SECOND REGULAR SESSION

SENATE BILL NO. 706

92ND GENERAL ASSEMBLY

INTRODUCED BY SENATORS MATHEWSON, CASKEY AND WHEELER.

Pre-filed December 1, 2003, and ordered printed.

TERRY L. SPIELER, Secretary.

2892S.02I

AN ACT

To repeal sections 516.105, 538.210, and 538.225, RSMo, and to enact in lieu thereof eighteen new sections relating to medical malpractice.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 516.105, 538.210, and 538.225, RSMo, are repealed and eighteen new sections enacted in lieu thereof, to be known as sections 135.161, 135.163, 383.199, 383.200, 383.300, 383.303, 383.306, 383.309, 383.312, 383.315, 383.318, 383.321, 516.105, 538.210, 538.217, 538.225, 538.227, and 538.228, to read as follows:

135.161. As used in sections 135.161 and 135.163, the following words or phrases shall mean:

(1) "Eligible taxpayer", any physician, hospital, health maintenance organization, ambulatory surgical center, long-term care facility, dentist, registered or licensed practical nurse, optometrist, podiatrist, pharmacist, chiropractor, professional physical therapist, psychologist, physician-in-training, and any other person or entity that provides health care services under the authority of a license or certificate;

(2) "Medical malpractice insurance", insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as a result of the negligence or malpractice in rendering professional service by any health care provider;

(3) "Policy period", the period of time that an eligible taxpayer contracts with an insurance company to receive medical malpractice insurance.

135.163. 1. In order to encourage the retention of physicians and other

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

health care providers in this state, an eligible taxpayer shall be allowed a credit not to exceed ten thousand dollars per eligible taxpayer against the tax otherwise due pursuant to chapter 143, RSMo, not including sections 143.191 to 143.265, RSMo, in an amount equal to ten percent of the increase in amount paid by an eligible taxpayer for medical malpractice insurance premiums in the aggregate from one policy period to the next immediate policy period. For purposes of this section, the base policy period for calculation of the credit shall be the medical malpractice insurance policy in effect on August 28, 2004.

2. The tax credit allowed by this section shall be claimed by the taxpayer at the time such taxpayer files a return. Any amount of tax credit which exceeds the tax due shall be carried over to any of the next five subsequent taxable years, but shall not be refunded and shall not be transferable.

3. The director of the department of insurance and the director of the department of revenue shall jointly administer the tax credit authorized by this section. The director of the department of insurance shall enact procedures to verify the amount of the allowable credit and shall issue a certificate to each eligible taxpayer that certifies the amount of the allowable credit. Both the director of the department of insurance and the director of the department of revenue are authorized to promulgate rules and regulations necessary to administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

4. The tax credits issued pursuant to this section shall not exceed a total for all tax credits issued of fifteen million dollars per fiscal year.

5. The provisions of this section shall become effective on January 1, 2005, and shall expire on December 31, 2008.

383.199. 1. Notwithstanding any law or regulation to the contrary, beginning on the effective date of this act, no insurer authorized to sell medical malpractice liability insurance in this state shall:

(1) Increase the premium of any medical malpractice insurance liability policy in effect in Missouri on the effective date of this section, unless the insured knowingly and voluntarily contracts for increased coverage; or

(2) Cancel or nonrenew, or issue any notice of cancellation or nonrenewal for, any medical malpractice liability insurance policy in effect in Missouri on the effective date of this section, unless the insured is in material breach of a provision of the policy or unless the insured knowingly and voluntarily cancels or does not renew the policy; or

(3) Modify any provision of any medical malpractice insurance liability policy in effect in Missouri on the effective date of this section, which modification would have the effect of reducing, limiting or restricting the coverage of such policy from that coverage which was in effect on the effective date of this section.

2. Rates in effect on or before August 28, 2004, shall remain in effect until the effective date of a new rate filing approved pursuant to section 383.200.

