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FINDING A CURE FOR HIGH MEDICAL MALPRACTICE PREMIUMS: THE LIMITS OF MISSOURI'S DAMAGE CAP AND THE NEED FOR REGULATION

I. INTRODUCTION

> I'm here to talk about how we need to fix a broken medical liability system. . . . I'm here to . . . say as clearly as I can, the United States Congress needs to pass real medical liability reform this year.
>
> What's happening all across this country is that lawyers are filing baseless suits against hospitals and doctors. That's just a plain fact. And they're doing it for a simple reason. They know the medical liability system is tilted in their favor. Jury awards in medical liability cases have skyrocketed in recent years. That means every claim filed by a personal injury lawyer brings the chance of a huge payoff or a profitable settlement out of court.
>
> This liability system of ours is . . . out of control. And you people in this area and the doctors in this area understand what I'm talking about.[1]

On January 5, 2005, President Bush spoke these words to a crowd in Madison County, Illinois, just miles from downtown St. Louis. The President's speech fueled an already heated debate over the high price of medical malpractice insurance premiums. The President blamed "junk lawsuits," "big jury verdicts," and an "out of control" liability system for driving up the price of physicians' premiums.[2] According to the President, physicians faced with high medical malpractice premiums have few choices—they can pass the costs onto patients, move to a state with lower premiums, or quit practicing in their field.[3] As a result, the President warned that high

1. President George W. Bush, Address at the Gateway Center, Collinsville, Illinois (Jan. 5, 2005) [hereinafter President Bush Address] (transcript *available at* http://www.whitehouse.gov/news/releases/2005/01/20050105-4.html).

2. *Id.*

3. *Id.* Reimbursements for medical services from sources such as Medicare, Medicaid, and managed health care plans often prevent physicians from increasing the price of their services, and the option of passing on the cost of increased premiums to patients may not be available. MO. DEP'T OF INS., MEDICAL MALPRACTICE INSURANCE IN MISSOURI: THE CURRENT DIFFICULTIES IN PERSPECTIVE 31 (2003) [hereinafter MDI 2002 REPORT].

medical malpractice premiums hurt not only physicians—but all Americans—by making health care less affordable and available.[4]

To lower and stabilize medical malpractice premiums, the President urged Congress to pass medical liability reform.[5] The centerpiece of the President's plan is a nationwide cap on non-economic damages in medical malpractice lawsuits.[6] Non-economic damages are usually awarded for a plaintiff's pain and suffering,[7] and are already subject to caps in nineteen states.[8] Most Republicans, physician groups, and insurance companies support a cap on non-economic damages.[9] Like the President, they believe that caps lower costs for

4. President Bush Address, *supra* note 1. However, a recent report by the Congressional Budget Office showed that malpractice costs represented less than two percent of overall health care spending. CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 6 (2004), *available at:* http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf.

5. President Bush Address, *supra* note 1. The President's plan was passed by the House of Representatives and is pending a vote in the Senate. Patients First Act of 2003, H.R. 5, 108th Cong. (2003); S. 11, 108th Cong. (2003).

6. H.R. 5. The cap on non-economic damages is set at $250,000. *Id*. In addition to the cap, awards for future non-economic damages would not be discounted to present value. *Id*. The bill also does away with joint liability, thus, each tortfeasor's liability would be limited to his/her/its several share of any damages only, and not include the share of any other person. *Id*. The bill also limits punitive damages and an attorney's entitlement to contingent fees in a medical malpractice liability lawsuit. *Id*.

7. In Missouri and most jurisdictions, non-economic damages are one of three types of damages a plaintiff may recover. MDI 2002 REPORT, *supra* note 3, at 9. Non-economic damages compensate the victim or family for loss in the quality of life from the injury. "These damages may cover a patient's pain and suffering, loss of enjoyment of life, inability to engage in usual activities, emotional distress, disfigurement and mental anguish of survivors or disruption of family in wrongful death cases." *Id.* Most awards in Missouri are in the form of economic damages. *Id.* Economic damages include "the cost of medical treatment needed for the negligent injury and the loss of earnings that resulted." *Id.* Punitive damages are the third and rarest type of damages awarded. Punitive damages are awarded against providers for willful misconduct. *Id.* Such damages are strictly limited under Missouri law and are not covered by malpractice insurance. *Id.*

8. Other states with non-economic damage caps include Alaska, California, Colorado, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Montana, New Mexico, North Dakota, Utah, Virginia, West Virginia, and Wisconsin. Adam D. Glassman, *The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?*, 37 AKRON L. REV. 417, 433–58 (2004).

9. *Id.* at 419. According to a recent survey conducted by the Kaiser Family Foundation and the Harvard School of Public Health, the public favors reducing jury awards in malpractice lawsuits but ranks it relatively low on the list of health care priorities. News Release, Kaiser Family Foundation, Americans Favor Malpractice Reform and Drug Importation, But Rank Them Low on Health Priority List for the Congress and President (Jan. 11, 2005), *available at* http://www.kff.org/kaiserpolls/pomr011105nr.cfm. Sixty-three percent of Americans favored caps on non-economic damages in medical malpractice lawsuits. *Id.* But only twenty-six percent of the public cited reducing malpractice jury awards as a top priority for the President and Congress, ranking it eleventh on the list. *Id.*

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insurers by reducing malpractice claims, damages payouts, and insurer uncertainty.[10] The savings from a cap can then be passed onto physicians as lower premiums.[11]

Across the Mississippi River from the President's speech, the debate over medical malpractice reform in Missouri has intensified. Medical malpractice premiums hit record highs in 2002 and 2003, despite Missouri's damage cap, which was enacted in 1986.[12] The rapid increase in the price of premiums has sparked new movements for reform. Supporters of Missouri's cap argue that it is too weak and seek to tighten it in two ways.[13] First, they seek to overrule recent Missouri court decisions allowing multiple caps in a single case.[14] Second, they hope to lower the cap amount and eliminate the yearly increase for inflation.[15] By tightening the cap, they hope it will provide greater savings for insurers, and insurers will then pass the savings on as lower premiums.

But despite these movements for reform, experts and data suggest that a cap is too limited of a solution, "more symbolic than substantive" in

10. *See* President Bush Address, *supra* note 1; Glassman, *supra* note 8, at 419–20.

11. JACOB A. STEIN, STEIN ON PERSONAL INJURY DAMAGES § 8:31 (3d ed. 1997).

12. *See infra* Part II.B; MO. REV. STAT. § 538.210 (2000).

13. *See, e.g.,* Matt Blunt, *A Prescription for Missouri,* 101 MO. MED. 440–41 (2004) (calling for the reform of Missouri's cap by eliminating multiple caps and lowering the cap amount). Executive vice president of the Missouri State Medical Association (MSMA), C.C. Swarens, believes that "an effective cap that's enforced and not expanded" is the "'key ingredient' to stable premiums." John Carroll, *Are New Liability Caps Working?*, MANAGED CARE, Feb. 2003, at 15–16, *available at* www.managedcaremag.com/archives/0302/0302.regulation.html.

14. Blunt, *supra* note 13, at 441. Under recent judicial decisions interpreting Missouri's damage cap statute, a plaintiff may recover damages equal to multiple cap amounts if there are multiple defendants, plaintiffs, or occurrences of negligence. Before these decisions, Missouri's damage cap, which was $565,000 in 2004, was the most plaintiffs could recover for non-economic damages in a medical malpractice lawsuit. *See* discussion *infra* Part II.C.

Multiple damage caps has become a "hot-button issue for Missouri physicians and malpractice insurers, who claim the uncertainty spawned . . . has helped fuel a medical liability crisis, led to escalating malpractice premiums, and caused doctors and malpractice insurers to flee the state." Dan Margolies, *Undeterred, Tort Reformers Will Return to Capitol,* KAN. CITY STAR, Sept. 21, 2004, at D25. According to the past president of the Missouri Organization of Defense Lawyers (MODL), Lisa Weixelman, multiple caps substantially increased physicians' exposure, and "[t]he direct outcome [is] on their malpractice premiums. [Multiple caps are the reason] why tort reform is really needed and why it needs to be done legislatively at this point in time." Dan Margolies, *Missouri Court Further Limits Noneconomic Damages in Medical Malpractice Cases,* KAN. CITY STAR, July 28, 2004, at C1. According to the Missouri Hospital Association, "[a] top priority should be to reverse [multiple cap decisions] and restore a single cap on noneconomic damages per episode of care . . . . This should result in reduced uncertainty for insurers, which in turn would help stabilize the market." Jennifer Bethurem, *Malpractice Insurance Costs Threaten Access to Care*, INSIDE CONNECTION, Spring 2004, at 3 (publication of the Missouri Hospital Association).

15. Blunt, *supra* note 13, at 441; *see also* Carroll, *supra* note 13, at 16; Bethurem, *supra* note 14, at 3.

controlling malpractice premiums.[16] According to Bill Turley, an insurance industry executive involved in Missouri's tort reform efforts in the 1980s, "[f]ocusing on noneconomic damages is a search for 'a magic bullet' that misses the larger target."[17] Data from the Missouri Department of Insurance (MDI) supports his claim.[18] Contrary to the President's rhetoric of an "out of control" liability system, few cases reach the cap limit in Missouri, and the number is declining. In 2003, only *five* cases were limited by the cap, down from thirteen in 2002.[19] Moreover, these cases were hardly "junk lawsuits"—they typically involved severe injuries, such as quadriplegia or severe brain damage, with terminal diagnosis or the need for lifetime care.[20] While few cases reach the cap limit, most awards remain far below the cap amount. In 2003, Missouri's cap was $557,000, but the average non-economic damage award was only $85,140, and the median or typical award was even lower, $27,872, only five percent of the cap amount.[21] Moreover, Missouri's damage cap limits only non-economic damages, such as for pain and suffering.[22] But *economic* damages, for medical expenses and lost wages, are the largest part of the average medical malpractice award and remain unlimited under Missouri law.[23] Perhaps most obvious, a cap on damages does not require insurers to pass any savings onto physicians as lower premiums. In Missouri, claims filed

16. Paul Wenske & Julius A. Karash, *Caps and Damages,* KAN. CITY STAR, Jan. 11, 2005, at D1.

17. *Id.*

18. MDI reports data that is filed and reported by insurers themselves. *See* discussion *infra* Part III.A.

19. Press Release, Missouri Department of Insurance, MDI Report: Limiting Malpractice Data to Insurers Yields Same Result—17-Year Lows on Claims Filed, Paid (Apr. 27, 2004), *available at* http://www.insurance.state.mo.us/cgi-bin/news/ news2.cgi?newsid=EplFpAkZulIqOYcjhO [hereinafter MDI Press Release, Apr. 27, 2004].

