# STUDY OF INSURANCE AGAINST MEDICAL MALPRACTICE

*Bulletin No. 87-18*


**LEGISLATIVE COMMISSION**

**OF THE**

**LEGISLATIVE COUNSEL BUREAU**

**STATE OF NEVADA**



August 1986

# STUDY OF INSURANCE AGAINST MEDICAL MALPRACTICE

BULLETIN NO. 87-18

LEGISLATIVE COMMISSION

LEGISLATIVE COUNSEL BUREAU

STATE OF NEVADA

SEPTEMBER 1986

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Assembly Concurrent Resolution No. 53—Committee on Legislative Functions

FILE NUMBER 106

ASSEMBLY CONCURRENT RESOLUTION—Directing the legislative commission to study insurance against medical malpractice.

WHEREAS, The cost of health care in this state is increasing dramatically; and

WHEREAS, Premiums for insurance against medical malpractice are also increasing dramatically; and

WHEREAS, There is concern over these problems being expressed throughout the country; and

WHEREAS, Insufficient information is presently available to the legislature for it to determine whether the increasing cost of health care is attributable in significant part to the cost of the underwriting of insurance against medical malpractice by insurance companies; now, therefore, be it

RESOLVED BY THE ASSEMBLY OF THE STATE OF NEVADA, THE SENATE CONCURRING, That the legislative commission is hereby directed to study the business of insuring against medical malpractice including the cost and benefit of such insurance; and be it further

RESOLVED, That the legislative commission report the results of its study and any recommended legislation to the 64th session of the Nevada legislature.

# REPORT OF THE LEGISLATIVE COMMISSION

TO THE MEMBERS OF THE 64TH SESSION OF THE NEVADA LEGISLATURE:

This report is submitted in compliance with Assembly Concurrent Resolution No. 53 of the 63rd session of the Nevada legislature which directed the legislative commission to study insurance against medical malpractice in Nevada.

The legislative commission, under the auspices of the joint committee on judiciary, appointed a subcommittee composed of the following members of the legislature to conduct the study:

Assemblyman Charles W. Joerg, Chairman
Senator Thomas R. C. Wilson, Vice Chairman
Senator Raymond D. Rawson
Assemblyman Robert M. Sader
Assemblyman Myrna T. Williams

In the course of its deliberations, the subcommittee heard testimony from accountants, actuaries, attorneys, physicians and representatives of the insurance industry. The subcommittee also received information and recommendations by correspondence. In this report, the subcommittee presents its recommendations. Supporting documents and minutes are on file with the legislative counsel bureau.

This report is transmitted to the members of the 64th session of the Nevada legislature for their consideration and appropriate action.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

Carson City, Nevada
September 1986

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## LEGISLATIVE COMMISSION

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Assemblyman James W. Schofield
Assemblyman Danny L. Thompson
Assemblyman Barbara A. Zimmer

## SUMMARY OF RECOMMENDATIONS

The legislative commission's subcommittee studying insurance against medical malpractice recommends for the consideration of the 64th session of the Nevada legislature:

1. Limit recovery against a defendant whose negligence is less than 50 percent of the total negligence which contributed to an injury or death. (BDR 3-135)

2. Tie the limit on prejudgment interest rates to the rate paid on treasury bills or similar instruments. (BDR 2-137)

3. Grant independent contractors, who provide medical services to the prison system, the protection of the immunity and indemnity and hold harmless provisions provided for in Nevada Revised Statutes (NRS) Chapter 41. (BDR 3-133)

4. Establish an office of public advocate within the office of the attorney general to intervene in rate cases on behalf of consumers of insurance. (BDR 57-132)

5. Change insurance ratemaking procedures to provide that rate increases will not go into effect until a public rate hearing is held, if such a hearing is requested by the public advocate or other party. (BDR 57-132)

6. Amend NRS 686B.050 and NRS 686B.060 to remove the presumption that rates set by insurance companies in a competitive market are reasonable. (BDR 57-132)

7. Require that all physicians carry medical malpractice insurance with policy limits of at least $500,000 or provide proof of financial responsibility in the same amount as a condition for acquiring or retaining a license to practice medicine in Nevada. Allow the commissioner of insurance to waive this requirement if, because of geographic area or area of specialty of practice, insurance coverage is not affordable or available. Require that companies offering medical malpractice insurance inform the board of medical examiners of policy cancellations. (BDR 54-131)

8. Provide the board of medical examiners with authority to supplement its licensure requirements by examining the curriculum of foreign medical schools attended by applicants for a license to practice medicine. (BDR 54-134)

The subcommittee also asked that a bill draft request be prepared on the following subject without the endorsement of the subcommittee:

**Amend the statutes to allow the courts at the request of either party to award damage payments in excess of $50,000 in installments rather than as lump sums. (BDR 3-128)**

# REPORT TO THE 64TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO STUDY INSURANCE AGAINST MEDICAL MALPRACTICE

## I. INTRODUCTION

In 1985, the Nevada legislature adopted Assembly Concurrent Resolution No. 53 (File No. 106), directing the legislative commission to study insurance against medical malpractice. The commission appointed a subcommittee to conduct this study and report its recommendations. The subcommittee consisted of five members:

Assemblyman Charles W. Joerg, Chairman
Senator Thomas R. C. Wilson, Vice Chairman
Senator Raymond D. Rawson
Assemblyman Robert M. Sader
Assemblyman Myrna T. Williams

The subcommittee met four times. The first meeting was held on August 27, 1985, at the legislative building in Carson City, Nevada. At this meeting, the subcommittee heard testimony regarding the implementation of Assembly Bill 696 (chapter 620, Statutes of Nevada, 1985) which provides for medical malpractice screening panels.

The second meeting of the subcommittee was held on November 13, 1985, at the North Las Vegas Library, 2300 Civic Center Drive, North Las Vegas, Nevada. At this meeting, the subcommittee received testimony regarding patient compensation funds. The subcommittee also heard public testimony regarding the problems involved in obtaining and paying for malpractice insurance.

The third meeting was held on February 20, 1986, in the Reno City Council Chambers, 490 South Center, Reno, Nevada. At this meeting, the subcommittee heard testimony from attorneys, physicians, representatives of the insurance industry and members of the public regarding malpractice insurance problems.

