IN THE SUPREME COURT OF THE STATE OF NEVADA

LYNN YAFCHAK, Statutory Heir and Special Administrator to the ESTATE OF JOAN YAFCHAK, Deceased, Appellants, vs. LIFE CARE CENTERS OF AMERICA, a foreign corporation d/b/a LIFE CARE CENTER OF SOUTH LAS VEGAS; and DOES 1-10, inclusive, Respondent.	Case No.: 82746

APPELLANTS' ADDENDUM TO OPENING BRIEF PURSUANT TO NRAP 28(f)

VOLUME 4 (ADD 0655–0790)

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Journal

OF THE

SENATE OF THE STATE OF NEVADA

EIGHTEENTH SPECIAL SESSION
THE FIRST DAY

CARSON CITY (Monday), July 29, 2002

Senate called to order at 9:30 a.m.

President Hunt presiding.

President Hunt requested that her remarks be entered in the Journal.

We gather today for this Special Session because an issue of public health has become so critical that it's impact on the people of Nevada can be devastating. It is an issue where there is no consensus and where there is only heated, and at times, contentious debate.

It is an issue that has reached a point/where a wide impasse exists causing this body to be brought together.

It goes without saying that settling the issue without a Special Session would have been preferable to us, to the people of Nevada and certainly to our Governor Kenny Guinn.

But there is a time when leadership must rise to the occasion and take over and that is exactly what Governor Guinn did. And that is exactly what he, and all Nevadans, is looking for us to do.

This is what we were elected to do. The voters didn't send us to the state legislature/to make the easy decisions.

We are the ones to whom they are looking for solution.

To whom they are looking for resolution.

To whom they are looking/to protect them and their families.

We are it folks.

Let's put politics aside and do the right thing for the people of Nevada.

SENATE IN SESSION

At 10:49 a.m.

President Hunt presiding.

Quorum present.

Senator Rawson reported that his committee had informed the Assembly that the Senate is organized and ready for business.

Senator Washington reported that his committee had informed the Governor that the Senate is organized and ready for business.

MESSAGES FROM THE GOVERNOR

STATE OF NEVADA
OFFICE OF THE GOVERNOR
EXECUTIVE ORDER

A PROCLAMATION BY THE GOVERNOR:

WHEREAS, Section 9 of Article V of the Constitution of the State of Nevada provides that, "The Governor may on extraordinary occasions, convene the Legislature by Proclamation and shall state to both houses when organized, the purpose for which they have been convened, and the Legislature shall transact no legislative business, except that for which they were specially convened, or such other legislative business as the Governor may call to the attention of the Legislature while in Session;"

WHEREAS, believing that an extraordinary occasion now exists which requires immediate action by the Legislature;

NOW, THEREFORE, I, KENNY C. GUINN, GOVERNOR OF THE STATE OF NEVADA, by virtue of the authority vested in me by the Constitution of the State of Nevada, do hereby convene the Legislature into a Special Session to begin at 9:00 a.m., on July 29, 2002.

During this Special Session, I ask the Legislature to consider:

1. Establishing limits on the amount of non-economic damages available in medical malpractice cases;
2. Adopting a several liability standard for medical malpractice cases when non-economic damages are considered;
3. Adopting a new joint and several liability standard for medical malpractice cases when economic damages are considered;
4. Limiting the liability for acts occurring in a governmental or non-profit center for the treatment of trauma;
5. Allowing a judge, at the request of either party, discretion to enter a judgment providing that money for future damages be paid periodically;
6. Shortening the time period within which a medical malpractice case may be filed;
7. Reviewing the medical and dental screening panels to revise existing procedures and/or change the composition of the panels;
8. Providing discretion in the award of pre-judgment interest;
9. Strengthening the reporting requirements regarding disciplinary actions, claims, settlements and/or awards against physicians;
10. Requiring that district court judges have training in medical malpractice litigation before handling such cases;
11. Making it mandatory for attorneys to personally pay for the additional costs, expenses and fees that arise as a result of their unreasonable conduct in civil litigation.

