Legislative Subcommittee to Study Medical Malpractice

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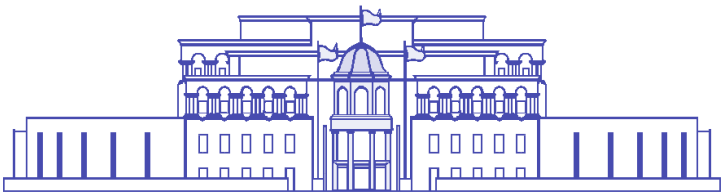

LEGISLATIVE SUBCOMMITTEE TO STUDY MEDICAL MALPRACTICE

BULLETIN NO. 03-9

JANUARY 2003

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REPORT TO THE 72ND SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE SUBCOMMITTEE TO STUDY MEDICAL MALPRACTICE

I. INTRODUCTION

In 2002, Nevada experienced a crisis involving both the cost and availability of medical malpractice coverage for its physicians. Because of the skyrocketing premiums, physicians considered closing their practices or severely limiting the services they could provide, and the State's only Level I Trauma Center in Southern Nevada closed for a short period in July 2002. The ability of Nevadans to access health care was at risk, particularly in Southern Nevada.

This report summarizes the work of the Legislative Subcommittee to Study Medical Malpractice and includes an overview of the legislation enacted during the Eighteenth Special Session. Also provided in the report is a list of additional resources concerning Nevada's medical malpractice crisis, including the data and analysis generated through the work of the Subcommittee.

A. CREATION OF AN INTERIM STUDY

The 2002 crisis involving the affordability and availability of medical malpractice coverage developed when the Nevada Legislature was not in session. Constitutionally, the Nevada Legislature meets once every two years, and only the Governor is authorized to call a Special Session. Due to the urgency of the situation and the threatened shortage of health care providers, the Legislative Committee on Health Care and the Nevada Legislative Commission acted jointly in March and April 2002 to create the Subcommittee to Study Medical Malpractice to determine the steps necessary to address the crisis and report its findings to the 2003 Session.

The following six legislators (three Senators and three Assembly members) were appointed to the Subcommittee:

Assemblywoman Barbara E. Buckley, Chairwoman
Senator Mark E. Amodei (Appointed in May 2002 to replace Senator James)
Senator Mark A. James (Until May 2002)
Senator Dina Titus
Senator Randolph J. Townsend
Assemblyman Bernie Anderson
Assemblyman Lynn C. Hettrick

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B. OVERVIEW OF COMMITTEE PROCEEDINGS

The Subcommittee received extensive testimony regarding the impact of rising medical malpractice premiums, possible causes for the increases, and recommended solutions. Between March and July 2002, the Subcommittee held three lengthy meetings. All of the meetings were held in Las Vegas with simultaneous videoconferencing between meeting rooms at the Grant Sawyer State Office Building in Las Vegas and the Legislative Building in Carson City.

For more detailed information, please consult the minutes and exhibits from the meetings, which are available from the LCB's Research Library. The minutes (without exhibits) and a copy of this report are electronically available on the Legislature's Internet Web Site at www.leg.state.nv.us.

Meeting on March 21, 2002 – Status and Impact of the Crisis

During its first meeting, the Subcommittee focused on the status and impact of the medical malpractice crisis nationally and in Nevada. Following is an overview of the topics discussed.

- **National Perspective on the Medical Malpractice Crisis** – A national perspective of the concerns involving medical malpractice insurance coverage and efforts by other states to address the problem presented by the National Conference of State Legislatures (NCSL). Also discussed were the primary areas of reform targeted in other jurisdictions and possible methods of addressing the rising medical malpractice premiums;

- **Nevada History** – A chronology of Nevada legislative actions since 1975 to address past increases in medical malpractice premiums;

- **Creation of a Joint Underwriting Association** – An update on the recently established joint underwriting association (The Medical Liability Association of Nevada or "MLAN");

- **Medical Community Perspectives on the Causes and Impact of the Crisis** – A presentation on the medical malpractice crisis from the perspective of the medical community. Speakers included representatives of the Nevada State Medical Association, the Clark County Medical Society, the Clark County Obstetrics and Gynecology Society, the West-Crear Medical Society, the Nevada Hospital Association, Nevada Concerned Physicians, and the Nevada Osteopathic Medical Association. The physicians also presented historical information on the current increases in premiums and identified possible causes and solutions;

- **Legal Community Perspectives on the Causes and Impact of the Crisis** – A presentation on the medical malpractice crisis from the perspective of the legal community from representatives of the Nevada Trial Lawyers Association;

- **Insurance Industry Perspectives on Nevada's Situation** – An overview by the Division of Insurance, Nevada's Department of Business and Industry, of its *Survey on the Nevada Medical Malpractice Marketplace*; and

- **Options for Increasing Coverage Availability and Affordability** – An overview of the options for increasing the availability of affordable medical malpractice coverage under Nevada's existing insurance laws, including the types of insurance groups or associations that may be created to provide medical malpractice coverage and a discussion of the creation of the Nevada Essential Insurance Association.

Meeting on May 13, 2002 – Civil Justice Reform

At its second meeting, the Subcommittee received an update on the status and operation of the State's newly established joint underwriting association (MLAN) and focused on medical malpractice cases in Nevada, Nevada's civil justice system, and potential reforms. Following is a summary of the topics discussed:

- **Nevada's Joint Underwriting Association** – Alice A. Molasky-Arman, Nevada's Commissioner of Insurance, testified on the nonlegislative efforts in Nevada to address the medical malpractice crisis, including the creation of the Nevada Essential Insurance Association and efforts in Nevada to create a locally owned company for medical malpractice insurance;

- **Civil Justice Laws** – The National Conference of State Legislatures presented an overview of civil justice laws relating to medical malpractice in other states. The Subcommittee received a detailed overview of civil justice laws in other states, including limitations on damage awards, collateral source rules, joint and several liability, and statutes of limitation. Members also discussed mechanisms enacted in other states to address medical malpractice premiums, including patient compensation funds. Nevada legislative staff provided an overview of Nevada's enacted civil justice laws, including a statute of limitations, immunity from liability for physicians involved in certain emergency situations, comparative negligence, medical malpractice screening panels, use of expert witnesses to demonstrate a deviation from accepted standards of care and to prove causation, circumstances establishing patient consent, collateral source rule, and periodic payments for future damages;

- **National Perspective of the Impact of Imposing Caps on Damages** – The Subcommittee also received information on the impact of caps nationally from the American Medical Association, which indicated physicians in other states were also experiencing problems

similar to Nevada's. Representatives of the Nevada Trial Lawyers Association discussed the impact of caps and provided testimony from persons injured while under medical care;

