LEGISLATIVE BUDGET AND FINANCE COMMITTEE

A JOINT COMMITTEE OF THE PENNSYLVANIA GENERAL ASSEMBLY

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

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REPORT SUMMARY

Study Objectives

Our objectives for the study were the following:

1. *To evaluate the feasibility and the overall positive and negative impacts of establishing a no-fault catastrophic loss fund for birth-related neurological injury claims in Pennsylvania.*

2. *To analyze medical malpractice insurance premiums in states that have implemented a no-fault catastrophic loss fund for birth-related neurological injuries.*

Report Overview

Childbirth is an occasion that is emotional, difficult, and expected to end in a healthy mom and baby. Although rare, in some instances complications in the labor and delivery (L&D) process occur due to provider bad judgment, negligence, or accidents from unpredictable events. In those rare instances, newborns can sustain birth-related neurological injuries that can result in a spectrum of outcomes including minor effects to death. These rare instances are devastating for all involved and can result in civil legal action against providers and hospitals and a lifetime of expensive care and needs for injured infants and their families. Due to the nature of the injuries and the age of the plaintiffs, providers and hospitals can face multimillion-dollar settlements or judgments. Some states, including Virginia, Florida, and New York, have implemented birth-related neurological injury funds (BRNIF) to decrease the burden of high pay outs from the medical malpractice liability marketplace to a special state fund, and provide lifelong care for infants and children impacted by birth-related neurological injuries.

Senate Resolution 27 (SR 27) directed the Legislative Budget and Finance Committee (LBFC) to conduct a study on the feasibility of establishing a no-fault catastrophic loss fund to provide payment for claims brought because of birth-related neurological injuries in Pennsylvania.

The Pennsylvania Senate adopted SR 27 on June 4, 2025. Subsequently, on June 25, 2025, the LBFC officers adopted SR 27 as a staff project. The objectives of our study are delineated in the text box to the left. Our findings and conclusions are summarized on pages S-1 through S-5.

Our report is organized as follows:

Section I	**Objectives, Scope, and Methodology**
Section II	**Contextual Review of Challenges Facing Obstetrics in Pennsylvania**
Section III	**The Feasibility of Establishing a Birth-Related Neurological Injury Fund**

Section II
Contextual Review of Challenges Facing Obstetrics in Pennsylvania

Obstetrics and Gynecology (OB-GYN) is a branch of medicine that specializes in the care of women during pregnancy and childbirth and in diagnosing and treating diseases of the female reproductive organs. 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.

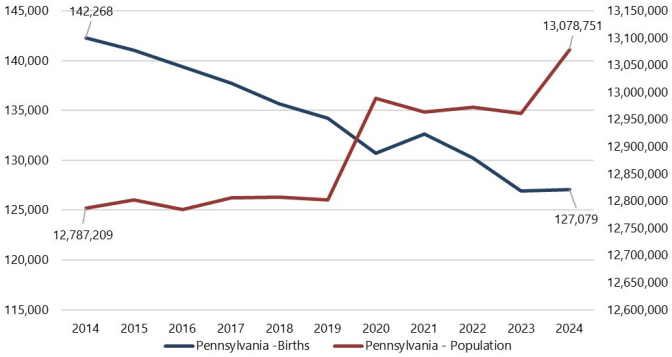

Figure 1: Pennsylvania Births Compared to Population 2014-2024

At the same time, access to care also decreased. From 2004 to 2024, 78 hospitals in Pennsylvania permanently closed, including 7 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.

Bringing life into the world comes with immense risks. 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.

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 that there has been a shift toward OB-GYNs

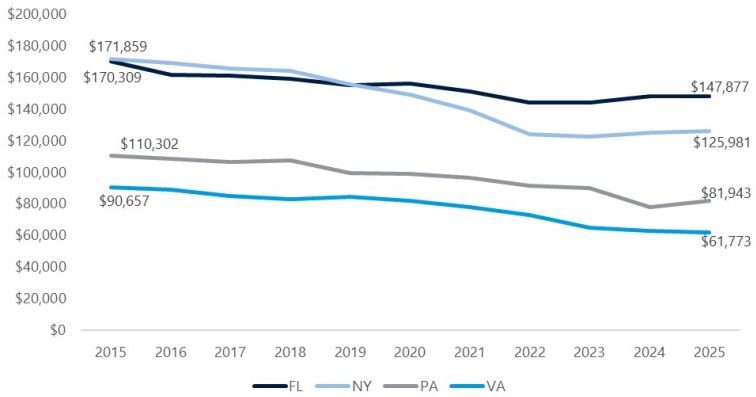

Figure 2: Average Inflation-Adjusted OB-GYN Medical Malpractice Premiums 2015-2025

employed by health systems rather than being independently employed. This shifts the liability burden to health systems, which may impact health systems' financial decision-making in liability coverage and services offered, instead of the more traditional thinking that liability costs impact physician decisions on where to practice medicine.

According to many of the health systems we spoke with, obtaining excess coverage beyond the Medical Care Availability and Reduction of Error (MCARE) Fund threshold is becoming more difficult for hospitals. An insurance broker for one of Pennsylvania's health systems stated that six large commercial insurers exited the state from 2019 to 2024. The broker also indicated that there were reduced limits, with carriers decreasing hospital risk capacity from $10 to $25 million to $5 to $10 million. This worries health systems, as there has been an increase in what are referred to as nuclear verdicts, or those over $10 million. From 2014 to 2024, the Administrative Office of Pennsylvania Courts (AOPC) reported 21 verdicts of $10 million or more, with the most (8) in Philadelphia County. AOPC's data does not include specificity on case details; however, from recent news articles, we noted that there were two recent birth-related verdicts in Philadelphia, one totaling $207 million ($183 million initially, with an increase to $207 million due to delayed damages), and another totaling over $108 million. As of the writing this report, both cases are on appeal.

Section III
The Feasibility of Establishing a Birth-Related Neurological Injury Fund

Three states have implemented BRNIFs; 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 their waiver of the 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, when it created the New York State Medical Indemnity Fund (NYMIF) to fund 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 verdict or a court-approved settlement confirms that medical negligence caused a child's injury. This differs from no-fault systems such as VBIF and FNICA, both of which remove court action as an option for participants.

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 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 are no government sources of data to estimate exactly how many birth-related neurological injuries occurred 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 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. We also reviewed data from the Pennsylvania Insurance Department's (PID) MCARE newborn claims 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. However, PID only codes these claims as "newborn" and cannot delineate the data by injury type.

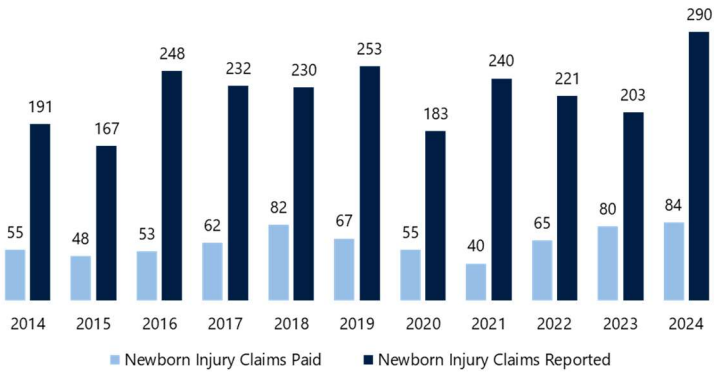

Figure 3: MCARE Newborn Injury Claims 2014-2024

Report Recommendations

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 obstetrics and gynecology physician 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:

   i. Administration of the program.
   ii. Funding of the program.
   iii. Fitting the program within existing legal frameworks.
   iv. Eligibility criteria.
   v. Structure of the law.
   vi. Potential legal challenges.
   vii. 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.

SECTION I
OBJECTIVES, SCOPE, AND METHODOLOGY

Why we conducted this study…

The Senate of Pennsylvania adopted Senate Resolution 27 (SR 27) on June 4, 2025. The Legislative Budget and Finance Committee officers then adopted SR 27 as a staff project on June 25, 2025.

SR 27 directs the LBFC to study the feasibility of establishing a no-fault catastrophic loss fund to provide payment for claims brought because of birth-related neurological injuries in Pennsylvania.

The Senate of Pennsylvania adopted Senate Resolution 27 (SR 27) on June 4, 2025, and the Legislative Budget and Finance Committee (LBFC) officers adopted the resolution as a staff project on June 25, 2025.

SR 27 directs the 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.

Objectives

In response to SR 27, the LBFC Officers adopted two study objectives:

1. To evaluate the feasibility and the overall positive and negative impacts of establishing a no-fault catastrophic loss fund for birth-related neurological injury claims in Pennsylvania.

2. To analyze medical malpractice insurance premiums in states that have implemented a no-fault catastrophic loss fund for birth-related neurological injuries.

Scope

The scope of our study was January 1, 2014, through December 31, 2024. Due to data availability, some information is presented before or after this period. We note the specific period for each dataset presented in the report.

Methodology

To address the objectives of this study, we employed a multi-pronged methodology that combined quantitative data analysis, legal and policy review, and stakeholder interviews. Our approach was designed to evaluate both the feasibility and the potential impacts of establishing a birth-related neurological injury fund (BRNIF) in Pennsylvania, and to

analyze existing programs in other states, including Florida, Virginia, and New York.

We reviewed data on Pennsylvania births, the number of women of childbearing age, and the population to understand birth-rate trends and the demand for obstetrics and gynecology (OB-GYN) and labor and delivery (L&D) services. We also reviewed rates of neonatal deaths and maternal mortality, as these rates can be related to access to care.

We analyzed data on the number of practicing OB-GYNs and nurse midwives in Pennsylvania and the other selected states from the US Bureau of Labor Statistics (BLS) and the Pennsylvania Department of Health (DOH). We analyzed county- and regional-level data to identify differences between rural and urban areas. We reviewed residency program data to assess trends in physician entry into OB-GYN programs. Additionally, we examined definitions of practitioner shortages and maternity care deserts and reviewed information from the March of Dimes and the Center for Rural Pennsylvania regarding access to care, particularly in rural counties. We also reviewed DOH *Report 5, Active Medical Staff with Clinical Privileges in Selected Departments or Services*, and *Report 6*, *Facility Employment: Full-Time and Part-Time Personnel as of December 31st* covering FY 2003-04 through CY 2024. This data included physicians, medical interns, and residents in general acute care hospitals, state hospitals, and specialty hospitals across 29 specialties. We reviewed board-certified OB-GYN physicians and other active medical staff with clinical privileges within obstetrics and gynecology. We reviewed the data by county for all hospitals.

Although there is no national or state data on the number of birth-related neurological injuries, we reviewed the states that have BRNIFs, including the number of compensable claims in Florida, and admitted participants in Virginia and New York. We also reviewed Pennsylvania Department of Insurance data on the number of Medical Care Availability and Reduction of Error (MCARE) Fund newborn injury claims reported and claims paid.

We examined data on medical malpractice insurance premiums for OB-GYNs, internists, and general surgeons in Pennsylvania, sourced from the Medical Liability Monitor. We compared Pennsylvania's medical malpractice premiums to those of states with birth-related neurological injury funds. We also compared the number of medical malpractice payments made in our four selected states from National Practitioner Databank data and Pennsylvania county-level data from the Administrative Office of Pennsylvania Courts. We also reviewed information about nuclear verdicts, including from the US Chamber of Commerce and news articles about recent nuclear verdicts regarding birth-related injuries in Pennsylvania.

To determine whether a definition of "birth-related neurological injury" exists, we reviewed Pennsylvania's statutes and case law, and reviewed definitions in the other states with BRNIFs. We defined a normal or uncomplicated birth based on clinical guidelines and peer-reviewed literature.

We provided information about the MCARE Fund, should the General Assembly decide to implement a no-fault catastrophic loss fund, including oversight structures that could be or are already established in Pennsylvania.

We conducted interviews with Pennsylvania and New York health systems, plaintiff attorneys, and individuals with knowledge about Florida and New York's birth-related injury funds.

In the context of this report, we defined "feasibility" as the legal, financial, administrative, and practical ability of Pennsylvania to establish and sustain a BRNIF.

When analyzing BRNIFs in Florida, Virginia, and New York, we documented the legislative history of the programs, including co-sponsorship memoranda, fiscal notes, press releases, and hearing records. We analyzed the programs' structures, including legal frameworks, governance, and funding mechanisms. We conducted an exhaustive review of program outcomes using government reports, annual program reports, accrual reports, audited financial statements, and peer-reviewed studies. We identified other variables that may affect OB-GYN workforce levels, premiums, and birth-related outcomes.

In the report, we identified limitations in the available data, including potential underreporting or non-reporting of birth-related injuries and variations in definitions and reporting requirements across jurisdictions. We mitigated these limitations by triangulating data from multiple sources and clearly noting where definitions and measures differ.

Frequently Used Abbreviations and Definitions

Throughout this report, we use several abbreviations for government-related agencies, terms, and functions. These abbreviations are defined as follows:

Abbreviation	Name	Definition
ALAE	Allocated Loss Adjustment Expenses	Costs directly assignable to settling a specific insurance claim, such as legal fees, expert witnesses, and investigator costs. Unlike allocated expenses, ALAE is tracked per claim to accurately assess financial reserves, often covering third-party defense services.
ALJ	Administrative Law Judge	A quasi-judicial official who presides over formal hearings, adjudicates disputes, and makes findings of fact and law.
BLS	Bureau of Labor Statistics	A unit of the US Department of Labor that serves as the principal fact-finding agency in the broad field of labor economics and statistics, and serves as the principal agency of the US federal statistical system.
CDC	Centers for Disease Control	A federal agency of the Department of Health and Human Services whose mission is centered on preventing and controlling disease, and promoting environmental health and health education in the US.
CHQPR	Center for Healthcare Quality and Payment Reform	A national policy center focused on the design and implementation of payment systems supporting affordable, patient-centered health care.
CM	Certified Midwife	Individuals trained and certified in midwifery, who are non-nurse practitioners holding bachelor's degrees or higher in a health-related field and certified by the American Midwifery Certification Board. CMs provide comprehensive prenatal, childbirth, postpartum, and gynecological care, holding the same scope of practice as Certified Nurse Midwives (CNMs).
CMS	Centers for Medicare and Medicaid Services	A federal agency that provides health coverage to more than 160 million people through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace, and works in partnership with the entire health care community to improve quality, equity, and outcomes in the health care system.
CNM	Certified Nurse Midwife	An advanced practice registered nurse specializing in women's reproductive health, pregnancy, and childbirth, holding at least a master's degree.
DHHS	Department of Health and Human Services	A cabinet-level executive branch department of the federal government created to set guidelines for the private health care system and provide essential human services in areas such as funding medical studies.
DO	Doctor of Osteopathic Medicine	A fully licensed physician in the US trained to practice all areas of medicine, similar to a Doctor of Medicine. They emphasize a holistic, whole-person approach, focusing on prevention and the relationship between the body's structure and function.

DOH	Department of Health	A Pennsylvania cabinet-level agency that provides programs and services that benefit the health, safety, and well-being of all Pennsylvanians.
FAHCA	Florida Agency for Health Care Administration	The chief health policy and planning entity for the state.
FDMS	Florida Department of Management Services	A department of the Florida government with a primary mission to support sister agencies and current and former state employees with workforce- and business-related functions so they can focus on their core missions.
FDOH	Florida Department of Health	A cabinet-level agency responsible for protecting the public health and safety of residents of and visitors to the state.
FIRTF	Florida Insurance Regulatory Trust Fund	The primary funding source for the Florida Office of Insurance Regulation covers operating costs, financial examinations, and administrative expenses. The fund is supported by fees from insurance company publications, license fees, and assessments, rather than general state tax revenue.
FNICA	Florida Birth-Related Neurological Injury Compensation Act	A statutory organization that manages the Florida Birth Related Neurological Injury Compensation Plan used to pay for the care of infants born with certain neurological injuries.
FOIR	Florida Office of Insurance Regulation	The lead regulatory agency overseeing Florida's insurance industry.
GFR	General Fertility Rate	Number of births per 1,000 women of childbearing age (typically aged 15 to 44).
HCP	Health Care Providers	An individual who directly or indirectly administers interventions that are designed to improve the physical or emotional status of patients, or an individual licensed, certified, or otherwise authorized or permitted by law to administer health care or practice of a profession, including a health care facility.
HRSA	Health Resources and Services Administration	A federal agency of the US Department of Health and Human Services that serves as the primary agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification	The official US system for assigning codes to diagnoses, symptoms, and procedures for health insurance billing and medical record reporting. Developed by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), it enhances clinical documentation and tracks health outcomes with over 68,000 alphanumeric codes.

L&D	Labor and delivery	A specialized hospital department providing comprehensive care for pregnant individuals during labor, childbirth, and immediate postpartum recovery.
LAE	Loss Adjustment Expense	The costs insurers incur to investigate, defend, and settle claims, excluding claim payments.
MCARE	Medical Care Availability and Reduction of Error	A Pennsylvania act passed in 2002 created a Patient Safety Authority to track medical errors. It implemented medical malpractice insurance requirements for providers and hospitals, and required the creation of a special fund to ensure reasonable compensation for persons injured due to medical negligence. Funds are used to pay claims against participating healthcare providers and eligible entities for losses or damages awarded in medical professional liability actions in excess of basic insurance coverage (primary coverage) provided by primary professional liability insurance companies (primary carriers) or self-insurers.
MD	Doctor of Medicine	A professional degree for physicians who diagnose and treat illnesses using conventional medicine.
MPL	Medical Professional Liability Insurance	Insurance that covers physicians and other health care professionals in cases of malpractice resulting in a patient's bodily injury, medical expenses, and property damage.
NYDOH	New York Department of Health	A department of the state government responsible for public health.
NYMIF	New York Medical Indemnity Fund	A state fund designed to provide a funding source for future health care costs of qualified plaintiffs, as defined by law, who suffered birth-related neurological injuries due to medical malpractice during a delivery admission.
OB-GYN	Obstetrics and Gynecology	A branch of medicine specializing in women's care during pregnancy and childbirth and in the diagnosis and treatment of diseases of the female reproductive organs. Also specializes in other women's health issues, such as menopause, hormone problems, contraception, and infertility.
PAJUA	Pennsylvania Professional Liability Joint Underwriting Association	A state-mandated, nonprofit organization founded in 1975 to act as the medical malpractice insurer of last resort. It provides coverage to high-risk health care providers who cannot obtain insurance through the standard market.
PID	Pennsylvania Insurance Department	A cabinet-level agency responsible for protecting and assisting consumers, licensing insurance professionals and companies, and regulating the insurance marketplace.
UCR	Usual, Customary, and Reasonable	The amount health insurance companies pay for a medical service is based on what providers in a

		specific geographic area typically charge. It sets the allowed amount for out-of-network care, meaning patients often pay the difference if a provider's fee exceeds this limit.
VBIF	Virginia Birth Injury Fund	A fund created as part of the Virginia Birth-Related Neurological Injury Compensation Program, to provide lifetime benefits to children who suffer from birth-related neurological injuries.
VBOM	Virginia Board of Medicine	A state agency responsible for licensing and regulating physicians, osteopaths, podiatrists, physician assistants, and various other allied professionals to ensure competent patient care.
VJLARC	Virginia Joint Legislative Audit and Review Commission	Conducts program evaluation, policy analysis, and oversight of state agencies on behalf of the Virginia General Assembly.
VDOH	Virginia Department of Health	The lead state agency dedicated to protecting and promoting the health and well-being of all people in Virginia.
VSCC	Virginia State Corporation Commission	An independent, constitutional state agency regulating businesses, utilities, insurance, and financial institutions, while serving as the central filing office for corporation registration. It holds judicial, legislative, and administrative powers.
VWCC	Virginia Workers' Compensation Commission	An independent state agency operating as a specialized court to administer Virginia's Workers' Compensation Act, handling workplace injury claims, disputes, and settlements. It ensures employer compliance, processes claims for medical care/wage replacement, and serves as an independent adjudicator in workers' compensation cases.
WHO	World Health Organization	The United Nations' specialized agency responsible for directing and coordinating international public health.

Acknowledgments

We thank the Florida Birth-Related Neurological Injury Compensation Association and Greater New York Hospital Association for information and input about birth-related injury funds in their respective states. Additionally, we thank the numerous Pennsylvania stakeholder groups and hospitals/health systems that provided insight into the problems facing both obstetrics and plaintiffs in birth-related neurological injury cases.

Important Notes

This report was developed by the staff of the Legislative Budget and Finance Committee, including Deputy Executive Director Stevi Sprenkle, MPA, Counsel Stephen Kramer, Esq., Senior Analyst Shanika Mitchell-Saint Jean, MPA, MPH, Analyst/Legislative Coordinator Amy Hockenberry, and Analyst James Wynne. The release of this report should not be construed as an indication that the Committee as a whole, or its individual members, necessarily concur with the report's findings, conclusions, or recommendations.

The legal information contained within this report is for informational purposes only. Individuals seeking guidance or legal assistance regarding programs in Florida, Virginia, or New York should consult an attorney licensed in those states.

Any questions or comments regarding the contents of this report should be directed to the following:

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SECTION II
CONTEXTUAL REVIEW OF CHALLENGES FACING OBSTETRICS IN PENNSYLVANIA

Fast Facts…

- *Of all live births in Pennsylvania in 2023, 95 percent occurred in a hospital.*
- *From the decade 2013 to 2023, the number of women of childbearing age increased in Pennsylvania while the birth rate declined.*
- *By 2038, the federal government estimates a 10 percent shortage of OB-GYNs in Pennsylvania.*
- *In 2024, medical malpractice accounted for one percent of all civil case types in Pennsylvania.*

Overview

Everyday in the US just under 10,000 babies are born, with about 3.5 percent of those babies born in Pennsylvania. Obstetrics and Gynecology (OB-GYN) is "a branch of medicine that specializes in the care of women during pregnancy and childbirth and in diagnosing and treating diseases of the female reproductive organs."[1,2] In 2023, 97.7 percent of expectant mothers gave birth in a US hospital, 0.6 percent in freestanding birth centers, 1.5 percent at home, and 0.1 percent in other locations, such as clinics, doctors' offices, or even in a car.[3]

Despite most expectant mothers giving birth in hospitals, several hospitals and health systems have stopped providing maternity care and are either planning to close, pause services, or consolidate labor and delivery (L&D) services; due to various reasons, including decreased birth rates, financial challenges, and workforce shortages.[4] From 2013 to 2020, the US Government Accountability Office (GAO) found that 101 rural hospitals had closed, in part due to financial distress and low patient volumes.[5]

Approximately 47.0 percent of all US counties lack an OB-GYN, and 61.8 percent lack a Certified Nurse Midwife (CNM) or a Certified Midwife (CM); these shortages disproportionately affect rural areas.[6] According to the March of Dimes, approximately "one in ten birthing people reside in counties without full access to maternity care," and 60 percent of maternity care deserts are rural, less populated areas."[7] This is an important issue in Pennsylvania, as 48 out of 67 counties are designated

[1] National Institute of Health. National Cancer Institute. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/ob-gyn. Accessed August 4, 2025.
[2] Aside from pre-and post-partum care, OB-GYNs also specialize in other women's health issues, such as menopause, hormone problems, contraception (birth control), and infertility.
[3] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/natality.html on August 4, 2025.
[4] Becker's Hospital Review. *The 'why' behind increased maternity service closures and what can be done.* April 2025.
[5] United States Government Accountability Office. *Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas*. October 2022.
[6] March of Dimes. *Nowhere to Go: Maternity Care Deserts Across the US*. 2024.
[7] Maternity care deserts are counties without a hospital offering obstetric services, a birth center, or an obstetric clinician. (Ibid.)

as rural. As of 2024, 25.8 percent (3.3 million people) of the commonwealth's population resided in one of the 48 rural counties.

Bringing life into the world comes with immense risks. OB-GYNs are more likely than other physicians (other than surgeons) to be sued in their careers. As a result, OB-GYNs pay the highest medical malpractice insurance rates. Pennsylvania and other states have faced medical malpractice crises in the past, driven by unstable market conditions that led to higher rates. As a result, states implemented various reforms.

One such reform specific to OB-GYNs was the creation of a birth-related neurological injury fund (BRNIF), which attempted to target high-risk scenarios and stabilize the medical malpractice market. We discuss BRNIFs in detail in Section III. In this section, we provide context on the challenges facing obstetrics in Pennsylvania, including the medical malpractice landscape for OB-GYN and hospitals with L&D services. We also compare medical malpractice rates in Pennsylvania without a BRNIF to rates in states with BRNIFs: Florida, Virginia, and New York.

Key Findings

1. From 2004 to 2024, the number of obstetrics and gynecology physicians increased while birth rates decreased in Pennsylvania.

2. As of 2026, 23 counties with 145,642 females of childbearing age (5.9 percent) in Pennsylvania have no labor and delivery services.

3. There was a nominal to no impact on medical malpractice insurance premiums in states that implemented birth-related neurological injury funds.

Recommendations

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 obstetrics and gynecology physician shortage.

Issue Areas

A. Obstetrics in Pennsylvania

Board-certified OB-GYNs are licensed to treat disorders of the female reproductive system and provide medical and surgical care for women during pregnancy and childbirth.[8] Other clinicians, such as family physicians, nurse practitioners, physician assistants, and midwives, can also provide OB-GYN care. Additionally, doulas are non-clinical, trained professionals who may offer non-clinical support and postpartum care.[9] In 2022, OB-GYN physicians delivered approximately 85 percent of all live births in the US.[10]

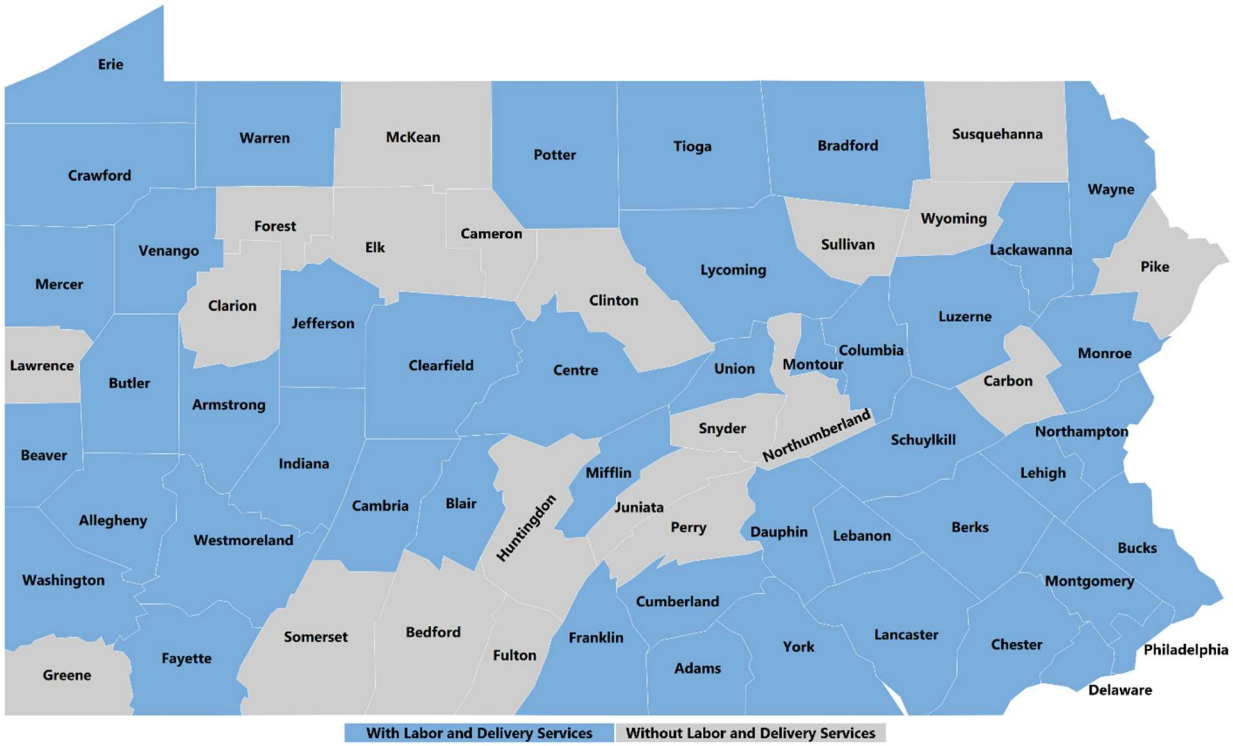
Of all live births in Pennsylvania in 2023, 95 percent occurred in a hospital, 3.3 percent at home, 0.9 percent in freestanding birthing centers, and 0.5 percent in other locations (e.g., clinics or doctors' offices).[11] Of all birthing locations, approximately 79.2 percent were attended by a physician, 18.7 percent by a CNM or other MW, and 2.1 percent by other, unknown, or not stated.[12]

As of 2024, in the commonwealth, 73 hospitals provided L&D services in 45 counties; 26 of those hospitals were rural. According to DOH, there were also five licensed birth centers in four counties: Allegheny, Lancaster, Delaware, and Berks.[13] Among the hospitals with L&D services, 80.7 percent of OB-GYNs/cross-specialty providers were located in urban county hospitals, while 19.3 percent were located in rural county hospitals. Exhibit 1 shows counties with hospitals that provide L&D services.[14]

[8] Health Resources and Services Administration.
[9] KFF. *Access to OB-GYNs: Evaluating Workforce Supply and ACA Marketplace Networks*. July 2025.
[10] March of Dimes. *Nowhere to Go: Maternity Care Deserts Across the US*. 2024.
[11] Centers for Disease Control, National Vital Statistics System.
[12] Statistics representing fewer than ten (one to nine) births or persons are suppressed. The "other" category encompasses locations and clinics/doctors' offices that are unknown or unstated.
[13] The birth center in Delaware County closed in March 2026.
[14] Information is current as of the 2024 calendar year. The maternity care landscape in Pennsylvania continues to evolve. As of the date of this report, some counties may no longer offer L&D services. For example, as of January 13, 2026, Warren General Hospital no longer provides inpatient L&D services. This was the only birthing hospital within the county. As of writing this report, L&D services are now available in 44 counties, 25 of which are rural.

Exhibit 1

Pennsylvania Counties with Hospital Labor and Delivery Services
CY 2024



Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Health.

In 2024, 22 (45.8 percent) rural Pennsylvania counties had no hospitals that provided L&D services, compared to 26 (51.1 percent) that had at least one hospital with L&D services. In contrast, all 19 urban counties had at least one hospital with L&D services.

Health care access is defined as the "timely use of personal health services to achieve the best possible health outcomes."[15] March of Dimes uses two distinct continuous county-level metrics that, when combined, provide a comprehensive assessment of maternity access: maternity access designations (quantitative measures of service access) and the Health Resources and Services Administration (HRSA) six-factor index.

Maternity access designations include three factors:

1. Ratio of obstetric clinicians to births.
2. Availability of birthing facilities.
3. The proportion of women without health insurance.

[15] March of Dimes. *Nowhere to Go: Maternity Care Deserts Across the US*. 2024.

Based on these three factors, counties are classified as low, moderate, or full access. Those that do not meet the thresholds are considered maternity care deserts. In addition to these designations, HRSA's six-factor index assigns counties scores on a scale of 0 to 25, with higher scores indicating greater need. Factors in the HRSA index include:

1. Travel time to care.
2. Availability of obstetric clinicians.
3. Health insurance coverage.
4. Fertility rates.
5. Chronic conditions.

Of the rural counties in Pennsylvania, six (12.4 percent of rural counties or 7.5 percent of the entire commonwealth) were designated as maternity care deserts, while other counties had varying levels of maternity care access, from low to full.[16,17] For example, while not completely maternity care deserts, 16.4 percent of Pennsylvania counties have low or moderate access to maternity care, but not full access.[18]

We note that there are differing definitions of maternity care deserts. The Center for Rural Pennsylvania described a 6,000-square-mile "northern maternity care desert" that includes Cameron, Clarion, Clinton, Elk, Forest, McKean, Potter, and Warren counties. These areas lack a hospital offering L&D services and are home to approximately 35,000 women of childbearing age. Whereas, the March of Dimes classified only Forest and Cameron as maternity deserts and Tioga and McKean as having moderate access to care.

We note that the absence of a maternity desert designation in urban counties does not necessarily indicate that access to care is adequate; access in these areas may still be limited or at risk of becoming limited.

[16] As previously noted, hospital closures continued to occur while we researched and wrote this report, and due to our scope ending in 2024, the statistics may not be the most up-to-date.

[17] Low access - counties with one or fewer hospitals or birth centers that provide obstetric care, few obstetric clinicians (fewer than 60 per 10,000 births), or a high proportion of women without health insurance (greater than or equal to 10 percent of reproductive-aged women).; Moderate access- counties with access to one or fewer hospitals/birth centers and few obstetric clinicians or adequate health insurance coverage (less than 10 percent of women of reproductive age uninsured).; and Full access - availability of two or more hospitals or birth centers providing obstetric care in a given county or availability of at least 60 clinicians offering obstetric care.

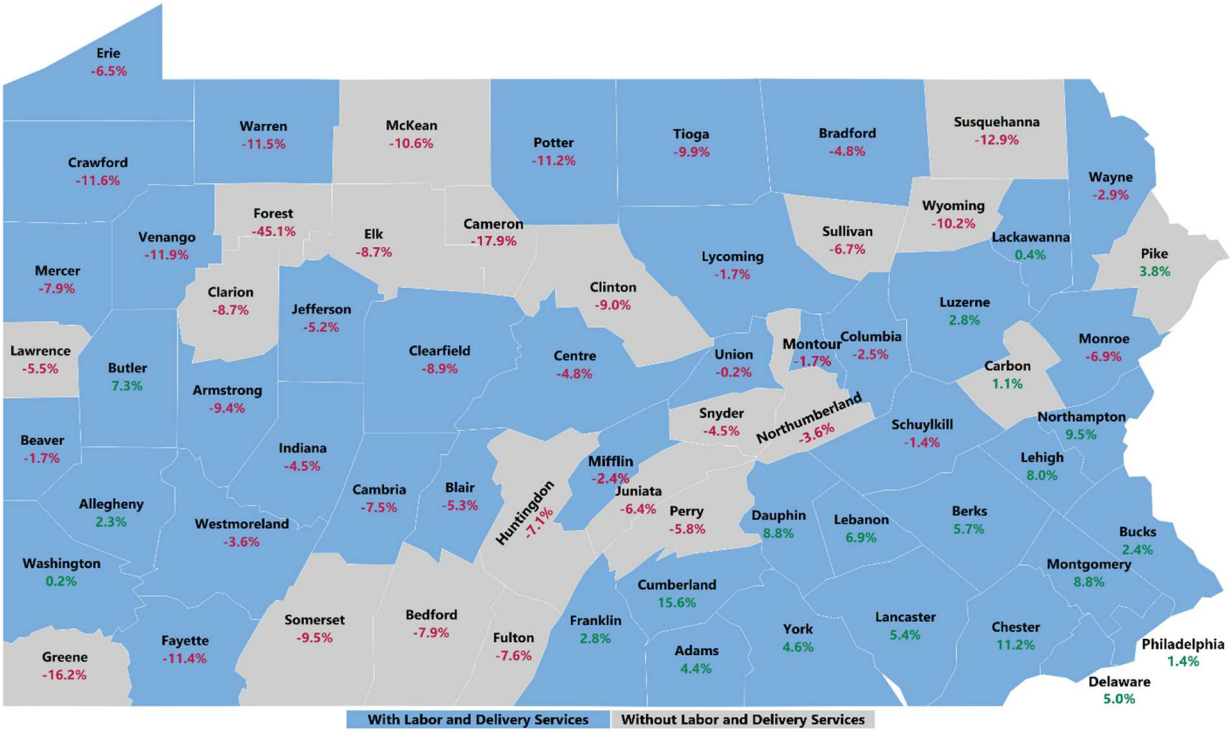
[18] US Health Resources and Services Administration, Area Health Resources Files, 2022-2023 file; American Board of Family Medicine, 2019-2022; American Association of Birth Centers, 2023; Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System, November 2023 file; National Center for Health Statistics, 2022 final natality data; US Census Bureau, 2022 American Community Survey 5-Year Estimates; American Hospital Association, 2022. Accessed April 8, 2026, from www.marchofdimes.org/peristats.

Pennsylvania Women of Child-Bearing Age

The US Department of Health and Human Services (DHHS), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC) define women of childbearing age as those aged 15 to 44. In Pennsylvania, from 2013 to 2023, the total number of females of childbearing age increased by 2.0 percent, while the state's total population increased by 1.9 percent. Exhibit 2 below shows the percentage change among females aged 15 to 44 by county from 2013 to 2023.