During the Special Session, the Legislature may also consider other matters brought to its attention by the Governor.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Nevada to be affixed in Las Vegas, this 26th day of July, in the year two thousand two

KENNY C. GUINN
Governor

DEAN HELLER
Secretary of State

RENEE PARKER
Chief Deputy Secretary of State

REMARKS FROM THE FLOOR

Senator Raggio requested that his remarks be entered in the Journal.

Pursuant to his constitutional authority, Governor Kenny C. Guinn has convened a special session of the legislature to address an issue of extraordinary importance to all Nevadans. There is a crisis in the availability and affordability of medical liability insurance that threatens to impact access to health care.

It is essential that Nevada retain its medical providers, especially for those citizens who suffer traumatic injuries where literally every second counts.

The Senate will be considering a package of proposals to ensure continued access to medical care while protecting the interests of patients injured in the course of receiving treatment. However, pursuant to article 5, section 9 of the Constitution of Nevada: "...the legislature shall transact no legislative business, except that for which they were specially convened, or such other legislative business as the governor may call to the attention of the legislature while in session."

We have before us the Governor's proclamation detailing the issues we have been convened to address and we are constitutionally bound to restrict our transactions to those items.

Because the subject of medical malpractice has numerous aspects and special sessions are of necessity limited in duration, we need to proceed expeditiously. To facilitate this process, we will meet as a Committee of the Whole.

We anticipate morning, afternoon and evening meetings for the next three days. This approach will require careful management of the time allotted for each phase of our process. We will attempt to provide a reasonable opportunity for all positions to be heard but it will be necessary to observe time limits so this body can conclude its work in a reasonable period. The Senate will therefore pursue its deliberations in the following manner:

We will focus on one specific topic at a time;

Within a fixed amount of time, representatives of interested groups will be accorded equal time to address each topic without interruption;

At the conclusion of these presentations, the majority party and the minority party will have equal time allotted to their members to pose questions or to make statements. We will observe time limits in this phase of our proceedings as well;

Because of the constitutional limits on subject matter, any discussions beyond the topics in the Governor's proclamation will not be in order;

After legislators have finished their questions or statements, there will be an opportunity for public comment on the item under discussion;

Following public comment, the Senate will vote on that specific agenda item. In this manner, we will not only help move discussions along, we will also allow our bill drafters to keep pace with us and avoid prolonged delay at the end of our deliberations while we wait for a final version;

Thereafter, the process will be repeated for each agenda item until we have considered the proposal before us in its entirety.

Finally, at the end of each day, the Committee of the Whole will rise and return to the Senate Chamber to adjourn for the day.

We are faced with a critical task and an arduous schedule. However, I am confident our combined efforts can produce a sound public policy solution to the present crisis.

MOTIONS, RESOLUTIONS AND NOTICES

Senator Raggio moved that the Senate resolve itself into a Committee of the Whole for the purpose of considering Senate Bill No. 2.

Motion carried.

President Hunt:

The Senate will convene the Committee of the Whole in Room 1214 with Senator Raggio as Chairman. Once the Committee of the Whole is dissolved, we will return to the Senate Chamber. The Senate is now resolved into a Committee of the Whole.

IN COMITTEE OF THE WHOLE

At 3:11 p.m.

Senator Raggio presiding.

Senate Bill No. 2 considered.

The Committee of the Whole was addressed by Senator Raggio; Governor Kenny Guinn; Jan Needham, Principal Deputy Legislative Counsel; Bradley

A. Wilkinson, Principal Deputy Legislative Counsel; Scott Young, Principal Research Analyst; Bill Bradley, Nevada Trial Lawyers Association; Mark Brown, Chairman, Nevada Mutual Insurance Company; John Cotton, Attorney, Nevada Physicians Task Force; J. R. Crockett, Attorney, Nevada Trial Lawyers Association; James D. DeRoche, Attorney; John Echeverria, Attorney; Lonnie L. Hammargren, M.D., Neurosurgical Associates of Nevada; Dean Hardy, Nevada Trial Lawyers Association; Florence Jameson, M.D., OB/GYN; Ikram U. Khan, M.D., General Surgery; Charles Laws, Green Party, Candidate for Governor; Robert B. McBeath, M.D., Nevada Medical Liability Physicians Task Force; Daniel S. McBride, M.D., Physician, Chairman, Nevada Mutual Insurance Company; Diane Meyer; Wende Nostro; Kristie O'Neill; Tim O'Neill; Susan Roe, Registered Nurse; Robert Schreck, M.D., President, Nevada Medical Association; Charles (Chip) Wallace, Nevada Mutual Insurance Company.

