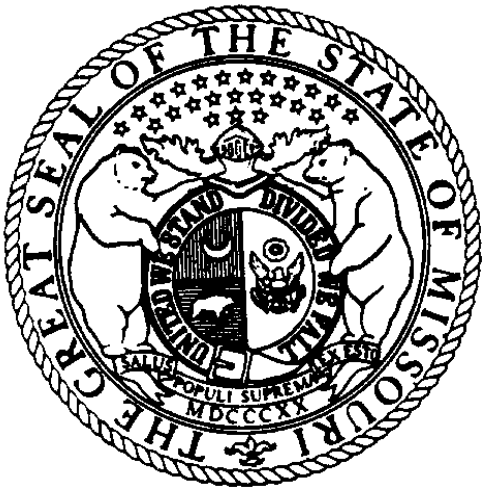
Report

of the

Joint Interim Committee

on

Missouri Health Care Stabilization Fund



December 2005

Missouri General Assembly

December 2005

The Honorable Michael Gibbons
President Pro Tem
Missouri Senate
Jefferson City, Missouri

The Honorable Rod Jetton
Speaker
Missouri House of Representatives
Jefferson City, Missouri

Dear Mr. President and Mr. Speaker:

Pursuant to your charge and the provisions of Senate Concurrent Resolution 19, your Joint Interim Committee on a Missouri Health Care Stabilization Fund gathered information from a variety of sources during the summer of 2005. The committee heard testimony from members of the medical community, insurance company representatives, and employees from the Missouri Department of Insurance. The committee also went to Topeka, Kansas, to observe how Kansas implements its health care stabilization fund.

There is widespread interest in improving the state's access to quality health care and assuring that Missouri's health care providers are adequately covered by affordable medical malpractice insurance. The committee expresses its gratitude to all the parties who provided vital information and assistance on the issue of establishing a health care stabilization fund.

The committee recognizes that it is essential for health care providers in Missouri to be able to obtain affordable medical malpractice insurance. We have explored the feasibility of establishing a health care stabilization fund as one option of meeting this goal. Enclosed is our report and recommendations.

Sincerely,

Senator Bill Stouffer

Representative Tom Dempsey

REPORT OF THE
JOINT INTERIM COMMITTEE ON A
MISSOURI HEALTH CARE STABILIZATION FUND

Committee Members

Senator Bill Stouffer
District 21

Representative Tom Dempsey
District 18

Senator Jason Crowell
District 27

Representative Rob Schaaf
District 28

Senator Delbert Scott
District 28

Representative Raymond Weter
District 142

Senator Joan Bray
District 24

Representative John Burnett
District 40

Senator Charles Wheeler
District 10

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Report of the
Joint Interim Committee on a
Missouri Health Care Stabilization Fund

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Report of the Joint Interim Committee
on a Missouri Health Care Stabilization Fund
December 2005

I. INTRODUCTION

Senate Concurrent Resolution No. 19, passed by the Missouri General Assembly during the regular session of 2005, was enacted to address significant concerns regarding the availability and affordability of professional medical liability insurance (medical malpractice insurance). The resolution authorized the establishment of the Joint Interim Committee on a Missouri Health Care Stabilization Fund. The joint interim committee was charged primarily with examining the feasibility of establishing a health care stabilization fund or patient injury compensation fund to cover medical malpractice claims. The joint interim committee was also charged with:

1) Investigating the primary objective of assuring health care providers that there will be reasonable medical malpractice liability coverage available within the state of Missouri;

2) Researching the possibility of requiring health care providers to carry primary medical malpractice coverage with another insurer in order to participate in the fund;

3) Investigating the feasibility of the fund paying moneys to an aggrieved party if his or her damages exceed the health care provider's primary level of coverage; and

4) Exploring any other ideas necessary to the creation of the fund.

Senate Concurrent Resolution No. 19 directed the interim committee to deliver a report of findings and recommendations to the General Assembly by December 31, 2005.

II. COMMITTEE MEMBERSHIP

The membership of the joint interim committee consisted of five senators and five representatives. Pursuant to Senate Concurrent Resolution No. 19, the Speaker of the House of Representatives appointed Representative Tom Dempsey, Representative Robert Schaaf, Representative Raymond Weter, Representative John Burnett, and Representative Sam Page. The President Pro Tem of the Senate appointed Senator Bill Stouffer, Senator Jason Crowell, Senator Delbert Scott, Senator Joan Bray, and Senator Charles Wheeler.

III. BACKGROUND OF HEALTH CARE STABILIZATION FUNDS

A. Overview

A health care stabilization fund, more commonly referred to as a patient compensation fund, is a medical malpractice insurance mechanism, created by state law, designed to increase professional liability coverage availability and/or affordability primarily by providing coverage for a specific type of injury or an excess layer of coverage.[1] The liability of the health care provider is often capped by requiring the provider to maintain a certain level of insurance coverage, and the fund is available to pay any excess damages above that amount. Patient compensation funds are typically funded through a surcharge on insurance premiums or annual assessments on health care providers. Participation in a state patient compensation fund may be voluntary or mandatory.

The underlying rationale for establishing patient compensation funds is that the private market is not a highly reliable source of reinsurance for primary insurers or excess insurance for large provider organizations such as hospitals. When private reinsurers or excess insurers experience a few large claims, it is difficult for them to determine whether a change is a random occurrence or a true shift in risk. For this reason, insurers raise premiums sizeably or simply refuse to underwrite coverage.[2] Patient compensation funds offer certainty to health care providers and their insurers by establishing an upper limit on the amount of losses the health care provider and insurance company must bear. Establishing an upper limit adds predictability to pricing medical malpractice insurance and increases an insurance company's ability to insure more health care providers because their risk exposure is decreased by writing policies with lower limits.[3]

At least 12 states have statutes that authorize the establishment of a patient compensation fund.[4] Most of these funds were established during the mid-1970s in an attempt to increase the availability and reduce the cost of medical malpractice insurance by creating a more attractive market for medical malpractice insurance companies. The patient compensation funds statutes created a guaranteed source of "excess insurance" for health care providers, redistributed the costs of maintaining the availability of medical malpractice insurance, and attempted to provide a

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[1] Pinnacle Actuarial Resources, Inc., "Final Report on the Feasibility of an Ohio Patient Compensation Fund," 2003.

[2] Frank Sloan, "Public Medical Malpractice Insurance," The Pew Charitable Trust's Project on Medical Liability in Pennsylvania, 2004, p. 31.

[3] Eric Nordman, Davin Cermak and Kenneth McDaniel, “Medical Malpractice Insurance Report: A Study of Market Conditions and Potential Solutions to the Recent Crisis,” (NAIC 2004), p. 56.

[4] Florida, Indiana, Kansas, Louisiana, Nebraska, New Mexico, Oregon, Pennsylvania, South Carolina, West Virginia, Wisconsin and Wyoming.

more reliable and efficient compensation mechanism for medical malpractice victims.[5] The majority of the state patient compensation funds established in the mid-1970s are still active; however, the Florida[6], Wyoming[7] and Oregon[8] patient compensation funds are currently inactive and the Pennsylvania fund is scheduled to be phased out by 2009.[9]

B. Patient Compensation Fund Eligibility and Participation

Patient compensation funds differ among states on who may participate within the respective funds. Generally, there are three categories of participants in most state patient compensation funds: physicians (including osteopaths), other types of health care providers (midwives, nurse practitioners, optometrists, pharmacists, registered nurses, etc.), and hospitals and other health care facilities (nursing homes, outpatient treatment centers, mental health clinics, surgery centers, etc.). While limiting participation in the fund to certain specialties (and avoiding high-risk specialties such as emergency room doctors and OB/GYNs) appears attractive on the surface, a recent report from Ohio suggests that allowing broad participation among all types of health care providers is a more flexible strategy. The Ohio report recommended that hospitals and other health care facilities be eligible for patient compensation fund coverage.[10]

Participation in most patient compensation funds is voluntary. Some states, however, such as Kansas, require all eligible health care providers to participate in the state fund. Proponents of voluntary participation argue that participation should be voluntary so that patient compensation

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[5] Patient Injury Compensation Fund Study Board, "Report and Recommendations on the Feasibility of a West Virginia Patient Injury Compensation Fund," December 1, 2003, page 4.

[6] Florida's patient compensation fund program closed in 1983 but was still paying claims as of April 2003. See, Sloan, Frank A., Randall R. Bovbjerg, and Penny Githens, 1991. *Insuring Medical Malpractice*. New York: Oxford University Press.

[7] Wyoming established a patient compensation fund in the mid-1970s, but a physicians' mutual insurance company entered the market to fill the void. The Wyoming patient compensation fund has never been formally created.

[8] Under Oregon law, the Oregon's Director of the Department of Consumer and Business Services is authorized to implement a professional liability fund if, after hearings, he or she finds that qualified members of any profession are unable to obtain insurance for damages arising out of professional negligence or that insurance is not available at a reasonable cost. No fund has ever been established.

[9] Due to a deficit of more than $2 billion, the Pennsylvania legislature is phasing out its old fund and replacing it with the Medical Care Availability of Error Act (MCARE) fund .

[10] Pinnacle, *supra* note 1, pages 7-9.

fund coverage is primarily offered and purchased when market forces are not able to provide sufficient availability or affordability. During a "hard market,"a fund may be able to reduce market premiums. During a "soft market," however, the fund may not be able to provide the additional insurance coverage at a competitive price compared to the free market. Voluntary funds are vulnerable to adverse selection, which dramatically increases the fund's risk exposure. In states where participation in a fund is voluntary, a health care provider can avoid a surcharge by not renewing after fund coverage becomes more expensive than the private insurance market. Low-risk health care providers will drop out of the fund, leaving only high-risk health care providers enrolled.[11] Compulsory participation in a patient compensation fund can alleviate the problem of adverse selection.[12]

C. Coverage

1. Primary Coverage Requirements

All patient compensation funds require a primary level of coverage as a condition of eligibility for coverage. Typically, the health care provider will purchase the primary level of coverage from an insurance company, but the health care provider may self-insure or purchase a primary policy from the state's joint underwriting association.

There are basically two types of medical malpractice insurance policies a health care provider can purchase as primary coverage: claims-made and occurrence policies. Claims-made policies provide coverage for malpractice claims that are reported during the policy period. Occurrence policies, however, provide coverage for claims that occur during the coverage period, regardless of when the claims are reported. The downside of a claims-made policy involves cancellation. For example, assume a physician purchases a medical malpractice policy on January 1, 2000. The policy is renewed in 2001 and 2002. In 2003, however, the physician decides to terminate coverage. Six months later, a lawsuit is filed alleging malpractice that allegedly occurred in 2002. Under an occurrence policy, the physician is afforded coverage under the 2002 policy in that the incident occurred during that period. Under a claims-made policy, however, no coverage exists as there was no policy in force when the suit was filed. The solution to this problem is tail coverage. Tail coverage is a supplement to a claims-made policy that provides coverage for any incident that occurred while the claims-made insurance was in effect but had not been brought as a claim by the time the insurer-policyholder relationship terminated. Tail coverage, also known as an extended reporting endorsement, is generally necessary whenever an insured covered by a claims-made policy changes carriers, retires, becomes disabled, or dies. Tail coverage is often very expensive and difficult to obtain.