Exhibit 2

Change in Pennsylvania Population of Females Aged 15 to 44
CY 2013 to CY 2023



Source: Developed by LBFC staff from information obtained from the Pennsylvania State Data Center.

From 2013 to 2023, the number of females aged 15 to 44 in urban counties increased by 4.2 percent, while the total number in rural counties decreased by 4.5 percent. Overall, there was an increase in this age demographic in 16 urban and six rural counties.[19]

[19] Urban counties include Allegheny, Berks, Bucks, Chester, Cumberland, Dauphin, Delaware, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Northampton, Montgomery, Philadelphia, and York. Rural counties include Adams, Butler, Carbon, Franklin, Pike, and Washington.

Pennsylvania has been among the best states in terms of maternal mortality rates; between 2013 and 2023, the maternal mortality rate was 17.5 per 100,000 live births, compared to the US rate of 18.6 per 100,000 live births during the same period.[20] Still, according to researchers and the Centers for Disease Control (CDC), maternal mortality remains a public health crisis in the US.[21]

Pennsylvania Births and Neonatal Deaths

According to Johns Hopkins Bloomberg School of Public Health, the US fertility rate, the number of children born to women of childbearing age, reached a record low in 2024.[22] As shown in Exhibit 3, from 2014 to 2024, the birth rate in Pennsylvania declined by 10.7 percent while the population increased by 2.3 percent.

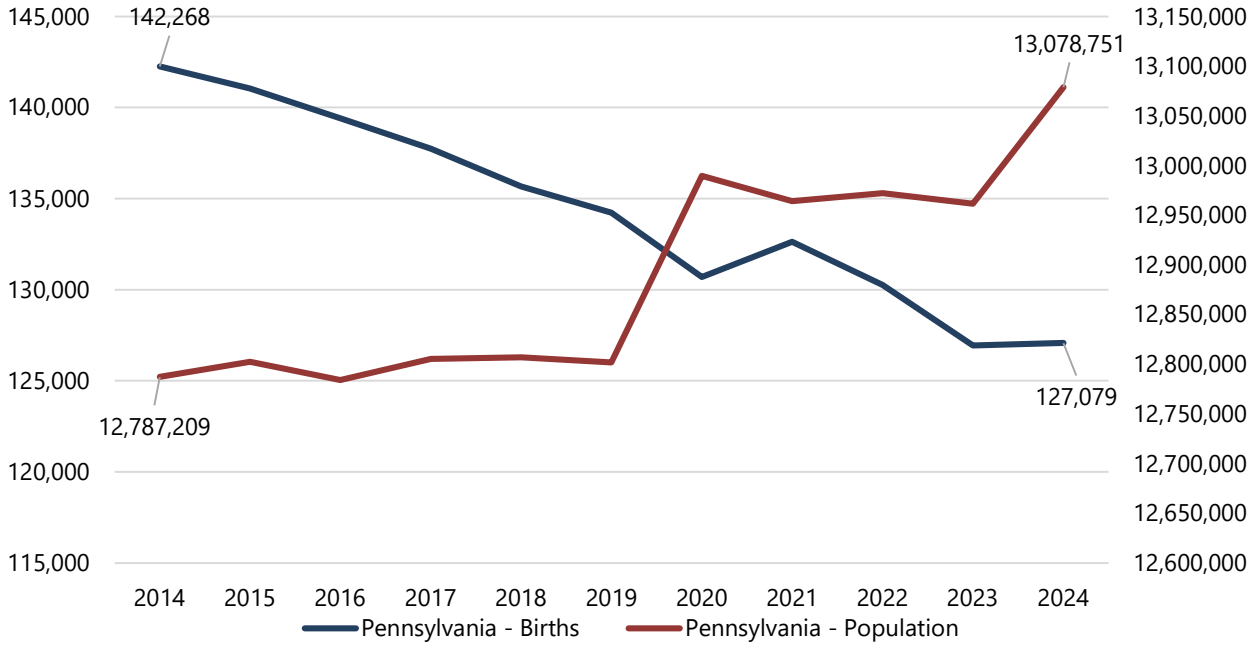
[20] Maternal deaths include deaths of women while pregnant or within 42 days of termination of pregnancy, regardless of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. (March of Dimes. *Mortality and Morbidity Data for Pennsylvania and the United States*. February 2024.)

[21] Declercq, Eugene and Laurie Zephyrin. *Maternal Mortality in the United States 2025*. The Commonwealth Fund. July 2025.

[22] https://publichealth.jhu.edu/2026/is-the-us-birth-rate-declining. Accessed April 1, 2026.

Exhibit 3

Pennsylvania Births Compared to Total Population
CY 2014 to CY 2024[a/]



Note:
[a/]The 2024 numbers are based on provisional estimates.

Source: Developed by LBFC staff from information obtained from the National Vital Statistics System and Pennsylvania Vital Statistics.

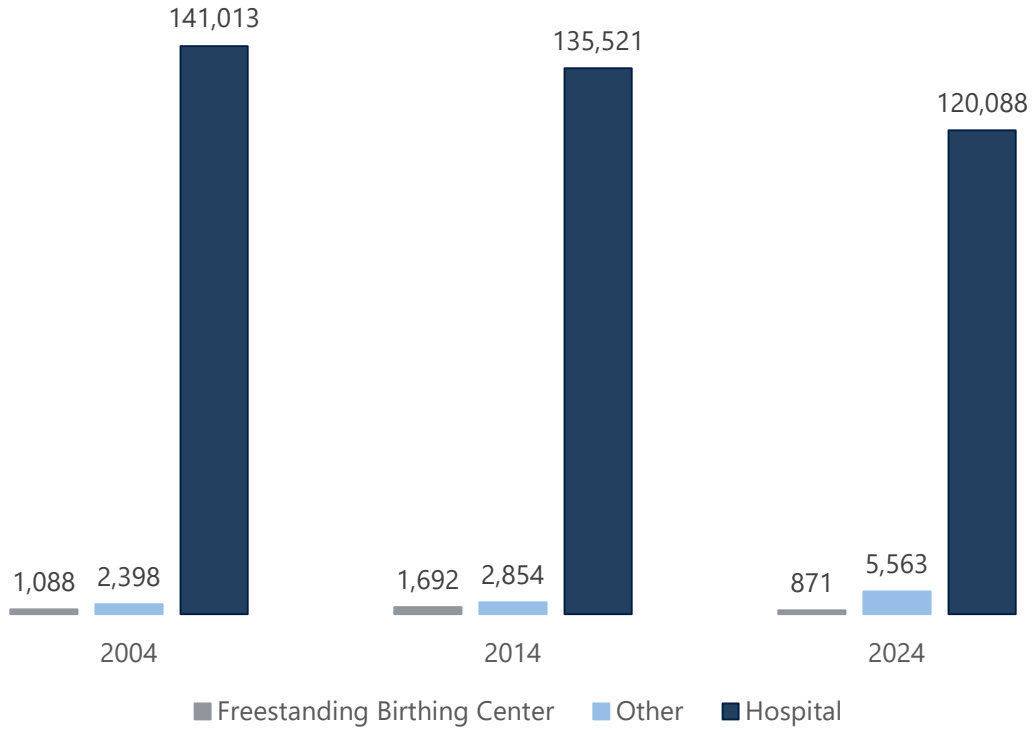
Rural Pennsylvania experienced higher declines in live births. According to the Center for Rural Pennsylvania, the number of births decreased 11 percent in rural counties and 8 percent in urban counties. In 2022, 47 of Pennsylvania's 48 rural counties had more deaths than births.[23]

Next, we examined the number of live births in hospitals across the commonwealth and the number of OB/OB-GYN combined hospital beds set up and staffed.[24,25] Exhibit 4 below shows the statewide numbers of live births by location.[26]

[23]Center for Rural Pennsylvania. *Rural Quick Facts – Demographics*.
[24] A hospital live birth is defined as the complete expulsion or extraction from the mother, in a hospital facility, of a product of conception irrespective of the duration of pregnancy, which after such separation, breathes or shows any other evidence of life such as movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached, each product of such a birth is considered live born.
[25] Beds setup and staffed are those that are regularly maintained in the hospital for the use of patients and which furnish accommodations with supporting services (such as food, laundry, and housekeeping) for patients or residents who stay 24 hours or more.
[26] Department of Health, Divisions of Informatics, *Live Births by Hospital and Method of Delivery, Pennsylvania Occurrences*, 2024.

Exhibit 4

Statewide Live Births by Location[a/]
CYs 2004, 2014, and 2024



Note:
[a/]Other includes locations outside a hospital or a freestanding birthing center, such as a clinic/doctor's office, residence, or other location.

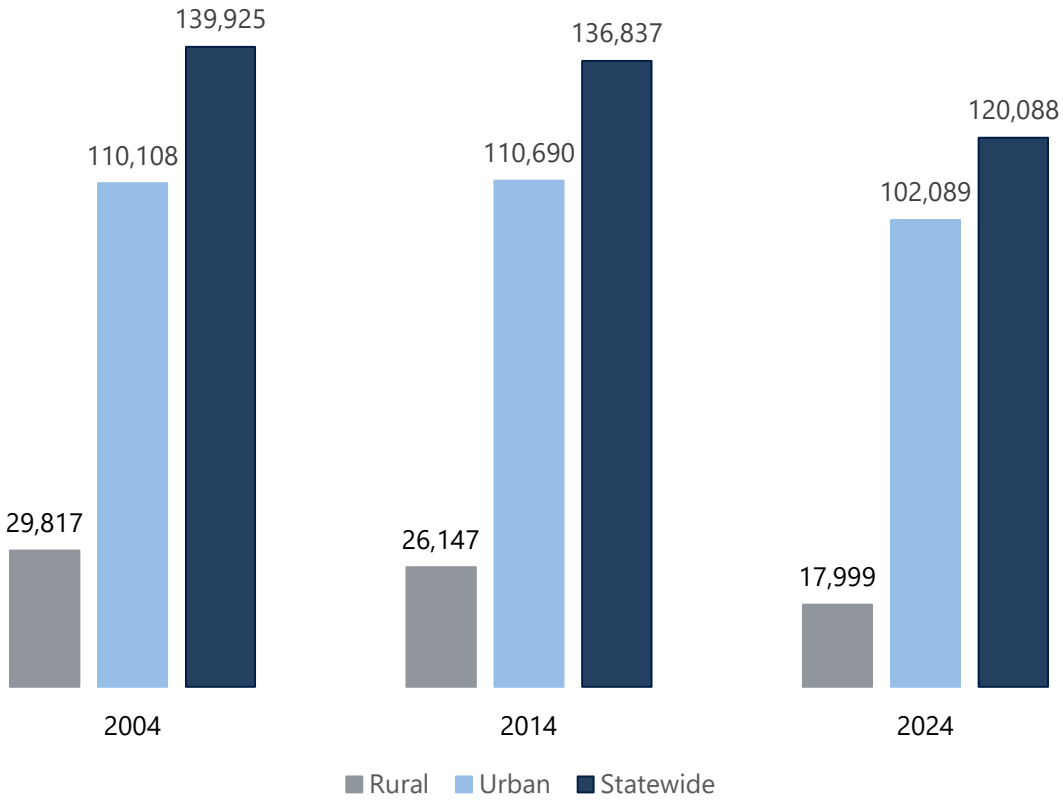
Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Health.

Statewide, live births occurring in freestanding birthing centers decreased by 19.9 percent, and in hospitals decreased by 14.8 percent. While the "other" delivery location category increased by more than 100 percent.

In 2024, 85.0 percent of hospital births occurred in urban county hospitals. Exhibit 5 shows the total number of births in rural and urban hospitals for calendar years 2004, 2014, and 2024.

Exhibit 5

Hospital Live Births
Rural and Urban Counties
CYs 2004, 2014, and 2024



Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Health.

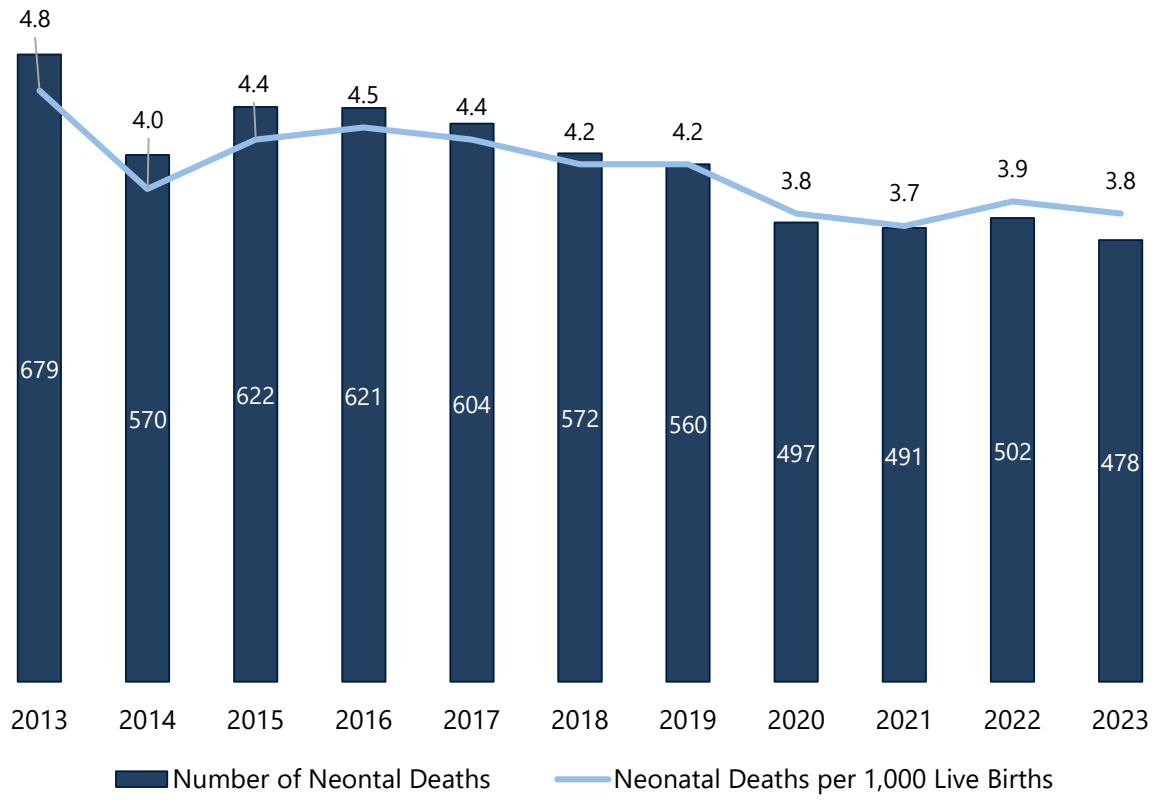
From 2004 to 2024, live births in rural hospitals decreased by 39.6 percent, while in urban county hospitals, they decreased by 7.3 percent.

As discussed in Section III, birth outcomes, including injuries and death, are a common topic of discussion with public health researchers. The Pennsylvania Patient Safety Authority (PSA) found that the number of serious event reports related to neonatal complications increased by 92 percent between 2018 and 2022.[27] Neonatal deaths totaled 478 in 2023, with a death rate of 3.8 per 1,000 live births.[28] Exhibit 6 shows the total number of neonatal deaths and the death rates over a 10-year period.[29]

[27] Pennsylvania Patient Safety Authority. *2024 Patient Safety Authority Annual Report*. April 2025.
[28] A neonatal death occurs from birth through 27 days of life.
[29] National Center for Health Statistics, period-linked birth/infant death data. Retrieved March 13, 2026, from www.marchofdimes.org/peristats.

Exhibit 6

Pennsylvania Neonatal Deaths
CY 2013 to CY 2023



Source: Developed by LBFC staff from information obtained from the March of Dimes.

From 2013 to 2023, neonatal deaths decreased by 201 (29.6 percent), and the neonatal death rate declined by 20.8 percent. Exhibit 7 shows the top causes of infant deaths in the US and the rates of each per 100,000 births.[30]

[30] Causes of infant death are classified by the International Classification of Diseases. (March of Dimes. *Mortality and Morbidity Data for Pennsylvania*. February 2024.)

Exhibit 7

Top Causes of Infant Deaths in the United States
CY 2023

Cause of Infant Death	Rate Per 100,000 Births
Birth Defects	100.5
Prematurity/Low Birth Weight	81.9
Maternal Complications of Pregnancy	39.4
Sudden Infant Death Syndrome	38.6
Respiratory Distress Syndrome	11.8

Source: Developed by LBFC staff from information obtained from the March of Dimes.

Birth defects were the primary cause of infant deaths in 2023.

Access to Obstetrics

In the US, maternal deaths and infant deaths are consistently the highest among similarly high-income countries.[31] Among other outcome determinants, such as race, socioeconomic status, and health insurance coverage, public health researchers often point to access to care as a determinant of outcomes for moms and their babies. In other words:

> Access to obstetric care is an important determinant of maternal and infant health outcomes, and amidst a maternal health crisis in the United States, hospital-based obstetric care has declined in both rural and urban communities.[32]

The Number of OB-GYNs, Residents, and Midwives.

There is no national standard for determining a sufficient number of OB-GYNs needed in a community based on a ratio of providers to women of childbearing age or to the population. However, the federal government projects a national shortage of 7,660 OB-GYNs (86 percent adequacy) by 2038 based on the current supply of OB-GYNs compared to retirements and new hires.[33] Of the four states we highlight in this report, HRSA estimated that Florida will face the most significant OB-GYN shortage by 2038 (72 percent adequacy), followed by Virginia (79 percent adequacy)

[31] Gunja, Munira, and Rehebohile Masitha. *Insight into the U.S. Maternal Mortality Crisis: An International Comparison*. The Commonwealth Fund. June 2024.
[32] Kozhimannil, K., et al. *Obstetric Care Access at Rural and Urban Hospitals in the United States*. The Journal of the American Medical Association. December 2024.
[33] United States Department of Health and Human Services, Health Resources and Services Administration. *Health Workforce Projections*. December 2025.

and Pennsylvania (90 percent adequacy).[34] HRSA projects that New York will be one of the few states with a surplus of OB-GYNs, with the highest projection of all states (117 percent adequacy).[35]

According to KFF, there is no established ratio of OB-GYNs to patients or women of childbearing age; however, longer appointment wait times, increased travel distances, and other factors contribute to estimated OB-GYN shortages. Since approximately 95 percent of all live births occurred in hospitals, we reviewed relevant reports for hospital-based OB-GYNs, certified nurse midwives, medical residents, and interns across the commonwealth.

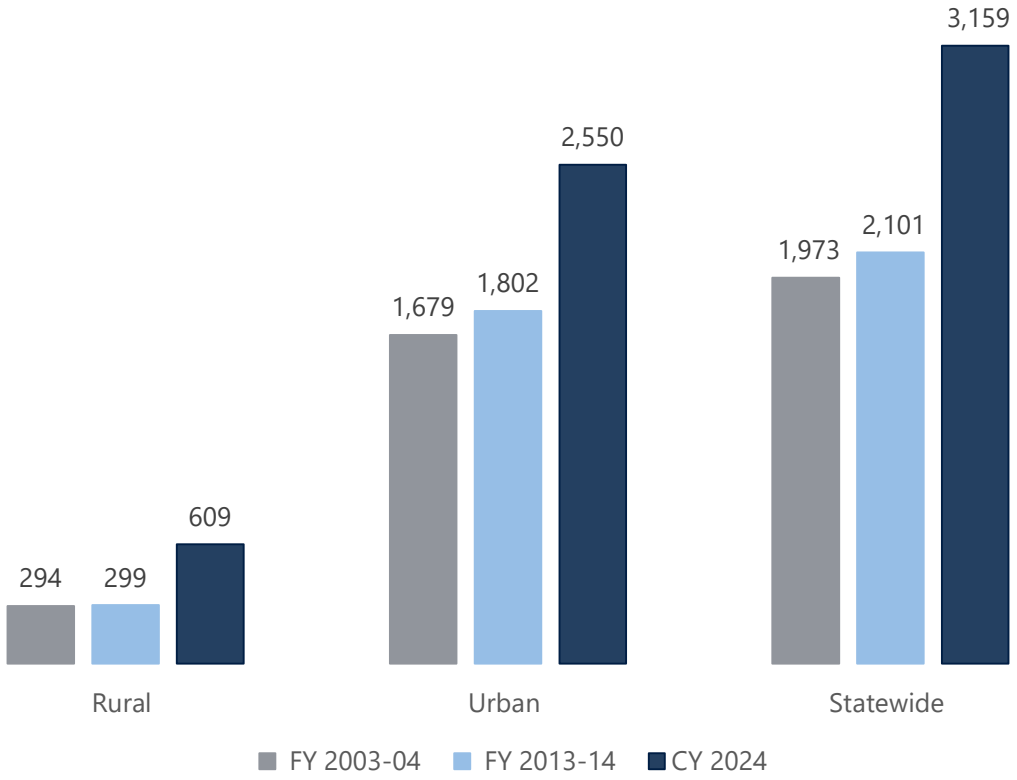
In Pennsylvania, state law requires all hospitals licensed by the Pennsylvania Department of Health (DOH) to complete an Annual Hospital Questionnaire.[36] We reviewed the data from questionnaires pertinent to this study. The information we reviewed appeared complete from FY 2003-04 to CY 2024.[37] The total number of other active medical staff with clinical privileges after 2019, due to a change in the Annual Hospital Questionnaire, Report 5, in which DOH now reports other active medical staff within a single column, labeled as "all others."

We reviewed OB-GYNs in general acute care hospitals across the commonwealth. Exhibit 8 shows the number of OB-GYN and cross-specialty providers, statewide, and in rural and urban counties.[38]

[34] Ibid.
[35] Ibid.
[36] PA Code 28 § 101.56.
[37] In 2016, DOH changed the Annual Hospital Questionnaire, reporting from fiscal year to calendar year, due to "a shift in questionnaire administration and reporting." Pennsylvania does not license federally owned hospitals, so they are not required to respond to the Annual Hospital Questionnaire.
[38] Data limitations: duplicate counts may exist; physicians may hold clinical privileges in multiple specialties and across various hospitals.

Exhibit 8

Physicians Specializing in Obstetrics and Gynecology in General Acute Care Hospitals in Pennsylvania[a/]
FY 2003-04, FY 2013-14, and CY 2024



Note:
[a/]Totals include cross-specialty Obstetrics and Gynecology physicians.

Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Health.

From FY 2003-04 through CY 2024, the total number of hospital-based OB-GYNs and cross-specialty physicians increased overall, across urban and rural counties.

According to an analysis by KFF, as of 2021-22, 11 Pennsylvania counties had no OB-GYNs, including Cameron, Forest, Fulton, Greene, Jefferson, Juniata, Perry, Snyder, Sullivan, Tioga, and Wyoming.[39]

OB-GYN Residents. Pennsylvania is home to many medical schools and teaching hospitals. As of 2025, there were 18 active OB-

[39] Long, Michelle, et al. *Access to OB-GYNs: Evaluating Workforce Supply and ACA Marketplace Networks*. KFF. July 2025.

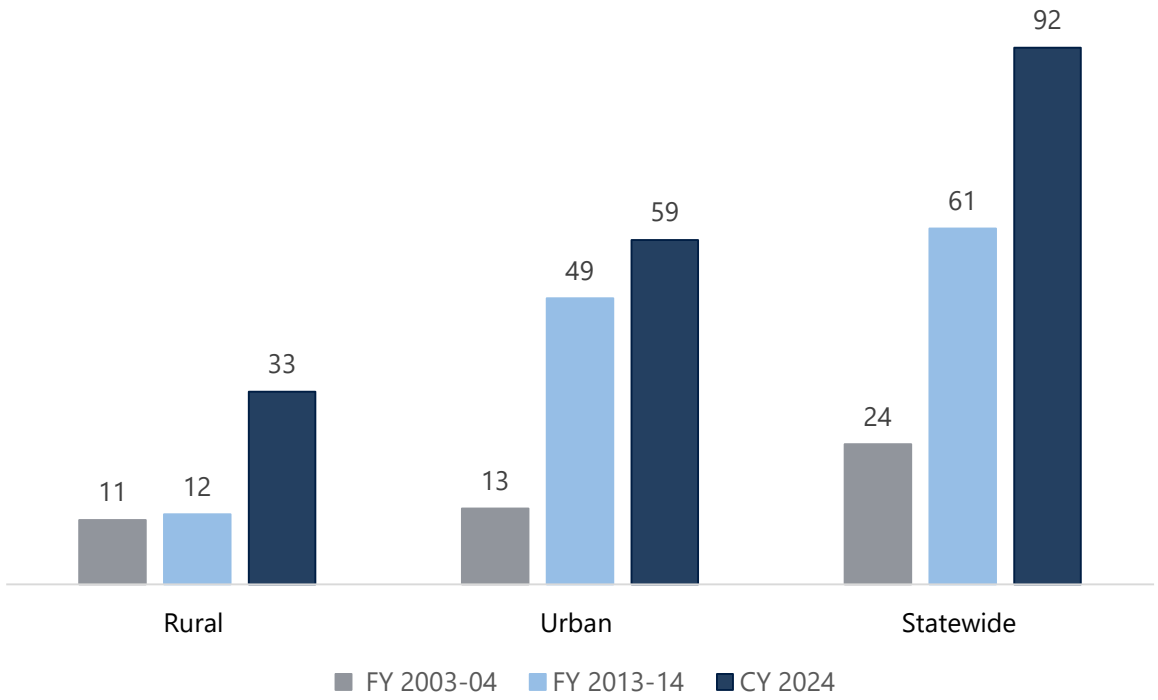
GYN residency programs.[40] Between CYs 2004 and 2024, the number of medical residents and interns grew by 32.5 percent. However, DOH does not collect information on the number of full-time interns and residents by specialty, so we were unable to determine the number of OB-GYN residents from DOH data.

According to the American Medical Association (AMA), as of February 2023, there were 356 OB-GYN residents in Pennsylvania, of whom 96.7 percent worked in an urban county hospital, and 3.3 percent worked in a rural county hospital.

Nurse Midwives (NM) also play an important role in providing care in women's reproductive health, pregnancy, and childbirth. Hospital-based NM have increased from FY 2003-04 to CY 2024, among both rural and urban hospitals. Exhibit 9 shows the total number of Certified Nurse Midwives (CNM) in rural and urban county hospitals.

Exhibit 9

Pennsylvania Certified Nurse Midwives in General Acute Care Hospitals
FY 2003-04, FY 2013-14, and CY 2024



Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Health.

[40] American Medical Association. *Workforce Mapper*. Accessed September 18, 2025.

As of CY 2024, 35.9 percent of hospital-based Certified Nurse Midwives worked in rural county hospitals, while 64.1 percent worked in urban county hospitals.

According to one GAO report, the types of clinicians attending childbirth vary by geographic location. OB-GYNs and NMs are more commonly found in urban areas, while family physicians are more prevalent in rural regions. Additionally, the distribution of these clinicians varies among states.[41] According to HRSA projections, by 2037, the supply of OB-GYNs will meet 85 percent of demand in metro areas and 51 percent in nonmetro areas.[42,43]

Hospitals with Labor and Delivery (L&D) Services.

Hospital closures or reductions in services have been occurring across the US. Over 500 US hospitals have stopped providing L&D services since 2010, and closures have occurred in both rural and urban areas. From 2010 to 2022, eight states, including Pennsylvania, had hospital-based obstetric service closures in more than a quarter of their hospitals.[44]

In Pennsylvania, 78 hospitals have been permanently closed from 2004 to 2024, including 7 that offered L&D services.[45,46] Like OB-GYNs and other practitioners, hospitals are required to report annually to DOH, through the Annual Hospital Questionnaire, regarding hospital operations, patients, services, and staff.[47] Hospitals can be licensed for either or both OB and OB-GYN inpatient unit beds. From FY 2004-05 through CY 2024, 64 hospitals experienced OB or OB-GYN bed closures across the commonwealth.[48]

Of those hospitals, 23 (35.9 percent) closed a single-bed type (either OB or OB-GYN), but still maintain an alternate obstetric unit, albeit with fewer obstetric beds. However, 41 hospitals (64.1 percent) closed OB or OB-GYN beds and have no alternate unit; therefore, they remain open but no longer provide L&D services.

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[41] United States Government Accountability Office. *Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas*. October 2022.

[42] United States Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *State of the U.S. Maternal Health Workforce, 2024*. November 2024.

[43] Metro counties are those in Metropolitan Statistical Areas (core urban area ≥ 50,000 residents). Non-metro (rural) areas are counties outside these areas.

[44] Other states, including Iowa, Oklahoma, Rhode Island, South Carolina, Washington, D.C., and West Virginia. (Kozhumannil, K., et al. *Obstetric Care Access Declined in Rural and Urban Hospitals Across US States, 2010-22*. July 2025.

[45] The total includes general acute care hospitals, state hospitals, and specialty hospitals.

[46] Counties with hospitals that have permanently closed since 2004: Chester, Clinton, Columbia, Lawrence, Philadelphia, Potter, and Susquehanna.

[47] Data includes beds, admissions, discharges, length of stay, occupancy rates, emergency services, medical staff, heart surgeries, diagnostic exams, and organ transplants.

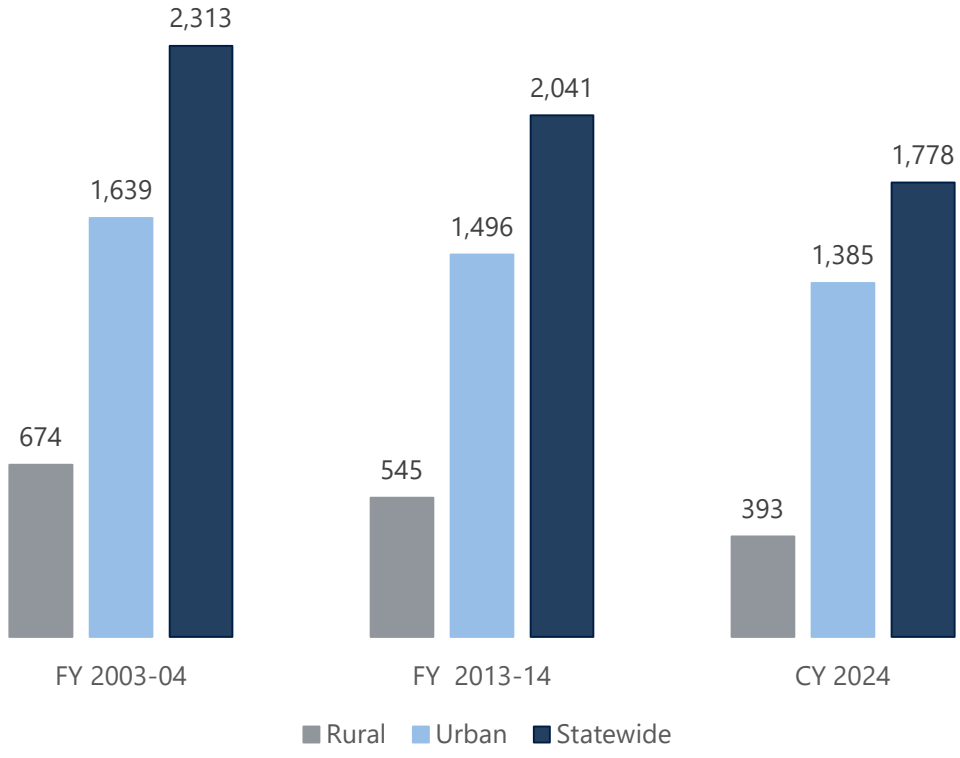
[48] Pennsylvania Department of Health.

Obstetric bed closures may not provide a complete picture. For example, Penn State Health relocated the Holy Spirit Hospital L&D and NICU to the Penn State Health Hampden Medical Center. While the obstetric services have ceased at the first hospital, they have been relocated to the new hospital within a six-mile radius. Holy Spirit Hospital would show a closure of its obstetric beds; however, the total number of obstetric beds within the health system shifted due to the new service relocation. In this scenario, services remained within the health system, which is not always the case in rural counties.

Exhibit 10 below shows staffed OB/OB-GYN hospital beds statewide, including rural and urban counties.[49]

Exhibit 10

Statewide Hospital Beds Set Up and Staffed
FY 2003-04, 2013-14, and CY 2024



Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Health, Annual Hospital Questionnaire.

[49] Data from the DOH Annual Hospital Questionnaire, with the reporting year change to calendar year starting in 2016.

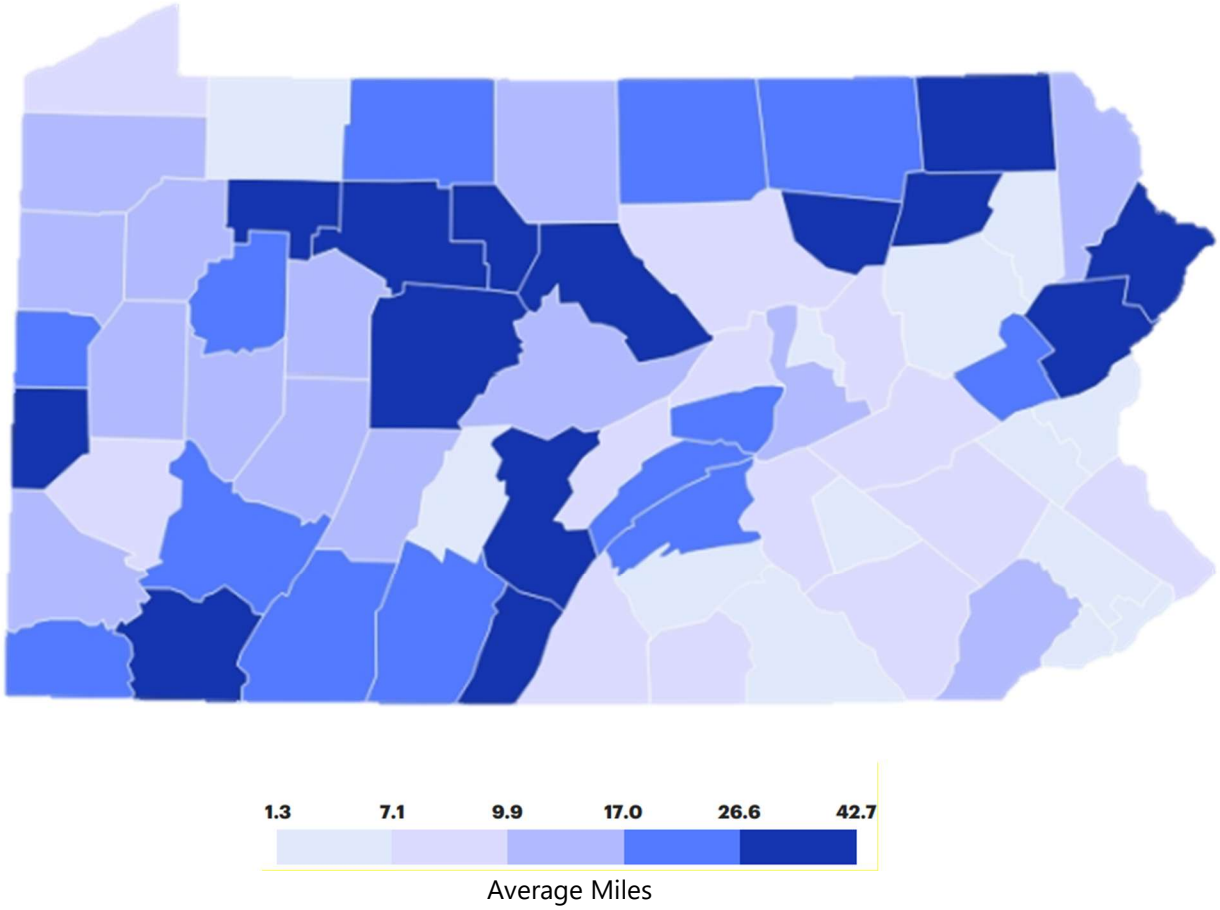
Statewide, from FY 2003-04 through CY 2024, the number of staffed OB/OB-GYN beds decreased by 535, or 23.1 percent. In rural hospitals, the total number of staffed OB and OB-GYN beds decreased by 281 (41.7 percent) and by 254 (15.5 percent) in urban hospitals. See Appendix B for 2024 county-level data on populations, live births, hospitals, obstetric beds, and staffed OB/OB-GYN beds.

