

Insurance & Banking Subcommittee

Thursday, January 29, 2026
9:30 AM - 11:30 AM
Morris Hall (17 HOB)

Meeting Packet

Daniel Perez
Speaker

Bradford Yeager
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Insurance & Banking Subcommittee

Start Date and Time: Thursday, January 29, 2026 09:30 AM

End Date and Time: Thursday, January 29, 2026 11:30 AM

Location: Morris Hall (17 HOB)

Duration: 2.00 hrs

Consideration of the following bill(s):

HB 271 Foreign and Alien Bail Bond Insurers by Valdés
HB 1291 Florida Birth-Related Neurological Injury Compensation Association by Anderson
HB 1311 Legal Tender by Bankson
HB 1343 Insurance Customer Representative Licensing Qualifications by Hodgers

NOTICE FINALIZED on 01/27/2026 4:31PM by Marks.Amie

HB 271

FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

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

BILL #: HB 271	**COMPANION BILL:** SB 642 (Burgess)
TITLE: Foreign and Alien Bail Bond Insurers	**LINKED BILLS:** None
SPONSOR(S): Valdés	**RELATED BILLS:** None

Committee References

Insurance & Banking ➤ Commerce

SUMMARY

Effect of the Bill:
The bill subjects foreign and alien bail bond insurers transacting in Florida to the current reporting requirements for domestic bail bond insurers.

Fiscal or Economic Impact:
The bill may have an indeterminate fiscal impact on foreign and alien bail bond insurers.

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION BILL HISTORY

ANALYSIS

EFFECT OF THE BILL:

The bill subjects foreign and alien bail bond insurers doing business in Florida to the current reporting requirements for domestic bail bond insurers. These include:

- reporting direct written premiums for bail bonds minus any amounts retained by licensed bail bond agents or appointed managing general agents;
- establishing that direct written premiums for bail bond insurance may not be reported as less than 6.5% of the total premiums received by agents for all bonds issued;
- applying the same reporting requirements to premiums assumed by foreign and alien bail bond insurers;
- keeping complete and accurate record of the total premiums amounts for all bail bonds written; and
- disclosing the following information within the insurer's annual statement filed with the Office of Insurance Regulation (OIR):
  - gross bail bond premiums written in each state by the agents of the insurer;
  - premium taxes incurred by the insurer in each state;
  - total premium withheld by agents and not reported as an expense in the insurer's financial statements; and
  - the amount of bail bond premiums included as surety in the insurer's financial statements. (Section 1)

The bill provides an effective date of July 1, 2026 (Section 2).

FISCAL OR ECONOMIC IMPACT:

PRIVATE SECTOR:

The bill may have an indeterminate impact on foreign and alien bail bond insurers due to expanded reporting, recordkeeping, and compliance requirements. Under current law, foreign and alien insurers may report lower premiums and, as result, potentially pay less taxes as compared to domestic bail bond insurers.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Types of Insurers in Florida

The Florida Insurance Code defines three types of insurers. Domestic insurers are insurers that are formed under the laws of Florida.[1] Foreign insurers are insurers formed under the laws of any state, district, territory, or commonwealth of the United States other than Florida.[2] Alien insurers are insurers that are not defined as domestic or foreign insurers.[3]

Active Bail Bond Insurers in Florida

According to OIR, there are 89 insurers who currently hold Certificates of Authority[4] to issue bail bonds. Of these insurers, 15 are considered domestic insurers and 74 are considered foreign insurers.[5]

Annual Statement Reporting Requirements

Authorized insurers in Florida must file annual statements with OIR containing information on their financial condition, transactions, and affairs. The statements must include information typically included on the insurer's financial statements following generally accepted insurance accounting principles and practices (GAAP). Annual statements must be filed by March 1st for the previous calendar year.[6] Each insurer's annual statement filing must include: [7]

- a statement of opinion on loss and loss adjustment expense reserves;
- an actuarial opinion summary;[8] and
- a certificate verifying that the assets required by OIR as a deposit have a market value equal to or in excess of the required deposit.

Domestic bail bond insurers are also required to provide additional information in the notes of their financial statements that comprise their annual report. The insurers must provide: [9]

- the gross bail bond premiums[10] written in each state by agents for the company;
- the amount of premium taxes incurred by the company in each state;
- the total premiums withheld by agents and not reported as an expense in the insurer's financial statements; and
- the amount of bail bond premiums included as surety in the insurer's financial statements.

Under current law, foreign and alien bail bond insurers are required to file an annual statement but are not required to disclose the additional information that domestic bail bond insurers must.

Bail Bond Premiums

When an individual purchases a bail bond, the bail bond agent keeps a portion of the premium earned while the insurer who financially guarantees the full court-ordered bail amount keeps the remainder.[11] Current law states

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[1] S. 624.06(1), F.S.
[2] S. 624.06(2), F.S.
[3] S. 624.06(3), F.S.
[4] "Certificate of Authority" is defined as the regulatory license issued by OIR allowing an insurer to transact insurance in Florida. S. 624.401(1), F.S.
[5] Stubbs, S. (Director of Legislative & Cabinet Affairs, OIR), "RE: Verification of Bail Bond Insurers", November 13, 2025.
[6] S. 624.424(1)(a), F.S.
[7] S. 624.411, F.S.
[8] S. 624.424(1)(b), F.S.
[9] S. 624.4094(4), F.S.
[10] "Gross bail bond premiums" means direct premiums written and reinsurance assumed. *See*, S. 624.4095(3), F.S.
[11] *See* S. 624.4094(1), F.S.

that the Legislature recognizes that agents typically retain a significant portion of the bail bond premium, not the insurer.[12]

In the state of Florida, bail bond premium fees are fixed amounts. Premiums are earned in full and considered nonrefundable as soon as a defendant is released from jail. For state bonds, premiums are 10% of the court-ordered bail amount whereas premiums for federal bonds are 15% of the court-ordered bail amount.[13] Bail bonds cannot be executed at a premium rate other than the rate filed and approved by OIR.[14]

Each domestic bail bond insurer is required to keep a complete and accurate record of the total premium amounts paid for all bail bonds written.[15]

Under current law, foreign and alien bail bond insurers are subject to the premium cap, but are not required to record premiums in the same manner as domestic bail bond insurers.

Reporting Direct Written Premiums

Current law requires domestic bail bond insurers to report direct written premiums as the actual amount of premiums they receive from the issuance of the bond. This is the total premium minus what agents retain. Regardless of the premium amount actually collected by the domestic insurer, the direct written premiums reported to OIR cannot be less than 6.5% of the total collected premiums by any agent on the insurer's behalf.[16]

Under current law, foreign and alien bail bond insurers are not subject to these provisions.

Reporting Premiums Assumed

Premiums assumed by a domestic bail bond insurer, either through reinsurance contracts or other risk arrangements, are also reported net of any amounts retained by agents. When reported to OIR, assumed premiums also cannot be less than 6.5% of the total collected premiums by an any agent on the insurer's behalf.[17]

Under current law, foreign and alien bail bond insurers are not subject to these provisions.

Bail Bond Premium Taxes

The tax base for bail bond insurers is the direct written premiums received for all bail bond policies issued in Florida excluding the amount kept by agents. Bail bond insurers owe the Florida Department of Revenue an amount equal to 1.75% of total premiums written in the preceding year, excluding the agent-retained portion, by March 1st each year[18].

Examples of Premium Reporting and Premium Taxes

Below are examples as to how domestic, foreign, and alien bail bond insurers are required to report their transacted premiums and pay taxes on such premiums under current law.

Domestic Bail Bond Insurers Reporting Premiums Inferior to the 6.5% Minimum Example

An individual purchases a bail bond for $1,000 and the bail bond agent keeps $950 of the $1,000 premium as their service fee. Even though domestic insurers report direct written premiums minus what the agent retained, the $50 actually retained by the domestic insurer does not satisfy the 6.5% minimum. Therefore, the domestic insurer must report at least $65 to OIR as the premium for the bail bond. The domestic insurer would then be taxed $1.14, or 1.75%, for the reported $65 premium.

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[12] S. 624.4094(1), F.S.
[13] Bail Bonds Overview, Florida Department of Financial Services, https://myfloridacfo.com/division/consumers/understanding-insurance/bail-bonds-overview (last visited Jan. 27, 2026).
[14] S. 648.33(2), F.S.
[15] S. 624.4094(3), F.S.
[16] *Id.*
[17] S. 624.4094(2), F.S.
[18] S. 624.509(1)(c), F.S.

Foreign and Alien Bond Insurers Reporting Premiums Example

An individual purchases a bail bond for $1,000 and the bail bond agent keeps $950 of the $1,000 premium as their service fee. Even though the foreign/alien insurer writes a total of $1,000 in premium, the direct written premium may be reported as the $50 the foreign/alien insurer actually retained, as it is not subject to the 6.5% minimum that domestic insurers are. The foreign/alien insurer would then be taxed $0.88, or 1.75%, for the reported $50 premium.

