

FIRST REGULAR SESSION

HOUSE BILL NO. 529

93RD GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES WITTE (Sponsor), LAMPE, WILDBERGER, DONNELLY, YOUNG, ROBINSON, BARNITZ, ROORDA, BURNETT, BAKER (25), SPRENG, HARRIS (110), HARRIS (23), LeVOTA, JOLLY, LOWE (44), AULL, KUESSNER, DOUGHERTY, HENKE, WHORTON, DARROUGH, ZWEIFEL, SWINGER, STORCH, MEADOWS, FRASER, BOWMAN, YAEGER AND OXFORD (Co-sponsors).

Read 1st time February 10, 2005 and copies ordered printed.

STEPHEN S. DAVIS, Chief Clerk

1537L.011

AN ACT

To repeal sections 379.316, 383.150, 538.210 and 538.225, RSMo, and to enact in lieu thereof seventeen new sections relating to medical malpractice, with an emergency clause.

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

Section A. Sections 379.316, 383.150, 538.210 and 538.225, RSMo, are repealed and
2 seventeen new sections enacted in lieu thereof, to be known as sections 135.163, 379.316,
3 383.112, 383.150, 383.151, 383.200, 383.205, 383.210, 383.215, 383.220, 383.225, 383.230,
4 537.072, 538.210, 538.211, 538.225, and 538.226, to read as follows:

135.163. 1. For all tax years beginning on or after January 1, 2006, in order to
2 **encourage the retention of physicians and other health care providers in this state, an**
3 **eligible taxpayer shall be allowed a credit not to exceed fifteen thousand dollars per eligible**
4 **taxpayer against the tax otherwise due pursuant to chapter 143, RSMo, not including**
5 **sections 143.191 to 143.265, RSMo, in an amount equal to fifteen percent of the increase**
6 **in amount paid by an eligible taxpayer for medical malpractice insurance premiums in the**
7 **aggregate from one policy period to the next immediate policy period. For purposes of this**
8 **section, the base policy period for calculation of the credit shall be the medical malpractice**
9 **insurance policy in effect on the effective date of this section.**

10 **2. The tax credit allowed by this section shall be claimed by the taxpayer at the time**
11 **such taxpayer files a return. Any amount of tax credit which exceeds the tax due shall be**

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.

12 carried over to any of the next five subsequent taxable years, but shall not be refunded and
13 shall not be transferable.

14 **3. The director of the department of insurance and the director of the department**
15 **of revenue shall jointly administer the tax credit authorized by this section. The director**
16 **of the department of insurance shall enact procedures to verify the amount of the allowable**
17 **credit and shall issue a certificate to each eligible taxpayer that certifies the amount of the**
18 **allowable credit. Both the director of the department of insurance and the director of the**
19 **department of revenue are authorized to promulgate rules and regulations necessary to**
20 **administer the provisions of this section. Any rule or portion of a rule, as that term is**
21 **defined in section 536.010, RSMo, that is created under the authority delegated in this**
22 **section shall become effective only if it complies with and is subject to all of the provisions**
23 **of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter**
24 **536, RSMo, are nonseverable and if any of the powers vested with the general assembly**
25 **pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and**
26 **annul a rule are subsequently held unconstitutional, then the grant of rulemaking**
27 **authority and any rule proposed or adopted after the effective date of this section, shall be**
28 **invalid and void.**

29 **4. The tax credits issued pursuant to this section shall not exceed a total for all tax**
30 **credits issued of fifteen million dollars per fiscal year.**

379.316. 1. Section 379.017 and sections 379.316 to 379.361 apply to insurance
2 companies incorporated pursuant to sections 379.035 to 379.355, section 379.080, sections
3 379.060 to 379.075, sections 379.085 to 379.095, sections 379.205 to 379.310, and to insurance
4 companies of a similar type incorporated pursuant to the laws of any other state of the United
5 States, and alien insurers licensed to do business in this state, which transact fire and allied lines,
6 marine and inland marine insurance, to any and all combinations of the foregoing or parts
7 thereof, and to the combination of fire insurance with other types of insurance within one policy
8 form at a single premium, on risks or operations in this state, except:

- 9 (1) Reinsurance, other than joint reinsurance to the extent stated in section 379.331;
10 (2) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection
11 and indemnity, or other risks commonly insured pursuant to marine, as distinguished from inland
12 marine, insurance policies;
13 (3) Insurance against loss or damage to aircraft;
14 (4) All forms of motor vehicle insurance; and
15 (5) All forms of life, accident and health, [and] workers' compensation insurance, **and**
16 **medical malpractice liability insurance.**

17 2. Inland marine insurance shall be deemed to include insurance now or hereafter defined

18 by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the
19 director, or as established by general custom of the business, as inland marine insurance.

