FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/CS/HB 1291	**COMPANION BILL:** CS/SB 1668 (Burton)
TITLE: Florida Birth-related Neurological Injury Compensation Association	**LINKED BILLS:** None
SPONSOR(S): Anderson	**RELATED BILLS:** None

Committee References

Insurance & Banking	➤	State Administration Budget	➤	Commerce
17 Y, 0 N		11 Y, 0 N, As CS		23 Y, 0 N, As CS

SUMMARY

Effect of the Bill:
The bill amends operational and financial requirements for the Florida Birth-Related Neurological Injury Compensation Association ("NICA"), codifies current benefit policies, and increases access to psychotherapy providers. It requires continuous comprehensive major medical health coverage for the participant or enrollment in Medicaid, if eligible, and requires the Birth-Related Neurological Injury Compensation Plan ("Plan") to cover a participant's premiums and out-of-pocket costs. The bill requires NICA to compensate the Medicaid program for services furnished to Plan participants. The bill authorizes NICA to recoup overpaid expenses from family members via an administrative proceeding.

The bill revises NICA financial oversight by establishing timelines for existing provider assessments to ensure timely collection, requiring NICA to perform actuarial soundness analyses, revising requirements for management of Plan assets and liabilities, revising the actuarial valuation review process conducted by the Office of Insurance Regulation ("OIR"), restructuring the remedies available to OIR for addressing potential financial unsoundness of NICA, and increasing the limit on the fund transfer by OIR required for instances of inadequate cash flow.

Fiscal or Economic Impact:
The bill may have an indeterminant savings for the private sector.

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ANALYSIS

EFFECT OF THE BILL:

The bill makes several changes to the governing framework of the Florida Birth-Related Neurological Injury Compensation Association ("NICA"), relating to the petition process, Medicaid payments, compensation awards, and financial solvency.

Definitions
The bill defines "participant" to mean "the person who suffered a birth-related neurological injury as an infant and who accepted compensation under the plan by final order entered by an administrative law judge pursuant to s. 766.309, F.S." (Section 2).

The bill replaces the terms "infant" and "child" with "participant." According to NICA, 40% of its participants are adults.[1] (Sections 3, 6, and 8).

The bill revises the definition of "claimant" to mean any person who files a claim, regardless of whether they're seeking compensation or not. It also substitutes the term "injuries" for "injury claims." The bill also removes

[1] Email from Hilary Brazzell, External Affairs Manager, Florida Birth-Related Neurological Injury Compensation Association, NICA Information (Jan. 28, 2026).

references to "compensation" from the petition filing process, allowing claimants who are neither the participant nor a family member of the participant to file a petition with the Division of Administrative Hearings (DOAH). (Sections 2, 3, and 4).

The bill renames "family residential or custodial care" as "family care" and, provides that family members will be compensated based on rates established by Medicaid for private duty services provided by a home health aide regardless of whether the family member providing the care was previously employed. The bill removes the 10-hour per day limit on compensation for care provided by a family member. (Section 2).

The bill defines "office" as the Office of Insurance Regulation. (Section 2).

Medicaid and Health Care Coverage for the Participant

The bill authorizes the Agency for Health Care Administration ("AHCA") to recover the full amount of all medical assistance provided by Medicaid on behalf of recipients to the full extent of third-party benefits, including incurred costs of NICA plan participants. (Section 1).

The bill requires NICA to reimburse AHCA for fee-for-service[2] claims and capitation payments[3] for participants enrolled in Medicaid, as well as for the payment of administrative and support costs associated with the provision of the Medicaid services. (Section 6).

The bill requires a family member to continuously maintain comprehensive major medical health coverage for the participant. A family member must obtain insurance coverage within 60 days after an administrative law judge enters a final order approving a claim for compensation or apply for Medicaid coverage within 30 days after entry of such order. If the participant is ineligible for Medicaid, the family member must obtain other coverage within 60 days after receipt of a Medicaid denial. A family member of an individual who is a participant on June 30, 2026, must obtain the required coverage for the participant by January 1, 2027. (Section 6).

Compensation Awards

The bill revises the types of compensation of actual expenses for medically necessary care or services an administrative law judge may award. The bill provides the following changes in benefits:

- Codifies coverage of medically necessary dental services.
- Coverage for medically necessary supplies.
- Coverage for family care, instead of family residential or custodial care.
- Coverage for facility care and nursing and home health, instead of professional residential and custodial care and service.
- Expands coverage of behavioral health services for the participant's family. It adds coverage for psychotherapeutic services for any relative who resided with the participant, rather than only the father, mother, or legal guardians.
    - Such relatives will share in the aggregate annual benefit of $10,000 currently allotted for psychotherapeutic services for immediate family members. In addition, the bill expands the providers covered to include psychiatrists and psychotherapists who maintain equivalent licensure in another jurisdiction.
- Codifies coverage for legal costs associated with establishing and maintaining guardianship for a participant.
- The bill expands the type of vehicles covered to include vehicles rather than just vans.