According to researchers, although "closures may consolidate care at 'higher acuity' facilities, the loss of these units can increase distance to care for pregnant patients and eliminate obstetric care access for large geographic areas."[50] This results in "greater distances to care, which are associated with maternal morbidity and adverse infant outcomes."[51] In the US, a pregnant female living in a maternity care desert travels 2.6 times farther to reach the nearest birthing hospital compared to those living in full-access counties.[52] Distance to care can vary widely among counties, depending on the level of maternity care access. Exhibit 11 below shows average miles to birthing hospital by Pennsylvania county.

[50]Kozhumannil, K., et al. *Obstetric Care Access Declined in Rural and Urban Hospitals Across US States, 2010-22*. July 2025.
[51] Ibid.
[52] March of Dimes. *Nowhere to Go: Maternity Care Deserts Across the US*. 2024.

Exhibit 11

Distance to Birthing Hospital by Pennsylvania County
CY 2023



Source: March of Dimes.

The average distance to a birthing hospital, by rurality, was 23.5 miles for women living in rural counties and 9.4 miles for those living in urban counties.[53,54]

A retrospective cohort study of Pennsylvania live birth records found that "increasing driving distance to the delivery hospital was associated with

[53] United States Census Bureau. https://mtgisportal.geo.census.gov/arcgis/apps/storymaps/collections/189aa1dbd64c4c81b3b4a2b71124f6c6?item=1. Accessed: April 22, 2026.

[54] Rurality is defined as the percentage of the decennial census population living in rural areas. Counties were classified as "mostly urban" (less than 50 percent of the population lived in rural areas), "mostly rural" (50 to 99.9 percent of the population lived in rural areas), and "completely rural" (100 percent of the population lived in rural areas).

elevated risks of adverse maternal outcomes and NICU admissions."[55] The distance to a hospital may delay prenatal screenings and interventions, and increase maternal stress and anxiety. However, shorter distances to the delivery hospital do not necessarily mean a lower risk of adverse outcomes. [56]

In the commonwealth, NICU admissions increased from 2017 to 2023, from 9.1 percent to 10.2 percent.[57] Reasons for a NICU admission include preterm birth, birth defects, breathing and feeding problems, infections, or other medical conditions.[58]

Furthermore, geographic distance to care has been associated with delayed labor arrival, more emergency interventions, and lower rates of routine prenatal visit initiation, all of which are established risk factors for poor maternal and neonatal outcomes.[59]

The closure of Penn Highlands Elk's maternity unit in rural Elk County, for example, forced patients to adjust their birth plans with less than three months' notice and travel an hour or more to reach an alternative facility. This undermined continuity of care and increased stress for expectant mothers.[60]

Exhibit 12 contains analysis by the Center for Healthcare Quality and Payment Reform on rural L&D closures, the number of rural hospitals without L&D services, and facts about rural hospitals still providing L&D in our four selected states and across the US.

[55] Minion, S.C., et al. *Association of Driving Distance to Maternity Hospitals and Maternal and Perinatal Outcomes*. American College of Obstetricians and Gynecologists. November 2022.
[56] Ibid.
[57] National Center for Health Statistics, final natality data. Retrieved March 25, 2026, from www.marchofdimes.org/peristats.
[58] Ibid.
[59] Fontenot, J., et al. Navigating Geographical Disparities: *Access to Obstetric Hospitals in Maternity Care Deserts and Across the United States*. BMC Pregnancy and Childbirth. May 2024.
[60] Pennsylvania Health Access Network. *Pennsylvania's Maternity Care Desert Expands to Seven Counties*. June 2025.

Exhibit 12

Rural Labor and Delivery (L&D) Closures, Risk of Closure, and Travel Times
March 2026

	Rural L&D Closures			Rural Hospitals With L&D				Driving Distance (in Minutes)	
State	# L&D Units Closed Since 2020	% of Hospital L&D Closures	# of Hospitals with No L&D in 2025	# of Hospitals with L&D	% of Hospitals with L&D	# of L&D Units at Risk of Closing	% of L&D Units at Risk of Closing	Median Time to Hospital with L&D Services	Median Time to Alternate L&D Hospital
Virginia	3	25%	23	9	28%	0	0%	43	44
Pennsylvania	5	22	33	19	37	1	5	38	38
New York	3	11	30	24	44	4	17	38	41
Florida	0	0	20	2	9	0	0	50	>90
US Total	**133**	**12%**	**1,361**	**940**	**41%**	**104**	**11%**	**36**	**40**

Source: Developed by LBFC staff with information obtained from the Center for Healthcare Quality and Payment Reform.

All selected states, except Florida, have experienced rural L&D closures since 2020. Pennsylvania had the most; however, Virginia had a higher percentage of rural L&D closures. Florida had the highest median driving distance (in minutes) to hospitals with L&D services and alternate L&D hospitals.

Why Hospitals Closed or Stopped L&D Services. A 2025 study examining obstetric care access at urban and rural hospitals from 2012 to 2022 found that hospital-based obstetric services have declined across most states in both rural and urban communities.[61] During this period, there were "major federal and state health policy initiatives, from the Affordable Care Act to the COVID-19 pandemic response, as well as targeted maternal health efforts (for example, state perinatal quality collaboratives), all of which have influenced obstetric care across states."[62]

The Center for Healthcare Quality and Payment Reform (CHQPR)'s most recent report found that over 100 L&D units in rural hospitals have closed in the US since 2020; in Pennsylvania, four L&D units, or approximately 18 percent, have closed.[63] Additionally, based on an

[61] Kozhumannil, K., et al. *Obstetric Care Access Declined in Rural and Urban Hospitals Across US States*, 2010-22. July 2025.
[62] Ibid.
[63] Center for Healthcare Quality and Payment Reform. *Stopping the Loss of Rural Maternity Care*. August 2025.

analysis of the Centers for Medicare and Medicaid Services (CMS) hospital cost reports, 17 hospitals (34 percent) in Pennsylvania are at risk of closure, and 9 hospitals (18 percent) are at immediate risk of closure within the next two to three years.[64]

In one study of 19 hospitals that closed their obstetric units, 15 (79 percent) identified staffing difficulties, such as retention, recruitment, and liability concerns related to obstetricians, as the most common reason for closure. Other frequently cited reasons for closure included low birth volume (nine hospitals, or 47 percent), low reimbursement (three hospitals, or 16 percent), and other financial issues (six hospitals, or 32 percent), such as surgical and anesthesia coverage, the cost of operating the units, and budget cuts.[65,66]

In a recent review with health care leaders, several reasons for maternity care service closures in rural America were identified, echoing findings from other studies, which included.[67]

- Decline in birth rates.
- Recruitment and retention.
- OB-GYN shortages.
- Resource-intensive services.
- Aging population.
- Malpractice insurance.
- Cost to sustain maternity services/Medicaid reimbursement rates.

Disruptions in local access to obstetric care are more than just logistical issues; they are linked to clinical outcomes and health care utilization patterns. Economic factors, such as low Medicaid reimbursement rates and shrinking profit margins for low-volume obstetric services, continue to strain hospitals that are already operating with limited resources. As rural facilities try to cover obstetric operating costs, such as staffing obstetricians and certified nurse midwives, providing pediatric support, anesthesia, and maintaining 24/7 availability, many have determined that sustaining these units is financially impossible.[68]

In Pennsylvania, closures have changed how pregnant women access obstetric care. According to the Center for Rural Pennsylvania, since May 2025, the northern maternity care desert has expanded to include eight

[64] Ibid.
[65] Hung, P., et al. *Why are Obstetric Units in Rural Hospitals Closing Their Doors?* Health Services Research. August 2016.
[66] This study utilized data from Colorado, Iowa, Kentucky, New York, North Carolina, Oregon, Vermont, Washington, and Wisconsin; however, the authors noted that "the results may not be generalizable to other states."
[67] Becker's Hospital Review. *The 'Why' Behind Increased Maternity Service Closures and What Can Be Done?* April 2025.
[68] Pennsylvania Office of Rural Health. *Pregnant Women in Rural Pennsylvania Face Expanding Maternity Deserts*. 2022.

counties (Cameron, Clarion, Clinton, Elk, Forest, McKean, Potter, and Warren), covering about 6,000 square miles (an area larger than Connecticut).[69]

The loss of hospital-based birthing services has forced pregnant women to travel farther for delivery care. Leaders attribute the latest hospital closure in Warren County, PA, to nationwide shortages of obstetricians-gynecologists, calling it "impossible to secure the staffing levels required to safely operate a 24/7 labor and delivery unit."[70]

Hospitals have steadily reduced obstetric services for decades, primarily due to economic pressures, workforce shortages, and reimbursement challenges that have disproportionately affected rural and lower-volume providers.

The Impact of Hospital Closures. Women living in maternity care deserts and low-access counties have poorer health before pregnancy, receive less prenatal care, and experience higher rates of preterm birth. In Pennsylvania, approximately 12.4 percent of women live more than 30 minutes from a hospital that offers birthing services, and 7.5 percent of the state's counties are considered maternity care deserts.[71] These distances create significant barriers to timely prenatal care and safe delivery.

Peer-reviewed research consistently shows that reduced access to obstetric care is associated with higher rates of severe maternal morbidity (SMM), NICU admissions, preterm births, and low birth weight.[72,73] In a recent study of birthing hospitals in the US, researchers found that fewer than 20 percent of rural hospitals have access to higher-level neonatal care, compared to 74 percent in urban hospitals. This decline in rural birthing hospitals' capacity is happening while "urban birth hospitals are expanding higher-level neonatal care, accentuating geographic discrepancies in access to care for high-risk infants."[74]

According to the Center for Rural Pennsylvania, statewide, approximately 3.5 million Pennsylvanians experience an average travel time of over 20 minutes to reach the nearest hospital with L&D services. Rural residents' average driving distance from the county seat to the nearest hospital

[69] Center for Rural Pennsylvania. *Update: The Expanding Maternity Care Desert in Pennsylvania*. January 2026.
[70] https://www.wgh.org/news/warren-general-hospital-announces-changes-to-obgyn-services-due-to-national-physician-shortage. Accessed March 23, 2026.
[71] March of Dimes. *Where You Live Matters: Maternity Care in Pennsylvania*. 2023.
[72] Evans, M., et al. *Association of Driving Distance to Maternity Hospitals and Maternal and Perinatal Outcomes*. American Journal of Obstetrics & Gynecology. 2022.
[73] Severe maternal morbidity (SMM) is defined as the unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.
[74] Kozhimannil, K. et al. *Availability of Higher-Level Neonatal Care in Rural and Urban US Hospitals, 2010-2022*. February 2026.

with OB-GYN services is 27 miles. Additionally, "increased travel time is associated with a higher risk of maternal and neonatal complications and can result in a greater incidence of births occurring outside of hospital settings."[75]

As shown previously, in Exhibit 4, live births outside of hospitals in the "other" category have increased by over 100 percent from CY 2004 to 2024, while births at hospitals and birth centers have decreased over the 20-year span. Further analysis of births outside hospitals may be warranted to determine whether they are associated with distance from birthing hospitals.

In Pennsylvania, the SMM annual rate rose from 75.2 per 10,000 deliveries in 2016 to 105.2 per 10,000 deliveries in 2022, representing an average annual increase of 7 percent.[76] This period coincides with ongoing reductions in obstetric services.

The impact of hospital closures is multifaceted, including increased driving distances, reduced or delayed access to care, increased NICU utilization, strained emergency departments, economic and workforce impacts, health equity and racial disparities, and maternal and neonatal mortality and morbidity.

To address workforce shortages, states across the US are launching initiatives focused on maternal health, with workforce retention and recruitment as top priorities. Exhibit 13 below highlights state and federal workforce programs aimed at recruiting and retaining health care practitioners.

[75] Center for Rural Pennsylvania. *Update: The Expanding Maternity Care Desert in Pennsylvania.* January 2026
[76] Pennsylvania Department of Health. *Severe Maternal Morbidity in Pennsylvania, 2016-2022: Individual Level & Regional Factors.* April 2024.

Exhibit 13

General Workforce Programs for Health Care Practitioners

State	Workforce Priorities	Description
Florida	Live Healthy Initiative	CS/SB 2016, Chapter 2024-15 - one key component of the legislation increased Graduate Medical Education residency slots.
	Florida Reimbursement Assistance for Medical Education (FRAME)	Provides healthcare practitioners with loan repayment for medical education.
New York	Doctors Across New York Physician Loan Repayment and Physician Practice Support Programs	A state-funded initiative enacted in 2008 to train and place physicians in underserved communities across various settings and specialties, aiming to serve New York's diverse population.
Pennsylvania	Primary Care Loan Repayment Program (LRP)	The Department of Health offers loan repayment opportunities as incentives to recruit and retain primary care practitioners who are willing to serve underserved Pennsylvania residents and commit to working in federally designated Health Professional Shortage Areas (HPSAs). The program's goal is to improve access to primary health care services and enhance recruitment and retention of health care practitioners in underserved communities.
Virginia	Graduated Medical Education Supplemental Awards	Virginia Health Workforce Development Authority (VHWDA), in partnership with the Virginia Department of Medical Assistance Services (DMAS), provides supplemental GME awards. The supplemental award payments are issued quarterly for up to four years, depending on the length of the specialty training.
Federal Loan Repayment & National Programs	Rural Health Transformation Program	Section 71401 of Public Law 119-21 outlines awards to states over five years. PHTP funding includes: (1) transforming care delivery; (2) improving access to quality and affordable health care in rural America; (3) expanding or enhancing services, ensuring no duplication of programs; (4) investing in technology and infrastructure, including start-up costs, which will have a lasting impact beyond the program's end.
	National Health Service Corps	Support primary medical, dental, and behavioral health providers with scholarships and loan repayment programs that encourage work in high-need areas.

Source: Developed by LBFC staff from information obtained from various state resources.

Among states, workforce priorities vary, including improving accessibility, increasing rural health investments, maintaining an adequate workforce, and offering financial incentives for recruitment and retention.

Finally, through the CMS Rural Health Transformation Program (RHTP), all 50 states have obtained funding to enhance and modernize health care in rural communities over the next five years, 2026-2030. With this funding, state efforts will include: (1) increasing care accessibility; (2) strengthening and maintaining the rural clinical workforce; (3) modernizing rural health infrastructure and technology; (4) boosting efficiency and empowering community providers; and (5) encouraging innovative care models and payment reforms.

B. Medical Malpractice

A tort is a legal term that refers to a "civil wrong, other than a breach of contract, for which a remedy may be obtained."[77] Tort liability refers to the legal responsibility to pay damages resulting from committing a legal wrong. It is governed by state law, and each state sets its own legal principles, time limits, and rules for determining a party's fault. Additionally, states prescribe their own statutes of limitations for filing lawsuits, access to punitive damages, and rules governing intervening insurance coverage.

One area of tort law is medical malpractice, in which a plaintiff claims a medical provider deviated from accepted medical standards, causing injury. Under a traditional tort liability system, the plaintiff brings a claim by filing a lawsuit in court and going to trial, unless the parties reach a settlement.

Pennsylvania experienced three medical malpractice liability crises: the first in the mid-1970s, the second in the mid-1980s, and the third in the early 2000s. A series of reforms over 30 years included several measures, such as the enactment of the Health Care Services Malpractice Act and the Medical Care Availability and Reduction of Error (MCARE) Act.[78, 79]

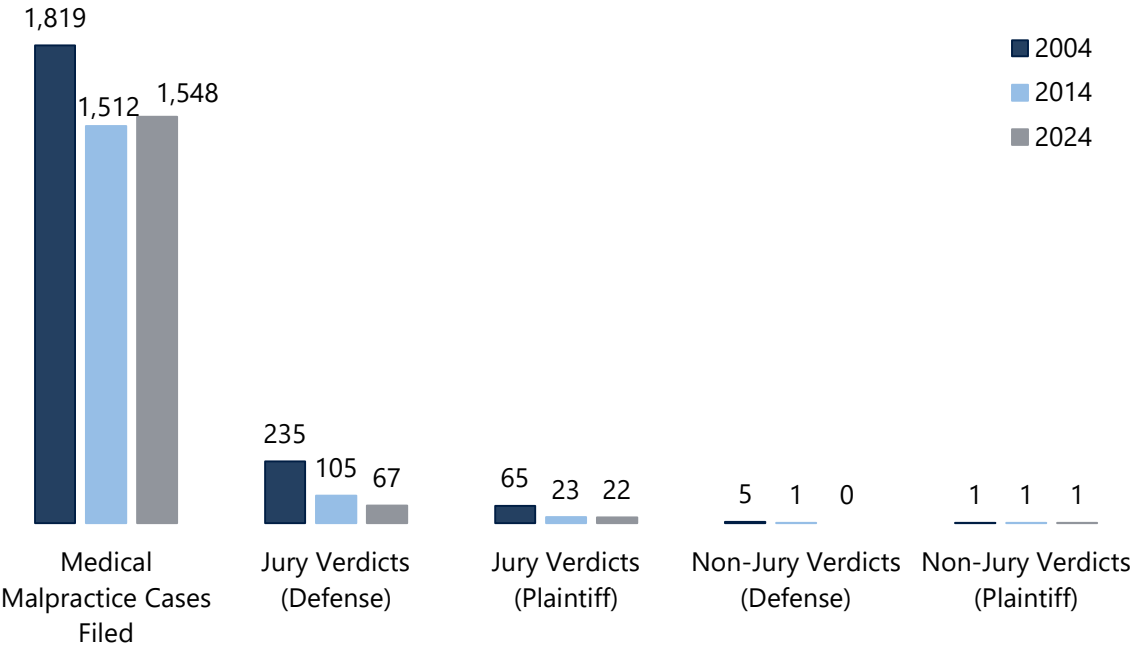
Market conditions were responsible for the crisis in the early 2000s, which saw three of the commonwealth's five major private medical liability insurers stop writing policies, and insurance premiums quickly increased in certain specialties, threatening providers' financial viability. Additionally, reinsurance costs soared after the 9/11 terrorist attacks.

[77] Black's Law Dictionary (12th ed. 2024).
[78] Act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act.
[79] Act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (MCARE) Act.

Medical malpractice claims can be filed in Pennsylvania within two years of the date of injury, or the date the injury was discovered (or should have been discovered), commonly known as the "discovery rule."[80] Despite receiving a lot of attention, in 2024, medical malpractice accounted for one percent of all civil case types in Pennsylvania.[81] Medical malpractice case filings in Pennsylvania decreased by 16.9 percent from CYs 2004 to 2014, then increased by 2.4 percent from CYs 2014 to 2024. Exhibit 14 shows medical malpractice filings and verdicts for CYs 2004, 2014, and 2024.[82]

Exhibit 14

Medical Malpractice Filings and Verdicts in Pennsylvania
CYs 2004[a/], 2014, and 2024



Notes:
[a/]Annualized totals for CY 2004 from June 2003 to December 31, 2004.
[b/]Zero non-jury defense verdicts during the 2024 calendar year.

Source: Developed by LBFC staff from information obtained from the Unified Judicial System of Pennsylvania.

Both defense and plaintiff (jury and non-jury) verdicts decreased by more than 50 percent from CY 2004 to 2014; however, from CY 2014 to 2024,

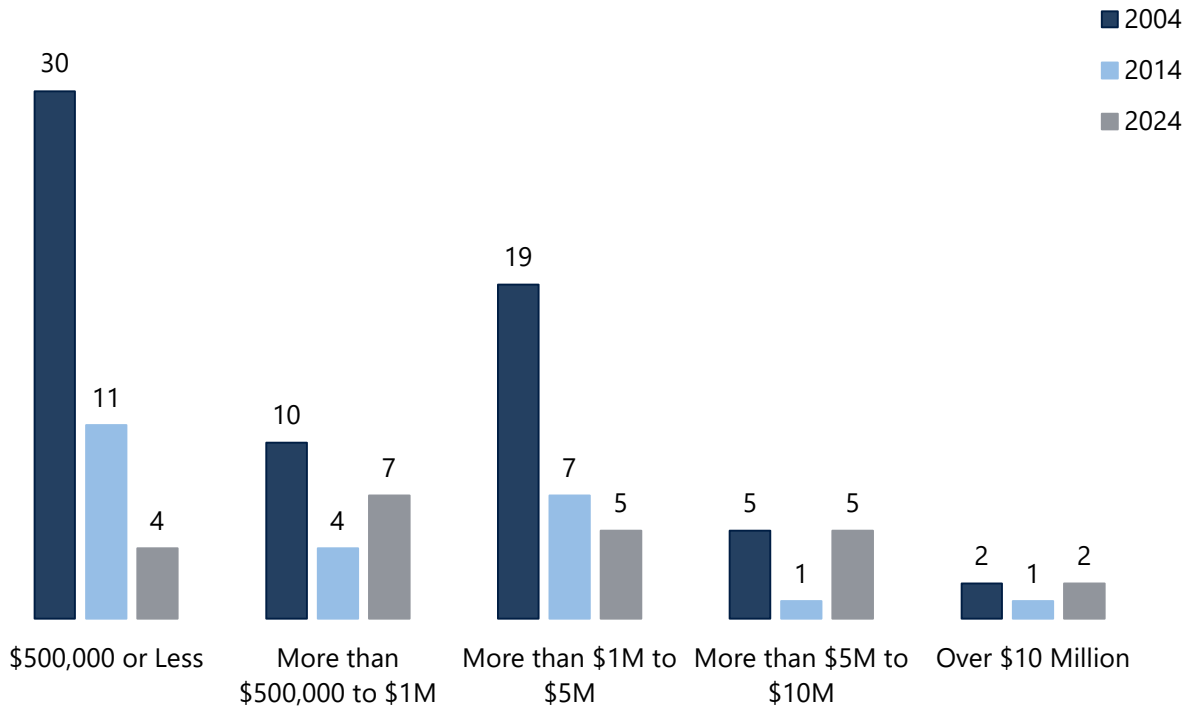
[80] Exceptions: minors and wrongful death. 42 Pa. C.S. Chapter 55.
[81] Nieves, K., et al. *2024 Caseload Statistics of the Unified Judicial System of Pennsylvania*. Supreme Court of Pennsylvania.
[82] Totals include all medical malpractice case filings and verdicts, not specific to injuries to newborns.

defense verdicts decreased by 36.8 percent, while plaintiff verdicts decreased by 4.2 percent.

Exhibit 15 shows jury and non-jury verdicts for the plaintiff by award range.

Exhibit 15

Plaintiff Medical Malpractice Jury and Non-Jury Verdicts by Award Range
Cys 2004, 2014, and 2024



Source: Developed by LBFC staff from information obtained from the Administrative Office of Pennsylvania Courts.

From CYs 2004 to 2024, the number of plaintiff verdicts fell by 65.2 percent across all award categories. Examining each award range individually, verdicts in the $5 million to $10 million range and above $10 million remained steady, while verdicts in the $500,000 or less range and $1 million up to $5 million range declined.

We also reviewed other states' reported medical malpractice payments made on behalf of physicians (MDs and DOs) from 2004 through 2024 in

the National Practitioner Data Bank (NPDB).[83,84] This includes judgments and settlements, as well as certain adverse actions related to health care practitioners, providers, and suppliers. We note that settlements with hospitals that do not name a specific individual, such as a doctor, are not included in the data because the NPDB was designed to track individual practitioners, not organizations. Exhibit 16 below shows the total number of malpractice payments for each state, by payment range for the calendar years 2004, 2014, and 2024.[85]

Exhibit 16

Medical Malpractice Payment Counts by State and Payment Range[a/]
Cys 2004, 2014, 2024

State	Calendar Year	< $50,000	$50,000 - $99,999	$100,000 - $249,999	$250,000 - $499,999	$500,000 - $999,999	$1,000,000 - $1,999,999	>= $2,000,000	Total
Florida	2004	236	187	364	289	127	35	4	1,242
	2014	111	125	219	233	71	25	4	788
	2024	80	139	159	279	131	63	9	860
New York	2004	274	252	440	438	364	210	22	2,000
	2014	127	130	322	304	270	185	28	1,366
	2024	50	60	198	249	213	155	24	949
Pennsylvania	2004	119	118	314	413	252	32	3	1,251
	2014	49	43	105	144	300	15	12	668
	2024	26	36	95	117	542	24	22	862
Virginia	2004	38	28	52	44	22	10	0	194
	2014	13	9	28	28	24	12	2	116
	2024	4	6	14	21	32	15	4	96

Note:
[a/]Includes all medical malpractice payments made on behalf of a physician (MDs and DOs) in each state; however, payments made under a no-fault program/system, such as Florida's and Virginia's birth-related injury funds, are excluded.

Source: Developed by LBFC staff from information obtained from the National Practitioner Databank.

[83] 42 U.S.C. § 11131 *et seq.* known as the Health Care Quality Improvement Act of 1986.
[84] The NPDB is a repository of reports that, under federal law (42 U.S.C. § 11131) and NPDB regulations (45 C.F.R. Part 60), requires all entities that make medical malpractice payments (such as insurance companies, self-insured employers, and government agencies) to report these payments to the NPDB.
[85] Virginia and Florida's no-fault funds are not required to report to the NPDB, as there is no "judgment or settlement." Therefore, totals don't include no-fault fund participants. In New York, admission into the MIF must be triggered by a judgment; therefore, it must be reported to the NPDB.

Overall, the total number of medical malpractice payments decreased between 2004 and 2024; however, Pennsylvania and Florida had decreases between CYs 2004 and 2014, and increases between CYs 2014 and 2024. Both states' 2024 payment counts were lower in 2024 than in 2004. Exhibit 17 shows the change in the number of malpractice payment counts between CYs 2004 and 2014, 2014 and 2024, and the entire 20-year period.

Exhibit 17

Percent Change in Malpractice Payment Counts by State and Payment Range[a/]

CYs 2004 to 2014 and CYs 2014 to 2024

State	Time Period, % Change Calculated	< $50,000	$50,000 - $99,999	$100,000 - $249,999	$250,000 - $499,999	$500,000 - $999,999	$1,000,000 - $1,999,999	>= $2,000,000	Total
Florida	2004 to 2014	-53.0%	-33.2%	-39.8%	-19.4%	-44.1%	-28.6%	0.0%	-36.6%
	2014 to 2024	-27.9	+11.2	-27.4	+19.7	+84.5	+152.0	+125.0	+9.1
	20 Year Change	-66.1	-25.7	-56.3	-3.5	+3.1	+80.0	+125.0	-30.8
New York	2004 to 2014	-53.6	-48.4	-26.8	-30.6	-25.8	-11.9	+27.3	-31.7
	2014 to 2024	-60.6	-53.8	-38.5	-18.1	-21.1	-16.2	-14.3	-30.5
	20 Year Change	-81.8	-76.2	-55.0	-43.2	-41.5	-26.2	+9.1	-52.6
Pennsylvania	2004 to 2014	-58.8	-63.6	-66.6	-65.1	+19.0	-53.1	+300.0	-46.6
	2014 to 2024	-46.9	-16.3	-9.5	-18.8	+80.7	+60.0	+83.3	+29.0
	20 Year Change	-78.2	-69.5	-69.7	-71.7	+115.1	-25.0	+633.3	-31.1
Virginia	2004 to 2014	-65.8	-67.9	-46.2	-36.4	+9.1	+20.0	+100.0	-40.2
	2014 to 2024	-69.2	-33.3	-50.0	-25.0	+33.3	+25.0	+100.00	-17.2
	20 Year Change	-89.5	-78.6	-73.1	-52.3	+45.5	+50.0	+100.0	-50.5

-%	Indicates a decrease in the number of payment counts.
+%	Indicates an increase in the number of payment counts.
0.0%	Indicates no change in the number of payment counts.

Note:
[a/]Includes all medical malpractice payments made on behalf of a physician in each state; however, payments made under a no-fault program/system (such as Florida's and Virginia's birth-related injury funds) are excluded.

Source: Developed by LBFC staff from information obtained from the National Practitioner Databank.

From CY 2004 to CY 2024, all four states saw fewer medical malpractice payments of $499,999 or less and more payments of $2 million or more. As noted, overall medical malpractice payments declined in these states. However, because NPDB data do not include details such as birth injury

payments, it is not possible to determine the impact of the BRNIF on total payments.

The Nuclear Verdict. The health systems we interviewed for this report indicated the prospect of nuclear verdicts is their primary concern regarding medical malpractice suits. A nuclear verdict is often defined as a verdict of $10 million or more. According to a national analysis from CY 2013 to CY 2022, 20.3 percent of all nuclear verdicts were medical liability cases, with a mean of $33.6 million and a median of $19.6 million.[86] Exhibit 18 shows the top 10 states with nuclear verdicts, cumulative and per capita. Note that the data includes all civil cases, not just medical malpractice.

Exhibit 18

States with Most Nuclear Verdicts
CY 2013 to CY 2022

State	Cumulative Nuclear Verdicts	Rank by Cumulative Nuclear Verdicts	Nuclear Verdicts per 100K People	Rank by Nuclear Verdicts Per Capita
California	199	1	0.51	8
Florida	**197**	**2**	**0.94**	**1**
Georgia	64	5	0.61	4
Illinois	64	6	0.50	9
Missouri	30	9	0.49	10
New Mexico	-[a/]	-[a/]	0.57	5
New York	**131**	**3**	**0.66**	**2**
Ohio	27	10	-[b/]	-[b/]
Pennsylvania	**58**	**7**	**-[b/]**	**-[b/]**
Rhode Island	-[a/]	-[a/]	0.56	6
Texas	130	4	-[b/]	-[b/]
Washington	47	8	0.63	3
Wyoming	-[a/]	-[a/]	0.52	7

Notes:
[a/]State is not in the top 10 states of cumulative nuclear verdicts from 2013 to 2022.
[b/]State is not in the top 10 states of nuclear verdicts per capita from 2013 to 2022.

Source: Developed by LBFC staff from information obtained from the United States Chamber of Commerce Institute for Legal Reform.

[86] Ibid.

Pennsylvania, Florida, and New York were among the states with the most cumulative nuclear verdicts. Florida and New York were among the most per capita.

Verdicts can also vary by county. As shown in Exhibit 19, only 10 out of Pennsylvania's 67 counties had a medical malpractice verdict over $10 million from 2014 to 2024. Case details are not included in the data, making it unclear how many are birth-related neurological injuries.

Exhibit 19

Medical Malpractice Number of Verdicts $10 Million in Pennsylvania[a/]
CY 2014 to CY 2024

Calendar Year	Verdicts Over $10 Million	Counties with Jury Verdicts Over $10 Million
2014	1	Chester
2015	3	Delaware (2), Philadelphia (1)
2016	1	Philadelphia
2017	0	-
2018	2	Allegheny (1), Delaware (1)
2019	2	Bucks (1), Washington (1)[a/]
2020	1	Blair
2021	0	-
2022	3	Chester (1), Luzerne (1), Philadelphia (1)
2023	6	Beaver (1), Delaware (1), Philadelphia (4)
2024	2	Philadelphia (1), York (1)
Total	**21**	**Allegheny (1), Blair (1), Bucks (1), Beaver (1), Chester (2), Delaware (4), Luzerne (1), Philadelphia (8), Washington (1), York (1)**

Note:
[a/]All verdicts were jury verdicts except the 2019 verdict in Washington County, which was a non-jury verdict.

Source: Developed by LBFC staff from information obtained from the Administrative Office of Pennsylvania Courts.

Philadelphia juries are especially known for nuclear verdicts. As of 2023, there have been two notable birth-related verdicts in Philadelphia. One totaling $207 million ($183 million initially, with an increase to $207 million due to "delayed damages"), and another totaling over $108 million.[87] As of the writing of this report, both cases are on appeal.

[87] Brubaker, Harbold. *Jefferson Health Hit with $108.6 Million Verdict in Einstein Birth Injury Case*. The Philadelphia Inquirer. March 2026.

The Medical Care Availability and Reduction of Error Fund (MCARE)

In response to an apparent medical malpractice crisis in the commonwealth in the 2000s, the General Assembly established the MCARE Fund through Act 13 of 2002, commonly known as the MCARE Act.[88] At the time, three of Pennsylvania's five major private medical liability insurers stopped writing policies, resulting in a sharp increase in insurance premiums for certain specialties. In the 1970s, insurers were either seeking triple-digit rate increases or leaving the medical professional liability insurance market.[89]

The General Assembly's solution to address this issue was to require participating health care providers to purchase $1.2 million in medical malpractice coverage, consisting of private market insurance and excess coverage from the Medical Professional Catastrophic Loss Fund (CAT).[90] CAT was established by § 701(e) of the Health Care Services Malpractice Act and began accepting coverage and accruing unreserved liabilities in 1976. The MCARE Act repealed the CAT Fund in 2002 and transferred all its assets and liabilities to the MCARE Fund.

Established within the Pennsylvania State Treasury, MCARE is a catastrophic injury fund that provides compensation for individuals injured due to all types of medical negligence. MCARE pays claims against participating health care providers and eligible entities for losses or damages awarded in medical professional liability lawsuits that exceed primary insurance coverage provided by primary professional liability insurance companies or self-insurers.

Under MCARE, covered health care providers must maintain required levels of medical professional liability insurance through an insurer licensed or approved by the Pennsylvania Insurance Department or demonstrate approved self-insurance. The Act also requires eligible providers to participate in the MCARE Fund, which provides excess coverage above the mandated primary insurance limits.[91]

[88] Act of March 20, 2002 (P.L.154, No.13), § 712 known as the Medical Care Availability and Reduction of Error (MCARE) Act; 40 P.S. § 1303.712.
[89] Pennsylvania Insurance Department. *Medical Care Availability and Reduction of Error Fund 2024 Annual Report*. February 2025.
[90] Despite efforts to completely phase out CAT and have all mandatory professional liability coverage provided by medical malpractice insurance entities, this transition has not yet been fulfilled. Act of October 15, 1975 (P.L.390, No.111), § 701(e) amended by the act of July 15, 1976 (P.L.1028, No.207) and the act of November 6, 1985 (P.L.311, No.78) and repealed in part by the act of February 23, 1996 (P.L.27, No.10); Commonwealth of Pennsylvania, *The Medical Care Availability and Reduction of Error Fund*, https://www.pa.gov/agencies/insurance/departments-and-offices/mcare. Accessed October 9, 2025.
[91] 40 P.S. §§ 1303.711(a).

Participating health care providers (HCPs) pay an assessment to MCARE, which funds claims against the HCP and MCARE's administrative costs. HCPs include hospitals, nursing homes, birth centers, primary health centers, physicians, podiatrists, and CNMs licensed in Pennsylvania. All HCPs must also conduct more than 50 percent of their health care business in Pennsylvania.[92] If an HCP provides less than 50 but more than zero percent of care to Pennsylvania patients, the HCP is afforded the option to participate in MCARE. If these HCPs elect not to participate, they must still meet the insurance requirements of the MCARE Act.[93]

The MCARE Act exempts the following HCPs from participating in MCARE:

- A forensic pathologist.
- An HCP who is a member of the Pennsylvania military forces while performing assigned duties under orders.
- An HCP providing care outside of Pennsylvania.
- A retired licensed participating HCP providing care only to the provider or the provider's immediate family.[94]

According to the Pennsylvania Insurance Department, professional corporations, associations, and companies and partnerships that are entirely owned by HCPs and elect to purchase basic insurance coverage must also participate in MCARE. Physicians and podiatrists are only required to participate in MCARE when they become eligible for an unrestricted license (meaning they can practice independently without supervision), regardless of whether they apply for one.[95]

MCARE Assessments and Administration. The MCARE assessment is a percentage of the Pennsylvania Professional Liability Joint Underwriting Association (PAJUA) rates as approved by PID. This percentage fluctuates annually and is determined based on a formula that, in the aggregate, generates sufficient revenue to do the following:

- Reimburse the fund for the payment of reported claims that became final during the preceding claims period.
- Pay administrative and operational expenses incurred during the preceding claims period.
- Pay the principal and interest on any money transferred into the fund.

[92] 40 P.S. §§ 1303.711(a)(1)-(2), (e). Note: § 702 was repealed in part insofar as it relates to health care providers that conduct less than 50 percent of their health care business or practice within the commonwealth, pursuant to the act of December 23, 2003 (P.L.237, No.44), § 4(a), effective January 1, 2004.
[93] 40 P.S. §§ 1303.712(c); Pennsylvania Insurance Department, *Medical Care Availability and Reduction of Error Fund 2024 Annual Report*, February 28, 2025, p. 3.
[94] 40 P.S. § 1303.711(j).
[95] Ibid.