20 3. Commercial property and commercial casualty insurance policies are subject to rate
21 and form filing requirements as provided in section 379.321.

**383.112. Any insurer or self-insured health care provider that fails to timely report
2 claims information as required by sections 383.100 to 383.125 shall be subject to the
3 provisions of section 374.215, RSMo.**

383.150. As used in sections 383.150 to 383.195, the following terms shall mean:

2 (1) "Association" [means], the joint underwriting association established pursuant to the
3 provisions of sections 383.150 to 383.195;

4 (2) **"Competitive bidding process", a process under which the director seeks, and
5 insurers may submit, rates at which insurers guarantee to provide medical malpractice
6 liability insurance to any health care provider unable to obtain such insurance in the
7 voluntary market;**

8 (3) "Director" [means], the director of the department of insurance;

9 [(3)] (4) "Health care provider" includes physicians, dentists, clinical psychologists,
10 pharmacists, optometrists, podiatrists, registered nurses, physicians' assistants, chiropractors,
11 physical therapists, nurse anesthetists, anesthetists, emergency medical technicians, hospitals,
12 nursing homes and extended care facilities; but shall not include any nursing service or nursing
13 facility conducted by and for those who rely upon treatment by spiritual means alone in
14 accordance with the creed or tenets of any well-recognized church or religious denomination;

15 [(4)] (5) "Medical malpractice insurance" [means], insurance coverage against the legal
16 liability of the insured and against loss, damage, or expense incident to a claim arising out of the
17 death or injury of any person as a result of the negligence or malpractice in rendering
18 professional service by any health care provider;

19 [(5)] (6) "Net direct premiums" [means], gross direct premiums written on casualty
20 insurance in the state of Missouri by companies authorized to write casualty insurance under
21 chapter 379, RSMo [1969], in the state of Missouri, less return premiums thereon and dividends
22 paid or credited to policyholders on such direct business.

**383.151. When the department determines after a public hearing that medical
2 malpractice liability insurance is not reasonably available for health care providers in the
3 voluntary market, the director shall establish a method for providing such insurance to
4 such health care providers. The director may:**

5 (1) **Establish a competitive bidding process under which insurers may submit rates
6 at which they agree to insure such health care providers; or**

7 (2) **Establish any other method reasonably designed to provide insurance to such**

8 health care providers.

383.200. 1. As used in sections 383.200 to 383.225, the following terms mean:

2 (1) "Director", the same meaning as such term is defined in section 383.100;

3 (2) "Health care provider", the same meaning as such term is defined in section
4 383.100;

5 (3) "Insurer", an insurance company licensed in this state to write liability
6 insurance, as described in section 379.010, RSMo;

7 (4) "Medical malpractice insurance", the same meaning as such term is defined in
8 section 383.100.

9 2. The following standards and procedures shall apply to the making and use of
10 rates pertaining to all classes of medical malpractice insurance:

11 (1) Rates shall not be excessive, inadequate, or unfairly discriminatory. A rate is
12 excessive if it is unreasonably high for the insurance provided. A rate is inadequate if it
13 is unreasonably low for the insurance provided and continued use of it would endanger the
14 solvency of the company. A rate is unfairly discriminatory if it does not reflect equitably
15 differences in reasonably expected losses and expenses;

16 (2) (a) Every insurer that desires to increase a rate by less than fifteen percent shall
17 file such rate, along with data supporting the rate change as prescribed by the director, no
18 later than thirty days after such rate becomes effective. Filings under this paragraph shall
19 not be subject to approval or disapproval by the director.

20 (b) Every insurer that desires to increase a rate by fifteen percent or more shall
21 submit a complete rate application to the director. A complete rate application shall
22 include all data supporting the proposed rate and such other information as the director
23 may require. The applicant shall have the burden of proving that the requested rate
24 change is justified and meets the requirements of this act.

