Claims for Medical Malpractice

Legislative Counsel Bureau

Bulletin No. 97-2

January 1997

CLAIMS FOR MEDICAL MALPRACTICE

BULLETIN NO. 97-2

JANUARY 1997

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SUMMARY OF RECOMMENDATIONS

The following are the recommendations approved by the Legislative Commission's Subcommittee to Study Claims for Medical Malpractice (Sections 7 and 8 of Assembly Bill 520, Chapter 686, *Statutes of Nevada 1995*).

RECOMMENDATIONS FOR LEGISLATION

The subcommittee recommends that the 69th Session of the Nevada Legislature:

1. **Require the Commissioner of Insurance to collect information regarding closed claims for medical malpractice and maintain a data base including the items of information specified in Section 7 of Assembly Bill 520 of the 1995 Legislative Session. (BDR 57-933)**

2. **Require that, in any action for medical malpractice in which the claim is $75,000 or less, the parties must submit the dispute to mediation before it is heard before the medical-legal screening panel. Require that both parties participate in good faith. (BDR 3-932)**

3. **Amend NRS 41A.059 ("Conference for settlement of claim: Attendance; powers and duties of judge; effect of failure to settle.") to require that both parties to an action for medical malpractice and a witness designated by the plaintiff who will testify regarding damages be deposed before the mandatory settlement conference is held. (BDR 3-934)**

REPORT TO THE 69TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO STUDY CLAIMS FOR MEDICAL MALPRACTICE

I. INTRODUCTION AND BACKGROUND

Medical malpractice has been an important issue in the Nevada Legislature for more than two decades. During the early 1970s, the incidence of medical malpractice actions increased across the nation, particularly in the State of California. Physicians and hospitals in Nevada experienced substantial increases in premiums for malpractice insurance, leading to a demand for legislative action.

In 1975, the Legislature approved a series of bills designed to stem the malpractice crisis and assure the availability of malpractice insurance at reasonable rates. The following is a list of actions taken by the Legislature:

1. Authorizing the creation of joint underwriting associations to provide essential malpractice insurance when the private insurance market was unable or unwilling to do so;[1]

2. Providing legal protection for health care providers who render care without charge in medical emergencies;[2]

3. Limiting the *res ipsa loquitur* rule and requiring that expert testimony be presented to establish medical negligence in other cases;[3]

4. Providing for the tolling of the statute of limitations for persons under legal disability and placing the responsibility for bringing suit on the person's legal guardian;[4]

5. Defining the necessary elements for informed consent;[5]

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[1]Senate Bill 401, Chapter 296, *Statutes of Nevada 1975.*

[2]Senate Bill 402, Chapter 298, *Statutes of Nevada 1975.*

[3]Senate Bill 405, Chapter 299, *Statutes of Nevada 1975.*

[4]Senate Bill 406, Chapter 300, *Statutes of Nevada 1975.*

[5]Senate Bill 408, Chapter 301, *Statutes of Nevada 1975.*

6. Creating medical-legal screening panels in northern and southern Nevada composed of three physicians and three attorneys to screen cases before they go to trial and encourage settlements;[6] and

7. Increasing the powers of the Board of Medical Examiners to assure medical competency and discipline physicians.[7]

In addition, the Legislature adopted a resolution[8] which directed the Legislative Commission to undertake a study of the problems of medical malpractice insurance. This resolution provided for the appointment of a subcommittee composed of members of the Legislature, the Commissioner of Insurance, and representatives of the insurance, legal, and medical professions. This subcommittee was directed to assess the effectiveness of the measures enacted in 1975 and make recommendations to the Legislature in 1977. The report of this subcommittee, entitled *The Problems of Medical Malpractice Insurance*[9] is available in the Legislative Library.

Partly as a result of the recommendations made by the subcommittee, the Legislature in 1977 enacted a number of significant measures relating to medical malpractice, including the following:

1. Requiring that all awards, judgments, or settlements in malpractice actions be reported to the Commissioner of Insurance and the Board of Medical Examiners and requiring that the Board of Medical Examiners investigate any physician who has paid $5,000 or more as a result of a malpractice action;[10]

2. Granting immunity from civil liability for the Board of Medical Examiners, medical review panels of hospitals, medical-legal screening panels, medical societies, and others involved in a lawful investigation concerning physician discipline;[11]

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[6]Senate Bill 409, Chapter 302, *Statutes of Nevada 1975.*

[7]Senate Bill 432, Chapter 303, *Statutes of Nevada 1975.*

[8]Senate Concurrent Resolution 21, File No. 115, *Statutes of Nevada 1975.*

[9]Legislative Counsel Bureau Bulletin No. 77-1.

[10]Senate Bill 190, Chapter 326, *Statutes of Nevada 1977.*

[11]Ibid.

3. Repealing the provisions enacted during the 1975 Session regarding the tolling of the statute of limitations for persons under a legal disability;[12]

4. Amending the law regarding screening panels to add nurses to the panel in cases involving nurses, expanding the list of doctors from which panel members could be chosen, granting subpoena powers to the panels, and exempting panels from the open meeting law and the law regarding doctor-patient privilege;[13]

5. Authorizing health care providers covered by a joint underwriting association to pay a fee in addition to the premium to ensure that they will not be required to pay assessments in later years;[14]

6. Guaranteeing access to patient medical records by the Board of Medical Examiners;[15] and

7. Amending the physician licensing law to clarify references to unprofessional conduct and malpractice.[16]

In 1979, the Legislature enacted only one significant measure relating to medical malpractice. That bill[17] expanded the membership of the medical malpractice screening panels to include hospital administrators in those cases involving members of that profession.

In 1981, the Legislature abolished the medical malpractice screening panels.[18] Testimony before the Senate Committee on Commerce and Labor[19] indicated that the panels had been ineffective. Many cases were being taken to trial regardless of the panels' recommendations. In addition, the panels had large backlogs of cases, resulting in

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[12]Assembly Bill 268, Chapter 519, *Statutes of Nevada 1977.*

[13]Assembly Bill 267, Chapter 481, *Statutes of Nevada 1977.*

[14]Assembly Bill 269, Chapter 160, *Statutes of Nevada 1977.*

[15]Senate Bill 185, Chapter 538, *Statutes of Nevada 1977.*

[16]Senate Bill 413, Chapter 428, *Statutes of Nevada 1977.*

[17]Assembly Bill 546, Chapter 368, *Statutes of Nevada 1979.*

[18]Assembly Bill 183, Chapter 327, *Statutes of Nevada 1981.*

[19]Minutes of the Senate Committee on Commerce and Labor, April 29, 1981.

significant delays in processing malpractice actions. The same bill also required providers of health care to report malpractice claims, and allowed professional licensing boards to consider repeated claims of malpractice in determining whether a licensee should be disciplined.

Four years later, in 1985, the Legislature reinstituted medical malpractice screening panels, with some changes. The Legislature reestablished panels in northern and southern Nevada,[20] as had been the case under the former law that was repealed in 1981. However, in this instance, the Legislature attempted to put some "teeth" into the law by requiring that if the panel found against the claimant, he could proceed in court only after posting a $5,000 bond which would be forfeited if he did not prevail. The bill also provided for the screening panel statute to expire in three years if not renewed by the Legislature. During the 1985 Session, the Legislature also provided an exemption from civil liability for persons observing a practitioner of the healing arts.[21]

Finally, the Legislature adopted a resolution[22] directing the Legislative Commission to study the business of insuring against medical malpractice. The object of the study was to determine whether the increasing cost of health care was attributable in a significant part to the rising cost of malpractice coverage.

The subcommittee appointed to carry out this study investigated a number of issues relating to medical malpractice, including: changes in insurance rate-setting procedures, the effect of graduates of foreign medical schools, the effectiveness of medical malpractice screening panels, immunity for prison doctors, joint and several liability, judgment interest, mandatory malpractice coverage, and periodic payments. The report of this study, entitled *Study of Insurance Against Medical Malpractice*[23], is available in the Legislative Library.