- **Closed Medical Malpractice Claims in Nevada** – Commissioner Molasky-Arman presented data collected on closed claims for medical malpractice by the Division of Insurance pursuant to *Nevada Revised Statutes* 679B.144. The presentation focused on the amount of reserves and average claim severity for closed claims from 1999 to 2001. The total average claim severity for 1999 to 2001 (including those closed with no payment) for physicians was $138,734 (based on a sum total of $86,985,957 in paid indemnity on 627 claims, 349 of which were not decided by trial or settled. The 349 were "closed otherwise" with no payment). In addition, according to the database, from 1999 to 2001, the majority of physicians with claims closed (with and without payment) had only one claim filed against them (393 of 487). One had eight claims, and one had 14 claims;

- **Nevada Screening Panels** – Commissioner Molasky-Arman also provided an overview on the operation of Nevada's medical malpractice screening panels, which are administered by the Division of Insurance. Since 1985, Nevada has required a review of medical malpractice cases by the Medical/Legal Screening Panel prior to proceeding to court. In addition to the overview of the panel operations, Commissioner Molasky-Arman also presented statistics on the decisions and number of claims filed with the panel and noted areas of delays in the process, including stipulations for extensions for time and conflicts for panel members resulting in rescheduling of hearings. As presented in the statistics, claims filed with the panel increased from 152 in 1995 to 220 in 2001; and

- **Insurance Company Presentations** – Representatives of two insurance companies (the Physicians Insurance Company of Wisconsin and The Medical Protective Company) testified on the factors involved in determining rates and reserve amounts for medical malpractice coverage.

Meeting on July 22, 2002 – Prevention of Medical Malpractice

At its third meeting, the Subcommittee received an update on the status and impact of the closure of the Trauma Center at the University Medical Center of Southern Nevada. The meeting then focused on the following presentations involving methods of preventing medical malpractice:

- **Licensure and Discipline of Physicians** – The State's Board of Medical Examiners testified on its procedures for licensing and disciplining physicians;

- **Medical Error Reporting** – Representatives of the National Academy for State Health Policy provided a national overview of the medical malpractice crisis and of systems for reporting medical errors. The Subcommittee also received an update on the work of other legislative subcommittees studying this issue and discussed Nevada issues relating to medical errors reporting legislation; and

- **Reimbursement of Physicians for Services** – Finally, the Subcommittee discussed the combined financial impact on physicians of problems involving reimbursement for services and the high cost of medical malpractice coverage. The discussion included an overview of laws enacted or considered in other states to authorize collective bargaining for physicians.

Meeting on July 29, 2002 – The Insurance Industry and Medical Malpractice Coverage

The Subcommittee scheduled a meeting for July 29, 2002, to focus on the insurance industry. However, on July 26, 2002, Governor Kenny C. Guinn issued a proclamation convening a Special Session of the Legislature to address medical malpractice insurance issues on July 29, 2002. As a result, the Subcommittee's fourth scheduled meeting was cancelled.

Following the conclusion of the Eighteenth Special Session and the enactment of legislation to address the crisis (as discussed below), no future meetings of the Subcommittee were scheduled prior to the 2003 Session.

II. PRELIMINARY FINDINGS

In May 2002, the Subcommittee prepared a "white paper" containing its preliminary findings on the medical malpractice situation in Nevada. The white paper includes findings regarding the insurance market and the impact of the withdrawal of the St. Paul Companies from the Nevada market in December 2001; proposals to limit damages awards; and potential recommendations for reform. A copy of the white paper is provided as Appendix A to this report.

There are no formal recommendations for legislation or other action by the Subcommittee, as its study of the issue concluded when the Eighteenth Special Session convened on July 29, 2002.

III. SPECIAL LEGISLATIVE SESSION ON MEDICAL MALPRACTICE

On July 26, 2002, Governor Guinn issued a proclamation calling for a Special Session of the Legislature and specifying the issues that may be considered. The Legislature convened on the morning of July 29, 2002, and concluded its work early in the morning on August 1, 2002. At the start of the Special Session, legislators received three volumes of background information concerning medical malpractice prepared by LCB staff at the request of Subcommittee Chairwoman Barbara E. Buckley. A list of the information contained in the three volumes is provided under Appendix C ("Additional Resources").

During the Special Session, legislators received extensive testimony from medical providers, attorneys, representatives of health care facilities, and members of the public as it reviewed the causes and consequences of the broad malpractice issue. After much testimony and debate, the Legislature passed Assembly Bill 1 (Chapter 3, *Statutes of Nevada 2002 Special Session*), which addresses many of the issues identified as contributing to the unstable medical malpractice insurance environment. This bill includes the following provisions:

- A limit on civil liability in certain emergency situations for care rendered gratuitously;
- A $350,000 cap on noneconomic damages with certain exceptions;
- Changes to address the delays in bringing cases to trial and shorten the statute of limitations;
- Required pretrial settlement conferences and elimination of the Medical/Legal Screening Panel;
- Standards for expert testimony and mandatory training for district judges who hear malpractice cases;
- Requirements for physicians and dentists to carry malpractice insurance with minimum limits in certain circumstances;
- Submission of periodic reports on disciplinary action by the Board of Medical Examiners and the State Board of Osteopathic Medicine;
- Stronger requirements for physicians and dentists to report malpractice claims; and
- A system for reporting medical errors.

A detailed summary of Assembly Bill 1 is provided under Appendix B. The bill and its history are available electronically on the Legislature's Web Site at www.leg.state.nv.us and by request through the LCB's Research Library.

IV. CONCLUSION

Although the convening of a Special Session to address the medical malpractice crisis interrupted the work of the Subcommittee, its hearings on the issue and the efforts of its members played an important role in the State's analysis and understanding of the crisis. The preliminary findings of the Subcommittee and the information compiled through its study were utilized during the course of the Special Session as a readily available source of data necessary to consider difficult legislation during a short period of time. With the complexity of the problems surrounding medical malpractice coverage for health care providers that may again be debated during the 2003 Session, the work of the Subcommittee will be a vital source of information as the Legislature continues its discussion of the issues.

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APPENDIX A

Preliminary Findings
The Legislative Subcommittee to Study Medical Malpractice
May 2002

PRELIMINARY FINDINGS

The Legislative Subcommittee to Study Medical Malpractice

May 2002

This document provides an overview of consensus information, research, and observations concerning Nevada's medical malpractice crisis presented to date to the members of the Legislative Subcommittee to Study Medical Malpractice. The Subcommittee will continue its work and report its official findings and recommendations to the 2003 Legislature.