Senator Raggio requested that the remarks made during the Committee of the Whole be entered in the Journal.

SENATOR RAGGIO:

We are sitting as a Committee of the Whole to consider Senate Bill No. 2. As I noted this morning in the Senate, we have before us the Governor's proclamation detailing the issues we have been convened to address. We are constitutionally bound to restrict our transactions to those items. We will meet in the Committee of the Whole, morning, afternoon and evenings, for whatever time is necessary to hear all of the matters that come before us properly. I want to re-emphasize we will attempt to provide a reasonable opportunity for all positions to be heard, but it will be necessary to observe time limits so that we can conclude our work in a timely fashion. At a press conference, that was just convened, there is an indication that the parties that have been at opposite ends of these issues have come together in an accord, and that accord is, apparently, now reflected in Senate Bill No. 2. It may be that we will not have opponents on each one of these issues that are before us.

In any event, let me again mention the procedures we will be observing in the Committee of the Whole. After the Governor's presentation on the bill, we will focus on one specific topic at a time. Today, our attention will be on the portion of the bill dealing with the cap on noneconomic damages and any related item to caps on damages. Within a fixed amount of time, representatives of interested groups will testify, and we will provide equal time to address each topic without interruption. At the conclusion of these presentations, the members of the majority party and the members of the minority party will have an equal amount of time for questions and statements. We will observe time limits in this phase of our proceedings to accommodate efficiency.

Because of the constitutional limits on the subject matter, any discussions beyond the topics in the Governor's proclamation will be ruled out of order. After legislators have finished questions or statements, there also will be an opportunity for any additional public comment. It may not be necessary, now the sides have come together, but we will afford them that opportunity. We will have to observe some time limits as well if we are going to be able to conclude an orderly presentation and have the deliberations that are necessary. Following that, the Senate may vote on that specific agenda item. We will do so if we make a decision in this committee, and if there are any changes or amendments, then the bill drafters can prepare a final version of the bill. As I explained on the floor this morning, any amendment to the bill or any request for a bill draft will require a majority vote of the committee for that purpose. The process is going to be repeated, if necessary, for each agenda item until we consider the proposal before us in its entirety.

During these hearings, in the Committee of the Whole, the members of the committee as well as others will please turn off all pagers, cell phones and computers. This is not as formal as the Senate itself, although, we will observe the decorum that is usual in the Senate. If you want to remove your jackets or be more comfortable, please feel free to do so. Finally, at the end of each day, the Committee

on the Whole will rise and return to the Senate Chambers to adjourn for the day. After the Governor and his staff's presentation, we will adopt some rules for the committee, and then proceed to our agenda.

Before we hear from the Governor, are there any questions or comments from members of the committee? Are there any comments from the staff?

If not, we are pleased, today, to have with us Governor Kenny Guinn. We appreciate your efforts in calling forth this session to deal with this crisis, and we welcome your appearance before this committee.

GOVERNOR GUINN:

Good afternoon. Before I begin my testimony, I want to be sure everyone understands that my testimony is not all-inclusive of the bill. You have a copy of the bill. It is in great detail. It is incumbent of me, as a Governor to make sure that I produce testimony that will be a formal record as we move forward in this process. In many cases I will read the testimony because it is important for us to stay on track and to indicate the support on the basis of which we make these recommendations to you through this law. I would like to thank my staff; Marybel Batjer, Chief of Staff; Mike Hillerbee, Deputy; and Keith Monroe, Legal Counsel. Also, I want to thank Brenda Erdoes, Kim Morgan and the other Legal staff members. I do not know how they work as many hours as they do without sleep. Without them, we could not have brought you this law in this time period. I want to thank them publicly. Without them, we would not be here today. They have all done a tremendous amount of work.

I have convened this special session, today, because Nevada is in a health care crisis. The cost of medical liability insurance has risen to unacceptable levels. The inability of doctors to obtain their insurance at reasonable rates is endangering the health of our citizens. Therefore, I believe immediate change in our laws is necessary to address this health care crisis.

