A bill to be entitled

An act relating to the Florida Birth-Related Neurological Injury Compensation Association; amending s. 409.910, F.S.; requiring the Agency for Health Care Administration to recover from the Florida Birth-Related Neurological Injury Compensation Association specified costs incurred by Medicaid; reordering and amending s. 766.302, F.S.; defining terms; revising definitions; amending s. 766.303, F.S.; revising the exclusiveness of rights and remedies of the Florida Birth-Related Neurological Injury Compensation Plan; making technical and conforming changes; amending s. 766.305, F.S.; making technical and conforming changes; amending s. 766.309, F.S.; conforming a cross-reference; amending s. 766.31, F.S.; revising the expenses covered by an award for compensation under the plan; revising services eligible for compensation under certain annual benefits under the plan; providing an additional benefit for psychotherapeutic services for family members upon the death of a participant; revising eligibility criteria for transportation and housing assistance benefits under the plan; providing coverage of certain legal costs under the plan; requiring the plan to reimburse certain claims and payments for plan participants also enrolled in the state Medicaid program; requiring that such funds be credited to the agency's Medical Care Trust Fund; requiring the plan to reimburse certain participants by a specified date; prohibiting

compensation under the plan for family residential or custodial care under certain circumstances; authorizing the association to file a petition with the Division of Administrative Hearings if there is a dispute regarding overpayment of an expense reimbursement under the plan; deleting obsolete language; requiring family members of plan participants to continuously maintain certain health insurance coverage for the participant; requiring family members of plan participants to obtain such coverage or apply for Medicaid coverage within a specified timeframe after entry of a final order for an award for compensation under the plan; requiring family members of current plan participants to obtain the requisite health insurance coverage by a specified date; amending s. 766.314, F.S.; revising requirements for the administration of assessments and appropriations dedicated to the Florida Birth-Related Neurological Injury Compensation Plan; revising the schedule of assessments participating hospitals and physicians are required to pay to the association; requiring the association to submit revised quarterly claim estimates to the office within a specified timeframe; requiring the association to assess its financial condition and issue a specified notice to the Office of Insurance Regulation in certain circumstances; requiring the Office of Insurance Regulation to review the association's financial condition upon receipt of such report; providing

criteria for review; providing the timeframe and criteria for the Office of Insurance Regulation's biennial review of the association's financial condition; requiring a determination regarding the plan's short term cash flow; requiring the office to authorize transfers of funds to the association within a specified timeframe under certain circumstances; providing that the cumulative amount of such transfers may not exceed a specified amount over the life of the plan; providing the office with specified responsibilities; providing limitations on time and value of potential assessments; deleting reporting requirements; repealing a public records exemption; amending s. 766.315, F.S.; revising membership of the association's board of directors; prohibiting the board of directors from creating new benefits or expanding existing benefits under the plan under certain circumstances; providing construction; revising requirements for certain reports of the association; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (a) of subsection (7) of section 409.910, Florida Statutes, is amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(7) The agency shall recover the full amount of all medical assistance provided by Medicaid on behalf of the recipient to

the full extent of third-party benefits.

(a) Recovery of such benefits shall be collected directly from:

1. Any third party;

2. The recipient or legal representative, if he or she has received third-party benefits;

3. The provider of a recipient's medical services if third-party benefits have been recovered by the provider; notwithstanding any provision of this section, to the contrary, however, no provider shall be required to refund or pay to the agency any amount in excess of the actual third-party benefits received by the provider from a third-party payor for medical services provided to the recipient; ~~or~~

4. Any person who has received the third-party benefits; or

5. The Florida Birth-Related Neurological Injury Compensation Association for plan participant costs incurred under s. 766.31.

The provisions of this subsection do not apply to any proceeds received by the state, or any agency thereof, pursuant to a final order, judgment, or settlement agreement, in any matter in which the state asserts claims brought on its own behalf, and not as a subrogee of a recipient, or under other theories of liability. The provisions of this subsection do not apply to any proceeds received by the state, or an agency thereof, pursuant to a final order, judgment, or settlement agreement, in any matter in which the state asserted both claims as a subrogee and additional claims, except as to those sums specifically identified in the final order, judgment, or settlement agreement

as reimbursements to the recipient as expenditures for the named recipient on the subrogation claim.

Section 2. Section 766.302, Florida Statutes, is reordered and amended to read:

766.302 Definitions; ss. 766.301-766.316.—As used in ss. 766.301-766.316, the term:

(1) "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.

(2) ~~(4)~~ "Administrative law judge" means an administrative law judge appointed by the division.

(3) ~~(1)~~ "Association" means the Florida Birth-Related Neurological Injury Compensation Association established in s. 766.315 to administer the Florida Birth-Related Neurological Injury Compensation Plan and the plan of operation established in s. 766.314.

(4) ~~(2)~~ "Birth-related neurological injury" means injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and does ~~shall~~ not include disability or death caused by genetic or congenital abnormality.