[2] The Medicaid fee-for-service model is the one in which doctors and other providers are paid directly by the state for each service provided to the patient. *See* HealthCare.gov, *Fee for Service*, https://www.healthcare.gov/glossary/fee-for-service/ (last visited Feb. 17, 2026).
[3] The Medicaid capitated model is one in which the state pays health plans a set rate for each enrollee. *See* Centers for Medicare & Medicaid Services, *Capitated Model*, https://www.cms.gov/medicaid-chip/medicare-coordination/financial-alignment/capitated-model (last visited Feb. 17, 2026).

- Clarifies the coverage of housing assistance benefit of up to $100,000 for the life of the participant includes, but is not limited to, a down payment on a new home, and moving expenses. Currently, this benefit includes home construction and modification costs.
- Requires NICA to reimburse plan participants for the payment of a health insurance policy or contract that provides major medical or similar comprehensive health coverage, which includes the premium and any out-of-pocket expenses incurred by the participant.
- Clarifies that NICA will not provide compensation for nursing, home health care, or family care provided while such care is being provided by another person or entity. (Section 6).

Currently, expenses for items or services that the participant has received from their comprehensive health coverage, or for which the participant has received reimbursement from their comprehensive health coverage, are not subject to compensation under the Plan. The bill provides that the Plan may provide compensation for medically necessary expenses when coverage under a comprehensive major medical health coverage plan would not adequately meet the participant's needs, would involve significant disruption in continuity of care, or would be significantly burdensome to access. (Section 6).

The bill provides that the Plan must reimburse any participant for reasonable, medically necessary care received by the participant on or before June 30, 2026, which was reduced or not paid by the Plan because the participant did not have health coverage. (Section 6).

The bill provides that in the case that NICA believes an overpayment was made and the family member disputes that an overpayment has occurred, NICA is authorized to file a petition for DOAH review of an overpayment for a determination of the amount, if any, to be recouped by NICA. (Section 6).

Financial Soundness of NICA

Current law requires NICA to estimate the present value of the total cost of a claim within 60 days after a claim is filed and to update these estimates quarterly based on the actual costs incurred by NICA. The bill requires NICA to submit these quarterly estimates to the Office of Insurance Regulation ("OIR") within 10 business days after completion. (Section 7).

The bill also requires NICA to calculate whether the plan is actuarially sound after the completion of its quarterly revisions of claims estimates. The bill defines "actuarily sound" as the total plan assets available to fund future liabilities being equal to or greater than 90 percent of the present value of total estimated liabilities excluding any risk margin. This term is used in the NICA provisions; however, it is currently not defined. (Section 2).

The bill defines "risk margin" as "an additional, explicit allowance above the best-estimate reserve to reflect uncertainty in future claim payments, including variation in claimant life expectancy and the number and cost of pending or unreported claims. The risk margin is not included in the reserve amount used to calculate the funding ratio." (Section 2).

If NICA determines the plan is not actuarially sound, NICA must immediately notify OIR. Then, OIR must review NICA's calculations and, within 60 days after NICA's notification, determine whether to initiate an actuarial valuation, and notify NICA of its determination. OIR must, at a minimum, make its determination based on the degree to which NICA's calculations indicate that the plan is not actuarially sound, the direction and consistency of recent trends in the calculations of the plan's actuarial soundness, and the length of time since the most recent actuarial analysis conducted by OIR and until the next biennial valuation. OIR must initiate such actuarial valuation within 30 days after its determination there is a need for a valuation. (Section 7).

The bill requires OIR to make an actuarial valuation as provided upon calculation and notification by NICA that the plan is not actuarially sound, in addition to the current requirement that OIR biennially review NICA's actuarial valuation. (Section 7).

The valuation by OIR must be based on the assets and liabilities of the plan for the calendar year before the year in which the actuarial valuation is due. Further, OIR must determine whether the plan has adequate estimated cash flows for the following fiscal year, whether, based on actuarial valuation, the plan is actuarially sound, and if not, whether the plan is likely to return to actuarial soundness before the next biennial review. (Section 7).

The bill revises and reorders the priority order of the increased assessments that are triggered if NICA becomes actuarially unsound, as follows:

- The assessments on hospitals and participating providers must be increased first.
- The assessments on non-participating providers must be increased second.
- The assessments on certain casualty providers[4] must be increased last.
    - Currently, these assessments must be increased first. (Section 6).

The bill limits assessment increases on providers to 100% of the value of the current regular assessment. (Section 6).

