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Colorado Court of Appeals, No. 22CA1502 (Opinion by Lipinsky, J., joined by Welling, J. and Gomez, J.) Weld County District Court, No. 19CV30976 Hon. Todd L. Taylor	▲ **COURT USE ONLY** ▲
Defendant/Petitioner: BANNER HEALTH d/b/a NORTH COLORADO MEDICAL CENTER, **v.** **Plaintiffs/Respondents:** C.G., INDIVIDUALLY, ERIN GRESSER, INDIVIDUALLY, and CHANCE GRESSER and ERIN GRESSER, as parents, natural guardian, next of friend and on behalf of their daughter, C.G.	Case No. 2023SC959
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BRIEF OF *AMICUS CURIAE* AMERICAN ASSOCIATION FOR JUSTICE IN SUPPORT OF PLAINTIFFS/RESPONDENTS

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with all relevant requirements of C.A.R. 28, 29, and 32, including all formatting requirements set forth in these rules. Specifically, I attest that this brief contains 4,629 words, which is less than the word limit in C.A.R. 29(d) (4,750 words), including headings, quotations, and footnotes, but excluding the caption, certificate of compliance, table of contents, table of authorities, signature block, and certificate of service.

I acknowledge that this Court may strike this brief if it does not comply with any of the requirements of C.A.R. 28, 29, and 32.

/s/ *Nelson Boyle*

Nelson Boyle, Reg. No. 39525

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IDENTITY AND INTEREST OF *AMICUS CURIAE*

The American Association for Justice ("AAJ") is a national, voluntary bar association established in 1946 to strengthen the civil justice system, preserve the right to trial by jury, and protect access to the courts for those who have been wrongfully injured. With members in the United States, Canada, and abroad, AAJ is the world's largest plaintiff trial bar. AAJ members primarily represent plaintiffs in personal injury actions, employment rights cases, consumer cases, and other civil actions, including medical malpractice claims filed on behalf of Coloradan patients and their families. Throughout its 78-year history, AAJ has served as a leading advocate for the right of all Americans to seek legal recourse for wrongful conduct.

The American Association for Justice, whose core mission is to preserve the constitutional right to trial by jury for all Americans, believes that the court below, after finding that application of the Health Care Accountability Act's cap on damages would be unfair in this case, properly awarded additional damages in the amount determined by the jury based on the evidence.

ARGUMENT

I. NEITHER IMPOSING NOR EXPANDING CAPS ON RECOVERABLE DAMAGES IN MEDICAL MALPRACTICE ACTIONS CAN REDUCE MALPRACTICE INSURANCE COSTS BECAUSE MARKET FORCES CAUSE PREMIUMS TO RISE AND FALL.

A. The General Assembly's HCAA Objective of Lowering Malpractice Insurance Premiums Should Not Justify Even Greater Barriers to Holding Negligent Providers Accountable for the Full Harm They Inflict.

In 1988 the General Assembly enacted the Health Care Availability Act (HCAA) to "contain[] the significantly increasing costs of malpractice insurance for medical care institutions and licensed medical care professionals." § 13-64-102(1), C.R.S. 2023. To that end, the HCAA limits the total damages awardable against health care professionals or institutions to $1 million. § 13-64-302(1)(b), C.R.S. 2023. The legislature acted on the belief that lower liability payments would lead insurers to voluntarily reduce the premiums paid by doctors and hospitals, which in turn would "increase the availability of health care" in Colorado. *Scholz v. Metro. Pathologists, P.C.*, 851 P.2d 901, 907 (Colo. 1993).

The HCAA also provides that "upon good cause shown" that imposing the cap "would be unfair," the court may award "additional past and future economic damages." § 13-64-302(1)(b). The narrow question

presented here is whether the trial court may award additional damages in the amount determined by the jury based on the evidence, as the appellate court held. See COA ¶ 5. AAJ agrees with plaintiffs and *amicus* Colorado Trial Lawyers Association that the statutory text and legislative history fully support the decision below.

