IN THE SUPREME COURT OF THE STATE OF MONTANA
No. DA 24-0203

JOEY ZAHARA,

Plaintiff/Appellant,

v.

ADVANCED NEUROLOGY SPECIALISTS,

Defendant/Appellee.

MONTANA MEDICAL ASSOCIATION, ET AL, AMICI CURIAE BRIEF IN SUPPORT OF ADVANCED NEUROLOGY

On Appeal from the Eighth Judicial District of the State of Montana, in and for Cascade County, Cause No. CDV-14-093; The Honorable John Kutzman

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INTERESTS OF AMICI CURIAE

The Montana Medical Association ("MMA") is the largest professional association of physicians in Montana. Founded in 1879 as a not-for-profit corporation and based in Helena, the MMA has served as the unified voice for Montana physicians dedicated to improving patient care. The MMA's mission is to serve its members as an advocate for the medical profession, quality patient care, and the health of all Montana citizens. MMA members practice in all medical specialties.

The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Its purpose is to promote the art and science of medicine and the betterment of public health. Substantially all physicians, residents and medical students in the United States are represented in its policymaking process through state and specialty medical societies and other physician groups seated in its House of Delegates. AMA members practice in every medical specialty and reside in all 50 states, including Montana.

The AMA and MMA also offer this brief as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition among the AMA and the state medical societies, whose purpose is to represent the viewpoint of organized medicine in the courts.

The Montana Hospital Association ("MHA") is the principal advocate for the state's hospitals and health care facilities, as well as the communities they serve. MHA's diverse membership of over 80 members includes organizations that provide hospital, nursing home, physician, home health, hospice and other health services. MHA's membership includes every acute care hospital in the state of Montana, including small critical access hospitals in rural Montana communities as well as the largest tertiary care hospitals in the state.

The MMA, AMA, and MHA have a substantial interest in the proper application of medical liability laws and maintaining an effective environment for healthcare in Montana. All three organizations on behalf of their memberships have a direct interest in maintaining and upholding the noneconomic damages cap at issue in this appeal, given the adverse effects to the medical community should the existing statute be found unconstitutional. The noneconomic damages cap is critical to maintaining access to healthcare in Montana, particularly in rural communities, and reflects an appropriate balance between the rights of plaintiffs and the viability of Montana's healthcare system. Without this statute, liability insurance costs would rise significantly, having a direct impact on both the cost and availability of care.

INTRODUCTION

The district court properly applied this Court's established precedent in rejecting Appellant's challenge to the constitutionality of Montana Code Annotated § 25-9-411 ("MCA 25-9-411"). Appellant's challenge fails, or, at minimum, faces rational basis review under this Court's long-established precedent articulated in *Meech* and other cases. Amici trust Appellees' brief will fully develop the legal analysis of this Court's prior decisions establishing the appropriate constitutional scrutiny that applies to the issues raised in this appeal. Rather than rehash that analysis, this brief focuses on the sound public policy underlying the Legislature's reasoning and purpose in enacting MCA 25-9-411's cap on noneconomic damages in medical liability cases.

Looking, as this Court must, through the lens of the 1995 Legislature and the state of the medical-legal environment at that time both in Montana and nationwide, MCA 25-9-411 presented a reasonable and appropriate measure of tort reform that was soundly supported by facts and data. Those same bases and rationales for implementing MCA 25-9-411 at that time apply with equal or greater force today, as corroborated by numerous peer-reviewed studies and the experiences of other states. The Legislature's policy-making decision was, and remains, sound and should not be disturbed.

SUMMARY OF ARGUMENT

Statutory limits on noneconomic damage awards present a reasonable and appropriate response to controlling the explosive growth in jury verdicts in medical liability cases. Noneconomic damages are subjective in nature, and juries are thereby susceptible to a growing number of legal arguments and tactics that have historically resulted in larger and larger verdicts. These growing verdicts directly impact the health care community, pricing doctors out of practicing in rural communities, discontinuance of certain types of specialty care in rural areas such as obstetrics and surgery, and resistance by doctors to treat highly complex patients.

