ADMINISTRATIVE PERFORMANCE OF "NO-FAULT" COMPENSATION FOR MEDICAL INJURY[†]

RANDALL R. BOVBJERG,[*] FRANK A. SLOAN,[**] AND PETER J. RANKIN[***]

I

INTRODUCTION: POLICY CONTEXT

"No-fault" is the leading alternative to traditional liability systems for resolving medically caused injuries. Some form of no-fault is often mentioned as an ultimate reform goal, often with relatively little specification of exactly what it entails. Policy interest in such reform reflects numerous concerns with the traditional tort system as it operates in the medical field through malpractice insurance. Tort is often said to fall short of achieving its three main goals.[1] First, it provides insufficient and inefficient *compensation* for injuries because only a tiny fraction of legitimate claims are brought, and claims resolution is very slow and costly in administrative "overhead."[2] Second, tort provides only poorly focused *deterrent* incentives for patient safety, yet also seems to cause inappropriate defensive medicine. Third, there is inadequate *accountability* or justice in dispute resolution, as most problems are never discovered, much less

---

Copyright © 1997 by Law and Contemporary Problems

† This article was supported by a grant from the Robert Wood Johnson Foundation's IMPACS program. Neither it nor its companion analyses would have been possible without the willing cooperation of the two agencies studied and their boards. Special mention must be made of Lynn B. Dickinson, Executive Director of the Florida Birth-Related Neurological Injury Compensation Association, and Elinor J. Pyles, R.N., Executive Director of the Virginia Birth-Related Injury Fund. These two executives spent large amounts of time with the authors and affiliated researchers and also shared substantial amounts of internal, administrative data. The Chairs of the two Boards were also very helpful: Amelia C. Cruz, M.D., in Florida, and C.M. Kinloch Nelson, M.D., in Virginia.

* Principal Research Associate, Health Policy Center, The Urban Institute, Washington D.C.; formerly Senior Attorney, State Rating Bureau, Massachusetts Division of Insurance.

** J. Alexander McMahon Professor of Health Policy and Management, Professor of Economics, and Director of the Center for Health Policy, Law, and Management, Duke University.

*** M.A., 1995, Ph.D. Candidate, Department of Economics, and Research Associate, Health Policy Center, Duke University.

1. *See, e.g.,* Randall R. Bovbjerg, *Medical Malpractice on Trial: Quality of Care Is the Important Standard*, 49 LAW & CONTEMP. PROBS. 321, 335 (Spring 1986).

2. For good summaries of complaints about the traditional medical liability system in the context of proposed no-fault reform, see, for example, Laurence R. Tancredi, *Designing a No-Fault Alternative*, 49 LAW & CONTEMP. PROBS. 277 (Spring 1986). For more general complaints about medical liability, see, for example, MEDICAL LIABILITY PROJECT, AMERICAN MED. ASS'N, TORT REFORM CODIFICATION: MODEL MEDICAL LIABILITY AND PRACTICES REFORM ACT (1989); PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL (1991). For the same with regard to liability processes generally, see, for example, PETER W. HUBER, LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES (1988); JEFFREY O'CONNELL & C. BRIAN KELLY, THE BLAME GAME: INJURIES, INSURANCE, AND INJUSTICE (1987).

systematically addressed.

At least conceptually, no-fault addresses these concerns by changing eligibility and payment standards, along with the location and process of decision-making. Different forms of no-fault have different goals,[3] but a reformed system is generally expected to *compensate* more cases than tort, including many that could not meet the liability standards of negligence. Its delivery of compensation should also be more efficient, measured as costs of delivery in dollars and time, because of expert administration and less formal process. On the other hand, potentially offsetting new costs arise under no-fault because eligibility confers ongoing benefits in the fashion of a disability insurance policy and hence may lead to ongoing disputes not possible after final tort resolutions. Also, no-fault typically restricts or eliminates payment for non-pecuniary loss. Such savings should allow a given "compensation budget" to cover more injuries. Removing some or all cases from tort should reduce physicians' defensive over- or under-service to patients. Comprehensive risk management might improve *deterrence*, and ties to quality regulation could also promote safety. Improved *accountability* is meant to come from objective and consistent investigation of suspected medical injuries and ties to licensure review, and justice may be served by promoting consistency of results across similar cases.[4]

The first actual implementation of no-fault for medical liability occurred in the late 1980s for newborns with severe birth-related neurological impairments in Virginia and Florida, largely under the Workers' Compensation model.[5] These no-fault programs were designed to take relatively few injuries out of the tort system, but are nonetheless consequential. They deal with major injuries

---

3. No-fault may be as broadly compensatory as the society-wide New Zealand accident compensation system or, alternatively, more narrowly targeted, as under Workers' Compensation or auto no-fault. *See generally* A. P. BLAIR, ACCIDENT COMPENSATION IN NEW ZEALAND: THE LAW RELATING TO COMPENSATION FOR PERSONAL INJURY BY ACCIDENT IN NEW ZEALAND (2d ed. 1983); MARK S. RHODES & GORDON OHLSEN, WORKERS' COMPENSATION ANSWER BOOK (1997); ALAN I. WIDISS ET AL., NO-FAULT AUTOMOBILE INSURANCE IN ACTION: THE EXPERIENCES IN MASSACHUSETTS, FLORIDA, DELAWARE AND MICHIGAN (1977). The latter alternatives are still rather broad, covering all accidents "arising out of" the workplace or the operation of a motor vehicle. For medicine, no-fault proposals have typically been more restricted, as many injuries "arising out of" medical care are unavoidable side effects of desirable treatment. *See generally* Clark C. Havighurst & Laurence R. Tancredi, *Medical Adversity Insurance—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 MILBANK MEM. FUND Q. 125 (1973), *reprinted in* 1974 INS. L.J. 69; Tancredi, *supra* note 2. "Neo-no-fault" has even been proposed as a way to make tort liability more efficient by promoting voluntary settlements. *See* Jeffrey O'Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROBS. 125, 129 (Spring 1986). No-fault systems may emphasize deterrence as well as compensation, through investigation of and intervention in injury-prone areas discovered through claims data and risk management. No-fault design can encourage such activities through experience rating. *See, e.g.,* Havighurst & Tancredi, *supra*, at 73; WEILER, *supra* note 2, at 152-54.

4. For more detail on these arguments in the medical no-fault context, see, for example, Randall R. Bovbjerg et al., *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System*, 265 JAMA 2835 (1991); Laurence R. Tancredi & Randall R. Bovbjerg, *Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, A Malpractice and Quality Reform Ripe for a Test*, 54 LAW & CONTEMP. PROBS. 147 (Spring 1991).

5. *See infra* text accompanying notes 27-31.

in one of the more troublesome areas in the field of medical malpractice.[6] They also represent the only operational medical no-fault systems in the United States and are hence subject to American legal-administrative culture, unlike the often cited foreign no-fault models.[7] Most importantly, though narrow in focus, their experience potentially offers valuable lessons for the design of broader no-fault programs. Any broader programs will face such issues as defining and enforcing eligibility rules, determining causation, managing ongoing expenses and generally providing compensation efficiently. To reach their target populations, programs need to develop case-intake mechanisms. To avoid excess cost, they have to optimize ongoing oversight of care and find ways to limit compensation per paid claimant.

This article reports on the administrative experience of the Florida and Virginia programs, with emphasis on Florida. It briefly describes these compensation systems as established by statute and implemented administratively. It then considers evidence on no-fault performance, especially with regard to efficiency of compensation, as measured by speed of resolution and level of administrative cost, compared with similar obstetrical tort cases in Florida. This article goes beyond prior legal analyses of legislative history and program design[8] or descriptive case studies of early implementation[9] to analyze seven years

---

6. *See generally* INSTITUTE OF MED., MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE (1989).

7. *See* GEOFFREY W.R. PALMER, COMPENSATION FOR INCAPACITY: A STUDY OF LAW AND SOCIAL CHANGE IN NEW ZEALAND AND AUSTRALIA (1979); MARILYN M. ROTHENTHAL, DEALING WITH MEDICAL MALPRACTICE: THE BRITISH AND SWEDISH EXPERIENCE 174-86 (1988); Eva D. Cohen & Samuel P. Korper, *The Swedish No-Fault Patient Compensation Program: Provisions and Preliminary Findings*, 1976 INS. L.J. 70; Walter Gellhorn, *Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (N.Z.),* 73 CORNELL L. REV. 170 (1988).

8. Virginia, as the first state to go no-fault, attracted more legislative history and legal commentary. *See, e.g.,* James A. Henderson, *The Virginia Birth-Related Injury Compensation Act: Limited No-Fault Statutes as Solutions to the "Medical Malpractice Crisis," in* 2 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE 194 (Victoria P. Rostow & Roger J. Bulger eds., 1989); Richard A. Epstein, *Market and Regulatory Approaches to Medical Malpractice: The Virginia Obstetrical No-Fault Statute*, 74 VA. L. REV. 1451 (1988); Jeffrey O'Connell, *Pragmatic Constraints on Market Approaches: A Response to Professor Epstein*, 74 VA. L. REV. 1475 (1988); Jane R. Ward, Comment, *Virginia's Birth-Related Neurological Injury Compensation Act: Constitutional and Policy Challenges*, 22 U. RICH. L. REV. 431 (1988); Peter H. White, Note, *Innovative No-Fault Tort Reform for an Endangered Specialty*, 74 VA. L. REV. 1487 (1988).

For Florida, public policy was heavily influenced by the Academic Task Force for Review of the Insurance and Tort Systems. *See* Academic Task Force for Review of the Insurance and Tort Systems, Preliminary Fact-Finding Report on Medical Malpractice 237-39 (Aug. 14, 1987) (unpublished report to governor and legislature, on file with Randall Bovbjerg) (noting high premiums of obstetricians); Academic Task Force for Review of the Insurance and Tort Systems, Medical Malpractice Recommendations 30-34 (Nov. 6, 1987) (unpublished report, on file with Randall Bovbjerg) (recommending a no-fault system based on the one in Virginia); *see also* text accompanying note 21 *infra*. Thomas R. Tedcastle & Marvin A. Dewar, *Medical Malpractice: A New Treatment for an Old Illness*, 16 FLA. ST. U. L. REV. 535 (1988), provides very good legislative history. *See also* Cynthia L. Gallup, *Can No-Fault Compensation of Impaired Infants Alleviate the Malpractice Crisis in Obstetrics?*, 14 J. HEALTH POL. POL'Y & L. 691 (1989) (analyzing symptoms and causes of liability insurer problems in obstetrics and likely influence of reform on insurer behavior); David E.M. Sappington, *Designing Optional No-Fault Insurance Policies for Health Care Systems*, 3 J. ECON. & MGMT. STRATEGY 113 (1994) (examining incentive effects of the two programs).

9. Much descriptive information about the programs' design and their very early experience has already appeared. *See, e.g.*, OFFICE OF TECH. ASSESSMENT, IMPACT OF LEGAL REFORMS ON

of policy-relevant administrative data. The focus is on claims-handling administration as compared with tort litigation, not on general administration such as personnel practices or collection of premiums. The first three years' experience was considered separately, as more "mature" performance was presumed to be more typical and generalizable. It is of course important for these states to consider how well the specific administrative operations of these particular programs meet their statutory goals. The most important lessons for policy makers elsewhere, however, are how well limited no-fault compensation systems meet the general no-fault goal of improved efficiency and how observed administrative practice might be generalizable to other, larger programs.

II

NO-FAULT STRUCTURE AND PROCESS

A. Legislative History

Virginia enacted its Birth-Related Neurological Injury Compensation Act in 1987,[10] governing births on and after January 1, 1988.[11] Although the reform had roots in "neo-no-fault,"[12] it was enacted primarily as a tort reform, to deal with the same sort of liability insurance crisis that inspired most 1970s and 1980s legislation in the field.[13] The Virginia crisis was a very specific one—the threatened withdrawal of liability coverage for Virginia physicians delivering babies.[14] The statute sought to remove expensive and unpredictable "bad

---

MEDICAL MALPRACTICE COSTS (1993); Kenneth V. Heland & Penny Rutledge, *No-Fault Compensation for Neurologically Impaired Infants: The Virginia Experience*, 2 CURRENT OBST. & GYNECOL. 58 (1992); Jill Horwitz & Troyen A. Brennan, *No-Fault Compensation for Medical Injury: A Case Study*, HEALTH AFF., Winter 1995, at 164; Walter Wadlington & Warren J. Wood III, *Two "No-Fault" Compensation Schemes for Birth Defective Infants in the United States*, 7 PROF. NEGL. 40 (1991). A very detailed description of Florida appears in Jill R. Horwitz, No-Fault Medical Malpractice Reform: A Case Study of the Florida Birth-Related Neurological Injury Compensation Association (1994) (unpublished thesis, Harvard University School of Government) (on file with Randall Bovbjerg). A similarly detailed state-specific assessment of Virginia was undertaken in response to House Joint Resolution 641, passed by the House and Senate on February 19 and 20, 1997. The report, won by a team of researchers at the College of William and Mary, was scheduled to be published in 1998.

10. VA. CODE ANN. §§ 38.2-5001 to -5021 (Michie 1994).

11. *Id.* § 38.2-5014.

12. *See, e.g.*, Ronald K. Davis & Sandra L. Kramer, *The Policy Implications of the Injured Infant Act*, VA. HOSP. ASS'N PERSP. May 22, 1987, at 1; Ken Heland, *The Virginia Birth-Related Neurological Injury Compensation Act (H. 1216)*, LEGIS-LETTER (American College of Obstetricians and Gynecologists), May 1987, at 2; O'Connell, *supra* note 8, at 1476-77. These nearly contemporaneous accounts were confirmed by this study's recent interviews. *See infra* note 90 and accompanying text.

13. *See, e.g.,* Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499 (1989), *reprinted in* 3 NAT'L INS. L. REV. 217 (1989); Glen O. Robinson, *The Malpractice Crisis of the 1970's: A Retrospective*, 49 LAW & CONTEMP. PROBS. 5 (Spring 1986).

14. Two leading carriers suspended sales of new policies, and another planned to drop all obstetricians except those in medical groups of 10 or more. *See* White, *supra* note 8, at 1488 n.5. The air of crisis in access to medical care was quite real for many state legislators debating the no-fault bill in the waning days of the 1987 session, as seen in videotape of the Assembly debate. *See* Videotape: The 1987 General Assembly—The Injured Infants' Act (Medical Society of Virginia, created from Assem-

baby" cases from the courts to an administrative forum, to be resolved at a lower cost under no-fault standards.[15] The laws resemble "caps" on tort awards in that they aim to hold down tort spending and keep liability coverage available by addressing the largest cases.[16] The immediate goals were to keep liability insurance available and to prevent the "negative defensive medicine" of curtailed access to obstetrical services, especially in inner-city and rural areas.[17] Secondarily, the law was intended to cover costs for a very needy eligible population. It is, after all, labeled a "compensation" act.[18]

Florida followed Virginia's lead the next year.[19] Its Birth-Related Neurological Injury Compensation Act was created by a 1988 statute and implemented for births on or after January 1, 1989.[20] Its provisions explicitly copied Virginia's law, often almost verbatim, in keeping with the recommendation of a

---

bly footage, Nov. 25, 1987) (on file with Randall Bovbjerg); *see also* Beverly Orndorff, *Malpractice Insurance Problem Is Called Real Crisis*, RICH. TIMES-DISPATCH, Jan. 7, 1987, at B3; Ward, *supra* note 11. In the mid-1980s, obstetrical malpractice claims generally received a lot of policy attention. For example, a panel of the prestigious Institute of Medicine produced a two-volume book on the topic. *See* INSTITUTE OF MED., *supra* note 6. Many thought birth-related claims unjustified but difficult to defend. *See* Marvin Cornblath & Russell L. Clark, *Neonatal "Brain Damage": An Analysis of 250 Claims*, 140 W.J. MED. 298 (1984). Virginia and Florida, however, were the only states ever to adopt obstetrics-specific reforms.

15. The leading liability insurer, The Virginia Insurance Reciprocal, specifically signaled that it would reopen enrollment of policyholders if severe birth-related injuries were removed from the liability system. *See, e.g.,* Davis & Kramer, *supra* note 12.