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[11] Iowa Medical Society, "Iowa Medical Society Patient Compensation Funds White Paper," November 11, 2004, page 5.

[12] Sloan, *supra* note 2 at page 38.

A broad range of coverage limits are required by the state patient compensation funds.[13] Some patient compensation funds require as little as $100,000 per occurrence in coverage (e.g. Louisiana), while other states require as much as $1 million per occurrence and $3 million in aggregate coverage (e.g. Wisconsin). In general, most funds require a primary level of coverage in the range of $200,000 to $250,000 per occurrence and $600,000 to $1 million in aggregate coverage to be eligible for patient compensation fund coverage.[14] Many states set higher aggregate limits for hospitals and other types of health care facilities since such entities possess a much larger aggregate loss potential.

2. Coverage Provided by the Fund

The amount of excess liability coverage provided by a patient compensation fund varies from state to state. In Pennsylvania, the fund only provides $500,000 excess coverage while other states, such as New Mexico, South Carolina, and Wisconsin, provide unlimited fund coverage. Some states have a limit on total damages that an injured patient may recover. Under Indiana law, there is a $1.25 million cap on total damages. The health care provider and his or her insurer is responsible for the first $250,000 while the patient compensation fund is responsible for the remainder (up to $1 million). Similarly, health care providers who participate in the Nebraska Excess Liability Fund enjoy a total cap on damages of $1.75 million, with the health care provider and his or her insurer only being responsible for the first $500,000. Health care providers who practice in a state without total cap damages retain liability after the state's patient compensation fund limits have been exhausted.

Many state patient compensation funds also provide tail coverage to health care providers who retire or otherwise leave their practice. For example, in Kansas, a health care provider who maintains private practice compliance with the fund for five or more years and then becomes an inactive health care provider is eligible for the tail coverage without any additional surcharge payment.[15]

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[13] Patient compensation funds generally require two types of primary insurance coverage limits: occurrence limits and aggregate limits. Occurrence limits apply per claim while aggregate limits are a cap on the cumulative total for all claims in a policy year. For example, a primary policy with limits of $250,000 per occurrence and $1 million in aggregate means that each individual claim is covered up to the $250,000 limit and the most that will be paid for all claims in the policy period in total will not exceed $1 million.

[14] Kansas, for example, requires primary coverage of $200,000 per occurrence and $600,000 in the aggregate.

[15] Some other states offer inactive health care providers tail coverage. Louisiana provides free tail coverage if a provider retires and has participated ten or more years with the fund. If the provider has less than ten years, the provider must purchase tail coverage if the provider has a claims-made policy and the provider must provide proof that he has underlying

3. Prior Acts Coverage

Another issue to determine when establishing a patient compensation fund is whether the fund will provide coverage for the health care provider's prior acts of malpractice. Several funds will not provide coverage for prior acts. Generally, all claims against a provider that are based on acts before joining the fund are the responsibility of the provider and/or his insurance company. Kansas has addressed this issue by requiring all insurers to include prior acts coverage in their policies. This provision of the law eliminates the need for Kansas health care providers to purchase tail coverage when changing insurance companies.

D. Patient Compensation Fund Funding Mechanism

Although patient compensation funds are quasi-government insurance programs, the programs are typically funded from premium surcharges and investment returns, not from state subsidies.[16] Health care providers pay two insurance premiums: one to the primary insurer and one to the state patient compensation fund. As a result, patient compensation funds are more likely to address the issue of availability but not the issue of affordability. The cost to health care providers will be offset to a degree by the reduction in their primary insurance premiums due to the reduction in primary limits.[17]

The assessments on the health care providers generally are structured as a fraction of the premium paid for primary insurance coverage and may be paid separately to the patient compensation fund or collected and forwarded to the fund by the primary insurance company. An example of a percentage assessment funded system is Nebraska. In Nebraska, the annual surcharge levied on health care providers cannot exceed 50 percent of the annual premium paid by the health care provider for primary medical malpractice coverage.[18] In Kansas, the Kansas Health Care Stabilization Fund is funded by an annual premium surcharge on each health care provider. The annual premium surcharge is based on a rating classification system established by the fund's board of governors. The rating classification system is based on a number of variables including the number of years the health care provider has complied with the Kansas Health Care Stabilization Fund, the level of fund coverage selected by the health care provider, the group classification the health care provider belongs to (general practice, nonsurgical, etc.) and whether

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tail coverage before the fund will provide excess liability coverage.

[16] New York, however, has publicly subsidized the purchase of private excess insurance for health care providers since 2000. In 2004, West Virginia established the Patient Injury Compensation Fund. In the fund's first three fiscal years, initial funding for the fund will come from money initially earmarked for the state's tobacco account.

[17] Pinnacle, *supra* note 1, page 15.

[18] R.R.S. Neb. § 44-2829 (2004).

the health care provider conducts any of his or her practice outside the state of Kansas (e.g. an additional 20 percent practice surcharge is added for Kansas health care providers who also practice within Missouri).

Regardless of the funding method chosen, the assessments or surcharges levied by the patient compensation fund must be actuarially sound for the payment of all claims and operating costs. The patient compensation fund surcharges or assessments should include:

1) past and prospective loss and expense experience in the different types of health care practice;

2) past and prospective experience of the patient compensation fund; and

3) loss expense of the health care provider.[19]

Considering past and prospective loss of a certain medical specialty is important to maintain fund solvency. Patient compensation fund surcharges should reflect the relative risk posed by different medical specialties. In Indiana, for example, the amount of the surcharge must be based upon actuarial principles and actuarial studies. Based upon the actuarial studies, a uniform surcharge for all health care providers practicing in a specialty class is established.[20]

The issue of considering past and prospective experience of the patient compensation fund generally turns on the issue of whether the fund will establish a reserve for future anticipated losses or whether the fund will operate on a pay-as-you-go basis. Some states patient compensation funds are financed on a pay-as-you-go basis. When a health care provider pays an annual surcharge or assessment in these states, the health care provider does not buy coverage for the current year's medical malpractice claims, but instead pays for losses incurred in previous years that have just become due.[21] Thus, a pay-as-you-go financing mechanism fails to account for possible future losses suffered by the fund. Although a pay-as-you-go system can offer providers lower premium surcharges initially, the ultimate costs associated with administering the fund must be made up at a later date.[22]

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[19] Pinnacle, *supra* note 1, page 15. Wisconsin law (§ 655.27) provides that the annual assessment shall be based on: 1) the past and prospective loss expense experience in different types of practice; 2) the past and prospective loss and expense experience of the fund; and 3) the loss and expense experience of the individual health care provider that resulted in the payment of money from the fund.

[20] Indiana Code 34-18-5-2.

[21] Sloan, *supra* note 2, page 42.

[22] Pay-as-you-go financing helps solve the availability of medical liability insurance without requiring large initial premium assessments. Inadequate loss reserving, however, eventually results in large premium increases. See, Sloan, *supra* note 2, pages 39-40.

Instead of adopting a pay-as-you-go funding strategy, other states use standard loss reserving principles, including Kansas, New Mexico, Wisconsin, and Louisiana.[23] Maintaining a reserve for future losses does have some potential pitfalls. The governor of Wisconsin recently proposed to take $200 million from the state's patient compensation fund to plug a hole in the state's Medicaid budget. The proposal failed and the Wisconsin legislature recently passed a bill providing that the moneys in the fund are to be held in an "irrevocable trust," and to be used only by proper claimants and not other state purposes.[24] In its final report regarding the feasibility of establishing a patient compensation fund in Ohio, the study group recommended that any fund established in Ohio should be based upon an accrual basis to reflect all future costs associated with the risk transfer.[25]

The surcharge should reflect the loss experience of the individual health care provider. Generally, this can be accomplished by some form of merit rating or experience rating. Health care providers without any claims could receive a discount and those with several claims could be levied an additional surcharge based upon actuarial principals.

Finally, in order to ensure the financial stability of the patient compensation fund, the administrator of the fund should be allowed to regularly establish appropriate rate levels. In Kansas, for example, the premium surcharge is determined every fiscal year by the board of governors. Allowing the surcharge to be determined annually will help maintain the solvency of the fund by basing the surcharge on the most up-to-date information.

E. Patient Compensation Fund Administration

1. Governance Structure

Typically, a patient compensation funds is administered either by the state's department of insurance or by a board or governors or directors. In some states, including Indiana, Nebraska, New York, and Pennsylvania, the department of insurance is given broad administrative responsibilities for the fund. Other states, including Florida, Kansas, South Carolina, and Wisconsin, call for the appointment of a board of directors or governors to administer the fund. It is common for the governor to have authority to appoint members to the board.[26] The boards are

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[23] See Louisiana Revised Statues, section 40:1299.44, which requires that the fund maintain a surplus of 50 percent of the annual surcharge premiums .

[24] Assembly Bill 487 (2003).

[25] Pinnacle, *supra* note 1, page 16.

[26] In Kansas, the commissioner of insurance appoints ten members of the medical profession to the board from a list of nominees submitted by various medical associations. An official from the Kansas Health Care Stabilization Fund has noted that having the members

typically comprised of various interests such as the insurance industry, the state medical profession, hospitals, the state bar association and other groups.[27]

2. Administrative Duties of the Fund

The most common statutory duties assigned to a board include collecting premium surcharges, collecting claims experience, employing or contracting for services necessary to the operation of the fund, defending claims made against the fund, and paying valid claims and administrative expenses associated with the fund.[28] Surcharges or assessments are generally paid to the primary insurance company when the underlying insurance policy premiums are paid. The insurance company, in turn, remits the assessment to the fund. Failure to remit the assessments can lead to the insurer having its license revoked.

Perhaps the most important duty performed by a board or its staff is claims management. Claims management consists of all functions, including legal representation, that aim to lower payments from the fund. Most patient compensation funds are authorized to hire independent counsel to represent the interests of the fund. Louisiana, for example, contracts with the state's office of risk management for the administration and processing of claims. Some funds require the primary insurer to defend the fund prior to involving the fund in the defense of a claim.[29] Imposing a statutory duty upon an insurer to defend the fund helps reduce inflated claim settlements when claims exceed the primary insurance coverage level.[30]

3. Involvement of the Department of Insurance

In many states, the states' departments of insurance provide regulatory oversight and staff services necessary for the operation of the patient compensation fund. A key decision when creating a patient compensation fund is whether to house it in the state's department of insurance or to establish the fund as a separate state agency. According to one commentator, insurance

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appointed by the commissioner rather than the governor has made the board less political.

