CHAMBER ACTION

Senate House

.

Representative Anderson offered the following:

Amendment (with title amendment)

Remove lines 467-833 and insert:

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 a transfer of up to $20 million from the Insurance Regulatory Trust Fund to the association within 30 calendar days.

(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 paragraph 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 paragraph, projected revenues for such assessments.

(e) If the office finds that the plan is not actuarially sound and the remedies provided under subsection (7) 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.~~

T I T L E A M E N D M E N T

Remove lines 45-62 and insert:

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; authorizing the office to provide a cash transfer under certain conditions; providing the office with specified responsibilities; providing limitations on time and value of potential

assessments; deleting reporting requirements;
repealing a public records exemption;