16. Contemporaneous accounts suggest that legislative desire to enact birth-related no-fault grew in part from a lower court's invalidating Virginia's previously enacted cap on non-pecuniary loss. *See* Ward, *supra* note 8, at 431-33. Certainly, high awards, even exceeding the then-current cap, were a major concern for doctors in the mid-1980s. *See* Ronald K. Davis, *Searching for a New System*, 112 VA. MED. 235 (1985) ("crisis" argument citing three multimillion dollar awards—two involving childbirth—by the chair of the Ad Hoc Committee to Study Malpractice in the monthly publication of the medical society); s*ee also* Videotape: Working Together We Made History: The Medical Society of Virginia's 1987 Professional Liability Reform Legislative Campaign (Medical Society of Virginia, 1987) (on file with Randall Bovbjerg) (overturning the cap was a "real bombshell" that caused "near panic" just 60 days before the start of the 1987 legislative session, according to Richard L. Fields, M.D., President of the Society). The cap was later upheld. *See* Boyd v. Bulala, 877 F.2d 1191 (4th Cir. 1989).

17. In an interview, Professor O'Connell particularly stressed the political importance of this unusual urban-rural alliance. Interview with Jeffrey O'Connell, Samuel H. McCoy II Professor of Law at University of Virginia Law School, in Washington, D.C. (Feb. 12, 1998) [hereinafter O'Connell interview]. The Virginia statute requires that participating hospitals have a plan for improving access to obstetrical services. *See* VA. CODE ANN. § 38.2-5001 (Michie 1994). The focus of this article and the study from which it comes was claims administration, not other aspects of the programs, but it appears that this statutory provision has not received any administrative attention.

18. The Florida enactment, but not the Virginia one, specifies legislative findings and intent. The findings relate to reducing the cost of obstetrical liability insurance. The intent is to compensate a limited class of catastrophic obstetrical injuries. *Compare* FLA. STAT. ch. 766.301(1)(a)-(d) (1996) *with id.* ch. 766.301(2).

19. Ironically, in seeking to build support for the childbirth reform beyond the obstetrical community, leaders of the Virginia Medical Society had argued that reform was needed to help prevent the state from going the way of Florida, perceived as a far more litigious and problematic area for medical practice generally. *See* Memorandum from Ronald K. Davis, Chair of Professional Liability Committee of the Medical Society of Virginia, to all Virginia Physicians (Fall 1987) (on file with Randall Bovbjerg).

20. FLA. STAT. chs. 766.301-.316 (1996).

blue-ribbon commission.[21] The Florida legislation also arose primarily from a perceived liability insurance crisis, but a more general one.[22] Other tort reforms received far more attention from the commission,[23] but in a special legislative session, no-fault was among the minority actually adopted.[24] There are some differences in the statutes, as highlighted below, notably in the breadth of eligibility for no-fault benefits. Additional differences have arisen in the course of administrative implementation.

The programs were not born or raised as identical twins, but they nonetheless bear a strong "sororital" resemblance, and their administrators frequently consult each other about issues of common concern.[25] This paper accordingly describes and discusses them together. More reliance is placed on Florida data because of that program's larger size and the availability in Florida of information on comparable obstetrical malpractice cases.[26]

B. Administrative Structure

1. *Operations and Governance.* The programs are easily analogized to Workers' Compensation.[27] Both statutes gave decisionmaking authority to their Workers' Compensation Commissions.[28] Moreover, the constitutionality

---

21. *See* Academic Task Force, Medical Malpractice Recommendations, *supra* note 8, at 30-34.

22. *See, e.g.,* Dave Bruns, *Malpractice Battle Looms Again,* TALLAHASSEE DEMOCRAT, Feb. 1, 1988, at 1A. Florida's generally litigious climate had by that time already led to the complete withdrawal of the nation's largest single insurer of physicians. According to a contemporaneous interview, the St. Paul Group, of St. Paul, Minnesota, ceased underwriting any coverage in the state in the mid-1980s. Numerous other alternatives for coverage remained, including a physician-run mutual and a large number of "trust" vehicles. Obstetrical coverage has been available throughout. The overall atmosphere of crisis in Florida is shown by the legislative preamble to 1988 Fla. Laws ch. 88-1 (*e.g.*, "WHEREAS, the Legislature finds that there is in Florida a financial crisis in the medical liability insurance industry ..."). No-fault was established by sections 60-77 of this chapter's 87 sections.

23. The Florida legislative provisions ("NICA") follow numerous tort reform and medical regulatory provisions in its enabling legislation. NICA begins with section 60 of 1988 Fla. Laws ch. 88-1. The Academic Task Force covered many other reforms before turning to NICA, also developing much less supporting documentation for it than for others. *See* Academic Task Force for Review of the Insurance and Tort Systems, *supra* note 8.

24. *See* Tedcastle & Dewar, *supra* note 8.

25. Each program has had a single Executive Director for virtually its entire life—Elinor J. Pyles, R.N., in Virginia; Lynn B. Dickinson in Florida. These two capable administrators provided extensive access to data and many interviews and follow-up sessions, both in person and by telephone, starting in December 1994 during preparation of the funding proposal for this project and continuing to the present. Most operational information about the programs presented in this section, unless otherwise cited, comes from these discussions.

26. *See infra* text accompanying notes 88-89. Some other states in the early 1990s seriously considered similar legislation, including North Carolina for cerebral palsy and New York for birth-related neurological impairment. *See* Kenneth Heland, *Birth-Related Neurological Injury Compensation Funds: Solution or Stopgap?* 77 AM. C. SURGEONS BULL. 27 (1992); Maxwell J. Mehlman, *Bad "Bad Baby" Bills*, 20 AM. J.L. & MED. 126 nn.4-5 (1994); *see also* Julian D. Bobbitt, Jr., *et al., North Carolina's Proposed Birth-Related Neurological Impairment Act: A Provocative Alternative*, 26 WAKE FOREST L. REV. 837 (1991) (discussing unsuccessful North Carolina proposal). No state has followed Virginia and Florida.

27. *See generally* ARTHUR LARSON, WORKERS' COMPENSATION LAW (1992); MARK S. RHODES & GORDON OHLSSEN, WORKERS' COMPENSATION ANSWER BOOK (1997).

28. In Virginia, this is the Workers' Compensation Commission (previously the Industrial Com-

of the acts was grounded in the venerable workplace precedent of trading away access to tort for a new, no-fault payment program.[29] Claimants file petitions with the Commissions, which are empowered to hold hearings and approve or deny payment, exercising their customary powers and authority.[30] In Florida, dissatisfaction with Commission procedures led to a statutory amendment urged by the no-fault administration to move jurisdiction over no-fault cases to the Division of Administrative Hearings ("DOAH").[31]

However, the no-fault programs are mainly administered outside the Commissions. As for most of Worker's Compensation, outside entities receive premiums, investigate claims, and bear the risk that claims will outrun the funding collected to cover them. The Virginia and Florida programs, however, operate not through private insurance but through public entities outside the conventional state departmental structure. In Virginia the entity is the Birth-Related Injury Compensation Program (popularly known as BIF, for Birth Injury Fund).[32] In Florida it is the Florida Birth-Related Neurological Injury Compensation Association ("NICA").[33]

Virginia's BIF is governed by a board of seven unsalaried directors appointed by the Governor, four representing medical providers and liability insurers, and three representing the public at large.[34] NICA's corresponding board is appointed by the Insurance Commissioner, and has only one citizen

---

mission of Virginia). In Florida, it is the Division of Workers' Compensation of the Department of Labor and Employment Security. Professor Jeffrey O'Connell has argued the desirability of using Workers' Compensation models and agencies for reform, as their constitutionality is well established. Professor O'Connell is one of the fathers of "no-fault" auto insurance in the United States (with Robert Keeton) and a proponent of not dissimilar approaches to medical injury. He was closely associated with the Virginia Medical Society's proposals that ultimately led to the enacted statute. *See* O'Connell interview, *supra* note 17.

29. *See* New York Cent. R.R. v. White, 243 U.S. 188 (1917); Mountain Timber Co. v. Washington, 243 U.S. 219 (1917). *See generally* LARSON, *supra* note 27. The Virginia and Florida no-fault programs are much smaller in scope than Workers' Compensation, and they exclude from tort only a comparably small number of cases. Neither state's statute has had a reported judicial decision on its basic constitutionality. The assessment mechanism of both states has been upheld against constitutional challenges by non-participating doctors. *See* King v. Virginia Birth-Related Neurological Injury Compensation Program, 410 S.E.2d 656 (Va. 1991); McGibony v. Florida Birth Related Neurological Injury Compensation Plan, 576 So. 2d 288 (Fla. 1990); Coy v. Florida Birth Related Neurological Injury Compensation Plan., 595 So. 2d. 943 (Fla. 1992). In both states, all licensed physicians are swept in, with some exceptions for public employees as well as teaching faculty and graduate medical students.

30. *See* FLA. STAT. ch. 766.315 (1996); VA. CODE ANN. § 38.2-5008 (Michie 1994).

31. By operation of 1993 Fla. Laws ch. 93-251, the transfer occurred effective May 15, 1993. According to NICA and DOAH sources, there was an initial issue as to whether pending cases would remain at Workers' Compensation. Litigation was required to compel at least one judge of compensation claims to relinquish authority to DOAH to make the final order in the case. *See* Florida Birth Related Neurological Injury Compensation Ass'n v. DeMarko, 640 So. 2d. 181 (Fla. Dist. Ct. App. 1994). DOAH records show that many were transferred by June. *See, e.g.,* Acebo v. Florida Birth-Related Neurological Injury Compensation Ass'n, Case No. 93-3000N (State of Florida, Division of Administrative Hearings) (June 2, 1993).

32. *See* VA. CODE ANN. § 38.2-5002 (Michie 1994).

33. *See* FLA. STAT. ch. 766.303 (1996).

34. *See* VA. CODE ANN. § 38.2-5016(C) (Michie 1994).

representative, five members in all.[35] The same physician (a non-obstetrician physician) has chaired the Virginia board for most of its existence. There has been more turnover in Florida. As a matter of program operations, the Florida board acts more like a corporate board, considering matters of general policy. In contrast, the Virginia board actively reviews nearly every claim made (of which there are far fewer than in Florida).

Day-to-day operations are handled by BIF and NICA staff, each headed by an Executive Director. BIF has one additional employee, and NICA has several others. Office space is rented on the private market, and many functions are contracted out, either to private entities or to other public entities. In Virginia, for a time, even claims handling was contracted out to a liability insurer, although the function was brought back "in house" because of dissatisfaction with the level of service and information systems capability maintained under the fixed-price contract. BIF now runs all of its own claims investigation. Medical opinions are obtained from consultant physicians in both states.

The exact legal status of BIF and NICA is ambiguous. They exercise legislatively conferred authority under their enabling acts, operate under the direction of Boards appointed by state officials, and use state letterhead. However, they do not operate under administrative procedure acts, sunshine laws, or civil service provisions.[36] Their style of operations resembles that of an advisory commission. Technically, BIF and NICA are advisory in that final authority in a sense lies with Workers' Compensation, which holds *de novo* hearings and is a regular "line" agency of government subject to normal administrative rules.[37] However, in practice BIF and NICA decisions are very influential, not merely advisory.

2. *Funding.* In both states, funding comes primarily from premiums paid by voluntarily participating physicians and hospitals.[38] Though popularly termed "premiums," the statutory term "assessment" is more accurate, as the statutory fees resemble a head tax. The flat physician assessment amounts are unrelated either to risk (for example, number of childbirths attended, location or nature of medical practice) or experience (for example, past claims frequency). In both states, the statutory assessment was $5,000 annually for participating physicians (those wanting their patients to be covered by no-fault in lieu of tort). Hospitals are assessed $50 per live birth, limited in Virginia to

---

35. *See* FLA. STAT. ch. 766.315(c) (1996).

36. As stated by the Judge of Compensation Claims in the first administrative case involving NICA: "While [NICA] is not a state agency within the purview of the Administrative Procedures Act nor a corporation under the laws of the State of Florida, it is a chartered ministerial body operating under the authority and powers of the Constitution and the laws of the State of Florida." Ross v. Florida Birth-Related Neurological Injury Comp. Ass'n, No. 000-01-8951 (State of Florida, Office of Compensation Claims, District "M") (final order awarding benefits).

37. *See* VA. CODE ANN. § 38.2-5008 (Michie 1994). In Florida, an amendment replaced the Workers's Compensation Department with the Division of Administrative Hearings of the Department of Management Services. *See* 1993 Fla. Laws ch. 93-251 § 2.

38. *See* VA. CODE ANN. § 38.2-5020(A) (Michie 1994); FLA. STAT. ch. 766.314(4)(c) (1996).

an annual ceiling of $150,000 for large and small institutions alike.[39] The statutory assessment for non-participating physicians is $250 a year.[40] Backstop funding, if needed to maintain actuarial soundness, can also be raised by pro rata assessments on all liability or casualty insurers in the state, up to 0.25% of their premiums. Reinsurance is permitted, but not required. Virginia has not obtained reinsurance. NICA has a policy, but has never faced high enough no-fault claims to trigger the reinsurance coverage. In Virginia, funds collected must be held by an independent fund manager; in Florida, by the Department of Insurance.

The boards were also given the power to reduce the assessments if actuarially justified.[41] In light of its low level of paid claims, Virginia has eliminated the non-participants' fees and reduced the assessments for participants according to the length of time they have already paid into the program. There is no access to the state general fund or other state revenues in either state, except that in Florida NICA received a start-up transfer of $20 million from surplus in an Insurance Department account.[42]

Insurance regulators are charged with periodically assessing the programs' actuarial soundness.[43] To date, the resulting reviews have found the programs' funding to be adequate and not excessive.

3. *Eligibility.* For an infant's injury to be covered, both Virginia and

---

39. In Virginia, participating providers are entitled to a credit on their liability insurance premiums by statutory amendment. *See* VA. CODE ANN. § 38.2-5020.1 (Michie 1994). In Florida, the two largest insurers give NICA participating physicians a "dollar-for-dollar credit," according to an unpublished interim report for the House Committee on Insurance. *See* Leonard Schulte, Staff Attorney, Financial Status of [NICA] 5-6 (Dec. 23, 1992) (on file with Randall Bovbjerg). One leading underwriter in Virginia planned to give a discount to BIF participating doctors from the very first days of BIF in January 1988. *See* Letter from Judy Kelley, Second Vice President, Virginia Insurance Reciprocal, to Ronald K. Davis, of the Virginia Medical Association (Jan. 20, 1988) ($3500 for obstetricians buying $1 million per claim/$1 million annual aggregate coverage, $800 for family practitioners).

40. Legislative success in Virginia depended on having all funding come from medical sources. 1987 was a non-budget year in the legislature, so no tax revenues could be used. Moreover, having medical interests agree to provide funding was "immensely helpful" in increasing their credibility in the legislature, according to Medical Society top lobbyist Lawrence H. Framme III. *See* Videotape: Working Together, *supra* note 16 (explaining that normally doctors are seen as looking for a "handout," whereas the Act was a "hand-back"). In both states, some non-participating physicians challenged the constitutional legitimacy of assessing them to pay for a program that directly benefits only participants. The Virginia Supreme Court and the Florida District Court of Appeals both upheld program funding. *See supra* note 29.

41. *See* VA. CODE ANN. § 38.2-5020(G) (Michie 1994); FLA. STAT. ch. 766.314 (1996).

42. A $20 million transfer from the Insurance Commissioner's Regulatory Trust Fund was authorized by FLA. STAT. ch. 766.314(5)(b) (1996) and received during the year ending June 30, 1989. This was larger than the first year's collection of $4.8 million from hospital assessments and $10.0 million from physicians, according to Florida Birth-Related Neurological Injury Compensation Association, Financial Statements, June 30, 1989 (on file with Randall Bovbjerg). An additional $20 million transfer from the Insurance Department fund was subsequently authorized but never used. *See* Florida Birth-Related Neurological Injury Compensation Plan, Tallahassee, Florida, Financial Statements, June 30, 1995 (on file with Randall Bovbjerg). As of the end of NICA's fiscal 1995, total assets were $151 million, balanced by $149 million in claims reserves and $2.3 million in retained earnings. *See id.*

43. In Virginia, the assessment is performed by the State Corporation Commission. *See* VA. CODE ANN. § 38.2-5020(E) (Michie 1994). In Florida it is done by the Department of Insurance. *See* FLA. STAT. ch. 766.314 (1996).