- Establish a reserve equal to 10 percent of the sum of the three bullet points above.[96]

MCARE-Participating HCPs must obtain primary coverage in the amount of $500,000 per occurrence and $1,500,000 per annual aggregate. Hospitals are required to obtain primary coverage in the amount of $500,000 per occurrence and $2,500,000 per annual aggregate. MCARE provides participating HCPs coverage of $500,000 per occurrence and $1,500,000 per annual aggregate in excess of the primary coverage.[97]

PID levies the assessments on or after January 1 of each calendar year. The primary insurer invoices, collects, and remits the assessment to the MCARE Fund on behalf of each insured health care provider. The department notifies all basic insurance coverage insurers and self-insured providers of the assessment by November 1. Assessment appeals can be made directly to PID.[98] In CY 2024, the fund collected $272.8 million in assessment revenue, an increase from $194.9 million, driven by a 26 percent increase in rates.[99]

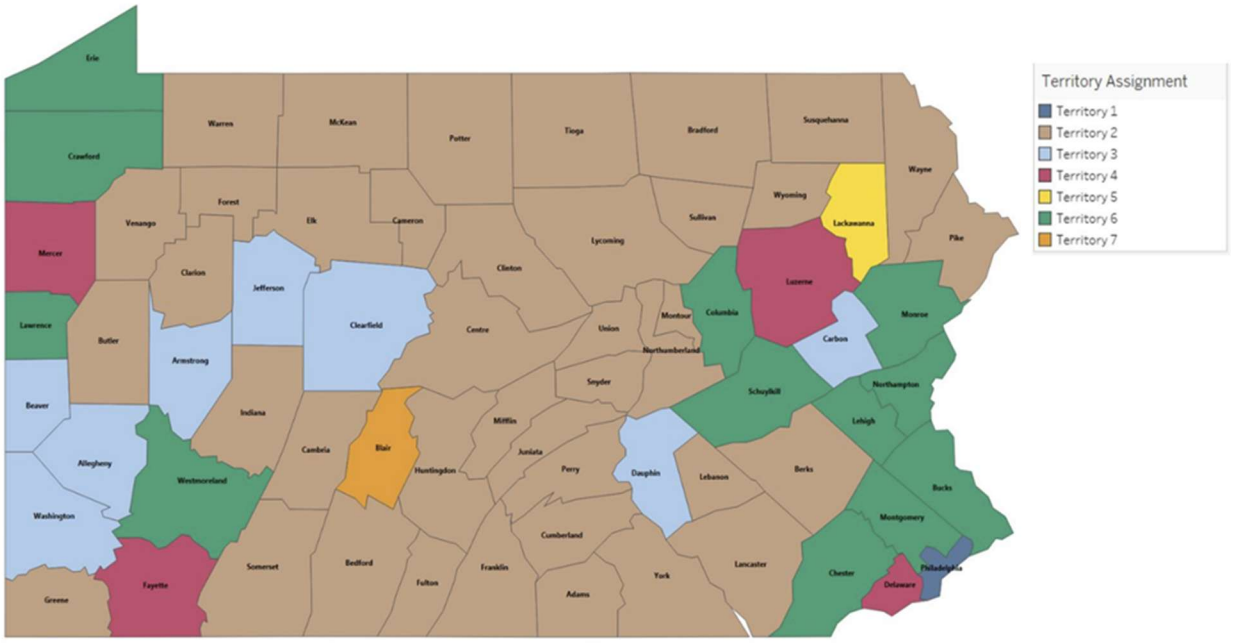
The MCARE program has core responsibilities, including collecting annual assessments from eligible providers, monitoring compliance with statutory insurance requirements, managing and resolving claims that exceed primary malpractice coverage, and serving as a neutral mediator in cases involving multiple defendants.

MCARE is divided into seven administrative territories, shown in Exhibit 20, in which MCARE assesses rate adjustments, analyzes regional claim trends, and facilitates localized claim reviews.

[96] 40 P.S. § 1303.712(d)(1); Pennsylvania Insurance Department. *Medical Care Availability and Reduction of Error Fund 2024 Annual Report*. February 2025.
[97] 40 P.S. § 1303.711(d)(1)-(3). Excess coverage in medical malpractice is the layer of protection that kicks in after the provider's primary insurance limit has been exhausted. In other words, it covers large claims that exceed the liability limits of the provider's base policy.
[98] 40 P.S. § 1303.712(d)(2)-(3).
[99] Pennsylvania Insurance Department. *Medical Care Availability and Reduction of Error Fund 2024 Annual Report*. February 2025, Pg. 8.

Exhibit 20

Seven MCARE Geographical Territories
As of 2025



Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Insurance.

Providers in higher-risk regions may be subject to higher annual assessments than those in lower-risk regions. These territories also help MCARE identify and map any geographic patterns and trends in malpractice claims. Additionally, within the seven territories, MCARE facilitates claim reviews by taking into consideration regional medical practices, standards of care, and jury verdict trends.

The MCARE claims process is triggered when a malpractice claim exceeds the provider's primary malpractice insurance limit. MCARE then acts as a neutral mediator in complex or multiple defendant cases, coordinating with insurers and legal teams to advance a resolution. MCARE also covers payments for any judgments, settlements, or awards that exceed the provider's primary malpractice insurance policy, provided that statutory conditions are met. MCARE does not limit the compensatory damages recoverable in a malpractice claim.

As of December 31, 2023, Pennsylvania's MCARE fund reported an unfunded liability of $1.16 billion.[100] This figure reflects the actuarial

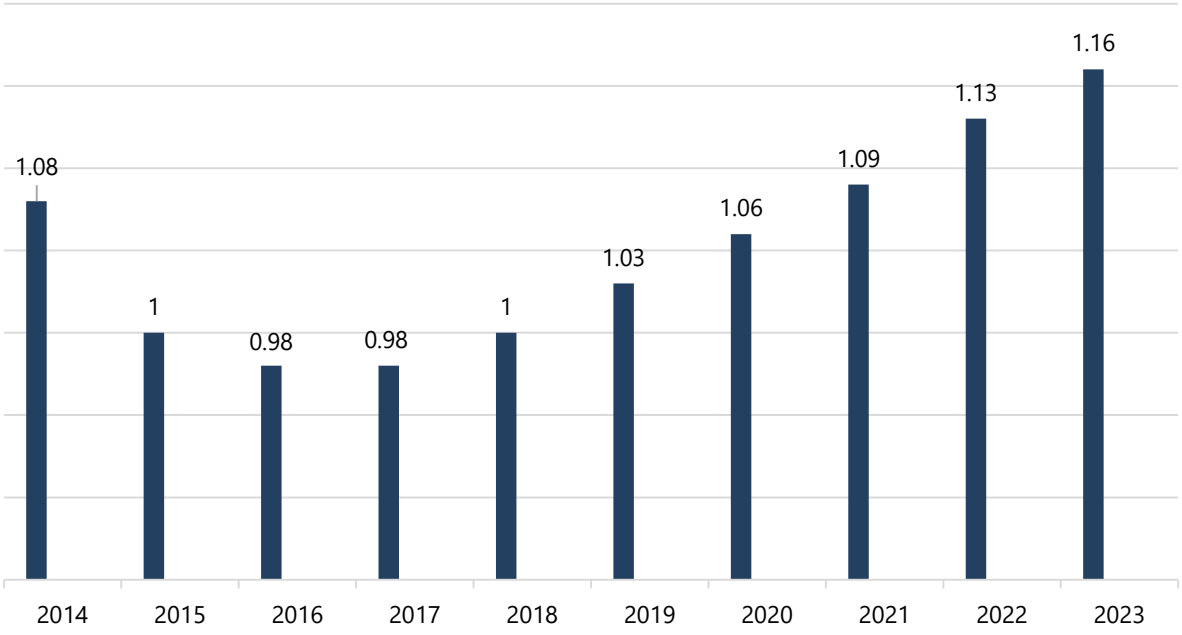
[100] Pennsylvania Insurance Department. M*edical Care Availability and Reduction of Error (MCARE) Fund 2024 Annual Report*. February 2025. p. 11.

estimate of future obligations exceeding available assets and marks a modest increase from the prior year's liability of $1.13 billion.[101,102]

Unfunded liability for 2014 to 2023 is shown in Exhibit 21 below. Figures for 2024 were unavailable for this report.

Exhibit 21

Medical Care Availability and Reduction of Error Fund
Projected Unfunded Liability
(in Billions $)
As of December 31, 2023



Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Insurance.

While the unfunded liability remains substantial, Pennsylvania continues to monitor and adjust its funding mechanisms to ensure the MCARE Fund remains able to fulfill its statutory obligations. Pennsylvania employs several strategies to manage the unfunded liability:

- **Annual Provider Assessments.** These assessments are calculated by PID based on projected claims and fund

[101] Pennsylvania Insurance Department. M*edical Care Availability and Reduction of Error (MCARE) Fund 2023 Annual Report.* p. 11.
[102] The Fund does not have an established provision for case reserves on open claims. According to the 2024 Annual Report, case reserves are an estimate of the case value based on the claim adjuster's assessment of the relevant case-specific facts and circumstances.

obligations and are collected from eligible health care providers and insurers.

- **Investment Income.** Investment income is generated from the investment of the fund's assets through the Pennsylvania Treasury.

- **Legislative Oversight and Capacity Studies**. Studies are conducted periodically to evaluate the fund's solvency and long-term sustainability, and to inform policy decisions regarding assessment rates and fund structure.

- **Claims Management and Litigation Reserves.** The fund maintains these reserves for anticipated claims and adjusts its liability estimates based on litigation outcomes and actuarial projections.

Excess Coverage

According to many of the health systems we spoke with, obtaining excess coverage beyond the MCARE threshold is becoming more difficult for hospitals. For example, according to our review of one Pennsylvania health system's financial statements, the health system had coverage up to $500,000 from a risk retention group, $500,000 and up to $1 million from MCARE, $1 million up to $5 million covered by self-insurance, and then excess coverage of losses between $5 million and $35 million was commercially insured.[103]

An insurance broker from one of Pennsylvania's health systems stated the following commercial insurers exited hospital primary and excess liability recently, with the year of their exit: Beazley (2024), CNA Insurance (2021), Hallmark Insurance Group (2022), QBE Insurance Group (2020), Zurich Insurance Group (2020), and Swiss Re Group (2019). Additionally, the broker stated capacity reductions, or decreased limits, are also a problem as primary and excess liability limits offered by commercial carriers have decreased capacity on hospital risk from $10 to $25 million to $5 to $10 million.

We asked PID if it are involved in the approval of medical malpractice insurance coverage above the minimum requirements set by the MCARE Act to get a sense of whether the information the health system's insurance broker conveyed to us was verifiable in state data. PID stated:

[103] The National Association of Insurance Commissioners (NAIC) define risk retention groups (RRGs) as liability insurance companies owned by its members. RRGs allow businesses with similar insurance needs to pool their risks and form an insurance company that they operate under state regulated guidelines.

> Currently, hospitals are required to insure or self-insure to Medical Professional Liability (MPL) limits of $500,000 per occurrence or claim and $2,500,000 per annual aggregate… MCARE provides an additional $500,000/$2,500,000 of excess coverage for medical malpractice incidents. Anything a hospital insures or self-insurers beyond $1,000,000 per occurrence or claim and $5,000,000 per annual aggregate is done at their option and without a statutory requirement. Most hospitals and health systems are going to be large commercial risks, as defined at 40 P.S. § 710-3. This means that MPL rates and policy forms are not required to be filed with PID for our prior review or approval. Sometimes insurers don't assert this exemption, but for the most part, PID doesn't see their rates and policy forms.
>
> PID does regulate MPL self-insurance for some hospitals, but our authority (and review) is limited and only extends to the primary layer of coverage (i.e., $500,000 per occurrence or claim and $2,500,000 per annual aggregate primary layer). MPL self-insurance for hospitals is regulated in accordance with regulations found at Chapter 243 of Title 31 of the Pennsylvania Code. Self-insured hospitals are required to contract with a trustee, establish a trustee reporting system, fund the basic limits indemnity exposure as set forth in the regulations, and submit annual accounting reports to PID. The trust agreement itself is approved by PID, and changes cannot be made to it without PID's prior approval.

Judgments above a health system's liability coverage are not always required to be paid as an entire lump sum. For example, there may be parts of the award payable for health care costs over the plaintiff's life. This may be paid through a structured financial product such as an annuity.

OB-GYN Malpractice

According to the American Medical Association (AMA), OB-GYNs and general surgeons are the medical specialists most likely to be sued. "Controlling for other factors, OB-GYNs and general surgeons are 33.6 and 28.6 percentage points more likely than general internists to have

ever been sued."[104] Exhibit 22 shows the claim frequency of all physicians compared to OB-GYNs and general surgeons from 2020 to 2022.

Exhibit 22

Medical Liability Claim Frequency
All Physicians vs. OB-GYNs and General Surgeons
CY 2020 to CY 2022[a/]

Physician Type	Frequency of Claims	2020	2022
All Physicians	Sued in Previous Year	2.1%	1.8%
	Sued in Career to Date	33.1	31.2
OB-GYNs	Sued in Previous Year		3.2
	Sued in Career to Date		62.4
General Surgeons	Sued in Previous Year		7.9
	Sued in Career to Date		59.3

Note:
[a/]The American Medical Association presented data on all physicians in two-year increments, but presented the specialist data for the entire period 2020 to 2022.

Source: Developed by LBFC staff from information obtained from the American Medical Association.

OB-GYNs face risk in bringing life into the world.

> In obstetrics, the objective of a perfect outcome, characterized by the birth of a healthy baby, stands as the paramount aspiration… malpractice is often associated with complications arising during L&D, while in gynecology, it frequently involves surgical errors and failures in patient communication regarding treatment options and risks.[105]

Additionally, from an actuarial standpoint, OB-GYNs face higher-dollar claims because, when a newborn is injured or dies, there is an entire lifetime of losses, including lost earning capacity. OB-GYNs also care for two or more patients at once, the birthing female and the newborn (or newborns in the case of a multiple pregnancy).

[104] Guardo, Jose. *Policy Research Perspectives: Medical Liability Claim Frequency Among U.S. Physicians*. American Medical Association. April 2023.
[105] Toma-Tumbar, L., et al. *Navigating the Complex Terrain of Obstetrics and Gynecology Malpractice: Stakeholders, Expectations, and Legal Implications.* Journal of Clinical Medicine. March 2025.

Medical Malpractice Markets

Medical Professional Liability (MPL) insurance covers physicians and other health care professionals in cases of malpractice resulting in a patient's bodily injury, medical expenses, and/or property damage. Physicians and hospitals purchase MPL insurance to mitigate the financial risks associated with medical negligence claims.

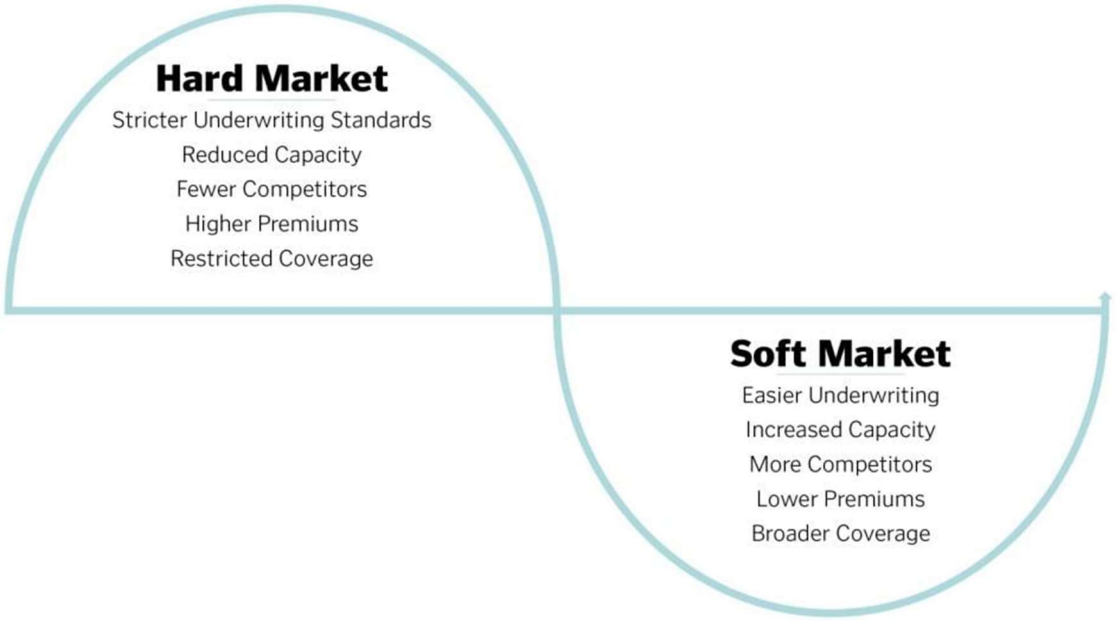
MPL Market. The commercial insurance market, MPL or otherwise, is cyclical, fluctuating between hard and soft markets. These cycles affect coverage availability, terms, and pricing for individuals and businesses.

A soft market is characterized by stable or even declining premiums and by broader terms of coverage, increased capacity, higher available limits of liability, and greater competition among insurance carriers due to new insurers entering the market.

A hard market is characterized by higher premium expenses for policyholders, stricter underwriting criteria, reduced capacity, restricted coverage terms, and less competition among insurance carriers for new business. During a hard market, insurance carriers may end some policies depending on their associated risk compared to market conditions. Hard market cycles may prompt carriers to stop writing policies in high-risk locations or even exit certain unprofitable lines of insurance altogether. Exhibit 23 below shows characteristics of a hard and soft market.

Exhibit 23

Hard Market Versus Soft Market Characteristics



Source: Bitner Henry Insurance Group.

While the data do not show that the MPL industry is currently in a hard market, there are signs that such conditions may become a reality soon. AMA reported an upward trend in the prevalence of medical liability premium increases from 2019 to 2024, with 46 states reporting at least one premium increase in 2024 and 22 states reporting a premium increase of 50 percent or more. For context, the most recent hard market for MPL insurance was in the early 2000s. Specifically, in 2003 and 2004, when 77.4 percent and 82.1 percent of MPL premiums nationwide increased from the previous year, respectively.

Although a nationwide hard market has not yet emerged, certain states are already experiencing hard market conditions. For example, in Illinois, 90.7 percent, 81.5 percent, and 88.2 percent of reported premiums, respectively, increased in the last three years.

Claims Made Versus Occurrence. MPL insurance policies are offered in two types: claims-based and occurrence-based. Claims-made policies cover incidents that occur and are reported while the policy is active. Occurrence-based policies cover claims arising from incidents that occurred during the policy period, regardless of when the claim is made.

Most MPL insurance policies are claims-based. Most policies contain limits of coverage ranging from $100,000 to $300,000 and $1 million to $3 million.[106]

Contributing Factors. A wide range of factors can affect insurance pricing, but the following are the most impactful on medical malpractice premiums:

- **Specialty.** High-risk specialties, such as obstetrics and gynecology, neurosurgery, and anesthesiology, have higher premiums due to the greater likelihood of complications.[107] These specialties are more prone to malpractice lawsuits, making them more expensive to insure. In contrast, medical professionals in specialties like dermatology or psychiatry tend to have lower premium rates, as they are less likely to face high-risk litigation.[108]

- **Geographic Location and Legal Environment.** Malpractice insurance rates vary by location. Some states or counties have higher litigation rates and larger settlement amounts for malpractice claims, which can lead to higher insurance premiums.

  Legal environments in certain states or counties may be more favorable to plaintiffs, increasing the frequency of lawsuits. States with tort reform laws, such as damage caps, typically have lower malpractice rates because the potential financial impact of claims is limited, making these states more viable for insurers. [109]

- **Experience and Claims History.** Physicians early in their careers may pay higher premiums due to a perceived lack of experience, which is often associated with a higher risk of errors.[110] Additionally, a physician's history of malpractice claims can affect insurance premiums. Physicians with a record of past claims or lawsuits are considered higher risk and may face higher premiums.[111]

[106] The first number is the maximum amount the insurance company will pay for a single claim during the policy period, which is usually one calendar year. The second amount is the maximum the company will pay for all claims during the same policy period.
[107] Jena, A., et al. *Malpractice Risk According to Physician Specialty*. The New England Journal of Medicine. August 2011.
[108] Ibid.
[109] United States General Accountability Office. *Medical Malpractice: Effects of Varying Laws in the District of Columbia, Maryland, and Virginia*. October 1999.
[110] Mehrotra, A, et al. *Physicians with the least experience have higher cost profiles than do physicians with the most experience*. Health Affairs. November 2012.
[111] Hyman, D.A, et al. *Association of Past and Future Paid Medical Malpractice Claims.* JAMA Health Forum. February 2023.

- **Practice Type.** The type and size of the medical practice employing physicians can impact rates. Individual practitioners may pay more for malpractice insurance compared to those in larger group practices or hospital-employed settings, where the institution may share some of the liability.

- **Coverage Type.** The type of insurance policy chosen also affects premium rates. Occurrence policies are typically more expensive than claims-made policies.

Medical Professional Liability Insurance Premiums: Data and Trends Analysis

To analyze trends in insurance premiums, we used data extracted from the Annual Rate Survey Issues of Medical Liability Monitor (MLM). Each year, the MLM surveys medical liability insurers and collects detailed state-level data on liability premiums.[112]

MLM only reports premiums for three specialties: general surgery, OB-GYN, and internal medicine. Additionally, the list of insurers in each state can change over time due to factors such as market exits, insurers no longer accepting new business, or mergers between insurance companies. As a result, the data may not provide a complete representation of MPL insurers in a given market.

Pennsylvania Analysis. To analyze trends in MPL insurance premiums, we averaged the premiums reported by insurers in the MLM Rate Survey from 2015 to 2025. These figures represent the base rate charged by insurers and do not include additional surcharges collected for the MCARE Fund.

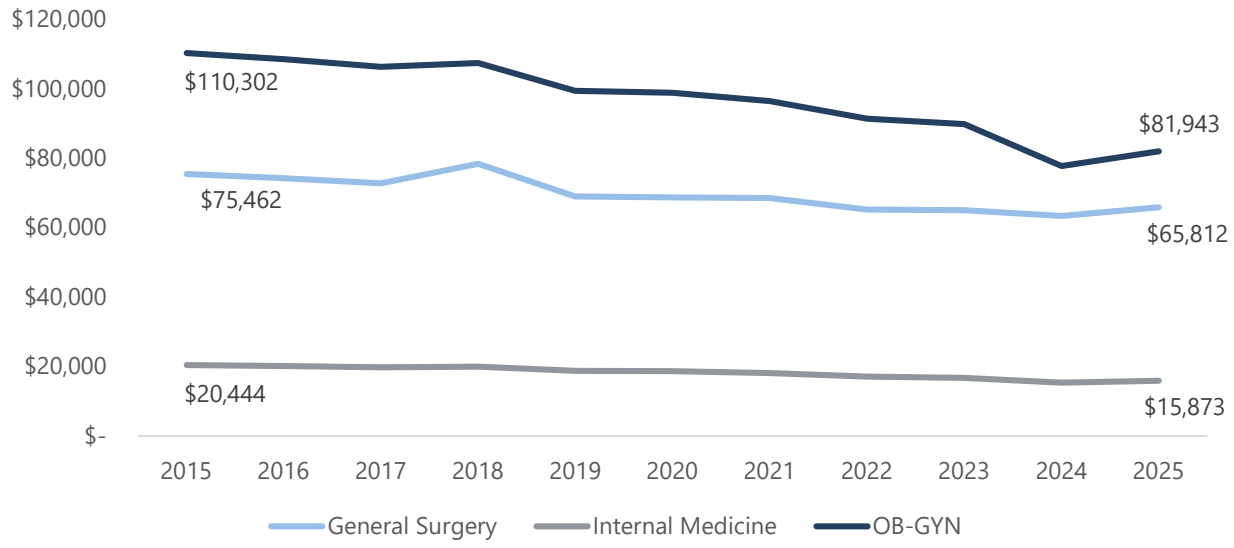
Exhibit 24 shows the inflation-adjusted MPL insurance premiums from the General Surgery, Internal Medicine, and OB-GYN specialties.

[112] All insurance premium data in this section were adjusted for inflation using the November 2025 CPI.

Exhibit 24

Inflation-Adjusted Medical Malpractice Average Premiums For Selected Medical Specialties
CY 2015 to CY 2025

Year	General Surgery	Internal Medicine	OB-GYN
2015	$75,462	$20,444	$110,302
2016	74,247	20,115	108,526
2017	72,762	19,712	106,356
2018	78,475	19,977	107,405
2019	68,995	18,737	99,367
2020	68,666	18,619	98,844
2021	68,531	18,057	96,411
2022	65,245	17,053	91,353
2023	64,989	16,752	89,773
2024	63,359	15,371	77,780
2025	65,812	15,873	81,943
Average	$69,686	$18,246	$97,096
10 Year % Change	**-13%**	**-22%**	**-26%**



Source: Developed by LBFC staff from information obtained from the Medical Liability Monitor.

Physicians in the OB-GYN specialty had the highest premiums each year. In 2025, the average OB-GYN premium was $81,943, more than the average premiums for General Surgery and Internal Medicine combined. Since the OB-GYN specialty has higher potential for complications,

insurers view policies for OB-GYN physicians as high-risk, leading to increased premiums.

Inflation-adjusted MPL insurance premiums decreased overall from 2015 to 2025. The OB-GYN specialty realized the largest decline, 29 percent, with general surgery and internal medicine specialties having 16 and 25 percent decreases, respectively.

The premiums charged by medical malpractice insurers also vary by county, as insurers often charge a single premium to groups of counties based on their assessed risk. Philadelphia and Delaware counties had the highest average OB-GYN premiums of $104,833, and 40 counties saw the lowest premiums of $58,633 in 2025. OB-GYN insurance premiums at the county level are available in Appendix C.

OB-GYN Premiums: State Comparative Analysis

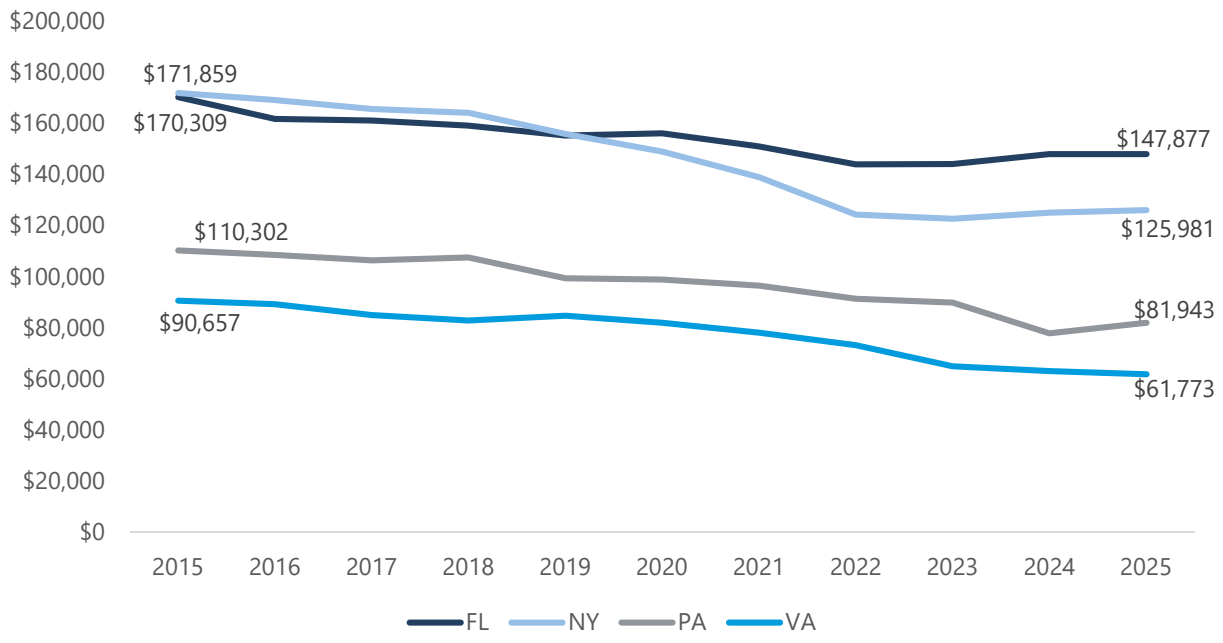
To analyze trends in MPL insurance premiums in the OB-GYN specialty in states with BRNIFs, we averaged insurer-reported premiums from the MLM Rate Survey for each state from 2015 to 2025.

Exhibit 25 shows the average inflation-adjusted MPL insurance premiums for the OB-GYN specialty in Florida, New York, Pennsylvania, and Virginia.

Exhibit 25

Average Inflation-Adjusted OB-GYN Medical Malpractice Premiums
CY 2015 to CY 2025

Year	Florida	New York	Pennsylvania	Virginia	Selected States-Average
2015	$170,309	$171,859	$110,302	$90,657	$135,782
2016	161,697	169,093	108,526	89,197	132,128
2017	161,083	165,616	106,356	84,915	129,493
2018	159,109	164,065	107,405	82,826	128,351
2019	155,239	155,841	99,367	84,670	123,779
2020	156,053	148,910	98,844	81,920	121,432
2021	150,954	138,874	96,411	77,998	116,059
2022	144,013	124,247	91,353	73,183	108,199
2023	144,061	122,702	89,773	64,891	105,357
2024	147,965	125,031	77,780	63,003	103,445
2025	147,877	125,981	81,943	61,773	104,394
Average	$154,396	$146,565	$97,096	$77,730	$118,947
10 Year % Change	**-13%**	**-27%**	**-26%**	**-32%**	**-23%**



Source: Developed by LBFC staff from information obtained from the Medical Liability Monitor.

Florida had the highest OB-GYN insurance premiums, with an average premium of $154,396 from 2015 to 2025, which was 5.3 percent higher than New York's next-highest average of $146,565, and 59.0 percent higher than Pennsylvania's average of $97,096.

Average inflation-adjusted MPL insurance premiums decreased overall in each state from 2015 to 2025. OB-GYN physicians in Florida had the largest decline of 32 percent, followed by New York, Pennsylvania, and Florida with 27 percent, 26 percent, and 16 percent decreases, respectively.

While comparable data were not available prior to the implementation of Florida's and Virginia's BRNIF (1980s) to measure pre- and post-implementation, of the years we reviewed, Florida and Virginia followed a similar trend to Pennsylvania. As discussed in Section III, studies on the impact of BRNIFs were limited. Therefore, based on the data we reviewed, we found that BRNIFs likely had a negligible impact on OB-GYN malpractice rates.

Decreases in average inflation-adjusted premiums across all measured states and years could possibly be explained by gains from investment. It is common for insurers to invest, particularly in the US bond market, in addition to generating revenue from premium payments. The National Association of Insurance Commissioners reported that net investment income in the property and casualty insurance industry, which includes MPL insurance, was $43.8 billion in 2024, a 26.2 increase from the previous year. Insurers that experience increased investment income are less reliant on premium revenue.

The US Bureau of Labor Statistics (BLS), Occupational Employment and Wage Statistics (OEWS), provides national and state-level data, including occupational profiles, for full-time and part-time wage and salary employees from 2013 to 2024.[113] We reviewed data for Pennsylvania, Florida, Virginia, and New York, where available.[114]

Exhibit 26 shows the total number of OB-GYNs and NM by state, wage and salaried employees, from 2013 to 2024.

[113] The OEWS survey does not cover self-employed workers, owners and partners in unincorporated firms, employees of private households, and unpaid family workers.

[114] Using BLS Standard Occupational Classification (SOC) system, SOC 29-0000 Healthcare Practitioners and Technical Occupations, within this profile: (1) 29-1160 Nurse Midwives: SOC 29-1161 Nurse Midwives: Diagnose and coordinate all aspects of the birthing process, either independently or as part of a health care team. May provide well-woman gynecological care. Must have specialized, graduate nursing education; and (2) 29-1210 Physicians: SOC 29-1218 Obstetricians and Gynecologists: Provide medical care related to pregnancy or childbirth. Diagnose, treat, and help prevent diseases of women, particularly those affecting the reproductive system. They may also provide general care for women and perform medical and gynecological surgeries.

Exhibit 26

Obstetrics and Gynecology Physicians and Nurse Midwives Full-Time and Part-Time, Wage and Salary Employees[a/]

CY 2013 to CY 2024

Calendar Year	Florida		New York		Pennsylvania		Virginia	
	OB-GYN	NM	OB-GYN	NM	OB-GYN	NM	OB-GYN	NM
2013	930	270	2,320	490	290	130	960	160
2014	1,360	300	2,400	450	340	150	1,040	120
2015	1,340	330	1,330	420	360	180	990	-[b/]
2016	1,670	260	1,270	480	390	230	930	-[b/]
2017	1,170	330	1,200	510	530	300	730	-[b/]
2018	1,000	330	1,200	450	500	320	730	170
2019	1,090	330	1,580	480	430	430	570	570
2020	1,170	340	1,830	460	380	340	750	750
2021	-[b/]	250	2,240	490	640	340	500	-[b/]
2022	-[b/]	500	2,480	790	400	260	-[b/]	-[b/]
2023	1,470	270	2,350	740	460	290	390	-[b/]
2024	-[b/]	860	2,990	490	310	530	-[b/]	-[b/]

Notes:
[a/]Data does not include self-employed or cross-specialty providers.
[b/]Data not available.

Source: Developed by LBFC staff from information obtained from the United States Bureau of Labor Statistics.

Each state, except Virginia, saw increases in OB-GYNs from 2013 to 2023. Pennsylvania and New York saw increases in NMs from 2013 to 2023; however, there was no change in Florida, and NM data for Virginia were unavailable.

Based on the female population of childbearing age, the number of OB-GYNs and NMs per capita was calculated for each state from 2013 to 2024. Exhibit 27 below displays the per capita rates for each state concerning OB-GYNs and NMs, including both wage and salaried personnel.

Exhibit 27

Obstetrics and Gynecology Physicians and Nurse Midwives Full-Time and Part-Time, Wage and Salary Employees per 100,000 Females Aged 15 to 44[a/]

CY 2013 through CY 2024

State	Florida		New York		Pennsylvania		Virginia	
CY	OB-GYN	NM	OB-GYN	NM	OB-GYN	NM	OB-GYN	NM
2013	25.5	7.4	57.6	12.2	12.0	5.4	57.3	9.6
2014	36.9	8.1	59.9	11.2	14.1	6.2	62.0	7.2
2015	35.9	8.8	33.4	10.6	15.0	7.5	59.1	-[b/]
2016	44.1	6.9	32.2	12.2	16.4	9.7	55.5	-[b/]
2017	30.5	8.6	30.6	13.0	22.3	12.6	43.5	-[b/]
2018	25.9	8.5	30.8	11.5	21.0	13.4	43.4	10.1
2019	28.0	8.5	40.8	12.4	18.0	18.0	33.8	33.8
2020	29.9	8.7	45.8	11.5	15.7	14.0	43.9	43.9
2021	-[b/]	6.3	57.1	12.5	26.1	13.9	29.2	-[b/]
2022	-[b/]	12.3	63.7	20.3	16.3	10.6	-[b/]	-[b/]
2023	35.1	6.4	60.1	18.9	18.6	11.8	22.5	-[b/]
2024	-[b/]	20.0	75.7	12.4	12.5	21.3	-[b/]	-[b/]

Notes:
[a/]Data does not include self-employed or cross-specialty providers.
[b/]Data not available.

Source: Developed by LBFC staff from information obtained from the United States Bureau of Labor Statistics and the United States Census Bureau.

Compared to other states, Pennsylvania exhibited the lowest number of obstetricians-gynecologists per capita. However, the distribution of nurse midwives varied among states. During the review period, Florida and New York had the largest populations of females aged 15 to 44, whereas Virginia had the smallest. Due to demographic differences and variations in provider distribution across states, direct comparisons are limited and may not accurately reflect equivalency.

To understand how liability premiums for OB-GYNs changed relative to the number of waged and salaried OB-GYNs in Florida, New York, Pennsylvania, and Virginia from 2015 to 2024, we calculated the changes in premiums and the number of OB-GYNs. Exhibit 28 below shows the percentage of change in premiums and OB-GYNs for each state.[115]

[115] The percentage change is calculated from actual premiums and is not inflation-adjusted.

