STATE OF MICHIGAN
IN THE SUPREME COURT

IN RE CERTIFIED QUESTION

WHITNEY BEAUBIEN, as Personal Representative of the Estate of CRAIG A. BEAUBIEN

Plaintiff,

v.

CHARU TRIVEDI, M.D., TOLEDO CLINIC, INC. d/b/a TOLEDO CLINIC CANCER CENTERS.

Defendant.

Michigan Supreme Court Case No. 167831
United States District Court for the Eastern District of Michigan Case No. 21-cv-11000

Filed under AO 2019-6

BRIEF OF THE AMERICAN ASSOCIATION FOR JUSTICE AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF

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Date: March 24, 2025

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STATEMENT OF THE QUESTIONS PRESENTED

I. Whether this Court should answer the certified questions?

Plaintiff answers: Yes

Defendants answer: No

Amicus answers: Yes

II. Whether the statutory caps on noneconomic damages in medical-malpractice cases is constitutional under the right to a jury trial, equal protection, and separation of powers?

Plaintiff answers: No

Defendants answer: Yes

Amicus answers: No

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 in state and federal courts nationwide, including in Michigan. Throughout its 78-year history, As a leading advocate for the right of all Americans to seek legal recourse for wrongful conduct and the right to trial by jury, AAJ has an acute interest in the issue in this case.[1]

INTRODUCTION & SUMMARY OF ARGUMENT

I. The American Association for Justice urges this Court to accept the certified question from the federal district court and to declare that Mich. Comp. Laws § 600.1483 violates the Michigan Constitution. The statute's cap on non-economic damages violates both the state constitutional right to trial by jury and the doctrine of separation of powers. AAJ here submits that the cap also violates the Michigan Constitution's guarantee of equal protection of the laws. Even under the most deferential standard of review – the rational basis test – depriving the most seriously harmed victims of malpractice of their full measure of compensatory damages cannot pass constitutional muster.

A. Rational-basis scrutiny looks to whether an enactment has both a legitimate governmental purpose and some factual basis for expecting the statute can achieve that purpose.

[1] All parties have consented to the filing of this brief. No person or entity other than the amicus curiae, its members, and its counsel authored this brief in whole or in part. No person or entity other than amicus curiae, its members, and its counsel, contributed money that was intended to fund the preparation or submission of this brief.

The first prong is satisfied by any purpose that is legal for legislative action. Even if the lawmakers did not articulate their objective, the court may infer a proper basis if any conceivable set of facts might support it.

But the any-conceivable-facts deference is not enough to satisfy the second prong. There must be some factual basis for an impartial lawmaker to expect that legislative action can accomplish its objective in the real world. And although an act of the legislature is clothed in a presumption of constitutionality, it would be a violation of due process to deny a challenge to the statute's factual basis. In a line of equal-protection decisions in a variety of contexts, the Supreme Court of the United States has held that state statutes failed the rational basis test because, in the real world in which they would operate, there was no reasonable basis for expecting they would achieve their stated governmental purposes.

On that basis, a number of state supreme courts have held that their states' caps on non-economic damages lacks a rational basis for expecting them to result in lower medical malpractice insurance premiums for health care providers or lower medical costs for consumers generally.

B. The Michigan Legislature's purpose in enacting section 600.1483 was, as in other states, to lower malpractice insurance premiums and thereby ease health care costs for the people of Michigan. But there was no basis for any reasonable legislator to expect the cap on non-economic damages to accomplish this purpose. The Legislature looked to the caps enacted in California and Indiana, but neither state experienced the anticipated results.

The Legislature expected the cap to result in substantial savings to malpractice insurers, which they would voluntarily use to lower premiums for doctors and hospitals, who would lower their prices for patients. None of those hopeful assumptions had any basis in fact.

First, the insurance industry itself declared that the amount of savings involved in limiting the few claims above the cap amount was insufficient to affect premiums. In fact, following the adoption of caps, insurers in some states pressed for *increases* in their premium rates. Additionally, placing a ceiling on *non-economic damages* results in more cases and verdicts with higher *economic* damages.

Secondly, there was no basis for lawmakers to expect that insurers would use any of their savings to lower premiums. Multiple empirical studies confirm that when malpractice liability insurers gain higher profits from the litigation system, they devote those windfalls to investments, executive compensation, administrative overhead, or other purposes.

Third, there was no reason for Michigan legislators to expect that capping non-economic damages would lower health care costs for Michigan consumers. Malpractice insurance premiums are simply not a large portion of the total cost of health care. Even if doctors and hospitals decided to pass any reduction in their liability insurance premiums along to consumers of medical care, the amount, if any, would be miniscule

C. Researchers looking at the growing body of malpractice claims data have confirmed that enacting damage caps have not reduced premiums or lowered the cost of health care. Empirical studies of claims before and after the adoption of caps as well as studies comparing the experiences of states with and without caps all confirm that there is no cause-and-effect relationship that could provide a rational basis for such legislation.

II. If sudden the frequency and severity of malpractice awards is not responsible for sudden spikes in medical malpractice insurance premiums, what is?

A. Data for the past 40 years shows that payouts by insurers to medical malpractice victims have increased steadily, in pace with the increases in medical inflation. The premiums paid

by doctors and hospitals, on the other hand, have gone up and down. In fact, their roller-coaster pattern closely matches the business cycle of interest rates and investment returns in the larger economy.

B. A medical malpractice insurance company consist of two enterprises. Its underwriting side sells indemnity policies based on actuarial estimates of future losses. Its investment side puts those premium dollars to work until they are needed to pay claims, which can be many years. When investments have a high rate of return—a "soft market"—insurers cut premiums and drain reserves to compete to obtain more cash to invest. When investment markets trend downward, as they inevitably do, companies are compelled to raise premiums sharply to replenish reserves to meet future claims—a "hard market."

The hard market of the mid-1980s, which prompted the Legislature to impose a cap on medical malpractice damages, resembled other "crises." Rather than address the true cause of disruptions of the insurance cycle, the industry launched a campaign to convince legislators that the insurance crisis was, instead, a liability crisis. Insurers manufactured a crisis and blamed it on patients and the attorneys representing them for seeking legal redress for wrongful injury. The tort reform campaign succeeded in persuading lawmakers in about 30 states to impose limits on recoverable damages in medical malpractice cases.

III. As a plan to "reform" the medical liability system, these caps on non-economic damages are wholly irrational.

A. First, even if Michigan's civil justice system needs "reform" it is fundamentally unfair to force the relatively small number of very seriously injured victims of malpractice to shoulder the entire cost of this supposed public benefit. State supreme court jurists around the country have decried such caps as arbitrary and irrational. They turn the very purpose of insurance

on its head: Instead of spreading the risk of a major loss among many policyholders, caps promise policyholders a tiny by making seriously harmed victims bear much of their losses alone. If liability insurance companies marketing policies in this state are in such need of a subsidy, the Legislature ought to impose the costs of this public benefit on the public at large.

B. Second, limiting the accountability of negligent doctors and hospitals undermines the deterrent effect that is a primary purpose of imposing tort liability. Hospitals can and do respond to the cost of malpractice insurance by undertaking improvements in patient safety. Insurers themselves play a role by requiring doctors and hospitals to comply with requirements that result in fewer harms caused by negligence. Empirical data confirms that shielding providers from the full consequences of substandard care tends to increase substandard care. Expecting caps to reduce the cost of premiums and health care costs by increasing the incidence of malpractice is plainly irrational.

