The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 1668
INTRODUCER:	Senator Burton
SUBJECT:	Florida Birth-Related Neurological Injury Compensation Association
DATE:	January 27, 2026 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			AEG	
3.			RC	

I. Summary:

SB 1668 revises provisions relating to the Florida Birth-Related Neurological Injury Compensation Association (NICA). In 1988, the Legislature created the Florida Birth-Related Neurological Injury Compensation plan[1] (plan) to provide compensation, long-term medical care, and other services to individuals with birth-related neurological injuries.[2] If an infant suffers such an injury, and the physician participates in NICA and delivers obstetrical services in connection with the birth, then an administrative award for a compensable injury is the individual's sole and exclusive remedy for the injury, with exceptions.[3] Although the benefits paid under the plan are limited, the plan does not require the claimant to prove malpractice and provides a streamlined administrative hearing process to resolve the claim.[4] The primary, initial funding for the plan is provided through assessments on physicians and hospitals with exceptions.

SB 1668 revises the process for NICA and the Office of Insurance Regulation (OIR) to evaluate the actuarial soundness and adequacy of cash flows of the plan and to access additional revenue for the plan if OIR determines that the plan does not have adequate cash flows or is not actuarially sound. The bill:

- Defines the term, "actuarially sound," to mean the total plan assets available to fund future liabilities are equal to or greater than 90 percent of the present value of total estimated liabilities excluding any risk margin.
- Defines the term, "risk margin," to mean an additional, explicit allowance above the best-estimate reserve to reflect uncertainty in future claim payments, including variation in

[1] Section 766.303(1), F.S.

[2] Chapter 88-1, Laws of Fla., was enacted by the Legislature to stabilize and reduce malpractice insurance premiums for physicians practicing obstetrics. The intent of the Legislature is to provide compensation for birth-related neurological injuries, that result in unusually high costs for custodial care and rehabilitation. Section 766.301, F.S.

[3] Section 766.31(1), F.S.

[4] See *Florida Birth-Related Neurological Injury Compensation Ass'n v. McKaughan*, 668 So.2d 974, 977 (Fla. 1996).

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.

- Revises the scope and process of OIR's actuarial valuation of the assets and liabilities of the plan. OIR must conduct such a valuation based on the assets and liabilities of the plan for the calendar year before the year in which the actuarial valuation is due. Further, the OIR must also determine whether:
  - The plan has adequate estimated cash flow for the following fiscal year;
  - The plan is actuarially sound, and if not, whether the plan is likely to return to actuarial soundness before the next biennial review.
- Increases the amount the OIR may transfer from the Insurance Regulatory Trust Fund to NICA for funding the plan, to up to $50 million, if OIR determines that the plan lacks adequate cash flow for the following fiscal year. Currently, the OIR may transfer up to $20 million from the trust fund to NICA if the annual hospital and provider assessments are insufficient to maintain the plan on an actuarially sound basis.
- Limits to 5 years the assessments OIR may impose on each casualty insurer writing liability, malpractice, and miscellaneous casualty insurance annually up to 0.25 percent of net direct premiums written to achieve actuarial soundness of the plan.
- Provides that, if OIR finds that the plan is not actuarially sound pursuant to its review, NICA must submit quarterly reports to that provide projections of the plan's financial condition and, if assessments were ordered by OIR, NICA must submit projected revenues for such assessments.
- Requires that, if NICA finds the plan is not actuarially sound and the remedies provided through assessments are insufficient to reestablish actuarial soundness, NICA must, within 60 days after such finding, notify the Governor, the President of the Senate, the Speaker of the House of Representatives, and OIR. Once NICA issues this notice, NICA may not accept any new claims without explicit authority from the Legislature. However, this does not preclude NICA from accepting any claim if the injury occurred 18 months or more before the effective date of this enrollment suspension. 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.

The bill also:

- Updates the statutory provisions to replace the term, "child" with "participant." According to NICA, 40 percent of current NICA participants are adults.
- Requires family members to continuously maintain comprehensive major medical health coverage for a NICA participant or the participant must be covered by Medicaid.
- Specifies that NICA benefits include:
  - The costs of major medical health coverage for the participant, including the premium and out-of-pocket costs.
  - Reimbursement of Florida Medicaid fee-for-service and capitation rate paid claims for NICA participants.
  - Dental services for the participant.
  - Legal costs associated with establishing and maintaining guardianship for a participant.

