Merrill F. Nelson (3841)
Alexander Dushku (7712)
Tiffany Smith (11767)
KIRTON McCONKIE
60 East South Temple, Suite 1800
Salt Lake City, Utah 84111
Telephone: (801) 328-3600
Facsimile: (801) 328-4893
mnelson@kmclaw.com
adushku@kmclaw.com

Attorneys for Amici Curiae
Utah Hospital Association
Utah Medical Association
American Medical Association
UMIA, Inc.

IN THE SUPREME COURT OF THE STATE OF UTAH

ROBBY D. ROBINSON and LISA ROBINSON, individually and as Personal Representatives for the Heirs of the ESTATE OF BRADFORD ROBINSON, Plaintiffs/Appellees, vs. MOUNTAIN VIEW FAMILY CARE, PC; PAUL RAY TAYLOR, M.D. and DOES 1 through 10, Defendant/Appellant.	**BRIEF OF AMICI CURIAE UTAH HOSPITAL ASSOCIATION, UTAH MEDICAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AND UMIA IN SUPPORT OF APPELLANT** Case No. 20130463-SC

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INTERESTS OF THE AMICI

Amici Utah Hospital Association (UHA), Utah Medical Association (UMA), American Medical Association (AMA), and UMIA represent or support a substantial portion of the health care providers in the State of Utah. Amici submit this brief out of deep concern with the district court's refusal to apply the cap on noneconomic damages found in Utah Code § 78B-3-410 in this wrongful death action. The cap is an essential part of the strenuous efforts of the State of Utah and health care providers like amici to control rising health care costs. Thus far those efforts have been remarkably successful. Removing the cap in wrongful death actions would severely undermine that success. Amici urge this Court to uphold the cap.

Amicus UHA has a profound interest in the outcome of this case. Founded in 1920, UHA is the trade association for the 53 acute and specialty hospitals operating in Utah as well as Utah's 11 health systems. UHA represents a broad cross-section of hospitals including non-profit, for-profit, and government-owned hospitals. As well as representing many acute-care hospitals, UHA also represents a teaching hospital, children's hospital, rehabilitation hospital, and psychiatric hospitals. UHA also represents health systems that are based in Utah as well as a number of health systems based elsewhere in the United States. UHA was involved in the passage of the Utah Health Care Malpractice Act and is familiar with the economic and healthcare reasons for its passage. Each of UHA's members will be directly affected

by this Court's ruling on the non-economic damage cap at issue in this appeal, as they are the subject of current or potential litigation on this issue.

Amicus UMA represents some 3,500 members, including physicians, medical students, and non-physician affiliates throughout the State of Utah. UMA strives to prevent and cure disease, improve public health, be an informational resource for the people of the State of Utah in matters of medical care, support the enactment of appropriate medical and healthcare legislation in Utah, and provide effective representation for its members. UMA has significant expertise in the practice and economics of health care in Utah. Its members have a direct interest in the statutory non-economic damage cap, as they are the subjects of current or potential litigation on the issue.

Amicus American Medical Association (AMA) is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups, seated in the AMA's House of Delegates, substantially all U.S. physicians, residents and medical students are represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. Its members practice in every state, including Utah, and in every specialty. The AMA joins this brief in its own capacity and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center was formed in 1995 as a coalition of

the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts.

Amicus UMIA was born out of necessity in 1978 as the Utah Medical Insurance Association when all commercial for-profit insurance providers discontinued medical liability coverage in Utah. In order to provide a source of liability coverage sensitive to the needs of its members, approximately 800 physicians across the state formed an insurance exchange that was the beginning of UMIA. In 2013, after 35 years of providing stable, physician-owned and directed liability coverage in Utah, Montana, Wyoming and Idaho, UMIA joined the MMIC family – the largest policyholder-owned medical liability insurance (medical malpractice) company in the Midwest . UMIA continues to empower caregivers to provide the best medical care possible while promoting safety and minimizing risk. UMIA serves the entire health care community, including hospitals and health care systems, physician practices, and outpatient and long-term care facilities. UMIA focuses on risk financing, improving patient safety and physician well-being. UMIA provides peace of mind so clients can focus on delivering health care in an era of health care reform, increasing regulations and health care costs. A stable tort environment with stable and predictable insurance costs is part of that peace of mind.