In response, the Legislature had numerous, specific, and compelling bases for implementing Montana's cap on noneconomic damages, relying on data from sister states who successfully implemented similar caps. Unprotected by a cap on noneconomic damage awards, Montana's health care liability insurance market would become unaffordable and would threaten access to needed health care. Without access to affordable liability insurance, doctors cannot keep a practice open. The Legislature enacted MCA 25-9-411 to stabilize insurance rates and protect access to care.

Moreover, numerous peer-reviewed studies have demonstrated that implementation of noneconomic damage caps in medical negligence cases helps

safeguard the availability and affordability of heath care, particularly in Montana's many rural communities. The benefits from this type of reasonable and commonplace tort reform are numerous, including objectively demonstrable lower medical liability insurance premiums, higher physician supply, improved patient access to care, lower defensive medicine and health care costs, and lower claim severity and frequency.

Amici urge this Court to reject Appellant's challenge to the constitutionality of MCA 25-9-411, and to uphold the compelling public policy rationale underlying this statute.

STATEMENT OF THE CASE AND FACTS

Resisting duplication of briefing, Amici defer to the statement of the case and factual background section of Appellee's brief and thereby will not restate those background facts here. This brief focuses on the sound policy and supported decision making implemented by the Legislature in implementing MCA 25-9-411, as well as the peer-reviewed body of research that compels upholding this policy.

ARGUMENT

I. Noneconomic Damage Limits Provide an Appropriate Response to the Irrational Growth in Noneconomic Damage Awards.

To ensure access to quality and affordable care, Montana joined the majority of states in enacting legislation intended to protect the viability of the

health care system by implementing a cap on noneconomic damages recoverable in a medical liability case. Nearly two-thirds of all other states have statutory caps on damage awards. Twenty-four states have caps on noneconomic damages specifically related to medical liability cases, like Montana, and six others have a cap on total damages. One reason states have limited jury awards for noneconomic damages is because they are inherently subjective and unpredictable. There is "no standard for measuring pain and suffering damages, or even a conception of those damages or what they represent." Dan B. Dobbs, *Law of Remedies* § 8.1(4) at 383 (2d ed. 1993).[1]

Historically, the availability of noneconomic damages did not raise serious concern because "personal injury lawsuits were not very numerous and verdicts were not large." Philip L. Merkel, *Pain and Suffering Damages at Mid-Twentieth Century: A Retrospective Review of the Problem and the Legal Academy's First Responses*, 34 Cap. U. L. Rev. 545, 560 (2006). Prior to the 20th century, courts often reversed large noneconomic awards. *See* Ronald J. Allen & Alexia Brunet Marks, *The Judicial Treatment of Noneconomic Compensatory Damages in the Nineteenth Century*, 4. J. Empirical Legal Stud.

[1] *See* Restatement (Second) of Torts § 903 cmt. a (1979) ("There is no scale by which . . . suffering can be measured and hence there can be only a very rough correspondence between the amount awarded as damages and the extent of the suffering.").

365, 379-87 (2007) (finding no such awards exceeding $450,000 in present dollars prior to the 20th century).

The average size of pain and suffering awards took its first leap after World War II, as personal injury lawyers became adept at finding ways to enlarge awards. *See generally* Melvin M. Belli, *The Adequate Award*, 39 Cal. L. Rev. 1 (1951); *see also* Merkel, 34 Cap. U. L. Rev. at 560-65 (examining post-war expansion of pain and suffering awards). In a nine-month period in 1957, for example, there were fifty-three verdicts of $100,000 or more. *See* Merkel, 34 Cap. U. L. Rev. at 568. Scholars began to question the proper role and measurements for pain and suffering. *See, e.g.*, Charles A. Wright, *Damages for Personal Injuries*, 19 Ohio St. L.J. 155 (1958); Marcus L. Plant, *Damages for Pain and Suffering*, 19 Ohio St. L.J. 200, 210 (1958) (proposing "a fair maximum limit" as a viable solution).