The fourth meeting of the subcommittee was held on June 4, 1986, at the legislative building in Carson City, Nevada. The first part of this meeting was dedicated to receiving public testimony regarding suggestions for legislative action which the subcommittee had received through testimony at previous meetings and through correspondence. The second part of the meeting was a work session, devoted to the consideration of the suggestions which had been received and the adoption of legislative recommendations. At this meeting, the subcommittee authorized the preparation of this report.

## II. BACKGROUND

The legislature's decision to authorize a study of insurance against medical malpractice was prompted by rapid and persistent increases in malpractice insurance premiums and widespread concern that these increases would result in increased medical costs, reduced availability of medical care and diminishing quality of care.

### A. PREVIOUS LEGISLATIVE ACTIONS

During the mid-1970's, many physicians in Nevada experienced malpractice insurance premium increases of several hundred percent. At the same time, a major malpractice insurer withdrew from the Nevada market, making it necessary for many physicians to obtain coverage elsewhere.

In response to this crisis, the 1975 legislature took the following actions:

1. Authorized the creation of a joint underwriting association to provide professional liability coverage where none existed (Senate Bill 400, chapter 295);

2. Provided for the deduction from a judgment of payments made by a defendant in a malpractice action prior to judgment (Senate Bill 403, chapter 298);

3. Provided additional legal protection to health care providers who render assistance gratuitously in a medical emergency (Senate Bill 402, chapter 297);

4. Provided for the limitation of the Res Ipsa Loquitur rule and for expert testimony to establish medical negligence (Senate Bill 405, chapter 299);

5. Altered the statute of limitations on malpractice actions as it applies to persons under legal disabilities (Senate Bill 406, chapter 300);

6. Provided the necessary elements of informed consent to a medical procedure (Senate Bill 408, chapter 301);

7. Provided for medical legal screening panels composed of three doctors and three lawyers each to screen malpractice claims before they went to court and encourage out-of-court settlements (Senate Bill 409, chapter 302); and

8. Increased the powers of the board of medical examiners to assure medical competency and discipline physicians (Senate Bill 432, chapter 303).

The 1975 legislature also enacted Senate Concurrent Resolution No. 21 which authorized the legislative commission to continue to study and monitor the malpractice insurance problem. The subcommittee appointed by the commission to conduct that study recommended several statutory changes which were enacted the following session. These included:

1. Making various changes in the laws governing medical legal screening panels and joint underwriting associations;

2. Providing legal guarantees for access to patient records by patients and investigatory entities such as the attorney general's office and the board of medical examiners;

3. Providing civil immunity for the board of medical examiners and other agencies and associations engaged in lawful investigations regarding physician discipline;

4. Requiring the board of medical examiners to investigate any physician who has paid $5,000 or more as a result of a medical malpractice action;

5. Requiring insurers to report all settlements, awards or judgments for breach of professional duty to the commissioner of insurance who, in turn, must report them to the board of medical examiners; and

6. Adding lay members to the board of medical examiners.

During the late 1970's, the medical malpractice insurance crisis eased somewhat. Between 1976 and 1983 the average malpractice insurance premium for physicians in the United States rose only 51 percent. For this reason, perhaps, there was little legislative activity related to medical malpractice during the late 1970's. (One exception was the abolishing of screening panels in 1981. This action is discussed in the next section.)

This respite proved to be temporary. In 1984 and 1985, premiums again increased dramatically, prompting the legislature to take a renewed interest in the issue. The following actions were taken during the 1985 session:

1. Persons observing the rendering of care by a health care practitioner were exempted from liability (Senate Bill 38, chapter 597);

2. The statutes governing the licensing and discipline of physicians were extensively revised (Senate Bill 64, chapter 667); and

3. Medical malpractice screening panels were reinstituted (Assembly Bill 696, chapter 620). These panels are discussed in the next section.

## B. MEDICAL MALPRACTICE SCREENING PANELS

A medical malpractice screening panel is a panel which examines malpractice claims to determine whether they have sufficient merit to warrant proceeding to file a case in court. These panels were intended to reduce the volume of frivolous litigation, decrease the backlog of court cases, encourage early settlement of meritorious claims before initiation of litigation and, thereby, stabilize the cost of health care.

Voluntary malpractice screening panels were instituted in Las Vegas during the early 1960's and in Reno a few years later. These panels were staffed by members of the legal and medical communities and charged a small fee to consider claims. In 1975, the legislature made formal legal provision for the panels and required all medical malpractice claims to be submitted to these panels. In 1977, the panels were expanded to include nurses, as well as attorneys and physicians, in cases involving nurses. In 1979, hospital administrators were added to the panels for cases involving hospitals.

The panels did not work as well as many had expected. Funding problems arose and, in 1979, the legislature failed to pass legislation allowing the panels to levy a fee on respondents. In both Las Vegas and Reno, the panels accumulated a large backlog of cases. Finally, the panels were not entirely effective in screening out problem cases. About 30 percent of the claims rejected by the panels went to court anyway.

In 1981, the legislature, with the support of the Nevada State Medical Association, the Nevada Nurses Association and the Nevada Bar Association, repealed its 1975 act and allowed the panels to revert to their original voluntary status.

Four years later, faced with a resurgence of the medical malpractice insurance crisis, the legislature again turned to screening panels as a possible solution. Benefiting from its earlier experiment, the legislature adopted a much tougher law than that passed in 1975.

The 1985 law (Assembly Bill 696, chapter 620) provides for the appointment of two pools from which screening panel members may be selected. One pool is to be created for northern Nevada; the other for southern Nevada. Each panel

consists of 20 attorneys designated by the Nevada Trial Lawyers' Association, 20 physicians designated by the Nevada State Medical Association and 20 administrators of hospitals designated by the Nevada Hospital Association.

All medical malpractice claims must be considered by a screening panel. When a claim is submitted, a screening panel consisting of three attorneys, three physicians and, in cases involving hospitals, one nonvoting member who is a hospital administrator must be impaneled to hear the claim.

The procedure for selecting the panel members is as follows: First, the plaintiff and defendant are each provided, by the commissioner of insurance, with a list of physicians and attorneys who have been designated as members of the pool. Second, the plaintiff and defendant may each strike three attorneys and three physicians from the list. Each party may also challenge potential screening panel members for cause. Third, the commissioner of insurance selects three attorneys, three physicians and, if the case requires, one hospital administrator at random from those remaining on the list.