The events leading up to this crisis began late last year, when, as many of you know, the St. Paul Insurance Company announced its decision to stop providing medical liability insurance to over 60 percent of Las Vegas doctors. St. Paul's decision was based upon an estimate that it was losing several million dollars annually because of lawsuits and claims against Nevada doctors.

As Governor, it was my duty to address this crisis head on. On Wednesday, January 23, I met with over 30 Las Vegas area doctors. At this meeting the doctors told me that medical liability insurance had become unavailable to them, and as a result, doctors were going to have to turn patients away, limit their services, or in the worst case, close their practices. At this meeting, I also learned that some insurers were quoting premium increases of 300 to 500 percent, citing the high number of medical malpractice lawsuits in Nevada, and the lack of a "cap" on noneconomic damages. To illustrate this concern, the doctors told me that medical malpractice cases in Clark County more than doubled over the past six years, with $21 million in jury awards last year alone.

Concerned that a lack of medical liability insurance was affecting access to medical care, on February 4, only eight days after my first meeting with the doctors, I directed the Insurance Commissioner to issue a Notice of Hearing. I wanted each and every medical liability insurance carrier authorized to do business in Nevada to provide testimony regarding their market intentions and conduct, practices in rating and underwriting, their premium payment plans, including "tail coverage," and their loss experience in Nevada. The hearing was scheduled for March 4, the first possible day for holding the hearing under Nevada legal notice requirements.

At the hearing, representatives from 13 insurance companies were present and testified on medical liability insurance coverage in the State. Also present and testifying were several medical representatives and associations, individual physicians and surgeons, insurance agents and brokers, representatives of the Nevada Trial Lawyers Association, and a representative from the Reinsurance Association. The record of the hearing also remained open for an additional week to allow all parties the opportunity to submit testimony. At the close of the administrative record, on March 12, the Insurance Commissioner determined that the unavailability of medical malpractice insurance had reached a critical stage.

The Commissioner found, and I quote, "There is overwhelming evidence that medical malpractice insurance is unavailable for medical practitioners in the State of Nevada. It is essential that services provided to Nevada citizens by the medical community not be curtailed. There is evidence that, in particular, certain medical specialties are affected by the unavailability of medical malpractice insurance, including, but not limited to, those physicians in OB/GYN, emergency trauma, radiology, surgery and ophthalmology, and there is evidence that, of the insurers present at the hearing, two companies are

leaving the State of Nevada, and of the remaining insurers offering medical malpractice insurance in Nevada, most would not offer it to those doctors in the specialty areas of OB/GYN, emergency trauma, radiology, surgery and ophthalmology."

After reviewing the evidence and findings, I knew Nevada was indeed in a health care crisis of great magnitude. It became abundantly clear to me that the State needed to intervene with a short-term solution to prevent doctors from limiting their services, and, at the very worst, closing their doors. I am responsible for the health and safety of all citizens of Nevada. I am compelled to ensure that pregnant women and those in distress receive adequate medical care. Therefore, I took an extraordinary step, I directed the Insurance Commissioner to establish the Nevada Essential Insurance Association, now the Medical Liability Association of Nevada, to provide medical liability insurance to Nevada doctors so that our citizens could continue to receive medical care from experienced and competent doctors, doctors they know and trust. The Association was established by emergency regulations on March 15, 2002.

On March 26, the State Board Of Examiners approved spending $250,000 to create and initially fund the Association. The Association was able to begin accepting applications from Nevada doctors on April 15, just one month after the Insurance Commissioner declared that Nevada was in a health care crisis. Initially, the Association's coverage was "claims-made" with coverage provided on a "go forward" basis from the inception date of the policy. There was no coverage for acts committed prior to the inception date of a policy issued by the Association. Because insurance companies pulled out of Nevada, doctors were forced to pay tens of thousands of dollars, and in some cases more, for "prior acts" or "tail coverage" in addition to increased cost of premiums.