The bill limits assessment increases imposed by OIR on certain casualty insurers if the Plan is not actuarially sound. The assessments must generate a total amount no greater than the amount required to achieve actuarial soundness of the plan within five years after the date of the order imposing the assessments. Additionally, the assessments may not extend five years after the date of the order. (Section 7).

The bill requires that if NICA finds that the plan is not actuarially sound and the insurer assessments and hospital and physician assessments are insufficient to achieve actuarial soundness of the plan, NICA must within 60 days of such finding, notify the Governor, the President of the Senate, the Speaker of the House of Representatives, and OIR. If NICA issues the notice, it may not accept any new claims without express authority from the Legislature. However, this provision does not preclude NICA from accepting any claim if the injury occurred 18 months or more before the effective date of the claim suspension. (Section 7).

Under current law, for the 2025-2026 fiscal year, NICA is authorized to accept new claims during the fiscal year if the total current estimates exceed 100 percent of the funds on hand and the funds that will be available to NICA within the next 12 months. (Section 7).

The bill does not make changes to the amount paid by hospitals and physicians as annual assessments. (Section 7).

The bill provides that the NICA Board of Directors may not create new benefits or expand existing benefits that result in additional costs to the Plan, if the Plan's operating expenses exceed assessment revenue, plus investment income, as documented in the plan's audited financial statements for the prior fiscal year. (Section 8).

Annual Reporting

The bill requires NICA to report and publish compensation paid to independent contractors, in addition to existing financial transparency requirements. (Section 8).

Effective Date

The bill provides an effective date of July 1, 2026. (Section 9).

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

OIR may experience workload increases related to the bill's more rigorous, actuarial, approach to NICA financial oversight. OIR can absorb these costs within existing resources.

[4] These assessments apply to insurers writing liability insurance, malpractice insurance, and miscellaneous casualty insurance. *See* ss. 766.314(5) and 624.605, F.S.

PRIVATE SECTOR:

The bill may have an indeterminate economic impact on the private sector. The bill may have an indeterminate impact on obstetricians' malpractice premiums and on patients' medical costs to the extent that the bill may preserve the current obstetrics tort environment.

Additionally, the bill expands certain benefits to NICA participants, which will assist parents, other family members, and legal guardians in funding medical and legal expenses and other necessary services for the care of plan participants.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Florida Birth-Related Neurological Injury Compensation Association (NICA).

In 1988, the Legislature established the Florida Birth-Related Neurological Injury Compensation Plan (Plan) to provide compensation, on a no-fault basis, for a limited class of catastrophic birth-related neurological injuries that result in unusually high costs for custodial care and rehabilitation. The Legislature ventured to design the Plan to stabilize and reduce malpractice insurance premiums for OB/GYNs.[5] To manage the Plan, the Legislature created the Florida Birth-Related Neurological Injury Compensation Association (NICA).[6]

Petition Process

DOAH Jurisdiction

A recent opinion from the First District Court of Appeal (DCA) put at issue whether DOAH has jurisdiction over claims involving parents or legal guardians who assert that they do not seek compensation under the plan and assert that they are not "claimants" as the term is currently defined in the NICA statutes.[7] That opinion was subsequently withdrawn by the First DCA.[8] NICA has expressed concerns that while the opinion was not binding, the issue of whether an ALJ has jurisdiction to enter a Final Order in a case in which a NICA claimant is not seeking compensation from the plan may be affirmatively raised in future proceedings.[9]

Claim Adjudication

A prospective plaintiff must exhaust all administrative remedies at the Division of Administrative Hearings (DOAH)[10] before he or she may pursue medical malpractice litigation for a birth-related neurological injury. Current law vests the presiding administrative law judge (ALJ) with exclusive original jurisdiction to hear claims filed for birth-related neurological injury compensation under the Plan.[11] The ALJ makes a determination of whether a claim is compensable. To this end, the ALJ considers all available evidence related to the nature of the injury alleged as well as the immediate circumstances surrounding the alleged injury.[12]

Adjudication

If the ALJ determines a claim is compensable, meaning the infant sustained a birth-related neurological injury and that obstetrical services were delivered by an attending or supervising participating physician at the infant's birth, current law requires the ALJ to make an award providing compensation.[13]

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[5] Ss. 766.301 and 766.303(1), F.S.
[6] *See* s. 766.302(1), F.S.
[7] *Shands Jacksonville Medical Center, Inc. v. Chavez*, 2024 WL 5059326 (Fla. 1st DCA 2024).
[8] *Shands Jacksonville Medical Center, Inc. v Chavez*, 416 So.3d 1226 (Fla. 1st DCA 2025).
[9] NICA, *HB 1291/SB 1668 Florida Birth-Related Neurological Injury Compensation Association Summary and Analysis*, at 9, January 8, 2026.
[10] DOAH is housed within the Florida Department of Management Services.
[11] Ss. 766.304, and 766.305(1), F.S. A claimant may appeal a DOAH order to the District Court of Appeal. S. 766.311, F.S.
[12] S. 766.309, F.S.
[13] S. 766.31(1), F.S.

