BENEFIT HANDBOOK

February 6, 2020

IMPORTANT NOTE: This handbook is intended solely to provide summaries and practical information about benefits provided to accepted participants of the Florida Birth-Related Neurological Injury Compensation Association. This handbook is not a guarantee of benefits. All benefits are provided only in accordance with Association Guidelines and the Florida Birth-Related Neurological Injury Compensation Statute.

NICA

SUPPORTIVE SERVICES FOR FAMILIES AND PHYSICIANS

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FLORIDA BIRTH-RELATED NEUROLOGICAL

INJURY COMPENSATION PLAN

February 6, 2020

The Florida Birth-Related Neurological Injury Compensation Plan ("Plan") is an example of provisions of Florida law that is working. Known as NICA, the Plan provides a wide range of benefits to a participant who has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury during labor, delivery, or in the immediate post-delivery period in a hospital which renders the participant permanently and substantially mentally and physically impaired. See: Section 766.302(2), Florida Statutes. The Plan was initiated to:

(1) stabilize and reduce malpractice insurance premiums for providers of obstetric services in Florida; and

(2) provide compensation, on a no-fault basis, for a limited class of catastrophic injuries which result in unusually high costs for custodial care and rehabilitation.

The benefits of the Plan are limited to "medically necessary and reasonable expenses" "for medical and hospital, habilitative and training, residential or custodial care, professional residential, and custodial care and service, for medically necessary special equipment, and facilities, and for related travel." See: Section 766.31(1)(a), Florida Statutes. The Plan is the payer of last resort; that is, the Plan pays after available insurance or governmental programs have paid for such medically necessary and reasonable expenses. These payments are referred to as the "Collateral Sources."

The Plan is financed by tax assessments, in varying amounts, upon hospitals that

have obstetric units, licensed physicians who practice obstetrics or perform services, licensed nurse-midwives, all licensed physicians, and, in certain instances, the insurance industry.

A five member Board of Directors ("Board") appointed by the Chief Financial Officer of the State of Florida is responsible for the administration of the Plan. The Plan employs an Executive Director. The Board members are assisted by a number of professionals to provide eligible participants with medically necessary and reasonable services. The Board meets regularly, and all meetings are open to the public.

Initial Claims for compensation under the Plan are made to the Division of Administrative Hearings ("DOAH") pursuant to Section 766.305, Florida Statutes, and approved by order of an Administrative Law Judge ("ALJ"). Once a claim has been determined to be compensable by the ALJ, the Florida Birth-Related Neurological Injury Compensation Association ("NICA" or "Association") will communicate with the parents or legal guardian of the participant to determine the medically necessary and reasonable needs of the participant and the family. Following is a listing of benefits and the procedures that the Board has set up to carry out the statutory mandate under which it operates.

The provisions of Sections 766.301-766.316, Florida Statutes, are the statutory mandate, and any conflict between these guidelines and the statutory mandate shall be resolved in favor of the statutory mandate. These guidelines are solely to assist the parents or legal guardians in navigating NICA, and are not to be construed as to entitlement to any particular benefit. NICA pays the benefits under the Plan based upon evaluation of each participant and their needs.

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NICA is not an entitlement Plan and each participant may or may not be eligible for the same identical benefits because of individual condition, medical necessity and other available coverage. However, NICA strives to ensure that all medically necessary and reasonable expenses are covered, subject to the offsets allowed by law from the Collateral Sources. See: §766.31, Florida Statutes.

Reminder: Most benefits, except emergencies, should have prior approval.

BENEFITS

All reimbursements require proof of medical necessity and denial of coverage or proof that other coverage is not available. Co-pays, deductibles and other out of pocket expenses that are medically necessary and reasonable are eligible for reimbursement when a service or item is otherwise covered under another plan or program.

Professional Nursing Care:

A. The Plan will provide appropriate medically necessary and reasonable professional nursing or attendant care for the covered participant.

B. The Plan will review periodically with medical professionals the continued appropriateness of the professional care.

C. The Plan utilizes agencies when available. If an agency is unable to provide care, the Executive Director is authorized to approve other arrangements.

D. When professional nursing or attendant care is required, the Plan may reimburse a parent or legal guardian for medically necessary and reasonable residential custodial care in lieu of a nurse or other professional attendant. For participants born prior to June 7, 2002, reimbursement is

subject to limitations specified in the Class Action Settlement Agreement and Final Judgment and Order Approving the Class Action Settlement Agreement. (Copy available on the NICA website at www.nica.com) For participants born on or after June 7, 2002, reimbursement is subject to the limitations specified in Sections 766.302(10) and 766.31, Florida Statutes.

E. For those participants born before June 7, 2002, The Plan may reimburse a parent or legal guardian for up to 20 hours per day for care that they provide directly to their covered participant. If there are other caregivers involved the combined limit is 20 hours per day. School hours are also deducted. For those participants born on or after June 7, 2002, The Plan may reimburse a parent or legal guardian for up to 10 hours of family residential or custodial care which they provide directly to their covered participant within a 24-hour period and may pay other care providers up to a combined 24 hours per day if it is determined to be medically necessary. NICA does not reimburse for any hours that the participant is in school.

F. To request nursing care for your participant NICA requires a completed participant nursing and caregiver form, signed by your participant's physician and any and all other insurance, prepaid plan, HMO or governmental reimbursement information. In addition, a form requesting periodic payments must be submitted by each person providing care to request payment for the specific dates, times and number of hours of care provided during that time period. NICA reserves the right to request other information pertinent to this request.

Therapy:

A. The Plan will reimburse for therapy, which is determined to be medically necessary and reasonable, and for which there is a certificate or letter of medical necessity.

B. The Plan may consult periodically with appropriate medical professionals retained by NICA regarding the medical necessity for continuing various therapies, such as, but not limited to occupational, physical and speech therapy.