[27] For a detailed look of how patient compensation funds are governed see the appendix at the end of this report.

[28] Pinnacle, *supra* note 1, page 18.

[29] Kansas law requires a medical malpractice claim to be defended by the insurer, but allows the board to employ independent counsel if it believes that it would be in the best interest of the fund. Similarly, Wisconsin law requires insurers to act in good faith and in a fiduciary relationship with respect to any claim affecting the fund.

[30] Pinnacle, *supra* note 1, page 19.

departments potentially offer expertise and economies of scale.[31] Establishing the patient compensation fund as a separate state agency, however, may insulate it from the political considerations that affect the state's department of insurance more generally.[32] In some states, the influence of state departments of insurance over administering patient compensation funds has decreased. In Kansas, for example, the Health Care Stabilization Fund was administered by the insurance commissioner until 1995. In 1995, the board of governors took over all administrative responsibilities of operating the fund.[33]

4. Patient Compensation Fund Staffing

Staffing among the various patient compensation funds varies greatly. Authorized staff sizes range from zero in New York to 55 in Pennsylvania. As noted above, in many states the insurance department provides staff services necessary for the operation of the fund. Some services, such as actuarial, legal, loss prevention, and billing are outsourced. In Wisconsin, administrative staff is provided by the Office of the Commissioner of Insurance. Fund staff consists of an administrative officer and six full-time employees. The staff ensures compliance with the filing of primary insurance certificates, billing and collection of assessments, and claims. The fund contracts with outside consultants for other types of services, such as claims administration and actuarial services. The Kansas Health Care Stabilization Fund is staffed by 16 full-time employees and 2 part-time employees. The executive director oversees the daily office management and administrative activities on behalf of the board of directors, while the chief attorney is responsible for fund activities related to claims. An efficient staff will help keep administrative costs low and thereby make the excess liability insurance more affordable. A Louisiana report states that on average, commercial insurance carriers have an expense ratio above 20 percent (i.e., every dollar received loses 20 cents for expenses). In contrast, the Louisiana Patient's Compensation Fund averages a 4-5 percent expense ratio.[34]

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[31] Sloan, F.A., C.A. Mathews, C. J. Conover, W.M. Sage, Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds, 54 DePaul Law Review 247, 255 (2005). According to this article, seven patient compensation funds are located in their state department of insurance. Id. at 256.

[32] Id. at 255.

[33] See the appendix for a comparison of the various modes of governance and administration employed by patient compensation funds.

[34] See "A Brief History of the Louisiana Patient's Compensation Fund, http://www.lapcf.louisiana.gov/Brief%20History%20Of%20LAPCF.htm. Officials from the Kansas Health Care Stabilization Fund stated that their fund's administrative costs are approximately 3 percent while private insurance companies experience administrative costs as high as 38 percent.

F. Success of State Patient Compensation Funds

Whether patient compensation funds are effective or successful is a disputed issue. Proponents of patient compensation funds argue that such funds alleviate medical malpractice crises by: 1) stabilizing private market premiums, 2) increasing medical malpractice insurance availability, and 3) ensuring injured patients receive full compensation.[35] In some respects, patient compensation funds have been successful in that they have been around for almost 30 years. It is often difficult, however, to determine whether patient compensation funds have made medical malpractice insurance more affordable and available due to the diversity of the different state funds. One study has noted that "[t]he notion that medical malpractice insurance is more available and affordable because of the presence of [patient compensation funds] cannot be conclusively demonstrated with available data or data that could be assembled at reasonable cost."[36]

1. Availability

With respect to medical malpractice insurance availability, private insurance was available in most states with patient compensation funds. A recent study found "no evidence that private excess insurance was unavailable in any [patient compensation fund] state except where [the funds] had crowded out the coverage."[37] Some representatives of the state patient compensation funds, however, provided anecdotal evidence that their funds made excess coverage more available. Theresa Wedekind, the top official for the Wisconsin Patient Compensation Fund, stated that their fund has made coverage more available. She noted that in 1975 there was only a handful of insurance carriers, but today there are over 20 carriers in Wisconsin.

2. Affordability

Premiums have increased spectacularly in some states, including states with funds, but the increases are most likely for reasons beyond the control of funds.[38] The losses paid by patient compensation funds during 1998-2002 varied among the states. While Kansas experienced a decrease in paid losses during this period, Pennsylvania, Louisiana, Wisconsin, and South Carolina experienced increases in paid losses.[39] One study notes that patient compensation funds will not control costs in that such funds merely shift a portion of private insurance costs from the private market to the fund. Since the health care provider will pay two premiums, one to the

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[35] Iowa Medical Society, *supra* note 11, page 2.

[36] Sloan, *supra* note 31, page 261.

[37] Id. at 267.

[38] Id. at 262.

[39] Id.

private insurer and one to the fund, the provider may still pay approximately the same amount as before.[40] Whether a health care provider will realize any savings through the implementation of a patient compensation fund may depend upon the administrative costs of operating the fund and other structural designs of the fund.[41]

Some states that were contacted noted that the creation of their patient compensation fund helped stabilize rates. For example, an official from Nebraska noted that the creation of the Nebraska Excess Liability Fund limited the liability of insurers to a point where an insurer of modest size could write the business without being totally dependent on reinsurance. Without the provision of excess liability coverage, private insurance companies would have to purchase more reinsurance to cover potential large losses. In turn, private insurance companies would have to increase their premium rates to reflect the cost of reinsurance. Wisconsin also noted that their patient compensation fund has made coverage more affordable; noting that the fund rates for the excess coverage could not be matched on the private market. Wisconsin officials noted that their rates are low due to mandatory participation within the fund (large pool).

3. Frequency of Claims

Trends in claim frequency are very similar between states with patient compensation funds and states without such funds.[42] From an intuitive standpoint, this makes sense. Patient compensation funds are not designed to limit lawsuits or reduce claims. Instead, patient compensation funds more aptly address the issues of affordability, availability, and compensation for malpractice victims. Tort reforms, such as damage caps, statute of limitations, risk prevention strategies, and other similar measures are more likely to address the issue of claims frequency or lawsuit prevention.

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[40] Iowa Medical Society, *supra* note 11, page 2.

[41] A General Accounting Office report from 2003 titled “Medical Malpractice: Multiple Factors Have Contributed to Increased Premium Rates" (GAO-03-702) indicated that losses on medical malpractice claims are the primary long-term driving force for insurance companies in setting insurance premium rates. While legal reforms such as damage caps are associated with reducing medical expenditures, indirect medical malpractice reforms such as patient compensation funds are not generally associated with reducing expenditures. See, Daniel P. Kessler and Mark B. McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics*, vol. 111, no. 2 (1996): 353-90.

[42] Sloan, *supra* note 31, page 262. Officials from both Nebraska and Louisiana noted that they had no evidence that their funds reduced the number of claims filed within their respective states.

4. Successful Design of a Patient Compensation Fund

One study notes that the key to the value and success of a patient compensation fund lies in the details of its design. The authors of the study offer the following recommendations for creating an effective patient compensation fund:

1) Determine whether participation within the fund should be voluntary or mandatory. Voluntary participation lends itself to the problem of adverse selection leaving a pool of high-risk providers while mandatory participation negates adverse selection and spreads the risk across a larger pool.

2) The patient compensation fund limits should clearly position the fund as an excess liability insurer.

3) Establish liability limits on non-economic damages and total medical malpractice damages. Caps are a useful tool for loss control. Recently, the Wisconsin Supreme Court held that the state cap on noneconomic damages is unconstitutional. Whether or not this decision will dramatically affect the operation of Wisconsin's patient compensation fund remains to be seen.

4) Require the patient compensation funds to offer incentives for injury deterrence. This can be done by experience rating premiums or by providing premium discounts to low-risk health care providers.

5) Avoid pay-as-you go financing. In the first few years of a pay-as-you-go financing system, losses are low because most claims have not been reported or resolved. Later, however, losses will rise, and fund administrators will be forced to raise surcharges to pay off claims.[43]

III. COMMITTEE MEETINGS

After its establishment, the Joint Interim Committee on a Missouri Health Care Stabilization Fund met four times. Following are the dates and places of the committee's public hearings:

July 6, 2005	Jefferson City
August 3, 2005	Excelsior Springs
August 17, 2005	Springfield
September 15, 2005	Jefferson City

At these meetings, the joint interim committee heard testimony from many different

[43] Sloan, *supra* note 31, pages 268-271.

interest groups. The following pages include a summary of the relevant testimony and the recommendations of the Joint Interim Committee on Missouri Health Care Stabilization Fund.

A. JEFFERSON CITY - ORGANIZATION MEETING

On July 6, 2005, the Joint Interim Committee on the Health Care Stabilization Fund held an organizational meeting. Senator Stouffer was recognized as the committee's chairman and Representative Dempsey was elected as its vice-chair. In addition to selecting the committee's leadership, reviewing possible meeting times, and adopting a mission statement, the committee heard testimony from Kimberly Grinston, from the Department of Insurance. Kimberly Grinston gave a PowerPoint presentation that outlined the Kansas Health Care Stabilization Fund and presented the advantages and disadvantages of creating such a fund within Missouri .

The committee also heard testimony from Geri Morrison from Medical Assurance Company, a medical malpractice insurance company licensed in Missouri. Ms. Morrison testified that the success of the Kansas Health Care Stabilization Fund cannot be separated from the fact that (1) strong tort reform measures were enacted at the same time the fund was created; (2) participation within the fund by health care providers is mandatory; and (3) the fund offers affordable tail insurance. According to Ms. Morrison, the key to implementing a successful fund is pricing and tracking losses. Ms. Morrison argued, however, that establishing a fund at this date would not result in immediate medical malpractice rate reductions.

The committee also heard testimony from Mike Delaney, president of Missouri Hospital Plan. Missouri Hospital Plan is a Chapter 383 medical malpractice insurance company that insures hospitals only. Mr. Delaney pointed out that Missouri's law and health care climates are not the same as in Kansas. Mr. Delaney suggested that Missouri should wait to see what the results are from the recent tort reform legislation before creating a health care stabilization fund.

B. EXCELSIOR SPRINGS MEETING

On August 3, 2005, the committee met in Excelsior Springs, Missouri. The committee heard testimony from doctors who represented various medical associations, as well as testimony from medical malpractice defense attorneys.