If the ALJ determines a claim is compensable, the rights and remedies granted by the Plan on account of a birth-related neurological injury become the exclusive remedy, which means the successful claimant is barred from pursuing a medical malpractice claim against any person or entity directly involved with the labor, delivery, or immediate postdelivery resuscitation during which a birth-related neurological injury occurs.[14],[15] In addition, an award may not be rendered if the claimant recovers under a settlement or a final judgment in a civil action.[16]

If the ALJ determines a claim is not compensable, current law authorizes him or her to file a medical malpractice lawsuit.[17]

Awards Approved without a Determination
After a claimant files a petition for claim under the Plan, DOAH serves the Florida Birth-Related Neurological Injury Compensation Association (NICA) with a copy of the petition.[18] After its own independent review, NICA may accept the claim for compensation and ask the ALJ to approve the claimant's claim as compensable. The ALJ may, without determining whether the claim is compensable, approve such claim as compensable.[19] If the claimant accepts an award under the Plan benefits, current law precludes the claimant from bringing or continuing a medical malpractice lawsuit.[20]

Compensation Awards

Lifetime Benefits
Once an ALJ determines a child is eligible under the Plan, the child is covered for life, and no other compensation from a medical malpractice lawsuit or settlement is available. Instead, there are lifetime benefits and care available through the Plan, which include actual expenses for:[21]

- medical and hospital services;
- habilitative services and training;
- family residential or custodial care;
- professional residential care;
- medications;
- special equipment and facilities; and
- related travel expenses.

At a minimum, immediate family members who reside with the covered child are entitled to a total annual benefit of $10,000, to be shared amongst themselves, for psychotherapeutic services obtained from licensed psychologists and psychotherapists.[22]

For the life of the covered child, the Plan must also provide the child's parents or legal guardians with a reliable method of transportation, accounting for the special accommodations required for the covered child regardless of the child's age or weight.[23] In addition, the Plan must fund home construction and modification costs, which current law caps at a lifetime limit of $100,000 in housing assistance.[24]

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[14] S. 766.304, F.S.
[15] However, current law does permit plaintiffs to bring a civil action in cases where there is clear and convincing evidence of bad faith, malicious purpose, or willful and wanton disregard of human rights, safety, or property. S. 766.303(2), F.S.
[16] S. 766.304, F.S.
[17] S. 766.304, F.S. Current law tolls the five-year statute of limitations period for birth-related neurological injury administrative claims pending or on appeal. S. 766.306, F.S. *See* s. 766.313, F.S.
[18] S. 766.305(2), F.S.
[19] S. 766.305(7), F.S.
[20] S. 766.304, F.S.
[21] S. 766.31, F.S.
[22] S. 766.31(1)(a), F.S.
[23] S. 766.31(1)(a), F.S.
[24] S. 766.31(1)(a), F.S.

Current law limits actual expenses to the reasonable prevailing charges within the community for similar treatment of injured persons when the injured person pays for the treatment. The parents or legal guardians may dispute the amount of actual expenses reimbursed or the denial of reimbursement by filing a petition with DOAH.[25]

Intermittent Benefits

The Plan may also provide:

- Periodic payments or a lump sum cash award as determined by the ALJ to the infant's parents or guardians, not to exceed $250,000.[26]
- A $50,000 death benefit for the infant.
- Compensation for reasonable expenses incurred for filing the claim, including attorney's fees.[27]

Current law requires the Plan to immediately pay expenses previously incurred at the time the ALJ awards compensation, and future expenses as they are incurred.[28]

In 2025, NICA incurred $143,129,789 in claims; in 2024, NICA incurred $189,722,125 in claims.[29]

Medicaid Third-Party Payer Liability

The Plan does not reimburse or pay expenses that might otherwise be covered by insurance or any private or governmental programs, unless such exclusion is prohibited by federal law.[30] Many children with birth-related injuries are either covered by programs such as Children's Medical Services or Medicaid. Under current state and federal law, Medicaid is the payor of last resort for medically necessary goods and services furnished to Medicaid recipients; therefore, current law prohibits NICA from shifting covered costs onto Medicaid.[31]

In 2022, NICA entered into a settlement agreement with the United States to resolve a lawsuit[32] which alleged that NICA held itself out as the payer of last resort for Plan expenses and submitted false reimbursement claims to Medicaid in violation of the federal False Claims Act.[33] The settlement agreement declares that it does not constitute an admission of liability by NICA nor a concession by the United States that its claims are not well founded.[34] NICA paid $51 million plus interest to the federal government to settle the suit.[35]

In July 2025, AHCA and NICA formalized an interagency agreement to coordinate payment for Medicaid services for individuals dually enrolled in Medicaid and the Plan, with the Plan being the primary payor for services rendered. NICA reimburses AHCA for managed care capitation rate payments and fee-for-service payments made.