25 (c) Every insurer that has filed a rate increase under paragraph (a) of this
26 subdivision for two consecutive years and in the third year desires to file a rate increase
27 which in the aggregate over the three-year period will equal or exceed a total rate increase
28 of forty percent or more shall be required to submit a complete rate application pursuant
29 to paragraph (b) of this subdivision.

30 (d) Every insurer that has not filed or had a rate increase approved for three
31 consecutive years may file a rate increase in the fourth year in an amount not to exceed a
32 twenty-five percent increase without being required to submit a complete rate application
33 pursuant to paragraph (b) of this subdivision;

34 (3) The director of insurance shall promulgate rules setting forth standards that
35 insurers shall adhere to in calculating their rates. Such rules shall:

36 (a) Establish a range within which an expected rate of return shall be presumed
37 reasonable;

38 (b) Establish a range within which categories of expenses shall be presumed
39 reasonable;

40 (c) Establish a range for the number of years of experience an insurer may consider
41 in determining an appropriate loss development factor;

42 (d) Establish a range for the number of years of experience an insurer may consider
43 in determining an appropriate trend factor;

44 (e) Establish a range for the number of years of experience an insurer may consider
45 in determining an appropriate increased limits factor;

46 (f) Establish the proper weights to be given to different years of experience;

47 (g) Establish the extent to which an insurer may apply its subjective judgment in
48 projecting past cost data into the future;

49 (h) Establish any other standard deemed reasonable and appropriate by the
50 director;

51 (4) The director shall require an insurer to submit with any rate change
52 application:

53 (a) A comparison, in a form prescribed by the director, between the insurer's initial
54 projected incurred losses and its ultimate incurred losses for the eight most recent policy
55 years for which such data is available;

56 (b) A memorandum explaining the methodology the insurer has used to reflect the
57 total investment income it reasonably expects to earn on all its assets during the period the
58 proposed rate is to be in effect. The director shall disapprove any rate application that
59 does not fully reflect all such income;

60 (5) The director shall notify the public of any application from an insurer seeking
61 a rate increase of fifteen percent or more, and shall hold a hearing on such application
62 within forty-five days of such notice. The application shall be deemed approved ninety
63 days after such notice unless it is disapproved by the director after the hearing;

64 (6) If after a hearing the director finds any rate of an insurer to be excessive, the
65 director may order that the insurer discontinue the use of the rate and that the insurer
66 refund the excessive portion of the rate to any policyholder who has paid such rate. The
67 director shall not be required to find that a reasonable degree of competition does not exist
68 to find a rate excessive.

69 3. For insurers required to file pursuant to paragraph (b) of subdivision (2) of
70 subsection 2 of this section, if there is insufficient experience within the state of Missouri
71 upon which a rate can be based with respect to the classification to which such rate is

72 applicable, the director may approve a rate increase that considers experiences within any
73 other state or states which have a similar cost of claim and frequency of claim experience
74 as this state. If there is insufficient experience within Missouri or any other states which
75 have similar cost of claim and frequency of claim experience as Missouri, nationwide
76 experience may be considered. The insurer in its rate increase filing shall expressly show
77 the rate experience it is using.

78 4. All information provided to the director under this section shall be available for
79 public inspection.

80 5. The remedies set forth in this chapter shall be in addition to any other remedies
81 available under statutory or common law.

82 6. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo,
83 that is created under the authority delegated in this section shall become effective only if
84 it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if
85 applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable
86 and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo,
87 to review, to delay the effective date, or to disapprove and annul a rule are subsequently
88 held unconstitutional, then the grant of rulemaking authority and any rule proposed or
89 adopted after the effective date of this section, shall be invalid and void.

2 383.205. For all medical malpractice insurance policies written for insureds in the
3 state of Missouri, the ratio between the base rate of the highest-rated specialty and the base
4 rate of the lowest-rated specialty shall be no more than a ratio of six-to-one.

2 383.210. In determining the premium paid by any health care provider, a medical
3 malpractice insurer shall apply a credit or debit based on the provider's loss experience,
4 or shall establish an alternative method giving due consideration to the provider's loss
5 experience. The insurer shall include a schedule of all such credits and debits, or a
6 description of such alternative method in all filings it makes with the director of insurance.
7 No medical malpractice insurer may use any rate or charge any premiums unless it has
8 filed such schedule or alternative method with the director of insurance and the director
9 has approved such schedule or alternative method. A debit shall be based only on those
claims that have been paid on behalf of the provider.

