MINUTES OF THE MEETING
OF THE
LEGISLATIVE SUBCOMMITTEE TO STUDY MEDICAL MALPRACTICE
May 13, 2002
Las Vegas, Nevada

The second meeting of the Legislative Subcommittee to Study Medical Malpractice was held on Monday, May 13, 2002, at 9:30 a.m., in Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada, and videoconferenced to Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Pages 3 through 5 contain the "Meeting Notice and Agenda" for this meeting.

SUBCOMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Barbara E. Buckley, Chairwoman
Senator Dina Titus
Assemblyman Bernie Anderson
Assemblyman Lynn C. Hettrick

SUBCOMMITTEE MEMBER PRESENT IN CARSON CITY:

Senator Randolph J. Townsend

SUBCOMMITTEE MEMBER EXCUSED:

Senator Mark A. James

OTHER LEGISLATORS PRESENT IN LAS VEGAS:

Assemblywoman Merle A. Berman
Assemblyman Mark A. Manendo
Assemblywoman Genie Ohrenschall

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Allison Combs, Principal Research Analyst
Vance A. Hughey, Principal Research Analyst
Risa B. Lang, Principal Deputy Legislative Counsel
Bradley A. Wilkinson, Principal Deputy Legislative Counsel
Ricka Benum, Senior Research Secretary

R E V I S E D
MEETING NOTICE AND AGENDA

Name of Organization: Legislative Subcommittee to Study Medical Malpractice

Date and Time of Meeting: Monday, May 13, 2002
9:30 a.m.

Place of Meeting: Grant Sawyer State Office Building
Room 4401
555 East Washington Avenue
Las Vegas, Nevada

Note: Some members of the subcommittee may be attending the meeting and other persons may observe the meeting and provide testimony, through a simultaneous videoconference conducted at the following location:

Legislative Building
Room 4100
401 South Carson Street
Carson City, Nevada

If you cannot attend the meeting, you can listen to it live over the Internet. The address for the legislative Web site is http://www.leg.state.nv.us. For audio broadcasts, click on the link "Listen to Meetings Live on the Internet."

A G E N D A

I. Opening Remarks

*II. Approval of Minutes of the March 21, 2002, Meeting

*III. Update on the Non-Legislative Efforts in Nevada to Address the Medical Malpractice Crisis

A. Work of Nevada's Division of Insurance, Including the Creation of the Nevada Essential Insurance Association
Alice A. Molasky-Arman, Commissioner, Nevada's Division of Insurance

B. Update on Efforts in Nevada to Create a Company for Medical Malpractice Insurance
Chip Wallace, Nevada Mutual Insurance Company

*IV. Presentation on the Data Collected on Closed Claims for Medical Malpractice by Nevada's Division of Insurance (*Nevada Revised Statutes* 679B.144)
Alice A. Molasky-Arman, Commissioner, Nevada's Division of Insurance

*V. Overview of Civil Justice Laws Relating to Medical Malpractice in Other States and in Nevada
Cheye Calvo, Program Manager, Employment and Insurance, National Conference of State Legislatures
Allison Combs, Principal Research Analyst, Research Division, Nevada Legislative Counsel Bureau

*VI. Nevada Medical Liability Screening Panel

A. Overview of the Operation of the Panel and Statistical Data Concerning Medical Malpractice Actions in Nevada
Alice A. Molasky-Arman, Commissioner, Nevada's Division of Insurance

B. Recommendations for Changes Concerning the Panel
Alice A. Molasky-Arman, Commissioner, Nevada's Division of Insurance
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Representatives of Insurance Companies Operating in Nevada (Invited)
Bill Bradley, Nevada Trial Lawyers Association

*VII. Caps on Damage Awards in Medical Malpractice Actions: Discussion of the Status of Medical Malpractice Premiums in States with and without Caps on Damages, and the Impact of Caps on Damages

A. Perspective of the Medical Community
Dr. Donald J. Palmisano, Secretary-Treasurer, American Medical Association
Meg Draper, Senior Legislative Attorney, American Medical Association
Lawrence P. Matheis, Executive Director, Nevada State Medical Association

B. Perspective of the Insurance Community
Representatives of Insurance Companies Operating in Nevada (Invited)

C. Perspective of the Legal Community
Bill Bradley, Nevada Trial Lawyers Association
Ken Sigelman, J.D., M.D., Consumer Attorneys of California, Medical Malpractice Chairman

*VIII. Medical Malpractice Insurance: Discussion of Factors Involved in Determining Rates and Reserve Amounts
Representatives of Insurance Companies Operating in Nevada (Invited)

*IX. Presentation on the Monetary Amounts Involved in Settlements and Jury Verdicts in Past Medical Malpractice Cases in Nevada
Bill Bradley, Nevada Trial Lawyers Association
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Representatives of Insurance Companies Operating in Nevada (Invited)

*X. Presentation and Discussion of Recommendations for Modifications to Nevada's Civil Justice System
Bill Bradley, Nevada Trial Lawyers Association
Matt Sharpe, Nevada Trial Lawyers Association
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Representatives of Insurance Companies Operating in Nevada (Invited)

XI. Public Testimony

*XII. Discussion of Future Meetings and Topics for Review

XIII. Adjournment

*Denotes items on which the subcommittee may take action.

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, 401 South Carson Street, Carson City, Nevada 89701-4747, or call Debby

Richards at (775) 684-6825 as soon as possible.

Notice of this meeting was posted in the following Carson City, Nevada, locations: Blasdel Building, 209 East Musser Street; Capitol Press Corps, Basement, Capitol Building; City Hall, 201 North Carson Street; Legislative Building, 401 South Carson Street; and Nevada State Library, 100 Stewart Street. Notice of this meeting was faxed for posting to the following Las Vegas, Nevada, locations: Clark County Office, 500 South Grand Central Parkway; and Grant Sawyer State Office Building, 555 East Washington Avenue. Notice of this meeting was posted on the Internet through the Nevada Legislature's Web site at www.leg.state.nv.us.

OPENING REMARKS

Chairwoman Buckley called the meeting to order and asked the secretary to call the roll. All members except Senator James were present. Ms. Buckley briefly discussed the background of the subcommittee and introduced its members.

Exhibit A is a packet prepared by staff of the Research Division, Legislative Counsel Bureau, for the members' use during this meeting. Please see the "List of Exhibits" for these minutes for details concerning the contents of Exhibit A.

APPROVAL OF MINUTES OF THE MARCH 21, 2002, MEETING

The Chairwoman asked for approval of the minutes of the subcommittee's first meeting.

ASSEMBLYMAN HETTRICK MOVED FOR APPROVAL OF THE MINUTES OF THE SUBCOMMITTEE'S MEETING HELD ON MARCH 21, 2002, IN LAS VEGAS, NEVADA. THE MOTION WAS SECONDED BY SENATOR TITUS AND PASSED UNANIMOUSLY.

UPDATE ON THE NON-LEGISLATIVE EFFORTS IN NEVADA TO ADDRESS THE MEDICAL MALPRACTICE CRISIS

WORK OF NEVADA'S DIVISION OF INSURANCE, INCLUDING THE CREATION OF THE NEVADA ESSENTIAL INSURANCE ASSOCIATION

Alice A. Molasky-Arman

Alice A. Molasky-Arman, Commissioner of Insurance, Division of Insurance, Nevada's Department of Businesses and Industry, appeared before the subcommittee and introduced Bruce P. Heffner, JD, CPCU, ARM, ARe, ASLI, Chief Insurance Assistant, and Janice C. Moskowitz, ACAS, MAAA, Lead Actuary, Property and Casualty Section, Division of Insurance.

Ms. Molasky-Arman explained that Nevada's medical liability crisis started approximately one year ago when the St. Paul Companies requested an 83.6 percent increase in the medical malpractice insurance rates for Clark County, Nevada. She denied St. Paul's rate request and scheduled a public hearing on this matter. This hearing was canceled and ultimately, through a consent agreement, St. Paul was granted a 70 percent rate increase, which would be phased in as follows:

C A 35 percent increase effective September 1, 2001;

C An additional 15 percent increase effective December 1, 2002; and

C Finally, an additional 9.5 percent increase effective March 1, 2002.

According to Ms. Molasky-Arman, the incremental implementation of the rate increase was sought to permit doctors to search for replacement coverage in a market that was "considerably dwindling."

Continuing, Ms. Molasky-Arman advised that:

C On September 11, 2001, there was a "collision of many forces." The reinsurance market cannot survive another catastrophe of that proportion and expected payouts have affected all lines of insurance. At the same time, insurers were experiencing lower returns in the stock market. There also were increasing loss ratios in the medical malpractice market. In 2000, the annual combined loss ratio for all insurers in Nevada was 84.8 percent and in 2001 that figure rose to 145.9 percent.

C In late December 2001, St. Paul announced its national withdrawal from the medical liability insurance market. Its departure was compounded by the insolvency and liquidation of several other insurers including FICO and Reliance. Chicago Insurance Company also announced that it no longer would offer medical liability insurance in Nevada.

C Consequently, Governor Kenny C. Guinn ordered Ms. Molasky-Arman to hold a hearing to determine the availability of medical malpractice insurance in Nevada. After this hearing, which took place on March 4, 2002, it was found that there was increasing unavailability of medical professional liability insurance and displacement of over 40 percent of the physicians who had been insured by St. Paul.

C On March 15, 2002, Governor Guinn and Ms. Molasky-Arman issued an emergency regulation that enabled the establishment of a Nevada Essential Insurance Association known as the Medical Liability Association of Nevada (MLAN).

C A five-member board of directors of MLAN was appointed on April 2, 2002. The members include: (1) Mr. Robert A. Byrd, Chairman; (2) Dr. William Stephan, Vice Chairman; (3) Mr. Richard Jost; (4) Mr. Harry Brandise; and (5) Ms. Sandy Peltyn. A list of these board members was provided by the Division of Insurance and appears as Exhibit B. The board met frequently to meet the Governor's desire to implement the availability of coverage by April 15, 2002.

C The board has selected American Governmental Risk and Insurance Programs (AMGRIP) to serve as its insurance services management company. Among other things, AMGRIP will be responsible for underwriting as well as risk and claims management. A permanent contract with AMGRIP is pending.

C An organization capable of setting the rates for MLAN was not available and, therefore, Ms. Moskowitz (identified on page 6 of these minutes) and Chuck Knaus (formerly with the Division of Insurance) established the rates to be charged to MLAN insureds. Those initial rates have been set at approximately 80 percent of St. Paul's newly approved rate filing.

C At the Governor's request, Ms. Molasky-Arman sent a letter on April 25, 2002, to at least 4,000 medical physicians in Nevada explaining the MLAN process and cautioned them about the growth of unauthorized insurers. The Division of Insurance is investigating several cases concerning solicitations from unauthorized insurers.

C The Office of the Governor and the Division of Insurance have negotiated with St. Paul to establish an installment plan to ease the methodology for payment of tail coverage by medical professionals.

C As of the morning of May 13, 2002, MLAN has received 178 applications. Coverage has been found for 59 physicians.

C The Medical Liability Association of Nevada is not a high-risk pool. It will write policies for all specialties, including emergency room and trauma doctors, general surgeons, and obstetricians/gynecologists (OB/GYNs). Some physicians with a high loss experience may not qualify for coverage through MLAN.

C Funding for MLAN will be provided through the premiums of its insureds. In the event there is a deficit, *Nevada Revised Statutes* (NRS) allows the association to assess the policyholders up to 100 percent of their premium. If a deficit remains, the Commissioner of Insurance may assess all insurers who write casualty insurance in this state. Those assessments would offset premium taxes that are owed by the insureds. However, that offset could not be taken until after dissolution of the association. Therefore, the ultimate effect is that insurers would raise their rates in all casualty lines (e.g., automobile, homeowner, and medical

professional) to cover any assessments that might be made.

Chairwoman Buckley noted that Marybel Batjer, Chief of Staff, and Mike Hillerby, Deputy Chief of Staff for Legislative Affairs, Office of the Governor; and Michael J. Willden, Director, Nevada's Department of Human Resources were in attendance at this meeting.

In response to a question by Mr. Hettrick concerning potential insurers that would provide medical liability coverage to Nevada's medical professionals, Ms. Molasky-Arman advised that:

C The Division of Insurance has received three applications for a solicitation permit, which is a prerequisite for the formation of any domestic insurer. The proponents of a new insurer cannot seek funding or financial support for the company without this permit. One permit was issued, which subsequently led to the issuance of a certificate of authority to Nevada Mutual Insurance Company on May 3, 2002; one application is pending approval of a solicitation permit; and a third application has been withdrawn.

C Approximately six remaining companies are writing medical liability insurance in Nevada. However, they have restricted the number of medical professionals they will insure and most have requested significant rate increases. The Division of Insurance recently approved rate increases for the American Physicians Assurance Company and Medical Insurance Exchange of California. Rate requests from The Doctors' Company and The Medical Protective Company currently are pending.

Ms. Molasky-Arman explained that the affordability of medical malpractice insurance is an overriding concern; however, it cannot be solved by MLAN. She noted that MLAN must charge adequate premiums to support the administration and management of the program, the payment of claims, and the purchase of reinsurance. Further, Ms. Molasky-Arman stated that Governor Guinn is working with insurers to address the problem in which many doctors, particularly OB/GYNs, are "locked into" managed care contracts. The fees these physicians receive from health insurers and health maintenance organizations (HMOs) are set and do not recognize the significant rate increases they are facing, she said.

Responding to questions by Senator Titus, Ms. Molasky-Arman advised that:

C Several issues concerning St. Paul have been referred to the Deputy Attorney General who represents the Division of Insurance on this matter. This individual has successfully negotiated with St. Paul concerning certain topics (e.g., notices for physicians).

C The premiums charged by St. Paul are based on rates that were approved by the Division of Insurance. When the rates initially were filed, two actuaries with the Division reviewed the documentation and data provided by St. Paul and determined that the experience of the company justified a 70 percent increase rather than the requested 83.6 percent increase.

C Upon receipt of a request for a rate increase by an insurer, the Commissioner of Insurance provides a notice to the press and the public. During the rate filing process, the Commissioner of Insurance may determine if a public hearing will be held. The Division has 60 days to review and approve or disapprove a rate filing. If the Commissioner does not approve or disapprove the proposal within that period, it is deemed approved. If the Commissioner denies a rate request, the insurer may ask for reconsideration by requesting a public hearing.

Senator Titus expressed concern about whether the public hearing process for rate filings would have presented any indication of Nevada's forthcoming medical liability insurance crisis and, therefore, provided an opportunity to prevent such a situation.

Ms. Molasky-Arman advised that although a public hearing concerning St. Paul's request for an increase in medical malpractice insurance rates for Clark County was noticed, there was "very little" response from members of the medical community and the public.

Mr. Anderson inquired about limitations on the number of patients a physician may provide care to within a certain period of time (e.g., limiting the number of deliveries an OB/GYN may perform each calendar year).

According to Ms. Molasky-Arman, the Nevada Medical Liability Association (NMLA), which was established in the 1970s as a Nevada Essential Insurance Association and subsequently became a private insurer, instituted a limit of 125 deliveries by an OB/GYN per year. She explained that besides The Doctors' Company, which initially served as a surplus lines carrier and eventually held the highest market share in Nevada, NMLA was the only insurance company providing medical liability coverage to doctors in this state during that time. Further, as other insurance companies began to offer this coverage in Nevada, they adopted the limitation rule established by the NMLA. Ms. Molasky-Arman noted it is her understanding that all medical malpractice insurers in Nevada have adopted the NMLA's rule. She said that because this limit does not represent a national standard, her staff will seek from those insurance companies substantiation that the frequency or severity of claims significantly increases after deliveries surpass 125 per year. Ms. Molasky-Arman stated that if there is not a reason for that limit, it should not be part of the rating rule.

In response to a further question by Mr. Anderson, Ms. Molasky-Arman explained that an insurance company that is using the limitation rule could be required to provide to the Division of Insurance evidence and data to support its existence. If the rule cannot be substantiated, she said, the Division could request that it be amended or removed by the insurer. Additionally, if the company declines to comply with such a request, the Division would be obliged to proceed to a hearing process.

Mr. Anderson noted that this limitation is an important element in Nevada's medical malpractice crisis and asked Chairwoman Buckley to direct the subcommittee's staff to provide the members with additional information.