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[25] S. 766.31(1)(c), F.S.

[26] This one-time award is in addition to the other recoverable lifetime expenses. Each January 1st, the award cap authorized in current law will increase by 3 percent. As of January 1, 2026, this one-time cash award cap is $289,818.51.

[27] S. 766.31(1)(d), F.S.

[28] S. 766.31(2), F.S.

[29] THF Certified Public Accountants, *Florida Birth-Related Neurological Injury Compensation Association: Years ended June 30, 2025 and 2024 with Report of Independent Auditors*, at 6 (Sept. 9, 2025) https://nica.com/wp-content/uploads/2025/09/Audited-Financial-Statements-06-30-2025.pdf (last visited Jan. 9, 2026).

[30] S. 766.31(1)(b), F.S.

[31] S. 409.910, F.S. (which may be cited as the "Medicaid Third-Party Liability Act"); 42 C.F.R. § 433.136; 42 U.S.C. § 1396a.

[32] *U.S. ex. rel. Arven v. The Florida Birth-Related Neurological Injury Compensation Association, et al*., No. 0:19-cv-61053 (S.D. Fla. 2019) and No. 20-13448 (11th Cir. 2022).

[33] The federal False Claims Act allows the federal government to pursue perpetrators of fraud against government programs, including its authorization of private citizens to file civil suits on behalf of the United States. Successful litigants receive a portion of the government's recovery. Civil Division, "The False Claims Act," *U.S. Department of Justice* (updated Jan. 15, 2025) https://www.justice.gov/civil/false-claims-act (last visited Jan. 9, 2026). *See* 31 U.S.C. §§ 3729-3733.

[34] *U.S. ex. rel. Arven supra* note 35, at 4 (available at https://nica.com/reports/medicaid-settlement/) (last visited Jan. 9, 2026).

[35] *Id*.

AHCA is currently seeking an average of $11.5 million for state fiscal years 2022-2023 through 2024-2025 in reimbursable expenses from NICA.[36]

Financial Soundness of NICA

Provider Assessments

Provider assessments primarily finance the Plan, and the Legislature may appropriate additional funds to Plan.[37] NICA holds assessment deposits and must use all funds and income collected solely for making benefit disbursements under the Plan and for reasonable administrative expenses.[38] Currently, the Plan is funded by assessments from hospitals and physicians. In 2025, NICA collected $38,012,647 in hospital and physician assessments; in 2024, NICA collected $37,945,268.[39]

Hospitals

Each hospital licensed under Chapter 395 must pay an annual assessment of $50 per infant delivered during the previous calendar year.[40] However, infants born to a charity patient[41] or to a patient for whom the hospital receives Medicaid reimbursement must not be included in the annual assessment, provided that the sum of the annual charges for charity patients plus Medicaid patients exceeds 10 percent of the hospital's total annual gross operating revenues.[42]

Participating Physicians

A participating physician under the Plan is a licensed Florida physician who either practices obstetrics or performs obstetrical services on a full or part-time basis[43] and pays an annual assessment[44] of $5,000 for coverage running January 1st through December 31st.[45] Participating physicians are bound by DOAH rulings, or any appeals of DOAH rulings, with respect to whether a birth-related neurological injury occurred.[46]

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[36] AHCA, *Agency Bill Analysis for HB 1291* (2026), at 2 (Jan. 13, 2026) http://abar.laspbs.state.fl.us/ABAR/Attachment.aspx?ID=37304 (last visited Jan. 21, 2026).

[37] Ss. 766.314(1) and 766.314(2), F.S.

[38] S. 766.314(3), F.S.

[39] THF Certified Public Accountants, *supra* note 32, at 6.

[40] S. 766.314(5)(a), F.S.

[41] AHCA rule defines a charity care patient as a medically indigent patient whose charges are, in whole or in part, classified according to the Florida Hospital Uniform Reporting System Manual. Rule 59E-5.101(3), F.A.C. *See* s. 766.314(4)(a), F.S.

[42] S. 766.314(4)(a), F.S. Current law makes the hospital responsible for documenting, to NICA's satisfaction, the exclusion of any birth from the computation of the assessment. Upon demonstration of financial need by a hospital, current law authorizes NICA to provide for installment payments of assessments.

[43] The term "participating physician" does not apply to any physician who practices medicine as an officer, employee, or agent of the federal government. S. 766.302(7), F.S.