INTRODUCTION

America's health care system is in crisis. Although the United States spends over $2.7 trillion annually on health care—roughly 18% of its GDP—costs continue

to rise.[1] There are many drivers of health care costs. One important driver is America's aggressive medical malpractice litigation system, which results in high insurance premiums for doctors and hospitals, overly defensive medical practices, early physician retirements, and physician relocations, which all contribute to rising health care costs for patients.

Fortunately, as discussed below, Utah has a lower rate of medical inflation than 37 other states and the District of Columbia. This is no accident. A key factor in Utah's successful health care strategy is the cap in Utah Code §78B-3-410(1)(c) on recovery for noneconomic losses in medical malpractice actions. The cap is vital for creating a stable risk environment for health care providers and their malpractice insurers while still allowing a fair recovery for noneconomic losses. The cap eliminates the risk of unlimited jury verdicts and thus the upward pressure that such risk puts on insurance premiums. As this Court stated in *Judd v. Drezga*, 2004 UT 91, ¶ 16, 103 P.3d 135, "Intuitively, the greater the amount paid on [malpractice] claims, the greater the increase in premiums. Limiting recovery of quality of life damages to a certain amount [as the cap does] gives insurers some idea of their potential liability." Put simply, the risk of unlimited damage verdicts requires higher insurance reserves, which are obtained through higher premiums, which are passed to patients through

[1] *See* Centers for Medicare & Medicaid Services, *National Health Expenditures 2011 Highlights* (2012), *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf.

higher charges for services. By limiting potential liability, the cap allows for smaller reserves, lower premiums, and reduced charges for patient care. The cap also results in health care practices that are more focused on proper treatment than liability avoidance, fewer early physician retirements, and little or no flight to other states by Utah's corps of skilled physicians—all leading to lower health care costs for Utah patients.

Removing the cap for wrongful death cases would render it ineffective. Many malpractice cases are potentially wrongful death cases. To account for the risk of wrongful death verdicts, insurers would have to return to higher reserves, resulting in higher premiums, higher charges by providers, excessively risk-averse medical practices, and fewer physicians in Utah.

In brief, striking down the cap as applied to wrongful death actions would be a serious blow to Utah's successful strategy for controlling health care costs. Amici strongly urge this Court to uphold both the cap's application to the facts of this case and its constitutionality.

ARGUMENT

Few areas of social policy require as much expertise and flexibility in policymaking as health care. The Legislature not only has the power but the "duty," *Drezga*, 2004 UT at ¶ 5, to make difficult policy choices in this critical arena. To be sure, constitutional limits must be respected. But in construing those limits, this Court should be aware of the unique public policy challenges that health care presents

and the preeminent role that the political branches must of necessity play in balancing competing interests. Unduly expansive interpretations of constitutional provisions—whether the wrongful death provision in Article XVI, § 5 or, as argued by plaintiff below (*see* R. 3064-67), the open courts provision in Article I, § 11—can seriously undermine vital public policies that are essential to the welfare of millions.

In rejecting an open-courts challenge to the cap, this Court in *Judd v. Drezga* explained the cap's important legislative purpose and its constitutional reasonableness: "The cap is designed to reduce health care costs, increase the availability of medical malpractice insurance, and secure the continued availability of health care resources—all legitimate legislative goals given the clear social and economic evil of rising health care costs and a shortage of qualified health care professionals. In attempting to meet its goals, the legislature has not unreasonably or arbitrarily limited recovery. Rather, it has chosen to place a limit on the recovery of 'noneconomic' quality of life damages—one area where legislation has been shown to actually and substantially further these goals." 2004 UT at ¶ 40; *see also id.* at ¶ 19 ("The damage cap is reasonable [under equal protection principles], and it substantially furthers and is reasonably necessary to the legislative goal of decreasing health care costs and ensuring the continued availability of health care."). This Court's deferential approach in *Drezga* should also inform its analysis of the constitutional arguments here.

