# NICA Update 2015

## The American Congress of Obstetricians and Gynecologists District XII Florida Task Force Report on the Florida Birth-Related Neurological Injury Compensation Association

July 2015



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### NICA Background

In 1986, the Tort and Insurance Reform Act created the Academic Task Force for Review of the Insurance and Tort Systems (the "Task Force"). This panel was tasked with evaluating Florida's insurance and tort systems and preparing a report that would recommend specific changes to be enacted by the State legislature.

The need for changes was urgent in light of the sharply rising malpractice premiums that were causing Florida's physicians to find it difficult to provide obstetric services to expectant mothers. A shortage of practicing Ob/Gyn physicians was, in turn, negatively affecting the health of Florida's women and children. The Task Force thus recommended the creation of a no-fault insurance plan to compensate plaintiffs for neurological injuries, as had been done by the State of Virginia.

The Florida Legislature agreed and in 1988 enacted the Florida Birth-Related Neurological Injury Compensation Association (NICA) as Florida Statute Chapter 88-1, Laws of Florida. The Act addressed medical malpractice issues by establishing a no-fault plan for hospitals and doctors that covered specific birth-related neurological injuries—typically among the most costly in tort settlements.

### NICA 2015 Update

In May 2014, the ACOG District XII Florida NICA Task Force met for the first of several sessions to conduct a review of the past seven years of the NICA program, which offers no-fault coverage

to Florida families who experience certain types of childbirth-related injury. The Task Force, (originally the Florida Obstetric and Gynecologic Society NICA Task Force) had previously released a 2007 report that evaluated the program to gauge its effectiveness across numerous metrics.

The 2007 report, *the Florida Obstetric and Gynecologic Society Task Force Report on the Florida Birth-Related Neurological Injury Compensation Association Act (NICA),* found the NICA program to be largely fulfilling its mission of reducing malpractice costs for Florida's obstetricians, supporting physicians and hospitals, assisting families covered by the program, and operating in a fiscally sound manner.

This update report reexamines NICA's functioning over the period since then, both in light of its original mandate and in terms of the Task Force's 2007 recommendations.

### The 2014 NICA Review

Chaired by Dr. Robert Yelverton, the Task Force met three times in 2014, in Orlando, Florida. The objective of the first meeting was to report on whether NICA is still doing the job that it is intended to do, meeting all of its goals and, if not, to make recommendations on areas of improvement. Participants were given an overview of the NICA program.

The second review meeting aimed at judging the fiscal position, challenges, and prospects for the program. The purpose of the third and final meeting for the year was to assess the data collected in 2014 and formulate specific recommendations for the NICA program going forward.

### State of the NICA Program

Following a general program overview of the status of NICA at present, the NICA general counsel explained to the Task Force the legal framework and issues facing the program, and applicable legislative matters. Because the infant injuries addressed by NICA are often cases abated in circuit court for NICA assessment, there is a significant legal aspect to NICA. For this reason it was deemed appropriate to have attorneys for the both defense and plaintiff present their views on NICA to the Task Force.

The NICA executive director noted that in the kind of neurological injury cases NICA addresses, it is not unusual for verdicts of $20 million on average. In the last report from the Florida Office of Insurance Regulation (OIR), there was a $149 million settlement reported. This makes it difficult to assess liability insurance rates correctly across a relatively small group of physicians. Regardless of the actual expense needed to provide care to infants, in practice, jury awards tend to be considerable. The costs ultimately are spread across insured physicians to some degree.

**ACOG District XII NICA Task Force Members:**

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### Program Assessment

The NICA program continues to be fiscally sound. Its investment portfolio has recovered from the turbulent financial markets of 2008 and 2009 thanks to the counsel of NICA's investment advisors. The program is regularly audited by third parties, and found to be in good standing. The two most recent inspections (including one by the Office of Insurance Regulation) resulted in clean audits, very unusual for a program of this size.

Since 1989, participation in the NICA program has increased significantly. More than 1,200 Ob/Gyns were participating as of November 2014 (Figure 1). Growth in the program is attributed to changes made with the Office of Insurance Regulation, enhanced communication with the physicians regarding the success of the program, as well as significant discounts provided to individuals from their medical malpractice insurance carriers for participating in the NICA program. According to Turner Consulting, Inc., actuarial consultant, the average medical malpractice insurance saving for an insured Ob/Gyn is $57,535 and the average for all other insured physicians is $1,041 (Figure 2).