[44] Current law exempts certain "participating physicians" from paying the annual assessment, including:

- A resident physician, assistant resident physician, or intern in an approved postgraduate training program, as defined by the Board of Medicine or the Board of Osteopathic Medicine by rule;
- A retired physician who maintains an active license with the Department of Health;
- A physician who holds a limited license pursuant to s. 458.317 and who is not being compensated for medical services;
- A physician employed full-time by the U.S. Department of Veterans Affairs (VA) and whose practice is confined to VA hospitals;
- A physician in the U.S. Armed Forces and who meets the requirements of s. 456.024;
- A physician employed full-time by the State of Florida and whose practice is confined to state-owned facilities; and
- A physician employed full-time by the Department of Health. S. 766.314(4)(b), F.S.

[45] *See* ss. 766.314(5)(a), 766.314(7)(a), and 766.302(7), F.S. Current law requires the Office of Insurance Regulation to establish the rate of contribution for participating physicians for each tax year. s. 766.314(7)(a). If NICA receives the assessment after January 31 of any calendar year, the physician shall qualify as a participating physician for that calendar year only from the date the payment was received by the association. S. 766.314(5)(a), F.S.

[46] S. 766.309(3), F.S.

If the physician did not pay his or her assessment for the year in which the injury occurred, there is no NICA coverage. Hospitals that allow doctors who do not participate in NICA to deliver babies are subject to multi-million-dollar catastrophic injury lawsuits.[47]

Other Physicians

Current law requires all licensed allopathic or osteopathic physicians, regardless of medical specialty, to pay an annual assessment of $250. This means obstetricians who decline to pay the $5,000 annual assessment for NICA coverage must still pay the $250 assessment.[48]

OIR Assessments

If OIR finds that provider assessments and appropriations from the Insurance Regulatory Trust Fund are not sufficient to maintain the Plan on an actuarily sound basis, then OIR must require each licensed insurer writing liability insurance, malpractice insurance, and miscellaneous casualty insurance to pay into NICA an annual assessment as determined by OIR, which may not exceed 0.25% of the insurer's net direct premiums written.[49] Casualty insurers may recover theses assessments through a surcharge on future policies, a rate increase applicable prospectively, or a combination of the two.[50]

If OIR finds that the Plan cannot be maintained on an actuarially sound basis based on assessments to providers, appropriations from the Insurance Regulatory Trust Fund, and the special assessments to casualty insurers, then OIR must increase the assessments to providers on a proportional basis as needed.[51]

Plan Assets and Liabilities

Current law declares that Plan funds are funds of the State of Florida.[52] Current law requires each person authorized to receive deposits, issue vouchers, or withdraw or otherwise disburse any funds to post a fidelity bond in an amount reasonably sufficient to protect Plan assets.[53] Current law requires the cost of fidelity bonds to be paid from Plan assets.[54]

Current law authorizes NICA to only invest Plan funds in the investment and securities described in s. 215.47, F.S. Investment income are Plan funds. NICA may approve a trust agreement with the State Board of Administration ("SBA"), where the SBA may invest and reinvest Plan funds within the provisions of s. 215.44-215.53.[55]

As of June 30, 2025, NICA's total assets increased by 8.08%, primarily due to an increase in investments, from approximately $1.4 billion to more than $1.5 billion. However, NICA's total liabilities remain greater than its total assets; NICA's total liabilities amount to $1.7 billion for 2025, which increased by almost $100 million from 2024 levels.

This means NICA has a deficit net position of approximately $189.3 million. Notwithstanding this figure, NICA's deficit net position is an improvement from June 30, 2024, where NICA's deficit net position was about $216.6 million. This indicates that, for the moment, the growth in total assets currently exceeds the growth of total

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[47] Brad Blystone, *A Statutory Primer: Birth-Related Neurological Injury Compensation Act*, Florida Medical Business (March/April 2012), https://marshalldennehey.com/sites/default/files/pdf-articles/O%20243%20by%20B.%20Blystone%20%2803_04.12%29.pdf (last visited Jan. 28, 2026).
[48] Ss. 766.314(4)(b) and 766.314(5)(a), F.S.
[49] S. 766.314(5), F.S.
[50] *Id*.
[51] S. 766.314(7), F.S.
[52] S. 766.315(5)(f), F.S.
[53] Current law prohibits withdrawals of funds from the Plan unless NICA authorizes a withdrawal voucher. S. 766.315(5)(a), F.S.
[54] S. 766.315(5)(d), F.S.
[55] S. 766.315(5)(f), F.S.

liabilities, which was 5.31% year-over-year. The independent auditors of NICA's financial statements attribute the increase is total liabilities to an increase in claim reserves.[56]

The independent auditors' report also notes that the five-year change in average claim size for an open active claim increased from $3.68 million (June 30, 2020) to $5.42 million (June 30, 2025). The average number of open claims increased from 225 to 261. During this same five-year period, NICA's overall claims reserve liability increased by $660.5 million while the annual revenues from assessments only increased by $10.2 million.[57]