20. According to MDI, "the severity of the claims receiving judgments equal to the Missouri caps averages a 7 or 8—permanent injury like quadriplegia, blindness, severe brain damage requiring lifetime care or terminal diagnosis." MDI 2002 REPORT, *supra* note 3, at 20. This ranking of "7 or 8" is on a 1 to 9 scale, with 9 being death. *Id.* at 17.

21. MO. DEP'T OF INS., 2003 MISSOURI MEDICAL MALPRACTICE INSURANCE REPORT (2004), *available at* http://www.insurance.state.mo.gov/reports/medmal/index.pdf, http://www.insurance.state.mo.gov/reports/2003medmal/2003medmalfinancial.htm & http://www.insurance.state.mo.us/reports/2003medmal/2003medmal.htm [hereinafter MDI 2003 REPORT]. Only thirteen awards exceeded $1 million in 2003, and only three exceeded $2 million. *Id.* Most the damages in these cases were economic damages, not covered by Missouri's damage cap. *Id.*

22. MDI 2003 REPORT, *supra* note 21.

23. *Id.* Non-economic damages consisted of just forty-one percent of the average medical malpractice award in 2003 (dividing $85,140 by $207,068). *Id.* Only seven states have caps on all damages, including economic: Colorado, Indiana, Louisiana, Nebraska, New Mexico, South Dakota and Virginia. MDI 2002 REPORT, *supra* note 3, at 32. Kansas passed a cap on total damages, but it was held unconstitutional. *Id.*; *see* Kansas Malpractice Victims Coalition v. Bell, 757 P.2d 251 (Kan. 1988).

and paid reached record lows in 2003, and malpractice insurers' cash-flow ratio,[24] the percentage of premium paid on claims, was the lowest since 1994, yielding a cash-flow windfall for insurers.[25] But despite these profitable indicators, premiums remained high in 2003.[26] Without market competition or state regulation, insurers can keep premiums high and any profits that result.[27]

Reform of Missouri's damage cap is practically certain, regardless of whether Congress passes President Bush's proposal. For the first time in eighty-four years, Missouri is controlled by a Republican Governor and Republican majorities in both legislative houses.[28] In the 2004 election, Governor Matt Blunt made achieving low, stable medical malpractice premiums through medical liability reform a priority.[29] But the question remains: what kind of reform will cure Missouri's high medical malpractice premiums? This is the subject of this article.

This Comment examines the history of Missouri's damage cap and the judicial decisions allowing multiple caps. Then, it evaluates proposals to tighten Missouri's cap by eliminating multiple caps and lowering the cap amount. This Comment concludes that these proposals provide only minimal savings for insurers and will not necessarily result in lower premiums unless MDI is given more power to regulate premiums.

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24. The cash flow ratio is equal to actual losses paid divided by premium written in a given year. MDI 2003 REPORT, *supra* note 21. Actual losses paid are all claim payments made during the year, regardless of when the claims were filed. *Id.* Premium written is the amount charged when a policyholder contracts for insurance coverage and includes projected revenues from policies written during the year. *Id.* The cash flow ratio is different from the loss ratio, discussed *infra* and at note 32, in that the loss ratio is equal to "losses incurred," which includes *estimated* losses on new claims, divided by "premium earned," which is revenues received from those parts of policies lapsing during the year. *Id.*

25. The cash-flow ratio was approximately forty-five percent in 2003. *Id.* This means that for every dollar of premium collected, insurers paid out only forty-five cents on malpractice claims. *Id.* By comparison, the cash-flow ratio was approximately sixty-three percent in 2002, and the average over the past ten years was sixty-two percent. *Id.*

26. *See* discussion *infra* Part III.A.3.

27. For a discussion regarding the lack of competition and regulation of Missouri's medical malpractice insurance market, *see infra* Part III.B.3. Five insurers provide eighty-three percent of malpractice coverage for Missouri physicians (dividing $112,296,943 by $135,743,399). MDI 2003 REPORT, *supra* note 21. Only three insurers are writing new policies. MDI 2002 REPORT, *supra* note 3, at 7. A recommendation for strengthening the regulatory power of the Missouri Department of Insurance is discussed *infra* Part III.C.

28. *Missouri Legislature: A New Season,* ST. LOUIS POST-DISPATCH, Jan. 10, 2005, at B6. "It is all but certain that Mr. Blunt and the Legislature will accomplish . . . caps on damages for pain and suffering in medical malpractice lawsuits." *Id.* "But the $250,000 limit proposed by the GOP is too low. . . . To balance the need for affordable insurance against justice for victims, we might look to the . . . cap that existed in Missouri before it was weakened by court decisions." *Id.*

29. Blunt, *supra* note 13, at 441.

II. HISTORICAL ANALYSIS

A. Statutory History of Missouri's Damage Cap

In 1986, Missouri enacted a statutory cap on non-economic damages in response to an increase in medical malpractice claims and insurance pricing problems.[30] In 1986, overall claims hit a high of nearly 2100, tripling from 695 in 1979.[31] The loss ratio, or percentage of premiums estimated to be paid on claims, reached a record high for medical malpractice insurers.[32] In 1984, the loss ratio for medical malpractice insurance was 136%.[33] Hospitals had posted a 188.1% figure in 1984, while physicians reached an all-time high of 131% in 1981.[34] By comparison, the loss ratio was 81% overall and 61% for physicians in 2001.[35]

Missouri's damage cap was a product of a task force including health-care providers, health-care insurers, and attorneys representing both plaintiffs and defendants.[36] The task force made several proposals in response to the high medical malpractice premiums, including a cap on non-economic damages in medical malpractice lawsuits.[37] The cap was approved by the legislature in Senate Bill 663.[38] The statute provides:

> In any action against a health care provider for damages for personal injury or death arising out of the rendering of or the failure to render health care

30. MO. REV. STAT. § 538.210 (2000); MDI 2002 REPORT, *supra* note 3, at 11.

31. MDI 2002, *supra* note 3, at 12. Overall claims filed include claims against hospitals, physicians, and other health care providers. *Id.*

32. Insurers' loss ratio is equal to incurred losses divided by earned premium. MDI 2003 REPORT, *supra* note 21. Incurred losses are *estimates* by insurers of their liability for payouts on claims filed during the year, projected future payments for such claims, and revised payments and projections for claims filed in previous years. *Id.* Earned premium includes revenues from those parts of policies lapsed during the year. *Id.* Loss ratios differ from cash flow ratios by including insurers' estimated projections on future payments, as calculated in their incurred losses. *Id.* Thus, when the loss ratio is fifty percent, insurers estimate that only fifty cents will be paid out *or reserved* for future payment for every one dollar in premiums earned. *Id.*

33. MDI 2002 REPORT, *supra* note 3, at 12.

34. *Id.*

35. *Id.*

36. Bruce Keplinger, *Multiple Damage Caps for Claims Against Health Care Providers,* 60 J. MO. B. 116, 116 (2004).

37. *Id.*

38. MDI 2002 REPORT, *supra* note 3, at 11. The 1986 bill also required: a showing of "willful, wanton or malicious" misconduct for punitive damages; plaintiffs to file an affidavit of merit for each defendant; defendants to be jointly liable only with other defendants whose fault was equal to or less than his or her own; physicians on staff at a hospital in populated counties to maintain at least $500,000 in medical malpractice insurance; hospitals and outpatient surgical centers to report disciplinary actions against providers to state licensing boards; insurers and self-insured providers to report claims information to MDI, which forwards the information to licensing boards. *Id.*

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> services, no plaintiff shall recover more than [$350,000][39] *per occurrence* for noneconomic damages from any one defendant as defendant is defined in Subsection 2 of this section.[40]

B. The Cap's Purpose: Reduce Medical Malpractice Premiums and Health Care Costs[41]

The purpose of Missouri's cap was described in *Adams v. Children's Mercy Hospital*.[42] In *Adams*, the Missouri Supreme Court held the cap was constitutional because it was rationally related to the state interest of ensuring public health and maintaining affordable health care costs.[43] According to the court:

> The legislature could rationally believe that the cap on non-economic damages would work to reduce in the aggregate the amount of damage awards for medical malpractice and, thereby, reduce malpractice insurance premiums paid by health care providers. Were this to result, the legislature could reason, physicians would be willing to continue "high risk" medical practices in Missouri and provide quality medical services at a less expensive level than would otherwise be the case.[44]

To understand how a damage cap impacts malpractice premiums, a general discussion of how insurers calculate premiums is necessary. Insurers set premiums using actuarial techniques to generate funds for: "(1) losses occurring during the period, (2) the administrative costs of running the company, and (3) an amount for unknown contingencies, which may become a

39. The cap amount changes annually based on the Implicit Price Deflator for Personal Consumption Expenditures as published by the Bureau of Economic Analysis of the United States Department of Commerce. MO. REV. STAT. § 538.210.4 (2000). The cap amount for 2004 was $565,000. Wenske & Karash, *supra* note 16, at D1.

40. MO. REV. STAT. § 538.210.1 (2000) (emphasis added).

41. The impact of damage caps on overall health care costs is beyond the scope of this Comment. However, a recent report by the Congressional Budget Office showed that malpractice costs represented less than two percent of overall health care spending. CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE, 6 (2004), *available at* http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf.

42. 832 S.W.2d 898, 904–05 (Mo. 1992) (en banc) (holding the caps constitutional in response to an equal protection challenge).

43. *Id.* at 904–05. The plaintiff argued that the statutory cap on non-economic damages was an unconstitutional violation of federal and state equal protection rights. *Id.* at 903. The Missouri Supreme Court disagreed, holding that the statute did not violate state and federal guarantees of equal protection because the cap on non-economic damages in a malpractice action against a health care provider was rationally related to the goals of reducing medical malpractice premiums, preventing physicians and others from discontinuing high risk practices and procedures, and preserving public health. *Id.* at 904.