(5) ~~(3)~~ "Claimant" means any person who files a claim

pursuant to s. 766.305 ~~for compensation~~ for a birth-related neurological injury to an infant. Such a claim may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claim may be filed by an administrator, personal representative, or other legal representative thereof.

(6)~~(5)~~ "Division" means the Division of Administrative Hearings of the Department of Management Services.

(7)~~(9)~~ "Family member" means a father, mother, or legal guardian.

(8)~~(10)~~ "Family residential or custodial care" means care normally rendered by trained professional attendants which is beyond the scope of child care duties, but which is provided by family members. Family members who provide nonprofessional residential or custodial care may not be compensated under this act for care that falls within the scope of child care duties and other services normally and gratuitously provided by family members. Family residential or custodial care shall be performed only at the direction and control of a physician when such care is medically necessary. Reasonable charges for expenses for family residential or custodial care provided by a family member shall be determined as follows:

(a) If the family member is not employed, the per-hour value equals the federal minimum hourly wage.

(b) If the family member is employed and elects to leave that employment to provide such care, the per-hour value of that care shall equal the rates established by Medicaid for private duty services provided by a home health aide. A family member or a combination of family members providing care in accordance

with this definition may not be compensated for more than a total of 10 hours per day. Family care is in lieu of professional residential or custodial care, and no professional residential or custodial care may be awarded for the period of time during the day that family care is being provided.

(9)~~(6)~~ "Hospital" means any hospital licensed in Florida.

(10) "Office" means the Office of Insurance Regulation.

(11) "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.

(12)~~(7)~~ "Participating physician" means a physician licensed in Florida to practice medicine who practices obstetrics or performs obstetrical services either full time or part time and who had paid or was exempted from payment at the time of the injury the assessment required for participation in the birth-related neurological injury compensation plan for the year in which the injury occurred. Such term does ~~shall~~ not apply to any physician who practices medicine as an officer, employee, or agent of the Federal Government.

(13)~~(8)~~ "Plan" means the Florida Birth-Related Neurological Injury Compensation Plan established under s. 766.303.

(14) "Risk margin" means an additional, explicit allowance above the best-estimate reserve to reflect uncertainty in future claim payments, including variations 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 3. Section 766.303, Florida Statutes, is amended to

read:

766.303 Florida Birth-Related Neurological Injury Compensation Plan; exclusiveness of remedy.—

(1) There is established the Florida Birth-Related Neurological Injury Compensation Plan for the purpose of providing compensation, irrespective of fault, for birth-related neurological injuries ~~injury claims~~. Such plan shall apply to births occurring on or after January 1, 1989, and shall be administered by the Florida Birth-Related Neurological Injury Compensation Association.

(2) The rights and remedies granted by this plan on account of a birth-related neurological injury shall exclude all other rights and remedies of such infant, her or his personal representative, family members ~~parents~~, dependents, and next of kin, at common law or otherwise, against any person or entity directly involved with the labor, delivery, or immediate postdelivery resuscitation during which such injury occurs, arising out of or related to a medical negligence claim with respect to such injury; except that a civil action may ~~shall~~ not be foreclosed where there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property, provided that such suit is filed prior to and in lieu of payment of an award under ss. 766.301-766.316. Such suit shall be filed before the award of the division becomes conclusive and binding as provided for in s. 766.311.

(3) Sovereign immunity is hereby waived on behalf of the Florida Birth-Related Neurological Injury Compensation Association solely to the extent necessary to assure payment of

compensation as provided in s. 766.31.

(4) The association shall administer the plan in a manner that promotes and protects the health and best interests of participants ~~children~~ with birth-related neurological injuries.

Section 4. Subsections (1) and (3) of section 766.305, Florida Statutes, are amended to read:

766.305 Filing of claims and responses; medical disciplinary review.—

(1) All claims filed ~~for compensation~~ under the plan must ~~shall~~ commence by the claimant filing with the division a petition that includes all of ~~seeking compensation. Such petition shall include~~ the following information:

(a) The name and address of the legal representative and the basis for her or his representation of the injured infant.

(b) The name and address of the injured infant.

(c) The name and address of any physician providing obstetrical services who was present at the birth and the name and address of the hospital at which the birth occurred.

(d) A description of the disability for which the claim is made.

(e) The time and place the injury occurred.

(f) A brief statement of the facts and circumstances surrounding the injury and giving rise to the claim.

(3) The claimant shall furnish to the ~~Florida Birth-Related Neurological Injury Compensation~~ association the following information, which must be filed with the association within 10 days after the filing of the petition as set forth in subsection (1):

(a) All available relevant medical records relating to the

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

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

(c) Documentation of expenses and services incurred to date which identifies any payment made for such expenses and services and the payor.

(d) Documentation of any applicable private or governmental source of services or reimbursement relative to the impairments.

The information required by paragraphs (a)-(d) shall remain confidential and exempt under the provisions of s. 766.315(6)(b) ~~s. 766.315(5)(b)~~.