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Insurance & Banking Subcommittee			Brackett	Veigle
Commerce Committee				

A bill to be entitled

An act relating to foreign and alien bail bond insurers; amending s. 624.4094, F.S.; providing duties of certain foreign and alien bail bond insurers relating to reporting bail bond premiums to the Office of Insurance Regulation, keeping records of considerations paid for bail bonds written by the insurers, and disclosing certain information in the financial statements filed with the office; providing an effective date.

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

Section 1. Section 624.4094, Florida Statutes, is amended to read:

624.4094 Bail bond premiums.—

(1) The Legislature finds that a significant portion of bail bond premiums is retained by the licensed bail bond agents or appointed managing general agents. For purposes of reporting in financial statements required to be filed with the office pursuant to s. 624.424, direct written premiums for bail bonds by a domestic, foreign, or alien insurer doing business in this state shall be reported net of any amounts retained by licensed bail bond agents or appointed managing general agents. However, in no case shall the direct written premiums for bail bonds be

CODING: Words stricken are deletions; words underlined are additions.

less than 6.5 percent of the total consideration received by the agent for all bail bonds written by the agent. This subsection also applies to any determination of compliance with s. 624.4095.

(2) Premiums assumed by a domestic, foreign, or alien insurer shall be reported consistent with subsections (1) and (4) for purposes of filing financial statements with the office.

(3) Each domestic, foreign, or alien bail bond insurer shall keep complete and accurate records of the total consideration paid for all bail bonds written by such insurer.

(4) Each domestic, foreign, or alien bail bond insurer shall disclose the following information in the notes to the financial statement in the insurer's annual statement filed with the office.

(a) The gross bail bond premiums written in each state by agents for the company.

(b) The amount of premium taxes incurred by the company in each state.

(c) Total consideration withheld by agents and not reported as an expense by the insurer in financial statements filed with the office.

(d) The amount of bail bond premium included on the surety line of the annual statement filed with the office.

Section 2. This act shall take effect July 1, 2026.

CODING: Words stricken are deletions; words underlined are additions.

HB 1291

FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

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

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

Committee References

Insurance & Banking ➤ State Administration Budget ➤ Commerce

SUMMARY

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

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

Fiscal or Economic Impact:
The bill may have an indeterminate fiscal impact on state government and the private sector.

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION BILL HISTORY

ANALYSIS

EFFECT OF THE BILL:

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

Definition of "Participant"
The bill defines "participant" to mean "the person who suffered a birth-related neurological injury as an infant and who accepted compensation under the plan by final order entered by an administrative law judge pursuant to s. 766.309, F.S." (Section 2). The bill replaces the terms "infant" and "child" with "participant." According to NICA, 40% of its participants are adults.[1]

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

Petition Process

The bill revises the definition of "claimant" to mean any person who files a claim, regardless of whether they're seeking compensation or not. It also substitutes the term "injuries" for "injury claims." The bill also removes references to "compensation" from the petition filing process, allowing claimants who are neither the participant nor a family member of the participant to file a petition with the Division of Administrative Hearings (DOAH). (Sections 2, 3, and 4).

Medicaid and Health Care Coverage for the Participant

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

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

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

Compensation Awards

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

- Codifies coverage of medically necessary dental services.
- Expands coverage of behavioral health services for the participant's family. It adds coverage for psychotherapeutic services for any relative who resided with the participant, rather than only the father, mother, or legal guardians.
    - Such relatives will share in the aggregate annual benefit of $10,000 currently allotted for these services for those immediate family members. In addition, the bill expands the potential providers covered to include psychiatrists and psychotherapists who maintain equivalent licensure in another jurisdiction.
- Codifies coverage for legal costs associated with establishing and maintaining guardianship for a participant.
- Revises the current statutory benefit for transportation to provide family members, rather than only parents and guardians, with a reliable method of transporting the participant's wheelchair and medically necessary equipment. The bill expands the type of vehicles covered to include vehicles rather than just vans.
- Clarifies the coverage of housing assistance benefit of up to $100,000 for the life of the participant to include, but is not limited to, a down payment on a new home, and moving expenses. Currently, this benefit includes home construction and modification costs.
- Requires NICA to reimburse plan participants for the payment of major medical health insurance coverage, which includes the premium and any cost sharing incurred by the participant.
- Clarifies that NICA will not provide compensation for professional custodial care provided by a family member while such care is being provided by another person or entity or the family member is being compensated from another source of work during the same time for which compensation is sought from NICA.
- Expands the list of individuals eligible to receive a periodic payment of an award of up to $250,000 to include family members instead of only parents or legal guardians. (Section 6).

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

Financial Soundness of NICA

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

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

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

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

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

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

The bill requires that, if OIR determines that the plan lacks adequate cash flow for the following fiscal year pursuant to its review, OIR must authorize a transfer of up to $50 million from the Insurance Regulatory Trust Fund to NICA within 30 calendar days. Currently, OIR is authorized to transfer up to $20 million from the Insurance Regulatory Trust Fund if these conditions are met. (Section 7).

The bill requires that, if OIR finds that the plan is not likely to return to actuarial soundness before the next biennial review, OIR must, within 60 calendar days after this finding, order one or more of the following actions:

- Require each licensed casualty insurer writing liability insurance, malpractice insurance, and miscellaneous casualty insurance to pay into NICA an annual assessment that is calculated to generate a total amount no greater than the amount required to achieve actuarial soundness of the plan within 5 years after the date of the order.
    - The assessment must be made on the basis of net direct premiums written for the business activity used as the basis for each such insurer's inclusion as a funding source for the plan in the state during the prior year ending December 31, as reported to OIR, and must be in proportion that the net direct written premium written for each insurer on account of the business activity forming the basis for its inclusion in the plan bears to the aggregate net direct premiums for all such business activity written in this state by all such insurers.

  - The annual assessment is capped at 0.25 percent of the insurer's net direct premiums written. An assessment may not extend five years after the date of the order. Insurers are authorized to recoup their assessments through a surcharge on future policies, a rate increase applicable prospectively, or a combination of the two.
- Provide that, if the actuarial soundness cannot be achieved through the assessment on casualty insurers, OIR is authorized to increase the assessments on hospitals and physicians on a proportional basis to generate a total amount of revenue no greater than the amount required to maintain the plan on an actuarially sound basis. (Section 7).

The bill requires that if NICA finds that the plan is not actuarially sound and the insurer assessments and hospital and physician assessments are insufficient to achieve actuarial soundness of the plan, NICA must within 60 days of such finding, notify the Governor, the President of the Senate, the Speaker of the House of Representatives, and OIR. If NICA issues the notice, it may not accept any new claims without express authority from the Legislature. However, this provision does not preclude NICA from accepting any claim if the injury occurred 18 months or more before the effective date of the claim suspension. Under current law, for the 2025-2026 fiscal year, NICA is authorized to accept new claims during the fiscal year if the total current estimates exceed 100 percent of the funds on hand and the funds that will be available to NICA within the next 12 months. (Section 7).

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

Board of Directors

The bill substitutes the one board director representative for a parent or legal guardian of an injured infant with one family member of a participant. (Section 8).

Effective Date

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

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

The bill increases, from $20 million to $50 million, the funds that would be transferred from the Insurance Regulatory Trust Fund in the event NICA experiences inadequate cash flow. The Insurance Regulatory Trust Fund is used by DFS and OIR to cover their expenses in the discharge of their administrative and regulatory powers and duties, and the bill may reduce the funds available to cover those costs. NICA, on the other hand, would receive an additional $30 million to cover claims and expenses.

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

PRIVATE SECTOR:

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

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

RELEVANT INFORMATION

SUBJECT OVERVIEW:

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

In 1988, the Legislature established the Florida Birth-Related Neurological Injury Compensation Plan (Plan) to provide compensation, on a no-fault basis, for a limited class of catastrophic birth-related neurological injuries that result in unusually high costs for custodial care and rehabilitation. The Legislature ventured to design the Plan to stabilize and reduce malpractice insurance premiums for OB/GYNs.[2] To manage the Plan, the Legislature created the Florida Birth-Related Neurological Injury Compensation Association (NICA).[3]

Board of Directors

To manage the Plan, the Legislature created NICA as an independent association governed by a seven-member board of directors.[4] Although NICA is not a state agency, board, or commission, the Chief Financial Officer (CFO) appoints NICA board members for staggered terms of three years or until the CFO appoints their successors. While there is no limit on the number of terms a director may serve, current law prohibits a director from serving on the board for more than six consecutive years.[5] The Governor or CFO may remove a NICA board director from office for misconduct, malfeasance, misfeasance, or neglect of duty in office.[6]

Petition Process

DOAH Jurisdiction

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

Claim Adjudication

A prospective plaintiff must exhaust all administrative remedies at the Division of Administrative Hearings (DOAH)[10] before he or she may pursue medical malpractice litigation for a birth-related neurological injury. Current law vests the presiding administrative law judge (ALJ) with exclusive original jurisdiction to hear claims filed for birth-related neurological injury compensation under the Plan.[11] The ALJ makes a determination of

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[2] S. 766.301, F.S., s. 766.303(1), F.S.