Florida statutes impose rather restrictive conditions. Virginia requires that the following conditions be met: (1) the infant was born alive; (2) an injury occurred to the spinal cord or brain; (3) the cause of injury was deprivation or mechanical injury during labor, delivery, or resuscitation; (4) the infant is permanently disabled as a result[44] and is "in need of assistance in all activities of daily living" ("ADLs"); (5) the injury was not caused by "congenital or genetic abnormality, degenerative neurological disease, or maternal substance abuse"; and (6) the injury was either caused by a physician participating in the program or occurred in a participating hospital.[45]

The Florida statute limits recovery to live infants weighing over 2,500 grams,[46] effectively excluding not only still births but also premature deliveries that could be covered by Virginia's plan.[47] However, it is otherwise less restrictive than the Virginia statute, requiring only that the infant be "permanently and substantially mentally and physically impaired."[48] The law does not require that the infant require assistance in all ADLs. Most observers consider that, on balance, Virginia's eligibility criteria are substantially more restrictive than Florida's.[49]

In Florida, as in Virginia, causation by "genetic or congenital abnormality" is explicitly excluded.[50] The enabling statutes make their no-fault remedy the "exclusive remedy" for eligible injuries.[51] Liability claims are barred for any such injuries unless they were caused "intentionally or willfully"[52] or there is evidence of "bad faith or malicious purpose or willful and wanton disregard of human rights."[53] However, claimants are free to bring tort claims if rejected for no-fault, and the tort statute of limitations is tolled during the pendancy of a no-fault claim.[54] Additionally, in practice, there is no bar to a claimant's going to tort first.

The statutes thus single out for compensation a particular class of unfortunate medical outcomes that is relatively well-defined by the laws. This approach to determining payment responsibility is quite different from the con-

---

44. The original statute required the infant to be "permanently nonambulatory, aphasic, [and] incontinent." 1987 Va. Acts ch. 540. This was changed in 1990 to the slightly less restrictive "permanently motorically disabled and (i) developmentally disabled or (ii) for infants sufficiently developed to be cognitively evaluated, cognitively disabled." 1990 Va. Acts ch. 534.

45. VA. CODE ANN. § 38.2-5001 (Michie 1994).

46. *See* FLA. STAT. ch. 766.302(2) (1996).

47. *See* VA. CODE ANN. § 38.2-5001 (Michie 1994).

48. FLA. STAT. ch. 766.302(2) (1996).

49. One measure of how much more restrictive Virginia is than Florida comes from a large Virginia malpractice insurer. According to its proprietary data, in April 1997, the company had 19 similar obstetrical malpractice cases pending, of which 13 involved BIF-participating providers where the injuries were not severe enough to qualify under current BIF criteria. Moving to the Florida standards would cover the "vast majority" of them. *See* Letter from W. Scott Johnson, counsel for The Reciprocal Group, to Randall Bovbjerg 2 (Apr. 14, 1997) (on file with Randall Bovbjerg).

50. FLA. STAT. ch. 766.302(2) (1996); VA. CODE ANN. § 38.2-5001 (Michie 1994).

51. FLA. STAT. ch. 766.303(2) (1996); *see also* VA. CODE ANN. § 38.2-5002.

52. VA. CODE ANN. § 38.2-5002(C) (Michie 1994).

53. FLA. STAT. ch. 766.303(2) (1996).

54. *See* FLA. STAT. ch. 766.306 (1996); VA. CODE ANN. § 38.2-5005 (Michie 1994).

ventional medical tort approach, under which every element of the "coverage" definition—duty of care, breach of duty through substandard care, causation, and damages—must be determined case by case through expert testimony.[55] The Virginia-Florida approach to defining a "compensable event" in advance resembles that of no-fault programs for adverse immunization reactions[56] or the series of proposals for general "avoidable event" no-fault reform.[57] This approach has the potential to make it easier for claimants to realize that they have a potentially valid claim, thus simplifying the filing of claims. It should also simplify the resolution of claims once brought. Both effects could make no-fault faster and less expensive to administer than the tort system.[58]

4. *Benefits.* Compensation in Virginia is limited to monetary loss ("medically necessary and reasonable expenses" of medical, residential, and custodial care).[59] Florida imposes similar limits.[60] All collateral sources are offset (public and private), and payments are made as expenses are incurred.[61] Virginia also makes allowance for lost earnings from ages 18-65, scheduled at fifty percent of average wages, but Florida does not.[62] Neither state covers "pain and suffering" or other explicitly non-monetary loss, but Florida does provide a one-time parental allowance of up to $100,000, unchanged since the start of the program.[63] This parental payment may be thought of as coverage for non-pecuniary loss.[64] Reasonable attorneys' fees approved by the

---

55. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 188 (5th ed. 1984).

56. The National Vaccine Program uses a "vaccine injury table" to determine eligibility for administrative coverage. 42 U.S.C. § 300aa-14 (1994). It replaces the right to litigate, 42 U.S.C. § 300aa-11 (1994), and mandates that doctors report injuries, 42 U.S.C. § 300aa-25 (1994). *See* Wendy K. Mariner, *Innovation and Challenge: The First Year of the National Vaccine Injury Compensation Program*, *in* ADMINISTRATIVE CONFERENCE OF THE UNITED STATES: RECOMMENDATIONS AND REPORTS 1991 at 409. For a current description and data, see Health Resources and Services Administration, Bureau of Health Professions, National Vaccine Injury Compensation Program ("VICP") <http://www.hrsa.dhhs.gov/bhpr/vicp/new.htm>. An "Adverse Event Reporting System" is maintained by the Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, Vaccine Adverse Event Reporting System ("VAERS"). For current information, see <http://www.fda.gov/cber/vaers.html>. VAERS resembles the agency's more general Adverse Drug Experience Reporting System. *See, e.g.,* <http://www.fda.gov/cder/aers/chapter53.htm>.

57. *See* Havighurst & Tancredi, *supra* note 3; COMMISSION ON MED. PROF. LIABILITY, AMERICAN BAR ASS'N, DESIGNATED COMPENSABLE EVENT SYSTEM: A FEASIBILITY STUDY (1979); Tancredi, *supra* note 2; Laurence R. Tancredi & Randall R. Bovbjerg, *Creating Outcomes-Based Systems for Quality and Malpractice Reform: Methodology of Accelerated-Compensation Events (ACEs),* 70 MILBANK MEM. FUND Q. 183 (1992). A contemporary account terms the Florida reform a "'designated compensable event' no-fault plan." *See* Tedcastle & Dewar, *supra* note 8, at 556 n.140.

58. *See* Tancredi & Bovbjerg, *supra* note 4.

59. VA. CODE ANN. § 38.2-5009(1) (Michie 1994).

60. *See* FLA. STAT. ch. 766.31 (1996).

61. *See* VA. CODE ANN. § 38.2-5009(1) (Michie 1994).

62. *Compare* VA. CODE ANN. § 38.2-5009(3) (Michie 1994) *with* FLA. STAT. ch. 766.31 (1996).

63. *See* FLA. STAT. ch. 766.31(4)(b) (1996).

64. FLA. STAT. ch. 766.31(1)(b) (1996) simply calls the allowable $100,000 "an award to the parents or legal guardians of the infant" without specifying its purpose or how to calculate it; it is distinguished from the "[a]ctual expenses for medically necessary" and other services in subsection (a). Chapter 766.314(9)(a), however, in addressing NICA reserving practice says that reserves should include the maximum possible for "non-economic damages."

Commission are also covered in both states.[65]

C. Claims Processes

1. *Initiation of Claims*. BIF and NICA both rely upon claimants (or their attorneys) to discover and file no-fault claims. There is no mandatory reporting by covered medical providers, and little outreach by the programs.[66] In Virginia, the no-fault statute of limitation is ten years.[67] In Florida it is five, reduced from the original seven in 1993.[68] Statutes call on both entities to provide notice of the programs to possible beneficiaries.[69] Virginia calls only for a "clear and concise explanation" to be given "obstetrical patients" about their "rights and limitations under the program."[70] Florida requires that this explanation be provided on forms furnished by NICA.[71] Providing notice satisfactorily has been a significant political and judicial issue in both states.

Technically, claims first come to the Commissions, which provide official copies to BIF and NICA. In practice, many claimants or their attorneys contact the programs first.[72] Both entities will help claimants prepare cases for filing. Many families perceive a need for help, as obtaining and duplicating the required medical records can seem quite onerous. Many appear to rely on their lawyers for this service.[73]

Both BIF and NICA have engaged in some public speaking and other forms of outreach, but the main avenue of dissemination appears to be a brochure that briefly describes program eligibility, benefits, and claiming process. The brochures are written for patients and certainly seem clear and concise.[74] BIF and NICA print the brochures in large quantities and distribute copies to obstetricians and other providers to give to patients.

---

65. *See* FLA. STAT. ch. 766.31(1)(c) (1996); VA. CODE ANN. § 38.2-5009(4) (Michie 1994).

66. A duty to report potential claims at the time of incident is a common contractual provision in liability insurance, and the federal no-fault vaccine legislation requires reporting. *See supra* note 56. In Florida, medical providers seeking to report likely NICA eligibility by actively making a claim on behalf of an injured patient were rebuffed. *See* White v. Florida Birth-Related Neurological Injury Comp. Ass'n., 655 So. 2d. 1292 (Fla. Dist. Ct. App. 1995). No-fault was held to allow only claims made by the families or legal representatives of injured infants. *See id.* at 1296. As to no-fault outreach, see *infra* text accompanying note 155.

67. *See* VA. CODE ANN. § 38.2-5013 (Michie 1994).

68. *See* FLA. STAT. ch. 766.313 (1996) (original version at 1993 Fla. Laws ch. 93-251).

69. *See* FLA. STAT. ch. 766.316 (1996); VA. CODE ANN. § 38.2-5016(F) (Michie 1994).

70. VA. CODE ANN. § 38.2-5016(F) (Michie 1994).

71. *See* FLA. STAT. ch 766.316 (1996).

72. The programs do not routinely track the number of informal inquiries they receive about possible claims that do not mature into claims. The director's recollection is that there are not very many of them.

73. *See generally* Frank A. Sloan et al., *The Road from Medical Injury to Claims Resolution: How No-Fault and Tort Differ*, 60 LAW & CONTEMP. PROBS. 35 (Spring, 1997). Given only partial no-fault replacement of tort, families must choose between NICA and tort, and many probably know little about either, so it is not surprising that they routinely seek legal advice.

74. The programs provide single-sheet brochures; each had been once revised as of mid-1996. *See A Lifetime of Help* (Virginia); *Peace of Mind for An Unexpected Problem* (Florida) (on file with Randall Bovbjerg).

Both statutes provide that the administrative process is to be exclusive,[75] but this too has proved problematic in practice. Notably, in Florida, courts have held that a trial judge can make an independent judgment about NICA eligibility, so that a tort claimant need not exhaust her NICA remedies before proceeding to tort; tort claimants can also allege insufficient notice of exclusivity.[76]

2. *Administrative Process.* BIF and NICA have a limited time period after receiving notice of a claim to inform the Commission or DOAH whether the injury falls within the statutory definition and what benefits are appropriate to the case.[77] Medical evidence comes mainly from the written contemporaneous medical records of each case. Both BIF and NICA hire consultant physicians to review these records. In Florida, the main consultant often makes a physical examination of the infant. Delays sometimes occur if agreement is not quickly reached as to when and how to do this.

Next, the Commissions have a short statutory time period within which to hold a hearing.[78] In practice, hearings occur mainly in disputed cases. BIF or NICA and the claimants are parties in any hearing. Physician "defendants" seldom attend or send an attorney.[79] Medical evidence comes in mainly as depositions, sometimes as live testimony. Discovery by parties is allowed through interrogatories or depositions, just as in actions at law.[80] Both statutes have special provisions for independent, three-physician panels to review cases, but this seldom occurs.[81] Proceedings range in formality from a telephone conference call to a full-dress administrative proceeding. The Virginia statute calls for proceedings to be held in the city or county of birth or a neighboring one.[82]

In Virginia, Commission cases are heard by one commissioner, but the full

---

75. *See* FLA. STAT. ch. 766.303(2) (1996); VA. CODE ANN. § 38.2-5002(B) (Michie 1994).

76. *See* Florida Birth-Related Neurological Injury Comp. Ass'n v. McKaughan, 668 So.2d 974 (Fla. 1996). Kenneth V. Heland of the American College of Obstetricians and Gynecologists has argued—for example, at the conference at which this article was presented—that bypassing NICA will require tort claimants to undercut their own liability cases. Address at the IMPACS/Duke Medical Malpractice Conference (Sept. 12-13, 1997). He suggests, quite plausibly, claimants will have to convince a judge that their cases do *not* involve very serious birth-related neurological injury, which will, in practice, limit the number of viable tort claims for high damages or bar much evidence about medical conduct during delivery. However, arguing lack of notice, per Galen v. Braniff, 696 So.2d 308 (Fla. 1997), does not constrain plaintiffs' factual arguments. *See also* notes 156-61 *infra* and accompanying text.

77. The time limit on a written response to the Commission is 30 days in Virginia. *See* VA. CODE ANN. § 38.2-5004(C) (1996). In Florida the limit is 45 days. *See* FLA. STAT. ch. 766.305(3) (1996).

78. In Virginia, the Commission has 45-120 days after filing. *See* VA. CODE ANN. § 38.2-5006(A) (Michie 1994). In Florida, the limit is 60-120 days. *See* FLA. STAT. ch. 766.307(1) (1996).

79. The language of tort liability continues under no-fault operations. For example, administrators track "defense" costs. *See* NICA, Total Payments by Birth Year/Claims Year (administrative report on file with Randall Bovbjerg).

80. *See* FLA. STAT. ch. 766.307(3) (1996); VA. CODE ANN. § 38.2-5007 (Michie 1994).

81. In Virginia, the deans of the state medical schools are to arrange for panels, whose composition is statutorily defined. *See* VA. CODE ANN. § 38.2-5008(B) (Michie 1994). In Florida, the Insurance Commissioner appoints the panel. *See* FLA. STAT. ch. 766.308(1) (1996). The process exists in Virginia (deans of the two schools alternate years and name panel members), but, in practice, panel input is seldom called for. In Florida, the process has evidently not been funded, according to NICA and DOAH officials.

82. *See* VA. CODE ANN. § 38.2-5006(A) (Michie 1994).

Commission must rehear the case if requested within twenty days.[83] Upon a final order, the programs pay the claimant(s), attorneys, medical providers, and any others entitled to remuneration.[84] Administrative determinations are final as to matters of fact, and questions of law may be appealed to the state Court of Appeals within thirty days in Virginia.[85] In Florida, appeals go to the District Court of Appeal.[86]

III

STUDY DATA AND METHODS

This evaluation of administrative performance was possible only because the no-fault programs maintain administrative data systems with information on each claim. Moreover, in Florida, DOAH maintains remarkably complete public files on each case, with automated docket records and hearing officer decisions. No comparable data system exists for litigation. It is fortunate for evaluation that Florida requires all insurers and self-insurers to report substantial information on closed malpractice claims. Basic data are automated, and narrative descriptions of claims and circumstances can be photocopied.[87]

Most study data come from Florida, the larger program, on which more detailed information is available, and for which comparable tort data exist. We obtained automated administrative data from NICA on all claims made as of June 1996.[88] For each claim, data included the following: date of birth and of claim; all payments made, by type (for example, for investigation, lawyers' fees, and costs), and for benefits by type of payment; claims status; and reserve established, if any. Additional data on each NICA claim were obtained from DOAH automated docket books and matched to the NICA administrative data.[89] Some Virginia no-fault claims data were also obtained from program administrators.

To provide context and interpretation of administrative performance in both states, we conducted legal and literature reviews, as well as executive interviews with program administrators and other informed observers.[90] In the

83. *See id.* § 38.2-5010.

84. *See id.* § 38.2-5009; FLA. STAT. ch. 766.31 (1996)

85. *See* VA. CODE ANN. § 38.2-5011(B) (Michie 1994).