C. To request therapy for your participant NICA requires a letter of medical necessity from your participant's physician and any and all other insurance, prepaid plan, HMO or governmental reimbursement information. NICA reserves the right to request other information pertinent to this request.

Equipment:

A. Equipment documented as a medical necessity and reasonable will be reimbursed for by the Plan. Because there is a gamut of equipment that might be provided, no attempt is made to categorize each individual piece of equipment. Equipment provided to date, however, does include oxygen concentrators, bipap machines, feeding pumps, gait trainers, wheelchairs, Wizard strollers, suction machines, apnea monitors, IV poles, pulse oximeters, therapy balls, therapy mats, car seats, wheelchair lifts, and wheelchair tie-downs. Equipment not provided to date includes jogging strollers and other equipment used solely for convenience or recreation which is not medically necessary. To request any type of equipment for

your participant NICA requires a letter of medical necessity from your participant's therapist signed by their physician and any and all other insurance, prepaid plan, HMO or governmental reimbursement information. NICA reserves the right to request other information pertinent to this request.

B. All medical equipment purchased by the Plan remains the property of the Plan. It is expected, depending upon the type of equipment and the condition of the equipment that it be returned to the Plan or donated when no longer required by the participant.

Transportation:

Upon submission of receipts, the Plan will reimburse parking fees and tolls associated with medically necessary travel. **Medically necessary travel generally means travel with the participant in the vehicle to attend appointments including physician visits, therapy or other similar travel.** One trip to the pharmacy per month for prescriptions related to the NICA covered individual's birth injury may be reimbursed. The Plan will reimburse documented mileage for medically necessary travel at the following rates:

1. Mileage will be reimbursed at $.23 per mile for vans provided by the Plan. Since the Plan provides the van and pays for all necessary maintenance, the Plan's mileage reimbursement is intended only to cover the cost of gasoline associated with medically necessary transportation.

2. For use of other personal vehicles, reimbursement will be at the

prevailing rate according to the State of Florida. The rate as of February 6, 2020, is $.445 cents per mile. In the event a van provided by the Plan is unavailable, the mileage reimbursement allowance provided would be that allowed for vans purchased by the Plan. Upon submission of receipts, the Plan will reimburse other medically necessary transportation expenses, not otherwise reimbursed.

Travel:

A. Travel will be reimbursed for medically necessary appointments when the participant is traveling.

B. All airline travel shall be for one parent or legal guardian and the participant at the fare for coach travel.

C. Hotels will be reimbursed at an appropriate rate when it is necessary for a participant and the parent to travel more than 50 miles from home for a medically necessary appointment.

D. Meals for one parent and the covered participant will be reimbursed at a reasonable rate upon submission of receipts when a parent and participant must stay overnight for a medically necessary appointment. It is presumed that the rate approved for travel for State employees is reasonable.

E. If a participant lives in a different city or state than the parents or legal guardians, for example, a participant is away at a therapy camp or is enrolled in a college or university, travel will be reimbursed for a parent or legal guardian to travel to provide professional care for the participant in an

emergency such as illness.

Handicapped Accessible Van:

A. The Plan will fund the purchase of a van when it becomes medically necessary for wheelchair transportation. As a general guideline, when the covered participant reaches 6 years of age or 45 pounds in weight, and is wheelchair bound for transportation purposes it will be considered medically necessary. The Plan will pay the purchase price and associated costs of acquisition of the Vehicle, and the Plan will be listed as lien holder on the van's title, although the van itself will be titled in the name of the parents or legal guardians, as custodian for the Participant under the Florida Uniform Transfer to Minors Act. The Plan will pay for license tag/registration and renewals and maintenance. The Plan will pay for the basic mandatory insurance coverage and full collision and comprehensive coverage for the van subject to competitive quotes. Cost in excess of the basic mandatory insurance coverage will be at the parents' expense. Mileage will be reimbursed for medical appointments or pre-approved travel (the participant must be transported) at the rate of $.23 per mile. To request a van once your participant reaches the age or weight requirements, the Plan will need a prescription from your participant's physician. The Plan reserves the right to ask for any other pertinent information while reviewing this request.

B. Van Replacement: Vans will be replaced at approximately 7 years or 150,000 miles. Documentation of the vehicle's service history will be

considered in determining the timing of van replacement. Vehicles that are not properly maintained may not be replaced.

C. Van Return: In the event use of the van becomes no longer necessary for the benefit of Participant for any reason, the van shall be returned to NICA within 60 days. All vans returned to the Plan shall be in good working order.

Augmentative Communication Technology:

The Plan will pay for devices, equipment and computer software for the purpose of aiding in communication of a covered participant who otherwise is unable to communicate verbally, if the equipment is medically necessary and has been denied through other coverage sources. The Plan may require an evaluation be completed by a Plan assigned augmentative communication consultant to ensure the appropriate equipment is recommended and/or purchased.

For all equipment supplied by the Plan, it is expected that the covered participant and those involved in the care of the participant will utilize the equipment as intended and invest the time and effort required for the equipment to be utilized successfully.

The Plan will pay for reasonable repairs and will pay for replacement after 5 years. Any requests prior to this limit may be subject to review by the Executive Director. In accordance with the Plan's general policy on purchasing medically necessary and reasonable equipment, all augmentative communication technology equipment remains the property of the Plan. If for any reason the equipment no longer is necessary or not utilized by the covered participant, it must be returned to the Plan. To request augmentative communication technology equipment of any kind, please provide the Plan

with a letter of medical necessity and an insurance denial or payment information.

Housing:

A. Privately-owned Housing Assistance

The Board's statutory authority concerns awards for the medical needs of the participant it serves. If a participant has medically necessary and reasonable housing needs that can be addressed in the non-rental home currently owned and occupied by the participant's parents or legal guardians, the Plan will provide one-time funding for medically necessary modification to, or construction of, ramps, railing, an accessible bedroom and/or bathroom if such modification or construction is feasible and reasonable. This modification or construction must be within the Plan's allowable standards of cost, space and other facts which as of February 6, 2020 is $30,000. Before funding for an accessible bedroom and bathroom will be authorized, the Plan's construction manager or other qualified professional will determine the feasibility of these modifications or construction and whether the needs of participant will be met in the contemplated project.