Appellant's opening brief demonstrates why the wrongful death provision in Article XVI, § 5 did not historically apply to non-pecuniary losses and thus cannot now be read to prohibit caps on such damages. *See* Brief of Appellant, at pp. 39-52. Amici endorse that argument fully. Although it is not the purpose of this brief to advance constitutional arguments, it bears mention that few constitutional rights or limits are absolute. Even fundamental constitutional rights are often subject to judicial balancing tests that weigh the interests of the state against those of the individual. *See, e.g.*, *Ward v. Rock Against Racism*, 491 U.S. 781, 791 (1989) (despite First Amendment ban on laws abridging freedom of speech, "even in a public forum" where protections for speech are greatest "government may impose reasonable restrictions on the time, place, or manner of protected speech" under a balancing test). This Court's open courts jurisprudence similarly engages in a balancing of interests despite seemingly absolute constitutional language. *See Berry v. Beech Aircraft Corp.*, 717 P.2d 670, 680 (Utah 1985) (despite guarantee under Article I, § 11 of a "remedy by due course of law," "abrogation of the remedy ... may be justified" provided there is a "clear social or economic evil to be eliminated and the elimination of an existing legal remedy is not an arbitrary or unreasonable means for achieving the objective.").

Amici submit that in the event this Court rejects Appellant's categorical argument, the constitutionality of the cap should still be evaluated under the economic-evil/reasonableness standard used in open courts cases like *Berry* and

Drezga. As the following demonstrates, the cap readily passes that reasonableness test. Indeed, that was the holding in *Drezga*. *See* 2004 UT at ¶ 29. The cap is essential to the welfare of Utah's health care system and the millions it serves and thus should be upheld.

I. America's Highly Litigious Approach to Medical Malpractice Hurts Its Health Care System.

Physicians practice under the constant threat of medical malpractice suits: 61% of physicians age 55 and older have been sued; "among surgeons and obstetricians/gynecologists" the numbers are as high as "69.2 percent;"[2] and among surgeons age 55 and older, nine out of ten have been sued.[3] The American Medical Association ("AMA") reports research indicating that "99 percent of physicians in high-risk specialties [will have] been subject to a claim" by age 65.[4]

This lawsuit frenzy creates significant problems for our health care system: rising medical malpractice insurance rates for physicians, rising health care costs for patients, overly defensive (and thus overly expensive) medical practices, early physician retirements, and physician relocations to states that have adopted effective

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[2] *See* Carol K. Kane, American Medical Association, *Medical Liability Claim Frequency: A 2007-2008 Snapshot of Physicians* 5 (2010), *available at* http://www.ama-assn.org/resources/doc/health-policy/prp-201001-claim-freq.pdf.

[3] *See id*.

[4] American Medical Association, *Medical Liability Reform NOW! The facts you need to know to address the broken medical liability system* 4 (2013 ed.)[hereinafter AMA, *Medical Liability Reform*], *available at* http://www.ama-assn.org/resources/doc/arc/mlr-now.pdf (*citing* B. Jena Anupam et al., *Malpractice Risk According to Physician Specialty*, 365 New Eng. J. Med. 7, 629-636 (2011), *available at http://www.nejm.org/doi/full/10.1056/NEJMsa1012370#t=articleTop*).

medical malpractice reforms. In 2003 and 2004, medical malpractice premiums rose nationwide by over 20% annually.[5] And while the prices of numerous consumer products have remained relatively stable or even decreased in recent years, health care spending per capita increased by 5.3% annually from 1991-2009[6]—an aggregate increase of 153% in less than 20 years. Excessively defensive medicine induced by fear of litigation is a significant driver of such increases, costing the nation an estimated $45.6 billion to over $126 billion annually.[7] Doctors are retiring earlier than ever,[8] although states with limitations on malpractice claims have increased their cadre of physicians by 2.4 % relative to states without reforms.[9] In the mid-2000s, the AMA declared that 22 states were in "crisis," with rising premiums, patients losing access to health care, and physicians struggling to stay in practice.[10]