The Chairwoman advised that she recently requested information concerning this topic from staff and called upon Allison Combs, Principal Research Analyst, Research Division, Legislative Counsel Bureau (LCB), to provide an update.

Ms. Combs reported that she did not have information in addition to the comments presented by Ms. Molasky-Arman. She advised that the national average for deliveries by an OB/GYN is 141, and the total number of deliveries in Clark County during 2000 was approximately 22,372.

Chairwoman Buckley expressed concern about insurance companies limiting the number of deliveries a physician may perform each year. She noted that some physicians are dropping medical malpractice coverage for the delivery of babies because if they perform deliveries beyond a certain number, their premium substantially will increase and the cost of coverage will exceed their reimbursement rate. Ms. Buckley said it is important to determine why insurers are using this limit and whether it has an actuarial basis. She noted that it has had an adverse effect on the community and stressed the importance of ensuring that obstetric physicians can deliver babies.

Ms. Molasky-Arman advised that the Division of Insurance immediately will address the rule of certain medical liability insurers that limits an OB/GYN to 125 deliveries per year.

UPDATE ON EFFORTS IN NEVADA TO CREATE A COMPANY FOR MEDICAL MALPRACTICE INSURANCE

Chip Wallace

Chip Wallace, Nevada Mutual Insurance Company (NMIC), provided an overview of NMIC, which recently was created to provide medical malpractice insurance in Nevada. Mr. Wallace advised that NMIC:

C Is based upon the fundamental criteria to: (1) find industry experts who have wherewithal experience and good reputations; (2) contract a management team that is detached from reinsurance companies to ensure market flexibility in the longevity of the plan; and (3) minimize vicarious financial exposure from companies conducting business in other markets and require that NMIC remains domiciled in Nevada.

C Cannot be sold nor turned into a for-profit entity without a two-thirds vote of all policy shareholders.

C Has raised $2 million of its $3 million goal, and another $1 million has been pledged. It is the position of NMIC that hospitals should make financial contributions to the company.

C Will require its management company to locate and maintain an office in Nevada.

C Must maintain a nonprofit ideal—shareholder profits are not a staple to its core function as a business.

Mr. Wallace stated that the above-mentioned mandates established for NMIC have been met.

Continuing, Mr. Wallace noted that NMIC has received its certificate of authority from the Commissioner of Insurance and is underwriting and binding policies. It has received more than 300 applications and has insured one physician and declined coverage for another doctor, he said.

Responding to questions by Chairwoman Buckley, Mr. Wallace stated that:

C Nevada Mutual Insurance Company is underwriting policies according to the expiration date of an applicant's current coverage. Physicians whose policies expire in May 2002 are the first to be addressed. If necessary, the company's personnel will work overtime to process applications and meet deadlines.

C Concerning whether NMIC's rates might provide relief to obstetricians in Nevada, it is incumbent upon the company to conduct business appropriately and meet certain financial obligations. There are cost-saving measures from the formation of NMIC; however, the company will not be an arbitrary "parachute" for any specialty. This ongoing problem for obstetricians recently has become "very overt"; however, NMIC will not be the "windfall" for these medical professionals. The company's first policyholder is an obstetrician who purchased tail coverage and its first declination also was an obstetrician.

C The NMIC's rates for obstetricians are "in the ballpark" with those being quoted by other companies and its rating structure is relatively close to that of the Medical Liability Association of Nevada. The NMIC is offering tail coverage to doctors as well as related financing options.

In response to questions by Mr. Anderson, Mr. Wallace stated that tail coverage is a function of the insurer that has provided medical malpractice insurance to a physician to this point. He said he is aware of costs for such coverage ranging from 185 percent to 230 percent a physician's premium. Mr. Wallace noted that the factors upon which the price for tail coverage is based depend upon each insurance company. Additionally, he mentioned that it would be helpful to the subcommittee if it could obtain the written criteria of insurers concerning this type of insurance. Mr. Wallace also advised that NMIC is willing to provide "nose" coverage and individual criteria regarding the tail, and tail coverage is available to physicians after a five-year period.

The Chairwoman suggested that it may be helpful to direct staff of the Research Division to work with the Commissioner of Insurance as well as insurance companies and develop information that will provide the subcommittee members a better understanding of tail coverage.

Concerning the possibility of "price gouging" by medical malpractice insurers, Mr. Wallace stated that this situation is perpetuated by the "price slashing" that occurred in previous years and is demonstrated by double-digit rate increases by all of these companies since that time. He also noted that NMIC is not undercutting the marketplace, will write all classes, and has individual writing criteria based against each policyholder.

Mr. Wallace suggested that in the near future a panel consisting of insurance professionals, legal counsel, and physicians be established to address some of the problems associated with medical malpractice insurance.
Chairwoman Buckley and Mr. Wallace briefly discussed the statute of limitation for obstetricians in Nevada. Ms. Buckley advised that contrary to recent newspaper reports, 18 years is not the statute of limitation for a child in this state. Further, if that number is being used by insurers to quote physicians' premiums, it is illegal and the physicians deserve a refund.

Ms. Combs informed the subcommittee that:

C As of April 2000, there were 139 licensed OB/GYNs in Nevada.

C The number of OB/GYNs who are working with State of Nevada programs and accepting new patients is estimated to be: (1) Baby Your Baby Campaign – 43 (some on a limited basis); (2) Maternal/Child Health Prenatal Program – 23 of 84; and (3) Medicaid Program – 49 of 121 (some on an extremely limited basis). Therefore, approximately 40 to 50 OB/GYNs in the state are taking new clients.

C The American College of Obstetrics and Gynecology has not set a minimum or maximum number of deliveries that a doctor should perform each year.

C Since January 2002, Nevada's State Board of Medical Examiners has issued 102 new medical licenses for various specialties.

PRESENTATION ON THE DATA COLLECTED ON CLOSED CLAIMS FOR MEDICAL MALPRACTICE BY NEVADA'S DIVISION OF INSURANCE (*NEVADA REVISED STATUTES* 679B.144)

Alice A. Molasky-Arman and Janice C. Moskowitz

Ms. Molasky-Arman (previously identified on page 6 of these minutes) advised that Ms. Moskowitz (also identified on page 6) would provide an overview of Exhibit C, which consists of several tables relating to data collected on closed claims for medical malpractice by Nevada's Division of Insurance. Please see Exhibit C for complete details.

According to Ms. Moskowitz, pursuant to NRS 679B.144 ("Commissioner required to collect information regarding closed claims for medical malpractice; submission to legislature; regulations"), the Commissioner of Insurance maintains a database concerning each closed claim for medical malpractice filed against physicians and surgeons in this state. She advised that she prepared Exhibit C, which consists of summary statistics from this database, in response to the subcommittee's request for the following information:

C The number of cases settled, resolved by trial, and otherwise closed for each year in which data has been collected and, if available, information on the region of the state in which these cases originated.

C The amount of money awarded in these cases, by year, through settlements and verdict amounts.

C The amount of the initial, highest, and last reserves of an insurer for claims before the final resolution of the claims by settlement or trial, and any additional information which may be useful to the work of the subcommittee.

C The number of doctors who have had more than one action filed against them.

Ms. Moskowitz stated that closed claims data that was collected prior to 1999 has been determined to be unreliable and, therefore, is not included in these statistics.

Continuing, Ms. Moskowitz explained that Exhibit C consists of the following items:

C Exhibit I, which provides an indemnity reserve history for: (1) closed claims involving physicians only; and (2) total closed claims. *Nevada Revised Statutes* 690B.050 ("Physicians: Reports to commissioner and board of medical examiners") requires that insurers report to the Commissioner of Insurance certain information concerning closed claims against physicians. The Division of Insurance also receives data regarding closed claims against other medical professionals (e.g., dentists, nurses, and optometrists). However, because the reporting of this information is not required, the total closed claims data is incomplete.

C Exhibit II is a multiple closed claim analysis.

C Exhibit III is a summary of closed claims by county.

Ms. Moskowitz provided the following background information concerning the information contained in Exhibit C:

C Exhibit I is similar to information that was presented at a hearing held by the Commissioner of Insurance on March 4, 2002, on the availability of essential insurance coverage. Subsequent to the preparation of those statistics, a significant number of errors were found in the data (e.g., duplicate entries) and a few additional claims for 2001 were reported to the Commissioner. During the process of correcting this information, claims that involved dentists, hospitals, optometrists, physicians, and so on, have been identified.

C An insurance company that writes only in northern Nevada had not reported any closed claims because it was unaware that the state's law applies to a claim amounting to less than $5,000. This insurer had 12 closed claims from 1999 to 2001 for which it has paid zero indemnity. Upon receipt of this information, it will be included in the closed claim database.

C The location of a claim is not an available field in the closed claim database. However, the address a physician listed on licensing information received by the Division of Insurance from Nevada's Board of Medical Examiners and the State Board of Osteopathic Medicine was used as a proxy for the location of a claim. Information concerning the location of a claim may not be entirely accurate because some physicians practice in more than one place. When the physician was not listed on the extracts (e.g., several were deceased or no longer licensed because they left the state or retired), information available in the medical screening panel database or the location of the co-defendant was used. For instance, if the co-defendant was Sunrise Hospital it was apparent that the claim was in Clark County, Nevada. Because of time constraints, this data is limited to claims closed in 2001; however, statistics for 1999 and 2000 will be prepared in the near future.

Referring to Exhibit IA, Ms. Moskowitz explained that this data reflects the indemnity reserve development on all claims against physicians that were closed between 1999 and 2001. She briefly addressed the following statistics that appear in this document:

C Grand total for total sum of paid indemnity—$86,985,957 (page 1).

C Grand total for total count of paid indemnity—627 closed claims (238 settled, 35 decided by trial, 5 unknown, and 349 closed otherwise) (page 2).

C Grand total of total paid severity (overall average claim size including claims closed without payment)—$138,734 ($387,988 for cases decided by trial, $307,170 for cases settled, and $60,000 for cases with an unclear disposition) (page 3).

C Grand total for total sum of initial reserves—$33,051,236 (page 1).

C Grand total for total sum of paid indemnity—$86,985,957 (page 1).

C Grand total for total sum of highest reserves—$118,384,013 (136 percent) (page 1).

C Grand total for sum of last reserves—$109,524,582 (126 percent) (page 1).

Responding to a question by the Chairwoman concerning the 22 medical malpractice verdicts in favor of plaintiffs in Clark County during the last five years, Ms. Moskowitz advised that the number of awards for noneconomic damages that exceeded $250,000 could not be determined through the closed claim database. She explained that the Division of Insurance does not collect information regarding economic versus noneconomic awards. However, she said, the number of totals that exceed $250,000 could be determined through this database.

The Chairwoman stressed the importance of the subcommittee reviewing this information, determining how many of the 22 plaintiff verdicts exceeded $250,000, and evaluating the impact of these awards on medical malpractice insurance. She mentioned the possibility of staff of the subcommittee working with the Division of Insurance in an attempt to obtain this data.

Ms. Moskowitz said she could attempt to obtain this information through a survey of insurance companies. She noted, however, that in previous conversations with insurers, she was informed that the data was not readily available and in some cases the files are not accessible to the public.

Continuing, Ms. Moskowitz provided an overview of Exhibit II, which is a multiple claim analysis for 1999 through 2001. She advised that the two physicians who had 8 and 14 claims against them no longer practice in Nevada.

In response to questions by Mr. Anderson, Ms. Moskowitz explained that the identity of the insurer(s) that provided coverage to the two doctors who had 8 and 14 claims against them is confidential and may not be disclosed. Further, she would attempt to determine the number of claims appearing in Exhibit II (particularly for those two doctors) that the medical screening panel recommended be settled but a settlement agreement was not reached.

Responding to a question by Ms. Buckley, Ms. Moskowitz explained that in Exhibit II the table titled "Total (Closed with Payment and Without)" indicates that 487 physicians had cases in the closed claim database between 1999 and 2001. The table titled "With Indemnity Payment" demonstrates that 209 physicians had paid cases during that three-year period.

Senator Townsend stated it would be helpful to overlay the information contained in Exhibit II with the recommendation of the medical screening panel. He presented a hypothetical situation in which a physician is sued for a policy limit of $1 million. The physician agrees to settle; however, the insurance company chooses to proceed to court. The case then goes to trial and the verdict is $5 million. The Senator asked if for purpose of setting new premium levels for a covered physician whether an insurer includes the experience above the policy limit for which the physician was willing to settle.

Ms. Moskowitz replied that she is not aware of any doctors who have exceeded their policy limit. She said large verdicts generally involve multiple defendants and the policy limit is adequate. Ms. Moskowitz offered to verify this information.

Additionally, Senator Townsend inquired if any state law or regulation in Nevada allows insurance companies to include a physician's experience above the policy limit for which a physician is willing to settle for the purpose of setting a new premium level.

Ms. Moskowitz advised that she is not aware of any prohibition on this manner of setting premiums; however, it may be an unfair trade practice. She said experience rating plans usually include a cap on the severity of a claim and weigh frequency to a larger extent than severity. Further, whether this approach is used in determining premiums could vary by company depending on the particular formula used.
Chairwoman Buckley asked Ms. Molasky-Arman to address this topic at the subcommittee's next meeting.

Senator Townsend presented a second hypothetical situation involving a claim for the limit of a policy. Before the claim reaches a mature level, the doctor decides to settle for $100,000 for which the plaintiff agrees. The insurance company chooses not to settle and prepares for trial for which there is a significant expense for both parties. Immediately before the trial, the insurer decides to settle for the policy limit and that is accepted by the other party. Again, there is an experience rating above what the two parties were willing to agree to. He questioned whether that amount is included in the experience rating for the purpose of setting the new premium level.

Ms. Moskowitz responded that the inclusion of that experience rating in determining a new premium level may depend on the company's position.

Senator Townsend asked if it is possible to determine how any other jurisdiction addresses that "substantial inequity" on behalf of a physician.

Ms. Molasky-Arman replied that she is not aware of any state that addresses Senator Townsend's concern.

Concluding her presentation, Ms. Moskowitz referred to Exhibit III and advised that although Reno, Nevada, appears as a separate entry on these tables it should be included with Washoe County, Nevada. She explained that Exhibit III indicates that during 2001, Clark County accounted for the most dollars spent on closed claim payments ($31,712,615) and highest number of such claims in the state (179 of 220 claims).

OVERVIEW OF CIVIL JUSTICE LAWS RELATING TO MEDICAL

MALPRACTICE IN OTHER STATES AND IN NEVADA

Cheye Calvo

Cheye Calvo, Program Manager, Employment and Insurance Program, National Conference of State Legislatures (NCSL), explained that NCSL is the national bipartisan organization representing legislators of all states, territories, and commonwealths. He noted that NCSL does not take positions on state matters and, therefore, he would not recommend to the subcommittee any particular course of action.

Mr. Calvo mentioned that during the subcommittee's first meeting on March 21, 2001, he framed the policy issues associated with medical malpractice and outlined four primary issues of reform: (1) prevention; (2) tort reform; (3) alternatives to litigation; and (4) insurance options. He advised that during this second meeting he would provide a national perspective and a framework to address tort reform and alternatives to litigation and share the experiences of other states.

According to Mr. Calvo, all states rely on the tort system to make determinations of medical malpractice and, if found, hold health providers financially responsible. He said medical malpractice is a tort (i.e., a wrongful act or omission) and an injured party must sue to show that a health provider failed to meet the appropriate standard of care and that this negligence caused an injury. Mr. Calvo stated that this system is used to deal with medical mistakes and when it works it fairly compensates victims of medical negligence and deters future malpractice.

Additionally, Mr. Calvo noted that the tort system by design is adversarial but it also is the mechanism used to resolve disputes, make determinations of negligence, and assign relief. In the end a jury, under the guidance of a judge, makes a decision. Yet, he said, the process is "steeped" in civil procedure that has evolved over centuries of common law. Mr. Calvo stated that tort reform is intervention by the democratic institutions of government (i.e., the legislature) with the intent to improve the system.

Mr. Calvo explained that vast public policy interest is to produce a system that is:

- Equitable—People receive fair compensation for their injury.
- Efficient—Claims are resolved quickly and at a reasonable expense.
- Consistently applied—Like injuries are compensated in a similar way and, therefore, the system is more predictable.