B. Rental Housing Assistance

If the participant resides in a non-handicapped accessible rental unit and moves to a handicap accessible rental unit, the Plan will reimburse the difference between the former monthly rental payment and the cost for the appropriate handicapped accessible rental unit of similar size and quality based on cost per square foot. Any substantial increases in the square

footage of the handicapped accessible unit to be reimbursed must be attributable to medically necessary requirements and not exceed the overall guidelines utilized when the Plan constructs additional space for a participant.

A participant living in a qualifying handicapped accessible rental unit (as of the implementation date of this policy) may qualify for similar reimbursement.

Up to $2,000 for qualified moving expenses will be paid direct to a moving company or reimbursed to the participant's parents or legal guardians for a one time move to a handicap accessible home or rental unit. No other moving costs will be reimbursed.

The handicapped accessible rental unit should meet all applicable regulations of the Americans with Disabilities Act (ADA). Exceptions to meeting the ADA regulations must be approved by the Executive Director or the Board of Directors. Prior to providing reimbursement, the Plan may require certification of the rental unit's suitability for the participant and/or compliance with this policy.

C. Total Lifetime Housing Benefits

The maximum lifetime housing benefit per participant for any one or combination of housing benefits (rental and/or construction), including moving, may not exceed $30,000. Once a participant has received the full benefit as outlined under the Privately Owned Housing Assistance, the participant is no longer eligible for benefits as outlined in the Rental

Housing Assistance section.

Death Benefit:

The Plan will pay a $10,000 death benefit for a participant who has been accepted into the Plan.

MISCELLANEOUS EXPENSES:

Diapers:

Beginning at age three, the Plan will reimburse for diapers, including wipes, an approved diaper service or disposable diapers for the participant. In order to request reimbursement for diapers the Plan requires a prescription from the participant's physician and denial information from insurance or Medicaid.

Pureed Food:

Beginning at age two, the Plan will reimburse for a blender to prepare pureed foods or pre-prepared pureed baby food. The baby food market changes remarkably often and there are numerous products available which fit into almost any eating pattern. NICA will reimburse for those pre-prepared pureed products which provide needed nutritional value and are medically necessary due to a digestive system dysfunction related to the neurological injury. Pureed baby foods will be reimbursable for as long as they are medically necessary or until a participant is capable of eating or utilizing table foods. There are many types of products available, however, there will be a limit of $2.05 per jar or pouch for any pre-processed baby food, including organic foods. NICA encourages parents to use fresh foods and will allow up to $500 to purchase a blender with a minimum 3 year replacement cycle.

A receipt and a letter of medical necessity will be required for reimbursement of a blender or pre-packaged pureed or baby foods. In those instances

The actual fresh foods to be processed, including nuts, seeds, nutrients and supplements are not eligible for reimbursement.

Annual Special Benefit:

On an annual basis, the Plan will reimburse the NICA covered individual for limited items that provide a general therapeutic benefit or enhance the quality of life when accompanied with documentation by a licensed healthcare professional. They must provide a benefit or enhance the quality of life rather than be other routine supplies or equipment which are medically necessary. These items are not to exceed $500 in a calendar year, and must be requested within the calendar year.

Other:

Insurance Premiums. Although not specifically an identifiable medically necessary expense, The Plan encourages families to carry health insurance if the participant is not otherwise covered under a family plan, a state or Federal program or other type of health plan. The Plan may reimburse for the participant's portion of a health insurance premium on a prospective basis if reimbursement is requested. For reimbursement, the Plan requires a copy of the coverage document and premium with the participant's portion of the premium identified. If the participant's portion of the premium is not otherwise specifically identifiable in the coverage and premium documentation the Plan reserves the right to calculate the appropriate premium that will be reimbursed on a pro-rata basis.

The Plan may pay for other medically necessary supplies, equipment or other expenses for the participant. Requests for medically necessary expenses, which are not otherwise addressed in the Guidelines, should be submitted for review to the case manager assigned to the NICA covered individual.

PROCEDURES

Filing a Claim for Benefits:

A claim shall be initiated by the filing of a Petition with DOAH seeking compensation pursuant to Sections 766.301 – 766.316, Florida Statutes. A petition should include the names and address of the infant, and the parents or legal guardian, information regarding the participating physician and hospital where the birth occurred, a description of the injury and a brief statement of the facts pertinent to the claim. See Section 766.305, Florida Statutes, for specific requirements. Sufficient number of copies of the Petition shall be filed with DOAH so that DOAH may serve the Association, the physicians, the hospital and the Division of Medical Quality Assurance. The Petition must be accompanied by a $15.00 filing fee.

The claimant is also required to provide the Association, within 10 days after the filing of the Petition, all available medical records pertaining to the injury along with any other assessments, evaluations and prognosis to assist in the determination of the amount of compensation to be paid. Documentation of expenses and services incurred to date and documentation of applicable private or governmental sources of services or reimbursement relative to the Petition shall be provided to NICA. See Section 766.305, Florida Statutes, for specifics.

NICA will then respond to the Petition with a determination as to whether

the claim is compensable. If yes, then the claim can be accepted by the Association for compensation if NICA's acceptance of the claim is approved by the ALJ. If the claim is determined not to be compensable, then the parties may proceed to an administrative hearing. The ALJ must issue an order of approval for an accepted claim before any payment can be made.