Utah has not been immune to these national trends, but it has had remarkable success in limiting increases in health care costs. Between 1991 and 2009, Utah's per

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[5] Chad C. Carls, *Becalmed & Bewildered: When Will the Professional Medical Liability Market Break Out of the Doldrums, Begin to Harden?*, Medical Liability Monitor, Vol. 37 No. 10, 3 (Oct. 2012), *available at* http://www.thehybridsolution.com/articles/MedicalLiabilityMonitor2012.pdf.

[6] The Henry J. Kaiser Family Foundation, *Average Annual Percent Growth in Health Care Expenditures per Capita by State of Residence*, 1991-2009, http://kff.org/other/state-indicator/avg-annual-growth-per-capita/ [hereinafter Kaiser, *Percent Growth*].

[7] *See* AMA, *Medical Liability Reform*, *supra* note 4, at 9.

[8] Gregory Roslund, *Liability and the ER Doc: Location, Location, Location*, Medscape Multispecialty, Aug. 27, 2013, http://www.medscape.com/viewarticle/809171.

[9] *See* AMA, *Medical Liability Reform*, *supra* note 4, at 5-6 (*citing* D.P. Kessler et al., *Impact of Malpractice Reforms on the Supply of Physician Services*, 2005 JAMA 293(21), 2618-25 (2005)).

[10] *See* AMA, *Medical Liability Reform*, *supra* note 4, at 11.

capita spending on health care increased at a lower rate than 37 other states and the District of Columbia.[11] As discussed next, Utah's noneconomic damages cap is a significant factor in Utah's strategy for controlling health care costs.

II. Tort Reforms, Particularly Noneconomic Damages Caps, Help to Relieve the Health Care Crisis by Minimizing the Effects of Malpractice Litigation.

Many states have addressed these problems through integrated tort reforms that allow appropriate recovery for malpractice injuries but include elements like damages caps that protect the integrity of the health care system by limiting the risk of runaway recoveries. Researchers have quantified the effect of tort reforms—particularly noneconomic damages caps such as the one at issue here—on medical malpractice insurance rates, public and private health care costs, and physician practice choices. States with limited or no tort reforms are experiencing significant medical malpractice premium increases, facility shut downs, and physicians who are reluctant to perform high-risk procedures or who wish to retire early.[12] By contrast, states that have implemented specific tort reforms, including noneconomic damages caps, are seeing medical malpractice premiums rise more slowly, lower overall health care costs, and higher in-state physician presence.[13]

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[11] *See* Kaiser, *Percent Growth*, *supra* note 6.

[12] *See* Kenneth E. Thorpe, "The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms," *Health Affairs*, W4-27 (Jan. 21, 2004), http://content.healthaffairs.org/content/early/2004/01/21/hlthaff.w4.20.full.pdf+html [hereinafter Thorpe, *Health Affairs*].

[13] *See generally* AMA, *Medical Liability Reform*, *supra* note 4, at 1-37.

A. Medical malpractice insurance premiums and losses are lower in states with noneconomic damages caps.

In the course of evaluating proposed federal tort reform, the non-partisan Congressional Budget Office ("CBO") prepared several reports summarizing studies on whether various state medical malpractice reforms, including noneconomic damages caps, actually reduced malpractice costs.[14] For almost a decade, CBO has summarized and reported on multiple studies that have consistently concluded that noneconomic damages caps induce lower medical malpractice insurance premiums.[15] In 2004, CBO examined Professor Kenneth Thorpe's study showing that noneconomic damages caps led to lower premiums.[16] Thorpe found that "no other tort reform was associated with lower premiums or loss ratios."[17] The same study reported that noneconomic damages caps were associated with reducing

