel shall be available to testify at the hearing. The Commission shall consider, but shall not be bound by, the recommendation of the panel.

§ 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.

Reimbursement for, and payment of, expenses of medical and hospital services, including nursing care, doctors' visits, hospitalization, and prescription drugs shall be limited to the allowable amounts as determined by the primary payer's contracted rates or allowable rates, or up to 120 percent of the Medicaid rate to be applied to reimbursements for medically necessary services that are not covered under the primary payer's agreement. If the board of directors of the Program determines that a medically necessary treatment, facility use, product, service, pharmacy service, or drug is not covered by a Medicaid payment system, the board of directors of the Program shall establish maximum fees therefor, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicaid for services that require comparable resources.

If medically necessary nursing care, beyond the scope of child care duties and services normally and gratuitously provided by family members, is provided by a father, mother, or legal guardian of a claimant participating in the Program, or an individual healthcare provider, pursuant to the Program's guidelines, the rate of reimbursement to be applied is up to 120 percent of the Virginia consumer-directed Medicaid rate applied for the mental retardation waiver for personal care aides.

If medically necessary nursing care is provided by an individual healthcare provider, pursuant to the Program's guidelines, the rate of reimbursement to be applied is up to 120 percent of the Virginia consumer-directed Medicaid rate applied for the skill level of care prescribed and provided.

If medically necessary nursing care is provided through a nursing agency, the rate of reimbursement to be applied is up to 120 percent of the agency-directed Medicaid rate applied for the mental retardation waiver. Contracts for nursing care that existed prior to July 1, 2008, shall be honored at the contracted-for rate, rather than at 120 percent of the applicable Medicaid rate, until the specific individual provider-patient relationship ceases to exist.

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. *Payments shall be calculated based on the Commonwealth's reporting period immediately preceding the 18thbirthday of the claimant child, and subsequently adjusted based upon the succeeding annual reports of the Commonwealth.* 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. 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.

§ 38.2-5016. Board of directors; appointment; vacancies; term; list of Program claimants.

A. The Birth-Related Neurological Injury Compensation Program shall be governed by a board of seven directors.

B. Except as provided in subsection C, directors shall be appointed for a term of three years or until their successors are appointed and have qualified.

C. 1. The directors shall be appointed by the Governor as follows:

a. Four citizen representatives. The term of the member appointed in 1999 shall commence when appointed and shall end on July 1, 2002. When the terms of the two members expire in 2001, one shall be appointed for a term of two years ending July 1, 2003, and one shall be appointed for a term of three years ending July 1, 2004. ~~Two~~ *One* of the members shall have a minimum of five years of professional investment experience; *one of the members shall have a minimum of five years experience in finance and be licensed as a certified public accountant or hold a similar professional designation;* one of the members shall have professional experience working with the disabled community; and one of the members shall be the parent *or guardian* of a ~~disabled~~ child~~.~~ ~~Citizen members shall not have children or relatives who are claimants or~~ who ~~have~~ *has* been awarded benefits under the Act;

b. One representative of participating physicians. The initial term of the member appointed in 1999 shall commence when appointed and shall be for one year;

c. One representative of participating hospitals. The initial term of the member appointed in 1999 shall commence when appointed and shall be for two years; and

d. One representative of liability insurers. The initial term of the member appointed in 1999 shall commence when appointed and shall be for three years.

2. The Governor may select the representative of the participating physicians from a list of at least three names to be recommended by the Virginia Society of Obstetrics and Gynecology; the representative of participating hospitals from a list of at least three names to be recommended by the Virginia Hospital & Healthcare Association; and the representative of liability insurers from a list of at least three names, ~~one of which is recommended by the American Insurance Association, one by the Alliance of American Insurers, and one by the National Association of Independent Insurers~~ *two of which are recommended by the Property Casualty Insurers Association of America*. *The Governor may select the representative of parents of children awarded benefits under the Act from a list of at least three names to be recommended by the board of directors of the Program, which shall solicit from claimants' families a list of at least five names from which the board of directors shall select three names to be recommended.* In no case shall the Governor be bound to make any appointment from among the nominees of the respective associations *or the Program's board of directors*.

D. The Governor shall promptly notify the appropriate association, which may make nominations, of any vacancy other than by expiration among the members of the board representing a particular interest and like nominations may be made for the filling of the vacancy.

E. The directors shall act by majority vote with four directors constituting a quorum for the transaction of any business or the exercise of any power of the Program. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the Program. The directors shall not be subject to any personal liability with respect to the administration of the Program or the payment of any award.

F. The board shall have the power to (i) administer the Program, (ii) administer the Birth-Related Neurological Injury Compensation Fund, which shall include the authority to purchase, hold, sell or transfer real or personal property and the authority to place any such property in trust for the benefit of claimants who have received awards pursuant to § 38.2-5009, (iii) appoint a service company or companies to administer the payment of claims on behalf of the Program, (iv) direct the investment and reinvestment of any surplus in the Fund over losses and expenses, provided any investment income generated thereby remains in the Fund, (v) reinsure the risks of the Fund in whole or in part, and (vi) obtain and maintain directors' and officers' liability insurance. The board shall discharge its duties with respect to the Fund solely in the interest of the recipients of awards pursuant to § 38.2-5009 and shall 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, provided that any investment advisor retained by the board shall be registered pursuant to the provisions of Article 3 (§ 13.1-504 et seq.) of Chapter 5 of Title 13.1 or shall be a federal covered advisor as defined in § 13.1-501 who has filed such documents and paid such fees as may be necessary to transact business in the Commonwealth pursuant to § 13.1-504. The board shall

report annually to the Governor and to the Speaker of the House of Delegates and the Clerk of the House of Delegates and to the Chairman of the Senate Rules Committee and the Clerk of the Senate regarding the investment of the Fund's assets. The board shall establish a procedure in the plan of operation for notice to be given to obstetrical patients concerning the no-fault alternative for birth-related neurological injuries provided in this chapter, such notice to include a clear and concise explanation of a patient's rights and limitations under the program.

G. The board shall establish a procedure in the plan of operation for maintaining a list of Program claimants. Each claimant may consent to have his name, address, phone number, and other personal information included on such list, for distribution to other Program claimants. The Board shall distribute the list to Program claimants who have given consent to be included on such list, and to no other person.

§ 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~~ *2008*, the total annual assessment shall be ~~$5,100~~ *$5,600*, and shall increase by ~~$100~~ *$300 for the 2010 assessment and by $100* each year thereafter, to a maximum of ~~$5,500~~ *$6,200* 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 30 days' notice to the Program of the request for a prorated assessment.

B. Notwithstanding the provisions of subsection A, 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 30 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 $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 12-month period until January 1, 2005. *Effective January 1, 2008, the annual participating hospital assessment shall increase by $2.50 per live birth for the prior year, as reported to the Department of Health in the Annual Survey of Hospitals, and shall be increased at that rate each year thereafter to a maximum of $55 per live birth so reported for the prior year.* Effective January 1, 2005, the maximum 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 *physicians* 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 until January 1, 2005. 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 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 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~~ *a prorated share* of his or her annual assessment for the calendar year ~~if he or she retires on or before July 1 of that year~~ *that corresponds to the portion of the calendar year remaining following his or her retirement*.

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. The annual assessment 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. ~~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.~~

In conducting the actuarial evaluation, a loss reserving methodology consistent with the one employed by the Florida Birth-Related Neurological Injury Compensation Association as of July 1, 2007, may be employed in order to account for individual participant costs and injury characteristics.

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.