No. S-23-0860

In the Nebraska Supreme Court

VIVIANNE T. MAROUSEK, a minor, by and through her mother, Andrew D. Marousek, and her father, Jacob L. Marousek, as next friends and natural guardians; ANDREA D. MAROUSEK, individually; and JACOB L. MAROUSEK, individually,

Plaintiffs-Appellants,

v.

NEBRASKA PEDIATRIC PRACTICE, INC.; CHILDREN'S HOSPITAL AND MEDICAL CENTER d/b/a/ Children's Specialty Physicians, d/b/a Children's Hospital & Medical Center, and d/b/a Children's Hospital and Medical Center; and HEIDI N. KILLEFER, M.D.,

Defendants-Appellees.

On Appeal from the District Court of Douglas County
Hon. James M. Masteller
Case No. CI 18-00781

BRIEF OF THE AMERICAN ASSOCIATION FOR JUSTICE AND NEBRASKA ASSOCIATION OF TRIAL ATTORNEYS AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS-APPPELLANTS

Mark Richardson #24719
REMBOLT LUDTKE LLP
3 Landmark Centre
1128 Lincoln Mall, Suite 300
Lincoln, NE 68508
(402) 475-5100
mrichardson@remboltlawfirm.com

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STATEMENT OF THE CASE, PROPOSITIONS OF LAW, AND STATEMENT OF FACTS

Amici Curiae adopt the statement of the case, propositions of law, and statement of facts set forth in Appellants' Brief.

NATURE OF INTEREST OF AMICI 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 in Nebraska. 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 Nebraska Association of Trial Attorneys ("NATA") is an organization of lawyers and law students established in 1958 in the State of Nebraska who are dedicated to the preservation of the justice system and the representation of injured persons in civil cases.

ARGUMENT

I. NEBRASKA'S CAP ON TOTAL DAMAGES RECOVERABLE IN MEDICAL MALPRACTICE ACTIONS CANNOT MEET EVEN RATIONAL BASIS SCRUTINY.

Vivianne Marousek was a healthy eleven-month-old when she fell and was placed in Defendants' care. That care was tragically deficient in several ways, causing Vivianne to suffer a series of seizures at home and leading to massive brain damage. She is now blind, unable to walk or communicate, and experiences multiple seizures every day. After a two-week trial, the jury found that Defendants were responsible for this harm, and that the medication

and constant care Vivianne will need to live out her full life expectancy will require $17,500,000, in addition to $3.15 million in expenses to her parents. Appellants' Br. 25–26.

As a result of the cap on damages enacted as part of the Nebraska Hospital-Medical Liability Act, Neb. Rev. Stat. § 44-2801, the lower court excused the medical providers, their insurers, and the Nebraska Excess Liability Fund from paying all but $2.25 million of these costs. But the remaining expenses do not disappear; they must instead be borne by Vivianne and her family. Even where government programs may assist, those subsidies will simply shift the costs of medical negligence from providers who are can increase patient safety, to the taxpayers who cannot.

The particular cruelty of depriving patients like Vivianne of the medical care they need to live was justly condemned by Kansas trial judge Franklin Theis, who characterized his state's cap as "economic euthanasia," with "brain damaged babies and their grieving parents taking the brunt of this 'justice.'" *Kansas Malpractice Victims Coal. v. Bell*, No. 86-CV-1700, 20 (Shawnee Cty. Dist. Ct. Jan. 22, 1988), *aff'd*, 757 P.2d 251 (Kan. 1988) (emphasis added). Under these circumstances, economic damages caps "represent nothing more than the modern-day equivalent of walking the plank." *Id.* at 30.

A. This Court Should Determine Whether the Cap on Medical Malpractice Damages Meets the Rational Basis Standard.

Twenty-two years ago, this Court upheld the medical malpractice damages cap against an equal protection challenge in *Gourley ex rel. Gourley v. Nebraska Methodist Health Sys., Inc.*, 265 Neb. 918, 663 N.W.2d 43 (2003). As this Court determined: "Reducing health care costs and encouraging the provision of medical services are legitimate goals which can reasonably be thought to be furthered by lowering the amount of medical malpractice judgments" so that "a rational relationship exists between the concern and the statutory

means selected by the Legislature to accomplish its goal." *Id.* at 949, 663 N.W.2d at 72.

However, in the decades since this Court handed down its decision in *Gourley*, empirical studies have repeatedly demonstrated that limiting the recoveries of relatively few victims of severe malpractice injuries in order to bring down malpractice premiums and the cost of health care is a link so attenuated as to render the cap arbitrary and irrational.