Dr. Steve Reintjes, representing Kansas City Neurosurgery Group, testified that the Kansas Health Care Stabilization Fund has made medical malpractice insurance more affordable and available since the fund's inception in 1976. He stated that in the mid-1970s, Kansas was experiencing a large migration of health care providers leaving Kansas due to the unavailability of medical malpractice insurance. In fact, the state of Kansas started paying people to go to medical school provided they would stay in Kansas following their education. Dr. Reintjes stated that the fund was able to make insurance more affordable because Kansas law requires all health care providers to participate in the fund. Mandatory participation creates a large pool to spread the risk (between high and low specialties). Dr. Reintjes distributed a chart to the committee members demonstrating the insurance premium costs for Missouri and Kansas health care

providers for the current year. According to the data provided by Dr. Reintjes, the rates for a million dollar policy for an internal medicine doctor, a general surgeon, or an OB/GYN under the Kansas plan is approximately 50 percent less expensive than a similar policy for a Missouri health care provider. Dr. Reintjes also hailed the Kansas Health Care Stabilization Fund because it provides free tail coverage. He noted that tail coverage is often difficult to obtain on the private market and is very expensive.

Tom Reardon from the Metropolitan Medical Society of Greater Kansas City stated that there is a crisis in the western part of Missouri because doctors are leaving the state due to high medical malpractice insurance. He noted that Missouri has a hostile medical malpractice environment. He also stated that the Department of Insurance needs more statistical data regarding medical malpractice claims such as the number of cases filed versus the number of claims actually litigated.

Patricia Smith, an OB/GYN who practices in the northern part of Kansas City, testified that she has trouble retaining competent doctors because of expensive medical malpractice insurance. She noted that her hospital has lost 43 physicians recently, some to Kansas. Dr. Smith also stressed that besides high medical malpractice insurance rates, Kansas City doctors are receiving lower reimbursements for services compared to other areas of the state (stated that Springfield doctors receive 30 percent more). Finally, Dr. Smith noted that she would prefer stability over market competition between insurance companies.

Dr. John Lorei of Missouri Physicians Mutual testified against the establishment of a health care stabilization fund in Missouri. He stated that there is no conclusive evidence that patient compensation funds make medical malpractice insurance more affordable or available. He noted that several states are phasing out their PCFs. Dr. Lorei did state that Kansas has the most successful patient compensation fund due to the fact that it requires mandatory participation, employs loss reserving, and bases its rates on actuarial principles. He stated that a patient compensation fund might not work in Missouri due to demographics. First, payouts are three times higher in Missouri than in Kansas. He also noted that St. Louis and Kansas City are more plaintiff friendly venues than Kansas in general. He stated that an AMA study found 5 out of 9 states that had patient compensation funds were considered problem or medical malpractice crisis states.

Dr. Lorei listed the following problems with patient compensation funds:

1) Lack of empirical evidence that patient compensation funds make medical malpractice insurance rates more affordable or make insurance more available;

2) Kansas and Missouri have different demographics;

3) Mandatory participation within a patient compensation fund is unfair in that it requires low-risk health care providers to subsidize the high-risk providers;

4) Unfair competition – a fund would replace reinsurance for the most part. Only 1 percent of claims are $1 million or more. 95 percent of claims are $300,000 or less;

5) Patient compensation funds create a moral hazard for insurance companies because the companies will not defend lawsuits beyond the amount they are obligated to pay. Insurance companies will not have the incentive to defend the lawsuits in that the failure to so will not affect the reinsurance rates they pay because the fund is now the reinsurer for the most part;

6) Patient compensation funds do not promote patient safety; and

7) Patient compensation funds will be too bureaucratic.

Terry Kilroy and Perry Toll from the law firm of Shugart, Thompson and Kilroy lauded the success of the Kansas Health Care Stabilization Fund. Perry Toll posited the following factors for the success of the Kansas Health Care Stabilization Fund:

1) The elimination of vicarious liability among health care providers;

2) Kansas law allows judgments or settlements over $300,000 to be paid over a period of time;

3) Kansas fund does not cover sexual misconduct claims;

4) Kansas fund has the ability to expel health care providers with several claims (bad apples);

5) Kansas has created the Health Care Provider Insurance Availability Plan to provide basic coverage for providers who cannot obtain coverage from the private market;

6) Kansas fund provides tail coverage for inactive health care providers, and Kansas law requires insurers to provide prior acts coverage for all periods of fund compliance – this provision keeps providers from purchasing tail coverage when changing primary insurers; and

7) The Kansas fund is actuarially sound.

Bill Yocum, an attorney with Shugart, Thompson and Kilroy, stated that he supports the concept of a patient compensation fund because a fund would limit the primary insurance company's exposure to risk and that mandatory participation of all health care providers helps spread the risk across a large pool.

Dr. Rose, a doctor from Higginsville, stated that a PCF would be a temporary fix. He would prefer a no-fault system or something similar to the Second Injury Fund.

John Parisi, a plaintiff's attorney from the law firm Shamberg, Johnson & Bergman, testified regarding the positive and negative aspects of creating a patient compensation fund. He stated

that a fund is good from a medical malpractice victim's standpoint in that it provides money in which victims can utilize. If the fund is mandatory, doctors will not be able to practice "naked." Mr. Parisi stated that if Missouri was to implement a fund similar to Kansas, the fund should provide interest payments on future payouts. Kansas law requires interest on future payments but requires a judgment to be obtained first. Mr. Parisi also stated that if Missouri created its own fund it should not follow Kansas law with respect to forfeiting fund coverage if the plaintiff does not serve notice upon the fund within 10 days of filing a claim. Mr. Parisi also stated that Missouri should require all insurance companies issuing medical malpractice policies to make their records available (claims data, premium breakdown, etc.).

Sally Nance, the CEO of Excelsior Springs Medical Center, testified that Missouri's high medical malpractice rates have made it difficult for the city-owned hospital to retain physicians. Many of the physicians have moved to Kansas, and the loss of physicians is placing a tremendous stress on the hospital.

Kimberly Grinsten from the Department of Insurance fielded questions from members of the committee. The committee asked her to provide a list of the type of information the department would like to obtain from insurance companies regarding medical malpractice claims.

C. TOPEKA, KANSAS MEETING

On August 4, 2005, the committee traveled to Topeka, Kansas, to meet with officials from the Kansas Health Care Stabilization Fund. Fund officials presented an overview and history of the Kansas fund.

Rita Noll, the chief attorney for the Kansas Health Care Stabilization Fund noted that the fund was created in 1976 not to address the issue of affordability but to address the issue of availability. Mrs. Noll also stated that the success of the Kansas fund is also due in large part to tort reform measures such as caps on wrongful death damages and non-economic damages and the abrogation of vicarious liability among health care providers.

Kansas officials noted various reasons why coverage provided by the fund is more affordable than that provided by the private market. The fund's administrative costs are approximately 3 percent while other private insurers have administrative costs hovering around 38 percent. The fund is not profit-driven and does not have the expenses of private insurers (advertising, commissions, etc.). Kansas officials also emphasized that, unlike the private insurance market, the fund has stabilized rates. Even when fund rates have increased, the increases have not been dramatic. The fund has fostered a climate of stability and predictability with respect to medical malpractice insurance rates.

Kansas officials did note that they probably would modify their state law by increasing the $200,000 threshold which triggers fund coverage. Today the $200,000 threshold is frequently breached, making the fund act less like an excess liability carrier. Furthermore, the lower attachment point makes private insurance companies spread their fixed administrative costs over

a lower premium volume.

D. SPRINGFIELD, MISSOURI MEETING

On August 17, 2005, the committee traveled to Springfield, Missouri to meet with various insurance companies and the Missouri Hospital Association. The testimony centered upon whether insurance companies and the Missouri Hospital Association would support establishing a patient compensation fund.

Walter "Buck" Long, the Vice President of Marketing/Underwriting of Intermed Insurance Company, testified on behalf of the company. Mr. Long gave a brief overview of the history of patient compensation funds. Mr. Long stated that he does not believe a patient compensation fund in Missouri would be as successful as the Kansas Health Care Stabilization Fund due to the legal climate in Missouri. He stated that Intermed Insurance Company was generally opposed to patient compensation funds due to their inflexibility and bureaucratic nature. He cited an example from Kansas where doctors must consult the board of directors in order to change their primary coverage limits. He also stated that settling claims could be more cumbersome with the existence of a patient compensation fund. Mr. Long emphasized that Missouri's recent tort reforms will help stabilize premiums.

Daniel Landon, the Vice President of Governmental Relations for the Missouri Hospital Association, testified that hospitals should be excluded from participating in any fund that might be established by the Missouri legislature. Mr. Landon stated that a patient compensation fund system was not a better method for hospitals to insure their liability and that of their employees for various reasons. Information from Kansas and other states indicates that most funds were formed to address the issue of availability rather than the issue of affordability of coverage. He stated that Missouri already has addressed the issue of availability of coverage for hospitals by allowing physicians and hospitals to form "383" companies. Mr. Landon testified that 75 Missouri hospitals are covered by a "383" company (Healthcare Services Group). In essence, a "383" company offers health care providers several of the benefits ascribed to patient compensation fund. For example, low administrative and procurement expenses are passed along to the provider in the form of lower premiums. In addition, "383s" are managed by health care providers just as the Kansas Health Care Stabilization Fund Board is comprised of health care providers.

Mr. Landon also noted that in Kansas and in other states with patient compensation funds, it is common for hospitals to purchase excess coverage beyond the liability limits available from such funds. This creates a three-tier system of coverage - primary, patient compensation fund, and excess coverage. Mr. Landon expressed concern that unless a fund's limit on liability is sufficiently high, there might be a gap of coverage between the fund's liability limit and the attachment point of private excess coverage, thereby leaving hospitals exposed to higher degree of risk.

Mr. Landon also stated that hospitals should not be required to participate in a patient

compensation fund because it may not include coverage for long-term care services provided within the hospital, requiring the hospitals to purchase supplemental private coverage.

Finally, Mr. Landon stated that hospitals should not be required to participate in any patient compensation fund that might be established because of the overall track record of the funds in other states. He noted that although the Kansas program appears to be successful, state programs in states such as Florida and Pennsylvania have been forced to terminate their operations.

Tom Holloway, the Director of Governmental Relations for the Missouri State Medical Association, presented a list of questions he received from physicians concerning the creation of a health care stabilization fund. Mr. Holloway noted that the association members' interest in creating a patient compensation fund varied depending upon where the physician practiced medicine. In Eastern Missouri, the interest is not very great. Physicians in the Springfield area are not very interested in creating a fund in that their insurance is provided by their employers, the hospitals. The interest in creating a fund comes primarily from physicians who practice in Western Missouri who know of doctors practicing on the opposite side of the border that are paying lower rates.

D. JEFFERSON CITY MEETING

On September 15, 2005, the committee met in Jefferson City to determine and finalize the committee's recommendations.