44. *Id*. at 904.

profit if not used."[45] Because of the time lag from when a claim is filed to when it is paid, insurers measure losses in two ways. First, insurers look at *actual losses* paid on claims in a given year, regardless of when the claim was filed.[46] Actual losses are used to calculate insurers' cash-flow ratio (the percent of premium actually paid out on claims during the year).[47] Second, insurers estimate their *incurred losses* by projecting payouts on new claims to be paid in the future and revising payments and projections for claims filed in previous years.[48] These estimated or incurred losses are used to calculate insurers' loss ratio (the percent of premium estimated to be paid out on claims).[49] As discussed later, insurers consider incurred losses when setting premium prices but are not required to explain or justify their estimates or to follow a uniform standard or method in calculating them.[50]

Missouri's cap represents the maximum amount a plaintiff may receive in non-economic damages.[51] By limiting non-economic damages, the cap limits insurer costs by reducing actual payouts and uncertainty in estimating future payouts.[52] While a cap is intended to reduce costs for insurers, it does not require that these savings get passed on to physicians in the form of lower premiums. Instead, a cap relies on competition or state regulation to translate the savings into lower premiums.[53]

C. Judicial Decisions Allowing Multiple Damage Caps

As discussed earlier, Missouri enacted a cap on non-economic damages in medical malpractice lawsuits in 1986.[54] The purpose of the cap was to lower the price of medical malpractice insurance by limiting non-economic damage payouts and reducing insurer uncertainty.[55] But recent Missouri court rulings allow multiple caps in cases with multiple defendants, occurrences of

45. BARRY R. FURROW ET AL., LIABILITY AND QUALITY ISSUES IN HEALTH CARE 426 (5th ed. 2004) (summarizing report on the insurance industry from the U.S. General Accounting Office).

46. MDI 2003 REPORT, *supra* note 21.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

51. It is important to note that Missouri's cap does not limit most damages in the average award because most damages are *economic*, for medical expenses and lost wages. *See* discussion *infra* Part III.A.2.

52. STEIN, *supra* note 11, § 8:31. Caps reduce "legal uncertainty and thereby . . . decrease the costs of liability insurance." *Id.*

53. But if competition is not present in the market, insurers may refuse to reduce premiums even with lower costs, opting instead to keep the profits. *See* discussion *infra* Part III.B.3.

54. *See* discussion *supra* Part II.A.

55. *See* discussion *supra* Part II.B; Adams v. Children's Mercy Hospital, 832 S.W.2d 898, 904–05 (Mo. 1992) (en banc).

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negligence, and plaintiffs.[56] This section analyzes the reasoning behind these decisions and clarifies when multiple caps are permitted.

1. A Cap per Defendant: *Vincent v. Johnson*

In the 1992 case of *Vincent v. Johnson*, the Missouri Supreme Court addressed the issue of multiple caps for the first time.[57] In *Vincent,* the issue was whether two statutory damage caps applied in a medical malpractice lawsuit with two defendants, a hospital and a physician.[58] The *Vincent* Court looked to the damage cap statute's definition of "defendant."[59] Under section 538.210.2(1), if the employees and physicians are insured by the hospital's malpractice policy, then the hospital and its "employees and physicians" are counted as one defendant and only one cap applies.[60] Otherwise, if the physician was not insured by the hospital, they count as two defendants, and the plaintiff may be awarded non-economic damages equal to two caps.[61] The *Vincent* Court remanded the case to decide this issue.[62]

2. A Cap per Occurrence of Negligence: *Romero v. United States*

Missouri's damage cap statute provides no plaintiff shall recover non-economic damages in excess of the cap "per occurrence."[63] In *Romero v. United States,* the issue was what constituted an "occurrence" under Missouri's damage cap statute and whether multiple caps were allowed for multiple occurrences.[64] The *Romero* Court held that the statutory meaning of "occurrence" was "a singular wrongful act sued upon" and not the "receipt of injury" by the plaintiff.[65] The *Romero* Court concluded two caps were permitted because the defendant committed two separate and distinct acts of medical malpractice, even though only one injury resulted.[66]

56. Missouri's damage cap statute states that "no plaintiff" may recover more than the statutory cap amount "per occurrence . . . from any one defendant." MO. REV. STAT. § 538.210.1 (2000). Thus, the issue of multiple damage caps turns on the definition and relationship of the following three statutory terms: defendant, occurrence, and plaintiff.

57. 833 S.W.2d 859, 864 (Mo. 1992) (en banc).

58. *Id.*

59. MO. REV. STAT. § 538.210.2(1) (2000).

60. *Id.* A defendant under section 538.210.2(1) is "[a] hospital . . . and its employees and physician employees who are insured under the hospital's professional liability insurance policy or the hospital's self-insurance maintained for professional liability purposes . . . ." *Id.*

61. *Vincent,* 833 S.W.2d at 864.

62. *Id.* at 867.

63. MO. REV. STAT. § 538.210 (2000).

64. 865 F. Supp. 585, 593 (E.D. Mo. 1994). *Romero* was filed in federal court because the plaintiff sued the United States under the Federal Tort Claims Act, but the federal court was bound by Missouri's damage cap statute. *Id.* at 587.

65. *Id.* at 593.

66. *Id.*

The plaintiff in *Romero* alleged two acts of medical malpractice, a misdiagnosis and an improper surgery based on the misdiagnosis.[67] The plaintiff claimed non-economic damages of $673,000, which exceeded the damage cap of $462,000.[68] The plaintiff argued there were two occurrences of negligence because there were two acts of malpractice, a misdiagnosis and an improper surgery. Thus, two caps were permitted, and full recovery was possible.[69] The defense argued that "occurrence" meant the plaintiff's receipt of injury.[70] Because the plaintiff was only injured in the surgery, the defense contended that one cap applied.[71]

The *Romero* court agreed with the plaintiff and held two caps applied because the misdiagnosis and improper surgery were two separate occurrences of negligence, each establishing a prima facie case of medical malpractice.[72] Because two caps were appropriate, the plaintiff was entitled to the full $673,000 sought in non-economic damages.[73]

3. A Cap per Plaintiff: *Burns v. Elk River Ambulance, Inc.* and *Wright v. Barr*

In the 2001 case of *Burns v. Elk River Ambulance*, *Inc*., the Missouri Court of Appeals Southern District held a single damage cap applied in a wrongful death action brought by a single plaintiff, the victim's mother, even though the mother claimed to have brought the action on behalf of the victim's nonparty father as well as on her own behalf.[74]

The decedent in *Burns* was an eighteen-year-old male who suffered a fatal asthma attack while being transported by ambulance to the hospital.[75] The plaintiff, the decedent's mother, sued the ambulance company, the emergency medical service (EMS) provider, and the hospital for medical negligence.[76] The jury found the EMS provider to be 100% at fault and awarded the plaintiff $1,500,000 in non-economic damages.[77] Pursuant to section 538.210, the trial court reduced the award to $528,000, equal to one damage cap in 2000, the year of the trial.[78]

67. *Id*. at 588–90.

68. *Id*. at 593. Under section 538.210, the cap is adjusted each year for inflation, and the amount that applies in a case depends on the year the case is brought. MO. REV. STAT. § 538.210.4 (2000).

69. *Romero*, 865 F. Supp. at 591.

70. *Id.* at 593.

71. *Id.*

72. *Id.* at 591–92.

73. *Id.*

74. Burns v. Elk River Ambulance, Inc., 55 S.W.3d 466, 485 (Mo. Ct. App. 2001).

75. *Id.* at 471–72.

76. *Id.*

77. *Id.* at 472.

78. *Id.* at 484.

In *Burns*, the Missouri Court of Appeals affirmed the trial court's denial of multiple damage caps for three reasons.[79] First, the plain language of the statute states "no *plaintiff*" shall recover more than a statutory cap amount.[80] The decedent's father was not a plaintiff or even a party to the action.[81] Moreover, the father had "the right to intervene at any time before any judgment" was entered in the case, but the record showed no such effort on his part.[82]

Second, under Missouri's wrongful death statute, a surviving spouse, children, parents or others named in the statute may sue for damages for the wrongful death of a decedent.[83] But, "[o]nly one action may be brought . . . against any one defendant for the death of any one person."[84] The court reasoned that since the legislature knew the wrongful death statute created only "one indivisible cause of action" and did not make special provisions in the damage cap for a wrongful death action, multiple damage caps were not permitted.[85]

Third, the legislative intent of the damage cap statute was "to impose specific limitations on the traditional tort causes of action available against a health care provider . . . to temper the high cost of health care."[86] Allowing multiple caps in a wrongful death suit would permit a widow to "sue for her husband's wrongful death and recover a separate cap for herself and each of the couple's six children."[87] Because this did not "further the legislative goal of harnessing increasing health care costs," the *Burns* Court rejected multiple caps in a wrongful death suit.[88]

Just weeks after the *Burns* court denied multiple caps for plaintiffs in a wrongful death suit, the Missouri Court of Appeals Western District permitted two caps for two plaintiffs in a suit for medical malpractice and loss of consortium.[89] In *Wright v. Barr*, Mrs. Wright sued a physician for negligently causing her to suffer a stroke, and her husband sued for loss of consortium.[90] Unlike a wrongful death claim, Mr. Wright's loss of consortium claim was found separate from and independent of his wife's claim of medical

79. *Burns*, 55 S.W.3d at 485–87.

80. *Id.* at 485 (quoting MO. REV. STAT. § 538.210 (2000)) (emphasis added).

81. *Id.*

82. *Id.* (quoting MO. REV. STAT. § 537.095.2, Missouri's permissive joinder statute).

83. MO. REV. STAT. § 537.080.1 (2000).

84. MO. REV. STAT. § 537.080.2; *Burns*, 55 S.W.3d. at 486 (citing Nelms v. Bright, 299 S.W.2d 483, 487 (Mo. 1957) (en banc)).

85. *Burns*, 55 S.W.3d at 486–87; *see also* Martinez v. State, 24 S.W.3d 10, 17 (Mo. Ct. App. 2000) (presuming the legislature to be aware of state law at the time it enacts a statute).

86. *Burns*, 55 S.W.3d at 486; *see also* discussion *supra* Part II.B.

87. *Burns,* 55 S.W.3d.at 486–87.

88. *Id.* at 487.

89. Wright v. Barr, 62 S.W.3d 509, 537–38 (Mo. Ct. App. 2001).

90. *Id.* at 515.

negligence.[91] Because Mr. Wright's loss of consortium claim was separate, he was a second plaintiff and entitled to a second statutory cap.[92] The *Wright* Court found this outcome supported by the policy of the loss of consortium action because a person claiming loss of consortium suffers different damages than the injured spouse.[93] Thus, under *Wright,* two caps are permitted when there are two plaintiffs, one injured from negligence and the other claiming damages from loss of consortium.[94]

4. Multiple Caps Upheld: *Scott v. SSM Healthcare* and *Cook v. Newman*

In *Scott v. SSM Healthcare*, the Missouri Court of Appeals Eastern District revisited the issue of whether multiple caps were allowed for multiple occurrences of negligence.[95] The *Scott* court followed the ruling in *Romero*, permitting a cap for every act of negligence, even if only one injury resulted.[96]

In *Scott,* the plaintiff sued a hospital for medical malpractice of two of its physicians under vicarious liability.[97] The plaintiff alleged two negligent acts: misdiagnosis and failure to direct the plaintiff to the emergency room.[98] These two acts caused a single injury, a sinus infection that spread to the plaintiff's brain.[99]

Persuaded by *Romero,* the *Scott* Court interpreted "occurrence" as a singular wrongful act sued upon, not the receipt of injury by the plaintiff.[100] The *Scott* court determined that if the legislature intended one damage cap to apply regardless of the number of negligent acts, "the clearest and most unambiguous way . . . to have expressed such an intent would have been to simply leave the words 'per occurrence' out of the statute entirely."[101]

91. *Id.* at 537–38.