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[14] *See* U.S. Congress, Congressional Budget Office, *Cost Estimate for H. Con. Res. 112: Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2011* 1 (April 26, 2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/HelpEfficientAccessibleLow-costTimelyHealthcareActof2011_0.pdf; U.S. Congress, Congressional Budget Office, *Letter to Senator Rockefeller*, 4 (Dec. 10, 2009), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/108xx/doc10802/12-10-medical_malpractice.pdf; U.S. Congress, Congressional Budget Office, *Background Paper: Medical Malpractice Tort Limits and Health Care Spending*, 10, Pub. No. 2668 (April 2006), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/71xx/doc7174/04-28-medicalmalpractice.pdf [hereinafter CBO, *Tort Limits*]; U.S. Congress, Congressional Budget Office, *A CBO Paper, The Effects of Tort Reform: Evidence from the States*, 12-13 (June 2004), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/55xx/doc5549/report.pdf [hereinafter CBO, *Tort Reform*].

[15] *See id*.

[16] *See* Thorpe, *Health Affairs*, *supra* note 12, at W4-26; CBO, *Tort Reform*, *supra* note 14, at 12-13.

[17] *See* CBO, *Tort Reform*, *supra* note 14, at 18.

premiums per physician by about 12 percent,[18] and that medical malpractice premiums in states with medical malpractice payment caps were 17.1 percent lower than those without caps.[19]

In 2006, CBO reported that "certain types of limits can reduce medical malpractice premiums below what they would be in the absence of the limits," and cited Professor Patricia Born's research indicating that noneconomic damages caps are also "associated with substantial long-term reductions in medical malpractice insurers' developed losses."[20] Noneconomic damages caps are, in fact, the most influential malpractice reform measure on reducing incurred losses.[21]

> [O]n average, internal medicine premiums in states with caps on noneconomic damages were 17.3 percent smaller than in states without caps. . . . Moreover . . . the authors found that every $100,000 increase in a cap raised premiums by 3.9 percent. Their results suggest that enacting a $250,000 cap in states without caps, or with higher-level caps, would result in premium savings of $1.4 billion.[22]

B. <u>Public and private health care costs are lower in states with noneconomic damages caps.</u>

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[18] *See* Thorpe, *Health Affairs*, *supra* note 12, at W4-26 to 4-27; CBO, *Tort Limits*, *supra* note 14, at 10.
[19] *See* Thorpe, *Health Affairs*, *supra* note 12, at W4-20 & W4-26.
[20] CBO, *Tort Limits*, *supra* note 14, at 10 (*citing* Patricia Born et al., *The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses* (National Bureau of Econ. Research, Working Paper No. 12086, 2006), *available at* http://www.nber.org/papers/w12086.pdf [hereinafter Born, *Tort Reform*]).
[21] *See* Born, *Tort Reform*, *supra* note 20, at 2.
[22] AMA, *Medical Liability Reform*, *supra* note 4, at 14 (*citing* Meredith L. Kilgore et al., *Tort Law and Medical Malpractice Insurance Premiums*, 43 Inquiry 255, 265-66 & 268 (2006)).

Medical liability issues affect patients' health costs because the "medical liability system causes health care expenditures to be higher than they otherwise would be" both in the public and private sectors.[23] CBO cited a 2002 study showing that states that enacted tort reforms had lower Medicare spending for some patients, with no significant increase in adverse health outcomes, and also experienced malpractice claims with lower costs.[24]

In 2006, CBO "estimated that total Medicare spending per beneficiary was 4 percent lower in states with caps."[25] In 2010, a study of private sector health care costs demonstrated that integrated tort reforms reduced health insurance premiums of employer-sponsored self-insured health plans by 2.1 percent, citing noneconomic damages caps as one of the tort reforms with the greatest impact.[26]