Exhibit 28

States' Percentage Change in Premiums and OB-GYN Physicians[a/]
CY 2015 to CY 2024

Year	Florida		New York		Pennsylvania		Virginia	
	Change in Premiums	Change in OB-GYNs	Change in Premiums	Change in OB-GYNs	Change in Premiums	Change in OB-GYNs	Change in Premiums	Change in OB-GYNs
2015	-	-	-	-	-	-	-	-
2016	**-3.5%**	**24.6%**	0.0%	-4.5%	0.0%	8.3%	**0.0%**	**-6.1%**
2017	**1.7**	**-29.9**	-0.1	-5.5	0.0	35.9	-2.9	-21.5
2018	**1.3**	**-14.5**	1.6	0.0	**3.5**	**-5.7**	0.0	0.0
2019	**-0.7**	**9.0**	**-3.3**	**31.7**	-5.9	-14.0	**4.0**	**-21.9**
2020	1.7	7.3	**-3.3**	**15.8**	**0.6**	**-11.6**	**-2.1**	**31.6**
2021	2.8	-	**-0.9**	**22.4**	3.6	68.4	**1.1**	**-33.3**
2022	2.8	-	**-3.6**	**10.7**	**2.1**	**-37.5**	1.1	-
2023	3.3	-	**2.0**	**-5.2**	1.5	15.0	-8.5	-
2024	5.4	-	4.5	27.2	-11.1	-32.6	-0.4	-

Note:
[a/]Percentages in bold show inverse changes. Unlike the rates presented on other pages, this calculation did not account for inflation because we compared with actual number of OB-GYNs in the same year.

Source: Developed by LBFC staff from information obtained from the United States Bureau of Labor Statistics and Medical Liability Monitor.

In Florida, increases in premium rates generally coincided with decreases in the number of OB-GYNs, and vice versa. However, from 2019 to 2020, premium rates increased, while the number of OB-GYNs increased.[116]

Between 2015 and 2016, OB-GYN premium rates remained stable in New York. The number of employed OB-GYNs declined. While data show that increases in rates generally coincided with reductions in OB-GYNs, an inverse pattern emerged between 2016 and 2017 and again from 2019 to 2022.

In Pennsylvania, OB-GYN premium rates remained consistent from 2015 to 2017, while the number of OB-GYNs employed increased. Subsequent increases in premium rates occurred in 2018 and between 2020 and 2023. During this period, the number of employed OB-GYNs declined annually, except in 2021 and 2023.

[116] Data unavailable for calendar years 2021, 2022, and 2024.

In Virginia, OB-GYN premium rates were stable from 2015 to 2016 and from 2017 to 2018. During these periods, the number of employed OB-GYNs declined. In 2018, both premium rates and the number of OB-GYNs stayed constant. Premium rates for OB-GYNs fluctuated between 2019 and 2020. The data suggest that increases in premium rates generally coincided with decreases in the number of employed OB-GYNs, and vice versa.[117]

Another variable that may counter the correlation between rates and the number of employed OB-GYNs is the trend toward more physicians being employed by hospitals instead of being independent or self-employed. MPL is often part of a compensation and benefits package rather than procured by physicians themselves. Health systems employ an estimated 70 to 80 percent of all physicians.[118] As fewer physicians are independently employed, there is a shift toward health systems in financial decision-making regarding liability coverage. The cost of medical malpractice premiums may impact health systems' decisions on which services to offer, with higher-risk areas most likely to be eliminated first, which in turn may impact access to care.

[117] Data unavailable for calendar years 2022 and 2024.
[118] Bailey, Patrick. *Is There a Correlation Between Physician Employment and Liability Premiums?* American College of Surgeons. February 2022.

SECTION III
THE FEASIBILITY OF ESTABLISHING A BIRTH-RELATED NEUROLOGICAL INJURY FUND

Fast Facts…

- *Only three states have enacted special state-level funds to address compensation and care for birth-related neurological injuries: Florida and Virginia have a no-fault compensation system, and New York has a post-settlement or post-judgment indemnity mechanism.*
- *Definitions of "birth-related neurological injury" differ by state.*
- *Florida, Virginia, and New York's birth-related neurological injury funds are underfunded, particularly long-term.*

Overview

Medical malpractice lawsuits increased in the 1970s and 1980s, while medical malpractice insurance premiums for physicians surged nationwide. Liability insurance costs were partially passed to patients and their health insurance companies and became so costly to practitioners that coverage was functionally unavailable. Many physicians refused to treat high-risk patients or practice in high-risk jurisdictions, resulting in the near disenfranchisement of sick patients.[119]

States sought to address medical malpractice insurance costs in various ways. Some states implemented catastrophic-loss funds as an alternative to medical malpractice litigation, particularly in high-risk specialties. For example, Virginia and Florida enacted catastrophic loss statutes aimed at birth-related neurological injuries with narrowly defined no-fault compensation programs. Unlike traditional tort liability, no-fault systems define adverse medical outcomes in advance, for which compensation is awarded, and process claims outside of the court system.

This section discusses the history, funding, outcomes, and oversight of Virginia's and Florida's no-fault birth-related neurological injury funds and New York's post-settlement or post-judgment medical indemnity fund. Note that in this report, when we refer to birth-related neurological injury funds (BRNIF), we are speaking more generally about the concept. In instances where we discuss specific funds, we identified them by state.

We conclude this section with the feasibility of such a fund in Pennsylvania. Should the General Assembly determine that a birth-related neurological fund is the best way to protect birthing hospitals and obstetrics and gynecology (OB-GYN) physicians from "nuclear verdicts" and ensure adequate and expedited financial compensation for injured infants, we provide legislative considerations for the General Assembly to contemplate.[120] The legislative considerations we discuss are based on Pennsylvania's existing laws and administrative frameworks, as well as lessons learned in Virginia, Florida, and New York.

[119] Martin, Sandy. *NICA – Florida Birth-Related Neurological Injury Compensation Act: Four Reasons Why this Malpractice Reform Must be Eliminated.* 26 Nova L. Rev. 609. 2002.
[120] Nuclear verdicts are generally defined as those of $10 million or more.

Key Findings

1. 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.

2. There is no statewide tracking of birth-related injuries in Pennsylvania.

Recommendations

1. 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.

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

Issue Areas

A. Virginia Birth-Related Neurological Injury Compensation Program

The Virginia Birth-Related Neurological Injury Compensation Act was enacted by the Virginia General Assembly in 1987.[121] The Virginia Birth-Related Neurological Injury Compensation Program, often referred to as the "Virginia Birth Injury Fund" (VBIF), protects participating physicians

[121] VA Code Ann. § 38.2-5000.

and hospitals from lawsuits arising from children's eligible birth-related neurological injuries. Participation in VBIF is voluntary for OB-GYNs; however, if a family elects to receive care from a participating provider (after receiving notice of the provider's participation), and its newborn child suffers a birth-related neurological injury that falls squarely within the statute's eligibility criteria, the family's participation is mandatory. Accepting care from a participating provider waives the right to pursue traditional legal remedies through the court system. In other words, the injured child's exclusive remedy for compensation will be through the program, absent evidence of malice or intent by the provider or hospital. A claimant files an initial eligibility claim and then seeks compensation from the program for all related, eligible expenses.

Virginia developed its fund in response to rising medical malpractice lawsuits, malpractice insurance premiums, and the inaccessibility of liability insurance. The goal was to "alleviate the medical malpractice insurance availability crisis for obstetricians."[122] During the crisis, obstetricians were most significantly impacted, many of whom "were reportedly eliminating obstetrical care from their practices."[123] Rural Virginia health systems struggled, with some counties lacking a single obstetrician. Infants severely injured at birth were singled out because lawsuits associated with these cases had a relatively high rate of success, and the successful cases tend to result in significant monetary awards.[124]

Virginia Definition of "Birth-Related Neurological Injury"

To be eligible for the program, a child must suffer a birth-related neurological injury. Virginia defines "birth-related neurological injury" as follows:

> Injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation necessitated by a deprivation of oxygen or mechanical injury that occurred in the course of labor or delivery, in a hospital which renders the infant permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled.[125]

[122] Joint Legislative Audit and Review Commission of the Virginia General Assembly. *Review of the Virginia Birth-Related Neurological Injury Compensation Program*. 2003. Pg. ii.
[123] Ibid.
[124] Ibid.
[125] VA Code Ann. § 38.2-5001.

The resulting disability must cause the infant to require permanent assistance in all activities of daily living. Virginia's definition only applies to live births and does not include disability or death caused by genetic or congenital abnormality, degenerative neurological disease, or maternal substance abuse.

VBIF Funding

A state appropriation does not fund the VBIF program. Instead, VBIF's funding is generated through the following sources:

- **$6,200 annually per participating physician assessment.** Physicians participating in the program (including nurse midwives) pay assessments to fund it.[126]

- **$300 annually per non-participating physician assessments.** With certain exceptions, physicians practicing in Virginia who are not participating in the program must also pay assessments (at a lower amount than participating physicians).[127]

- **$55 per live birth, hospital assessments.** Hospitals in Virginia pay assessments for each live birth.[128]

- **Liability insurance assessments.** Liability insurance carriers licensed and operating in Virginia also pay assessments, if required, to maintain the VBIF on an actuarially sound basis, after considering payments from providers and hospitals for all other

[126] VA Code Ann. § 38.2-5020A. Although not expressly mentioned in this section, certified nurse midwives are included in the definition of "participating physician" in VA Code Ann. § 38.2-5001. A participating physician covered under the provisions of this section who has paid an annual assessment to the program for a particular calendar year and who retires from the practice of medicine during that particular calendar year shall be entitled to a refund of a prorated share of their annual assessment for the calendar year that corresponds to the portion of the calendar year remaining following their retirement.

[127] VA Code Ann. § 38.2-5020D. If the State Corporation Commission determines the Fund is actuarially sound, it will enter an order suspending this assessment. The annual assessment is reinstated whenever the State Corporation Commission determines that such assessment is required to maintain the Fund's actuarial soundness. VA Code Ann. § 38.2-5020G.

[128] VA Code Ann. § 38.2-5020C. VA Code Ann. § 38.2-5020D. ''Participating hospitals'' are defined as "general hospital licensed in Virginia which at the time of the injury (i) had in force an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the hospital agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the State Department of Health whereby the hospital agreed to submit to review of its obstetrical service, as required by subsection C of § 38.2-5004, and (iii) had paid the participating hospital assessment pursuant to § 38.2-5020 for the period of time in which the birth-related neurological injury occurred. The term also includes employees of such hospitals, excluding physicians or nurse midwives who are eligible to qualify as participating physicians, acting in the course of and in the scope of their employment." VA Code Ann. § 38.2-5001.

assessments. The Virginia State Corporation Commission (VSCC) determines the amount paid by carriers.[129]

Participating physicians and hospitals have limited immunity from malpractice lawsuits that fall within the program's scope of coverage. The last time the Virginia General Assembly adjusted fees was January 1, 2009, for physicians and January 1, 2010, for hospitals.

VBIF requires each physician, hospital, and nurse-midwife to disclose in writing to their obstetrical patients whether they are participating providers under the program. In addition to any other postpartum materials provided to the birthing mother or other appropriate person, every hospital must provide a brochure prepared or approved by the VBIF board of directors for each infant hospitalized in a neonatal intensive care unit. The brochure must describe the rights and limitations under the program, including the program's exclusive remedy provision.[130]

Some physicians in Virginia are exempt from the annual fee assessment. Exempt physicians include the following:

- A physician employed by the Commonwealth of Virginia or federal government and whose income from professional fees is less than an amount equal to 10 percent of the physician's annual salary.
- A physician enrolled in a full-time graduate medical education program accredited by the American Council for Graduate Medical Education.
- A physician who has retired from active clinical practice.
- A physician whose active clinical practice is limited to the provision of services, voluntarily and without compensation, to any patient of any clinic organized in whole or in part for the delivery of health care services without charge.[131]

Liability insurance carriers are not individually liable for an annual assessment greater than one quarter of one percent of that entity's net direct premiums written.[132] Further, carriers are permitted to recover

[129] VA Code Ann. § 38.2-5020E.
[130] VA Code Ann. § 38.2-5004.1A.-B.
[131] VA Code Ann. § 38.2-5020D.1.-4.
[132] VA Code Ann. § 38.2-5020E.1.-3. All annual assessments against liability insurance carriers must 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 Virginia during the prior year ending December 31, as reported to the State

their initial and annual assessments through a surcharge on future policies, a prospective rate increase, or a combination of the two, at the discretion of VSCC.

VBIF Program Governance and Administration

Professional staff, including an executive director, claims and case management staff, and financial and investment personnel, handle VBIF's day-to-day operations. VBIF is governed by a board of nine gubernatorially appointed directors, selected based on the following:

- One representative for casualty insurers.
- One representative for the participating hospitals.
- One representative for participating physicians.
- One individual with at least five years of professional investment experience.
- One individual with at least five years of professional experience in finance and is a Certified Public Accountant or has a similar professional designation.
- One individual with professional experience working with a disability community.
- One representative of a child with a disability who is experienced in the care of the child.
- One attorney with a minimum of three years of experience in personal injury.
- One at-large representative, consisting of a person deemed qualified to serve by knowledge, education, training, interest, or experience.

The board has the statutory authority to do the following:

- Administer the program.
- Administer the VBIF, which includes 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.
- Appoint a service company or companies to administer the payment of claims on behalf of the program.

Corporation Commission, and must 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 Virginia 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.

- Direct the investment and reinvestment of any surplus in the fund over losses and expenses, provided any investment income generated remains in the Fund.
- Reinsure the risks of the fund in whole or in part.
- Obtain and maintain directors' and officers' liability insurance.[133]

The VBIF staff and board are not involved in claims adjudication (determining whether a claimant is eligible); instead, that process is handled by Virginia's Workers' Compensation Commission (VWCC).

VBIF Claims Process

To receive compensation under the program, the parents or legal guardians of a child (claimant) must file a petition with VWCC by the affected child's tenth birthday, and must include the following information:

- Name and address of the attorney and basis for representation of the injured infant.
- Name and address of the injured infant.
- 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.
- Description of the disability for which the claim is made.
- Time and place where the birth-related neurological injury occurred.
- Brief statement of the facts and circumstances surrounding the injury and giving rise to the claim.
- Documentation regarding medical records, assessments, evaluations, prognoses, and other records and documents as reasonably necessary. The claimant must also provide documentation of expenses and services incurred to date, indicating whether such costs and services have been paid for, and if so, by whom, and all applicable private or governmental sources of services or reimbursement relative to the alleged impairments.[134]

The claimant must provide VWCC with copies of the petition as required for service upon the program, any physician and hospital named in the petition, the Virginia Board of Medicine (VBOM), and the Virginia Department of Health (VDOH), along with a $15 filing fee. Upon receipt, the VWCC immediately serves the program by having the VBIF-designated agent serve by registered or certified mail, and mails copies

[133] VA Code Ann. § 38.2-5016F.
[134] VA Code Ann. § 38.2-5004A.1.-2 ; VA Code Ann. § 38.2-5013.

of the petition to any physician and hospital named in the petition, VBOM, and VDOH.[135]

Upon receipt of a petition relating to the conduct of a participating physician, VDOH professionals must investigate. If VBOM issues a notice or order for disciplinary action for a physician's conduct, a copy is mailed to the claimant.[136]

If VDOH determines that there is reason to believe the alleged injury resulted from, or was aggravated by, substandard care by the hospital where the birth occurred, it takes disciplinary action.[137]

VBIF must file a response to the petition within 10 days of the date the medical school panel report is filed with the VWCC, and submit written information relating to whether a birth-related neurological injury exists.[138] Upon receipt of written notice from the legal representative of an injured infant, any hospital where the birth occurred must provide all available medical records relating to the infant.[139]

Immediately after VBIF's response is filed, VWCC sets a date for a hearing, which is held no sooner than 15 days and no later than 90 days after filing VBIF's response. VBIF must notify the parties of the time and place of such hearing. The hearing is held in the city or county where the injury occurred, or in a contiguous city or county, unless otherwise agreed to by the parties and authorized by VWCC.[140]

The medical school panel prepares a report with its opinion regarding whether the infant's injury satisfies the criteria of a birth-related neurological injury. The medical school panel must file its report with VWCC 60 days from the date the petition was filed with VWCC. At VWCC's request, at least one medical school panel member must be available to testify at the hearing. VWCC must consider, but is not bound by, the medical school panel's recommendation.[141]

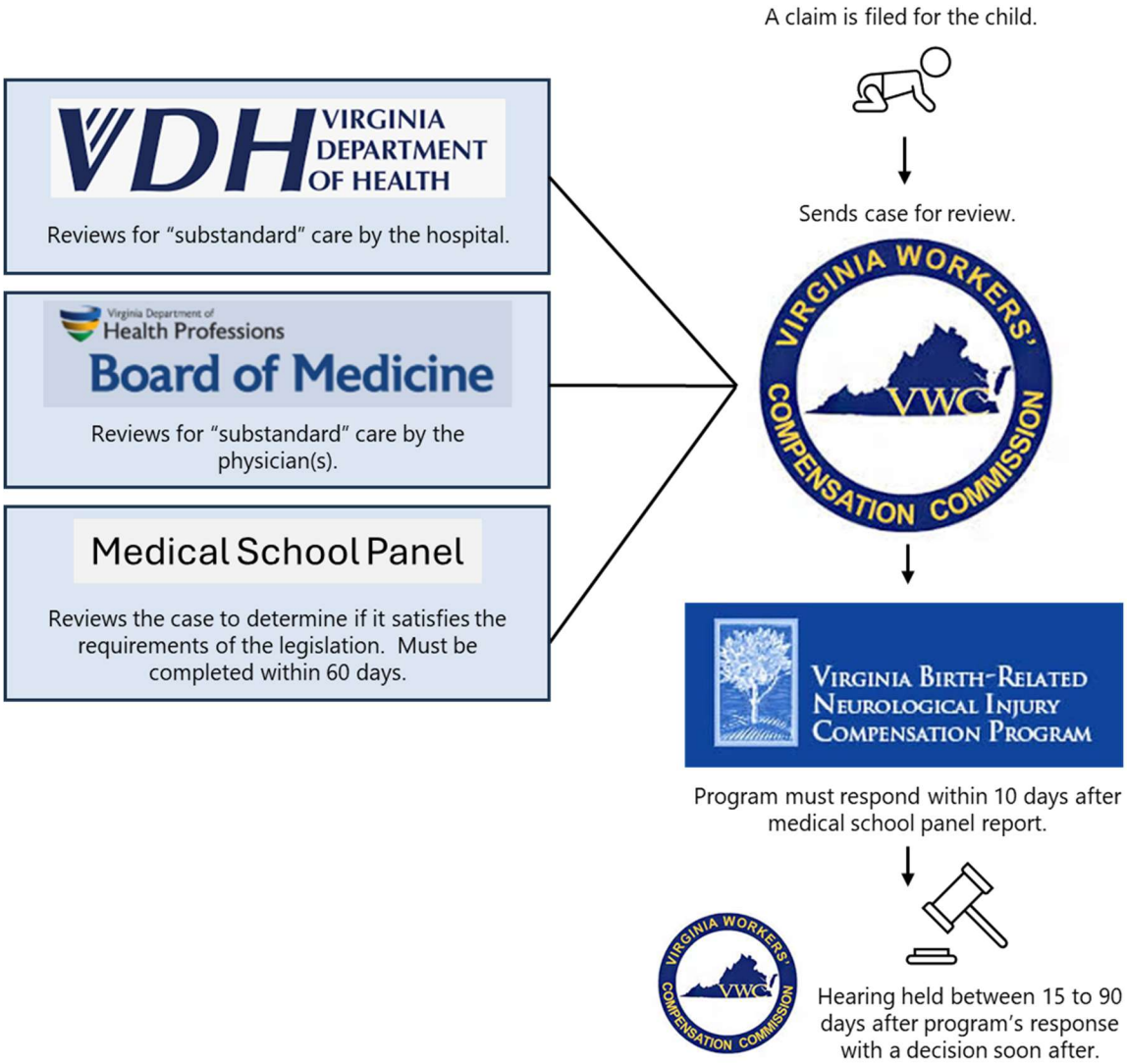
VWCC determines, based on the evidence presented, whether a claimant is eligible and entitled to an award under the VBIF program.[142] The entire

[135] VA Code Ann. § 38.2-5004A.2.
[136] VA Code Ann. § 38.2-5004B.
[137] VA Code Ann. § 38.2-5004C.
[138] The deans of the schools of medicine of the Eastern Virginia Health Sciences Center at Old Dominion University, the University of Virginia School of Medicine, and the Virginia Commonwealth University School of Medicine are tasked with forming a panel and developing the plan each filed with VWCC. As directed by VWCC, the VBIF pays $3,000 per claim reviewed to the medical school panel that performed the assessment. VA Code Ann. § 38.2-5008B.
[139] VA Code Ann. § 38.2-5004D.-E.
[140] VA Code Ann. § 38.2-5006A.
[141] VA Code Ann. § 38.2-5008C.
[142] VA Code Ann. § 38.2-5008A.

process can take several months or longer. See Exhibit 29 for a simplified illustration of the claims process.

Exhibit 29

Virginia Birth Injury Fund Claims Process



Source: Developed by LBFC staff from information obtained from the Virginia Birth Injury Fund.

Appeals. Claimants may appeal VWCC determinations. The notice of appeal must be filed with VWCC within 30 days from the date of a determination or award, or within 30 days after receipt by registered or certified mail of a determination or award, whichever occurs last. An

appeal to the Virginia Court of Appeals suspends the award, and VBIF is not required to pay until the court makes its decision.[143]

If the appeal is not reviewed within the prescribed appeal time, the VWCC determination is conclusive and binding on all questions of fact. No appeal can be taken from the decision of one commissioner until a review of the case has been held before the full VWCC.[144]

Payment of Compensation. Upon determining that an infant has sustained a birth-related neurological injury, VWCC makes an award providing compensation. Individual claims are filed to VBIF for eligible health care costs. Exhibit 30 lists compensable and non-compensable expenses under the program.

Exhibit 30

Virginia Birth Injury Fund Compensation vs. Not Compensable Expenses

Compensable	Non-Compensable
✓ Medical and hospital, rehabilitative, therapeutic, nursing, attendant, residential, and custodial care, and services expenses. ✓ Medications, supplies, special equipment, or facilities expenses. ✓ $100,000 death benefit for a child in the plan. ✓ Related transportation for the child's care. ✓ Loss of earnings from 18 through 65 years old. ✓ Reasonable expenses incurred in connection with the filing of a claim, including attorney's fees.	× Expenses for items or services a child is entitled to receive under the laws of any state or the federal government (except as prohibited by federal law). × Expenses for items or services the child has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity. × Expenses for which the child received reimbursement, or is entitled to receive reimbursement, under state or federal law, except to the extent an exclusion may be prohibited by law. × Expenses for which the infant received reimbursement, or the infant is contractually entitled to reimbursement, from any health insurance policy.

Source: Developed by LBFC staff from information obtained from the Virginia Code.

No remedy is available to the infant, its parents, or representatives outside of the program. However, a civil action can still be filed against a physician or a hospital where there is evidence of intentional or willful

[143] VA Code Ann. § 38.2-5011C.
[144] VA Code Ann. § 38.2-5011A.

misconduct, provided the suit is filed before and in lieu of the VBIF program. In addition, if eligibility under the program cannot be established, a claimant can file a civil lawsuit.

VBIF Program Outcomes

Despite VBIF being established over three decades ago, there is mixed evidence that Virginia met the goals it set when creating the fund. VBIF removed potential malpractice lawsuits from the court system and provided an alternative to compensate patients for medical expenses related to birth injuries through an administrative claims process. As noted in Section II, Virginia historically had the lowest average medical malpractice insurance rates among the four states we reviewed; however, it is also important to note that Virginia has had a cap on medical malpractice damages since the 1970s.[145]

Annual Financial Audits. Virginia law requires an independent certified public accountant to complete an audit of VBIF's financial statements each fiscal year (FY). Three years of audits (FY 2022, 2023, and 2024) were delayed due in part to a fraud case involving a former VBIF executive.

The FY 2021 audit noted the following findings:

- **Finding 1:** The program has a material weakness related to account reconciliations due to a lack of timely preparation and review.
- **Finding 2:** The program has a material weakness due to the lack of review and approval of journal entries.
- **Finding 3:** The program has a significant deficiency in internal control over financial reporting. The auditors found that the program was not preparing its financial statements, complete with notes, under accounting principles generally accepted in the United States.
- **Finding 4:** The program has a significant deficiency in annual budget preparation, leading to a lack of oversight over program expenditures.

While the purpose of the financial audit was not necessarily related to program outcomes and performance, the 2021 financial audit's findings

[145] The Virginia General Assembly passed the Medical Malpractice Act in 1976 and instituted a $750,000 cap on damages. Beginning July 1, 2024, there is a $2.65 million cap on total damages, which increases $50,000 per year until it reaches $3 million for claims after July 1, 2031. VA Code Ann. § 8.01-581.15.

and the events surrounding the former Chief Financial Officer/Deputy Executive Director stealing $6.7 million from VBIF, discussed further in a later section, provide considerations for guardrails should the Pennsylvania General Assembly consider creating a similar fund.

Actuarial Reviews. VSCC's Bureau of Insurance conducted an actuarial review of VBIF's experience in the first year of operation, including reviews of assets and liabilities. During this review, VSCC established the assessed parties' contribution rates. Following this initial valuation, an actuarial valuation of VBIF's assets and liabilities must be performed at least biannually. Based on the results of such valuations, VSCC prepares a statement on the contribution rate applicable to the assessed parties. However, the rate cannot exceed one-quarter of one percent of net direct premiums written.

According to the 2024 actuarial review, VBIF was not actuarially sound.[146] VBIF had an outstanding liability of $801.4 million for future benefits payments to program participants born on or before December 31, 2023, regardless of whether they were admitted to the program. Compared to VBIF's assets of $695.3 million, the fund had an estimated shortfall of $106.2 million. Actuaries estimated the shortfall will increase to $135.4 million by the end of 2026. The report also recommended that reviews of VBIF should be undertaken annually "to assess the Fund's actuarial soundness due to the current uncertainty in annual benefits payments."

Virginia Joint Legislative Audit and Review Commission. In 2003, the Virginia Joint Legislative Audit and Review Commission (VJLARC) issued a review of the VBIF program, which generated several findings and 41 specific recommendations. VJLARC assessed VBIF's structure and operations and examined the extent to which the program had satisfied its intended purpose over the first 15 years of its existence.

VJLARC found that the program appeared to benefit the children it served, compared to Virginia's capped tort system. VJLARC also found the program beneficial to participating physicians, hospitals, and medical malpractice insurers through reduced medical malpractice insurance rates, fewer birth injury-related lawsuits, and lower subsequent claims costs. The review 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.[147] It also highlighted that the most recent actuarial report (at the time of VJLARC's review) determined the fund to be actuarially unsound due to "flaws in the basic assessment

[146] Commonwealth of Virginia State Corporation Commission, Bureau of Insurance. *2024 Analysis of the Virginia Birth-Related Neurological Injury Compensation Program*. January 2025.
[147] Joint Legislative Audit and Review Commission of the Virginia General Assembly. *Review of the Virginia Birth-Related Neurological Injury Compensation Program*. January 2003.

structure and inadequate financial oversight of the fund by the birth injury board."[148]

Some of VJLARC's recommendations included revising the definition of program eligibility, improving the eligibility determination process, strengthening medical panel reviews, and enhancing the level of assistance offered to families who petition to enter the program.[149] VJLARC has not reviewed the program since 2003, and it is unclear how many of the 41 recommendations have been implemented.

Other Noted Outcomes. As noted by VJLARC, it is difficult to determine VBIF's success in increasing the number of OB-GYNs providing services within Virginia. However, as shown in Section II of this report, a 2026 report on rural maternity health indicated that 28 percent of rural hospitals within Virginia have labor and delivery (L&D) units. Moreover, the report found that the median driving time to a hospital with an L&D unit was 43 minutes. This indicates that Virginia still struggles with access to obstetric care, particularly in rural areas.

B. Florida Birth-Related Neurological Injury Compensation Program

In 1988, the Florida Legislature established the Florida Birth-Related Neurological Injury Compensation Act (the Act).[150] The Act provides compensation for neurological injury claims arising from birth, regardless of fault.[151] The creation of the Florida Birth-Related Neurological Compensation Association (FNICA) was intended to protect participating providers from tort action in cases where a claimant is eligible for and accepted into the FNICA program.

Like the VBIF program, a child's entry into FNICA depends on whether the child meets the statutory criteria, and is not an elective choice by parents or other parties.[152] Participation in the program is voluntary for OB-GYNs; however, once families elect to receive care from a participating provider and receive notice of the provider's participation, and their children suffer a qualifying birth-related neurological injury, their ability to pursue legal recourse outside the program is closed.

[148] Ibid.
[149] Ibid. Pg. v-viii.
[150] Florida program is also referred to by the oversight organization, the Florida Birth-Related Neurological Injury Compensation Association, and we use FNICA interchangeably in this report when talking about the act and the association.
[151] F.S.A. §§ 766.301 *et seq.*
[152] A civil action filed by the parents or party can be pursued outside of the program if "there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property, provided that such suit is filed prior to and in lieu of payment of an award under [the program]." F.S.A. § 766.303(2).

FNICA was created in response to Florida's growing medical malpractice crisis. In 1986, the Florida Legislature commissioned the Academic Task Force for Review of the Insurance and Tort Systems to study the escalating costs of medical malpractice and the waning availability of liability insurance in the state. The task force determined that OB-GYNs "…were a high-risk, essential specialty that had suffered rapid advances in their malpractice liability costs."[153] The task force found that the surge in premium costs resulted from a sustained increase in malpractice claims, which led some physicians to avoid performing high-risk, but essential, medical procedures and others to retire or practice in different states.

The task force also recognized that "birth-related neurological injuries were an especially high-risk and expensive tort subset, and… therefore required a dramatic new mechanism to deal with the problem."[154] Consequently, the task force recommended FNICA as its proposed solution. The law's legislative intent was to "…provide compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation."[155]

The Florida Legislature and task force's finding that Florida was in the midst of a medical malpractice crisis, threatening Floridians' access to health care, was debated between the branches of state government at the time. The Florida Supreme Court found "the Legislature's determination that 'the increase in medical malpractice liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early from the practice of medicine' is unsupported."[156]

[153] Martin, Sandy. *NICA – Florida Birth-Related Neurological Injury Compensation Act: Four Reasons Why this Malpractice Reform Must be Eliminated*. Nova Law Review. 2002. In 1985, OB-GYNs in Florida paid an average medical malpractice liability premium of $185,460, whereas the national average was $23,300.
[154] Tedcastle, Thomas, R., and Dewar, Marvin, A. *Medical Malpractice: A New Treatment for an Old Illness*. Florida State University Law Review. 1988.
[155] F.S.A. § 766.301. F.S.A § 766.302(10) defines "family residential or custodial care" as "care normally rendered by trained professional attendants which is beyond the scope of childcare duties, but which is provided by family members. Such care is performed only at the direction and control of a physician when such care is medically necessary, and the award of such care is to be excluded from the present value estimates calculation."
[156] *Estate of McCall v. United States*, 134 So.3d 894, 909 (FL. 2014).

Florida Definition of "Birth-Related Neurological Injury"

Florida defines "birth-related neurological injury" as follows:

> Injury to the brain or spinal cord of a live infant weighing at least 2,500 grams [five pounds, five ounces] for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams [four pounds, four ounces] at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired.[157,158]

The definition does "not include disability or death caused by genetic or congenital abnormality."[159]

The weight requirements for infant eligibility distinguish Florida's and Virginia's laws. This requirement was challenged in court and held to be rationally related to preserving the actuarial soundness of FNICA's no-fault coverage. Thus, the Florida District Court of Appeal (First District) determined that differing birth weight requirements in the provision did not violate equal protection under the US Constitution.

The Florida Legislature recognized that multiple gestation infants had lower birth weight than single gestation infants because they were required to share womb space and nutrition. Moreover, the court determined that "…the Legislature conceivably chose not to reduce weight requirements for single gestation infants to further the legitimate governmental interest of preserving the availability of exclusive benefits on a no-fault basis for a limited class of catastrophic injuries."[160]

[157] F.S.A. § 766.302.

[158] *Bennett v. St. Vincent's Medical Center, Inc.,* 71 So.3d 828 (2011), *rehearing denied.* "Physical impairment" relates to an infant's motor abnormalities or impairment of his physical functions, which along with the brain injury, significantly affects the infant's mental capabilities so that the infant will not be able to translate cognitive capabilities into adequate learning or social development in a normal manner. *Matteini v. Florida Birth-Related Neurological*, 946 So.2d 1092 (2006). An infant qualifies as "substantially mentally and physically impaired" even when certain test results indicated the child was average or even above in his cognitive skills and preacademic skills." *Florida Birth-Related Neurological Injury Compensation Ass'n v. Florida Div. of Administrative Hearings*, 686 So.2d 1349 (1997).

[159] F.S.A. § 766.302.

[160] *Putnum Community Medical Center v. Florida Birth-Related Neurological Injury Compensation Ass'n, App. 1* Dist., 204 So.3d 598 (2016).

FNICA Funding

The FNICA program receives funding through the following sources:

- **Participating OB-GYN physicians and certified nurse midwives' fees**. Participating OB-GYN physicians and certified nurse midwives must pay annual assessments to obtain coverage for births for which they provide care.

- **Nonparticipating physician fees.** With certain exceptions, all other Florida-licensed physicians, regardless of specialty, must pay an assessment fee.[161]

- **Hospital assessments.** Hospitals must pay assessments for each live birth during the previous calendar year.

- **State appropriations.** The FNICA fund has also received a $20 million appropriation from Florida's Insurance Regulatory Trust Fund (FIRTF). Florida law permits the FIRTF to transfer an appropriate amount of up to $20 million in additional funding to the FNICA fund if the physician and hospital assessments and the appropriation of funds provided by § 76, Ch. 88-1, Laws of Florida, as amended by § 41, Ch. 88-277, Laws of Florida, to the Plan from the FIRTF are insufficient to maintain the FNICA plan on an actuarially sound basis.[162]

There is no provision for a prorated fee; if payment is made after January 31st, coverage begins the day the payment is received, and fees can be paid online.[163] Participation in FNICA does not replace medical malpractice insurance, as the program only covers eligible birth-related neurological injuries. Florida law lacks a clear mechanism to adjust assessments to account for increases in the cost of living, resulting in the assessment remaining unchanged since the 1980s.

FNICA program participants' contributions provide immunity from lawsuits for birth-related neurological injuries within the scope of the FNICA's coverage. The following are required assessment fees:

[161] According to F.S.A. § 766.314(4)(b)4, some Florida-licensed physicians are exempt from the fee assessment. These physicians include: (1) Resident physicians, assistant resident physicians, and interns in postgraduate training programs approved by the Board of Medicine. (2) Retired physicians who maintain an active license but have withdrawn from employment in any medically related field. (3) Physicians who hold a limited license but do not receive any compensation for medical services. (4) Physicians employed full-time by the Veterans Administration (VA) whose practices are confined to VA hospitals. (5) Any licensed physician on active duty with the U.S. Armed Forces. (6) Physicians who are full-time State of Florida employees and whose practice is confined to state-owned correctional facilities, mental health or developmental services facilities, or the Florida Department of Health or County Health Department.

[162] F.S.A. § 766.314(5)(b).

[163] Florida Birth-Related Neurological Injury Compensation Association. *A Unique Partnership.*

- $5,000 for participating OB-GYNs.
- $2,500 for participating certified midwives.
- $250 Florida-licensed physicians (all specialties).
- $50 per live birth in Florida hospitals.

For claims to be considered, they must be filed by the child's fifth birthday, and care must have been provided by a physician participating in the FNICA plan. Each hospital with a participating physician on its staff, and each participating physician (other than residents, assistant residents, and interns), must notify obstetrical patients of the FNICA alternative. Hospitals must provide notice on forms furnished by FNICA, and the program must be clearly and concisely explained. A pre-delivery notice must be given within a reasonable time after the commencement of the provider-obstetrical patient relationship, and a subsequent emergency does not excuse the failure to do so.[164]

The hospital or the participating physician may choose to have the patient sign a form acknowledging receipt of the notice. This creates a rebuttable presumption that the notice requirements were met, and notice need not be given to a patient with an emergency medical condition.[165] However, a pre-delivery notice must be given within a reasonable time after the commencement of the provider-obstetrical patient relationship, and a subsequent emergency does not excuse the failure to do so.[166]

FNICA Governance and Administration

FNICA administers Florida's program, with day-to-day operations run by an executive director and other staff. The association has a seven-member board of directors appointed by the Florida Chief Financial Officer. The board is comprised of one representative from each of the following groups:

- One representative for casualty insurers.
- One representative for non-participating physicians.
- One representative for the general public.
- One representative for participating physicians.
- One representative for parents/legal guardians of children under the plan.
- One representative for participating hospitals.