92. *Id.* (explaining that while loss of consortium claim is "derivative" of the underlying claim of negligence, it is still a separate action that permits another cap).

93. *Id.* at 537; *see also* Stahlheber v. Am. Cyanamid Co., 451 S.W.2d 48, 64 (Mo. 1970).

94. *Wright,* 62 S.W.3d at 537–38.

95. 70 S.W.3d 560, 570–71 (Mo. Ct. App. 2002).

96. *Id.* at 571. The *Scott* court also followed the ruling in *Vincent v. Johnson,* 833 S.W.2d 859, 864 (Mo. 1992) (en banc), which held that the hospital and the physicians insured by the hospital's malpractice policy counted as only one defendant. *Scott*, 70 S.W.3d at 569 n.9; *see* discussion *supra* Part II.C.1. In *Scott,* Judge Teitelman pointed out that while this issue was addressed in *Vincent,* the "Vincent [case] did not decide" the issue in *Scott* of "whether a defendant hospital could be liable to a plaintiff for two non-economic damage caps based on two separate acts of negligence by its agents." *Scott,* 70 S.W.3d at 569 n.9.

97. *Id.* at 562.

98. *Id.* at 563.

99. *Id.*

100. *Id.* at 571 (citing Romero v. United States, 865 F. Supp. 585, 593 (E.D. Mo. 1994)). Because the ruling in *Romero* was by the U.S. District Court, it was not binding on the Missouri Court of Appeals in *Scott. Id.* As a result, the issue of the interpretation of "occurrence" as used in the damage cap statute was of first impression for Missouri courts. *Id.*

101. *Scott*, 70 S.W.3d at 571 (quoting MO. REV. STAT. § 538.210 (2000)).

Otherwise, the words "per occurrence" would be "mere surplusage which added nothing at all to the intended statutory meaning."[102] Thus, because two separate occurrences of malpractice contributed to plaintiff's injury, two statutory damage caps applied.[103]

In July 2004, the Missouri Court of Appeals Western District decided the most recent case involving multiple damage caps, *Cook v. Newman.*[104] In *Cook,* a decedent's husband and two children sued two physicians and a health care corporation for the wrongful death of their spouse and mother.[105] The *Cook* Court had two significant holdings. First, *Cook* affirmed the trial court and permitted multiple caps for multiple defendants and occurrences of negligence.[106] Because two defendants each committed two acts of negligence, four caps applied in *Cook*.[107] Second, *Cook* reversed the trial court and denied multiple caps for multiple plaintiffs in a wrongful death action.[108] Even though three plaintiffs brought the wrongful death suit in *Cook*, only one cap applied.[109] Thus, the number of damage caps in *Cook* was reduced from twelve to four, and the non-economic damages were reduced from $6.56 to $2.19 million.[110]

In reaching its conclusion, the *Cook* Court distinguished and relied on several cases discussed above. In finding two caps applied for two defendants, the *Cook* court looked to the definition of defendants in Missouri's damage cap statute, section 538.210.2.[111] The *Cook* Court decided that section 538.210.2(3) applied because the defendants were a health care corporation and the corporation's physician.[112] Under section 538.210.2(3), a health care provider and its *employees* count as one defendant, but physicians are not mentioned.[113] The *Cook* Court found this omission significant: "the legislature

102. *Id.*; *see* Rich v. Peters, 50 S.W.3d 814, 819–20 (Mo. Ct. App. 2001) (holding that the legislature is presumed not to insert superfluous language in a statute).

103. *Scott,* 70 S.W.3d at 571.

104. 142 S.W.3d 880 (Mo. Ct. App. W.D. 2004).

105. *Id.* at 884–85.

106. *Id.* at 890–92.

107. *Id.*

108. *Id.* at 887–88.

109. *Cook*, 142 S.W.3d at 887–88. The decedent's husband and two children were treated as one plaintiff with one cap. *Id.* at 888.

110. *Id.* at 886, 895.

111. *Id*. at 891; MO. REV. STAT. § 538.210.2 (2000).

112. *Id*. at 891–92. This is distinguishable from *Vincent* and *Scott* where the defendants were a hospital and its physicians and the first paragraph of section 538.210.2 applied. *See supra* note 96 and accompanying text.

113. MO. REV. STAT. § 538.210.2(3). This language is different than that of section 538.210.2(1), which was applied in *Vincent* and *Scott*. *See supra* note 96 and accompanying text. In section 538.210.2(1), a hospital and "employees and physicians" who are insured by the hospital's policy are one defendant. MO. REV. STAT. § 538.210.2(1). But under section

did not intend the term 'employees' . . . to include physicians."[114] As a result, two separate damage caps were allowed for the health care corporation and the physician.[115]

In *Cook,* the Court agreed with the reasoning of *Scott* and *Romero* and allowed multiple damage caps for multiple acts of negligence, even though one injury resulted.[116] Moreover, the *Cook* Court followed *Burns* and held only one cap applied in a wrongful death action with multiple plaintiffs.[117]

After the Missouri Supreme Court declined to rehear *Scott* and *Cook,* multiple caps were clearly permitted under Missouri's damage cap statute.[118] As discussed earlier, supporters of Missouri's cap argue that these decisions weakened the cap's effectiveness in controlling medical malpractice premiums.[119] The next section analyzes Missouri medical malpractice data to assess proposals to tighten Missouri's cap by eliminating multiple caps and lowering the cap amount. But these proposals to tighten Missouri's cap are found inadequate and stronger regulations are needed.

III. ANALYSIS: THE LIMITS OF MISSOURI'S CAP AND THE NEED FOR REGULATION

As discussed earlier, reform of Missouri's damage cap is practically certain because supporters of the cap believe it is too weak to effectively control premiums.[120] This section analyzes Missouri's medical malpractice insurance data and considers whether proposals to tighten Missouri's damage cap will ensure low, stable malpractice premiums. After these proposals, this Comment concludes that a cap alone will not solve the problem of high, unstable malpractice premiums—stronger regulation of medical malpractice insurance is needed.

A. Missouri's Medical Malpractice Insurance Data

Missouri law requires medical malpractice insurers of health-care providers and facilities to report malpractice claims data to the Missouri

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538.210.2(3), a health care provider and only its employees are one defendant—physicians are not mentioned. MO. REV. STAT. § 538.210.2(3).

114. *Cook*, 142 S.W.3d at 892.

115. *Id.*

116. *Id.* at 889–91.

117. *Id.* at 887–88. The *Cook* court limited its holding to wrongful death actions, distinguishing the ruling in *Wright* where multiple caps were allowed for multiple plaintiffs in a loss of consortium action. *Id.*; *see also supra* Part II.C.3.

118. Scott v. SSM Healthcare, 70 S.W.3d 560 (Mo. Ct. App. 2002), *reh'g denied*; Cook v. Newman, 142 S.W.3d 880 (Mo. Ct. App. 2004), *reh'g denied*.

119. *See* discussion *supra* Part I. and notes 13–14.

120. *See* discussion *supra* Part I.

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Department of Insurance (MDI).[121] MDI also obtains certified annual financial data as reported by insurers operating in Missouri.[122] MDI analyzes and publishes the data in an annual report.[123] These MDI reports show trends in the medical malpractice insurance market over the past seventeen years.[124] In November 2004, MDI released the data for 2003.[125]

MDI's data confirms the problem—despite Missouri's cap, premiums and loss estimates hit record highs in 2002 and 2003.[126] But the data also reveals an inconsistency. Premiums and loss estimates increased despite substantial, often record, decreases in medical malpractice claims, payouts, and actual losses.[127] This inconsistency raises the question considered in the next section: what reform will solve the problem of high medical malpractice premiums?[128]

1. Medical Malpractice Claims Fell to Record Lows

In 2003, Missouri medical malpractice claims both filed and paid fell to record lows.[129] New claims filed against health care providers fell to 1369, a 16% drop from 1638 in 2002, and the lowest number of new claims since MDI began collecting data in 1986.[130]

New claims filed against physicians also dropped to a record low of 664, down nearly 14% from 770 in 2002.[131] In 2003, claims that received payment

121. MO. REV. STAT. § 383.105 (2000). MDI collects and maintains the most extensive state database in the country on medical malpractice insurance using data from medical malpractice insurers. MDI 2002 REPORT, *supra* note 3, at 13.

122. MDI Press Release, Apr. 27, 2004, *supra* note 19.

123. *Id.*

124. *Id.* In 2003, legislators and physicians attacked MDI's report because many larger hospitals in the state are self-insured and have refused to report their data. *Id.* While self-insurers are still required by state law to report their claims data, MDI has no enforcement powers. *Id.* MDI sought the ability to fine entities that violated the reporting law in both the 2003 and 2004 legislative sessions, but Missouri's General Assembly did not approve the changes. *Id*. As a result, it has been argued that missing data from these self-insureds have skewed data results. *Id.* But MDI maintains that the failure of a few self-insured institutions has little effect on overall trends reported because these institutions have not reported for years. *Id.* Moreover, MDI omitted all self-insureds from its data; no changes resulted—there were still record lows in claim and decreases in average payments. *Id.* The trends reported by MDI follow those of the National Practitioner Data Bank (NPDB), a federally mandated database of malpractice claims against physicians, which is the only other source of data. Press Release, Missouri Department of Insurance, 2003 Final Count: Claims Continue Downward Trend; Actual Malpractice Payouts Drop Substantially (Nov. 4, 2004), *available at* www.insurance.state.mo.us [hereinafter MDI Press Release, Nov. 4, 2004].

125. MDI Press Release, Nov. 4, 2004, *supra* note 124.

126. *See infra* Part III.A.3.

127. *See infra* Parts III.A.1–4.

128. *See* discussion *infra* Parts III.B and III.C.

129. MDI 2003 REPORT, *supra* note 21.

130. *Id.*

131. *Id*.