THE INSURANCE MARKET

Dramatic increases in medical malpractice premiums have had a severe impact on Nevada's physicians, particularly those in Clark County. Although the causes of these increases are the subject of much discussion, certain facts regarding the insurance market nationally and in Nevada are evident:

- **Developing "Hard Market" –** Prior to the September 11, 2001, terrorist attack in the United States, a "hard market" was developing throughout the insurance industry. Hard markets involve conditions in which premiums are high and coverage is difficult to obtain.[1] Since the late 1980s the insurance industry had generally experienced a "soft market" in which competition for the premium dollar was strong, and as a result, premiums remained lower. Prior to September 11, most major commercial lines were experiencing increases in renewals from 10 to 15 percent.[2]

- **Post September 11, 2001** – The September 11th terrorist attack has had a severe impact throughout our nation's economy. For the insurance industry, cost estimates have varied widely—from $30 billion to $70 billion. After that event, the rate of increases for 2002 renewals in commercial lines doubled, on average, to 30 percent.[3] Reinsurers (companies that insure other insurance companies) are expected to pay a large percentage of the insurance costs for September 11th, thus raising the rates charged by reinsurers and by insurance companies to its customers to cover those costs.

- **Importance of Investment Income –** The two main sources of income for insurance companies are underwriting profits and returns on investments from policyholder surplus. One measure of the financial status of an insurance company is the combined ratio, which is the ratio of the total insurance costs (losses incurred plus all expenses) to the revenues from premiums. A company is operating with an underwriting profit if it

[1] *Rupp's Insurance and Risk Management Glossary*.
[2] "Special Report: Groundhog Forecast 2002," Insurance Information Institute.
[3] "Special Report: Groundhog Forecast 2002," Insurance Information Institute.

has a combined ratio under 100 percent. If a company has a combined ratio over 100 percent, it is operating at an underwriting loss.

In a strong economy, because of investment returns, insurers can accept higher combined ratios because their losses can be recouped in the market. However, the recent downturn in the nation's economy has had a significant effect on the insurance industry.[4]

- **National Market for Medical Malpractice –** As noted by the Insurance Information Institute in an April 2002 report, "The medical malpractice combined ratio, a measure of profitability, is likely to hit the 140 percent mark nationally for 2001. This means that insurers on average have been paying out $1.40 for every dollar they collected in premiums. In most of the 1990s when the bull market and higher interest rates generated higher earnings on securities, investment income helped offset underwriting losses. In addition, insurers were keeping rates artificially low by using reserves accumulated in earlier years, but reserves are now depleted."[5]

National Withdrawal of the St. Paul Company

- **Decision to Leave Market –** In December 2001, the St. Paul Company announced its decision to exit the medical malpractice business on a global basis, not just Nevada.

- **Entrance into Nevada's Market –** In the mid-1990s, St. Paul purchased the Nevada Medical Liability Insurance Company, which was a doctor-owned company originally formed by the State as a joint underwriting association during an earlier crisis involving medical malpractice in the 1970s. At that time of its acquisition by St. Paul, the Nevada Medical Liability Insurance Company was one of the State's three major medical malpractice insurers. (The other two insurers with a large market share were The Doctors Company and the Medical Insurance Exchange of California [MIEC].)

- **Impact on Nevada's Market** – At the time of its withdrawal, St. Paul insured a large percentage of Nevada's physicians, and therefore the effect of its exit was heightened. According to the Nevada State Medical Association, in September 2000, the company

[4] Testimony of Cheye Calvo, Program Manager, Employment and Insurance, National Conference of State Legislatures (NCSL), at the May 13, 2002, meeting of the Legislative Subcommittee to Study Medical Malpractice.

[5] In a May 17, 2001, press release from the Conning Corporation, the following observation is reported:

> According to the Conning study, "Medical Malpractice Insurance: A Prescription for Chaos," in 1999 the medical malpractice line of insurance ended a twelve-year streak of outperforming the property-casualty industry as a whole. This coincided with insurer reserve deficiencies growing to $1.7 billion, leaving insurers little margin for any negative surprises in 2001. "From 1992-1997, medical malpractice insurers aggressively took down reserves to increase their investment portfolios," said Geri Riley, assistant vice president at Conning and author of the study. "This strategy helped them maximize their investments during the bull market." However, insurers have depleted reserves and must utilize surplus to reduce the deficiency.

insured approximately 60 percent of the state's physicians (a total of 1,328 physicians under 522 policies).

- **Relationship of St. Paul's Experience to Market Decisions of Other Companies in Nevada –** Because St. Paul had a large share of the medical malpractice market in Nevada and Clark County, other companies (particularly companies new to Nevada's marketplace) utilized St. Paul's rates and experience to determine their rates. As noted recently by one of these companies:

> [St. Paul] not only had the greatest market share, but their data was relied upon by many of the carriers for both pricing and loss reserving. * * * While Nevada has had a very competitive market, most of that competition came from companies new to the market and therefore unfamiliar with its historic volatility. Physicians enjoyed those years of competition, but it came at the cost of a stable market and healthy insurers. Rates are only now approaching the levels they should have been at over the years, and even then may not be adequate.[6]

Nevada's Medical Malpractice Marketplace

- **Multiple Rate Increases Requested and Approved Since September 2000 –** Insurance companies have requested and received approval of numerous increases in medical malpractice premiums in Nevada, many of which only affect Clark County. In September 2000, the St. Paul Company received approval for a 7.5 percent increase for Clark County. Two companies followed suit with similar increases: The Doctors' Company with a 13.9 percent increase for Clark County in January 2001, and the Physicians Insurance Company of Wisconsin, Inc. (PIC Wisconsin) with a 7.5 percent increase for Clark County in May 2001. In December 2001, PIC Wisconsin received an additional 20.7 percent increase for Clark County.[7]

  In August 2001, the CNA Group requested a 100 percent increase, which was decreased to 52 percent by Nevada's Insurance Commissioner before approval. At the hearing, the Commissioner urged the company, which had not requested an increase since it started doing business in Nevada in 1994, to file requests on a regular basis in the future to avoid such large increases.

  More recently, the Medical Insurance Exchange of California received a 30 percent increase for Clark County physicians effective May 1, 2002. The MIEC had also received approval in 2001 for a 19.5 percent increase.

[6] Response of Physicians Insurance Company of Wisconsin in its response to survey questions posed by Nevada's Insurance Commissioner prior to the March 4, 2002, hearing on medical malpractice.
[7] Source: Nevada State Medical Association.

American Physicians Assurance Company and Obstetricians

The American Physicians Assurance Company recently received approval for a rate increase, the impact of which is estimated to be between 70.6 percent and 85.1 percent depending on how many of the company's obstetricians qualify for a new 25 percent underwriting credit, which will be available to obstetricians who perform no more than 125 annual deliveries.[8] Based upon testimony at the Subcommittee's hearing on May 13, 2002, it appears this standard may be based upon the underwriting practices of other companies formerly operating in Nevada, including St. Paul and Nevada Medical Liability Insurance Company.

At this time, however, it is unclear how this standard developed. Nationally recognized medical organizations, including the American College of Obstetricians and Gynecologists (ACOG), do not publish recommended guidelines on the minimum or maximum number of deliveries obstetricians/gynecologists (OB/GYNs) should optimally perform annually. Based upon the ACOG's last survey (1997), OB/GYNs nationally performed an average of 141 deliveries annually.