[164] *Weeks v. Florida Birth-Related Neurological*, 977 So.2d 616 (5th Dist. Ct. of Appeal of Florida, 2008).
[165] F.S.A. § 766.316.
[166] Ibid.

The FNICA board administers all payments for claims on behalf of the program. Other powers of the board include the following:[167]

- Directing the investment and reinvestment of any surplus funds over losses and expenses.
- Reinsuring the risks of the program in whole or in part.
- Suing, appearing, and defending, in all actions and proceedings in its name.
- Exercising all the necessary powers to carry out the purposes of the program.
- Entering contracts related to the program.
- Employing and retaining individuals.
- Taking legal action to avoid payment of improper claims.
- Indemnifying employees and agents acting on behalf of the program.

The board is also responsible for filing an annual financial report to the Florida Auditor General.[168]

FNICA Claims Process

To receive compensation under the FNICA program, a claimant must file a claim or petition with the Florida Department of Management Services' (FDMS) Division of Administrative Hearings. The petition must include the following information:

- Name and address of the legal representative and the basis for his or her representation of the injured infant.
- Name and address of the injured infant.
- Name and address of any physician providing obstetrical services who was present at birth and the name and address of the hospital at which the birth occurred.
- Description of the disability for which the claim is made.
- Time and place the injury occurred.
- Brief statement of the facts and circumstances surrounding the injury giving rise to the claim.[169]

The claimant must provide FDMS with as many copies of the petition as required for service upon FNICA, any physician and hospital named in the petition, and the Florida Department of Health's (FDOH) Division of Medical Quality Assurance, along with a $15 filing fee payable to the Florida Division of Administrative Hearings (FSAH). Upon receipt of the petition, FDMS must immediately serve FNICA by registered or certified

[167] F.S.A. § 766.315(4)(a)-(k).
[168] F.S.A. § 766.315(5)(e).
[169] F.S.A. § 766.305(1)(a)-(f).

mail and mail copies to any physician, health care provider, and hospital named in the petition. FDMS must also furnish a copy by regular mail to the Florida Division of Medical Quality Assurance and the Florida Agency for Health Care Administration (FAHCA).[170]

The claimant is responsible for providing FNICA with the following information, which must be filed within 10 days after filing the petition:

- All available relevant medical records relating to birth-related neurological injury and a list identifying any unavailable records known to the claimant and the reasons for the records' unavailability.

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

- Documentation of expenses and services incurred by the child to date, identifying any payment made for such expenses and services and the payor.

- Documentation of any applicable private or governmental source of services or reimbursement relative to the child's impairments.[171]

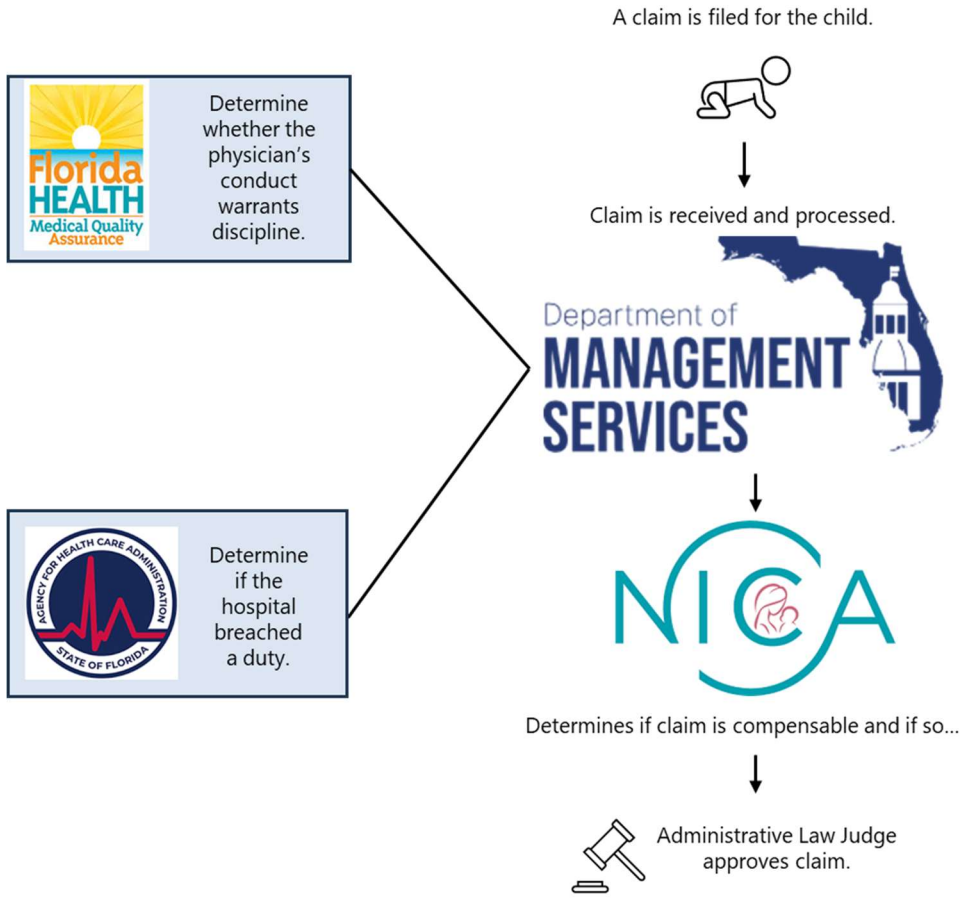
The FNICA has 45 days from the date of service of a claim to file a response to the petition and submit relevant written information relating to whether the injury alleged is a birth-related neurological injury. Upon receipt of such a petition, FDMS must review the information and determine whether it involves conduct by a licensed physician that is subject to disciplinary action.

Upon receipt of the petition, FAHCA investigates the claim. If FAHCA determines that the injury resulted from, or was aggravated by, a hospital's breach of duty in violation of state law, it must take appropriate disciplinary action. If a claim is determined to be compensable by FNICA, compensation may occur, subject to approval by an assigned administrative law judge (ALJ). The ALJ determination is conclusive and binding as to all questions of fact.[172] Exhibit 31 provides a visual summary of the claims process.

[170] F.S.A. § 766.305(2).
[171] F.S.A. § 766.305(3)(a)-(d).
[172] F.S.A. § 766.305(4)-(7); F.S.A. § 766.311(1).

Exhibit 31

Florida Birth-Related Neurological Injury Compensation Association Claims Process



Source: Developed by LBFC staff from information obtained from the Florida Birth-Related Neurological Injury Compensation Association.

The statute of limitations regarding any civil action that may be brought by or for an injured infant arising out of or related to a birth-related neurological injury "shall be tolled by the filing of a claim in accordance with [FNICA], and the time such claim is pending or is on appeal shall not be computed as part of the period within which such civil action may be brought."[173] This means that any time limitation on the child's parents or guardians to file a lawsuit will be paused once the FNICA claim is filed.

Denials. An ALJ can deny a claimant's request for several reasons:

- The child does not meet the weight requirements.

[173] F.S.A. § 766.306.

- The alleged injury does not constitute a permanent or substantial mental or physical impairment.
- The physician does not participate in the program.

Of the 148 claims (60 percent) that were denied from FY 2020-21 to FY 2023-24, the most common reason was that the child did not suffer a permanent or substantial mental or physical impairment. Exhibit 32 shows reasons for all claims denials for this period.

Exhibit 32

Florida NICA Reasons for Claim Denials
July 1, 2020, to June 30, 2024

Denial Reason	Number of Denials
Did not suffer a permanent and substantial mental and physical impairment	69
Did not occur during labor, delivery, or the immediate post-delivery period	50
Below the statutory minimum weight requirement	23
Non-participating physician	9
Petition withdrawn	4
Petitioners elected remedy-declining NICA benefits	3
No oxygen deprivation	2
Settlement in court	2
No identifiable injury at birth, or substantial mental and physical impairment	1
No oxygen deprivation/ No permanent or substantial mental or physical impairment	1
Birth did not take place in a hospital	1
Not a live birth	1

Source: Developed by LBFC staff from information obtained from the Florida Birth-Related Neurological Injury Compensation Association.

Appeals. Claimants can appeal an ALJ determination to the District Court of Appeals, which must be filed in accordance with the Florida Supreme Court's rules of procedure for the review of such orders.[174]

Payment of Compensation/Benefits. Upon approval and admission to the FNICA program, an accepted family receives an initial payment of $250,000.[175] After this initial payment, FNICA continues lifetime payments for all medically necessary and reasonable expenses for children born with substantial physical and/or mental neurological injuries, including whatever is needed to support their care and quality of

[174] F.S.A. § 766.311(1).

[175] Initially, this amount was limited to $100,000, but it increased to a maximum of $250,000 beginning January 1, 2021, and was set to increase 3 percent each January 1 thereafter. Payments can be made periodically or in a lump sum, at the ALJ's discretion. F.S.A. § 766.31(1)(d)(1)(a).

life. Individual claims are filed to FNICA for eligible health care costs. Allowable and unallowable expenses are summarized below in Exhibit 33:

Exhibit 33

Compensable vs. Non-Compensable Expenses under the Florida Birth-Related Neurological Injury Compensation Association Program

Compensable	Non-Compensable
✓ One-time award to infant's parents/legal guardians not to exceed $250,000.[a/]	× Expenses to which an infant is entitled under other state or federal laws (except as prohibited by federal law).
✓ Housing assistance of up to $100,000 for the child's lifetime.	× Expenses for items or services the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity.
✓ $50,000 death benefit for an infant in the plan.	× Expenses for which the infant has received or is entitled to receive reimbursement under state or federal law (except to the extent such exclusion may be prohibited by law).
✓ Reliable transportation for the child's care, with replacement vans to be purchased by FNICA every 7 years or 150,000 miles, whichever occurs first.	× Expenses for which the infant has received reimbursement, or is contractually entitled to reimbursement, under any health insurance policy.
✓ Annual benefit up to $10,000 for immediate family members living with the child for psychotherapeutic services.	
✓ Reasonable expenses incurred in connection with the filing of a claim, including attorney's fees.[b/]	

Notes:
[a/]The $250,000 is adjusted by 3 percent annually for inflation.
[b/]For attorney fees in connection with filing claim, the ALJ must consider (1) time and labor required, novelty and difficulty of questions involved, and skill requisite to perform legal services; (2) fee customarily charged in the locality for similar legal services; (3) time limitations imposed by the claimant or the circumstances; (4) nature and length of the professional relationship with claimant; (5) experience, reputation, and ability of lawyer performing services; (6) contingency or certainty of a fee.

Source: Developed by LBFC staff from information obtained from the Florida Birth-Related Neurological Injury Compensation Association.

The compensable expenses are "…limited to reasonable charges prevailing in the same community for similar treatment of injured

persons when [that] treatment is paid for by the injured person."[176] The parents or legal guardians receiving benefits under the program can file a petition with the FDMS's Division of Administrative Hearings to dispute the actual expenses reimbursed or a denial of reimbursement.[177]

Between July 1, 2023, and June 30, 2024, the FNICA fund paid compensation to claimants for the expense types and amounts shown in Exhibit 34.

Exhibit 34

Paid Compensation for Expenses by the Florida Birth-Related Neurological Injury Compensation Association
July 1, 2023, to June 30, 2024

Category	Individual Payments	Amount
Custodial Day Care	28	$50,318
Custodial Residential	1	801
Death Benefit	27	1,050,000
Drugs	600	298,671
Equipment	315	673,270
Family Psychotherapeutic Services	281	110,785
Health Insurance Premiums	866	356,596
Housing	166	2,197,525
Hospitalizations	11	10,226
Nursing Care by Other	2,081	4,024,525
Nursing Care by Parent/Family Care	7,198	30,093,747
Parental Award	108	8,205,899
Physician Charges	246	91,082
Supplies	3,088	726,515
Therapy	1,478	897,727
Transportation & Travel	1,083	416,319
Transportation-Insurance	377	457,281
Transportation-Maintenance	452	251,659
Transportation-Mileage	2,298	162,299
Transportation-Purchase	206	2,060,021
Total	**20,910**	**$52,084,948**

Source: Developed by LBFC staff with information obtained from the Florida Birth-Related Neurological Injury Compensation Association.

[176] F.S.A. § 766.31(1)(c). When asked how FNICA negotiates reimbursements from providers, officials explained that they start from the rationale that the Medicaid rate is always reasonable. If the provider wants a rate higher than the Medicaid rate, they must provide a valid justification. This can be difficult, especially for therapy-related health care—most primary health insurance does not cover certain therapies, which means FNICA is essentially the primary payor for this care. Because FNICA has program participants who reside outside of Florida, it can be challenging to negotiate with providers from other states. Therefore, FNICA uses a third-party service to negotiate reimbursement requests with providers.

[177] Ibid.

Between July 1, 2023, and June 30, 2024, FNICA denied compensation to claimants for the expense types and amounts shown in Exhibit 35.

Exhibit 35

Denied Compensation for Expenses by the Florida Birth-Related Neurological Injury Compensation Association
July 1, 2023, to June 30, 2024[a/]

Category	Reason for Denial	Denials	Amount
Equipment	Not a covered benefit	3	$1,141
Equipment	Did not meet requirements for reimbursement	5	7,280
Family Psychotherapeutic Services	Did not meet requirements for reimbursement	3	2,495
Health Insurance Premiums[a/]	Did not meet requirements for reimbursement	1	-
Nursing Care by Other[a/]	Exceeded authorized amount	2	-
Nursing Care by Parent	Did not meet requirements for reimbursement	1	831
Other	Not a covered benefit	2	2,470
Other	Did not meet requirements for reimbursement	1	2,000
Supplies	Beyond statutory time limit	1	200
Supplies	Not a covered benefit	4	111
Supplies	Did not meet requirements for reimbursement	4	596
Therapy	Exceeded authorized amount	2	377
Therapy	Incomplete documentation	1	4,157
Transportation & Travel	Exceeded authorized amount	1	1,640
Transportation & Travel	Incomplete documentation	2	6,154
Transportation-Maintenance	Did not meet requirements for reimbursement	3	742
Transportation-Mileage	Did not meet requirements for reimbursement	1	8
Total		**37**	**$30,202**

Note:
[a/]No specific amount requested to FNICA.

Source: Developed by LBFC staff from information obtained from the Florida Birth-Related Neurological Injury Compensation Association.

Effect on/Exclusion of Other Remedies. As in Virginia, rights and remedies granted by FNICA are exclusive. However, a civil action remains a remedy where there is clear and convincing evidence of bad faith, malicious purpose, or willful and wanton disregard of human rights, safety, or property, provided that such suit is filed before and in lieu of payment of an award. In other words, if eligibility requirements for entry into the program are not met, the claimant can pursue other legal action in court.

FNICA Program Outcomes

Like Virginia's program, FNICA has existed for over three decades. However, the program's success in achieving its intent is unclear. FNICA provided physicians who were most significantly impacted by the "medical malpractice crisis" in the 1970s and 1980s with an affordable alternative to costly premiums for medical malpractice insurance. Whether this alternative was effective in retaining OB-GYNs in Florida is unclear. The program's goal of improving access to OB-GYNs is currently unmet in rural Florida, as none of the state's rural hospitals have OB-GYN physicians. The program has also faced problems with internal controls and a rising unfunded liability.

Florida Auditor General Operational Audit (2023). In October 2023, the Florida Auditor General released an operational audit of FNICA, focusing on FNICA's administration of the program, including compliance with all governing statutes, applicable state public records and meetings laws, and the status of recommendations from the Florida Auditor General's 2021 operational audit.[178] The 2023 audit produced six findings related to program administration and information technology controls, as shown in Exhibit 36.

[178] State of Florida Auditor General. *Florida Birth-Related Neurological Injury Compensation Association*. October 2023.

Exhibit 36

Florida Auditor General Operational Audit of Florida Birth-Related Neurological Injury Compensation Association
2023

Plan Administration Findings		Information Technology Controls Findings	
Finding 1	The December 2021 and December 2022 quarterly claims cost estimates were not provided to the actuarial consultant, resulting in actuarial threshold and reserve calculations being delayed. This resulted in a delay in determining whether sufficient funds were available to accept new claims. Additionally, had state law not excluded family residential and custodial care expenses from the reserve calculation for the quarter ended September 30, 2022, FNICA would have exceeded the claims threshold by $95,015,565, preventing FNICA from accepting new claims.	**Finding 4**	FNICA controls and retention over text messaging and Apple iMessages in accordance with state law and the state records retention schedule need improvement.
Finding 2	FNICA's exclusion of the Interim Executive Director's compensation from FNICA's November 2022 annual report appeared to frustrate the intent of state law.	**Finding 5**	FNICA controls for timely disabling user access privileges to the FNICA network domain and the Claims Accounting and Reserve Electronic System upon an employee's separation from FNICA employment need improvement.
Finding 3	Analysis of FNICA participant survey responses indicated that, while improvements to participant satisfaction were noted from the prior audit survey, FNICA could enhance the Benefit Handbook to better respond to participant complaints.	**Finding 6**	Certain security controls related to network domain, virtual private network, and Claims Accounting and Reserve Electronic System user authentication need improvement to ensure the confidentiality, integrity, and availability of FNICA data and information technology resources.

Source: Developed by LBFC staff with information obtained from the Florida Auditor General.

Annual Financial Audit. On an annual basis, FNICA must provide audited financial statements to the Florida Office of Insurance Regulation of the Financial Services Commission, the Florida Joint Legislative Auditing Committee, and any participant upon request.[179] At any time deemed necessary, the Office of Insurance Regulation or the

[179] The financial statements must be audited in accordance with generally accepted auditing standards and include any information required by the Florida Office of Insurance Regulation or the Florida Joint Legislative Auditing Committee.

Joint Legislative Auditing Committee may conduct an audit of the program.[180]

FNICA's audits for the years ended June 30, 2023, and 2024, showed net deficits of approximately $216.6 million and $152.9 million, respectively. While total operating revenues increased from $35.1 million in 2023 to $37.9 million in 2024, FNICA incurred $194.3 million in 2024 operating expenses, resulting in a total operating loss of $156.4 million. FNICA's change in net deficit significantly increased from FY 2021-22 to FY 2022-23 (-$122.2), primarily due to a 2023 Medicaid settlement expense of $52.7 million (this is discussed later in this section). The auditors concluded that the financial statements presented fairly, in all material respects, the financial position of FNICA as of June 30, 2025, and 2024, and the changes in its financial position and its cash flows for the years then ended in accordance with US generally accepted accounting principles.

Actuarial Review. The Florida Office of Insurance Regulation (FOIR) performs an actuarial valuation of the program's assets and liabilities at least biennially. Based on these valuations, FOIR prepares a statement detailing the contribution rate of hospitals, physicians, and certified nurse midwives required to contribute to the fund. If FOIR determines the program cannot be maintained on an actuarially sound basis with the current fee assessments and state appropriations, FOIR must increase the assessments proportionally as needed. However, the law prescribes the rate may never exceed 0.25 percent of net direct premiums written.[181]

The FNICA program incurs a greater loss in funds than it receives in revenue. According to its *Actuarial Review of Loss Reserves as of December 31, 2023, Including Additional Costs of the 2024 Birth/Accident Year*, FNICA has total outstanding loss and loss adjustment expenses (LAE) of $1.08 million, higher than the corresponding outstanding loss and LAE of $1.02 million calculated for December 31, 2021.[182] The review opines that the reserve increase is driven by a rise in claim frequency in recent years and two years of inflation. The projected 2024 allocated loss adjustment expenses (ALAE) of $111.9 million are much higher than the collected assessments of $37.9 million as of the fiscal year ending June

[180] F.S.A. § 766.315(5)(e).
[181] F.S.A. § 766.314(7)(a)-(b).
[182] "Loss Adjustment Expense" is typically an insurance company's financial obligation, covering the operational costs of negotiating and settling policy claims. Kagan, Julia, *Understanding Loss Adjustment Expense: Definition, Types, and Profit Impact*, Investopedia, (Feb. 25, 2026), https://www.investopedia.com/terms/l/loss-adjustment-expense-lae.asp, accessed March 18, 2026.

30, 2024.[183] The projected 2024 losses were discounted for the time value of money, indicating a present value net loss of $74.0 million.[184] The review summed up its findings with the recommendation that:

> Corrective action should be considered before the underwriting losses compound to an unmanageable level. Such action may include, but not be limited to, assessment increases, reduction of benefits, reconsideration of FNICA's status relative to Medicaid, and potentially, sunsetting the program.[185]

Other Noted Outcomes. The most obvious goal of FNICA was to mitigate the "medical malpractice crisis" of the 1970s and 1980s and ensure that physicians most significantly impacted by it, OB-GYNs, had an affordable alternative to costly medical malpractice premiums. This alternative was thought to have encouraged OB-GYNs to continue practicing and offering much-needed services in Florida. Consequently, Florida's current ability to retain these physicians is one key metric in determining the program's success. However, determining with any level of precision the extent to which FNICA has succeeded in retaining OB-GYNs is challenging and has not been directly studied in Florida.

A secondary goal of improving access to obstetric care remains unmet in rural Florida. As shown in Section II, as of March 2026, only nine percent of Florida's rural hospitals offer L&D services, with a median drive time of over 90 minutes to an alternative L&D hospital. Florida ranks last nationwide in access to early prenatal care.[186] According to Becker's Hospital Review, even large, urban systems in Florida are "struggling to hire and retain OB-GYN staff."[187]

Data on the program's impact on malpractice liability premium rates is limited; however, we presented an analysis of rates in Section II. A 2012 survey of Florida physicians and attorneys found that most respondents felt they lacked sufficient information to form an opinion on how FNICA

[183] "Allocated Loss Adjustment Expenses" are costs resulting from the processing of a specific insurance claim. These costs often include third-party services, such as investigators and legal counsel. Kagan, Julia, *Understanding Allocated Loss Adjustment Expenses (ALAE): Key Insights & Examples*, Investopedia, (Oct. 5, 2025), https://www.investopedia.com/terms/a/allocated-loss-adjustment-expenses-alae.asp, accessed March 18, 2026.
[184] Florida Birth-Related Neurological Injury Compensation Association. Actuarial Review of Loss Reserves as of December 31, 2023, Including Additional Costs of the 2024 Birth/Accident Year December 2024.
[185] *Ibid*., Pg. 3-4. The review notes that "[p]rojections of loss and LAE liabilities are subject to potentially large errors of estimation, since the ultimate disposition of claims incurred prior to the annual report date, whether reported or not, is subject to the outcome of events that have not yet occurred."
[186] Center for Healthcare Quality and Payment Reform. *Stopping the Loss of Rural Maternity Care.* March 2026.
[187] Taylor, Mariah. '*We can't keep working in silos': Florida Systems Tackle OB-GYN Deserts.* Becker's Hospital Review. May 2025.

impacted medical malpractice rates. The survey is summarized in Exhibit 37.[188]

Exhibit 37

Florida Physician and Attorney Survey Results[a/]
2012

Questions	Responses	Physicians[b/]	Attorneys[c/]
How FNICA has affected obstetric malpractice insurance rates.	Indicated they lacked sufficient information to form an opinion	45.3%	49.2%
	FNICA has had no effect	39.8	35.3
	Caused decreased rates	13.3	13.1
	Caused increased rates	1.6	2.4
FNICA's effect on defensive medicine practices.	Not enough information	36.8	52.8
	Increase	8.8	4.2
	Decrease	1.6	7.2
	No effect	52.8	35.8
Preferences for legal proceedings.	Administrative process	37.5	12.0
	Arbitration	37.5	4.8
	No preference	19.5	8.2
	Courtroom setting	5.5	57.2
	Unsure what FNICA covers	0.0	17.8

Notes:
[a/]Numbers may not equal 100 percent due to rounding.
[b/]Of survey respondents, there were 172 obstetricians, with 97.5 percent indicating they participated in the FNICA program and 10.1 percent indicating they had a patient compensated by FNICA.
[c/]Of survey respondents, there were 917 attorneys (attorneys who did not accept medical malpractice cases were excluded from the survey). 82.9 percent of respondents were familiar with FNICA, 25.0 percent represented a client with an FNICA claim, and 19.1 percent defended an FNICA claim on behalf of a provider.

Source: Developed by LBFC staff from information obtained from the Florida Public Health Review.

The survey also inquired about FNICA's effect on defensive medicine practices. Defensive medicine is defined as "a deviation from acceptable medical practice due to the threat of liability."[189] A 2017 report sought to determine the impact of physician medical malpractice liability exposure on primary Cesarean and vaginal births after Cesarean (VBACs), using Florida data.[190] Although many variables determine if a VBAC is

[188]Geletko, Karen, Andrew Hunt, and Leslie Beitsch. *Impact of the Florida Birth-Related Neurological Injury Compensation Association (NICA) on Obstetrician and Attorney Practices.* Florida Public Health Review. April 2012.
[189] Vickers, Holly, and Swati Jha. *Medicolegal Issues in Gynaecology*. Obstetrics, Gynaecology and Reproductive Medicine. February 2020.
[190] Durrance, Christine Piette, and Scott Hankins. *Medical Malpractice Liability Exposure and OB/GYN Physician Delivery Decisions*. Health Services Research. December 2017.

appropriate, avoiding VBAC solely due to liability fears is considered defensive behavior. The study found:

- No evidence that the first malpractice claim affected primary Cesarean deliveries.
- The first malpractice claim decreased the likelihood of a VBAC (conditional on a prior Cesarean delivery) by 1.2 to 1.9 percentage points (approximately 10 percent relative to the mean VBAC incidence).
- Physician malpractice liability exposure was responsible for a relatively small share of the VBAC decrease; there must have been other primary causes driving the large increases in Cesareans overall.[191]

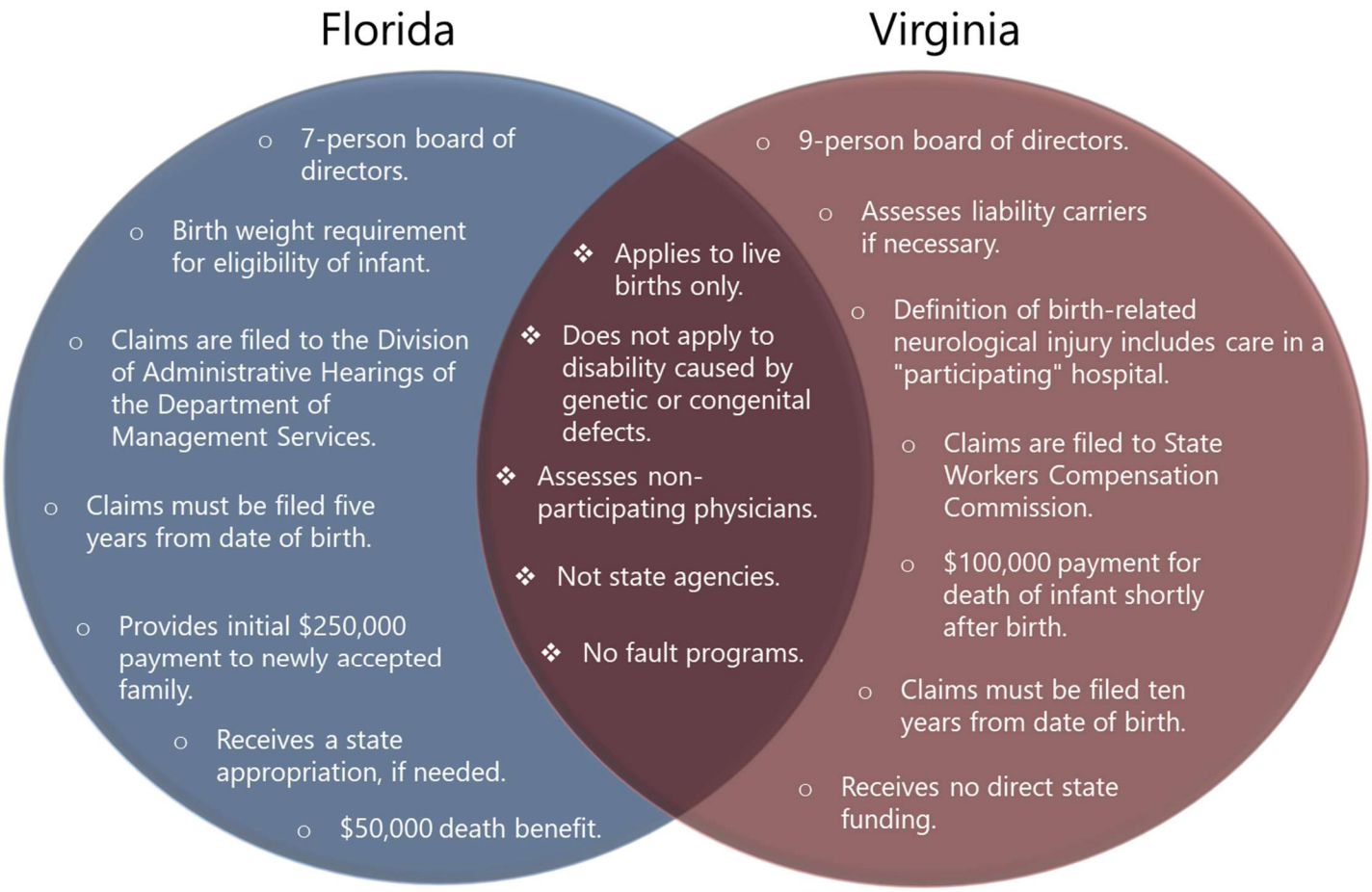
Comparing Florida's and Virginia's Programs

Administratively, the VBIF and FNICA programs are similar. Each is a statutorily authorized, no-fault tort alternative, narrowly tailored to qualifying children who have suffered a birth-related neurological injury. Differences between VBIF and FNICA include funding, governance, claims process, and eligibility. For a more specific, visual comparison of the programs, see Exhibit 38 below.

[191] The study stated that "other possible reasons (not tested in this study) include hospital or insurer restrictions over [trial of labor after Cesarean] (TOLAC) and/or VBAC, physician practice or preferences, or patient preferences." *Ibid.*

Exhibit 38

Overview Comparison of Florida Birth-Related Neurological Injury Compensation Association and Virginia Birth Injury Fund Programs



Source: Developed by LBFC staff from information obtained from the Florida Birth-Related Neurological Injury Compensation Association and Virginia Birth Injury Fund.

Both programs have been sued under the False Claims Act, with allegations that they improperly instructed eligible claimants to first file claims with Medicaid before filing claims for compensation under their respective provisions. In addition, both programs require a claimant's participation once the injured child is deemed eligible. In other words, participation is not elective unless there is evidence of malice from the attending physician or hospital. According to reviews, neither program is actuarially sound.

Despite their existence for over three decades, both programs have been under legal scrutiny. VBIF and FNICA claim denials are frequently litigated, and legal arguments under the Fourteenth Amendment's due process and equal protection clauses have been raised.

C. New York Medical Indemnity Fund

In March 2011, the New York State Legislature amended Article 29-D of the New York State Public Health Law (Public Health Law), creating the New York State Medical Indemnity Fund (NYMIF). NYMIF aims to "provide a funding source for future health care costs associated with birth-related neurological injuries, in order to reduce premium costs for medical malpractice insurance coverage."[192]

Much like the Virginia and Florida programs, New York designed NYMIF to provide financial assistance to individuals who have suffered birth-related neurological injuries. However, there is a critical difference; Virginia and Florida are no-fault programs that eliminate litigation as an option. Conversely, NYMIF requires eligibility to be determined through a malpractice lawsuit, where a court determination or court-approved settlement confirms medical negligence caused a child's injury. In other words, it must be demonstrated that the provider failed to meet the required standard of care, resulting in the injury.

Once a case is settled or a judgment is entered, NYMIF eligibility can be determined. Under the NYMIF statute, children who sustain birth-related neurological injuries no longer receive monetary payments for their future health needs. Rather than receiving a cash settlement to pay for ongoing care, eligible children and their families are enrolled in NYMIF. Enrollees must apply to the fund administrator for approval of expenditures for specific health care needs. Basically, "The Fund substitutes services for up-front cash."[193]

While NYMIF is statutorily authorized under the Public Health Law, many of the fund's requirements are prescribed under § 69-10 of the New York Codes, Rules, and Regulations. Due to recent financial concerns, NYMIF has become a recurring topic of public discussion.[194]

New York Definition of "Birth-Related Neurological Injury"

New York law defines "birth-related neurological injury" as follows:

> Injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation,

[192] New York Public Health Law § 2999-g.
[193] Mendez ex rel. Mendez v. New York and Presbyterian Hospital, 934 N.Y.S.2d 662, 670 (2011 N.Y. Slip Op. 21407).
[194] Saeidi, Mahsa. *Families in New York's Medical Indemnity Fund Desperate for Much-Needed Help to Keep Program Afloat.* CBS News. April 2025.

or by other medical services provided or not provided during delivery admission, that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as that term is defined by section 1.03 of the mental hygiene law, or both. This definition shall apply to live births only.[195]

NYMIF Eligibility

Eligibility for NYMIF includes any individual who, through a court-approved settlement or judicial judgment, is determined to have sustained a "birth-related neurological injury" resulting from medical malpractice or alleged medical malpractice. A "qualified plaintiff" is defined in Exhibit 39, below:

Exhibit 39

New York's Definition of a "Qualified Plaintiff"

Has been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice.
OR
Has sustained a birth-related neurological injury as a result of alleged medical malpractice, and has settled their lawsuit or claim.
AND
Has been ordered to be enrolled in the fund by a court in New York state.

Source: Developed by LBFC staff from information obtained from New York Public Health Law.

NYMIF Settlement Allocation

The courts traditionally approve settlements on behalf of injured children and determine whether a portion of settlement proceeds is to be

[195] New York Public Health § 2999-h.1. Section 1.03 of the New York Mental Hygiene Law defines "developmental disability" as a disability of a person which: (1) Is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome, or autism. (2) Is attributable to any other condition of a person found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services like those required for such person; or is attributable to dyslexia resulting from a disability. (3) Originating before such person attains age twenty-two. (4) Has continued or can be expected to continue indefinitely, and constitutes a substantial handicap to such a person's ability to function normally in society.

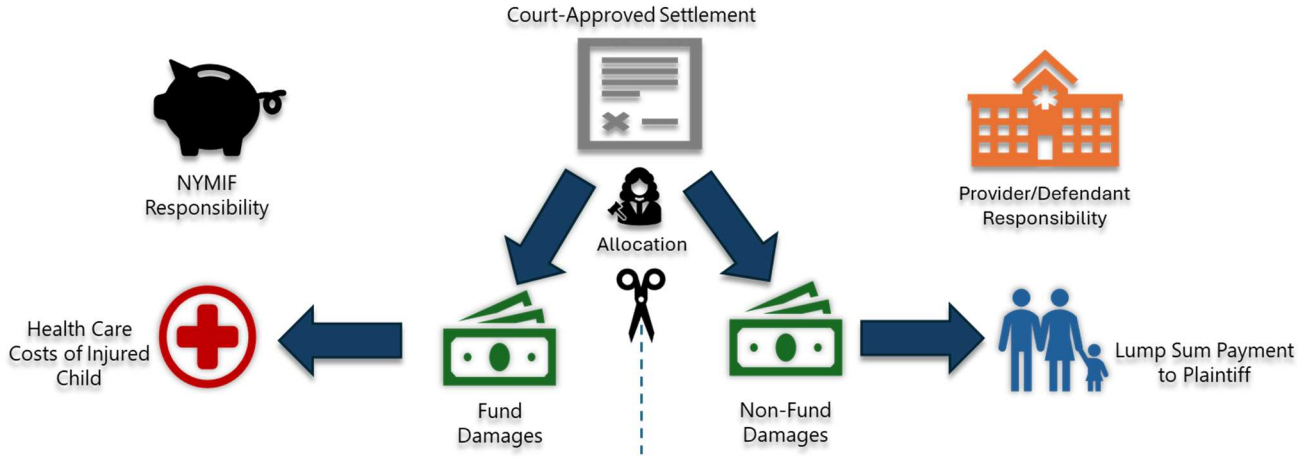
allocated to a Medicaid lien.[196] However, the court must allocate the settlement proceeds between "fund damages" and "non-fund damages" under NYMIF. Fund damages are the health care costs resulting from the child's injury, while non-fund damages include pain, suffering, and lost earnings.

The allocation determines how much lump sum cash the plaintiff receives (non-fund damages) and how much the medical provider (the case defendant) saves because of NYMIF's obligation to assume the future medical expense component of the award (fund damages).