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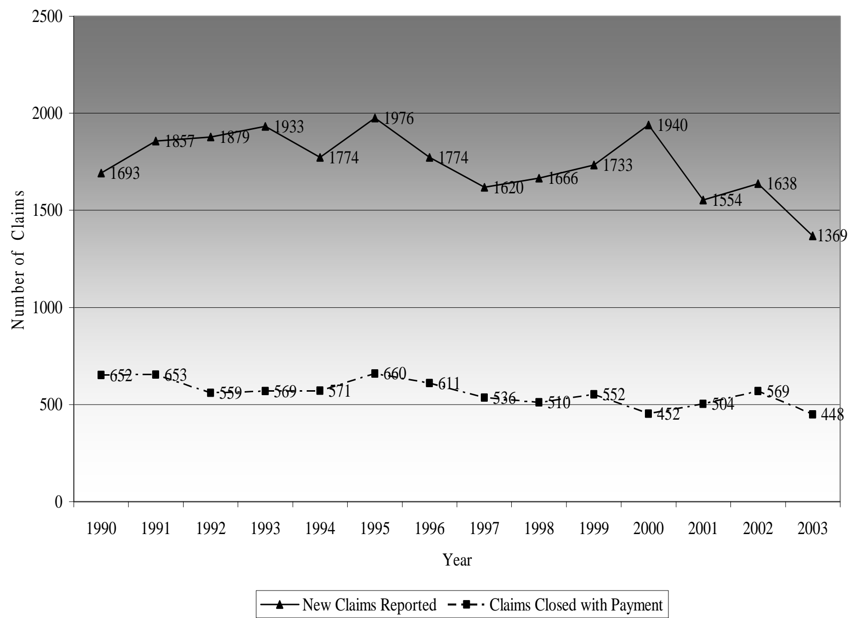
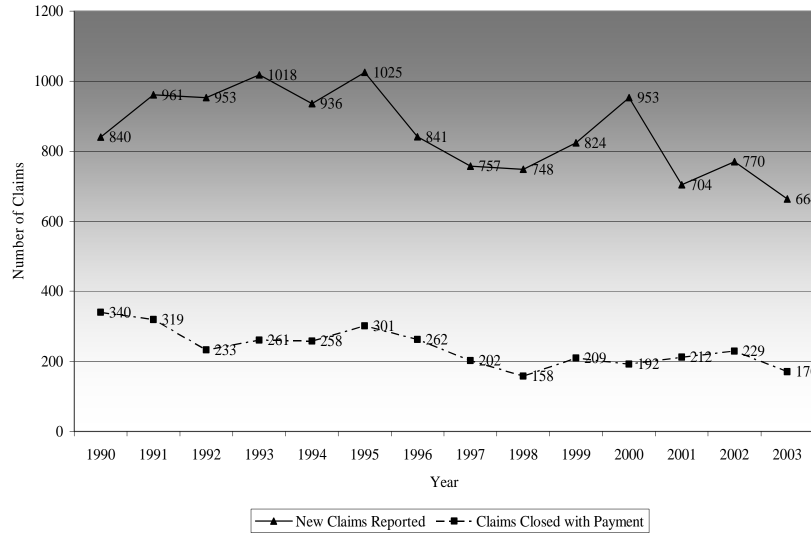
fell to a record low of 448, a 21% drop from 569 in 2002.[132] Claims paid on physician policies in 2003 fell to 170—nearly 26% lower than 229 in 2002, and the second lowest number of paid claims on record.[133] Claims filed and paid by all medical malpractice insurers from 1990 to 2003 are displayed in Figure 1.[134] Claims filed and paid by physician medical malpractice insurers are shown in Figure 2.[135]

Figure 1. Claims Filed and Paid: All Medical Malpractice Insurers 1990-2003



132. *Id*.
133. *Id*.
134. Data taken from MDI's 2003 report. MDI 2003 REPORT, *supra* note 21.
135. *Id.*

Figure 2. Claims Filed and Paid: Medical Malpractice Insurers of Physicians 1990-2003



2. Damages Paid for Medical Malpractice Decreased Substantially

Damages paid to victims of medical malpractice also dropped substantially in 2003.[136] Overall damages paid by insurers to malpractice victims decreased from $118.7 million to $93.5 million, or by 21%.[137] Even greater reductions occurred in payouts for physician malpractice, which dropped from $79.4 million to $52.9 million, or by 33%.[138]

The average damage award remained essentially flat in 2003, falling less than 1% to $207,068.[139] Because a handful of larger awards skew the figures, the average awards were considerably higher than the typical or median payment, which was $111,250 in 2003.[140] The majority of these awards were for *economic* damages, such as lost wages and medical bills, and are not

136. *Id*.

137. *Id.*

138. *Id.*

139. MDI 2003 REPORT, *supra* note 21. Average awards have remained stable since 2000, when they jumped dramatically. *Id.* MDI studies have shown that the long-term increase in awards has not keep pace with increases in general inflation on lost wages, medical inflation of health care costs, and the severity of injuries. MDI 2002 REPORT, *supra* note 3, at 18.

140. MDI 2003 REPORT, *supra* note 21.

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limited by Missouri law.[141] On the contrary, non-economic damages, which are limited by Missouri's cap, were only a small portion of this total amount and far below the cap limit. In 2003, the average non-economic damage award was only $85,140—40% of the total average award.[142] The median or typical non-economic award was even lower, $27,872—just 25% of the total median award.[143] Both of these figures were *far below* Missouri's cap amount of $557,000 in 2003.[144] The average and median total and non-economic damages paid for medical malpractice claims are shown in Table 1.[145]

Table 1. Average and Median Payment Per Claim, All Medical Malpractice Claims in Missouri, 1990-2003

	Total Damages Paid		Non-Economic Damage Paid		
Close Year	Median	Mean	Median	Mean	Cap For Year
1990	$22,760	$99,621	$5,000	$45,235	$401,000
1991	$37,500	$124,233	$8,333	$57,430	$430,000
1992	$35,000	$146,470	$12,500	$81,276	$446,000
1993	$40,000	$143,811	$15,000	$69,754	$462,000
1994	$50,000	$130,766	$18,300	$69,450	$474,000
1995	$50,000	$126,228	$20,000	$69,724	$482,000
1996	$50,000	$170,534	$20,000	$86,928	$492,000
1997	$40,000	$163,404	$15,000	$79,679	$513,000
1998	$45,000	$161,938	$12,500	$79,166	$513,000
1999	$50,000	$131,265	$9,250	$59,380	$517,000
2000	$99,950	$202,948	$27,630	$95,296	$528,000
2001	$81,667	$167,863	$21,092	$78,280	$540,000
2002	$100,000	$207,734	$35,000	$97,910	$547,000
2003	$111,250	$207,068	$27,872	$85,140	$557,000

Contrary to the President's rhetoric of "big jury verdicts" and an "out of control" liability system, few claims reach the cap limit in Missouri, and the number is declining.[146] Only *five* payouts reached Missouri's cap on non-economic damages of $557,000 in 2003, down from thirteen in 2002, and the

141. Press Release, Missouri Department of Insurance, 2003 Malpractice Claims Reach Record Lows—Cash Flow Yields Windfall for Insurers (April 16, 2004), *available at* www.insurance.state.mo.us [hereinafter MDI Press Release, Apr. 16, 2004].

142. MDI 2003 REPORT, *supra* note 21.

143. *Id.*

144. MDI Press Release, Apr. 16, 2004, *supra* note 141.

145. Data taken from MDI's 2003 report. MDI 2003 REPORT, *supra* note 21.

146. President Bush Address, *supra* note 1.

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lowest number on record.[147] Only eleven awards exceeded $1 million in 2003, down from fifteen in 2002.[148] Again, most of the damages in these large awards were economic and not limited by Missouri's non-economic damage cap.[149]

3. Medical Malpractice Premiums and Loss Estimates at Record Highs

Despite these substantial decreases in claims and payouts, medical malpractice premiums climbed to record highs.[150] From 2000 to 2003, overall malpractice insurance premiums doubled, rising from $113.5 to $227 million.[151] But this increase in premiums far exceeded the increase in payouts in the same period. From 2000 to 2003, payouts increased by 32%, from $70.6 million to $93.5 million.[152] Similarly, from 2000 to 2003, premiums paid by physicians increased 121%, from $61.4 million to $136.4 million, while actual payments rose only 14%.[153]

The increase in premiums coincided with dramatic increases in *estimated* losses, amounts reserved for future payouts on claims.[154] In 2001, insurers estimated future losses of $65.1 million for claims filed that year.[155] In 2002, estimated losses skyrocketed more than 250% to a record high of $167.9 million and remained high at $164.3 million in 2003.[156] Also in 2002, insurers' loss ratio, the percentage of earned premiums estimated to be paid out on new claims, increased from 81% to 108%.[157] In 2003, the loss ratio improved slightly but remained high at 97%.[158] In 2002, insurers of physicians and surgeons also experienced a dramatic increase in the loss ratio—nearly doubling from 61% to 117%.[159] But in 2003, loss ratio improved for

147. MDI Press Release, Apr. 27, 2004, *supra* note 19.

148. *Id.* Only two awards exceeded $2 million in 2003; the same as in 2002. *Id.* No awards exceeded $3 million. MDI 2003 REPORT, *supra* note 21.

149. MDI Press Release, Apr. 16, 2004, *supra* note 141.

150. MDI 2003 REPORT, *supra* note 21.

151. *Id.*

152. *Id.* MDI studies have shown that the long-term increase in awards has not keep pace with increases in general inflation on lost wages, medical inflation of health care costs, and the severity of injuries. MDI 2002 REPORT, *supra* note 3, at 18.

153. MDI 2003 REPORT, *supra* note 21.

154. *Id.*

155. *Id.*

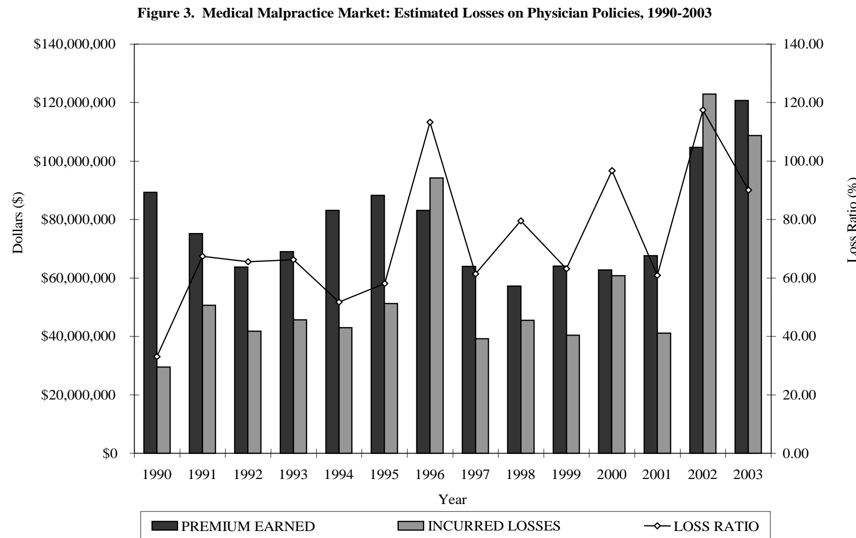
156. *Id.*

157. *Id.* The loss ratio is equal to losses incurred divided by premium earned. *See supra* note 32 and accompanying text.