- **Tail Coverage** – The increased cost for coverage for many physicians also includes "tail coverage" for physicians who change to a new insurance company. The cost covers actions that may be filed for injuries that occurred prior to the time the coverage with the new company starts. Nevada limits the time in which injuries for medical malpractice can be filed.

  Statute of Limitations – In Nevada, medical malpractice actions must be filed within 4 years after the date of the injury or 2 years after the plaintiff discovers the injury, *whichever occurs first*. This limitation is tolled during the time the medical screening panel is considering the complaint.

  Parents or guardians of children are responsible for filing an action within this time period. However, the statute of limitation is extended until the child is 10 years of age for brain damage or birth defects. In addition, the limitation is extended in cases of sterility until 2 years after the child discovers the injury. (*Nevada Revised Statutes* 41A.097)

- **Creation of a Joint Underwriting Association** – Pursuant to laws established in the 1970s, Nevada has again created a joint underwriting association to offer coverage at competitive rates to doctors unable to obtain coverage through the voluntary market. Information concerning the Medical Liability Association of Nevada (MLAN) is available through the Division of Insurance and its Web Site (**http://doi.state.nv.us/**).

[8] Source: Nevada's Division of Insurance.

PROPOSALS TO LIMIT DAMAGE AWARDS

Many groups are involved in the intense effort to find solutions for Nevada's medical malpractice crisis to ensure such rapid and severe increases in premiums do not reoccur in the future. One of the main targets for change is the civil justice system. Nevada has enacted laws providing for comparative negligence, immunity from liability for medical professionals who provide emergency obstetrical care, periodic payments for future damages, and a medical malpractice screening panel to review cases prior to trial.

In addition to these enacted reforms, limiting the amount of damages that may be awarded by a jury is a focal point of the discussions concerning Nevada's civil justice system.

- **Punitive Damages** – Punitive damages are not at issue in Nevada because, in order to award punitive damages, a finding of malice is required. Medical malpractice cases involve allegations of negligence, not intentional or malicious acts.

- **Caps on Damages in Other States** – The medical malpractice situation in states with and without caps on noneconomic damages varies.[9]

  Nevada is one of 27 states that do not have caps on noneconomic damages. Of these states, some are experiencing problems with rising medical malpractice costs (Florida, Nevada, Texas, and Pennsylvania). It does not appear that other states like Minnesota and Vermont are experiencing a crisis at this time.

  In comparison, the states with caps on damages that are not reportedly experiencing a crisis include California, New Mexico, and South Dakota. However, states like Missouri, Virginia, and West Virginia are faced with sharp increases in medical malpractice premiums. In addition, certain localities within states with caps on noneconomic damages (like Detroit, Michigan) are facing similar problems.

  Proponents of caps on noneconomic damages argue enactment of caps, while not necessarily guaranteeing lower rates, will provide stable rates because losses will be more predictable for insurance companies. The proponents often cite the effect of the $250,000 cap on noneconomic damages in California as an example, and note that injured persons will not be capped on the amount that can be awarded for economic damages.

[9] Based upon testimony and information on laws in other states provided by Cheye Calvo, Program Manager, Employment and Insurance, NCSL, during the March 21, 2002, and May 13, 2002, meetings of the Legislative Subcommittee to Study Medical Malpractice. Sources also include the October 1, 2001, survey conducted by the *Medical Liability Monitor* ("Trends in 2001 Rates for Physicians' Medical Professional Liability Insurance") and news accounts of medical malpractice premiums in other states.

Opponents of caps on noneconomic damages argue an injured person should not be deprived of the right to have a jury determine the extent of the impact of a health care provider's malpractice. Opponents also note noneconomic damages are often the only means to compensate injured individuals with no demonstrable loss of earnings, including minors, homemakers, and seniors.

Variety of Rates in States With and Without Caps on Damages

Because experience demonstrates damage caps alone do not explain rate differentials, it appears a variety of factors (in addition to the existence of caps on noneconomic damages) must be considered in determining the reasons for higher or lower rates within a particular jurisdiction.

Rates within Nevada vary between the higher rates for Clark County and the lower rates in the remainder of the State. In addition, the actual rates between states with and without caps on noneconomic damages also vary drastically. For example, according to the 2001 survey of medical malpractice rates published in October 2001 by the *Medical Liability Monitor*, the rates for OB/GYNs in states with no caps varied between a low range in Minnesota of $16,141 to $18,439 to a high range in Florida of $61,908 to $208,949.

In states with caps, the rates are also diverse. In California, the rates of OB/GYNs ranged from $22,899 to $71,728. In Michigan, the rates in the survey ranged from $43,722 to $123,890. Lower rates ($12,288 to $17,297) were charged in Nebraska.

- **Lapse of Time Before the Impact of Enacted Caps is Recognized** – When a legislature enacts caps on noneconomic damages, lawsuits challenging the constitutionality of those caps inevitably follow. In some states (including Alabama, Florida, Illinois, New Hampshire, Oregon, Texas, Washington, and Wyoming), the courts found such a cap to be unconstitutional. In addition, caps typically only affect future claims, and the average amount of time nationally for filing a claim after an injury is approximately 22 months.[10]

  It is probable that if Nevada were to enact a cap on noneconomic damages, it would be years before doctors noticed any impact on their rates. Further, if a cap were enacted, it is not clear that Clark County would realize any benefit from the caps in future years. The current experience of Clark County and other large counties and cities (like Detroit, Michigan) demonstrates that the urban, more populated areas often have premiums that are much higher than the rest of the state regardless of whether or not the state has enacted caps on noneconomic damages.

[10] Testimony of Cheye Calvo, Program Manager, Employment and Insurance, NCSL, at the May 13, 2002, meeting of the Legislative Subcommittee to Study Medical Malpractice.

As an example of the delayed effect of enacting caps, California's Medical Injury Compensation Reform Act (MICRA), which included a cap of $250,000 on noneconomic damages, was enacted in 1975, but more stable rates were not realized until many years later. According to a 1986 General Accounting Office study, during the period from 1980 to 1986, premiums continued to increase, varying throughout the state and between particular specialties. In Southern California, increases in premiums ranged from 16 percent for general practice to 337 percent for radiology. In Northern California, the change in premiums ranged from a decrease of 27 percent for anesthesiology to an increase of 92 percent for obstetrics/gynecology.[11]

As reported in the 1986 study, "Since the legislation was enacted in 1975, its provisions have been frequently contested in California courts. * * * Several officials believe that the full impact of the act will now be felt since the U.S. Supreme Court in 1985 refused to hear a case questioning the constitutionality of California's cap on noneconomic losses, such as pain and suffering, which in effect, upheld the provision's constitutionality."[12]

RECOMMENDATIONS FOR REFORM

The Subcommittee will continue its in-depth review of the causes contributing to Nevada's medical malpractice crisis at its future meetings scheduled for July 29th, October 2nd, and December 2nd. Based upon this examination, the Subcommittee will vote on recommendations to the 2003 Legislature for legal and regulatory reforms designed to avoid future crises.