Recently, CBO updated its tort reform research summaries "to include not only direct savings from lower premiums for medical liability insurance but also indirect savings from reduced utilization of health care services," depending on the type of reform.[27] CBO indicated that studies in 2007 and 2009 "found that reductions in the

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[23] *See* AMA, *Medical Liability Reform*, *supra* note 4, at 7.
[24] *See* CBO, *Tort Reform, supra* note 14, at 12-13 (*citing* Daniel Kessler & Mark McClellan, *Malpractice law and health care reform: optimal liability policy in an era of managed care*, 84 J. of Pub. Econ. 175, 175-197 (2002)).
[25] CBO, *Tort Limits*, *supra* note 14, at 23.
[26] AMA, *Medical Liability Reform*, *supra* note 4, at 9 (*citing* Ronen Avraham et al., *The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums*, J.L. Econ. & Org., 1 & 24 (Dec. 2010), *available at* http://ssrn.com/abstract=1441903.
[27] *See* U.S. Congress, Congressional Budget Office, *Letter to Senator Hatch*, 3 (Oct. 9, 2009), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/

cost of medical liability lowered health care expenditures."[28] Moreover, CBO currently estimates that the "nation's direct costs for medical malpractice . . . would be reduced by about 10 percent . . . if the common package of tort reforms [were] implemented nationwide," increasing CBO's earlier estimate of six percent.[29]

In 2012, CBO determined that the proposed federal tort reforms would:

> lower costs for health care both directly and indirectly: directly, by lowering premiums for medical liability insurance; and indirectly, by reducing the use of health care services prescribed by providers when faced with less pressure from potential malpractice suits. Those reductions in costs would, in turn, lead to lower spending in federal health programs and to lower private health insurance premiums.[30]

C. Physicians provide more care options in states with noneconomic damages caps and do not relocate from those states to avoid liability claims.

Because physicians know lawsuits are inevitable, fear influences their practices.[31] In 2002, "[m]ore than three-fourths of physicians believed that concern about medical liability litigation negatively affected their ability to provide quality care."[32] In 2008, more than 60 percent of physicians nationally agreed with the

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106xx/doc10641/10-09-tort_reform.pdf.

[28] *See id*.

[29] *See* U.S. Congress, Congressional Budget Office, *Letter to Senator Rockefeller*, 4 (Dec. 10, 2009), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/108xx/doc10802/12-10-medical_malpractice.pdf.

[30] *See* U.S. Congress, Congressional Budget Office, *Cost Estimate for H. Con. Res. 112: Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2011* 1 (April 26, 2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/HelpEfficientAccessibleLow-costTimelyHealthcareActof2011_0.pdf.

[31] *See* AMA, *Medical Liability Reform*, *supra* note 4, at 4.

[32] *Id*. at 10.

statement, "I order some tests or consultations simply to avoid the appearance of malpractice."[33]

As an example, in a 2012 American Congress of Obstetricians and Gynecologists ("ACOG") survey, over half the obstetricians/gynecologists ("Ob/Gyn") respondents indicated they have made changes to their practices because of the affordability/availability of professional liability insurance and fear of professional liability claims.[34] Specifically, a significant percentage of Ob/Gyns have decreased the number of high-risk patients they treat and have stopped performing VBACs.[35] Between 5-6% percent of Ob/Gyns who reported making changes to their practice have stopped practicing obstetrics altogether because of liability issues.[36] They stopped practicing obstetrics, on average, at 48.8 years of age, the former midpoint of an Ob/Gyn's professional career.[37]

A state's medical malpractice liability environment is also a major factor in its ability to retain physicians.[38] Forty-five percent of hospitals report "that the professional liability crisis" has resulted in physician loss or reduced emergency