86. *See* FLA. STAT. ch. 766.311(1) (1996).

87. The Florida data are a unique resource of *all* malpractice claims closed in Florida since 1976. The data are maintained by the state Insurance Department and can be obtained for a fee. The data have been used for this and other studies. *See, e.g.,* Randall R. Bovbjerg & Kenneth R. Petronis, *The Relationship Between Physicians' Malpractice Claims History and Later Claims: Does the Past Predict the Future?,* 272 JAMA 1421 (1994); Sloan et al., *supra* note 73; Frank A. Sloan et al., *Medical Malpractice of Physicians: Predictable or Haphazard?,* 262 JAMA 3291 (1989).

88. Our claims universe was set as of our site visit to Florida on June 10, 1996, which included micro-data on files opened and payments made through May 15, as well as status as of that date from summary sheets.

89. We obtained DOAH docket information through October 15, 1996. A longer observation period enabled us to track time to resolution better for 1995 cases. *See infra,* text following note 93.

90. Interviews were conducted during numerous site visits by the authors and others to Florida and Virginia from February 1995 to April 1997, as well as by telephone. We spoke most often with no-

interviews, the focus was on general issues, but the administrators were sometimes asked to clarify other information about specific cases. We also obtained a sample of written opinions from DOAH and Workers' Compensation hearing officers. In addition, official reports, financial statements, and some aggregate data were obtained from both programs.

This article provides descriptive analyses about no-fault performance. The main focus is Florida, for which comparisons are drawn with similar tort cases. Most results for Virginia are presented as footnotes, given the very small size of the latter's program, the lack of comparison tort data, and a rather erratic pattern of filings.[91] Analysis used cases brought through calendar year 1995, which included almost all resolved cases and relatively few unresolved ones.[92] Limited quantitative data were added from interviews, notably on the nature of disputes in each case.

Analysis often focuses on "mature" Florida experience, which is more representative than early experience. Any new program or insurance coverage can be expected to undergo a shakedown period before settling into longer-run patterns. Administrators, claimants, and attorneys all face a learning curve in beginning to deal with a new system. Most fundamentally, it takes time for people to learn even that a new program exists. Prior research on health care regulation found a difference in program effectiveness after the initial three years.[93] Moreover, early in NICA's fourth year, administrative jurisdiction shifted from Workers' Compensation to DOAH. For these reasons, Florida results from years one through three (filed 1989-92) are often distinguished from the fourth year onward (filed 1993-95). Analysis covers only cases brought before 1996, so that an additional six months of information could be gathered before the end of our observation period in mid-1996. All years are calendar years, as the programs both began on January first.

Comparison tort data come from the Florida closed claims data base, for claims closed to June 1996. We selected as the most comparable comparison group the universe of obstetrical tort cases that were "NICA-like,"[94] but were filed before 1989.[95] Comparability was assessed on the basis of several attrib-

---

fault administrators, but also with other officials, interest group representatives, and observers. To assure access and full cooperation, all interviewees were promised confidentiality and that we would not quote them by name without their prior approval.

91. *See infra* Appendix A.

92. The small number of claims observed from the first half of 1996 had very incomplete information. Only one of the 11 Florida claims from 1996 was resolved by the end of our observation period, and the single Virginia claim was unresolved.

93. *See, e.g.,* Frank A. Sloan & Bruce Steinwald, *Effects of Regulation on Hospital Costs and Input Use*, 80 J. POL. ECON. 107 (1980) (noting such a time-related difference in administrative performance in an early analysis of regulatory "rate setting" for hospital prices).

94. Comparison cases were selected from among labor and delivery malpractice claims on the basis of being NICA-like according to the objective statutory criteria, using information from the 0-9 point severity of injury scale, descriptions of the injury, and allegations of negligence. *See* Sloan et al., *The No-Fault System for Obstetric Injury: Winners and Losers*, OBSTET. & GYNECOL. (forthcoming).

95. For purposes of some comparisons and also to enlarge the size of the data set generally, we

utes characteristic of NICA cases,[96] including: permanent injury, incurred in the delivery room, to a full term, live birth baby (as NICA does not cover any child under 2500 grams or stillborns). The closed claims were aggregated to the case level using a matching algorithm. An initial group of 138 claims was condensed into 110 cases, each based on a single incident.

IV

FINDINGS ON ADMINISTRATIVE PERFORMANCE

A. Number of Filings

The single most notable administrative attribute of these programs is their very small scale (Table 1). Both got off to a slow start. Florida's first claim was not filed until the second year of the program, and Virginia's not until its third year. A slow start is unsurprising, for two reasons. First is the shakedown period noted above.[97] Second is the usual lag between the occurrence of an injury, its discovery, and the filing of any claim.[98] In any given year most filings come from injuries during prior years, and in no-fault's first year there were no prior years' cases "in the pipeline." NICA applied to births beginning on January 1, 1989, allowing on average only six months for birth-related injuries to be detected and brought as claims. The second year's filings included births from two years, the third from three years, and so on. In general, additional cases continue to come in over time until the statute of limitations is reached.[99]

---

also considered tort cases filed through 1991, but arising from births before NICA. We stopped observation at the end of 1991 to allow five full years of "run off" for the tort claims to close, which, from prior work, we know to include almost all claims. It was inadvisable to include more recent years' tort filings, because larger and slower cases would disproportionately be excluded and because tort operations were expected to be affected by the existence of the parallel NICA remedy.

96. *See supra* note 94.

97. *See supra* text accompanying note 93.

98. No-fault proponents have suggested that no-fault should speed filings, but there is still a lag. Results on speed of filing are presented in subsection C of this part. *See infra* text following note 112.

99. This start-up period of NICA resembles the start-up of new liability coverage for physicians. In the first year of any malpractice policy, very few claims are discovered and brought in that policy year. The older "occurrence" style policy nonetheless immediately charges a full premium because insurers accrue the costs of anticipated future claims attributable to first-year incidents. Coverage that is sold on a "claims made" basis, in contrast, has very low premiums in its initial year, because only claims made during the policy year must be paid from that year's premiums. Subsequent years' premiums cover later claims arising from earlier year incidents. Claims made policies are considered "mature" in the fifth year of continuous coverage when they reach occurrence policy levels, *i.e.,* they have reached a steady-state of claims flow and premiums, absent changes in underlying causative factors. *See* FRANK A. SLOAN ET AL., INSURING MEDICAL MALPRACTICE 6-9 (1991).

TABLE 1
NO-FAULT CLAIMS BY YEAR OF FILING

Florida NICA		Virginia BIF	
Claims Year	Number	Claims Year	Number
		1988	0
1989	0	1989	0
1990	6	1990	1
1991	18	1991	1
1992	26	1992	3
1993	33	1993	1
1994	42	1994	7
1995	60	1995	16
1996	11	1996	1
TOTAL	196	TOTAL	30

SOURCE: NICA and BIF data.
NOTE: 1996 data through 5/15 (NICA), 5/31 (BIF)

As expected, Florida NICA filings increased steadily over time—from six claims in 1990 to a high of sixty claims in 1995 (Table 1). Virginia BIF filings did not rise until 1994 and 1995, when they jumped to seven and sixteen claims. Those two years contain three quarters of all claims from BIF's first eight years. Through 1995, NICA filings totaled 185, an average of twenty-six a year. BIF had thirty filings, fewer than four per year.[100]

In the long run, without significant legislative or administrative change,[101] one expects a program to reach a steady state of filings per year that is related to the underlying phenomena that generate injuries. What, then, are the likely steady-state sizes of NICA and BIF? The best evidence on the underlying rate of claims is the accumulated pattern of claims from each *birth* year (in contrast to the *filing* year presentation of Table 1). Appendix A presents claims by years of birth and of filing in Appendix Tables A and B. It confirms the lag in filings noted above. For each birth year, claims came in during many filing years (for example, for 1989 Florida births, claims were made in every year from 1990 through 1996). Typically, there was a bulge in filings two years after each birth year (for example, for 1989 births, the most common filing year was 1991).

The number of annual claims by birth year held much steadier over time

100. As already noted, this small size leads us to present further BIF data only in footnotes. Four cases per year is not only a very low average, but Virginia's program has also had an uneven pattern of filings. *See* Appendix A.

101. Virginia legislation made the eligibility criteria slightly less restrictive in 1990. *See supra* note 44. Significant Florida changes in claiming seem to have resulted from judicial decisions. *See infra* note 159 and accompanying text.

than the pattern for filings, even in Virginia. For most of its history, NICA claims ranged from thirty-one to forty per birth year; BIF claims from three to six. Based on our observation period through 1995, these claims rates appear to be the steady-state experience for each program operating under their "mature" eligibility criteria and administrative processes.

Filings declined sharply in 1996, however, even after correcting for our observation of only half of that year (Table 1).[102] Looking again at the data by birth year, Appendix A suggests what may have happened: Filings dropped for births occurring in 1994-96 in both states, leading to lower filings for 1995-96.[103] For example, whereas based on prior experience 1996 should have been the prime year for filing claims from 1995 births, zero such claims were actually observed in either state.[104] This pattern suggests that our estimates of a long-term annual caseload of thirty-one to forty in Florida and three to six in Virginia may be too high. Possible reasons for such a drop are discussed below.[105]

B. Nature of Disputes

Once filed, one expects NICA cases to be resolved differently according to the type of issue that might lead to dispute. Almost half of the NICA disputes involved major issues of eligibility—severity of injury or causality (Table 2). Such relatively complex issues seem at highest risk of causing a long and expensive process. Some seven percent more of the disputes involved significant benefits issues, such as the nature, utilization, and price of services covered or the amount of allowable attorneys' fees. The fee issue normally arises at the very end of a case, after the attorney submits billings and justification, and can lead to separate administrative proceedings. Minor issues of eligibility that should be resolvable with little difficulty accounted for another fifteen percent of disputes, including claims against non-participating doctors, with birth weight below the 2500 gram threshold, or filed by the wrong filer (by physician rather than parent or guardian). Finally, fully a quarter of NICA filings involved no dispute at all, either because of prompt NICA approval or as the result of an agreement between NICA and the claimant to allow claimants to withdraw without prejudice, subject to DOAH approval. These withdrawals

---

102. The decline was confirmed by more recent claims counts obtained for the preparation of this paper from NICA Executive Director Dickinson and BIF Executive Director Pyles and updated in February 1998. Year-end totals show that there were 31 NICA claims filed in 1996 and 29 in 1997, which supports the expectation of a drop-off in claims for births after 1993 and 1994 in Florida. BIF had 3 claims filed in 1996 and 12 in 1997, continuing its irregular experience.

103. When data are arrayed by birth year, one expects to see fewer claims late in the observation period than for prior years, because claims totals are cumulative, and prior birth years have more complete experience—more of their "run off" of claims subsequent to injury is actually observed. Thus, for instance, viewed from 1996, the birth year 1990 is expected to have nearly complete data, there having been six years after the average 1990 birth in which to bring claims. For birth year 1995 as observed in 1996, however, many claims remain "in the pipeline." This phenomenon results from claims lag, just like the rapid build up of claims filed in the early years of a program. *See supra* note 99. It is also why the text compares the second year after births rather than comparing cumulative totals for 1995 with earlier years.

104. *See* Appendix Table A.

105. *See infra* notes 158-59 and accompanying text.

seldom occur with a hearing in the absence of an active dispute between NICA and the claimant. Voluntary withdrawal without prejudice allows a claimant to re-file for benefits later. This could be desirable for the plaintiff, for example, in case an injury not yet shown severe enough to qualify becomes demonstrably worse over time.

TABLE 2
NO-FAULT ISSUES IN DISPUTE: ALL NICA CASES

Issue(s) In Dispute	1989-1991 No.	1989-1991 Percentage	1992-1995 No.	1992-1995 Percentage	Total No.	Total Percentage
Major Issues Of Eligibility						
Severity Of Injury	2	8	42	27	44	25
Causality	7	28	39	25	46	26
Significant Benefit Issues						
Attorney Fees	4	16	5	3	9	5
Coverage/Benefit Levels	2	8	2	1	4	2
Minor Issues Of Eligibility						
Birth Weight Too Low	1	4	10	7	11	6
Non-Participating Doctor	0	0	15	10	15	8
Wrong Filer	0	0	1	1	1	1
No Issue Disputed	9	36	39	25	48	27
TOTAL ISSUES	25	100	153	100	178	100

SOURCE: NICA Executive Director
NOTE: Cases have between 0 and 3 issues each; overall there are slightly fewer issues than cases.

We expected the number of less consequential disputes to decline over time. Plausibly, claiming should grow more accurate over time, as administrators clarify their standards and claimants (as well as their lawyers) learn more about what is required to succeed with a claim. After all, losers get nothing from NICA. Despite these expectations, the proportion of claims over minor issues has actually risen over time.[106]

Use of lawyers by claimants appears to be very high. Except for recording the amounts of payments made for successful claims, neither program keeps information on use of lawyers. However, administrators indicated that many people bring claims without a lawyer. According to our survey of no-fault claimant families,[107] however, almost all went to an attorney first—100% in Virginia and 94% in Florida.[108] Many survey interviewees also said that they first

106. *See* Table 2.

107. *See* Kathryn Whetten-Goldstein et al., Compensation for Birth-Related Injury: No-Fault Compared to Tort Systems (unpublished manuscript, on file with Randall Bovbjerg).

108. Project interviews covered a large share of claimants in each state—16 in Virginia (about half of all claimants through mid-1996) and 79 in Florida (about 40%). The interviewees appear to have

heard about no-fault from their lawyer. Moreover, according to administrative interviews, claimants do not normally go to DOAH or Commission hearings without a lawyer.

The proportion of cases receiving benefits varies between NICA and tort. About half of NICA filings receive payment.[109] Similarly, about half of general malpractice claims receive compensation.[110] However, for our comparable Florida obstetrical tort cases, the payment percentage is even higher, fully seventy percent.[111] NICA's lower percentage seems consistent with its lower cost of access to dispute resolution. Almost a third of claims are quickly resolved by voluntary withdrawal, often without prejudice to future filing should an infant's injury over time prove severe enough to qualify for no-fault.[112]

C. Speed of Resolution

Time to resolution is presented in Table 3 for both NICA and comparable tort cases. Overall, NICA cases are resolved in about two thirds the time (at the median) needed for tort, that is, more than a full year faster. Most of the difference is accounted for by paid cases. The median or mean unpaid NICA case takes nearly as long from injury to resolution as its tort counterpart.[113] For NICA, unpaid cases resolve more slowly than paid ones, possibly reflecting the

---

been representative of the entire populations of claimants. *See* Whetten-Goldstein et al., *supra* note 107, at 6.

109. *See* Table 3.

110. *See* PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY 42 (1985) (stating that, of claims closed nationally, mainly from the mid 1970s, about half closed with payment); U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984 (1987) (citing national data that 43% of claimed closed in 1984 received payment); Bovbjerg & Petronis, *supra* note 87, at 1423 tbl.1 (showing that, of Florida claims closed between 1975 and 1983, 40% of those with a named claimant received some payment).

111. These percentages are not exactly comparable because of the differences between the data bases from which they are calculated. Only one NICA claim can result from each birth, which is either paid or not. Tort "cases" as we present them, in contrast, can involve multiple defendants. Presentation of tort results by case rather than claim increased the payment percentage. For example, if both obstetrician and hospital are sued, even if only one claim results in payment, the per-case payment percentage is 100%, whereas per claim is 50%. On the other hand, the tort payment percentage may understate the true per-case payment percentage because it is calculated from closed-claim data. Some unknown share of our tort cases may have companion claims still open that will be paid after our observation period.

112. Also, some NICA claims appear to be brought as part of litigation strategy. *See infra* note 170.

113. Both sets of data somewhat understate the true length of time to resolution. Some observed NICA cases are known to be still open, and some tort cases can be presumed to involve related claims against additional defendants. *See supra* note 111. Tort cases were considered opened at the earliest date of claim against any defendant, and date of resolution is that of the last closed against any defendant, both tabulated at the date reported by the insurer or self insurer submitting the closed-claims report. Tort closure is the date of final settlement or judicial decree, even where a "structured" financial award pays out future losses under an annuity or other scheduled basis. Paid NICA cases were considered resolved at the time of first payment of benefits (typically, the parental award), which occasionally can occur before administrative processes and judicial appeals are completed. For closed but unpaid NICA cases, the date is that of the final administrative-judicial action. For open and unpaid cases, resolution is deemed to be the date of last significant action. Some cases appear to be abandoned in that there is no administrative action for some time; for these, we coded last date rather than end of observation period.

influence of some long disputes over open cases. For tort, the reverse holds true, possibly because of the predominance of cases quickly discovered to be unlikely to recover and hence abandoned with little or no formal judicial action.