Additionally, over the past several decades, plaintiffs' lawyers have successfully employed aggressive and controversial tactics to inflate jury awards for noneconomic damages, with increasing success. The practice of summation "anchoring" – requesting an unjustifiably high noneconomic damage award in closing – is highly effective, particularly where, as here, sympathetic jurors lack an objective reference point when evaluating compensation for pain and suffering. Mark A. Behrens, Cary Silverman,

Christopher E. Appel, *Summation Anchoring: Is it Time to Cast Away Inflated Requests for Noneconomic Damages?*, 44 Am. J. Trial Advoc. 321, 321 (2021). The anchor establishes an arbitrary but psychologically powerful baseline for jurors who are struggling with assigning a monetary value to pain and suffering. *Id*. at 322. Studies show that anchoring "dramatically increases" noneconomic damage awards. John Campbell et al., *Time is Money: An Empirical Assessment of Non-Economic Damages Arguments*, 95 Wash. U. L. Rev. 1, 28 (2017). "[T]he more you ask for, the more you get." Gretchen B. Chapman & Brian H. Bornstein, *The More You Ask for, the More You Get: Anchoring in Personal Injury Verdicts*, 10 Applied Cognitive Psychol. 519, 526 (1996).

Given the significant impact these tactics can have on influencing jury verdicts, some states prohibit or limit these types of arguments before a jury. *See* Behrens, 44 Am. J. Trial Advoc. at 330 (citing statues and cases). Pennsylvania courts do not permit lump sum demands "in cases where the damages are unliquidated and incapable of measurement by a mathematical standard . . . because they tend to instill impressions in the minds of the jury that are not founded upon the evidence." *Stassun v. Chapin*, 324, Pa. 125, 127, 188 A. 111, 111 (1936); *see also Mohnkern v. Gould*, 225 A.3d 1154 (Pa. Super. Ct. 2019) ("a jury should determine the amount of non-economic damages to award based on the evidence presented at trial, rather than at the

suggestion of counsel.") (citation omitted). Delaware courts agree, reasoning these types of tactics may be used "solely to introduce and keep before the jury figures out of all proportion to those which the jury would otherwise have had in mind, with the view of securing from the jury a verdict much larger than that warranted by the evidence." *Henne v. Balick*, 51 Del. 369, 376, 146 A.2d 394, 398 (1958). Numerous other courts recognize the impropriety of tactics that attempt to impress upon juries noneconomic damage figures that are otherwise not founded on or appearing in evidence. *See* Behrens, 44 Am. J. Trial Advoc. at 331 (discussing cases). These tactics are particularly effective in cases where, as here, the plaintiff does not put on evidence of economic losses, electing instead to argue only for an award of noneconomic damages, untethered to any objective figures reflecting the plaintiff's other losses.[2]

This has resulted in substantially distorted litigation outcomes. By the 1970s, pain and suffering in personal injury cases became "the largest single

[2] In one published article, the authors question the ethics of such tactics:

> In urging jurors to return a certain sum for pain and suffering, a lawyer implicitly indicates to the jury that the suggested sum is supported by facts or by law. When an attorney suggests an amount that is well beyond any award sustained for a similarly situated individual with comparable injuries, or is certain, if awarded, to be reduced by the court, he or she may be stepping over the ethical line.

Behrens, 44 Am. J. Trial Advoc. at 333.

item of recovery, exceeding by far the out-of-pocket 'specials' of medical expenses and loss of wages." *Nelson v. Keefer*, 451 F.2d 289, 294 (3d Cir. 1971). Scholars attribute this rise to the (1) availability of future pain and suffering damages; (2) rise in automobile ownership and personal injuries resulting from automobile accidents; (3) greater availability of insurance and willingness of plaintiffs' attorneys to take on lower-value cases; (4) rise in affluence of the public and a change in public attitude that "someone should pay"; and (5) better organization by the plaintiffs' bar. *See* Merkel, 34 Cap. U. L. Rev. at 553-66. It has been observed that verdicts in medical liability cases far exceed those in other tort trials. Thomas H. Cohen, *Medical Malpractice Trials and Verdicts in Large Counties, 2001*, Bureau of Justice Statistics, Civil Justice Data Brief at 1 (2004) (median award in medical malpractice cases was sixteen times greater than the overall median award in all tort trials). Overall, pain and suffering awards in the United States are often more than ten times those in the most generous cases of other nations. Stephen D. Sugarman, *A Comparative Look at Pain and Suffering Awards*, 55 DePaul L. Rev. 399, 399 (2006).

