LEGISLATIVE BUDGET AND FINANCE COMMITTEE
A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

REPORT HIGHLIGHTS

A Study Pursuant to Senate Resolution 27: Feasibility of a No-Fault Catastrophic Loss Fund For Birth-Related Neurological Injuries

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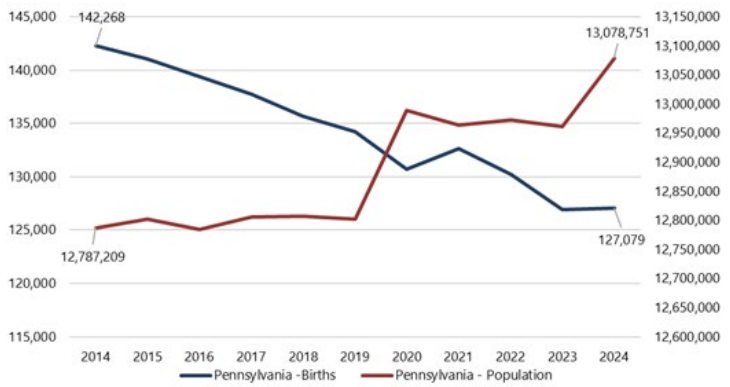
Senate Resolution 27 (SR 27) directs the Legislative Budget and Finance Committee (LBFC) to conduct a study as to the feasibility of establishing a no-fault catastrophic loss fund to provide payment for claims brought as a result of birth-related neurological injuries in Pennsylvania. Key highlights from this study include the following:

- **From 2004 to 2024, the number of obstetrics and gynecology (OB-GYN) physicians increased while birth rates decreased in Pennsylvania; there are projected OB-GYN shortages in the future.** According to researchers, the US fertility rate (the number of children born to women of childbearing age) reached a record low in 2024. From 2014 to 2024, the birth rate in Pennsylvania declined by 10.7 percent while the population increased by 2.3 percent; the decrease in births was higher in rural counties than in urban counties. The federal government projects that by 2038, Pennsylvania will have a 10 percent shortage of OB-GYNs based on current supply versus retirements and new hires.



- **As of 2026, 23 counties in Pennsylvania have no labor and delivery (L&D) services.** These counties are home to 145,642 females of childbearing age (5.9 percent). From 2004 to 2024, 78 hospitals in Pennsylvania permanently closed, including seven that offered labor and delivery (L&D) services. From fiscal year (FY) 2004-05 to calendar year (CY) 2024, 64 hospitals experienced OB or OB-GYN bed closures across the commonwealth. Of those hospitals, 23 closed a single-bed type (either OB or OB-GYN), but still maintained an alternative obstetric unit, albeit with fewer obstetrics beds. However, 41 hospitals closed OB or OB-GYN beds and kept no alternate unit; therefore, they remain open but no longer provide L&D services.

- **OB-GYNs are more likely than other physicians to be sued during their careers.** According to the American Medical Association (AMA), 62.4 percent of OB-GYNs were sued during their careers to date (as of 2022) compared to 31.2 percent of all physicians. As a result, OB-GYNs generally face the highest medical malpractice premiums. In Pennsylvania, the average medical malpractice premium from 2015 to 2025 was $97,096 for OB-GYNs, $69,686 for general surgeons, and $18,246 for internists.

- **There was a nominal to no impact on medical malpractice insurance premiums in states that implemented birth-related neurological injury funds (BRNIF).** We compared OB-GYN medical malpractice premiums for the states with BRNIFs (Florida, New York, and Virginia) to those in Pennsylvania. From 2015 to 2025, all four states had reductions in rates, with Virginia recording the largest decrease (32 percent) and Florida the smallest (13 percent). Florida had the highest average rates ($154,396), followed by New York ($146,565) and Pennsylvania ($97,096). Virginia had the lowest rates ($77,730). While medical malpractice premiums offer an important benchmark, we note a shift toward OB-GYNs employed by health systems rather than practicing independently. This shifts the liability burden to health systems, which may affect their financial decision-making regarding liability coverage and services offered, instead of the more traditional thinking that liability costs impact physician decisions on where to practice medicine.

- **Three states have implemented BRNIFs, with Virginia and Florida implementing their programs in the late 1980s**. The first was Virginia, which created the Virginia Birth Injury Fund (VBIF) in 1987. Florida followed soon after in 1988, creating the Florida Birth-Related Neurological Injury Compensation Association (FNICA). VBIF and FNICA are no-fault compensation programs and are intended to provide guaranteed, lifetime medical benefits for children with birth-related neurological injuries and their families in exchange for waiving their right to sue a provider, hospital, and/or health system for malpractice. When the BRNIFs were created, both states referenced rising medical malpractice premiums and the inaccessibility of liability insurance as reasons for creating the funds.