- Revises the NICA plan of operation to include a fraud and overpayment prevention and detection program.

The effective date of the bill is July 1, 2026.

II. Present Situation:

In 1988, the Legislature created the Florida Birth-Related Neurological Injury Compensation Association (NICA) to provide exclusive remedy, irrespective of fault, for infants who have sustained a birth-related neurological injury.[5] A "birth-related neurological injury" is an injury to the brain or spinal cord of a live infant who weighs at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant who weighs at least 2,000 grams at birth caused by oxygen deprivation or by mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital.[6] Such an injury addressed by this statute renders the infant permanently and substantially mentally and physically impaired.[7] As of June 30, 2025, there were 253 NICA participants receiving ongoing benefits through the plan.[8]

NICA is governed by a board of directors appointed by the Chief Financial Officer.[9] Board meeting are subject to public meeting and record requirements of s. 286.011, F.S.[10]

Filing a Claim for Benefits

A claim for compensation under the plan must be filed within five years of the birth of an infant alleged to be injured.[11] First, the parents or guardians of the infant must file a petition with the Division of Administrative Hearings (DOAH).[12] Then, the DOAH serves a copy of the petition upon NICA, the physician and hospital named in the petition, the Division of Medical Quality Assurance of the Department of Health, and the Agency for Health Care Administration (agency).[13] Within 10 days of filing the petition, the parents or guardian must provide to NICA all medical records, assessments, evaluations and prognoses, documentation of expenses, and documentation of any private or governmental source of services, or reimbursement relative to the impairments.[14]

Within 45 days from the date of service of a complete claim, NICA must file a response to the petition and submit relevant written information relating to the issue of whether the injury

[5] Section 766.301, F.S.
[6] Section 766.302(2), F.S.
[7] *Id.*
[8] NICA, Report of the Florida Birth-Related Neurological Injury Compensation Association to the Governor, Legislature, and Chief Financial Officer (Nov. 2025), (2025-Legislatively-Mandated-Report-Nov.pdf) (last visited Jan. 23, 2026).
[9] Section 766.315(1), F.S.
[10] Section 766.315(5), F.S.
[11] Section 766.313, F.S.
[12] Section 766.305, F.S.
[13] Section 766.305(2), F.S.
[14] Section 766.305(3), F.S.

alleged is a birth-related neurological injury.[15] An administrative law judge (ALJ) from DOAH will set a hearing on the claim to be conducted 60-120 days from the petition filing date.[16]

The issue of whether the claim for compensation is covered by the plan is determined exclusively in an administrative proceeding.[17] The ALJ presiding over the hearing makes the following determinations:

- Whether the injury claimed is a birth-related neurological injury;
- Whether obstetrical services were delivered by a participating physician;
- How much compensation, if any, is awardable under s. 766.31, F.S.; and
- Whether, if raised by the claimant or other party, the factual determination regarding the notice requirement in s. 766.316, F.S.[18]

If the ALJ determines that an injury meets the definition of a birth-related neurological injury, compensation from the Plan is the exclusive legal remedy.[19] If the ALJ determines that, the injury alleged is not a birth-related neurological injury or that a participating physician did not deliver the obstetrical services, the ALJ will enter an order to that effect.[20] The ALJ may also bifurcate the proceeding and address compensability and notice first, and address an award, if any, in a separate proceeding.[21] If any party chooses to appeal the ALJ's order under s. 766.309, F.S., the appeal must be filed in the District Court of Appeal.[22]**Benefits**[23]

The plan pays benefits, on behalf of a participant, including actual expenses for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care and service, professional residential, and custodial care and service, drugs, special equipment, facilities, and related travel.[24] At a minimum, the statutes require the plan to pay compensation for the following actual expenses:

- Annual psychotherapeutic services benefit of up to $10,000 for immediate family members who reside with the plan participant.
- Transportation benefits, which includes providing parents or legal guardians with a reliable method of transportation for the care of the participant or reimbursing the cost of upgrading an existing vehicle to accommodate the participant's needs when it becomes medically necessary for wheelchair transportation. The plan must replace any vans purchased by the plan every 7 years or 150,000 miles, whichever comes first.
- Housing assistance of up to $100,000 for the life of the participant, including home construction and modifications.