AAJ addresses this Court regarding the broader, policy-based arguments advanced by the *amici* supporting Banner Health. *See* Brief of *Amici Curiae* Colorado Medical Society and American Medical Association in Support of Petitioner ["AMA Br."]; and Brief of *Amicus Curiae* Coloradans Protecting Patient Access in Support of Petitioner ["CPPA Br."]. Those briefs argue that the General Assembly's objective of lowering premiums should persuade this Court to clothe negligent health care providers with even greater immunity from accountability for the full harm they cause.

Specifically, the defense *amici* would require trial courts to make their own determination of damages that would be less than the jury's award. AMA Br. 4 (proposing that a trial court "reach a fair middle ground" between the statutory limit and the jury's verdict); CPPA Br. 6. (This Court "should adopt a test considering the totality of the

circumstances" for trial courts to make their own finding of damages). In addition, CPPA urges this Court to rewrite the HCAA to preclude plaintiffs like the Gressers from benefitting from using special needs trusts. *See* CPPA Br. 16–17 (proposing that any benefit a severely disabled plaintiff may obtain by establishing a special needs trust be credited to defendant). CPPA also proposes allowing a defendant "a set-off based on a plaintiff's third-party health insurance benefits." *Id.* at 17–18.

AAJ submits that depriving medical negligence victims of full compensation does not lower malpractice premiums for providers or the cost of health care for Coloradans. Defense *amici*'s proposals would simply increase the unfairness of the cap to the victims of medical malpractice in Colorado and undermine the quality of health care for all Coloradans.

B. Periodic Medical Malpractice Insurance "Crises" Are Not Caused by Rising Jury Awards, But by the Liability Insurance Industry's Own Irresponsible Marketing and Investment Actions During Ordinary Business Cycles.

The HCAA was enacted in the 1980s in response to complaints by health care providers of "rising costs of malpractice insurance premiums in Colorado." *Scholz*, 851 P.2d at 907.

The defense *amici* recite to this Court the same narrative that tort reform proponents presented to the General Assembly at that time: Due to high malpractice awards, "insurance companies are forced to raise premiums for healthcare providers . . . [which] puts financial strain on medical practices, increasing the costs of practicing medicine and providing access to quality care in Colorado." CPPA Br. 20–21. Capping damages, the lawmakers were told, "will lead to lower insurance premiums [and] higher physician supply." AMA Br. 17. Based on those claims, the General Assembly determined that limiting plaintiffs' recoverable damages would ensure the availability of health care in Colorado by reducing the costs of malpractice insurance. *See* § 13-64-102(1), C.R.S. 2023.

The malpractice insurance crisis at the time was, in fact, not due to an out-of-control civil justice system. One early indicator was that state after state enacted damages caps, but the lower premiums promised by the insurance industry did not materialize. Often premiums went *up*.

In November 1975, only a few months after California became the first state to adopt a medical malpractice damages cap, the state's malpractice insurers levied huge premium increases of over 400 percent.

Todd M. Kossow, Note, Fein v. Permanente Medical Group*: Future Trends in Damage Limitation Adjudication*, 80 Nw. U. L. Rev. 1643, 1649, 1649 n.48 (1986). Premiums in California continued to rise sharply during the next decade. *Case Study on California*, *in* U.S. General Accounting Office, Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms 12, 22 (Dec. 1986), https://www.gao.gov/assets/hrd-87-21s-2.pdf. Rates stabilized only after the state enacted strict insurance regulation demanded by the voters in 1988 when they approved Proposition 103. *See generally* Found. for Taxpayer and Consumer Rts., Rate Regulation: The Rx For Medical Malpractice Insurance Rates (2013), https://consumerwatchdog.org/wp-content/uploads/2021/03/2021-03_RateRegulationReport.pdf.

In 1987, the year after the Florida legislature enacted its noneconomic damages cap, Florida's largest malpractice carriers filed for an increase in premiums. *See* Jay Angoff, *Insurance Against Competition: How the McCarran-Ferguson Act Raises Prices and Profits in the Property-Casualty Insurance Industry*, 5 Yale J. on Reg. 397, 400–01 (1988). Shortly after Texas enacted its cap on medical malpractice awards in 2003, Medical Protective Co., its largest carrier, filed a request

with the Texas Department of Insurance for a 19 percent rate increase. Darrin Schlegel, *Some Malpractice Rates to Rise Despite Prop. 12*, Houston Chron., Nov. 19, 2003.

