COMMONWEALTH OF KENTUCKY
SUPREME COURT
Nos. 2017-SC-614 and 2017-SC-615

COMMONWEALTH OF KENTUCKY, CABINET FOR HEALTH AND FAMILY SERVICES, *EX REL.* VICKIE YATES BROWN GLISSON, in her official capacity as Secretary — APPELLANT

V.

ON REVIEW FROM THE COURT OF APPEALS
NO. 2017-CA-1770

FRANKLIN CIRCUIT COURT
ACTION NO. 17-CI-708

EZRA CLAYCOMB, a minor, by and through his next friend, natural guardian, and parent, TONYA CLAYCOMB, individually and on behalf of all others similarly situated — APPELLEES

AMICUS CURIAE BRIEF OF THE KENTUCKY MEDICAL ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION

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Certificate of Service

I hereby certify that, on January 23, 2018, a true copy of this brief was sent via U.S. Mail to: Samuel P. Givens, Jr., Clerk of the Kentucky Court of Appeals, 360 Democrat Drive, Frankfort, Kentucky 40601; Paul A. Casi, II, 440 S. 7th St., Suite 100, Louisville, KY 40203; J. Guthrie True, True Guarnieri Ayer, LLP, 124 W. Clinton St., Frankfort, KY 40601; M. Stephen Pitt, S. Chad Meredith, Matthew F. Kuhn, Office of the Governor, 700 Capitol Avenue, Frankfort, KY 40601; Johann Herklotz, Catherine York, Matthew Kleinert, Cabinet for Health and Family Services, 275 E. Main St., 5W-B, Frankfort, KY 40621; and Hon. Phillip Shepherd, Franklin Circuit Court, 222 S. Clair St., Frankfort, KY 40601.

Sarah Cronan Spurlock

STATEMENT OF POINTS AND AUTHORITIES

STATEMENT OF THE CASE

This appeal arises from a lawsuit challenging the constitutionality of Senate Bill 4 relating to medical review panels, which took effect on June 29, 2017 (the "MRP Act"). The MRP Act establishes a medical review panel process to review proposed malpractice complaints against health care providers. KRS 216C.005.

The General Assembly passed the MRP Act in an effort to lower malpractice premium costs and attract health care providers to come to and remain in the Commonwealth, thereby improving Kentucky's health care system and improving access to quality health care for Kentuckians. The medical review panel legislation has a long history in the Commonwealth, with the public policy considerations behind such legislation having been considered and debated within the legislative process for six consecutive years before passage of the MRP Act in 2017.

The Circuit Court permanently enjoined enforcement of the MRP Act, finding it to be unconstitutional for various reasons. Included among the reasons was a finding that the MRP Act violates Kentucky constitutional equal protection and special legislation provisions because, despite an admittedly legitimate state interest, the MRP Act was so attenuated as to render it arbitrary and irrational. (R. 1365-92.) The Cabinet appealed and received emergency relief in a one-judge decision from the Court of Appeals which also stayed the Circuit Court's injunction of the MRP Act. (R. 1463-70.) Both parties requested transfer to this Court.

The Kentucky Medical Association and the American Medical Association[1]

[1] The AMA appears as *amicus curiae* in this case on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the state medical societies, with the purpose of advancing American Medical Association policies through the American legal system.

submit this *amicus curiae* brief to address a narrow subset of the issues before this Court. This brief confirms facts considered by the legislature but which were undercut by the Circuit Court's flawed equal protection and special legislation analysis in which it misapplied evidentiary principles applicable to statutory interpretation disputes and ultimately deemed the MRP Act arbitrary and irrational. Further, this brief demonstrates the adverse impact of Kentucky's physician shortage on the availability of health care services, describes how Kentucky's perennial reputation for having a negative medical malpractice litigation climate contributes to health care provider shortages and impedes access to quality care, and further demonstrates why attracting and retaining health care providers, including physicians, is important in advancing the health of Kentucky's citizens, its economy, and Kentucky's health care system as a whole.

Kentucky is perceived as having a hostile medical malpractice litigation climate which makes it difficult to attract and retain physicians and increases malpractice premium costs for health care providers doing business in Kentucky, which, in turn, impacts Kentucky's health care system as a whole and negatively impacts patients' access to care. The establishment of medical review panels to review proposed malpractice complaints is important legislation for the Commonwealth as it will foster a liability system which facilitates early resolution of claims, reduces costs for claimants and health care providers, encourages health care providers to come and stay in Kentucky, and ultimately improves access to health care for all Kentuckians, while still ensuring access to the courts.