Topics Identified for Possible Recommendations

During the Subcommittee's first two hearings on March 21, 2002, and May 13, 2002, multiple topics were raised during the hearings for the Subcommittee's consideration. Following is a list that broadly identifies many of the topics for reform raised for consideration by various speakers to date. ***The Subcommittee has not formally endorsed any of these recommendations at this time.***

- **Civil justice reforms:**
  - ***California-Like Legislative Package*** – Enact laws in Nevada like those under California's Medical Injury Compensation Reform Act of 1975 (MICRA), including the following:

[11] "Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms," published by the General Accounting Office in December 1986. (GAO/HRD-87-21).

[12] "Medical Malpractice: Case Study on California," published by the General Accounting Office in December 1986. (GAO/HRD-87-231S-2).

- **Cap on damages** – Limit awards for noneconomic damages to $250,000.
- **Collateral source payments** – Allow a defendant to introduce evidence of collateral source payments. (Nevada has a collateral source law requiring damages to be reduced by amounts received by an injured person for medical care, loss of income, or other financial losses from a collateral source.)
    - A related recommendation was presented to require that collateral source payment information be provided to a jury prior to the awarding of damages.
- **Periodic payments** – Allow health care professionals to elect to pay a claimant's future economic damages over $50,000 in periodic amounts. (Nevada has a law under which the claimant elects to receive future damages in a lump sum at present value or under an annuity with periodic payments.)
- **Attorney contingency fees** – Limit attorneys' fees based upon a sliding scale: 40 percent of the first $50,000 recovered; 33 percent of the next $50,000; 25 percent of the next $500,000; and 15 percent of any amount over $600,000.
- **Statute of limitations** – Require that claims be brought within 3 years from the injury or within 1 year of discovery.
    - A related recommendation was presented to establish an 8-year statute of limitations for birth injuries.
    - A second recommendation was presented to create a statute of limitations of 2 years after the date of the injury.

  (Currently, Nevada requires that actions must commence within 4 years from the date of the injury or 2 years after discovering the injury, whichever occurs first. The limitation is tolled during the time the medical malpractice screening panel is considering the complaint. Parents or guardians of children must file actions within the statutory time frame, except the time for filing actions for brain damage or birth defect is extended until the child is 10 years of age.)
- **Binding arbitration of disputes** – Allow written contracts for medical services to include a clause requiring parties to resolve disputes through binding arbitration.
    - A related recommendation was presented to require arbitration for cases with a screening panel finding of probable malpractice or no malpractice.

- ***Encourage Settlements*** – Examine methods of encouraging parties to settle meritorious cases at an early stage. Create an automatic bad faith finding when an insurer fails to settle a claim within policy limits and prohibit the insurer from using losses in excess of policy limits in these situations to justify rate increases.

- ***Medical Malpractice Screening Panel*** – Evaluate the effectiveness of the panel in screening out nonmeritorious cases.

C **Insurance Reform:**

- ***Rate approval*** **–** Ensure that the procedures involved in approval of rates are fair and grounded in actual losses.

- ***Intervention*** **–** Allow for intervention in rate filings by interested parties and individuals.

- ***Tail coverage*** **–** Eliminate the ability to charge for tail coverage or from profiteering on the amounts charged for tail coverage.

- ***Public disclosure*** – Publicly disclose underwriting decisions so that physicians are informed regarding the reasons they were declined or rated at higher than average premiums.

- ***Confidentiality agreements and consent clauses*** **–** Examine confidentiality agreements and consent provisions existing in medical malpractice policies and consider eliminating or modifying these provisions. Any changes should improve settlement negotiations, not discourage settlement negotiations.

- ***Claims-made policy*** **–** Evaluate the claims-made policy (as opposed to occurrence based policies) and discuss the continued viability of this policy.

- ***Definition of "claim"*** **–** Define "claim" so that there is a universal definition applicable to all insurers for the consideration of a "claim" in underwriting.

- ***Business practices*** **–** Hold insurers accountable for bad business practices and for poor claims decisions.

- ***Surplus lines*** **–** Consider regulatory authority over surplus lines in the area of medical malpractice.

C **Prevention/Reduction of Incidents of Medical Malpractice:**[13]

- ***Risk Management*** **–** Mandate greater risk management on the part of hospitals and individual doctors. Incorporate risk management classes into licensing for medical providers.

[13] Cheye Calvo, Program Manager, Employment and Insurance, NCSL, raised some of the issues involving prevention and reduction of medical malpractice for the Subcommittee's consideration in conjunction with an overview of laws in other states. Mr. Calvo emphasized that neither he nor NCSL was taking a position on the issues or endorsing a specific proposal.

- ***Discipline of Doctors*** – Ensure that Nevada's Board of Medical Examiners is effectively disciplining negligent physicians and protecting the public from physicians who are the subject of disciplinary actions both in Nevada and in other jurisdictions.

- ***Medical Error Reporting*** – Create a system of medical error reporting to increase patient safety and provide information on incidences of medical malpractice so that appropriate corrective measures may be taken. At least 20 states have enacted medical reporting systems, 15 of which have mandatory systems.

C **Other Topics Raised for Consideration:**

- ***Patient compensation fund*** – Create a patient compensation fund for emergency obstetrical care, other high-risk obstetrical care, and emergency department physicians and surgeons.

- ***Collective bargaining*** – Allow physicians to collectively bargain with health care companies so they can effectively negotiate and pass along additional costs.

Emerging Areas of Consensus

During the Subcommittee's first two hearings, possible reforms were identified on which the parties to the debate (including physicians, insurance companies, and attorneys) appear able to agree, and thus may be included in the final package presented to the 2003 Legislature. These potential reforms include improvements to enhance the operation of the medical malpractice screening panel if it is determined that the panel is effective in screening out frivolous claims, and methods of addressing the unpredictable length of time that elapses before a claim is filed in court.

- **Limitation on Time to Trial** – Currently, taking a case to trial may take as long as 5 years, including the time to process the case with the medical malpractice screening panel. One generally accepted proposal for reform is to decrease this time to 2 years. Cases not brought to trial within the 2-year period would be barred from any future consideration. Such a requirement should positively impact pricing of medical malpractice rates because of the increased predictability.

- **Improve the Medical/Legal Screening Panel** – Assuming it is determined that the panel is effective in eliminating frivolous claims, the following recommendations would improve the panel's operation and eliminate delays in the process:

  - **Panel Resources –** Provide sufficient resources (including adequate staffing) for the Division of Insurance to administer the medical malpractice screening panels;

- **Panel Member Conflicts** – Address the number of conflicts for screening panel members resulting in numerous delays in scheduling the panels. These conflicts reportedly include both issues raised in preemptory challenges and challenges for cause by parties and actual scheduling conflicts; and

- **Stipulations** – Decrease the number of stipulations approved for extensions of time within the screening panel process.