383.200. 1. Notwithstanding the provisions of sections 383.037 and 383.160, no insurer shall issue or sell in the state of Missouri a policy insuring a health care provider, as defined in section 538.205, RSMo, for damages for personal injury or death arising out of the rendering of or failure to render health care services, unless the rates for such policy are approved by the director of the department of insurance.

2. The director of the department of insurance shall review and approve or reject rates pursuant to subsection 1 of this section based on the following factors:

(1) Rates shall not be excessive or inadequate, nor shall they be unfairly discriminatory;

(2) No rate shall be held to be excessive unless such rate is unreasonably high for the insurance provided with respect to the classification to which such rate is applicable;

(3) No rate shall be held to be inadequate unless such rate is unreasonably low for the insurance provided with respect to the classification to which such rate is applicable;

(4) Rates shall be based on Missouri loss experience and not the insurance company's or the insurance industry's loss experiences in states other than Missouri unless the failure to do so jeopardizes the financial stability of the insurer; provided however, that loss experiences relating to the specific proposed insured occurring outside the state of Missouri may be considered in allowing a surcharge to such insured's premium rate;

(5) Investment income or investment losses of the insurance company for the ten-year period prior to the request for rate approval may be considered in reviewing rates. Investment income or investment losses for a period of less than ten years shall not be considered in reviewing rates. Industry-wide investment income or investment losses for the ten-year period prior to the request for rate

approval may be considered for any insurance company that has not been authorized to issue insurance for more than ten years;

(6) The locale in which the health care practice is occurring;

(7) Inflation;

(8) Reasonable administrative costs of the insurer;

(9) Reasonable costs of defense of claims against Missouri health care providers;

(10) A reasonable rate of return on investment for the owners or shareholders of the insurer when compared to other similar investments at the time of the rate request; except that, such factor shall not be used to offset losses in other states or in activities of the insurer other than the sale of policies of insurance to Missouri health care providers;

(11) Rates shall reflect any impact resulting from any state or federal legislation regarding tort reform or medical malpractice insurance that directly or indirectly affects medical malpractice insurance rates. In determining the impact resulting from such state or federal legislation, the director shall use generally accepted actuarial techniques and standards; and

(12) Any other reasonable factors may be considered in the approval or rejection of the rate request.

3. Rate approval requests may be approved or denied based on any subcategory or subspecialty of the health care industry that the director determines to be reasonable.

4. The insurer may charge any reasonable additional premium or grant any reasonable discount rate to any health care provider based on the following criteria as it relates to a specified insured health care provider or other specific health care providers within the specific insured's employ or business entity:

(1) Loss experiences;

(2) Training and experience;

(3) Number of employees of the insured entity;

(4) Availability of equipment, capital, or hospital privileges;

(5) Loss prevention measures taken by the insured;

(6) The number and extent of claims not resulting in losses;

(7) The specialty or subspecialty of the health care provider;

(8) Access to equipment and hospital privileges; and

(9) Any other factors determined to be reasonable by the director.

5. Any rate application shall be approved or disapproved within sixty days, unless the director extends such period due to the applicant's failure to timely provide requested information.

6. The director of the department of insurance shall annually provide the governor and the general assembly a report as to the rate increases or decreases of the rates approved pursuant to this section and the number of requests disapproved pursuant to this section.

7. As used in this section, "insurer" includes every insurance company authorized to transact business in this state, every unauthorized insurance company transacting business pursuant to chapter 384, RSMo, every risk retention group, every insurance company issuing policies or providing benefits to or through a purchasing group, and any other person providing insurance coverage in this state.

8. The director of the department of insurance shall promulgate rules for the enforcement of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

383.300. As used in sections 383.300 to 383.321, the following terms mean:

(1) "Director", the director of the department of insurance;

(2) "Fund", the Missouri patients' compensation fund established pursuant to sections 383.300 to 383.321;

(3) "Health care provider", includes physicians, dentists, clinical psychologists, pharmacists, optometrists, podiatrists, registered nurses, physicians' assistants, chiropractors, physical therapists, nurse anesthetists, anesthetists, emergency medical technicians, hospitals, nursing homes, and extended care facilities; but shall not include any nursing service or nursing facility conducted by and for those who rely upon treatment by spiritual means alone in accordance with the creed or tenets of any well-recognized church or religious denomination;

(4) "Insurer", any insurance company, association, exchange, or legal entity authorized to issue policies of medical malpractice insurance in this state;

(5) "Medical malpractice insurance", insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as a result of the negligence or malpractice in rendering professional service by any health care provider.