Section 5. Paragraph (a) of subsection (1) of section 766.309, Florida Statutes, is amended to read:

766.309 Determination of claims; presumption; findings of administrative law judge binding on participants.—

(1) The administrative law judge shall make the following determinations based upon all available evidence:

(a) Whether the injury claimed is a birth-related neurological injury. If the claimant has demonstrated, to the satisfaction of the administrative law judge, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury and that the infant was thereby rendered permanently and substantially mentally and physically

impaired, a rebuttable presumption shall arise that the injury is a birth-related neurological injury as defined in s. 766.302 ~~s. 766.302(2)~~.

Section 6. Section 766.31, Florida Statutes, is amended to read:

766.31 Administrative law judge awards for birth-related neurological injuries; notice of award.—

(1) Upon determining that an infant has sustained a birth-related neurological injury and that obstetrical services were delivered by a participating physician at the birth, the administrative law judge shall make an award providing compensation for the following items relative to such injury:

(a) Actual expenses incurred since the date of birth for medically necessary and reasonable:

1. Medical and hospital care and services;~~,~~

2. Habilitative services; ~~and training,~~

3. Dental services;

4. Family residential or custodial care;~~,~~

5. Professional residential care;~~, and~~

6. Professional custodial care; ~~and service,~~

7. ~~for medically necessary~~ Drugs;~~,~~

8. Special equipment;~~, and facilities,~~ and

9. ~~for~~ Related travel.

(b) At a minimum, compensation must be provided for the following actual expenses:

1. Psychotherapeutic services for ~~A total annual benefit of up to $10,000 for immediate~~ family members and other relatives who have resided ~~reside~~ with the participant, which are ~~infant for psychotherapeutic services~~ obtained from a psychiatrist

licensed under chapter 458 or chapter 459, a provider ~~providers~~ licensed under chapter 490 or chapter 491, or a psychiatrist or provider who has equivalent licensure by another jurisdiction. This benefit for such family members and relatives shall be up to a total of $10,000 annually during the participant's lifetime and up to a total of $20,000 subsequent to the participant's death.

2. For the life of the participant ~~child~~, providing family members ~~parents or legal guardians~~ with a reliable method of transporting ~~transportation for the care of~~ the participant and ~~child or reimbursing the cost of upgrading an existing vehicle to accommodate~~ the participant's wheelchair and medically necessary equipment ~~child's needs when it becomes medically necessary for wheelchair transportation. The mode of transportation must take into account the special accommodations required for the specific child~~. The plan may not limit such transportation assistance based on the participant's ~~child's~~ age or weight. The plan must replace any vehicle ~~vans~~ purchased by the plan every 7 years or 150,000 miles, whichever comes first.

3. Housing assistance of up to $100,000 for the life of the participant ~~child~~, including, but not limited to, a down payment on a new home, moving expenses, and home construction and modification costs.

4. Legal costs associated with establishing and maintaining guardianship for a participant.

(c)1. The costs of a health insurance policy or health maintenance contract that provides major medical or similar comprehensive health insurance coverage for the participant obtained pursuant to subsection (3), including, but not limited

to, the premium and out-of-pocket costs. For participants enrolled in the state Medicaid program, the plan must reimburse fee-for-service paid claims and capitation payments, as applicable, for services provided to such participants pursuant to this section and for the administrative and support costs associated with the provided medical assistance. Such funds shall be credited to the Agency for Health Care Administration's Medical Care Trust Fund.

2. By December 31, 2026, the plan shall 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 such participant did not have comprehensive or major medical health insurance coverage through an insurer or a health maintenance organization.

(d) ~~(b)~~ However, the following expenses are not subject to compensation:

1. Expenses for items or services that the participant ~~infant~~ has received, or is entitled to receive, under the laws of any state or the Federal Government, except to the extent such exclusion may be prohibited by federal law.

2. Expenses for items or services that the participant ~~infant~~ has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity.

3. Expenses for which the participant ~~infant~~ has received reimbursement, or for which the participant ~~infant~~ is entitled to receive reimbursement, under the laws of any state or the Federal Government, except to the extent such exclusion may be prohibited by federal law.

4. Expenses for which the participant ~~infant~~ has received reimbursement, or for which the participant ~~infant~~ is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

5. Expenses for family residential or custodial care provided by a family member while:

a. Care and supervision of the participant is simultaneously being provided by another person or entity; or

b. The family member receives compensation from another source for work performed during the same time for which compensation is sought from the association.

(e) ~~(c)~~ Expenses included under paragraphs ~~paragraph~~ (a) and (b) are limited to reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person.

(f)1. A family member ~~The parents or legal guardians~~ receiving benefits under the plan may file a petition with the division ~~of Administrative Hearings~~ to dispute the amount of actual expenses reimbursed or a denial of reimbursement.

2. In the case of an alleged overpayment of an expense reimbursement by the association to a family member, if the family member does not agree that an overpayment has occurred, the association may file a petition for division review of the overpayment for a determination of the amount, if any, to be recouped by the association.