Erasing large medical malpractice jury awards did not bring down doctors' insurance premiums because large jury awards were never the driving force.

The sharp rise in the price of medical malpractice insurance during the mid-1980s, which prompted the enactment of the HCAA in Colorado, resembled similar premium spikes in the mid-1970s, and again in the early 2000s. In the years between those "hard" markets, premiums declined substantially. Americans for Insurance Reform, a coalition of nearly 100 consumer and public interest groups, studied insurance data covering this period. The study found that "total payouts [to malpractice victims] over the last four decades have never spiked and have generally tracked the rate of inflation." J. Robert Hunter & Joanne Doroshow, Ams. for Ins. Reform, Stable Losses/Unstable Rates 2016 2 (Nov. 2016), https://centerjd.org/content/stable-losses-unstable-rates-2016.
Malpractice insurance premiums, on the other hand, followed a rollercoaster path. The "sudden 'hard market' rate hikes" in the mid-

1970s, mid-1980s, and early 2000s, "did not track malpractice claims or payouts whatsoever," but closely followed the ups and downs of the business cycle in the larger economy. *Id.*

Professor Tom Baker offers a clear and even-handed description of this cyclical behavior: A medical malpractice liability insurance company consists of two enterprises, whose teams are often in tension. Its underwriters issue indemnity coverage against liability, based on actuarial principles, for which the company collects premiums; its investment team invests those premiums until the company must pay out an insured loss—often many years. Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DePaul L. Rev. 393, 410–12 (2005).

That income is often substantial. During the soft market of about 1977 to 1984, investment income more than offset underwriting losses. David J. Nye et al., *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 Geo. L.J. 1495, 1521 (1988). An insurer's financial health is tethered to its investment prospects, which rise and fall in a pattern of economic expansion, followed by recession and recovery, that appears to repeat

roughly every 10 to 15 years. *See* Stable Losses/Unstable Rates, *supra*, at 4–11.

The AMA itself has in recent years come to acknowledge that investment losses are the triggers for "hard" markets for malpractice insurance. A recent forecast of malpractice insurance trends stated,

> [W]e were already in the early stages of a hard market in 2020, as insurers started raising premiums in response to deteriorating underwriting results, lower loss reserve margins, and lower returns on investment. Thus, it was expected that insurers would sustain or even push for higher premiums in 2021.

José R. Guardado, Policy Research Perspectives: Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Fourth Year in a Row (Am. Med. Ass'n ed., 2023), https://www.ama-assn.org/system/files/prp-mlm-premiums-2022.pdf (citation omitted).

Business cycles and their impact on the insurance industry are well known and should be manageable for large and well-resourced insurance enterprises adhering to sound underwriting principles. The industry experiences periodic "crises" due to insurers' own irresponsible conduct during the "soft market" years of optimistic investment prospects, when insurers compete for premium dollars to invest by cutting prices and

relaxing underwriting standards.[1]

The early to mid-1980s was such a time. Industry observers warned that by the end of 1980, "the lessons of the last downturn are being forgotten" and insurers cut prices by 10, 15, and even 50 percent on some risks. *A Rate War Rips Casualty Insurers*, BusinessWeek, Dec. 8, 1980. When the business cycle turns, as it inevitably does, insurers find that their reserves may not be sufficient to meet the indemnity obligations on their cut-rate policies. When the underwriters hiked premiums sharply in the mid-1980s, Business Week correctly diagnosed the cause:

> For many years, insurance carriers slashed premium prices and wrote as much insurance as they could get. Many companies abandoned traditional underwriting standards and competed fiercely for premium dollars they could invest in high-yield debt. This so-called cash-flow underwriting is probably responsible for most of the damage to company balance sheets today. The party ended when interest rates declined just as claims began to pour in. . . . With careful management, these mistakes can be corrected. But instead, the industry has spent most of its time and energy lately mobilizing attacks on the U.S. tort system.

BusinessWeek, Mar. 10, 1986.

