SECOND REGULAR SESSION

HOUSE BILL NO. 2256

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES SCHAAF (Sponsor) AND DOUGHERTY (Co-sponsor).

Read 1st time February 25, 2008 and copies ordered printed.

D. ADAM CRUMBLISS, Chief Clerk

4926L.02I

AN ACT

To repeal sections 383.100, 383.105, 383.106, 383.107, 383.108, 383.110, 383.115, 383.125, and 383.206, RSMo, and to enact in lieu thereof six new sections relating to medical malpractice insurance, with penalty provisions.

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

Section A. Sections 383.100, 383.105, 383.106, 383.107, 383.108, 383.110, 383.115, 383.125, and 383.206, RSMo, are repealed and six new sections enacted in lieu thereof, to be known as sections 383.100, 383.105, 383.106, 383.107, 383.108, and 383.206, to read as follows:

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

(1) "Director", **[**the director shall be**]** the director of the department of insurance**, financial institutions and professional registration**;

(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) **"Insurer", every insurance company authorized to transact insurance business in this state, every unauthorized insurance company transacting business under chapter 384, RSMo, every risk retention group, every insurance company issuing insurance to or**

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.

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;

(4) "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.

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 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 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.**] Such reports shall be made to the director quarterly on dates and in the form prescribed by the director.**

4. 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.

5. 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 (3) to (8) of subsection 2 of this section to the director of the department of social services or the director's designee. Information shall be disclosed to the department of social services so that the department 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.

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, shall annually report such Missouri medical malpractice insurance premium, loss, exposure, and other information as the director may require.

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 shall include:**

(1) Written and earned premium at filed base rates;

(2) Written and earned premium;

(3) Written and earned exposures;

(4) Paid and incurred losses;

(5) Paid and incurred loss adjustment expenses;

(6) Basic limits paid and incurred losses;

(7) Assessments;

(8) Loss and expense reserves, including case basis reserves, total reserves, and basic limits reserves;

(9) Open claims, closed claims, open occurrences, and closed occurrences;

(10) Cancellations and nonrenewals;

(11) Policies renewed and new policies issued.

3. The data required under this section shall be reported in accordance with a uniform statistical plan developed by the director. The statistical plan shall include dates; type and magnitude of exposure; type of coverage or policy; individual, group, or

institutional coverage; method of coverage of corporate and employee exposure; policy limits; county of practice; medical specialty class; retroactive date; claims-made year; legal defense coverage; consent to settle arrangements; deductible amounts; individual risk rating factors; claim history; and other relevant policy, coverage, and risk characteristics. To the extent practical, the director shall utilize existing industry medical specialty classes, such as those developed by the insurance services office (ISO).

[3.**] 4.** The director shall **[**collect**] compile** the information **[**required**] collected** 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 malpractice action**. The director may combine such information with similar information obtained through insurer examinations so as to cover periods of more than one year.

[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.**]**

5. 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 unless the data meets each of the following criteria:

(1) The threshold rule: nonzero data cells or totals shall include a minimum of five observations;

(2) The p-percent rule: the sum of all but the largest three observations in a data cell or total shall be less than a specified percent (p) of the largest value;

(3) The (n,k) rule: no single observation can exceed a specified percent (k) of a data cell total;

(4) The values for each of the three preceding criteria shall be calculated in accordance with the methods prescribed in the Statistical Policy Working Paper 22 (Second version, 2005), Report on Statistical Disclosure Limitation Methodology, Federal Committee on Statistical Methodology, Office of Management and Budget;

(5) The value of the parameter *p* in the p-percent rule, and of *k* in the (n,k) rule shall be determined by the director. As prescribed in the Statistical Policy Working Paper 22, to lessen the likelihood that public malpractice data can be used to infer individual identities and other sensitive information, the value of such parameters 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.

6. Except as expressly permitted, 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.

7. To ensure the integrity of the confidentiality of such information, the director, the director of insurance market regulation, and all employees of the department and its divisions shall be bound to keep secret all information obtained under this section, except as authorized upon a finding by the director that the criteria in this section have been met. If any employee of the department discloses to a nonemployee of the department any confidential information without the authorization of the director, the disclosing person is guilty of a class B misdemeanor.

