FIRST REGULAR SESSION

SENATE BILL NO. 83

93RD GENERAL ASSEMBLY

INTRODUCED BY SENATOR BRAY.

Pre-filed December 1, 2004, and ordered printed.

TERRY L. SPIELER, Secretary.

0444S.03I

AN ACT

To repeal sections 379.316, 383.150, 538.210 and 538.225, RSMo, and to enact in lieu thereof seventeen new sections relating to medical malpractice, with an emergency clause.

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

Section A. Sections 379.316, 383.150, 538.210 and 538.225, RSMo, are repealed and seventeen new sections enacted in lieu thereof, to be known as sections 135.163, 379.316, 383.112, 383.150, 383.151, 383.200, 383.205, 383.210, 383.215, 383.220, 383.225, 383.230, 537.072, 538.210, 538.211, 538.225, and 538.226, to read as follows:

135.163. 1. For all tax years beginning on or after January 1, 2006, in order to encourage the retention of physicians and other health care providers in this state, an eligible taxpayer shall be allowed a credit not to exceed fifteen thousand dollars per eligible taxpayer against the tax otherwise due pursuant to chapter 143, RSMo, not including sections 143.191 to 143.265, RSMo, in an amount equal to fifteen percent of the increase in amount paid by an eligible taxpayer for medical malpractice insurance premiums in the aggregate from one policy period to the next immediate policy period. For purposes of this section, the base policy period for calculation of the credit shall be the medical malpractice insurance policy in effect on August 28, 2005.

2. The tax credit allowed by this section shall be claimed by the taxpayer at the time such taxpayer files a return. Any amount of tax

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

credit which exceeds the tax due shall be carried over to any of the next five subsequent taxable years, but shall not be refunded and shall not be transferable.

3. The director of the department of insurance and the director of the department of revenue shall jointly administer the tax credit authorized by this section. The director of the department of insurance shall enact procedures to verify the amount of the allowable credit and shall issue a certificate to each eligible taxpayer that certifies the amount of the allowable credit. Both the director of the department of insurance and the director of the department of revenue are authorized to promulgate rules and regulations necessary to administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

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

379.316. 1. Section 379.017 and sections 379.316 to 379.361 apply to insurance companies incorporated pursuant to sections 379.035 to 379.355, section 379.080, sections 379.060 to 379.075, sections 379.085 to 379.095, sections 379.205 to 379.310, and to insurance companies of a similar type incorporated pursuant to the laws of any other state of the United States, and alien insurers licensed to do business in this state, which transact fire and allied lines, marine and inland marine insurance, to any and all combinations of the foregoing or parts thereof, and to the combination of fire insurance with other types of insurance within one policy form at a single premium, on risks or operations in this state, except:

(1) Reinsurance, other than joint reinsurance to the extent stated in section 379.331;

(2) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured pursuant to

marine, as distinguished from inland marine, insurance policies;

(3) Insurance against loss or damage to aircraft;

(4) All forms of motor vehicle insurance; and

(5) All forms of life, accident and health, **[**and**]** workers' compensation insurance**, and medical malpractice liability insurance**.

2. Inland marine insurance shall be deemed to include insurance now or hereafter defined by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the director, or as established by general custom of the business, as inland marine insurance.

3. Commercial property and commercial casualty insurance policies are subject to rate and form filing requirements as provided in section 379.321.

383.112. Any insurer or self-insured health care provider that fails to timely report claims information as required by sections 383.100 to 383.125 shall be subject to the provisions of section 374.215, RSMo.

383.150. As used in sections 383.150 to 383.195, the following terms shall mean:

(1) "Association" **[**means**]**, the joint underwriting association established pursuant to the provisions of sections 383.150 to 383.195;

(2) **"Competitive bidding process", a process under which the director seeks, and insurers may submit, rates at which insurers guarantee to provide medical malpractice liability insurance to any health care provider unable to obtain such insurance in the voluntary market;**

(3) "Director" **[**means**]**, the director of the department of insurance;

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

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

provider;

[(5)**]** **(6)** "Net direct premiums" **[**means**]**, gross direct premiums written on casualty insurance in the state of Missouri by companies authorized to write casualty insurance under chapter 379, RSMo 1969, in the state of Missouri, less return premiums thereon and dividends paid or credited to policyholders on such direct business.

383.151. When the department determines after a public hearing that medical malpractice liability insurance is not reasonably available for health care providers in the voluntary market, the director shall establish a method for providing such insurance to such health care providers. The director may:

(1) Establish a competitive bidding process under which insurers may submit rates at which they agree to insure such health care providers; or

(2) Establish any other method reasonably designed to provide insurance to such health care providers.