Senator Stouffer noted at the outset that he thought there was not unanimous consensus among the committee members to recommend the creation of a health care stabilization fund. Senator Stouffer stated that medical community was divided on the issue. Health care providers in the western part of the state generally supported the idea of a health care stabilization fund, while health care providers in the southern and eastern parts of the state were either opposed to its creation or were indifferent to such an idea. Senator Stouffer also emphasized that the committee did not have enough data to determine whether the Missouri market would support the creation of a health care stabilization fund. Senator Stouffer stated that there are too many unknown variables in the insurance market to recommend the creation of a health care stabilization fund at this date.

Senator Stouffer suggested that the legislature should give the Department of Insurance the authority to collect data it is currently unable to collect from medical malpractice insurance companies. The Department of Insurance provided a list of the current data collected pursuant to section 383.105, RSMo. Representatives from the Department of Insurance noted that the department had limited enforcement authority in enforcing the current law and that it only limited enforcement authority to collect data from surplus line carriers and self-insured providers. The department also provided a list of the additional types of data it would like to collect from insurance companies.

With the additional data collected by the Department of Insurance, Senator Stouffer suggested

that a legislatively created board under the control of the Department of Insurance could analyze the data and better determine whether a health care stabilization fund would be feasible in Missouri. Senator Stouffer also noted that the data might support the idea of creating a limited health care stabilization fund, which might be comprised of health care providers from a certain geographical region of the state or perhaps a fund comprised of only certain specialties.

Although the charge of the committee was primarily to determine the feasibility of creating a health care stabilization fund, Senator Stouffer suggested that the General Assembly should consider enacting further tort reform and insurance reform. Noting that Kansas' tort environment is different than Missouri's, Senator Stouffer stated that the success of any fund created in Missouri might depend on mirroring Kansas' tort laws. Specifically, he suggested that the General Assembly explore whether to eliminate vicarious liability among health care professionals as Kansas has done. Kansas law bars vicarious liability between two medical care providers if both are covered under the Health Care Stabilization Fund. Other members of the committee suggested that the General Assembly should review Kansas' law on bad faith and review panels. Other members of the committee also noted that the General Assembly should explore medical malpractice insurance reforms such as those contained in House Bill 394 (2005), particularly requiring insurance companies to provide 60 to 90 days notice before cancelling a policy.

IV. RECOMMENDATIONS

After review of all the information received by the committee during its four public hearings, the committee has determined that the following recommendations should be made to the General Assembly:

1. The General Assembly should delay enacting any legislation creating a health care stabilization fund in that there is insufficient information regarding its feasibility in Missouri. The testimony adduced during the hearings did not reveal whether creating a health care stabilization fund would significantly lower medical malpractice premium rates for health care providers although it was clear that at least in Kansas it has both significantly stabilized and lowered those rates;

2. The General Assembly should enact legislation authorizing the Department of Insurance to collect additional medical malpractice insurance data. Although current law (section 383.105) requires insurance companies to report medical malpractice claim data, the statute is not comprehensive with respect to the types of data that must be reported, and the department lacks little authority to enforce the law. The General Assembly should give the Department of Insurance the authority to collect data which is regional and speciality specific because different areas of the state and different medical specialties are affected differently by the medical malpractice insurance crisis. The General Assembly should also give the Department of Insurance the authority to collect the additional data for the past four years as well as prospectively. The department also noted that it has limited enforcement authority to collect data from surplus lines and self-insured providers;

3. The General Assembly should create a board for a period of two years, similar to which oversees the Kansas Health Care Stabilization Fund, to analyze the additional data collected by the Department of Insurance and make recommendations derived from that data regarding the adequacy of Missouri's laws as they pertain to promoting affordable medical malpractice rates for physicians and thus adequate access to care for Missouri patients;

4. The General Assembly should explore Kansas' tort reform laws. The committee has determined that if Missouri were to establish a health care stabilization fund, it should be patterned after the Kansas model. The success of the Kansas Health Care Stabilization Fund is partially due the state's tort reform laws. Specifically, the General Assembly should determine whether abrogating vicarious liability among health care providers, eliminating bad faith actions, and adopting other tort reform measures would lower medical malpractice rates;

5. The General Assembly should adopt some medical malpractice insurance reform measures. For instance, the General Assembly should require insurance companies to provide notice to health care providers 60 to 90 days before canceling their medical malpractice insurance policies. Other insurance reform measures that were contained in Representative Byrd's bill (House Bill 394) from the 2005 legislative session should be reconsidered.

***Exhibit 1 Patient Compensation Fund State Comparison**

	Florida Birth-Related Neurological Injury Compensation Association	Florida Patient Compensation Fund	Indiana Patient Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patient Compensation Fund	Medical Care Availability and Reduction of Error (Mcare) (PA)	South Carolina Patients Compensation Fund	Virginia Birth-Related Injury Compensation Fund	Wisconsin Injured Patients and Families Compensation Fund
Goal of PCF	To provide an exclusive no-fault remedy for birth-related neurological injury claims	"paying out that portion of any claim arising out of the rendering of or failure to render medical care services.. For health care providers.. Which is in excess of the fund entry level"	To provide a system of excess insurance for health care providers	"to provide excess professional liability coverage for defined health care providers"	"to guarantee that affordable medical malpractice coverage was available to all private providers"	"an alternate way to determine medical malpractice claims and to ensure that malpractice insurance coverage in Nebraska is available at reasonable rates"	"to promote the health and welfare of the people of New Mexico by making available professional liability for health care providers in New Mexico"	"to pay claims against participating health care providers for losses or damages awarded in medical professional liabililty actions in excess of the basic insurance coverage required"	To pay that portion of a medical malpractice or general liability claim, settlement, or judgment against a licensed health care provider which is in excess of $100,000	The exclusive remedy for birth-related neurological injuries in Virginia	"(T)o provide excess medical malpractice coverage for health care providers"
Enabling Legislation	Florida Statute 766.303	Florida Statute 766.105	IC 34-18	K.S.A. 40-3401 K.S.A. 40-3419	R.S. 40:1299.41 R.S. 40:1299.48	Neb. Rev. Stat. 44-2801-2855	N.M.S.A 41-5	MCARE Act	Code of Laws, Section 38, Chapter 79	V.C.A. 38.2-5000 V.C.A. 38.2-5021	W.S. 655.27
Creation Date	1988	1975	1975	1976	1975	1976	1978	2002	1976	1987	1975
Governance	5 member Board of Directors	11 Member Board of Governors	Commissioner of Department of Insurance	10 Member Board of Governors	PCF Oversight Board	Director of Department of Insurance	Director of Department of Insurance	DOI Administers the Fund	13 Member Board of Governors	7 Member Board of Directors	13 Member Board of Governors
Participation	Voluntary	Hospitals Mandatory, Physicians Voluntary	Voluntary	Mandatory	Voluntary	Voluntary	Voluntary	Mandatory	Voluntary	Voluntary	Mandatory, with exemptions
Eligibility **	Physicians	Physicians, Hospitals, HMOs, Ambulatory Surgical Centers, other medical facilities	Physicians, Hospitals	Physicians, Ostepaths, Chiropractors, Podiatrists, RNAs, Medical Care Facilities, Mental Health Clinics, Dentists, health care LLCs Corps, etc.	Physicians, Hospitals, other health care providers	Physicians, Hospitals, other Health Care Providers	Physicians, Hospitals, other Health Care Providers	Physicians, Hospitals	Physicians, Hospitals	Physicians, Registered Nurses, Midwives, Hospitals	Physicians, Osteopaths, RNs, Nursing Homes, Hospitals, Ambulatory Surgery Centers, Cooperative sickness care associations
Required Primary Coverage ***		$250 K/claim or $500 K/ occurrence	Physicians $250 K/$750 K, Hospitals $250K/ $5M	$200 K /$600K	$100K/$300K	Physicians $500K/$1M, Hospitals $3M aggregate limit	$200K/$600K	Physicians $500K/$1.5M, Hospitals $500K/$2.5M	$200K/$600K	Not applicable, exclusive remedy	$1M/$3M
Primary Coverage Options		Private Insurance or qualified Self-insurance (for hospitals), of JUA	Private Insurance or Qualified Self-Insurance (for Hospitals)	Private Insurance or qualified Self-Insurance	Private Insurance or qualified Self-Insurance	Private Insurance or qualified Self-Insurance	Private Insurance	Private Insurance, JUA or qualifed self-insurance	Private Insurance or qualified Self-Insurance	Not applicable, exclusive remedy	Private Insurance, WHCLIP, or qualified Self-Insurance

	Florida Birth-Related Neurological Injury Compensation Association	Florida Patient Compensation Fund	Indiana Patient Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patient Compensation Fund	Medical Care Availability and Reduction of Error (Mcare) (PA)	South Carolina Patients Compensation Fund	Virginia Birth-Related Injury Compensation Fund	Wisconsin Injured Patients and Families Compensation Fund
PCF Coverage Limits	Unlimited	Physicians either $1M/3M or $2M/$4M (including entry limits), Hospitals $2.5M per claim (no agg.)	$1.25M per occurrence in excess coverage	1. 100K/300K; 2. 300K/900K; 3. 800K/2.4M options available	$500K plus future medical expenses less primary coverage	$1.25M per occurrence in excess coverage	$600K non-economic, unlimited medical	$500K/1.5M	Unlimited	Unlimited medical and 1/2 VA average weekly wage after age 18 for all birth-related neurological injuries	Unlimited
Funding Approach & Revenues	Hospitals ($50 per live birth) and physicians ($5K annually) are assessed by the Association	Annual, Semi-annual, or quarterly assessments	Assessments "on the same as premiums"	Assessments "on the same basis as premiums"	Assessments "on the same basis as premiums"	Assessments as a percentage of underlying premiums	Assessments "on the same basis as premiums"	"rates shall be based on the prevailing primary premium"	Pay-as-you-go Funding	Hospitals ($50 per live birth) and physicians ($5K annually are assessed by the Fund	Administrative costs, operating costs, and claim payments are funded through assessments on participating health care providers"
Funding Collection		Paid to Fund	Collected primary insurer or risk manager as "pass through"	Collected by primary insurer as "pass through"	Collected by primary insurer as "pass through"	Collected by primary insurer as "pass through"	Collected by primary insurer as "pass through"	Collected by primary insurer as "pass through"	Annual payments to the Fund		Health Care providers are billed annually with lump sum or quarterly payments
Claims Administration	Administrative law judge determines covergae, Association staff administers		DOI Staff	Fund Staff monitors all Med Mal claims and suits in the state	Executive Director, Office of Risk Management	Director Administrative Services	DOI Staff	Outsourced	Agency Staff	VA Workers Compensation Commission, servicing carrier to administer payment of claims	Outsourced
Medical Review Board/Pretrial Screenings		Each insurance company has a 90-day period to do any internal pretrial screening	Mandatory for Claims > $15K		Mandatory	Mandory, unless waived	Mandatory		None	Review Panel set by Medical School Deans to determine Fund average	PCF Peer Review Council
Damage Caps	Punitives are limited to three times compensatory damages	Punitives are limited to three times compensatory damages	$250,000 per provider, $1.25M for all qualified providers and the Fund	$250K for non-economic, punitives limited to $5M or highest income in the last 5 years	$500K plus future medical expenses	$1.75M per occurrence	$600K non-economic, unlimited medical	Punitives cannot exceed 200% of compensatory but cannot be < $100K	None	$1M cap on recoveries for bodily injury or death, $350K on punitives	Limits on non-economic damages