ADDITIONAL INFORMATION

Attachment A provides an overview of Nevada's existing civil justice laws relating to the medical malpractice issue.

For additional information on the Subcommittee, including a schedule of future meetings, please call Assemblywoman Barbara E. Buckley, Chairwoman, at 702/386-1070, or Allison Combs, Principal Research Analyst, Nevada Legislative Counsel Bureau, at 775/684-6825.

ATTACHMENT A
NEVADA LAWS RELATING TO THE CIVIL JUSTICE SYSTEM AND MEDICAL MALPRACTICE

Statute of Limitations	Immunity from Liability for Certain Emergency Care	Comparative Negligence	Medical Malpractice Screening Panels	Use of Expert Witnesses	Patient Consent	Limits on Punitive Damages	Damages from Collateral Source	Periodic Payments for Future Damages	Damages in Cases Involving Wrongful Death
NRS 41A.097	NRS 41.505	NRS 41.141	NRS 41A.003-41A.069	NRS 41A.100	NRS 41A.110-41A.120	NRS 42.005	NRS 42.020	NRS 42.020	NRS 41.085
Must commence actions against a provider of health care for injury or death not more than 4 years after the date of the injury ***or*** 2 years after plaintiff discovers or should have discovered the injury, ***whichever occurs first***. Limitation tolled during the screening panel process. Also tolled for any period during which physician concealed acts, errors, or omissions ***and*** which are known, or should have been known, to him. Parents, guardians, or legal custodians of minor child are responsible for determining whether to prosecute, and if the period commencing the action passes, child prohibited from bringing action. Exceptions: (1) brain damage or birth defect (extended until child is 10 years of age); or (2) sterility (extended until 2 years after the child discovers the injury).	No liability for damages for certain acts or omissions in good faith not amounting to gross negligence: 1. For physicians or registered nurses giving instruction or supervision to emergency personnel at scene or while transporting, and for emergency medical attendants and nurses obeying instructions. 2. For physicians, physicians assistants, practitioners of respiratory care, nurses, or osteopaths for rendering emergency care gratuitously. (Exception if preexisting relationship with patient.) Also for retired licensees rendering emergency care gratuitously to indigent person. Emergency Obstetrical Care No liability for civil damages for acts or omissions for physicians, physicians assistants, practitioners of respiratory care, nurses, or osteopaths rendering emergency obstetrical care to a pregnant woman during labor or the delivery if: (a) In good faith and not amounting to gross negligence or reckless, willful, or wanton conduct; (b) Has not previously provided prenatal or obstetrical care to the woman; and (c) Damages related to or caused by a lack of prenatal care. (Licensed medical facility also not liable for civil damages in this situation.)	In action to recover damages for death or injury to persons, no recovery if plaintiff's comparative negligence is greater than defendant's negligence or the combined negligence of multiple defendants. If jury determines plaintiff entitled to recover, two jury verdicts required: general verdict on total amount of recoverable damages; and special verdict on percentage of negligence of each party. Exempt from statute: actions based on strict liability, intentional tort; hazardous waste, toxic materials; concerted acts of defendants; or injuries from products manufactured, sold, distributed, or used in this state.	Before a cause of action for malpractice is filed in court, it must be submitted to a screening panel, and any action filed without going first to a screening panel is subject to dismissal. The written findings of the panel are admissible in court, with the exception of any findings of a panel that is unable to reach a decision on the issue of medical malpractice.	Imposition of liability on physician for personal injury or death requires evidence to demonstrate alleged deviation from accepted standard of care and to prove causation of the alleged personal injury or death. Such evidence not required, and rebuttable presumption exists that the personal injury or death was caused by negligence, in certain circumstances such as unintentionally leaving a foreign substance in patient's body following surgery or performing a surgical procedure on the wrong patient or on the wrong organ, limb, or part of a patient's body.	Patient consent conclusively obtained if physician explains procedures to be undertaken, alternative methods of treatment, and risks involved. Must also obtain signature of patient on statement explaining these items. Consent to a medical or surgical procedure is implied if person authorized to consent is not readily available, procedure reasonably necessary, and any delay in performing procedure could reasonably be expected to result in death, disfigurement, impairment of faculties or serious bodily harm.	Punitive damages limited to 3 times any compensatory damages awarded, or $300,000 if the compensatory award is less than $100,000. Must prove the defendant guilty, by clear and convincing evidence, of "oppression, fraud or malice, express or implied."	In action for damages for medical malpractice, the amount of damages awarded must be reduced by the amount of any prior payment made by or on behalf of the provider of health care against whom the action is brought to the injured person or to the claimant to meet reasonable expenses of medical care, other essential goods or services or reasonable living expenses. Court must hold separate hearing to determine if expenses incurred by claimant for medical care, loss of income, or other financial loss have been paid or reimbursed as a benefit from a collateral source. If the court determines claimant has received such a benefit, amount of damages awarded reduced by the amount of the benefit.	If future economic damages are awarded in an action for medical malpractice, the award must be paid, at the election of the claimant: (1) in lump sum reduced to its present value as determined by the trier of fact and approved by the court; **or** (2) by an annuity purchased to provide periodic payments (award not reduced to present value).	When the death of any person is caused by the wrongful act or neglect of another, heirs and the personal representatives of the decedent may each maintain action for damages. Heirs may be awarded pecuniary damages for grief or sorrow, loss of probable support, companionship, society, comfort and consortium, and damages for pain, suffering, or disfigurement of the decedent. Damages recoverable by the personal representatives of a decedent on behalf of his estate include special damages (such as medical expenses) that the decedent incurred before his death; funeral expenses; and any penalties, including exemplary or punitive damages, which the decedent would have recovered if he had lived. Damages recoverable by personal representatives do not include damages for pain, suffering or disfigurement of the decedent.

Prepared by the Research Division, Nevada Legislative Counsel Bureau
May 2002

APPENDIX B

Summary of Assembly Bill 1
(Chapter 3, *Statutes of Nevada 2002 Special Session*)

PREPARED BY
RESEARCH DIVISION
LEGISLATIVE COUNSEL BUREAU
Nonpartisan Staff of the Nevada State Legislature

BILL SUMMARY

18th SPECIAL SESSION
OF THE NEVADA STATE LEGISLATURE

ASSEMBLY BILL 1
(Enrolled)

Topic

Assembly Bill 1 makes various changes related to medical and dental malpractice.

Summary

This bill limits civil damages in some emergency situations for care rendered gratuitously, limits noneconomic damages, addresses delays in bringing cases to trial, shortens the statute of limitations, requires pretrial settlement conferences, eliminates malpractice screening panels, regulates expert testimony, requires training for district judges who try malpractice cases, requires physicians and dentists to carry malpractice insurance with minimum limits in certain circumstances, requires the Board of Medical Examiners to submit periodic reports on disciplinary actions and malpractice cases, requires physicians and dentists to report malpractice claims, and establishes the Repository for Health Care Assurance.