[3] *See* S. 766.302(1), F.S.

[4] S. 766.315(1), F.S., s. 766.315(4), F.S. The board of directors is composed of one citizen representative, one representative of participating physicians, one representative of hospitals, one representative of casualty insurers, one representative of physicians other than participating physicians, one parent or legal guardian representative of an injured infant under the Plan, and one representative of an advocacy organization for children with disabilities.

[5] S. 766.315(1), F.S. The CFO may not appoint a participating physician named in a pending petition for a claim to the board. A NICA board member who is concurrently a participating physician may not vote on any board matter relating to a claim accepted for an award for compensation if the physician is named in the petition for the claim. s. 766.315(2)(a), F.S.

[6] S. 766.315(2)(c), F.S. Current law applies a code of ethics to board directors, the NICA executive director, and NICA senior manager employees. In addition, as a condition of employment, all prospective NICA employees must signa and submit a conflict-of-interest statement, which attests that they do not have a conflict of interest. s. 766.3145, F.S.

[7] *Shands Jacksonville Medical Center, Inc. v. Chavez*, 2024 WL 5059326 (Fla. 1st DCA 2024).

[8] *Shands Jacksonville Medical Center, Inc. v Chavez*, 416 So.3d 1226 (Fla. 1st DCA 2025).

[9] Florida Birth-Related Neurological Injury Compensation Association, *HB 1291/SB 1668 Florida Birth-Related Neurological Injury Compensation Association Summary and Analysis*, at 9, January 8, 2026.

[10] The Division of Administrative Hearings is housed within the Florida Department of Management Services.

[11] S. 766.304, F.S., s. 766.305(1), F.S. A claimant may appeal a DOAH order to the District Court of Appeal. s. 766.311, F.S.

whether a claim is compensable. To this end, the ALJ considers all available evidence related to the nature of the injury alleged as well as the immediate circumstances surrounding the alleged injury.[12]

Adjudication

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

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

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

Awards Approved without a Determination

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

Compensation Awards

Lifetime Benefits

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

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

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[12] S. 766.309, F.S.
[13] S. 766.31(1), F.S.
[14] S. 766.304, F.S.
[15] However, current law does permit plaintiffs to bring a civil action in cases where there is clear and convincing evidence of bad faith, malicious purpose, or willful and wanton disregard of human rights, safety, or property. S. 766.303(2), F.S.
[16] S. 766.304, F.S.
[17] S. 766.304, F.S. Current law tolls the five-year statute of limitations period for birth-related neurological injury administrative claims pending or on appeal. s. 766.306, F.S., see s. 766.313, F.S.
[18] S. 766.305(2), F.S.
[19] S. 766.305(7), F.S.
[20] S. 766.304, F.S.
[21] S. 766.31, F.S.

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

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

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

Intermittent Benefits
The Plan may also provide:

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

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

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

Medicaid Third-Party Payer Liability

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

In 2022, NICA entered into a settlement agreement with the United States to resolve a lawsuit[32] which alleged that NICA held itself out as the payer of last resort for Plan expenses and submitted false reimbursement claims to

[22] S. 766.31(1)(a), F.S.
[23] S. 766.31(1)(a), F.S.
[24] S. 766.31(1)(a), F.S.
[25] S. 766.31(1)(c), F.S.
[26] This one-time award is in addition to the other recoverable lifetime expenses. Each January 1st, the award cap authorized in current law will increase by 3 percent. As of January 1, 2026, this one-time cash award cap is $289,818.51.
[27] S. 766.31(1)(d), F.S.
[28] S. 766.31(2), F.S.
[29] THF Certified Public Accountants, *Florida Birth-Related Neurological Injury Compensation Association: Years ended June 30, 2025 and 2024 with Report of Independent Auditors*, at 6 (Sept. 9, 2025) https://nica.com/wp-content/uploads/2025/09/Audited-Financial-Statements-06-30-2025.pdf (last visited Jan. 9, 2026).
[30] S. 766.31(1)(b), F.S.
[31] S. 409.910, F.S. (which may be cited as the "Medicaid Third-Party Liability Act"); 42 C.F.R. § 433.136; 42 U.S.C. § 1396a.
[32] *U.S. ex. rel. Arven v. The Florida Birth-Related Neurological Injury Compensation Association, et al.*, No. 0:19-cv-61053 (S.D. Fla. 2019) and No. 20-13448 (11th Cir. 2022).

Medicaid in violation of the federal False Claims Act.[33] The settlement agreement declares that it does not constitute an admission of liability by NICA nor a concession by the United States that its claims are not well founded.[34] NICA paid $51 million plus interest to the federal government to settle the suit.[35]

In July 2025, AHCA and NICA formalized an interagency agreement to coordinate payment for Medicaid services for individuals dually enrolled in Medicaid and the Plan, with the Plan being the primary payor for services rendered. NICA reimburses AHCA for managed care capitation rate payments and fee-for-service payments made. AHCA is currently seeking an average of $11.5 million for state fiscal years 2022-2023 through 2024-2025 in reimbursable expenses from NICA.[36]

Financial Soundness of NICA

Provider Assessments

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

Hospitals

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

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

[34] *U.S. ex. rel. Arven supra* note 32, at 4 (available at https://nica.com/reports/medicaid-settlement/) (last visited Jan. 9, 2026).

[35] *Id*.

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

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

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

[39] THF Certified Public Accountants, *supra* note 29, at 6.

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

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

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

Participating Physicians

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

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

Other Physicians

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

Plan Assets and Liabilities

Current law declares that Plan funds are funds of the State of Florida.[49] Current law requires each person authorized to receive deposits, issue vouchers, or withdraw or otherwise disburse any funds to post a fidelity bond in an amount reasonably sufficient to protect Plan assets.[50] Current law requires the cost of fidelity bonds to be paid from Plan assets.[51]

Current law authorizes NICA to only invest Plan funds in the investment and securities described in s. 215.47, F.S. Investment income are Plan funds. NICA may approve a trust agreement with the State Board of Administration (SBA), where the SBA may invest and reinvest Plan funds within the provisions of s. 215.44-215.53.[52]

As of June 30, 2025, NICA's total assets increased by 8.08%, primarily due to an increase in investments, from approximately $1.4 billion to more than $1.5 billion. However, NICA's total liabilities remain greater than its total

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

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

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

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

[47] Brad Blystone, *A Statutory Primer: Birth-Related Neurological Injury Compensation Act*, Florida Medical Business (March/April 2012), https://marshalldennehey.com/sites/default/files/pdf-articles/O%20243%20by%20B.%20Blystone%20%2803_04.12%29.pdf (last visited Jan. 28, 2026).

[48] S. 766.314(4)(b), F.S., s. 766.314(5)(a), F.S.

[49] S. 766.315(5)(f), F.S.

[50] Current law prohibits withdrawals of funds from the Plan unless NICA authorizes a withdrawal voucher. s. 766.315(5)(a), F.S.

[51] S. 766.315(5)(d), F.S.

[52] S. 766.315(5)(f), F.S.

assets; NICA's total liabilities amount to $1.7 billion for 2025, which increased by almost $100 million from 2024 levels.
This means NICA has a deficit net position of approximately $189.3 million. Notwithstanding this figure, NICA's deficit net position is an improvement from June 30, 2024, where NICA's deficit net position was about $216.6 million. This indicates that, for the moment, the growth in total assets currently exceeds the growth of total liabilities, which was 5.31% year-over-year. The independent auditors of NICA's financial statements attribute the increase is total liabilities to an increase in claim reserves. [53]

The independent auditors' report also notes that the five-year change in average claim size for an open active claim increased from $3.68 million (June 30, 2020) to $5.42 million (June 30, 2025). The average number of open claims increased from 225 to 261. During this same five-year period, NICA's overall claims reserve liability increased by $660.5 million while the annual revenues from assessments only increased by $10.2 million.[54]

Claims Management

Current law requires NICA to estimate the present value of a new claim's total cost within 60 days after a claimant files a claim for a birth-related neurological injury.[55] NICA must revise its initial estimate for a claim each quarter based upon the actual costs incurred and any additional information that becomes available to the association since the last review of such estimate, deducting amounts paid by NICA towards the claim balance.[56]

In the event the total liability of all claim estimates equals or exceeds 100% of the Plan's cash flow, which includes cash-on-hand and all provider assessments received during the next 12-month period, current law prohibits NICA from accepting any new claims for birth-related neurological injuries without express legislative authorization.[57] If this freeze on new claims occurs, NICA must notify the Governor, the Speaker of the House of Representatives, the President of the Senate, OIR, AHCA, and the Department of Health of the claims freeze within the first 30 days.[58]

NICA's quarterly calculation at September 2023 revealed that NICA came within $2 million of breaching the liability-to-cash-flow threshold. The Plan's ratio of assets to liabilities was about 89%, which NICA attributes to a significant loss in market value due to aggressive interest rate hikes by the Federal Reserve in response to inflation during the preceding 17 months.[59]