	Florida Birth-Related Neurological Injury Compensation Association	Florida Patient Compensation Fund	Indiana Patient Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patient Compensation Fund	Medical Care Availability and Reduction of Error (Mcare) (PA)	South Carolina Patients Compensation Fund	Virginia Birth-Related Injury Compensation Fund	Wisconsin Injured Patients and Families Compensation Fund
Attorneys' Fees	Sliding scale depnding on recovery amount and type of judicial processes required	Sliding scale depnding on recovery amount and type of judicial processes required	15% of PCF awards	Fees require judicial approval	None	No limits, fees are reviewable by judge	None	Unconstitutional	None	None	(a) 33 1/3% of first $1M; (b) 25% of first $1M if liability stipulated within 180 days; and (c) 20% of amount that exceeds $1M
Structured Settlements	Any party may request for future economic damages in excess of $250K	Any party may request for future economic damages in excess of $250K	Allowed, but not required	Not mandatory, but judges are authorized to require	PCF payments "paid as incurred"	Not required	Medical Payments must be paid as they are incurred	Allowed, but not Mandated	Allowed, but not Mandated	Allowed	Encouraged for payments > $100K
Arbitration: Alternative Dispute Resolution (ADR)	Judges can refer cases to nonbinding arbitration. Defendants who admit liability can enter binding arbitration to limit non-economic damages	Judges can refer cases to nonbinding arbitration. Defendants who admit liability can enter binding arbitration to limit non-economic damages	Mandatory Medical Review panel for Claims > $15K	Arbitration Option available	Allowed, but optional	Medical review Panel is a non-binding option	Medical Review Commission Mandatory	Unconstitutional	None		Mediation System

1. This chart is based upon an exhibit found in "Report and Recommendations on the Feasibility of a West Virginia Patient Injury Compensation Fund (2003)."

** The types of providers eligible to participate in a fund are explictly stated in state law. Other health care providers that are listed in this chart may be eligible to partcipate in the fund

*** Where there are two numbers, the first is the limit for each occurrence and the second is the aggregate limit for one year.

		Florida Patient's Compensation Fund	Indiana Patient's Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient's Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patients Compensation Fund	Hospital Excess Liability Pool (NY)	Medical Care Availability and Reduction of Error (Mcare)(PA)	South Carolina Patients' Compensation Fund	Wisconsin Patients Compensation Fund	Wyoming Medical Liability Compensation Account
Governance	**Type of Governing Structure**	11 Member Board of Governors	Commissioner of Department of Insurance	10 Member Board of Governors	9 Member Patient's Compensation Fund Oversight Board	Director of Department of Insurance	Superintendent of Department of Insurance	Commissioner of Health and Superintendent of Insurance	Department of Insurance	13 Member Board of Governors	13 Member Board of Governors	6 Member Medical Liability Compensation Account Board
	Makeup of Board	Board consists of various interest groups: attorney, hospitals, physicians, insurance companies, etc.	Not applicable	Board consists of various medical professionals: MDs, hospitals, nurses, D.O.s, chiropractors	Board is represented by various health care providers based upon percentage of surcharge contribution	Not applicable	Not applicable	Not applicable	Not applicable	Board is comprised of 3 doctors, 2 dentists, 2 hospital representatives, 2 attorneys, 2 insurance representatives and 2 members of general public	Board is compirsed of various interest groups -attorneys, doctors, insurance industry, hospitals, etc.	Board consists of 1 physician, 1 attorney, 1 health care consumer, 1 insurance agent, the commissioner of insurance, and the state treasurer
	Appointment Process	Members are appointed by various interest groups such state bar association and hospital association	Not applicable	Members are appointed by the commissioner of insurance. Commissioner receives a list of nominees from the various associations to choose from	Members are appointed by the governor, subject to Senate confirmation. Governor receives a list of nominees from various professional organizations.	Not applicable	Not applicable	Not applicable	Not applicable	Members are appointed by the governor after consultation with the various professional associations	Members of insurance industry are appointed by commissioner, others are named by professional organization, and governor appoints 4 members of the general public	Members are appointed by the governor with the advice and consent of the Senate

Administration		Florida Patient's Compensation Fund	Indiana Patient's Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient's Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patients Compensation Fund	Hospital Excess Liability Pool (NY)	Medical Care Availability and Reduction of Error (Mcare)(PA)	South Carolina Patients' Compensation Fund	Wisconsin Patients Compensation Fund	Wyoming Medical Liability Compensation Account
	Compliance/Policy Management Staff	Agency for Health Care Administration (for Board of Governors)		Fund Employees	Executive Director	DOI Administrative Staff		Commissioner of Health and Superintendent of Insurance	Department of Insurance Staff	Agency Staff	Administrative Staff	Never formally created
	Billing & Collection		DOI Staff administer payments from Primary Insurers	Fund Employees	Executive Director	DOI Administrative Staff	DOI Staff administer payments from Primary Insurers		Department of Insurance Staff	Agency Staff	Administrative Staff	Never formally created
	Claims Administration		DOI Staff	Fund Staff monitors all Med Mal claims and suits in the state	Executive Director, Office of Risk Management	Director of Administrative Services	DOI Staff	HANYS Services, Inc.	Outsourced	Agency Staff	Outsourced	Never formally created
	Asset Management		Commissioner of Insurance	Director of Investments	PCF Oversight Board	State Treasurer	State Investment Department		State Treasury	State Treasurer	State of Wisconsin Investment Board	State Treasurer
	Asset Allocation	Board of Governors	Claims handling, attorney fees, expense approval, rate setting	Board of Governors, legislative limits		State Treasurer			Old "Cat Fund" Assets and Liabilities were transferred	State Treasurer	Developed by Board of Governors	State Treasurer
	Actuarial Services		Outsourced, Annual reserve and funding study	Outsourced, Annual reserve and funding study	Outsourced, Annual reserve and funding study	DOI Administrative Staff	Outsourced, Biennial Report			Outsourced	Outsourced, annual report required	Never formally created
	DOI Obligations		Claims Handling	Expertise and assistance to Board	Rate Approval	Very broad administrative responsibilities	Rates, administration, claims	Broad Administration	DOI Administers the Fund	Minimal	Provides administrative staff	Administer, Premium Collection, Rates, Reinsurance Purchase

This chart is based upon a chart found in "Preliminary Report on the Feasibility of an Ohio Patients Compensation Fund" prepared by Pinnacle Actuarial Resources, Inc. (February 2003)

FIRST REGULAR SESSION

[PERFECTED]

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 394

93RD GENERAL ASSEMBLY

Reported from the Committee on Insurance Policy March 10, 2005 with recommendation that House Committee Substitute for House Bill No. 394 Do Pass. Referred to the Committee on Rules pursuant to Rule 25(26)(f).

Reported from the Committee on Rules March 14, 2005 with recommendation that House Committee Substitute for House Bill No. 394 Do Pass with no time limit for debate.

Taken up for Perfection March 30, 2005. House Committee Substitute for House Bill No. 394 ordered Perfected and printed, as amended.

STEPHEN S. DAVIS, Chief Clerk

1301L.05P

AN ACT

To repeal sections 383.010, 383.035, 383.079, 383.105, 383.160, 383.165, and 538.230, RSMo, and to enact in lieu thereof twenty-three new sections relating to insurance for health care providers in Missouri.

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

Section A. Sections 383.010, 383.035, 383.079, 383.105, 383.160, 383.165, and 538.230, RSMo, are repealed and twenty-three new sections enacted in lieu thereof, to be known as sections 383.010, 383.035, 383.079, 383.105, 383.112, 383.160, 383.165, 383.400, 383.401, 383.402, 383.403, 383.404, 383.405, 383.406, 383.407, 383.408, 383.409, 383.410, 383.412, 383.425, 383.430, 383.435, and 538.230, to read as follows:

383.010. 1. Notwithstanding any direct or implied prohibitions in chapter 375, 377, or 379, RSMo, any three or more persons, residents of this state, being licensed under the provisions of chapter 330, 331, 332, 334, 335, 336, 338 or 339, RSMo, or under rule 8 of the supreme court of Missouri or architects licensed pursuant to chapter 327, RSMo, may, as provided in sections 383.010 to 383.040, form a business entity for the purpose of providing malpractice insurance or indemnification for such persons upon the assessment plan, and upon compliance with section 379.260, RSMo, liability and automobile insurance as defined in

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

subdivisions (1) and (3) of section 379.230, RSMo, may be provided upon the assessment plan to those persons licensed pursuant to chapter 197, RSMo, and for whom medical malpractice insurance is provided under this section, except that automobile insurance shall be provided only for ambulances as defined in section 190.100, RSMo. Hospitals, public or private, whether incorporated or not, as defined in chapter 197, RSMo, if licensed by the state of Missouri, professional corporations formed under the provisions of chapter 356, RSMo, for the practice of law and corporations, copartnerships or associations licensed under the provisions of chapter 339, RSMo, may also become members of any such entity. The term "persons" as used in sections 383.010 to 383.040 includes such hospitals, professional corporations and real estate business entities.

2. Anything in this section to the contrary notwithstanding, any persons duly licensed under the provisions of the laws of any other state who, if licensed under any similar provisions of the laws of this state, would be eligible to become members and insureds of an entity created under the authority of this section, may become members and insureds of such an entity, irrespective of whether such persons are residents of this state; provided, however, that any such persons must be employed by, or be a partner, shareholder or member of, a professional corporation, corporation, copartnership or association insured by or to be insured by such an entity.