383.303. 1. There is hereby created in the state treasury the "Missouri

Patients' Compensation Fund". Membership fees and premium surcharges collected pursuant to section 383.312 shall be deposited in the fund. Notwithstanding the provisions of section 33.080, RSMo, to the contrary, moneys in the Missouri patients' compensation fund shall not revert to the general revenue fund. Interest accruing to the fund shall be part of the fund. Moneys in the fund shall be invested and reinvested in the same manner as provided by law for the investment of other state funds in interest-bearing investments. All expenses of collecting, protecting, and administering the fund shall be paid from the fund.

2. The Missouri patients' compensation fund shall be used for the purpose of paying that portion of a medical malpractice claim, settlement, or judgment which is in excess of the limits expressed in section 383.318 or the maximum liability limits for which the health care provider is insured, whichever limit is greater. The fund is liable only for payment of claims against licensed health care providers in compliance with the provisions of sections 383.300 to 383.321 and includes reasonable and necessary expenses incurred in payment of claims and the fund's administrative expense. The fund shall not be liable for damages for injury or death caused by an intentional crime committed by a health care provider or an employee of a health care provider, whether or not the criminal conduct is the basis for a medical malpractice claim. The fund shall have no obligation for the payment of punitive damages rendered in any judgment. The state shall not be responsible for any costs, expenses, liabilities, judgments, or other obligations of the fund.

3. The maximum amount recoverable under the patient compensation fund for any single claim pursuant to sections 383.300 to 383.321 shall be established by the board by rule.

383.306. 1. There is hereby created within the department of insurance the "Patients' Compensation Board", which shall be composed of the director and nine members appointed by the governor with the advice and consent of the senate. The board shall be composed of:

(1) One member who is licensed to practice medicine and surgery in Missouri who is a doctor of medicine and who is on a list of nominees submitted to the director by an organization representing Missouri's medical society;

(2) One member who is a doctor of osteopathy and who is on a list of nominees submitted to the director by an organization representing Missouri doctors of osteopathy;

(3) One member who is a licensed nurse in Missouri and who is on a list submitted to the director by an organization representing Missouri nurses;

(4) One member who is a representative of Missouri hospitals and who is on a list of nominees submitted to the director by an organization representing Missouri hospitals;

(5) Two members who are insurance representatives and who are on a list of nominees submitted to the director by the insurance industry;

(6) Two members who are attorneys that handle medical malpractice and who are on a list of nominees submitted to the director by an organization representing Missouri attorneys;

(7) One member of the general public appointed by the governor who is unaffiliated with the insurance or health care industries or the medical or legal professions; and

(8) The director.

2. The board is created to manage and operate the Missouri patients' compensation fund. The appointed members shall serve for a term of six years. Each member shall serve until a successor is appointed and qualified. The board must meet at the call of the director or a majority of the members but in any event it must meet at least once a year. A majority of the board members shall constitute a quorum for the transaction of any business of the board. The affirmative vote by a majority of the quorum present at a duly called meeting after notice is required to exercise any function of the board.

3. The board may promulgate any regulations necessary to carry out the provisions of sections 383.300 to 383.324. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

4. When a vacancy occurs in the membership of the board created by this section, the governor, with the advice and consent of the senate, shall appoint a successor of like qualifications from a list of three nominees submitted to the director by the professional society or association prescribed by this section. Whenever a vacancy occurs in the membership of the board created by this section for any reason other than the expiration of a member's term of office, the governor, with the advice and consent of the senate, shall appoint a successor of like qualifications to fill the unexpired term. In each case of a vacancy

occurring in the membership of the board, the director shall notify the professional society or association required for the vacant position and request a list of three nominations from which to make the appointment.