(g)1. ~~(d)1.a.~~ Periodic payments of an award to the family members ~~parents or legal guardians~~ of the participant ~~infant found to have sustained a birth-related neurological injury~~,

which award may not exceed $100,000. However, at the discretion of the administrative law judge, such award may be made in a lump sum. Beginning on January 1, 2021, the award may not exceed $250,000, and each January 1 thereafter, the maximum award authorized under this paragraph shall increase by 3 percent.

~~b. Parents or legal guardians who received an award pursuant to this section before January 1, 2021, must receive a retroactive payment in an amount sufficient to bring the total award paid to the parents or legal guardians pursuant to sub-subparagraph a. to $250,000. This additional payment may be made in a lump sum or in periodic payments as designated by the parents or legal guardians and must be paid by July 1, 2021.~~

2.~~a.~~ Death benefit for the participant ~~infant~~ in an amount of $50,000.

~~b. Parents or legal guardians who received an award pursuant to this section, and whose child died since the inception of the program, must receive a retroactive payment in an amount sufficient to bring the total award paid to the parents or legal guardians pursuant to sub-subparagraph a. to $50,000. This additional payment may be made in a lump sum or in periodic payments as designated by the parents or legal guardians and must be paid by July 1, 2021.~~

(h)~~(c)~~ Reasonable expenses incurred in connection with the filing of a claim under ss. 766.301-766.316, including reasonable attorney ~~attorney's~~ fees, which shall be subject to the approval and award of the administrative law judge. In determining an award for attorney ~~attorney's~~ fees, the administrative law judge shall consider the following factors:

1. The time and labor required, the novelty and difficulty

of the questions involved, and the skill requisite to perform the legal services properly.

2. The fee customarily charged in the locality for similar legal services.

3. The time limitations imposed by the claimant or the circumstances.

4. The nature and length of the professional relationship with the claimant.

5. The experience, reputation, and ability of the lawyer or lawyers performing services.

6. The contingency or certainty of a fee.

If there is ~~Should there be~~ a final determination of compensability, and the claimants accept an award under this section, the claimants are not liable for any expenses, including attorney fees, incurred in connection with the filing of a claim under ss. 766.301-766.316 other than those expenses awarded under this section.

(2) The award shall require the immediate payment of expenses previously incurred and shall require that future expenses be paid as incurred.

(3) A family member must continuously maintain a health insurance policy or health maintenance contract that provides comprehensive major medical health insurance coverage for the participant.

(a) If the participant does not have such coverage at the time of entry of a final order by an administrative law judge approving a claim for compensation, the family member must obtain coverage within 60 days after entry of such order or

apply for Medicaid coverage within 30 days after entry of such order.

(b) If the participant is determined to be ineligible for Medicaid, the family member must obtain other coverage within 60 days after receiving the Medicaid application denial.

(c) 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.

(4)~~(3)~~ A copy of the award shall be sent immediately by registered or certified mail to each person served with a copy of the petition under s. 766.305(2).

Section 7. Section 766.314, Florida Statutes, is amended to read:

766.314 Assessments; plan of operation.—

(1) The assessments established under ~~pursuant to~~ this section shall be used to finance the Florida Birth-Related Neurological Injury Compensation Plan.

(2) The assessments and appropriations dedicated to the plan shall be administered by the Florida Birth-Related Neurological Injury Compensation Association established in s. 766.315, in accordance with the following requirements:

(a) ~~On or before July 1, 1988,~~ The directors of the association shall submit to the office ~~Department of Insurance~~ for review and approval a plan of operation and any amendment thereto which shall provide for the efficient administration of the plan and for prompt processing of claims against and awards made on behalf of the plan.

(b) The plan of operation must ~~shall~~ include provision for:

1. Establishment of necessary facilities;

2. Management of the funds collected on behalf of the plan;

3. Processing of claims against the plan;

4. Assessment of the persons and entities listed in subsections (4) and (7) ~~(5)~~ to pay awards and expenses~~, which assessments shall be on an actuarially sound basis subject to the limits set forth in subsections (4) and (5)~~;

5. A fraud and overpayment prevention and detection program; and

6.~~5.~~ Any other matters necessary for the efficient operation of the Florida Birth-Related Neurological Injury Compensation Plan.

~~(b) Amendments to the plan of operation may be made by the directors of the plan, subject to the approval of the office of Insurance Regulation of the Financial Services Commission.~~

(3) All assessments shall be deposited with the ~~Florida Birth-Related Neurological Injury Compensation~~ association. The funds collected by the association and any income therefrom shall be disbursed only for the payment of awards under ss. 766.301-766.316 and for the payment of the reasonable expenses of administering the plan.