If the claims freeze precludes a prospective plaintiff from asserting a claim for a birth-related neurological injury against NICA, current law waives his or her requirement to exhaust all administrative remedies with DOAH and NICA before pursuing medical malpractice litigation.[60]

Actuarial Soundness

Current law requires NICA to inform the Legislature of its determination as to the annual cost of maintaining the Plan on an actuarially sound basis.[61] Current law also requires OIR to conduct an actuarial valuation of the Plan's assets and liabilities on a biennial basis.[62] Should a time come when these funds prove insufficient to keep the Plan

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[53] THF Certified Public Accountants, *supra* note 29 at 5.
[54] THF Certified Public Accountants, *supra* note 29 at 25.
[55] The total cost analysis includes the estimated amount to be paid to the claimant, the claimant's attorney, the attorney's fees of the association incident to the claim, and any other expenses that are reasonably anticipated to be incurred by the association in connection with the adjudication and payment of the claim. NICA factors in the maximum benefits for noneconomic damages. s. 766.314(9)(a), F.S.
[56] S. 766.314(9)(b), F.S.
[57] S. 766.314(9)(c), F.S. Notwithstanding this suspension, current law authorizes NICA to accept new claims as long as the birth-related neurological injury occurred at least 18 months prior to the effective date of the suspension. NICA may also accept all new claims during the 2025-2026 fiscal year if the total of all current estimates exceeds prescribed limits.
[58] S. 766.314(9)(c), F.S.
[59] Florida Birth-Related Neurological Injury Compensation Association, *supra* note 9, at 14, January 8, 2026.
[60] S. 766.314(9)(d), F.S.
[61] S. 766.314(8), F.S.
[62] S. 766.314(7), F.S.

actuarially sound, current law authorizes OIR to transfer another $20 million from the Insurance Regulatory Trust Fund to the Plan.[63]

In the event the additional $20 million transfer is insufficient to bring the Plan back to actuarial soundness, current law authorizes OIR to levy an annual assessment on licensed casualty insurance carriers, not to exceed 0.25% of its net direct premiums written individually.[64] If OIR finds that NICA cannot maintain the Plan on an actuarially sound basis, current law requires OIR to increase provider assessments on a proportional basis.[65]

In 2024, the Legislature required NICA, in consultation with OIR and AHCA, to provide a report by September 1, 2024, to the Governor, CFO, President of the Senate, and the Speaker of the House of Representatives that recommends how to define actuarial soundness for NICA, how to structure a reporting obligation timeline for actuarial soundness updates, and how to ensure a sufficient revenue level for NICA to maintain actuarial soundness.[66] Pursuant to this directive, NICA recommends that:

- the funding ratio of assets-to-liabilities should be used as a point-in-time measure of actuarial soundness and as a key indicator for revenue increases;
- actuarial soundness accounts for net cash flow;
- NICA posts funding ratios for each quarter on its website to document adherence to reporting timelines;
- NICA requests any increase in provider assessments as a percentage of the reserve requirement in relation to the funding ratio, subject to OIR approval; and
- the casualty insurer assessment becomes the last option for additional Plan revenue.[67]

RECENT LEGISLATION:

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

OTHER RESOURCES:

2025 NICA Actuarial Report (June 30, 2025)
2025 NICA Audited Financial Statements (September 2025)
Agency for Health Care Administration Report on NICA as Third-Party Benefit Payer (November 2021)
Auditor General Operational Audit of NICA (October 2023)
Medicaid Settlement Agreement (December 2022)
NICA Report on Actuarial Soundness (September 2024)
Legislatively Mandated Report (January 2026)

[63] S. 766.314(5)(b), F.S.
[64] S. 766.314(5)(c), F.S. Casualty insurance carriers may recover their initial and annual assessments through a surcharge on future policies, a rate increase applicable prospectively, or a combination of the two.
[65] S. 766.314(7), F.S.
[66] Ch. 2024-182, Laws of Fla.
[67] Florida Birth-Related Neurological Injury Compensation Association, *Report on Actuarial Soundness: September 2024*, at 3 (Sept. 2024) https://nica.com/wp-content/uploads/2025/06/NICA-Report-on-Actuarial-Soundness-%E2%80%93-September-2024-Final.pdf (last visited Jan. 11, 2026).

U.S. ex. rel. Arven v. Florida Birth-Related Neurological Injury Compensation Association, 2020 WL 5540367 (S.D. Fla. September 8, 2020)
U.S. ex. rel. Arven v. Florida Birth-Related Neurological Injury Compensation Association, 2022 WL 1180142 (11th Cir. April 22, 2022)

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Insurance & Banking Subcommittee			Brackett	Miguez
State Administration Budget Subcommittee				
Commerce Committee				

A bill to be entitled

An act relating to the Florida Birth-Related Neurological Injury Compensation Association; amending s. 409.910, F.S.; requiring the agency to recover the full amount of medical assistance from the neurological injury compensation association; amending s. 766.302, F.S.; providing and revising definitions; amending s. 766.303, F.S.; revising the exclusiveness of remedy under the Florida Birth-Related Neurological Injury Compensation Plan; amending s. 766.305, F.S.; revising provisions relating to filing claims; amending s. 766.309, F.S.; conforming a cross-reference; amending s. 766.31, F.S.; revising items that are eligible for an award providing compensation; requiring compensation to be provided for certain actual expenses; requiring compensation for the costs of major medical health coverage; requiring the plan to reimburse certain payments made for services provided; exempting expenses for professional custodial care in certain circumstances; requiring that, upon entry of a final order for compensation, parents or legal guardians obtain private health insurance or submit an application for the Medicare program; amending s. 766.314, F.S.; requiring the directors to maintain a plan of operation; requiring

certain assessments to be paid into the Florida Birth-Related Neurological Injury Compensation Association at certain times for certain purposes; requiring the plan of operation to include a provision for fraud; removing obsolete provisions; revising provisions relating to an actuarial valuation of the plan; requiring the association to submit quarterly estimates; requiring the association to state whether the plan is actuarially sound; authorizing a transfer of funds to the association from the Insurance Regulatory Trust Fund if the plan is not actuarially sound; requiring the association to require each entity to issue casualty insurance and pay an annual assessment; providing requirements for annual assessments; requiring an increase in assessments after certain findings; requiring the association to determine whether the plan is actuarially sound after certain revisions; providing criteria for such determination; requiring notification to the Governor, Legislature, and Office of Insurance Regulation after certain findings; amending s. 766.315, F.S.; revising membership of the directors of the association; providing an effective date.

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

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

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

(7) The agency shall recover the full amount of all medical assistance provided by Medicaid on behalf of the recipient to the full extent of third-party benefits.

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

1. Any third party;

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

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

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

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

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

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

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

(1) "Actuarially sound" means that the total plan assets available to fund future liabilities are equal to or greater than 90 percent of the present value of total estimated liabilities excluding any risk margin.

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

(3)~~(1)~~ "Association" means the Florida Birth-Related

Neurological Injury Compensation Association established in s. 766.315 to administer the Florida Birth-Related Neurological Injury Compensation Plan and the plan of operation established in s. 766.314.

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

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

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

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

guardian.

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

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

(b) If the family member is employed and elects to leave that employment to provide such care, the per-hour value of that care shall equal the rates established by Medicaid for private duty services provided by a home health aide. A family member or a combination of family members providing care in accordance with this definition may not be compensated for more than a total of 10 hours per day. Family care is in lieu of professional residential or custodial care, and no professional residential or custodial care may be awarded for the period of time during the day that family care is being provided.

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

(10) "Participant" means the person who suffered a birth-related neurological injury as an infant and who accepted compensation under the plan by final order entered by an administrative law judge pursuant to s. 766.309.

(11)~~(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.

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

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

Section 3. Section 766.303, Florida Statutes, is amended to read:

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

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

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

(3) Sovereign immunity is hereby waived on behalf of the Florida Birth-Related Neurological Injury Compensation Association solely to the extent necessary to assure payment of compensation as provided in s. 766.31.

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

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

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

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

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

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

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

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

(e) The time and place the injury occurred.

(f) A brief statement of the facts and circumstances

surrounding the injury and giving rise to the claim.

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

(a) All available relevant medical records relating to the birth-related neurological injury and a list identifying any unavailable records known to the claimant and the reasons for the records' unavailability.

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

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

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

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

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

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

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

(a) Whether the injury claimed is a birth-related neurological injury. If the claimant has demonstrated, to the satisfaction of the administrative law judge, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury and that the infant was thereby rendered permanently and substantially mentally and physically impaired, a rebuttable presumption shall arise that the injury is a birth-related neurological injury as defined in s. 766.302 ~~s. 766.302(2)~~.

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

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

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

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

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

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

3. Dental services.

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

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

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

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

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

9. ~~for~~ Related travel.