383.107. Not later than December 31, 2009, and at least annually thereafter, the director shall, utilizing the information provided pursuant to section 383.106, **[**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 with at least a three percent market share of the medical malpractice insurance market as of December thirty-first of the prior year, which are certified to have rates which are not inadequate by an actuary selected and approved by the director**] on the department's web site the average of the actual rates charged to medical professionals, including their incidental corporate coverage, calculated as the ratio of written premium to written exposures. The average rate shall be determined for categories in the uniform statistical plan developed under section 383.106 relating to the type of coverage, limit of liability, territory, practitioner medical specialty class, and claims-made year**.

383.108. **[**The director shall, utilizing the information provided under section 383.106, publish comparisons of the base rates charged by each insurer actively writing medical malpractice insurance.**] 1. Beginning September 30, 2008, and annually thereafter, all insurers actively writing medical malpractice insurance shall submit base rates to the director in accordance with the uniform classification system developed under section**

383.106. Surplus lines insurers, foreign risk retention groups, and self-insureds are not required to submit base rates in accordance with this section.

2. If an insurer modifies its base rates between annual base rate filings, the insurer shall notify the director within thirty days after such base rate modification is effective. Such notification shall be in the form and manner prescribed by the director.

3. No later than January 1, 2009, and annually thereafter, the director shall, utilizing the information submitted under this section and section 383.106, publish comparisons of the base rates charged by each insurer actively writing medical malpractice insurance.

383.206. 1. Notwithstanding the provisions of sections 383.037 and 383.160, no insurer shall issue or sell in the state of Missouri a policy insuring a health care provider, as defined in section 538.205, RSMo, for damages for personal injury or death arising out of the rendering of or failure to render health care services if the director finds, based upon competent and compelling evidence, that **[**the base rates of such insurer are excessive, inadequate, or unfairly discriminatory**] a rating plan, rule, manual, or system used by such insurer produces actual rates which are excessive, inadequate, or unfairly discriminatory**. A **base** rate**, rating plan, manual, or system** may be used by an insurer immediately after it has been filed **in a rate filing** with the director, until or unless the director has determined under this section that **[**a rate is**] the rating plan, rule, manual, or system produces actual rates that are** excessive, inadequate, or unfairly discriminatory.

2. **No rating plan, rule, manual, or system shall be held to produce actual rates that are excessive, unless the actual rates produced are unreasonably high for the insurance provided with respect to the classification to which such actual rates are applicable.**

3. No rating plan, rule, manual, or system shall be held to produce actual rates that are inadequate, unless the actual rates produced are unreasonably low for the insurance provided with respect to the classifications to which such actual rates are applicable and are insufficient to sustain projected losses and expenses, or in the aggregate under the rating plan, rule, manual, or system, the continued use of such actual rates endangers the solvency of the insurer using the same or will have the effect of destroying competition or of creating a monopoly.

4. No rating plan, rule, manual, or system shall be held to produce actual rates that are unfairly discriminatory, unless the actual rate charged a provider differs significantly from the actual rate to be charged another provider with essentially the same hazard.

5. In making a determination under subsection 1 of this section, the director **[**of the department of insurance**]** may use the following factors:

(1) **[**Rates shall not be excessive or inadequate, nor shall they be unfairly discriminatory;

(2) No rate shall be held to be excessive unless such rate is unreasonably high for the insurance proved with respect to the classification to which such rate is applicable;

(3) No rate shall be held to be inadequate unless such rate is unreasonably low for the insurance provided with respect to the classification to which such rate is applicable;

(4)**]** To the extent Missouri loss experience is available, **[**rates and projected**] the determination of actual rates and the projection of** losses shall be based on Missouri loss experience and not the insurance company's or the insurance industry's loss experiences in states other than Missouri unless the failure to do so jeopardizes the financial stability of the insurer; provided however, that loss experiences relating to **[**the**] a** specific proposed insured occurring outside the state of Missouri may be considered in allowing a surcharge to such insured's premium rate;

[(5)**] (2)** Investment income or investment losses of the insurance company for the ten-year period prior to the request for rate approval may be considered in reviewing rates. Investment income or investment losses for a period of less than ten years shall not be considered in reviewing rates. Industrywide investment income or investment losses for the ten-year period prior to the request for rate approval may be considered for any insurance company that has not been authorized to issue insurance for more than ten years;

[(6)**] (3)** The locale in which the health care practice is occurring;

[(7)**] (4)** Inflation;

[(8)**] (5)** Reasonable administrative costs of the insurer **taking into account all relevant factors in the insurer's business plan**;

[(9)**] (6)** Reasonable costs of defense of claims against Missouri health care providers **taking into account the insurer's policy provisions and claim management practices**;

[(10)**] (7)** A reasonable rate of return on investment for the owners or shareholders of the insurer when compared to other similar investments at the time of the rate **[**request**] filing**; except that, such factor shall not **apply to insurers organized under section 383.010, and shall not** be used **by an insurer** to offset losses in other states or in activities of **[**the**] such** insurer other than the sale of policies of insurance to Missouri health care providers; and

[(11)**] (8)** Any other reasonable factors may be considered **[**in the disapproval of the rate request**] by the director in making the determination under subsection 1 of this section**.