TABLE 3
SPEED OF RESOLUTION: NICA VERSUS TORT

Calendar Days From Incident To Claims Resolution

Florida NICA Cases 1989-1995

Status	(# Cases)	5%ile	Median	95%ile	Mean
Paid	(94)	206	810	1680	850
Not Paid	(91)	440	1151	2267	1229
Total	(185)	316	899	2107	1036

Comparable Tort Cases 1984-1991

Status	(# Cases)	5%ile	Median	95%ile	Mean
Paid	(77)	428	1361	2441	1348
Not Paid	(33)	771	1220	2505	1428
Total	(110)	630	1322	2441	1372

SOURCES: NICA administrative data; Florida closed-claims database

Under no-fault, one expects both faster filing (because of simpler standards and less adversarial “stonewalling” of discovery) and faster resolution (also because of simpler standards as well as simplified administrative processes). To see what happened in Florida, Table 4 separates total time to resolution into two separate components: (1) from incident (birth) to filing, and (2) from filing to resolution. Table 4 shows that there are notable differences in delays before and after filing in the two systems. NICA and tort are very similar in time from injury to filing, but very different in time from filing to resolution. This difference is most directly attributable to administrators’ actions or inactions. Claims under NICA take almost exactly the same time to be filed as under tort. In the early periods, the median time to filing was 632 days for all NICA cases, versus 651 for tort. Both systems had slower filing in the more recent cases (medians of 766 and 726). NICA thus shows no advantage over tort in ease of discovery or filing.

TABLE 4
SPEED OF FILING AND OF ADMINISTRATIVE PROCESS:
NICA VERSUS TORT

	EARLY EXPERIENCE (NICA: 1989-1991; COMPARABLE TORT: 1984-1988)			MORE CURRENT EXPERIENCE (NICA: 1992-1995; COMPARABLE TORT: 1989-1991)		
(1) *Time From Incident To Filing (In Calendar Days)*						
	(No. Cases)	Median	Mean	(No. Cases)	Median	Mean
NICA						
Paid	(29)	625	526	(65)	766	807
Not Paid	(21)	709	663	(70)	760	877
TOTAL	(50)	632	584	(135)	766	844
TORT						
Paid	(60)	609	589	(17)	720	665
Not Paid	(27)	746	727	(6)	840	775
TOTAL	(87)	651	632	(23)	726	694

(2) *Time From Filing To Resolution (In Calendar Days)*						
	(No. Cases)	Median	Mean	(No. Cases)	Median	Mean
NICA						
Paid	(29)	114	174	(65)	60	110
Not Paid	(21)	681	728	(70)	264	303
TOTAL	(50)	207	407	(135)	148	210
TORT						
Paid	(60)	685	790	(17)	542	577
Not Paid	(27)	555	680	(6)	640	743
TOTAL	(87)	661	756	(23)	591	620

SOURCES: NICA administrative data; Florida closed-claims database

Once filed, however, NICA cases are resolved much faster than tort cases, particularly in NICA's more recent, relatively mature phase. NICA cut median time from filing to resolution from the early experience of 114 days to only 60 for paid cases, and from 681 to 264 for unpaid cases. Measured as means, NICA speed also increased, but by lesser amounts. Tort speeds are slower in nearly every comparison, and although tort speed from filing to resolution also dropped over time, it dropped by much lesser amounts. NICA's speed advan-

tage after filing has thus increased substantially in more recent experience.[114]

D. Administrative Costs

Overall, NICA carries substantially lower "overhead" costs for benefits payments, compared with comparable tort cases (Table 5).[115] Whereas nearly half of total tort costs go to expenses of dispute resolution (46.9%),[116] we estimate that NICA's administrative costs account for only 10.3% of total NICA spending, leaving almost ninety percent for benefits (payments to date plus reserves for future payments). In average dollars per case, NICA is able to deliver $486,000 in benefits for only $55,000 in administrative cost, while tort provides $399,000 in benefits at an administrative cost of $352,000.[117]

The biggest single source of savings under NICA is claimants' lawyers fees and expenses, which are a tiny fraction of comparable tort legal fees (one percent versus twenty-seven percent of totals).[118] Defense costs (attorneys fees and

---

114. Virginia data also show slow filing and prompt no-fault resolution. Virginia cases were brought very slowly—only two in the program's first four years, then fully 16 in 1995, then few again in 1997. The average time to filing was 1216 days (the median was 1139), or nearly three and a half years, even longer than Florida's medians of about two years. *See* Table 4. The time from filing to resolution was astonishingly fast in Virginia—only 69 days on average for paid cases, 127 for unpaid, for an overall average of 96 days, or only three months (the median was 72)—faster even than Florida's 148-day median for current experience. *See id.* The three fastest cases were resolved only 8, 10, and 12 calendar days after filing. We are uncertain about the strict accuracy or interpretation of coded information on dates, however. For reasons noted above, we did not seek to resolve such technical analysis-file-construction issues for this data set.

115. The costs in Table 5 are computed as total system cost, averaged per case, whether paid or unpaid. Data for NICA are for 1989-95, for comparable tort cases, for 1984-91. NICA data are all from the program, and DOAH costs are imputed from volume 19 of Florida's FINAL BUDGET REPORT AND TEN-YEAR SUMMARY OF APPROPRIATIONS DATA, 1987-88 THROUGH 1996-97 (Oct. 1, 1996). Tort benefits and legal expense data come from the Florida closed-claims data base for comparable NICA-like cases. Plaintiff attorneys' fees are estimated at 33% of indemnity payment. Insurer overhead and profit are a malpractice insurer average from BEST'S AGGREGATES AND AVERAGES 200 (1994). Court costs are based on the estimate of JAMES S. KAKALIK & NICHOLAS M. PACE, COSTS AND COMPENSATION PAID IN TORT LITIGATION (1986). Court costs are assumed to account for the same percentage loading for expensive obstetrics cases as for the much smaller average case in the tort system at large. The NICA court cost is estimated to be the same as that for tort cases, although a far lower percentage of NICA cases than tort cases are taken to court.

116. Although most of the cost elements of Table 5 are computed with Florida-specific data on NICA-like cases, administrative cost totals are very similar to those previously computed for the tort system generally. *See* KAKALIK & PACE, *supra* note 115, at 74 fig.7.2.

117. We also examined data from Virginia on total benefit payouts through May 1996. Of the 29 Virginia cases filed through 1995, 23 were paid by the end of our observation period in mid-1996 (79%, as opposed to 51% in Florida), at an average cumulative amount (undiscounted) of $116,400. The Virginia data cover only spending to date. BIF does not create reserves for future claims payments. Thus, it understates ultimate benefits spending relative to Florida's NICA or for tort settlements. Curiously, three cases found eligible had received no payments for a year or more, in at least one instance because the infant was hospitalized with all expenses being met, according to the Virginia executive director.

118. Brown's analysis of Virginia tort claims in 1980-89 found similarly high levels of attorney payment in paid tort suits. There, 38% of loss payments went to attorneys in cases of surviving infants (There were 31 paid claims, 20 for survivors and 11 for decedents). *See* Barbara S. Brown, Birth-Injured Infants: Claims Frequency and Costs in Virginia 1980-1988, tbl.6 (undated manuscript done for state estimation purposes by Williamson Institute for Health Studies, Medical College of Virginia, on file with Randall Bovbjerg). The comparable ratio for our Florida tort data is 50%. *See* Table 5 (26.6%/53.1%).

other allocated loss expense) are also much lower for NICA (one percent versus six percent).[119]

TABLE 5
NICA AND TORT COST COMPARISON
(AVERAGE 1995 DOLLARS PER CASE AND PERCENTAGE SHARES)

Category Of Expense	Ave. $/Case	%Of Tot.	Category Of Expense	Ave. $/Case	%Of Tot.
NICA Admin	$55,549	10.3	Tort Admin	$351,837	46.9
Courts & DOAH	$17,688	3.3	Courts	$15,018	2.0
Courts	$12,823				
DOAH Claims Administration	$4,865				
NICA Overhead	$24,068	4.4	Insurer Overhead	$95,664	12.7
Claimant Legal Expense	$6,489	1.2	Plaintiff Legal	$199,530	26.6
NICA Legal Expense For Claims	$7,304	1.3	Defense Legal (LAE)	$41,625	5.5
NICA Benefits	$486,324	89.7	Tort Benefits	$399,061	53.1
Payments Made	$45,852	8.5	Payments, Net		
Reserves Held	$440,472	81.3	Of Attorney	$399,061	
NICA Total	$541,873		Tort Total	$750,898	

SOURCES: NICA admin data, Florida closed-claims data, Florida budget data, Kakalik & Pace (1985), Best's & Co. (1995)

NOTE: Dollars adjusted to 1995 values by CPI; NICA 1990-95, N = 185; comparable tort 1984-91, N = 108; LAE = loss adjustment expense; plaintiff legal estimated at 1/3 of indemnity payment

It might be argued that the exact percentage "loading" of administrative costs is quite sensitive to the level of reserves for future benefits and related costs, which far exceed program cash outlays to date.[120] Fiscal conservatism might lead the program to over-reserve to reduce the risk of going over budget.[121] Any such systematic over-reserving would make the administrative cost rate shown in Table 5 lower than the true rate.

---

119. These expensive obstetrical injuries pay far more to the plaintiffs' attorneys than to the defense bar, whereas, for non-automobile tort as a whole, the two account for very similar shares of spending. *See* KAKALIK & PACE, *supra* note 115, at 74 fig. 7.2 (showing that plaintiffs' legal costs are 20% of the total, and those of defense 18%).

120. *See* Table 5.

121. *See* Schulte, *supra* note 39, at 3 (noting a "conservative reserving practice" of not fully discounting to the level estimated by the actuarial report). With regard to matching future claims costs with future expenses, a more refined comparison might judgmentally adjust administrative costs by adding a projection for ongoing claims administration for cases already reserved. The goal would be to accrue future expenses to match present reserves for benefits payments. In NICA practice and the presentation of Table 5, reserves cover both expected future benefits and future claims-related administrative costs. There is no obvious and principled way to generate from current data reliable estimates of future claims costs that match the future benefits included as reserves, however, and the affected amounts seem small.

The basic finding of much lower NICA administrative costs nonetheless seems strong, for several reasons. Qualitatively, it is notable that NICA administrative practice periodically has the program's main consulting physician estimate each covered infant's remaining lifetime. He reviews written records on development as well as videotapes of each infant made, in part, for this period.[122] Moreover, the program's consultant actuaries review and have approved Florida's reserving practice, and there is some suggestive evidence from a companion study that NICA costs are quite close to researchers' estimated five-year costs for these severely injured children.[123]

Most importantly for consideration of administrative performance, NICA's payout percentage will surpass that of tort even if the program eventually proves to have greatly over-reserved for future losses. In order for the estimated $56,000 in administrative costs per NICA case (now only ten percent of total spending with reserves) to be found as high as the forty-seven tort percentage, current reserves would have to be judged seven times too high.[124] This degree of over-reserving seems quite implausible.[125]

Also, NICA payouts differ markedly from previous awards for malpractice claims in services covered. Of actual dollars paid out through mid-May 1996 for cases filed by the end of December 1995, two thirds of payments have consisted of the parental allowance of up to $100,000 per case, almost twenty percent have consisted of medical payments, nine percent have been for nonmedical goods and services, and less than four percent have consisted of administrative costs, mainly compensability exam testing.[126] For the more recent period, the percentage accounted for by the parental payments is even higher, as the allowance is paid early, whereas medical and other bills continue to accrue over time. Typically, the allowance is not paid in cash, as such assets would make recipient families ineligible for social security disability and Medicaid, which are far more valuable.[127] The administrative data lack information

---

122. *See also* Whetten-Goldstein et al., *supra* note 107.

123. *See id.* at tbl.3.

124. These figures are calculated from data in Table 5. Current NICA administrative cost is $55,549, now 10.3% of total spending with reserves at the actual level of $440,472. To reduce this percentage to the tort level of 46.7%, reserves would have to be cut by $377,580 or 85.7%.

125. Recall also that estimated NICA court costs were simply estimated at tort levels, although they are arguably lower, given that most fact finding occurs at the administrative level. Part of any over-reserving that might affect the denominator of the administrative cost percentage is offset by this potential over-estimate of a cost in the numerator.

126. This information comes from NICA data and is not presented in a table.

127. Different cash or other assets ceilings (and exclusions of particular types of property, such as homes) apply under different programs. Two major programs are Medicaid and Social Security disability. *See generally* COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, 1996 GREEN BOOK: BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS 1-115, 879-914 (1996). The ceilings range from about one thousand to several thousand dollars, nationally. Possessing too many assets can be quite costly in foregone benefits. For example, blind or disabled Florida recipients of Medicaid each received average medical benefits of $4,251 in 1990 and $5,767 in 1995. NICA recipients can expect to receive much more, as they are far more profoundly disabled than average. *See* Debra J. Lipson et al., Health Policy for Low-Income People in Florida 15 tbl.4 (Washington, DC: Urban Institute paper, July 1997) (accessible at <http://newfederalism.urban.org/html/reports.html>).

on amounts paid by "collateral" sources, but our parental interviews suggest that it is considerable.[128]

Finally, NICA's legal and other claims-associated costs dropped markedly after the first three years, from an average of nearly $30,000 to under $3,000 per case.[129] In the belief that this phenomenon was driven by the very extreme outliers of high-cost cases, we examined all cases with legal expenses over $100,000,[130] of which there were six. All but one of these high-cost cases were filed in the first twenty months of claims, among the first fifteen filings.[131] The last one came in the fifth year of operations, among the second 100 NICA filings. Most are landmark cases that set precedent for NICA operations, although most also involved fact-based disputes and ongoing disputes over the appropriateness and cost of benefits requested. All but one are paid cases, and benefits issues and attorneys' fees caused the most disputes.[132] Also unlike the typical case, all the high-cost cases involved significant legal process. Five began in Workers' Compensation, and most of these had disputes continue over to DOAH's assumption of jurisdiction in May 1993.[133] Although similar benefits disputes can occur at any time under an ongoing program, disputes of this magnitude seem likely to be rare past the first few years.[134]

E. Nature of Administrative Process

There was generally little disagreement between NICA administrators and the ultimate resolution of cases by the DOAH administrative law judge or the civil court judge on appeal. Over 1989-95, only five to six percent of NICA recommendations on eligibility (whether to accept or reject a claim) were countermanded by DOAH or appeals judges. There was no difference between the early and the more mature pattern.[135]

Relatively few NICA cases go to hearing, and fewer still to judicial appeal.[136]

---

128. *See* Whetten-Goldstein et al., *supra* note 107, tbl.3 (For paid NICA claims to claimant age five, NICA paid an average of $123,121 out of $200,205 estimated total expenses. For unpaid claims, NICA paid zero of $198,433 average family costs, and non-tort sources of payment accounted for 62% of the total.).

129. These figures are calculated from NICA administrative data. They are not presented in a table.

130. *See* Appendix B.

131. That is, they were filed in August 1991 or before, in NICA's third year, but the second year in which the program received claims. *See* Table 1.

132. The cases also all involved very severe injury, even for NICA. This impression from the written record is confirmed by the NICA Executive Director and by the fact that four of the five paid cases received the maximum parental award of $100,000. For the other, the micro-data entry is missing. The sixth was not a paid case.

133. Of the high-cost cases listed in Appendix B, cases A-E all started under Workers' Compensation. Only case F was filed after the 1993 transfer of no-fault authority to DOAH.

134. To test the possibility that we could be misled by the "round number" cut-off of $100,000 used to select cases, we quickly examined the nine next biggest administrative cases for a total of 15. Their legal costs were smaller, but still well above even the early average of $30,000. Like the top six, the top 15 were predominantly early cases, almost all starting under the jurisdiction of Workers' Compensation.