Many states, including Montana, responded to these dramatic rises in noneconomic damage awards by adopting commonsense statutory ceilings on them. Today, many states limit noneconomic damages, particularly in medical

liability cases. In each state, the limits provide a rational response to a sustained distortion of liability law by recognizing the broader public good is served when medical liability remains reasonable and predictable.

II. The Legislature's Demonstrable and Appropriate Rationale for Addressing These Issues Should Not Be Disturbed.

The legislative history of MCA 25-9-411 reveals the Legislature was evaluating these very issues when it enacted the cap on noneconomic damages. The Legislature's sound policy-making decisions survive any level of constitutional scrutiny, and should not be usurped by this Court.

The Legislature adopted a cap on noneconomic damages in 1995, in the midst of a volatile medical-legal environment both in Montana and across the country, and at a time when other states were adopting similar measures. The bill's sponsor articulated the need for this legislation, noting how the open-ended nature of financial liability created an environment of "exorbitant" rates for medical liability insurance. Appellant Zahara's App. at 57, June 18, 2024 ("App."). The sponsor indicated that without a cap on noneconomic damages, jury verdicts can be in the tens of millions of dollars. App. at 144. The Legislature relied upon data from other states demonstrating significant and favorable impacts on insurance costs and availability of care in those states that had passed caps on noneconomic damages. App. at 72-78, 145. The Governor's Office noted the premium rates for a family practitioner who practices

obstetrics was about three times the premium of a family practitioner who did not practice obstetrics. App. at 145.

The Legislature considered testimony as to increasing insurance premiums and increasing insurance costs and the need to stabilize the volatility in insurance rating. *See, e.g.*, App. at 148 ("The cost of malpractice insurance has been a significant problem in Montana and nationally since the early 1970s"). Testimony included the detrimental effect rising costs has had on decreasing access to care, particularly in rural communities. Numerous representatives from Wheatland Memorial Hospital in Harlowton testified that the hospital stopped providing obstetrical care to its community due to the unsustainable cost of medical liability insurance. App. at 66, 78, 87-89. This required women living in Harlowton to travel 90 miles to Billings or 60 miles to Lewistown to deliver their babies. App. at 78. The high cost of such insurance was debilitating to this small rural hospital and caused that community to go without any physician for long periods of time. App. at 66. The administrator of Big Sandy Medical Center echoed these concerns for his rural hospital, noting the then-present system "encourages astronomical amounts to be sought in all cases, consequently driving up the price of insurance and health care costs," and stressing the financial pressures small rural hospitals in Montana face from high insurance costs. App. at 85. The Montana Chapter of the American College of

Obstetricians and Gynecologists further testified as to the lack of availability of OB/GYN physician services in rural Montana communities due to the high cost of insurance premiums. App. at 141; *see also* App. at 196.

The sponsor and many proponents noted that *economic* awards for damages would not be capped under the bill. App. at 57. In testimony before the Senate Judiciary Committee, the Montana Medical Association observed that damage caps were not new to Montana, highlighting the $750,000 cap on total damages against the state. App. at 145-46. To illustrate, the testimony continued, if a person had $500,000 for lost wages, $500,000 for medical expenses, and $500,000 for pain and suffering, the recovery would be limited to $750,000 if against a state hospital, but only limited to $1,250,000 if against a private entity; the reduction only applying to that portion of the damages that were noneconomic in nature. App. at 146.

This rationale is legitimate and appropriate, and the Legislature reasonably presumed that a plaintiff in a medical negligence case would put forth evidence of both economic and noneconomic loss. To the extent Appellant argues he was denied redress for "95.8% of his jury-determined damages," this result appears to have been within his control. Appellant's Op. Br. at 47, June 18, 2024. The verdict form only reflects requests for noneconomic damages, demonstrating Appellant did not even request an award of economic losses,

such as past and future medical expenses, lost wages, and other objectively determinable losses. App. at 238. It is these very types of tactics – attempting to anchor the jury to a request for millions of dollars in noneconomic damages, without any tie to objective, economic loss – that the Legislature was specifically concerned about when enacting MCA 25-9-411. The subjective nature of noneconomic damages was specifically and thoroughly discussed, along with the concern that, as here, skilled attorneys using the sympathy factor can manipulate juries into awarding high amounts for noneconomic damages. App. at 70, 147 (noting that with a cap, the "lottery aspect of the damages has been limited").