While doctors were first confronted with a lack of available insurance, the crisis of availability had now also turned into a crisis of affordability. In the case of OB/GYNs, doctors were receiving insurance quotes that limited them to 125 births per year. With the requirement that if they went beyond 125 births they would have to pay an additional $20,000. This came at a time when doctors had been delivering an average of 240 babies annually. This made the crisis greater. As one doctor said "It's a terrible day for the entire community when a doctor cannot afford to deliver a baby."

On May 29, I announced that the Association would make upgrades to the plan. The plan would offer prior-acts' coverage to all physicians, would reduce rates for surgical OB/GYNs by 18 percent, approximately $16,000, and would eliminate tiered premiums on deliveries, no longer discouraging OB/GYNs from delivering more than 125 babies a year. I felt the upgraded plan offered by the State would help to provide necessary medical care in emergency rooms and maternity wards.

In addition to our OB/GYN community limiting services, Nevada's only level-1 trauma center, UMC, was now warning the State it might be forced to close its doors. In June, several trauma surgeons and specialty surgeons resigned or requested leave from the UMC trauma center facing imminent closure. As early as February, physicians at the UMC trauma center had warned the community that the lack of affordable malpractice insurance could force the only trauma facility in Southern Nevada to divert patients to other states. In late February, we were told that the UMC trauma center might have to reduce hours because there were not enough trauma surgeons to fill all three shifts. It was quite possible the trauma center would close its doors in June.

On May 31 the trauma surgeons issued another warning; they would be forced to sever their ties with the UMC trauma center unless they could obtain insurance that would protect them at a reasonable rate. As many as 15 specialty surgeons who assist the trauma center's general surgeons said they would not be available this summer unless they could get financial relief from skyrocketing insurance costs, and limited liability.

On June 6, five trauma surgeons and 26 specialty surgeons resigned or requested leave from UMC's trauma center. On June 18, twenty-one doctors were denied their request for a leave of absence from the UMC trauma center when the Clark County Commission decided that the quality of care would be jeopardized if the leaves were granted. The Commission also eliminated voluntary on-call policies, which meant that private physicians with privileges at the medical center would have to cover mandatory hospital shifts in the emergency room and trauma center if necessary. This forced doctors to decide between taking risky on-call emergency shifts or resigning from the hospital. Subsequently, 56 of the 58 orthopedic surgeons resigned from UMC, forcing the trauma center to close its doors on July 3, 2002, during the July 4 holiday. Fortunately, no lives were lost as a result of the closure, and a short-term

solution was reached. The center reopened on July 13 after the Attorney General issued an opinion concluding that physicians would be protected by a temporary $50,000 cap on noneconomic damages if they returned to work at the UMC trauma center. Thankfully, 15 doctors returned.

In the meantime, another urgent situation was temporarily averted on June 12, 2002, when the State Board of Examiners recommended an emergency allocation of almost $400,000 to help pay the rising cost of medical malpractice insurance for the doctors and interns at the University of Nevada School of Medicine. I had hoped the short-term solutions would provide stable and reliable medical malpractice insurance for Nevada's doctors until the 2003 legislative session, when laws could be adopted to resolve the crisis. It is incumbent upon me to exercise every emergency power that I have as Governor to address this crisis.

In mid-June, I formally called upon all affected parties to sit down at the table and work in good faith towards finding a common ground on the many complex issues, and to come up with a solution to the crisis within 45 daysÑa tort reform package I could bring to you. I called for 45 days of earnest negotiations among doctors, lawyers and insurance representatives. I informed the parties that if they could not come up with a plan by July 26 I would follow through as the Governor of this State and recommend a law, which I am doing today.

While the parties agreed on four topics for discussion: tort reform, insurance reform, medical records disclosures, and the State's Medical Dental Legal Screening Panel, they could not reach consensus on the issues. However, great progress was made with many of their ideas, which are contained in this bill. Nevada is out of short-term solutions to mend a long-term problem. We are now faced with the urgent need to develop a long-term solution to the health crisis.

In response to this predicament I was left with only one choice, to convene this special session and present to you my plan to address the crisis, a bill which lays the foundation for reforming the system, and which is a critical first step towards a long-term solution to the health care crisis. As the representatives of the people of Nevada, it is incumbent upon you, the Nevada Legislature, to adopt this bill. The purpose of this law as put forth, today, will be a strong foundation for us to begin the process to bring stability to the entire health care area. You have a unique and special opportunity. We must assure our citizens that quality health care is available now and well into the future.