C. Finally, keeping Michigan's cap in place perpetuates the periodic spikes in malpractice insurance premiums that harm medical providers, negligently harmed patients, and the malpractice insurance industry itself. Liability "reform" cannot address this condition because it is unrelated to the true cause. The way to mitigate the effect of the insurance cycle has been demonstrated to be careful insurance regulation.

ARGUMENT

I. THE CAP ON DAMAGES FAILS TO MEET EVEN THE RATIONAL RELATIONSHIP STANDARD.

The American Association for Justice urges this Court to accept the certified question from the federal district court and to declare that the noneconomic damages cap under MCL 600.1483 violates the Michigan Constitution, including the right to trial by jury and the doctrine of separation

of powers. See Pl's Br 24–48. AAJ here addresses the statute's violation of the guarantee of "equal protection of the laws." Const 1963, art 1, § 2.

On its face, MCL 600.1483 treats two groups of Michigan victims of medical malpractice differently: those seeking redress for negligent harm at the hands of a health care provider are subject to the limit on noneconomic damages, while other tort plaintiffs are not. Malpractice victims who have proved noneconomic damages below the statutory ceiling may recover all damages awarded to them. But those whose noneconomic damages exceed the cap are deprived of a significant portion of the jury's award.

The United States District Court for the Eastern District of Michigan correctly stated that under this Court's precedents, "the right to trial by jury encompasses the right to have a jury determine the damages a plaintiff is entitled to recover." Dist Ct Op 11–12. Consequently, strict scrutiny of this legislative classification is appropriate. *Id.* at 13–14. Nevertheless, the cap on noneconomic damages falls far short of even the most minimal level of judicial scrutiny, the rational basis test.

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

1. The Rational Basis Standard Requires Judicial Inquiry into Both Ends and Means.

To be at all valid under Michigan's constitutional guarantee of equal protection—and under the Fourteenth Amendment of the Constitution of the United States[2]—a legislative classification must be "rationally related to a legitimate governmental interest." *Andary v USAA Cas Ins Co*, 512 Mich 207, 265; 1 NW3d 186, 218 (2023) (quoting *Shavers v Kelley*, 402 Mich 554, 613; 267

[2] This Court has "interpreted this clause to be coextensive with its federal counterpart." *Harvey v State, Dep't of Mgt & Budget, Bureau of Retirement Servs*, 469 Mich 1, 6; 664 NW2d 767, 770 (2003).

NW2d 72 (1978)); *accord Romer v Evans*, 517 US 620, 631; 11 S Ct 1620, 1627; 134 L Ed 2d 855 (1996) ("[W]e will uphold the legislative classification so long as it bears a rational relation to some legitimate end.").

The Defense declares that this Court "must uphold" the damages cap if there could be any "conceivable basis which might support it." Defs' Br 54. That may be "an impossible task," *id.*, but that is not the law. Rational-basis scrutiny, while deferential to the legislature, is not "toothless." *Matthews v Lucas*, 427 US 495, 510; 96 S Ct 2755, 2764; 49 L Ed 2d 651 (1976).

As this Court indicated in *Andary*, and as is widely accepted, rational-basis scrutiny "involves two related but distinct inquiries—the legitimacy of the government interest (ends) and the rationality of its action in furthering that interest (means)." Boone, *Perverse & Irrational*, 16 Harv L & Pol'y Rev 393, 402 (2022).

In practice, the "ends" requirement is easily satisfied. Any objective that "is legal for the government to pursue" is legitimate. Chemerinsky, *The Rational Basis Test Is Constitutional (and Desirable)*, 14 Geo JL & Pub Pol'y 401, 405 (2016). Even when lawmakers have not identified their legislative purpose, courts may presume that the legislature acted within its constitutional power. For example, in *Armour v City of Indianapolis*, 566 US 673; 132 S Ct 2073; 182 L Ed 2d 998 (2012), although the city did not "actually articulate at any time the purpose or rationale" for its new property tax regulation, *id.* at 685, it would be upheld as long as "there is any reasonably conceivable state of facts that could provide a rational basis." *Id.* at 681, quoting *FCC v Beach Communications, Inc*, 508 US 307, 313; 113 S Ct 2096, 2101; 124 L Ed 2d 211 (1993).

Defendant's insistence that *any* "conceivable basis" can save MCL 600.1483's cap, Defs' Br 54, confuses the two prongs of the rational basis test., As Justice Thomas emphasized when writing for the Court in *Beach Communications*, deference to "any reasonably conceivable state

of facts" applies only to the first, "ends" prong, "because we never require a legislature to articulate its reasons for enacting a statute." 508 US at 313.

The second prong, however, requires some reasonable basis to believe the law can actually accomplish its purpose in the real world.

2. A Statute Fails Rational Basis Review If There Was No Basis for a Lawmaker Reasonably to Expect It to Actually Accomplish Its Purpose.

A statute does not satisfy the second prong of the rational basis test if a court can simply imagine some "conceivable set of facts" under which the law might accomplish its purpose. 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 US 422, 442; 102 S Ct 1148, 1161; 71 L Ed 2d 265 (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 US 432, 452; 105 S Ct 3249, 3261; 87 L Ed 2d 313 (1985) (STEVENS J., concurring). Rational basis scrutiny may require factual inquiry into that inquiry. After all, the presumption of the constitutionality of legislative enactments is a rebuttable one.

The rational basis test finds its origin in *United States v. Carolene Products Company*, 304 US 144; 58 S Ct 778; 82 L Ed 1234 (1938), where Justice Stone indicated that the factual basis underlying the legislature's judgment that its actions will accomplish its objective "is to be presumed . . . *unless* in light of the facts . . . it is of such a character as to preclude the assumption that it rests upon some rational basis." *Id.* at 152 (emphasis added). Facts that come to light after the law has gone into effect may also be presented to the court. The rational basis 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." *Id.* at 153.

Indeed, precluding a party from adducing facts that would show the statute had no rational basis "would deny due process." *Id*. This Court has expressly adopted the *Carolene Products* approach, stating that a court "may establish adequate findings of facts to determine whether . . . the legislative judgment is without rational basis." *Shavers*, 402 Mich at 614–15.

Oddly, the Defense contends that "Rational-basis review doesn't require that the legislation actually work." Defs' Br 57. To the contrary,

> [Even under] the most deferential of standards, we insist on knowing the relation between the classification adopted and the object to be attained. The search for the link between classification and objective . . . provides guidance and discipline for the legislature, which is entitled to know what sorts of laws it can pass.

Romer, 517 US at 632. This demands "a sufficient factual context for us to ascertain some relation between the classification and the purpose it served." *Id.* at 632–33. 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 US 469, 488 n 20; 125 S Ct 2655, 2667; 162 L Ed 2d 439 (2005).

Cleburne is instructive on this point. At issue was a zoning requirement that effectively barred a home for persons with disabilities from a residential location. The municipality's justifications included prevention of crowding, fire protection, proximity to a school, and protection of the residents themselves—all conceivably valid justifications. But the Court examined the *actual circumstances* in which the regulation was intended to operate and found that there was no rational basis for the council to believe that the restriction would serve those ends. *Cleburne*, 473 US at 449–50. The Court concluded that there was no rational basis for the council to believe that singling out this particular group to exclude would serve its stated purposes. *Id.* "The State may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *Id*. at 446.