383.200. 1. As used in sections 383.200 to 383.225, the following terms mean:

(1) "Director", the same meaning as such term is defined in section 383.100;

(2) "Health care provider", the same meaning as such term is defined in section 383.100;

(3) "Insurer", an insurance company licensed in this state to write liability insurance, as described in section 379.010, RSMo;

(4) "Medical malpractice insurance", the same meaning as such term is defined in section 383.200.

2. The following standards and procedures shall apply to the making and use of rates pertaining to all classes of medical malpractice insurance:

(1) Rates shall not be excessive, inadequate, or unfairly discriminatory. A rate is excessive if it is unreasonably high for the insurance provided. A rate is inadequate if it is unreasonably low for the insurance provided and continued use of it would endanger the solvency of the company. A rate is unfairly discriminatory if it does not reflect equitably differences in reasonably expected losses and expenses;

(2) (a) Every insurer that desires to increase a rate by less than

fifteen percent shall file such rate, along with data supporting the rate change as prescribed by the director, no later than thirty days after such rate becomes effective. Filings under this paragraph shall not be subject to approval or disapproval by the director.

(b) Every insurer that desires to increase a rate by fifteen percent or more shall submit a complete rate application to the director. A complete rate application shall include all data supporting the proposed rate and such other information as the director may require. The applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this act.

(c) Every insurer that has filed a rate increase under paragraph (a) of this subdivision for two consecutive years and in the third year desires to file a rate increase which in the aggregate over the three-year period will equal or exceed a total rate increase of forty percent or more shall be required to submit a complete rate application under paragraph (b) of this subdivision.

(d) Every insurer that has not filed or had a rate increase approved for three consecutive years may file a rate increase in the fourth year in an amount not to exceed a twenty-five percent increase without being required to submit a complete rate application under paragraph (b) of this subdivision;

(3) The director of insurance shall promulgate rules setting forth standards that insurers shall adhere to in calculating their rates. Such rules shall:

(a) Establish a range within which an expected rate of return shall be presumed reasonable;

(b) Establish a range within which categories of expenses shall be presumed reasonable;

(c) Establish a range for the number of years of experience an insurer may consider in determining an appropriate loss development factor;

(d) Establish a range for the number of years of experience an insurer may consider in determining an appropriate trend factor;

(e) Establish a range for the number of years of experience an insurer may consider in determining an appropriate increased limits factor;

(f) Establish the proper weights to be given to different years of experience;

(g) Establish the extent to which an insurer may apply its subjective judgment in projecting past cost data into the future;

(h) Establish any other standard deemed reasonable and appropriate by the director;

(4) The director shall require an insurer to submit with any rate change application:

(a) A comparison, in a form prescribed by the director, between the insurer's initial projected incurred losses and its ultimate incurred losses for the eight most recent policy years for which such data is available;

(b) A memorandum explaining the methodology the insurer has used to reflect the total investment income it reasonably expects to earn on all its assets during the period the proposed rate is to be in effect. The director shall disapprove any rate application that does not fully reflect all such income;

(5) The director shall notify the public of any application from an insurer seeking a rate increase of fifteen percent or more, and shall hold a hearing on such application within forty-five days of such notice. The application shall be deemed approved ninety days after such notice unless it is disapproved by the director after the hearing;

(6) If after a hearing the director finds any rate of an insurer to be excessive, the director may order that the insurer discontinue the use of the rate and that the insurer refund the excessive portion of the rate to any policyholder who has paid such rate. The director shall not be required to find that a reasonable degree of competition does not exist to find a rate excessive.

3. For insurers required to file pursuant to paragraph (b) of subdivision (2) of subsection 2 of this section, if there is insufficient experience within the state of Missouri upon which a rate can be based with respect to the classification to which such rate is applicable, the director may approve a rate increase that considers experiences within any other state or states which have a similar cost of claim and frequency of claim experience as this state. If there is insufficient experience within Missouri or any other states which have similar cost

of claim and frequency of claim experience as Missouri, nationwide experience may be considered. The insurer in its rate increase filing shall expressly show the rate experience it is using.

4. All information provided to the director under this section shall be available for public inspection.

5. The remedies set forth in this chapter shall be in addition to any other remedies available under statutory or common law.

6. 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.

383.205. For all medical malpractice insurance policies written for insureds in the state of Missouri, the ratio between the base rate of the highest-rated specialty and the base rate of the lowest-rated specialty shall be no more than a ratio of six-to-one.

