3142L.04F

HOUSE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

SENATE BILL NO. 807

AN ACT

To repeal sections 383.010, 383.015, 383.030, 383.035, 383.150, 383.155, 383.160, 383.165, 383.170, 383.175, 383.180, 383.185, 383.190, 383.195, 538.210, and 538.225, RSMo, and to enact in lieu thereof twenty-four new sections relating to civil actions, with an emergency clause for certain sections.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 383.010, 383.015, 383.030, 383.035, 383.150, 383.155, 383.160, 383.165, 383.170, 383.175, 383.180, 383.185, 383.190, 383.195, 538.210, and 538.225, RSMo, are repealed and twenty-four new sections enacted in lieu thereof, to be known as sections 383.010, 383.015, 383.030, 383.035, 383.090, 383.091, 383.112, 383.150, 383.155, 383.160, 383.165, 383.170, 383.175, 383.180, 383.185, 383.190, 537.072, 538.210, 538.211, 538.225, 538.226, 1, 2, and 3, 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,

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 boldface type in the above law is proposed language.

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 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] No association organized under this section shall require as a condition in any insurance contract or policy issued by such association the insured health care provider to waive any right to pursue a cause of action against the managers or directors of the association for mismanagement or other breach of fiduciary duties.

383.015. 1. Any such group of persons desiring to provide malpractice insurance or indemnification for its members shall pay a license fee of one hundred dollars and shall file articles of association with the director of insurance. The articles shall be filed in accordance with the provisions of sections 375.201 to 375.236, RSMo, and shall also include the names of persons initially associated, the method by which other persons may be admitted to the association as members, the purposes for

which organized, the amount of the initial assessment which has been paid into the association, the method of assessment thereafter, and the maximum amount of any assessment which the association may make against any member. The articles of association shall provide for bylaws and for the amendment of the articles of association and bylaws.

2. Each association shall designate and maintain a registered agent within this state, and service upon the agent shall be service upon the association and each of its members.

3. The articles of association shall be accompanied by a copy of the initial bylaws of the association. The bylaws shall provide for a governing body for the association, a manner of election thereof, the manner in which assessments will be made, the specific kinds of insurance or indemnification which will be offered, the classes of membership which will be offered, and may provide that assessments of various amounts for particular classes of membership may be made. All assessments shall be uniform within classes. The bylaws may provide for the transfer of risks to other insurance companies or for reinsurance.

4. The articles of association and the bylaws of the association shall:

(1) Specify and define the types of assessments, including but not limited to, initial, regular, operating, special, any other assessment to cover losses and expenses incurred in the operation of the association, or any other assessment to maintain

or restore the association's assets, solvency, or surplus;

(2) Specify by type of assessment the assessments that shall apply to members, former members, or both members and former members of the association; and

(3) With respect to any assessment to cover losses and expenses incurred in the operation of the association, and any assessment to maintain or restore the association's assets, solvency, or surplus, specify the exact method and criteria by which the amounts of each type of assessment are to be determined, the time in which such assessments must be paid, that such assessments may be made without limitation as to frequency, and the maximum amount of any one such assessment.

383.030. 1. The director of the department of insurance shall be authorized in accordance with sections 374.190 and **[**374.200**]** 374.202 to 374.207, RSMo, or in the event that either or both of such sections are repealed, then any successor sections relating to **[**financial**]** examination, to examine the activities, operations, market conduct, financial condition, affairs and management of any association organized under the provisions of sections 383.010 to 383.040, and the association shall pay the expenses of any such examination in accordance with sections 374.160 and 374.220, RSMo. Annually thereafter, within thirty days before the expiration of its license, each association shall pay a renewal license fee of one hundred dollars.

2. Any existing association shall also, at the time it files for renewal of its license, file any amendments to its articles of association or bylaws which have been adopted in the preceding year.

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**]** Sections 375.163 and 375.164, RSMo, relating to the competence of managing officers and management contract;

(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 383.090 and 383.091;

(11) Sections 375.930 to 375.948, RSMo, relating to unfair trade practices; and

(12) Sections 375.1000 to 375.1018, RSMo, relating to unfair claims settlement practices.