The U.S. Supreme Court has repeatedly struck down state statutes shown to lack a rational relationship to their stated objectives when examined in light of the real-world facts in which those laws actually operate. For example, in *Metropolitan Life Insurance Company v Ward*, 470 US 869; 105 S Ct 1676; 84 L Ed 2d 751 (1985), the Court struck down a tax preference for in-state insurers because, in view of the manner in which insurers actually operate, it would be irrational to believe that the measure would further its purpose of fostering domestic insurance companies. In *United States Department of Agriculture v Moreno*, 413 US 528; 93 S Ct 2821; 37 L Ed 2d 782 (1973), the Court likewise invalidated the denial of food stamps to households composed of unrelated persons, purportedly to prevent fraud, because the regulation "in practical effect . . . simply does not operate so as rationally to further the prevention of fraud." *Id.* at 537.

In *Zobel v Williams*, 457 US 55; 102 S Ct 2309; 72 L Ed 2d 672 (1982), the Court invalidated Alaska's decision to allocate a greater share of state oil dividends to long-term residents, rejecting the State's assertion that this encouraged new settlers. The Court doubted whether the distinction made sense in practical terms. "In fact, newcomers seem more likely to become dissatisfied and to leave the State than well-established residents; it would thus seem that the State would give a larger, rather than a smaller, dividend to new residents if it wanted to discourage emigration." *Id.* at 65 n 9. See also *Hooper v Bernalillo Co Assessor*, 472 US 612, 619; 105 S Ct 2862, 2867; 86 L Ed 2d 487 (1985) (reasoning that a property tax break for Vietnam veterans who were longtime New Mexico residents "cannot plausibly encourage veterans to move to the State," and, as a practical matter, might have discouraged some). See also *Plyler v Doe*, 457 US 202, 229; 102 S Ct 2382, 2401; 72 L Ed 2d 786 (1982) (striking down Texas law denying free public education to undocumented children where the Court found no "credible supporting evidence" that this would be effective in dealing with the problem of illegal immigration).

Inquiry by this Court into the factual basis for adopting a statute capping medical malpractice damage proceeds from this Court's responsibility to exercise independent judicial review "not [as] the critic of the legislature, but rather, the guardian of the Constitution." *Kansas Malpractice Victims Coalition v Bell*, 243 Kan 333, 340; 757 P2d 251, 256 (1988). "To permit the legislature to act as the sole arbiter of [the relationship between the cap and the goal of reducing the cost of health care] would be to vacate our judicial role." *Moore v. Mobile Infirmary Ass'n*, 592 So 2d 156, 167–68 (Ala, 1991); *Estate of McCall v. United States*, 134 So 3d 894, 905–06 (Fla, 2014) ("[W]e would abandon our obligation . . . were we to simply rubber stamp the Legislature's asserted justification for the cap . . . and fail to consider the existing factors and circumstances to determine whether there is legitimacy to that justification.").

The highest courts of at least nine other states have undertaken an objective examination of the factual basis for their state legislature's assumption that enacting a cap on medical malpractice damages will result in lower malpractice insurance rates or health care costs for their citizens. Regardless of whether the courts struck down a cap on equal protection grounds or another constitutional principle, they all found no rational factual basis for the legislation. See, e.g., *Moore*, 592 So 2d at 168–69 ("We conclude that the correlation between the damages cap . . . and the reduction of health care costs to the citizens of Alabama is, at best, indirect and remote. . . . [T]he size of claims against health care providers represents but one among many elements composing the cost of malpractice premiums, which, in turn, represent only a small component of the total burden borne by health care consumers."); *Estate of McCall*, 134 So 3d at 907–09 (answering a certified question, holding that Florida's cap on noneconomic damages has no rational relationship to its purpose of easing the malpractice "crisis" that was caused by cyclical insurance market conditions, not jury awards); *North Broward Hosp Dist v. Kalitan*, 219 So 3d 49, 58–59 (Fla, 2017)

(holding that Florida's noneconomic damage cap failed rational basis test where empirical evidence "failed to establish a direct correlation between damage caps and reduced medical malpractice premiums"); *Kansas Malpractice Victims Coalition*, 243 Kan at 345 (stating that, even if Kansas's cap might reduce malpractice premiums, "[s]hould a doctor decide to pass these savings on to his hundreds of patients, each person's savings would be minuscule."); *Brannigan v Usitalo*, 134 NH 50, 56; 587 A2d 1232, 1235 (1991) (holding that New Hampshire's $875,000 cap on noneconomic damages in personal injury actions violated equal protection where "paid-out damage awards constitute only a small part of total insurance premium costs" and "few individuals suffer noneconomic damages in excess of" the cap.); *see also Carson v Maurer*, 120 NH 925; 424 A2d 825 (1980) (same); *Arneson v Olson*, 270 NW2d 125, 136 (ND, 1978) (holding that North Dakota's $300,000 limit on total damages recoverable in malpractice cases violated equal protection based on factual findings "that there did not appear to be an availability or cost crisis in this State" and that "either the Legislature was misinformed or subsequent events have changed the situation substantially"); *Morris v Savoy*, 61 Ohio St 3d 684, 698; 576 NE2d 765, 770–71 (1991) (holding that Ohio's limit on noneconomic damages in medical malpractice actions "does not bear a real and substantial relation to public health or welfare" based on evidence showing that enactment of caps in other states has not resulted in lower premiums); *Knowles v United States*, 544 NW2d 183, 190; 1996 SD 10 (1996) ("The arbitrary classification of malpractice claimants based on the amount of damages is not rationally related to the stated purpose of curbing medical malpractice claims."); *Lucas v United States*, 757 SW2d 687, 691 (Tex, 1988) (invalidating Texas's cap on damages in malpractice actions and citing a study that "concluded that there is no relationship between a damage cap and increases in insurance rates . . . given that less than .6% of all claims brought are for over $100,000."); *Ferdon ex rel Petrucelli v Wisconsin Patients*

Compensation Fund, 284 Wis 2d 573, 630–34; 2005 WI 125; 701 NW2d 440, 468–70 (2005) (finding that Wisconsin's cap on noneconomic damages was "not rationally related to the legislative objective of lowering medical malpractice insurance premiums," based on studies indicating that relatively few individuals' claims exceed the cap and that there is no tangible evidence caps improve the quality, availability or cost of health care).[3]

B. Michigan's Cap on Noneconomic Damages Bears No Rational Relationship to Its Legislative Purpose.

1. The Legislative Purpose of MCL 600.1483 Was to Lower Medical Malpractice Insurance Premiums and Thereby Lower Healthcare Costs for the People of Michigan.

It is undisputed that the Legislature's purpose in enacting the damage cap was to slow rising health care costs in Michigan. This Court has recognized that MCL 600.1483

> was prompted by the Legislature's concern over the effect of medical liability on the availability and affordability of health care in the state. The purpose of the damages limitation was to control increases in health care costs by reducing the liability of medical care providers, thereby reducing malpractice insurance premiums, a large component of health care costs.