The panel may subpena expert witnesses and records and conduct its deliberations in accordance with rules of practice and procedure promulgated by the commissioner of insurance. The panels must determine whether the claim has sufficient merit to justify proceeding to file a case in court.

If the panel rejects the claim, the claimant may file an action in court only after posting a $5,000 bond. If the claimant does not prevail in court, the bond is forfeited.

If the panel decides that the claim has some merit, and the claimant files suit in the district court, the judge must order the claimant, the defendant, a representative of the defendant's insurance company and their attorneys to attend a settlement conference to determine the amount of the plaintiff's damages.

The screening panels are authorized by law for a 3-year period. The law expires June 30, 1989, if it is not renewed by the legislature. This temporary authorization will permit the legislature to assess the effects of the screening panel process and determine whether it should be retained and, if so, what changes in the law may be necessary.

One of the purposes of the subcommittee established by the 1985 legislature under A.C.R. No. 53 was to oversee the implementation of the screening panel. The subcommittee conferred several times with the commissioner of insurance in the insurance division, department of commerce, during

the course of its deliberations regarding the progress that had been made toward implementing the screening process. The commissioner of insurance reported to the subcommittee regarding the funding and staffing of the panels and the preparation of regulations to govern their activities. At the time the subcommittee concluded its activities, 22 cases had been filed and two screening panels were in the process of being selected. The first meetings of these panels were to be held 2 to 3 weeks after the last meeting of the subcommittee. Ample cooperation has been received from both the legal and medical communities.

The subcommittee has not recommended any changes in the law governing the screening panels.

## III. ISSUES AND RECOMMENDATIONS

During the first three meetings of the subcommittee, witnesses offered numerous suggestions for resolving the medical malpractice insurance crisis. The subcommittee also solicited the opinion of those unable to appear before the subcommittee and received a number of suggestions by correspondence. At the subcommittee's final meeting, adequate opportunity was afforded to all those who wished to comment on these suggestions before the subcommittee decided which ones would be recommended to the 1987 legislature. Background and supporting information regarding the recommendations which were approved by the subcommittee are presented by subject area in this section of the report.

### A. AWARDS

#### 1. Joint and Several Liability

Under common law principles of tort law, if each of two or more persons is responsible for a single harm to an injured person, the multiple parties are also jointly liable for the damages resulting from the injury. This means that a plaintiff who successfully sued multiple defendants could recover the full amount of his damages from one or both of the defendants. In modern times, the rule may lead to conspicuously bad results, one of which is the so-called "deep pocket" phenomenon. A plaintiff may try to include in a lawsuit all conceivable defendants in order to collect a damage award from at least one of the defendants. A defendant whose actual contribution to an injury is found to be relatively minor may nevertheless be held responsible for a large damage award because the defendant is well insured. This works to the disadvantage of hospitals and physicians with ample insurance coverage.

The 1979 Nevada legislature amended NRS 41.131, "Waiver of immunity from liability and action; actions; State of Nevada as defendant; service of process." The amendment limited the joint liability of a joint defendant whose negligence resulting in injury is less than the contributory negligence of the plaintiff. A defendant whose fault is less than that of the plaintiff must pay only his share of the damages.

The subcommittee, therefore, recommends:

**That the legislature further limit joint liability to provide that a defendant who is less than 50 percent liable (irrespective of the plaintiff's percentage of contributory negligence) can be required to pay only that portion of the judgment which represents the percentage of negligence attributable to him. (BDR 3-135)**

2. Judgment Interest

Often a considerable period of time elapses between the time that a suit is filed and the time when a judgment is made. To compensate plaintiff for this delay, interest is paid on the judgment. The exact rate at which this interest is paid may make a considerable difference in the amount of money eventually paid to the plaintiff.

Nevada law presently sets the rate of interest on judgments at 12 percent per annum (NRS 17.130, "Computation of amount of judgment; interest," subsection 2). During the last few years, the market rate of interest has fluctuated widely. Sometimes, it was well above 12 percent; sometimes, well below 12 percent.

The subcommittee, therefore, recommends:

**That the rate of prejudgment interest be tied to the rate paid on treasury bills or similar instruments. (BDR 2-137)**

3. Periodic Payments

In most cases, unless otherwise agreed upon by the parties, judgments are paid as lump sum awards. This type of payment mechanism may be ill-suited to medical malpractice cases, because awards in these cases often include payments for anticipated future medical care, lost earnings and pain and suffering. The premature death of the plaintiff may create a windfall for the plaintiff's heirs where a significant portion of the award is based upon future damages. In addition, lump sum awards make it possible for plaintiffs, or their guardians, to squander the money foolishly, or invest it imprudently with the result that money may not be available to support the plaintiff or pay for future medical expenses.

Under a periodic payments system, payments are made over the actual lifetime of the plaintiff or for the actual period of disability. Thus, funds are available for the purpose for which they were intended, and there is no windfall to the heirs of a plaintiff who dies sooner than expected. Also, insurers may be able to fund periodic payments at a lower cost than a lump sum award.

The subcommittee, therefore, asked:

**That a bill draft request be prepared allowing the courts, at the request of either party, to award damage payments in excess of $50,000 in installments rather than as lump sum payments. (BDR 3-128)**

Because of the extreme complexity of this issue, the members of the subcommittee did not wish to recommend this bill draft request to the legislature until they have had the opportunity to review its provisions in detail.

B. IMMUNITIES FOR PROVIDERS OF MEDICAL SERVICES FOR DEPARTMENT OF PRISONS (PRISON DOCTORS)

Nevada Revised Statutes 41.035, "Limitation on award for damages in tort actions," subsection 1, states that:

> An award for damages in an action sounding in tort brought under NRS 41.031 or against a present or former officer or employee of the state or any political subdivision or any state legislator or former state legislator arising out of an act or omission within the scope of his public duties or employment may not exceed the sum of $50,000, exclusive of interest computed from the date of judgment, to or for the benefit of any claimant. An award may not include any amount as exemplary or punitive damages.

This provision grants partial immunity to the state and its employees from damage suits. However, physicians working in the prison system are not covered by this provision because they are considered independent contractors rather than employees.

The subcommittee, therefore, recommends:

**That these physicians be granted the same immunities provided to state employees in NRS chapter 41, "Actions And Proceedings In Particular Cases Concerning Persons." (BDR 3-133)**

## C. CHANGES IN THE INSURANCE SYSTEM

Although there is widespread disagreement regarding the causes of the medical malpractice insurance crisis, some believe that the insurance industry is at least partially responsible. The subcommittee considered several proposals related to insurance.