383.210. In determining the premium paid by any health care provider, a medical malpractice insurer shall apply a credit or debit based on the provider's loss experience, or shall establish an alternative method giving due consideration to the provider's loss experience. The insurer shall include a schedule of all such credits and debits, or a description of such alternative method in all filings it makes with the director of insurance. No medical malpractice insurer may use any rate or charge any premiums unless it has filed such schedule or alternative method with the director of insurance and the director has approved such schedule or alternative method. A debit shall be based only on those claims that have been paid on behalf of the provider.

383.215. On or before March first of each year, every insurer providing medical malpractice insurance to a health care provider shall file the following information with the director of insurance:

(1) Information on closed claims:

(a) The number of new claims reported during the preceding calendar year, and the total amounts of reserve for such claims and for allocated loss adjustment expenses in connection with such claims;

(b) The number of claims closed during the preceding year, and the amount paid on such claims, detailed as follows:

a. The number of claims closed each year with payment, and the amount paid on such claims and on allocated loss adjustment expenses in connection with such claims;

b. The number of claims closed each year without payment, and the amount of allocated loss adjustment expenses in connection with such claims;

(2) Information regarding judgments, payment, and severity of injury in connection with judgements:

(a) For each judgment rendered against an insurer for more than one hundred thousand dollars:

a. The amount of the judgment and the amount actually paid to the plaintiff;

b. The category of injury suffered by the plaintiff. Injuries shall be categorized as follows:

Category 1: Temporary injury, emotional only.

Category 2: Temporary insignificant injury, including lacerations, contusions, minor scars, and rash.

Category 3: Temporary minor injury, including infections, missed fractures, and falls in hospitals.

Category 4: Temporary major injury, including burns, left surgical material, drug side effects, and temporary brain damage.

Category 5: Permanent minor injury, including loss of fingers, and loss or damage to organs.

Category 6: Permanent significant injury, including deafness, loss of limb, loss of eye, and loss of one kidney or lung.

Category 7: Permanent major injury, including paraplegia, blindness, loss of two limbs, and brain damage.

Category 8: Permanent grave injury, including quadriplegia, severe brain damage, and any injury requiring lifelong care or having a fatal prognosis.

Category 9: Death;

(3) Information on each rate change implemented during the preceding five-year period by state and medical specialty;

(4) Information on premiums and losses by medical specialty:

(a) Written premiums and paid losses for the preceding year, and earned premiums and incurred losses for the preceding year, with specifics by medical specialty;

(b) Number of providers insured in each medical specialty;

(5) Information on premiums and losses by experience of the insured:

(a) Written premiums and paid losses for the preceding year, and earned premiums and incurred losses for the preceding year, with specifics as follows:

a. As to all insureds with no incidents within the preceding five-year period;

b. As to all insureds with one incident within the preceding five-year period;

c. As to all insureds with two incidents within the preceding five-year period;

d. As to all insureds with three or more incidents within the preceding five-year period;

(b) Number of providers insured:

a. With no incidents within the preceding five-year period;

b. With one incident within the preceding five-year period;

c. With two incidents within the preceding five-year period;

d. With three or more incidents within the preceding five-year period;

(6) Information on the performance of the investments of the insurer, including the value of the investments held in the portfolio of the insurer as of December thirty-first of the preceding calendar year, and the rate of return on such investments, detailed by category of investment as follows:

(a) United States government bonds;

(b) Bonds exempt from federal taxation;

(c) Other unaffiliated bonds;

(d) Bonds of affiliates;

(e) Unaffiliated preferred stock;

(f) Preferred stock of affiliates;

(g) Unaffiliated common stock;

(h) Common stock of affiliates;

(i) Mortgage loans;

(j) Real estate; and

(k) Any additional categories of investments specified by the director of insurance.

383.220. 1. On or before July 1, 2006, and after consultation with the medical malpractice insurance industry, the director shall establish an interactive Internet site which will enable any health care provider licensed in this state to obtain a quote from each medical malpractice insurer licensed to write the type of coverage sought by the provider.

2. The Internet site shall enable health care providers to complete an online form that captures a comprehensive set of information sufficient to generate a quote for each insurer. The director shall develop transmission software components which allow such information to be formatted for delivery to each medical malpractice insurer based on the requirements of the computer system of the insurer.

3. The director shall integrate the rating criteria of each insurer into its online form after consultation with each insurer using one of the following methods:

(1) Developing a customized interface with the insurer's own rating engine;

(2) Accessing a third-party rating engine of the insurer's choice;

(3) Loading the insurer's rating information into a rating engine operated by the director;

(4) Any other method agreed on between the director and the insurer.