Zdrojewski v Murphy, 254 Mich App 50, 80; 657 NW2d 721, 739 (2002) (citation omitted).

Defendant asserts that "the Legislature determined that a noneconomic damages cap would address the problems that the committees identified," including that "medical-liability insurance premiums were high." Defs' Br 56. In fact, the Legislature's confidence that the proposed cap would achieve its goal was conspicuously equivocal:

> A number of states, most notably California and Indiana, have enacted limits on noneconomic damages in malpractice actions. A 1982 Rand Institute for Civil Justice report found that states which have adopted caps have experienced an average drop of 19 percent in the severity of awards within two years of enactment. This might lead to a stabilization of the medical malpractice insurance premiums.

[3] Several of these decisions have been overruled or superseded by subsequent legislation. They stand for the proposition that damage caps are open to challenge by a factual showing that they cannot achieve their stated goal of reducing malpractice insurance rates or health care costs.

> In turn, this could lead to lower premiums and reduced health care cost to consumers.

AE Apx 000039, Senate Select Committee on Civil Justice Reform Report, p 18. Defendant also contends that the a "Senate committee's comparison of premiums with capped states "provided ample basis for the Legislature's judgment." Defs' Br 57. In fact, they prove quite the opposite.

In November 1975, only a few months after California became the first state to adopt a cap on noneconomic damages, the state's malpractice insurers hit doctors and hospitals with huge premium increases of over 400%. Kossow, *Future Trends in Damage Limitation Adjudication*, 80 Nw U L Rev 1643, 1649 (1986). Premiums continued to rise sharply during the next decade. US General Accounting Office, *Medical Malpractice: Case Study on California*, pp 12, 22 (December 1986) <https://www.gao.gov/assets/hrd-87-21s-2.pdf> (accessed March 22, 2025). See also Finkelstein, *California Civil Section 3333.2 Revisited: Has It Done Its Job?*, 67 S Cal L Rev 1609, 1617–18 (1994). Rates stabilized only after the state enacted strict insurance regulation demanded by the voters in 1988 when they approved Proposition 103. See generally Foundation for Taxpayer and Consumer Rights, *How Insurance Reform Lowered Doctors' Insurance Rates in California* (March 7, 2003) <https://consumerwatchdog.org/resources/1008.pdf> (accessed March 22, 2025).

In Indiana, researchers looking at more than 6,000 malpractice claims filed with the state's Department of Insurance from 1975 to 1988 found that, after the medical malpractice cap had been enacted, large claim payments were *higher* in Indiana than in Michigan and Ohio, comparable neighboring states without damage caps in those years. See Kinney, Gronfein, & Gannon, *Indiana's Medical Malpractice Act: Results of a Three–Year Study*, 24(3) Ind L Rev 1275, 1286, 1294–96 (1991), available at <https://journals.indianapolis.iu.edu/index.php/inlawrev/article/view/2926/2850> (accessed March 23, 2025). Claim frequency rose as well. *Id.* at 1286.

As to easing the costs of health care, one study, found that, despite Indiana's reforms, Indiana and Illinois had similar patterns of health care expenditure inflation suggesting that Indiana's reforms have not affected health system costs. Kinney, *Indiana's Medical Malpractice Reform Revisited: A Limited Constitutional Challenge*, 31 Ind L Rev 1043, 1048 (1998), citing 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." Bovbjerg, *Lessons for Tort Reform from Indiana*, 16 J Health Pol Pol'y & L 465 (1991).

2. There Was No Basis for Reasonable Lawmakers to Believe That Capping Noneconomic Damages Would Reduce Malpractice Premiums or Healthcare Costs.

The Legislature's plan to control the cost of health care, as outlined by the court of appeals in *Zdrojewski*, featured a chain of very hopeful assumptions. Specifically, the lawmakers assumed that lowering the severity of awards would result in significant savings for malpractice insurers. Secondly, the lawmakers assumed that those insurers would use their savings to lower malpractice insurance premiums. Finally, they assumed doctors and hospitals would pass those lower costs along to their patients. Reasonable legislators could not have expected their handiwork to accomplish that goal.

The second and third links in the chain are entirely voluntary; nothing in MCL 600.1483 requires insurers to reduce malpractice premiums or providers to reduce their fees. There was no rational basis for counting on them doing so, and there was no reason to assume that capping noneconomic damages would result in any savings to insurance companies in the first place.

3. Legislators Had No Reasonable Basis to Expect That the Cap on Noneconomic Damages Would Reduce Losses by Malpractice Insurance Carriers.

   a. *Capping Noneconomic Damages Affects Too Few Cases to Result in Significant Savings to Insurers.*

The first essential step in the Legislature's plan for controlling healthcare costs depended upon reducing the amount of money insurers paid out in verdicts and settlements to malpractice victims. It is clear the lawmakers had no rational basis for believing this was so.

Regardless of what the tort reform proponents were telling lawmakers around the country in the mid-1980s, the insurance industry itself very publicly declared that caps on noneconomic damages simply do not generate the savings that would allow them to lower premiums.

Following Florida's adoption of a $450,000 cap on noneconomic damages, the two largest insurers in the state, St. Paul Fire and Marine Insurance Company and Aetna Casualty and Surety Company, made formal statements to the Insurance Commissioner of Florida. The companies stated that, based on studies of their own claims experience, Florida's cap on noneconomic damages would not result in any savings that allow them to lower premiums. See 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).

Direct evidence demonstrates that the insurance industry's industry was, in that instance, telling the truth. A study conducted by the Insurance Service Organization, the rate advisory arm of the insurance industry at that time, evaluated the effects of tort reforms (including a $250,000 cap on noneconomic damages) and found that savings ranged from "marginal to nonexistent." *Morris*, 61 Ohio St 3d at 690. See also *State ex rel Ohio Academy of Trial Lawyers v Sheward*, 86 Ohio St 3d 451, 486; 715 NE2d 1062, 1092 (1999). This study led the Ohio Supreme Court to conclude that Ohio's cap on noneconomic damages was arbitrary and irrational. *Morris*, 61 Ohio St 3d at 691.

One of the nation's largest medical malpractice insurance companies, MedPro Group (formerly known as The Medical Protective Company), caused a stir when it told regulators that

noneconomic damages caps, enacted in Texas, would lower payouts by only 1%. See Hallinan & Zimmerman, *Malpractice Insurer Sees Little Savings in Award Caps*, Wall Street Journal (October 28, 2004), p A6. Medical Protective's disclosure was made in a filing to the Texas Department of Insurance that sought a 19% premium rate *increase*. *Id*. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 NYU L Rev 391, 512 n 46 (2005).

In the Michigan Legislature, there appears to have been no evidence of the number or size of medical malpractice awards of noneconomic damages that exceeded the cap. There was no estimate of the total amount insurers would not have to pay to victims because of the cap. Certainly there is no mention in Defendant's Brief.

Michigan's lawmakers were largely legislating in the dark.

b. Capping Noneconomic Damages Alters the Mix of Cases Coming to Trial in Favor of Cases with Higher Recoverable Economic Damages.

Even if a minimal reduction in indemnity payments were theoretically possible due to the cap, no reasonable legislator would assume that insurers would actually realize these savings. The resolution of medical malpractice claims is a dynamic process. As one researcher observed, noneconomic damage caps "do not have a significant economic effect on total payments" because plaintiff's lawyers "adapt their legal strategies to the new legal regime." Avraham, *An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Settlement Payments*, 36 J Legal Studies S183, S222 (2007).