Although the study subcommittee recommended several changes in the laws relating to medical malpractice, including requiring physicians to carry insurance coverage of at least $500,000, the Legislature did not enact any major malpractice legislation during the 1987 Session.

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[20]Assembly Bill 696, Chapter 620, *Statutes of Nevada 1985.*

[21]Senate Bill 38, Chapter 597, *Statutes of Nevada 1985.*

[22]Assembly Concurrent Resolution 53, File No. 106, *Statutes of Nevada 1985.*

[23]Legislative Counsel Bureau Bulletin No. 87-18.

In 1989, the Legislature repealed the sunset provision in the screening panel statute and made major changes in the operations of the panels.[24] These changes included expanding the pool from which panel members were chosen and limiting peremptory challenges for panel members. It also expanded the panels' access to relevant records and granted plaintiffs the opportunity to respond to allegations raised in the defendant's answer. The bill eliminated the requirement that plaintiffs post a $5,000 bond before proceeding in court after an adverse finding by the panel, but provided that the successful litigant in those cases was entitled to attorney's fees and costs. Finally, the bill streamlined the panels' procedures and extended the statute of limitations until 30 days after the decision of the panel.

Other bills relating to medical malpractice passed during the 1989 Session included a measure that clarified the law regarding joint and several liability to make it clear that when health care providers act jointly in providing patient care, each provider is liable only for the portion of the judgment attributable to his own negligent acts,[25] and a bill that granted licensed nurses immunity from liability for care rendered without charge in an emergency.[26]

During the 1991 Session, the Legislature considered the relationship between the cost of insurance for medical malpractice and the lack of obstetric care in Nevada's rural communities. The high cost of malpractice insurance and the small population base in those communities had caused many physicians to stop delivering babies, forcing rural women to travel long distances to obtain obstetric care. The Legislature appropriated $100,000 for grants to subsidize a portion of the malpractice insurance premiums for providers of prenatal care in rural Nevada.[27] During the same session, the Legislature also enacted legislation authorizing the Board of Medical Examiners to revoke the license of a physician if his license in another jurisdiction had been revoked for gross medical negligence.[28]

During the 1995 Session, the issue of medical malpractice again came to the forefront. An organization called the Nevada Coalition Allied for Patient Protection (NEVCAP), a

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[24]Senate Bill 83, Chapter 193, *Statutes of Nevada 1989.*

[25]Assembly Bill 249, Chapter 39, *Statutes of Nevada 1989.*

[26]Senate Bill 52, Chapter 19, *Statutes of Nevada 1989.*

[27]Senate Bill 477, Chapter 651, *Statutes of Nevada 1991.*

[28]Assembly Bill 279, Chapter 407, *Statutes of Nevada 1991.*

group representing physicians, other health care professionals, health care facilities, and liability insurers, advocated the passage of Assembly Bill 520 (Chapter 686, *Statutes of Nevada 1995*).

In its original form, this measure included provisions limiting the liability of physicians involved in providing emergency obstetrical care or uncompensated care to indigent persons, limiting contingency fees for attorneys in medical malpractice cases, reducing the period during which malpractice cases could be filed, requiring that punitive damages in malpractice actions be paid to the State treasury rather than to the plaintiff, limiting awards for noneconomic losses to $250,000, providing for periodic payment of future damages, and providing for an offset of compensation the plaintiff has received from collateral sources. These proposals, which were advocated by representatives of the medical community and opposed by many trial lawyers, generated substantial controversy and the subject of extensive legislative hearings.

Throughout the debate on A.B. 520, members of the Legislature were presented with varying data regarding malpractice claims in Nevada. Members of the standing subcommittees in which the bill was heard expressed their frustration with the apparent lack of hard data and solid numbers on which they could rely in making policy decisions. The result was a call for an independent review of all open and closed claims for medical malpractice in Nevada to produce reliable information that could serve as a basis for future discussions.

After considerable deliberation, the Legislature approved a modified version of Assembly Bill 520.[29] As enacted, the bill provides that licensed physicians who render emergency obstetrical care to pregnant women during labor are not liable in a civil action if the care is not grossly negligent and is rendered in good faith; the person has not previously provided such care to the woman; and the damages are associated with a lack of prenatal care. Hospitals are extended similar immunity if the care of the physician does not amount to gross negligence. Immunity is also extended to retired or part-time physicians who gratuitously render medical care to indigent persons, unless the care amounts to gross negligence.

The bill also increases from 40 to 60 for each profession, the number of attorneys and doctors designated to assist the Southern Medical-Legal Malpractice Screening Panels. A complaint to the panel must include an affidavit from a medical expert, or it may be summarily dismissed. The Division of Insurance, Nevada's Department of Business and Industry, is required to keep confidential the names of members selected for the screening

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[29]Assembly Bill 520, Chapter 686, *Statutes of Nevada 1995.*

panels. This bill also requires that a person be named in the action before the screening panel in order to also be named a party in any subsequent action filed in court.

In a medical malpractice action where liability is established or admitted, A.B. 520 requires the court to hold a separate hearing to determine if any of the plaintiffs' damages have been paid from a collateral source. The court must reduce the amount of the damages by the amount of the benefit. The amount reduced must not include any amount for which there is a right of subrogation to the rights of the claimant, if the subrogation right is exercised. This measure allows the claimant to choose to have future economic damages paid in a lump sum or periodically. The bill provides the procedures for the periodic payment of damages utilizing the purchase of an annuity. After the purchase of the annuity, the claimant must release the defendant and his or her insurer from any obligation to make future periodic payments.

Finally, Sections 7 and 8 of A.B. 520 made an appropriation for the purpose of conducting an independent study of medical malpractice claims in Nevada over the last ten years. The bill required the Interim Finance Committee to select an independent organization to conduct the study. The organization was granted the same authority to conduct examinations of insurers under the same authority as that provided for the Commissioner of Insurance. The bill also outlined the parameters of the study and required identifying data to remain confidential except for nonidentifying aggregate data.

II. SUBCOMMITTEE ACTIVITIES

As was mentioned previously, Sections 7 and 8 of A.B. 520 of the 68th Session of the Nevada Legislature directed the Interim Finance Committee to contract with an independent organization to conduct a study of claims for medical malpractice filed in Nevada. Accordingly, the subcommittee, after reviewing proposals from several organizations, contracted with the actuarial firm of Milliman & Robertson, Inc., to carry out the study.

Assembly Bill 520 also directed the Legislative Commission to appoint a legislative oversight subcommittee to supervise the conduct of the study. The commission designated the following members of the Legislature to serve on the oversight subcommittee:

Assemblyman Jack D. Close, Sr., Chairman
Senator Mark A. James
Senator Raymond D. Rawson
Assemblywoman Barbara E. Buckley

The subcommittee held its first meeting on Tuesday, November 21, 1995. At that meeting, Robert J. Finger, the leader of the project team appointed by Milliman & Robertson, Inc., presented the subcommittee with a plan and timetable for the study. The subcommittee also provided Mr. Finger with detailed instructions. Over the next five months, the project team visited the offices of the malpractice insurers, examined each claim file, collected information regarding each claim, and prepared a preliminary analysis of the data. Mr. Finger provided regular written reports to the members of the subcommittee, describing the progress of the study.

On May 10, 1996, the subcommittee again convened to review the data and analysis provided by Milliman & Robertson, Inc. At that meeting, the subcommittee directed the contractor to prepare additional analyses on certain aspects of the data and to prepare a preliminary report. On July 12, 1996, the subcommittee reviewed the preliminary report in detail and provided Milliman & Robertson, Inc., with directions for the preparation of the final report.