Claims Management

Current law requires NICA to estimate the present value of a new claim's total cost within 60 days after a claimant files a claim for a birth-related neurological injury.[58] NICA must revise its initial estimate for a claim each quarter based upon the actual costs incurred and any additional information that becomes available to the association since the last review of such estimate, deducting amounts paid by NICA towards the claim balance.[59]

In the event the total liability of all claim estimates equals or exceeds 100% of the Plan's cash flow, which includes cash-on-hand and all provider assessments received during the next 12-month period, current law prohibits NICA from accepting any new claims for birth-related neurological injuries without express legislative authorization.[60] If this freeze on new claims occurs, NICA must notify the Governor, the Speaker of the House of Representatives, the President of the Senate, OIR, AHCA, and the Department of Health of the claims freeze within the first 30 days.[61] NICA's quarterly calculation at September 2023 revealed that NICA came within $2 million of breaching the liability-to-cash-flow threshold. The Plan's ratio of assets to liabilities was about 89%, which NICA attributes to a significant loss in market value due to aggressive interest rate hikes by the Federal Reserve in response to inflation during the preceding 17 months.[62]

If the claims freeze precludes a prospective plaintiff from asserting a claim for a birth-related neurological injury against NICA, current law waives his or her requirement to exhaust all administrative remedies with DOAH and NICA before pursuing medical malpractice litigation.[63]

Actuarial Soundness

Current law requires NICA to inform the Legislature of its determination as to the annual cost of maintaining the Plan on an actuarially sound basis.[64] Current law also requires OIR to conduct an actuarial valuation of the Plan's assets and liabilities on a biennial basis.[65] Should a time come when these funds prove insufficient to keep the Plan actuarially sound, current law authorizes OIR to transfer another $20 million from the Insurance Regulatory Trust Fund to the Plan.[66]

In the event the additional $20 million transfer is insufficient to bring the Plan back to actuarial soundness, current law authorizes OIR to levy an annual assessment on licensed casualty insurance carriers, not to exceed 0.25% of its

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[56] THF Certified Public Accountants, *supra* note 32 at 5.
[57] THF Certified Public Accountants, *supra* note 32 at 25.
[58] The total cost analysis includes the estimated amount to be paid to the claimant, the claimant's attorney, the attorney's fees of the association incident to the claim, and any other expenses that are reasonably anticipated to be incurred by the association in connection with the adjudication and payment of the claim. NICA factors in the maximum benefits for noneconomic damages. S. 766.314(9)(a), F.S.
[59] S. 766.314(9)(b), F.S.
[60] S. 766.314(9)(c), F.S. Notwithstanding this suspension, current law authorizes NICA to accept new claims as long as the birth-related neurological injury occurred at least 18 months prior to the effective date of the suspension. NICA may also accept all new claims during the 2025-2026 fiscal year if the total of all current estimates exceeds prescribed limits.
[61] S. 766.314(9)(c), F.S.
[62] NICA, *supra* note 12, at 14, January 8, 2026.
[63] S. 766.314(9)(d), F.S.
[64] S. 766.314(8), F.S.
[65] S. 766.314(7), F.S.
[66] S. 766.314(5)(b), F.S.

net direct premiums written individually.[67] If OIR finds that NICA cannot maintain the Plan on an actuarially sound basis, current law requires OIR to increase provider assessments on a proportional basis.[68]

In 2024, the Legislature required NICA, in consultation with OIR and AHCA, to provide a report by September 1, 2024, to the Governor, CFO, President of the Senate, and the Speaker of the House of Representatives that recommends how to define actuarial soundness for NICA, how to structure a reporting obligation timeline for actuarial soundness updates, and how to ensure a sufficient revenue level for NICA to maintain actuarial soundness.[69] Pursuant to this directive, NICA recommends that:

- the funding ratio of assets-to-liabilities should be used as a point-in-time measure of actuarial soundness and as a key indicator for revenue increases;
- actuarial soundness accounts for net cash flow;
- NICA posts funding ratios for each quarter on its website to document adherence to reporting timelines;
- NICA requests any increase in provider assessments as a percentage of the reserve requirement in relation to the funding ratio, subject to OIR approval; and
- the casualty insurer assessment becomes the last option for additional Plan revenue.[70]

Financial Transparency Requirements

NICA must provide on an annual basis audited financial reports to any plan participant upon request, to OIR and to the Joint Legislative Auditing Committee.[71] The reports must be prepared following accepted accounting procedures and must include information as may be required by OIR and the Joint Legislative Auditing Committee.[72]

NICA must also publish a report on its website by January 1 of each year, which must include:[73]

- The names and terms of each board member and executive staff member.
- The amount of compensation paid to each association employee.
- A summary of reimbursement disputes and resolutions.
- A list of expenditures for attorney fees and lobbying fees.
- Other expenses to oppose each plan claim. Any personal identifying information of the parent, legal guardian, or child involved in the claim must be removed from this list.