Continuing, Mr. Calvo noted the importance of specific reforms promoting these public policy interests. He said typically a specific situation, namely an insurance crisis and one of affordability, availability, or in some instances both, leads to reform. Therefore, it also is important to evaluate tort reforms for two immediate objectives: (1) to reduce costs (either by reducing claim frequency or severity); and (2) to produce stability in the insurance marketplace by improving insurers' ability to predict future expected losses.

Mr. Calvo stated that although there is a wide array of possible tort reforms, his remarks would focus on five specific types of reform. He provided the following information:

- Statute of Limitations

  Basically, a statute of limitations requires that a claim be filed when pertinent evidence and witnesses are available and ensures that threats of claims do not continue for a long period of time.

  Exhibit D, titled "National Conference of State Legislatures—Employment and Insurance Program—Medical Liability Statutes—State Summary Chart," provides a review of the medical liability laws of all 50 states and the District of Columbia. This information indicates a statute of limitations usually consists of three main components:

  1. The number of years or time period from the act;

2. An additional time period from the point of reasonable discovery; and

3. A provision that addresses minors specifically.

Most state laws have an initial period of two years in which a person can file a claim and provide an additional period of reasonable discovery, often from six months to two years. Some jurisdictions also set a maximum limit that cannot be exceeded.

For situations involving minors, states usually give a longer period of time, often to age 6 or 8, and a few states begin to run their statute of limitation at the age of majority for those minors.

There is some evidence where states have reduced their statute of limitation or actually given people a shorter period of time to file a claim and that can affect claim frequency. This especially is a problem with OB/GYNs because the laws usually allow a longer period of time for claims to be filed regarding minors. Often after 8 to 10 years the evidence is less clear and it is difficult to determine whether negligence caused a particular injury.

C Joint and Several Liability

Joint and several liability is the standard rule of common law and has been in place in 46 states. It requires any one of two or more co-defendants to pay the full amount of an award. Basically, a person can be required to pay 100 percent of an award if he or she is at all responsible or at fault for an injury. However, 33 states (including Nevada) have abolished or reformed their joint and several liability laws for medical malpractice. States typically have imposed a proportionate liability where one party pays only that portion of an award based on their percentage of fault or they hold defendants jointly liable only above a certain threshold. For instance, if a person is more than 50 percent liable he or she then can be held liable for 100 percent.

C Attorneys' Fees

Under a contingency fee system lawyers receive no fees unless or until they obtain an award and those fees typically are based on a percentage. Contingencies provide access to the courts for many persons who could not afford to undergo litigation at their own expense. However, they also may take a large portion of an award (typically a percentage amount in the thirties but sometimes more than 40 percent).

States have three types of laws that limit attorneys' contingency fees:

1. Seven states require that contingency fees undergo court review for reasonableness;

2. Eleven states have established sliding scales that cap contingency fees. Usually, lower rates or percentages are put in place (especially when the award is very large) and, therefore, the contingency declines as the award increases; and

3. Five states impose a fixed cap on contingency fees (typically one-third of the award).

Also, there is limited evidence that contingency fees can: (1) affect the number of cases litigated until a verdict is reached; (2) increase the number of cases that are dropped; and (3) reduce the size of settlements.

C Collateral Source Rule

Collateral source rule prohibits the introduction of evidence about compensation a plaintiff receives from sources other than the defendant. The rule aims to force defendants to pay for negligence and it places a disincentive for persons to have insurance to take care of the unexpected. However, in general, insurers actually pay for the claims and third parties typically subrogate to collect the benefits paid. For instance, even if that money is not paid to the injured party, the health provider, life insurer, and/or disability insurer usually will attempt to collect it from the medical malpractice insurer or the defendant. It has been shown that the repeal or modification of collateral source rule can reduce the size of jury awards and settlements. However, it does not necessarily improve insurance costs because the money is paid.

Sixteen states, including Nevada, require mandatory offset of collateral sources. Eighteen states (13 states through their statutes and 5 states through their rules of civil procedure) allow discretionary offsets by either giving that choice to the judge or jury to make that decision or allowing them to be factored into the larger issue.

C Damage Award Caps

There are three types of damages and caps:

1. Economic damages cover medical expenses and lost wages. No state explicitly caps economic damages, but four states limit total damages. Therefore, while total damage caps tend to be higher, they indirectly cap economic damages.

2. Noneconomic damages relate to pain or suffering or damages not associated with any economic cause.

3. Punitive damages punish the negligent party and usually the negligence involved must meet a certain threshold (the party must be particularly malfeasant or malicious in their action). Juries rarely impose punitive damages in medical malpractice cases. Some states have caps on punitive damages in medical malpractice cases, but they are not as significant a factor in jury awards.

Some states have separate caps for wrongful death. A noneconomic damage cap may be overturned but the constitutionality of the wrongful death component often is upheld.

An economic loss can be quantified, but it is virtually impossible to objectively assign a monetary value to pain and suffering. Absent legislative guidance, juries must reach a specific dollar amount based on their subjective assessment of the situation and often the information upon which their decision is based is circumstantial. Although the jury system has flaws and the process is subjective, it is a right granted by the United States Government.

Fourteen states have noneconomic damage caps for medical liability and four states have caps on total damages:

1. Four states (California, Colorado, Montana, and Utah) have caps of $250,000.

2. Four states (Alaska, Hawaii, Massachusetts, and North Dakota) have fixed caps above $250,000. In certain circumstances, Hawaii and Massachusetts allow exceptions to this limit.

3. Five states (Idaho, Maryland, Michigan, Missouri, and Wisconsin) have instituted hard caps that increase annually based on either a specific formula or reference to inflation.

4. One state (West Virginia) has a $1 million cap.

The Chairwoman asked how caps on damages help insurance companies if a policy limit already is in place. She explained that insurers want stability in knowing their ultimate exposure and the subcommittee is trying to lower premiums for medical malpractice insurance.

Responding to Ms. Buckley's question, Mr. Calvo stated that an argument could be made that higher caps on noneconomic damages are less effective in restraining jury awards and do not provide stability. He noted that West Virginia, which has the highest cap in the nation, is in a crisis situation. Mr. Calvo added that the benefit derived from a high cap is different from the perspective of doctors and insurers. He said California, Colorado, Montana, and Utah have "relatively stable" markets and in comparison to similar jurisdictions, their prices are "remarkably low." Mr. Calvo stated that the cap on noneconomic damages in California has had a significant role in stabilizing the state's medical malpractice market. He noted that in other states, especially those with adjustable caps, the experience of some jurisdictions is better than others. Further, many of those states that have premium increases are experiencing greater problems and less stability in their market. Mr. Calvo advised that there is a relationship between a higher cap and a less stable market.

Continuing his presentation, Mr. Calvo provided the following answers to the most common questions

concerning damage award caps:

1. Do noneconomic damage caps steady the market and reduce costs? Generally, noneconomic damage caps do steady the market and reduce costs. However, some states with such limits are having difficulties.

2. Are there other factors involved in the experiences of states? "Absolutely." This system of recovery is complex and multifaceted.

3. Are noneconomic damage caps essential to a stable marketplace? No. Some states (e.g., Minnesota and Vermont) with "very steady" marketplaces do not have caps. A story in *Medical Economics* examined five markets (three states with caps and two without caps) in the United States that currently are not experiencing problems with medical malpractice insurance. Among other things, it indicates that caps are not essential to a stable marketplace because they can change socioeconomic conditions only to a certain point.

4. Do noneconomic damage caps increase insurer profits? Generally, yes they do. If you look at combined ratios and returns on net investment insurers tend to fair more favorably in states that have noneconomic damage caps in place. They benefit from stability but they also pass lower costs on to doctors as well. Is there a vested interest on their part in noneconomic damage caps? Yes and generally their experience in those states with them fairs that out.

5. Are noneconomic damage caps equitable? This is a question for the subcommittee to decide based on the data and values of the State of Nevada.

Mr. Calvo further advised that:

1. Caps in North Dakota and South Dakota may not be significant because of the mindset of their citizens and cultural, economic, and social factors. Fairly urbanized and dense states (e.g., Maryland and Massachusetts) tend to have more litigious societies and, therefore, noneconomic damage caps have proven less effective in those jurisdictions. Other laws and civil procedures also must be considered because the medical malpractice system is complex and multifaceted.

2. There are conflicting studies concerning caps on damages, but the overall analysis is that they do have an effect on the medical malpractice insurance system. However, other factors should be considered: (a) the effect of damage caps on an injured party; (b) the party or parties who benefit from caps on damage awards; and (c) the percentage of overall claims involving large noneconomic damage awards.

   Evidence from previous years suggests that a "very small" percentage of total cases with claims paid have large economic damage awards (i.e., over $100,000 or $250,000) and yet they tend to account for a "very large" percentage of overall costs.

   It is important to note that economic damages are fixed and, therefore, more predictable. Even if negligence is shown to have caused an injury, the associated economic damages can be calculated. Oftentimes, insurers are more willing to settle when limited noneconomic damages are focused upon.

   The pursuit of large awards can drive cases into litigation and prolong them. There is a question of whether the few cases with large noneconomic damage awards actually are based on the particular injury involved and pain and suffering. In claims paid cases, most injured parties do not receive large noneconomic damage awards. An injured party has one case to litigate; however, trial lawyers may accept more cases and those that are lost often are made up by a single case that is won.

According to Mr. Calvo, the previously mentioned article from *Medical Economics* references "The One Million Dollar Club," which consists of trial attorneys who have received $1 million verdicts. It reports that the number of club members is "considerably greater" in the Las Vegas area than in the State of California.

Mr. Anderson inquired about the amount of time that may lapse before the effect of an enacted cap would be recognized.

Answering Mr. Anderson's question, Mr. Calvo explained that caps usually only affect future claims and the average amount of time nationally for a claim to be filed after an injury is approximately 22 months. He also mentioned that the *Medical Liability Monitor* is the best source of information concerning premiums in the 50 states.

Mr. Calvo advised that a recent report by the Consumer Federation of America and the Center for Justice and Democracy makes the argument that tort reforms put in place in the mid-1980s have not demonstrated any savings. He stated his opinion that this report is "a little biased" and some of its methodology is "problematic." For example, although California has strong tort reform, it is categorized with states having the least reform. The report groups states based on the number of tort reforms (not the significance of the reforms) they have passed since 1986. It discounts California because its program was enacted in the 1970s. Additionally, Mr. Calvo noted that the report actually shows that states with what it describes as the most severe reforms have experienced more favorable premium increases annually (about 6 percent) since 1986 versus the states in the two lower categories.

Continuing with his presentation, Mr. Calvo provided the following information concerning alternatives to litigation:

C Arbitration/Pretrial Screening Panels

Generally speaking, there is no evidence that pretrial screening panels have effectively reduced costs or encouraged settlement in cases. Many of these panels are nonbinding and voluntary, their findings are not admissible in court, and they do not have repercussions for people who do not follow that course. The parties involved in a case often view such panels as a "hoop to jump through."

In the 1970s, Michigan instituted a program that: (1) encouraged doctors to have patients sign a binding arbitration agreement prior to undergoing surgery; (2) placed a cap of $250,000 (which increased over time) on noneconomic damages; and (3) waived the noneconomic damage cap for patients who entered into a binding arbitration agreement. During a 16-year period, the participation rate for this program was approximately 8 percent. The program "fell apart" after a $1.7 million judgment in 1991 and the law eventually was sunseted.

C No-Fault

No-fault systems essentially compensate injured parties for expenses (e.g., medical bills) regardless of who is at fault. They also include an understanding that the injured person will not receive noneconomic damages. In general, no-fault systems: (1) limit noneconomic damages; and (2) increase claims (because health care is easier to access). These systems are more administrative than litigious in nature and, therefore, higher costs can result.

Only Florida and Virginia have no-fault systems for medical malpractice. These programs consist of funds for birth-related neurological injuries and the oldest individuals covered by these plans are about 14 years old. It is important that the funding mechanisms for such programs are sound so they: (1) can provide basic economic coverage and medical care to these injured persons during their lifetimes; and (2) will not cause future financial problems for a state.

In response to a question by Ms. Buckley, Mr. Calvo explained that the current medical malpractice crisis may be attributed to the September 11, 2001, terrorist attack on the United States. He noted that the insurance market was "hardening across the board" and became worse after that date. [Note: A "hard market" in the insurance industry involves conditions in which premiums are high and coverage is difficult to obtain.] Mr. Calvo also stated that events on September 11 had a significant impact on the nation's economy and as a result, insurers have received low returns on their investment income. Further, no line of insurance is more dependent on investment income than medical malpractice. Mr. Calvo added that in comparison to other property and casualty lines of insurance (e.g., automobile and workers' compensation), medical malpractice is "relatively small."

Responding to a question by Mr. Hettrick, Mr. Calvo provided the following information concerning states that have fixed total damage awards:

C Indiana's patient compensation fund, which is similar to an excess fund, has a cap of $250,000. This program also has other mechanisms to address economic losses.

C New Mexico has a $600,000 cap.

C South Dakota has a $1 million cap.

C Virginia has an adjustable cap that increases up to $50,000 annually. Currently, this limit is set at $1.6 million.

Additionally, Mr. Calvo noted that the total cap for these states includes both economic and noneconomic damages. He said if punitive damages are assessed, they may or may not be included in the total cap.

Mr. Calvo concluded his presentation by explaining that in relation to recoveries and contingency fees, noneconomic damages are an important part of the system because there is a loss associated with economic damages (e.g., medical expenses and/or wages). Further, noneconomic damages often are used to pay attorneys' fees and if an injured person does not receive an award for such damages, these fees must be paid with money received for economic damages. He said pain and suffering is "real" and the subcommittee should consider whether juries or a structure that is established by state law should determine the awards for noneconomic damages.

Exhibit E is a document, titled "National Conference of State Legislatures—Employment and Insurance Program—State Patient Compensation Funds," which was provided by Mr. Calvo.

Allison Combs

Allison Combs, Principal Research Analyst, Research Division, Nevada Legislative Counsel Bureau, directed the subcommittee's attention to page 74 of Exhibit A and provided a brief overview of Nevada's laws relating to the civil justice system and medical malpractice:

C Statute of Limitations (NRS 41A.097, "General rule; tolling of limitation.")

1. Actions against a provider of health care for an injury or death must commence not more than four years after the date of the injury or two years after the plaintiff discovers or should have discovered the injury, whichever occurs first.

2. The time limitation is tolled during the screening panel process.

3. The parent, guardian, or legal custodian of a minor child is responsible for determining whether to prosecute a cause of action. If the period commencing the action passes, the child is prohibited from bringing an action based on the same injury, except in the case of: (a) brain damage or a birth defect (extended until the child is 10 years of age; or (b) sterility (extended until two years after the child discovers the injury).

C Immunity from Liability for Certain Emergency Care (NRS 41.505, "Physicians, nurses and emergency medical attendants; licensed medical facilities in which certain emergency obstetrical care is rendered.")

Among other things, this law provides that a physician, physician's assistant, practitioner of respiratory care, nurse, or osteopath rendering emergency obstetrical care to a pregnant woman during labor or delivery is not liable for civil damages for acts or omissions if:

1. The actions are in good faith and do not amount to gross negligence or reckless, willful, or wanton conduct;

2. The physician or medical provider has not previously provided prenatal or obstetrical care to the woman; and

3. The damages are related to or caused by a lack of prenatal care.

C Comparative Negligence (NRS 41.141, "When comparative negligence no bar to recovery; jury instructions; liability of multiple defendants.")

In an action to recover damages for death or injury to a person, there is no recovery if the plaintiff's comparative negligence is greater than the defendant's negligence or the combined negligence of multiple defendants.

C Medical Malpractice Screening Panels (NRS 41A.003, "Definitions," through NRS 41A.069, "Instructions to jury.")

Before a cause of action for malpractice is filed in court, it must be submitted to a screening panel.

C Use of Expert Witnesses (NRS 41A.100, "Expert testimony required; exceptions; rebuttable presumption of negligence.")

The imposition of liability on a physician for personal injury or death requires evidence to demonstrate a deviation from the accepted standard of care and to prove causation of an alleged personal injury or death.

C Patient Consent (NRS 41A.110, "Consent of patient: When conclusively established," and NRS 41A.120, "Consent of patient: When implied.")