135. These data from DOAH docket records are not presented as a table.

136. This information was abstracted from the DOAH docket books, and is not presented as a ta-

Overall, only twenty-eight percent (51 of 185) of our observed universe of cases had any hearing at all. Only a few had two or more hearings.[137] There were twenty judicial appeals (eleven percent). The balance accepted non-eligibility before hearing or the final DOAH ruling without appeal. There was little difference in this regard between early and recent cases.

Returning to qualitative information, note that both BIF and NICA operate on a very informal basis. Both programs have promulgated the formal plans of operation called for by their statutes. These plans, however, cover broad operational issues rather than specific standards to guide claimants and facilitate consistency of program determinations.[138] The applicable state regulations are those of the final administrative authorities—Workers' Compensation and DOAH. As noted above, the programs are not subject to Administrative Procedure Acts, and they have not promulgated formal rules or guidelines. For example, there are no written standards governing what constitutes a "permanently and severely" injured infant in Florida. Nor do rules specify exactly what types of services are covered under what circumstances, or just how to determine what fraction of the maximum $100,000 parental award should be allowed for what extent of injury.[139] Instead, the programs have relied on case-by-case development of administrative "common law" to elaborate upon the basic statutory provisions. Thus, claimants or their lawyers in search of quick answers have no "codification" of no-fault practice to which to refer.

Each no-fault case is investigated on its own merits, relying upon medical and other experts to inform the common sense of program administrators. Program directors and board members think that this approach is consistent with the statutory intent to depart from the formal adversary process of litigation and even of Workers' Compensation proceedings for initial investigation. Developing rules through experience also makes sense because there was little relevant precedent upon which these very first no-fault operating systems could draw and because their very small scope of operations militated against trying to develop comprehensive rules before starting up. The case-by-case approach to decision rules does have the defects of its virtues, however. Notably from an

---

ble.

137. The DOAH dockets only list hearings that may result in a judicial order. Lawyers' presentations in the course of discovery or requests for pre-hearing rulings are not entered. The DOAH information may undercount proceedings at Workers' Compensation during the initial years of NICA, as those data were entered as a matter of historical record rather than as ongoing conduct of DOAH business.

138. In this article, we do not examine the accuracy or consistency of determinations. However, Sloan et al., *supra* note 73, show that determinations correlate well with relatively simple, objective decision standards based on the statutes. Medical experts blindly reviewing no-fault, tort, and no claim cases also found patterns of differences across those classes of cases that support consistency. Cases in each class are more like one another than like members of the other classes, and the number of medical errors observed in medical records rose linearly from no claim, to no-fault, to tort cases.

139. As late as the end of our observation period, the definition of "permanently and severely" was still being determined on a case-by-case basis by NICA consultants. *See, e.g.*, Deposition of Michael Duchowny, M.D., in Walsh v. Florida Birth Related Neurological Injury Comp. Ass'n 8-9 (taken May 16, 1996, filed with DOAH June 12, 1996).

efficiency standpoint, it fails to generalize knowledge about the programs as well as access to them, particularly where the systems lack the scope to foster the development of a specialized bar that would provide expertise about program operating procedures and rules in the absence of written standards.

V

DISCUSSION: THREE MAIN FINDINGS AND THEIR POLICY IMPLICATIONS

Three findings stand out: the programs' very small size, their efficiency (high speed of resolution and low administrative cost), and the informality of their operations. These findings are discussed in turn, then the conclusion considers their implications for broader no-fault programs.

A. Size

The Virginia and Florida no-fault programs are clearly very small, having received just over 220 cases between them in eight years of operations. The key policy issue here is whether the programs are small by legislative design or as an unintended side-effect of administrative implementation.[140] The statutes intentionally create very limited "carve outs" from the tort system for a problematic subset of very severe injuries. Virginia has somewhat more than half as many births per year as Florida,[141] and Virginia's no-fault statute is even more limited than Florida's,[142] so one expects a smaller program in Virginia. Virginia's program is indeed smaller, only a sixth as large, an extreme difference in magnitude. Similarly, Virginia received more filings after loosening its standards somewhat.[143] This result is also in the expected direction, although the pattern of filings in Virginia is irregular and hard to extrapolate or interpret.[144]

As to whether BIF and NICA reached their target populations, consider first the legislative expectations. Projections at the time of legislative action were for much higher annual caseloads, some forty in Virginia and sixty in Florida.[145] However, those projections may have been intentionally made on the high side, so as to yield conservative budget estimates. Both legislatures were quite concerned that their programs be affordable within the legislated assessments.[146] Moreover, expectations have changed with the development of

140. Public policy implementation often differs from legislative goals, and "unintended consequences" are a common focus of policy literature. *See, e.g.,* JEFFREY PRESSMAN & AARON WILDAVSKY, IMPLEMENTATION (1984).

141. In 1992, there were 97,198 live births in Virginia and 191,713 in Florida. *See* U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 75 (1995). No-fault filings of about 40 a year thus amount to about two thousandths of one percent of births in Florida, which has the larger program.

142. *See supra* notes 48-49 and accompanying text.

143. *See supra* notes 100-01 and accompanying text.

144. *See* Table 1 and Appendix A.

145. *See* Tedcastle & Dewar, *supra* note 8, at 584, n.374; White, *supra* note 8, at 1490, n.16. Given that Florida has nearly double the number of Virginia's births per year as well as a less restrictive no-fault definition, it is interesting that the ratio of expected beneficiaries was only 60:40.

146. *See* Davis & Kramer, *supra* note 12; Tedcastle & Dewar, *supra* note 8, at 583 n.364; White, *su-*

additional scientific evidence on the share of neurological birth injuries caused by medical care as against other factors, including genetics and conditions during pregnancy. The expected level of birth-related injury is thus lower than was widely thought in the mid-1980s when these programs were conceived.[147] For these reasons, we expected that the programs, as implemented over time, would not meet original legislative expectations.

As another comparison, we estimated the annual number of births with cerebral palsy ("CP") in Florida. CP cases are a major contributor to severe neurological impairment, though more than half of CP cases involve lesser conditions.[148] Our estimate is about 500—at least ten times higher than our estimated long-run annual rate of NICA filings.[149] Another point of comparison is the number of birth-related negligent injuries in Florida, estimated at roughly 1000 a year.[150] One would expect only a fraction of negligent events or CP cases to involve the very severe injuries needed to qualify for NICA, but even these universes of possible NICA cases are far larger than actual NICA filings per year.

A final comparison is to similar tort filings. NICA filings are substantially more numerous than comparable tort claims,[151] even without any adjustment to

---

pra note 8. Another indication of fiscal conservatism is the Florida requirement that NICA claims reserves be kept to cover the maximum possible parental award. *See supra* note 64.

147. *See generally* JOHN WITREDGE WILLIAMS, WILLIAMS OBSTETRICS 991 (20th ed. 1997) (Chapter 44, Diseases and Injuries of the Fetus and Newborn Infant); Karen B. Nelson & J. H. Ellenberg, *Antecedents of Cerebral Palsy: The Multivariate Analysis of Risk*, 315 NEW ENG. J. MED. 81 (1986). Casual observation suggests that this shift in scientific evidence, and hence in the expert opinion on which tort law relies, has made it less difficult to defend malpractice claims of severe birth-related neurological injury. This may well have lessened the political support for the no-fault programs. No other state has emulated Virginia or Florida.

148. CP estimates derive from our review of the literature about cerebral palsy, concluding that about one quarter of one percent of cases are caused by medical care as opposed to other causative factors. *See, e.g.,* sources cited *supra* note 147. Earlier estimates of the incidence of CP were higher. In sum, it is now believed that the share of CP cases caused by medical care is much lower than many people believed when these statutes were debated. *See* Nelson & Ellenberg, *supra* note 147, at 81.

149. *See supra* text accompanying note 105. These figures would be more disproportionate if a reduction to the filing rate were made for clearly erroneous NICA filings such as claims for birth weights of under 2500 grams. *See supra* Table 2 and accompanying text. Moreover, according to the program director, an unquantified share of NICA filings do not appear to be "serious," in that they apparently do not seek recovery, but rather a ruling that NICA does not apply, so as to eliminate any NICA defense in the subsequent tort claim.

150. The best estimate is that the rate of negligent adverse events for newborns is 0.6%, as found in hospitals' medical records by the Harvard Medical Practice Study. *See* PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 6-23, tbl. 6.6 (1990).

151. NICA-comparable tort claims for 1984-91 totaled 108, or about 12 per year. *See supra* note 96. NICA's long-run rate is estimated at 30-40 per year. *See supra* note 105 and accompanying text. NICA's actual average for the first eight years was 26, based on a total of 216, 185 for 1989-95, plus 31 for 1996. *See supra* Table 1 and text following note 99. In Virginia, however, there have been only three or four BIF cases per year, *see* Table 1 and Appendix A, as against about eight comparable tort cases per year in the pre-no-fault period. *See* Barbara S. Brown, Birth-Injured Infants: Claims Frequency and Costs in Virginia 1980-1988, tbl.1 (undated manuscript done for state estimation purposes by Williamson Institute for Health Studies, Medical College of Virginia, on file with Randall Bovbjerg) (noting 78 claims from 1980 through 1989, counting both open and closed claims from five insurers that

the higher mature filings rate for NICA.[152]

On balance, it appears that some substantial number of potentially eligible no-fault-like cases remain unfiled for various reasons, even after many years of program operations. Just why the rate of filing is lower than expected is a matter of some conjecture on which there is no direct evidence,[153] but several factors may relate to low claiming rates:

(1) *Case finding and reporting* relies almost exclusively upon claimant initiative, and some potential claimants may not come forward. Although both programs will help potential claimants prepare their filings if asked, it appears that potential claimants normally go to attorneys instead. Considerations favoring use of lawyers include the expense of getting records and the difficulty of deciding whether to sue or to file in no-fault.[154] Moreover, the administrative reality is that such small programs necessarily operate only from offices in each capital city, whereas lawyers and their referral networks cover the entire state.[155]

(2) *Program outreach* to possible claimant populations has been limited. Despite the huge number of births per year, neither program has directly sought to educate mothers or families. Both have relied principally upon medical providers to hand out program brochures about no-fault. The brochures are printed in very large quantities, and revised over time to improve readability. However, they are distributed mainly to participating physicians. There is no continuing formal outreach to CP specialists, for example, nor to parents' self-help groups, although both directors sometimes give talks to some patient or provider groups.

(3) The *persistence of a tort remedy* also seems influential. These programs constitute a very limited carve-out approach to no-fault, with mainly voluntary participation. As a consequence, there are naturally many "boundary" issues that can be litigated. Claimants often go directly to court, especially in Florida.[156] Indeed, Florida courts have begun to rule on NICA eligibility, taking evidence and finding facts judicially, without any need to exhaust administra-

---

insured 94% of the physician market). No directly comparable number of tort cases since BIF is available. Our project survey of families found that many filed a tort case either before or after bringing a BIF claim. *See* Sloan et al., *supra* note 73.

152. *See supra* note 95 and accompanying text.

153. This project surveyed claimants in tort and no-fault, *see* Sloan et al., *supra* note 73, because these claimants had important information, they were relatively inexpensive to find, a sample frame was available, and there was program support to do so. Funding and other support for surveying a broad sample of injured infants was not available. One might start, for example, from medical clinics that see many CP patients or from health insurance or Medicaid data. In both states, there was concern that any such survey could foment claiming, both in tort and in no-fault. Similar concerns faced the Harvard Medical Practice Study, which obtained special confidentiality protections from the state before proceeding. *See supra* note 150.

154. *See* Sloan et al., *supra* note 73, for a discussion of the reasons.

155. By the end of our observation period, both BIF and NICA had obtained toll-free telephone numbers, which should improve claimant access to program advice.

156. *See* Sloan et al., *supra* note 73, at 46-63. Not only do many claimants bypass NICA, some of those in NICA appear to be there for tort-related strategic reasons. *See supra* note 76.

tive remedies.[157] In April 1996, just before the end of the observation period, the state supreme court upheld the authority of trial courts to make these determinations judicially rather than administratively.[158] Therefore, in Florida, the statutory language about NICA exclusivity does not mean exclusivity as to fact finding or to decisionmaking on eligibility, but only to exclusivity in the provision of benefits in eligible cases. Conversely, Florida courts are not limited to judicial review of administrative fact finding or to questions of law.

An even more significant judicial interpretation of the NICA-DOAH administrative role came in May 1997, when the supreme court ruled that NICA's carve-out from tort was dependent upon a tort defendant's ability to prove to a judge or jury that actual notice of NICA's exclusivity was given to a plaintiff before delivery, approving appellate reasoning that the purpose of notice is to allow a prospective parent to decide whether to change doctors.[159] Just how these decisions will be applied in litigation is not yet clear. No more apparent is just how many additional plaintiffs may opt for court over NICA; plausibly, these test cases had some influence on the downturn in NICA filings for early 1996.[160] Also, the small size of NICA coupled with these prior losses in court may make it harder for NICA to defend itself in any future constitutional challenge than it would have been at the onset of the program.[161]

(4) *Incentives of administrators and claimant attorneys* may also play a role. The programs have a statutory duty to pay valid claims, and their executives clearly show great compassion for injured claimants. Still, the economic incentives for program administration created by the requirements to maintain fiscal

---

157. *See, e.g.,* Central Florida Reg'l Hosp. v. Wager, 656 So. 2d 491, 493 (Fla. Dist. Ct. App. 1995); Central Florida Reg'l Hosp. v. Wager, 672 So. 2d 34 (Fla. 1996).

158. *See* Florida Birth-Related Neurological Injury Compensation Ass'n v. McKaughan, 668 So. 2d 974, 979 (Fla. 1996). However, plaintiffs who argue that they are not covered under NICA face two practical disincentives. First, the statute of limitations for tort is tolled during an administrative proceeding, but the administrative statute of limitations is not tolled during a tort litigation. Second, to stay in tort, a plaintiff's attorney must explain to the judge why the alleged injury is not NICA-eligible (*i.e.,* that it is either not birth-related, permanent, and severe, or an impairment both mental and physical). Making this argument over a defense claim of NICA eligibility would seem to preclude subsequent action under NICA, as well as to limit claims for damages. *See supra* note 76.

159. *See* Galen v. Braniff, 696 So. 2d 308, 309-10 (Fla. 1997). The notice issue is somewhat analogous to informed consent in the malpractice context. However, the courts appear not to discuss the issue of whether an obstetrical patient claiming lack of notice must further demonstrate that she herself or a reasonable patient would in fact have changed providers based on improved knowledge, as an informed consent plaintiff needs to show that a reasonable patient would have foregone a medical procedure if better informed about risks and alternatives. If and when courts reach this issue, they seem likely to have to consider that few patients change doctors and that those wishing to do so would discover that the overwhelming majority of obstetricians participate in NICA.

160. Lower claiming levels seem to have continued after our observation period ended in mid-1996. *See supra* note 102. The percentage going to tort first is already substantial. *See* Sloan et al., *supra* note 73.

161. We were unable to study the extent of "leakage" of NICA cases to tort because no data are available on current tort filings to compare with NICA. *See generally* Sloan et al., *supra* note 73. It is too early for detailed use of administrative data to study changes in tort and tort-NICA inter-relations in the post-no-fault era, especially past the early NICA era of 1989-91. Claims are observable from time of opening in NICA, but only closed tort claims are available for study, and these take some years to close. *See supra* Tables 3 and 4.

solvency reward stringency rather than generosity.[162] Supplementing this effect is an overall climate that emphasizes tort reform over no-fault goals, and the reliance upon medical providers for funding.[163]

For their part, trial lawyers considering whether to go to court or to NICA for recovery have a clear economic incentive to choose tort. In tort, there is often the potential for a reputation-enhancing large award, even though total payouts from NICA over time may ultimately average nearly as much and sometimes more than could be won in court. Additionally, there is constant awareness that winning cases bring far higher fees from tort than from NICA.[164] Lawyers' fees in tort are a customary one third of recovery, whereas no-fault approves only hourly billings, only in paid cases, and subject to administrative review.[165] Several observers report that attorneys handling NICA cases overwhelmingly come from the trial bar, not from specialists in administrative cases including Workers' Compensation.

