FIRST REGULAR SESSION

SENATE BILL NO. 410

95TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR STOUFFER.

Read 1st time February 23, 2009, and ordered printed.

TERRY L. SPIELER, Secretary.

1203S.03I

AN ACT

To repeal sections 383.100, 383.105, 383.106, 383.120, 383.160, 383.165, 383.250, and 383.500, RSMo, and to enact in lieu thereof eight new sections relating to medical malpractice insurance.

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

Section A. Sections 383.100, 383.105, 383.106, 383.120, 383.160, 383.165, 383.250, and 383.500, RSMo, are repealed and eight new sections enacted in lieu thereof, to be known as sections 383.100, 383.105, 383.106, 383.120, 383.160, 383.165, 383.250, and 383.500 to read as follows:

383.100. As used in sections 383.100 to 383.125, the following terms mean:

(1) **"Claim", a formal written demand for payment of damages received in writing by an insurer, a lien letter from legal counsel received by an insurer, or a filed lawsuit, and any incident for which a payment has been made shall also be considered a claim, however, knowledge of a medical incident by an insured for which no demand for payment has been made shall not constitute a claim;**

(2) "Director", the director shall be the director of the department of insurance, financial institutions and professional registration;

[(2)**]** **(3)** "Health care provider" includes physicians, dentists, clinical psychologists, pharmacists, optometrists, podiatrists, registered nurses, physicians' assistants, chiropractors, physical therapists, nurse anesthetists, anesthetists, emergency medical technicians, hospitals, nursing homes and extended care facilities; but shall not include any nursing service or nursing facility conducted by and for those who rely upon treatment by spiritual means

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

alone in accordance with the creed or tenets of any well-recognized church or religious denomination;

[(3)**]** **(4) "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, any captive insurance company formed under sections 379.1300 to 379.1350, RSMo, every entity operating under this chapter, and any other person providing insurance coverage in this state, including self-insured health care providers and any other entity or person that otherwise assumes liability to pay claims arising out of the death or injury of any person as a result of the negligence or malpractice in providing professional service by any health care provider;**

(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**;**

(6) "Self-insurer", any health care provider, hospital, facility, or other individual or entity that assumes operational or financial risk for claims or other entity or person that otherwise assumes liability to pay claims 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, and any other entity to the extent it is self-insuring its exposure to medical malpractice liability.

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**, and every self-insurer, or any other person or entity that otherwise assumes liability to pay claims 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,** shall submit to the director **quarterly** 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); **and**

(8) **[**Expenses**]** **Loss adjustment expense** incurred**[**; and

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

3. **[**As used in sections 383.100 to 383.125, "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, including self-insured health care providers.**]** **Information submitted under subdivisions (1), (3), and (6) of subsection 2 of this section shall be deemed to be confidential communications except as provided in subsection 5 of this section.**

4. The director shall, upon receipt, submit in writing the pertinent and appropriate data and information submitted under subsection 2 of this section to the applicable health care licensing board. The director shall also submit a report containing the information described in subdivisions (4) to (8) of subsection 2 of this section to the director of the department of social services. Information shall be disclosed to the department of social services so that the department of social services can determine whether the claimant or plaintiff was concurrently enrolled in the MO HealthNet program during the period in which the alleged incident occurred. The information provided to the department of social services shall be subject to the confidentiality requirements in this section and subsection 7 of section 208.217, RSMo.

5. All data submitted pursuant to this section shall be considered confidential communications and immune from requests made under chapter 610, RSMo, nor shall such data otherwise be made available to the public, except that medical malpractice data submitted by insurers and self-insurers under this section that is the subject of a filed lawsuit may be released only after such claims are closed and only in the form consistent with the following:

(1) All data elements that reasonably could reveal any parties involved, either directly or indirectly, to a malpractice actions or claims, shall be removed prior to making any such data public. Any references to a county or smaller geographic unit shall be suppressed, though county-level data may be released in aggregate form. Dates shall be no more precise than the year associated with the date;

(2) No records that include any indemnity payments or expense amounts that identify a particular medical specialty may be released on an individual record basis unless there are a minimum of four additional claims during an annual period against practitioners of the same medical specialty for each identifiable unit of geography. However, medical specialties may be combined and identified by a new specialty code to attain the minimum of five records;