3. **[**Notwithstanding any provision of law which might be construed to the contrary, sections 379.882 and 379.888, RSMo, defining "commercial casualty insurance", shall not include professional malpractice insurance policies issued by any insurer in this state.**] Insurers writing professional malpractice insurance shall be subject to the provisions of section 379.321, RSMo; provided, however, that insurers writing medical malpractice insurance shall also be subject to the provisions of sections 383.400 to 383.412.**

383.035. 1. Any association licensed pursuant to the provisions of sections 383.010 to 383.040 shall be subject to the provisions of the following provisions of the revised statutes of Missouri:

(1) Sections 374.010, 374.040, 374.046, 374.110, 374.115, 374.122, 374.170, 374.210, 374.215, 374.216, 374.230, 374.240, 374.250 and 374.280, RSMo, relating to the general authority of the director of the department of insurance;

(2) Sections 375.022, 375.031, 375.033, 375.035, 375.037 and 375.039, RSMo, relating to dealings with licensed agents and brokers;

(3) Sections 375.041 and 379.105, RSMo, relating to annual statements;

(4) Section 375.163, RSMo, relating to the competence of managing officers;

(5) Section 375.246, RSMo, relating to reinsurance requirements, except that no association shall be required to maintain reinsurance, and for insurance issued to members who

joined the association on or before January 1, 1993, an association shall be allowed credit, as an asset or as a deduction from liability, for reinsurance which is payable to the ceding association's insured by the assuming insurer on the basis of the liability of the ceding association under contracts reinsured without diminution because of the insolvency of the ceding association;

(6) Section 375.390, RSMo, relating to the use of funds by officers for private gain;

(7) Section 375.445, RSMo, relating to insurers operating fraudulently;

(8) Section 379.080, RSMo, relating to permissible investments, except that limitations in such section shall apply only to assets equal to such positive surplus as is actually maintained by the association;

(9) Section 379.102, RSMo, relating to the maintenance of unearned premium and loss reserves as liabilities, except that any such loss reserves may be discounted in accordance with reasonable actuarial assumptions**;**

(10) Sections 383.100 to 383.112 relating to reports from medical malpractice insurers;

(11) Section 379.321, RSMo, relating to commercial casualty rate filing requirements;

(12) Sections 374.202 to 374.207, RSMo, relating to the examination powers of the director of insurance; and

(13) Sections 383.400 to 383.412 relating to notification, data reporting, and rating requirements.

2. Any association which was licensed pursuant to the provisions of sections 383.010 to 383.040 on or before January 1, 1992, shall be allowed until December 31, 1995, to comply with the provisions of this section as they relate to investments, reserves and reinsurance.

3. Any association licensed pursuant to the provisions of sections 383.010 to 383.040 shall file with its annual statement a certification by a fellow or an associate of the Casualty Actuarial Society. Such certification shall conform to the National Association of Insurance Commissioners annual statement instructions unless otherwise provided by the director of the department of insurance.

4. The director of the department of insurance shall have authority in accordance with section 374.045, RSMo, to make all reasonable rules and regulations to accomplish the purpose of sections 383.010 to 383.040, including the extent to which insurance provided by an association may be extended to provide payment to a covered person resulting from a specific illness possessed by such covered person; except that no rule or regulation may place limitations or restrictions on the amount of premium an association may write or on the amount of insurance or limit of liability an association may provide.

5. Other than as provided in this section, no other insurance law of the state of Missouri shall apply to an association licensed pursuant to the provisions of this chapter, unless such law shall expressly state it is applicable to such associations.

6. If, after August 28, 1992, and after its second full calendar year of operation, any association licensed under the provisions of sections 383.010 to 383.040 shall file an annual statement which shows a surplus as regards policyholders of less than zero dollars, or if the director of the department of insurance has other conclusive and credible evidence more recent than the last annual statement indicating the surplus as regards policyholders of an association is less than zero dollars, the director of the department of insurance may order such association to submit, within ninety days following such order, a voluntary plan under which the association will restore its surplus as regards policyholders to at least zero dollars. The director of the department of insurance may monitor the performance of the association's plan and may order modifications thereto, including assessments or rate or premium increases, if the association fails to meet any targets proposed in such plan for three consecutive quarters.

7. If the director of the department of insurance issues an order in accordance with subsection 6 of this section, the association may, in accordance with chapter 536, RSMo, file a petition for review of such order. Any association subject to an order issued in accordance with subsection 6 of this section shall be allowed a period of three years, or such longer period as the director may allow, to accomplish its plan to restore its surplus as regards policyholders to at least zero dollars. If at the end of the authorized period of time the association has failed to restore its surplus to at least zero dollars, or if the director of the department of insurance has ordered modifications of the voluntary plan and the association's surplus has failed to increase within three consecutive quarters after such modification, the director of the department of insurance may allow an additional time for the implementation of the voluntary plan or may exercise his powers to take charge of the association as he would a mutual casualty company pursuant to sections 375.1150 to 375.1246, RSMo. Sections 375.1150 to 375.1246, RSMo, shall apply to associations licensed pursuant to sections 383.010 to 383.040 only after the conditions set forth in this section are met. When the surplus as regards policyholders of an association subject to subsection 6 of this section has been restored to at least zero dollars, the authority and jurisdiction of the director of the department of insurance under subsections 6 and 7 of this section shall terminate, but this subsection may again thereafter apply to such association if the conditions set forth in subsection 6 of this section for its application are again satisfied.

8. Any association licensed pursuant to the provisions of sections 383.010 to 383.040 shall place on file with the director of the department of insurance, except as to excess liability risks which by general custom are not written according to manual rates or rating plans, a copy of every manual of classifications, rules, underwriting rules and rates, every rating plan and every

modification of the foregoing which it uses. Filing with the director of the department of insurance within ten days after such manuals, rating plans or modifications thereof are effective shall be sufficient compliance with this subsection. Any rates, rating plans, rules, classifications or systems in effect or in use by an association on August 28, 1992, may continue to be used by the association. Upon written application of a member of an association, stating his reasons therefor, filed with the association, a rate in excess of that provided by a filing otherwise applicable may be used by the association for that member.

383.079. The director shall compile a statistical summary of all data submitted and shall issue a public report to the Missouri Bar and the supreme court of the state of Missouri. **Beginning not later than December 31, 2005, and annually thereafter, the director shall report to the general assembly an accurate report as to the actual rates charged for malpractice insurance and any changes in those rates from the previous year.**

383.105. 1. Every insurer providing medical malpractice insurance to a Missouri health care provider and every health care provider who maintains professional liability coverage through a plan of self-insurance shall submit to the director of the department of insurance a report of all claims, both open claims filed during the reporting period and closed claims filed during the reporting period, for medical malpractice made against any of its Missouri insureds during the preceding three-month period.

2. The report shall be in writing and contain the following information:

(1) Name and address of the insured and the person working for the insured who rendered the service which gave rise to the claim, if the two are different;

(2) Specialty coverage of the insured;

(3) Insured's policy number;

(4) Nature and substance of the claim;

(5) Date and place in which the claim arose;

(6) Name, address and age of the claimant or plaintiff;

(7) Within six months after final disposition of the claim, the amounts paid, if any, and the date and manner of disposition (judgment, settlement or otherwise);

(8) Expenses incurred; and

(9) Such additional information as the director may require.

3. As used in this section, "insurer" includes every insurance company authorized to transact insurance business in this state, every unauthorized insurance company transacting business pursuant to chapter 384, RSMo, every risk retention group, every insurance company issuing insurance to or through a purchasing group, **every entity operating under this chapter,** and any other person providing insurance coverage in this state**[**. With respect to any insurer transacting business pursuant to chapter 384, RSMo, filing the report required by this section

shall be the obligation of the surplus lines broker or licensee originating or accepting the insurance**], including self-insured health care providers**.

383.112. 1. Any insurer, as defined in section 383.105, that fails to timely report claims information as required by sections 383.100 to 383.125 shall be subject to the penalties applicable to insurance companies under section 374.215, RSMo.

2. For purposes of sections 383.100 to 383.125, any guarantee association paying claims on behalf of an insolvent insurer shall be subject to the same reporting requirements as the insolvent insurer.

383.160. 1. All association policies of insurance shall be written so as to apply to injury which results from acts or omissions occurring during the policy period. No policy form shall be used by the association unless it has been filed with the director and approved **[**or thirty days have elapsed and he has not delivered to the board written disapproval of it as misleading or not in the public interest**]**. The director shall have the power to disapprove any policy form previously approved if found by him after hearing to be misleading or not in the public interest.

2. Cancellation of the association's policies shall be governed by law.

3. The rates, rating plans, rating rules, rating classifications and territories applicable to the insurance written by the association and statistics relating thereto shall be subject to the casualty rate regulation law giving due consideration to the past and prospective loss and expense experience in medical malpractice insurance of all of the insurers, trends in the frequency and severity of losses, the investment income of the association, and such other information as the director may require. All rates shall be actuarially sound and shall be calculated to be self-supporting.

4. In the event sufficient funds are not available for the sound financial operation of the association, additional funds shall be raised by making an assessment on all member companies. Assessments shall be made against members in the proportion that the net direct premiums for the preceding calendar year of each member for each line of insurance requiring it to participate in said plan bear to the net direct premiums for the preceding calendar year of all members for such line of insurance; provided that, assessments made pursuant to sections 383.150 to 383.195 shall not exceed in any calendar year one percent of each member's net direct premiums attributable to the line or lines of insurance the writing of which requires it to be a member.

5. All members shall deduct the amount of any assessment from past or future premium taxes due but not yet paid the state.

6. Any funds which result from policyholder premiums and other revenues received in excess of those funds required for reserves, loss payments and expenses incurred and accrued at the end of any calendar year shall be paid proportionately to the general fund to the extent that credit against premium tax liability has been granted pursuant to subsection 5 **of this section** and

to members which have been assessed but have not received tax credits as provided in subsection 5 **of this section**.

383.165. Each policyholder shall pay to the association in the first policy year, in addition to the premium payment due for insurance through the association, an amount equal to said premium payment. Such charge shall be separately stated in the policy. **Such charge shall be paid in the form of cash or cash equivalent and not in the form of a promissory note.**

383.400. 1. As used in sections 383.400 to 383.412, the term "insurer" or "insurers" means any insurance company, mutual insurance company, medical malpractice association, any entity created under this chapter, or other entity providing any insurance to any health care provider, as defined in section 538.205, RSMo, practicing medicine in the state of Missouri, against claims for malpractice or professional negligence; provided, however, that the term "insurer" or "insurers" shall not mean any surplus lines insurer operating under chapter 384, RSMo, or any entity to the extent it is self-insuring its exposure to medical malpractice liability.

2. Notwithstanding any other provision of law, no insurer shall, with regards to medical malpractice insurance, as defined in section 383.150:

(1) Charge an assessment or surcharge, or increase the premium charges, by more than ten percent for such insurance without first providing written notice by certified United States mail to the insured at least sixty days prior to the effective date of such actions; provided, however, such notice is not required if the premium change is due to the request of the insured;

(2) Fail or refuse to renew the aforesaid insurance without first providing written notice by certified United States mail to the insured at least sixty days prior to the effective date of such actions, unless such failure or refusal to renew is based upon a failure to pay sums due or a termination or suspension of the health care provider's license to practice medicine in the state of Missouri, termination of the insurer's reinsurance program, or a material change in the nature of the insured's health care practice; or

(3) Cease the issuance of such policies of insurance in the state of Missouri without first providing written notice by certified United States mail to the insured and to the Missouri department of insurance at least one hundred eighty days prior to the effective date of such actions.