At the time the subcommittee was appointed, the Legislative Commission also authorized it to enter into a contract with a second independent organization, if it saw fit, to review the initial study and provide a second opinion regarding its conclusions. At a meeting held on July 25, 1996, the subcommittee reviewed proposals submitted by several firms for the completion of the second independent review and chose to enter into a contract with AIS Risk Consultants, Inc., to prepare a second analysis.

On August 6, 1996, the subcommittee met with Mr. Robert J. Finger of Milliman & Robertson, Inc., to provide him with final instructions for preparation of the report. Mr. Alan I. Schwartz of AIS Risk Consultants, Inc., also attended that meeting to receive the subcommittee's directions for the topics to be covered by his study and to review his proposed timetable for its completion.

On October 23, 1996, the subcommittee again met with Mr. Schwartz to review a preliminary draft of the report from AIS Risk Consultants, Inc., and provide him with further instructions. On December 2, 1996, the subcommittee held its final meeting to review the report from AIS Risk Consultants, Inc., to discuss differences between the findings of the two consultants, and to adopt recommendations based upon testimony that had been received at previous meetings. The reports of both consulting firms are discussed in the following sections.

III. THE STUDY BY MILLIMAN & ROBERTSON, INC.

In accordance with the provisions of Assembly Bill 520, Milliman & Robertson, Inc., visited the offices of the six major malpractice insurers and physically examined about 4,400 claims files. The firm collected the following items of data for each claim:

- The cause of loss;
- A description of the injury;
- The sex of the injured person;
- The names and numbers of the defendants;
- The provisions of the insurance coverage;
- The amount of case reserves;
- The disposition of the claim;
- The amounts of money awarded through settlement or verdict;
- The amounts of money paid to each claimant and the source of the payment; and
- The cost of allocated loss adjustment expenses.

In addition, the firm also collected information regarding insured exposures, other claim details, premiums, and rate filings. Although the study originally required that data be collected for a period of ten years, Milliman & Robertson, Inc., collected data for a period of 13 years (from January 1, 1985, through December 31, 1995) to allow for an analysis of the effectiveness of medical legal screening panels.

An executive summary of the study, including its major findings, is found in Appendix A. The full report, entitled *Medical Malpractice Claims Study* (August 23, 1996), is available in the Legislative Counsel Bureau's Research Library.

IV. THE STUDY BY AIS RISK CONSULTANTS, INC.

As was mentioned earlier, the Legislative Commission authorized the subcommittee to contract with a second consultant to produce a second independent analysis of the data regarding malpractice claims. The firm chosen, AIS Risk Consultants, Inc., did not physically examine the claim files. Instead, it relied on the information previously collected by Milliman & Robertson, Inc., for its analysis. An executive summary of this study may be found in Appendix B. The complete report, entitled *Analysis of Nevada Medical Malpractice Experience* (November 1, 1996), is available in the Legislative Counsel Bureau's Research Library.

Although the findings of the two consultants are broadly consistent, they differ significantly in their estimates of the profitability of malpractice insurers in Nevada. Appendix C contains two memorandums in which the consultants explain the reasons for their differences.

V. RECOMMENDATIONS OF THE SUBCOMMITTEE

Although the main focus of the subcommittee was the collection and analysis of data regarding malpractice claims, it received testimony indicating a need for legislative action in a number of areas. As a result, it adopted the three recommendations, an explanation of which is provided in this section.

1. **Require the Commissioner of Insurance to collect information regarding closed claims for medical malpractice and maintain a data base including the items of information specified in Section 7 of Assembly Bill 520 of the 1995 Legislative Session. (BDR 57-933)**

The data base assembled by Milliman & Robertson, Inc., at the direction of the subcommittee represents an invaluable resource for future discussions of medical malpractice in Nevada. However, if this data base is to retain its value, it must be constantly brought up to date. As claims are settled, the information must be added to the base so that it can be included in any future analyses that the Legislature may choose to request. For this reason, the subcommittee recommends that the Commissioner of Insurance be entrusted with the responsibility for maintaining this information.

2. **Require that, in any action for medical malpractice in which the claim is $75,000 or less, the parties must submit the dispute to mediation before it is heard before the medical-legal screening panel. Require that both parties participate in good faith. (BDR 3-932)**

Testimony presented to the subcommittee indicated that claims for medical malpractice are expensive and difficult to pursue. Many attorneys are reluctant to undertake the prosecution of small claims, leaving some claimants without legal recourse. For this reason, the subcommittee recommends that the Legislature establish an expeditious, fair, and inexpensive means for resolving small claims through mandatory mediation.

3. **Amend NRS 41A.059 ("Conference for settlement of claim: Attendance; powers and duties of judge; effect of failure to settle.") to require that both parties to an action for medical malpractice and a witness designated by the plaintiff who will testify regarding damages be deposed before the mandatory settlement conference is held. (BDR 3-934)**

The mandatory settlement conference provided for in NRS 41A.059 is intended to stimulate a quick resolution of malpractice cases. Unfortunately, according to testimony presented to the subcommittee, it is rarely successful, largely because the parties lack the necessary information that might serve as the basis for a settlement. Consequently, the subcommittee recommends that this conference be postponed until some of the witnesses have been deposed.

VI. APPENDICES

APPENDIX A

Executive Summary of the *Medical Malpractice Claims Study*
(August 23, 1996)

ANALYSIS OF NEVADA MEDICAL MALPRACTICE EXPERIENCE

1. Introduction

A. Background

AIS Risk Consultants (AIS) was retained by the Nevada Legislative Counsel Bureau (LCB) to perform an analysis of Nevada medical malpractice experience. This analysis was prepared in connection with the provisions of A.B. 520 (1995). The initial study authorized by A.B. 520 was prepared for the LCB by Milliman & Robertson (M&R). Our report is intended to supplement the M&R study.

Our study was based upon data and information for three insurance companies doing business in Nevada for physicians' medical malpractice insurance. These companies are: (i) The Doctors Company [TDC], (ii) Medical Insurance Exchange of California [MIEC] and (iii) NML Insurance Company [NML].

B. Summary of Results

A summary of the results of our study of Nevada medical malpractice insurance are as follows:

> Nevada medical malpractice insurance has been fairly profitable during the ten year period from 1985 to 1994. However, the results have been highly variable between individual years. The after-tax return on net worth has averaged 21.5%, ranging from a high of 83.6% to a low of -11.0% (Schedule AIS-1, Sheets 1 and 2).

> The largest sources of outgo for Nevada medical malpractice are losses and loss adjustment expenses. The largest source of income is premium, although investment income is also a very large source of revenue. (Schedule AIS-1, Sheet 3).

> For the three companies under review in this analysis, Nevada physicians' medical malpractice has been moderately profitable on an overall basis, although there are significant differences between companies (Schedule AIS-2).

> The incurred loss ratio for Nevada physicians' medical malpractice has been about 62% from 1983 to 1995, which is consistent with insurance companies earning a profit. The loss ratio was high in the early 1980's (1983 - 1984), low in the middle 1980's to early 1990's (1985 - 1992), high in the two years after that (1993 - 1994) and then dropped significantly during the last year for which data are available (1995). (Schedule AIS-3).

> Loss adjustment expenses (LAE) constitute a significant cost for insurance companies. In total, LAE is about 55% of losses. This figure is consistent with countrywide experience for medical malpractice insurance. The majority of LAE is allocated loss adjustment expenses (ALAE), with a smaller portion being unallocated loss adjustment expenses (ULAE). ALAE and ULAE are about 43% and 12% of losses, respectively. (Schedule AIS-4).

> Administrative / overhead expenses of insurance companies consist of: (i) commissions & brokerage, (ii) other acquisition expenses, (iii) general expenses, and (iv) premiums taxes, licenses and fees. In total, these expenses are about 18% of premium. This is fairly close to the countrywide cost for these expenses for medical malpractice insurance. (Schedule AIS-5).

> The investment yield on reserves has been somewhat over 7%. The yield was in excess of 8% for TDC and MIEC, but only about 4% for NML. (Schedule AIS-6).