This Court accords the Legislature broad deference precisely because lawmakers have extensive investigative authority and fact-finding powers. *See Gourley*, 265 Neb. at 943, 663 N.W.2d at 68. But election to office does not confer clairvoyance. Instead, "the constitutionality of a statute predicated upon the existence of a particular state of facts may be challenged by showing . . . that those facts have ceased to exist." *United States v. Carolene Prods. Co.*, 304 U.S. 144, 153 (1938).

The fact that statute was found to have had a rational basis at one time does not make it immune from subsequent scrutiny or a judicial finding that it no longer has a rational relationship to its purpose due to changed circumstances. Indeed, it would be an oddly myopic rule that would bar this Court from making use of what has been learned from two decades of experience and research following the enactment of damage caps here, and in many states across the country.

Amici urge this Court to take a fresh look at the asserted connection between the Legislature's stated objectives and the harm of depriving a small group of severely injured Nebraskans of their full legal remedy. As Appellants contend, the question of whether the cap violates substantive due process when its application deprives the harmed individual of the means necessary to preserve life itself, is "an

issue of first impression" Appellants' Br. 28. Because Vivianne's due process right to life is at stake, heightened scrutiny is appropriate. *Id.* at 33–34. As Amici explain below, the damage cap does not even clear the rational basis bar.

B. The Rational Basis Standard Requires Both a Legitimate Objective and a Factual Basis for Expecting the Legislation to Achieve That Objective.

This Court has held that the rational basis test is satisfied if:

> (1) there is a plausible policy reason for the classification, (2) the legislative facts on which the classification is apparently based may rationally have been considered to be true by the governmental decisionmaker, and (3) the relationship of the classification to its goal is not so attenuated as to render the distinction arbitrary or irrational.

Gourley, 265 Neb. at 947–48, 663 N.W.2d at 71 (citing *Pfizer v. Lancaster Cty. Bd. of Equalization*, 260 Neb. 265, 616 N.W.2d 326 (2000)). The third element is the focus of the rational basis analysis in this case.

At the outset, it is worth addressing the assertion by the State of Nebraska and Excess Liability Fund ["State's Br."] that a successful challenge to the statute requires the challenger to negate "any reasonably conceivable state of facts that could provide a rational basis" for the statute. State's Br. 17–18 (quoting *REO Enters., LLC v. Vill. of Dorchester*, 306 Neb. 683, 692, 947 N.W.2d 480, 487 (2020)).

The key word, of course, is "reasonably." It would be an extraordinarily ephemeral constitutional protection that depended upon the creative imagination of the reviewing court. Fundamental freedoms, such as due process and equal protection, do not operate in a

hypothetical, "conceivable set of facts"; Nebraskans look to these constitutional safeguards to shield them in the real world.

The connection between the statute's means and its ends "must be something more than the exercise of a strained imagination." *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 442 (1982) (Blackmun, J., concurring). The "rational" part of the rational basis test "includes a requirement that an impartial lawmaker could logically believe that the classification would serve a legitimate public purpose." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 452 (1985) (Stevens J., concurring). Even under "the most deferential of standards, we insist on knowing the relation between the classification adopted and the object to be attained." *Romer v. Evans*, 517 U.S. 620, 632 (1996). Therefore, a reviewing court must determine not only that the objective of the statute was legitimate, but also that the lawmakers "rationally could have believed that the provisions would promote that objective." *Kelo v. City of New London*, 545 U.S. 469, 488 n.20 (2005).

The very decision the State relies upon for its contention that "any reasonably conceivable state of facts" will suffice, State's Br. 17–18, makes clear that reasonableness is limited to real-world practicalities. In *REO Enterprises*, this Court applied its three-part analysis to an ordinance requiring tenants to obtain a landlord's guarantee that the landlord would pay any unpaid utility charges. After determining that the village had a legitimate interest in ensuring collection of utility bills, 306 Neb. at 690, 947 N.W.2d at 486, this Court found that the legislative facts in support of imposing the requirement on tenants but not on residential owners (namely, that tenants were more likely to move away), provided a "reasonably conceivable" basis. *Id.* at 692, 947 N.W.2d at 487. The Court then turned to the third prong of review—the relationship between the law's ends and means. On the basis of its own factual inquiry into the costs and practical difficulties of securing payment of unpaid utility accounts from tenants, as compared to owners, this Court concluded that the

additional burden on renters was sufficiently related to the village's stated purpose. *Id.* at 694, 947 N.W.2d at 488.

Although the rational basis test is "the most relaxed and tolerant form of judicial scrutiny" of the legislature's work, *id.* at 948, 663 N.W.2d at 71, it is "not a toothless one." *Mathews v. Lucas*, 427 U.S. 495, 510 (1976). Whether an enactment is likely to achieve its goal in the real world is central to the application of the rational basis test in this case. In theory, Nebraskans could wake up in an alternate universe in which liability insurance companies derive all of their income from premiums, which they use to pay out claims. In theory, reducing expected payouts could allow companies to lower premiums. But we do not live in such a world. In reality, liability insurers depend heavily on investment income—the tail that so frequently wags the dog, and the reason why capping tort recoveries is arbitrary and irrational. *See infra* Part II.