Insurance:

The Plan is the payer of last resort. As such, the Plan must be provided with a copy of the NICA covered individual's health insurance policy, if there is one, and Medicaid/Medicare eligibility before benefits can be paid from the Plan. It is the responsibility of the parents or legal guardians to seek benefits from other sources for which they are eligible. The Plan may not reimburse or may reimburse at a lower amount for benefits that the participant would be eligible for under an insurance policy or program when the parent or legal guardian refuses to seek those benefits.

Prior Authorization:

Although a participant has been determined eligible for benefits from the Plan, parents or legal guardians should contact the Plan before committing to the purchase of equipment or incurring other expenses for which they might seek reimbursement. Failure to do so may jeopardize the amount of reimbursement from the Plan as the Plan has certain providers which will provide such equipment or services at a more reasonable cost.

Claims for Reimbursement:

Requests for reimbursement of expenses from medical providers, and pharmacies will be honored if submitted within one year from the date incurred when accompanied by documentation of medical necessity and receipts from providers. This time limit is not applicable to expenses incurred prior to acceptance into the Plan. Reimbursement will be paid in a timely fashion.

Authorization to Obtain Services Outside your Insurance Plan's Covered Area:

In the event it is medically necessary to take a participant outside of your insurance plan's covered area, or outside of the State of Florida for evaluation, surgery, and other medically necessary treatment, it must be determined by the Plan, in advance, if the Plan will pay for benefits (the "Treatment"). The Plan must pre-authorize out-of-state Treatment. **Treatment outside the insurance plan's covered area or out-of-state travel that is not pre-authorized may not be paid unless an emergency situation existed at the time of treatment.**

Benefits not specifically addressed in Handbook:

The Board authorizes the Executive Director to approve the benefits described in the Handbook. The Board, however, realizes that there may be equipment, or other items, which may be of value to the participant that this Handbook does not address. If the parents or legal guardians feel a benefit not described in the Handbook would be of advantage to the participant, the parents or legal guardians may request by letter that the benefit be reviewed by the Executive Director as an exception. If the finding is not satisfactory, the parent or guardian may bring the dispute to the Administrative Law Judge.

Experimental Programs:

When a request is made to fund participation in an Experimental Program, the Executive Director may approve the request based on the following criteria:

1. Overall cost associated with the Program must not be excessive and must be submitted for pre-approval and may include: Cost for one person to accompany the participant (if necessary); duration of the Program; expected medical benefits to the participant; and availability of the Program in Florida) if located outside of the area of residency.
2. A Report must be received from the participant's primary care physician detailing the medical necessity for the Experimental Program.
3. Proof must be provided that the Experimental Program has shown objective, observable or demonstrable medical benefit to other participants as well as proof of results that the claimant has benefited.
4. The expected frequency and duration of the Experimental Program requested must be approved.
5. Continuation of the program may be permitted if periodic evaluation by a physician shows the program to be of objective, observable or demonstrable medical benefit to the claimant.

If evaluation indicates other criteria should be considered they should be submitted for prior review.

Benefit Disagreements:

Disagreements may arise. If the Nurse Claim Supervisor is unable to resolve a

dispute the Executive Director will review and attempt to resolve with the parent or guardian. If the Executive Director cannot resolve a disagreement, then the parent or guardian may file a petition with the Division of Administrative Hearings. The address is:

Division of Administrative Hearings
1230 Apalachee Parkway
Tallahassee, FL 32399
Phone: (850) 488-9675
Fax: (850) 921-6847

Attachments:

A. Van Agreement

B. NICA Law - Sections 766.301 – 766.316, Florida Statutes.

C. How to contact us:

Florida Birth-Related Neurological
Injury Compensation Association
2360 Christopher Place Suite 1
Tallahassee, Florida 32308
1-800-398-2129 – Toll Free
(850) 488-8191 - Telephone
(850) 922-5369 – Facsimile
Website: www.nica.com

AGREEMENT GOVERNING NICA - PURCHASED VEHICLE

THIS AGREEMENT is entered into this _____ day of _____ 20___, by and between the Florida Birth-Related Neurological Injury Compensation Association ("NICA") and _____ ("Parents") as parents/guardians/person with custody of _____, ("Participant").

1. Participant is covered by NICA pursuant to Section 766.31, Florida Statutes, and it has been deemed medically necessary/desirable for a specially equipped vehicle ("Vehicle") to be provided for use in transporting Participant. NICA is willing to supply such a vehicle on the terms and conditions set forth in this Agreement and in consideration thereof Parents agree to abide by the terms and conditions of this Agreement.

2. NICA will pay the purchase price and associated costs of acquisition of the Vehicle, but NICA will not retain title to the Vehicle and shall have no legal responsibility or liability arising in any fashion from ownership or use of the Vehicle. Parent acknowledges that the Vehicle is not Parent's personal property and is to be used primarily for the benefit of Participant and because of Participant's NICA covered impairments. Any rebate or refund which may be forwarded to or received by the Parent as a result of NICA's purchase of the Vehicle shall be the sole property of NICA, and shall be forwarded or returned to NICA within ten (10) days of its receipt by Parent. In the event that any such rebate or refund is not returned to NICA, NICA may offset any other payments due to the Parent for any reason up to and including the amount of such refund and rebate.

3. The Vehicle shall be titled in the name of the Parent, as Custodian for Participant under the Florida Uniform Transfer to Minors Act. NICA shall be listed as a lien holder on the title certificate to the Vehicle, but the parties acknowledge that Parent and Participant shall not be obligated to repay NICA the purchase price of the Vehicle so long as Parent abides by all terms and conditions of this Agreement.