[15] Section 766.305(4), F.S.
[16] Section 766.307(1), F.S.
[17] Section 766.301(1)(d), F.S.
[18] Section 766.309(1), F.S.
[19] Section 766.303(2), F.S., only allows a civil action in place of a claim under the plan where there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property.
[20] Section 766.309(2), F.S.
[21] Section 766.309(4), F.S.
[22] Section 766.311(1), F.S.
[23] Section 766.31, F.S.
[24] The plan excludes coverage for expenses that are compensable by state or federal governments, or by private insurers. Section 766.31(1)(a), F.S.

In addition, the plan must provide compensation for the following items:

- Periodic or lump-sum award to the parents or legal guardians, in an amount not to exceed $250,000;[25]
- Death benefit in the amount of $50,000 for the participant;[26] and
- Reasonable expenses for filing the claim under the plan, including attorney's fees.[27]

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 state or federal law.[28]

NICA Funding

The Florida Legislature appropriated $20 million[29] to initially fund the plan at its inception and authorized annual assessments of physicians and hospitals thereafter.[30] A participating physician is required to pay a $5,000 fee each year for coverage on a calendar year basis.[31] All licensed Florida physicians pay a mandatory fee of $250, regardless of specialty.[32] Hospitals pay $50 for each live birth during the previous calendar year. Certain exemptions apply to all of these categories, including resident physicians, retired physicians, government physicians, and facilities.[33] The amount of the physician and hospital assessments have remained unchanged since the plan's inception in 1988.[34] Section 755.314, F.S., also requires OIR to maintain an appropriation of $20 million in the Insurance Regulatory Trust Fund for NICA.

Section 766.314, F.S., provide alternative funding mechanisms for the plan if the assessments collected by NICA "are insufficient to maintain the plan on an actuarially sound basis." The first remedy is to require OIR to transfer up to $20 million from the Insurance Regulatory Trust Fund,[35] If the appropriation and assessments do not result in the plan being maintained on an actuarially sound basis, the OIR may assess casualty insurers up to 0.25 percent of net direct premiums written in proportion to the total amount of all net direct premiums written by casualty insurers.[36] Lastly, s. 766.314(7)(b), F.S., requires that, if OIR finds that the plan cannot be

[25] Section 766.31(1)(d), F.S. This amount is increased annually by three percent.
[26] Section 766.31(1)(d)2.a., F.S.
[27] Section 766.31(1)(e), F.S.
[28] Section 766.31(1)(a), F.S.
[29] Ch. 88-277, Laws of Fla.
[30] Section 766.314, F.S.
[31] *Id.*
[32] Section 766.314(4), F.S.
[33] *Id.*
[34] If the assessments amounts at June 30, 1988, were adjusted for inflation, as of June 30, 2024, the assessments would increase in the following manner: participating physicians $5,000 would be $13,312.50; participating nurse midwives $2,500 would be $6,656.26; hospital assessments $50 would be $133.12; and nonparticipating physician assessments of $250 would be $665.62. *See* NICA Report on Actuarial Soundness (Sep. 2024) *NICA-Report-on-Actuarial-Soundness-–-September-2024-Final.pdf* (last visited Jan. 26, 2026).
[35] Section 766.314(5)(b), F.S.
[36] Section 766.314(5)(c)1, F.S. provides that casualty insurance described in s. 624.605(b),(k), and (q) would be subject to this assessment, which would include liability insurance, malpractice insurance, and miscellaneous insurance (insurance against liability for any other kind of loss or damage to person or property, properly a subject of insurance and not within any other kind of insurance as defined in the Florida Insurance Code).

maintained on an actuarially sound basis based on the assessments and appropriations, OIR must increase the assessments on physicians and hospitals on a proportional basis as needed. The statutory provisions do not define the term, "actuarial soundness," and while the OIR is required to biennially produce an actuarial valuation, that valuation does not opine on the actuarial soundness of the plan.

Within 60 days after a claim is filed, NICA must estimate the present value of the total cost of the claim, including the estimated amount to be paid to the claimant, the claimant's attorney, the attorney's fees of NICA incident to the claim, and any other expenses that are reasonably anticipated to be incurred by NICA in connection with the adjudication and payment of the claim.[37] Every quarter, NICA must update these estimates based upon the actual costs incurred and any additional information that becomes available to the NICA since the last review of this estimate.[38] The estimate must be reduced by any amounts paid by NICA that were included in the current estimate.