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**]** shall 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**]** shall monitor the performance of the association's plan and **[**may**]** shall order modifications thereto, including assessments upon its members liable to assessment in accordance with the articles and bylaws of the association or rate or premium increases, if the association fails to meet any targets proposed in such plan for three consecutive quarters. It shall be an unfair trade practice within the meaning of sections 375.930 to 375.948, RSMo, for any association or agent thereof to make any assertion or statements, orally or in writing, contrary to the articles and bylaws of the association to members liable to assessment that assessments shall not be made.

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 in accordance with subsection 6 of this section and the [association's surplus] association has failed to [increase] restore its surplus to at least zero dollars 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] shall order the association to make an assessment upon its members liable to assessment 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.

383.090. 1. As used in sections 383.090 and 383.091, the following terms shall mean:

(1) "Director", "health care provider" and "medical malpractice insurance' shall have the same meaning as defined in section 383.100;

(2) "Insurer", an insurance company licensed in this state that writes medical malpractice insurance, including malpractice associations formed pursuant to sections 383.010 to 383.040 and insurance issued under the state's MEDIC plan pursuant to sections 383.150 to 383.190.

2. In addition to the provisions of sections 379.420 to 379.510, RSMo, rates and policies for medical malpractice insurance shall be subject to the following specific requirements:

(1) An insurer writing medical malpractice insurance shall comply with the filing requirements in section 379.321, RSMo, applicable to types of insurance other than commercial property and commercial casualty insurance;

(2) The director may disapprove any medical malpractice policy form that contains terms that are contrary to law, misleading or not in the public interest. An insurer may request a hearing before the director to appeal any disapproval;

(3) The director may disapprove any medical malpractice rate that:

(a) Relies upon past or prospective loss experience from outside the state of Missouri, unless the insurer can demonstrate to the satisfaction of the director that there is insufficient Missouri data to develop a rate with respect to the classification to which such rate is applicable;

(b) Imposes a surcharge or other price differential on a

health care provider, whether currently insured or applying for coverage, that is based on the fact that the insured or applicant has a pending medical malpractice claim or lawsuit filed against the health care provider; or

(c) Is excessive, inadequate or unfairly discriminatory. No rate shall be held to be excessive unless such rate is unreasonably high for the insurance coverage provided. No rate shall be held to be inadequate unless such rate is unreasonably low for the insurance coverage provided and is insufficient to sustain projected losses and expenses or unless such rate is unreasonably low for the insurance coverage provided and the use of such rate has, or if continued will have, the effect of destroying competition or creating a monopoly. Unfair discrimination shall be defined to include, but shall not be limited to, the use of rates which unfairly discriminate between risks in the application of like charges or credits or the use of rates which unfairly discriminate between risks having essentially the same hazard. An insurer may request a hearing before the director to appeal any disapproval.

3. Insurers writing medical malpractice insurance shall comply with the requirements of sections 379.882 to 379.886, RSMo, with regard to the cancellation or nonrenewal of medical malpractice insurance.

4. Insurers writing medical malpractice insurance shall provide insured health care providers with written notice of any

increase in renewal premium rates at least sixty days prior to the date of the renewal. At a minimum, the notice shall be sent by first class mail at least sixty 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.

5. The director may designate an advisory organization as defined in section 379.455, RSMo, to assist in gathering, compiling and reporting relevant statistical information regarding medical malpractice insurance premiums and losses in Missouri. The designated advisory organization may develop a statistical reporting plan to accomplish this purpose, subject to the approval of the director. Every medical malpractice insurer shall record and report its medical malpractice experience to the designated advisory organization in the manner required under the statistical plan. The designated advisory organization shall use the information provided to develop annual advisory loss costs for medical malpractice insurance in Missouri in order to assist medical malpractice insurers in setting their premium rates.

383.091. 1. In order to help stabilize the premium rates in the Missouri medical malpractice insurance market, any insurer that proposes to increase or decrease the premium rates applicable to medical malpractice insurance in this state by fifteen percent or more in any twelve-month period 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.

2. Within ten days of receipt of the notice from the insurer, the director shall set a date for a public 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 this subsection to any person making a written request for such information.

3. At the hearing, the director or the director's designees shall question the insurer about the proposed premium rate change. The insurer may provide additional information in support of its proposed rate change, and any member of the public may provide information in support of or in opposition to the proposed premium rate change.

4. Within twenty days after the close of the hearing, the director shall review all of the information submitted to 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 is not justified, 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.