The KMA and the AMA support the Appellant's request to reverse the Circuit Court's decision and affirm the constitutionality of Kentucky's medical review panels.

ARGUMENT

I. The lower court engaged in erroneous and improper analysis of information which supports the legislature's legitimate state interests, thereby pre-ordaining its ultimate conclusion that the MRP Act and its stated legislative purpose is "so attenuated as to render the statute arbitrary and irrational."

Instead of conducting the appropriate constitutional equal protection and special legislation analysis of information considered by the legislature before adopting the MRP Act, the Circuit Court devoted three pages of its opinion to challenging the evidentiary value of the MRP Act's legislative history. (Op., R. 1365, pp. 10-12.) In doing so, the court applied inappropriate principles of statutory construction in a case that does not involve a dispute as to a statute's *meaning*. That misapplication of the wrong analysis, and reliance on reports outside the record to discredit sources relied upon by the legislature, substantially undercut the court's ultimate finding that a legitimate state interest is involved—increasing the number of physicians in Kentucky. Thus, even though the court concluded that increasing the number of physicians is a legitimate state interest, its exercise in discrediting sources relied on by the legislature tainted its consideration of whether the Act bore a rational relationship to achieving that admittedly legitimate state purpose.

By questioning the relevance and evidentiary value of the MRP Act's legislative history, the Circuit Court effectively foreclosed any possibility that the MRP Act could survive its equal protection and special legislation analysis. A portion of the evidence supporting a rational relationship between the MRP Act and its stated purpose was necessarily found in the information broadly cited as legislative history, including the professional reports considered by the legislature, which the court discredited under its misapplied statutory construction analysis. The court also too narrowly described the

legitimate state interest involved as being limited only to increasing the number of physicians in Kentucky, thereby effectively excluding from its analysis consideration of other concerns the legislature attempted to address, including lowering malpractice premium costs for physicians and other categories of health care providers, such as long term care facilities, which concerns were established by references in the legislative debates and reports questioned by the Circuit Court.

Only by describing and analyzing an interest more narrow than that which the legislature sought to address in the MRP Act did the court conclude the MRP Act fails rational basis review. For example, the Circuit Court cites as evidence of irrationality the fact that the "legislature developed the MRP Act to address the shortage of *physicians* in Kentucky, yet the Act imposes a panel review process for any medical malpractice claim brought against *any* health care provider." (R. 1379.) This oversimplifies the complex issue before the legislature. The legislature was dealing with how *various types of health care providers*, not just physicians, are impacted by the medical liability climate in Kentucky. For example, the Cabinet's brief cites statements by legislators that confirm that the MRP Act is intended to address concerns about the malpractice climate's impact, not only on physicians, but also on nurses, hospitals, and nursing homes. (Cabinet's Brief, p. 3.) And, legislators cited a professional study by Aon Global Risk Consulting as authority that long-term care facilities in Kentucky pay the highest amount per occupied bed for defending, settling, or litigating claims of any of the seventeen other states surveyed in the report. *See* "2016 Long Term Care: General Liability and Professional Liability Actuarial Analysis" at 25 ("Aon Report"), R. 746-805.

Kentucky's health care system involves a variety of complex and interconnected relationships between health care providers and various types of health care facilities.

For example, physicians need access to hospitals as a venue for providing surgical services that cannot reasonably be provided to their patients in an office setting. Specialties such as radiology, anesthesiology, pathology, and emergency medicine require hospitals as a venue for their services. Likewise, hospitals need physicians, as well as other types of health care providers, such as nurses, social workers, and physical therapists, to care for patient needs. Long-term care facilities, too, depend on physicians and other health care providers to serve their residents' needs.

Given the interconnected and interdependent nature of many aspects of our health care delivery system, any one of a number of factors may disrupt the effective delivery of care—whether it be too few physicians to meet the demand of patient needs, difficulty securing specialty physicians for communities and hospitals in rural areas, or long-term care facilities ceasing operations due to exorbitant malpractice premiums. In short, the failure of any one provider type to thrive negatively impacts the others and ultimately has a negative impact on the availability and quality of health care for all Kentuckians.

