SECOND REGULAR SESSION

[P E R F E C T E D**]**

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILLS NOS. 905 & 910

93RD GENERAL ASSEMBLY

Reported from the Committee on Small Business, Insurance and Industrial Relations, March 16, 2006, with recommendation that the Senate Committee Substitute do pass.

Senate Committee Substitute for Senate Bills Nos. 905 & 910, adopted March 30, 2006.

Taken up for Perfection March 30, 2006. Bill declared Perfected and Ordered Printed, as amended.

TERRY L. SPIELER, Secretary.

4389S.05P

AN ACT

To repeal section 383.105, RSMo, and to enact in lieu thereof twelve new sections relating to medical malpractice insurance, with an expiration date for certain sections.

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

Section A. Section 383.105, RSMo, is repeated and twelve new sections enacted in lieu thereof, to be known as sections 383.105, 383.106, 383.107, 383.108, 383.124, 383.196, 383.197, 383.198, 383.199, 383.450, 383.515, and 1, to read as follows:

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;

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

(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**]** **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**[**. 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**.

383.106. 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 chapter 383 in each county of the state in establishing the risk reporting categories.

3. The director shall collect the information required in this section and compile it in a manner appropriate for assisting Missouri medical malpractice insurers in developing their future base rates, schedule rating, or individual risk rating factors and other aspects of

their rating plans. In compiling the information and making it available to Missouri insurers and the public, the director shall remove any individualized information that identifies a particular insurer as the source of the information. 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, including self-insured health care providers, 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.

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.

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.

383.124. 1. If the director determines that a person has engaged, is engaging, or is about to engage in a violation of sections 383.100 to 383.125 or a rule adopted or order issued pursuant thereto, or that a person has materially aided, is materially aiding, or is about to materially aid an act, practice, omission, or course of business constituting a violation of sections 383.100 to 383.125 or a rule adopted or order issued pursuant thereto, the director may issue such administrative orders as authorized under section 374.046, RSMo. A violation of any provisions under these sections is a level two violation under section 374.049, RSMo. The director of insurance may also suspend or revoke the license or certificate of authority of any person for any such willful violation as authorized under section 374.047, RSMo.

2. If the director believes that a person has engaged, is engaging,

or is about to engage in a violation of sections 383.100 to 383.125 or a rule adopted or order issued pursuant thereto, or that a person has materially aided, is materially aiding, or is about to materially aid an act, practice, omission, or course of business constituting a violation of sections 383.100 to 383.125 or a rule adopted or order issued pursuant thereto, the director may maintain a civil action for relief authorized under section 374.048, RSMo. A violation of any provision under these sections is a level two violation under section 374.049, RSMo.

383.196. 1. As used in sections 383.196 to 383.199, "insurer" includes every insurance company authorized to transact insurance business in this state and every entity operating under this chapter, except unauthorized insurance companies transacting business pursuant to chapter 384, RSMo, risk retention groups, and insurance companies issuing insurance to or through a purchasing group.

2. Notwithstanding the provisions of sections 383.037 and 383.160, every insurer shall file with the director every manual, minimum premium, class rate, rating schedule or rating plan, and every other rating rule, and every modification of any of the foregoing for any 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 or failure to render health care services, which it proposes to use. Every such filing shall state the proposed effective date thereof, and shall indicate the character and extent of the coverage contemplated.

3. Rates shall not be excessive, inadequate, or unfairly discriminatory. Rates are excessive if they are likely to produce a long-run profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered. Rates are inadequate when they are clearly insufficient to sustain projected losses and expenses and the use of such rates, if continued, will tend substantially lessen competition or create a monopoly in the market. The following factors may be considered:

(1) A rate is not excessive unless such rate is unreasonably high for`the insurance provided with respect to classification to which the rate is applicable;

(2) A rate is not inadequate unless such rate is unreasonably low for the insurance provided with respect to classification which the rate

is applicable;

(3) To the extent Missouri loss experience is available, rates should be based on this experience and not on the insurer's or industry's loss experience in other states, unless failure to do so jeopardizes the financial stability of the insurer; provided however, that loss experiences relating to the specific proposed insured occurring outside the state may be considered in allowing a surcharge to such insured's premium rate;

(4) To the extent that such information is available, investment income or investment losses of the insurance company for the ten-year period prior to the rate approval may be considered; and

(5) To the extent that such information is available and impacts losses, the locale in which the health care practice is occurring.

4. Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

5. Due consideration shall be given to past and prospective loss and expense experience within and outside of this state, to catastrophe hazards and contingencies, to events or trends within and outside of this states, and to all other relevant factors, including judgment.

6. Rates may contain a provision for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of profit, consideration should be given to all investment income attributable to premiums and reserves.

7. The director, under section 374.045, RSMo, shall promulgate rules for the administration and enforcement of sections 383.196 to 383.199. 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.

8. The provisions of sections 383.196 to 383.199 shall expire on December 31, 2010.

383.197. 1. Every insurer shall file with the director all rates and supplementary rate information which is to be used in this state. Such rates and supplementary rate information and supporting information required by the director shall be filed at least ninety days before the effective date. Upon application by the filer, the director may authorize an earlier effective date.

2. Rates filed pursuant to this section shall be filed in such form and manner as prescribed by the director. Whenever a filing is not accompanied by such information as the director has required under this section, the director shall so inform the insurer within thirty days and the filing shall not be deemed to be made until the information is furnished or the insurer certifies that the additional information is not maintained or it cannot reasonably be provided.

3. The director shall make a determination of whether or not to approve a rate within sixty days of the filing being made under this section, but notwithstanding this requirement, if the director fails to make an approval or disapproval determination within that sixty-day period, a rate application shall be deemed approved.

4. All rates, supplementary rate information and any supporting information shall, as soon as filed, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge.

383.198. 1. The director may disapprove a rate if the director finds that the rate is inadequate, excessive or unfairly discriminatory under section 383.196.

2. The director may disapprove, without hearing, rates prefiled pursuant to section 383.196 that have not become effective; however, the insurer whose rates have been disapproved shall be given a hearing upon a written request made within thirty days after the disapproval order.

3. Notwithstanding a prior approval under section 383.197, a rate may be disapproved at any time subsequent to the effective date;

however, the director may disapprove rates that have become effective only after the insurer has been provided a hearing thereon.

4. Whenever an insurer has no legally effective rates as a result of the director's disapproval of rates or other act, the director shall on request of the insurer specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the director. When new rates become legally effective, the director shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds of less than ten dollars per policyholder shall not be required.

383.199. Notwithstanding any other provision of law, no insurer shall, with regards to medical malpractice insurance, as defined in section 383.150, implement any rate increase without first providing clear and conspicuous written notice by United States mail to the insured at least thirty days prior to implementation of the rate increase.

383.450. 1. As used in this section, "insurer" includes every insurance company authorized to transact business in this state, every unauthorized insurance company transacting business pursuant to chapter 384, RSMo, every risk retention group, every insurance company issuing policies or providing benefits to or through a purchasing group, and any other person providing medical malpractice insurance coverage in this state.

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

(1) Fail or refuse to renew the insurance without first providing written notice by certified 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

(2) Cease the issuance of such policies of insurance in the state of Missouri without first providing written notice by certified 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 subdivision (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.

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

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

(1) The director of the department of insurance, or his or her designee;

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

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

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

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

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

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

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

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

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

5. The director of the department of insurance shall provide and coordinate staff and equipment services to the board to facilitate the board's duties.

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

performance of their duties.

7. The provisions of this section shall expire December 31, 2010.

Section 1. The articles of association and the bylaws of any association created under the provisions of sections 383.010 to 383.040 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:

(a) The exact method and criteria by which the amounts of each type of assessment are to be determined;

(b) The time in which the assessments must be paid;

(c) That such assessments shall be made without limitation as to frequency;

(d) The maximum amount of any single assessment; and

(e) That such assessments shall apply to members and former members.

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