158. MDI 2003 REPORT, *supra* note 21.

159. *Id.*

physicians and surgeons, falling to 90%.[160] The loss ratios for physician medical malpractice insurers from 1990 to 2003 are displayed in Figure 3.[161]



But while insurers' loss estimates increased, actual losses fell dramatically. Insurers' cash-flow ratio, the percentage of premiums actually paid out on claims, declined to 45%, the lowest since 1994.[162] This means that medical malpractice insurers actually paid out only 45 cents of every dollar in premium collected—a significant drop from 63 cents in 2002 and a ten-year average of 62 cents.[163] The cash-flow ratio for physician malpractice fell to a record low 39%; insurers paid out only 39 cents of every dollar in premium collected from physicians.[164] Thus, MDI concluded, "the growth of premiums is far outstripping actual losses,"[165] and this is creating a "cash-flow windfall" for insurers.[166] The cash-flow ratios for insurers of physician malpractice are displayed in Figure 4.

160. *Id.*

161. Data taken from MDI's 2003 report. MDI 2003 REPORT, *supra* note 21.

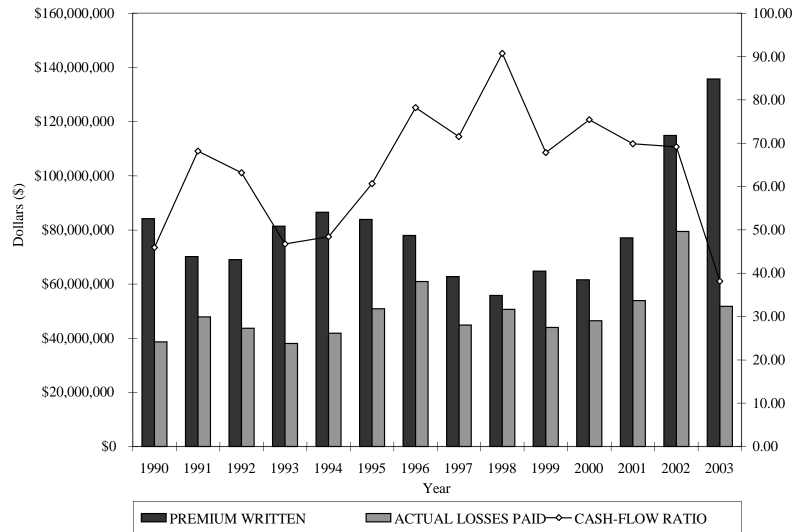
162. *Id.* Cash flow ratio is equal to direct losses paid divided by direct premium written in a given year. *See supra* note 24 and accompanying text.

163. MDI 2003 REPORT, *supra* note 21.

164. *Id.*

165. MDI Press Release, Nov. 4, 2004, *supra* note 124.

166. MDI Press Release, Apr. 16, 2004, *supra* note 141.



4. Conclusion

Missouri's medical malpractice insurance data reveals an inconsistency: premiums and loss estimates climbed to record highs while claims, payouts, and actual losses fell to record lows.[167] This casts doubt on the President's theory that "junk lawsuits" and an "out of control" liability system are driving up the price of premiums,[168] and raises two critical questions. First, are the past increases in premiums justified? Second, what kind of reform will best ensure low, stable premiums in the future? Unfortunately, further data to answer the first question is unavailable.[169] Missouri's insurance regulations do

167. *See supra* Parts III.A.1–III.A.3.

168. *See supra* text accompanying note 1.

169. A nationwide study from the United States General Accounting Office (GAO) explained that premium increases may be more a product of a cyclical insurance industry and overall economy because the insurance industry derives most of its income from the investment of premiums. U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO-03-836, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES (2003), *at* www.gao.gov/new.items/d03702.pdf [hereinafter GAO, MULTIPLE FACTORS]. The GAO report found that "[m]ultiple factors, including falling investment income and rising reinsurance costs, have contributed to recent increases in premium rates." *Id.* MDI has noted that Missouri's premiums have spiked three times in the past thirty years, all coinciding with recessions in the national economy. MDI 2002 REPORT, *supra* note 3, at 10. The GAO explained the industry cycle as follows:

> [I]nsurer losses anticipated in the late 1980s did not materialize as projected, so insurers went into the 1990s with reserves and premium rates . . . higher than the actual losses they would experience . . . [and] began a decade of high investment returns. This

not require insurers to explain or justify increases in premiums or loss estimates.[170] Nevertheless, the high price of premiums confirms the need for some reform. The next section considers the second question: What reform will achieve low, stable medical malpractice premiums in Missouri?

B. Reforming Tort Reform: Tightening the Damage Cap

The previous section analyzed data describing Missouri's malpractice insurance market and found an inconsistency—despite low claims, payouts, and actual losses, premiums and loss estimates remained high in 2003.[171] The data supports the need for further reform to achieve low, stable medical malpractice premiums. The only question that remains is what kind of reform. This section evaluates proposals to tighten Missouri's cap by eliminating multiple caps and lowering the cap amount.[172] Supporters of these proposals argue that tightening the cap will more effectively control malpractice

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> emerging profitability encouraged insurers to expand their market share, as both the downward adjustment of loss reserves and high investment returns increased insurers' income. As a result, insurers were generally able to keep premium rates flat or even reduce them, although the medical malpractice market as a whole continued to experience modestly increasing underlying losses throughout the decade. Finally, by the mid- to late 1990s, as excess reserves were exhausted and investment income fell below expectations, insurers' profitability declined. Regulators found that some insurers were insolvent, with insufficient reserves and capital to pay future claims. . . . As a result of all of these factors, insurers . . . requested and received large rate increases in many states. It remains to be seen whether these increases will, as occurred in the 1980s, be found to have exceeded those necessary to pay for future claims losses, thus contributing to the beginning of the next insurance cycle.

GAO, MULTIPLE FACTORS, *supra*, at 44–45.

Moreover, GAO investigators found that the reports of physicians moving to other states, retiring, or closing practices in response to the purported "crisis" complained of by the AMA were, in fact, not accurate. U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO-03-702, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 5 (2003), *at* www.gao.gov/new.items/d03836.pdf. As to the issue of availability to medical care, the GAO found that there were localized but not widespread access problems, and these particular instances were often in rural locations where keeping physicians has always been a problem. *Id.* In the end, the GAO recommended no "executive action" be taken but suggested that to "further the understanding of conditions in current and future medical malpractice markets, Congress may wish to consider encouraging the National Association of Insurance Commissioners and state insurance regulators to identify and collect additional, mutually beneficial data necessary for evaluating the medical malpractice insurance market." GAO, MULTIPLE FACTORS, *supra* note 169.

170. The need for Missouri to adopt stronger regulations that both require insurers to report data used in calculating loss estimates and premiums and permit MDI to reject excessive or inadequate premiums on the basis of this data is discussed *infra* Part III.C.

171. *See supra* Part III.A.

172. There are state and federal proposals to tighten the damage cap. *See supra* notes 12-14 and accompanying text.

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premiums.[173] But these reforms alone will not solve the problems of high medical malpractice premiums. These proposals will limit recoveries in only a few cases and provide minimal savings for insurers.[174] Moreover, they do not require insurers to translate their savings into lower premiums.[175] Thus, stronger insurance regulation is necessary, which is considered in the following section.[176]

1. Eliminating Multiple Caps

The potential problem of multiple caps is obvious—plaintiffs can be awarded several times more non-economic damages than allowed before multiple caps.[177] Multiple parties and negligent acts are common in medical malpractice litigation.[178] Higher payouts from multiple caps can increase insurers' losses, and these losses must be recovered by raising the price of malpractice premiums.[179]

But according to MDI's 2003 report, multiple caps "continued to have a minimal impact on payouts."[180] This is because multiple caps are not necessary in most cases, even if permitted by law. As discussed above, non-economic damages rarely exceed a single cap, and in most cases, they are far less.[181] According to MDI, multiple caps affected only *nine* cases in 2003.[182] Because few cases are affected by multiple caps, eliminating multiple caps would provide only minimal savings for insurers. Eliminating multiple caps would have saved \$3.1 million in 2003.[183] This amount was only 1.7% of premiums and 3.3% of overall losses in 2003.[184] In 2002, multiple caps increased payments in only twelve cases.[185] Eliminating multiple caps would have saved \$2.6 million, only 1.5% of premiums and 2.2% of losses that

173. *See supra* text accompanying notes 12–14.

174. *See infra* Parts III.B.1, III.B.2.

175. *See infra* Part III.B.3

176. *See infra* Part III.C.

177. *See supra* Part II.C.

178. In the past 14 years, fifty-six percent of medical malpractice claims that closed with payment in Missouri had multiple defendants. MDI 2002 REPORT, *supra* note 3, at 42.

179. Insurance company lobbyists initially estimated multiple caps would double or triple overall losses. MDI 2003 REPORT, *supra* note 21.

180. *Id*. As shown above, payouts and actual losses declined in 2003. *See supra* Part III.A.2 and III.A.3

181. *See infra* Part III.B.2. The typical non-economic damage award was only five percent of total damages awarded in 2003. MDI 2003 REPORT, *supra* note 21.