The MRP Act does not pick winners and losers. (Cabinet's Brief, p. 22.) Rather, it assists all parties, including claimants, by encouraging early discussion and settlement of cases that are typically difficult, time consuming, and expensive to try in court. As the Cabinet explains, medical review panels will enable "claimants and health care providers to pursue meaningful settlement discussions, informed by the facts, before initiating costly litigation." (*Id.* at p. 6.) Medical review panels will benefit claimants with meritorious claims as they offer early, low-cost access to potential experts, giving health care providers an immediate incentive to consider settlement where the panel issues an opinion favorable to the claimant. Medical review panels will also promote better use of judicial resources as they will deter filing of meritless complaints, and allow actions that

do proceed to circuit court to proceed more expeditiously. (*Id.*, pp. 12-14.)

Although the discussion above highlights a number reasons, this brief is not an effort to recount all the reasons legislators reasonably believed medical review panels will achieve the primary and legitimate interests of attracting physicians to Kentucky and reducing malpractice premiums. The Cabinet aptly addresses those topics in its brief. Rather, this brief aims to offer additional support and context for the concerns before the legislature in enacting the MRP Act. Striking the appropriate balance in seeking solutions to complex social and economic problems is fully within the purview of the General Assembly as policy makers. *Wehr Constructors, Inc. v. Assurance Co. of America*, 384 S.W.3d 680, 687 (Ky. 2012) (The establishment of public policy is granted to the legislature alone)). The General Assembly exercised that purview in enacting the MRP Act and its constitutionality should be upheld.

II. Kentucky's physician shortage is supported by credible evidence, and action is required to secure access to health care for Kentuckians.

The Circuit Court devoted significant attention in its opinion to questioning the relevance and evidentiary value of the 2013 Health Care Workforce Capacity Report commissioned by the Beshear Administration and compiled by Deloitte (the "Deloitte Report," R. 562-646). But the Circuit Court's view of the relevance of the Deloitte Report is immaterial to the constitutional challenge before this Court. That report was unquestionably relevant during debate of the MRP Act in the General Assembly, as both senators and representatives cited it as an important reason to vote for the MRP Act.[2] The Deloitte Report found that 3,790 more physicians were needed in addition to the

[2] The Deloitte Report was referenced in support of the MRP Act during debate and testimony in the legislature. *See* Legislative History, R. 460-805, at 1/4/17 Tr., p. 4; 1/5/17 Tr., p. 11; 2/28/17 Tr., pp. 8-9; and 3/1/17 Tr., pp. 38, 53.

10,475 active physicians then in Kentucky, and it specifically recommended consideration of medical review panels as a solution. (Deloitte Report at 2, 15, 53.)

The Circuit Court, however, conducted its own analysis of a 2015 Data Book from the Association of American Medical Colleges (AAMC) concluding it "obviously conflicts with the legislature's determination that Kentucky suffers from a severe physician shortage and retention problem." (Opinion, R. 1365, p. 11.) Not only was the court's questioning of the evidentiary value of the Deloitte Report erroneous and unnecessary to a proper constitutional equal protection analysis, but even were it not so, the court's interpretation and application of that report was also flawed.

The Circuit Court noted that the AAMC Data Book indicates that "Kentucky has more active physicians per 100,000 citizens than several other states, including states with medical review panels, such as Indiana." *Id.* Simply looking at physician numbers relative to population, however, fails to take into account state-specific differences, including the possibility of higher concentrations of unmet need and professional shortages in geographic locations within each state that impact patients' access to care. As an example, data as of September 30, 2016, available from the Health Resources and Services Administration showed that, in the specialty of primary care, Kentucky had 144 geographic areas, populations groups, or health care facilities designated as having a shortage of health professionals (also known as health professional shortage areas or HPSAs) as compared to 117 such HPSAs in Indiana. *See* HRSA Fact Sheet FY 2016 Kentucky, p. 4 and HRSA Fact Sheet FY 2016 Indiana, p. 4, available at https://datawarehouse.hrsa.gov/tools/factsheets.aspx. Notably, the Deloitte Report found that 61% of unmet need for physicians in Kentucky is concentrated in rural counties. (Deloitte Report, p. 15.)