5. The board shall develop a plan of operation for the efficient administration of the fund consistent with the provisions of sections 383.300 to 383.321. The fund must operate pursuant to a plan of operation which shall provide for the economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of excess medical malpractice insurance and which may contain other provisions including, but not limited to, assessment of all members for expenses, deficits, losses, commissions arrangements, reasonable underwriting standards, acceptance and cession of reinsurance appointment of servicing carriers, and procedures for determining the amounts of insurance to be provided by the Missouri patients' compensation fund. The plan of operation and any amendments to the plan are subject to the approval of the director. If the board fails to develop a plan of operation within the time frame established by the director, the director or the director's designee shall develop the plan of operation for the fund.

6. The board may appoint such additional employees, and provide all office space, services, equipment, materials and supplies, and all budgeting, personnel, purchasing and related management functions required by the board in the exercise of the powers, duties, and functions imposed or authorized by sections 383.300 to 383.321.

7. The department of insurance shall:

(1) Provide technical and administrative assistance to the board with respect to administration of the fund upon request of the board; and

(2) Provide such expertise as the board may reasonably request with respect to evaluation of claims or potential claims.

383.309. All Missouri licensed health care providers shall participate in the fund and shall remit to the board the appropriate membership fees and premium surcharges as are required by section 383.312 on or before the provider's membership anniversary date.

383.312. 1. All healthcare providers shall participate in the Missouri patients' compensation fund and shall pay annual membership fees. The board, by rule, shall set the membership fees. The rule shall provide that fees may be paid annually or in semiannual or quarterly installments.

2. In addition to the membership fees delineated in subsection 1 of this section, the board shall levy an annual premium surcharge on each participating health care provider who has obtained a policy meeting the requirements of

section 383.315 and upon each self-insurer. The surcharge shall be determined by the board based upon sound actuarial principles, using data obtained from Missouri experience if available. The amount of the surcharge shall be adequate for the payment of claims and expenses from the Missouri patients' compensation fund.

3. The surcharge shall be collected on the same basis as premiums by each insurer from the health care provider. The surcharge with accrued interest shall be due and payable within thirty days after the premiums for medical malpractice insurance have been received by the insurer from the health care provider in Missouri.

4. If the annual premium surcharge is collected but not paid within the time limit specified in subsection 3 of this section, the certificate of authority of the insurer, risk manager, or surplus lines agents shall be suspended until the annual premium surcharge is paid.

5. Membership in the fund is contingent upon the participating member making timely payment of all membership fees and all premium surcharges.

6. Self-insureds shall be eligible for membership in the fund upon compliance with the requirements of the board and shall pay similar membership fees and premium surcharges as the members. The surcharge for self-insureds shall be in an amount determined by the board. The amount of the surcharge imposed on the self-insured shall be in an amount comparable to what a health care provider would be required to pay if the provider's surcharge was based upon a policy of medical malpractice insurance.

383.315. 1. All books, records, and audits of the fund are open for reasonable inspection to the general public.

2. On or before December thirty-first of each year the state auditor shall audit the records of the fund and shall furnish an audited financial report to all fund participants, the department of insurance, and the general assembly.

383.318. 1. All health care providers shall participate in the Missouri patients' compensation fund and shall either insure and keep insured the health care provider's liability by a policy of medical malpractice insurance issued by an insurer authorized to do business in this state or shall qualify as a self-insurer. Qualification as a self-insurer is subject to conditions established by the board. The board may establish conditions that permit a self-insurer to self-insure for claims that are against employees who are health care providers and that are not covered by the fund.

2. The minimum liability limits for each policy of medical malpractice insurance for each health care provider shall be established by the board by

rule. When determining the minimum level of primary coverage for health care providers, the board shall consider the health care provider's area of practice, past risk experience, and any other factors the board deems relevant. The director shall also consider the financial solvency of the fund when establishing the minimum liability limits.