Nevada law provides that patient consent is conclusively obtained if the physician explains the procedures to be undertaken, alternative methods of treatment, and the risks involved. The physician must also obtain the patient's signature on a statement explaining these items.

C Limits on Punitive Damages (NRS 42.005, "Exemplary and punitive damages: In general; limitations on amount of award; determination in subsequent proceeding.")

The defendant must be proven guilty, by clear and convincing evidence, of oppression, fraud or malice, whether express or implied.

C Damages from Collateral Source (NRS 42.020, "Actions for damages for medical malpractice: Reduction of damages by amount previously paid or reimbursed; payment of future economic damages.")

Damages from a collateral source must be considered.

C Periodic Payments for Future Damages (NRS 42.020)

If future damages are awarded, the award must be paid at the election of the claimant either in a lump sum at the present value or by an annuity purchased to provide periodic payments.

C Damages in Cases Involving Wrongful Death (NRS 41.085, "Heirs and personal representatives may maintain action.")

There are provisions regarding damages in wrongful death cases in which heirs may be awarded damages for items such as comfort, grief, loss of probable support, pain and suffering, and sorrow.

Please see Exhibit A for details of the laws addressed by Ms. Combs.

CAPS ON DAMAGE AWARDS IN MEDICAL MALPRACTICE ACTIONS: DISCUSSION OF THE STATUS OF MEDICAL MALPRACTICE PREMIUMS IN STATES WITH AND WITHOUT CAPS ON DAMAGES, AND THE IMPACT OF CAPS ON DAMAGES

PERSPECTIVE OF THE MEDICAL COMMUNITY

Dr. Robert W. Shreck

Dr. Robert W. Shreck, President, Nevada State Medical Association (NSMA), advised that he is a long-time family physician in Las Vegas. Dr. Shreck stated that Nevada, especially Clark County, has a "very immediate" crisis of access to medical care, particularly the high-risk specialties of obstetrics and surgery. He advised the subcommittee that:

C Clark County has approximately 90 obstetricians who are scheduled to deliver an estimated 25,000 babies during 2002. Their medical liability insurance has limited each of them to less than 125 deliveries per year for "somewhat" affordable insurance rates. Therefore, approximately 12,000 deliveries will be performed without prenatal and obstetrical care.

C Neurosurgeons, orthopedic specialists, and trauma surgeons working at the University Medical Center's (UMC's) Trauma Center in southern Nevada either have resigned or are strongly considering their resignation. This will result in the facility losing its designation as a Category I trauma center. The subcommittee should consider the impact that the closure of this Trauma Center would have on the community (e.g., acute and skilled nursing facilities, emergency services, hospitals, and the need for helicopter and/or transport services to carry severely injured persons to out-of-state hospitals with designated trauma centers).

Dr. Shreck listed several physicians in Nevada who are leaving their practices as a result of the current medical liability insurance crisis and thanked them for their service.

Additionally, Dr. Shreck advised that although he has been a "claims free" family physician for over 20 years, his medical liability rates will double in July 2002. He said he has given up many high-risk activities (e.g., obstetrics would have tripled his rates).

Concluding his remarks, Dr. Shreck stated that the way in which he and his colleagues deliver medical service is not the reason for the medical liability insurance crisis. He said the problem is predictability and stability in the marketplace. Further, the medical legal screening panel has decreased the number of frivolous lawsuits; however, it does not address the severity issue concerning medical malpractice cases. Dr. Shreck advised that the NSMA supports reform similar to California's Medical Injury Compensation Reform Act (MICRA) to stabilize the medical liability market in Nevada.

Dr. Donald J. Palmisano

Donald J. Palmisano, M.D., J.D., Secretary-Treasurer, American Medical Association (AMA), and a surgeon in New Orleans, Louisiana, advised the subcommittee that "fixing the broken liability system is a top priority" of the AMA. He said the AMA is committed to working at the federal and state levels to achieve meaningful and lasting reform, and is encouraged by the subcommittee's effort to address this "difficult and multifaceted" issue that could have a devastating impact on patient access to care in Nevada.

During his presentation, Dr. Palmisano discussed the following items:

C Effects of Damage Awards

1. The current liability climate is "unacceptable" and liability verdicts are "skyrocketing."

2. According to data released in March 2002 by Jury Verdict Research, the median medical liability award increased 43 percent between 1999 and 2000. Between 1994 and 1996, 34 percent of verdicts were at least $1 million. During the next two years, the frequency of excessive verdicts increased to 39 percent. By the year 2000, 52 percent of all awards were for $1 million or more and now are averaging near $3.5 million.

3. The current system for resolving health care liability claims is "critically" flawed and it:

   a. Stifles the advancement of new medical treatments and medications;

b. Inhibits patient safety and quality improvement initiatives;

c. Encourages physicians to practice defensive medicine;

d. Overwhelms the health care system with paperwork and, therefore, leaves less time for patient care; and

e. Discourages qualified candidates from pursing a career in medicine or from moving to a state with an unfavorable liability climate.

Most importantly, the current system adversely affects patients by driving up the costs of care. In many cases, it creates long trips or waits for certain procedures that patients cannot access locally because specialists have been forced from high-risk practice areas.

4. Emergency departments in some states are losing staff or closing as good physicians are forced to limit services, retire early, or move to another state with a less litigious climate. Patients who need care the most are left without access to services. The elderly are particularly affected since higher health care costs result in higher out-of-pocket Medicare expenses.

C Effects of Damages on Insurance Market

1. An "out-of-control" legal system adversely affects the medical malpractice insurance market. Insurers have both pricing power and a need to increase revenues through premiums, as returns on investments are unable to subsidize underwriting losses.

Dr. Palmisano directed the subcommittee's attention to "Exhibit 3—Underwriting Profit and Profit on Insurance Transactions (as a percent of direct premium earned)," which appears on page 4 of the April 2002 *Health Care Financial Trends Report*. "Exhibit 3" consists of two bar graphs titled "Underwriting Profit as % of Direct Premium" and "Profit on Insurance Transactions as % of Direct Premium," respectively. (Please see Exhibit F of these minutes for complete details.) Concerning these bar graphs, the report states, in part:

> These profitability trends are important for two reasons. First, they show that licensed carriers' medical PLI [professional liability insurance] business has, on average, been unprofitable in every year from 1990-2000. . . . The second reason these graphs are important is because they illustrate the trend in licensed carriers' profitability. Specifically, they show that PLI lines have become considerably less profitable over the period 1990-2000, particularly from 1998 to 2000.

According to Dr. Palmisano, these trends present a "serious" problem to physicians who try to purchase insurance.

2. Insurers began raising rates in 2000 after several years of "price-cutting competition" that left premiums "trailing" inflation. A 14 percent increase in premiums in the year 2000 was the largest since 1994 and according to the *Medical Liability Monitor* these rates are continuing to rise. Some carriers increased their rates mid-year, which "is virtually unheard of."

3. Insurance companies that continue to write medical malpractice policies are refusing to cover certain categories of physicians. Others, such as PHICO, have been taken over by state regulators when claims threatened to exceed the company's ability to pay. New Jersey's largest insurer, the MIXX Company, went out of business and "pulled out" of Ohio, Pennsylvania, and Texas specifically because of the "overly litigious markets" in those states.

4. According to the Carlyle Group, a New York investment firm that focuses on the health care industry, increases in liability premiums are becoming one of the most important factors driving inflation for medical services, particularly for specialists in obstetrics and surgery.

5. Premium increases and the unavailability of coverage are "driving doctors to take desperate measures."

Many of the nation's physicians have closed their practices, retired early, or are seriously considering moving to another state to practice medicine because they are having problems finding medical malpractice insurance or affording the "skyrocketing" rates. Dr. Palmisano cited several examples of the effect that the medical malpractice has had on physicians and patients throughout the nation. Please see his prepared remarks, which are included with Exhibit F, for complete details.

6. The current trend in the medical malpractice system "is bringing Nevada—and states across America—to the brink of a health care crisis. An out-of-control legal system has created the 'perfect storm' for health care access."

C Solutions to the Problem

Dr. Palmisano stated it is the AMA's position that tort reforms based on California's Medical Injury Compensation Reform Act of 1975 will effectively stabilize the liability climate. He advised that MICRA has stabilized California's professional liability insurance market and reduced the cost of medical malpractice while continuing to fairly compensate plaintiffs. Dr. Palmisano further noted that according to the AMA Center for Health Policy Research, several economic studies have proven that MICRA reforms are effective. Please see Dr. Palmisano's prepared remarks in Exhibit F for details concerning the findings of such studies.

According to Dr. Palmisano, in 1975, Louisiana passed a cap of $500,000 on total damages. This cap is a combination of the programs that limit damage awards in Indiana and New Mexico. In 1984, a governor's commission in Louisiana recommended the payment of future medical expenses as they are incurred. Louisiana's law has been found constitutional by its state supreme court and the United States Supreme Court. Dr. Palmisano advised that a recent survey by Wirthlin Worldwide for the Health Care Liability Alliance indicates that the vast majority of Americans agreed there is a need for "common sense" medical liability reform. This study found that of those persons surveyed:

1. Seventy-one percent agree that medical liability lawsuits are the main reason health care costs are rising.

2. Seventy-eight percent are concerned about access to care being affected because doctors are leaving their practices as a result of rising liability costs.

3. Seventy-three percent support reasonable limits on awards for pain and suffering in medical malpractice lawsuits.

4. Seventy-six percent favor a law limiting the percentage of a client's settlement a personal injury attorney can receive in fees.

Concluding his presentation, Dr. Palmisano advised that the AMA views the tort reforms in states such as California, Colorado, and Louisiana as "national models for success." He also offered to assist the subcommittee in its effort to resolve Nevada's medical malpractice crisis.

Please see Exhibit F for complete details of Dr. Palmisano's remarks.

Chairwoman Buckley asked Dr. Palmisano if he would characterize the 22 plaintiff verdicts that have occurred in Clark County during the last five years as a "legal system out of control."

Dr. Palmisano responded that states with "good" tort reform (e.g., California and Louisiana) are affected by nationwide activities. He noted that during the mid-1970s when California and Louisiana were trying to pass their tort laws, physicians throughout the nation formed their own insurance companies. Currently, he said, 60 percent of doctors in America are insured by physician-associated companies and have found that it is more favorable to conduct business in states with noneconomic damage caps than in jurisdictions without such limits. Dr. Palmisano advised if an insurance company that writes policies in more than one state cannot obtain reinsurance or loses too much money, it may "pull out" of both "good" and "bad" environments.

Continuing, Dr. Palmisano said it is important to determine the exact damages involved with the 22 plaintiff verdicts in Clark County. He advised it is the AMA's position that whatever occurs in one state will happen in all states that

do not have effective cap reform. Dr. Palmisano further stated that if, hypothetically, the awards in each of those 22 cases did not exceed $250,000 in noneconomic loss, there is a question about what will happen in the future. He noted that competition among insurers in the State of Nevada is important because it will provide physicians the best available rate.
Dr. Palmisano stated that upon receipt of additional information concerning the 22 jury verdicts, it is important for the subcommittee to review the amount of money involved and any trends that may exist.

The Chairwoman said that 22 jury verdicts seem relatively low and less than one-half of the awards for noneconomic damages in those cases exceeded $250,000. Regarding the AMA's position that the medical malpractice crisis may be attributed to "out-of-control" jury and legal systems, she asked if the organization is suggesting that the Nevada Legislature enact tort reform because of the experiences of other states.

Concerning the Medical Liability Association of Nevada, Dr. Palmisano noted there does not appear to be a "dramatic" decrease in medical malpractice insurance rates. He said MLAN is a "local" company and because the State of Nevada is bringing in its own experts, it does not have to be concerned that the insurer is providing the "right" figures. Dr. Palmisano stated that if those rates apply to Nevada without a $250,000 cap, there "really is a problem" and he asked how those rates are determined.

Chairwoman Buckley explained that the subcommittee is attempting to obtain the data necessary to make "more intelligent" decisions concerning these rates. She noted that St. Paul's underwriting practices could have affected the experience base and artificially distorted a rate.

Dr. Shreck (previously identified on page 28 of these minutes) noted that:

C The severity of medical malpractice cases in Nevada recently has increased. The 22 cases involving plaintiff verdicts might indicate that there has been a "great escalation" in the severity of noneconomic damages.

C The medical legal screening panel has assisted in reducing the frequency of medical malpractice cases.

C It is the NSMA's position that the screening panel needs improvement. For example, the long delays that occur before a claim is filed in court should be addressed.

C Statistical information about past claims and insurance companies' predictability of the future should be weighed. Although historical data is important, the predictability of the future will affect insurance rates.

Mr. Hettrick referred to the table titled "Eighth Judicial District Court—Civil Trial Verdicts 1996-2001," which appears on page 156 of Exhibit A, and stated that the total awards in Nevada between 1996 and 2001 have increased significantly. He said if an insurance company reviews past awards to determine future premiums, Nevada's environment could indicate that its costs will be significant. Mr. Hettrick noted that the significant increase in these figures could be the reason why the AMA is asking for a cap on damages.

PERSPECTIVE OF THE INSURANCE COMMUNITY

David Maurer

David Maurer, Chief Financial Officer and Treasurer, Physicians Insurance Company of Wisconsin (PIC Wisconsin), testified via videoconference from Madison, Wisconsin. Mr. Maurer informed the subcommittee that in 1995, the Wisconsin State Legislature enacted a cap of $350,000 on noneconomic damages in medical malpractice cases. He advised that this cap was based on a study conducted by an actuarial firm (Milliman USA) concerning the impact of noneconomic damages in the State of Wisconsin from 1980 to 1989. Further, this study determined that about 30 percent of all verdicts during that period were related to noneconomic damages. As a result of that finding, he said, the Wisconsin Legislature placed a limit on noneconomic damages. Mr. Maurer stated that as a result of this cap: (1) there has been about a 20 percent credit to the assessment to health care providers in the state; and (2) health care providers have recognized a savings of approximately $100 million since 1995.

In response to a question by Ms. Buckley, Mr. Maurer advised that he would provide to the subcommittee a copy of the Milliman USA study.

According to Mr. Maurer, PIC Wisconsin has been writing medical professional liability insurance in the State of Nevada since 1998. He advised that in 2001, the company: (1) wrote approximately $3 million of premiums, which represented about 5 percent of the market; and (2) expects to write an estimated $6 million of premiums at the end of 2002, which includes about $1.6 million of new business. Mr. Maurer noted that the new business has been limited to supporting the company's current agency system in Nevada. Further, the company has taken steps to help ease the burden of transferring business from St. Paul and other carriers that have exited the market. Mr. Maurer stated that PIC Wisconsin has a fairly limited role in Nevada; however, it remains committed to the state and seeks further information concerning the various tort reform measures the subcommittee is evaluating.

Responding to questions by Mr. Anderson, Mr. Maurer stated that:

C At the end of 2002, Nevada will represent approximately 10 percent of PIC Wisconsin's total business.

C Most of the other states in which PIC Wisconsin provides medical malpractice insurance have some type of medical screening panel. Wisconsin's patient compensation fund includes a panel that evaluates every claim. All physicians contribute to this fund, which is managed by a state agency.

In response to questions by Ms. Buckley regarding Wisconsin's patient compensation fund, Mr. Maurer advised that:

C Health care providers appreciate having this fund available to protect them.

C Primary carriers are required to write up to $1 million and the fund covers expenses above that amount. This limit has gradually increased from $300,000 to $400,000 in 1994 to $1 million in 1997. Before it was increased to $1 million, PIC Wisconsin experienced complications when it chose to defend a nonmeritorious case and representatives of the fund preferred to pursue an economic settlement. This situation has occurred less often since the $1 million limit was instituted.

C The fund has had an impact on premiums in the state. The primary carrier's limit of $1 million provides a level of stability for PIC Wisconsin because its losses are more predictable. The volatility lies with the fund and large claims could have a major impact on the assessments to health care providers on an annual basis.

C Policy limits of $1 million are typical. There may be some difficulty with such a limit because of the volatility that might be experienced in various states and how it applies to the ratemaking process. A more stable medical malpractice environment makes it easier for an insurer to take losses. As part of the overall expense of the marketplace, it is important to consider the defense costs an insurance company incurs in a medical malpractice case (typically between 35 and 50 percent of the ultimate claim, depending on whether it proceeds to trial).