(4) The following persons and entities shall pay into the association assessments as follows ~~an initial assessment in accordance with the plan of operation~~:

(a)1. ~~On or before October 1, 1988,~~ Each hospital licensed under chapter 395 shall pay an ~~initial~~ assessment of $50 per infant delivered in that ~~the~~ hospital ~~during the prior calendar year~~, as reported to the Agency for Health Care Administration; provided, however, that a hospital owned or operated by the state or a county, special taxing district, or other political

subdivision of the state shall not be required to pay ~~the initial assessment or~~ any assessment required by this subsection or subsection (7) ~~(5)~~. The term "infant delivered" includes live births and not stillbirths, but the term does not include infants delivered by employees or agents of the board of trustees of a state university, those born in a teaching hospital as defined in s. 408.07, or those born in a teaching hospital as defined in s. 395.806 that have been deemed by the association as being exempt from assessments since fiscal year 1997 to fiscal year 2001. The ~~initial~~ assessment and any assessment imposed pursuant to subsection (7) ~~(5)~~ may not include any infant born to a charity patient (as defined by rule of the Agency for Health Care Administration) or born to a patient for whom the hospital receives Medicaid reimbursement, if the sum of the annual charges for charity patients plus the annual Medicaid contractuals of the hospital exceeds 10 percent of the total annual gross operating revenues of the hospital. The hospital is responsible for documenting, to the satisfaction of the association, the exclusion of any birth from the computation of the assessment. Upon demonstration of financial need by a hospital, the association may provide for installment payments of assessments.

2. Assessments are due, and hospitals shall pay all assessments required under this section, by December 31 of the calendar year immediately subsequent to the birth year.

(b)1.a. ~~On or before October 15, 1988,~~ All physicians licensed pursuant to chapter 458 or chapter 459 ~~as of October 1, 1988~~, other than participating physicians, shall be assessed an annual ~~initial~~ assessment of $250.~~,~~

b. Payment for all assessments required under this paragraph is due on or before December 31 of each year ~~which must be paid no later than December 1, 1988~~.

~~2. Any such physician who becomes licensed after September 30, 1988, and before January 1, 1989, shall pay into the association an initial assessment of $250 upon licensure.~~

~~3. Any such physician who becomes licensed on or after January 1, 1989, shall pay an initial assessment equal to the most recent assessment made pursuant to this paragraph, paragraph (5)(a), or paragraph (7)(b).~~

2.~~4.~~ However, if the physician is a physician specified in this subparagraph, the assessment is not applicable:

a. 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;

b. A retired physician who has withdrawn from the practice of medicine but who maintains an active license as evidenced by an affidavit filed with the Department of Health. Prior to reentering the practice of medicine in this state, a retired physician as herein defined must notify the Board of Medicine or the Board of Osteopathic Medicine and pay the appropriate assessments pursuant to this section;

c. A physician who holds a limited license pursuant to s. 458.317 and who is not being compensated for medical services;

d. A physician who is employed full time by the United States Department of Veterans Affairs and whose practice is confined to United States Department of Veterans Affairs hospitals; or

e. A physician who is a member of the Armed Forces of the United States and who meets the requirements of s. 456.024.

f. A physician who is employed full time by the State of Florida and whose practice is confined to state-owned correctional institutions, a county health department, or state-owned mental health or developmental services facilities, or who is employed full time by the Department of Health.

(c)1. ~~On or before December 1, 1988,~~ Each physician licensed pursuant to chapter 458 or chapter 459 who wishes to participate in the Florida Birth-Related Neurological Injury Compensation Plan and who otherwise qualifies as a participating physician under ss. 766.301-766.316 shall pay an annual ~~initial~~ assessment of $5,000 and any assessment required under paragraph (7)(c), if assessed. However, if the physician is either 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, and is supervised in accordance with program requirements established by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association by a physician who is participating in the plan, such resident physician, assistant resident physician, or intern is deemed to be a participating physician without the payment of the assessment. Participating physicians also include any employee of the board of trustees of a state university who has paid the assessment required by this paragraph and, if assessed, paragraph (7)(c) ~~(5)(a)~~, and any certified nurse midwife supervised by such employee. Participating physicians include any certified nurse midwife who has paid 50 percent of the physician assessment

required by this paragraph and, if assessed, paragraph (7)(c), ~~(5)(a)~~ and who is supervised by a participating physician who has paid the assessment required by this paragraph and, if assessed, paragraph (7)(c) ~~(5)(a)~~. Supervision for nurse midwives shall require that the supervising physician will be easily available and have a prearranged plan of treatment for specified patient problems which the supervised certified nurse midwife may carry out in the absence of any complicating features. ~~Any physician who elects to participate in such plan on or after January 1, 1989, who was not a participating physician at the time of such election to participate and who otherwise qualifies as a participating physician under ss. 766.301-766.316 shall pay an additional initial assessment equal to the most recent assessment made pursuant to this paragraph, paragraph (5)(a), or paragraph (7)(b).~~

2. Payment of assessments required by this paragraph is due on or before December 31 of each year for qualification as a participating physician during the next calendar year. If payment of the assessments is received by the association on or before January 31 of any calendar year, the physician shall qualify as a participating physician for that entire calendar year. If the payment is received after January 31, the physician shall qualify as a participating physician for that calendar year only from the date the payment was received by the association.