The provider benefits because NYMIF covers a portion of the health care costs resulting from neurologic injuries caused by malpractice.[197] Alternatively, the provider only pays the non-fund damages portion of the judgment or settlement as shown in Exhibit 40 below:

Exhibit 40

New York State Medical Indemnity Fund Settlement Allocation



Source: Developed by LBFC staff from information obtained from New York Public Health Law.

The settlement allocation process is not explicitly spelled out in the NYMIF statute or regulations. Instead, it was established in the 2011

[196] States may impose liens for Medicaid benefits incorrectly paid pursuant to a court judgment. States may also impose liens on real property during the lifetime of a Medicaid enrollee who is permanently institutionalized, except when a spouse, child under age 21, blind or disabled child of any age, or sibling who has an equity interest in the home resides in the home. The states must remove the lien when the Medicaid enrollee is discharged from the facility and returns home. (https://www.medicaid.gov/medicaid/eligibility-policy/estate-recovery, Accessed April 2, 2026).

[197] Unused fund damage monies to NYMIF are not recuperated by the claimant's family.

court case opinion of *Mendez ex rel. Mendez v. New York and Presbyterian Hospital*, requiring that:

> [A] court must insist on a "good faith" allocation of a lump settlement between the Medical Indemnity Fund damages and non-fund damages in an obstetrical malpractice case; in other words, an allocation which satisfies the legislative intent of the Medical Indemnity Fund statute and generates a savings to an insurer or medical provider appropriate to the facts of the case.[198]

The judge approves the allocation and records it in a judgment order or settlement agreement.

NYMIF Administration

The New York Department of Health (NYDOH) oversees NYMIF, and the New York Commissioner of Taxation and Finance (commissioner) serves as the custodian of the NYMIF account.[199] In consultation with the Superintendent of Financial Services (superintendent), the New York State Commissioner of Health is responsible for establishing the regulations that govern the administration of the NYMIF.[200]

The commissioner makes payments from the fund upon signed certificates; however, NYDOH contracts with a private consulting company to administer health care and pharmacy benefit claims processing, as well as the fund's day-to-day operations. New York law requires NYMIF to remain separate from other funds or state monies. The fund's money may be invested; however, no NYMIF funds can be transferred to any other fund or applied for any other purpose.[201]

Any funds not immediately used may be invested at the commissioner's discretion in consultation with the budget director, and the fund must retain the proceeds of any investment as assets. The superintendent is authorized to assign, and the commissioner is authorized to receive assignments for all contracts to administer the fund for periods before October 1, 2019. Since October 1, 2019, funds must be deposited into the NYMIF each fiscal year by either the commissioner or the superintendent.[202]

[198] Ibid.
[199] Effective October 1, 2019, the New York State Department of Health took over the responsibility of overseeing the NYMIF, previously managed by the New York Department of Financial Services.
[200] The New York State Commissioner of Health and the Commissioner of Taxation and Finance are distinguished under the fund's regulations. NY Comp. Codes. R. & Regs. Tit. 10 §§ 69-10.1.
[201] NY Pub. Health Law § 2999-i.1.(a).
[202] NY Pub. Health Law § 2999-i.1.-2.

After deposits are completed, the commissioner conducts an actuarial calculation of the NYMIF's estimated liabilities for the coming year based on enrolled qualified plaintiffs. The administrator adjusts the calculation as required by law. If the total current liabilities estimate equals or exceeds 80 percent of the fund's assets, the fund cannot accept new enrollments until a new deposit has been made. If enrollment is suspended, the administrator must deny each application received but not accepted before the date of suspension and each application for enrollment received thereafter.

Notification of the suspension period must be inserted on the NYDOH's website, and each plaintiff or claimant must be notified of any denials. Judgments and settlements for plaintiffs or claimants with denied applications or enrollment ineligibility due to suspension are satisfied outside of NYMIF through the traditional medical malpractice liability process.[203] Following a suspension, notice must be promptly posted on the NYDOH website whenever enrollment resumes. Enrollment suspension does not impact fund payments for qualified plaintiffs already enrolled in NYMIF.[204]

NYMIF Funding

Beginning April 1, 2014, and annually thereafter, the superintendent or commissioner must authorize a deposit into the fund, subject to available appropriations, an amount equal to the difference between the amount appropriated to the fund in the preceding fiscal year, as increased by the adjustment factor, and the assets of the fund at the conclusion of that fiscal year.[205] The adjustment factor is the ten-year rolling average medical component of the consumer price index, as published by the US Bureau of Labor Statistics, for the preceding ten years.[206]

NYMIF Application and Enrollment Process

To enroll in the NYMIF, an application must be submitted by a qualified plaintiff (as previously defined), a person authorized to act on the plaintiff's behalf, or a defendant in a medical malpractice claim that results in a court-approved settlement or judgment issued on or after April 1, 2011, stating that the plaintiff sustained a birth-related neurological injury. The qualified plaintiff may submit an application by

[203] NY Pub. Health Law § 2999-i.6.(a)-(b).
[204] NY Pub. Health Law § 2999-i.6.(c)-(d).
[205] NY Pub. Health Law § 2999-i.5.
[206] NY Pub. Health Law § 2999-i.7. An adjustment factor is a numerical value used to modify a measurement or calculation to account for changes or differences in conditions.

downloading it, requesting it by phone, or submitting it in writing. The completed application must include the following:

- A signed medical release form on patient confidentiality.
- A certified copy of the court-approved settlement or judgment, including all documents and/or exhibits.
- Documentation regarding the specific nature and degree of the applicant's birth-related neurological injury or injuries.
- Documentation in the form of copies of medical records that support the allegation that the injury was a result of oxygen deprivation, a mechanical injury, or other action or failure to act.
- The names, addresses, and phone numbers of all providers providing services to the applicant at time of enrollment.
- Documentation of all other present sources of health care coverage or reimbursement, including commercial insurance and/or government program(s).

The fund administrator reviews the settlement or judgment to ensure it explicitly states the fund will pay all future medical expenses of the plaintiff or claimant. If the language is missing or unclear, the application is considered incomplete, and the fund administrator will advise the applicant to return to the court that approved the settlement or issued the judgment for clarity.[207]

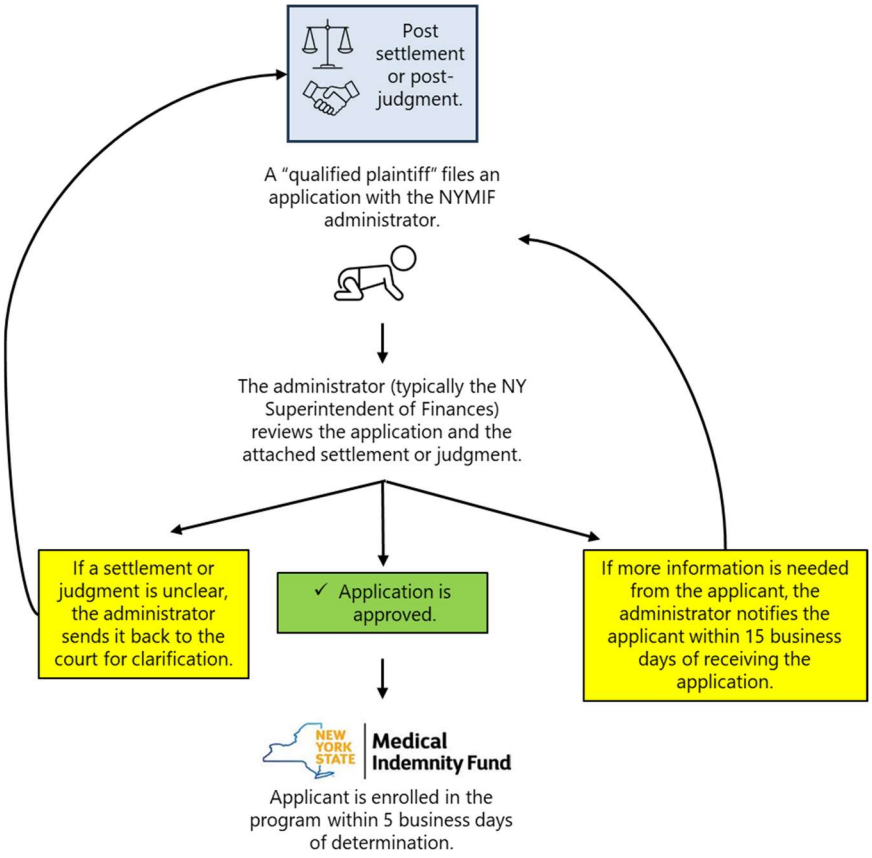
The fund administrator reviews all required documentation and notifies the applicant within 15 business days of application receipt if any information is still needed. No application is considered submitted until all required documentation is provided.

If the fund administrator determines the applicant is eligible, the qualified plaintiff is enrolled within five business days. NYMIF provides written notification of enrollment to applicants. The fund will then reimburse all appropriate health care expenses incurred between the date the court approved the settlement or judgment and the date the qualified plaintiff becomes a fund enrollee.[208] Once enrolled, the enrollee remains in the NYMIF for life and receives NYMIF identification cards. See Exhibit 41 for a visual of the application and enrollment process.

[207] NY Comp. Codes. R. & Regs. Tit. 10 §§ 69-10.2.(d).
[208] NY Comp. Codes. R. & Regs. Tit. 10 §§ 69-10.2.(f)(1)-(2). The NY Public Health Law prescribes a procedure by which any party in a medical malpractice action resulting in a birth-related neurological injury may petition the court to add language that NYMIF will reimburse medical expenses in the judgment.

Exhibit 41

New York Medical Indemnity Fund Application and Enrollment Process



Source: Developed by LBFC staff from information obtained from the New York Medical Indemnity Fund.

Eligibility for or continued enrollment in NYMIF does not depend on the current or past residency of a qualified plaintiff or enrollee. However, enrollees are advised to notify the fund administrator of any address changes within 10 business days to prevent delays in payments or services.[209]

NYMIF Claims Process

New York regulations require providers treating an enrollee to accept payment from the fund. The claims submission process includes both electronic and manual options, and an enrollee identifier must be included on the claim form. Claims must be submitted within 90 days of the date of service and paid within 45 days of receipt. Requests to

[209] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.22.

submit a claim more than 90 days after the date of service may be granted by the fund administrator upon showing good cause.[210]

The regulations also authorize claims assistance managers to answer questions regarding the application process; handle issues raised about alleged delays in processing applications, claims, reviews of claim denials, and prior approval initial determinations and reviews; and assist in resolving any issues involving enrollees and case managers or the assignment of case managers.[211]

NYMIF Compensation

NYMIF will pay for all "qualifying health care costs" necessary to meet a plaintiff's needs. Qualifying health care costs include the following shown in Exhibit 42:

Exhibit 42

New York Medical Indemnity Fund Qualifying Health Care Costs

- ✓ Medical treatment.
- ✓ Hospital-based care.
- ✓ Surgical care.
- ✓ Nursing care.
- ✓ Dental care.
- ✓ Durable medical equipment.
- ✓ Vehicle modifications.
- ✓ Prescription and non-prescription medications.
- ✓ Rehabilitative care.
- ✓ Habilitation care.
- ✓ Home modifications.
- ✓ Respite care.
- ✓ Custodial care.
- ✓ Assistive technology.
- ✓ Transportation for purposes of health care-related appointments.
- ✓ Other health care costs.

Source: Developed by LBFC staff from information obtained from New York Public Health Law.

Qualifying health care costs do not include any services or equipment potentially available to the enrollee under an Individualized Education Program, Preschool Supportive Health Services Program, Early Intervention Program (or equivalent program in another country), unless the enrollee's parent or guardian demonstrates a reasonable effort to obtain the services or equipment through such a program and was denied.

Once claims have been submitted directly to the NYMIF administrator, they are reviewed, and the fund pays the provider directly upon approval.

[210] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.5(a)-(d).
[211] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.3.

NYMIF provides a general reimbursement form for claims, shown below in Exhibit 43.

Exhibit 43

New York Medical Indemnity Fund General Reimbursement Form

NEW YORK STATE | Department of Health | Medical Indemnity Fund

Enrollee Name _____

Enrollee MIF ID # NYS_____

Payment will be issued to the enrollee.
Enrollee is responsible for reimbursing the provider.

Questions on how to fill this out?
Please call Customer Service:
1-855-NYMIF33 (855-696-4333) and press Claims Option

GENERAL REIMBURSEMENT FORM - USE FOR:

- Provider services, including office co-pays, co-insurance, and deductibles
- Respite Care
- Supplies

Instructions

- Add as many/few lines as you would like (no other alterations can be made)
- Each service/item must be broken out on individual rows
- Must include all requested data per **all** column headers.
- Attach **all** itemized receipts which must include providers printed name & signature, address, phone number, date(s) of service, and paid amount
- Respite Care: If more than 1,080 hours are provided in a calendar year, prior approval is required
- Co-pay receipts must be on office or pharmacy letterhead
- Additional forms may be used if necessary
- Send completed forms to NY_DOH_MIF@pcgus.com or mail to:
  MIF c/o PCG, P.O. Box 784 Greenland, NH 03840-0784

Provider's Last Name	Providers First Name	Providers Address	Place of service (Ie. Home, Office, Retail Store)	Date of Service From	Date of Service To	Description of Service/Item: As shown on receipt or as described by provider	Total Unit of Service/Item (Ie. Days, Hours, Quantity)	Total Amount Billed ($)

I certify the information given is accurate and no items and/or services have been reimbursed or are pending reimbursement by another source(s)

SIGNATURE _____ RELATIONSHIP TO ENROLLEE _____

PRINT NAME _____ DATE: _____/_____/_____

Source: New York Department of Health.

Some medical expenses covered under NYMIF require prior approval and additional documentation. The NYMIF administrator has 30 days from receipt of the necessary documentation to approve the request. Prior approval is required for the following:[212]

[212] NY Comp. Codes. R. & Regs. Tit. 10 §§ 69-10.6(a)-(b). A vehicle modification request may only be made for a vehicle owned by the enrollee or a member of the enrollee's household who has consistent and ongoing contact with the enrollee and provides unpaid primary, long-term support. NY Comp. Codes. R. & Regs. Tit. 10 §§ 69-10.9. A home modification, or "emod," must be for the enrollee's primary residence, except if physical custody is being shared pursuant to a court order, it may also be approved when made to the primary residence of the enrollee's non-custodial parent. Proof of ownership of the residence must be submitted to the fund administrator. If the requesting party does not own the residence, written permission from the property owner must be provided. A non-custodial parent applying for an emod to his or her primary residence must also provide a certified copy of the court order awarding shared physical custody. NY Comp. Codes. R. & Regs. Tit. 10 §§ 69-10.7.

- Assistive technology.
- Vehicle modifications.
- Environmental modifications.
- Myo-electric limbs.[213]
- Certain types of transportation for medical care and services (including travel involving overnight accommodation).
- Private duty nursing.
- Treatment with a specialty drug.
- Experimental treatment for which the enrollee's provider has submitted documentation.[214]
- Custom-made durable medical equipment.
- Hearing aids.
- More than 1,080 hours of respite care in a calendar year.

NYMIF Denial Review Process

New York regulations provide a review process for claims denials and prior approval requests. To begin the process, a request for review must be submitted within 30 days of receipt of the denial. The request form is provided to all enrollees and/or their parent(s), guardian(s), or legal representative(s) and is available on the fund administrator's website. Upon completion, the form is electronically submitted, mailed, or faxed to the fund administrator's office.[215]

A request for review must specify the denial the enrollee is seeking to appeal, including justification, and indicate whether the requester wants a review:

- Based on documents submitted by both parties.
- In the form of a telephone or in-person hearing.[216]

The enrollee's chosen review option will be the exclusive review form, and a hearing officer will conduct the review.[217]

An enrollee who has had a prior approval request denied may seek an informal conference and formal review. In that case, the fund administrator designates a person to participate in an informal conference with the enrollee and/or their authorized representative to discuss the reason(s) for the denial. The conference may be scheduled

[213] Myoelectric limbs are advanced, battery-powered prosthetic devices controlled by electoral signals generated by a user's remaining muscles.
[214] Documentation must comply with the same standards set out in section 4910 (2)(b)(i)-(iii) of the Public Health Law.
[215] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.16(a).
[216] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.16(b).
[217] Ibid.

no later than one week before the formal review.[218] The regulations also specify requirements for the three types of reviews (document review, telephonic review, and in-person review). Expedited denial reviews are provided if enrollees can show that:

- They submitted a formal written statement from a provider stating that the enrollee had an emergency need for the medical service(s) or item(s) at issue and the reason the service or item was needed on an expedited basis.

- The fund administrator denied the request for expedited prior approval. Such reviews must be conducted within 10 business days of receiving the request for expedited review and include all supporting documentation.[219]

The hearing officer makes a written recommendation within five business days of the document-based review or hearing. The commissioner issues a written decision within five business days of receiving the hearing officer's recommendation.[220]

NYMIF Rates of Payment

NYMIF pays physicians at the 80th percentile of the usual and customary charges for services provided in private physician practices, as reported by FAIR Health, Inc., in its Usual, Customary and Reasonable (UCR) database at the time of billing.[221]

Vehicle modifications and assistive technology are paid at an amount established by the prior approval process. Services, supplies, and equipment for which a Medicaid fee or rate is available will be paid at that fee or rate. Medications are paid at the Medicaid rate; however, if the NYDOH determines Medicaid rates are unavailable due to technological issues and related administrative costs, a pharmacy benefits manager designated by the fund administrator and approved by the NYDOH may be used to price medications.[222]

Other services are paid at a reasonable rate, based on geographic area and determined by the fund administrator. Rates are deemed

[218] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.16(c).
[219] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.17(a)(1)-(2).
[220] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.17(b)-(c).
[221] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.21(a). FAIR Health is an independent, national nonprofit organization that aids in understanding health care costs and health coverage.
[222] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.21(b)-(d).

"reasonable" if they are sufficient to provide the enrollee with access to services and do not exceed the prevailing rates in the region.[223]

NYMIF Actuarial Calculations

The superintendent conducts an actuarial calculation following the NYMIF's annual deposit to determine the fund's estimated liabilities for the year. This calculation is performed on a quarterly basis thereafter.

The analysis includes a review of all elements contributing to the amount of benefits paid by the fund and the fund's administrative expenses, including:[224]

- The number of qualified plaintiffs admitted in the fund, and estimates of the number of qualified plaintiffs not yet admitted;
- The mortality experience of the qualified plaintiffs admitted to the fund;
- The amounts of benefits paid by the fund by types of services provided;
- The patterns of utilization by types of services provided;
- The inflationary patterns by types of services provided;
- The expenses of administration of the fund;
- The impact available health insurance has on the benefits paid by the fund;
- The investment earnings on the assets held by the fund.

Its latest actuarial analysis for the fourth quarter of 2024 (as of December 31, 2024), noted several conclusions, some of which include the following:

- As of December 31, 2024, NYMIF accepted 1,111 participants (1,083 living) with expected future benefit payments of approximately $7.12 billion and future administrative expenses of $521.4 million (assuming a discount rate of 1.0 percent and future medical inflation of 3.0 percent). With a fund balance of approximately $70.7 million, the fund has an unfunded liability of approximately $7.57 billion.

- From January 1, 2024, to December 31, 2024, the average benefit payments per participant were $34,112 per quarter, representing a 177.1 percent increase over the average payments in FY 2016-17.

[223] NY Comp. Codes. R. & Regs. Tit. 10 § 69-10.21(e).
[224] NY Comp. Codes. R. & Regs. Tit. 10 §§ 69-10.19(a)-(b).

- As of December 31, 2024, 159 participants received more than $1 million in benefit payments, with 88 of these participants receiving more than $2 million in benefit payments, and 57 receiving more than $3 million in benefit payments. It is anticipated that 19 more enrolled participants will cross the $1 million threshold in FY 2025-26.[225]

The analysis also noted that early in NYMIF's operations, New York Medicaid erroneously paid some health care benefits that the fund should have paid.[226]

NYMIF Program Outcomes and Funding Challenges

While one health system we interviewed indicated that NYMIF was a "game changer" when addressing the cost of birth-related neurological injury malpractice lawsuits, there is scant evidence that the NYMIF program lowered malpractice premiums (as shown in Section II).

Additionally, sustaining adequate funding for NYMIF has been a significant challenge. In June of 2025, the fund was reported to have a projected shortfall of $3 billion. New York has had to quadruple its funding, setting aside $52 million in taxpayer funds to maintain the fund. Because of rising costs and liabilities to NYMIF and the requirement that new enrollment be suspended if liabilities equal or exceed 80 percent of the fund's assets, access to the fund has been delayed.[227]

New York's governor and legislature agreed to increase appropriations to address the NYMIF's funding concerns. The FY 2025-26 New York state budget appropriated $211 million, representing an increase of $159 million from the recurring $52 million appropriation of previous years.[228]

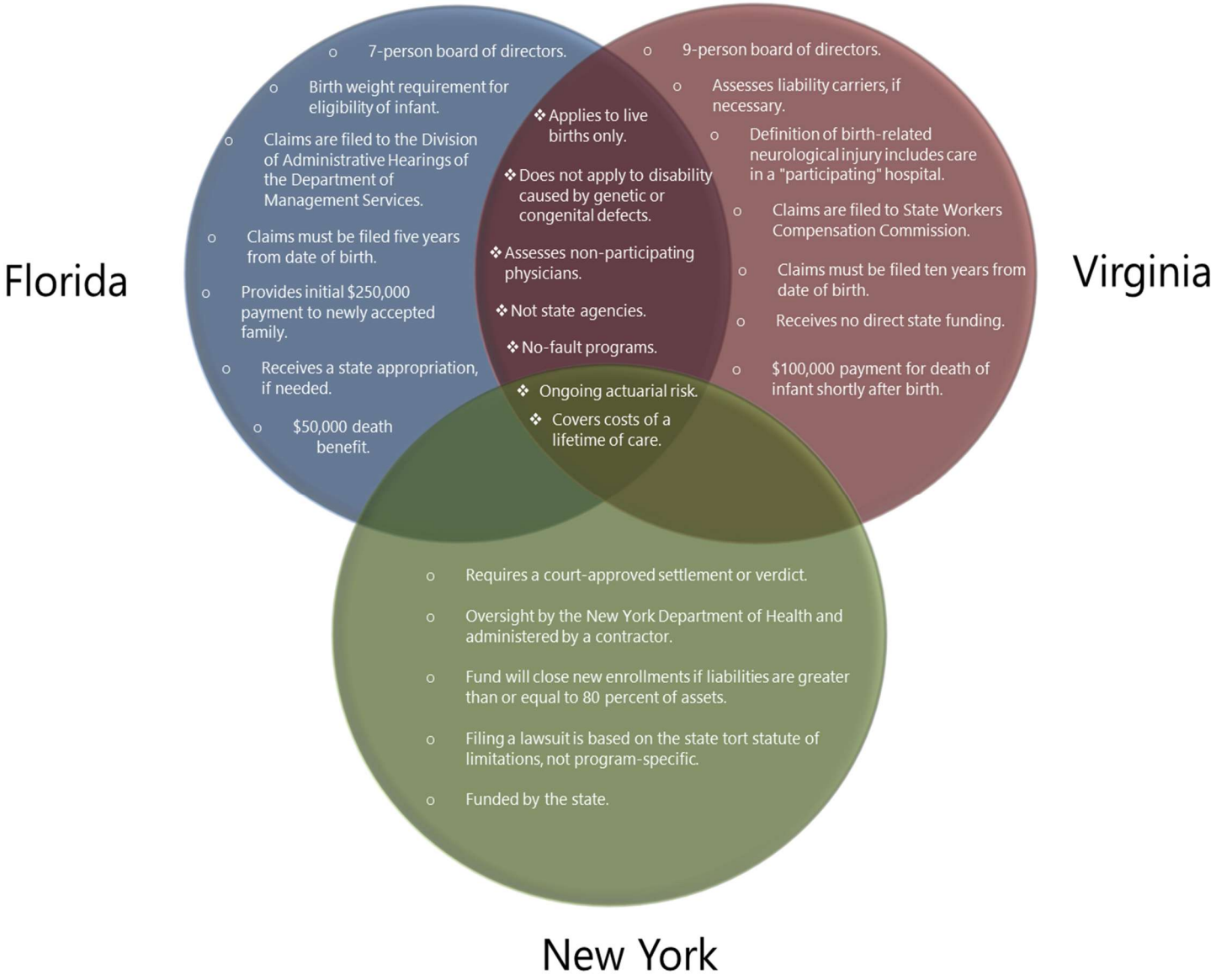
[225] New York State Department of Health, New York State Medical Indemnity Fund 4th Quarter 2024 Analysis as of December 31, 2024, PINNACLE, (Mar. 2025), pgs. 1-2.
[226] If a plaintiff has health insurance (excluding Medicaid and Medicare), the insurance must be used first for each claim before NYMIF is obligated to pay. The fund may reimburse copayments and deductibles, but not health insurance premiums. However, NYMIF must pay expenses before any Medicaid payments are made for the enrollee. Like Virginia and Florida's programs, NYMIF previously allowed erroneous Medicaid payments to be made.
[227] Saeidi, Masha. New York State Quadruples Funding for Medical Indemnity Fund. Here's Why There are Still Concerns," CBS News. June 2025.
[228] MLMIC Insurance. *Albany Report* 02-2025.

Comparison of New York, Florida, and Virginia Programs

Like the Virginia and Florida programs, NYMIF is narrowly focused on birth-related neurological injuries. Each program defines "birth-related neurological injury" similarly and is designed to address high medical malpractice premiums in its respective state. All three programs have erroneously allowed Medicaid to pay claims for which the programs themselves were responsible. Florida's and Virginia's programs are more similar to each other than New York's. For a visual comparison of the NYMIF the three programs, see Exhibit 44.

Exhibit 44

Key Similarities and Differences Between the FL, VA, and NY Birth-Related Neurological Injury Funds



Source: Developed by LBFC staff from information obtained from the Virginia Birth Injury Fund, Florida Birth-Related Neurological Injury Compensation Association, and New York Indemnity Fund.

D. The Feasibility of a No-Fault Birth-Related Neurological Injury Fund in Pennsylvania and Legislative Considerations

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 in the commonwealth, we offer the following considerations.

Program Administration

The General Assembly should consider which entity would oversee the fund. Based on Pennsylvania's existing agency structures, it is likely that the Insurance Department (PID) would be the best fit for administering the fund, as PID already administers the Medical Care Availability and Reduction of Error Fund (MCARE). Although MCARE differs from a possible BRNIF (see later in this section), PID has some basic structures in place that would be needed for a birth-related injury fund.

The General Assembly may also want to consider creating a new board to serve as the fund's governing entity, like those in Virginia and Florida. As stated by the US Government Accountability Office (GAO): "An oversight body oversees the entity's operations; provides constructive criticism to management; and, where appropriate, makes oversight decisions so that the entity achieves its objectives in alignment with the entity's integrity and ethical values."[229]

Program Funding

The General Assembly should consider how BRNIF would be funded. For example, if health care providers, health care facilities, insurance companies, or some combination were to be charged assessments, the frequency of such charges and the amount necessary to fully fund the program would need to be determined. Additionally, a mechanism to increase the fee(s) should be implemented, particularly to address inflation.

We could not determine how many cases of birth-related injuries occur in Pennsylvania, because occurrences are not tracked. In some instances, birth-related neurological injuries are not obvious until months or years

[229] United States Government Accountability Office. *Standards for Internal Control in the Federal Government*. September 2014.

after the birth. In turn, it is difficult to predict potential costs to the fund using the current publicly available datasets. One national study concluded: "Among the ten leading types of pediatric claims between 1985 and 2008, the brain-damaged infant was at the top of the list. The average indemnity for these cases was $524,047, and only meningitis claims were more costly."[230] Adjusted for inflation, that would likely be over $800,000 today.

There is a range of birth-related neurological injuries, making the costs of care hard to predict. Cerebral Palsy (CP) is the leading cause of childhood disabilities in the US and one possible result of a birth-related neurological injury, although not all instances of CP are caused by birth-related injuries. CP can range from mild to severe.[231] In one study of the cost of care in Medicaid for children with CP, researchers found:

- The most common management options were physical therapy (37.1 percent), orthotics (29.9 percent), oral baclofen (13.5 percent), and botulinum toxins (9.4 percent).

- Overall annualized Medicaid costs were higher for children with CP versus children in the overall database population ($22,383 vs. $1,358).

- Within the CP population, costs were higher for children who were likely non-ambulatory than for those who were likely ambulatory ($43,687 vs. $10,368).[232]

Birth injury data specific to neurological injury is not easily extrapolated from state or federal data sources. When Florida's and Virginia's programs were first implemented, "program officials in both states expected about 40 claims to be filed under each program annually… [however] the actual number filed has been much lower."[233] A comprehensive actuarial analysis using data from Florida's and Virginia's BRNIFs found that, under both states' programs, the average [covered] birth-related neurological injury meeting the states' eligibility criteria was 0.9 to 1.0 per 10,000 live births.[234]

[230] Donn, Steven, Malcom Chiswick, and Jonathan Fanaroff. *Medico-Legal Implications of Hypoxic-Ischemic Birth Injury*. Seminars in Fetal and Neonatal Medicine. 2014.
[231] National Institute of Neurological Disorders and Stroke. https://www.ninds.nih.gov/health-information/disorders/cerebral-palsy, Accessed November 19, 2025.
[232] Pulgar, Sonia, et al. *Prevalence, Patterns, and Cost of Care for Children with Cerebral Palsy Enrolled in Medicaid Managed Care*. Journal of Managed Care and Specialty Pharmacy. July 2019.
[233] United States General Accounting Office (now named the Government Accountability Office). *Medical Malpractice: Alternatives to Litigation*. January 1992.
[234] Using elements of definitions used in Florida and Virginia birth funds, Pinnacle defined birth-related neurological injury as an injury to the brain or spinal cord of a live infant that was caused by oxygen deprivation or mechanical injury; occurred in the course of labor or delivery in a hospital; and resulted in death or permanent and substantial mental and physical disability. (Pinnacle Actuarial Resources, Inc. *The Case for Birth Injury Funds*. March 2017.)

Exhibit 45 shows the number of FNICA's claims ruled compensable versus non-compensable and the compensable claims per 10,000 births from 2014 to 2024.

Exhibit 45

Florida Birth-Related Neurological Injury Compensation Association
Number of Claims Ruled Compensable or Non-Compensable
2014 to 2024

Adjudication Year	Compensable Claims	Non-Compensable Claims	Compensable Claims Per 10,000 Births
2014	14	39	0.64
2015	17	30	0.76
2016	12	33	0.53
2017	14	30	0.63
2018	14	32	0.63
2019	17	36	0.77
2020	25	32	1.19
2021	19	32	0.88
2022	18	48	0.80
2023	31	37	1.40
2024	18	53	0.80[a/]

Notes:
[a/]Based on 2024 provisional birth data.

Source: Developed by LBFC staff from information obtained from the Florida Birth-Related Neurological Injury Compensation Association and the United States Department of Health and Human Services.

According to VBIF, since its founding, "more than 150 children, about two-thirds of all applicants, have been admitted into the Program."[235] Exhibit 46 shows the number of admitted participants, the total number of participants, and the ratio of admitted participants per 10,000 births.

[235] https://www.vabirthinjury.com/why-the-birth-injury-program/, Accessed March 16, 2026.

Exhibit 46

Virginia Birth-Related Neurological Injury Compensation Program Participants

2014 to 2024

Year	Admitted Participants	Admitted Participants Per 10,000 Births[a/]
2014	11	1.06
2015	14	1.36
2016	3	0.29
2017	7	0.70
2018	2	0.20
2019	5	0.51
2020	5	0.53
2021	2	0.21
2022	2	0.21
2023	8[b/]	0.86
2024	8[b/]	0.85[c/]

Notes:
[a/]Neurological injuries are not always reported in the same year as the child's birth, but for comparison purposes, we compared admitted participants with total births from the same year.
[b/]Virginia's reporting was different in 2023 and 2024 to include total claimants, newly admitted claimants, deceased upon admission, and deceased. It was unclear if prior years included the same information.
[c/]Based on 2024 provisional birth data.

Source: Developed by LBFC staff from information obtained from the Virginia Birth-Related Neurological Injury Compensation Program and the United States Department of Health and Human Services.

As previously noted, New York's program structure differs from those in Florida and Virginia. Since enrollees go through the traditional malpractice litigation process and the statutory criteria are broader, New York has more fund participants. As shown in Exhibit 47, NYMIF admitted participants were a maximum of 4.78 out of every 10,000 births.

Exhibit 47

NYMIF Admitted Participants
2014 to 2024

Year	Admitted Participants	Admitted Participants Per 10,000 Births
2014	91	3.81
2015	85	3.58
2016	91	3.88
2017	72	3.13
2018	73	3.23
2019	106	4.78
2020	100	4.78
2021	74	3.51
2022	79	3.80
2023	73	3.59
2024	75	3.66[a/]

Note:
[a/]Based on 2024 provisional birth data.

Source: Developed by LBFC staff from information obtained from the New York Department of Health and the United States Department of Health and Human Services.

Although the number of birth-related neurological injuries that occur in Pennsylvania annually is unknown, some public-facing data sources do provide surveillance data on birth morbidity and mortality.

In 2024, the Patient Safety Authority (PSA) conducted a study of serious events that were reported as "Neonatal complication subtype of the Complication of Procedure/Treatment/Test.[236] The study was conducted due to a 92 percent increase in serious L&D events between 2018 and 2022.[237] Ultimately, after a manual review and supplemental data request, 162 serious events met the study definition between January 1 and December 31, 2022. PSA found shoulder dystocia to be the most frequent type of serious neonatal complication based on the Pennsylvania Patient Safety Reporting System (PA-PSRS) reports and supplemental data. However, due to the study's limitations, PSA concluded that further research on neonatal complications would be

[236] Pennsylvania Patient Safety Authority. *Neonatal Serious Events Related to Labor and Delivery*. April 2024. PSA is an "independent state agency that collects reports of patient safety events from Pennsylvania healthcare facilities." Reporting to the Pennsylvania Patient Safety Reporting System (PA-PSRS) is mandated by Pennsylvania law under Act 13 of 2002, Act 30 of 2006, and Act 52 of 2007; effective June 28, 2004, for hospitals, ambulatory surgical facilities, and birthing centers.
[237] The study definition was "an event related to labor and delivery that occurred or became apparent during labor and delivery or within three hours after birth, and resulted in an unanticipated injury or the death of a neonate."

beneficial, along with more comprehensive data reporting, to assist PSA in identifying "trends and future opportunities to prevent neonatal complications and death across the commonwealth."

Another analysis of patient safety trends in serious events and incidents reported to the PA-PSRS in 2023 revealed that under the event type Complication of Procedure/Treatment/Test (P/T/T), subtype Neonatal complication, there were 2,461 reports, of which 150 were serious events.[238] Neonatal serious events accounted for approximately 0.1 percent of all 2023 live births.

Serious events do not necessarily imply a claim for medical malpractice purposes. Additionally, annual reports to the PA-PSRS provide regional surveillance on patient safety events across all health care facilities for "serious events" and "incidents," but lack specificity about exact birth-related injuries.

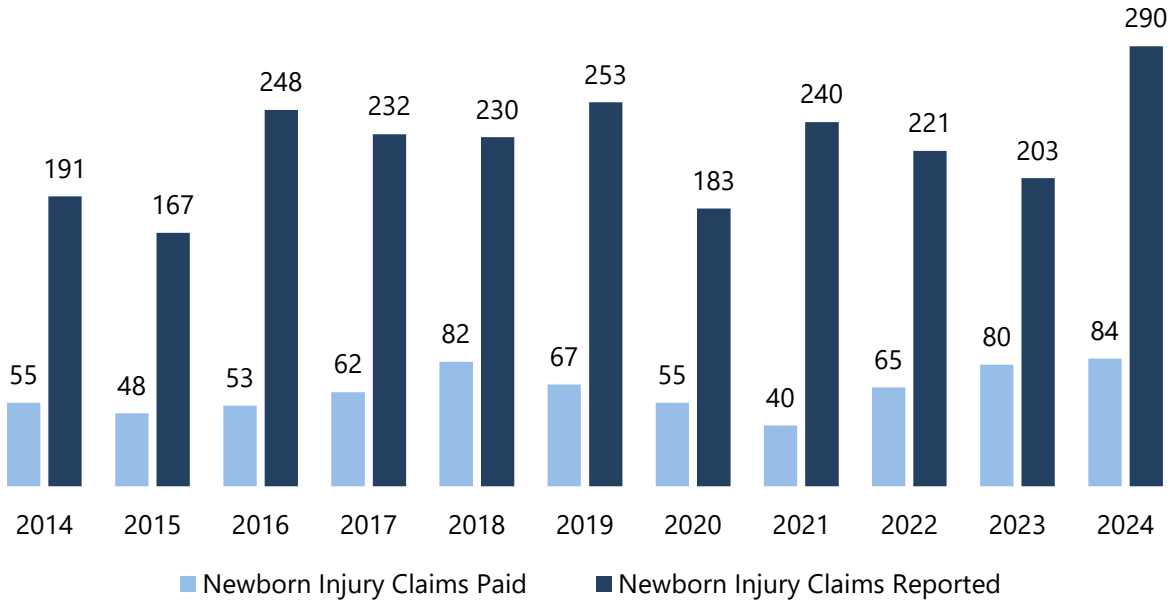
To further estimate birth-related injuries in Pennsylvania, we also examined MCARE data. Insurers report medical professional liability claims to MCARE that surpass the policyholder's primary coverage of $500,000. Not all claims made against health care providers are reported to the fund, and those reported are not necessarily within a specific time frame after a claim is filed. To give a brief overview of birth injuries, we reviewed claims data from MCARE coded as "newborn." According to PID, claims reported and claims paid that were coded as newborn cannot be easily broken down by injury type (e.g., neurological) from other immediate birth injuries. Exhibit 48 below shows newborn claims reported and paid by calendar year.[239]

[238] Kepner S. et al. *Patient Safety Trends in 2023: An Analysis of 287,997 Serious Events and Incidents from the Nation's Largest Event Reporting Database*. April 2024.