And, again comparing Indiana to Kentucky, the percentage of adults between the ages of 18 and 64 without a usual place of medical care in 2014 was 23.3% in Kentucky as compared to 14.8% in Indiana. Kaiser Family Foundation, Percent of Adults Without a Usual Place of Medical Care, https://www.kff.org/other/state-indicator/percent-of-adults-without-a-usual-place-of-medical-care (last visited January 17, 2018). In fact, Kentucky's percentage of adults without a usual place of medical care in 2014 was higher than that of each of Kentucky's seven contiguous states. *Id.*

These figures demonstrate that an accurate state-by-state comparison of unmet need for physicians requires consideration of not only the number of physicians relative to overall population, but also the geographic distribution of those physicians within the state and how that distribution impacts patient access to care. Regardless, weighing the value of state comparable data is a task properly left for the legislature and not for a court when conducting a rational basis review. *Comm.v. Howard*, 969 S.W.2d. 700, 703 (Ky. 1998) (Legislative classification is not subject to a court-room fact finding process.)

In questioning the relevance of the Deloitte Report and citing the AAMC 2015 Data Book, the Circuit Court seems to suggest that if Kentucky fares better than another state with respect to physician supply and retention, then the legislature must be mistaken in finding that there is a physician shortage in Kentucky. In addition to the fact that it is not the Circuit Court's role to decide in the context of this case what constitutes a physician shortage, even assuming Kentucky may fare better than some other states, simply faring better than other states is cold comfort when the AAMC 2015 Data Book itself ranked Kentucky at 36 out of 50 for physician supply based on active physicians, and studies continue to show that demand for physician services will outgrow supply *across the United States* over the next decade.

Projections by the AAMC released in March of 2017 indicate that "the nation continues to face a significant physician shortfall" projected to reach between 7,300 and 43,100 primary care physicians, and between 33,500 and 61,800 physicians in non-primary care specialties, by the year 2030.[3] This 2017 report, the findings of which were largely consistent with its 2015 and 2016 reports, also found that "the numbers of new primary care physicians and other medical specialists are not keeping pace with the healthcare demands of a growing and aging population." *Id.*

No judicial principle or rule of law requires Kentucky legislators to find it acceptable for Kentucky to have *less of a physician shortage* than a small number of other states. As the legislature chose to do in enacting the MRP Act, Kentucky has every legitimate reason to position itself to attract more health care providers, to work to narrow the gap of unmet physician need, and to address health care access issues now rather than risk falling further behind as physician workforce demand grows and exceeds supply across the nation.

III. Kentucky's medical liability climate contributes to the physician shortage, negatively impacts health care consumers, and impedes access to care.

High malpractice insurance costs and negative malpractice litigation environments have a detrimental impact on patients' ability to access important health care services and on the care they receive. A 2011 study analyzing malpractice data from 1991 through 2005 estimated that roughly 55% of physicians practicing in internal medicine and its subspecialties would face a malpractice claim by the age of 45, increasing to 89% by the age of 65. (R.1014, Anupam B. Jena, et al., *Malpractice Risk*

[3] "New Research Reaffirms Physician Shortage; Shortages Likely to Have Significant Impact on Patient Care," AAMC News Press Release (March 14, 2017), available at https://news.aamc.org/press-releases/article/workforce_projections_03142017/ (last visited January 18, 2018).

According to Physician Specialty, New England J. of Med., 365:7 (Aug. 18, 2011) at 634.) Among certain specialties the risk is even higher, with an estimated 80% of physicians in general surgery and surgical specialties and 74% of physicians in obstetrics and gynecology facing a claim by age 45. (*Id.*)

A negative malpractice litigation environment impacts how and where physicians practice medicine, and leads physicians to alter their practice behaviors and their care for patients. For example, a 2015 survey from the American Congress of Obstetricians and Gynecologists (ACOG) assessed the effects of professional liability litigation and related liability insurance issues on the practice of obstetrics and gynecology. (R. 1030-35, Andrea M. Carpentieri, et al., Overview of the 2015 ACOG Survey on Professional Liability, Am. Congress of Obstetricians and Gynecologists (Nov. 2015).) The survey concluded that more than one-third of ob-gyn respondents made one or more changes to their practice as a result of the affordability or availability of professional liability insurance. More specifically: 13.6% decreased the number of high-risk obstetric patients; 12% decreased gynecological surgical procedures; 9.6% increased the number of cesarean deliveries; and, 3.9% stopped practicing obstetrics altogether. Almost half of respondents reported more extreme changes made in their practices based on fear of professional liability claims or litigation: 23.8% decreased the number of high-risk obstetric patients; 19.7% decreased gynecological surgical procedures; 17% increased the number of cesarean deliveries; and, 5.1% stopped practicing obstetrics altogether. (*Id.*)