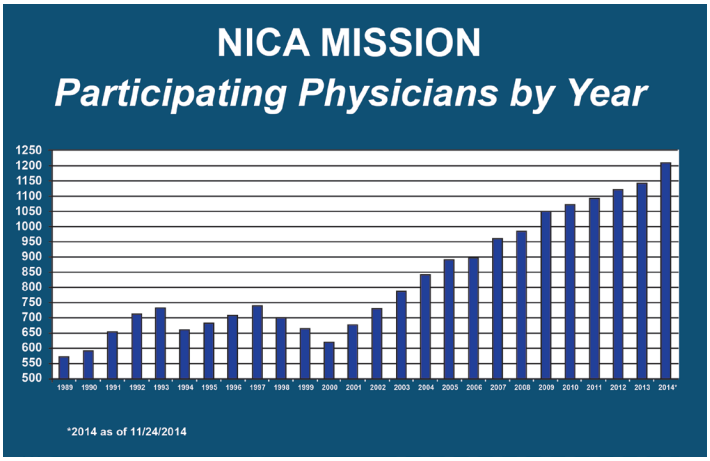


Figure 1.

| NICA Savings in Malpractice Premiums | | |
|---|---|---|
| | *Ob/Gyns* | *All Physicians* |
| Reduction in premiums | $62,535 | $1,291 |
| - NICA Assessment | $5,000 | $250 |
| =Annual benefit | $57,535 | $1,041 |

Figure 2.

The Task Force extensively reviewed the quality of the care administered to the recipients of NICA benefits. The administration of benefits has always been at a superior level. NICA family surveys have improved in the past 10 years, as the program has responded to participants' family recommendations over the life of the program. The care and compassion delivered by the staff involved also contribute to participant satisfaction.

The status of physician liability for NICA payments and hospital-sponsored discounts, hospital exemptions—particularly those of teaching hospitals—were examined and trending data suggests that the number of hospitals claiming exemption has increased slightly during the period under review (Figure 3).

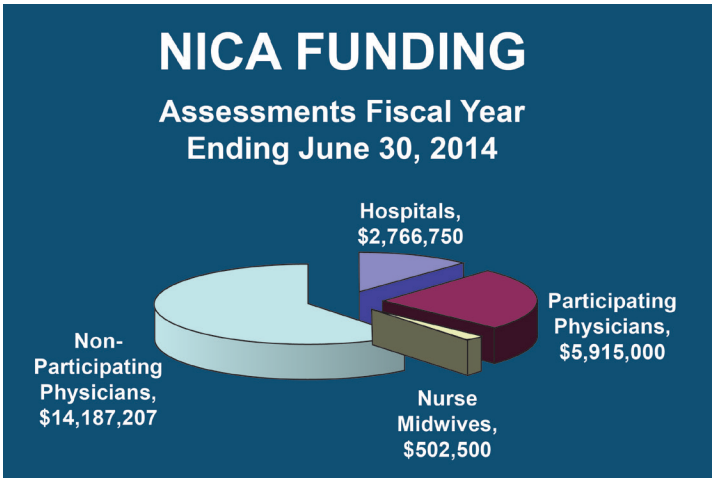


Figure 3.

Note: Non-participating physicians pay $250 per year, participating physicians pay $5,000 per year, nurse midwives pay $2,500 per year, and hospitals pay $50 per live birth unless exempt.

In terms of NICA solvency, the program typically accrues approximately $23 million per year in funding, has never paid out that amount annually, so it continues to operate with a positive margin. However, as the average life expectancy of a NICA claimant is currently 34 years, the range of severities presents a continuum of liability. Until the program has been running for at least 34 years, it cannot be considered a mature program and the true long-term costs will remain indeterminate.

More than 345 children have been served by the NICA Program. Currently 164 children are actively receiving care. As life expectancy is not subject to precise estimation, total payouts remain uncertain. The NICA actuarial consultant reported that over time, baseline averages may emerge and offer more stability in forward program cost projections (Figure 4).