### 1. Public Advocate for Consumers of Insurance

In 1981, the Nevada legislature created the office of the advocate for customers of public utilities to intervene in rate cases brought before the public service commission of Nevada. The effectiveness of this office has been closely reviewed by a special committee of the legislature since 1981, and the importance of retaining this office has been demonstrated.

The subcommittee, therefore, recommends:

**That an office similar to the office of the advocate for customers of public utilities be created to advocate the interests of insurance consumers and to intervene in hearings to consider requests for insurance rate cases. (BDR 57-132)**

### 2. Rate Increase Hearings

At the present time, Nevada has a "use and file" law for insurance rate changes. Under the authority of NRS 686B.070, "Filing of rates and supplementary information," an insurer may implement a rate change immediately after filing appropriate notice. The new rate may later be disapproved by the commissioner of insurance. In actual practice, however, companies presently file rate increases with the commissioner of insurance and await approval before the increases go into effect.

The subcommittee, therefore, recommends:

**That the legislature amend the statutes to provide that rate increases will not go into effect until a public hearing has been held, if a hearing is requested by the public advocate for consumers of insurance or another party. (BDR 57-132)**

### 3. Presumption of Reasonableness

Nevada Revised Statutes 686B.050, "Standards," subsection 2, states that:

> Rates are presumed not to be excessive if a reasonable degree of price competition exists at the consumer level with respect to the class of business to which they apply.

Because it is difficult to determine whether actual competition exists, this provision limits the ability of the commissioner of insurance to control premiums.

The subcommittee, therefore, recommends:

**That the presumption of reasonableness be removed. (BDR 57-132)**

4. Mandatory Coverage

As medical malpractice insurance premiums have increased, some physicians have decided to drop their insurance coverage altogether. In some cases, physicians have believed that this would make them a less attractive target for malpractice suits. Unfortunately, this action may make it impossible for some plaintiffs to recover damages if they are injured by the physician's actions.

The subcommittee, therefore, recommends:

**That the legislature require that physicians carry malpractice insurance coverage of at least $500,000 or show proof of financial responsibility in the same amount as a condition for practicing medicine. The commissioner of insurance would be allowed to waive this requirement if it would reduce the availability of medical care in a geographic area or specialty in which availability of care is a problem. Companies offering malpractice insurance would be required to report policy cancellations to the board of medical examiners so that this requirement would be enforced. (BDR 54-131)**

D. GRADUATES OF FOREIGN MEDICAL SCHOOLS

During the last two decades, increasing numbers of Americans have enrolled in foreign medical schools. The quality of education provided by some of these schools falls short of American standards. Accordingly, Nevada requires that all graduates of foreign medical schools who apply for a license to practice medicine in Nevada must supply evidence that they have received a degree of Doctor of Medicine or its equivalent and a standard certificate showing that they have passed an examination given by the Educational Commission for Foreign Medical Graduates (NRS 630.195, "Applicant who is graduate of foreign medical school must furnish evidence of degree and certificate").

In testimony given before the subcommittee, the secretary for the board of medical examiners for the State of Nevada indicated that these requirements may not adequately ensure that graduates from foreign medical schools are fully qualified.

The subcommittee, therefore, recommends:

That the Nevada legislature provide the board of medical examiners with authority to supplement its licensure requirement by examining the curriculum of foreign medical schools attended by applicants for a license to practice medicine. (BDR 54-134)

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## V. SUGGESTED LEGISLATION

SUMMARY---Requires interest on judgment to be paid at rate paid on United States Treasury bills. (BDR 2-137)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to judgments; requiring the payment of interest at the rate paid on United States Treasury bills; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 17.130 is hereby amended to read as follows:

17.130 1. In all judgments and decrees, rendered by any court of justice, for any debt, damages or costs, and in all executions issued thereon, the amount must be computed, as near as may be, in dollars and cents, rejecting smaller fractions, and no judgment, or other proceedings, may be considered erroneous for that omission.

2. When no rate of interest is provided by contract or otherwise by law, or specified in the judgment, the judgment draws interest [at the rate of 12 percent per annum] from the time of service of the summons and complaint until satisfied, except for any amount representing future damages, which draws interest [at that rate] only from the time of the entry of the judgment until satisfied [.] , at a rate equal to the yield on the face value, as determined by the Secretary of the Treasury, of the average price accepted at the auction of 52-week United States Treasury bills in the first week of January or July immediately preceding the date of the judgment.

Sec. 2. The provisions of this act apply only to causes of action which arise on or after July 1, 1987.

SUMMARY---Provides for periodic payments of certain damages recovered in action for medical malpractice. (BDR 3-128)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to medical malpractice; providing for the periodic payment of future damages recovered against a provider of health care; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 42 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this act.

Sec. 2. As used in this chapter, unless the context otherwise requires:

1. "Future damages" means:

(a) The cost of providing medical treatment, care and custody for an injured person after a judgment in his favor has been entered; and

(b) The amount by which his ability to earn income has been reduced as a result of the injury.

2. "Provider of health care" means a physician, dentist, registered nurse, dispensing optician, optometrist, registered physical therapist, podiatrist, licensed psychologist, chiropractor, doctor of traditional Oriental medicine in any form or medical laboratory director or technician, or a licensed hospital as the employer of any such person.

Sec. 3. 1. In any action for damages for personal injury against a provider of health care which is based upon a breach of his professional duty toward a patient and in which the plaintiff has requested that future damages be awarded, the court shall:

(a) If the action is tried before a jury, direct the jury to return a special verdict declaring the life expectancy of the plaintiff and the amount, if any, of future damages to which the plaintiff is entitled; or

(b) If the action is tried without a jury, make the determinations required by paragraph (a).

2. If the award for future damages is $50,000 or more, the court may, at the request of a party, determine whether to allow monetary compensation for future damages to be made in periodic payments.

3. In making the determination under subsection 2, the court shall consider:

(a) The age and life expectancy of the plaintiff;

(b) The extent of the plaintiff's disability, if any, and whether he is or will be able to receive income from employment;

(c) Whether there are persons dependent on the plaintiff for financial support;

(d) The plaintiff's financial need at the time the judgment is entered; and

(e) Any other information which has a bearing on the plaintiff's financial condition.