3. Any insurer that fails to provide the notice required under subdivisions (1) and (2) of subsection 2 of this section shall, at the option of the insured, continue the coverage in accordance with the provisions of subdivision (2) of subsection 6 of section 379.321, RSMo.

383.401. The Missouri department of insurance shall, prior to May 30, 2006, establish risk-reporting categories for medical malpractice insurance premiums, as defined in section 383.150, and shall establish regulations for the reporting of all premiums charged by such categories. The Missouri department of insurance shall consider the history of prior court judgments for claims under chapter 383, in each county of the state in establishing the risk reporting categories.

383.402. All insurers shall, with regards to medical malpractice insurance as defined in section 383.150, provide to the Missouri department of insurance, beginning on June 1, 2006, and not less than annually thereafter, an accurate report as to the actual rates, including assessments levied against members, charged by such company for such insurance, for each of the risk-reporting categories established in section 383.401.

383.403. Not later than December 31, 2008, and at least annually thereafter, the Missouri department of insurance shall, utilizing the information provided pursuant to section 383.402 establish and publish, a market rate reflecting the median of the actual rates charged for each of the aforesaid risk-reporting categories for the preceding year by all insurers with at least a three percent market share of a respective risk-reporting category as of December thirty-first of the prior year which have been certified to have rates which are not inadequate by an actuary chosen by the Missouri department of insurance.

383.404. After January 1, 2009, insurance premium rates charged by any insurer, with regards to medical malpractice insurance as defined in section 383.150, which are no greater than twenty percent higher, or twenty percent lower than the market rate established pursuant to section 383.403, shall be presumed to be reasonable.

383.405. After January 1, 2009, insurance premium rates charged by any insurer, with regards to medical malpractice insurance as defined in section 383.150, which are greater than twenty percent higher, or twenty percent lower than the market rate established pursuant to section 383.403, shall be presumed to be unreasonable.

383.406. 1. As used in this section, "director" means the director of the department of insurance.

2. If any insurer proposes to increase or decrease the premium rates so that they are presumed to be unreasonable under section 383.405 for medical malpractice insurance as defined in section 383.150, the insurer shall notify the director in writing at least sixty days prior to the effective date of the proposed premium rate change. The notice shall include a detailed description of the proposed premium rate change, actuarial justification for the premium rate change, and such other information as the director may prescribe by rule.

3. Within ten days of receipt of the notice from the insurer, the director shall set a date for a hearing on the proposed premium rate change and shall publish notice of the hearing. The date set for the hearing shall be within thirty days after receipt of the notice from the insurer. The director shall provide a copy of any information filed by the insurer under subsection 2 of this section to any person making a written request for such information. The hearing may, at the director's discretion, be a public hearing.

4. At the hearing, the insurer may provide additional information in support of its proposed premium rate change, and any member of the public may provide information in support of or in opposition to the proposed premium rate change. The director may call upon the director's own experts to review the proposed premium change and may question the insurer about the proposal at the hearing.

5. Within twenty days after the close of the hearing, the director shall review all of the information submitted and determine whether the proposed premium rate change is justified. No rate shall be considered justified that is excessive, inadequate, or unfairly discriminatory. If the director determines that the rate is justified, the director shall issue an order authorizing the insurer to use the premium rate as proposed. If the director determines that the rate has not been justified by the insurer, the director shall issue an order prohibiting the use of the premium rate as proposed. The insurer may appeal the order under chapter 536, RSMo.

6. No insurer who charges a premium rate that is presumed to be unreasonable under section 383.405 because the rate is greater than twenty percent lower than the market rate shall be subject to the hearing requirements in this section if the insurer files a certificate of actuarial soundness with the director of the department of insurance.

383.407. For purposes of sections 383.404 to 383.412, the following terms mean:

(1) "Base rate", the premium rate designed to reflect the average aggregate experience of a particular health care provider classification prior to adjustment for individual risk characteristics;

(2) "Schedule rating or individual risk rating credits or debits", rating factors or adjustments applied to an insurer's base rates to increase or decrease the premium of an individual insured or unit or exposure to adjust the base rate to account for individual risk characteristics not reflected in the base rate. As used in sections 383.404, 383.405, and 383.406, "insurance premium rate" means the base rate as established herein plus such schedule rating or individual risk rating credits or debits as allowed under regulations promulgated by the department of insurance.

383.408. 1. The department of insurance shall establish reporting standards for insurers by which the insurers shall report their base rates for the health care provider

classifications designated by the department, in whatever categories the department determines to be actuarially appropriate.

2. The department shall collect the information required in subsection 1 of this section and shall create a database to be made available to the public that compares the base rates charged by each insurer actively writing a particular health care provider classification code. Such database may distinguish between base rates for different types of coverage.

383.409. 1. The department of insurance shall establish reporting standards for insurers by which the insurers, or an advisory organization designated by the department, shall annually report such Missouri medical malpractice insurance premium, loss, exposure, and other information as the department may require for the purpose of compiling a Missouri medical malpractice ratemaking database. The reports shall be in a format determined by the department. Such information shall be considered confidential information and shall be a closed record under chapter 610, RSMo.

2. The department shall collect the information required in subsection 1 of this section and compile it in a manner appropriate for assisting Missouri medical malpractice insurers in developing their future base rates, schedule rating or individual risk rating factors, and other aspects of their rating plans. In compiling the information and making it available to Missouri insurers and the public, the department shall remove any individualized information that identifies a particular insurer as the source of the information. The department may combine such information with similar information obtained through insurer examinations so as to cover periods of more than one year.

383.410. After August 28, 2005, when evaluating the base rates of any medical malpractice insurer, including any insurer newly admitted to write medical malpractice insurance in Missouri or any insurer entering such line, in order to determine whether such rates are excessive, inadequate, or unfairly discriminatory, the director of insurance shall, in addition to any other methods of evaluation, use the base rates collected under section 383.408 as a basis for comparison.

383.412. 1. If the director finds that any insurer or filing organization has violated any provision of sections 383.400 to 383.411, the director may impose a penalty of not more than five hundred dollars for each violation, but if the director finds the violation to be willful, the director may impose a penalty of not more than five thousand dollars for each violation. Such penalties may be in addition to any other penalty provided by law.

2. The director may suspend the license of any rating organization or insurer that fails to comply with an order of the director relating to sections 383.400 to 383.411 within the time limited by such order, or any extension thereof which the director may grant. The

director shall not suspend the license of any rating organization or insurer for failure to comply with an order until the time prescribed for an appeal therefrom has expired or if an appeal has been taken, until the order has been affirmed. The director may determine when a suspension of license shall become effective and it shall remain in effect for a period fixed by the director, unless the director modifies or rescinds such suspension or until the order upon which such suspension is based is modified, rescinded, or reversed.

3. No penalty shall be imposed or no license shall be suspended or revoked except upon a written order of the director, stating the director's findings, made after a hearing held upon not less than ten days' written notice to such person or organization specifying the alleged violation.

383.425. 1. Beginning January 1, 2007, any public corporation organized pursuant to section 287.902, RSMo, may form a corporation, association or company for the purpose of issuing medical malpractice insurance, as that term is defined in section 383.100, under the provisions of this section. Any corporation, association, or company formed under the provisions of this section shall be organized and operated as a stock company. The incorporators of such a stock company shall also meet the requirements of chapter 379, RSMo, relating to the organization of insurance companies and the laws of this state governing the organization of private corporations unless the provisions of this section provide otherwise. All insurance laws of this state shall apply to any corporation, association, or company formed under the provisions of this section unless the provisions of this section provide otherwise. No company, corporation or association authorized to issue medical malpractice insurance pursuant to chapter 379 prior to August 28, 2005, shall incorporate under the provisions of this section.

2. In addition to the requirements set forth in section 379.035, RSMo, the declaration and the articles of incorporation filed by the incorporators of the proposed stock company shall provide that the stock insurance company shall issue medical malpractice insurance to health care providers in Missouri.

3. Any company formed under the provisions of this section shall be subject to all provisions of the statutes that relate to private insurance carriers and to the jurisdiction of the department of insurance in the same manner as private insurance carriers, except as provided by the director. The director of the department of insurance may waive the capital and surplus requirements of chapter 379 solely for medical malpractice for any company formed under the provisions of this section for a period of ten years after its incorporation.

4. Notwithstanding section 375.772, RSMo, any stock company incorporated or formed under this section shall not be a member of the Missouri property and casualty

insurance guarantee association, be subject to assessments from such association, nor be classified as an insolvent insurer under sections 375.771 to 375.779, RSMo, unless the company meets the capital and surplus requirements provided in chapter 379, RSMo, and maintains such capital and surplus requirements for a period of not less than three consecutive years. But in no event shall such stock company become a member until its tenth anniversary. After qualifying under this section, the stock company incorporated under the provisions of this section shall participate in the Missouri property and casualty insurance guarantee association pursuant to sections 375.771 to 375.779, RSMo, provided that the company shall continue to meet the capital and surplus requirements provided in chapter 379, RSMo.

5. Any association formed pursuant to sections 383.020 to 383.040 for the purpose of providing medical malpractice insurance to its members, may be merged into one of the stock companies formed under this section.

383.430. The department of insurance shall promulgate rules defining the term "claim" as it applies to claims made for medical malpractice. 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, 2005, shall be invalid and void.

383.435. By January 1, 2010, all insurers writing medical malpractice insurance in this state shall offer medical malpractice policies of insurance which are written so as to apply to injury which results from acts or omissions occurring during the policy period, regardless of the timing of the filing of a claim based on such acts or omissions.

538.230. 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 where fault is apportioned among the parties and persons released pursuant to subsection 3 of this section, the court, unless otherwise agreed by all the parties, shall instruct the jury to apportion fault among such persons and parties, or the court, if there is no jury, shall make findings, indicating the percentage of total fault of all the parties to each claim that is allocated to each party and person who has been released from liability under subsection 3 of this section.

2. The court shall determine the award of damages to each plaintiff in accordance with the findings, subject to any reduction under subsection 3 of this section and enter judgment

against each party liable on the basis of the rules of joint and several liability**[**. However, notwithstanding the provisions of this subsection, any defendant against whom an award of damages is made shall be jointly liable only with those defendants whose apportioned percentage of fault is equal to or less than such defendant**] as established in section 537.067, RSMo**.

3. Any release, covenant not to sue, or similar agreement entered into by a claimant and a person or entity against which a claim is asserted arising out of the alleged transaction which is the basis for plaintiff's cause of action, whether actually made a party to the action or not, discharges that person or entity from all liability for contribution or indemnity but it does not discharge other persons or entities liable upon such claim unless it so provides. However, the claim of the releasing person against other persons or entities is reduced by the amount of the released persons' or entities' equitable share of the total obligation imposed by the court pursuant to a full apportionment of fault under this section as though there had been no release.