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

1. Psychotherapeutic services for ~~A total annual benefit of up to $10,000 for immediate~~ family members and other relatives who have resided ~~reside~~ with the participant, which are ~~infant for psychotherapeutic services~~ obtained from a psychiatrist licensed under chapter 458 or chapter 459, a provider ~~providers~~ licensed under chapter 490 or chapter 491, or a psychiatrist or provider who has equivalent licensure by another jurisdiction. This benefit for such family members and relatives shall be up to a total of $10,000 annually during the participant's lifetime and up to a total of $20,000 subsequent to the participant's death.

2. For the life of the participant ~~child~~, providing family

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

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

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

(c) The costs of major medical health coverage for the participant obtained pursuant to subsection (3), including, but not limited to, the premium and out-of-pocket costs. For participants enrolled in Florida Medicaid, the plan must reimburse fee-for-service paid claims and capitation payments, as applicable, for services to persons enrolled in the Medicaid program for compensation pursuant to this section and for the administrative and support costs associated with the provided

medical assistance. Such funds shall be credited to the Agency for Health Care Administration Medical Care Trust Fund.

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

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

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

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

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

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

a. Care and supervision of the participant is

simultaneously being provided by another person or entity; or

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

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

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

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

(g)1. ~~(d)1.a.~~ Periodic payments of an award to the family members ~~parents or legal guardians~~ of the participant ~~infant found to have sustained a birth-related neurological injury,~~ which award may not exceed $100,000. However, at the discretion of the administrative law judge, such award may be made in a lump sum. Beginning on January 1, 2021, the award may not exceed $250,000, and each January 1 thereafter, the maximum award

authorized under this paragraph shall increase by 3 percent.

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

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

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

(h)~~(e)~~ 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 ~~are~~ not be liable for any expenses, including attorney fees, incurred in connection with the filing of a claim under ss. 766.301-766.316 other than those expenses awarded under this section.

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

(3) A family member must continuously maintain comprehensive major medical health coverage for the participant.

(a) If the participant does not have such coverage at the time of entry of a final order by an administrative law judge

approving a claim for compensation, the family member must obtain coverage within 60 days after entry of such order or apply for Medicaid coverage within 30 days after entry of such order.

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

(c) A family member of an individual who is a participant on June 30, 2026, must obtain the required coverage for the participant by January 1, 2027.

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

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

766.314 Assessments; plan of operation.—

(1) The assessments established 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 maintain ~~submit to the 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 (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 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 shall be 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)(d), 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)(d) ~~(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)(d), ~~(5)(a)~~ and who is supervised by a participating physician who has paid the assessment required by this paragraph and, if

assessed, paragraph (7)(d) ~~(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 shall 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 10 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 up to $50 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. These 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 health and, if assessments were ordered by the office under this paragraph, projected revenues for such assessments.

(e) If the association 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 60 days after such finding, notify the Governor, the President of the Senate, the Speaker of the House of Representatives, and the office. If the plan issues

the notice, 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 ~~cannot be maintained on an actuarially sound basis based on the assessments and appropriations listed in subsections (4) and (5), the office shall increase the assessments specified in subsection (4) on a proportional basis as needed~~.

~~(8) The association shall report to the Legislature its determination as to the annual cost of maintaining the fund on an actuarially sound basis. In making its determination, the association shall consider the recommendations of all hospitals, physicians, casualty insurers, attorneys, consumers, and any associations representing any such person or entity. Notwithstanding the provisions of s. 395.3025, all hospitals, casualty insurers, departments, boards, commissions, and legislative committees shall provide the association with all relevant records and information upon request to assist the association in making its determination. All hospitals shall, upon request by the association, provide the association with information from their records regarding any live birth. Such information shall not include the name of any physician, the name of any hospital employee or agent, the name of the patient, or any other information which will identify the infant involved~~

~~in the birth. Such information thereby obtained shall be utilized solely for the purpose of assisting the association and shall not subject the hospital to any civil or criminal liability for the release thereof. Such information shall otherwise be confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.~~

Section 8. Subsection (1) of section 766.315, Florida Statutes, is amended to read:

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

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

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

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

1. One citizen representative who is not affiliated with

any of the groups identified in subparagraphs 2.-7.

2. One representative of participating physicians.

3. One representative of hospitals.

4. One representative of casualty insurers.

5. One representative of physicians other than participating physicians.

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

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

Section 9. This act shall take effect July 1, 2026.

HB 1311

FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

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

BILL #: HB 1311	**COMPANION BILL:** SB 1588 (Gruters)
TITLE: Legal Tender	**LINKED BILLS:** None
SPONSOR(S): Bankson	**RELATED BILLS:** None

Committee References

Insurance & Banking ➤ Commerce

SUMMARY

Effect of the Bill:
The bill ratifies rules promulgated by the Department of Financial Services and the Office of Financial Regulation in order for HB 999 (2025), which designates qualifying gold and silver coin as legal tender, to take effect. The bill amends the definition of "custodian of gold coin or silver coin," to clarify that it means a person or entity holding gold or silver coin that is intended to be able to be transferred for legal tender and does not include a person or entity holding gold or silver coin that is not intended to be used as legal tender.

Fiscal or Economic Impact:
The bill may have an indeterminate fiscal impact on the private sector.

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION BILL HISTORY

ANALYSIS

EFFECT OF THE BILL:

Definition of "custodian of gold coin or silver coin or custodian":
The bill amends the definition of "custodian of gold coin or silver coin," or "custodian," as used for purposes of transactional gold or silver, to provide that it means a person or entity safeguarding and storing gold or silver coin that is intended to be able to be transferred electronically for legal tender. The bill clarifies that the term does not include a person or entity holding gold or silver coin that is not intended to be used as legal tender. (Section 3).

Rule ratification pursuant to HB 999:
The bill ratifies rules promulgated by the Department of Financial Services ("DFS") and the Office of Financial Regulation ("OFR"), as required by HB 999(2025) in order for HB 999 to take effect. (Section 1).

The rules are described below:

- 69C-2.004–Definitions:
  - Defines "custodian of gold coin or silver coin" to have the same meaning as under Florida Statutes.
  - Defines "deposit or share insurance" as insurance afforded by either the Federal Deposit Insurance Corporation or the National Credit Union Share Insurance Fund.

- 69C-2.005–Designation of a Qualified Public Depository:
  - Clarifies that custodians of gold or silver coin do not have to maintain deposit or share insurance to become a qualified public depository and instead have to maintain an all-risk insurance policy.[1]

[1] Instead of maintaining deposit or share insurance, custodians of gold or silver coin must maintain insurance covering 100 percent of the full replacement value of the stored gold or silver coin under an all-risk insurance policy for loss, theft, damage, and employee dishonesty by an authorized insurer or eligible surplus lines insurer. Ss. 280.21, F.S. and 560.214(1)(i), F.S.

- Amends the qualified public depository application and contingent liability agreement forms to include gold and silver coin.

- 69C-2.016–Financial Information Reports by a Qualified Public Depository:
  - Amends the qualified public depository report forms to include gold and silver coin.

- 69C-2.022–Requirements of Public Depositors:
  - Amends the public deposit identification and acknowledgment form to include gold and silver coin.

- 69C-2.026–Administration of Payment of Losses:
  - Amends the public deposit claim form and agreement to include gold and silver coin.

- 69C-2.034–Disqualification, Suspension, and Administrative Penalty:
  - Provides that when determining the appropriate disciplinary action for a qualified public depository, the Chief Financial Officer will consider the violations of any Florida law or rule.

- 69C-2.035–Custodians of Gold Coin or Silver Coin:
  - Provides that a qualified public depository that is a custodian of gold or silver coin may not hold public deposits other than gold or silver coin, unless they have deposit or share insurance.

- 69U-100.097–Gold Coin or Silver Coin Deposits:
  - Provides requirements for any financial institution that intends to accept gold or silver coin deposits or otherwise hold it on behalf of its customers, members, or the public.

- 69V-560.1000–Disciplinary Guidelines:
  - Creates disciplinary guidelines for money services businesses related to gold or silver coin, such as imposing fines and suspending licenses for violations.[2]

- 69V-560.1012–Adoption of Forms:
  - Amends the money services business license application and quarterly report forms to incorporate gold and silver coin.
  - Creates a gold and silver coin disclosure form for money services businesses that must be provided to customers before the purchase of a product or service related to gold or silver coin.

- 69V-560.102–Application or Appointment Procedures and Requirements:
  - Provides that an applicant for a money services business license who intends to engage in conduct as a custodian of gold coin or silver coin is required to be examined by OFR prior to licensure.
  - Establishes procedures for examination and requires applicants to agree to schedule an examination within sixty days after notification by OFR that the applicant is ready for examination.
  - Provides that a material change[3] to a money services business application includes changes to whether the applicant intends to offer services related to gold or silver coin.
  - Requires licensed money services businesses who wish to become custodians of gold or silver coin to file a new money services business license application with OFR as well as a notice of termination of licensure, which is effective upon disposition of the new application by OFR.

- 69V-560.7032–Records to Be Maintained when Engaged in Transactions Involving Gold and Silver Coin:
  - Requires money services businesses that transmit, store, exchange, or accept payments in gold or silver coin to maintain and make available various records to OFR.