- **Despite Florida and Virginia's BRNIFs having existed for over three decades, their success in achieving their intended outcomes is unclear.** A review of VBIF approximately 15 years after its implementation indicated that the program benefited participating physicians, hospitals, and medical malpractice insurers by reducing medical malpractice insurance rates, fewer birth injury-related lawsuits, and lower subsequent claims costs. However, we note that Virginia also implemented liability caps on medical malpractice. The review of VBIF

further noted a lack of clarity about whether the program was achieving the intended societal benefits, such as the availability of obstetrical care in rural areas of the state.

- **The third state to develop a BRNIF was New York in 2011.** New York created the New York State Medical Indemnity Fund (NYMIF) to provide funding for health care costs associated with birth-related neurological injuries and to reduce premium costs for medical malpractice insurance. However, unlike Florida and Virginia, New York requires that eligibility be determined through a malpractice lawsuit, in which a court determination or a court-approved settlement confirms that medical negligence caused a child's injury. In other words, NYMIF is not a no-fault system like VBIF and FNICA.

- **We found that birth-related neurological injury compensation programs may provide an alternative mechanism to fund lifetime care for catastrophic birth injuries; however, documented fraud, second and third-party payer challenges, potential constitutional obstacles, and transparency concerns highlight oversight and accountability risks.** While New York's BRNIF differs from Florida's and Virginia's, all three have actuarial risks, Medicaid payment issues, and generally lack sufficient oversight and evaluation mechanisms to measure program success. Like Pennsylvania's Medical Care Availability and Reduction of Error Fund (MCARE), all three BRNIFs have growing projected unfunded liabilities.

- **For this report, we defined feasibility as the legal, financial, administrative, and practical ability of Pennsylvania to establish and sustain a BRNIF.** Should the General Assembly deem a BRNIF necessary to address medical malpractice rates for OB-GYNs, our report offers legislative considerations, including:

    - Administration of the program through the Pennsylvania Department of Insurance (PID).
    - The creation of a governing board.
    - Fitting the program within existing legal frameworks, including the possible structure of a new law and potential legal challenges.
    - Eligibility criteria, including defining birth-related neurological injuries, birth weight, types of birthing facilities, health care providers covered, types of disability applicable, and needs of the child.
    - Internal controls, transparency, oversight, accountability, and evaluation.

- **There is no statewide tracking of birth-related injuries in Pennsylvania.** We reviewed data on the three existing BRNIFs: from 2014 to 2024, FNICA ranged from 0.53 to 1.40 compensable claims per 10,000 births, whereas VBIF had fewer, ranging from 0.21 to 1.36 admitted participants per 10,000 births. Because NYMIF enrollees go through the traditional malpractice litigation process and the statutory criteria are broader, NYMIF has more admitted participants. From 2014 to 2024, in New York admitted participants ranged from 3.13 to 4.78 per 10,000 births.

- **In the Pennsylvania Department of Insurance's MCARE data, between 2014 and 2024, there was an average of 223.5 newborn claims per year, and the average number of newborn injury claims paid each year was 62.8.** By comparison, there were 127,079 births in Pennsylvania in 2024, meaning 6.6 MCARE claims over $500,000 were paid per 10,000 births. PID only codes these claims as "newborn" and cannot delineate the data by injury type. In 2024, the Patient Safety Authority (PSA) conducted a study following a 92 percent increase in serious L&D events in Pennsylvania between 2018 and 2022. However, due to the study's limitations, PSA concluded that further research on neonatal complications would be beneficial, along with more comprehensive reporting of data.

Our report recommendations include:

1. The General Assembly should consider requiring LBFC to perform a performance audit to assess the commonwealth's efforts to address maternity care deserts, maternal and infant deaths, and the OB-GYN shortage.

2. Should the General Assembly deem a birth-related neurological injury fund as a necessary public policy addition, the General Assembly should consider and institute many different factors to protect the commonwealth, including but not limited to:
    a. Administration of the program.
    b. Funding of the program.
    c. Fitting the program within existing legal frameworks.
    d. Eligibility criteria.
    e. Structure of the law.
    f. Potential legal challenges.
    g. Internal controls, transparency, oversight, accountability, and evaluation.

3. The General Assembly should consider legislation to require the annual tracking of specific birth-related injuries through the Pennsylvania Patient Safety Reporting System.