[3.**] 6.** The director's determination under subsection 1 of this section **[**of whether a base rate is excessive, inadequate, or unfairly discriminatory**]** may be based on any subcategory or subspecialty of the health care industry that the director determines to be reasonable. **Insurers shall be allowed to group risks by classifications for the establishment of base rates and minimum premiums. In order to determine actual rates, base rates for specific classifications may be modified for individual risks in accordance with standards set by the**

insurer for measuring variations in hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect on losses or expenses. Classifications or modifications of classification, or any portion or division thereof, of risks may be predicated upon size, expense, management, individual experience, purpose of insurance, location or dispersion of hazard, or any other reasonable considerations, provided such classifications and modifications of classification shall be applicable to the fullest practicable extent to all risks under the same or substantially the same circumstances or conditions. Rates for specific classifications may also be modified to determine actual rates to be charged for individual or special risks which are not susceptible to measurement by any established standards.

[4.**] 7.** If **[**actuarially supported and**]** included in a **[**filed rate, rating plan, rule, manual, or rating system**] rate filing**, an insurer may charge an additional premium or grant a discount rate to any **[**health care provider**] proposed insured** based on criteria **[**as it relates to a specified insured health care provider or other specific health care providers within the specific**] specific to such proposed insured or specific to other health care providers within such proposed** insured's employ or business entity. **The effect of such criteria and resulting additional premiums and discounts shall be considered by the director in making the determination under subsection 1 of this section.** Such criteria may include:

(1) Loss experiences;

(2) Training and experience;

(3) Number of employees of the insured entity;

(4) Availability of equipment, capital, or hospital privileges;

(5) Loss prevention measures taken by the insured;

(6) The number and extent of claims not resulting in losses;

(7) The specialty or subspecialty of the health care provider;

(8) Access to equipment and hospital privileges; and

(9) Any other reasonable criteria identified by the insurer and filed with the department of insurance.

[5.**] 8.** Supporting actuarial data **in the possession of an insurer** shall be filed in support of a rate**[**, rating plan, or rating system filing,**] filing made after August 28, 2008,** when requested by the director to **[**determine whether rates should be disapproved as**] be used in the determination of whether a rating plan, rule, manual, or system produces actual rates that are** excessive, inadequate, or unfairly discriminatory, whether or not the insurer has begun using the **filed base** rate**, rating plan, rule, manual, or system**.

[6. The director of the department of insurance shall promulgate rules for the administration and enforcement of this section. Any rule or portion of a rule, as that term is

defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2006, shall be invalid and void.**]**

9. If, under subsection 1 of this section, the director determines an insurer's rating plan, rule, manual, or system to produce actual rates that are excessive, inadequate, or unfairly discriminatory, the director may issue such administrative orders as authorized under section 374.046, RSMo.

[383.110. Such reports shall be made to the director of the department of insurance quarterly on dates and in the form to be determined by the director.**]**

[383.115. 1. Information submitted pursuant to subsection 2 of section 383.105, subdivisions (1), (3) and (6) shall be deemed to be confidential communication except as provided in section 383.125.

2. Statistics in summary form of the information submitted pursuant to sections 383.100 to 383.125, except as provided in subsection 1, shall be a matter of public record.**]**

[383.125. The director shall, upon receipt, submit in writing the pertinent and appropriate data and information submitted pursuant to subsection 2 of section 383.105 to the applicable health care licensing board.

The director shall also submit a report containing the information described in subdivisions (3) to (8) of subsection 2 of section 383.105 to the director of the department of social services or the director's designee. 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 Medicaid program during the period in which the alleged incident occurred. The information provided to the department shall be subject to the confidentiality restrictions provided in subsection 7 of section 208.217, RSMo, and of section 383.115.**]**

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