182. MDI 2003 REPORT, *supra* note 21. Based on insurer evaluations, these cases that involve multiple caps are serious—most involved death, quadriplegia or severe brain damage with the need for lifetime care or a terminal diagnosis. *Id.*

183. *Id.*

184. *Id.*

185. *Id.*

year.[186] These savings are relatively minor considering that malpractice premiums doubled from 2000 to 2003, from $113.5 to $227 million.[187]

While multiple caps have had a minimal impact on actual losses, they have likely increased *estimated* losses and higher premiums.[188] As discussed earlier, insurers set premiums to cover actual losses from damages paid and estimated losses on claims to be paid in the future.[189] After the *Scott* decision in 2002, estimated losses increased by more than 250%.[190] In 2002, the loss ratio for medical malpractice insurance was 108% overall, an increase from 81% in 2001.[191] The loss ratio for physician malpractice insurance was even higher, 118% in 2002, nearly double the 61% figure in 2001.[192] While loss estimates and ratios fell slightly in 2003, they remained near record highs.[193]

According to MDI, the *Scott* decision contributed to the drastic increase in loss estimates. Before *Scott,* malpractice insurers priced their coverage assuming Missouri's damage cap statute provided a single, per-injury cap.[194] But after *Scott* confirmed that multiple caps were permitted, malpractice insurers could not retroactively re-price their product and had to increase their loss estimates and premiums.[195] MDI's 2003 Report stated:

> Predictability allows insurers to have greater confidence in their risk projections. Missouri's 1986 reforms have been tested by time and provide a substantial pool of loss data on their effect. Uncertainty because of *Scott* likely will encourage insurers to raise rates and keep them high for several years until the effect becomes clear.[196]

According to MDI, multiple caps have not helped attract new insurers to Missouri's medical malpractice insurance market.[197] Potential insurers thinking of entering Missouri's medical malpractice market likely see multiple caps as an "added risk."[198] As discussed later, the lack of competition in Missouri's medical malpractice insurance market has kept premium prices high.[199] Thus, in 2003, MDI supported legislation to overrule *Scott* and limit multiple caps.[200]

186. *Id.*
187. MDI 2003 REPORT, *supra* note 21.
188. *See id.*
189. *See supra* Part II.B.
190. MDI 2003 REPORT, *supra* note 21.
191. *Id.*
192. *Id*.
193. *Id.*
194. *Id.*
195. MDI 2003 REPORT, *supra* note 21.
196. MDI 2002 REPORT, *supra* note 3, at 42.
197. *Id.*
198. *Id.*; *see infra* Part III.C.3.
199. MDI 2002 REPORT, *supra* note 3, at 42.
200. *Id.*

The data from MDI shows that eliminating multiple caps may reduce insurer uncertainty, loss estimates, and ultimately, premiums. But because few cases are actually affected by multiple caps and eliminating them will provide only minor savings for insurers, further reform is necessary. The next section considers the proposal of a lower cap amount.

2. Lowering the Cap Amount

Another proposal to tighten Missouri's damage cap is to lower the cap amount.[201]It is argued that a lower cap would provide more savings, reducing claims, payouts, and the overall cost of medical malpractice insurance.[202] Insurers' savings could then translate into lower premiums.[203]

MDI analyzed the effect of a lower cap in its 2003 Report.[204] It found that "legislative proposals to further reduce Missouri's cap on non-economic damages would have produced few savings—or premium reductions—in 2003."[205] The report evaluated the 2003 bill approved by Missouri's House that lowered the cap from $565,000 to $350,000, without an adjustment for inflation.[206] In 2003, the lower cap would have reduced payments in only 23 cases, 5% of all paid claims that year.[207] The lower cap would have reduced payments by $4.4 million, which was only 2.2% of premiums collected that year.[208] A lower cap also would adversely affect those cases with the most severe injuries. Of the cases reaching Missouri's cap in 2003, most involved permanent injuries, such as quadriplegia or severe brain damage, with terminal diagnosis or the need for lifetime care.[209]

Recent proposals have called for an even lower cap of $250,000. A cap of $250,000 is part of President Bush's medical malpractice reform bill pending in Congress.[210] But even a cap of $250,000 provides insufficient savings. The reduction would affect only 37 cases, or 7% of claims receiving payment,[211] and reduce overall damages by $8.1 million, or 4.7% of premiums collected.[212] Considering that premiums have doubled from 2000 to 2003, from $113.5 to

201. *Id.* at 35.
202. *Id.*
203. *Id.*
204. MDI Press Release, Apr. 16, 2004, *supra* note 141.
205. *Id.*
206. *Id.*
207. *Id*.
208. *Id.*
209. According to MDI, "the severity of claims receiving judgments equal to the Missouri caps averages a 7 or 8—permanent injury like quadriplegia, blindness, severe brain damage requiring lifetime care or terminal diagnosis." MDI 2002 REPORT, *supra* note 3, at 20. This ranking of "7 or 8" is on a 1 to 9 scale, with 9 being death. *Id.* at 17.
210. *See* President Bush Address, *supra* note 1.
211. MDI 2002 REPORT, *supra* note 3, at 35.
212. *Id.*

$227 million, savings from these proposals are inadequate.[213] As MDI concluded, a lower cap provides limited savings "at a considerable cost for the small number of cases in which patients suffer the greatest."[214]

3. The Real "Limit" of a Cap

As discussed above, Missouri's cap is a limited solution to the problem of high medical malpractice premiums. The cap restricts only non-economic damages, while the largest portion of medical malpractice awards are economic damages, which are unlimited.[215] The cap reduces payouts in only a few cases, typically involving the most severely injured patients.[216] Thus, tightening Missouri's cap will provide minimal savings and only by restricting the rights of those with claims far from frivolous.[217]

But perhaps the greatest limitation is that a cap does not require insurers to lower premiums, even if savings result. Instead, market competition or state regulation is necessary to induce lower premiums. But in Missouri, both competition and regulation are lacking, and as a result, insurers can maintain high premiums, despite the cap, and keep the savings as profit.[218]

After massive contractions in Missouri's medical malpractice insurance market, the level of competition has reached a new low. In 2002, Missouri's market for physicians seeking malpractice coverage shrunk by 57%, due to

213. MDI 2003 REPORT, *supra* note 21.

214. MDI 2002 REPORT, *supra* note 3, at 35.

215. *See infra* Part III.B.2. The typical or median non-economic damage award was only five percent of total damages awarded in 2003. MDI 2003 REPORT, *supra* note 21.

216. *See infra* Part III.B.2. The average non-economic damage award was $85,140, and the typical or median non-economic damage award was $27,872 in 2003, which was five percent of the cap amount. MDI 2003 REPORT, *supra* note 21. Missouri's non-economic damage cap was $557,000 in 2003. *Id.*

217. Medical malpractice insurers have agreed with these criticisms of caps. *See* Wenske & Karash, *supra* note 16, at D1. A major insurer of physicians in Missouri, the Medical Protective Company, has stated that "[n]on-economic damages are a small percentage of total losses paid. Capping non-economic damages will show loss savings of 1 percent." *Id.* Moreover, it has been argued that non-economic damage caps discriminate against patients with limited economic damages, such as retired persons, children, and housewives. Rachel Zimmerman & Joseph T. Hallinan, *Life Values: As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, WALL ST. J., Oct. 8, 2004, at A1. These victims of malpractice have minimal lost wages, a major component of unlimited economic damages. *Id.* Caps on non-economic damages make these claims less valuable, and studies have show that they may have difficulty finding representation. *Id.* Others have argued that caps on non-economic damages lead to greater reliance on public assistance because low-income patients have no other resource to pay for unforeseen medical expenses and basic needs. *Insurance Regulation vs. Tort Reform: Hearings Before the House Energy and Commerce Comm., Subcomm. on Oversight and Investigations,* 109th Cong. 18 (2003) (statement of Harvey Rosenfield, Foundation for Taxpayer and Consumer Rights).

218. MDI 2002 REPORT, *supra* note 3, at 7, 44.

insurer withdrawals and insolvencies.[219] As a result, five companies control 83% of the Missouri market for physician malpractice insurance.[220] Only three companies offer new malpractice policies for physicians.[221] Thus, physicians without coverage or who are shopping for lower premiums have extremely limited options.[222] According to MDI, this lack of competition has forced physicians to absorb premium increases, regardless of the amount.[223]

In July 2003, the Missouri's Director of Insurance, Scott B. Lakin, held a public hearing and determined that medical malpractice insurance was "not reasonably available" in the state.[224] According to Lakin, "Our major problem is convincing companies to enter and compete in the Missouri market after so many insurers folded or withdrew nationally. Policyholders desperately need price competition again, but insurers across the U.S. have been unwilling to devote more capital to this line of business so far."[225]

In addition to the lack of competition, MDI has "extremely limited authority" to regulate premiums charged by medical malpractice insurers.[226] Under the current regulatory scheme, MDI cannot reject premiums that are excessive or require insurers to explain or justify premium increases.[227] According to Jay Angoff, the state's insurance director from 1993 to 1998, "Insurers in Missouri can charge whatever they want, and the director is absolutely impotent to do anything about it. . . . That is an amazing aspect of the law."[228] Without competition or regulation, insurers can keep premiums high and any profits that result. Thus, the proposals to tighten Missouri's cap will not solve the problem of high premiums alone. Instead, MDI needs more power to regulate medical malpractice insurance and ensure that savings from

219. *Id*. at 7. Four companies withdrew or became insolvent in 2002, and a company representing twenty-six percent of Missouri's market stopped writing new physician policies. *Id.* at 26, 30.

220. *See supra* note 27.

221. *See* MDI 2002 REPORT, *supra* note 3, at 7.

222. *Id.* at 27.

223. *See id.*

224. In response Missouri established a joint underwriting association (JUA) in 2003. JUA provide medical malpractice coverage for several higher-risk specialties, including obstetricians, neurosurgeons, orthopedic surgeons, and emergency room physicians. *See* Press Release, Missouri Department of Insurance, State Insurance Plan Begins Taking Medical Malpractice Applications (June 16, 2004), *available at* http://www.insurance.state.mo.us/cgi-bin/news/news2.cgi?newsid=EplZuEulAuUVgGZTId.

225. MO. DEP'T OF INS., 3 PUBLIC POLICIES 1,3 (2004), *available at* http://www.insurance.state.mo.us/news/pubpol/0405.pdf.

226. MDI 2002 REPORT, *supra* note 3, at 28.

227. *Id*.

228. Wenske & Karash, *supra* note 16, at D1.

a cap are passed onto physicians in lower premiums.[229] This reform is discussed next.

C. Beyond the Cap: Insurance "Reform"

As discussed above, proposals to tighten Missouri's damage cap provide little actual savings and adversely affect the worst injured patients.[230] Moreover, a cap does not guarantee that the savings are translated into lower premiums.[231] Because Missouri's medical malpractice insurance market lacks competition, MDI needs more regulatory power to ensure premiums remain low and stable.