> Total reserves (loss, LAE and unearned premium) constitute about 280% of premium. When combined with the 7% investment yield, the investment gain on reserves is about 20% of premium. (Schedule AIS-7).

> Based upon the various sources of income and outgo for an insurance company, a break-even loss ratio for Nevada physicians' medical malpractice insurance would be about 66% of premium. On a loss plus ALAE ratio basis, the break-even value is about 94% of premium. These break-even values are on an operating return basis as opposed to a total return basis (i.e., they do not reflect investment gains on surplus).

> Rate levels for physicians' medical malpractice insurance generally increased during the middle 1980's, decreased during the late 1980's to early 1990's and then increased thereafter. (Schedules AIS-8 and AIS-9)

> The average rate level increase for physicians' medical malpractice during the period from 1986 to the present has been about 5% per year. However, the rate increases have been much higher during the last few years. From 1993 to the present, the average rate level has increased by about 41%. (Schedules AIS-8 and AIS-9).

> The average annual physicians' medical malpractice

rate increase of about 5% has been higher than general levels of inflation as measured by the CPI-U and average hourly wages (about 3% to 4% per year), but lower than levels of inflation as measured by the physicians' services CPI and medical care CPI (about 7% per year). (Schedule AIS-10)

> Rate changes for physicians' medical malpractice appear to be highly correlated with the loss experience during the prior several years. A high experience loss ratio corresponds to ensuing rate increases and a low experience loss ratio corresponds to ensuing rate decreases. (Schedule AIS-11)

> The amount of total financial loss reserves (case plus IBNR) in relation to various measures of exposure to loss has fluctuated between years. There has been a long-term erratic downward trend in these total financial reserve ratios. (Schedule AIS-12)

> The split of total financial reserves into case reserves and IBNR reserves has stayed relatively level over time for MIEC and NML. However, for TDC, case reserves in relation to total reserves has been increasing significantly during the last few years. (Schedule AIS-13)

> On a countrywide basis, the financial level reserves have tended to be excessive for TDC and MIEC, but inadequate for NML. (Schedule AIS-14)

> The case loss reserves for Nevada physicians' medical malpractice are low during the first two development maturity years of a report year, approximately adequate in the year thereafter, and then becomes excessive for several years before becoming approximately adequate again. (Schedule AIS-15, Sheets 1 and 2).

> The case ALAE reserves for Nevada physicians' medical malpractice are very low during the first two development maturity years of a report year, moderately low during the next several years, and then becomes close to adequate thereafter. (Schedule AIS-15, Sheets 3 and 4).

> Both case reserves and financial level total reserves, by themselves, do not determine the amount of reserves included in a rate level analysis. The final value of the reserves used to calculate a rate level indication depends upon the specific actuarial reserve methods used in that filing, and can be unique to each such rate filing.

> The payment pattern of loss and ALAE for Nevada physicians' medical malpractice is fairly drawn out. It takes about three to four years for 50% of costs to be paid, about five years for 80% of costs to be paid, and about six to seven years for 90% of costs to be paid. (Schedule AIS-15, Sheets 5 to 8).

> The average paid claim cost has been increasing at about 15% per year from 1984 to 1995. (Schedule AIS-16)

> The average open claim cost has been increasing at about 11% per year from 1984 to 1995. (Schedule AIS-17)

> Losses have been increasing faster than premiums (adjusted to a common rate level) at about 8% to 12% per year. (Schedule AIS-18)

> The majority of costs (about 60%) for medical malpractice have arisen from four types of injury descriptions. These injuries types appear to be of a serious nature. (Schedule AIS-19).

> The amount of ALAE tends to increase as the indemnity dollar amount associated with the injury description increases. (Schedules AIS-20 and AIS-21).

> For claims coded with a cause of loss description, three categories constitute the majority (over 80%) of costs. (Schedule AIS-22).

> The amount of ALAE tends to increase as the indemnity dollar amount associated with the cause of loss description increases. (Schedules AIS-23 and AIS-24).

> The majority of costs (about 90%) arise from claims with an indemnity payment. (Schedule AIS-25 and AIS-26).

> Claims closed with an indemnity payment have a smaller percentage of disposition associated with courts, than do claims without an indemnity payment. (Schedule AIS-27).

> Claims with an indemnity payment have a larger percentage associated with injury findings from the screening panel, than do claims closed without an indemnity payment. (Schedule AIS-27)

> The majority of costs, on both a paid and incurred basis, arise from claims with a large indemnity

amount. These large claims, although a majority of the dollars of costs, are only a small percentage of the total number of claims. (Schedules AIS-28, AIS-29, AIS-30 and AIS-31).

C. Limitations

In our analysis we relied upon data and information collected and supplied by M&R. AIS did not take part in determining what data to collect, or in the actual data collection process. In addition, AIS did not check or verify the accuracy of the data supplied.

Medical malpractice is an inherently variable line of insurance. For this study, the variability of the data was greater than normal since the medical malpractice experience in Nevada is of limited size, and furthermore, only a subset of the entire experience was used.

This report was prepared for the LCB in connection with its specific needs and the provisions of A.B. 520. For this reason, other entities should not rely upon this study. Any party should have an actuary or similarly qualified person review this report before using it in any manner.

APPENDIX B

Executive Summary of study conducted by Milliman & Robertson, Inc., entitled *Analysis of Nevada Medical Malpractice Experience* (November 1, 1996)

EXECUTIVE SUMMARY

This study was conducted in accordance with A.B. 520 (1995). One purpose of the study was to collect individual claim data on all medical malpractice claims against doctors reported during the 13 years, 1983 through 1995. Other purposes included an analysis of premiums, frequency, severity, and various claim characteristics. Finally, the study gathered and analyzed data on the Medical Legal Screening Panel ("MLSP"), which was implemented in 1986. This study dealt primarily with three insurers that insured upwards of 80% of the doctors in the State of Nevada during the 13 years.

Medical malpractice cost projections involve considerable uncertainty. To place the findings in a proper perspective, the reader should review the "Caveats" and "Methodology" sections of the report, as well as various comments throughout the report.

Among the major findings of the study are the following:

- A relatively few claims (under 100 per year) account for the vast majority of the costs (indemnity and allocated loss adjustment expense);
- There has been substantial volatility in costs from year-to-year, due to the low number and high variability of individual claims;
- The trend in claim frequency (claims per doctor) may be a 1% to 2% increase, per year;
- The trend in the average cost per claim may be a 8% to 9% increase, per year;
- The trend in the cost per doctor may be about a 10% increase, per year;
- Each of the above trends arguably could be 2% higher or lower;
- The break-even loss ratio for insurers lies within a range of about 85% to 95% (varying with interest rates and company expenses);
- A profitable loss ratio for insurers lies within a range of about 80% to 90%;
- The three insurers, combined, appear to have been profitable from 1986 through 1990 and unprofitable since 1991 (subject to the considerable uncertainty that still remains for 1994 and 1995); and
- The MLSP seems to have had a major impact on costs, reducing the number of claims, the number of less meritorious claims, and the percentage of claims closed with indemnity payments (although other factors may also account for some of the differences in costs between the 1983-1985 period and the 1986-1990 period).

APPENDIX C

Two memorandums in which the consultants explain their reasons for differences in estimates of profitability of malpractice insurers in Nevada

Memorandum

DATE: November 6, 1996

TO: Allan Schwartz

FROM: Bob Finger

RE: ***Return on Equity Calculation- Nevada Doctors Medical Malpractice***

CC: Chuck Knaus

With one exception, it would appear that our conclusions are similar. The exception is return on equity, for which I did not do a specific calculation. However, I can apply a set of assumptions to my conclusions and derive some return on equity numbers. The assumptions that I have used are quite similar to your conclusions. I derive a return on equity that is far lower than your number. Perhaps you would like to ponder how the result can be so different, when the inputs are relatively similar.