C. Nebraska's Cap on Medical Malpractice Damages Bears No Rational Relationship to Its Legislative Purpose.

Nebraska's legislators endeavored to "[r]educe health care costs . . . by lowering the amount of medical malpractice judgments." *Gourley*, 265 Neb. at 949, 663 N.W.2d at 72. But to accomplish this objective, they presumed that a series of highly unlikely assumptions would come true.

First, the lawmakers assumed that by not paying the full amounts that their insured doctors and hospitals owed to malpractice victims, insurers would save a sufficiently vast sum of money that would, ultimately, curtail health care costs. Secondly, they assumed that those insurers would actually use their savings to lower malpractice insurance premiums. Finally, they assumed doctors and hospitals would pass those lower costs along to their patients.

No reasonable legislator could expect this Rube Goldberg construct to accomplish its goal.

1. The Cap on Damages Recoverable in Malpractice Actions Affects Too Few Cases to Result in Significant Savings.

Nebraska legislators had no reason to believe that capping damages on the few highest awards would result in enough savings to allow malpractice insurers to lower premiums for doctors and hospitals. As this Court noted, "the proponents of the Nebraska statute expressed concern that an insurance crisis existed but admitted that it was likely impossible to know if a cap on damages would solve the problem." *Gourley*, 265 Neb. at 944, 663 N.W.2d at 69.

In contrast, other states required proponents to submit actuarial projections of the effect a cap would have on total liability payouts. Based on such projections, Florida insurers told their state legislators that a damages cap would have an insubstantial impact on claim values and would not reduce 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, 400–02 (1988). Kansas lawmakers similarly heard from actuaries that the impact of their state's cap on health care costs of Kansas patients would be "minuscule." *Bell*, 757 P.2d at 259.

But Nebraska's lawmakers were largely legislating in the dark. Although actuarial projections would have been readily available to the insurers who were lobbying for the cap, that information was not disclosed to Nebraska legislators. As it has turned out, "jury verdicts have exceeded the cap only six times since its advent in 1976." Appellants' Br. 34–35.

2. Legislators Had No Reason to Believe That Insurers Would Use Their Savings to Reduce Malpractice Premiums for Nebraska Doctors and Hospitals.

Quite apart from whether insurance companies would realize significant savings, it is irrational to assume that insurers would automatically pass along those savings to their insured doctors and hospitals in the form of lower premiums. The statute doesn't require them to do so. Malpractice insurance companies are free to use that money for other purposes including investments, advertising, dividends to shareholders, and executive bonuses. And experience has shown 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).

For example, in *Estate of McCall v. United States*, 134 So. 3d 894 (Fla. 2014), the Florida Supreme Court struck down their state's cap on noneconomic damages in wrongful death medical malpractice actions, in part, because the state's largest medical-malpractice insurers enjoyed "an increase in their net income of *more than 4300 percent*" but did not pass those savings along to Florida physicians. *Id.* at 914, 914 n.10. Similarly, a Texas study of closed claims data revealed that, when insurers experienced a drop in paid losses after adopting a damage cap, "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 Institute, 2021) (emphasis added).

Nebraska lawmakers had no reason to expect this state's malpractice insurers to behave differently.

3. *Legislators Had No Reason to Believe That Capping Noneconomic Damages Would Lower Health Care Costs for Nebraska Consumers.*

Proponents promised Nebraskans that lower malpractice insurance premiums would "encourage physicians to enter into the practice of medicine in Nebraska and to remain." Neb. Rev. Stat. § 44-2801. At the same time, the Legislature expected that doctors and hospitals would use their lower premiums to "reduce the cost" of health care for all Nebraskans. *Id.* These anticipated outcomes are plainly contradictory: Either providers are rewarded with higher net incomes or patients are rewarded with lower health care costs.

Even if the savings generated by the cap were distributed among all Nebraskans, the effect on each person's medical bills would be vanishingly small. Consider that while total premiums paid by United States health care providers in 2023 was just under $6.8 billion, *Statement of Income*, in *Annual Statement for the Year 2023 of the Medical Professional Liability Composite* (AM Best ed, 2024), Americans paid $4.6 *trillion* for their health care within that same year. Ctrs. for Medicare & Medicaid Servs., *The Nation's Health Dollar ($4.9 Trillion), Calendar Year 2023* (2024), https://www.cms.gov/files/document/nations-health-dollar-where-it-came-where-it-went.pdf.