$50,000 Cap on Damages for Emergency Care

Assembly Bill 1 limits civil damages in certain emergencies to no more than $50,000 for any claimant. The limit applies to certain parties that in good faith render care or assistance made necessary by a "traumatic injury" demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center. A "traumatic injury" is defined as any acute injury, which, according to standardized criteria for triage in the field, involves a significant risk of death or the precipitation of complications or disabilities. The parties affected by this limit include:

- A hospital;
- An employee of a hospital who renders care or assistance to patients;
- A physician or dentist who renders care or assistance at a hospital, whether the care is gratuitous or for a fee; and
- A physician or dentist whose liability is not otherwise limited and who renders care or assistance at such a hospital, whether the care is gratuitous or for a fee.

This limitation on liability does not apply:

- If there is gross negligence or reckless, willful, or wanton conduct;
- To any act or omission in rendering care or assistance occurring after a patient is stabilized, unless surgery is required within a reasonable time after stabilization; and
- To any act or omission in rendering care or assistance that is unrelated to the original traumatic injury.

Total Immunity for Treatment in Governmental or Nonprofit Facilities

Assembly Bill 1 further provides that any licensed physician, osteopathic physician, or dentist who renders care at a health care facility of a governmental entity or a nonprofit organization is not liable for any civil damages if the care or assistance is rendered gratuitously, in good faith, and in a manner not amounting to gross negligence or reckless, willful, or wanton conduct.

$350,000 Cap on Noneconomic Damages

The bill establishes a general limit on the amount of noneconomic damages that may be awarded to a plaintiff in a malpractice action brought against a dentist, physician, hospital, or employee of a hospital. Noneconomic damages are defined to include damages for pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damages.

Unless certain exceptions apply, the noneconomic damages awarded to each injured plaintiff must not exceed $350,000. The exceptions to the $350,000 cap on noneconomic damages apply when the conduct of the defendant is grossly negligent or the court determines by clear and convincing evidence at trial that an award in excess of $350,000 for noneconomic damages is justified because of exceptional circumstances.

Subsection 3 of Section 5 of the bill provides that in all cases of medical malpractice the amount of damages awarded to the plaintiff may not exceed the amount of money remaining under the professional liability insurance policy limit covering the defendant after subtracting the economic damages awarded to the plaintiff. In addition, a single defendant cannot be held liable for noneconomic damages in an amount that exceeds the defendant's professional liability insurance policy limit even if there is more than one plaintiff. Economic damages are defined as damages for medical treatment, care or custody, loss of earnings, and loss of earning capacity.

Moreover, A.B. 1 provides that in order for physicians, dentists, and osteopathic physicians to obtain the benefit of the $350,000 cap on noneconomic damages they must maintain professional liability insurance of not less than $1 million per occurrence and not less than $3 million in the aggregate.

Several Liability

The measure also provides that each defendant is individually liable for noneconomic damages only to the extent of that defendant's percentage of negligence, but is not jointly liable for the total amount of such damages. This provision applies to a certified nurse midwife and a certified registered nurse anesthetist, as well as to physicians, hospitals, and hospital employees.

Expediting Trials

Assembly Bill 1 also limits delays in bringing medical malpractice cases to trial. Cases filed between October 1, 2002, and October 1, 2005, must be dismissed if they are not brought to trial within three years unless good cause is shown for a delay. Cases filed on or after October 1, 2005, must be brought to trial within two years. Dismissal of an action bars the filing of another action upon the same claim. Assembly Bill 1 further requires dismissal of an action for medical or dental malpractice if the action is filed without an affidavit submitted by a qualified medical expert supporting the allegations.

The bill also requires district courts to adopt rules on or before March 1, 2003, to expedite medical and dental malpractice trials.

Pretrial Settlement Conferences

The bill requires that settlement conferences be held before a judge other than the judge assigned to the case. Each plaintiff, defendant, representative of the physician's or dentist's insurer, and each of their respective attorneys must attend and participate in the settlement conference. The judge presiding at the settlement conference must decide what information the parties may submit. The failure of any party, his insurer, or his attorney to participate is grounds for sanctions. The settlement conference replaces the medical and dental malpractice screening panels, which are eliminated.

Statute of Limitations

Additionally, A.B. 1 shortens the statute of limitations for commencing an action for injury or death that occur after October 1, 2002, from four years to three years, or two years after the plaintiff discovers or should have discovered the injury, whichever occurs first.

Expert Medical Testimony

Further, this measure specifies that expert medical testimony may only be given by a medical care provider who practices or practiced in an area substantially similar to the type of practice engaged in at the time of the alleged negligence.

Periodic Payment of Future Damages

Assembly Bill 1 also provides that future economic damages may be awarded in periodic payments by a means other than an annuity if the defendant posts an adequate bond or other security to ensure full payment by periodic payments of the damages. Upon termination of the payment of the periodic payments, the court shall order the return of the bond or other security to the defendant.

Special Training for Trial Judges

This measure requires the Supreme Court of Nevada to provide for training concerning the complex issues of medical malpractice litigation for each district judge to whom actions involving medical malpractice are assigned.

Malpractice Reporting Requirements

The Board of Medical Examiners must submit to the Governor and the Director of the Legislative Counsel Bureau a written report compiling disciplinary actions taken by the Board during the previous biennium against physicians for malpractice or negligence and other information reported to the Board. Additionally, the Court Administrator of the Supreme Court of Nevada must submit to the Governor and the Director of the Legislative Counsel Bureau a written report compiling the information pertaining to physicians and osteopathic physicians submitted by the clerks of the courts. These reports must include aggregate information for statistical purposes and exclude any identifying information related to a particular person.

Further, A.B. 1 strengthens requirements for physicians, osteopathic physicians, their insurers, a person, medical school, or medical facility to report to licensing boards actions that could be grounds for discipline, as well as all actions filed or claims submitted to arbitration or mediation for malpractice or negligence against the physician or osteopathic physician. The measure also requires similar reports from the clerks of the courts. Administrative fines of $10,000 may be imposed on certain parties for failure to comply.

Assembly Bill 1 also requires insurers to report to the Commissioner of Insurance within 30 days on a breach of professional duty by osteopathic physicians. Current law only applies to physicians. Additionally, the Commissioner of Insurance must report to the State Board of Osteopathic Medicine within 30 days after receiving the report of the insurer.

Medical Error Reporting

In addition, Assembly Bill 1 requires reporting of "sentinel events" to the Health Division of the Department of Human Resources. A "sentinel event" is defined as an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of a

serious adverse outcome. The term includes the loss of a limb or function. An employee of a medical facility must report "sentinel events" to the facility's patient safety officer within 24 hours. Subsequently, within 13 days, the patient safety officer must report the date, time, and description of the sentinel event to the Health Division. Medical facilities include hospitals, obstetric clinics, ambulatory surgery centers, and independent centers for emergency medical care.