[2] The disciplinary guidelines can be found here, Disciplinary Guidelines (last visited Jan. 23, 2026).
[3] Requests to make material changes to applications for a money services business license are grounds for denial and a new application will be required. Rule 69V-560.102(6), F.A.C.

- 69V-560.7033–Gold Coin and Silver Coin Disclosures:
  - Requires money services businesses to make specific disclosures available to a customer before the customer purchases or uses a service or product related to gold or silver coin.

- 69V-560.7034–Accredited Refiner or Wholesaler of Gold Coin or Silver Coin:
  - Provides that an accredited refiner or wholesaler of gold coin or silver coin means a person who has received accreditation by the London Bullion Market Association ("LBMA").[4]

- 69V-560.7035–Chain of Custody Related to Gold or Silver Coin:
  - Creates chain of custody requirements for money services businesses for gold and silver coin, such as requiring documentation and maintenance of information on the owners, sellers, buyers, shippers and/or deliverers of gold and silver coin as well as details relating to the coin.

- 69V-560.7036–Rapid Response Time by Law Enforcement:
  - Provides criteria for determining whether a custodian of gold and silver coin is located in a manner that enables rapid response time by law enforcement.

Repeal of Section 18 of ch. 2025-100, Laws of Fla.:
The bill repeals Section 18 of ch. 2025-100, Laws of Fla. which provides that the provisions of HB 999 will be repealed on June 30, 2026, unless reviewed and saved from repeal through reenactment by the Legislature after ratification of the required rules. (Section 2).

Effective date:
The bill provides that the act shall take effect upon becoming a law. (Section 4).

FISCAL OR ECONOMIC IMPACT:

PRIVATE SECTOR:

The bill may have an indeterminate fiscal impact on the private sector, to the extent that amending the definition of "custodian of gold coin or silver coin" narrows the scope of who constitutes a custodian and therefore who must comply with applicable laws and regulations.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Financial Services Regulatory Bodies in Florida:
Florida's financial regulatory framework includes OFR and FSC. OFR is responsible for overseeing and licensing financial institutions, money services businesses, securities firms, and mortgage entities.[5] FSC, composed of the Governor and Cabinet, serves as the rulemaking body for OFR and provides overall policy direction.[6] OFR operates under the policy direction of FSC and enforces state financial laws and regulations. Together, these entities are responsible for implementing and enforcing Florida's financial regulatory laws.

Legal Tender under Federal and State Law:
Article I, Section 10, Clause 1 of the United States Constitution, prohibits states from coining money but permits them to "make gold and silver coin a tender in payment of debts."[7] This provision authorizes states to recognize

[4] LBMA is an international trade association representing the gold and silver bullion market. LBMA sets standards for trading precious metals. LBMA, *About Us,* https://www.lbma.org.uk/about-us/about-the-lbma (Last visited Jan. 26, 2026).
[5] S. 20.121(3), F.S.
[6] S. 20.121(3)(c), F.S.
[7] U.S. Const. art. 1. § 10. Cl. 1.

gold and silver coin as legal tender for the payment of debts and taxes but prohibits states from creating or issuing their own currencies or recognizing other forms of money as tender.[8]

Article I, Section 8, Clause 5 of the U.S. Constitution grants Congress the exclusive power to coin money and regulate its value.[9] However, Congress has not preempted state authority to recognize specie[10] as legal tender for state and private transactions.

Under 31 U.S.C. § 5103, only United States coins and currency (including Federal Reserve notes) are recognized as legal tender for the payment of debts, public charges, taxes, and dues. Foreign gold or silver coins are not legal tender for debts under federal law, though they may be lawfully bought, sold, and owned as commodities or investment assets.[11] However, a state may choose to recognize gold and silver coins as legal tender within its jurisdiction, though such coins would not have national legal tender status.

HB 999:

House Bill 999 ("HB 999"), which designates gold and silver coins as legal tender, passed the Legislature during the 2025 legislative session and was approved by the Governor on May 27, 2025. HB 999 required the Chief Financial Officer ("CFO") and the Financial Services Commission ("FSC") to adopt implementing rules by November 1, 2025, and required DFS and OFR to submit said rules as part of a joint report to the Governor and Legislature by November 1, 2025. HB 999 required the report to include implementation plans and any concerns or recommendations for additional legislation.[12]

The implementing rules adopted by the CFO and the FSC will not take effect unless ratified by the Legislature. The provisions requiring rule adoption and submission of a joint report took effect upon HB 999 becoming law. The remaining provisions of HB 999 are scheduled to take effect on July 1, 2026, subject to rule ratification. Section 18 of Chapter 2025-100, Laws of Fla. provides that if the Legislature does not ratify the rules, the provisions of HB 999 will be repealed on June 30, 2026.[13]

Legal tender designation:

HB 999 recognizes certain gold coin and silver coin as legal tender in Florida for the payment of debts incurred on or after July 1, 2026.[14] HB 999 defines key terms such as "gold coin"[15] and "silver coin"[16] and provides that only coin meeting specified purity and marking standards qualifies. No individual, business, or government entity is required to accept such coin unless agreed to by contract.[17]

[8] *Id*.
[9] U.S. Const. art. 1. § 8. Cl. 5.
[10] *Specie* refers to money in the form of coins, especially those made of gold or silver. See *Black's Law Dictionary* (11th ed. 2019) ("Specie: Coined money, as opposed to paper money; esp., gold or silver coins.").
[11] 31 U.S.C. § 5103.
[12] The required rules and report were submitted by the deadline.
[13] Ch. 2025-100, Laws of Fla.
[14] *Id.*
[15] HB 999 defines "gold coin" as a precious metal with the chemical element of atomic number 79 in solid form, in the shape of rounds, bars, ingots, or bullion coins, which is valued for its metal content and stamped or imprinted with its weight and purity and which solid form of chemical element atomic number 79 consists of at least 99.5 percent purity. The term does not include any goods as defined in s. 672.105(1), such as jewelry, other items of utility, such as picture frames, or collectables. Ch. 2025-100, Laws of Fla.
[16] HB 999 defines "silver coin" as a precious metal with the chemical element of atomic number 47 in solid form, in the shape of rounds, bars, ingots, or bullion coins, which is valued for its metal content and is stamped or imprinted with its weight and purity and which solid form of chemical element atomic number 47 consists of at least 99.9 percent purity. The term does not mean any goods as defined in s. 672.105(1), such as jewelry, other items of utility, such as picture frames, or collectables. Ch. 2025-100, Laws of Fla.
[17] Ch. 2025-100, Laws of Fla.

Sales and Use Tax:
HB 999 exempts from sales tax any gold or silver coin that is legal tender in Florida under the newly created legal tender statute.[18] HB 999 establishes a presumption of eligibility for this exemption if the coin is stamped with appropriate purity markings or transacted electronically.[19]

Licensing and Regulation of Custodians:
HB 999 defines "custodian of gold coin or silver coin" as any person or entity providing secure vault facilities to one or more persons for the safekeeping and storage of gold coin or silver coin, the ownership of which is or may be transferred electronically, and includes any person who holds gold or silver coin for more than 10 days.[20] The term does not include a person holding gold or silver coin for personal use as legal tender.[21]

HB 999 creates a distinct licensing framework for custodians of gold and silver coin by expanding the definition of money transmitters[22] to include such custodians, thereby requiring them to obtain a money transmitter license[23] and comply with regulatory examinations.[24]

Applicants seeking a money transmitter license to become a custodian of gold or silver coin must meet existing requirements for money transmitters and must comply with additional requirements for custodians, including submitting evidence of insurance coverage, secure physical custody, accreditation from an OFR-approved entity, and a statement of how the business will operate in a safe and sound manner.[25]

Custody of Public Deposits:
HB 999 requires custodians of gold or silver coin that hold public deposits to be meet the standards of a qualified public depository under Florida law.[26]

In Florida, institutions holding state funds must be a qualified public depository[27] under the Qualified Public Depository Act, which requires designation by the CFO, collateralization of public deposits,[28] reporting,[29] and compliance with minimum liquidity and solvency standards.[30] Generally, institutions must be federally insured, although limited exemptions may apply for entities that hold non-cash assets.[31]

[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] "Money transmitter" means a corporation, limited liability company, limited liability partnership, or foreign entity which receives currency, monetary value, a payment instrument, or virtual currency for the purpose of acting as an intermediary for transmission from one person to another location or person by any means, including transmission by wire, facsimile, electronic transfer, courier, the Internet, or through bill payment services or other businesses that facilitate such transfer within this country, or to or from this country. The term includes only an intermediary that has the ability to unilaterally execute or indefinitely prevent a transaction. S. 560.103(24), F.S.
[23] A money transmitter is one type of money services business. S. 560.103(23), F.S.
[24] *Id.*
[25] *Id.*
[26] Except that such custodians are not required to be insured by the Federal Deposit Insurance Corporation or the National Credit Union Share Insurance Fund.
[27] *See* S. 280.02(26), F.S. (defining "qualified public depository").
[28] *See* S. 280.04(1), F.S.
[29] *See* S. 280.16, F.S.
[30] *See* Rule 69C-2.026, F.A.C.
[31] *See* S. 280.03(3), F.S. (permitting exceptions to federal insurance requirements under certain conditions).