In convening this special session, I am asking that you adopt new laws and change others, which will maintain the integrity of health care for all Nevadans. As our people's representatives, we all have an obligation to address the serious problems faced by our health care providers. I am presenting a bill to you, which represents comprehensive reform to our State and is the result of extensive discussions with doctors, patients, lawyers, insurance representatives and citizens. The intent of this legislation is to solve our health care crisis. We need to reduce health care premiums paid by health care providers. We need to create an environment where our doctors can continue to treat the most critically injured trauma patients, and where expectant mothers get the specialized care they need. We need to control medical costs and thereby make health care more readily available.

I feel now it is time to take a few minutes to explain the fundamental elements of my bill. One of the most unpredictable elements in the medical malpractice insurance marketplace is the awarding of noneconomic damages by a jury, damages for pain and suffering. The reason for this is because it is inherently difficult for a jury to place a monetary value on noneconomic losses. As a result, these awards can substantially vary from case to case and do. To provide a greater stability in the medical liability insurance market, I recommend the passage of legislation providing that in a medical malpractice case, noneconomic damages, such as pain and suffering, may not exceed $350,000, with exceptions that protect the most grievously injured patients. Such legislation will provide the State of Nevada with greater stability and will make the underwriting practices within the medical liability insurance industry more predictable.

To prevent the real possibility that many doctors will close their practices, leave our State, or turn away patients, I am recommending that you adopt a several liability standard for noneconomic damages in medical malpractice cases. Under the several liability standard, health care providers are ensured that they are responsible only for the portion of noneconomic damages directly attributable to their conduct. This is another established method of dealing with the inherent difficulties in placing monetary value on pain and suffering. Enacting this standard will provide health care providers with greater security so that

they can perform high-risk procedures and should also work to lower medical liability insurance costs. Under our existing laws, persons who in good faith render emergency care, such as ambulance operators, firefighters, and members of search and rescue teams, receive immunity from civil liability.

In order to control health care costs to the public and thereby make health care more readily available, I believe it is necessary to extend similar protection to doctors who work in our trauma centers. For a doctor in a trauma setting, who in good faith renders medical care that has been caused by a sudden, unexpected situation, which demands immediate medical attention, I recommend legislation that would limit civil liability to not more than $50,000. Such legislation would provide additional protection for those doctors who work in a difficult environment performing high-risk procedures and will keep health care readily available to our citizens.

As you know, current law pertaining to reporting disciplinary actions, claims, settlements and court awards against providers requires doctors and certain other persons to report this conduct. The intent of this law is to address the issue of doctors who do not practice at the standard of care we expect in our State. The law is comprehensive and provides for severe penalties for failure to report such claims. I recommend that the existing reporting requirements regarding disciplinary actions, claims, settlements and court awards against providers be strengthened. For example, a doctor who fails to report such a claim would be subject to discipline or non-renewal of his or her license. Insurers who fail to report claims within 30 days would be punishable by a fine of up to $10,000 per incident. The same would hold true for hospitals and other medical facilities that fail to report changes in a provider's privileges and fail to report disciplinary proceedings. Everyone must enjoy a presumption of innocence, so the existence of these claims and proceedings in medical facilities would be confidential, unless required by a court. The claim and settlement information, such as jury awards, which is presently considered a public record, would remain public.

I am recommending that you approve a change to Nevada law to allow a judge the discretion to order that jury-awarded settlements for future damages be paid on a periodic basis. Periodic payments ensure that money paid to an injured plaintiff will be available when the plaintiff incurs the anticipated expenses or losses in the future. Allowing greater discretion to our judges will allow for better flexibility in meeting the needs of the injured patient.

Next, I am recommending legislation to amend our statute of limitations provisions. Having a longer time period for permitting claims to be brought allows for an increase in insurance rates, an increase in medical costs and a lack of medical services available to our public. Under our current law, a plaintiff must file his medical malpractice action not more than four years after the date of injury or two years after the plaintiff discovers or through the use of reasonable diligence, should have discovered the injury. Our courts have long recognized that the legislature may establish time periods affecting liability for past acts. Therefore, I am recommending that legislation be approved that shortens the time frame for filing a medical malpractice action and requires an action to be filed within three years of the date of injury and two years after the date of discovery.