Finally, two potential caveats about the size of the programs deserve mention. First, it has been hypothesized that even seven or eight years is not long enough to project long-term trends under current operations because the trial lawyers who handle so many of these cases may be keeping eligible cases "in a drawer."[166] Postponing a no-fault filing for a severely injured newborn may make some sense if a constitutional or other judicial challenge may eventually succeed, making it possible to bring a tort suit even in cases that appear to fall within BIF or NICA. Delay in seeking recovery could be ethical and in the client's interest where the likely tort recovery is far higher than could be obtained under no-fault, even discounted for delayed payment in tort, and important medical or other services are not being delayed for want of funds that no-fault might provide. Neither state has yet had a reported constitutional challenge on the merits.[167]

We have some suggestive evidence of anomalous variations in patterns of

---

162. NICA's administration sees itself as "[c]harged with administering claims, running an efficient organization and maintaining an actuarially sound fund," Lynn Dickinson, *Professional Liability in Florida*, MIAMI MEDICINE, Mar. 1993, at 21, not with finding all valid claims that may occur, which would probably threaten NICA's solvency, as argued in the text.

163. NICA administration, for example, strongly resisted an expansionary DOAH interpretation of its eligibility criteria, in the *Birnie* litigation. *See infra* note 177.

164. *See* Table 5.

165. Both states review submitted fees under the general, discretionary approach established by state compensation law. *See, e.g.,* Acebo v. Florida Birth-Related Neurological Injury Comp. Ass'n, Case No. 93-3000N (State of Florida, Division of Administrative Hearings, May 20, 1994) (applying the ruling of Florida Patient Comp. Fund v. Rowe, 472 So. 2d 1145 (Fla. 1985)).

166. Professor Walter Wadlington of the University of Virginia Law School has often emphasized this possibility, most recently at the conference at which this paper was presented, in informal remarks after the no-fault presentation at the IMPACS/Duke Medical Malpractice Conference (Sept. 13, 1997).

167. Only the constitutionality of assessments on non-participating physicians has been upheld. *See supra* note 29. The Academy of Florida Trial Lawyers has not taken a formal stance on NICA, according to interviewees there. Lawyers are split between those appreciative of new help for injured people not reached by tort and those opposed to any diminution of traditional tort remedies. A number of plaintiffs' attorneys surveyed by this project were vehement in denouncing NICA. *See* Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence* n.227 (submitted for publication Jan. 1998) (manuscript on file with Randall Bovbjerg).

times to filing consistent with lawyers' strategic behavior.[168] If there were many no-fault cases in a drawer we would expect at least some of them to begin to flow into NICA after some period of delay. This is not the pattern of filings observed in Florida. In contrast, filings predominantly occur in the second year after birth, then trail off for later years.[169] This trend changed only in the unusual year of 1995—the high year—when filings came in faster.[170] For Florida it seems likely that borderline cases are actively pursued in court, not kept in a drawer. Doing nothing raises at least some legal risk that the statute of limitations will run in tort.[171] Long delay also raises the very practical risk that the infant may die,[172] reducing the value of the case by cutting off claims for future losses and lessening allowance for non-pecuniary losses.[173] The "drawer" hypothesis is more plausible for Virginia, as discussed in Appendix A.

As a second caveat, program design and administration may change further, affecting the level of filings. Virginia lawmakers have twice broadened BIF coverage. Coverage was extended to births where *either* the doctor or the hospital participates, rather than both, and the restrictive requirement of "all ADLs" was changed to "permanently motorically disabled and (i) developmentally disabled or (ii) ... cognitively disabled."[174] In 1997, the state legislature mandated a study of BIF operations, including expansion.[175] There may also be serious political efforts to broaden the Virginia statute further.[176]

---

168. *See* Appendix A.

169. *See id.*

170. *See id.* tbl.1A. It is plausible that the pendancy of the *Galen v. Braniff* litigation on access to tort, *see supra* note 159, changed the 1995 pattern of NICA filings because lawyers wanted to see if the supreme court would make it possible to bring potentially NICA-eligible cases as tort suits by claiming lack of effective and timely notice to their clients about NICA. After the 1996 decision allowing access to tort, the ability to avoid NICA by claiming lack of notice to an expectant mother will probably reduce NICA claims and increase tort claims. Lawyers can make a notice claim in court, then return to NICA if unsuccessful, so long as the long NICA statute of limitations has not run.

171. The basic Florida tort statute of limitations is two years. *See* FLA. STAT. ch. 95.11(4)(a) (1996). A tort-reform statute of repose sets a maximum limit of seven years, but allows any case to be brought until a child's eighth birthday. *See* FLA. STAT. ch. 95.11(4)(b) (1996).

172. Among the small number of NICA claimants who actually did file, the NICA data show that only one infant was still alive and still receiving NICA support as of mid 1996 (not presented in tables). More recent cases may have longer expected lives. Almost 40 cases were still open as of the end of our observation period, and the reserves established for future payments are very substantial, as discussed *supra* note 42.

173. *See, e.g.,* Randall R. Bovbjerg et al., *Valuing Life and Limb in Tort: Scheduling "Pain and Suffering,"* 83 NW. U. L. REV. 908 (1989).

174. *Compare* VA. CODE ANN. § 38.2-5001 (Michie 1994) *with* 1987 VA. ACTS ch. 540.

175. The statutory mandate for a study of BIF operations was to consider the implications of broadening eligibility for no-fault in Virginia. *See supra* note 9. Moreover, as a matter of administrative application of statutory eligibility standards, some interview information suggested that the administrative response to claims had become more relaxed over time. Data from BIF's first five years do not support this view. There was only one claim denied in BIF's first six years of operation, the very first claim ever filed. All others were paid through 1993 (only five paid claims in all). Through 1995, 23 of 29 filings were paid, six denied. These numbers come from the authors' tabulation from primary claims data supplied by the program, based on filings through May 1996.

176. Considerable support for moving more cases from tort to BIF was expressed at a planning meeting for a legislatively required evaluation of BIF organized by BIF and the Medical Society and held at the Medical Society in Richmond on April 1, 1997. One strong supporter was a representative from a leading liability insurer of physicians.

For a time, Florida had a broader interpretation imposed by a DOAH decision and a lower court decision that the statutory requirement of severe impairment both "mentally *and* physically" should be construed to mean "mentally *or* physically," though the state supreme court eventually returned to the more obvious restrictive reading.[177] Presently, there appears to be little or no support for expansion of NICA in Florida.

B. Efficiency—Speed of Resolution and Administrative Costs

The measured speed advantage of NICA over comparable tort cases is great and has become greater recently. This finding seems quite robust, but times could become longer if some number of long-pending "cases in a drawer" do in fact come forward in the future.[178] However, the time advantage for no-fault will likely persist. The time advantage would even increase if the time from injury to filing could be reduced below tort levels. This could occur if the law and administrative practice became clearer as to just what cases belong in tort instead of no-fault. The recent judicial decisions affecting the exclusivity of NICA, however, seem likely to increase claimants' difficulty in determining how to proceed.[179]

The no-fault advantage with regard to administrative costs is very large, about ten percent for NICA versus nearly fifty percent for comparable tort cases.[180] Ten percent is a very low rate—closer to the costs of a largely informal, first-party, non-adversarial compensation system like group health insurance than to a rather adversarial process like Workers' Compensation, which has administrative costs of twenty percent or higher.[181] The authors' expectations were that NICA would resemble Workers' Compensation, but with higher costs of investigation and disputation because issues of medical causation ap-

---

177. The case dealt with a child who had to be given an intelligence test with unusual help, including a long time period, but so tested showed cognitive development in the normal range. *See* Birnie v. Florida Birth-Related Neurological Injury Comp. Ass'n., Case No. 93-2955N, at 11 (State of Florida, Division of Administrative Hearings) (1993) (final order). NICA accordingly denied the claim, but the DOAH hearing officer allowed it, reasoning that the very need for a special exam was an indication of severe mental impairment. *See id.* at 16. NICA appealed, but the Florida District Court of Appeals interpreted the statutory language as broadly as possible in light of the no-fault intent of the statute to provide benefits, ruling that the word "and" needed to be read as "and/or." *See* Florida Birth-Related Neurological Injury Comp. Ass'n. v. Florida Division of Admin. Hearings, 664 So. 2d 1016, 1021 (Fla. Dist. Ct. App. 1995). The state supreme court overruled this reading, upholding NICA's more restrictive interpretation. *See* 686 So. 2d 1349, 1356 (Fla. 1997). According to the executive director, the broader interpretation was never implemented for any other case, being held in abeyance while the DOAH decision was appealed. The exact nature of the dispute is of less relevance to no-fault generally than the observation that NICA so strongly opposed this intermediate reasoning of DOAH that would have expanded its no-fault reach, seemingly because of its perceived need to defend its solvency.

178. *See supra* notes 168-73 and accompanying text.

179. *See supra* notes 158-59 and accompanying text.

180. *See* Table 5 and accompanying text.

181. Loss ratios, benefits paid out divided by total cost to employers, ranged from 70-79% during 1988-1993. Jack Schmulowitz, *Workers' Compensation: Coverage Benefits and Costs, 1992-93*, SOC. SECURITY BULL., Summer 1995, at 56. A figure of 20% administrative cost is often heard. *See, e.g.*, Troyen A. Brennan, *An Empirical Analysis of Accidents and Accident Law: The Case of Medical Malpractice Law*, 36 ST. LOUIS U. L.J. 823, 856 (1992).

pear more complex than those of traumatic workplace injury.[182] It is possible to argue that this article could have estimated administrative cost rates differently,[183] but, as for speed, the differences found are so large that no reasonable adjustment would much alter the basic conclusion.

With regard to future changes, we note that any shift to more formal processes could also reduce the efficiency observed in Florida. It may also be that causation and other elements of eligibility are not as difficult to determine in these severe cases as is generally supposed.[184]

C. Informality of Agency Operations

Part of the speed and cost advantages calculated for NICA as against the tort process must derive from its informal process. Another consequence of the program's small scale combined with its informality and need for expertise seems less positive for no-fault. That is, program operations appear to be quite reliant upon the experience and professional performance of a small number of people. Creation of agency expertise is part of the rationale for moving to a predominantly administrative approach to investigation and dispute resolution.[185] The BIF and NICA Executive Directors had experience in nursing and in insurance claims management. Similarly, at DOAH and in the Virginia Workers' Compensation system, one administrative hearing officer hears almost all no-fault claims, which has fostered the development of expertise. Also, at NICA more than BIF, great reliance is placed on one medical consultant, whose name appears as reviewer in the large majority of case files.

This reliance on a small cadre of experts may be one reason that NICA can operate so informally and so inexpensively. The same reliance also makes such a small entity seem quite vulnerable to problems of succession at the time of inevitable turnover in personnel, which has yet to occur. This issue would pose far less of a problem for a larger no-fault program than for BIF or NICA.

A broader no-fault program would almost certainly have to operate more formally. More rules would be needed simply to educate new employees, as well as to maintain a consistent approach across cases that is now achieved by commonality of personnel and individual institutional memory. More formal operations could lengthen time to resolution and raise administrative costs. Offsetting this would be some economies of scale and scope. On balance, the

---

182. Occupational disease cases under Workers' Compensation involve similar difficulties of disentangling the extent to which injury derives from workplace factors as against outside disease etiologies, and it has been argued that such cases feature greater disputation and more common use of attorneys than do traumatic injury cases. *See* Mehlman, *supra* note 26, at 139 (implying higher administrative costs).

183. Some of the possible arguments are addressed *supra* note 121 and accompanying text.

184. An estimate of no-fault eligibility in Florida was determined by companion research that simply applied common sense to the objective criteria in the statute. The estimates correlated closely with actual no-fault determinations. *See* Sloan et al., *supra* note 73.

185. *See generally* MARVER H. BERNSTEIN, REGULATIONS BUSINESS BY INDEPENDENT COMMISSION (1985). *See also* Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L. REV. 1365 (1988) (discussing the virtues of administrative agency in the context of medical injury resolution).

observed efficiency advantages seem likely to persist despite rather significant increases in formality of operations, even if no-fault became somewhat less efficient absolutely.

Structurally, NICA's exercise of discretion in the absence of written rules or clear precedent resembles the role played by a private Workers' Compensation insurer that makes discretionary eligibility and payment determinations without public process but subject to administrative reconsideration. The private insurer also has a conflict with a covered employee that is similar to that of NICA facing a claimant, in that insurer payments come from a fixed pool of premium income. Indeed, they directly reduce insurer profit or surplus. For such an insurer, there appear to be two protections not yet present in these early medical no-fault models. First, insurers face a market test, whereas NICA, by statute, has exclusive authority to receive and attempt to resolve claims. Thus, a private insurer that boosts short-term profit through unreasonable claims denial faces long-term damage to reputation and market share.[186] Second, Workers' Compensation, as a much older and larger program, has a far more developed set of precedents and written rules about eligibility and benefits than does either BIF or NICA at their current stage of development.[187]

VI

CONCLUSION: IMPLICATIONS FOR BROADER NO-FAULT

The experience of these idiosyncratic no-fault programs in Virginia and Florida is relevant to the issues of broader no-fault performance, although the precise findings of this data-based study of two small programs seem unlikely to be precisely replicated. We draw six general lessons.

First, a form of no-fault is clearly feasible for at least some medical issues. Administration of BIF and NICA "works" successfully. That is, premiums are collected, and claims are received, investigated, and paid with not unreasonable results in an area that is very contentious in tort. In this, our interviews and other observations accord with prior study.[188]

Second, even these limited programs achieve major gains in efficiency compared with the tort process for similar cases. That is, no-fault delivers benefits quite similar in value to tort,[189] but much faster and with far lower administrative costs. The efficiency gains are so large that even somewhat different experience under broader no-fault would almost surely prove more efficient than

186. This argument assumes that employers represent employee interests either directly or because they face active unions or other employee interests.

187. *See, e.g.,* JONATHAN L. ALPERT ET AL., FLORIDA PRACTICE HANDBOOK: WORKERS' COMPENSATION WITH FORMS (1995).

188. *See* Horwitz & Brennan, *supra* note 9. A companion study from this project also found that families with no-fault experience and those with tort experience report similar levels of satisfaction with the two processes, *see* Whetten-Goldstein et al., *supra* note 107, although quite clearly these no-fault programs afford a less public forum than tort courtrooms for airing of grievances against medical providers.

189. *See supra* text accompanying note 117 and Table 5.

tort. Thus, any *quid pro quo* constitutional analysis[190] will very likely validate similar no-fault approaches.

Third, reaching the intended eligible population requires more than just legislating benefits and a claims process. Attention must be paid to administrative mechanisms, incentives, and financing. Virginia and Florida meant to create very limited "carve outs" from tort, but the programs in operation have proved more limited still. One problem is that the statutes decreed a new compensation and dispute resolution system but no new method of case finding and "intake." Accordingly, the old mechanism applies—families are left to recognize injuries and to seek counsel from plaintiffs' lawyers, and, in practice, underclaiming in no-fault seems nearly as severe as under tort. Another problem is that no-fault funding is essentially fixed and that program administrators have to give higher priority to maintaining solvency than to publicizing the availability of no-fault benefits or seeking out eligible claimants. In advance, we expected that medical providers, who benefit from the tort protection of no-fault, would refer eligible patients. In hindsight, this expectation seems naive, as providers cannot be certain that families encouraged to seek legal redress will not go to tort in place of no-fault.

Fourth, the survival of tort remedies is an Achilles heel for no-fault. Continued tort claiming is making no-fault smaller than intended, especially in Florida, which suggests two problems for any future program to remedy. For one thing, narrow no-fault eligibility and correspondingly only partial tort immunity leaves substantial disputation over boundaries. Claimants try to move their cases one way or the other depending upon the perceived merits and potential recoveries to themselves (and their attorneys) under the two competing systems.[191] This is not efficient. For another, judicial interpretation in Florida allows litigation even for cases potentially eligible for no-fault benefits. The possibility for attorneys to do an "end run" around no-fault probably helps explain the lack of direct frontal assault on the statute's constitutionality. Clearer draftsmanship might help future no-fault programs as a matter of law. Building a good administrative reputation for prompt, accurate, and efficient payment of benefits surely could not hurt as a matter of applied jurisprudence.[192] Routinely generating performance information like that in this article would surely help build both political and legal support where performance is indeed good—of course, non-performing programs do not deserve public support.