(3) All dates shall be anonymized prior to public release. Specific dates shall not be released in any form more precise than the year corresponding to the date. Such dates include, but are not limited to, the date of injury, the date a claim was reported to an insurer, the date a claim is reopened, and the date of closure of payment. However, information derived from such dates may be released to the public, such as the time elapsed between the date a claim was reported and the date it was closed;

(4) Data that reasonably could identify an insurer or self-insurer shall be anonymized prior to the public release of the individual claim records. The name and any identifying codes of an insurer or self-insurer shall not be made public. However, public data may include insurer categories, such as whether the insurer or self-insurer was a licensed insurer, a self-insured entity, risk retention group, or surplus lines company.

383.106. 1. To effectively monitor the insurance marketplace, rates,

financial solvency, and affordability and availability of medical malpractice coverage, **[**the director shall establish by rule or order reporting standards for insurers by which the insurers, or an advisory organization designated by the director,**] all insurers and self-insurers** shall annually report **[**such**] their** Missouri medical malpractice insurance premium, loss, **and** exposure**[**, and other information as the director may require**] data, if applicable, as required under subsection 2 of this section**.

2. The **[**director shall, prior to May 30, 2007, establish risk reporting categories for medical malpractice insurance, as defined in section 383.150, and shall establish regulations for the reporting of all base rates and premiums charged in those categories as determined by the director. The director shall consider the history of prior court judgments for claims under this chapter in each county of the state in establishing the risk reporting categories**] data required to be reported under subsection 1 of this section shall include only the following:**

(1) Aggregate premium;

(2) Written and earned premium;

(3) Aggregate exposure;

(4) Written and earned exposures; and

(5) Aggregated indemnity paid and aggregate indemnity incurred by not paid.

3. The director shall collect the information required in 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 director shall remove any individualized information that identifies a particular insurer **[**as the source of the information**], defendant, plaintiff, or other party to a medical malpractice claim or action**. The director may combine such information with similar information obtained through insurer examinations so as to cover periods of more than one year. **The information required to be reported in this section and section 383.105 shall be shared with the health care stabilization fund feasibility board established under section 383.250 and the information provided to such board shall be subject to the confidentiality requirements of this section. The director shall make information collected and compiled under this section**

available to Missouri insurers only as a medical malpractice industry aggregate of accurately submitted data of Missouri medical malpractice experience.

4. **[**All insurers with regards to medical malpractice insurance as defined in section 383.150 shall provide to the director, beginning on June 1, 2008, 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 under this section**]** **To ensure that sensitive information such as individual identities cannot be inferred from information collected under this section, directly or indirectly in combination with other public information, all collected information and data derived from such information is confidential information and is not discoverable or admissible as evidence in any legal action in any civil, criminal, or administrative proceeding, nor shall any of it be released by the director to the public.**

5. All information submitted by insurers under this section shall be deemed to be confidential communications and shall remain confidential unless such information is specifically allowed to be released and then only in the manner provided for in this section. Data collected pursuant to this section shall also be deemed by the department to be a trade secret as defined in section 417.453, RSMo, inasmuch as such data possesses economic value by virtue of its confidential status; the same or like information is unavailable through other sources; or an insurer has made reasonable efforts to maintain the confidentiality of the data. As such, all data submitted pursuant to this section shall be considered confidential communications and immune from requests made under chapter 610, RSMo, nor shall such data otherwise be made available to the public or unauthorized individuals except in the manner and form prescribed by sections 383.100 to 383.125.

6. Except as expressly permitted under subsections 4 and 5 of this section, all data collected under this section shall be considered proprietary and confidential, and immune from requests made under chapter 610, RSMo; nor shall such information be discoverable or admissible in any legal proceeding. The confidentiality created under this section is a matter of substantive law of this state and is not merely a procedural matter governing civil or criminal procedures in

the courts of this state.

383.120. There shall be no liability on the part of and a cause of action of any nature shall not arise against an insurer **or self-insurer** reporting hereunder, or its agents or employees, or the director or his representatives, for any action taken by them pursuant to this section.