4. Receipt of the Vehicle herein described constitutes compensation for medically necessary and reasonable travel expenses on behalf of the Participant, and is in lieu of any additional claim or payments of mileage and other expenses for such travel, except as specifically authorized by NICA. If authorized by NICA, gasoline for medically necessary and pre-approved travel will be reimbursed at a rate of $.23 per mile for map mileage. NICA agrees to pay for all license tag/registration and renewals of same, tires, batteries, and other maintenance which may be reasonably necessary. Parent must provide receipts for reimbursement of maintenance. Any expenses in excess of $150.00 require pre-approval or they may not be reimbursed. Parent agrees to maintain the Vehicle according to the manufacture's service schedule. Parent acknowledges that failure to maintain the Vehicle in good repair will result in a shortened life of the Vehicle. Vehicles that fail to reach seven (7) years or 150,000 miles in working order will not be replaced. Parent agrees to maintain at a minimum the State minimum mandatory coverages, including bodily injury/property damage liability insurance with limits of $10/$20/$10, full comprehensive and collision insurance with a $500 deductible, basic personal injury protection (no fault) as well as any other insurance as may be required by the state of residence or other applicable law. The Parent agrees to obtain three estimates of coverage for the vehicle, and NICA will reimburse the lowest of the three. NICA will only reimburse for insurance coverage for the Parent or legal guardian. **NICA will not reimburse for increases in automobile insurance premiums attributable to a poor driving record of the Parent or for any additional driver.** If the vehicle is involved in an accident or loss, the insurance deductible is the responsibility of the Parent. NICA shall be listed as loss payee on the comprehensive and collision insurance. Failure to maintain insurance as required in this Agreement may result in loss of the van or the van not being replaced.

5. This Agreement shall be binding upon any successor custodian, guardian, or similar fiduciary who may act on behalf of the Participant. The Vehicle shall have a life of seven (7) years or 150,000 miles from the date of Parent's possession of the Vehicle, and the Parent agrees

to deliver possession of and transfer title to the Vehicle to NICA seven (7) years from the date of possession. In the event use of the Vehicle becomes no longer necessary for the benefit of Participant for any reason, Parent shall so notify NICA and shall deliver possession of and transfer title to the Vehicle to NICA.

6. The Vehicle subject to this Agreement is identified as follows:

Year/Make/Model: _____

Color: _____

Vehicle I.D. No: _____

IN WITNESS WHEREOF, the parties have signed this Agreement as indicated below:

PARENT:

_____ _____

Signature Print Name

STATE OF FLORIDA
COUNTY OF_____

The foregoing instrument was acknowledged before me this _____day of _____, 20___, by _____, who is personally known to me or who has produced_____ as identification and who did (or did not) take an oath.

_____
NOTARY PUBLIC - STATE OF FLORIDA

_____
Print, Type, or Stamp Name of Notary Public;
Commission Number and date of Expiration:

PARENT:

_____ _____
Signature Print Name

STATE OF FLORIDA
COUNTY OF_____

The foregoing instrument was acknowledged before me this _____day of _____, 20___, by _____, who is personally known to me or who has produced_____ as identification and who did (or did not) take an oath.

_____
NOTARY PUBLIC - STATE OF FLORIDA

_____
Print, Type, or Stamp Name of Notary Public;
Commission Number and date of Expiration:

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION (NICA):

By: _____ Date: _____

_____
Print Name and Title

STATE OF FLORIDA
COUNTY OF_____

The foregoing instrument was acknowledged before me this _____day of _____, 20___, by _____, who is personally known to me or who has produced_____ as identification and who did (or did not) take an oath.

_____
NOTARY PUBLIC - STATE OF FLORIDA

_____
Print, Type, or Stamp Name of Notary Public;
Commission Number and date of Expiration:

766.301 Legislative findings and intent.—

(1) The Legislature makes the following findings:

(a) Physicians practicing obstetrics are high-risk medical specialists for whom malpractice insurance premiums are very costly, and recent increases in such premiums have been greater for such physicians than for other physicians.

(b) Any birth other than a normal birth frequently leads to a claim against the attending physician; consequently, such physicians are among the physicians most severely affected by current medical malpractice problems.

(c) Because obstetric services are essential, it is incumbent upon the Legislature to provide a plan designed to result in the stabilization and reduction of malpractice insurance premiums for providers of such services in Florida.

(d) The costs of birth-related neurological injury claims are particularly high and warrant the establishment of a limited system of compensation irrespective of fault. The issue of whether such claims are covered by this act must be determined exclusively in an administrative proceeding.

(2) It is the intent of the Legislature to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation. This plan shall apply only to birth-related neurological injuries.

History.—s. 60, ch. 88-1; s. 1, ch. 98-113.

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

(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.

(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 shall not include disability or death caused by genetic or congenital abnormality.

(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.

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

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

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

(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 shall not apply to any physician who practices medicine as an officer, employee, or agent of the Federal Government.

(8) “Plan” means the Florida Birth-Related Neurological Injury Compensation Plan established under s. 766.303.

(9) “Family member” means a father, mother, or legal guardian.

(10) “Family residential or custodial care” means care normally rendered by trained professional attendants which is beyond the scope of participant 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 participant 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.

(c) The award of family residential or custodial care as defined in this section shall not be included in the current estimates for purposes of s. 766.314(9)(c).

History.—s. 61, ch. 88-1; s. 36, ch. 88-277; s. 16, ch. 91-46; s. 2, ch. 93-251; s. 307, ch. 96-410; s. 149, ch. 2001-277; s. 5, ch. 2002-401.

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 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, 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 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.

History.—s. 62, ch. 88-1; s. 37, ch. 88-277; s. 1, ch. 89-186; s. 1154, ch. 97-102; s. 74, ch. 2003-416.