(d) Any hospital located in a county with a population in excess of 1.1 million as of January 1, 2003, as determined by the Agency for Health Care Administration under the Health Care Responsibility Act, may elect to pay the assessments required by

paragraph (c) ~~fee~~ for the participating physician and the certified nurse midwife if the hospital first determines that the primary motivating purpose for making such payment is to ensure coverage for the hospital's patients under the provisions of ss. 766.301-766.316; however, no hospital may restrict any participating physician or nurse midwife, directly or indirectly, from being on the staff of hospitals other than the staff of the hospital making the payment. ~~Each hospital shall file with the association an affidavit setting forth specifically the reasons why the hospital elected to make the payment on behalf of each participating physician and certified nurse midwife. The payments authorized under this paragraph shall be in addition to the assessment set forth in paragraph (5)(a).~~

~~(5)(a) Beginning January 1, 1990, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, as of the date determined in accordance with the plan of operation, taking into account persons licensed subsequent to the payment of the initial assessment, shall pay an annual assessment in the amount equal to the initial assessments provided in paragraphs (4)(b) and (c). If payment of the annual assessment by a physician is received by the association by January 31 of any calendar year, the physician shall qualify as a participating physician for that entire calendar year. If the payment is received 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. On January 1, 1991, and on each January 1~~

~~thereafter, the association shall determine the amount of additional assessments necessary pursuant to subsection (7), in the manner required by the plan of operation, subject to any increase determined to be necessary by the Office of Insurance Regulation pursuant to paragraph (7)(b). On July 1, 1991, and on each July 1 thereafter, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, shall pay the additional assessments which were determined on January 1. Beginning January 1, 1990, the entities listed in paragraph (4)(a), including those licensed on or after October 1, 1988, shall pay an annual assessment of $50 per infant delivered during the prior calendar year. The additional assessments which were determined on January 1, 1991, pursuant to the provisions of subsection (7) shall not be due and payable by the entities listed in paragraph (4)(a) until July 1.~~

~~(b) If the assessments collected pursuant to subsection (4) and the appropriation of funds provided by s. 76, chapter 88-1, Laws of Florida, as amended by s. 41, chapter 88-277, Laws of Florida, to the plan from the Insurance Regulatory Trust Fund are insufficient to maintain the plan on an actuarially sound basis, there is hereby appropriated for transfer to the association from the Insurance Regulatory Trust Fund an additional amount of up to $20 million.~~

~~(c)1. Taking into account the assessments collected pursuant to subsection (4) and appropriations from the Insurance Regulatory Trust Fund, if required to maintain the plan on an actuarially sound basis, the Office of Insurance Regulation shall require each entity licensed to issue casualty insurance~~

~~as defined in s. 624.605(1)(b), (k), and (q) to pay into the association an annual assessment in an amount determined by the office pursuant to paragraph (7)(a), in the manner required by the plan of operation.~~

~~2. All annual assessments shall be made on the basis of net direct premiums written for the business activity which forms the basis for each such entity's inclusion as a funding source for the plan in the state during the prior year ending December 31, as reported to the Office of Insurance Regulation, and shall be in the proportion that the net direct premiums written by each carrier 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 entities.~~

~~3. No entity listed in this paragraph shall be individually liable for an annual assessment in excess of 0.25 percent of that entity's net direct premiums written.~~

~~4. Casualty insurance carriers shall be entitled to recover their initial and annual assessments through a surcharge on future policies, a rate increase applicable prospectively, or a combination of the two.~~

(5)~~(6)~~(a) The association shall make all assessments required by this section, except initial assessments of physicians newly licensed by the Department of Health, which assessments will be made by the Department of Health, and except assessments of casualty insurers pursuant to paragraph (7)(c) ~~subparagraph (5)(c)1.~~, which assessments will be made by the office ~~of Insurance Regulation~~. The Department of Health shall provide the association, in an electronic format, with a monthly

report of the names and license numbers of all physicians licensed under chapter 458 or chapter 459.

(b)1. The association may enforce collection of assessments required to be paid pursuant to ss. 766.301-766.316 by suit filed in county court, or in circuit court if the amount due could exceed the jurisdictional limits of county court. The association is entitled to an award of attorney fees, costs, and interest upon the entry of a judgment against a physician for failure to pay such assessment, with such interest accruing until paid. Notwithstanding chapters 47 and 48, the association may file such suit in either Leon County or the county of the residence of the defendant. The association shall notify the Department of Health and the applicable board of any unpaid final judgment against a physician within 7 days after the entry of final judgment.

2. The Department of Health, upon notification by the association that an assessment has not been paid and that there is an unsatisfied judgment against a physician, shall refuse to renew any license issued to such physician under chapter 458 or chapter 459 until the association notifies the Department of Health that the judgment is satisfied in full.