My calculation is shown on the attached exhibit. (As an aside, my earned premium numbers are about $8 million higher than the earned premiums shown in your report. I don't know why they should be different or how my number can be higher).

I used your earned premium numbers. I assumed administrative expenses were 18% of earned premiums (your number). I used my projections of ultimate pure loss and ALAE. I assumed that ULAE was 8.5% of combined pure loss and ALAE. I discounted loss and total ALAE by 0.79, which is reasonably comparable to your approach. My projected profits are about $4 million for the 1985-1994 period, over which earned premiums were about $181 million. At 1:1 premium to surplus, this is about a 2% ROE; if the actual earned premiums were $8 million higher, this would be about a 6-7% ROE. Obviously, the numbers could be presented in a somewhat different matter, but the result is no where near a 20% ROE. My pure loss ratio is about 68%, my ALAE ratio about 25%, and my combined loss and total LAE ratio is about 101%; all of these are in line with your break-even analysis on Page 12 of your report (i.e., 66%, 28%, 102%, respectively). (My investment income is 21.2% of earned premiums, compared to your 20%).

There are a couple of obvious differences. The ROE's from the NAIC Profitability report include hospitals and, to some extent, other physician coverage. Applying the loss ratios shown on your AIS-1 exhibit to the 3-company earned premiums yields about a 61% pure loss ratio over the 85-94 period, as opposed to the 57% loss ratio for Nevada medical malpractice. This difference should reduce the ROE by at least 4%. (Considering ALAE and ULAE, the total reduction may be about 6%).

In addition, the NAIC Profitability report uses reported (calendar year) losses, as opposed to accident year/report year losses. My projections are very close to actual for most of the years 1990 and prior. Overall, I would expect my projections to be far more accurate than calendar year reported losses. My pure loss projections are about $12 million higher than the 3-company calendar year reported losses, for years 1985-1994. With ALAE and ULAE, the more accurate numbers might be $25 million higher than the NAIC Profitability report, or an additional 14% of premiums.

In summary, I believe that your 20% ROE conclusion is substantially misleading. The actual calendar year loss ratio (including LAE) for the 3 companies appears to have been up to 6% higher than the NAIC profitability report. The actual settled loss ratio, for the 3 companies, appears to be substantially higher (perhaps 14%) than the calendar year reported losses. The actual profitability for these three companies over the given time period would appear to be much closer to a break-even than the 20% of your report.

I know that the Legislature was motivated to get real data and use hard, verifiable numbers (to the extent this is possible). The Legislature did not want insurance companies to be able to mislead them with "funny" numbers, like reserves. Because of this, I believe that the Legislature will be more receptive to actual costs, as opposed to historical insurance company estimates. Thus, I think ROE's based on actual costs (to the extent available) will be more meaningful to the Legislature.

If you have any comments or questions, please let me know.

Return on Equity Calculation

3 Companies Combined

All $ in Millions

Year	EdPrem AIS-3	Admin 18.0%	PureLoss	ALAE	+ULAE 8.5%	DiscLs 0.79	Profit	M&R Prm	Diff NetvGrs? No Non-Phys? No
83	5.478	0.986	4.039	2.199	6.768	5.347	-0.855		
84	7.145	1.286	5.247	2.578	8.490	6.707	-0.848		
85	8.896	1.601	8.724	3.406	13.161	10.397	-3.103	9.9	1.004
86	11.298	2.034	6.750	2.974	10.551	8.335	0.930	12.343	1.045
87	13.865	2.496	5.831	2.439	8.973	7.089	4.280	14.523	0.658
88	17.680	3.182	9.837	3.597	14.576	11.515	2.983	18.872	1.192
89	20.283	3.651	5.540	2.995	9.260	7.316	9.316	20.511	0.228
90	19.393	3.491	10.533	3.946	15.710	12.411	3.492	19.998	0.605
91	18.516	3.333	19.499	7.044	28.799	22.751	-7.568	20.265	1.749
92	20.461	3.683	18.939	5.523	26.541	20.968	-4.190	22.009	1.548
93	23.639	4.255	16.665	6.381	25.005	19.754	-0.370	23.817	0.178
94	27.222	4.900	20.769	6.961	30.087	23.769	-1.447	27.044	-0.178
95	29.551	5.319	20.800	7.814	31.046	24.526	-0.295	29.673	0.122
Total	223.427	40.217	153.173	57.857	228.968	180.884	2.326		8.151
85-94	181.253	32.626	123.087	45.266	182.663	144.304	4.324		8.029
LsRatio			67.9%	25.0%	100.8%				

Year	3 Cos EdPrem AIS-3	3 Cos IncLoss AIS-3	3 Cos LossRatio	NevMedMal LossRatio AIS-1	IncLoss atLsRat
83	5.478	5.641			
84	7.145	6.423			
85	8.896	5.643	63.4%	93.6%	8.327
86	11.298	6.643	58.8%	69.2%	7.818
87	13.865	6.462	46.6%	80.6%	11.175
88	17.680	2.201	12.4%	-7.2%	-1.273
89	20.283	9.101	44.9%	35.2%	7.140
90	19.393	10.586	54.6%	40.4%	7.835
91	18.516	11.953	64.6%	52.0%	9.628
92	20.461	11.815	57.7%	37.6%	7.693
93	23.639	23.159	98.0%	97.7%	23.095
94	27.222	23.721	87.1%	83.8%	22.812
95	29.551	15.858			
Total	223.427	139.206			
85-94	181.253	111.284			104.250
LsRatio		61.4%			57.5%

AIS RISK CONSULTANTS, INC.

Consulting Actuaries • Insurance Advisors

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December 2, 1996

Ms. Risa Berger
State of Nevada
Legislative Counsel Bureau
Legal Division
401 S. Carson Street
Carson City, Nevada 89710

Re: Profitability of Nevada Medical Malpractice

Dear Ms. Berger:

As we previously discussed, I am writing to provide my comments regarding the November 6, 1996 memorandum from Mr. Finger regarding the above captioned subject.

Although it may not appear to the case, the conclusions reached by Mr. Finger and myself regarding profitability are not that different. This is explained below.

Mr. Finger derives a return on equity (ROE) in the range of 2% to 7% (the values derived by Mr. Finger are not a total ROE, but only reflect operating profit). This is actually very close to the 3% to 6% range set forth in Schedule AIS-2, Sheet 1 of my November 1, 1996 report. However, neither of those sets of values derived by Mr. Finger or myself includes consideration of investment income on the insurance company's surplus. As explained in our report (page 14) in order to obtain a total return on equity, including consideration of all investment income, the preceding figures should be increased by about 6%. Hence, the range of 3% to 6% excluding consideration of investment income on surplus would translate roughly into a range of 9% to 12% including consideration of all investment income.

This range for the three companies combined of 9% to 12% is still below the value of 21% shown in Schedule AIS-1, Sheet 1. As both Mr. Finger and I acknowledge, this is because the 21% value is based upon all medical malpractice in Nevada, and is not limited to just the three companies. Hence, the 21% figure would include the physicians' medical malpractice experience of other insurers, as well as other types of medical malpractice (e.g., hospitals, nurses, etc.). We believe it is reasonable to consider the profitability experience of all medical malpractice in Nevada, as well as the experience limited to just the three companies. The committee just needs to understand the differences between those figures in reaching any conclusions.

Please feel free to contact me if there is anything you would care to discuss.

