SECOND REGULAR SESSION

SENATE BILL NO. 727

92ND GENERAL ASSEMBLY

INTRODUCED BY SENATOR STEELMAN.

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

TERRY L. SPIELER, Secretary.

3154S.03I

AN ACT

To repeal sections 508.010, 516.105, 537.067, 538.210, and 538.225, RSMo, and to enact in lieu thereof twelve new sections relating to civil liability reform, with an emergency clause for certain sections.

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

Section A. Sections 508.010, 516.105, 537.067, 538.210, and 538.225, RSMo, are repealed and twelve new sections enacted in lieu thereof, to be known as sections 135.164, 135.165, 354.001, 383.200, 383.324, 508.010, 516.105, 537.067, 538.210, 538.225, 538.226, and 1, to read as follows:

135.164. As used in sections 135.164 and 135.165, the following words or phrases shall mean:

(1) "Eligible taxpayer", any physician that provides health care services under the authority of a license who practices in a high risk specialty as determined by the department of insurance and who provides health care services to patients, at least twenty percent of whom in one policy period are covered by the state Medicaid program;

(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.

135.165. 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, for all taxable years ending on or after December 31, 2004, 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 amount paid by an eligible taxpayer for medical malpractice insurance premiums in the aggregate in one policy period.

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 creating the tax credit shall expire on December 31, 2007, provided that any eligible taxpayer may carry over a claimed tax credit amount pursuant to subsection 2 of this section to a taxable year beyond December 31, 2007.

354.001. 1. Any health services corporation, health maintenance organization, or other entity organized pursuant to this chapter shall not require, as a condition of participation in the provider network of the corporation, organization, or other entity, that a physician maintain a medical malpractice insurance policy that is deemed by the director of the department of insurance to be excessive.

2. The director of the department of insurance is authorized to promulgate rules and regulations to effectuate the purposes 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.

383.200. 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. If the director holds a rate to be excessive, the director may order a refund of the excessive portion of the rate to any policyholder who has paid such rate.

7. 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.

8. 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.

9. 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.

383.324. Notwithstanding any other provision of the law to the contrary, no insurer authorized to issue policies of medical malpractice insurance in this state shall increase the renewal premium on any policy of medical malpractice insurance nor impose changes in deductibles or coverage that materially alter the policy, unless the insurer mails or delivers to the named insured written notice of such increase or change in deductible or coverage at least ninety days prior to the renewal or anniversary date.

508.010. Suits instituted by summons shall, except as otherwise provided by law, be brought:

(1) When the defendant is a resident of the state, either in the county within which the defendant resides, or in the county within which the plaintiff resides, and the defendant may be found;

(2) When there are several defendants, and they reside in different counties, the suit may be brought in any such county;

(3) When there are several defendants, some residents and others nonresidents of the

state, suit may be brought in any county in this state in which any defendant resides;

(4) When all the defendants are nonresidents of the state, suit may be brought in any county in this state;

(5) Any action, local or transitory, in which any county shall be plaintiff, may be commenced and prosecuted to final judgment in the county in which the defendant or defendants reside, or in the county suing and where the defendants, or one of them, may be found;

(6) In all tort actions the suit may be brought in the county where the cause of action accrued regardless of the residence of the parties, and process therein shall be issued by the court of such county and may be served in any county within the state; provided, however, that in any action for defamation or for invasion of privacy the cause of action shall be deemed to have accrued in the county in which the defamation or invasion was first published.

(7) Notwithstanding the provisions of subdivisions (1) to (6) of this section, in an action commenced against a healthcare provider pursuant to chapter 538, RSMo, no suit shall be brought in any county except the county where the cause of action accrued or an adjoining county.

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.

537.067. 1. In all tort actions for damages, in which fault is not assessed to the plaintiff, the defendants shall be jointly and severally liable for the amount of the judgment rendered against such defendants.

2. In all tort actions for damages in which fault is assessed to plaintiff the defendants shall be jointly and severally liable for the amount of the judgment rendered against such defendants except as follows:

(1) In all such actions in which the trier of fact assesses a percentage of fault to the plaintiff, any party, including the plaintiff, may within thirty days of the date the verdict is rendered move for reallocation of any uncollectible amounts;

(2) If such a motion is filed the court shall determine whether all or part of a party's equitable share of the obligation is uncollectible from that party, and shall reallocate any uncollectible amount among the other parties, including a claimant at fault, according to their respective percentages of fault;

(3) The party whose uncollectible amount is reallocated is nonetheless subject to contribution and to any continuing liability to the claimant on the judgment;

(4) No amount shall be reallocated to any party whose assessed percentage of fault is less than the plaintiff's so as to increase that party's liability by more than a factor of two;

(5) If such a motion is filed, the parties may conduct discovery on the issue of collectibility prior to a hearing on such motion;

(6) Any order of reallocation pursuant to this section shall be entered within one hundred twenty days after the date of filing such a motion for reallocation. If no such order is entered within that time, such motion shall be deemed to be overruled;

(7) Proceedings on a motion for reallocation shall not operate to extend the time otherwise provided for post-trial motion or appeal on other issues.

Any appeal on an order or denial of reallocation shall be taken within the time provided under applicable rules of civil procedure and shall be consolidated with any other appeal on other issues in the case.

3. This section shall not be construed to expand or restrict the doctrine of joint and several liability except for reallocation as provided in subsection 2.

4. Notwithstanding the provisions of subsections 1 to 3 of this section, 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 subsections 4 to 7 of this section.

5. 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.

6. 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.

7. 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.

538.210. 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 dollars, 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 unless the trier of fact determines that the hospital or other health care provider controlled or retained the right to control the actions of the entity or person who is not an employee.

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 attorney shall file an affidavit with the court stating that he 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.

2. **[**The affidavit shall state the qualifications of such health care providers to offer such opinion.**]** **The health care provider who offers such opinion shall have education, training, and experience in a like area of expertise, or logical extension of the field of expertise, as the defendant health care provider. In addition, the health care provider must be actively practicing within ten years of the date of the affidavit. The affidavit is, upon motion of a party, subject to in camera review by the court to ensure its compliance with this section.**

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**]** **defendant has filed an affidavit stating that all records pertaining to the patient have been disclosed to the plaintiff or the plaintiff's attorney** unless the court, for good cause shown, orders that such time be extended.

5. **[**If the plaintiff or his attorney fails to file such affidavit the court may, upon

motion of any party, dismiss the action against such moving party without prejudice.**] If the plaintiff or his attorney fails to file such affidavit within the time required, the action as to that defendant shall be stayed and the court shall, upon motion of any party, dismiss the action against that defendant without prejudice.**

538.226. 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 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 above shall not be inadmissible pursuant to this section.

2. As used in this section "benevolent gestures" means actions which convey a sense of compassion or commiseration emanating from humane impulses.

Section 1. The provisions of section 508.010, RSMo, section 516.105, RSMo, section 537.067, RSMo, and sections 538.210, 538.225, and 538.226, RSMo, shall only apply to causes of action filed after August 28, 2004.

Section B. Because of the pending medical malpractice insurance crisis, sections 354.001, 383.200, and 383.324 are deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and sections 354.001, 383.200, and 383.324 shall be in full force and effect upon its passage and approval.