Money Services Businesses:
HB 999 requires money services businesses[32] who offer products or services involving gold or silver coin to comply with operational and disclosure requirements.[33] These include maintaining separate accounts for precious metal coin, insuring gold and silver coin at full replacement value, securely storing gold and silver coin with a licensed custodian, purchasing gold and silver coin only from accredited refiners or wholesalers, and making disclosures.[34]

Financial Institutions:
HB 999 requires financial institutions[35] that offer products or services related to gold coin to comply with operational and disclosure standards.[36] These include insuring the full replacement value of any coin held, maintaining separate accounts and accurate transaction records, complying with anti-money laundering laws, and making full disclosures to customers about their rights, fees, and the institution's obligations.[37] A financial institution may contract with a licensed custodian to physically hold gold or silver coin on its behalf but remains responsible for ensuring that the custodian complies with all applicable requirements.[38]

Precious Metals-Backed Electronic Payment Systems:
Precious metals-backed electronic payment systems are digital platforms that allow users to store and transact using units backed by physical precious gold or silver.[39] These systems allow users to maintain accounts denominated in gold or silver and spend from those accounts using debit cards or mobile applications.[40]

Such systems rely on physical bullion stored in secure vaults, often accredited by international organizations that set industry standards. Users may conduct transactions based on their bullion holdings and may redeem their digital balances for physical delivery of gold or silver.[41] While these systems offer an alternative to traditional fiat currency (government-issued currency that is not backed by a physical commodity) transactions, they are typically not insured by the Federal Deposit Insurance Corporation and are subject to various state and federal regulatory requirements, including anti-money laundering, cybersecurity, and fraud prevention measures.[42]

RECENT LEGISLATION:

YEAR	BILL #/SUBJECT	HOUSE/*SENATE* SPONSOR(S)	OTHER INFORMATION
2025	CS/HB 999 - Legal Tender	Bankson, LaMarca	The bill passed in 2025.

[32] A "money services business" is, any person located in or doing business in this state, from this state, or into this state from locations outside this state or country who acts as a payment instrument seller, foreign currency exchanger, check casher, or money transmitter. Money services businesses must be licensed with OFR. Ss. 560.103, F.S. and 560.125, F.S.
[33] Ch. 2025-100, Laws of Fla.
[34] *Id.*
[35] "Financial institution" means a state or federally regulated bank, savings or thrift association, trust company, credit union, or other entity authorized under state or federal law to conduct domestic or international banking, trust, or financial activities. S. 655.005(1)(i), F.S.
[36] Ch. 2025-100, Laws of Fla.
[37] *Id.*
[38] *Id.*
[39] Christian Bender, *A Gold Standard for the Internet? An Introductory Assessment*, 11 Electronic Markets p. 123 (2001), Electronic Markets (last visited Jan. 22, 2026).
[40] Bender, supra note 1, at 122.
[41] *Digital Gold: Understanding Cryptocurrency Backed by Physical Gold*, BlockApps (2023), Digital Gold (last visited Jan. 22, 2026).
[42] Lael Brainard, Governor, Bd. of Governors of the Fed. Rsrv. Sys., *The Digitalization of Payments and Currency: Some Issues for Consideration* (Feb. 5, 2020), Digitalization of Payments and Currency (last visited Jan. 22, 2026).

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Insurance & Banking Subcommittee			Brackett	Highsmith
Commerce Committee				

A bill to be entitled

An act relating to legal tender; ratifying specified rules relating to legal tender for the sole and exclusive purpose of satisfying any condition on effectiveness pursuant to chapter 2025-100, Laws of Florida; repealing s. 18 of chapter 2025-100, Laws of Florida, which repeals specified provisions relating to legal tender; amending chapter 2025-100, Laws of Florida; revising the definition of the terms "custodian of gold coin or silver coin" and "custodian"; providing an effective date.

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

Section 1. The following rules are ratified for the sole and exclusive purpose of satisfying any condition on effectiveness imposed under chapter 2025-100, Laws of Florida: Rules 69C-2.004, 69C-2.005, 69C-2.016, 69C-2.022, 69C-2.026, 69C-2.034, 69C-2.035, 69U-100.97, 69V-560.1000, 69V-560.1012, 69V-560.102, 69V-560.7032, 69V-560.7033, 69V-560.7034, 69V-560.7035, and 69V-560.7036, Florida Administrative Code, entitled "Definitions," "Designation of a Qualified Public Depository," "Financial Information Reports by a Qualified Public Depository," "Requirements of Public Depositors," "Administration of Payment of Losses," "Disqualification,

Suspension, and Administrative Penalty," "Custodians of Gold Coin or Silver Coin," "Gold Coin or Silver Coin Deposits," "Disciplinary Guidelines," "Adoption of Forms," "Application or Appointment Procedures and Requirements," "Records to Be Maintained when Engaged in Transactions Involving Gold and Silver Coin," "Gold Coin and Silver Coin Disclosures," "Accredited Refiner or Wholesaler of Gold Coin or Silver Coin," "Chain of Custody Related to Gold or Silver Coin," and "Rapid Response Time by Law Enforcement," respectively, as filed for adoption with the Department of State pursuant to the certification packages dated October 31, 2025, and November 1, 2025.

Section 2. Section 18 of chapter 2025-100, Laws of Florida, is repealed.

Section 3. Subsection (13) of section 4 of chapter 2025-100, Laws of Florida, is amended to read:

Section 4. Effective July 1, 2026, upon legislative ratification of rules of the Financial Services Commission and the Chief Financial Officer as provided in section 17 of this act, present subsections (13) through (19), (20) through (34), and (35) and (36) of section 560.103, Florida Statutes, are redesignated as subsections (14) through (20), (22) through (36), and (38) and (39), respectively, new subsections (13) and (21) and subsection (37) are added to that section, and present subsections (18) and (24) of that section are amended, to read:

560.103 Definitions.—As used in this chapter, the term:

(13) "Custodian of gold coin or silver coin," or "custodian," as used for purposes of transactional gold or silver, ~~"Custodian of gold coin or silver coin" or "custodian"~~ means any person or entity providing secure vault facilities to one or more persons for the safekeeping and storage of gold coin or silver coin, the ownership of which is intended to be able to ~~or may~~ be transferred electronically as defined in s. 215.986(1) for legal tender. The term includes any person who holds gold coin or silver coin for more than 10 days. The term does not include a person who holds gold coin or silver coin for personal use as legal tender, or a person or entity that holds gold or silver that is not intended to be used as legal tender.

Section 4. This act shall take effect upon becoming a law.

INSURANCE & BANKING SUBCOMMITTEE

HB 1311 by Rep. Bankson
Legal Tender

AMENDMENT SUMMARY
January 29, 2026

Amendment by Rep. Bankson (line 19):

- Makes a rule number correction from 69U-100.97 to 69U-100.097.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Insurance & Banking Subcommittee

Representative Bankson offered the following:

Amendment

Remove line 19 and insert:

69C-2.034, 69C-2.035, 69U-100.097, 69V-560.1000, 69V-560.1012,

FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

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

BILL #: HB 1343	**COMPANION BILL:** SB 1504 (Calatayud)
TITLE: Insurance Customer Representative Licensing Qualifications	**LINKED BILLS:** None
SPONSOR(S): Hodgers	**RELATED BILLS:** None

Committee References

Insurance & Banking ➤ Careers & Workforce ➤ Commerce

SUMMARY

Effect of the Bill:
The bill provides that an individual who has earned a high school diploma in Florida satisfies the education requirement for an insurance customer representative's license, if the individual took courses in personal finance and money management, economics and personal finance, and insurance and personal finance as part of the curriculum.

Fiscal or Economic Impact:
There may be an indeterminate impact on the private sector.

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION BILL HISTORY

ANALYSIS

EFFECT OF THE BILL:

The bill provides that an individual who has earned a diploma from a Florida high school which included 0.5 credit hour in Personal Finance and Money Management, 0.5 credit hour in Economics and Personal Finance, and 0.5 credit hour in Insurance and Personal Finance satisfies the education requirement for an insurance customer representative's license if the diploma was obtained within 4 years before filing the license application with the Department of Financial Services (DFS). (Section 1).

Currently, students entering high school in 2023 are already required to complete courses in personal financial literacy and money management as well as economics to earn a high school diploma.[1]

The bill provides an effective date of July 1, 2026. (Section 2).

FISCAL OR ECONOMIC IMPACT:

PRIVATE SECTOR:

There may be an indeterminate impact on the private sector to the extent that creating a new pathway to licensure may encourage more people to obtain an insurance customer representative's license.