I am recommending the passage of legislation that repeals the medical and dental screening panels. The original intent of the screening panels was to minimize frivolous suits against doctors, to encourage settlement and to lower the costs of malpractice premiums. Conceptually, the screening panels are will intended. However, in practice, as evidenced by our current health crisis, the screening panels have not met the purposes for which they were created. In place of the screening panels, I recommend the legislation requiring the courts to create a fast-track system for medical malpractice cases. The courts should adopt provisions that expedite discovery, mandate early pre-trial and settlement conferences, and require the parties to engage in alternative forms of dispute resolution early in the litigation. This fast-track system should eliminate delay and allow our citizens to have their medical malpractice cases heard in an expedited manner by our courts.

As this health crisis unfolds, I have learned that our judges need more expertise in the area of medical malpractice litigation. Therefore, I am recommending that you enact the provisions of this bill to ensure that judges have training in complex medical malpractice litigation before handling such cases. This should ensure reliability and accuracy in the results of these difficult cases.

With this bill, I am also recommending that attorneys, who file and pursue frivolous lawsuits as determined by the judge, be required to pay for all costs, expenses and fees that arise as a result of their

unreasonable conduct. While most Nevada lawyers represent their clients in a professional manner, lawyers who are found to have pursued a frivolous case by the judge should be held accountable for their role in increasing costs and delaying justice for legitimate injured plaintiffs.

In conclusion, these measures will better serve our citizens and are intended to lower the cost of medical liability insurance for our health care providers. The bill before you balances the needs of injured parties, patients who seek the best medical care available and the doctors who must purchase and carry insurance to protect themselves and their patients. I called representatives from the legal, medical and insurance communities together and gave them 45 days to build consensus on these very important issues. They were unable to reach consensus. However, progress was made, and this bill contains the elements of their efforts. I have, therefore, written in this bill the elements that I feel will act to resolve our health care crisis. The time has run out. The people of Nevada and I, as Governor, now turn to you. The citizens of Nevada are depending on you to create new laws that will ease their fears and erase their doubts. Our citizens need to be assured that they will receive only the highest level of health care now, and well into Nevada's future.

This is especially true for the expectant mothers in our State. Each year, approximately 25,000 babies are born in Clark County alone. Having a baby is perhaps the most precious, important moment for a mother, father and their extended family. Expectant parents should not be robbed of this special time because there aren't enough doctors to provide adequate pre-natal care and to assist in the birth of a healthy newborn. If you do not act now, by October or November, there will not be enough OB/GYNs practicing in Clark County to provide proper care for thousands of women. You have a unique opportunity in this special session. This bill represents a beginning. I urge its consideration. Thank you.

My staff and I will be available to answer questions to expand on any of the areas because we can only highlight these issues in this presentation.

SENATOR RAGGIO:

I am going to ask our counsel, Brad Wilkinson, at the appropriate time, to go into detail on the bill. Are there any questions for the Governor at this time?

GOVERNOR GUINN:

I want to thank all the doctors, lawyers and the legislative committee. There are not many places outside of Nevada where we can come together from all walks of life and put a bill together as complex as this subject is. We listed 11 items in the proclamation, and those were listed after all the discussion. When we got finished everyone had their explanations that had this interest. I am pleased to say, publicly, that everyone agreed upon 9 out of 11 issues. The discussions we have gone through these last few days have only been for two issues, and those were for good cause. There was give and take on issues such as collateral sources and joint and several. Some of these other areas that we are talking about; lawyer pays, records and disciplinary procedures for doctors who don't follow procedures, and insurance companies, all came about. The only thing we changed out of the 11 is that we dropped 2 small items and added the fast-track system which everyone wanted. It took us to the last minute to put it in the language that we needed. That allowed us to take out the much more difficult recommendation on the hearing panel, the screening panel, and allowed us to say we are going to phase it out. We will keep our screening panel. It is not as clear. I would like it to be in the letter of the law, but the screening panel we have, today, will only be used, when we pass this bill, to phase out the 250 cases and then will "sunshine." Then we will be in a much better position with fast tracking. We are pleased to come about with 9 sustained agreements out of 11, changed 2 small items and turned them into 2 big ones.