2 383.215. On or before March first of each year, every insurer providing medical
3 malpractice insurance to a health care provider in this state shall file the following
4 information with the director of insurance:

4 (1) Information on closed claims:

5 (a) The number of new claims reported during the preceding calendar year, and
6 the total amounts of reserve for such claims and for allocated loss adjustment expenses in
7 connection with such claims;

8 **(b) The number of claims closed during the preceding year, and the amount paid**
9 **on such claims, detailed as follows:**

10 **a. The number of claims closed each year with payment, and the amount paid on**
11 **such claims and on allocated loss adjustment expenses in connection with such claims;**

12 **b. The number of claims closed each year without payment, and the amount of**
13 **allocated loss adjustment expenses in connection with such claims;**

14 **(2) Information regarding judgments, payment, and severity of injury in connection**
15 **with judgments:**

16 **(a) For each judgment rendered against an insurer for more than one hundred**
17 **thousand dollars:**

18 **a. The amount of the judgment and the amount actually paid to the plaintiff;**

19 **b. The category of injury suffered by the plaintiff. Injuries shall be categorized as**
20 **follows:**

21 **Category 1: Temporary injury, emotional only.**

22 **Category 2: Temporary insignificant injury, including lacerations, contusions,**
23 **minor scars, and rash.**

24 **Category 3: Temporary minor injury, including infections, missed fractures, and**
25 **falls in hospitals.**

26 **Category 4: Temporary major injury, including burns, left surgical material, drug**
27 **side effects, and temporary brain damage.**

28 **Category 5: Permanent minor injury, including loss of fingers, and loss or damage**
29 **to organs.**

30 **Category 6: Permanent significant injury, including deafness, loss of limb, loss of**
31 **eye, and loss of one kidney or lung.**

32 **Category 7: Permanent major injury, including paraplegia, blindness, loss of two**
33 **limbs, and brain damage.**

34 **Category 8: Permanent grave injury, including quadriplegia, severe brain damage,**
35 **and any injury requiring lifelong care or having a fatal prognosis.**

36 **Category 9: Death;**

37 **(3) Information on each rate change implemented during the preceding five-year**
38 **period by state and medical specialty;**

39 **(4) Information on premiums and losses by medical specialty:**

40 **(a) Written premiums and paid losses for the preceding year, and earned premiums**
41 **and incurred losses for the preceding year, with specifics by medical specialty;**

42 **(b) Number of providers insured in each medical specialty;**

43 **(5) Information on premiums and losses by experience of the insured:**

44 **(a) Written premiums and paid losses for the preceding year, and earned premiums**

45 **and incurred losses for the preceding year, with specifics as follows:**

46 **a. As to all insureds with no incidents within the preceding five-year period;**

47 **b. As to all insureds with one incident within the preceding five-year period;**

48 **c. As to all insureds with two incidents within the preceding five-year period;**

49 **d. As to all insureds with three or more incidents within the preceding five-year**
50 **period;**

51 **(b) Number of providers insured:**

52 **a. With no incidents within the preceding five-year period;**

53 **b. With one incident within the preceding five-year period;**

54 **c. With two incidents within the preceding five-year period;**

55 **d. With three or more incidents within the preceding five-year period;**

56 **(6) Information on the performance of the investments of the insurer, including the**
57 **value of the investments held in the portfolio of the insurer as of December thirty-first of**
58 **the preceding calendar year, and the rate of return on such investments, detailed by**
59 **category of investment as follows:**

60 **(a) United States government bonds;**

61 **(b) Bonds exempt from federal taxation;**

62 **(c) Other unaffiliated bonds;**

63 **(d) Bonds of affiliates;**

64 **(e) Unaffiliated preferred stock;**

65 **(f) Preferred stock of affiliates;**

66 **(g) Unaffiliated common stock;**

67 **(h) Common stock of affiliates;**

68 **(i) Mortgage loans;**

69 **(j) Real estate; and**

70 **(k) Any additional categories of investments specified by the director of insurance.**

383.220. 1. On or before July 1, 2006, and after consultation with the medical
2 **malpractice insurance industry, the director shall establish an interactive Internet site**
3 **which will enable any health care provider licensed in this state to obtain a quote from each**
4 **medical malpractice insurer licensed to write the type of coverage sought by the provider.**