Sec. 4. 1. If the court determines that periodic payment of the award for future damages is appropriate, it shall request each party to submit a proposed schedule for the periodic payment of the award. Such a proposal must include:

(a) The name of each recipient of the payments;

(b) The amount of the payments;

(c) The interval between the payments;

(d) The number of payments or the period over which the payments will be made;

(e) A procedure for the modification of the schedule if unforeseen circumstances occur;

(f) A statement of the manner in which the defendant will post and maintain adequate security for the debt; and

(g) Any other provision which is required by the court.

2. After each party has submitted a proposal, the court shall select the proposal which, together with any changes made by the court, best provides for the future needs of the plaintiff. The court shall enter its judgment according to the terms of the selected proposal, as modified by the court.

Sec. 5. 1. If the court enters a judgment for periodic payments and any security required by the judgment is not posted within 30 days, the court shall enter a judgment for the payment of the future damages in a lump sum.

2. If at any time following a judgment requiring periodic payments a judgment debtor fails for any reason to make a timely payment according to the terms of the judgment, the person entitled to the payments may petition the court for an order requiring payment by the judgment debtor of the outstanding payments in a lump sum.

3. In calculating the amount of a lump sum paid pursuant to this section, the court must total the remaining periodic payments and convert the total to present value. The court may also require the judgment debtor to pay interest on the outstanding judgment.

4. Upon the death of any person entitled to receive periodic payments, the court which rendered the original judgment may, upon petition of any party in interest, modify the judgment to award and apportion any amount of the award yet unpaid.

5. Any damages awarded for the loss of future earnings by the plaintiff must not be reduced or payments terminated by reason of the death of the plaintiff.

6. Upon satisfaction of a judgment for future damages any security posted by the judgment debtor must be returned to him.

Sec. 6. NRS 42.020 is hereby amended to read as follows:

42.020 [1.] In any action for damages for personal injury against any provider of health care, the amount of damages, if any, awarded in such an action [shall] must be reduced by the amount of any prior payment made by or on behalf of the provider of health care to the injured person or to the claimant to meet reasonable expenses of medical care, other essential goods or services or reasonable living expenses.

[2. As used in this section, "provider of health care" means a physician, dentist, registered nurse, dispensing optician, optometrist, registered physical therapist, podiatrist, licensed psychologist, chiropractor, doctor of traditional Oriental medicine in any form, medical laboratory director or technician, or a licensed hospital as the employer of any such person.]

SUMMARY---Provides for indemnification of independent contractors with state who provide medical services. (BDR 3-133)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to civil liability; providing indemnification of independent contractors with the state who provide medical services; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 41.0307 is hereby amended to read as follows:

41.0307 As used in NRS 41.031 to 41.039, inclusive : [, "public officer" or "officer" includes:]

1. "Employee" includes an employee of any part-time or full-time board, commission or similar body of the state or a political subdivision of the state which is created by law.

2. "Immune contractor" means any person who:

(a) Is an independent contractor with the state pursuant to NRS 284.173; and

(b) Contracts to provide medical services.

3. "Public officer" or "officer" includes:

(a) A member of a part-time or full-time board, commission or similar body of the state or a political subdivision of the state which is created by law. ["Employee" includes an employee of any such board, commission or similar body.

2.] (b) A public defender and any deputy or assistant attorney of a public defender.

Sec. 2. NRS 41.032 is hereby amended to read as follows:

41.032 Except as provided in NRS 278.0233 no action may be brought under NRS

41.031 or against an immune contractor or an officer or employee of the state or any of its agencies or political subdivisions which is:

1. Based upon an act or omission of an officer [or employee,] , employee or immune contractor, exercising due care, in the execution of a statute or regulation, whether or not such statute or regulation is valid, if the statute or regulation has not been declared invalid by a court of competent jurisdiction; or

2. Based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty on the part of the state or any of its agencies or political subdivisions or of any officer [or employee] , employee or immune contractor of any of these, whether or not the discretion involved is abused.

Sec. 3. NRS 41.0337 is hereby amended to read as follows:

41.0337 No tort action arising out of an act or omission within the scope of his public duties or employment may be brought against any [officer] present or former:

1. Officer or employee [, or former officer or employee,] of the state or of any political subdivision [or against any state legislator or former state] ;

2. Immune contractor; or

3. State legislator ,

unless the state or appropriate political subdivision is named a party defendant under NRS 41.031.

Sec. 4. NRS 41.0338 is hereby amended to reads as follows:

41.0338 As used in NRS 41.0339 to 41.0349, inclusive, "official attorney" means:

1. The attorney general, in an action which involves a present or former legislator, officer or employee of this state [or a present or former] , immune contractor or member of a state board or commission.

2. The chief legal officer or other authorized legal representative of a political subdivision, in an action which involves a present or former officer or employee of that political subdivision or a present or former member of a local board or commission.

Sec. 5. NRS 41.0339 is hereby amended to read as follows:

41.0339 The official attorney shall provide for the defense, including the defense of cross-claims and counterclaims, of any [officer or employee,] present or former officer or employee [, member or former member of any official board or commission] of the state or a political subdivision [or of any state legislator or former] , immune contractor or state legislator in any civil action brought against that person based on any alleged act or omission relating to his public duties if:

1. Within 15 days after service of a copy of the summons and complaint or other legal document commencing the action, he submits a written request for defense:

(a) To the official attorney; or

(b) If the officer [or employee] , employee or immune contractor has an administrative superior, to the administrator of his agency and the official attorney; and

2. The official attorney has determined that the act or omission on which the action is based appears to be within the course and scope of public duty and appears to have been performed or omitted in good faith.

Sec. 6. NRS 41.0346 is hereby amended to read as follows:

41.0346 1. At any time after the official attorney has appeared in any civil action and commenced to defend any person sued as a public officer, employee, immune contractor, member of a board or commission , [member] or legislator, the official attorney may apply to any court to withdraw as the attorney of record for that person based upon:

(a) Discovery of any new material fact which was not known at the time the defense was tendered and which would have altered the decision to tender the defense;

(b) Misrepresentation of any material fact by the person requesting the defense, if

that fact would have altered the decision to tender the defense if the misrepresentation had not occurred;

(c) Discovery of any mistake of fact which was material to the decision to tender the defense and which would have altered the decision but for the mistake;

(d) Discovery of any fact which indicates that the act or omission on which the civil action is based was not within the course and scope of public duty or was wanton or malicious;

(e) Failure of the defendant to cooperate in good faith with the defense of the case; or

(f) If the action has been brought in a court of competent jurisdiction of this state, failure to name the state or political subdivision as a party defendant, if there is sufficient evidence to establish that the civil action is clearly not based on any act or omission relating to the defendant's public duty.