C In addition to any tort reform measures the subcommittee considers, reducing the amount of time involved at the screening panel and trial levels would have a "tremendous" impact on lowering medical malpractice premiums. Such action would provide more predictability concerning the results of a claim.

C Ultimately, attorneys' fees are part of the cost of a claim and have a major impact on the rates insurers charge physicians. The loss component of a rate typically is between 75 percent and 90 percent. Anything that impacts the actual incurred losses (e.g., attorneys' fees, economic damages, noneconomic damages, et cetera) is part of the equation and, therefore, would have a major impact on the rates.

Mr. Hettrick referred to Exhibit E, a table concerning state patient compensation funds, which was provided to the subcommittee by Mr. Calvo with the National Conference of State Legislatures (identified on page 17 of these minutes). He asked how the annual surcharge, ranging from approximately $1,500 to $9,200, for Wisconsin's patient compensation fund is determined and expressed concern about the cost of increasing rates for physicians.

According to Mr. Maurer, this surcharge is based on the experience of the fund and the individual assessment fees of each physician depending on their classification or relativity. He said the current fee is about 80 percent of the amount a physician would be charged for the $1 million limit of the primary carrier. Mr. Maurer further noted that approximately 10,000 doctors are practicing in Wisconsin and it is important to consider the investment income generated from the surplus that has been paid into the fund since 1984.

Mr. Maurer stated he would submit to the subcommittee written remarks from the Vice President of Claims, PIC Wisconsin, concerning the screening panel.

The Chairwoman suggested that the subcommittee address patient compensation funds during its next meeting.

Joel D. Whitcraft

Joel D. Whitcraft, CPCU,ARe, Senior Vice President and Actuary, GE Medical Protective, The Medical Protective Company, Fort Wayne, Indiana, advised that The Medical Protective Company has been in the medical malpractice insurance business for over 100 years. Further, the company was licensed in the State of Nevada prior to the year 2000 and its first rate filing to establish a rate structure and policy forms was effective in March 2000. Mr. Whitcraft stated that although The Medical Protective Company does not have any experience in Nevada to share with the subcommittee, he would review his organization's perspective of the medical malpractice market and items for consideration during the members' deliberations.

Mr. Whitcraft referred to his handout, titled "The Medical Protective Company—State of Nevada Medical Professional Liability—Presentation to the Legislative Commission's Subcommittee to Study Medical Malpractice—May 13, 2002." Please see Exhibit G for complete details. Following are the items discussed and information provided by Mr. Whitcraft during his review of Exhibit G:

C Market Considerations

The availability and affordability of insurance coverage is an overriding issue. The Medical Protective Company, which is filed in 48 states, proceeds through a series of evaluations to determine the dynamics of the marketplace in each jurisdiction. The primary concerns considered by The Medical Protective Company, as well as other insurers, during this process include: (1) capital allocation; (2) reinsurance; (3) legal environment; (4) competitive barriers; and (5) regulatory environment.

1. Capital Allocation. Capital allocation involves different issues and especially relates to Nevada. Insurers must determine where they will write business and how they will allocate their capital and resources to various markets. Predictability in the marketplace is one consideration and includes items such as: (a) competitive nature; (b) foreseeable trends in the future; (c) past experience of other carriers; and (d) predictability of results.

   A primary consideration in Nevada has been the unpredictability of losses in medical malpractice insurance. There appears to have been a fairly significant increase in claim frequency in the last five years as a result of the number of claims that have been submitted to the screening panel. Also, concerning closed claims, there are high loss severities that tend to be volatile between the calendar years in which the claims were closed.

   In determining whether 22 plaintiff verdicts during the last five years indicate that Nevada's legal system is "out of control," it is important to realize that many factors are involved in this "dynamic" process. A few verdicts may have a "tremendous" influence on the ability to settle a case. The success of certain plaintiffs' attorneys receiving "very high" verdicts may begin to "dictate the benchmark" to which a settlement may rise.

   The closed claim data provided by the Division of Insurance indicates a distinction between the severities of cases decided by trial versus those that are settled. (See Exhibit C, Exhibit IA, page 3.) For example, in 1999 those amounts were fairly close (approximately $266,000 versus $258,000). In 2000, there was an influence of large losses through plaintiff verdicts and those figures increased (about $641,000 versus $275,000). Although the number of verdicts in 2001 decreased, the settlement value increased dramatically.

   Additionally, in 2001, the settlement averages were approximately $390,000 for Clark County and $247,000 for the remaining counties in the state. (See Exhibit C, Exhibit III, page 1.)

The closed claim data indicates a fairly significant upward movement in the severity of losses. Plaintiff verdicts alone do not drive the total value of a claim; however, they influence the value of settlements and an insurance company's ability to reach reasonable settlements with plaintiffs.

Responding to a question by Ms. Buckley, Mr. Whitcraft stated that a review of the previously referenced 22 plaintiff verdicts and the awards in those cases that are higher than the offers presented for settlement prior to trial should include consideration of an insurance company's internal claims administration process (e.g., the efficiency of the process and how well the value of a case is assessed). At some point during a medical malpractice case, an insurance company must decide whether it will accept a settlement or proceed to court. It sometimes will make a "right" or "wrong" decision. However, if those decisions are not consistent:

a. The insurer will convey the "wrong" message to the plaintiffs' bar that it is willing to settle "just about anything" and "won't fight," which does not help anyone; and

b. A certain "attitude" within a legal environment could result in verdicts that exceed the plaintiffs' original demands and result in an unpredictable system. This situation is problematic from an insurance carrier's perspective because predictability of experience is a primary concern of the industry.

Historical information indicates that St. Paul recognized an upward trend in experience in Clark County during 1999 and 2000, but did not adjust its rates accordingly until 2001. The claims process can be "very random" with variations from year to year. In many cases, an insurance company will not adjust its rates until it is certain that a trend rather than a variation up or down from a mean value is occurring. It appears that this was the situation with St. Paul. Unfortunately, such action disrupts the marketplace. It created a "great deal" of disruption for The Medical Protective Company because its rates for Nevada were predicated on both St. Paul's rate level and assessment of the territorial differences within the state. The Medical Protective Company has determined that its rates are inadequate relative to the actual experience within the territory and has filed a request for a rate increase with Nevada's Division of Insurance.

Senator Titus asked if The Medical Protective Company would require a physician who has had numerous medical malpractice claims filed against him or her to pay a higher premium than other doctors it insures or spread the cost to cover that person among all of its insureds. She further inquired if the company could decline coverage for such a physician, thereby removing that person from the process and preventing plaintiff verdicts as a result of his or her actions.

Mr. Whitcraft explained that The Medical Protective Company has various rules relating to its rate structure and because of the credibility issue it must work within certain parameters to differentiate insureds to a certain degree based on their individual claim experience. He noted that when assessing a person to determine their premium, a company must consider a physician who has no claims versus one who does. Further, one doctor may have three claims in three years and practice an additional 15 years without a claim and another could have three claims spread out over a 15-year period. Mr. Whitcraft stated that this situation raises a question concerning which physician has a better claim experience.

According to Mr. Whitcraft, a physician seeking medical malpractice coverage from The Medical Protective Company must first pass underwriting guidelines. The company probably would not write a person who has a high degree of frequency (i.e., named in complaints as well as found to be negligent).

Mr. Whitcraft advised that a rate can be modified through the following options:

a. The loss-free credit rule provides that if an insured has been loss-free for a certain number of years he or she will receive a credit off of the existing rate for that class of doctor.

b. A schedule rating plan, which is limited by either the statutes or regulations within a state, allows under certain conditions for an insured to be debited a specific percentage to reflect that he or she has had adverse loss experience.

Ultimately, he said, the majority of loss resulting from medical malpractice claims is spread among the premiums charged to all insureds.

2. Reinsurance. The influence of reinsurance will have an impact on the subcommittee's deliberations concerning excess and/or patient compensation funds. Reinsurance has been affected dramatically since the fall of 2001 and has had a significant impact on the medical malpractice industry. Reinsurers have become more cautious and conservative in reinsuring medical malpractice in jurisdictions with a propensity for high severity losses. They are not encouraging insurers who want to continue business with them to grow and write in those areas. Overall costs are influenced by this situation.

   The significance of reinsurance will increase if doctors in Nevada desire or need a medical liability limit above $1 million. Making a fund available to physicians who want higher limits to cover their type of exposure would eliminate the reinsurers' conservatism in viewing a marketplace, as well as the profit load that is inherent in the reinsurers' costs. Basically, such a system could operate on a cost only basis. The state would become an insurer and bear the burden for the volatility of the experience. Such a fund would alleviate some affordability issues to a certain extent; however, it would not have a dramatic effect because the vast majority of the costs are in the first $1 million of coverage for doctors.

3. Legal Environment. Legal expenses are a factor in insurers' costs. Page 5 ("Rating Considerations") of Exhibit G illustrates that The Medical Protective Company's overall loss costs in its rate are approximately 80 percent of the premium dollar. About 22 percent of that figure accounts for allocated expenses. This direct expense to the company is passed on to doctors. The plaintiffs' legal fees are passed on to the doctors as well. If plaintiffs' attorneys desire to make more money, they will "push up" the value of cases because their fees are predicated on those amounts. The only way the fees of plaintiffs' attorneys increase is if verdicts and settlements rise and such a change will influence insurers' overall costs.

C Industry Developments

Page 3 of Exhibit G includes the following graphics:

1. "Industry Combined Ratio" illustrates that the medical malpractice industry is breaking a combined ratio of about 115 percent. In the early 1980s the combined breaking ratio was slightly higher. The industry is experiencing another cycle.

2. "Industry Reports" indicates that market capitalization for medical malpractice companies is decreasing dramatically. According to this illustration, as a result of reserve deficiencies, two companies have been downgraded, one has exited the market, and another has reduced its market share by approximately 40 percent. There is a lot of disruption throughout the market and if one jurisdiction appears to be more problematic than another, an insurer will "pull back from Nevada first" when deciding where to invest its capital.

3. "Declining Market Caps" uses Standard & Poor's Insurance Index as a benchmark to demonstrate what has happened to the capitalization of medical malpractice companies based on the value of their stocks. This graph reflects the companies' overall financial performance, how reinsurers view them, and where they can invest resources. For example, some companies drain their surplus for large reserve increases. As a result, they report significant losses instead of profits and the value of their stock decreases significantly.

C Historical View

Page 4 of Exhibit G includes:

1. A list, titled "Historical Rate Level," which indicates that The Medical Protective Company first filed in Nevada in March of 2000, has no claim experience to date, and has a rate filing pending with the Division of Insurance. This filing is predicated on the filing submitted to the Division by St. Paul. The Medical

Protective Company also reviewed the filing by The Doctors' Company to determine if there was any consistency between the two insurers.

2. A graph, titled "St. Paul Experience—Incurred LALE Ratios by Territory," which demonstrates "tremendous" consistency between the loss ratios that St. Paul was experiencing in Clark County versus the rest of the state. This graph basically explains the difference in the rate level and the dramatic rate increase that doctors in Clark County have experienced.

C Rating Considerations

When developing a rate, The Medical Protective Company typically relies on its experience in a particular jurisdiction. It does not have experience in Nevada and, therefore, must rely on information submitted by other insurance companies. Page 4 of Exhibit G includes the following lists and the key elements of the rating process:

1. "Development of the Rate Structure"

   a. Reported and paid claim frequency;

   b. Indemnity per paid claim;

   c. Legal expense per reported claim;

   d. Geographic distinctions in frequency and severity;

   e. Class plan structure;

   f. Operating expenses; and

   g. Anticipated return on investment and target return on equity.

2. "Individual Insured Considerations"

   a. Historic frequency;

   b. Severity and circumstances of claims;

   c. Individual large losses;

   d. Characteristics of the medical practice (e.g., the type of procedures performed); and

   e. Risk management training and processes.

C Countrywide Ranking

The table titled "Comparison of Rates" on page 6 of Exhibit G indicates that Nevada's rates for a random spectrum of low-risk to high-risk procedures generally are in the top 20 percent to 25 percent nationwide. A comparison of Clark County with other metropolitan areas determined that its rates are in the top 5 percent to 10 percent. The relationship between metropolitan and nonmetropolitan areas is much higher in Nevada than in other states.

In response to a question by Mr. Anderson concerning Clark County's medical rates ranking in the top 5 percent to 10 percent among metropolitan areas, Mr. Whitcraft stated he has not reviewed enough information to explain these figures. He noted, however, that his subjective observation is that a high concentration of the state's population is in Clark County, the number of attorneys per capita may be higher there than anywhere else in the state, and the system may be more accessible. Mr. Whitcraft also noted that metropolitan areas tend to be more litigious than less populated communities and this factor could be the "primary driver."

Chairwoman Buckley questioned the accuracy of the statistics provided by Mr. Whitcraft concerning the rates for certain medical procedures in Clark County. She also stated that there are 3,000 active practicing lawyers in Clark County, which has a population of approximately 1.4 million people. Ms. Buckley said the number of attorneys per capita in the county appears to be "pretty low."

Mr. Whitcraft noted that his statements do not imply there is not access to an attorney but that people outside Clark County may be less likely than persons within that jurisdiction to pursue an adverse outcome.

C Claims Administration

Two graphs, titled "Life Cycle of a Claim" and "Life Cycle of a Lawsuit," appear on page 7 of Exhibit G. This information is based on The Medical Protective Company's general experience and is not specific to Nevada. It indicates that claims typically are resolved within 12 months and lawsuits often exceed 30 months.

Nevada's medical malpractice screening panel was designed to require less time than it actually is taking to process claims. A review of the flow chart titled "Overview of Medical Malpractice Screening Panel Process (Chapter 41A of *Nevada Revised Statutes*)," which appears on page 133 of Exhibit A; information provided by The Doctors' Company; and data provided to the screening panel indicates that the cases presented to the screening panel may be broken down approximately as follows:

1. Reasonable probability of malpractice – 20 percent (100 percent of which may be settled or proceed to trial).

2. No reasonable probability of medical malpractice – 42 percent (50 percent of which are dropped and 50 percent either are settled or proceed to trial).

3. No decision on the issue of malpractice – 38 percent (96 percent of which are pursued for settlement or filed in court).

According to these percentages, the screening panel limits about 22 percent of all actions and, therefore, does not appear to be accomplishing its intended goal (i.e., eliminating frivolous cases).

The following concerns relating to the state's screening panel should be addressed:

1. The screening panel encourages blanket inclusion in complaints, probably more than other jurisdictions. If a person is not named in a complaint before the panel, he or she cannot be included in a case that proceeds to district court. Therefore, the plaintiff's attorney is almost obligated to name a person whether he or she has any negligence or potential liability in their opinion.

2. An expert who must complete an affidavit to bring a complaint forward on each individual defendant should be well qualified in the same field in which the complaint is being made against the doctor so they are well versed in what the standard of care in that particular area should have been. The parameters for such experts vary among other jurisdictions from "very strict" to "virtually undefined."

C Texas Tort Reform

In 1995, the State of Texas passed legislation to address its medical malpractice problem, which was less severe than Nevada's current crisis. This tort reform became effective in 1996. Page 8, titled "Texas Tort Reform," of Exhibit G includes information on the following topics.

1. Mandated Rate Rollback

   This legislation included a mandatory rate rollback for insurance companies. The bar graph titled "Mandated Rate Rollback" on page 8 of Exhibit G shows the cumulative rate reduction for insurers by calendar year from 1996 through 2000.

   The Medical Protective Company disagreed with the assessment of the value of the tort reform by Texas'

Department of Insurance. It was difficult for the department to simulate what it anticipated would happen after a particular aspect of the law was changed. From the perspective of The Medical Protective Company, overestimating the effects of this reform would create a "tremendous" problem in the future and that actually did occur.

2. Tort Reform Components/Percentage of Impact

   a. Exemplary damages, frivolous lawsuits, and deceptive trade practices (5 percent);

   b. Joint and several liability, change in venue, and bond and expert report (55 percent); and

   c. Behavior modification (45 percent).

3. Impact on the Marketplace

   The greatest benefit of Texas' tort reform is that it has mitigated some of the trends that otherwise would have occurred. However, this reform artificially lowered rates and created an incorrect baseline for new entrants. The Medical Protective Company had been providing medical malpractice coverage in Texas when tort reform was enacted and, therefore, it understood what was happening with claim frequency and severity. Other companies came into the state, adopted rates based on the reduced rates of The Medical Protective Company, and eventually found those figures to be inadequate. Two of those companies have withdrawn from the market, experienced significant reserve inadequacies, and been downgraded.