Finally, the Legislature also weighed testimony regarding the concern of the practice of "defensive medicine" in Montana. Specific examples of defensive medicine were provided, including the example of ophthalmologists in Missoula refusing to examine children with certain complex injuries, and the excessive ordering of medically unnecessary x-rays, ordered only in an attempt to protect the physician against liability. App. at 195-198. These concerns over physicians being forced to practice defensive medicine given the liability climate presents another compelling and specific basis for implementation of a cap on noneconomic damages – as set forth in more detail below, studies have

demonstrated that caps on noneconomic damages can positively impact these types of pressures, among others.

To the extent Appellant attempts to pivot and argue that loss of established course of life is, in fact, an "economic" loss, this Court may swiftly dispatch of the issue through both the plain language of the statute, as well as the legislative history. Appellant's request for the Court to ignore the phrase "including but not limited to" is contrary to long-established rules of statutory construction. MCA 1-2-101 (completing Appellant's incomplete quote: "In the construction of a statute, the office of the judge is simply to ascertain and declare what is in terms or in substance contained therein, not to insert what has been omitted **or to omit what has been inserted**.") (emphasis added).

The Legislature relied on this language in the bill when grappling with the question of whether there could be ambiguity to the extent physical pain (a noneconomic damage) could also lead to loss of work (an economic damage). App. at 224. The Senate Judiciary Committee agreed an amendment was unnecessary, relying on the "lead in phrase of non-economic loss meant subjective non-monetary loss, **including but not limited to these causes.**" App. at 225 (emphasis added). If economic loss could also be caused, it would be excluded, otherwise noneconomic losses would be subject to the cap. App. at 225. Here, by contrast, the district court properly pointed out that Appellant's

closing argument made clear that his loss-of-course damages were entirely subjective. Ord. Den. Rule 59(e) Mot. at 3.

Given the Legislature's specific goals of capping those categories of damages that are subjective in nature to achieve stability in the medical-legal environment at the time, there can be no doubt the Legislature intended the loss-of-course damages awarded in this case to be subject to MCA 25-9-411. The balance of the written legislative history reveals that the policymaking decisions underlying this statute are supported by particularly compelling and appropriate bases, backed up by established facts and data and the real-world impact Montana's rural healthcare communities faced at the time.

III. Reasonable Limits on Damages in Medical Liability Cases Effectively Safeguard Available and Affordable Health Care.

Contrary to Appellant's arguments, limits on noneconomic damages are effective. They lead to lower medical liability insurance premiums, higher physician supply, improved patient access to care, lower defensive medicine and health care costs, and lower claim severity and frequency. *See*, *e.g.*, Am. Med. Ass'n, *Medical Liability Reform Now!* at 12-14 (2024 ed.) ("*Reform Now!")*; Patricia Born, et al., *The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses*, 76 J. Risk & Ins. 197 (2009); W. Kip Viscusi & Patricia Born, *Damages Caps, Insurability, and the Performance of Medical Malpractice Insurance*, 72 J. Risk & Ins. 23 (2005). Maintaining

reasonable limits on subjective awards is critical for ensuring that adequate, affordable health care is available to Montanans, particularly in rural communities where access to primary and specialty health care can be scarce.