If the total of all current estimates equals or exceeds 100 percent of the funds on hand and the funds that will become available to the association within the next 12 months from all sources, including physician and provider assessments, funds from the Insurance Regulatory Trust Fund, and assessments on specified casualty insurance, NICA may not accept any new claims without express authority from the Legislature.[39] However, this does not preclude NICA from accepting any claim if the injury occurred 18 months or more before the effective date of this enrollment suspension.[40] Notwithstanding this requirement, NICA is authorized to accept new claims during the 2025-2026 fiscal year if the total of all current estimates exceeds the limits described above during that fiscal year.[41]

Within 30 days after the effective date of this enrollment suspension, NICA must notify the Governor, the Speaker of the House of Representatives, the President of the Senate, the Office of Insurance Regulation, the agency , and the Department of Health of this suspension.[42]

Recent Financial Trends

Since its inception and until recently, NICA has taken in more cash than it has spent, thus, there was never an issue about its actuarial soundness and none of the above remedies have ever initiated.[43] Because NICA is operating at an annual cash flow deficit while the number of participants and associated expenses are increasing, significant cash from investment income and other income must be used to fund operating expenses.

[37] Section 766.314(9)(a), F.S.
[38] Section 766.314(9)(b), F.S.
[39] Section 766.314(9)(c)1., F.S.
[40] *Id.*
[41] This provision expires July 1, 2026.
[42] Section 766.314(9)(c)1.
[43] *Supra* NICA at 7.

For fiscal year 2023-2024, NICA collected approximately $37.9 million in annual physician and hospital assessment revenue. However, total operating expenses[44] exceeded total revenues by about $156 million, thereby requiring NICA to use about $93 million in investment income and other income to fund the plan's operations.[45] Subsequently, for fiscal year 2024-2025, NICA collected about $38 million in hospital and physician assessments. Although total operating expenses were significantly lower due to a decrease in claims incurred for this fiscal year; total operating expenses exceeded total revenues by about $110 million, resulting in NICA using investment income and other income to fund operations.[46] The average claim size for an open active claim increased from $3.68 million at June 30, 2020, to $5.42 million at June 30, 2025, and the amount of total annual claims payments increased from $19.8 million to $51.7 million for the same period.[47]

In recent years, many factors have increased NICA's financial obligations and expenses. For example, in 2021, the Florida Legislature substantially revised benefits and the provision of benefits in response to concerns of family members of plan participants, which has increased the financial obligations of NICA.[48] Further, as the result of the Medicaid settlement,[49] NICA was required to pay approximately $51 million to the federal government and Medicaid will no longer reimburse NICA participants for expenses, and instead NICA will be responsible for payment. (See discussion below.) Claim payments are expected to increase an additional $12 million annually once the Medicaid reimbursement process begins.[50]

Federal Medicaid Settlement and Agreement with the Agency for Health Care Administration

***Medicaid Program*[51]**

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities.[52] The federal government and states jointly fund and administer the Medicaid program. At the federal level, the Centers for Medicare and Medicaid Services (CMS) administers the program, and each state administers its Medicaid program according to a CMS

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[44] NICA Audited Financial Statements for years ended June 30, 2025 and 2024, (Sep. 9, 2025) 0625 Issued Financial Statement - NICA.pdf (last visited Jan. 20, 2026). Operating expenses for fiscal year 2023-2024 were comprised of claims incurred ($189 million) and other operating expenses ($4.6 million). For fiscal year 2024-2025, operating expenses were comprised of claims incurred of about $143 million and other operating expenses of about $4.9 million.
[45] *Id.*
[46] *Id.*
[47] NICA, Audited Financial Statements (NICA Audited Financial Statements for years ended June 30, 2025 and 2024 (Sep. 9, 2025) 0625 Issued Financial Statement - NICA.pdf (last visited Jan. 20, 2026). Operating expenses for fiscal year 2023-2024 were comprised of claims incurred ($189 million) and other operating expenses ($4.6 million). For fiscal year 2024-2025, operating expenses were comprised of claims incurred of about $143 million and other operating expenses of about $4.9 million.
[48] Ch. 2021-134, Laws of Fla.
[49] U.S. Department of Justice and NICA Settlement (Nov. 14, 2022) NICA-Settlement-Agreement-Executed.pdf (last visited Jan. 20, 2026).
[50] *Id.*
[51] Department of Health and Human Services, Office of Inspector General, States face ongoing challenges in meeting third-party liability requirements for ensuring that Medicaid functions as the payer of last resort (Oct. 2023), https://oig.hhs.gov/documents/audit/7897/A-05-21-00013-Complete%20Report.pdf (last visited Jan. 20, 2026).
[52] 42 U.S.C. ss. 1396-1396w-5.

approved State plan that establishes which services the Medicaid program will cover. Although each state has considerable flexibility in designing and operating its Medicaid program, it must comply with federal requirements. The federal government pays its share of a state's medical assistance costs under the Medicaid program on the basis of the Federal medical assistance percentage (FMAP). In Florida, the Agency for Health Care Administration, the State Medicaid agency, is responsible for computing and reporting the federal share, which is based on the total computable amount multiplied by the FMAP.