2. If any court grants a motion to withdraw on any of the grounds set forth in subsection 1 brought by the official attorney, the state or political subdivision has no duty to continue to defend any person who is the subject of the motion to withdraw.

Sec. 7. NRS 41.0347 is hereby amended to read as follows:

41.0347 If the official attorney does not provide for the defense of a present or former officer, employee, <u>immune contractor, member of a</u> board or commission [member] of the state or any political subdivision or of a legislator in any civil action in which the state or political subdivision is also a named defendant, or which was brought in a court other than a court of competent jurisdiction of this state, and if it is judicially determined that the injuries arose out of an act or omission of that person during the performance of any duty within the course and scope of his public duty and that his act or omission was not wanton or malicious:

1. If the attorney general was responsible for providing the defense, the state is liable to that person for reasonable expenses in prosecuting his own defense, including

court costs and attorney's fees. These expenses must be paid, upon approval by the state board of examiners, from the reserve for statutory contingency fund . [; or]

2. If the chief legal officer or attorney of a political subdivision was responsible for providing the defense, the political subdivision is liable to that person for reasonable expenses in carrying on his own defense, including court costs and attorney's fees.

Sec. 8. NRS 41.03475 is hereby amended to read as follows:

41.03475 No judgment may be entered against the State of Nevada or any agency of the state or against any political subdivision of the state for any act or omission of any present or former officer, employee, immune contractor, member of a board or commission , [member] or legislator which was outside the course and scope of his public duties or employment.

Sec. 9. NRS 41.0348 is hereby amended to read as follows:

41.0348 In every action or proceeding in any court of this state in which both the state or political subdivision and any present or former officer, employee, immune contractor or member of a board or commission [member] thereof or any present or former legislator are named defendants, the court or jury in rendering any final judgment, verdict, or other disposition shall return a special verdict in the form of written findings which determine whether:

1. The [officer, employee, member of a board or commission or legislator] individual defendant was acting within the scope of his public duty; and

2. The alleged act or omission by the [officer, employee, member of a board or commission or legislator] individual defendant was wanton or malicious.

Sec. 10. NRS 41.0349 is hereby amended to read as follows:

41.0349 In any civil action brought against any present or former officer [or employee, former officer or employee, member or former] , employee, immune contractor, member of a board or commission of the state or a political subdivision or [any] state legislator , [or former state legislator,] in which a judgment is entered

against the defendant based on any act or omission relating to his public duty, the state or political subdivision shall indemnify him unless:

1. The person failed to submit a timely request for defense;

2. The person failed to cooperate in good faith in the defense of the action;

3. The act or omission of the person was not within the scope of his public duty; or

4. The act or omission of the person was wanton or malicious.

Sec. 11. NRS 41.035 is hereby amended to read as follows:

41.035 1. An award for damages in an action sounding in tort brought under NRS 41.031 or against a present or former officer or employee of the state or any political subdivision , immune contractor or [any] state legislator [or former state legislator] arising out of an act or omission within the scope of his public duties or employment may not exceed the sum of $50,000, exclusive of interest computed from the date of judgment, to or for the benefit of any claimant. An award may not include any amount as exemplary or punitive damages.

2. The limitations of subsection 1 upon the amount and nature of damages which may be awarded apply also to any action sounding in tort and arising from any recreational activity or recreational use of land or water which is brought against:

(a) Any public or quasi-municipal corporation organized under the laws of this state.

(b) Any person with respect to any land or water leased or otherwise made available by that person to any public agency.

(c) Any Indian tribe, band or community whether or not a fee is charged for such activity or use. The provisions of this paragraph do not impair or modify any immunity from liability or action existing on February 26, 1968, or arising after February 26, 1968, in favor of any Indian tribe, band or community.

The legislature declares that the purpose of this subsection is to effectuate the public

policy of the State of Nevada by encouraging the recreational use of land, lakes, reservoirs and other waters owned or controlled by any public or quasi-municipal agency or corporation of this state, wherever such land or water may be situated.

3. The limitations of subsection 1 upon the amount and nature of damages which may be awarded apply also to any action sounding in tort arising out of any act or omission within the scope of the public duties or employment of any present or former officer or employee [, or former officer or employee,] of the state or of any political subdivision, [or against any] immune contractor or state legislator . [or former state legislator.]

Sec. 12. NRS 41.037 is hereby amended to read as follows:

41.037 Upon receiving the report of findings as provided in subsection 2 of NRS 41.036, the state board of examiners may allow and approve any claim or settle any action against the state, any of its agencies or any of its present or former officers, employees , immune contractors or legislators arising under NRS 41.031 to the extent of $50,000, plus interest computed from the date of judgment. Upon approval of any claim by the state board of examiners, the state controller shall draw his warrant for the payment thereof, and the state treasurer shall pay the claim from the trust fund for insurance premiums or from the reserve for statutory contingency fund. The governing body of any political subdivision whose authority to allow and approve claims is not otherwise fixed by statute may allow and approve any claim or settle any action against that subdivision or any of its present or former officers or employees arising under NRS 41.031 to the extent of $50,000, plus interest computed from the date of entry of any judgment, and pay it from any money appropriated or lawfully available for that purpose.

Sec. 13. NRS 41.038 is hereby amended to read as follows:

41.038 1. The state and any local government may:

(a) Insure itself against any liability arising under NRS 41.031.

(b) Insure any of its officers [or employees] , employees or immune contractors against tort liability resulting from an act or omission in the scope of his employment.

(c) Insure against the expense of defending a claim against itself or any of its officers [or employees] , employees or immune contractors whether or not liability exists on such a claim.

2. Any school district may insure any peace officer, requested to attend any school function, against tort liability resulting from an act or omission in the scope of his employment while attending such a function.

3. As used in this section:

(a) "Insure" means to purchase a policy of insurance or establish a self-insurance reserve or fund, or any combination thereof.

(b) "Local government" means every political subdivision and every other governmental entity in this state.