[1] S. 1003.4282(3), F.S.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Insurance Customer Representatives

A customer representative is an individual appointed by a general lines agent or agency to assist them in transacting the business of insurance from the office of that agent or agency.[2]

Current law requires a general lines agent to supervise a customer representative. If an agency appoints a customer representative, then it must designate an agent to supervise the customer representative. A customer representative may only be appointed to one agency or agent at a time.[3] The license expires if the licensee is unappointed for 48 months.[4]

Customer representatives may perform the following functions:[5]

- Take insurance applications.
- Give quotes.
- Interpret policies.
- Explain procedures.
- Give insurance advice.
- Solicit new customers at the agent's office or by telephone from the office.
- Bind new or additional coverages.
- A customer representative may perform preliminary work to assist in processing a claim, including:
    - taking claims statements;
    - getting estimates;
    - advising claimants about procedures;
    - preparing claims paperwork;
    - taking photos; and
    - assembling or ordering claims files.
- Any other function consistent with assisting insurance agents in the transaction of property and casualty insurance which is consistent with the Florida Insurance Code or any DFS rule.

Customer representatives may not make or sign the actual substantive determination of the amount of a claim, loss, or damage payable, nor conduct settlement negotiations, settle a claim, or issue or sign claims checks or drafts.[6] A customer representative may not transact life insurance or any kind of insurance for which the agent or agency by which he or she is appointed does not have a license to transact.[7]

Qualifications to Obtain a Customer Representative License

To obtain a resident customer representative license, the applicant must be at least 18 years old, be a resident of Florida, be a United States citizen or a legal alien with valid employment authorization, and not hold a resident license in another state.[8]

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[2] S. 626.015(6), F.S.
[3] S. 626.7351(5), F.S. and s. 626.7353, F.S.
[4] Department of Financial Services, *Resident Customer Representative License*, https://www.myfloridacfo.com/docs-sf/insurance-agents-and-agency-services-libraries/agents-docs/licensure/agents-adjusters/4-40-resident-customer-representative.pdf (last visited Jan. 25, 2026).
[5] Fla. Admin Code R. 69B-213.130.
[6] *Id*.
[7] S. 626.7354(1), F.S.
[8] Department of Financial Services, *Resident Customer Representative License*, https://myfloridacfo.com/docs-sf/insurance-agents-and-agency-services-libraries/agents-docs/licensure/agents-adjusters/4-40-resident-customer-representative332ddeb4-13d4-4c18-90f8-e105361c41a3.pdf?sfvrsn=c31941aa_1 (last visited Jan. 24, 2026).

Additionally, the applicant must have been awarded one of the following designations within the last four years:[9]

- Accredited Advisor in Insurance (AAI) from the Insurance Institute of America.
- Accredited Customer Service Representative (ACSR) from the Insurance Institute of America.
- Associate in General Insurance (AINS) from the Insurance Institute of America.
- Certified Insurance Counselor (CIC) from the Society of Certified Insurance Service Counselors.
- Certified Insurance Representative (CIR) from the All-Lines Training provider.
- Certified Insurance Service Representative (CISR) from the Society of Certified Insurance Service Representatives.
- Certified Professional Service Representative (CPSR) from the National Foundation for CPSR.
- Chartered Property and Casualty Underwriters (CPCU) from the American Institute for Chartered Property Casualty Underwriters.
- Insurance Customer Service Representative (ICSR) from Statewide Insurance Associates LLC.
- Professional Customer Service Representative (PCSR) from the Professional Career Institute.
- Registered Customer Service Representative (RCSR) from an Accredited Postsecondary Institution.

An applicant may also qualify for licensure without earning one of the designations above if they earned a degree which includes at least nine credit hours of insurance instruction with specific instruction in property, casualty, and inland marine insurance from an accredited college or university.[10]

The license application requires a $50 fee.[11] Applicants must also submit fingerprint verification, and the associated fees which must be paid directly to the vendor who processes the fingerprints.[12]

High School Diploma Graduation Requirements

Beginning with students entering grade 9 in the 2023-2024 school year, students are required to earn one-half credit in personal financial literacy and money management. This instruction must include discussion of or instruction in the following:[13]

- Types of bank accounts offered, opening and managing a bank account, and assessing the quality of a depository institution's services.
- Balancing a checkbook.
- Basic principles of money management, such as spending, credit, credit scores, and managing debt, including retail and credit card debt.
- Completing a loan application.
- Receiving an inheritance and related implications.
- Basic principles of personal insurance policies.
- Computing federal income taxes.
- Local tax assessments.
- Computing interest rates by various mechanisms.
- Simple contracts.
- Contesting an incorrect billing statement.
- Types of savings and investments.
- State and federal laws concerning finance.
- Costs of postsecondary education, scholarships and grants, and student loans.

Additionally, students are required to complete one-half credit in economics as a graduation requirement for a standard high school diploma.[14]

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[9] S. 626.7351(3), F.S.
[10] *Id*.
[11] Department of Financial Services, *Fees & Payment Methods*, https://myfloridacfo.com/division/agents/licensing/agents-and-adjusters/fees (last visited Jan. 23, 2026).
[12] *Id*.
[13] S. 1003.4282(3)(h), F.S.
[14] S. 1003.4282(3)(d), F.S.

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Insurance & Banking Subcommittee			Brackett	Miguez
Careers & Workforce Subcommittee				
Commerce Committee				

A bill to be entitled

An act relating to insurance customer representative licensing qualifications; amending s. 626.7351, F.S.; revising the methods by which applicants can qualify for the customer representative license; providing an effective date.

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

Section 1. Subsection (3) of section 626.7351, Florida Statutes, is amended to read:

626.7351 Qualifications for customer representative's license.—The department shall not grant or issue a license as customer representative to any individual found by it to be untrustworthy or incompetent, or who does not meet each of the following qualifications:

(3) Within 4 years preceding the date that the application for license was filed with the department, the applicant has earned the designation of Accredited Advisor in Insurance (AAI), Associate in General Insurance (AINS), or Accredited Customer Service Representative (ACSR) from the Insurance Institute of America; the designation of Certified Insurance Counselor (CIC) from the Society of Certified Insurance Service Counselors; the designation of Certified Professional Service Representative (CPSR) from the National Foundation for CPSR; the designation of

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

Certified Insurance Service Representative (CISR) from the Society of Certified Insurance Service Representatives; the designation of Certified Insurance Representative (CIR) from All-Lines Training; the designation of Chartered Customer Service Representative (CCSR) from American Insurance College; the designation of Professional Customer Service Representative (PCSR) from the Professional Career Institute; the designation of Insurance Customer Service Representative (ICSR) from Statewide Insurance Associates LLC; the designation of Registered Customer Service Representative (RCSR) from a regionally accredited postsecondary institution in the state whose curriculum is approved by the department and includes comprehensive analysis of basic property and casualty lines of insurance and testing which demonstrates mastery of the subject; a diploma from a Florida high school which includes 0.5 credit hour in Personal Finance and Money Management, 0.5 credit hour in Economics and Personal Finance, and 0.5 credit hour in Insurance and Personal Finance; or a degree from an accredited institution of higher learning approved by the department when the degree includes a minimum of 9 credit hours of insurance instruction, including specific instruction in the areas of property, casualty, and inland marine insurance. The department shall adopt rules establishing standards for the approval of curriculum.

Section 2. This act shall take effect July 1, 2026.

INSURANCE & BANKING SUBCOMMITTEE

HB 1343 by Rep. Hodgers
Insurance Customer Representative Licensing Qualifications

AMENDMENT SUMMARY
January 29, 2025

Amendment #785921 by Rep. Hodgers (line 40):

- Removes the requirement for an individual to complete courses in personal finance & money management and economics & personal finance to satisfy the education requirement for an insurance customer representative's license through a high school diploma.
    - Maintains the requirement for an individual to complete a course in insurance & personal finance to satisfy the education requirement for an insurance customer representative's license through a high school diploma.
- Directs the Department of Education, in consultation with the Department of Financial Services, to develop a course in insurance & personal finance.
    - This course must be available to school districts beginning in the 2027-2028 school year and must include a comprehensive analysis of basic property and casualty lines of insurance.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Insurance & Banking Subcommittee

Representative Hodgers offered the following:

Amendment (with title amendment)

Remove lines 40-49 and insert:

a diploma from a Florida high school in which the applicant completed the insurance and personal finance course provided in s. 1003.4207; or a degree from an accredited institution of higher learning approved by the department when the degree includes a minimum of 9 credit hours of insurance instruction, including specific instruction in the areas of property, casualty, and inland marine insurance. The department shall adopt rules establishing standards for the approval of curriculum.

Section 2. Section 1003.4207, Florida Statutes, is created to read:

1003.4207 Insurance and personal finance course.—No later than January 1, 2027, the Department of Education, in consultation with the Department of Financial Services, shall develop a 0.5 credit course in insurance and personal finance which is available to school districts for use beginning with the 2027-2028 school year. The course must include a comprehensive analysis of basic property and casualty lines of insurance consistent with the instructional designations provided under s. 626.7351(3).

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

Remove line 5 and insert:
for the customer representative license; creating s. 1003.4207, F.S.; requiring the Department of Education, in consultation with the Department of Financial Services, to develop a specified insurance and personal finance course no later than a specified date; providing an