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[1] "The insurance underwriting cycle . . . consists of alternating periods in which insurance is priced below cost (a "soft" market) and periods in which insurance is priced above cost (a "hard" market)." Baker, *supra*, at 396.

An American Bar Association blue-ribbon commission came to the same conclusion: The "violent cyclical swings of boom and bust, profitability and loss" were occasioned by economic downturns and low interest rates that forced insurance companies that had previously set premium rates "unrealistically low because of the hugely favorable investment climate" to "raise[] their rates dramatically." Robert B. McKay, *Rethinking the Tort Liability System: A Report from the ABA Action Commission*, 32 Vill. L. Rev. 1219, 1219–21 (1987).

The National Association of Insurance Commissioners, following its own investigation, agreed that poor planning and regulation of the property/casualty insurance market, not the tort system, was responsible for the industry's cyclical "crises." Nat'l Ass'n of Ins. Comm'rs, Cycles and Crises in Property/Casualty Insurance: Causes and Implications for Public Policy (1991), https://naic.soutronglobal.net/Portal/Public/en-US/DownloadImageFile.ashx?objectId=6433&ownerType=0&ownerId=11467.

Professor Baker points out that the "crisis" of the mid-1980s was consistent with the industry's pattern:

> Litigation behavior and malpractice claim payments did not change [to bring about the hard markets of the mid-1970s,

> mid-1980s or early 2000s]. What changed, instead, were insurance market conditions and the investment and cost projections that the insurance market built into medical malpractice insurance premiums over those periods.

Baker, *supra*, at 394.

Rather than formulate and implement plans to break this destructive cycle, the insurance industry devoted its efforts and resources to blaming patients, trial lawyers, jurors, and courts. When premium rates began to climb sharply in the mid-1980s, the Insurance Information Institute, the industry's public relations arm, announced a $6.5 million national advertising campaign to "change the widely held perception of an insurance crisis to a perception of a lawsuit crisis." Alan Herbert, *Tort Reform Drive Launched*, J. Com., Mar. 19, 1986, at 1, 20. *See also The Manufactured Crisis: Liability Insurance Companies Have Created a Crisis and Dumped It on You*, Consumer Reps., Aug. 1986, at 544. This campaign led to the enactment of a wave of "tort reform" measures across the country, including the HCAA.

II. DAMAGE CAPS HAVE NOT DELIVERED THE PROMISED CURE FOR LOWERING MALPRACTICE INSURANCE PREMIUMS.

The AMA proclaims that caps "have worked" in Colorado. AMA Br. 16. One would expect that the AMA would support this confident claim

with convincing evidence that § 13-64-302(1)(b) has reduced malpractice insurance premiums for Colorado doctors and hospitals as promised, leading to more available health care for their patients.

Instead, the AMA proclaims that Coloradans have enjoyed improved access to health care because the doctors in this state did not go on strike. *Id.* The AMA identifies a single year, 2007, when COPIC announced it would not raise rates for Colorado doctors. *Id.*[2]

The AMA also highlights a federal study which found that in 2001, Colorado insurers had a loss ratio far less than that of states without caps. *Id.* at 16 n.2. Loss ratio represents losses paid plus expenses divided by total premiums. *See, e.g.*, Adam Hayes, *Loss Ratio: What It Is, How It's Calculated, Types*, Investopedia (June 7, 2024), https://www.investopedia.com/terms/l/loss-ratio.asp. The smaller loss ratio after the cap had been in place for more than a decade indicates

[2] COPIC Insurance Co. provides coverage for 80 percent of Colorado's physicians. COPIC responded to the enactment in 2003 of the noneconomic damages cap by raising its rates by an average of 15.9 percent in 2005 and a smaller percentage in 2006. *See Change in Insurance Rates*, Am. Coll. of Emergency Physicians, https://www.acep.org/state-advocacy/liability-reform/state-by-state-comparison-on-liability-reforms-and-market-conditions/state-by-state-liability-reforms/change-in-insurance-rates (last visited Jan. 29, 2025).

that insurers have been reducing their losses by paying out less to the victims of malpractice, but have not been reducing premiums for their policyholders. It is not surprising that when insurance companies are not compelled to pass along their savings to their insureds, they "happily pay less out in tort-reform states while continuing to collect higher premiums from doctors and encouraging the public to blame the victim or attorney." *Zeier v. Zimmer, Inc.*, 152 P.3d 861, 870 (Okla. 2006).