(c) The Agency for Health Care Administration shall, upon notification by the association that an assessment has not been timely paid, enforce collection of such assessments required to be paid by hospitals pursuant to ss. 766.301-766.316. Failure of a hospital to pay such assessment is grounds for disciplinary action pursuant to s. 395.1065 notwithstanding any law to the contrary.

(6) ~~(9)~~ (a) Within 60 days after a claim is filed, the

association shall 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 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. For purposes of this estimate, the association should include the maximum benefits for noneconomic damages.

(b) The association shall revise these estimates quarterly based upon the actual costs incurred and any additional information that becomes available to the association since the last review of this estimate. The estimate shall be reduced by any amounts paid by the association that were included in the current estimate. The association must submit such quarterly estimates to the office within 15 business days after completion.

(c) After the revisions of estimates required under paragraph (b), each quarter, the association shall calculate whether the plan is actuarially sound. If the association's calculation indicates that the plan is not actuarially sound, the association shall immediately notify the office as described in subsection (7). The office must review the association's calculations and, within 60 days after the association's notification, determine whether to initiate an actuarial valuation as described in subsection (7), and notify the association of its determination. At a minimum, the office shall make its determination based on the degree to which the association'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 valuation conducted by the office and until the next biennial valuation. The office shall initiate such actuarial valuation within 30 days after its determination that there is a need for a valuation.

~~1. 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 described in subsection (4) and paragraph (5)(a), the association may not accept any new claims without express authority from the Legislature. This section does not preclude the association from accepting any claim if the injury occurred 18 months or more before the effective date of this suspension. Within 30 days after the effective date of this suspension, the association shall notify the Governor, the Speaker of the House of Representatives, the President of the Senate, the Office of Insurance Regulation, the Agency for Health Care Administration, and the Department of Health of this suspension.~~

~~2. Notwithstanding this paragraph, the association is authorized to accept new claims during the 2025-2026 fiscal year if the total of all current estimates exceeds the limits described in subparagraph 1. during that fiscal year. This subparagraph expires July 1, 2026.~~

~~(d) If any person is precluded from asserting a claim against the association because of paragraph (c), the plan shall not constitute the exclusive remedy for such person, his or her personal representative, parents, dependents, or next of kin.~~

(7)(a) The office ~~of Insurance Regulation shall undertake~~

~~an actuarial investigation of the requirements of the plan based on the plan's experience in the first year of operation and any additional relevant information, including without limitation the assets and liabilities of the plan. Pursuant to such investigation, the Office of Insurance Regulation shall establish the rate of contribution of the entities listed in paragraph (5)(c) for the tax year beginning January 1, 1990. Following the initial valuation, the Office of Insurance Regulation~~ shall cause an actuarial valuation to be made of the assets and liabilities of the plan at a minimum ~~no less frequently than~~ biennially on or before December 31 of even-numbered years and as provided in subsection (6). Such valuation shall be based on the assets and liabilities of the plan for the calendar year before the year in which the actuarial valuation is due. The office shall also determine whether the plan has adequate estimated cash flow for the following fiscal year, whether, based on the 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. ~~Pursuant to the results of such valuations, the Office of Insurance Regulation shall prepare a statement as to the contribution rate applicable to the entities listed in paragraph (5)(c). However, at no time shall the rate be greater than 0.25 percent of net direct premiums written.~~

(b) If the office determines that the plan lacks adequate cash flow for the following fiscal year pursuant to the review in paragraph (a), the office shall authorize transfers from the Insurance Regulatory Trust Fund to the association within 30 calendar days. Cumulative transfers authorized under this

paragraph may not exceed $20 million over the life of the plan.

(c) ~~(b)~~ If the office ~~of Insurance Regulation~~ finds that the plan is not likely to return to actuarial soundness before the next biennial review pursuant to the review in paragraph (a), the office shall, within 60 calendar days after this finding, order one or more of the following actions:

1. Require each entity licensed to issue casualty insurance as defined in s. 624.605(1)(b), (k), and (q) to pay into the association 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, subject to the limitations of this subparagraph.

a. Such assessments shall be made on the basis of net direct premiums written for the business activity which forms the basis for each such entity's inclusion as a funding source for the plan in the state during the prior year ending December 31, as reported to the office, and shall be in the proportion that the net direct premiums written by each carrier 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 entities.

b. No entity shall be individually liable for an annual assessment in excess of 0.25 percent of that entity's net direct premiums written.

c. Casualty insurance carriers shall be entitled to recover their assessments through a surcharge on future policies, a rate increase applicable prospectively, or a combination of the two.

d. An assessment under this subparagraph must not extend 5 years after the date of the order.

2. If actuarial soundness cannot be achieved after using the remedy in subparagraph 1., increase the assessments specified in subsection (4) on a proportional basis that is calculated to generate a total amount no greater than the amount required to maintain the plan on an actuarially sound basis.

(d) If the office finds that the plan is not actuarially sound pursuant to the review in paragraph (a), the plan shall provide the office with quarterly reports projecting the plan's financial condition and, if assessments were ordered by the office under this subsection, projected revenues for such assessments.