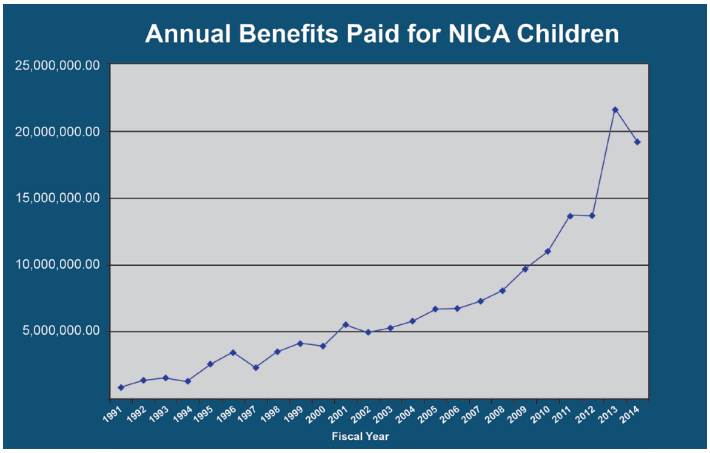


Figure 4.

NICA is not voluntary to the hospital if a participating physician is attending the birth. The hospital is potentially covered if a participating physician or midwife is attending. Absent a participating physician or midwife, the hospital involved is not protected by the NICA process.

The Task Force addressed the issue of the physician assessment for the first year of participation. Currently, the first payment is not prorated. Physicians joining at the end of the calendar year must pay the full annual assessment for that year (Currently $5,000).

While NICA assets currently stand at roughly $1.1 billion, this amount must be viewed against the large and uncertain liabilities of the long-term life expectancy of beneficiaries (Figure 5). Moreover, the program is accepting more children than those

exiting through end-of-life events, so funding must take future demands into account.

| Financial Data as of 6/30/2014 | |
|---|---|
| | |
| Total Assets | $1,077 million |
| Total Liabilities | $ 907 million |

Figure 5.

The NICA actuarial consultant testified that confounding factors include the as-yet unknown average life expectancy of program beneficiaries and the differences in payout scales accruing to them in relation to the severity of their injuries and the costs of care. Another factor is inflation as it affects investment income. The current assumption is that NICA will earn approximately 1.5 percent more on investment income than the association will experience in inflation over the life of the payments, but that increment may vary.

**NICA Challenges**

The number of hospitals in Florida that are not required to pay assessments but are covered for claims remains problematic—and continues to trend toward lower payments from hospitals that represent the most claims. Hospitals with exclusions are not required to pay the annual NICA assessments for some or all of their births. These hospitals include teaching hospitals, hospitals in special taxing districts, and some Medicaid covered births. All hospitals that provide obstetrical care incur significantly reduced liability as a result of NICA coverage. As hospitals have moved to consolidate licenses under an exempt license, or have developed teaching programs, they have paid a much lower portion of the annual revenue received by NICA while representing a much larger percentage of the claims received and paid by the association.

Challenges also exist in the adjudication process. The NICA general counsel found that the majority of cases are adjudicated properly. However, in some instances plaintiffs' attorneys deliberately waited until after the five-year period for NICA compensability, and then tried to bring a malpractice action, as these have a longer statute of limitations: seven years. NICA has prevailed in countering this attempt. Since its inception, there have been numerous efforts to weaken or terminate NICA as an effective program. The legal system plays a large role in NICA operations, even when NICA program administrators are of the opinion that a case is clearly covered under NICA statutes, it must still be approved by an administrative law judge (ALJ) before payment can be made.

Typical issues in NICA cases involve a determination of whether a brain injury was actually caused by the birth event or sustained concomitant with it, yet such injury may not be discernible soon after the event. NICA administrators may hold that a case is not qualified or, conversely, that it is, but in all cases they normally defer to the ruling of the ALJ. Similarly, in cases where notice of NICA availability was not presented by the physician or hospital in the mandated procedure, NICA again will defer to the ALJ's determination.

At any given time, there may be approximately 50 cases undergoing review at various stages. Some are on appeal, some are still awaiting an independent medical examination (IME), and some are awaiting an ALJ ruling. The NICA administrative staff is currently efficient in streamlining and expediting cases.

Defense bar representatives have noted that NICA could be more proactive as an institution in advocating for the interpretation of the NICA statutes in a manner that would result in an increase in the number of cases accepted for compensation.