A study of closed claims data in Texas disclosed that enactment of the Medical Malpractice and Tort Reform Act of 2003, imposing a hard cap of $250,000 on noneconomic damages, resulted in a substantial drop in malpractice payments to patients; "yet the premiums that [the state's largest malpractice insurer] charged remained well above pre-cap levels." Bernard S. Black et al., Medical Malpractice Litigation: How It Works and Why Tort Reform Hasn't Helped 115 (Cato Inst. ed., 2021).

Florida also enacted a cap on noneconomic damages in 2003. The Florida Supreme Court subsequently reported that, from 2003 to 2010 the state's largest medical-malpractice insurers enjoyed "an increase in their net income of *more than 4300 percent*," but did not pass along those savings to Florida physicians. *Estate of McCall v. United States*, 134 So.

3d 894, 914, 914 n.10 (Fla. 2014) (emphasis in original).

There is little evidence that caps have lowered malpractice premiums nationwide either. The AMA cites its own advocacy piece, "Medical Liability Reform Now!," which is not empirical research. The AMA also points to an HHS release arguing in favor of the Bush Administration's national tort reform proposals. AMA Br. 19 (citing U.S. Dep't of Health & Human Servs., Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System 15 (July 24, 2002), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//40241/litrefm.pdf). But even that study acknowledged: "Among the states with the highest average medical malpractice insurance premiums are Florida, Illinois, Ohio, Nevada, New York, and West Virginia." HHS, *supra*, at 12. Four of those states, excepting New York, had caps on damages. *Id.*

Finally, the AMA adds that "[o]ne study found internal medicine premiums were 17.3% lower in states with limits on damages." AMA Br. 19 (citing Meredith L. Kilgore et al., *Tort Law and Medical Malpractice Insurance Premiums*, 43 Inquiry 255, 265 (2006)). The study does not suggest that premiums were lower for all medical providers generally, or

even for most doctors. Most importantly, the study does not state that caps actually caused premium rates to be lower, as opposed to state-to-state differences in insurance regulation, taxation, and other factors. Most importantly for the case at bar, the study found that *states with caps above $500,000 actually experienced increases* in malpractice insurance premiums. Kilgore et al., *supra*, at 266.[3]

A comprehensive empirical study by the independent insurance analysis firm Weiss Ratings, Inc. found that imposing a ceiling on malpractice damages did not reduce medical malpractice insurance premiums. Martin D. Weiss et al., Medical Malpractice Caps: The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage 3 (Weiss Ratings, Inc. ed., 2003), https://www.dcinjuryfacts.com/files/medicalmalpracticecaps.pdf.

To the contrary, "doctors in states with caps actually suffered a significantly larger increase than doctors in states without caps." *Id.* at. 8. Median annual premiums went up by 48.2 percent in states with caps

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[3] The authors also found "a strong and highly significant [connection] between premiums and the Dow Jones industrial average," which "suggest[s] that malpractice premiums do depend, in part, on investment returns." *Id.* at 264.

but only 35.9 percent in states without caps. *Id.* at 3. Dr. Weiss concluded that capping damages "produced the worst of both worlds: the sacrifice by consumers plus a continuing—and even worsening—crisis for doctors. Neither party derived any benefit whatsoever from the caps." *Id.* at 14.

Another study observed that profit for malpractice insurance companies "on average across all states, has soared since 2000, but has done so with special strength" in states that have recently adopted caps. Further, that study found that states that had enacted caps saw *higher* insurance rates for physicians. Bernard S. Black, Jeffrey Traczynski, & Victoria Udalova, *How Do Insurers Price Medical Malpractice Insurance?* (IZA Inst. of Lab. Econ., Discussion Paper No. 15392, June 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4151271.