Because plaintiff lawyers do not bill by the hour like defense counsel who represent doctors and hospitals, their ability to continue in practice depends upon accepting cases that have the potential of resulting in a net return after expenses. Because preparation of a medical malpractice case requires a substantial outlay of time and expenses by the attorney, they have a strong incentive

to make those decisions carefully.[4] See Studdert, Mello, & Brennan, *Medical Malpractice*, 350 N Eng J Med 283 (2004) <https://www.nejm.org/doi/full/10.1056/NEJMhpr035470#body-ref-r015> (accessed March 22, 2025).

Medical malpractice specialists typically take "fewer than 10% of the cases that came to them, and the most demanding would take less than 1% or 2%." Martin & Daniels, *"The Juice Simply Isn't Worth the Squeeze in Those Cases Anymore:" Damage Caps, "Hidden Victims," and the Declining Interest in Medical Malpractice Cases* (American Bar Foundation, Research Paper No 09-01, 2009), available at <https://ssrn.com/abstract=1357092> (accessed March 22, 2025).

Imposing a cap on recoverable noneconomic damages skews that calculation against pursuing cases with high noneconomic damages and in favor of bringing more cases with high economic damages or cases with anticipated verdicts just below the cap that can be won with a lower outlay of expenses.

This "has caused an upward shift in the severity of claims being litigated which, in turn, should drive up the dollar value of the average settlement substantially." Peters, Jr., *On the Cusp of the Next Medical Malpractice Insurance Crisis*, 25 J Health Care L & Pol'y 133, 146 (2022).[5]

c. Noneconomic Damages Caps Result in Increased Verdicts and Settlements for Medical Expenses and Lost Income.

Proving damages in a medical malpractice trial requires reliable evidence, including expert testimony. In preparing and presenting a case on behalf of a victim of medical malpractice, a plaintiff's attorney is most likely to allocate time and resources to developing the damages that

[4] Plaintiff attorneys perform a vital role in the civil justice system as gatekeepers, screening out claims that may have merit but may not economically be worth the resources required to prevail. Damage caps distort and obfuscate this function. See generally the panel discussion in Daniels et al, *The Practical Consequences of Caps on Damages*, 96 Or L Rev 725 (2018).

[5] See also *Indiana's Medical Malpractice Act*, 24(3) Ind L Rev at 1295–96 (documenting a similar post-cap increase in size and frequency of malpractice awards in Indiana).

will be recoverable. Professor Catherine Sharkey has observed that, as attorneys adapt to practicing with a cap on noneconomic damages, "the plaintiffs' attorney (along with the attorney's experts) might simply direct greater efforts towards securing larger economic awards." *Unintended Consequences*, 80 NYU L Rev at 454. This "crossover effect" tends to erase the intended reductions of malpractice verdicts. *Id.* at 391. As a result, noneconomic damages caps "have little to no effect on the size of overall compensatory damages in litigated cases." *Id.* at 445.

In short, Michigan lawmakers had no rational basis for any reasonably expecting that insurers would receive a "cap dividend" that they could use to reduce premiums.

4. Legislators Had No Reason to Believe That Savings from Depriving Plaintiffs of Their Full Noneconomic Damages Would Be Used to Lower Premiums for Michigan Doctors and Hospitals.

Quite apart from whether insurance companies would realize significant savings, it was not rational to assume that insurers would automatically give those savings to their insured doctors and hospitals as lower premiums. The cap statute does not require them to do so. Malpractice insurance companies are free to divert the money not paid to malpractice victims to other purposes including profits, dividends to shareholders, investments, advertising, and executive bonuses.

Indeed, 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 P3d 861, 870; 2006 OK 98 (2006).

For example, a study of closed claims data in Texas disclosed that—following the enactment of Medical Malpractice and Tort Reform Act of 2003, which imposed a $250,000 cap

on noneconomic damages—the state saw a significant drop in malpractice paid losses.[6] Nevertheless "the premiums that [the state's largest malpractice insurer] charged remained well above pre-cap levels." Black et al, *Medical Malpractice Litigation: How It Works and Why Tort Reform Hasn't Helped* (Washington, DC: Cato Institute, 2021), p 115. See also 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, 661–62 (2019) (noting that "one outcome of tort reform, in both Texas and the other new-cap states, was a soaring ratio of med mal premia to payouts," indicating that insurers kept any savings for themselves, rather than reduce premiums).

A study of the 15 leading medical malpractice insurance companies by the former Missouri Insurance Commissioner found that, between 2000 and 2004, the amount that major medical malpractice insurers collected in premiums more than doubled, while their claims payments remained essentially flat. See Angoff, *Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry* (New York: Center for Justice & Democracy, July 2005), p 4, available at <http://centerjd.org/system/files/ANGOFFReport.pdf> (accessed March 23, 2025). The report also found that many insurers substantially *increased* their premiums while their claims payouts were decreasing. *Id.* at p 15.

In *Estate of McCall v. United States*, the Florida Supreme Court held that the state's cap on noneconomic damages in wrongful death medical malpractice actions violated equal protection. 134 So 3d 894 The cap failed the rational basis test, in part, because the state's largest medical-malpractice insurers enjoyed "an increase in their net income of *more than 4300 percent*" from 2003 to 2010 and did not pass those savings along to Florida physicians. *Id.* at 914, 914 n 10.

[6] This decline was likely attributable to the nationwide decline in medical malpractice claims in both cap and non-cap states. *See On the Cusp*, 25 J Health Care L & Pol'y at 134.

In fact, despite tort reformers' claims that limiting compensation to malpractice victims was needed to control insurance premiums, in state after state, malpractice carriers asked regulators for large *increases* in premium rates after caps were enacted. See, e.g., *Insurance Against Competition*, 5 Yale J on Reg at 400–01 (discussing Florida); Schlegel, *Some Malpractice Rates to Rise Despite Prop. 12*, Houston Chronicle (November 19, 2003) (discussing Texas).

5. Legislators Had No Reason to Believe That Capping Noneconomic Damages Would Lower Health Care Costs for Michigan Consumers.

As the Kansas Supreme Court accurately calculated: "Should a doctor decide to pass these savings on to his hundreds of patients, each person's savings would be minuscule." *Kansas Malpractice Victims Coalition*, 243 Kan at 345.

Malpractice insurance premiums are not "a large component of health care costs" *Zdrojewski*, 254 Mich App at 80. Global credit rating agency AM Best reports that total premiums earned by United States health care providers in 2023 was just under $6.8 billion.[7] This is a considerable sum, but Americans paid $4.6 *trillion* for their health care within the same year.[8] MCL 600.1483 does not purport to eliminate all malpractice premiums, or even the fraction attributable to awards of noneconomic damages. The figure representing the premiums that fund awards of noneconomic damages above the cap, divided among the population of Michigan, is truly microscopic. Reliance on the cap as a plan to control the cost of healthcare in Michigan is irrational.

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[7] *Statement of Income*, in *Annual Statement for the Year 2023 of the Medical Professional Liability Composite* (AM Best ed, 2024) (on file with author).