The Task Force also heard testimony that families who face a decision as to whether they should apply for NICA benefits, often seem unclear as to the risks they undertake by foregoing NICA compensation. Increased clarity regarding the program would be helpful. One example of such improved clarity is a case where NICA supported an appellate case decision that clarified an often-confusing segment of the statute resulting in case law confirming that if a participant or hospital gives notice and there is a participating physician doing the delivery that the notice hurdle has been cleared.

Average lifespan is increasing, as over the last 100 years, life expectancy has risen about 0.3 years per year. NICA patient lifespan is likewise affected. In addition, the level of Medicare, Medicaid, and insurance company contributions over the life of participants is subject to fluctuation. Given these uncertainties, NICA income and payout projections are estimated conservatively.

Typically, cases handled by NICA are averaging a cost of approximately $4.9 million per child over the claimant's lifespan. Gauged against cases settled in the tort system, which can exceed $100 million, the value of this semi-governmental program is readily apparent.

Expert testimony provided by a physician specializing in maternal-fetal medicine who has worked with the NICA program for 13 years and regularly reported to the Task Force revealed that, of the roughly 450 eligible cases he reviewed over that period, approximately 60 percent appeared to be compensable by NICA. (See Appendix 1.)

### Hospital Exclusions

A chief concern for the financial health of NICA is the reduction in revenues accrued as a result of the number of hospitals claiming program exemptions (Figure 6). This is due in part to a combination of hospitals in Florida seeking special taxing district exemptions that have been structuring themselves to qualify as teaching hospitals, and reductions in the numbers of live births in Florida.

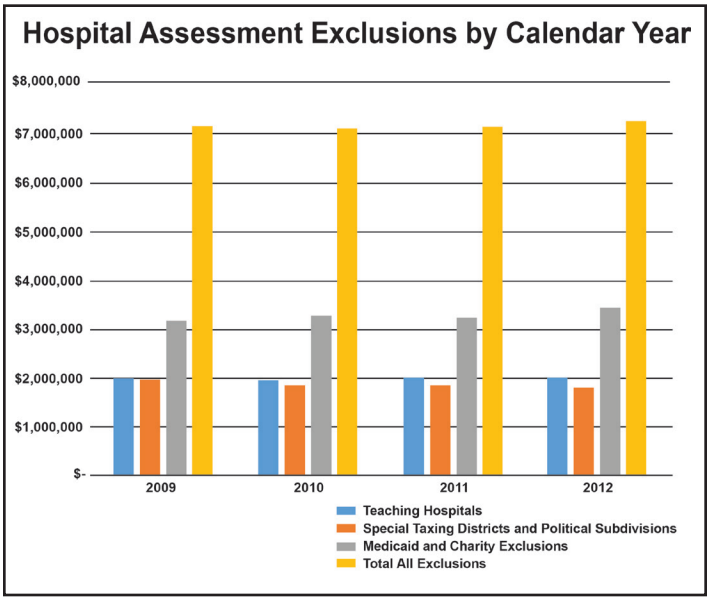


Figure 6.

As shown by the reduction in assessments over time, the figures reflect the increased number of hospital exclusions. The observed trend in the State of Florida is that medical schools are looking for more partners for their residency programs, thus more hospitals may qualify as teaching hospitals because they have the sufficient number of residents rotating through to qualify for exempt status.

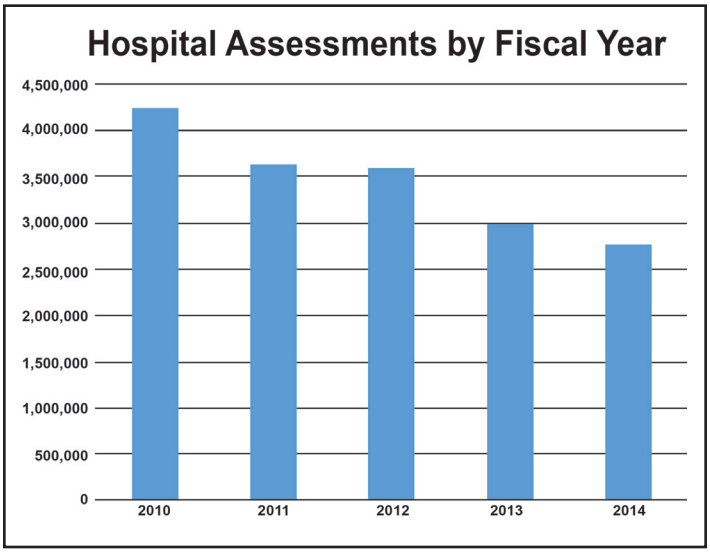


Figure 7.