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[33] *Id.* at 4.
[34] *See* Jeffrey Klagholz & Albert Strunk, *Overview of the 2012 ACOG Survey on Professional Liability* 5, *available at* http://www.acog.org/About_ACOG/ACOG_Departments/Professional_Liability/~/media/Departments/Professional%20Liability/2012PLSurveyNational.pdf.
[35] *See id.* "VBAC" refers to "vaginal birth after c-section." The result is that after a woman has a c-section, many doctors will not treat a woman who desires subsequent vaginal births out of fear of liability.
[36] *See id.*
[37] *See id.*
[38] *See* AMA, *Medical Liability Reform*, *supra* note 4, at 5.

coverage.[39] In a 2010 Illinois study, almost one-half of graduating Illinois residents and fellows were leaving the state to practice medicine elsewhere, citing Illinois' medical malpractice liability environment as a major consideration in the decision to depart.[40] The study indicated that "[m]alpractice insurance rates and the medical liability environment are contributing to Illinois' reputation of not being a physician-friendly state."[41]

However, states adopting direct tort reforms have increased their physician pool by 3.3 percent relative to non-reform states.[42] States with noneconomic damages caps also retain more physicians in "high-risk" specialties; they have four-to-seven percent more physicians per capita than states without caps.[43]

III. Since Damages Caps Have Been Implemented, Utah's Health Care Costs Have Remained Among the Lowest in the Nation.

The Utah Legislature has been actively concerned with rising health care costs for many years, passing the Utah Health Care Malpractice Act in 1976. Section 78B-3-403 of the Act explains the Legislature's concerns and its policy objectives:

> The legislature finds and declares that the number of suits and claims for damages and the amount of judgments and settlements arising from

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[39] *Id.* at 10.
[40] *See* Northwestern University Feinberg School of Medicine & Illinois Hospital Association. 2010 *Illinois New Physician Workforce Study* 4 (2010), *available at* http://www.ihatoday.org/uploadDocs/1/phyworkforcestudy.pdf.
[41] *Id.* at 5.
[42] *See* D.P. Kessler et al., *Impact of Malpractice Reforms on the Supply of Physician Services*, 2005 JAMA 293(21), 2618-25 (2005).
[43] *See* Jonathan Klick & Thomas Stratmann, *Medical Malpractice Reform and Physicians in High Risk Specialties*, 36 J. Legal Stud. 121, 121-139 (2007).

> health care has increased greatly in recent years. Because of these increases the insurance industry has substantially increased the cost of medical malpractice insurance. The effect of increased insurance premiums and increased claims is increased health care cost, both through the health care providers passing the cost of premiums to the patient and through the provider's practicing defensive medicine because he views a patient as a potential adversary in a lawsuit. Further, certain health care providers are discouraged from continuing to provide services because of the high cost and possible unavailability of malpractice insurance. [¶] In view of these recent trends . . . it is necessary to protect the public interest by enacting measures designed to encourage private insurance companies to continue to provide health-related malpractice insurance . . . . [44]

The legislature has amended the Act multiple times.[45] Utah's cap for noneconomic losses now stands at $450,000.[46] While still allowing a substantial recovery, the result of the predictability created by the cap is that Utah is one of 11 states with the lowest average payments for malpractice claims.[47] Consequently, in 2012, Utah had the largest medical malpractice insurance rate reduction in the western states—8.39%.[48]

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[44] *See* Utah Code § 78B-3-403.
[45] *See* U.C.A. §§ 78B-3-401 to -425.
[46] *See* U.C.A. § 78B-3-410(1)(d).
[47] Peter P. Budetti, The Henry J. Kaiser Family Foundation, *Medical Malpractice Law in the United States* 22 (2005), *available at* http://truecostofhealthcare.org/yahoo_site_admin/assets/docs/Medical-Malpractice-Law-in-the-United-States-Report.35212040.pdf.
[48] Chad C. Carls, *Becalmed & Bewildered: When Will the Professional Medical Liability Market Break Out of the Doldrums, Begin to Harden?*, Medical Liability Monitor, Vol. 37 No. 10, 3 (Oct. 2012), *available at* http://www.thehybridsolution.com/articles/MedicalLiabilityMonitor2012.pdf.