A detailed study of closed claim data concluded, "one outcome of tort reform, in both Texas and the other new-cap states, was a soaring ratio of med mal premia to payouts." Charles Silver et al., *Fictions and Facts: Medical Malpractice Litigation, Physician Supply, and Health Care Spending in Texas Before and After H.B. 4*, 51 Tex. Tech L. Rev. 627, 661 (2019). That is, the cap reduced payments to malpractice victims, but insurers kept much of those savings. Even when, years later, insurers

lowered premiums somewhat, *id*. at 662, the ratio for Texas malpractice insurers remained "among the highest in the nation." *Id*. at 630.

Experience has shown that depriving malpractice victims of the full measure of damages they need for medical care does not cause providers' malpractice insurance premiums to go down. Nor can that rationale justify disregarding the plain language of § 13-64-302(1)(b) to increase the deprivations visited upon malpractice victims by the HCAA.

III. THE HCAA CAP ON DAMAGES UNFAIRLY IMPOSES THE COSTS OF SAFEGUARDING THE COLORADO HEATH CARE SYSTEM ON THE SHOULDERS OF THE MOST SEVERELY HARMED VICTIMS OF MEDICAL NEGLIGENCE WHILE ERODING THE FINANCIAL INCENTIVES FOR MAKING HEALTH CARE SAFER.

The twin purposes of medical malpractice liability—and of tort law generally—are the fair compensation of the victims of "socially unreasonable" conduct and the deterrence of such conduct in the future. William L. Prosser, Handbook of the Law of Torts § 1 (4th ed. 1971). *See, e.g.*, *Town of Alma v. AZCO Const. Inc.*, 10 P.3d 1256, 1262 (Colo. 2000). Capping the damages awardable to victims of medical malpractice undermines both objectives.

A. Limiting Recoverable Medical Expenses Unfairly Imposes the Cost of Solving the Malpractice Insurance Crisis on the Most Severely Harmed Malpractice Victims.

The defense *amici* speak a great deal about making awards "not unfair." AMA seeks to convince this Court that reducing plaintiff's award to less than the amount required to meet her future medical expenses "is not unfair to the parties and protects the health care system as a whole." AMA Br. 4.

In the AMA's view, a $25 million award for past and future economic damages is categorically "unfair to the defendant." AMA Br. 13. The jury found that Banner's negligence caused baby Gresser's severe injuries. Ct. App. ⁋ 9. Her past medical expenses were over $2.5 million, *id.*at ⁋ 22, and the medical costs of treating and caring for her for the rest of her life will reach $22,712,545. *Id.* at ⁋ 71. Banner Health is a corporation whose annual revenues are in the billions and growing. There is no "fairness" in requiring plaintiffs to donate a portion of the compensation a jury awarded to fund their future medical needs to the defendants who harmed those plaintiffs solely to ease the pain to those defendants' bottom lines.

The AMA responds that "not unfair" has nothing to do with whether

the award is just, impartial, or supported by the evidence. AMA Br. 11. Large awards are always "unfair," and must be reduced "even when not individually excessive under the facts of a given case," in order to "protect[] the health care system as a whole." AMA Br. 3, 4. *See also* CPPA Br. 14 (stating the cap's purpose is "to contain costs and prevent exodus of medical professionals for the benefit of all Coloradans").

Accepting that "the effort to increase the availability of health care is . . . a legitimate governmental interest," *Scholz*, 851 P.2d at 907, and even assuming for the moment that imposing a ceiling on recoverable malpractice damages could achieve that goal, it is unconscionable to demand that the small number of very seriously injured victims of malpractice subsidize that public benefit.

A cap on damages, by its nature, turns the entire premise of liability insurance on its head. As California Chief Justice Rose Bird explained:

> There is no logically supportable reason why the most severely injured malpractice victims should be singled out to pay for social relief to medical tortfeasors and their insurers. The idea of preserving insurance by imposing huge sacrifices on a few victims is logically perverse. Insurance is a device for spreading risks and costs among large numbers of people so that no one person is crushed by misfortune. . . . In a strange reversal of this principle, the statute concentrates the costs of the worst injuries on a few individuals

Fein v. Permanente Med. Grp., 695 P.2d 665, 689–90 (Cal. 1985) (Bird, C.J., dissenting).