At best, the statute would eliminate only the tiny portion of those premiums that would have paid for the jury's award above the cap. That savings, divided among all Nebraskans who received medical care during that time, would be microscopic. *Cf. Bell*, 757 P.2d at 256.

Reliance on the cap as a means to reduce the cost of health care in Nebraska is wholly irrational.

II. MEDICAL MALPRACTICE INSURANCE PREMIUM SPIKES ARE NOT CAUSED BY INCREASES IN LIABILITY AWARDS, BUT BY INSURERS' REACTIONS TO THE BUSINESS CYCLE OF INTEREST RATES AND INVESTMENT RETURNS IN THE BROADER ECONOMY.

A. Medical Malpractice Insurance Premiums Rise and Fall Sharply with the Business Cycle, While Awards to Malpractice Victims Steadily Increase in Line with Inflation.

Throughout the past forty years, researchers have examined the growing body of available data regarding medical malpractice lawsuits and medical malpractice insurance. One conclusion has become clear: The notion that skyrocketing malpractice verdicts cause skyrocketing malpractice insurance premiums and healthcare costs has been a useful lobbyist's talking point, but it is a myth.

While payments to medical malpractice victims have steadily risen over time, they have roughly tracked the rate of inflation in the cost of medical care and inflation in wages to replace lost income—major components of medical malpractice awards. If liability insurers' only income was derived from the premiums they collect, those premiums would also rise steadily in tandem with inflation. But that is not what has happened in the medical malpractice insurance market.

The sharp rise in the price of medical malpractice insurance rates during the mid-1970s—which prompted the Nebraska Legislature to enact the damage cap—resembled premium spikes across the country during the mid-1970s, the mid-1980s, and the early-2000s. In the years between those "hard" markets, premiums paid by doctors and hospitals substantially *declined*. A coalition of nearly 100 consumer and public interest groups studying insurance data from this period concluded that the malpractice premiums insurers charged were entirely unconnected to their losses. J. Robert Hunter & Joanne Doroshow, *Stable Losses/Unstable Rates 2016* 2 (2016), http://centerjd.org/system/files/MasterStablelosses2016F9.pdf. Instead,

"total payouts [to malpractice victims] over the last four decades have never spiked and have generally tracked the rate of inflation." *Id.*

A much larger, ten-year analysis arrived at precisely the same conclusion. Analyzing over 124,000 medical malpractice claims between 2007 and 2016 (approximately 30% of all such claims in the United States,) researchers found a steady "rise in average payments [that] can be fully explained by medical and consumer inflation." Philip G. Peters, Jr., *On the Cusp of the Next Medical Malpractice Insurance Crisis*, 25 J. Health Care L. & Pol'y 133, 139 (2022). But as losses steadily rose during about the same period (from 2007 to 2018), "premiums steadily *declined* by 35% in adjusted dollars." *Id.* at 157.

Over time, malpractice insurance premiums have followed a rollercoaster path, closely tracking the ups and downs of the larger economy's business cycle. Hunter & Doroshow, *supra*, at 2. Nationally, "premiums declined in the early 1990s and then spiked in the early 2000s" but "the average med mal payout grew from 1991 to 2004, roughly in line with the increase in health care spending." Jing Liu & David A. Hyman, *The Impact of Medical Malpractice Reforms*, 16 Ann. Rev. L. & Soc. Sci. 405, 413 (2020). "These findings raise serious doubts about the supposed causal link between litigation trends and premium spikes." *Id.*

B. Empirical Studies Show That Damage Caps Do Not Reduce Malpractice Insurance Premiums and Have No Impact on the Cost of Healthcare.

Each of the three hard-market insurance "crises" was accompanied by strenuous lobbying for "tort reform." *See* Hunter & Doroshow, *supra*, at 5–12. *See also* Tom Baker, *The Medical Malpractice Myth* 3 (2005). Throughout these periods, approximately thirty states enacted damage caps of various types. Nat'l Ass'n of Benefits & Ins. Pros., *Malpractice Damage Caps by State* (2023), https://nabip.org/media/8331/medical_malpractice_cap.pdf.

One early indicator that enacting malpractice damages caps would not bring down malpractice insurance rates was that, across the country, *increases* in malpractice insurance premiums accompanied legislation capping malpractice damages. In state after state, malpractice carriers asked regulators for large increases in premium rates after caps were enacted. *See, e.g.*, Angoff, *supra*, at 400–01 (discussing Florida); Darrin Schlegel, *Some Malpractice Rates to Rise Despite Prop. 12*, Houston Chron., Nov. 19, 2003 (discussing Texas).