Potentially, up to 50 percent of the hospitals in the state could be considered teaching hospitals because they have a qualifying number of residents. Moreover, approximately 90 percent of NICA claims come from hospitals that are exempt—and therefore are nonpaying (Figures 8 & 9).

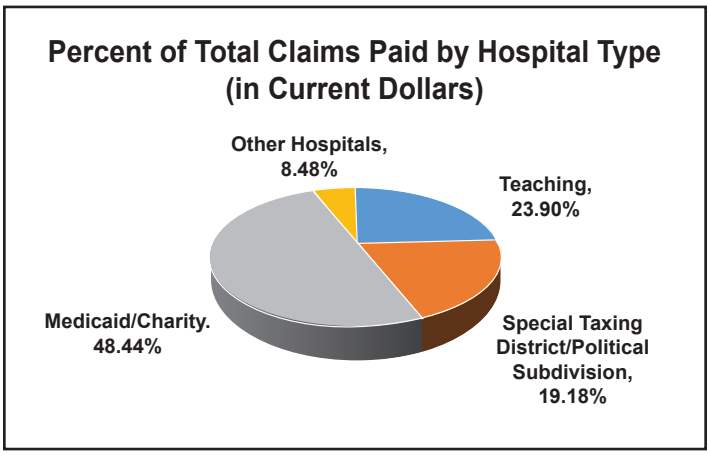


Figure 8.

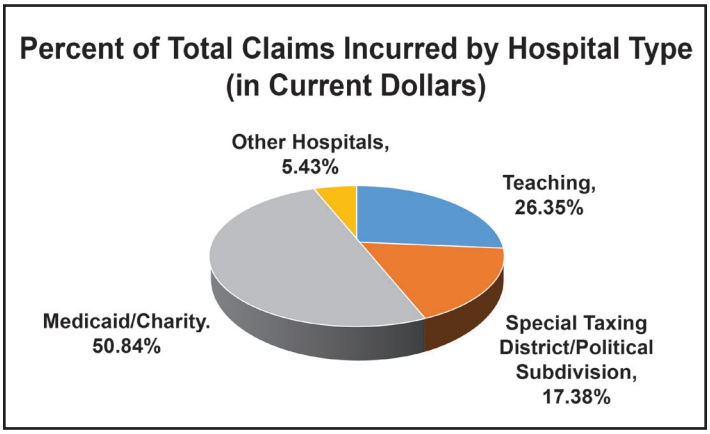


Figure 9.

While NICA has remained actuarially sound and has not had to increase assessments over the years, a cash-flow analysis suggests that at some point that may change and an increase in assessments may have to be considered. Other means of income for the program may need to be enacted in light of the number of hospitals that have been benefiting from NICA and thus should pay their fair share into the program.

**Task Force Conclusions**

NICA reserves are well managed and invested with excellent oversight and consultation. Regarding the inclusion criteria, the trend is toward accepting more claims. This was determined both through testimony provided to the Task Force and the observations of the NICA Medical Advisory Committee. As part of its report in 2007, the FOGS NICA Task Force recommended that NICA make use of an expert advisory panel to periodically review the inclusion process and criteria and to provide expert counsel to the NICA Board on any technical medical issues. The Medical Advisory Committee was established by the NICA Board in response to that recommendation and has reviewed cases, received testimony from the experts utilized by NICA, and provided support and counsel to NICA staff.

The Task Force was presented with testimonials, videos, and surveys that were done to assess patient care. The information was both impressive and much more detailed than that presented at the first meeting in 2007. The scope and depth of the care provided argues well for the effectiveness of the program in obtaining participant satisfaction.

While only a portion of hospitals pay assessments directly into the NICA program, approximately 44 percent of NICA claim payouts are derived from totally exempt hospitals. This number rises to 91 percent when considering all hospitals with some form of program exclusions.

Where the NICA program intersects with legal review, the Task Force notes that such legal activity is geared appropriately to the current circumstances and being properly managed.

When warranted by the inclusion criteria, representatives from maternal fetal medicine and pediatric neurology collaborate in the decision-making process. The Task Force heard from representatives from both disciplines and finds that such consultation is both appropriate and effective.