Medicaid Third-Party Liability

Federal law require states to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid State plan.[53] The third party liability effectuates the payor of last resort policy. Specifically, states are required to: (1) identify Medicaid enrollees' third-party health coverage, (2) determine third party liability[54] for services, (3) avoid payment for services in most circumstances in which the state believes that a third party is liable, and (4) recover reimbursement from liable third parties after Medicaid payment if the state can reasonably expect to recover more than it paid to seek reimbursement.

Section 409.910, F.S., the "Medicaid Third-Party Liability Act," which governs third party liability in Florida provides that "it is the intent of the Legislature that Medicaid be the payor last resort for medically necessary goods and services furnished to Medicaid recipients." This provision is consistent with federal law, which provides that Medicaid pays for services only after other responsible third parties have met their burden of costs.[55] In "applying for or accepting medical assistance [Medicaid], an applicant, recipient, or legal representative automatically assigns to the agency any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law." Section 409.910, F.S., also requires that "if benefits of a liable third party are discovered or become available after medical assistance has been provided by Medicaid, Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full, from and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid."

2022 Medicaid Settlement

On November 14, 2022, the plan and NICA, its administrator, agreed to pay $51 million to resolve allegations that they violated the False Claims Act by causing NICA participants to submit their health care claims to Medicaid rather than NICA, in violation of Medicaid's status as the payer of last resort under federal law.[56] The civil settlement resolves a lawsuit filed under

[53] Section 1902(a)(25) of the Social Security Act and 42 CFR part 433, subpart D. Federal regulations refer to amounts owed by non-Medicaid payers as third-party liability.
[54] 42 CFR part 433, subpart D.
[55] 42 U.S.C. s. 1396(a)(25). Third parties that may be liable to pay for services include private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and Federal programs (unless specifically excluded by Federal statute).
[56] Department of Justice, Florida Birth-Related Neurological Injury Compensation Plan and Association to Pay $51 Million to Resolve False Claims Act Allegations (Nov. 14, 2022) https://www.justice.gov/archives/opa/pr/florida-birth-related-neurological-injury-compensation-plan-and-association-pay-51-million (last visited Jan. 3, 2026).

the whistleblower provisions of the False Claims Act, which permits a private party to file a lawsuit on behalf of the United States and receive a portion of any recovery.[57] Incorporated in the settlement, NICA represented that it would, with respect to NICA participants who also qualified for Medicaid, set aside a financial reserve, effective August 31, 2021, to pay claims it will be responsible for as the primary payor but the agency would pay while a transition plan is developed by the agency and NICA.[58]

NICA and Agency for Health Care Administration Agreement[59]

The agency and NICA entered into an agreement to coordinate payment for services for individuals who are both enrolled in NICA and Florida Medicaid participant. The purpose of the agreement is to allow participants to receive services through the Medicaid delivery system while ensuring that NICA is the primary payor for these services. At the end of each quarter, the agency will calculate each participants' monthly plan capitation rate payments and any fee-for-service payments made. The agency will include the sum of these payments on an invoice and submit to NICA. NICA will reimburse the agency in accordance with F.S. 409.910 and the executed agreement.

In mid-December 2025, AHCA submitted a retroactive invoice to NICA for the collection of outstanding payments made by Medicaid on behalf of NICA participants. For this invoice, agency identified a little over 200 NICA members enrolled in Florida Medicaid. Pursuant to the agreement, NICA is required to provide the agency an updated member listing each month.