For example, only a few months after California became the first state to adopt a cap on noneconomic damages in 1975, the state's malpractice insurers hit doctors and hospitals with premium increases of over 400%. Todd M. Kossow, *Future Trends in Damage Limitation Adjudication*, 80 Nw. U. L. Rev. 1643, 1649 (1986). Premiums continued to rise sharply through the next decade. U.S. Gov't Accounting Off., *Medical Malpractice: Case Study on California* 12, 22 (1986), https://www.gao.gov/assets/hrd-87-21s-2.pdf. *See also* Mark A. Finkelstein, *California Civil Section 3333.2 Revisited: Has It Done Its Job?*, 67 S. Cal. L. Rev. 1609, 1617–18 (1994). Rates only stabilized after California voters insisted the state enact strict insurance regulation. *See generally* Found. for Taxpayer & Consumer Rts., *How Insurance Reform Lowered Doctors' Insurance Rates in California* (Mar. 7, 2003), https://consumerwatchdog.org/resources/1008.pdf.

Nebraska lawmakers specifically looked to the example of Indiana, which had adopted a cap on total medical malpractice damages along with a patient's compensation fund. But after the cap was enacted, researchers found that claim frequency rose, and large claim payments were *higher* than in neighboring states without damage caps. *See* Eleanor D. Kinney et al., *Indiana's Medical Malpractice Act: Results of a Three–Year Study*, 24 Ind. L. Rev. 1275, 1286, 1294–96 (1991), https://journals.indianapolis.iu.edu/index.php/inlawrev/article/view/2926/2850 (highlighting the results of a study of

more than 6,000 malpractice claims filed with the Indiana Department of Insurance from 1975 to 1988).

As to lowering the costs of health care, one study found that, despite Indiana's stringent cap, Indiana and Illinois had similar patterns of health care expenditure inflation, suggesting that Indiana's reforms had not reduced costs. Eleanor D. Kinney, *Indiana's Medical Malpractice Reform Revisited: A Limited Constitutional Challenge*, 31 Ind. L. Rev. 1043, 1048 (1998) (citing David Morrison, *In Search of Savings: Caps on Jury Verdicts Are Not a Solution to Health Care Cost Crisis*, 7 Loy. Consumer L. Rep. 141 (1995)). Another study "found no difference in patterns of health care expenditures . . . in Indiana before and after the Act." Randall R. Bovbjerg, *Lessons for Tort Reform from Indiana*, 16 J. Health Pol. Pol'y & L. 465 (1991).

Other empirical studies using data from numerous states during various time periods confirm that caps have not turned out to be the right cure for rising malpractice premiums and healthcare costs. In one of the earliest inquiries, data from 1974 to 1977 led Vanderbilt professor Frank Sloan to conclude that the economic correlation between average malpractice awards and malpractice premiums was "surprisingly low." Frank A. Sloan, *State Responses to the Medical Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment*, 9 J. Health Politics Pol'y & L. 629, 630 (1985).

A far more comprehensive empirical study by an independent insurance analysis firm later found that imposing a ceiling on malpractice damages did not reduce medical malpractice insurance premiums *at all*. Martin D. Weiss et al., *Medical Malpractice Caps: The Impact of Noneconomic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage* 3 (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. *See also* Bernard Black et al., *How Do Insurers Price Medical Malpractice Insurance?* (IZA Institute of Labor Economics, Discussion Paper No 15392, June 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4151271 (finding that states with caps actually saw *higher* insurance rates for physicians).

Studies looking at health care costs have likewise found that damage caps are no miracle cure. For example, a team of researchers analyzed states that adopted caps in the 1980s and during the "third reform wave" of 2002 to 2005 concluded that "[t]here is, at the least, no evidence that caps reduce healthcare spending." In particular, they found that caps have "no significant impact on Medicare Part A spending" (hospitals), but "a 4-5% post-cap *increase* in Medicare Part B spending" (doctors). Myungho Paik et al., *Damage Caps and Defensive Medicine, Revisited*, 51 J. Health Econ. 84, 84–97 (2017). Similarly, a study that looked at per-person spending between 1996 and 2012 concluded that noneconomic damages caps "have no significant effects on health expenditures." Hao Yu et al., *The Impact of State Medical Malpractice Reform on Individual-Level Health Care Expenditures*, 52 Health Serv. Res. 2018, 2030 (2017), https://pmc.ncbi.nlm.nih.gov/articles/PMC5682133/.

As Columbia Law professor Bernard Black and his colleagues concluded after analyzing 15 years of closed medical malpractice claims in Texas, "much of the rise in premiums reflects *insurance market dynamics, not litigation dynamics*." Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 J. Empirical Legal Stud. 207, 210 (2005), https://scholarship.law.tamu.edu/facscholar/1732 (emphasis added).

Those dynamics are worthy of this Court's attention.

C. Medical Malpractice Insurance Premium Spikes Are the Result of the Insurance Industry's Inability to Cope with the Business Cycle of Interest Rates and Investment Returns in the Broader Economy.