First, limits on damages increase physician supply and access to medical care. *See Reform Now!* at 2-4 (discussing studies). One study examined whether noneconomic damage caps are associated with physician supply, finding that states with damage caps experience less out-migration of physicians than states that did not. *Reform Now!* at 3, citing Perry, J.J. Clark, *C. Medical Malpractice Liability and Physician Migration.* Bus. Econ. 2012; 47(3): 202-213. Another study examined how physician supply responded to caps on damages from 1970 to 2000, finding the positive impacts of caps was concentrated in rural counties, particularly among surgical services. *Reform Now!* at 3, citing Matsa, DA. *Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps*. J Legal Stud. 2007; 36(2): 143–182. States that limit damages experience increases in physician supply per capita compared to states without them. *See* William Encinosa & Fred Hellinger, *Have State Caps on Malpractice Awards Increased the Supply of Physicians?,* 24 Health Aff. 250, 255- 56 (2005); Ronald Stewart et al., *Tort Reform is Associated with Significant Increases in Texas Physicians Relative to the Texas Population*, 17 J. Gastrointestinal Surgery 168, 173-74 (2013). If Montana's medical liability

climate is not stable, doctors will practice elsewhere. *See* Chiu-Fang Chou & Anthony Lo Sasso, *Practice Location Choice by New Physicians: The Importance of Malpractice Premiums, Damage Caps, and Health Professional Shortage Area Designation,* 44 Health Serv. Res. 1271, 1284 (2009). In rural Montana communities, access to quality primary and specialty medical services is paramount to the health of the community, which is furthered by maintaining the current noneconomic damages cap.

Second, limits on noneconomic damage awards reduce the pressure to engage in "defensive medicine." *See Reform Now!* at 5-8 (discussing studies).[3] "[T]he fear of being sued . . . leads to an increase in the quantity of care rather than an increase in the efficiency or quality of care." Scott Spear, *Some Thoughts on Medical Tort Reform*, 112 Plastic & Reconstructive Surgery 1159, 1160 (Sept. 2003). This can result in two types of defensive medicine, both of which have negative implications for patients. On one hand, doctors will order

[3] *See also* Timothy Smith et al., *Defensive Medicine in Neurosurgery: Does State-Level Liability Risk Matter?*, 76 Neurosurgery 105, 112 (Feb. 2015) (neurosurgeons are 50% more likely to practice defensive medicine in high-risk states); Manish K. Sethi et al., *Incidence and Costs of Defensive Medicine Among Orthopedic Surgeons in the United States: A National Survey Study,* 41 Am. J. Orthop. 69, 72 (2012) (96% of orthopedic surgeons surveyed reported having practiced defensive medicine to avoid liability); Mass. Med. Soc'y, *Investigation of Defensive Medicine in Massachusetts* at 3-5 (Nov. 2008) (83% of physicians reported practicing defensive medicine and 28% of all CT scans, 27% of MRI studies, and 24% of ultrasound studies were ordered for defensive reasons).

additional costly and more invasive tests (with added risks to the patient) or overtreat the patient to ward off potential liability; on the other, doctors end up avoiding high risk procedures or avoiding high risk patients altogether. *See Reform Now!* at 5; Brian Nahed et al., *Malpractice Liability and Defensive Medicine: A National Survey of Neurosurgeons*, PLoS ONE, vol. 7, no. 6, 6 (June 2012) ("Reductions in offering 'high-risk' cranial procedures have decreased access to care for potentially life-saving neurological procedures."); Mass. Med. Soc'y, *Investigation of Defensive Medicine in Massachusetts* at 3-5 (Nov. 2008) (finding 38% of physicians in the sample reduced the number of high-risk services or procedures they performed; 28% reduced the number of high-risk patients they saw). Overall, studies have shown damage limits and other reforms that reduce liability pressures "lead to reductions of 5 to 9 percent in hospital expenditures without substantial effects on mortality or medical complications." Donald Palmisano, *Health Care in Crisis: The Need for Medical Liability Reform,* 5 Yale J. Health Pol'y, L. & Ethics 371, 377 (2005) (citation omitted).

For example, one peer-reviewed study examined the effect of damage limits on testing and treatment decisions for coronary artery disease. *See* Steven Farmer et al., *Association of Medical Liability Reform with Clinician Approach to Coronary Artery Disease Management,* 10 JAMA Cardiology (June 2018).