(e) If the office finds that the plan is not actuarially sound and the remedies provided under this subsection are insufficient to reestablish the actuarial soundness of the plan, the association shall, within 5 days after such finding, notify the Governor, the President of the Senate, the Speaker of the House of Representatives, and the office. If the notice is issued, the association may not accept any new claims without express authority from the Legislature. This paragraph does not preclude the association from accepting any claim if the injury occurred 18 months or more before the effective date of this suspension.

(f) If any person is precluded from asserting a claim against the association because of paragraph (e), the plan shall not constitute the exclusive remedy for such person, his or her personal representative, parents, dependents, or next of kin ~~cannot be maintained on an actuarially sound basis based on the assessments and appropriations listed in subsections (4) and (5), the office shall increase the assessments specified in~~

~~subsection (4) on a proportional basis as needed~~.

~~(8) The association shall report to the Legislature its determination as to the annual cost of maintaining the fund on an actuarially sound basis. In making its determination, the association shall consider the recommendations of all hospitals, physicians, casualty insurers, attorneys, consumers, and any associations representing any such person or entity. Notwithstanding the provisions of s. 395.3025, all hospitals, casualty insurers, departments, boards, commissions, and legislative committees shall provide the association with all relevant records and information upon request to assist the association in making its determination. All hospitals shall, upon request by the association, provide the association with information from their records regarding any live birth. Such information shall not include the name of any physician, the name of any hospital employee or agent, the name of the patient, or any other information which will identify the infant involved in the birth. Such information thereby obtained shall be utilized solely for the purpose of assisting the association and shall not subject the hospital to any civil or criminal liability for the release thereof. Such information shall otherwise be confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.~~

Section 8. Present subsections (5) through (8) of section 766.315, Florida Statutes, are redesignated as subsections (6) through (9), respectively, a new subsection (5) is added to that section, and subsection (1), paragraph (e) of present subsection (5), and present subsections (7) and (8) of that section are amended, to read:

766.315 Florida Birth-Related Neurological Injury Compensation Association; board of directors; notice of meetings; report.—

(1)(a) The Florida Birth-Related Neurological Injury Compensation Plan shall be governed by a board of seven directors which shall be known as the Florida Birth-Related Neurological Injury Compensation Association. The association is not a state agency, board, or commission. Notwithstanding the provision of s. 15.03, the association is authorized to use the state seal.

(b) The directors shall be appointed for staggered terms of 3 years or until their successors are appointed and have qualified; however, a director may not serve for more than 6 consecutive years.

(c) The directors shall be appointed by the Chief Financial Officer as follows:

1. One citizen representative who is not affiliated with any of the groups identified in subparagraphs 2.-7.

2. One representative of participating physicians.

3. One representative of hospitals.

4. One representative of casualty insurers.

5. One representative of physicians other than participating physicians.

6. One <u>family member of a participant</u> ~~parent or legal guardian representative of an injured infant under the plan~~.

7. One representative of an advocacy organization for children with disabilities.

<u>(5) Notwithstanding this section, the board of directors may not create new benefits or expand existing benefits that</u>

result in additional costs to the plan if the plan is operating at an annual cash flow deficit, as documented in the plan's audited financial statements for the prior fiscal year. This subsection does not prohibit the plan from providing benefits set forth in s. 766.31.

(6) ~~(5)~~

(e) Annually, the association shall furnish audited financial reports to any plan participant upon request, to the office ~~of Insurance Regulation of the Financial Services Commission~~, and to the Joint Legislative Auditing Committee. The reports must be prepared in accordance with generally accepted auditing standards ~~accounting procedures~~ and must include such information as may be required by the office ~~of Insurance Regulation~~ or the Joint Legislative Auditing Committee. At any time determined to be necessary, the office ~~of Insurance Regulation~~ or the Joint Legislative Auditing Committee may conduct an audit of the plan.

(8) ~~(7)~~ The association shall publish a report on its website by January 1 of each year. The report must ~~shall~~ include all of the following:

(a) The names and terms of each board member and executive staff member.

(b) The amount of compensation paid to each association employee or independent contractor.

(c) A summary of reimbursement disputes and resolutions.

(d) A list of expenditures for attorney fees and lobbying fees.

(e) 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.

(9) ~~(8)~~ By November 1 of each year, the association shall submit a report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Financial Officer. The report must include all of the following:

(a) 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.

(b) 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.

(c) The average turnaround time for paying or denying compensation for expenses.

(d) Legislative recommendations to improve the program, including to create new benefits or expand current benefits for participants. Recommendations creating new benefits or expanding current benefits must include estimates of the costs to the plan for providing such benefits on an annual basis.

(e) A summary of any pending or resolved litigation during the year which affects the plan.

(f) The amount of compensation paid to each association employee, independent contractor, or member of the board of directors.

Section 9. This act shall take effect upon becoming a law.