What, then, causes periodic spikes in the price of malpractice liability insurance, such as the "crisis" that prompted the Nebraska legislature to enact the current cap on damages?

As Professor Baker explains:

> 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.

Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DePaul L. Rev. 393, 394 (2005).

These market conditions follow a pattern. "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)." *Id.* at 396.

As Professor Baker and others describe, a liability insurance company actually consists of two enterprises whose teams are often in tension: the company's underwriters issue indemnity coverage based on actuarial principles, for which the company collects premiums, while its investment team invests those premiums until the company must pay out an insured loss—often after many years. *The Medical Malpractice Myth*, *supra*, at 51–58. That income can be substantial. During the soft market period from 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 largely tethered to its investment prospects, which rise and fall in a pattern of economic expansion, followed by recession, and then by recovery. *See* Hunter & Doroshow, *supra*, at 4–11.

During soft markets, interest rates and returns on investment are high. Insurance companies compete for customers to obtain more premium dollars to invest. Investment income increases profits, and sufficient funds are held as reserves to satisfy anticipated future malpractice claim obligations. Trouble arises when the optimistic investment side of the company overrides its more conservative underwriting side, and the insurer too aggressively cuts its prices and underestimates its future obligations. So, the company draws down reserves to obtain more cash to invest.

> Eventually, however, excess reserves are exhausted. . . . A soft market nears its end when these rising costs intersect with shrinking real premiums and the exhaustion of surplus reserves. During that time, insurers are effectively selling coverage below cost. . . . At this point, insurers need to raise premiums and reserves as the market moves from soft to hard.

Peters, Jr., *supra*, at 148. *See also* Hunter & Doroshow, *supra*, at 4 (depicting the "Insurance Economic Cycle" from 1967 to 2013).

Business cycles and their impact on the insurance industry are well-known and should be manageable by large, well-resourced insurance enterprises adhering to sound underwriting principles. But instead of taking steps to prevent drastic price disruptions, the liability insurance industry has repeatedly committed insurance malpractice.

After the "crisis" of the mid-1970s industry observers warned that "the lessons of the last downturn are being forgotten as insurers cut prices by 10, 15, and even 50 percent on some risks." *A Rate War*

Rips Casualty Insurers, BusinessWeek, Dec. 8, 1980. 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.

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, 1221 (1987).

"The dark magic of the insurance cycle is that it converts gradual declines in revenue and gradual increases in expenses into sudden and steep price increases." Peters, Jr., *supra*, at 151. When physicians and hospitals "are told that plaintiff's attorneys and runaway juries are to blame, health care providers add their considerable credibility and political power to that of the insurance industry and lobby for tort reform." *Id.* The resulting legislative actions, including the cap before this Court, lack any rational basis.

III. THE CAP ON DAMAGES IS ARBITRARY AND IRRATIONAL.

A. It Is Fundamentally Unfair to Place the Burden of Keeping Health Care Affordable and Available for Nebraskans on the Most Severely Injured Victims of Medical Malpractice.

This Court described the underlying basis for the Nebraska Hospital-Medical Liability Act's damages cap by quoting the Indiana Supreme Court's decision upholding that state's similar statutory scheme, which "set limitations upon liability, *and placed the burden upon persons injured by the industry*." *Gourley*, 265 Neb. at 949, 663 N.W.2d at 72 (emphasis added). Indiana's rationale? Insurers require subsidization if they are to continue in the state, and that subsidy should be paid by those whose harm is greatest.

> An insurance operation cannot be sound if the funds collected are insufficient to meet the obligations incurred. It must, however, be accepted that the badly injured plaintiff who may require constant care will not recover full damages . . . .

Id. (quoting *Johnson v. St. Vincent Hosp., Inc.*, 404 N.E.2d 585, 599 (Ind. 1980)).

This Court does not "review the wisdom of legislative acts." *Gourley*, 265 Neb. at 943, 663 N.W.2d at 68. But the stated basis for the Nebraska damage cap is beyond unwise, it is irrational.

First, although its drafters relied upon an opt-out provision in the statute to guarantee its constitutionality, the provision is itself unconstitutional. Appellants' Br. 42–43. Meaningful notice is essential to a constitutionally valid waiver of rights, and "a mere gesture is not due process." *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314–15 (1950). On its face, the opt-out provision allows Nebraska patients to seek unlimited damages if they formally notify the state before receiving treatment. But, in practice, many patients are either

wholly unaware of or unable to exercise their right to opt out of the cap. As one legislator emphasized at the time of its enactment, patients have "no possibility of opting out of the act without . . . opting out of [their] potential of getting medical service." Hearing on L.B. 703 Before the S. Comm. on Health, 84th Leg., at 8067 (Neb. Mar. 12, 1976) (statement of Sen. Burrows). This is especially true in rural areas, where patients have limited access to medical care. Indeed, since 1976, only two families have opted out of the cap. Appellants' Br. 43. An opt-out provision that does not provide Nebraskans with proper notice or opportunity cannot transform a fundamentally irrational law into a valid one.