4. After a health care provider completes the online form, the provider will be presented with quotes from each medical malpractice insurer licensed to write the coverage requested by the provider.

5. Quotes provided on the Internet site shall at all times be accurate. When an insurer changes its rates, such rate changes shall be implemented at the Internet site by the director, in consultation with the insurer, as soon as practicable but in no event later than ten days after such changes take effect. During any period in which an insurer

has changed its rates but the director has not yet implemented such changed rates on the Internet site, quotes for that insurer shall not be obtainable at the Internet site.

6. The director shall design the Internet site to incorporate user-friendly formats and self-help guideline materials, and shall develop a user-friendly Internet user-interface.

7. The Internet site shall also provide contact information, including address and telephone number, for each medical malpractice insurer for which a provider obtains a quote at the Internet site.

8. By December 31, 2006, the director shall submit a report to the general assembly on the development, implementation, and affects of the Internet site established by this section. The report shall be based on:

(1) The director's consultation with health care providers, medical malpractice insurers, and other interested parties; and

(2) The director's analysis of other information available to the director, including a description of the director's views concerning the extent to which the information provided through the Internet site has contributed to increasing the availability of medical malpractice insurance and the effect the Internet site has had on the cost of medical malpractice insurance.

383.225. Each insurer shall file with the director of insurance new manuals of classifications, rules, underwriting rules, rates, rate plans and modifications, policy forms and other forms to which such rates are applied, that reflect the savings, if any, attributable to each provision of this act.

383.230. Insurers writing medical malpractice insurance shall provide insured health care providers with written notice of any increase in renewal premium rates at least ninety days prior to the date of the renewal. At a minimum, the notice shall be sent by first class mail at least ninety days prior to the date of renewal and shall contain the insured's name, the policy number for the coverage being renewed, the total premium amount being charged for the current policy term, and the total premium amount being charged to renew the coverage.

537.072. In all tort actions based upon improper health care, the parties shall make a good faith effort to engage in mediation, which shall be conducted by a trained mediator selected from a list approved

by the circuit court. The parties shall advise the circuit court in writing that mediation take place. If mediation does not occur, the parties shall set forth in writing to the circuit court their good faith effort to conduct mediation.

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

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

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

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

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

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

4. The limitation on awards for noneconomic damages provided for in this section shall be increased or decreased on an annual basis effective January first of each year in accordance with the Implicit Price Deflator for Personal Consumption Expenditures as published by the Bureau of Economic Analysis of the United States Department of Commerce. The current value of the limitation shall be calculated by the director of the department of insurance, who shall furnish that value to the secretary of state, who shall publish such value in the

Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021, RSMo.

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

538.211. 1. In all actions against a health care provider pursuant to this chapter, any health care defendant who has filed a timely motion to transfer venue may move for a hearing on the propriety of venue. All discovery shall be stayed except for discovery on the issue of venue raised in the motion. Within ninety days of the filing of the motion, the court shall set a hearing on the motion.

2. If after hearing the court determines that venue is improper, the court shall transfer venue to a county where venue is proper.

3. The court may award reasonable costs, expenses, and attorneys' fees associated with said motion to the prevailing party.

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

2. **[**The affidavit shall state the qualifications of such health care providers to offer such opinion.**]** **The health care provider who offers such opinion shall have education, training, and experience in a like area of expertise, or logical extension of the field of expertise, as the defendant health care provider. In addition, the health care provider must be actively engaged in the practice of medicine or have retired from actively practicing within five years of the date of the written opinion. The written opinion is, upon motion of a party, subject to in-camera review by the court without counsel or the parties present to**

assure its compliance with this section.

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

4. Such affidavit shall be filed no later than ninety days after the filing of the petition unless the court, for good cause shown, orders that such time be extended.

5. If the plaintiff or **[**his**]** **the plaintiff's** attorney fails to file such affidavit **[**the court may**]** **within the time required under subsection 4 of this section, the action as to that defendant shall be stayed and the court shall**, upon motion of any party, dismiss the action against **[**such moving party**]** **that defendant** without prejudice.

538.226. 1. The portion of statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person shall be inadmissible as evidence of an admission of liability in a civil action. A statement of fault, however, which is part of or in addition to any of the above shall be admissible under this section.

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

Section B. Because immediate action is necessary to take action regarding the circumstances facing the medical malpractice liability insurance market in this state section A of this act is deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and section A of this act shall be in full force and effect upon its passage and approval.