766.304 Administrative law judge to determine claims.—The administrative law judge shall hear and determine all claims filed pursuant to ss. 766.301-766.316 and shall exercise the full power and authority granted to her or him in chapter 120, as necessary, to carry out the purposes of such sections. The administrative law judge has exclusive jurisdiction to determine whether a claim filed under this act is compensable. No civil action may be brought until the determinations under s. 766.309 have been made by the administrative law judge. If the administrative law judge determines that the claimant is entitled to compensation from the association, or if the claimant accepts an award issued under s. 766.31, no civil action may be brought or continued in violation of the exclusiveness of remedy provisions of s. 766.303. If it is determined that a claim filed under this act is not compensable, neither the doctrine

of collateral estoppel nor res judicata shall prohibit the claimant from pursuing any and all civil remedies available under common law and statutory law. The findings of fact and conclusions of law of the administrative law judge shall not be admissible in any subsequent proceeding; however, the sworn testimony of any person and the exhibits introduced into evidence in the administrative case are admissible as impeachment in any subsequent civil action only against a party to the administrative proceeding, subject to the Rules of Evidence. An award may not be made or paid under ss. 766.301-766.316 if the claimant recovers under a settlement or a final judgment is entered in a civil action. The division may adopt rules to promote the efficient administration of, and to minimize the cost associated with, the prosecution of claims.

History.—s. 63, ch. 88-1; s. 17, ch. 91-46; s. 3, ch. 93-251; s. 308, ch. 96-410; s. 1803, ch. 97-102; s. 2, ch. 98-113; s. 90, ch. 99-3; s. 75, ch. 2003-416.

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

(1) All claims filed for compensation under the plan shall commence by the claimant filing with the division a petition 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.

(2) The claimant shall furnish the division with as many copies of the petition as required for service upon the association, any physician and hospital named in the petition, and the Division of Medical Quality Assurance, along with a $15 filing fee payable to the Division of Administrative Hearings. Upon receipt of the petition, the division shall immediately serve the association, by service upon the agent designated to accept service on behalf of the association, by registered or certified mail, and shall mail copies of the petition, by registered or certified mail, to any physician, health care provider, and hospital named in the petition, and shall furnish a copy by regular mail to the Division of Medical Quality Assurance and the Agency for Health Care Administration.

(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 insurance, prepaid plan, HMO or governmental reimbusement.

(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(5)(b).

(4) The association shall have 45 days from the date of service of a complete claim, filed pursuant to subsections (1) and (2), in which to file a response to the petition and to submit relevant written information relating to the issue of whether the injury alleged is a birth-related neurological injury.

(5) Upon receipt of such petition, the Division of Medical Quality Assurance shall review the information therein and determine whether it involved conduct by a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459 that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

(6) Upon receipt of such petition, the Agency for Health Care Administration shall investigate the claim, and if it determines that the injury resulted from, or was aggravated by, a breach of duty on the part of a hospital in violation of chapter 395, it shall take any such action consistent with its disciplinary authority as may be appropriate.

(7) Any claim which the association determines to be compensable may be accepted for compensation, provided that the acceptance is approved by the administrative law judge to whom the claim for compensation is assigned.

History.—s. 64, ch. 88-1; s. 2, ch. 89-186; s. 18, ch. 91-46; s. 4, ch. 93-251; s. 1, ch. 94-106; s. 309, ch. 96-410; s. 1804, ch. 97-102; s. 165, ch. 98-166; s. 287, ch. 99-8; s. 226, ch. 2000-160; s. 115, ch. 2002-1; s. 76, ch. 2003-416.

766.306 Tolling of statute of limitations.—The statute of limitations with respect to any civil action that may be brought by, or on behalf of, an injured infant allegedly arising out of, or related to, a birth-related neurological injury shall be tolled by the filing of a claim in accordance with ss. 766.301-766.316, and the time such claim is pending or is on appeal shall not be computed as part of the period within which such civil action may be brought.

History.—s. 65, ch. 88-1.

766.307 Hearing; parties; discovery.—

(1) The administrative law judge shall set the date for a hearing no sooner than 60 days and no later than 120 days after the filing by a claimant of a petition in compliance with s. 766.305. The administrative law judge shall immediately notify the parties of the time and place of such hearing, which shall be held in the county where the injury occurred unless otherwise agreed to by the parties and authorized by the division.

(2) The parties to the hearing shall include the claimant and the association.

(3) Any party to a proceeding under ss. 766.301-766.316 may, upon application to the administrative law judge setting forth the materiality of the evidence to be given, serve interrogatories or cause the depositions of witnesses residing within or without the state to be taken, the costs thereof to be taxed as expenses incurred in connection with the filing of a claim. Such depositions shall be taken after giving notice and in the manner prescribed for the taking of depositions in actions at law, except that they shall be directed to the administrative law judge before whom the proceedings may be pending.

History.—s. 66, ch. 88-1; s. 19, ch. 91-46; s. 2, ch. 94-106; s. 310, ch. 96-410.

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

(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(2).

(b) Whether obstetrical services were delivered by a participating physician in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital; or by a certified nurse midwife in a teaching hospital supervised by a participating physician in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital.

(c) How much compensation, if any, is awardable pursuant to s. 766.31.

(d) Whether, if raised by the claimant or other party, the factual determinations regarding the notice requirements in s. 766.316 are satisfied. The administrative law judge has the exclusive jurisdiction to make these factual determinations.

(2) If the administrative law judge determines that the injury alleged is not a birth-related neurological injury or that obstetrical services were not delivered by a participating physician at the birth, she or he shall enter an order and shall cause a copy of such order to be sent immediately to the parties by registered or certified mail.

(3) By becoming a participating physician, a physician shall be bound for all purposes by the finding of the administrative law judge or any appeal therefrom with respect to whether such injury is a birth-related neurological injury.

(4) If it is in the interest of judicial economy or if requested to by the claimant, the administrative law judge may bifurcate the proceeding addressing compensability and notice pursuant to s. 766.316 first, and addressing an award pursuant to s. 766.31, if any, in a separate proceeding. The administrative law judge may issue a final order on compensability and notice which is subject to appeal under s. 766.311, prior to issuance of an award pursuant to s. 766.31.

History.—s. 68, ch. 88-1; s. 4, ch. 89-186; s. 21, ch. 91-46; s. 3, ch. 94-106; s. 312, ch. 96-410; s. 1805, ch. 97-102; s. 77, ch. 2003-416; s. 1, ch. 2006-8.