Sincerely,

Allan I. Schwartz
FCAS, ASA, MAAA, FCA
President

cc: Robert Finger, Milliman and Robertson

APPENDIX D

Suggested Legislation

SUMMARY—Requires commissioner of insurance to collect and maintain certain information regarding closed claims for medical malpractice. (BDR 57-933)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to claims for medical malpractice; requiring the commissioner of insurance to collect and maintain certain information regarding closed claims for 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 679B of NRS is hereby amended by adding thereto a new section to read as follows:

1. The commissioner shall collect and maintain information regarding each closed claim for medical malpractice filed against physicians and surgeons in this state, including, without limitation:

(a) The cause of the loss;

(b) A description of the injury for which the claim was filed;

(c) The sex of the injured person;

(d) The names and number of defendants in each claim;

(e) The names and provisions of coverage of each insurer involved in the claim;

(f) The amount of reserves of an insurer before and after each such claim and the general allocation of the reserves and surplus of the insurer;

(g) The disposition of each claim;

(h) The amount of money awarded through settlement or by verdict;

(i) The sum of money paid to each claimant and the source of that sum; and

(j) Any sum of money allocated to expenses for the adjustment of losses.

2. The commissioner shall adopt regulations necessary to carry out the provisions of this section.

SUMMARY—Requires certain actions for medical or dental malpractice to be submitted to mediation before they are submitted to screening panel. (BDR 3-932)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to actions for malpractice; requiring certain actions for medical or dental malpractice to be submitted to mediation before they are submitted to a screening panel; 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 41A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *1. Each action for medical or dental malpractice for which the claim for damages is $75,000 or less must be submitted to mediation before it may be submitted to a screening panel pursuant to NRS 41A.039.*

2. The claimant and the person against whom the complaint is being made shall select a mediator by agreement. If the parties cannot agree upon a mediator within 45 days after

the claimant first selects a mediator, either party may petition the American Arbitration Association, the Nevada Arbitration Association, the Nevada Dispute Resolution Services or another organization that provides services of mediation and is acceptable to the parties for the appointment of a mediator. The mediator may discover only those documents or records that are necessary to conduct the mediation. The mediator shall convene the mediation within 60 days after the matter is submitted to him, unless the parties agree to extend the time.

3. The person against whom the complaint is being made shall deposit with the mediator before the mediation begins an amount estimated by the mediator as necessary to pay for the salary and expenses of the mediator. The person against whom the complaint is made shall deposit additional amounts demanded by the mediator as necessary to pay for the salary and expenses of the mediator. The total fees for each day of mediation, including, without limitation, the salary and expenses of the mediator, must not exceed $750 per day.

Sec. 3. *1. If, after undergoing mediation pursuant to section 2 of this act, the parties do not reach an agreement concerning the claim of medical or dental malpractice, the claimant may present his claim to a screening panel. Except as otherwise provided in subsection 2, if such an action is subsequently filed in a district court, the person who prevails may recover the reasonable costs and fees of the mediation as costs of the action.*

2. If the mediator determines that a party has not participated in good faith in the mediation, that party shall be responsible for all costs and fees of the mediation as determined by the mediator.

3. Upon conclusion of the mediation, if the claimant intends to submit the complaint to an appropriate screening panel, he shall request the mediator to prepare a document to be submitted to the screening panel which outlines the proceedings and discovery in which the mediator has participated. The document must include, without limitation, a statement regarding the belief of the mediator as to whether both parties participated in the mediation in good faith. The mediator shall prepare the document and give a copy of the document to the claimant not later than 5 days after receiving such a request from the claimant.

4. A document prepared by a mediator pursuant to subsection 3 is admissible in the cause of action, but a statement or admission made by either party in the course of mediation is not admissible.

Sec. 4. NRS 41A.039 is hereby amended to read as follows:

41A.039 1. A claim of medical or dental malpractice is properly presented to a screening panel by filing a complaint with the division. A fee of $350 must accompany the complaint. *In addition to the fee, if the claim was submitted to mediation pursuant to section 2 of this act, the document prepared by the mediator pursuant to section 3 of this act also must accompany the complaint.*

2. The complaint must contain a clear and concise statement of the facts of the case, showing the persons involved and the dates and circumstances, so far as they are known, of the alleged medical or dental malpractice. A screening panel may dismiss a complaint if the complaint is filed without an affidavit supporting the allegations of the complaint submitted by a medical expert.

3. The person against whom a complaint is made [must,] *shall,* within 30 days after receipt of the complaint, file an answer with the division, accompanied by a fee of $350.

4. The claimant may respond only to the allegations of the answer or any accompanying affidavit by filing a written response with the division within 21 days after he receives the answer. The panel shall disregard any portion of the response that does not address an allegation raised in the answer or an affidavit accompanying the answer. No fee may be charged or collected by the division for the filing of the response.

5. A copy of any pleading required by this section to be filed with the division must be delivered by the party, by certified or registered mail, to each opposing party or, if he is represented in the proceedings by counsel, to his attorney.

6. The fees provided by this section must not be charged or collected more than once:

(a) From any party; or

(b) For the filing of any complaint, regardless of the number of parties joined in the complaint.

Sec. 5. NRS 41A.039 is hereby amended to read as follows:

41A.039 1. A claim of medical malpractice is properly presented to a screening panel by filing a complaint with the division. A fee of $350 must accompany the complaint. *In addition to the fee, if the claim was submitted to mediation pursuant to section 2 of this act, the document prepared by the mediator pursuant to section 3 of this act also must accompany the complaint.*

2. The complaint must contain a clear and concise statement of the facts of the case, showing the persons involved and the dates and circumstances, so far as they are known, of the alleged medical malpractice. A screening panel may dismiss a complaint if the complaint is filed without an affidavit supporting the allegations of the complaint submitted by a medical expert.

3. The person against whom a complaint is made [must,] *shall,* within 30 days after receipt of the complaint, file an answer with the division, accompanied by a fee of $350.

4. The claimant may respond only to the allegations of the answer or any accompanying affidavit by filing a written response with the division within 21 days after he receives the answer. The panel shall disregard any portion of the response that does not address an allegation raised in the answer or an affidavit accompanying the answer. No fee may be charged or collected by the division for the filing of the response.

5. A copy of any pleading required by this section to be filed with the division must be delivered by the party, by certified or registered mail, to each opposing party or, if he is represented in the proceedings by counsel, to his attorney.

6. The fees provided by this section must not be charged or collected more than once:

(a) From any party; or

(b) For the filing of any complaint, regardless of the number of parties joined in the complaint.

Sec. 6. NRS 41A.049 is hereby amended to read as follows:

41A.049 1. A claim must be heard by the screening panel within 30 days after the panel is selected.

2. The screening panel shall consider all *of* the documentary material, including , *without limitation,* the complaint, answer and response, health care records, dental records and records of a hospital or office , *the document prepared by a mediator pursuant to section 3 of this act if the claim was required to be submitted to mediation* and the testimony of any expert witnesses the panel considers necessary, and shall determine only, from that evidence, whether there is a reasonable probability that the acts complained of constitute medical or dental malpractice and that the claimant was injured thereby. Except for the issue of whether there is a reasonable probability of medical or dental malpractice and whether the claimant was injured thereby, the screening panel shall not consider any pleading or paper to the extent that it addresses a legal issue presented by the claim or a legal argument of a party.

3. Copies of the original complaint and of the findings of the screening panel with regard to each matter considered by the panel must be forwarded to:

(a) In cases involving medical malpractice:

(1) The board of medical examiners; and

(2) The county medical society of the county in which the alleged malpractice occurred.

(b) In cases involving dental malpractice, the board of dental examiners of Nevada.

4. The commissioner of insurance shall mail to the parties a copy of the findings of the screening panel concerning the complaint.

5. The written findings must be based upon a vote of the members of the screening panel made by written ballot, must be rendered within 5 days after the review and must be in substantially the following form:

(a) Based upon a review of the materials submitted by the parties and the testimony of medical or other experts (if any were called) we find that there is a reasonable probability of medical or dental malpractice and that the claimant was injured thereby;

(b) Based upon a review of the materials submitted by the parties and the testimony of medical or other experts (if any were called) we find that there is no reasonable probability of medical or dental malpractice; or

(c) Based upon a review of the materials submitted by the parties and the testimony of medical or other experts (if any were called) we are unable to reach a decision on the issue of medical or dental malpractice.