Fifth, there are reasons to think that an expanded no-fault program would be more satisfactory. Reaching more of the eligible cases would have beneficial results for both compensation and deterrence. The improvement of compensation from increased coverage is obvious. Underclaiming leaves many

---

190. *See* Ward, *supra* note 8, at 438.

191. *See* Sloan et al., *supra* note 73.

192. It would also be easier to maintain clear boundaries between tort and no-fault systems if no-fault "carve outs" were broader, especially if based upon more objective criteria or *ex ante* circumstances rather than on more subjective circumstances relating to *ex post* injuries. How one might accomplish that goes well beyond the scope of this article.

losses to be borne by injured parties themselves. Bringing more such cases under no-fault would raise benefit costs, but presumably with some offsetting savings in tort administration and possibly elsewhere as well. Administratively, having more cases could also improve the delivery of benefits, if it enabled administrators to do more case management or contracting with service providers than is possible for a small program.[193] Potential improvements for deterrence are less obvious. Larger size could facilitate experience rating of assessments. It would also facilitate analyses of patterns of bad outcomes, so as to improve understanding of how and why injuries occur. Over time, administrators could then craft responses, through education, incentives, or regulation. These no-fault programs are just too small to do such broad risk management.

Sixth, larger no-fault programs could not operate just as these do now. For a start, a more comprehensive no-fault program would almost certainly draw more attacks from the trial bar and more judicial scrutiny, if only because it would be a larger threat to the status quo. For an ongoing program, efficiency could be affected in both directions. Larger size could result in some economies of scale, but there might be new costs of inevitable bureaucratization. A more formal style of operations would be necessary, including written rules. Creating clear rules can reduce search costs for claimants and their attorneys, as well as the costs of disputes for everyone, but it may increase costs to the rule makers who must develop and promulgate them. The sense of justice could thus be served by better accountability of program administration, paralleling potentially improved accountability of medical actors for medically caused injuries. Consistency of results might also be more easily maintained and demonstrated to outside observers. BIF and NICA now operate with great discretion, and controlling discretion at a reasonable cost is one of the *raisons d'etre* of administrative law and procedure.[194]

In sum, these pioneering no-fault programs demonstrate remarkable administrative achievements, although hardly without shortcomings, from which others can learn. Happily, administration on its own has also created good information with which to assess program performance. Perhaps one day, similar information will also be routinely created for the tort system.

---

193. For a discussion of possible management of ongoing severe injury, see James F. Blumstein et al., *Beyond Tort Reform: Developing Better Tools for Assessing Damages for Personal Injury*, 8 YALE J. REG. 171, 190 (1991).

194. *See, e.g.,* KENNETH C. DAVIS, 3 ADMINISTRATIVE LAW TREATISE 97 (1994).

APPENDIX A

PATTERNS IN FILING OF NO-FAULT CASES: BY YEAR OF INCIDENT AND YEAR OF CLAIM

It is hard to estimate mature no-fault caseload from the pattern of claims by filing year, as presented in Table 1 in the principal text. The more detailed tables A and B presented in this Appendix facilitate making the long-run caseload estimates already presented in the text—about thirty to forty cases per year in Florida and three to six per year in Virginia. They also make it possible to address the "cases in a drawer" hypothesis by observing how quickly birth-injury cases are filed in each state and whether this pattern changes over time. There is suggestive evidence that Virginia cases were held out of no-fault until filing year 1995 and that Florida filing patterns permanently shifted lower that year, plausibly because of judicial test cases affecting NICA jurisdiction.

Appendix Tables A and B array no-fault claims in the two states both by year of filing and by year of injury, *i.e.*, birth.[a] This presentation is very similar to the "claims development triangles" routinely used by malpractice actuaries in projecting likely future claims rates from past experience.[b] Table A presents the Florida experience, and B shows that of Virginia.

Consider Florida first.

TABLE A
PATTERNS IN FLOW OF NO-FAULT CASES FROM INJURY TO FILING: YEAR CLAIMS MADE BY YEAR OF BIRTH IN FLORIDA

		Year Of Claim								
		1989	1990	1991	1992	1993	1994	1995	1996	Birth Year Claims Tot.
	1989	0	5	12	4	4	3	2	1	31
	1990	--	1	6	11	9	3	7	0	37
Year	1991	--	--	0	6	11	7	5	3	32
Of	1992	--	--	--	5	6	20	8	1	40
Birth	1993	--	--	--	--	3	6	23	1	33
	1994	--	--	--	--	--	3	13	5	21
	1995	--	--	--	--	--	--	2	0	2
	1996	--	--	--	--	--	--	--	0	0
	Filing Year Claims Tot.	0	6	18	26	33	42	60	11	196

NOTE: Shading indicates mode of claims distribution (most common filing year per birth year).

[a] In each case, the year is calendar year, that is, from January 1 through December 31.

[b] *See* Frank A. Sloan et al., *The Road from Medical Injury to Claims Resolution: How No-Fault and Tort Differ*, 60 LAW & CONTEMP. PROBS. 37 (Spring 1997).

The bottom row of total claims by filing year shows a steady rise in claims until the unusual upsurge in 1995, then an abrupt decline for our partial year of 1996. It is equivalent to the Florida column of Table 1. To estimate the long-run, "steady state" flow of cases, we examine the vertical totals at the far right, which show how many cases NICA has received arising from each birth year since implementation. This "yield" of filings by birth year has been quite consistent—thirty-one, thirty-seven, thirty-two, etc.[c] The observed average is 32.3 filings per birth year,[d] but the long-run average might be expected to be higher because the recent birth years have had a much shorter period of "run off" during which claims can come in. Consider the birth year 1989. Three claims (ten percent of the total ever filed) came in during 1995-96, the sixth and seventh years after birth. So, for all subsequent years, we expect additional claims ultimately to be filed, up to the point where further claims "development" is cut off by the statute of limitations. The statute was seven years in 1989-92, reduced to five in 1993.

Based on these considerations alone, a good estimate for "ultimate" total claims per birth year is probably around forty, the high level observed through 1994. However, the totals for 1995 and 1996 dropped markedly. To consider the meaning of this, we examine birth-year claims development over time.

Claims development is shown across each of the horizontal rows. The top row of Appendix Table A, for example, displays all the births from 1989 that ever resulted in NICA filings (that is, all filed before June 1996). The birth year 1989 was the only possible one that could lead to 1989 filings; and, as already noted, no claims were filed that year, hence the zero at the upper left and the dashes, for "not applicable," in the rest of the column below. The filing year total for 1989, at the lower left, is therefore also zero.

Continuing to follow claims arising from 1989 births, five more claims were filed in the second possible year, 1990 (top of second column from left in Table A). The next filing year, 1991, saw twelve filings from 1989 births, then claims trailed off—to four in each of 1992 and 1993, three in 1994, two in 1995, and one in partial-year 1996. The statistical "mode"—or highest single number in the distribution, twelve in filing year 1992—is shaded. These shaded modes highlight the observation that cases most commonly are filed in the third year after birth. The shadings slant regularly down and right across the triangle.[e] That the third year is the most common is consistent with the finding in Table 4

[c] The discrepancy between steadily rising filing-year totals and relatively constant birth-year totals is easy to explain: It is a normal, arithmetic side-effect of observing early program development. During claims year 1989, filings could come from only a single birth year, that is, 1989. In 1990, claims could come from two birth years, in 1991 from three, and so on.

[d] This average number of filings per birth year omits birth years 1995 and 1996 as too recent for reliable observation, as they do not include the normally modal third year after birth. Even for 1995, the earlier omitted year, only twelve months on average was available for filing before the end of our data collection, that is, January 1995 through May 1996 maximum observation period, December 1995 through May 1996 minimum.

[e] The rectangular array is called a triangle because only the triangle in its upper right contains data.

that the median time to filing is 600-700 days after birth, longer in the more recent period.[f]

Something did change for birth years 1994 and 1995, however. Their modes were only two years and one year, respectively. This effect occurred partly because the observation period did not include the full third year after birth for either birth year. We also suspect that pending litigation in 1995-96 reduced the previously normal rate of flow of NICA cases.

In particular, we surmise that the underlying propensity to bring NICA claims was permanently reduced by the litigation leading to the Florida Supreme Court's 1996 *McKaughan* ruling that claimants could go directly to court for a judicial ruling on their NICA eligibility.[g] The *Galen* litigation allowing tort lawsuits alleging inadequate notice of NICA may also have cut back on NICA filings as early as 1995, the year of a lower court ruling.[h] Beyond the observation period of this study, we learned that 1996 and 1997 total filing year cases were below pre-existing levels, which also supports an expectation of reduced claiming.[i]

The developmental triangle for Virginia has the same format in Appendix Table B.[j] Viewed by birth year, total filings are relatively steady, at three to six per year, an average of four per year during 1988-1994 (far right column). From this, one would expect an ultimately somewhat higher per-year total, allowing for the truncated observation of claims development for recent birth years.

---

[f] The average time from birth to filing in the third year (the mode) is only two years, not three. That is, for births in year 1990, say, the typical case represents a birth on June 30, 1990, and a filing on June 30, 1992, each date being half way through the year. Elapsed time is thus two years.

[g] *See* principal text at note 158 and accompanying text.

[h] The lower court case was *Braniff v. Galen of Florida, Inc.*, 669 So. 2d 1051 (Fla. Dist. Ct. App. 1995), *aff'd sub nom.* 696 So. 2d 308 (Fla. 1997). *See also* principal text at note 159.

[i] *See* principal text at note 102 and accompanying text (31 claims filed in 1996, 29 in 1997).

[j] However, BIF took effect a year before NICA, so that there are nine rows in Table B, representing years 1988-96, not eight as in Table A for Florida.

TABLE B
PATTERNS IN FLOW OF NO-FAULT CASES FROM INJURY TO FILING:
YEAR CLAIMS MADE BY YEAR OF BIRTH IN VIRGINIA

		Year Of Claim									
		1988	1989	1990	1991	1992	1993	1994	1995	1996	Birth Year Claims Tot.
	1988	0	0	0	1	0	0	1	1	0	3
	1989	--	0	1	0	2	0	1	2	0	6
	1990	--	--	0	0	0	0	1	3	0	4
Year	1991	--	--	--	0	0	1	0	3	0	4
Of	1992	--	--	--	--	1	0	0	3	1	5
Birth	1993	--	--	--	--	--	0	4	1	0	5
	1994	--	--	--	--	--	--	0	1	0	1
	1995	--	--	--	--	--	--	--	2	0	2
	1996	--	--	--	--	--	--	--	--	0	0
	Filing Year Claims Tot.	0	0	1	1	3	1	7	16	1	30

NOTE: Shading indicates mode of claims distribution (single most common filing year for each birth year).

SOURCES: NICA administrative data, as of June 10, 1996; BIF data, as of June 4, 1996

However, the pattern of development of cases by claims year is highly unusual, as already noted.[k] Only five cases were filed all together in the first six filing years of the program's existence. Over half of them came in during a single filing year, 1995. The triangle of Table B shows how this occurred—the modal year of filing for almost every birth year was claims year 1995.[l] We know of no statistical test of significance for this finding, but it seems inconceivably unlikely to have occurred by chance. It seems almost certain to have occurred because of some interaction between program administrators, claimants and their lawyers, and the courts, which provide an alternative route to claim.

Administrators could not explain this "bulge" in filings, except to say that somewhat more than the usual outreach had occurred, including meetings with patient advocates. The bulge is consistent with the hypothesis that many early-year Virginia cases were kept "in a drawer" until 1995. Filings for all of 1996 fell drastically from the 1995 level, then for 1997 rose again to three-quarters of the 1995 total.[m] The up-and-down Virginia experience provides scant basis for

[k] *See* principal text at note 100 and accompanying text.

[l] Birth year 1989 was bi-modal, but 1995 was one of the two modes. Birth year 1988 had only three claims in all, one in each of three different, widely spaced years, so its distribution cannot be said to have a mode.

[m] *See* principal text at note 102 (3 claims filed in 1996, 12 in 1997).

predicting any one year's filings, but a range of three to six is not unreasonable. There is no basis for predicting a long-run decline in filings, unlike in Florida.

APPENDIX B

THE SIX NICA CASES EXCEEDING $100,000 IN DEDICATED LEGAL EXPENSES[a]

CASE A. *Filing year*: 1990. *Legal/total cost*: $253,000/$1,000,000. *Parental award*: $100,000. *Disputed issue(s)*: NICA status and powers (contract authority, rule making); benefits (nature of parental award, sharing between divorced parents; specialized transportation; parents' counseling; cost of family hospitalization insurance; housing; swimming pool for aquatic therapy; rehabilitative services; care manager; respite care; collateral source offset); allowable service providers (*e.g.,* mother, grandmother, family friend); attorneys' fees and costs (first as to amount, then as to interest). *Comments*: There were three separate proceedings: first at Workers' Compensation on benefits; second on attorneys' fees, then judicial review; third at DOAH on interest. Causation was undisputed. The infant's earlier born twin had only temporary problems from being born at the eighth month, while the claimant infant had a very difficult delivery ending with pitocin to induce labor, then manipulation and suction to deliver vaginally. Injury was severe, massive intra-cranial hemorrhage resulting in permanent blindness, incapability of purposeful movement, profound retardation. Many types of benefits were disputed, as well as the process by which the claimant could order services, and get NICA to pay. The powers of NICA were argued. Overall, this was an elaborate, litigation-like process, with lengthy formal hearing and opinions at Workers' Compensation, also hearing and opinion at DOAH.

CASE B. *Filing year*: 1990. *Legal/total cost*: $202,000/$522,000. *Parental award*: $100,000. *Disputed issue(s)*: benefits (experimental services, out-of-country care, European travel by infant and four accompanying adults). *Comments*: Causation was undisputed. Injury was severe, leaving the infant spastic, with cortical blindness, microcephaly and virtually no psychomotor development. The child operates at precognitive level, has problems swallowing, for which the mother sought unusual Hungarian treatment. NICA disputed medical necessity, and had referred infant to specialty institute in Baltimore. Had DOAH hearing (travel denied) and judicial review (travel approved).

CASE C. *Filing year*: 1991. *Legal/total cost*: $125,000/$604,000. *Parental award*: $100,000. *Disputed issue(s)*: causation. *Comments*: According to NICA, injury was severe but eligibility was unclear, because injury might have been caused by an underlying genetic syndrome. NICA never got a definitive medical opinion on causation and in absence of good evidence against, allowed eligibility. There was no hearing. High expense came from high investigative costs.

CASE D. *Filing year*: 1991. *Legal/total cost*: $128,000/$448,000. *Parental award*: $100,000. *Disputed issue(s)*: Causation/eligibility, attorneys' fees and costs (number of lawyers, extent of work done). *Comments*: Severity of injury

[a] Sources: Duplicated Workers' Compensation or DOAH order(s) for five cases, ancillary documents, including brief in sixth case; NICA administrative data; and administrative interviews.

was clear, but eligibility was initially disputed by NICA based on the consultant obstetrician's opinion being given more weight than the contrary neurologist's opinion, neither of which was given to opposing counsel. The NICA consultant and NICA opinion subsequently reversed when attorneys for the claimant found independent evidence of causation, so that eligibility was undisputed by the time of hearing. Two sets of attorneys submitted bills, one for eligibility claim, the other for assistance with claimant's immediate needs, including NICA-eligible services. Hearing dealt mainly with attorneys' fees, standards for determination, and application to this case.

CASE E. *Filing year*: 1991. *Legal/total cost*: $108,000/$115,000. *Parental award*: ineligible case. *Disputed issue(s)*: causation. *Comments*: There was a three-day hearing at Workers' Compensation in 1993, but no hearing order was entered. Proceedings began anew at DOAH. The denial of eligibility was on judicial review at the close of our observation period. NICA reports that non-eligibility was upheld.

CASE F. *Filing year*: 1994. *Legal/total cost*: $148,000/$185,000. *Parental award*: $100,000. *Disputed issue(s)*: benefits (special van, payment to mother for custodian attendant care); access to child by NICA to assess needs.