3. Each insurance company issuing medical malpractice insurance policies that meet the requirements of this section shall, at the times prescribed by the director, file with the director in a form prescribed by the director, a certificate of insurance on behalf of the health care provider upon original issuance and each renewal.

4. Each self-insured health care provider furnishing coverage that meets the requirements of this section shall, at the time and in a form prescribed by the board, file with the board a certificate of self-insurance and a separate certificate of insurance for each additional health care provider covered by the self-insured plan.

383.321. 1. A person filing a claim may recover from the fund only if the health care provider or the employee of the health care provider has coverage under the fund, the fund is named as a party in the action, and the action against the fund is commenced within the same time limitation within which the action against the health care provider or employee of the health care provider must be commenced.

2. If, after reviewing the facts upon which the claim or action is based, it appears reasonably probable that damages paid will exceed the limits provided in section 383.318, the fund may appear and actively defend itself when named as a party in an action against a health care provider, or an employee of a health care provider, that has coverage under the fund. In such action, the fund may retain counsel and pay out of the fund attorney fees and expenses including court costs incurred in defending the fund. The attorney or law firm retained to defend the fund shall not be retained or employed by the board to perform legal services for the board of other than those directly connected with the fund. Any judgment affecting the fund may be appealed as provided by law.

3. It shall be the responsibility of the insurer or self-insurer providing insurance or self-insurance for a health care provider who is also covered by the fund to provide an adequate defense of the fund on any claim filed that may potentially affect the fund with respect to such insurance contract or self-insurance contract. The insurer or self-insurer shall act in good faith and in a fiduciary relationship with respect to any claim affecting the fund. No settlement exceeding an amount which could require payment by the fund may be agreed to

unless approved by the board.

4. A person who has recovered a final judgment or a settlement approved by the board against a health care provider, or an employee of a health care provider, that has coverage under the fund may file a claim with the board to recover that portion of such judgment or settlement which is in excess of the limits provided in section 383.318 or the maximum liability limit for which the health care provider is insured, whichever limit is greater. In no event, however, shall the amount recoverable from the fund exceed the amounts established by the board. In the event the fund incurs liability for future payments exceeding five hundred thousand dollars to any person under a single claim as the result of a settlement or judgment that is entered into or rendered, the fund shall pay, after deducting the reasonable costs of collection attributable to the remaining liability, including attorney fees reduced to present value, the full medical expenses each year, plus an amount not to exceed five hundred thousand dollars per year that will pay the remaining liability over the person's anticipated lifetime, or until the liability is paid in full. If the remaining liability is not paid before the person dies, the fund may pay the remaining liability in a lump sum. Payments shall be made from money collected and paid into the fund and from interest earned thereon. For claims subject to a periodic payment made pursuant to this subsection, payments shall be made until the claim has been paid in full.

5. Claims filed against the fund shall be paid in the order received within ninety days after filing unless appealed by the fund. If the amounts in the fund are not sufficient to pay all of the claims, claims received after the funds are exhausted shall be immediately payable the following year in the order in which they were received.

6. The board may bring an action against an insurer, self-insurer or health care provider for failure to act in good faith or breach of fiduciary responsibility.

516.105. All actions against physicians, hospitals, dentists, registered or licensed practical nurses, optometrists, podiatrists, pharmacists, chiropractors, professional physical therapists, and any other entity providing health care services and all employees of any of the foregoing acting in the course and scope of their employment, for damages for malpractice, negligence, error or mistake related to health care shall be brought within two years from the date of occurrence of the act of neglect complained of, except that:

(1) In cases in which the act of neglect complained of is introducing and negligently permitting any foreign object to remain within the body of a living person, the action shall be brought within two years from the date of the discovery of such alleged negligence, or from the date on which the patient in the exercise of ordinary care should have discovered such alleged negligence, whichever date first occurs; and

(2) In cases in which the act of neglect complained of is the negligent failure to inform the patient of the results of medical tests, the action for failure to inform shall be brought within two years from the date of the discovery of such alleged negligent failure to inform, or from the date on which the patient in the exercise of ordinary care should have discovered such alleged negligent failure to inform, whichever date first occurs; except that, no such action shall be brought for any negligent failure to inform about the results of medical tests performed more than two years before August 28, 1999; and

(3) In cases in which the person bringing the action is a minor less than **[**eighteen**]** **twelve** years of age, such minor shall have until his or her **[**twentieth**]** **fourteenth** birthday to bring such action.