5 **2. The Internet site shall enable health care providers to complete an online form**
6 **that captures a comprehensive set of information sufficient to generate a quote for each**
7 **insurer. The director shall develop transmission software components which allow such**
8 **information to be formatted for delivery to each medical malpractice insurer based on the**
9 **requirements of the computer system of the insurer.**

10 **3. The director shall integrate the rating criteria of each insurer into its online form**
11 **after consultation with each insurer using one of the following methods:**

12 **(1) Developing a customized interface with the insurer's own rating engine;**

13 **(2) Accessing a third-party rating engine of the insurer's choice;**

14 **(3) Loading the insurer's rating information into a rating engine operated by the**
15 **director;**

16 **(4) Any other method agreed on between the director and the insurer.**

17 **4. After a health care provider completes the online form, the provider will be**
18 **presented with quotes from each medical malpractice insurer licensed to write the coverage**
19 **requested by the provider.**

20 **5. Quotes provided on the Internet site shall at all times be accurate. When an**
21 **insurer changes its rates, such rate changes shall be implemented at the Internet site by the**
22 **director, in consultation with the insurer, as soon as practicable but in no event later than**
23 **ten days after such changes take effect. During any period in which an insurer has**
24 **changed its rates but the director has not yet implemented such changed rates on the**
25 **Internet site, quotes for that insurer shall not be obtainable at the Internet site.**

26 **6. The director shall design the Internet site to incorporate user-friendly formats**
27 **and self-help guideline materials, and shall develop a user-friendly Internet user-interface.**

28 **7. The Internet site shall also provide contact information, including address and**
29 **telephone number, for each medical malpractice insurer for which a provider obtains a**
30 **quote at the Internet site.**

31 **8. By December 31, 2006, the director shall submit a report to the general assembly**
32 **on the development, implementation, and affects of the Internet site established by this**
33 **section. The report shall be based on:**

34 **(1) The director's consultation with health care providers, medical malpractice**
35 **insurers, and other interested parties; and**

36 **(2) The director's analysis of other information available to the director, including**
37 **a description of the director's views concerning the extent to which the information**
38 **provided through the Internet site has contributed to increasing the availability of medical**
39 **malpractice insurance and the effect the Internet site has had on the cost of medical**
40 **malpractice insurance.**

383.225. Each insurer shall file with the director of insurance new manuals of
2 **classifications, rules, underwriting rules, rates, rate plans and modifications, policy forms**
3 **and other forms to which such rates are applied, that reflect the savings, if any,**
4 **attributable to each provision of this act.**

383.230. Insurers writing medical malpractice insurance shall provide insured
2 **health care providers with written notice of any increase in renewal premium rates at least**
3 **ninety days prior to the date of the renewal. At a minimum, the notice shall be sent by first**
4 **class mail at least ninety days prior to the date of renewal and shall contain the insured's**

5 **name, the policy number for the coverage being renewed, the total premium amount being**
6 **charged for the current policy term, and the total premium amount being charged to renew**
7 **the coverage.**

537.072. In all tort actions based upon improper health care, the parties shall make
2 **a good faith effort to engage in mediation, which shall be conducted by a trained mediator**
3 **selected from a list approved by the circuit court. The parties shall advise the circuit court**
4 **in writing that mediation take place. If mediation does not occur, the parties shall set forth**
5 **in writing to the circuit court their good faith effort to conduct mediation.**

538.210. 1. In any action against a health care provider for damages for personal injury
2 or death arising out of the rendering of or the failure to render health care services, no plaintiff
3 shall recover more than three hundred fifty thousand dollars [per occurrence] for noneconomic
4 damages from any one defendant as defendant is defined in subsection 2 of this section.

5 2. "Defendant" for purposes of sections 538.205 to 538.230 shall be defined as:

6 (1) A hospital as defined in chapter 197, RSMo, and its employees and physician
7 employees who are insured under the hospital's professional liability insurance policy or the
8 hospital's self-insurance maintained for professional liability purposes;

9 (2) A physician, including his **or her** nonphysician employees who are insured under the
10 physician's professional liability insurance or under the physician's self-insurance maintained for
11 professional liability purposes;

12 (3) Any other health care provider having the legal capacity to sue and be sued and who
13 is not included in subdivisions (1) and (2) of this subsection, including employees of any health
14 care providers who are insured under the health care provider's professional liability insurance
15 policy or self-insurance maintained for professional liability purposes.