The cap is a critical factor in Utah's having the lowest health-care spending per capita of all 50 states.[49] Utah also has the lowest hospital care and physician and clinical services spending of all 50 states.[50] And it is the fourth lowest spending state in prescription drugs and other nondurable medical product spending.[51]

Moreover, while other states are seeing physicians retire early or flee, Utah's physicians tend to practice longer. A 2012 study of Utah doctors found a four-fold *decrease* since 2003 in the number of physicians wanting to retire early.[52] Since 2003, Utah's primary care workforce has grown by 37%, and its specialty workforce has grown by 32%.[53] In contrast with other states, Utah currently "has no problem meeting its physician workforce needs."[54] And in our experience, Utah patients do not have significant problems accessing most high-risk procedures, in contrast with other states.

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[49] *See* Louise Radnofsky, *Health-Care Costs: A State-by-State* Comparison, The Wall Street Journal, April 8, 2013, *available at* http://online.wsj.com/article/SB10001424127887323884304578328173966380066.html#project%3DIVCostsprint%26articleTabs%3Dinteractive.

[50] *See id*.

[51] *See id*.

[52] *See* Sri Koduri, The Utah Medical Education Council, *Utah's Physician Workforce, 2012: A Study on the Supply and Distribution of Physicians in Utah*, E.S.1 & 9 (2012), *available at* http://www.utahmec.org/uploads/files/75/2012-Physician-Workforce-Report.pdf.

[53] *See id*. at E.S.2.

[54] *See id*.

CONCLUSION

The noneconomic damages cap in Utah Code section 78B-3-410(1)(c) plays an essential role in controlling Utah's health care costs. Amici do not argue that the cap is the only reason for Utah's successful approach, but there is no question that it is vital to controlling health care costs. Holding that the cap does not apply under the facts of this case, or striking it down as unconstitutional in wrongful death actions, would be a serious blow to Utah health care, rendering the cap ineffective. Amici urge this Court to uphold the cap and apply it to this case.

DATED this _____ day of November 2013.

KIRTON McCONKIE

_____

Merrill F. Nelson
Alexander Dushku
Tiffany Smith
Attorneys for Amici Curiae
Utah Hospital Association
Utah Medical Association
American Medical Association
UMIA, Inc.

CERTIFICATE OF SERVICE

I hereby certify that on the _____ day of November 2013, I caused a true and correct copy of the foregoing **BRIEF OF AMICI CURIAE UTAH HOSPITAL ASSOCIATION, UTAH MEDICAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AND UMIA, INC.** to be mailed through United States mail, postage prepaid, to the following:

George T. Naegle
Zachary E. Peterson
Cortney Kochevar
RICHARDS BRANDT MILLER NELSON
PO Box 2465
Salt Lake City, UT 84110-2465

Michael D. Zimmerman
Troy L. Booher
Noella A. Sudbury
ZIMMERMAN JONES BOOHER LLC
136 South Main Street, Suite 721
Salt Lake City, UT 84101

Donald J. Winder
John W. Holt
Jerald V. Hale
WINDER & COUNSEL, P.C.
460 South 400 East
Salt Lake City, UT 84111

Paul M. Simmons
DEWSNUP KING & OLSEN
36 S. State Street, Suite 2400
Salt Lake City, UT 84111

James R. Hasenyager
Peter W. Summerill
HASENYAGER & SUMMERILL
1004 24th Street
Ogden, UT 84401

Ryan M. Springer
G ERIC NIELSON & ASSOCIATES
4790 S. Holladay Blvd.
Holladay, UT 84117

Matthew J. Morrison
Andrew Tuegel
HARRISON DAVIS STEAKLEY MORRISON, P.C.
5 Ritchie Road
Waco, TX 76712

Peter W. Summerill
HASENYAGER & SUMMERILL
1004 24th Street
Ogden, UT 84401

Lloyd A. Hardcastle
SCHWAB & HARDCASTLE, LLC
200 West 225 South, Suite 303
P.O. Box 118
Farmington, UT 84025

_____