5. The provisions of this section shall not apply to the initial premium rates filed by insurance companies when first entering the Missouri market unless and until they propose to change the premium rates they initially filed with the department upon entry into the state by more than fifteen percent.

383.112. 1. 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.

2. For the 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.

383.150. 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)**]** "Director" means the director of the department of insurance;

[(3)**]** (2) "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;

(3) "MEDIC plan" or "plan", the insurance entity created under the MEDIC program designed to permanently guarantee the availability of medical malpractice insurance in this state;

(4) "MEDIC program" or "program", the malpractice education, data and insurance capacity program created under sections 383.150 to 383.190;

[(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. The director of insurance may specify which lines of property and casualty insurance qualify as casualty insurance under this provision.

383.155. 1. [A joint underwriting association may be created upon determination by the director after a public hearing that medical malpractice liability insurance is not reasonably available for health care providers in the voluntary market.] There is hereby created a program to be known as the "Malpractice Education, Data and Insurance Capacity Program" or "MEDIC program" which shall replace and carry forward the functions of the previously authorized Missouri medical malpractice joint underwriting association. The mission of the MEDIC program shall be to perform the following functions:

(1) Educate health care providers insured under the program's MEDIC insurance plan on the current best practices in the medical profession designed to promote patient safety, avoid incidents of medical malpractice, and decrease litigation over medical care;

(2) Conduct an independent analysis of the data collected by the advisory organization selected by the director under subsection 5 of section 383.090 in determining the rates used for coverage provided under the MEDIC plan, which analysis, including an analysis of loss trends, shall be made available to the public

and to the state's other medical malpractice insurers; and

(3) Establish a permanent insurance entity to be known as the "MEDIC Plan" or "plan" designed to guarantee that Missouri health care providers will always have a source of coverage for medical malpractice insurance regardless of the conditions of the voluntary market for such coverage.

The [association] MEDIC program shall contain as members all companies authorized to write and engaged in writing, on a direct basis, any insurance or benefit, the premium for which is included under the definition of "net direct premiums". Membership in the [association] MEDIC program shall be a condition of continued authority to do business in this state.

2. A plan of operation shall be adopted to be effective concurrently with the effective date of the [association] MEDIC program.

3. The [association] MEDIC program shall, pursuant to the provisions of sections 383.150 to [383.195] 383.190 and the plan of operation, with respect to medical malpractice insurance, have the authority on behalf of its members:

(1) To issue, or to cause to be issued through the MEDIC plan, policies of insurance to applicants, including incidental coverages and subject to limits as specified in the plan of operation but not to exceed one million dollars for each claimant

under one policy and three million dollars for all claimants under one policy in any one policy year;

(2) To underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint a service company to perform those functions;

(3) To assume reinsurance from its members; [and]

(4) To cede reinsurance;

(5) To help educate the health care providers insured under the MEDIC plan on the current best practices in the medical profession designed to promote patient safety, avoid incidents of medical malpractice, and decrease litigation over medical treatment, including cooperative educational ventures with the patient safety commission;

(6) To perform an independent analysis of data collected by the state's medical malpractice insurance advisory organization for use in developing rates under the MEDIC plan, and to make such analysis freely available to the public; and

(7) To exercise the powers and authority of an insurance company authorized to write casualty insurance under chapter 379, RSMo, in a manner consistent with the provisions of sections 383.150 to 383.190.

4. [Within forty-five days following the creation of the association, the directors of the association shall submit to the director for his review, a proposed plan of operation, consistent with the provisions of sections 383.150 to 383.195.

5.] The plan of operation for the MEDIC program, which may incorporate some or all of the plan of operation of the previously authorized joint underwriting association, shall provide for economic, fair and nondiscriminatory administration and for the prompt and efficient distribution of medical malpractice insurance, and [shall] may contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses to commence operations, establishment of necessary facilities, management of the [association] program, assessment of members to defray losses and expenses, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of a servicing company and procedures for determining amounts of insurance to be provided by the [association] program. The preliminary assessment shall be an advance to be recouped under the provisions of subsection 5 of section 383.160.