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 for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel. However, such expenses shall not include:

1. Expenses for items or services that the 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 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 infant has received reimbursement, or for which the 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 infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program. Expenses included under this paragraph shall be 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.

(b)1. Periodic payments of an award to the parents or legal guardians of the infant found to have sustained a birth-related neurological injury, which award shall not exceed $100,000. However, at the discretion of the administrative law judge, such award may be made in a lump sum.

2. Death benefit for the infant in an amount of $10,000.

(c) Reasonable expenses incurred in connection with the filing of a claim under ss. 766.301-766.316, including reasonable attorney's fees, which shall be subject to the approval and award of the administrative law judge. In determining an award for 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. Should there be a final determination of compensability, and the claimants accept an award under this section, the claimants shall not be liable for any expenses, including attorney's 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 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).

History.—s. 69, ch. 88-1; s. 5, ch. 89-186; s. 22, ch. 91-46; s. 4, ch. 94-106; s. 313, ch. 96-410; s. 150, ch. 2001-277; s. 6, ch. 2002-401; s. 78, ch. 2003-416.

766.311 Conclusiveness of determination or award; appeal.—

(1) A determination of the administrative law judge as to qualification of the claim for purposes of compensability under s. 766.309 or an award by the administrative law judge pursuant to s. 766.31 shall be conclusive and binding as to all questions of fact. Review of an order of an administrative law judge shall be by appeal to the District Court of Appeal. Appeals shall be filed in accordance with rules of procedure prescribed by the Supreme Court for review of such orders.

(2) In case of an appeal from an award of the administrative law judge, the appeal shall operate as a suspension of the award, and the association shall not be required to make payment of the award involved in the appeal until the questions at issue therein shall have been fully determined.

History.—s. 70, ch. 88-1; s. 23, ch. 91-46; s. 6, ch. 93-251; s. 314, ch. 96-410.

766.312 Enforcement of awards.—

(1) The administrative law judge shall have full authority to enforce her or his awards and to protect herself or himself from any deception or lack of cooperation in reaching her or his determination as to any award. Such authority shall include the power to petition the circuit court for an order of contempt.

(2) A party may, if the circumstances so warrant, petition the circuit court for enforcement of a final award by the administrative law judge.

History.—s. 71, ch. 88-1; s. 24, ch. 91-46; s. 5, ch. 94-106; s. 315, ch. 96-410; s. 1806, ch. 97-102.

766.313 Limitation on claim.—Any claim for compensation under ss. 766.301-766.316 that is filed more than 5 years after the birth of an infant alleged to have a birth-related neurological injury shall be barred.

History.—s. 72, ch. 88-1; s. 38, ch. 88-277; s. 1, ch. 93-251.

766.314 Assessments; plan of operation.—

(1) The assessments established 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 [1]Department of Insurance for review a plan of operation 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. The plan of operation 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 (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); and

5. Any other matters necessary for the efficient operation of the 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 an initial assessment in accordance with the plan of operation:

(a) On or before October 1, 1988, each hospital licensed under chapter 395 shall pay an initial assessment of $50 per infant delivered in 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 subsection (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, [2]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 (5) may not include any infant born to a charity participant (as defined by rule of the Agency for Health Care Administration) or born to a participant for whom the hospital receives Medicaid reimbursement, if the sum of the annual charges for charity participants 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.

(b)1. 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 initial assessment of $250, 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).

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) 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 initial assessment of $5,000. 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 paragraph (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 paragraph (5)(a) and who is supervised by a participating physician who has paid the assessment required by this paragraph and paragraph (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 participant 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).

(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 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 participants 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 [3]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.

(6)(a) The association shall make all assessments required by this section, except initial assessments of physicians licensed on or after October 1, 1988, which assessments will be made by the Department of Business and Professional Regulation, and except assessments of casualty insurers pursuant to subparagraph (5)(c)1., which assessments will be made by the Office of Insurance Regulation. Beginning October 1, 1989, for any physician licensed between October 1 and December 31 of any year, the Department of Business and Professional Regulation shall make the initial assessment plus the assessment for the following calendar year. The Department of Business and Professional Regulation shall provide the association, with such frequency as determined to be necessary, a listing, in a computer-readable form, of the names and addresses 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. The association shall be entitled to an award of attorney's 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 the provisions of chapters 47 and 48, the association may file such suit in either Leon County or the county of the residence of the defendant.

2. The Department of Business and Professional Regulation, upon notification by the association that an assessment has not been paid and that there is an unsatisfied judgment against a physician, shall not renew any license to practice for such physician issued pursuant to chapter 458 or chapter 459 until such time as 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 provision of law to the contrary.

(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 no less frequently than biennially. 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 of Insurance Regulation finds that the plan 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 participant, 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.

(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.

(c) In the event the total of all current estimates equals 80 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 subsections (4) and (5) and paragraph (7)(a), the association shall not accept any new claims without express authority from the Legislature. Nothing herein shall preclude the association from accepting any claim if the injury occurred 18 months or more prior to the effective date of this suspension. Within 30 days of 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, the Department of Health, and the Department of Business and Professional Regulation of this suspension.

(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.

History.—s. 73, ch. 88-1; s. 39, ch. 88-277; s. 44, ch. 88-294; s. 6, ch. 89-186; s. 103, ch. 92-33; s. 122, ch. 92-149; s. 1, ch. 92-196; s. 94, ch. 92-289; s. 66, ch. 93-268; s. 1, ch. 94-85; s. 248, ch. 94-218; s. 426, ch. 96-406; s. 1807, ch. 97-102; s. 81, ch. 97-237; s. 167, ch. 98-166; s. 288, ch. 99-8; s. 227, ch. 2000-160; s. 7, ch. 2002-401; s. 4, ch. 2003-258; s. 1901, ch. 2003-261; ss. 79, 84, ch. 2003-416.