Imaging and invasive diagnostic studies "are often cited as overused defensive measures." *Id*. "Many experts believe that invasive tests and interventions are overused, with fear of malpractice liability a potential motivating factor." *Id*. After adoption of damage limits, "testing became less invasive (fewer initial angiographies and less progression from initial stress test to angiography), and revascularization through [percutaneous coronary intervention] following initial testing declined." *Id*. These authors explained the important policy implications of this research: curtailing clinically unnecessary treatments "spares patients invasive procedures and associated risk and saves resources." *Id.* As noted, the Montana Legislature heard specific testimony regarding the different types of defensive medicine practices observed at the time MCA 25-9-411 was implemented.

Third, these reforms reduce medical liability premiums, claim severity, and claim frequency. *See Reform Now!* at 12-13. One study found internal medicine premiums were 17.3% lower in states with limits on damages than in states without such limits. Meredith L. Kilgore, Michael A. Morrisey & Leonard J. Nelson, *Tort Law and Medical Malpractice Insurance Premiums,* 43 Inquiry 255, 265 (2006). Surgeons and OB-GYNs experienced 20.7% and 25.5% lower insurance premiums, respectively, in states with damage limits compared to those without them. *Id.* at 268. "[T]here is a substantial difference

in the level of medical malpractice premiums in states with meaningful caps… and states without meaningful caps." 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 (2002). Medical liability reforms also reduce the likelihood that a doctor will be sued. *See* Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and- Liability Reforms on Physicians' Perceptions of Medical Care,* 60 Law & Contemp. Problems 81, 99-100 (1997).

Finally, noneconomic damages limits facilitate the ability of parties to reach fair settlement. *See, e.g.*, Ronen Avraham, *An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Settlement Payments*, 36 J. Legal Stud. Sl83, S221 (June 2007) (reporting a study of 100,000 settled cases for injuries occurring between 1991 and 1998, showing caps on damages "do in fact have an impact on settlement payments.").

This extensive body of research belies Appellant's arguments that Montana's noneconomic damage cap does not work. The fact insurance premiums have increased in recent years, if anything, calls for more reform, not less, and Montana's existing cap has protected it from experiencing the extent of crises currently taking place in other states. On this note, Appellant's reliance on the AMA's Guardado study is misplaced. Appellant's Op. Br. at 34-35. In

the 2023 update to the Guardado paper cited by Appellant, the data shows that Montana had 16.7% of practices experience a significant (i.e. 10% or more) premium increase, compared to **63.3%** of practices in Illinois. Jose Guardado, *Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Fourth Year in a Row*, AMA Economic and Health Policy Research at 9 (April 2023), https://www.ama-assn.org/system/files/prp-mlm-premiums-2022.pdf. The largest increase in Montana was just 10%, while the largest increase in Illinois was **22.4%**. *Id*. And, only 25% of practices in Montana saw any level of increase, compared to **over 90%** of practices in Illinois. *Id*. Significant to this analysis, Illinois is not currently protected by a noneconomic damages cap, its prior cap having been ruled unconstitutional by the Illinois Supreme Court. *See LeBron v. Gottlieb Mem'l Hosp.*, 237 Ill 2d. 217, 341 Ill. Dec. 381, 930 N.E.2D 895 (2010). This data demonstrates the effect removal of a state's cap on noneconomic damages can have on affordability of medical liability insurance, highlighting again the very concerns underlying the Legislature's reasons for implementing Montana's cap.

Limits on damages work, and this Court should recognize and uphold the successful and reasonable public policy enacted by the Legislature through MCA 25-9-411.

CONCLUSION

For these reasons, Amici respectfully request the Court to affirm the holdings of the district court, find that Montana Code Annotated § 25-9-411 is constitutional, and find that it applies to all categories of noneconomic damages sustained by Appellant in this case.

DATED this 21st of August, 2024.

/s/ Justin K. Cole
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CERTIFICATE OF COMPLIANCE

Pursuant to Montana Rule of Appellate Procedure 11(4)(e), I certify that this Montana Medical Association, et al, Amici Curiae Brief in Support of Advanced Neurology, is printed with proportionately spaced Times New Roman text typeface of 14 points; is double-spaced; and the word count, calculated by Microsoft Word for Microsoft 365 MSO, is 4,712 words long, excluding Caption, Certificate of Service and Certificate of Compliance.

/s/ Justin K. Cole
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CERTIFICATE OF SERVICE

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