6. The plan of operation shall be subject to approval by the director after consultation with the members of the [association] program, representatives of the public and other affected individuals and organizations. If the director disapproves all or any part of the proposed plan of operation, the directors of the program shall within fifteen days submit for review a revised plan of operation. If the directors of the program fail to do so, the director shall promulgate a plan of operation or part thereof, as the case may be. The plan of

operation approved or promulgated by the director shall become effective and operational upon his order.

7. Amendments to the plan of operation may be made by the directors of the [association] program, subject to the approval of the director or shall be made at his direction.

383.160. 1. [All association] MEDIC plan policies of insurance [shall be written so as to apply to injury which results from acts or omissions occurring during the policy period] issued under the program may be written to provide medical malpractice insurance coverage as determined by the directors of the program, including but not limited to coverage written on a claims-made, occurrence, or 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 or nonrenewal of coverage of the [association's] plan'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] MEDIC plan and statistics relating thereto shall be subject to the [casualty rate regulation law

giving] same requirements as medical malpractice insurance written by insurance companies licensed in this state and shall give 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] MEDIC plan, additional funds shall be raised by making an assessment on all member companies of the MEDIC program. 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] such program 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] 383.190 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 board of the MEDIC program shall determine the extent to which each policyholder issued under the MEDIC plan shall pay to the **[**association**]** plan in the first policy year, in addition to the premium payment due for insurance through the **[**association, an amount equal to said**]** plan, a surcharge in an amount less than or equal to the first year's premium payment. Such charge shall be separately stated in the policy. The board may determine what methods of payment of such surcharge will be acceptable, and the board shall have the authority to use any amounts collected through such surcharge for any legitimate purpose connected to the activities of the MEDIC program.

383.170. 1. Any health care provider eligible for coverage through the MEDIC plan shall be entitled to apply to the **[**association**]** plan for medical malpractice liability insurance. Such application may be made on behalf of an applicant by a **[**broker or agent**]** producer licensed for casualty insurance and authorized by the applicant. While the board may establish standards regarding which health care providers are in good faith eligible for coverage under the MEDIC plan, it shall not be a

prerequisite for coverage under the plan for a health care provider to have been declined coverage by one or more insurers in the voluntary market.

2. If the [association] plan determines that the applicant meets the underwriting standards of the [association] plan as prescribed in the plan of operation and there is no unpaid, uncontested premium due from the applicant for prior insurance, then the [association] plan, upon receipt of the premium, or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of medical malpractice liability insurance.

383.175. The [association] plan shall be governed by a board of [eight] ten directors, to be appointed by the director for the terms specified in the plan of operation. [Two] Four directors shall represent insurers which write bodily injury insurance in Missouri and are members of the [National Association of Independent Insurers, two shall represent insurers which write bodily injury insurance in Missouri and are members of the American Mutual Insurance Alliance] Property Casualty Insurers Association of America, two shall represent insurers which write bodily injury insurance in Missouri and are members of the American Insurance Association, [and] two shall represent insurers which write bodily injury insurance in Missouri but are not members of any of the foregoing trade associations, and two shall represent health care providers. The directors shall be

reimbursed out of the administrative funds of the [association] program only for necessary and actual expenses incurred for attending meetings of the governing board.

383.180. The [association] program shall file in the office of the director annually on or before the first day of April, a statement which shall contain information with respect to its transactions, condition, operations and affairs during the preceding year, including its educational activities, its data analysis activities, and its insurance activities through the MEDIC plan. Such statement shall contain such matters and information as are prescribed and shall be in such form as is approved by the director. The director may, at any time, require the [association] program to furnish additional information with respect to its transactions, condition or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation and experience of the [association] program.

383.185. The director shall make an examination into the affairs of the [association] MEDIC program and the MEDIC plan at least annually. The expenses of every such examination shall be borne and paid by the [association] plan.

383.190. Appeals and judicial review.

(1) Any applicant to the [association] MEDIC plan, any person insured pursuant to this article, or their representatives, or any affected insurer, agent or agency, may

appeal to the director within thirty days after any ruling, action or decision by or on behalf of the [association] plan, with respect to those items the plan of operation defines as appealable matters.

(2) Any person aggrieved hereunder by any order or act of the director of the department of insurance may, within ten days after notice thereof, file a petition in the circuit court of the county of Cole for a review thereof. The court shall summarily hear the petition and may make any appropriate order or decree.