In no event shall any action for damages for malpractice, error, or mistake be commenced after the expiration of ten years from the date of the act of neglect complained of or for ten years from a minor's **[**twentieth**]** **fourteenth** birthday, whichever is later.

538.210. 1. In any action against a health care provider for damages for personal injury or death arising out of the rendering of or the failure to render health care services, no plaintiff shall recover more than three hundred fifty thousand dollars **[**per occurrence**]** for noneconomic damages from any one defendant as defendant is defined in subsection 2 of this section**, except as provided in subsection 3 of this section**.

2. "Defendant" for purposes of sections 538.205 to 538.230 shall be defined as:

(1) A hospital as defined in chapter 197, RSMo, and its employees and physician employees who are insured under the hospital's professional liability insurance policy or the hospital's self-insurance maintained for professional liability purposes;

(2) A physician, including his nonphysician employees who are insured under the physician's professional liability insurance or under the physician's self-insurance maintained for professional liability purposes;

(3) Any other health care provider having the legal capacity to sue and be sued and who is not included in subdivisions (1) and (2) of this subsection, including employees of any health care providers who are insured under the health care provider's professional liability insurance policy or self-insurance maintained for professional liability purposes**;**

(4) Any other individual or entity that is a defendant in a lawsuit brought against a health care provider pursuant to this chapter, or that is a defendant in any lawsuit that arises out of the rendering of or the failure to render health care services.

3. **Any plaintiff may recover noneconomic damages from any one defendant in excess of the limitation described in subsection 1 of this section, but not in excess of seven hundred thousand, where the damages for noneconomic losses suffered by the plaintiff were for:**

(1) Wrongful death;

(2) Permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system; or

(3) Permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities.

4. In any action against a health care provider for damages for personal injury or death arising out of the rendering of or the failure to render health care services, where the trier of fact is a jury, such jury shall not be instructed by the court with respect to the limitation on an award of noneconomic damages, nor shall counsel for any party or any person providing testimony during such proceeding in any way inform the jury or potential jurors of such limitation.

[4.**] 5. Beginning on August 28, 2004,** the limitation on awards for noneconomic damages provided for in this section shall be increased or decreased on an annual basis effective January first of each year in accordance with the Implicit Price Deflator for Personal Consumption Expenditures as published by the Bureau of Economic Analysis of the United States Department of Commerce. The current value of the limitation shall be calculated by the director of the department of insurance, who shall furnish that value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021, RSMo.

[5.**] 6.** Any provision of law or court rule to the contrary notwithstanding, an award of punitive damages against a health care provider governed by the provisions of sections 538.205 to 538.230 shall be made only upon a showing by a plaintiff that the health care provider demonstrated willful, wanton or malicious misconduct with respect to his actions which are found to have injured or caused or contributed to cause the damages claimed in the petition.

7. For purposes of sections 538.205 to 538.230, all individuals and entities asserting a claim for a wrongful death pursuant to section 537.080, RSMo, shall be considered to be one plaintiff.

8. No hospital or other health care provider shall be liable to any plaintiff based on the actions or omissions of any other entity or person who is not an employee of that hospital or other health care provider.

538.217. 1. In any action against the health care provider for damages for personal injury or death arising out of the rendering of or the failure to render health care services, the court shall enter judgment against each party liable on the basis of such party's percentage of fault and not on the basis of the doctrine of joint and several liability, except as provided in this section.