[8] National Health Statistics Group, *The Nation's Health Dollar ($4.9 Trillion), Calendar Year 2023: Where It Came from and Where It Went* (Washington, DC: Centers for Medicare & Medicaid Services, 2024), available at <https://www.cms.gov/files/document/nations-health-dollar-where-it-came-where-it-went.pdf> (accessed March 23, 2025).

C. Experience and Empirical Data Has Shown That Damage Caps Do Not Reduce Malpractice Insurance Premiums and Have No Impact on the Cost of Healthcare.

The malpractice insurance cost increase that prompted the Legislature to enact MCL 600.1483 was not the first time malpractice insurers drastically increased prices, nor the last. The United States has experienced three such "crises," occurring approximately from 1974 to 1976, 1984 to 1986, and 2002 to 2006. Hunter & Doroshow, *Stable Losses/Unstable Rates 2016* (New York: Americans for Insurance Reform, 2016), pp 5–12, available at <http://centerjd.org/system/files/MasterStablelosses2016F9.pdf> (accessed March 23, 2025). See also Baker, *The Medical Malpractice Myth* (Chicago: The University of Chicago, 2005), p 3. Each crisis was accompanied by a strenuous lobbying campaign in pressuring state legislatures for "tort reform." Approximately 30 states enacted damage caps of various types.[9]

One consequence of the extensive and expensive tort reform campaign to promote caps, was that the question of whether caps work has attracted the attention of researchers. They have examined various sets of insurance data from various jurisdictions over various time periods. The empirical data confirms that caps are not the right medicine for rising malpractice premiums and healthcare costs.

In one of the earliest studies, data from 1974 to 1977 led Vanderbilt University Economics Professor Frank Sloan to conclude: "The empirical results of the study presented here give no indication that individual state legislative actions, or actions taken collectively, have had their intended effects on premiums." Indeed, the correlation between average malpractice awards and malpractice premiums was "surprisingly low." Sloan, *State Responses to the Medical Malpractice*

[9] *Malpractice Damage Caps by State* (Washington, DC: National Association of Benefits and Insurance Professionals, 2023), available at <https://nabip.org/media/8331/medical_malpractice_cap.pdf> (accessed March 23, 2025).

Insurance "Crisis" of the 1970's: An Empirical Assessment, 9 J Health Politics Pol'y & L 629, 630 (1985).

A subsequent and far more 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 at all. Weiss et al, *Medical Malpractice Caps: The Impact of Noneconomic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage* (Palm Beach Gardens, FL: Weiss Ratings, Inc., 2003), p 3, available at <https://www.dcinjuryfacts.com/files/medicalmalpracticecaps.pdf> (accessed March 23, 2025).

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 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, indicating that the insurers diverted any savings from caps directly to profits. Further, that study found that states that had enacted caps actually saw *higher* insurance rates for physicians. Black, Traczynski, & Udalova, *How Do Insurers Price Medical Malpractice Insurance?* (IZA Institute of Labor Economics, Discussion Paper No 15392, June 2022), available at <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4151271> (accessed March 23, 2025).

Similarly, a study published by Americans for Insurance Reform found that states with caps "saw an average 21.8 percent decrease in pure premiums over the period [2002 to 2016] – but the

states that did not enact or lower caps saw an even greater average drop of 28.9." Hunter & Doroshow, *Premium Deceit 2016: The Failure of "Tort Reform" to Cut Insurance Prices* (New York: Americans for Insurance Reform, 2016), p 6, available at <https://centerjd.org/content/premium-deceit-2016-failure-tort-reform-cut-insurance-prices> (accessed March 23, 2025).

Studies looking at the impact of caps on health care costs have come to similar conclusions. For example, a team of researchers looked at 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 fact, they found that damage caps have no significant impact on Medicare Part A spending" (hospitals), but "a 4-5% post-cap *increase* in Medicare Part B spending" (doctors). Paik, Black, & Hyman, *Do Doctors Practice Defensive Medicine, Revisited*, 51 J Health Econ 84, 84–97 (2017).

Similarly, a study looking at per-person spending between 1996 and 2012, concluded that noneconomic damages caps "have no significant effects on health expenditures." Yu, Greenberg, & Haviland, *The Impact of State Medical Malpractice Reform on Individual-Level Health Care Expenditures*, 52(6) Health Serv Res 2018, 2030 (2017), available at <https://pmc.ncbi.nlm.nih.gov/articles/PMC5682133/> (accessed March 23, 2025).

An article by former Michigan Congressman John Conyers highlighted other studies that reach similar conclusions, including "data from the 2002 Medical Liability Monitor [that] shows that Michigan, a state with caps, has one of the highest average premiums in the country, while Minnesota and Oklahoma, two states without caps, have two of the three lowest average rates." Congressman John Conyers, Jr., *The Health Act: A Bad Prescription for Consumers*, 27 Seton Hall Legis J 191, 192 (2003).

The Defense nevertheless asserts that there is "evidence that caps work." Defs' Br 63. Indeed, the lead research work listed by Defendants is cited for the proposition that "caps resulted in lower premiums." Kilgore et al, *Tort Law and Medical Malpractice Insurance Premiums*, 43(3) Inquiry 255, 263 n 23 (2006). But that is not quite so. The study did not find that all medical providers, or even all doctors experienced lower premiums. The study included only internal medicine specialists. Most importantly, the study found that states with caps above $500,000, like Michigan, *actually experienced increases* in malpractice insurance premiums. *Id.* at 266. The next two cited studies found the "same."

Columbia University Law Professor Bernard Black and his colleagues analyzed 15 years of closed medical malpractice claims collected by the Texas Department of Insurance. They found no connection between the claimed "crisis" in medical liability insurance and outcomes in medical malpractice cases. "The more likely explanation is that much of the rise in premiums reflects *insurance market dynamics, not litigation dynamics*." Black et al, *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 J Empirical Legal Stud 207, 210 (2005), available at <https://scholarship.law.tamu.edu/facscholar/1732> (accessed Mar. 23, 2025) (emphasis added).

Those dynamics are worthy of this Court's attention.

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

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

Over 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 almost clear: The notion that skyrocketing malpractice verdicts cause skyrocketing

malpractice insurance premiums, which cause skyrocketing healthcare costs has been a useful lobbyist's talking point. But it is a myth.

Liability insurers pay malpractice awards out of the premiums they collect. In the long term, inflation in the price of medical care to remedy wrongful harm and wage inflation to replace lost income, major components of tort awards, require insurers to steadily increase premiums. But that is not what happens in the medical malpractice insurance market.

The sharp rise in the price of medical malpractice insurance rates during the mid-1980s, which prompted the Legislature to enact MCL 600.1483, resembled similar premium spikes around the country during the mid-1970s as well as in the mid-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." *Stable Losses/Unstable Rates*, p 2.

A much larger, 10-year analysis arrived at precisely the same conclusion. CRICO Strategies analyzed over 124,000 medical malpractice claims between 2007 and 2016, representing approximately 30% of all such claims in the United States. CRICO found a steady "rise in average payments [that] can be fully explained by medical and consumer inflation." *On the Cusp*, 25 J Health Care L & Pol'y at 139. Moreover, "the AM Best data for the last decade show the same trend." *Id*. at 145. The disconnect between malpractice awards and malpractice premiums is starkly illustrated by the fact that, during about the same period (from 2007 to 2018), "premiums steadily declined by 35% in adjusted dollars." *Id*. at 157.