NICA must provide an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Financial Officer.[74] The report must include:[75]

- The number of petitions filed for compensation with the division, the number of claimants awarded compensation, the number of claimants denied compensation, and the reasons for the denial of compensation.
- The number and dollar amount of paid and denied compensation for expenses by category and the reasons for any denied compensation for expenses by category.
- The average turnaround time for paying or denying compensation for expenses.
- Legislative recommendations to improve the program.
- A summary of any pending or resolved litigation during the year which affects the plan.

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[67] S. 766.314(5)(c), F.S. Casualty insurance carriers may recover their initial and annual assessments through a surcharge on future policies, a rate increase applicable prospectively, or a combination of the two.
[68] S. 766.314(7), F.S.
[69] Ch. 2024-182, Laws of Fla.
[70] NICA, *Report on Actuarial Soundness: September 2024*, at 3 (Sept. 2024) https://nica.com/wp-content/uploads/2025/06/NICA-Report-on-Actuarial-Soundness-%E2%80%93-September-2024-Final.pdf (last visited Jan. 11, 2026).
[71] S. 766.315(5)(e), F.S.
[72] *Id*.
[73] S. 766.315(7), F.S.
[74] S. 766.315(8), F.S.
[75] *Id*.

- The amount of compensation paid to each association employee or member of the board of directors.

RECENT LEGISLATION:

YEAR	BILL #/SUBJECT	HOUSE/*SENATE* SPONSOR(S)	OTHER INFORMATION
2025	SB 2502 - Implementing the 2025-2026 General Appropriations Act	McClure/ *Hooper*	Became law on July 1, 2025.
2024	CS/CS/HB 1611 - Insurance	Stevenson/ *Trumbull*	Became law on July 1, 2024.
2024	CS/CS/CS/HB 989 - Chief Financial Officer	LaMarca/ *DiCeglie*	Became law on May 2, 2024.
2021	CS/CS/SB 1786 - Florida Birth-Related Neurological Injury Compensation Plan	Koster/ *Book*	Became law on June 21, 2021.

OTHER RESOURCES:

2025 NICA Actuarial Report (June 30, 2025)

2025 NICA Audited Financial Statements (September 2025)

Agency for Health Care Administration Report on NICA as Third-Party Benefit Payer (November 2021)

Auditor General Operational Audit of NICA (October 2023)

Medicaid Settlement Agreement (December 2022)

NICA Report on Actuarial Soundness (September 2024)

Legislatively Mandated Report (January 2026)

U.S. ex. rel. Arven v. Florida Birth-Related Neurological Injury Compensation Association, 2020 WL 5540367 (S.D. Fla. September 8, 2020)

U.S. ex. rel. Arven v. Florida Birth-Related Neurological Injury Compensation Association, 2022 WL 1180142 (11th Cir. April 22, 2022)

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Insurance & Banking Subcommittee	17 Y, 0 N	1/29/2026	Brackett	Miguez
State Administration Budget Subcommittee	11 Y, 0 N, As CS	2/12/2026	Topp	Helpling
THE CHANGES ADOPTED BY THE COMMITTEE:	• Removed the increase to the NICA reserve in the Insurance Regulatory Trust Fund from $50 million to the current reserve of $20 million.			
Commerce Committee	23 Y, 0 N, As CS	2/26/2026	Hamon	Miguez

THE CHANGES ADOPTED BY THE COMMITTEE:	• Defined "family care" and removed the 10-hour limit on compensation provided by a family member.
	• Added "supplies" to the list of expenses that may be compensated under the Plan.
	• Provided that "facility care" and "nursing and home health" are compensable expenses under the Plan, instead of professional custodial care.
	• Provided that compensation for psychotherapeutic services for family members, transportation, housing assistance, and the legal costs associated with guardianship proceedings are only compensable when medically necessary, if applicable.
	• Specified that certain care expenses are not reimbursable if the care is simultaneously being provided by another provider.
	• Revised and reordered the priority order of the increased assessments that are triggered if NICA becomes actuarially unsound, as follows:
	  ○ The increased assessment on hospitals and participating providers is given first priority.
	  ○ The increased assessment on non-participating providers becomes second priority.
	  ○ The increased assessment on certain casualty insurers is moved from first priority to third (last priority).
	• Limited assessment increases on providers to 100% of the value of the current regular assessment.
	• Prohibited NICA from creating new benefits or expanding existing benefits, if operating expenses exceed gross revenue.
	• Required NICA to report and publish compensation paid to independent contractors, in addition to existing financial transparency requirements.
	• Restored current law regarding legal rights in the event NICA becomes actuarially unsound.			

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.