Medical facilities must also notify patients affected by a sentinel event within seven days. However, the notification cannot be considered an acknowledgement or admission of liability.

To the extent of legislative appropriation and authorization, the Health Division must safely and confidentially maintain reports of sentinel events. The Division must also contract with a quality improvement organization to analyze and report trends regarding sentinel events. If the Health Division receives notice from a medical facility that it has taken corrective action to remedy the causes or contributing factors of a sentinel event, the Division must make a record of the information and ensure that the information is aggregated and does not reveal the identity of the person or facility.

In addition, the information concerning corrective actions must also be forwarded to the quality improvement organization. The findings of the organization regarding its analysis of aggregated trends of sentinel events must be forwarded to the new Repository for Health Care Assurance. To the extent of legislative appropriation and authorization, the Repository serves as a clearinghouse of information relating to aggregated trends of sentinel events. Assembly Bill 1 specifies that no report, document, recommendation, or any other material compiled pursuant to the reporting of sentinel events is admissible as evidence in any administrative or legal proceeding.

Patient Safety Plans and Committees

Further, Assembly Bill 1 requires medical facilities to develop internal patient safety plans in consultation with licensed health care professionals at the facility, which must be submitted for approval to the facility's governing board. Compliance with the plan is a condition of employment at the facility. Medical facilities must also establish patient safety committees to meet monthly. Each committee must receive reports relating to patient safety, make recommendations to reduce the number and severity of sentinel events, and report quarterly to the facility's governing body regarding the number of sentinel events and any recommendations to reduce the number and severity of such events.

No person involved in the reporting, transmitting, or compiling of information concerning sentinel events is subject to any criminal penalties or civil liability if the reporting, transmitting, or compiling is made without malice.

Whistle-blower Protections

Finally, Assembly Bill 1 includes "whistle-blower" protections for employees of medical facilities, physicians, and osteopathic physicians who report either: (1) a sentinel event to the Health Division; or (2) grounds for initiating discipline or information that raises questions regarding a physician's competence to a physician licensing board. The bill prohibits the medical facility or physician from retaliating or discriminating against an employee for these actions and from restricting the rights of an employee to make these reports or participate in any related investigation.

An employee of a medical facility who believes he has been unlawfully retaliated or discriminated against for making these reports may file an action in court for appropriate relief.

Effective Date

The majority of this measure is effective on October 1, 2002, while the medical error reporting provisions are effective on July 1, 2003.

The State of Nevada is experiencing extreme difficulties attracting and maintaining a sufficient network of physicians to meet the needs of the residents of this state due to the escalating cost of obtaining professional liability insurance. The Governor of Nevada called a special session of the Legislature after it was determined that the shortage of physicians and the inability to attract new physicians to this state posed a serious threat to the health, welfare, and safety of the residents of the state. Subsequently, the Legislature enacted provisions to increase the availability and affordability of malpractice insurance while safeguarding the rights of patients and relatives to seek compensation for medical injuries.

APPENDIX C

Additional Resources

ADDITIONAL RESOURCES

Following is a list of additional resources for background information on the medical malpractice crisis in Nevada in 2002. Each of these resources is available through the Research Library of the Legislative Counsel Bureau. Many of the resources listed are also available electronically on the Legislature's Web Site at www.leg.state.nv.us.

A. PAST LEGISLATIVE STUDIES

- **1977 Legislative Report** – In 1975, the Legislature also adopted a resolution (Senate Concurrent Resolution No. 21, File No. 115, *Statutes of Nevada 1975*) directing the Legislative Commission to undertake a study of the problems of medical malpractice insurance. The 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* (Bulletin No. 77-1), is available in the legislative library.

- **1987 Legislative Report** – The 1985 Legislature also directed the Legislative Commission to study the business of insuring against medical malpractice (Assembly Concurrent Resolution No. 53, File No. 106, *Statutes of Nevada 1985*). The report of this study, entitled *Study of Insurance Against Medical Malpractice* (Bulletin No. 87-17), is available in the legislative library.

- **1997 Legislative Report** – The 1995 Legislature appropriated $75,000 for an independent study of all open and closed claims for medical malpractice in Nevada over the last ten years. The report of this subcommittee, entitled *Claims for Medical Malpractice* (Bulletin No. 97-2), is available in the legislative library.

B. BACKGROUND MATERIAL PREPARED FOR THE SPECIAL SESSION

Three volumes of material provided by the Research Division of the Legislative Counsel Bureau as background material for the Legislature at the request of Assemblywoman Barbara E. Buckley, Chairwoman of the Legislative Subcommittee to Study Medical Malpractice.

- **Volume 1** includes the following information regarding the work of the Subcommittee:
  - The white paper prepared by the Subcommittee;
  - The minutes of the March 21, 2002, meeting of the Subcommittee;
  - The minutes of the May 13, 2002, meeting of the Subcommittee;
  - The May 13, 2002, response from The Doctors Company to questions raised by the Subcommittee concerning medical malpractice coverage and rates;
  - The July 22, 2002, letter from Alice A. Molasky-Arman, Nevada's Commissioner of Insurance, responding to questions raised by the Subcommittee; and
  - A list of proposed insurance reforms presented throughout the course of the study.

- **Volume 2** contains data on the following issues:
  - Past Nevada legislative actions;
  - The Insurance Market – Generally and in Nevada;
  - Nevada's Civil Justice Laws;
  - An overview of tort laws in other states; and
  - An overview of California's Medical Injury Compensation Reform Act of 1975 (MICRA).

- **Volume 3** contains data on the following issues:
  - An overview of caps on damages in other states;
  - Statistical data and statutes pertaining to Nevada's Medical/Legal Screenings Panels;
  - Data regarding past medical malpractice claims and cases in Nevada (including information on the monetary amounts involved in judgments and settlements);
  - An overview of the operation of the State Board of Medical Examiners;
  - General information on the issue of reporting of medical errors;
  - Data on the number of physicians in Nevada and the number of physicians involved in medical malpractice claims;
  - General information on physician negotiating groups;
  - An overview of issues involving health care costs that relate to medical malpractice coverage; and
  - National statistics on the number of physicians.

C. THE INSURANCE INDUSTRY IN NEVADA

Nevada's Division of Insurance is a primary source of information concerning the insurance industry and the situation involving medical malpractice, in particular. The Division's Web Site (www.doi.state.nv.us/) includes information regarding medical malpractice coverage, the creation of the Medical Liability Association of Nevada (MLAN) and the operation of the Medical/Legal Screening Panels, which were repealed under Assembly Bill 1 of the Eighteenth Special Session of the Nevada Legislature in August 2002.

The Division maintains offices in Carson City and Las Vegas and may be contacted as follows:

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