Malpractice insurance premiums, on the other hand, have 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. *Stable Losses/Unstable Rates*, p 2.

That malpractice premiums rise and fall independently of tort outcomes has been demonstrated repeatedly. For example, one survey of empirical research found that, 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." Liu & Hyman, *The Impact of Medical Malpractice Reforms*, 16 Ann Rev L & Soc Sci 405, 413 (2020) (citing studies). Premiums subsequently nearly returned to the late-1990s level. *Id*. at 406–07. "These findings raise serious doubts about the supposed causal link between litigation trends and premium spikes." *Id.*

What, then, was the cause of these market fluctuations in the price of malpractice liability insurance?

B. 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.

Professor Baker explains the gyrations in the liability insurance market:

> 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, *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.[10]

[10] During the underwriting cycle, "the amount that insurers charge is not an accurate reflection of how much they pay for malpractice claims, especially in the short run." During a soft market,

As Professor Baker and others point out, a medical malpractice liability insurance company actually 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. *The Medical Malpractice Myth*, pp 51–58. That income can be substantial. During the soft market period from about 1977 to 1984, investment income more than offset underwriting losses. Nye et al, *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 Geo LJ 1495, 1521 (1988). An insurer's financial health is thus tethered to its investment prospects, which rise and fall in a pattern of economic expansion, followed by recession and recovery. See *Stable Losses/Unstable Rates*, pp 4–11.

During soft markets, interest rates and returns on investment are high. Insurance companies compete for customers to obtain more premiums to invest. Initially, investment income increases profits and sufficient funds are held as reserves to be available 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 cuts its prices and underestimates future obligations.[11] The company thereby draws down reserves to obtain more cash to invest.

"insurance companies underestimate future losses, so they charge low prices and set modest reserves against future payment. Then losses start to mount, and insurance companies conclude they were overly optimistic and must adjust their premiums and reserves. The market turns hard as premiums spike to cover the new reality." *The Impact of Medical Malpractice Reforms,* 16 Ann Rev L & Soc Sci at 414.

[11] "During the final stages of a soft market, new policies are underpriced and, to enable that, under-reserved. This occurred before both the 1986 and 2002 hard markets." *On the Cusp*, 25 J Health Care L & Pol'y at 150. See also *The Medical Malpractice Myth*, pp 50–52.

Eventually, however, excess reserves are exhausted. Meanwhile, inflation increases the cost of claims payments and operating expenses. 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. Their predicament becomes dire when operational losses exceed investment returns, depleting surplus equity and reducing carrier ability to write new policies and to invest. At this point, insurers need to raise premiums and reserves as the market moves from soft to hard. Unfortunately for health care providers, the turn from a soft market to a hard one has always been sharp. *On the Cusp*, 25 J Health Care L & Pol'y at 148. See also Fitzpatrick, *Fear is the Key: A Behavioral Guide to Underwriting Cycles*, 10 Conn Ins LJ 255, 256 (2004) (explaining how insurers create their own financial risk by competing to cut prices and loosen terms).[12]

Importantly, the spikes in malpractice premiums match precisely the timeline of the insurance economic cycle. See *Stable Losses/Unstable Rates*, graph depicting the "Insurance Economic Cycle" from 1967 to 2013, p 4. As Professor Baker explains:

> [T]he two most recent medical liability insurance crises [in the mid-1980s and early 2000s] did not result from sudden or dramatic increases in medical malpractice settlements or jury verdicts. Instead . . . the crises resulted from dramatic increases in the amount of money that the insurance industry put in reserve for claims. Those reserves increases were so big because the insurance industry systematically under reserved in the years leading up to the crisis.

The Medical Malpractice Myth, pp 53–54.

Business cycles and their impact on the insurance industry are well known and should be manageable by large and well-resourced insurance enterprises adhering to sound underwriting principles. In the early 1980s, just ahead of the "crisis" that moved the Legislature to enact MCL

[12] In fact, Professor Baker suggests that below-cost selling *is the characteristic sign* of a soft market in trouble. *Insurance Underwriting Cycle*, 54 DePaul L Rev at 396.

600.1483, industry observers were sounding warnings that another self-destructive cycle to a hard market was near. Instead of taking steps to prevent drastic price disruptions, the liability insurance industry essentially committed insurance malpractice.

It is worth reviewing what really caused that "crisis." At the end of 1980, 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 (December 8, 1980). When property-casualty 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 (March 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." McKay, *Rethinking the Tort Liability System: A Report from the ABA Action Commission*, 32 Vill L Rev 1219, 1219–21, 1221 (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.[13] Cummins et al, *Cycles and Crises in Property/Casualty Insurance: Causes and Implications for Public Policy* (Kansas City, MO: National Association of Insurance Commissioners, 1991).

It is worth asking why carriers do *not* peg their premium rates to their own reliable actuarial estimates of future losses. Why continue to sell policies below cost in a competition where the "winners" have put themselves in such financial peril that they must raise rates dramatically at the expense of their policyholders? Professor Baker suggests that they cannot help themselves: highly competitive soft markets force carriers to keep premiums low until it is too late to avoid a dramatic correction.

When investment income slows, sales managers and sales staff are afraid to be the first to raise premiums and lose market share. That fear puts pressure on the underwriters to keep their predictions of future losses low. *The Medical Malpractice Myth*, pp 56–57. Low predictions of future losses keep reserves low, enabling low premiums that fuel sales. Companies adopt employee pay incentives that reward increases in market share and revenue, and do not reward calls for increased reserves or costlier premiums. *Insurance Underwriting Cycle*, 54 DePaul L Rev at 418–20. Other insurers feel obliged to follow the market down to preserve their own market share and premium revenue. Even as profits are threatened, "herd mentality" leads carriers to wait until the rest of the pack is ready to raise prices. *The Medical Malpractice Myth*, p 57.

[13] Another indicator that the insurance industry itself, not medical malpractice victims and their lawyers, cause the periodic spikes in premiums is that across "such disparate lines as auto, surety, fire, crop, homeowners, inland marine, workers compensation, and product liability, the overall Properly and Casualty (P/C) industry has experienced nearly the same ups and downs as medical malpractice insurance. *Each spike in premiums for the P/C industry perfectly matches one of the three crises in the medical malpractice industry*." *On the Cusp*, 25 J Health Care L & Pol'y at 150 (emphasis added).

"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." *On the Cusp*, 25 J Health Care L & Pol'y at 151.

> [P]ressure builds until it erupts sharply in the twin scourge of higher premiums and greatly increased reserves . . . transferring the financial pain to physicians and hospitals who, in turn, are shocked and angered by the sudden and dramatic increases in their malpractice insurance premiums. When they 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. Yet, the explosive force of a malpractice hard market is usually a product of prior underpricing (and its companion, under-reserving), not a sharp increase in claims costs.

Id. at 150–51.

The industry's practice of competitively reducing premiums, and thereby under-reserving during soft markets magnifies the increase in prices when the hard market arrives. Not only do underwriters try to rapidly increase reserves to realistic levels for new coverage, "but they also correct the under-reserving that took place in the final years of a soft market." *Insurance Underwriting Cycle*, 54 DePaul L Rev at 399. This has a heavy impact on doctors and hospitals because the "long tail" of medical malpractice coverage for claims arising many years prior leaves a large volume coverage open to reassessment. It has been estimated that "the reserve increases in the years 2001-04 could have accounted for 60 percent of the price increases witnessed by doctors during the period." *Stable Losses/Unstable Rates*, p 10.