Concluding his presentation, Mr. Whitcraft advised that problems may result if a "good proposition" is not managed properly. He encouraged the subcommittee to consider why certain plans should be implemented to address the affordability of medical malpractice insurance in Nevada.

Additionally, Mr. Whitcraft explained that in assessing a program, more time will be required to address the affordability than the availability of medical malpractice insurance. He noted that as insurance companies realize that the State of Nevada is changing its laws concerning medical malpractice, they will be more interested in conducting business in the state. However, there will be a "wait and see" approach by insurers to make sure that a reaction does not offset certain legislative changes.

The Chairwoman encouraged Mr. Whitcraft to participate in future meetings of the subcommittee.

Mr. Whitcraft advised that he will continue to work on developing recommendations for the subcommittee's consideration.

PERSPECTIVE OF THE LEGAL COMMUNITY

Bill Bradley

Bill Bradley, Nevada Trial Lawyers Association (NTLA), Reno, Nevada, thanked the subcommittee and its staff, Governor Kenny C. Guinn and his staff, and Nevada's Commissioner of Insurance and her staff for addressing the state's medical malpractice crisis.

Mr. Bradley noted that during this meeting, representatives of the insurance industry acknowledged that frivolous cases do not appear to be an issue in this state because of Nevada's medical malpractice screening panel. Further, those persons "erroneously assumed" that 22 percent of the cases determined by the screening panel to have no reasonable probability of malpractice are eliminated from the system. He said the mere presence of the panel has eliminated a significant amount of cases that in other states proceed to go forward.

Concerning the terms "frequency" and "severity" as they relate to medical malpractice, Mr. Bradley stated that based on a comparison of the population growth and the number of cases processed by the screening panel, the frequency cases in Clark County has remained consistent. He explained that an increase in severity means people are getting hurt worse. Mr. Bradley expressed his opinion that it is "cynical" to limit the rights of medical malpractice victims at a time when people are being hurt worse and the cost of their care is increasing.

Mr. Bradley introduced Loretta Cummings and Dianne Meyer, both of whom were injured while under medical care. He advised the subcommittee that Ms. Cummings and Ms. Meyer would discuss the effects that medical negligence has had on their lives.

Loretta Cummings

Loretta Cummings of Las Vegas, Nevada, advised that she worked as a medical transcriptionist at Sunrise Hospital in southern Nevada for more than 30 years. Ms. Cummings explained that as she was on her way to work one day, she fell outside the hospital and injured her back. She said as a result of the back surgery she underwent to treat this injury, her left leg was amputated.

Ms. Cummings stated that as a result of her experience she has been hurt both emotionally and physically. She briefly discussed the difficulty she has with everyday activities (e.g., cleaning, shopping, showering, and traveling) and noted that her son has moved into her home to assist her.

Dianne Meyer

Dianne Meyer of Las Vegas, Nevada, informed the subcommittee that approximately a year and a half ago she was "fully healthy" and working at the Bellagio Hotel and Casino. She advised that she became severely ill as a result of kidney stones and eventually both of her legs were amputated. Ms. Meyer stated that every part of her life has changed and "every day it's a struggle." She briefly discussed the hardships she has experienced and the difficulty she has encountered with her medication, prosthetics, and wheelchair.

Bill Bradley

Mr. Bradley then introduced Dean Hardy, NTLA, Las Vegas, Nevada, and Ken Sigelman, J.D., M.D., Consumer Attorneys of California, Medical Malpractice Chairman. He noted that Dr. Sigelman would address California's experience with caps.

During his presentation, Mr. Bradley discussed the effect of caps in Nevada. He stated that a cap is the concept of not listening to an injured person before his or her damages are decided. Further, it conveys to a person who has experienced a catastrophic event that what he or she may tell a jury is not important because the value of his or her life already has been determined. Mr. Bradley noted it is important to not "lose sight" of the actual experiences of medical malpractice victims.

Mr. Bradley then addressed the $50,000 cap on an award for damages in a tort action against a state, county, or city government employee in Nevada. He mentioned that during the subcommittee's first meeting on March 21, 2002, he questioned why the State of Nevada continues to pay insurance companies $1 million to cover each University of Nevada School of Medicine resident if their liability is capped at $50,000. Mr. Bradley said it is important to determine the whereabouts of those premium dollars and the reason why, with a $50,000 cap in effect, the school is experiencing problems and threats have been made to close the University Medical Center in southern Nevada.

Continuing, Mr. Bradley provided the subcommittee with a handout, titled "Damages Recoverable in a Medical Malpractice Claim," which includes Nevada Jury Instruction (NJI) Nos. 10.02 (medical expenses), 10.03 (loss of earnings), and 10.04 (pain and suffering). Please see Exhibit H for details. Mr. Bradley stated that Exhibit H includes the language that is read by a judge to the jury at the end of a trial to assist jurors in deciding how they will award damages. He explained that whether a case relates to a car accident or medical malpractice, the damages consist of three categories: (1) medical expenses; (2) loss of earnings; and (3) pain and suffering experienced by a victim. Mr. Bradley further noted that this language is "very benign" and it is incumbent upon a victim to testify in court about the effect of his or her case. Finally, a judge reads the following language to a jury:

> There is no definite standard by which to fix reasonable compensation for pain and suffering. In making an award for pain and suffering you shall exercise your authority with calm and reasonable judgment and the damages you fix shall be just and reasonable in light of the evidence.

Mr. Bradley noted that after a jury makes a decision concerning damages, a judge may determine whether those

damages are fair and reasonable and has the ultimate power to reduce that figure if he or she deems it appropriate.

According to Mr. Bradley, a cap on pain and suffering has a devastating effect on senior citizens. These persons may only recover damages for pain and suffering because Medicare covers their medical bills and they do not have a wage loss.

Mr. Bradley briefly spoke about California's cap of $250,000 on noneconomic damages in medical malpractice cases, which was established in 1974. He explained that irrespective of the number of physicians involved in a case, the total cap is $250,000 and it has not been increased for cost-of-living expenses in 25 years. Mr. Bradley stressed that California does not fairly compensate victims of malpractice.

Regarding excess verdicts, Mr. Bradley said it is important to know what happens when the doctor and plaintiff involved in a medical malpractice case were willing to settle for the policy limit but the insurance company decided that irrespective of its insured's wishes, it would proceed to court. He advised that in virtually all of the cases that appear on the table titled "Plaintiff Medical Malpractice Verdicts (Clark County: 1996-2001)," which was prepared by the Nevada Trial Lawyers Association, the awards exceeded the policy limits. (Please see pages 154 and 155 of Exhibit A for details.) Additionally, Mr. Bradley noted that the NTLA has not received information from those insurers concerning the manner in which they use those losses. He said an important question to ask the insurance industry is if such losses are applied against the physicians involved or toward its loss ratios.

Mr. Bradley noted that in comparison to other states, Nevada has a relatively low number of doctors. He briefly spoke about the relationship between that figure and the few cases in which an insurance company decided not to settle prior to a trial or verdict, a jury decided in favor of the plaintiff, and a large verdict was awarded. Mr. Bradley said those verdict amounts are a result not of the legal system but of a company ignoring the results of the screening panel, as well as the wishes of its physician, and proceeding to court. He stated that if insurers make a "bad" decision and are allowed to use a multimillion-dollar verdict against the physician to increase his or her rates, work the resulting excess numbers into their loss ratios, and then assert that there is a problem with the medical malpractice system in this state, it is important to determine whether the insurance or legal system needs improvement.

Ken Sigelman, J.D., M.D.

Ken Sigelman, J.D., M.D., Consumer Attorneys of California, Medical Malpractice Chairman, San Diego, California, advised that he is a practicing attorney and retired licensed physician. Dr. Sigelman noted that during the last 19 years his law practice has focused on representing victims of medical malpractice.

According to Dr. Sigelman, the most obvious direct impact of California's cap on noneconomic damages has been to deprive the most severely injured victims and the families of victims who are killed by malpractice of what a judge or jury determines to be fair and reasonable compensation.

Dr. Sigelman stated that jurors, victims, and attorneys who represent victims have complained about the unfairness of this cap. Further, in 1994, a prominent medical malpractice defense attorney practicing in Los Angeles, California, testified before a congressional subcommittee that the cap was unfair and helped negligent doctors at the expense of victims. Dr. Sigelman noted that when this attorney refused to recant his remarks at the request of his insurance company clients, they discontinued their business relationship with him and he now practices in an area of law other than medical malpractice.

Continuing, Dr. Sigelman advised that in addition to the obvious direct impact on severely injured victims who are not permitted to receive an award that a judge or jury decides is fair and reasonable, there are significant indirect effects. He said particular categories of victims (i.e., children, senior citizens, and stay-at-home mothers) tend to have damages that primarily are noneconomic. In cases involving the death of those individuals or injuries to senior citizens or stay-at-home mothers, those victims have difficulty finding representation and do not have an opportunity to receive fair treatment in the system because of this arbitrary $250,000 cap.

Dr. Sigelman then discussed the effect that a cap on noneconomic damages has had on medical malpractice premiums in California. He said there are "eerie parallels" between some of the events that occurred in California during the mid-1970s and those that have taken place in Nevada since its current crisis has emerged. Dr. Sigelman advised that:

C During the mid-1970s, Travelers Insurance controlled the medical malpractice insurance market in California. As a result of questionable underwriting practices and "large hits" on its investment portfolio, this company declared in the early to mid-1970s that there was a crisis and raised its premiums approximately 350 percent and more than 400 percent the next year.

C In response to the actions by Travelers Insurance, the California State Legislature held a special session in 1975 and passed the Medical Injury Compensation Reform Act, which included a $250,000 cap on noneconomic damages.

C Shortly after MICRA became law, doctors who were insured by Travelers Insurance sued the company for overcharging them on their rates. Ultimately, Travelers Insurance paid these physicians tens of millions of dollars in premium overcharges.

C When evaluating reports that premiums in California have stabilized, it is important to consider:

1. The deterrent effect that the Travelers Insurance lawsuit has had on other insurance companies trying to gouge doctors on their rates; and

2. Proposition 103, a ballot initiative passed in 1988 that established stringent requirements for insurance companies to obtain rate increases in California.

From this perspective, it is difficult to attribute anything significant in terms of California's premiums to the passage of the statutory cap on noneconomic damages.

C The overriding issue is providing quality health care and remedies to patients who are injured by a medical wrongdoing. Throughout the nation, the ratio of medical malpractice premiums as a percentage of overall health care expenditures always has been less than 1 percent. According to a survey published by the Consumer Federation of America, California has been ranked in the middle with approximately 0.6 percent. During the same period surveyed, Nevada's figure was about 0.8 percent. If the right to recover damages in a medical malpractice action were completely eliminated, the cost of a $100 office visit in California and Nevada would be reduced by about 60 cents and 80 cents, respectively. These figures indicate that the cost of medical malpractice premiums does not have a significant impact on overall health care expenditures.

Referring to a letter dated May 9, 2002, to Ms. Combs (previously identified on page 10 of these minutes) from The Doctors' Company, Dr. Sigelman made the following observations:

C The bar graph titled "California vs. Nevada—1998-2002 Average Rate by Specialty" on page 5 includes arbitrary time periods for comparing California and Nevada. A comparison of the average rates by specialty beginning in 1998 provides a disproportionate weight to Nevada's "chaotic aberrant" years of 2001 and 2002. If a comparison concerning the relationship between premiums in California and Nevada since MICRA was enacted were made, full insurance cycles would be allowed to work through a reasonably extended period of time and a different type of relationship would be evident.

C The graphic titled "MICRA Helps Reduce California Medical Liability Premium Rates by 40%" on page 6 actually indicates that although premiums in California have nearly doubled, they have not kept up with inflation. A review of this same statistic at a national level would indicate that medical malpractice premiums throughout the country have increased at a rate significantly lower than inflation during the last 25 years.

C The graphic titled "MICRA Reduces Average Time to Settlement" on page 6 is "completely inaccurate." California's Trial Delay Reduction Act was passed into law in the late 1980s and has been gradually implemented during the last 14 years. The intent of this act is to resolve all civil cases (except for a few that are "very complex") within 12 to 18 months. Generally, its goal to resolve 95 percent of these cases within 18 months is being met. The average of 1.8 years that it takes to settle a case in California cannot be attributed to MICRA.

Concluding his remarks, Dr. Sigelman explained that an arbitrary general damages cap prevents patients and their families from receiving fair compensation for the medical wrongdoing of others. He noted that the benefit to society

in terms of reduced health care costs has never been found to exist. Further, the benefit of reduced premiums being a direct effect of damage caps has never been shown to be the case in California.

Please see Exhibit I for complete details of this correspondence.

Bill Bradley

Responding to questions by Mr. Anderson, Mr. Bradley explained that:

C Plaintiffs' lawyers are entitled to present their attorney's fees as part of the damages when an insurance company decides to proceed to court. They begin tracking their time when work on a case commences. When an insurance company decides to take a case to court, its own attorney's fees are doubled or tripled and its allocated loss adjustment expense (ALAE), which consists of plaintiff's fees of the defense counsel, increases severely. If a plaintiff's verdict exceeds a judge's recommendation concerning the value of a case, an additional award of attorney's fees and expenses are awarded to the plaintiff's attorney.

C In instances when his office has a "clearly meritorious" case, it attempts to reach a settlement with the insurance company before approaching the screening panel.

In response to a further question by Mr. Anderson, Dr. Sigelman advised that California does not have an attorney's fee provision that is comparable to Nevada's. He said the only penalty a party may incur for not accepting a settlement offer, going to trial, and experiencing a worse result is that it will have to pay the other party's expert witness costs. Dr. Sigelman added that if a plaintiff "betters" that settlement offer, he or she will receive prejudgment interest from the date of the offer.

Additionally, Dr. Sigelman addressed the 54.5 percent loss component of the premium dollar that was referenced earlier in this meeting by Mr. Whitcraft of The Medical Protective Company. (Please see page 5 of Exhibit G.) He stated that within the insurance industry this apparently is the standard amount paid to claimants. Dr. Sigelman advised that in California, between 1988 and 1997, 38.4 percent of that premium dollar was paid to claimants. He explained that insurance companies have not reduced premiums and have increased their profits.

Chairwoman Buckley noted the importance of reducing administrative costs and "waste" in the medical malpractice system in an effort to lower premiums. She asked about the possibility of strengthening penalties for cases that proceed to court although both the screening panel and settlement judge determine that clear malpractice exists and a doctor and patient are willing to settle. Ms. Buckley expressed concern that the doctor involved or all physicians covered by that particular insurance company may bear the expense of such cases.

Mr. Bradley advised that California has "strong" case law that states an excess verdict beyond the policy limits ultimately becomes the responsibility of a malpractice carrier if their actions are deemed to be in bad faith.

According to Mr. Bradley, after a doctor consents to pay a settlement amount, the carrier assumes his or her control. He noted if an insurer pursues the case in court against the physician's wishes, the physician may assign his or her rights to the victim who may file a lawsuit against the insurance company. Mr. Bradley stated that in these situations no one wants to create another lawsuit but an excess verdict has been made against the doctor and the victim has no recourse because the case will be appealed.

Mr. Bradley recommended the possibility of authorizing Nevada's Commissioner of Insurance to prevent an insurance company from using a "bad" decision to pursue a case in court to increase a medical specialty's rates or including the verdict amount in its losses to seek a rate increase. He stated that Nevada's system works well.

Responding to a question by Ms. Buckley, Mr. Bradley expressed support for decreasing the time in which a medical malpractice case may be brought to trial to two years. Mr. Bradley stressed that the intent of the screening panel was to screen out frivolous cases and screen meritorious cases toward an early resolution. He stated that such reform would limit the expenses related to these cases.