This section analyzes Missouri's insurance regulations and proposes giving MDI the authority to: (1) reject excessive or inadequate premiums, and (2) require insurers to justify premium changes.[232] After proposing changes to Missouri's regulations, the regulations are compared to those in California.[233] Like Missouri, physicians in California experienced high medical malpractice premiums despite a cap on non-economic damages.[234] However, after stronger regulatory laws were enacted in California, the price of premiums fell and remained stable.[235]

1. Missouri's Regulation of Medical Malpractice Insurance

MDI currently has the authority to regulate casualty or liability premiums under sections 379.420 to 379.510.[236] The key section, 379.470, provides that MDI may reject premium rates only if: (1) premiums are excessive or inadequate, and (2) the market is no longer competitive.[237] But while these

229. *Id.*
230. *See supra* Parts III.B.1–III.B.2.
231. *See supra* Part III.B.3.
232. *See infra* Part III.C.1.
233. *See infra* Part III.C.2.
234. *See infra* Part III.C.2.
235. *See infra* Part III.C.2.
236. *See generally* MO. REV. STAT. §§ 379.420–379.510 (2000).
237. MDI 2002 REPORT, *supra* note 3, at 28. MO. REV. STAT. § 379.470 provides:

> (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 provided and a reasonable degree of competition does not exist in the area 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 and the continued use of such rate endangers the solvency of the insurer using the same, or unless such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using same has, or if continued will have, the effect of destroying competition or creating a monopoly.

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regulations give MDI the authority to reject premiums, MDI is unable to exercise this authority and regulate medical malpractice premiums for two reasons. First, another state regulation allows policy forms, rating manuals, rating plans and modifications, to be filed ten days *after* their effective dates.[238] This regulation allows medical malpractice insurers to use new, higher premiums before filing with MDI—a system known as "use and file."[239] Under such a "use and file" system, MDI is unable to approve or reject premium changes before the premiums are in use.[240]

Second, MDI has no power to enforce data reporting by insurers or require justifications for changes in premiums or loss estimates. While MDI collects data reported by insurers pursuant to state law, this reporting requirement is voluntary, and MDI has no power to enforce the requirement with fines or penalties.[241] Furthermore, the data that is reported is limited and does not include specific information on how insurers calculate premium increases. Without more specific data, MDI cannot determine if premiums are excessive or inadequate. Moreover, no uniform method or standard exists in calculating premiums or estimating losses. Without further data or regulatory standards, MDI cannot determine if premium increases or loss estimates are justified. Thus, MDI cannot exercise its authority to reject and regulate premiums.

To correct these limitations, Missouri's insurance regulations should be reformed. The reforms should authorize MDI to: (1) reject excessive or inadequate medical malpractice insurance premiums, and (2) require insurers to justify premium changes.[242] For MDI to exercise its power to reject premiums, Missouri's current "use and file" system must be changed. Insurers should no longer be permitted to file premium changes *after* using them in the market. Instead, Missouri should adopt a "prior approval" system, so MDI can approve premiums before they are used in the market. Under such a system, insurers should be required to submit a rate-change application for changes that exceed a certain percentage of last year's premium.[243]

Insurers would be required to provide specific data justifying the proposed premium changes in the applications. MDI may call a public hearing regarding

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> (4) Due consideration shall be given to past and prospective loss experience within this state and consideration may also be given to past and prospective loss experience outside this state to the extent appropriate. . . .

MO. REV. STAT. § 379.470 (2000).

238. MO. CODE REGS. ANN. tit. 20 § 500–4.00(1)(b) (2000).

239. MDI 2002 REPORT, *supra* note 3, at 28.

240. *Id.*

241. MO. REV. STAT. § 383.115 (2000).

242. Regulatory changes similar to those discussed in this section are currently pending in Missouri's Senate. *See* S.B. 83, 93d Gen. Assem., 1st Sess. (Mo. 2005).

243. Under such a scheme, relatively minor fluctuations in premiums would not be regulated.

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these proposed premium changes. If MDI does not approve the change, MDI should propose a reasonable rate based on the data provided.

In addition to giving MDI "prior approval" power, the current reporting requirements should be expanded to require all medical malpractice insurers to report specific claims and loss for each medical specialty. Insurers should include historical loss data supporting their loss estimates, and the data should be accompanied with a memorandum explaining the standard and methodology used in calculating loss estimates and premiums. Insurers should file data projecting their earnings from premiums and investments that year and support this data with earnings from premiums and investments in years prior. MDI should be given the power to promulgate rules setting forth standards for insurers in calculating loss estimates and premiums.[244] MDI should also be able to enforce these reporting requirements through fines or other penalties.

By giving MDI the power to reject and require justification for premium increases, MDI can ensure that savings from Missouri's damage cap are passed on to physicians as lower premiums and prevent the current problem of high premiums despite low claims, payouts, and actual losses. With stronger regulatory power and better data reporting, MDI can hold insurers accountable and provide greater transparency in the premium-setting process. These changes would also help the industry predict and avoid dramatic changes in premiums due to investment cycles. The next section looks to California, a state with both a non-economic damage cap and regulatory laws similar to those proposed here. The experience of California shows why a damage cap is a limited solution that will not solve the problem of high medical malpractice insurance alone and why regulation needed.

2. California: Caps and Regulation

In 1975, California enacted the Medical Injury Compensation Reform Act (MICRA), which placed various restrictions on medical malpractice lawsuits, including a $250,000 cap on non-economic damages.[245] Even though multiple caps were not permitted and the cap was set low, the price of physician premiums increased 450% over thirteen years, reaching an all-time high in 1988.[246] In 1988, in response to the ineffectiveness of the damage cap,

244. Given an increase in power for MDI, Missouri's legislature should consider making the MDI Director an elected official. Under current Missouri law, MDI's director is appointed by the Governor. Missouri Department of Insurance, *MDI Administration*, *at* http://insurance.mo.gov/aboutMDI/admin.htm (last updated Jan. 6, 2005).

245. *Proposition 103: A Model for Insurance Regulation: Hearings Before the Senate Comm. on Commerce, Science, and Transp.,* 109th Cong. (2003) [hereinafter *Proposition 103 Hearings*] (statement of Douglas Heller, Foundation for Taxpayer and Consumer Rights).

246. FOUND. FOR TAXPAYER AND CONSUMER RIGHTS, HOW INSURANCE REFORM LOWERED DOCTOR'S MEDICAL MALPRACTICE RATES IN CALIFORNIA AND HOW MALPRACTICE CAPS

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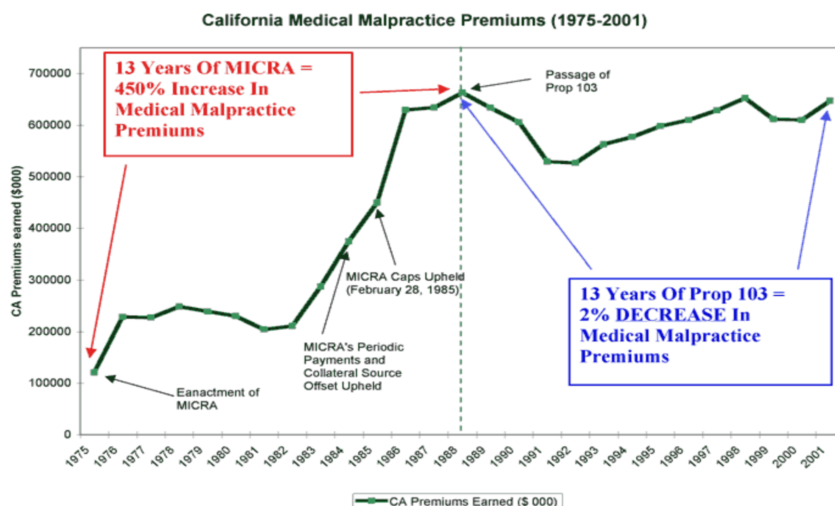
Californians passed Proposition 103.[247] Proposition 103 rolled back insurance rates by twenty percent and froze the premiums at that level for one year.[248] In doing so, millions of dollars were refunded to doctors to compensate for excessive past premiums.[249] Thereafter, medical malpractice insurance premiums were subject to a "prior approval" regulatory system.[250] The regulations required medical malpractice insurers to justify rate increases or decreases with the Department of Insurance and gave the insurance commissioner the power to reject an insurer's rate as too high or low at any time.[251] After three years under Proposition 103, medical malpractice premiums fell twenty percent and remained stable, increasing at or below the level of inflation every year and falling two percent overall.[252] The figure below illustrates the impact of the damage cap under MICRA and insurance regulation under Proposition 103 on California medical malpractice premiums.[253]



FAILED 1 (2003), *available at* http://www.consumerwatchdog.org/healthcare/rp/rp003103.pdf [hereinafter HOW INSURANCE REFORM LOWERED DOCTOR'S MEDICAL MALPRACTICE RATES].

247. *Id.* at 2.

248. *Id.* at 1–2.

249. *Id.* at 2.

250. *Id.*

251. HOW INSURANCE REFORM LOWERED DOCTOR'S MEDICAL MALPRACTICE RATES, *supra* note 246, at 6.

252. *Id.* at 3.

253. *Id.* at 6 (using data provided by the National Association of Insurance Commissioners). The Foundation for Taxpayer and Consumer Rights (FTCR), is a nonprofit consumer watchdog, founded by the author of Proposition 103, Harvey Rosenfield. The FTCR has conducted several studies evaluating the impact of California's caps and regulations.

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California's experience shows that a cap alone will not solve the problem of high medical malpractice premiums. Douglas Heller, an insurance specialist for the Foundation for Taxpayer and Consumer Rights, described the limits of the cap and the success of regulation in California, in testimony before the U.S. Senate.[254] Mr. Heller testified:

> The flaw in the promise of tort restrictions is that it depends upon insurers to reduce rates without requiring the companies to do so. . . . The insurance industry has invested millions of dollars to promote the notion that lawsuits are the sole barrier to affordable insurance, yet after the industry successfully shields itself from lawsuits, there is no commensurate rate decrease.
>
> The lesson from decades of legislation restricting victims' and consumers' rights is that the insurance crises keep happening and rates continue to cycle higher and higher unless lawmakers address the real problem by regulating rates.[255]

Missouri's legislature should follow the example of California and strengthen the state's insurance regulations. With stronger regulations, MDI can ensure that savings from Missouri's damage cap are passed onto physicians and that premiums remain low and stable in the future.

IV. CONCLUSION

Missouri's legislature is likely to pass reform of the state's cap on non-economic damages in medical malpractice lawsuits. But such reform is a limited solution to the problem of high medical malpractice insurance premiums. While a tighter cap will provide minimal savings for insurers, it does not guarantee that the savings will be passed onto physicians as lower premiums. Thus, Missouri's legislature should give MDI the power to reject excessive premiums and require justifications for premium changes. By strengthening Missouri's insurance regulations, MDI can ensure that savings from Missouri's cap are passed onto physicians as low, stable premiums.

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254. *Proposition 103 Hearings*, *supra* note 245.

255. *Id.* at 25.

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