SECOND REGULAR SESSION

HOUSE BILL NO. 1087

93RD GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES SCHAAF (Sponsor), TILLEY, MOORE, SMITH (118), WHORTON, FISHER, PAGE, THRELKELD AND COOPER (155) (Co-sponsors).

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STEPHEN S. DAVIS, Chief Clerk

3749L.01I

AN ACT

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

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

Section A. Sections 383.035, 383.079, 383.105, 383.160, and 383.165, RSMo, are repealed and seventeen new sections enacted in lieu thereof, to be known as sections 383.035, 383.079, 383.105, 383.111, 383.160, 383.165, 383.300, 383.302, 383.304, 383.306, 383.308, 383.310, 383.312, 383.314, 383.316, 383.330, and 383.335, to read as follows:

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

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

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

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

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

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

(5) Section 375.246, RSMo, relating to reinsurance requirements, except that no association shall be required to maintain reinsurance, and for insurance issued to members who joined the association on or before January 1, 1993, an association shall be allowed credit, as an asset or as a deduction from liability, for reinsurance which is payable to the ceding association's insured by the assuming insurer on the basis of the liability of the ceding association under contracts reinsured without diminution because of the insolvency of the ceding association;

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

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

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

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

(10) Sections 383.100 to 383.111 relating to reports from medical malpractice insurers;

(11) Sections 383.300 to 383.316 relating to notification, data reporting, and rating requirements.

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

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

[4.**] 3.** 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.**] 4.** 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.**]** **5.** If**[**, after August 28, 1992, and**]** after its second full calendar year of operation, any association licensed under the provisions of sections 383.010 to 383.040 shall file an annual statement which shows a surplus as regards policyholders of less than zero dollars, or if the director of the department of insurance has other conclusive and credible evidence more recent than the last annual statement indicating the surplus as regards policyholders of an association is less than zero dollars, the director of the department of insurance may order such association to submit, within ninety days following such order, a voluntary plan under which the association will restore its surplus as regards policyholders to at least zero dollars. The director of the department of insurance may monitor the performance of the association's plan and may order modifications thereto, including assessments or rate or premium increases, if the association fails to meet any targets proposed in such plan for three consecutive quarters.

[7.**]** **6.** If the director of the department of insurance issues an order in accordance with subsection **[**6**]** **5** 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**]** **5** of this section shall be allowed a period of three years, or such longer period as the director may allow, to accomplish its plan to restore its surplus as regards policyholders to at least zero dollars. If at the end of the authorized period of time the association has failed to restore its surplus to at least zero dollars, or if the director of the department of insurance has ordered modifications of the voluntary plan and the association's surplus has failed to increase within three consecutive quarters after such modification, the director of the department of insurance may allow an additional time for the implementation of the voluntary plan or may exercise his powers to take charge of the association as he would a mutual casualty company pursuant to sections 375.1150 to 375.1246, RSMo. Sections 375.1150 to 375.1246, RSMo, shall apply to associations licensed pursuant to sections 383.010 to 383.040 only after the conditions set forth in this section are met. When the surplus as regards policyholders of an association subject to subsection **[**6**]** **5** 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 **5 and** 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**]** **5** of this section for its application are again satisfied.

[8.**]** **7.** Any association licensed pursuant to the provisions of sections 383.010 to 383.040 shall place on file with the director of the department of insurance, except as to excess liability risks which by general custom are not written according to manual rates or rating plans, a copy of every manual of classifications, rules, underwriting rules and rates, every rating plan and every modification of the foregoing which it uses. Filing with the director of the department of insurance within ten days after such manuals, rating plans or modifications thereof are

effective shall be sufficient compliance with this subsection. **[**Any rates, rating plans, rules, classifications or systems in effect or in use by an association on August 28, 1992, may continue to be used by the association.**]** Upon written application of a member of an association, stating his reasons therefor, filed with the association, a rate in excess of that provided by a filing otherwise applicable may be used by the association for that member.

383.079. The director shall compile a statistical summary of all data submitted and shall issue a public report to the Missouri Bar and the supreme court of the state of Missouri. **Beginning not later than December 31, 2006, and annually thereafter, the director shall report to the general assembly an accurate report as to the actual rates charged for malpractice insurance and any changes in those rates from the previous year.**

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

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

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

(2) Specialty coverage of the insured;

(3) Insured's policy number;

(4) Nature and substance of the claim;

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

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

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

(8) Expenses incurred; and

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

3. As used in this section, "insurer" includes every insurance company authorized to transact insurance business in this state, every unauthorized insurance company transacting business pursuant to chapter 384, RSMo, every risk retention group, every insurance company issuing insurance to or through a purchasing group, **every entity operating under this chapter,** and any other person providing insurance coverage in this state**[**. With respect to any insurer transacting business pursuant to chapter 384, RSMo, filing the report required by this section shall be the obligation of the surplus lines broker or licensee originating or accepting the insurance**], including self-insured health care providers**.