The detrimental impact of a negative malpractice litigation environment extends beyond the specialty of obstetrics and gynecology and affects defensive medicine practices of other specialties as well. A 2011 survey of primary care physicians showed that 83% thought they could easily be sued for failing to order a test that was indicated,

but only 21% thought they could be sued for ordering a test that was not indicated (i.e. an unnecessary test). (R. 1039, Brenda E. Sirovich, M.D. *et al.*, Too Little? Too Much? Primary Care Physicians' Views on US Health Care, Arch Int. Med. (2011), p.3.)

Senator Alvarado spoke to this practice of "defensive medicine" in both the Senate Health and Welfare Committee and the House Health and Family Services Committees, stating:

> The full focus of our doctors, nurses, dentists, nursing homes, all medical professionals should be on their patients. And they should be allowed to use their knowledge and expertise to provide the care they believe to be best, not worrying about running every possible, and often completely unnecessary, and often very expensive tests to avoid . . . potential litigation down the road. The defensive practice of medicine is not good for caregivers, it's not good for taxpayers, and it definitely isn't good for patients.

(Legislative History, R. 460, at 2/28/17 Tr., p. 13, *See also* 1/5/17 Tr., p. 12.)

The surveys cited above are not unique to Kentucky, but their results help illustrate how the malpractice litigation climate in Kentucky impacts physician supply and retention, and impacts availability and access to quality and affordable health care services. According to the Deloitte Report, as of 2004, Kentucky was one of 20 states considered by the AMA to be in a "medical liability crisis" due to an unfavorable medical liability climate and the growing threat of patients losing access to care. (Deloitte Report at p. 52). The American College of Emergency Physicians provides additional perspective on the public perception of Kentucky's malpractice litigation environment in the College's state-by-state report card for the years 2009 and 2014 giving Kentucky an "F" grade for its medical liability environment. (R. 1044-45, American College of Emergency Physicians, America's Emergency Care Environment, A State-by-State Report Card – 2014 (Kentucky).) There the College specifically cited Kentucky's lack of

pretrial screening panels in support of Kentucky's failing grade and also noted "Kentucky continues to suffer from a poor medical liability environment, having made no progress since the previous Report Card and failing to enact even the most basic reforms." (*Id.* at R. 1044.) Kentucky's overall rank makes it the fifth worst emergency care environment in the nation. (*Id.*)

As Senator Ralph Alvarado noted in testimony before the House Health and Family Services Committee on February 28, 2017, reports like the one cited above by the American College of Emergency Physicians impede Kentucky's ability to attract physicians to practice here. "American College of ER Physicians look at Kentucky as one of the worst to practice in. We're having a struggle to find people willing to live in Kentucky and practice in our ERs." (Legislative Hist., R. 460 at 2/28/17 Trans., p. 21.)

States recognized as having more positive medical liability climates have enacted laws addressing liability and malpractice, such as apology inadmissibility laws, caps on damages, expert witness rules, and, as the Deloitte Report recommended for Kentucky—medical review panels. The legislature's establishment of medical review panels is an important step in addressing health care providers' concerns about the litigation risks and costs of practicing in Kentucky and in positioning Kentucky to attract and retain more health care providers to meet the Commonwealth's projected health care needs.

IV. Attracting physicians and other health care providers to Kentucky is not only beneficial to the health of its citizens, but it also has a positive economic impact on the Commonwealth.

The ability to attract and retain physicians and other health care providers is not only important to improving Kentuckians' access to health care, but it also offers significant and important economic advantages to the state. The American Medical Association recently released its 2018 Economic Impact Study (EIS), which places the

number of total active patient-care physicians in Kentucky at 8,106[4] and shows that physicians are a significant economic driver, contributing $557.2 million in state and local tax revenue. *See* The Economic Impact of Physicians in Kentucky, January 2018, available at https://www.physicianseconomicimpact.org/ (last visited January 19, 2018). The AMA's 2018 EIS also reports that Kentucky physicians generated $15.4 billion in direct and indirect economic activity for the Commonwealth, with each physician generating nearly $1.9 million of economic activity on average. Further, the AMA study reports that Kentucky physicians supported a total of 94,338 jobs, including those in the medical field and across other industries. That is an average of 11.6 jobs supported per physician, which then support the health care needs of the community, support the local economy, and draw investment into Kentucky.