Mr. Bradley directed the subcommittee's attention to the table titled "The Doctors Company—10-Year Rate Change History—State of Nevada," which appears on page 4 of the previously referenced letter from The Doctors' Company

(Exhibit I). He noted that this information indicates that The Doctors' Company acted responsibly by implementing incremental rate increases between 1992 and 2001, most likely to represent continuing increases in health care expenses. Further, the future cost of care is the most expensive element in a catastrophically injured person's claim and medical inflation has been "incredible." Mr. Bradley advised that in the year 2000, The Doctors' Company gave a rate decrease across all lines of insurance and The Medical Protective Company began providing medical malpractice coverage in Nevada. He stated that Nevada's current medical malpractice crisis may be attributed to the downturn in the economy as opposed to its medical malpractice system.

A brief discussion ensued between Senator Titus and Mr. Bradley regarding the merit of the screening panel process. Mr. Bradley expressed concern that this system is "falling horribly down" in the area of meritorious cases in which the panel reaches a unanimous decision concerning reasonable probability of malpractice and an insurance company chooses to proceed to court. He noted that such a decision by an insurer may adversely affect the doctor involved, as well as an entire medical specialty.

Mr. Bradley briefly spoke about a $9 million plaintiff verdict that was awarded during 2001 in Fallon, Nevada. This verdict appears on page 1 of the previously referenced letter from The Doctors' Company (Exhibit I). Mr. Bradley explained that despite "intense pleadings" by the physician to settle within the policy limits, The Doctors' Company chose to have this case decided by a jury. He said the future cost of care was determined before the case started and the insurer was aware of the large damage award if the jury decided in favor of the plaintiff.

Concluding his presentation, Mr. Bradley submitted a copy of Nevada Supreme Court opinion *Barrett v. Baird*, 111 Nev. 1496, 908 P.2d 705 (1995), which references a review of the screening panel by the United States Court of Appeals for the Ninth Circuit. Please see Exhibit J for details. The Ninth Circuit cautioned Nevada's Legislature and courts not to read too much into a screening panel decision because of the inability of that process to take depositions and find the true facts other than the information that is entered on a medical chart, which often is illegible. Mr. Bradley stated that absent discovery under oath, the limitations of this panel must be realized. Further, consideration must be given to the fact that the screening panel is not intended to be the final decider of the merits or demerits of a medical negligence case.

NEVADA MEDICAL LIABILITY SCREENING PANEL

OVERVIEW OF THE OPERATION OF THE PANEL AND STATISTICAL DATA CONCERNING MEDICAL MALPRACTICE ACTIONS IN NEVADA

Alice A. Molasky-Arman

Alice A. Molasky-Arman, Commissioner of Insurance, Division of Insurance, Nevada's Department of Businesses and Industry, provided the subcommittee with a handout titled "State of Nevada Department of Business & Industry Division of Insurance—Presentation to the Legislative Subcommittee to Study Medical Malpractice—Presented By: Alice A. Molasky-Arman, Commissioner of Insurance—May 13, 2002." This document reviews the steps involved in processing a medical dental screening panel case filed with the Division of Insurance. Please see Exhibit K for details.

Ms. Molaksy-Arman advised that it may take up to two years for some cases to proceed through the screening panel. She further noted that:

C Delays in this process may be attributed to the complexity of a case or stipulations for extension of time. The Division of Insurance supports placing restrictions on unlimited extensions of time. There are both "absurd" and "valid" reasons for these extensions. Valid reasons include the failure of a medical service to provide subpoenaed records in a timely manner and the voluntary nature of the panel (e.g., scheduling conflicts of attorneys and physicians).

C Currently, the screening panel has a backlog of 282 cases. The Division of Insurance attempts to schedule two panels per evening and is constantly "battling time." The complexity of some cases results in large amounts of information and it is "absolutely impossible" for voluntary panels to consider those in one evening. In an effort to address these "paper intensive" cases, the Division has adopted a regulation stating that documentary

evidence should not be duplicated in various pleadings.

C Steps should be taken to expedite the screening panel process because it is unfair to postpone resolution for a claimant with a meritorious case, as well as for a physician involved in a nonmeritorious case.

Pages 11 and 12 of Exhibit J address "Potential causes for delay in the panel process."

Additionally, Ms. Molasky-Arman referred to pages 14 through 17 of Exhibit J and discussed statistics regarding the number of medical claims filed against the same doctor or hospital in Nevada between 1995 and May 3, 2002. During her review of a pie chart, titled "Percentage Of Claims Filed Against The Same Doctor/Hospital," on page 17 of Exhibit J she provided the following information:

C 84.8 percent – 1 claim;

C 10.8 percent – 2 claims;

C 2.0 percent – 3 claims;

C 0.6 percent – 4 claims;

C 0.3 percent – 5 claims; and

C 1.5 percent – more than 5 claims.

Please see pages 14 through 17 of Exhibit J for complete details of this data.

In reference to a previous comment by Mr. Whitcraft of The Medical Protective Company (identified on page 36 of these minutes), Ms. Molasky-Arman advised that persons who are not under the jurisdiction of the medical legal screening panel are not considered during that process. However, she said, they must be named in a case for the purpose of the statute of limitation and if the respondents in the screening panel process are going to be codefendants in a lawsuit.

Ms. Molasky-Arman then discussed the following graphics that appear on pages 19 and 20, respectively, of Exhibit J:

C "Division of Insurance—Medical Dental Screening Panel—Disposition of Closed Medical Cases—Calendar Years 1996-2001—Disposition of Medical Cases Closed" indicates that the determinations by the screening panel during this timeframe have been "fairly consistent."

C "Division of Insurance—Medical Dental Screening Panel—Disposition of Closed Medical Cases—January-April, 2002" is a different rendition of the information that appears on page 19 of Exhibit J and applies to cases that were closed between January 2002 and April 2002. Between January 1, 2002, and April 2, 2002, the Division of Insurance has received 82 claims.

Continuing, Ms. Molasky-Arman noted that the graphics, titled "Division of Insurance—Number of Medical Claims Filed Against Physicians/Hospitals With the Medical Dental Screening Panel—Calendar Years 1996-2001" and "Number of Claims Filed Against Physician/Hospitals," on page 22 of Exhibit J relate to the number of medical claims filed against a doctor, hospital, or nurse by year. Further, this data refers to the number of respondents who are named in cases. She explained that more claims are filed each year as Nevada's population continues to grow. Ms. Molasky-Arman advised that the number of medical claims filed against physicians/hospitals with the screening panel has increased from 320 in 1996 to 456 in 2001.

The Chairwoman suggested that if the screening panel is retained, its operation and process could be improved and expedited by:

C Decreasing the number of stipulations approved for extensions of time; and

C Addressing the number of conflicts for screening panel members.

According to Ms. Molasky-Arman, the Division of Insurance frequently experiences difficulty in identifying six persons to serve on a panel because of scheduling conflicts, preemptory challenges, and challenges for cause by the parties involved in a case.

In response to a question by Ms. Buckley, Ms. Molasky-Arman advised that Governor Guinn has requested a "staffing plan" to improve the screening panel process. She noted that the present staffing level for the screening panel consists of 1.5 and 2.5 positions, respectively, in Carson City and Las Vegas.

Chairwoman Buckley stated that the subcommittee will coordinate with Governor Guinn's office and Ms. Molasky-Arman concerning this topic and will support the Governor's recommendation or include it in the work session document.

Responding to questions by Senator Townsend concerning the information on page 19 of Exhibit J, Ms. Molasky-Arman advised that a vote by four of the six screening panel members constitutes a "yes" finding that it is likely or a "no" finding that it is unlikely that medical malpractice occurred. She stated that the Division of Insurance does not track cases after the panel's decision is rendered. Ms. Molasky-Arman said many of these cases proceed to settlement and the claimants and respondents are not obligated to provide further information to the agency.

Senator Townsend expressed concern about the lack of information available to evaluate the effectiveness of the screening panel. He said it is important to know the number of claimants who received "yes" and "no" findings by the panel, whether they settled or proceeded to court, and the results of those trials.

Ms. Moskowitz (previously identified on page 6 of these minutes) explained that it may be possible to obtain this information by cross-referencing the Division of Insurance closed claim reports.

According to Ms. Molasky-Arman, Nevada law requires that the Division of Insurance maintain a database of information provided by insurance companies regarding closed medical malpractice claims for medical doctors only. Therefore, she said, other categories of respondents who are named in a screening panel case would not be included in the closed claims reports. Ms. Molasky-Arman added that the Division of Insurance could request that information from the insurance companies.

Mr. Anderson noted that although dentists and hospitals are an integral part of the screening panel process, they account for a small percentage of cases. He also stated that it appears that dentists in this state are not experiencing major problems with the panel. Mr. Anderson asked that the information requested of the Division of Insurance by Senator Townsend be provided to the subcommittee at its next meeting.

Senator Townsend stated that he primarily is interested in knowing how many plaintiffs who were turned down by the screening panel chose not to move on and how many did. He said this information would assist the subcommittee in determining the effectiveness of the panel.

Additionally, Senator Townsend stressed that the screening panel process must include a certain amount of accountability and discipline by both parties to accelerate a resolution. He noted that prolonging this process has no value to a person with a medical problem.

Ms. Molasky-Arman agreed with Senator Townsend's concerns and stated that both parties accommodate each other with stipulations for extensions of time.

RECOMMENDATIONS FOR CHANGES CONCERNING THE PANEL

Lawrence P. Matheis

Lawrence P. Matheis, Executive Director, Nevada State Medical Association (NSMA), Reno, Nevada, advised that from his organization's viewpoint, the screening panel is a success. However, he noted that question exists concerning the definition of success.

Mr. Matheis stated that the number of cases brought to the panel has not substantially changed. He said when

analyzing the panel process it is important to separate northern and southern Nevada because the experiences of those jurisdictions are different. Mr. Matheis noted that the statistics related to northern and southern Nevada have remained internally consistent over time.

Continuing, Mr. Matheis stated that the screening panel has been successful in discouraging nonmeritorious cases and provided statistics regarding the number of medical legal screening panel cases filed per 100,000 population during the following years:

- 1986 – 13.5 cases in Clark County and 6.1 cases in northern Nevada;
- 1996 – 10.2 cases in Clark County and 6.3 cases in northern Nevada; and
- 2001 – 11.7 cases in Clark County and 5.5 cases in northern Nevada.

Mr. Matheis advised that the panel has not been "all that successful" at serving as a "good screen" to determine which cases should be determined in a court, settled, and dropped. He explained that public health care involves a lot of screening and in setting parameters sensitivity and specificity must be considered. He said in the health care industry a person must determine whether to err by missing something or by having a false positive result. Further, this is a judgment call about the effects and consequences of such a decision.

Additionally, Mr. Matheis stated that from the NSMA's viewpoint, an example of why there is concern about the effectiveness of the screening panel is that from 1998 to 2001, 191 (65 percent) of the 296 cases in southern Nevada with a finding of no probable malpractice were filed in district court. He advised that this screen is not "dropping out" enough cases and should discourage the further processing of certain cases.

In response to a question by Senator Townsend about the availability of information concerning the tracking of cases after the screening panel renders its decision, Mr. Bradley explained that the Commissioner of Insurance must keep data on cases that go forward to trial despite a finding of no malpractice by the panel. However, he said, records regarding the final outcome of these cases are not maintained.

According to Mr. Matheis, the panel has been effective in discouraging a "huge" frequency increase in the number of medical malpractice cases. However, he said it has not been successful in: (1) discouraging cases from going through the court process; (2) processing cases in a timely manner; and (3) reducing costs.

Mr. Matheis stated that the screening panel should continue; however, this process must be improved. He recommended that state law be amended to provide for contracted attorneys and physicians to serve as a permanent panel to assure expeditious reviews. Mr. Matheis stated that the voluntary panel could continue and such a proposal could be implemented on a pilot basis. Further, an evaluation of this plan would be necessary to determine if it creates a pattern of decision-making that "goes too far" in one direction, decreases the time line, or increases efficiency in the screening panel process.

Responding to a question by Ms. Buckley, Mr. Bradley discussed a hypothetical case in which the screening panel decided that there was a legitimate issue between the defense and the plaintiff and both parties had "good" expert witnesses. However, the panel was unable to decide if malpractice occurred or three lawyers could not decide if malpractice was involved and three doctors determined there was no malpractice. Mr. Bradley advised that unless four of the six panel members are in agreement, the automatic decision is "unable to decide."

At this point, Mr. Bradley said, the statutory mandate of screening has been met, the case has been shown not to be frivolous, and it goes forward to trial. He added that since 1997, a jury may not be told if the panel rendered an "unable to decide" finding because before that time defense lawyers would ask jurors how they could reach a decision about a case if three doctors and three lawyers could not make a determination. Mr. Bradley stated that the panel was not comprised to make the ultimate decision on a case. Further, the panel was intended to ensure that both sides had credible experts who supported their opinions and to allow them to go forward with discovery to obtain information that is not available at the screening panel level. Mr. Bradley explained that there are no ramifications for either party in a case involving an "unable to decide" finding by the panel. He also noted that there is no settlement conference and both parties may utilize certain rules of civil procedure (e.g., the offer of judgment) that create incentives to settle a case.

According to Mr. Bradley, multiple defendant lawsuits probably constitute the majority of cases that go forward to trial despite a finding by the screening panel that it is unlikely that medical malpractice has occurred.

Mr. Bradley then discussed a hypothetical case involving three physicians (e.g., an anesthesiologist, an emergency room doctor, and a surgeon). He said the plaintiff's attorney may be compelled to hire an expert for each specific field and those experts may submit an affidavit stating that in their opinion, medical negligence was committed by each of the three physicians. The physicians' attorney then presents a unified defense, whether or not the defendants are insured by the same company, and no one will come forward with the truth and admit to any wrongdoing. Ultimately, the panel makes a finding against the anesthesiologist only. In his affidavit, the anesthesiologist was careful to not implicate anyone else with negligence and, therefore, the plaintiff's side does not know what actually happened in the events leading up to this case.

Continuing, Mr. Bradley stated that if the plaintiff's attorney wants to go forward against the other two doctors, the plaintiff must be advised that he or she will be held accountable and ordered to pay the defense fees if the jury makes a decision in favor of the defendants. He said Nevada has the most "draconian" loser pay law in the United States with respect to a plaintiff who goes forward to trial following a no malpractice decision by the screening panel. Further, it is difficult for a plaintiff and his attorney to know what actually happened in a case because the medical records may be altered, illegible, or incomplete, and depositions are not taken at the screening panel level.

Mr. Bradley further explained that it is difficult for a plaintiff's attorney to decide whether to go forward to trial with only the anesthesiologist or to also include the emergency room doctor and surgeon. If the plaintiff's attorney does not include the emergency room doctor and surgeon in the lawsuit, it is likely that the anesthesiologist will discuss what actually happened in this case. If the emergency room doctor and surgeon are included in the lawsuit although the panel had no malpractice findings, the plaintiff's attorney may be criticized for going forward with the case. Further, if the plaintiff's attorney does not include the emergency room doctor and surgeon in the lawsuit and the jury makes a decision in favor of the anesthesiologist, the plaintiff has a legitimate argument as to why his or her attorney did not include the other two physicians in the lawsuit. Mr. Bradley advised that a medical negligence case has the potential to be converted into a legal negligence case. Therefore, the plaintiff's attorney is forced, based on the "unity of defense" at the screening panel, to name all three of the physicians in a district court case in an attempt to determine who was at fault.

Concluding his remarks, Mr. Bradley recommended that the screening panel process be changed to allow for the segregation of individual cases from multiple defendant cases. He stated that if a physician in a multiple defendant case does not indicate at the screening panel level that a co-defendant is responsible for a wrongdoing, he or she should not be allowed to insinuate during a trial that the person did something wrong. Mr. Bradley stated that in the search for justice and the truth in medical malpractice cases, the "conspiracy defense" must be eliminated. He further noted that such a defense actually "dovetails" into the honest reporting of medical errors.

Mr. Matheis agreed with Mr. Bradley that information regarding the final outcome of cases that go forward to trial despite a finding of no malpractice by the screening panel should be maintained. He expressed his opinion that the physician community views the panel's credibility to be "very low" because from its perspective, the 65 percent of cases in which there was finding of no probability of malpractice that went forward to a jury makes it a failure.

The Chairwoman stated that the first step in addressing this concern is to determine what happened to those cases because the screening panel was not meant to replace a jury trial. She said the system operates in a manner in which a jury may find that there is malpractice. However, Ms. Buckley noted that if such a case proceeds to trial and the jury does not make a decision in favor of the plaintiff, a doctor may question why, after he or she won at the panel level and then experienced the negative effects of this process, nothing happens.