6. Whenever four members of the screening panel are unable to find that there is a reasonable probability of medical or dental malpractice and that the claimant was injured thereby or that there is no reasonable probability of medical or dental malpractice, the screening panel shall be deemed unable to reach a decision on the issue and shall make a finding to that effect.

Sec. 7. NRS 41A.049 is hereby amended to read as follows:

41A.049 1. A claim must be heard by the screening panel within 30 days after the panel is selected.

2. The screening panel shall consider all *of* the documentary material, including , *without limitation,* the complaint, answer and response, health care records and records of a hospital or office , *the document prepared by a mediator pursuant to section 3 of this act if the claim was required to be submitted to mediation* and the testimony of any expert witnesses the panel considers necessary, and shall determine only, from that evidence, whether there is a reasonable probability that the acts complained of constitute medical malpractice and that the claimant was injured thereby. Except for the issue of whether there is a reasonable probability of medical malpractice and whether the claimant was injured thereby, the screening panel shall not consider any pleading or paper to the extent that it addresses a legal issue presented by the claim or a legal argument of a party.

3. Copies of the original complaint and of the findings of the screening panel with regard to each matter considered by the panel must be forwarded to:

(a) The board of medical examiners; and

(b) The county medical society of the county in which the alleged malpractice occurred.

4. The commissioner of insurance shall mail to the parties a copy of the findings of the screening panel concerning the complaint.

5. The written findings must be based upon a vote of the members of the screening panel made by written ballot, must be rendered within 5 days after the review and must be in substantially the following form:

(a) Based upon a review of the materials submitted by the parties and the testimony of medical experts (if any were called) we find that there is a reasonable probability of medical malpractice and that the claimant was injured thereby;

(b) Based upon a review of the materials submitted by the parties and the testimony of medical experts (if any were called) we find that there is no reasonable probability of medical malpractice; or

(c) Based upon a review of the materials submitted by the parties and the testimony of medical experts (if any were called) we are unable to reach a decision on the issue of medical malpractice.

6. Whenever four members of the screening panel are unable to find that there is a reasonable probability of medical malpractice and that the claimant was injured thereby or that there is no reasonable probability of medical malpractice, the screening panel shall be deemed unable to reach a decision on the issue and shall make a finding to that effect.

Sec. 8. NRS 41A.097 is hereby amended to read as follows:

41A.097 1. Except as otherwise provided in subsection 2, an action for injury or death against a provider of health care may not be commenced more than 4 years after the date of injury or 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first, for:

(a) Injury to or the wrongful death of a person, based upon alleged professional negligence of the provider of health care;

(b) Injury to or the wrongful death of a person from professional services rendered without consent; or

(c) Injury to or the wrongful death of a person from error or omission in practice by the provider of health care.

2. This time limitation is tolled:

(a) For any period during which the provider of health care has concealed any act, error or omission upon which the action is based and which is known or through the use of reasonable diligence should have been known to him.

(b) In any action governed by the provisions of NRS 41A.003 to 41A.069, inclusive [, from] :

(1) From the date a claimant files a complaint for mediation until 30 days after the date the mediator provides the claimant with a copy of the document prepared by the mediator pursuant to section 3 of this act.

(2) From the date a claimant files a complaint for review by a screening panel until 30 days after the date the panel notifies the claimant, in writing, of its findings.

The provisions of this paragraph apply to an action against the provider of health care and to an action against any person, government or political subdivision of a government who is alleged by the claimant to be liable vicariously for the medical or dental malpractice of the provider of health care, if the provider, person, government or political subdivision has received notice of the filing of a complaint for *mediation or for* review by a screening panel within the limitation of time provided in subsection 1.

3. For the purposes of this section, the parent, guardian or legal custodian of any minor child is responsible for exercising reasonable judgment in determining whether to prosecute any cause of action limited by subsection 1. If the parent, guardian or custodian fails to commence an action on behalf of that child within the prescribed period of limitations, the child may not bring an action based on the same alleged injury against any provider of health care upon the removal of his disability, except that in the case of:

(a) Brain damage or birth defect, the period of limitation is extended until the child attains 10 years of age.

(b) Sterility, the period of limitation is extended until 2 years after the child discovers the injury.

4. As used in this section, "provider of health care" means a physician licensed under chapter 630 or 633 of NRS, dentist, registered nurse, dispensing optician, optometrist,

registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, doctor of acupuncture, medical laboratory director or technician, or a licensed hospital as the employer of any such person.

Sec. 9. NRS 41A.097 is hereby amended to read as follows:

41A.097 1. Except as otherwise provided in subsection 2, an action for injury or death against a provider of health care may not be commenced more than 4 years after the date of injury or 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first, for:

(a) Injury to or the wrongful death of a person, based upon alleged professional negligence of the provider of health care;

(b) Injury to or the wrongful death of a person from professional services rendered without consent; or

(c) Injury to or the wrongful death of a person from error or omission in practice by the provider of health care.

2. This time limitation is tolled:

(a) For any period during which the provider of health care has concealed any act, error or omission upon which the action is based and which is known or through the use of reasonable diligence should have been known to him.

(b) In any action governed by the provisions of NRS 41A.003 to 41A.069, inclusive [, from] :

(1) From the date a claimant files a complaint for mediation until 30 days after the date the mediator provides the claimant with a copy of the document prepared by the mediator pursuant to section 3 of this act.

(2) From the date a claimant files a complaint for review by a screening panel until 30 days after the date the panel notifies the claimant, in writing, of its findings.

The provisions of this paragraph apply to an action against the provider of health care and to an action against any person, government or political subdivision of a government who is alleged by the claimant to be liable vicariously for the medical malpractice of the provider of health care, if the provider, person, government or political subdivision has received notice of the filing of a complaint for *mediation or for* review by a screening panel within the limitation of time provided in subsection 1.

3. For the purposes of this section, the parent, guardian or legal custodian of any minor child is responsible for exercising reasonable judgment in determining whether to prosecute any cause of action limited by subsection 1. If the parent, guardian or custodian fails to commence an action on behalf of that child within the prescribed period of limitations, the child may not bring an action based on the same alleged injury against any provider of health care upon the removal of his disability, except that in the case of:

(a) Brain damage or birth defect, the period of limitation is extended until the child attains 10 years of age.

(b) Sterility, the period of limitation is extended until 2 years after the child discovers the injury.

4. As used in this section, "provider of health care" means a physician licensed under chapter 630 or 633 of NRS, dentist, registered nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, doctor of acupuncture, medical laboratory director or technician, or a licensed hospital as the employer of any such person.

Sec. 10. NRS 630.364 is hereby amended to read as follows:

630.364 1. [Any] *A* person or organization who furnishes information concerning an applicant for a license or a licensee in good faith and without malicious intent in accordance with the provisions of this chapter is immune from any civil action for furnishing that information.

2. The board and any of its members and its staff, counsel, investigators, experts, committees, panels, hearing officers and consultants are immune from any civil liability for:

(a) Any decision or action taken in good faith and without malicious intent in response to information acquired by the board.

(b) Disseminating information concerning an applicant for a license or a licensee to other boards or agencies of the state, the attorney general, any hospitals, medical societies, insurers, employers, patients and their families or any law enforcement agency.

3. A screening panel or any of its members, acting pursuant to NRS 41A.003 to 41A.069, inclusive, *who* initiates or assists in any proceeding concerning a claim of malpractice against a physician is immune from any civil action for that initiation or assistance or any consequential damages, if the panel or members acted without malicious intent.

4. A mediator, acting pursuant to sections 2 and 3 of this act, who initiates or assists in any proceeding concerning a claim of malpractice against a physician is immune from any civil action for that initiation or assistance or any consequential damages, if the mediator acted without malicious intent.