Sec. 14. NRS 41.039 is hereby amended to read as follows:

41.039 An action which is based on the conduct of any , immune contractor or employee or appointed or elected officer of a political subdivision of the State of Nevada while in the course of his employment or in the performance of his official duties may not be filed against such an immune contractor, employee or officer unless, [prior to] before the filing of the complaint in such an action, a valid claim has been filed, pursuant to NRS 41.031 to 41.038, inclusive, against the political subdivision for which such employee or officer was authorized to act.

SUMMARY---Limits recovery against defendant whose negligence is less than 50 percent of total negligence. (BDR 3-135)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to civil liability; limiting recovery against a defendant whose negligence is less than 50 percent of the total negligence which contributed to an injury or death; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 41.141 is hereby amended to read as follows:

41.141 1. In any action to recover damages for death or personal injury [to persons] or for injury to property in which contributory negligence may be asserted as a defense, the contributory negligence of the plaintiff or his decedent does not bar a recovery if that negligence was not greater than the negligence or gross negligence of the person or persons against whom recovery is sought, but any damages allowed must be diminished in proportion to the amount of negligence attributable to the person seeking recovery or his decedent.

2. In those cases, the judge may and when requested by any party shall instruct the jury that:

(a) The plaintiff may not recover if his contributory negligence or that of his decedent has contributed more to the injury than the negligence of the defendant or the combined negligence of multiple defendants.

(b) If the jury determines the plaintiff is entitled to recover, it shall return:

(1) By general verdict the total amount of damages the plaintiff would be entitled to recover without regard to his contributory negligence.

(2) A special verdict indicating the percentage of negligence attributable to each party.

(3) By general verdict the net sum determined to be recoverable by the plaintiff.

3. [Where] If recovery is allowed against more than one defendant in such an action, the defendants are jointly and severally liable to the plaintiff, except that a defendant whose negligence is less than [that of the plaintiff or his decedent] 50 percent of the total negligence which contributed to the death or injury is not jointly liable and is severally liable to the plaintiff only for that portion of the judgment which represents the percentage of negligence attributable to him.

SUMMARY---Requires physicians to maintain insurance against medical malpractice. (BDR 54-131)

FISCAL NOTE: Effect on Local Government: Yes.
Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to physicians; requiring the maintenance of insurance against medical malpractice; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 630 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as provided in subsections 4 and 5, every physician shall maintain a contract of insurance against medical malpractice in an amount not less than $500,000 for each occurrence.

2. Except as provided in subsections 4 and 5, a certificate of insurance must be furnished to the board as evidence that a contract is in force, and the board shall not issue or renew a license until that certificate is furnished.

3. Each contract of insurance must contain an endorsement providing for a notice of 90 days to the board before the effective date of a cancellation or nonrenewal of the policy.

4. After conducting a hearing, the commissioner of insurance may waive the requirements of subsection 1 if the physician submits satisfactory evidence that he is unable to obtain a contract of insurance because of his medical specialty or geographic area of service.

5. In lieu of a contract of insurance, a physician may submit proof that he possesses and will continue to possess the ability to pay judgments obtained against him in

amounts not less than $500,000 for each occurrence of medical malpractice. The proof must be approved by the commissioner of insurance.

Sec. 2. Chapter 630A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as provided in subsections 4 and 5, every homeopathic physician shall maintain a contract of insurance against medical malpractice in an amount not less than $500,000 for each occurrence.

2. Except as provided in subsections 4 and 5, a certificate of insurance must be furnished to the board as evidence that a contract is in force, and the board shall not issue or renew a license until that certificate is furnished.

3. Each contract of insurance must contain an endorsement providing for a notice of 90 days to the board before the effective date of a cancellation or nonrenewal of the policy.

4. After conducting a hearing, the commissioner of insurance may waive the requirements of subsection 1 if the homeopathic physician submits satisfactory evidence that he is unable to obtain a contract of insurance because of his medical specialty or geographic area of service.

5. In lieu of a contract of insurance, a homeopathic physician may submit proof that he possesses and will continue to possess the ability to pay judgments obtained against him in amounts not less than $500,000 for each occurrence of medical malpractice. The proof must be approved by the commissioner of insurance.

Sec. 3. Chapter 633 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as provided in subsections 4 and 5, every osteopathic physician shall maintain a contract of insurance against medical malpractice in an amount not less than $500,000 for each occurrence.

2. Except as provided in subsections 4 and 5, a certificate of insurance must be furnished to the board as evidence that a contract is in force, and the board shall not issue or renew a license until that certificate is furnished.

3. Each contract of insurance must contain an endorsement providing for a notice of 90 days to the board before the effective date of a cancellation or nonrenewal of the policy.

4. After conducting a hearing, the commissioner of insurance may waive the requirements of subsection 1 if the osteopathic physician submits satisfactory evidence that he is unable to obtain a contract of insurance because of his medical specialty or geographic area of service.

5. In lieu of a contract of insurance, an osteopathic physician may submit proof that he possesses and will continue to possess the ability to pay judgments obtained against him in amounts not less than $500,000 for each occurrence of medical malpractice. The proof must be approved by the commissioner of insurance.

Sec. 4. This act becomes effective on January 1, 1988.

SUMMARY---Permits board of medical examiners to conduct further examination of graduate of foreign medical school. (BDR 54-134)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to physicians; permitting the board of medical examiners to require a graduate of a foreign medical school to provide further proof of his qualifications for a license; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 630.195 is hereby amended to read as follows:

630.195 [In addition to the other requirements for licensure, an] 1. An applicant for a license to practice medicine who is a graduate of a foreign medical school shall submit to the board proof that he has received:

[1.] (a) The degree of Doctor of Medicine or its equivalent, as determined by the board; and

[2.] (b) The standard certificate of the Educational Commission for Foreign Medical Graduates or a written statement from that commission that he passed the examination given by it.

2. In addition to the requirements of subsection 1, the board may take such further evidence and require such further proof of the qualifications of the applicant as it deems necessary.

SUMMARY---Revises provisions concerning rates for insurance and creates office of public advocate. (BDR 57-132)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to insurance; revising provisions concerning rates for insurance; creating an office of public advocate to represent the public interest and insurance customers; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 686B.050 is hereby amended to read as follows:

686B.050 1. Rates [shall] must not be excessive, inadequate or unfairly discriminatory, nor [shall] may an insurer charge any rate which if continued will have or tend to have the effect of destroying competition or creating a monopoly.