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 took place. If mediation does not occur, the parties shall set forth in writing to the circuit court their good faith reasons for failure 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] four 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 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. Effective January 1, 2007, 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 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 may move for a hearing on the propriety of venue and in connection therewith:

(1) All discovery shall be stayed other than discovery on the issues of venue raised in the motion;

(2) 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 was improperly asserted, the court shall forthwith transfer venue to a county where venue is proper and shall award reasonable costs, expenses, and attorneys fees 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, upon motion of any party, dismiss the action against such moving party**]** 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 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 1. 1. Any person may file a miscellaneous case for

the purpose of securing copies of such person's health care records or the health care records of any other individual for whom such person is the guardian or attorney-in-fact, or is a potential claimant for a wrongful death.

2. A miscellaneous case shall be filed in the circuit in which any of the health care records sought to be obtained are located.

3. The petition shall be filed according to the following guidelines:

(1) The petition shall contain the following:

(a) The name of the individual who received the health care services or medical treatment;

(b) A brief summary of the health care services or medical treatment received;

(c) A brief summary of the outcome of the health care services or medical treatment; and

(d) The names of the health care providers from whom health care records are being sought;

(2) The petition shall not contain allegations of negligence or demands, other than a general demand for access to health care records.

4. Within five business days of filing the miscellaneous case, the petitioner shall mail a copy of the petition by regular and certified mail to each health care provider listed in the petition. The petitioner shall certify to the court that the

petition has been mailed as required.

5. After filing a miscellaneous case, the petitioner may request the health care records described in subsection 1 of this section by subpoena and, if necessary, subpoena the health care records custodian for a deposition for the sole purpose of securing copies of the health care records and verifying their authenticity. Refusal to provide the requested records may be the basis for the court to impose sanctions or orders of contempt.

6. Filing of a miscellaneous case petition shall toll the applicable statute of limitations for one hundred twenty days on any claim for injuries or death caused by professional negligence of a health care provider, but in no event shall the applicable statute of limitations be tolled under this section for more than one hundred twenty days.

7. The naming or listing of a health care provider as a person from whom records are requested shall not be considered for any reporting purposes as a claim made against the health care provider.

8. A health care provider or any person or entity acting on behalf of a health care provider shall not charge more than is allowable under section 197.227, RSMo, for providing copies of health care records.

Section 2. There is hereby authorized a "Health Care Stabilization Fund Study Commission", the purpose of which is to

study medical malpractice insurance stabilization funds in other states and make recommendations to the governor and the general assembly as to whether or to what extent the MEDIC program could or should act as a medical malpractice insurance stabilization fund for the state of Missouri. The commission shall be made up of nine members appointed by the governor, representing the medical malpractice insurance industry and the health care providers who are the consumers of such insurance. Staff support for the commission shall be provided by the Missouri department of insurance. The commission shall issue a written report containing its recommendations to the governor and the general assembly by January 10, 2005.

Section 3. 1. The director of the department of insurance shall, by rule, develop a standardized application form for medical malpractice coverage. Once said rule has been promulgated and has become effective, all insurers writing medical malpractice insurance in this state shall use said application form, or any duly authorized amendments thereto, as part of their underwriting process. The form shall be developed in consultation with medical malpractice insurers in order to assure that the form captures the information reasonably needed by insurers to underwrite the coverage. If an insurer demonstrates a need for additional information, the director may approve a supplemental form.

2. Once the form required under subsection 1 of this

subsection has been developed and has gone into effect, the department shall post the form, and any approved individual insurers' supplements thereto, on the department's web site.

3. The department shall construct its web site to link said site to those of medical malpractice insurers actively writing in Missouri. The department web site will allow health care providers to enter the appropriate information on the form via computer, and then submit said applications to the insurers of their choosing, electronically. The department's web site shall incorporate such security measures as are necessary to protect any confidential data.

[383.195. Termination of any plan created pursuant to the authority of sections 383.150 to 383.195 shall be by the director pursuant to a public hearing in which it is determined that medical malpractice liability insurance is reasonably available to health care providers in the voluntary market.]

Section B. Because immediate action is necessary to take action regarding the circumstances facing the medical malpractice liability insurance market in this state the enactment of sections 383.090 and 383.091 of 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 the enactment of sections 383.090 and 383.091 of section A of this act shall be in full force and effect upon its passage and approval.