Time Period	Total Fee for Service Expenditures	Total Capitation Rate Expenditures	Total Expenditures
08/31/2021-06/30/2022	$2,906,416.63	$7,032,986.75	$9,939,403.38
07/01/2022-06/30/2023	$2,583,022.26	$9,557,859.99	$12,140,882.25
07/01/2023-06/30/2024	$2,339,993.05	$9,648,253.73	$11,988,246.78
07/01/2024-06/30/2025	$2,314,719.61	$8,197,459.77	$10,512,179.38
Total Expenditures 08/31/2021-06/30/2025			$44,580,711.79

Office of Insurance Regulation

[57] *Supra,* NICA at 49.
[58] U.S. Department of Justice and NICA Settlement (Nov. 14, 2022) NICA-Settlement-Agreement-Executed.pdf (last visited Jan. 202, 2026). The Settlement Agreement is neither an admission of liability by NICA nor a concession by the United States that its claims are not well founded. NICA denies the allegations.
[59] Agency for Health Care Administration, email (Jan. 12, 2026). On file with Banking and Insurance Committee staff.

Florida's Office of Insurance Regulation (OIR)[60] is responsible for the regulation of all activities of insurers and other risk-bearing entities, including licensure, rates,[61] policy forms, market conduct, claims, solvency, administrative supervision, as provided under the Florida Insurance Code (code).[62] Insurance is classified into the following kinds of insurance: life, health, property, casualty, marine, and title.[63]

III. Effect of Proposed Changes:

Section 1 amends s. 409.910, F.S., the "Medicaid Third Party Liability Act," to authorize the Agency for Health Care Administration (agency) 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 pursuant to s. 766.31, F.S. The agency and NICA entered into an agreement to coordinate payment for services for individuals who are enrolled in NICA and Florida Medicaid. The purpose of the agreement is to allow participants to receive services through the Medicaid delivery system while ensuring that NICA is the "primary payor" for these services.

Section 2 amends s. 766.302, to revise the definition of the term, "claimant," to provide that the administrative law judge has exclusive jurisdiction to determine compensability and notice even if the claimant does not seek NICA compensation. Definitions for the following terms are created:

- "Actuarially sound" means that the total plan assets available to fund future liabilities are 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 undefined.
- "Participant" means 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. According to NICA, about 40 percent of participants are adults.
- "Risk margin" means 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.

NICA adjusts claim reserves to provide for a risk margin in the event future contingent events and actual payments significantly exceed management's best estimate. The risk margin was approximately $82 million as of June 30, 2025.[64]

[60] The OIR is an office under the Financial Services Commission (commission), which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. The commission is not subject to control, supervision, or direction by the Department of Financial Services in any manner, including purchasing, transactions involving real or personal property, personnel, or budgetary matters. Section 20.121(3), F.S.
[61] Pursuant to s. 627.062(1), F.S., rates may not be excessive, inadequate, or unfairly discriminatory.
[62] Section 20.121(3)(a)1., F.S.
[63] Section 624.6011, F.S.
[64] *Supra,* NICA at 43.

Section 3 amends s. 766.303, F.S., relating to the plan, to provide technical changes and clarify terms used. The term, "children," as used in the context of participants of the plan is replaced with the term, "participant."

Section 4 amends s. 766.305, F.S., relating to the filing of claims, to provide technical conforming changes.

Section 5 amends s. 766.309, F.S., to provide a technical, conforming cross reference.

Section 6 amends s. 766.31, F.S., relating to awards for birth-related injuries, to revise the types of compensation of actual expenses for medically necessary care or services an administrative law judge may award and to provide technical changes. The bill provides the following changes in benefits:

- Codifies coverage of medically necessary dental services. Many participants require medically necessary sedation due to their birth injury. However, routine cleanings are not currently covered.
- Revises the current statutory benefit for psychotherapeutic services to provide access to these services for immediate family members who no longer live with the participant or do not live in Florida. The board of NICA extended the benefit to families whose children are deceased. Family members and relatives would be capped at $10,000 annually during the participant's lifetime and up to a total of $20,000 subsequent to the participant's death.
- Codifies coverage for legal costs associated with establishing and maintaining guardianship for a participant.
- Revises the current statutory benefit for transportation to provide family members, rather than only parents and guardians, with a reliable method of transporting the participant's wheelchair and medically necessary equipment. The bill expands the type of vehicles covered to include vehicles rather than just vans.
- Clarifies the coverage of housing assistance benefit of up to $100,000 for the life of the participant to include, 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 major medical health insurance coverage, which includes the premium and any cost sharing incurred by the participant.
- Clarifies that NICA will not provide compensation for professional custodial care provided by a family member while such care is being provided by another person or entity or the family member is being compensated from another source of work during the same time for which compensation is sought from NICA. If the family member disputes that an overpayment has occurred, NICA is authorized to file a petition for division review of an overpayment for a determination of the amount, if any, to be recouped by NICA,
- Expands the list of individuals eligible to receive an award of up to $250,000 to include family members instead of only parents or legal guardians.