2. [Rates are presumed not to be excessive if a reasonable degree of price competition exists] The commissioner may disapprove rates if there is not a reasonable degree of price competition at the consumer level with respect to the class of business to which they apply. In determining whether a reasonable degree of price competition exists, the commissioner shall consider all relevant tests, including:

(a) The number of insurers actively engaged in the class of business and their shares of the market ; [shares;]

(b) The existence of [rate] differentials in rates in that class of business;

(c) Whether long-run profitability for insurers generally of the class of business is unreasonably high in relation to its riskiness; [and

(d) Consumer]

(d) Consumers' knowledge in regard to the market in question [.

If such] ; and

(e) Whether price competition is a result of the market or is artificial.

If competition does not exist, rates are excessive if they are likely to produce a long-run profit that is unreasonably high in relation to the riskiness of the class of business, or if expenses are unreasonably high in relation to the services rendered.

3. Rates are inadequate if they are clearly insufficient, together with the [investment] income from investments attributable to them, to sustain projected losses and expenses in the class of business to which they apply.

4. One rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with [like loss exposures] similar exposure to loss but different expense factors, or [like] similar expense factors but different exposure to loss , [exposures,] so long as the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise or blanket policy.

Sec. 2. NRS 686B.070 is hereby amended to read as follows:

686B.070 Every authorized insurer and every rate service organization licensed under NRS 686B.130 which has been designated by any insurer for the filing of rates under subsection 2 of NRS 686B.090 shall file with the commissioner all:

1. Rates;
2. Forms of policies to which the rates apply;
3. Supplementary rate information; and
4. Changes and amendments thereof,

made by it for use in this state [on or] at least 30 days before the date the rates become effective.

Sec. 3. Chapter 228 of NRS is hereby amended by adding thereto the provisions set forth as sections 4 to 11, inclusive, of this act.

Sec. 4. As used in sections 4 to 11, inclusive, of this act, unless the context otherwise requires:

1. "Insurer" means any person authorized to transact insurance in this state by a certificate of authority issued by the commissioner of insurance.

2. "Public advocate" means the advocate for customers of insurers.

3. "Public interest" means the interests or rights of the State of Nevada and of the citizens of the state, or a broad class of those citizens, which arise from the constitutions, court decisions and statutes of this state and of the United States and from the common law, as those interests and rights relate to the regulation of rates charged by insurers.

Sec. 5. The office of public advocate is hereby created within the office of the attorney general.

Sec. 6. 1. The attorney general shall appoint the public advocate for a term of 4 years. The public advocate is in the unclassified service of the state. The person appointed:

(a) Must be an atttorney at law licensed in this state;

(b) Must be knowledgeable about how rates are established by insurance companies;

(c) Must not be a stockholder in or directly or indirectly connected with the management or affairs of any insurer or insurance brokerage or agency; and

(d) Shall devote all of his time to the business of his office and shall not pursue any other business or vocation or hold any other office of profit.

2. The attorney general may remove the public advocate from office for inefficiency, neglect of duty or malfeasance in office.

Sec. 7. The public advocate may employ the staff necessary to carry out his duties and the functions of his office, in accordance with the practices and procedures for personnel established within the attorney general's office. The staff must include:

1. A person knowledgeable in rate making and principles and policies of the regulation of rates;

2. A specialist in the area of insurance knowledgeable in accounting, finance or economics or one or more related subjects;

3. When exceptional circumstances arise and with the approval of the attorney general, such other expert assistants as are necessary to protect the public interest, pursuant to a reasonable schedule of fees established in advance by the public advocate; and

4. An administrative assistant,

who must be in the unclassified service of the state. The public advocate has sole discretion to employ and remove the members of his staff who are in the unclassified service.

Sec. 8. The public advocate may:

1. Purchase necessary equipment.

2. Lease or make other suitable arrangements for office space, but any lease which extends beyond the term of 1 year must be reviewed and approved by a majority of the members of the state board of examiners.

3. Apply to the commissioner of insurance for an order or subpena for the appearance of witnesses or the production of books, papers and documents in any hearing before the commissioner in which the public advocate is a party or intervener, and make arrangements for and pay the fees or costs of any witnesses and consultants necessary to the hearing. If any person ordered by the commissioner of insurance to

appear as a witness pursuant to this subsection fails to obey the order, the commissioner shall apply for a subpena commanding the attendance of the witness.

4. Perform such other functions and make such other arrangements as may be necessary to carry out his duties and the functions of his office.

Sec. 9. 1. Each authorized insurer and each rate service organization which is required to file information with the commissioner of insurance pursuant to NRS 686B.070 shall provide the public advocate with copies of the information which is filed on or before the date it is filed with the commissioner.

2. If the public advocate objects to the proposed rates, he shall notify the commissioner of his objection not later than 10 days before the date the rates become effective. The commissioner shall schedule a hearing to determine whether the rates are excessive or unfairly discriminatory. The public advocate may represent the public interest or the interests of any particular class of insurance customers in any such hearing.

3. If the public advocate requests the review of a rate pursuant to subsection 2, the effective date of the proposed rate is stayed until the commissioner authorizes its imposition.

4. A hearing conducted pursuant to this section is subject to the provisions of NRS 679B.310 to 679B.370, inclusive.

Sec. 10. The public advocate may:

1. Conduct or contract for studies, surveys and research or solicit opinions or testimony from experts relating to matters affecting the public interest or the interest of insurance customers.

2. Examine any books, accounts, minutes, records or other papers or property of

any authorized insurer in the same manner and to the same extent as authorized by law for the commissioner of insurance and his staff.

3. Intervene in any proceeding concerning rates for insurance or any related matter before the commissioner of insurance or any court.

Sec. 11. 1. The public advocate has sole discretion to represent or refrain from representing the public interest and any class of insurance customers in any proceeding.

2. In exercising his discretion, the public advocate shall consider the importance and extent of the public interest or the customers' interests involved and whether those interests would be adequately represented without his participation.

3. If the public advocate determines that there would be a conflict between the public interest and any particular class of insurance customers or any inconsistent interests among the classes of insurance customers involved in a particular matter, he may choose to represent one of the interests, to represent no interest, or to represent one interest through his office and another or others through outside counsel engaged on a case basis.

Sec. 12. 1. This section and sections 1 and 2 of this act become effective on July 1, 1987.

2. Sections 3 to 11, inclusive, of this act become effective on January 1, 1988.