Second, contrary to the Indiana court's supposition, liability insurers generally do quite well, even when the premiums they collect are insufficient to meet their indemnity obligations. The "interest income earned on such investments typically dwarfs actual underwriting profits" and "many insurance companies prosper for years on end while consistently producing underwriting losses." Sean M. Fitzpatrick, *Fear Is the Key: A Behavioral Guide to Underwriting Cycles*, 10 Conn. Ins. L.J. 255, 261 (2004).

Finally, even assuming for a moment that Nebraska's malpractice insurance companies need additional subsidies to keep health care available and affordable for all Nebraskans, it is arbitrary and irrational to demand that the small number of very seriously injured victims of malpractice shoulder the entire cost of this public benefit.

A cap on damages turns the entire premise of liability insurance on its head. As California Chief Justice Rose Bird pointedly observed:

> 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).

Other state supreme courts have come to the same conclusion. As New Hampshire Supreme Court aptly declared, "[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, 836–37 (N.H. 1980). The Ohio Supreme Court agreed, stating "it is 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).

If there is a public good to be had or a public "crisis" to be solved by providing a financial subsidy to health care providers, the Legislature should do so with *public* funds. This Court should not continue imposing the cost of this ostensible public benefit on the most severely harmed victims of poor medical care.

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

It is axiomatic that tort law not only serves to compensate the victims of wrongful conduct, but also to improve the safety of others by deterring similar misconduct in the future.

> [T]he right amount of deterrence is produced by compelling negligent injurers to make good the victim's losses. . . . It is thus essential that the defendant be made to pay damages and that they be equal to the plaintiff's loss.

Richard A. Posner, *Economic Analysis of Law* § 6.12 (1972). Reducing compensatory damages below the full measure of the plaintiff's loss will leave some negligent conduct undeterred. *Id.* This is particularly the case in the medical malpractice context. *See Condemarin v. Univ. Hosp.*, 775 P.2d 348, 364 (Utah 1989).

Professor Gary Schwartz points to the example of hospitals, having been sued after surgical teams left foreign objects in their patients, "prescribing a variety of new operating-room procedures" and installing "computer systems in their operating rooms to assist nurses in keeping track of surgical instruments." Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 U.C.L.A. L. Rev. 377, 399 (1994). Physicians, too, report that potential malpractice liability, as well as continuing medical education and peer review, affects their standard of care in ways that benefit patients. *Id.* at 401–03. In fact, Harvard researchers examining the medical records of 31,000 patients who were hospitalized in New York hospitals found that the monetary value of negligent injuries deterred or prevented by the existence of the medical malpractice regime far exceeds the costs of malpractice lawsuits. *Id.* at 439–40.

Insurers also respond to liability-based incentives. Kenneth S. Abraham & Catherine M. Sharkey, *The Glaring Gap in Tort Theory*, 133 Yale L.J. 2165, 2237 (2024) (describing how liability insurers can and do work with policyholders to reduce risk). For instance, 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).

When a damage cap shields insurers 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," a result the authors found "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*, 84 J. Health Econ. 102638 (2022), https://www.sciencedirect.com/science/article/abs/pii/S0167629622000571?via%3Dihub.

Other researchers who examined patient outcomes in Texas using "standard patient safety measures" found "evidence that hospitals made more avoidable errors after the adoption of the caps." Charles Silver, *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, 630 (2019). The researchers concluded that, compared to states that did not adopt caps, "patient safety [in Texas] declined and physicians paid more premium dollars relative to payouts." *Id.* at 630–31.

Two years before this Court handed down its decision in *Gourley*, West Virginia Chief Justice Warren R. McGraw called upon his court to carefully reconsider its prior decision to uphold that state's cap on damages, cautioning that "[n]o legal principle is ever settled until it is settled right." *Verba v. Ghaphery*, 552 S.E.2d 406, 419 (2001) (McGraw, C.J., dissenting) (internal quote omitted). Amici urge this Court to heed that wisdom, and hold that it is irrational to continue trying to reduce Nebraska's malpractice premiums and healthcare costs by maintaining a damage cap that increases harm to Nebraska patients.

CONCLUSION

For the foregoing reasons, Amici ask this Court to declare the Nebraska Hospital-Medical Liability Act's cap on total damages unconstitutional as arbitrary and irrational.