The bill requires a family member to continuously maintain comprehensive major medical health coverage for the participant.[65] A family member must obtain insurance coverage within 60 days

[65] NICA-Benefit-Handbook-1-13-25.pdf (last visited Jan. 21, 2026). The benefit manual provides that it is NICA's expectation that health insurance is always maintained for participants. NICA reimburses families for the cost of the

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.

The bill requires NICA to reimburse the agency for fee-for-service claims and capitation payments for participants enrolled in Medicaid, as well as for the payment of administrative and support costs associated with the provision of the Medicaid services. This provision codifies the agreement between the Agency and NICA.

Section 7 amends s. 766.314, F.S., relating to assessments and plan of operation, to require NICA to include a fraud and overpayment prevention and detection program in the plan of operation that is subject to review and approval by the Office of Insurance Regulation (OIR).

The amount of the annual assessments paid by hospitals and physicians remain unchanged. Provisions relating to the assessment process are revised in the following manner:

- Requires NICA to submit updated claims estimates to OIR on a quarterly basis within 10 business days after completion.
- Requires NICA to calculate whether the plan is actuarially sound after the completion of its quarterly revisions of claims estimates. 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. The 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. The OIR must initiate such actuarial valuation within 30 days after its determination there is a need for a valuation.
- Requires OIR to make an actuarial valuation to be made of the assets and liabilities of the plan at a minimum biennially on or before December 31 of even-numbered years and as provided upon calculation and notification by NICA that the plan is not actuarially sound. The valuation by the 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.
- Requires that, if OIR determines that the plan lacks adequate cash flow for the following fiscal year pursuant to its review, OIR must authorize a transfer of up to $50 million from the Insurance Regulatory Trust Fund to NICA within 30 calendar days.

participant's health insurance. For families with Medicaid, NICA reimburses the Agency for Health Care Administration for the cost of those premiums. For items such as therapy, equipment, and some supplies, NICA may request documentation of an insurance denial prior to authorizing a reimbursement request. If there is a lapse in insurance coverage and expenses are incurred that would have been covered by insurance, NICA will not reimburse for those items.

- Requires that, if OIR finds that the plan is not likely to return to actuarial soundness before the next biennial review, OIR must, within 60 calendar days after this finding, order one or more of the following actions:
    - Require each licensed casualty insurer writing specified coverage, as defined in s. 624.60(1)(b),(k), and (q) to pay into NICA an annual assessment that is calculated to generate a total amount no greater than the amount required to achieve actuarial soundness of the plan within 5 years after the date of the order.
        - Requires the assessment to be made on the basis of net direct premiums written for the business activity used as the basis for each such insurer's inclusion as a funding source for the plan in the state during the prior year ending December 31, as reported to OIR, and must be in proportion that the net direct written premium written for each insurer on account of the business activity forming the basis for its inclusion in the plan bears to the aggregate net direct premiums for all such business activity written in this state by all such insurers.
        - The annual assessment is capped at 0.25 percent of the insurer's net direct premiums written. An assessment may not extend five years after the date of the order. Insurers are authorized to recoup their assessments through a surcharge on future policies, a rate increase applicable prospectively, or a combination of the two.
    - Provide that, if the actuarial soundness cannot be achieved through the assessment on casualty insurers, OIR is authorized to increase the assessments on hospitals and physicians on a proportional basis to generate a total amount of revenue no greater than the amount required to maintain the plan on an actuarially sound basis.
- 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. 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 8 amends s. 766.315, F.S., to substitute the one board director representative for a parent or legal guardian of an injured infant with one family member of a participant.

Section 9 provides the bill takes effect July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 1668 revises benefits available to plan participants which will assist parents, other family members, and legal guardians in funding significant medical expenses and other necessary services and care of plan participants.

C. Government Sector Impact:

SB 1668 increases the amount of funds the Office of Insurance Regulation (OIR) is authorized to transfer from the Insurance Regulatory Trust Fund to NICA from $20 million to $50 million if OIR determines that the plan lacks adequate cash flows for the following fiscal year.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill amends sections 409.910, 766.302, 766.303, 766.305, 766.309, 766.31, 766.314, and 766.315 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.