[239] Claims paid in the claim year, September 1 to August 31. Injuries may not have occurred during the same claim year. Claims are reported to MCARE during the annual period January 1 to December 31, with the claimant's age coded as "newborn."

Exhibit 48

Pennsylvania Medical Care Availability and Reduction of Error Fund Newborn Claims
2014 to 2024



Source: Developed by LBFC staff from information obtained from the Pennsylvania Department of Insurance.

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.

As mentioned later, if the General Assembly decides to implement a fund, it would have to determine specific eligibility criteria. Even then, it may be difficult to predict appropriate funding levels. For example, MCARE has generally been able to pay current claims since its inception, as has its predecessor (the Pennsylvania Catastrophic Loss Benefits Continuation Fund), but it has had a growing unfunded liability due to the "pay-as-you-go" format and tail coverage.[240]

A growing unfunded liability has also been the case with Virginia and Florida's BRNIFs. NYMIF is also considered financially unstable but has mechanisms in place to prevent new enrollees from entering the

[240] A tail in insurance terms involves claims made after a policy ends for incidents that occurred when it was active.

program when estimated liabilities reach or exceed 80 percent of the fund's assets. Historically, in this case, NYMIF has received an increased appropriation to better the fund's financial position.[241]

Existing Legal Frameworks

The existing legal framework is an important consideration. As discussed in Section II, the General Assembly sought to address broader concerns about medical malpractice when it established the MCARE Fund. Pennsylvania's MCARE Fund provides compensation to individuals injured by all types of medical negligence. MCARE pays claims against participating health care providers and eligible entities for losses or damages awarded in medical professional liability lawsuits that exceed primary insurance coverage provided by primary professional liability insurance companies or self-insurers.

Opponents of a no-fault BRNIF in Pennsylvania argue that such a program would essentially be another MCARE fund. Instead of limiting liability, some argue this would simply shift it from hospitals to taxpayers (particularly if there were another unfunded liability).

Structure of Law. To create a BRNIF in Pennsylvania, the General Assembly would need to determine the legal framework of the law. Of states with BRNIFs, Virginia and Florida have more detailed requirements embedded in statutory law, whereas New York has a less specific statutory framework that leaves the details to regulations. If the General Assembly creates a birth-related injury fund, it should be established in statutory law as specifically as possible to protect the fund and the commonwealth. Enacting a fund's specific requirements into statute also typically promotes greater transparency, as statutes are enacted by legislative bodies rather than promulgated by unelected executive agencies.[242] Statutory provisions can also provide clear mechanisms for legal compliance and enforcement.

Potential Legal Challenges. A no-fault program like Florida's and Virginia's could also face legal challenges if enacted in the commonwealth. In Pennsylvania, discussion on the constitutionality of lawfully enacted legislation must commence with the principle of law which creates a "presumption" in favor of constitutionality. "An Act of Assembly will not be declared unconstitutional unless it clearly, palpably and plainly violates the Constitution."[243] Further, "[t]he burden rests heavily upon the party seeking to upset legislative action on

[241] Saeidi, Mahsa. *New York State Quadruples Funding for Medical Indemnity Fund. Here's Why There are Still Concerns*. CBS News. June 2025.
[242] Both statutes and regulations are subject to public review.
[243] *Daly v. Hemphill*, 191 A.2d 835, 840 (Pa. 1963).

constitutional grounds; all doubt is to be resolved in favor of sustaining the legislation."[244]

A no-fault BRNIF could face challenges under the commonwealth's state constitution. Pennsylvania's constitution guarantees a right to a trial by jury.[245] Specifically, Article I, § 6 provides the fundamental guarantee, stating that a "[t]rial by jury shall be as heretofore, and the right thereof remain inviolate." The Pennsylvania Supreme Court has held that the "[c]onstitutional right to a jury trial, as set forth in the Commonwealth constitution, does not differentiate between civil cases and criminal cases."[246] Further, the court has opined that "[t]he right to a jury trial in a civil action is a fundamental aspect of our system of law."[247] The creation of a BRNIF with compulsory participation for a qualifying claimant and the exclusion of other remedies (as is the case in Florida and Virginia) could become the subject of litigation alleging a violation of the right to a jury trial.

However, some stakeholders argue there are already examples of statutory remedies serving as alternatives to court action and the right to a trial by jury, such as the Pennsylvania Workers' Compensation Act (WCA).[248] The WCA established a statewide electronic claim processing system through the Workers' Compensation Automation and Integration System (WCAIS). Claims filed through the system are adjudicated by Workers' Compensation Judges and the Workers' Compensation Appeal Board, which provides appellate review of those adjudications. Much like the Florida and Virginia programs, the Workers' Compensation system is funded through assessments; however, these assessments are placed on insurers and self-insurers and passed to the Workers' Compensation Administration Fund. The WCA generally prohibits Workers' Compensation claimants from filing lawsuits against their employers for workplace injuries under its exclusivity doctrine, which makes workers' compensation benefits the exclusive remedy against employers for work-related injuries.[249] The Pennsylvania Supreme Court has upheld the exclusivity of remedies under the WCA, explaining:

> …it reflects the historical *quid pro quo* between an employer and an employee whereby the employer assumes liability without fault for a work-related injury,

[244] *Milk Control Commission v. Battista*, 198 A.2d 840, 843 (Pa. 1964).
[245] PA CONST. art. I, § 6.
[246] *Bruckshaw v. Frankford Hospital of City of Philadelphia*, 58 A.3d 102 (Pa. 2012).
[247] *Siskos v. Britz*, 790 A.2d 1000, 1006, n. 4 (Pa. 2002).
[248] Act of June 2, 1915 (P.L.736, No.338), art I, § 101, known as the Workers' Compensation Act, as amended 77 P.S. § 1 *et seq*.
[249] 77 P.S. § 481. Notably, the WCA provides exceptions that allow claimants to file civil lawsuits against their employers. These exceptions include (1) lawsuits against third parties who cause workplace injuries under the act, (2) the personal animus exception under § 411 of the act, (3) the narrow Martin exception for cases involving an employer's fraudulent conduct. 77 P.S. §§ 481, 411; *Fry v. Atlantic States Ins. Co.*, 700 A.2d 974 (Pa. Super. 1997).

> but is relieved of the possibility of a larger damages verdict in a common [-] law action. The employee benefits from the expeditious payment of compensation but forgoes recovery of some elements of damages. The comprehensive system of substantive, procedural, and remedial laws comprising the [workers'] compensation system should be the exclusive forum for redress of injuries in any way related to the workplace.[250]

While the WCA provides a form of due process through adjudicatory review, workers' compensation claimants do not have a right to a jury trial. The WCA has been upheld repeatedly by Pennsylvania courts.

Another potential legal hurdle to consider is Pennsylvania's qualified prohibition on capping recoverable damages in lawsuits. Establishing programs analogous to those in Florida and Virginia could be viewed by the courts as a cap on recoverable damages. Both programs limit the amount of money a claimant or his or her family can receive and foreclose the right to seek redress in court. However, the commonwealth currently has no caps on non-economic damages for medical malpractice cases. In other words, injured plaintiffs can seek full compensation for non-economic harm such as pain and suffering and emotional distress. Furthermore, Pennsylvania has a constitutional prohibition on limiting the recovery of damages.[251]

Proponents of the no-fault tort alternative counter this concern by again drawing attention to Pennsylvania's workers' compensation system. This argument could face scrutiny if contested on constitutional grounds. Article III, § 18 of the Pennsylvania Constitution explicitly prohibits the General Assembly from limiting damage recovery "*in no other cases*" *except for workers*' *compensation matters*. While it is true that remedy exclusivity exists under the WCA, it is expressly permitted by the state constitution. Alternatively, the limitation of damage recovery in other cases is barred by it. The Pennsylvania Supreme Court has also narrowly interpreted this provision, holding that it applies only to private defendants and does not restrict the legislature's authority to impose damage caps on governmental entities. Consequently, while damage caps against private parties would violate the Pennsylvania Constitution, statutory damage caps against the commonwealth and local government

[250] *Franczyk v. Home Depot, Inc.*, 292 A.3d 852, 856 (Pa. 2023).

[251] The MCARE Act does not limit compensatory damages in medical malpractice cases. However, in cases alleging intentional misconduct, punitive damages, which are damages designed to punish a defendant, are limited in Pennsylvania medical malpractice cases to 200 percent of the compensatory damages awarded. 40 P.S. § 1303.505(d).

entities are constitutional and have been consistently upheld by Pennsylvania courts.[252]

Though the state constitution bars the limitation of damage recovery in cases other than workers' compensation, the Pennsylvania Supreme Court has upheld no-fault motor vehicle insurance laws. In the 1975 court case *Singer v. Sheppard*, the Pennsylvania Supreme Court held the following:

> [P]rovisions of No-Fault Motor Vehicle Insurance Act are not violative of constitutional provision that in no cases other than workmen's compensation laws shall General Assembly limit amount to be recovered for injuries to persons, even though provisions of the act allow recovery by one class and proscribe recovery by another for what appears to be same injury, where two classes remain free to recover without limit as to types of injuries assigned to each.[253]

We note that the act in question in this case allowed recovery for proven economic loss without limitation. The effect of the act was to create two classes of motor vehicle accident victims, each with different items of compensable damage. But in each class, the types of losses, which are compensable, have no limit. The court noted that "…where two classes remain free to recover without limit the types of injuries assigned to each, no violation of Article III, § 18 occurs."[254] This would differ from the BRNIF programs we discuss, because compensatory damages in these programs are effectively limited.

Proponents may argue that Article III, § 18 applies only to the filing of lawsuits. BRNIFs that serve as no-fault alternatives do not permit lawsuits for qualifying claimants (except for proof of malice). Since there would be no right to file a lawsuit, the prohibition would not apply, and there would be no material constitutional violation.

At a minimum, a no-fault BRNIF in Pennsylvania that would eliminate the right to a court remedy (outside the workers' compensation exception) is the subject of ongoing legal debate. A BRNIF permitting this could be challenged on constitutional grounds of improperly limiting damage recovery.

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[252] *Smith v. City of Philadelphia*, 516 A.2d 306, 309-10 (Pa. 1986). Recoverable damages are statutorily capped on claims against government entities. Under the Sovereign Immunity Act, damages sought against commonwealth entities cannot exceed $250,000 in favor of any plaintiff or $1,000,000 in the aggregate. 42 Pa.C.S. § 8528(b). Under the Political Subdivision Tort Claims Act, damages against local government entities are limited to $500,000 in the aggregate for claims arising from the same transaction or occurrence. 42 Pa.C.S. § 8553(b).

[253] *Singer v. Sheppard*, 346 A.2d 897 (Pa. 1975). The law in question in this case, the No-Fault Motor Vehicle Insurance Act was repealed by the act of February 12, 1984 (P.L.26, No.11), §8(a).

[254] *Ibid*., 901-2.

Eligibility Criteria

The General Assembly should consider the BRNIF criteria as specifically as possible. As noted throughout this report, other states included criteria such as:

- Birth weight.
- Definition of birthing facilities.
- Type of health care providers covered.
- Course of birthing events.
- Types of disability applicable.
- Types of assistance the child needs.

Defining birth-related injuries, and more specifically, birth-related neurological injuries.

Pennsylvania statutes do not provide a definition of "birth-related injury" or "birth-related neurological injury." A neonate, or newborn, is a baby who is four weeks old or younger; this is known as the neonatal period.[255] A birth injury in a neonate is defined as "a structural damage or functional deterioration of a newborn secondary to a traumatic event that occurred during labor, delivery, or both."[256] According to researchers, fetal presentation, delivery mechanisms, and maternal factors can influence neonatal birth injury risk, type, and severity.[257]

The definition of a "normal birth" varies by source. A commonly cited definition by the World Health Organization (WHO) from 1996 included these factors:

- Labor and birth are spontaneous in onset, low-risk at the start of labor, and remain so throughout labor and delivery.
- The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy.
- After birth, the mother and infant are in good condition.

Since the 1996 definition, the WHO has shifted from the term "normal" birth to "uncomplicated." Additionally, the WHO shifted

> The focus away from pure physiology towards optimal outcomes while retaining an acknowledgment that, for most women, this will occur by allowing physiological processes to proceed. They now allow for, and overtly recommend, certain interventions during birth such as

[255] National Library of Medicine. https://medlineplus.gov/ency/article/002271.htm, Accessed November 12, 2025.
[256] Ojumah N, Ramdhan R C, Wilson C, et al. *Neurological Neonatal Birth Injuries: A Literature Review*. Cureus. December 2017.
[257] Ibid.

> the provision of pharmacological analgesia, including epidural analgesia, where requested, and the routine use of uterotonic agents and controlled cord traction in the third stage.[258]

In other words, as society has advanced, there is an acknowledgment that certain interventions during labor and birth are normal, such as the use of medications for pain and induction or strengthening uterine contractions. The lack of a generally accepted definition of normal or uncomplicated birth leaves some subjectivity in determining when a problem occurs.

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a standardized system for coding diseases and medical conditions (morbidity) data. While the WHO's definition of uncomplicated is from a public health perspective, health care providers use ICD-10-CM codes when diagnosing patients. ICD-10-CM also uses the term "uncomplicated" when diagnosing a delivery encounter. Code O80 is used for full-time uncomplicated delivery, which is defined as:

> Delivery requiring minimal or no assistance, with or without episiotomy, without fetal manipulation [e.g., rotation version] or instrumentation [forceps] of a spontaneous, cephalic, vaginal, full-term, single, live-born infant. This code is for use as a single diagnosis code and is not to be used with any other code from chapter 15.

Code O82 is for an encounter for Cesarean delivery without indication. The outcomes of these delivery types are recorded under Z37.0.

Within the ICD-10-CM system, Section XVI, "Certain conditions originating in the perinatal period" are classified under [codes] P00-P96, which include "conditions that have their origin in the fetal or perinatal period (before birth through the first 28 days after birth), even if morbidity occurs later."

Birth injuries can range from mild to severe, with some injuries resolving shortly after birth. According to the Cleveland Clinic, birth injuries are generally uncommon, but when they do occur, they tend to fall into the following categories: (1) scalp injuries, (2) bone fractures, (3) eye injuries, (4) bleeding inside the skull, (5) nerve damage, and (6) brain injuries. In Exhibit 49, some of the most common types of birth injuries are shown, along with those that are less common and rare.

[258] White, Scott. *What is normal birth, and why does it matter?* The Australian and New Zealand Journal of Obstetrics and Gynecology. 2022.

Exhibit 49

Types of Birth-Related Injuries

More Common Birth Injuries	Less Common and Rare Birth Injuries
Broken collarbones (clavicles)	Certain types of brain bleeds, such as epidural or subarachnoid bleeding
Caput succedaneum (swelling of a newborn's scalp)	Brain damage from lack of oxygen (hypoxic-ischemic encephalopathy)
Cephalohematoma (pooling of blood under a newborn's scalp)	Internal organ injuries like liver or spleen hemorrhage
Erb's palsy (arm weakness or paralysis) from a brachial plexus injury	Rib fractures
Eyelid swelling	Spinal cord injuries
Subcutaneous fat necrosis of the newborn	Subgaleal hemorrhage
Facial nerve paralysis	
Fractured upper arm bone (humerus)	
Fractured upper leg bone (femur)	
Intracranial hemorrhage (brain bleeds)	
Lacerations of the face or scalp	
Nose injuries, such as a deviated septum.	
Retinal or subconjunctival hemorrhages (eye injuries)	
Skull fractures	

Source: Developed by LBFC staff from information obtained from the Cleveland Clinic.

Perinatal Hypoxia or Hypoxic-Ischemic Injury is defined as "the lack of oxygen or blood flow to or from the fetus before, during, or after birth. It can lead to severe systemic and neurological complications due to reduced oxygen and blood supply to vital organs, including the brain, heart, liver, and muscle."[259] Closely related, Hypoxic-Ischemic Encephalopathy (HIE) is the "umbrella term for a brain injury that happens before, during, or shortly after birth when oxygen or blood flow to the brain is reduced or stopped."[260,261] Notably, HIE is the leading cause of neonatal death and lifelong neurological impairment.[262] HIE injuries to the brain can result in developmental delays, intellectual disabilities, epilepsy, cerebral palsy, and heart problems or cardiac arrest.[263] HIE has an estimated incidence rate of 1.5 to 2.5 per 1,000 live

[259] Gillam-Krakauer M., et al. *Birth Asphyxia*. October 2024.
[260] National Institute of Neurological Disorders and Stroke. https://www.ninds.nih.gov/health-information/disorders/hypoxic-ischemic-encephalopathy, Accessed November 12, 2025.
[261] Tarvonen, M. et al. *Optimal Obstetric Care Reduces Neonatal Healthcare Costs Compared with Substandard Care in Hypoxic-Ischemic Encephalopathy.* American Journal of Obstetrics and Gynecology. December 2025.
[262] Ibid.
[263] Ibid.

births and is described in literature as one of the most serious birth complications affecting full-term infants.[264]

Should the General Assembly establish a BRNIF in Pennsylvania, at a minimum, it will need to develop a definition of birth-related neurological injury.

Internal Controls, Transparency, Oversight, Accountability, and Evaluation

If the General Assembly creates a BRNIF, it should consider mechanisms to protect the fund and the commonwealth from fraud, abuse, and weak internal controls, which are issues that have occurred in other states' BRNIFs. For example, in 2024, a former Chief Financial Officer/Deputy Executive Director of VBIF pled guilty to embezzling over $6.7 million from the fund between January 2022 and October 2023.[265] Fraud results from failures or deficiencies in internal controls.

Virginia's and Florida's BRNIFs also have a history of secondary payer and third-party liability issues in health care coverage. Under federal law, Medicaid and Medicare are the payers of last resort, meaning all other insurers and payers must pay a claim first.[266] Virginia's program is a secondary payer, meaning a claimant's medical insurance carrier must pay the expenses related to the birth-related injury first, with the program covering the other direct medical costs. When a claim is made to an insurance company licensed in Virginia or any self-insurer alleging a possible birth-related neurological injury occurred, the insurance company or self-insurer must report the claim to the program. Upon receipt, the program informs the parent(s) or guardian(s) of the child on whose behalf the claim has been made of the program's existence and eligibility requirements.[267]

A federal False Claims Act lawsuit alleged that the VBIF program instructed program participants to submit claims to Medicaid for the

[264] Allen K. and Brandon D. *Hypoxic Ischemic Encephalopathy: Pathophysiology and Experimental Treatments.* Newborn and Infant Nursing Reviews. September 2011.
[265] United States Attorney's Office, Eastern District of Virginia. *Former Executive of Injured Child Benefit Program Sentenced to Nine Years in Prison for Stealing Over $6.7 Million*. United States Department of Justice. March 2025.
[266] 42 C.F.R. § 433.136. Medicaid is the payor of last resort for medically necessary goods and services furnished to Medicaid recipients. Federal law expressly provides "Funds provided under section 1443 of this title may not be used to satisfy a financial commitment for services that would have been paid for from another public or private source, including any medical program administered by the Secretary of Defense, but for the enactment of this subchapter, except that whenever considered necessary to prevent a delay in the receipt of appropriate early intervention services by an infant, toddler, or family in a timely fashion, funds provided under section 1443 of this title may be used to pay the provider of services pending reimbursement from the agency that has ultimate responsibility for the payment." 20 U.S.C. § 1440(a).
[267] VA Code Ann. § 38.2-5004.1C.

lifetime care of the injured child, meaning claimants could send claims to the VBIF program to pay expenses related to the child's care only after exhausting their Medicaid appeal rights. This made VBIF's promise to pay the costs illusory and detrimentally impacted children's health. The practice also violated federal law on third-party liability, which makes Medicaid the payor of last resort. In response to the lawsuit, the program agreed to pay the federal government $20.7 million in a settlement.[268]

Likewise, in the 2020 federal court case of *United States ex rel. Arven v. Florida Birth-Related Neurological Injury Compensation Plan*, the U.S. District Court for the Southern District of Florida recognized FNICA as a third-party payor, primary to medical assistance provided by Medicaid. As in Virginia, the FNICA plan must legally pay all benefits under its plan provisions before Medicaid dollars can be used for medical expenses.[269]

In *Arven*, the FNICA program and its administrator, the FNICA Association, were sued in a *qui tam* action under the False Claims Act.[270,271] The complaint alleged that the administrator violated the False Claims Act by requiring FNICA participants to submit their health care claims to Medicaid rather than the FNICA, which is a direct violation of Medicaid's status as a payer of last resort. In this case, FNICA claimed it was an arm of the state government and could not be sued. However, the court found that FNICA was not an arm of the government but rather fell within the definition of a person and could be sued. In 2022, the FNICA Association agreed to a $51 million settlement to resolve the allegations. In a press release, the US Department of Justice (DOJ) reiterated that "[h]ealth care plans may not shift the payment of claims to federally funded programs like Medicaid."[272]

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[268] Fitzgerald, Bill. *Virginia State Senator Requests Investigation of Birth Injury Fund after CFO Embezzled Millions.* CBS 6 News. June 2025.

[269] 20 U.S.C. § 1440(a).

[270] *Qui tam* is the abbreviation for the Latin phrase "*qui tam pro domino rege quam pro se ipso in hac parte sequitur*" which means "Who sues on behalf of the King as well as for himself." In this type of legal action, a relator brings an action against a person or company on behalf of the government. The government, not the relator, is typically considered the plaintiff. If the government succeeds in the legal action, the relator filing the suit receives a share of the award. The False Claims Act permits *qui tam* actions against parties who have defrauded the federal government. A relator in the action may receive up to 30 percent of the government's award if successful. 31 U.S.C. § 3730. Jurisdictions have disagreed on the constitutionality of the *qui tam* provisions of the False Claims Act. For example, the U.S. District Court for the Middle District of Florida held in *United States ex rel. Zafirov v. Florida Medical Associates, LLC*, 751 F.Supp.3d 1293 (U.S. Dist. Ct. M.D. of Florida, 2024) that a realtor's self-appointment under the act violated the Appointments Clause of the U.S. Constitution. The United States District Court of Eastern Tennessee disagreed with the *Zafirov* decision in *United States v. Hamilton County Hospital Authority*, 2024 WL 4784372 (U.S. Dist. Ct. E.D. Tennessee, Southern Div.) (Unpublished Opinion).

[271] The False Claims Act is a federal law that provides for the recovery of civil penalties from those who knowingly present false or fraudulent claim to the federal government for payment or knowingly use false record to avoid or decrease obligation to pay the federal government. 31 U.S.C. § 3729.

[272] United States Department of Justice Press Release. *Florida Birth-Related Neurological Injury Compensation Plan and Association to Pay $51 Million to Resolve False Claims Act Allegation*. November 2022.

In the states we reviewed, we did not find any program evaluation mechanisms beyond financial and actuarial reporting and analysis. While these are important and necessary oversight tools, they do not evaluate the effectiveness of the programs from public policy and public health perspectives. The US Government Accountability Office defines performance management as:

> A three-step process by which organizations (1) set goals to identify the results they seek to achieve; (2) collect performance information (a type of evidence) to measure progress; and (3) use that information to assess results and inform decisions to ensure progress towards achieving those goals.[273]

If the General Assembly decides to proceed with a BRNIF in Pennsylvania, it should consider requirements for performance evaluation as part of the program.

[273] United States Government Accountability Office. Evidence-Based Policymaking: Practices to Help Manage and Assess the Results of Federal Efforts. July 2023.

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APPENDICES

Appendix A – Senate Resolution 27

PRIOR PRINTER'S NO. 290 PRINTER'S NO. 866

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE RESOLUTION

No. 27 Session of 2025

INTRODUCED BY BROWN, FONTANA AND SCHWANK, FEBRUARY 26, 2025

AS AMENDED, JUNE 3, 2025

A RESOLUTION

Directing the Legislative Budget and Finance Committee to conduct a study as to the feasibility of establishing a no-fault catastrophic loss fund to provide payment for claims brought as the result of birth-related neurological injuries in Pennsylvania.

WHEREAS, This Commonwealth is facing a critical shortage of physicians specializing in obstetrics in both its rural and urban areas; and

WHEREAS, Obstetrics is a high-risk medical specialty and physicians practicing obstetrics pay medical malpractice insurance premiums; and

WHEREAS, A birth that does not meet the medical definition of a "normal birth" may lead to a malpractice claim against the

attending physician; and

WHEREAS, The cost of claims related to birth-related neurological injuries can be high DUE TO THE AGE OF THE PATIENT, THE COST FOR A LIFETIME OF CARE AND THE SEVERITY OF THE INJURIES; and

WHEREAS, Obstetric services are vital to the health and welfare of the residents of this Commonwealth; therefore be it

RESOLVED, That the Senate direct the Legislative Budget and Finance Committee to conduct a study as to the feasibility AND OVERALL NEGATIVE AND POSITIVE IMPACTS of establishing a no-fault catastrophic loss fund to provide payment for claims brought as the result of birth-related neurological injuries; and be it further

RESOLVED, THAT THE LEGISLATIVE BUDGET AND FINANCE COMMITTEE STUDY THE COST OF MEDICAL MALPRACTICE INSURANCE PREMIUMS IN OTHER STATES THAT HAVE IMPLEMENTED A NO-FAULT CATASTROPHIC LOSS FUND FOR CLAIMS BROUGHT AS A RESULT OF BIRTH-RELATED NEUROLOGICAL INJURIES; AND BE IT FURTHER

RESOLVED, THAT THE LEGISLATIVE BUDGET AND FINANCE COMMITTEE COORDINATE WITH HOSPITALS, HEALTH CARE PROVIDERS, ATTORNEY ORGANIZATIONS, PATIENTS OR THEIR GUARDIANS THAT HAVE BEEN IMPACTED BY MALPRACTICE CLAIMS FOR BIRTHS THAT DO NOT MEET THE DEFINITION OF A "NORMAL BIRTH" AND HEALTH CARE SAFETY ADVOCATES; AND BE IT FURTHER

RESOLVED, That the Legislative Budget and Finance Committee submit a report of its findings to the Senate within one year of the adoption of this resolution.

Appendix B – County Populations, Live Births, Birthing Hospitals, and Obstetric Beds (2024)

County	Total Population	Females of Childbearing Age [15 to 44]	Live Births[a/]	Obstetric Beds	OB-GYN Beds	No. of Hospitals w/Labor and Delivery Services
Adams	107,914	18,981	439	0	12	1
Allegheny	1,231,814	246,448	18,475	96	23	4
Armstrong	63,679	10,046	272	0	15	1
Beaver	165,540	28,323	761	0	30	1
Bedford	47,643	7,352	-	-	-	-
Berks	439,117	83,816	3,702	75	0	2
Blair	120,269	21,062	1,537	22	0	1
Bradford	59,699	9,836	642	0	12	1
Bucks	650,131	112,469	3,515	29	72	4
Butler	199,341	35,497	470	0	33	1
Cambria	130,108	21,438	1,431	14	0	1
Cameron	4,348	581	-	-	-	-
Carbon	65,743	10,833	-	-	-	-
Centre	159,805	36,002	1,224	0	23	1
Chester	560,745	106,719	6,030	82	14	3
Clarion	36,855	7,144	-	-	-	-
Clearfield	78,132	11,730	1,021	18	0	1
Clinton	37,865	7,477	-	-	-	-
Columbia	66,012	13,924	418	10	0	1
Crawford	82,089	13,998	383	10	0	1
Cumberland	275,516	53,880	1,525	4	24	2
Dauphin	293,029	57,523	5,774	36	39	2
Delaware	584,882	117,368	2,046	16	0	1
Elk	30,124	4,451	56	0	4	1
Erie	267,750	50,637	3,152	24	32	2
Fayette	123,941	19,999	4	-	-	-
Forest	6,601	346	-	-	-	-
Franklin	159,285	28,549	1,456	28	0	1
Fulton	14,452	2,300	-	-	-	-
Greene	33,960	5,500	-	-	-	-
Huntingdon	43,359	6,857	-	-	-	-
Indiana	82,953	16,911	254	0	18	1
Jefferson	43,367	7,104	203	6	0	1
Juniata	23,395	3,859	-	-	-	-
Lackawanna	216,859	40,049	2592	0	42	2
Lancaster	563,293	106,513	5997	50	40	4

Lawrence	84,233	14,143	4	-	-	-
Lebanon	145,319	26,125	664	14	0	1
Lehigh	385,655	75,521	6,237	44	50	2
Luzerne	331,379	59,392	2713	0	41	2
Lycoming	113,236	21,044	958	17	0	1
McKean	39,478	6,501	-	-	-	-
Mercer	108,140	18,066	1,003	0	19	1
Mifflin	45,935	7,609	466	0	12	1
Monroe	166,523	28,845	674	0	20	1
Montgomery	879,190	165,868	14,346	154	36	5
Montour	18,115	3,131	1,876	25	0	1
Northampton	322,989	60,727	2,764	32	0	1
Northumberland	90,027	14,780	1	-	-	-
Perry	46,816	7,578	-	-	-	-
Philadelphia	1,573,916	373,590	16,671	179	23	4
Pike	62,376	9,405	-	-	-	-
Potter	15,993	2,360	172	0	3	1
Schuylkill	144,523	23,805	612	9	0	1
Snyder	39,627	7,287	-	-	-	-
Somerset	72,134	10,477	-	-	-	-
Sullivan	5,927	745	-	-	-	-
Susquehanna	38,100	5,720	1	-	-	-
Tioga	40,698	6,793	104	0	3	1
Union	42,159	7,671	693	16	0	1
Venango	49,476	7,656	499	10	0	1
Warren[b/]	37,373	5,623	166	0	10	1
Washington	210,434	36,055	546	0	13	1
Wayne	51,419	7,155	470	11	0	1
Westmoreland	350,935	56,813	984	0	23	1
Wyoming	25,771	4,323	-	-	-	-
York	471,240	86,082	4,085	8	53	3
Statewide	13,078,751	2,486,412	120,088	1039	739	73

Notes:
[a/]Statewide total does not include live births in: Birth Centers [871] and Other [5,563] locations (includes Clinic/Doctor's Office, Residence, and Other Than a Hospital or Freestanding Birthing Center).
[b/]As of January 13, 2026, Warren General Hospital [Warren County, PA] no longer provides inpatient labor and delivery services.

Appendix C – County Inflation-Adjusted Medical Professional Liability Insurance Premiums: OB-GYN Specialty (2020-2025)

County	2020	2021	2022	2023	2024	2025
Adams	$62,322	$72,102	$68,355	$71,792	$56,553	$58,633
Allegheny	62,223	72,102	68,355	71,792	56,553	58,633
Armstrong	62,322	72,102	68,355	71,792	56,553	58,633
Beaver	62,322	72,102	68,355	71,792	56,553	58,633
Bedford	62,322	72,102	68,355	71,792	56,553	58,633
Berks	62,322	72,102	68,355	71,792	56,553	58,633
Blair	62,322	72,102	68,355	71,792	56,553	58,633
Bradford	62,322	72,102	68,355	71,792	56,553	58,633
Bucks	107,153	104,691	99,312	97,121	81,522	90,591
Butler	62,322	72,102	68,355	71,792	56,553	58,633
Cambria	62,322	72,102	68,355	71,792	56,553	58,633
Cameron	62,322	72,102	68,355	71,792	56,553	83,266
Carbon	105,107	98,837	93,687	91,809	80,513	58,633
Centre	62,322	72,102	68,355	71,792	56,553	58,633
Chester	103,361	104,691	99,312	97,121	81,522	90,591
Clarion	62,322	72,102	68,355	71,792	56,553	58,633
Clearfield	62,322	72,102	68,355	71,792	56,553	58,633
Clinton	62,322	72,102	68,355	71,792	56,553	58,633
Columbia	105,107	98,837	93,687	91,809	80,513	83,266
Crawford	88,540	83,748	79,993	72,149	60,961	65,627
Cumberland	98,016	92,169	87,454	85,636	72,873	77,459
Dauphin	109,725	104,479	99,106	95,995	80,345	85,256
Delaware	123,006	123,330	117,111	115,695	97,019	104,883
Elk	62,322	72,102	68,355	71,792	56,553	58,633
Erie	88,540	83,748	79,993	72,149	60,961	65,627
Fayette	62,322	72,102	68,355	71,792	56,553	58,633
Forest	62,322	72,102	68,355	71,792	56,553	58,633
Franklin	98,016	92,169	87,454	85,636	72,873	77,459
Fulton	62,322	72,102	68,355	71,792	56,553	58,633
Greene	62,322	72,102	68,355	71,792	56,553	58,633
Huntingdon	62,322	72,102	68,355	71,792	56,553	58,633
Indiana	62,322	72,102	68,355	71,792	56,553	58,633
Jefferson	62,322	72,102	68,355	71,792	56,553	58,633
Juniata	62,322	72,102	68,355	71,792	56,553	58,633
Lackawanna	108,265	110,442	104,521	102,489	93,154	96,350
Lancaster	62,322	72,102	68,355	71,792	56,553	58,633
Lawrence	67,571	64,204	60,139	59,912	60,961	65,627
Lebanon	62,322	72,102	68,355	71,792	56,553	58,633
Lehigh	105,107	98,837	93,687	91,809	80,513	83,266

Luzerne	105,107	98,837	93,687	91,809	80,513	83,266
Lycoming	62,322	72,102	68,355	71,792	56,553	58,633
McKean	62,322	72,102	68,355	71,792	56,553	58,633
Mercer	84,290	83,748	79,993	72,149	60,961	65,627
Mifflin	62,322	72,102	68,355	71,792	56,553	58,633
Monroe	108,265	110,442	104,521	102,489	93,154	96,350
Montgomery	107,153	104,691	99,312	97,121	81,522	90,591
Montour	105,107	98,837	93,687	91,809	80,513	83,266
Northampton	105,107	98,837	93,687	91,809	80,513	83,266
Northumberland	105,107	98,837	93,687	91,809	80,513	83,266
Perry	62,322	72,102	68,355	71,792	56,553	58,633
Philadelphia	129,797	123,330	117,111	115,695	97,019	104,883
Pike	105,107	98,837	93,687	91,809	80,513	83,266
Potter	62,322	72,102	68,355	71,792	56,553	58,633
Schuylkill	112,058	110,442	104,521	102,489	93,154	96,350
Snyder	62,322	72,102	68,355	71,792	56,553	58,633
Somerset	62,322	72,102	68,355	71,792	56,553	58,633
Sullivan	62,322	72,102	68,355	71,792	56,553	58,633
Susquehanna	62,322	72,102	68,355	71,792	56,553	58,633
Tioga	62,322	72,102	68,355	71,792	56,553	58,633
Union	62,322	72,102	68,355	71,792	56,553	58,633
Venango	62,322	72,102	68,355	71,792	56,553	58,633
Warren	62,322	72,102	68,355	71,792	56,553	58,633
Washington	62,322	72,102	68,355	71,792	56,553	58,633
Wayne	105,107	98,837	93,687	91,809	80,513	83,266
Westmoreland	66,931	72,102	68,355	71,792	56,553	58,633
Wyoming	105,107	98,837	93,687	91,809	80,513	83,266
York	62,322	72,102	68,355	71,792	56,553	58,633