16 3. In any action against a health care provider for damages for personal injury or death
17 arising out of the rendering of or the failure to render health care services, where the trier of fact
18 is a jury, such jury shall not be instructed by the court with respect to the limitation on an award
19 of noneconomic damages, nor shall counsel for any party or any person providing testimony
20 during such proceeding in any way inform the jury or potential jurors of such limitation.

21 4. The limitation on awards for noneconomic damages provided for in this section shall
22 be increased or decreased on an annual basis effective January first of each year in accordance
23 with the Implicit Price Deflator for Personal Consumption Expenditures as published by the
24 Bureau of Economic Analysis of the United States Department of Commerce. The current value
25 of the limitation shall be calculated by the director of the department of insurance, who shall
26 furnish that value to the secretary of state, who shall publish such value in the Missouri Register
27 as soon after each January first as practicable, but it shall otherwise be exempt from the
28 provisions of section 536.021, RSMo.

29 5. Any provision of law or court rule to the contrary notwithstanding, an award of
30 punitive damages against a health care provider governed by the provisions of sections 538.205
31 to 538.230 shall be made only upon a showing by a plaintiff that the health care provider
32 demonstrated willful, wanton or malicious misconduct with respect to his **or her** actions which
33 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,
2 any health care defendant who has filed a timely motion to transfer venue may move for
3 a hearing on the propriety of venue. All discovery shall be stayed except for discovery on
4 the issue of venue raised in the motion. Within ninety days of the filing of the motion, the
5 court shall set a hearing on the motion.**

**6 2. If after hearing the court determines that venue is improper, the court shall
7 transfer venue to a county where venue is proper.**

**8 3. The court may award reasonable costs, expenses, and attorneys' fees associated
9 with said motion to the prevailing party.**

538.225. 1. In any action against a health care provider for damages for personal injury
2 or death on account of the rendering of or failure to render health care services, the plaintiff or
3 [his] **the plaintiff's** attorney shall file an affidavit with the court stating that he **or she** has
4 obtained the written opinion of a legally qualified health care provider which states that the
5 defendant health care provider failed to use such care as a reasonably prudent and careful health
6 care provider would have under similar circumstances and that such failure to use such
7 reasonable care directly caused or directly contributed to cause the damages claimed in the
8 petition.

9 2. [The affidavit shall state the qualifications of such health care providers to offer such
10 opinion.] **The health care provider who offers such opinion shall have education, training,
11 and experience in a like area of expertise, or logical extension of the field of expertise, as
12 the defendant health care provider. In addition, the health care provider must be actively
13 engaged in the practice of medicine or have retired from actively practicing within five
14 years of the date of the written opinion. The written opinion is, upon motion of a party,
15 subject to in-camera review by the court without counsel or the parties present to assure
16 its compliance with this section.**

17 3. A separate affidavit shall be filed for each defendant named in the petition.

18 4. Such affidavit shall be filed no later than ninety days after the filing of the petition
19 unless the court, for good cause shown, orders that such time be extended.

20 5. If the plaintiff or [his] **the plaintiff's** attorney fails to file such affidavit [the court
21 may] **within the time required under subsection 4 of this section, the action as to that
22 defendant shall be stayed and the court shall, upon motion of any party, dismiss the action**

23 against [such moving party] **that defendant** without prejudice.

2 **538.226. 1. The portion of statements, writings, or benevolent gestures expressing**
3 **sympathy or a general sense of benevolence relating to the pain, suffering, or death of a**
4 **person shall be inadmissible as evidence of an admission of liability in a civil action. A**
5 **statement of fault, however, which is part of or in addition to any of the above shall be**
6 **admissible under this section.**

7 **2. As used in this section, "benevolent gestures" means actions which convey a**
8 **sense of compassion or commiseration emanating from humane impulses.**

9 Section B. Because immediate action is necessary to take action regarding the
2 circumstances facing the medical malpractice liability insurance market in this state section A
3 of this act is deemed necessary for the immediate preservation of the public health, welfare,
4 peace, and safety, and is hereby declared to be an emergency act within the meaning of the
5 constitution, and section A of this act shall be in full force and effect upon its passage and
6 approval.