The pediatric neurologist reporting to the Task Force stated that he is satisfied with the process of medical review and examinations of potential NICA claimants. He sees higher-than-expected compliance on the part of patients and their families, who consistently receive appointment reminders from NICA coordinators and benefit from solid efforts made to facilitate their travel to his office.

Retaining physicians to conduct medial review and examinations is somewhat problematic. A compounding factor is that while many physicians are willing to work with NICA at various levels, most balk at major involvement in expert depositions and litigation, thus limiting the number of physicians willing to become involved. However, the quality of the reviews and examinations currently is excellent.

Lifespan prognosis is arguably one of the most difficult aspects facing the NICA program. Sometimes petitioners are brought for evaluation when they are very young so that even if they are shown to have substantial mental and motor impairment and are likely to be qualified for inclusion, it is problematic to formulate a lifespan prognosis.

With respect to initial examinations, physician testimony to the Task Force noted that plaintiffs' attorneys frequently request videotape of the proceedings, which can be intrusive and hamper the quality of examinations. The Task Force notes that patients do, however, have a constitutional right to protect their interests in this matter and thus this is a necessary process.

Eligible children must be shown to have been injured during labor, delivery, or the immediate post-resuscitative period. There must be permanent and substantial mental and physical injury, and cases must be brought to NICA within the first five years following an eligible incident.

The NICA program works to educate doctors and hospitals about how the program functions, but a continual problem occurs when hospital staff fails to give timely notice about the program to potential claimants. Failure to give mandated notice is one of the primary reasons eligible cases do not enter NICA.

The Task Force sees this as a challenge that needs to be addressed in some manner and will continue to explore ways of addressing the problem that are equitable to all parties concerned.

### Task Force Recommendations

**Pro-rated Physician Assessments:** Individual physicians who start NICA participation late in the year are subject to an initial fee of $5,000. Yet a full assessment is again levied at the beginning of the next calendar year. The Task Force recommends that the initial fee be prorated based on the time remaining in the year the physician enters the program. Note: this would require a statutory change.

**Annual Assessments:** The Task Force does not recommend an increase to the annual $250 physician assessment.

**Hospital Assessments:** Prior to recommending an increase of the assessment to the hospitals, clarification is required regarding the definition of whether a hospital is a teaching or a paying hospital versus a non-paying hospital based on Medicaid patients versus private-pay patients. The Task Force suggests that if the private-pay patients in a given hospital represent more than 52 percent of the obstetrical deliveries, then the hospital should pay a full assessment on all live births. All hospitals should pay assessments for all non-Medicaid and non-charity live births.

The Task Force recommends that participating physicians modify their EMR software to provide an intake form checkbox to indicate that a patient has received NICA counseling.

**Determination of Compensability:** Given that neurological testing is problematic with infants, it is recommended that pediatric neurological assessments with respect to compensability not be performed until the child under examination is 18 months to 2 years in age, except for cases so profound that such determination is readily apparent.

**Parental Benefit:** The current one-time benefit paid directly to NICA parents' stands at $100,000. The Task Force recommends that this amount be subject to cost-of-living adjustments, upon the advice and consent of the program actuaries. Note: this would require a statutory change.

**Program Oversight:** ACOG District XII should continue active involvement in NICA through participation in the Physician Advisory Committee, and through board activity.

**Program Representation:** The Task Force sees value in having more claimant family representation on the Board if desired.

**NICA Expansion:** In the previous 2007 NICA report, the Task Force recommended exploring the possibility of expanding the scope of the program to include brachial plexus injury. Since that time, the rate of occurrence and severity of such injuries remains essentially unchanged. NICA's actuaries have broken down brachial plexus injury into several different categories and estimate that covering these injuries under NICA would increase costs by approximately $11 and $20 million per year, depending on the extent of injury covered. In light of the current fiscal outlook for the program against future uncertainly regarding participant numbers and cost of care, the expansion of NICA to cover these injuries would likely result in a significant increase in annual assessments. Therefore, no recommendation for brachial plexus expansion is given at this time.

**Notification of Eligibility:** Plaintiff bar representatives urge for the creation of more detailed program brochures to aid in claimant education. These brochures should be distributed to all patients registering for prenatal care in the offices of participating physicians and at hospital preregistration when appropriate.

Appendix 1: NICA Participant Process