Jurists around the country have decried this cruel and irrational feature of damage caps. In the words of the New Hampshire Supreme Court, "[i]t is simply unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are most severely injured and therefore most in need of compensation." *Carson v. Maurer*, 424 A.2d 825, 837 (N.H. 1980). The Ohio Supreme Court called it "irrational and arbitrary to impose the cost of the intended benefit to the general public solely upon a class consisting of those most severely injured by medical malpractice." *Morris v. Savoy*, 576 N.E.2d 765, 771 (Ohio 1991).

And, as one dissenting justice reminded his colleagues on Maryland's highest court, "a sad, even tragic" feature of damage caps is that the "tort victims who will be most significantly affected by the cap" are children with permanent injuries "who can be expected to suffer from these injuries over the full seventy-plus years of their probable lifetimes." *Murphy v. Edmonds*, 601 A.2d 102, 120 (Md. 1992) (Chasanow, J., dissenting).

Assuming there is a public good to be pursued or a public "crisis" to be solved by providing financial assistance to providers like Banner, it is the General Assembly's province to make that decision, and it should do so with public funds. In no event should this Court extract the price of this ostensible public benefit by denying future medical care to the most severely harmed victims of poor medical care.

B. Limiting Recoverable Damages Unfairly Reduces Incentives for Insurers and Providers to Provide Coloradans with the Highest Quality Care.

Limiting a provider's potential liability also weakens the law's effectiveness in deterring future harms. Because nearly all liability payments to malpractice victims are made by the provider's malpractice carrier, insurers can play a major role in promoting patient safety. Kenneth S. Abraham & Catherine M. Sharkey, *The Glaring Gap in Tort Theory*, 133 Yale L.J. 2165, 2237 (2024).

For example, in the mid-1980s, anesthesiologists' premiums at Harvard's teaching hospitals, as elsewhere, were among the highest for any specialty. While some in the industry were lobbying heavily for legislative limits on damages, Harvard's insurer undertook a close study of paid malpractice injury claims and "recommended that the hospitals

prescribe new procedures and technologies designed to avoid similar results in the future." Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 Harv. L. Rev. 381, 411 (1994). The hospitals eventually adopted the new standards, with the result that, several years later, "anesthesia-related mishaps and claims had dropped sharply and . . . malpractice premium ratings for Harvard anesthesiologists had been cut in half." *Id.* at 412. *See also* Tom Baker & Charles Silver, *How Liability Insurers Protect Patients and Improve Safety*, 68 DePaul L. Rev. 209, 223 (2019).

But when insurers are shielded by damage caps from potentially large losses, their financial incentives to invest in proactive improvements in patient safety evaporate. A recent study of patient outcomes in states that adopted caps on malpractice damages found "a 15 percent increase in adverse patient safety events" which the authors conclude is "consistent with general deterrence, in which lower liability risk leads providers to invest less in safety and to be less careful in general." Zenon Zabinski & Bernard S. Black, *The Deterrent Effect of Tort Law: Evidence From Medical Malpractice Reform* (Nw. U. L. Sch., Working Paper, Paper No. 13-09 (2021),

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2161362.

Researchers who examined patient outcomes in Texas reported that, using "standard patient safety measures, we find evidence that hospitals made more avoidable errors after the adoption of the caps." Silver et al., *supra*, at 630. The researchers concluded that, compared to states that did not adopt caps, "patient safety declined and physicians paid more premium dollars relative to payouts." *Id*. at 630–31.

Coloradans deserve access to high quality health care. Depriving the most severely injured malpractice victims of the resources necessary to obtain that care is wrong-headed. This court should uphold the trial court's broad discretion to award additional damages under § 13-64-302(1)(b) to avoid inflicting even greater harm.

CONCLUSION

For these reasons, AAJ urges this Court to affirm the decision of the courts below.

Respectfully submitted on January 31, 2025.

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CERTIFICATE OF SERVICE

I certify that on January 31, 2025, a true and correct copy of the above **Brief of *Amicus Curiae* American Association for Justice in Support of Plaintiffs/Respondents** was filed with the Court and served via the Court E-Filing System upon all counsel of record, including:

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