Respectfully submitted,

Mark Richardson #24719
REMBOLT LUDTKE LLP
3 Landmark Centre
1128 Lincoln Mall, Suite 300
Lincoln, NE 68508
(402) 475-5100
mrichardson@remboltlawfirm.com

Counsel for Amici Curiae

CERTIFICATE OF WORD COUNT

I hereby certify that this brief complies with the type-volume limitation set forth by the ordered entered by this Court on April 4, 2025, because this brief contains 7,995 words, excluding this certificate. Pursuant to Neb. Ct. R. App. P. § 2-103(A)(4), this brief was prepared using Microsoft Word for Microsoft 365 in 12-point Century font.

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/s/ *Mark Richardson*

Mark Richardson #24719
REMBOLT LUDTKE LLP
3 Landmark Centre
1128 Lincoln Mall, Suite 300
Lincoln, NE 68508
(402) 475-5100
mrichardson@remboltlawfirm.com

Counsel for Amici Curiae

Certificate of Service

I hereby certify that on Friday, April 18, 2025 I provided a true and correct copy of this *Brief Amicus NATA and AAJ* to the following:

Jacob L Marousek represented by Joseph Patrick Cullan (22145) service method: Electronic Service to **jhendrix@cullanlaw.com**
Jacob L Marousek represented by Joseph Scott Fox (24581) service method: Electronic Service to **jfox@cullanlaw.com**
Jacob L Marousek represented by Patrick Joseph Cullan (23576) service method: Electronic Service to **jhendrix@cullanlaw.com**

Vivianne T Marousek represented by Joseph Patrick Cullan (22145) service method: Electronic Service to **jhendrix@cullanlaw.com**
Vivianne T Marousek represented by Joseph Scott Fox (24581) service method: Electronic Service to **jfox@cullanlaw.com**
Vivianne T Marousek represented by Patrick Joseph Cullan (23576) service method: Electronic Service to **jhendrix@cullanlaw.com**

Children's Hospital & Med Center represented by Michael Lee Storey (24960) service method: Electronic Service to **jhenderson@ldmlaw.com**
Children's Hospital & Med Center represented by Patrick G Vipond (16390) service method: Electronic Service to **pvipond@ldmlaw.com**
Children's Hospital & Med Center represented by Theresa W Benz (0) service method: **No Service**
Children's Hospital & Med Center represented by William R Settles (19879) service method: Electronic Service to **wsettles@ldmlaw.com**

Children's Physicians represented by Patrick G Vipond (16390) service method: Electronic Service to **pvipond@ldmlaw.com**
Children's Physicians represented by William R Settles (19879) service method: Electronic Service to **wsettles@ldmlaw.com**

Heidi N Killefer M.D. represented by Michael Lee Storey (24960) service method: Electronic Service to **jhenderson@ldmlaw.com**
Heidi N Killefer M.D. represented by Patrick G Vipond (16390) service method: Electronic Service to **pvipond@ldmlaw.com**
Heidi N Killefer M.D. represented by Theresa W Benz (0) service method: **No Service**
Heidi N Killefer M.D. represented by William R Settles (19879) service method: Electronic Service to **wsettles@ldmlaw.com**

Nebraska Pediatric Practice, Inc. represented by Andre Robert Barry (22505) service method: Electronic Service to **abarry@clinewilliams.com**
Nebraska Pediatric Practice, Inc. represented by Michael Lee Storey (24960) service method: Electronic Service to **jhenderson@ldmlaw.com**
Nebraska Pediatric Practice, Inc. represented by Patrick G Vipond (16390) service method: Electronic Service to **pvipond@ldmlaw.com**
Nebraska Pediatric Practice, Inc. represented by Theresa W Benz (0) service method: **No Service**
Nebraska Pediatric Practice, Inc. represented by William R Settles (19879) service method: Electronic Service to **wsettles@ldmlaw.com**

State of NE Department of Insurance represented by Amanda JoLee (26872) service method: Electronic Service to **amanda.jolee@huschblackwell.com**
State of NE Department of Insurance represented by David Andrew Lopez (24947) service method: **No Service**
State of NE Department of Insurance represented by Kamron Thomas Mitchell Hasan (25494) service method: Electronic Service to **kamron.hasan@huschblackwell.com**

State of NE Excess Liability Fund represented by Amanda JoLee (26872) service method: Electronic Service to **amanda.jolee@huschblackwell.com**
State of NE Excess Liability Fund represented by David Andrew Lopez (24947) service method: **No Service**
State of NE Excess Liability Fund represented by Kamron Thomas Mitchell Hasan (25494) service method: Electronic Service to **kamron.hasan@huschblackwell.com**

Nebraska Medical Association represented by Andre Robert Barry (22505) service method: Electronic Service to **abarry@clinewilliams.com**

Signature: /s/ Mark Richardson (24719)