At the time when Michigan—and much of the country—was experiencing wrenching premium increases, rather than formulating and implementing plans to break this destructive cycle, the insurance industry devoted its efforts and resources to blaming patients, trial lawyers, jurors, and courts. The industry's public relations arm, Insurance Information Institute, 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." Herbert, *Tort Reform Drive Launched*, Journal of Commerce

(March 19, 1986), pp 1, 20. See also Consumers Union, *The Manufactured Crisis: Liability Insurance Companies Have Created a Crisis and Dumped It on You*, Consumer Reports (August 1986), p 544.

This campaign was not a rationally-based effort to prevent gyrations in premium rates or ease the cost of healthcare for the people of Michigan.

III. AS A PURPORTED "REFORM" OF THE MEDICAL LIABILITY SYSTEM, THE CAP ON NONECONOMIC DAMAGES IS IRRATIONAL.

A. It Is Fundamentally Unfair to Place the Burden of Fixing Michigan's Liability Insurance System on the Most Severely Injured Victims of Medical Malpractice.

The defense repeatedly describes the cap on damages as medical liability "reform." *See* Defs' Br 63 n 23. Even assuming for a moment that Michigan's civil justice system needs repair, it is wholly arbitrary and irrational to demand that the relatively small number of very seriously injured victims of malpractice shoulder the entire cost of this supposed 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 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 Group, 38 Cal 3d 137, 173; 695 P2d 665, 689–90 (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. *Maurer*, 120 NH at 942. In the view

of the Ohio Supreme Court, "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*, 61 Ohio St 3d at 691. See also *Best v Taylor Machine Works*, 179 Ill 2d 367, 406–07; 689 NE2d 1057, 1077 (1997).

Respected insurance law scholar, Kenneth Abraham, and two other distinguished Reporters of the American Law Institute make the additional point that capping damage awards "imposes the burden of containing liability costs and premiums upon the most severely disabled, the people *who are most likely to be undercompensated* even without a damage cap." Abraham, Rabin, & Weiler, *Enterprise Responsibility for Personal Injury: Further Reflections*, 30 San Diego L Rev 333, 340 (1993) (emphasis added).

As a dissenting justice pointed out to 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*, 325 Md 342, 379–80; 601 A2d 102, 120 (1992) (CHASANOW, J., dissenting).

Indeed, one scholar has documented that caps on noneconomic damages fall most unfairly on injured women, children and the elderly, who frequently cannot prove loss of income and other economic damages. See Finely, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 Emory LJ 1263, 1313 (2004). To make the situation even worse, their lack of provable economic damages may render them unable to obtain representation to obtain access to court for any redress at all. *Declining Interest in Medical Malpractice Cases*, p 35.

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 Michiganders 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 by others in the future. The classic exposition of the Law and Economics view declares:

> [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.

Posner, *Economic Analysis of Law* (1st ed), § 6.12, p 143. 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 P2d 348, 364 (Utah, 1989).

Professor Gary Schwarts points to the example of hospitals, prompted by lawsuits based on leaving foreign objects in surgical 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." Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA 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. Indeed, analysis by Harvard researchers examining the medical records of 31,000 patients who were hospitalized in New York hospitals indicates 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.[14]

Insurers also respond to the incentives created by the tort system to invest in patient safety. Abraham & Sharkey, *The Glaring Gap in Tort Theory*, 133 Yale LJ 2165, 2237 (2024). 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." Abraham & 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* Baker & Silver, *How Liability Insurers Protect Patients and Improve Safety*, 68 DePaul L Rev 209, 223 (2019).

When insurers are shielded by damage caps from potentially large losses, their financial incentives to invest in proactive improvements in patient safety evaporate as well. 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." Zabinski & Black, *The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform*, 84 J Health Econ 102638 (2022), available at <https://www.sciencedirect.com/science/article/abs/pii/S0167629622000571?via%3Dihub> (accessed March 23, 2025).

[14] New York has never imposed a cap on medical malpractice damages.

Other 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." *Fictions and Facts*, 51 Tex Tech L Rev at 630. The researchers concluded that, in Texas, compared to states that did not adopt caps, "patient safety declined and physicians paid more premium dollars relative to payouts." *Id*. at 630–31.

It is irrational to continue to try to reduce Michigan malpractice premiums and healthcare costs by maintaining a damage cap that *increases* harms to Michigan patients.

C. The Cap Irrationally Perpetuates Periodic Spikes in Malpractice Premiums, Which Harms Insurers, Healthcare Providers, and Patients, and Diverts Attention from Insurance Regulation to Mitigate Insurance Cycles.

The empirical evidence overwhelmingly shows that "because malpractice claiming does not appear to be the cause of med mal crises, litigation-focused remedies are likely to be incomplete, underpowered, and inefficient in addressing what is, in the end, a problem in the market for med mal insurance." *The Impact of Medical Malpractice Reforms*, 16 Ann Rev L & Soc Sci at 416.

Malpractice insurance is currently in an unusually long soft market. During the 1986 crisis, in response to a "slight increase in payouts" insurers hiked premiums and reserves "more than eventually was required," so that "premiums could be reduced during the ensuing soft market to compete for market share." *On the Cusp*, 25 J Health Care L & Pol'y at 147–48. That set the table for the 2002–2006 crisis. The same pattern of industry behavior suggests that the next turn of the insurance cycle is not far off. *Id.*

These periodic market spasms that harm insurers, healthcare providers, and patients are not inevitable. Campaigns that blame patients and their attorneys simply divert attention away from sensible insurance regulation to address a problem that the market is unable to eliminate on its own.

As noted earlier, sharp increases in malpractice premiums continued in California for a decade after the state enacted a stringent $250,000 cap on noneconomic damages. Rates only stabilized after voters demanded and got insurance reform. See generally *How Insurance Reform Lowered Doctors' Insurance Rates in California*, p 2.

In Illinois, 5 years after the state adopted a package of insurance reforms, the Department of Insurance announced:

> The 2005 Reform Laws imposed changes to the Illinois Insurance Code that improved insurer reporting and transparency requirements and enhanced the Department's rate oversight authority. Since 2005, the Department has observed improvements in the medical malpractice insurance market. In particular, the Department observed . . . **A decrease in medical malpractice premiums.** Gross premium paid to medical malpractice insurers has declined from $606,355,892 in 2005 to $541,278,548 in 2008.

Illinois Department of Insurance, *Illinois Department of Insurance Encourages Insurers to Comply with 2005 Medical Malpractice Reforms*, issued February 20, 2010, available at <https://www.illinois.gov/news/press-release.8260.html> (accessed March 23, 2025).

CONCLUSION

This Court should accept the certified question from the federal district court and answer that question by declaring that the noneconomic damages cap contained in MCL 600.1483 is arbitrary and lacks any rational basis, and therefore violates Michigan's constitutional guarantee of equal protection of the laws.

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WORD COUNT CERTIFICATION

I hereby certify that this brief contains 12,125 words in the sections covered by MCR 7.212(C)(6)–(8).

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