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**] to provide medical malpractice insurance coverage as determined by the directors of the association including, but not limited to, coverage written on a claims-made, an occurrence, or a prior-acts basis**. 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 and to members which have been assessed but have not received tax credits as provided in subsection 5.

383.165. **The directors of the association shall determine the extent to which** each policyholder shall pay to the association in the first policy year, in addition to the premium payment due for insurance through the association, **a surcharge in** an amount equal to **twenty-five percent of** said **policyholder's** premium payment. Such charge shall be separately stated in the policy.

383.250. 1. There is hereby created within the department of insurance, financial institutions and professional registration the "Health Care Stabilization Fund Feasibility Board". The primary duty of the board is to determine whether a health care stabilization fund should be established in Missouri to provide excess medical malpractice insurance coverage for health care providers. As part of its duties, the board shall develop a comprehensive study detailing whether a health care stabilization fund is feasible within Missouri, or specified geographic regions thereof, or whether a health care stabilization fund would be feasible for specific medical specialties. The board shall analyze medical malpractice insurance data collected by the department of insurance, financial institutions and professional registration under sections 383.105 and 383.106 and any other data the board deems necessary to its mission. **The data provided to the board under sections 383.105 and 383.106 shall be subject to the confidentiality restrictions provided in section 383.106.** In addition to analyzing data collected from the Missouri medical malpractice insurance market, the board may study the experience of other states that have established health care stabilization funds or patient compensation funds. If a health care stabilization fund is determined to be feasible within Missouri, the report shall also recommend to the general assembly how the fund should be structured, designed, and funded. The report may contain any other recommendations relevant to the establishment of a health care stabilization fund, including but not limited to specific recommendations for any statutory or regulatory changes necessary for the establishment of a health care stabilization fund.

2. The board shall consist of ten members. Other than the director, the house members and the senate members, the remainder of the board's members shall be appointed by the director of the department of insurance, financial institutions and professional registration as provided for in this subsection. The board shall be composed of:

(1) The director of the department of insurance, financial institutions and professional registration, or his or her designee;

(2) Two members of the Missouri senate appointed by the president pro tem of the senate with no more than one from any political party;

(3) Two members of the Missouri house of representatives appointed by the speaker of the house with no more than one member from any political party;

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

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

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

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

(8) One member who is a physician and who is on a list submitted to the director by an organization representing family physicians in the state of Missouri.

3. The director shall appoint the members of the board, other than the general assembly members, no later than January 1, 2007. Once appointed, the board shall meet at least quarterly, and shall submit its final report and recommendations regarding the feasibility of a health care stabilization fund to the governor and the general assembly no later than December 31, 2010. The board shall also submit annual interim reports to the general assembly regarding the status of its progress.

4. The board shall have the authority to convene conferences and hold hearings. All conferences and hearings shall be held in accordance with chapter 610, RSMo.

5. The director of the department of insurance, financial institutions and

professional registration shall provide and coordinate staff and equipment services to the board to facilitate the board's duties.

6. Board members shall receive no additional compensation but shall be eligible for reimbursement for expenses directly related to the performance of their duties.

7. The provisions of this section shall expire December 31, **[**2010**]** **2012**.

383.500. 1. Beginning on January 1, 1987, any physician or surgeon who is on the medical staff of any hospital located in a county which has a population of more than seventy-five thousand inhabitants shall, as a condition to his admission to or retention on the hospital medical staff, furnish satisfactory evidence of a medical malpractice insurance policy of at least five hundred thousand dollars. **The furnishing of evidence of a policy in the amount of five hundred thousand dollars shall satisfy the requirements of this subsection and no hospital shall require a physician or surgeon to furnish evidence of a medical malpractice insurance policy in a greater amount as a condition to the physician's or surgeon's admission to or retention in the hospital medical staff.** The provisions of this section shall not apply to physicians or surgeons who:

(1) Limit their practice exclusively to patients seen or treated at the hospital; and

(2) Are insured exclusively under the hospital's policy of insurance or the hospital's self-insurance program.

2. This section shall not in any way limit or restrict the authority of any hospital in this state to issue rules or regulations requiring physicians or other health care professionals to carry minimum levels of professional liability insurance as a condition of membership on a hospital medical staff **provided the maximum level of professional liability insurance required by any hospital shall not exceed five hundred thousand dollars**.

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