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

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

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

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

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

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

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

6. Any funds which result from policyholder premiums and other revenues received in excess of those funds required for reserves, loss payments and expenses incurred and accrued at the end of any calendar year shall be paid proportionately to the general fund to the extent that credit against premium tax liability has been granted pursuant to subsection 5 **of this section** and to members which have been assessed but have not received tax credits as provided in subsection 5 **of this section**.

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

383.300. 1. As used in sections 383.300 to 383.316, the term "insurer" or "insurers" means any insurance company, mutual insurance company, medical malpractice association, any entity created under this chapter, or other entity providing any insurance to any health care provider, as defined in section 538.205, RSMo, practicing medicine in the state of Missouri, against claims for malpractice or professional negligence; provided, however, that the term "insurer" or "insurers" shall not mean any surplus lines insurer operating under chapter 384, RSMo, or any entity to the extent it is self-insuring its exposure to medical malpractice liability.

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

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

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

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

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

383.302. The department of insurance shall, prior to October 1, 2006, establish health care provider classification codes and risk-reporting categories for medical malpractice insurance premiums, as defined in section 383.150, and shall establish

regulations for the reporting of all premiums charged by such categories and/or codes. The department of insurance shall consider the available history or prior court judgments for claims under this chapter, in each county and any city not within a county in this state and the current risk categories in use by insurers in establishing the risk reporting categories.

383.304. All insurers shall, with regards to medical malpractice insurance as defined in section 383.150, provide to the department of insurance, beginning on January 1, 2007, and not less than annually thereafter, an accurate report as to the actual rates, including assessments levied against members, excluding members whose practice is part-time, charged by such company for such insurance, for each of the risk-reporting categories and/or codes established in section 383.302.

383.306. Not later than June 1, 2007, and at least annually thereafter, the department of insurance shall, utilizing the information provided under section 383.304 establish and publish, a market rate reflecting the median of the actual rates charged for each of the risk-reporting categories for the preceding year by all insurers.

383.308. For purposes of sections 383.308 to 383.316, the following terms mean:

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

(2) "Schedule rating or individual risk rating credits or debits", rating factors or adjustments applied to an insurer's base rates to increase or decrease the premium of an individual insured or unit or exposure to adjust the base rate to account for individual risk characteristics not reflected in the base rate.

383.310. 1. The department of insurance shall establish reporting standards for insurers by which the insurers shall report their base rates and schedule of rating or individual risk rating credits or debits for the health care provider classifications and/or codes designated by the department, in whatever categories the department determines to be actuarially appropriate.

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

383.312. 1. The department of insurance shall establish reporting standards for insurers by which the insurers, or an advisory organization designated by the department, shall annually report such Missouri medical malpractice insurance actual premium, actual premium deviation from the base rate, loss, exposure, and other information as the

department may require for the purpose of compiling a Missouri medical malpractice ratemaking database. The reports shall be in a format determined by the department. Such information shall be considered confidential information and shall be a closed record under chapter 610, RSMo.

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

383.314. After August 28, 2006, when evaluating the base rates of any medical malpractice insurer, including any insurer newly admitted to write medical malpractice insurance in Missouri or any insurer entering such line, in order to determine whether such rates are excessive, inadequate, or unfairly discriminatory, the director of insurance shall, in addition to any other methods of evaluation, use the base rates collected under section 383.310 as a basis for comparison.

383.316. 1. If the director finds that any insurer or filing organization has violated any provision of sections 383.300 to 383.316, the director may impose a penalty of not more than five hundred dollars for each violation, but if the director finds the violation to be willful, the director may impose a penalty of not more than five thousand dollars for each violation. Such penalties may be in addition to any other penalty provided by law.

2. The director may suspend the license of any rating organization or insurer that fails to comply with an order of the director relating to sections 383.300 to 383.316 within the time limited by such order, or any extension thereof which the director may grant. The director shall not suspend the license of any rating organization or insurer for failure to comply with an order until the time prescribed for an appeal therefrom has expired or if an appeal has been taken, until the order has been affirmed. The director may determine when a suspension of license shall become effective and it shall remain in effect for a period fixed by the director, unless the director modifies or rescinds such suspension or until the order upon which such suspension is based is modified, rescinded, or reversed.

3. No penalty shall be imposed or no license shall be suspended or revoked except upon a written order of the director, stating the director's findings, made after a hearing

held upon not less than ten days' written notice to such person or organization specifying the alleged violation.

383.330. The department of insurance shall promulgate rules defining the term "claim" as it applies to claims made for medical malpractice. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2006, shall be invalid and void.

383.335. By January 1, 2011, all insurers writing medical malpractice insurance in this state shall offer medical malpractice policies of insurance which are written so as to apply to injury which results from acts or omissions occurring during the policy period, regardless of the timing of the filing of a claim based on such acts and omissions.

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