Sec. 11. Section 2 of this act is hereby amended to read as follows:

Sec. 2. 1. Each action for medical [or dental] malpractice for which the claim for damages is $75,000 or less must be submitted to mediation before it may be submitted to a screening panel pursuant to NRS 41A.039.

2. The claimant and the person against whom the complaint is being made shall select a mediator by agreement. If the parties cannot agree upon a mediator within 45 days after the claimant first selects a mediator, either party may petition the American Arbitration Association, the Nevada Arbitration Association, the Nevada Dispute Resolution Services or another organization that provides services of mediation and is acceptable to the parties for the appointment of a mediator. The mediator may discover only those documents or records that are necessary to

conduct the mediation. The mediator shall convene the mediation within 60 days after the matter is submitted to him, unless the parties agree to extend the time.

3. The person against whom the complaint is being made shall deposit with the mediator before the mediation begins an amount estimated by the mediator as necessary to pay for the salary and expenses of the mediator. The person against whom the complaint is made shall deposit additional amounts demanded by the mediator as necessary to pay for the salary and expenses of the mediator. The total fees for each day of mediation, including, without limitation, the salary and expenses of the mediator, must not exceed $750 per day.

Sec. 12. Section 3 of this act is hereby amended to read as follows:

Sec. 3. 1. If, after undergoing mediation pursuant to section 2 of this act, the parties do not reach an agreement concerning the claim of medical [or dental] malpractice, the claimant may present his claim to a screening panel. Except as otherwise provided in subsection 2, if such an action is subsequently filed in a district court, the person who prevails may recover the reasonable costs and fees of the mediation as costs of the action.

2. If the mediator determines that a party has not participated in good faith in the mediation, that party shall be responsible for all costs and fees of the mediation as determined by the mediator.

3. Upon conclusion of the mediation, if the claimant intends to submit the complaint to an appropriate screening panel, he shall request the mediator to prepare a document to be submitted to the screening panel which outlines the proceedings and discovery in which the mediator has participated. The document must include, without limitation, a statement regarding the belief of the mediator as to whether both parties participated in the mediation in good faith. The mediator shall prepare the document and give a copy of the document to the claimant not later than 5 days after receiving such a request from the claimant.

4. A document prepared by a mediator pursuant to subsection 3 is admissible in the cause of action, but a statement or admission made by either party in the course of mediation is not admissible.

Sec. 13. 1. This section and section 10 of this act become effective on October 1, 1997.

2. Sections 1, 2, 3, 4, 6 and 8 of this act become effective on October 1, 1997, and expire by limitation on June 30, 1999.

3. Sections 5, 7, 9, 11 and 12 of this act become effective on July 1, 1999.

SUMMARY—Requires deposition of certain persons before holding mandatory conference for settlement in medical and dental malpractice claims. (BDR 3-934)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to actions for malpractice; requiring the deposition of certain persons before holding the conference for settlement required in medical and dental malpractice claims; 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 41A.059 is hereby amended to read as follows:

41A.059 1. In any action for medical or dental malpractice filed in a district court after a determination by a screening panel that there is a reasonable probability that medical or dental malpractice occurred and that the plaintiff was injured thereby, the plaintiff, the defendant, the representative of the physician's or dentist's insurer and, if applicable, the hospital's insurer and their respective attorneys shall attend a conference for settlement before a district judge, other than the judge assigned to the case, to determine the amount of the plaintiff's damages. The judge before whom the conference is held:

(a) Must be selected randomly by the clerk of the court upon filing of the notice pursuant to subsection 2, except that he may not be the judge assigned to the case.

(b) May, for good cause shown, waive the attendance of any party.

(c) Shall decide what information the parties may submit at the conference.

2. In any such action, the responsive pleading of the defendant must be accompanied by a notice to the clerk that the case must be scheduled for a conference for settlement. If this notice is not filed by the defendant, it may be filed by any other party. The clerk shall immediately notify the judge before whom the conference is to be held of the receipt of that notice.

3. The judge shall notify the parties, within 7 days after the receipt of the notice, of the time and place of the conference, which must not be later than 30 days after the receipt of the notice. *The judge shall cause the deposition of:*

(a) The plaintiff;

(b) The defendant; and

(c) A person designated by the plaintiff to testify regarding damages,

to be taken in the manner prescribed by rule of court for taking a deposition in a civil action in a district court before the date scheduled for the conference.

4. The judge before whom the conference is to be held may, for good cause shown, continue the conference for a period not to exceed 15 days. Only one such continuance may be granted.

[3.] *5.* Within 15 days after the conference, the judge before whom the conference was held shall determine, solely from the information submitted at the conference, the reasonable value of the claim for purposes of settlement and shall so notify the parties in writing.

[4.] *6.* Within 14 days after receipt of the determination of the judge, the defendant shall offer to the plaintiff the amount determined by the judge or reject the determination. If the defendant rejects the determination and the plaintiff is awarded an amount greater than the amount of the determination, the plaintiff must be awarded reasonable costs and attorney's fees incurred after the date of the rejection.

[5.] *7.* Within 14 days after the receipt of the defendant's offer of the amount determined by the judge, the plaintiff shall accept or reject the offer. If the plaintiff rejects the offer and the plaintiff is awarded an amount less than the amount of the offer, the defendant must be awarded reasonable costs and attorney's fees incurred after the date of the rejection.

Sec. 2. NRS 41A.059 is hereby amended to read as follows:

41A.059 1. In any action for medical malpractice filed in a district court after a determination by a screening panel that there is a reasonable probability that medical malpractice occurred and that the plaintiff was injured thereby, the plaintiff, the defendant, the representative of the physician's insurer and, if applicable, the hospital's insurer and their respective attorneys shall attend a conference for settlement before a district judge,

other than the judge assigned to the case, to determine the amount of the plaintiff's damages. The judge before whom the conference is held:

(a) Must be selected randomly by the clerk of the court upon filing of the notice pursuant to subsection 2, except that he may not be the judge assigned to the case.

(b) May, for good cause shown, waive the attendance of any party.

(c) Shall decide what information the parties may submit at the conference.

2. In any such action, the responsive pleading of the defendant must be accompanied by a notice to the clerk that the case must be scheduled for a conference for settlement. If this notice is not filed by the defendant, it may be filed by any other party. The clerk shall immediately notify the judge before whom the conference is to be held of the receipt of that notice.

3. The judge shall notify the parties, within 7 days after the receipt of the notice, of the time and place of the conference, which must not be later than 30 days after the receipt of the notice. *The judge shall cause the deposition of:*

(a) The plaintiff;

(b) The defendant; and

(c) A person designated by the plaintiff to testify regarding damages,

to be taken in the manner prescribed by rule of court for taking a deposition in a civil action in a district court before the date scheduled for the conference.

4. The judge before whom the conference is to be held may, for good cause shown, continue the conference for a period not to exceed 15 days. Only one such continuance may be granted.

[3.] *5.* Within 15 days after the conference, the judge before whom the conference was held shall determine, solely from the information submitted at the conference, the reasonable value of the claim for purposes of settlement and shall so notify the parties in writing.

[4.] *6.* Within 14 days after receipt of the determination of the judge, the defendant shall offer to the plaintiff the amount determined by the judge or reject the determination. If the defendant rejects the determination and the plaintiff is awarded an amount greater than the amount of the determination, the plaintiff must be awarded reasonable costs and attorney's fees incurred after the date of the rejection.

[5.] *7.* Within 14 days after the receipt of the defendant's offer of the amount determined by the judge, the plaintiff shall accept or reject the offer. If the plaintiff rejects the offer and the plaintiff is awarded an amount less than the amount of the offer, the defendant must be awarded reasonable costs and attorney's fees incurred after the date of the rejection.

Sec. 3. 1. Section 1 of this act becomes effective on October 1, 1997, and expires by limitation on June 30, 1999.

2. Section 2 of this act becomes effective on July 1, 1999.