2. Where a plaintiff is found to be at fault, the following shall apply:

(1) Any defendant found ten percent or less at fault shall not be subject to

joint and several liability;

(2) For any defendant found more than ten percent but less than twenty-five percent at fault, joint and several liability shall not apply to that portion of damages in excess of two hundred thousand dollars;

(3) For any defendant found at least twenty-five percent but not more than fifty percent at fault, joint and several liability shall not apply to that portion of damages in excess of five hundred thousand dollars;

(4) For any defendant found more than fifty percent at fault, joint and several liability shall not apply to that portion of damages in excess of one million dollars.

For any defendant under subdivisions (2), (3), or (4) of this subsection, the amount of damages calculated under joint and several liability shall be in addition to the amount of damages already apportioned to that defendant based on that defendant's percentage of fault.

3. Where a plaintiff is found to be without fault, the following shall apply:

(1) Any defendant found less than ten percent at fault shall not be subject to joint and several liability;

(2) For any defendant found at least ten percent but less than twenty-five percent at fault, joint and several liability shall not apply to that portion of damages in excess of five hundred thousand dollars;

(3) For any defendant found at least twenty-five percent but not more than fifty percent at fault, joint and several liability shall not apply to that portion of damages in excess of one million dollars;

(4) For any defendant found more than fifty percent at fault, joint and several liability shall not apply to that portion of damages in excess of two million dollars.

For any defendant under subdivisions (2), (3), and (4) of this subsection, the amount of damages calculated under joint and several liability shall be in addition to the amount of damages already apportioned to that defendant based on that defendant's percentage of fault.

4. With respect to any defendant whose percentage of fault is less than the fault of a particular plaintiff, the doctrine of joint and several liability shall not apply to any damages imposed against the defendant.

538.225. 1. In any action against a health care provider for damages for personal injury or death on account of the rendering of or failure to render health care services, the plaintiff or **[**his**]** **the plaintiff's** attorney shall file an affidavit with the court stating that he **or she** has obtained the written opinion of a legally qualified health care provider which states that the defendant health care provider failed to use such care as a reasonably prudent

and careful health care provider would have under similar circumstances and that such failure to use such reasonable care directly caused or directly contributed to cause the damages claimed in the petition. **The written opinion shall be subject to in camera review at the request of any defendant for a determination of whether the health care provider offering such an opinion meets the qualifications set forth in subsection 6 of this section.**

2. The affidavit shall state the qualifications of such health care providers to offer such opinion.

3. A separate affidavit shall be filed for each defendant named in the petition.

4. Such affidavit shall be filed no later than ninety days after the filing of the petition unless the court, for good cause shown, orders that such time be extended **for a period of time not to exceed an additional ninety days**.

5. If the plaintiff or his attorney fails to file such affidavit the court **[**may**]** **shall**, upon motion of any party, dismiss the action against such moving party without prejudice.

6. As used in this section, the term "legally qualified health care provider" means a health care provider licensed in this state or any other state in substantially the same profession and specialty as the defendant.

538.227. 1. The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person and made to that person or to the family of that person shall be inadmissible as evidence of an admission of liability in a civil action. A statement of fault, however, which is part of, or in addition to, any of the provisions of this subsection shall not be inadmissible pursuant to this section.

2. For the purposes of this section the following terms mean:

(1) "Benevolent gestures", actions which convey a sense of compassion or commiseration emanating from humane impulses;

(2) "Family", the spouse, parent, grandparent, stepmother, stepfather, child, grandchild, brother, sister, half brother, half sister, lifetime partner or significant other, adopted children of a parent, or spouse's parents of an injured party.

538.228. An action shall not be maintained against a health care provider pursuant to sections 538.205 to 538.230 or chapter 537, RSMo, by or on behalf of a third party nonpatient for rendering or failing to render health care services to a patient whose subsequent act is a proximate cause of injury or death to the third party unless the health care provider rendered or failed to render health care services in willful and wanton or reckless disregard of a foreseeable risk of harm to third persons. Nothing in this section shall be construed to prevent the personal representative of a deceased patient from maintaining a wrongful death action on behalf of such patient or to prevent a derivative claim for loss of

consortium arising from injury or death to the patient arising from the negligence of a health care provider.

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