Legislators considered the economic impact of Kentucky's physician shortage when they enacted the MRP Act. For example, Senator Alvarado said during the January 5, 2017, Senate Chambers Meeting, "Because of our current legal climate, we're having a hard time retaining and recruiting physicians to practice medicine in Kentucky. A physician shortage would also affect our business climate." Senator Alvarado reiterated his remarks about physician shortage impacting business climate at a February 28, 2017 House Health and Family Services Committee Meeting. (R. 460 at 2/28/17 Tr., pp. 7-8.)

Legislators also heard from a Kentucky Chamber of Commerce representative who testified: "the broader business community is at a disadvantage in this state because

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[4] This number is based on the AMA's Masterfile data as of December 2015 and is limited to physicians with their office location in Kentucky (since that is the location of the economic activity) and whose major professional activity is the provision of patient care, inclusive of both office and hospital-based physicians as well as locum tenens physicians. This number excludes Kentucky physicians reported as inactive or primarily in administration, medical teaching, research or other activities, and excludes physicians who may be licensed in more than one state if their office location is in a state other than Kentucky. EIS at pp. 3-4, 17-18.

of our legal liability climate . . . [and] we are at a distinct disadvantage to our neighboring states. This is not just a legal issue, it's not just a health care issue, it's a jobs issue." (*Id.* at 2/28/17 Tr., p. 15; *see also id.* at 1/4/17 Tr., pp 6-7.)

The legislators responsible for passing the MRP Act heard and considered arguments for and against the legislation, and, as the statements above demonstrate, they had ample basis to believe that the MRP Act would effect change that will benefit not just the health of individuals, but the health of the Commonwealth's economy as well. Though the Circuit Court disagrees with the General Assembly's ultimate decision, as evidenced by its statement that the MRP Act "protects the economic interest of the health care industry at the expense of consumers with no demonstrable benefit to the public at large" (Opinion, R. 1379), an equal protection challenge is not an authorization for the judiciary to "sit as a superlegislature to judge the wisdom or desirability of legislative policy determinations made in areas that neither affect fundamental rights nor proceed along suspect lines." *Steven Lee Enters. v. Varney*, 36 S.W.3d 391, 396 (Ky. 2000) (quoting *Heller v. Doe*, 509 U.S. 312, 319-21 (1993)). Further, "[i]t is beyond the power of a court to vitiate an act of the legislature on the grounds that public policy promulgated therein is contrary to what the court considers to be in the public interest." *Wehr Constructors,* 384 S.W.3d at 687 (internal citation omitted).

Where, as here, the policy decision made by the legislature in passing the MRP Act was supported by objective third-party studies such the Deloitte Report and the Aon Report, and had been the subject of consideration and public debate extending back more than five years before finally passing in 2017, this Court should refrain from second guessing or substituting its judgment for that of the General Assembly and should uphold the constitutionality of the MRP Act.

CONCLUSION

The MRP Act is intended to achieve certain important objectives such as a decrease in the shortage of physicians and the reduction of malpractice premiums for the betterment of Kentuckians' health care system. These objectives are documented and reflected in the transcripts of committee meetings and debates; and the methods chosen by the legislature to achieve those objectives are supported by professional studies performed by disinterested third-parties. Kentucky's current malpractice climate weakens the state's health care system because it adversely impacts the costs of health care providers who might choose to practice in Kentucky and makes it more difficult to attract and retain a sufficient supply of physicians to meet the Commonwealth's demand for health care services. The MRP Act is a reasonable attempt to lower the cost of defending malpractice litigation and lowering malpractice insurance premium rates, thereby attracting more health care providers to come to and stay in Kentucky and, in turn, improving access to health care in the Commonwealth.

The KMA and the AMA respectfully request that this Court reverse the Circuit Court's decision and affirm the constitutionality of Kentucky's medical review panels.

Respectfully submitted,

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