[1]Note.—Duties of the Department of Insurance were transferred to the Department of Financial Services or the Financial Services Commission by ch. 2002-404, and s. 20.13, creating the Department of Insurance, was repealed by s. 3, ch. 2003-1.

[2]Note.—As amended by s. 4, ch. 2003-258, enacted at the 2003 Regular Session. Section 79, ch. 2003-416, enacted at Special Session D, 2003, failed to incorporate the amendment by s. 4, ch. 2003-258, adding the language "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."

[3]Note.—As amended by s. 1901, ch. 2003-261, enacted at the 2003 Regular Session. Section 79, ch. 2003-416, enacted at Special Session D, 2003, failed to incorporate the amendment by s. 1901, ch. 2003-261, which substituted a reference to the Office of Insurance Regulation for a reference to the Department of Insurance.

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

(1)(a) The Florida Birth-Related Neurological Injury Compensation Plan shall be governed by a board of five 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.

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

1. One citizen representative.

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.

(2)(a) The Chief Financial Officer may select the representative of the participating physicians from a list of at least three names to be recommended by the Florida Obstetric and Gynecologic Society; the representative of hospitals from a list of at least three names to be recommended by the Florida Hospital Association; the representative of casualty insurers from a list of at least three names, one of which is recommended by the American Insurance Association, one by the Alliance of American Insurers, and one by the National Association of Independent Insurers; and the representative of physicians other than participating physicians from a list of three names to be recommended by the Florida Medical Association and a list of three names to be recommended by the Florida Osteopathic Medical Association. In no case shall the Chief Financial Officer be bound to make any appointment from among the nominees of such respective associations.

(b) The Chief Financial Officer shall promptly notify the appropriate medical association upon the occurrence of any vacancy, and like nominations may be made for the filling of the vacancy.

(3) The directors shall not transact any business or exercise any power of the plan except upon the affirmative vote of three directors. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his or her official duties as a director of the plan in accordance with s. 112.061. The directors shall not be subject to any liability with respect to the administration of the plan.

(4) The board of directors shall have the power to:

(a) Administer the plan.

(b) Administer the funds collected on behalf of the plan.

(c) Administer the payment of claims on behalf of the plan.

(d) Direct the investment and reinvestment of any surplus funds over losses and expenses, provided that any investment income generated thereby remains credited to the plan.

(e) Reinsure the risks of the plan in whole or in part.

(f) Sue and be sued, and appear and defend, in all actions and proceedings in its name to the same extent as a natural person.

(g) Have and exercise all powers necessary or convenient to effect any or all of the purposes for which the plan is created.

(h) Enter into such contracts as are necessary or proper to administer the plan.

(i) Employ or retain such persons as are necessary to perform the administrative and financial transactions and responsibilities of the plan and to perform other necessary and proper functions not prohibited by law.

(j) Take such legal action as may be necessary to avoid payment of improper claims.

(k) Indemnify any employee, agent, member of the board of directors or alternate thereof, or person acting on behalf of the plan in an official capacity, for expenses, including attorney's fees, judgments, fines, and amounts paid in settlement actually and reasonably incurred in connection with any action, suit, or proceeding, including any appeal thereof, arising out of such person's capacity acting on behalf of the plan; provided that such person acted in good faith and in a manner he or she reasonably believed to be in, or not opposed to, the best interests of the plan and provided that, with respect to any criminal action or proceeding, the person had reasonable cause to believe his or her conduct was lawful.

(5)(a) Money may be withdrawn on account of the plan only upon a voucher as authorized by the association.

(b) All books, records, and audits of the plan are open for reasonable inspection to the general public, except that a claim file in the possession of the association or its representative is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution until termination of litigation or settlement of the claim, although medical records and other portions of the claim file may remain confidential and exempt as otherwise provided by law. Any book, record, document, audit, or asset acquired by, prepared for, or paid for by the association is subject to the authority of the board of directors, which is responsible therefor.

(c) Each person authorized to receive deposits, issue vouchers, or withdraw or otherwise disburse any funds shall post a blanket fidelity bond in an amount reasonably sufficient to protect plan assets, as determined by the plan of operation. The cost of such bond will be paid from the assets of the plan.

(d) Annually, the association shall furnish audited financial reports to any plan participantt 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 accepted 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.

(e) Funds held on behalf of the plan are funds of the State of Florida. The association may only invest plan funds in the investments and securities described in s. 215.47, and shall be subject to the limitations on investments contained in that section. All income derived from such investments will be credited to the plan. The State Board of Administration may invest and reinvest funds held on behalf of the plan in accordance with the trust agreement approved by the association and the State Board of Administration and within the provisions of ss. 215.44-215.53.

History.—s. 74, ch. 88-1; s. 40, ch. 88-277; s. 7, ch. 89-186; s. 2, ch. 94-85; s. 427, ch. 96-406; s. 1808, ch. 97-102; s. 3, ch. 98-113; s. 2, ch. 98-409; s. 1902, ch. 2003-261; s. 3, ch. 2006-8.

766.316 Notice to obstetrical participants of participation in the plan.—Each hospital with a participating physician on its staff and each participating physician, other than residents, assistant residents, and interns deemed to be participating physicians under s. 766.314(4)(c), under the Florida Birth-Related Neurological Injury Compensation Plan shall provide notice to the obstetrical participants as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a participant's rights and limitations under the plan. The hospital or the participating physician may elect to have the participant sign a form acknowledging receipt of the notice form. Signature of the participant acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements of this section have been met. Notice need not be given to a participant when the participant has an emergency medical condition as defined in s. 395.002(8)(b) or when notice is not practicable.

History.—s. 75, ch. 88-1; s. 8, ch. 89-186; s. 4, ch. 98-113; s. 91, ch. 99-3; s. 205, ch. 2007-230.

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