Mr. Matheis stated that neither patients nor physicians benefit from a prolonged process in a medical malpractice case. Unfortunately, he said, this is not necessarily true about the other interests involved in this system.

According to Mr. Bradley, a problem is that if the plaintiff wins there is no ramification to the physician even if he or she did not consent. He said all the risk is removed from the physician and placed with the insurer. Mr. Bradley also noted that on the plaintiff side, all the risk is placed with the plaintiff. Further, it seems unfair to put the risks of a person who already has been injured against a company that is worth a substantial amount of money. Mr. Bradley advised that he is aware of two cases involving awards against plaintiffs who proceeded to trial.

Mr. Bradley then provided the following recommendations concerning the screening panel:

C Provide adequate funding for the Division of Insurance to administer the panels; and

C Decrease the number of stipulations approved for extensions of time within this process. The affidavits of expert witnesses are imperative to the panel function. Therefore, a limited continuance should be considered if a party has a legitimate reason for being unable to present an expert affidavit.

Additionally, Mr. Bradley stated that he disagrees with an assertion by The Doctors' Company that the screening panel is biased and he said the makeup of that body is one of its strengths.

Mr. Bradley also noted that the constitutionality of the panel cannot be jeopardized by reading into it things that could not occur because of the lack of discovery. He said the panel's "no" and "unable to decide" findings are based on evidence that usually is very limited. Mr. Bradley reiterated that in *Barrett vs. Baird*, the U.S. Court of Appeals for the Ninth Circuit cautioned Nevada to not "read more" into this panel.

In addition to his previous recommendation to amend state law to provide for contracted attorneys and physicians to serve as a permanent panel on a trial basis, Mr. Matheis expressed support for increasing the resources for the Division of Insurance.

Mr. Matheis advised that he will propose to the subcommittee language for defining experts. He also mentioned there is a need to determine what causes cases in which there is a finding of no probable malpractice to proceed to trial. Mr. Matheis explained that language and terms in the data used to make comparisons concerning medical malpractice cases are constantly shifting and, therefore, may cause a problem in analyzing this information.

A discussion ensued between Mr. Hettrick and Mr. Bradley regarding the table, titled "Plaintiff Medical Malpractice Verdicts—(Clark County: 1996-2001)," on pages 154 and 155 of Exhibit A. Mr. Bradley explained that multiple defendants were involved in the cases in which the screening panel rendered two findings. He added that the majority of cases arise in a hospital setting and more than one person typically brings about a lawsuit. Mr. Bradley advised that he could not explain the cases in which there was no finding by the panel. However, he did note that when an insurer realizes there is liability, the parties sometimes agree to not involve the panel in an attempt to resolve the case more quickly. Further, Mr. Bradley stated it also is possible that the NTLA did not receive information concerning those cases. Mr. Hettrick expressed an interest in knowing who was found at fault in the cases involving multiple defendants and panel findings of negligence, no negligence, and unable to determine when the verdict was rendered.

In response to a question by Mr. Hettrick regarding a statement in the May 9, 2002, letter from The Doctors' Company (Exhibit I), Mr. Bradley explained that following a screening panel finding, the insurer has the ability to depose the defendant doctor, plaintiff, and damage witness before proceeding to a settlement conference.

Chairwoman Buckley suggested that Agenda Item Nos. VIII, IX, and X be deferred to the subcommittee's next meeting, which is scheduled for July 29, 2002.

MEDICAL MALPRACTICE INSURANCE: DISCUSSION OF FACTORS INVOLVED IN DETERMINING RATES AND RESERVE AMOUNTS

This agenda item was deferred to the subcommittee's next meeting, which scheduled for July 29, 2002.

PRESENTATION ON THE MONETARY AMOUNTS INVOLVED IN SETTLEMENTS AND JURY VERDICTS IN PAST MEDICAL MALPRACTICE CASES IN NEVADA

This agenda item was deferred to the subcommittee's next meeting, which scheduled for July 29, 2002.

PRESENTATION AND DISCUSSION OF RECOMMENDATIONS FOR MODIFICATIONS TO NEVADA'S

CIVIL JUSTICE SYSTEM

This agenda item was deferred to the subcommittee's next meeting, which scheduled for July 29, 2002.

PUBLIC TESTIMONY

No one from the public testified.

DISCUSSION OF FUTURE MEETINGS AND TOPICS FOR REVIEW

The Chairwoman stated that during its next meeting on July 29, 2002, the subcommittee will address civil justice and insurance reforms. Additionally, she directed staff to follow up on members' requests for information presented during this meeting.

Mr. Anderson asked that staff provide charts regarding the ratio of attorneys and physicians to Nevada's population.

In an effort to determine any effect on rates, Mr. Hettrick requested a comparison concerning the number of medical malpractice cases per 100,000 population in Nevada with other states with and without caps and screening panels.

Mr. Hettrick referenced the testimony of Dr. Sigelman (identified on page 47 of these minutes) in which he stated the ratio of medical malpractice premiums as a percentage of overall health care expenditures in the nation always has been less than 1 percent. Mr. Hettrick said it is important to realize that if OB/GYNs are limited to a certain number of deliveries and insurance costs increase, this percentage would become "huge." Further, it seems that the database for any given set of numbers or statistics "moves" and an item that is included at any one time shifts. Therefore, he noted, it is difficult to determine how to make changes to address the medical malpractice crisis.

Senator Townsend mentioned that during this meeting the subcommittee had expressed an interest in determining how an insurance company responds actuarially when it decides not to settle prior to a trial or verdict, a jury decides in favor of the plaintiff, and a large verdict is awarded.

ADJOURNMENT

There being no further business, Chairwoman Buckley adjourned the meeting at 4:38 p.m.

Exhibit L is a letter dated May 13, 2002, to Ms. Allison Combs, Principal Research Analyst, Legislative Counsel Bureau-Research Division, from Lawrence P. Matheis, Executive Director, Nevada State Medical Association. This correspondence provides supplemental information to a letter dated April 25, 2002, to Ms. Combs from Mr. Matheis regarding physicians leaving their practices in Nevada.

Exhibit M, by Charles Perry, Nevada Health Care Association, Las Vegas, Nevada, consists of several documents relating to medical malpractice.

Exhibit N is the "Attendance Record" for this meeting.

Respectfully submitted,

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Debby Richards
Manager of Office Services

Allison Combs
Principal Research Analyst

APPROVED BY:

Assemblywoman Barbara E. Buckley, Chairwoman

Date:

LIST OF EXHIBITS

Exhibit A is a packet prepared by staff of the Research Division, Legislative Counsel Bureau, for the members' use during this meeting. This exhibit contains the following items:

C The "Revised Meeting Notice and Agenda" for this meeting.

C The draft minutes of the subcommittee's March 21, 2002, meeting in Carson City, Nevada.

C Documents provided by the Division of Insurance, Nevada's Department of Business and Industry, titled:

1. "Nevada Essential Insurance Association Fact Sheet";
2. "Medical Liability Association of Nevada Fact Sheet";
3. "Frequently Asked Questions"; and
4. "Installment Plans Fact Sheet."

C Selected pages from a report titled *Nevada Insurance Market*, which was prepared by the Division of Insurance, Nevada's Department of Business and Industry, and is dated February 2001. This information relates to medical professional liability.

C A table titled "Nevada Laws Relating to the Civil Justice System and Medical Malpractice," which was prepared by the Research Division, Nevada's Legislative Counsel Bureau, and is dated May 2002. Copies of the laws referenced in this table also are included.

C Selected pages from a report titled *Nevada Insurance Market*, which was prepared by the Division of Insurance, Nevada's Department of Business and Industry, and is dated February 2001. This information relates to the medical dental screening panel. Also included are the following documents prepared by the Research Division, Nevada's Legislative Counsel Bureau:

1. A flow chart titled "Overview of Medical Malpractice Screening Panel Process (Chapter 41A of *Nevada Revised Statutes*) and dated March 14, 2002; and
2. A paper titled "Overview of Medical Malpractice Screening Panels (Chapter 41A of *Nevada Revised Statutes*)" and dated May 2002.

C A table titled "Overview of Caps on Damages and Medical Malpractice Premiums Nationally," which was prepared by the Research Division of Nevada's Legislative Counsel Bureau.

C Three tables:

1. "Plaintiff Medical Malpractice Verdicts (Clark County: 1996-2001)," prepared by the Nevada Trial Lawyers Association (NTLA) and dated March 21, 2002;

2. "Eighth Judicial District Court Civil Trial Verdicts 1996-2001," provided by the Eighth Judicial District Court and dated February 21, 2002; and

3. "Eighth Judicial District Court Civil Trial Verdicts 1996-2001," provided by the Eighth Judicial District Court and dated April 25, 2002.

C Two papers:

1. "Nevada Trial Lawyers' Proposals for Medical Malpractice Insurance Crisis," prepared by the NTLA and dated March 21, 2002; and

2. "Nevada State Medical Association Presentation to Legislative Subcommittee to Study Medical Malpractice Regarding Agenda Item VII: Requests for the Subcommittee's Examination of Governing Civil Justice and Insurance to Address Concerns Regarding Medical Malpractice Coverage," prepared by the Nevada State Medical Association and dated March 21, 2002.

C Documents relating to "physicians information":

1. A letter dated April 25, 2002, to Ms. Allison Combs, Principal Research Analyst, Legislative Counsel Bureau-Research Division, from Lawrence P. Matheis, Executive Director, Nevada State Medical Association. This correspondence provides information regarding physicians leaving their practices in Nevada and includes two tables:

   a. "NSMA Survey Results: Physicians Leaving Nevada Practice, Jan 2-11, 2002"; and

   b. "NSMA Survey Results: Physicians Leaving (Or Actively Considering Leaving) Nevada Practice, April 5-25, 2002."

   (Note: Exhibit L is a supplemental response to this information.)

2. A table titled "Number of Physicians Licensed by Nevada's Board of Medical Examiners (April 2002)," which was compiled by Nevada's Legislative Counsel Bureau.

Exhibit B is a list, titled "Medical Liability Association of Nevada—Board Members," which was provided by the Division of Insurance.

Exhibit C was provided by the Division of Insurance and contains the following tables, which are based on a closed claim database extract as of March 20, 2002:

C "Exhibit IA—Page 1—Closed Claim Database (NRS 690B.050)—Dollar Summary" (Type—Physician).

C "Exhibit IA—Page 2—Closed Claim Database (NRS 690B.050)—Total Count Summary" (Type—Physician).

C "Exhibit IA—Page 3—Closed Claim Database (NRS 690B.050)—Average Claim Severities (Including Closed, no Pays)" (Type—Physician).

C "Exhibit IB—Page 1—Closed Claim Database (NRS 690B.050)—Dollar Summary of Paid Claims" (Type—Physician).

C "Exhibit IB—Page 2—Closed Claim Database (NRS 690B.050)—Count Summary of Paid Claims" (Type—Physician).

C "Exhibit IB—Page 3—Closed Claim Database (NRS 690B.050)—Average Paid Claim Severities" (Type—Physician).

C "Exhibit IA—Page 1—Closed Claim Database (NRS 690B.050)—Dollar Summary" (Type—All).

C "Exhibit IA—Page 2—Closed Claim Database (NRS 690B.050)—Total Count Summary" (Type—All).

C "Exhibit IA—Page 3—Closed Claim Database (NRS 690B.050)—Average Claim Severities (Including Closed, no Pays)" (Type—All).

C "Exhibit IB—Page 1—Closed Claim Database (NRS 690B.050)—Dollar Summary of Paid Claims" (Type—All).

C "Exhibit IB—Page 2—Closed Claim Database (NRS 690B.050)—County summary of Paid Claims" (Type—All).

C "Exhibit IB —Page 3—Closed Claim Database (NRS 690B.050)—Average Paid Claim Severities" (Type—All).

C "Exhibit II—Closed Claim Database (NRS 690B.050)—Multiple Claim Analysis—Total (Closed with Payment and Without)."

C "Exhibit III—Page 1—Closed Claim Database (NRS 690B.050)—Dollar Summary by County" (Closure Year—2001/Type—Physician).

C "Exhibit III—Page 2—Closed Claim Database (NRS 690B.050)—Count Summary by County" (Closure Year—2001/Type—Physician).

Exhibit D is a table, titled "National Conference of State Legislatures—Employment and Insurance Program—Medical Liability Statutes—State Summary Chart," which was provided by Cheye Calvo, Program Manager, Employment and Insurance Program, National Conference of State Legislatures.

Exhibit E is a document, titled "National Conference of State Legislatures—Employment and Insurance Program—State Patient Compensation Funds," which was provided by Cheye Calvo, Program Manager, Employment and Insurance Program, National Conference of State Legislatures.

Exhibit F is a packet of information concerning medical malpractice liability insurance, which was provided to the subcommittee by Donald J. Palmisano, M.D., J.D., Secretary-Treasurer, American Medical Association (AMA). Exhibit F also includes a biography and the prepared remarks of Dr. Palmisano.

Exhibit G is a handout, titled "The Medical Protective Company—State of Nevada Medical Professional Liability—Presentation to the Legislative Commission's Subcommittee to Study Medical Malpractice—May 13, 2002," which was provided by Joel D. Whitcraft, CPCU,ARe, Senior Vice President and Actuary, GE Medical Protective, The Medical Protective Company, Fort Wayne, Indiana. This exhibit contains information regarding the following topics:

C "Market Considerations";

C "Industry Developments";

C "Historical View";

C "Rating Considerations";

C "Countrywide Ranking";

C "Claims Administration";

C "Texas Tort Reform"; and

C "Considerations."

Exhibit H is a handout, titled "Damages Recoverable in a Medical Malpractice Claim," which was provided by Bill Bradley, Nevada Trial Lawyers Association, Reno, Nevada.

Exhibit I is a letter dated May 9, 2002, to Ms. Allison Combs, Principal Research Analyst, Legislative Counsel Bureau, from Philip E. Dyer, CIC, Vice President, The Doctors' Company, Napa, California. This correspondence provides information concerning medical professional liability in Nevada.

Exhibit J is a copy of Nevada Supreme Court opinion *Barrett v. Baird*, 111 Nev. 1496, 908 P.2d 705 (1995). This document was provided by Bill Bradley, Nevada Trial Lawyers Association, Reno, Nevada.

Exhibit K is a handout titled "State of Nevada Department of Business & Industry Division of Insurance—Presentation to the Legislative Subcommittee to Study Medical Malpractice—Presented By: Alice A. Molasky-Arman, Commissioner of Insurance—May 13, 2002." This document, which reviews the steps involved in processing a medical dental screening panel case filed with the Division of Insurance, was provided by Alice A. Molasky-Arman, Commissioner of Insurance, Division of Insurance, Nevada's Department of Business and Industry.

Exhibit L is a letter dated May 13, 2002, to Ms. Allison Combs, Principal Research Analyst, Legislative Counsel Bureau-Research Division, from Lawrence P. Matheis, Executive Director, Nevada State Medical Association. This correspondence provides supplemental information to a letter dated April 25, 2002, to Ms. Combs from Mr. Matheis regarding physicians leaving their practices in Nevada. It includes a table titled "NSMA Survey Results: Physicians Leaving (Or Actively Considering Leaving) Nevada Practice, April 5-May 12, 2002 (Changes Since April 25 Report Are Underlined)." The letter dated April 25, 2002, is included in Exhibit A.

Exhibit M was provided by Charles Perry, Nevada Health Care Association, Las Vegas, Nevada, and consists of the following documents:

C Two papers titled "AON Study Talking Points" and "Basic Questions and Answers about AON Study";

C A news release from the American Health Care Association dated May 6, 2002, titled "New Study Reveals Federal Tax Dollars Meant for Senior Care Instead Diverted to Trial Lawyers"; and

C A report titled *Long Term Care—General Liability and Professional Liability—Actuarial Analysis*, prepared by Aon Risk Consultants, Inc. (Theresa W. Bourdon, FCAS, MAAA, and Sharon C. Dubin, ACAS, MAAA), February 28, 2002.

Exhibit N is the "Attendance Record" for this meeting.

Copies of the materials distributed in the meeting are on file in the Research Library of the Legislative Counsel Bureau, Carson City. You may contact the library at 775/684-6827.