SENATOR RAGGIO:

I know that the bill covers a limited amount of liability for doctors operating in a trauma setting. Was any consideration given to situations where doctors act in a pro-bono manner and provide pro-bono service, but there is no egregious conduct or gross negligence, will these be given immunity?

GOVERNOR GUINN:

Yes, absolutely, hopefully, later today or tomorrow, we can work out a time schedule. I plan to do this after talking to you and some of the leadership people on the Assembly side. I. say to you that this is a great opportunity both for the lawyers and for the doctors. What they have agreed to do, and I am

certainly willing to add it to the expansion of the proclamation, is say that any doctor, who volunteers his or her time in a non-profit health center where services are given will get complete immunity unless they commit egregious conduct. These doctors can volunteer freely and go there and help those who need that special help. The lawyers agreed to it and worked hard on it, and the doctors have said this is great for everyone, but importantly, it will be great for those less fortunate than many of us in this room

SENATOR RAGGIO:
That is not in the bill at the present time?

GOVERNOR GUINN:
I will do that over the next day or so. It is a great opportunity.

SENATOR MATHEWS:
Governor, I was wondering in the deliberations was any consideration given to nurse-midwives? Was there any discussion in that area? Outside of Las Vegas, nurse-midwives are used quite a bit, and their malpractice insurance is going just as high, percentage wise.

GOVERNOR GUINN:
In this case, there was not, but there are a number of areas that we think need to come back during the session. We have to look at all the training and requirements of what it takes for them to be a midwife. I think it is a very good subject for us to look at in the next legislative session.

SENATOR MATHEWS:
Outside of Mississippi, they are lay people, but in this State, they all have to be "masters prepared."

GOVERNOR GUINN:
I am pleased to say I was born outside of a hospital, and I had that experience. They did well.

SENATOR NEAL:
Governor, I just had a cursory review of the bill. It seems to be put together very well. I have one question about the training requirements that are imposed upon the Supreme Court. You seem to want to mandate the court to rule for mandatory, appropriated training on these complex issues dealing with malpractice. My concern is the separation of powers. I wondered had there been any discussions with the Court relative to this issue.

GOVERNOR GUINN:
Yes, I have had a number of discussions and written communications on some of the laws that are already on our books. We were very careful in all these areas and that is why I read into the record what I did, to substantiate why we are doing this for the medical crisis area and not necessarily for insurance. We looked at passed laws. You have every right, but I don't have them. You can direct certain things to the Court, and you have done many times in the passed. It is an encouragement, and we are asking them to set up a procedure. They get to determine their time schedules and the courses needed. We are not directing them to do that. I want to make certain that the intent of this legislation, from your point of view, that the record would show that you would like them to have some specialized training. I can give you an example. I have appointed nine or so judges. I think they have all been doing an outstanding job. Their experience is varied. It goes all the way from 30 to 35 years as an attorney and then some are very young. The last few I appointed come out of a municipal court setting, and they handled a different kind of a case other then medical malpractice or construction defects. At the present time, the courts have a methodology whereby they randomly assign judges to cases. We are asking them not to be randomly appointed until these people get a chance to go to the judicial college and get some special training. Do not randomly hand it to someone with no background. I will say to you that Supreme Court Justice William Maupin has been exceptionally cooperative in that area.

SENATOR NEAL:
One of the things we normally do in this political process in dealing with the third branch of government is we make it permissive rather than mandatory because we cannot mandate to the third branch of government. When I saw this particular language saying, "the Supreme Court shall provide by

court rule mandatory training," I have a problem with that language, and I thought the Court would have a problem also. That is why I raised the question.

GOVERNOR GUINN:

They may, but if they do, they certainly can indicate they are not going to follow it. I don't want to get you in a fight, Senator Neal, with the Supreme Court. I can tell you there are a number of laws on our books right now that nobody follows, and I fully intend to see those laws are followed. A couple of them involve different branches of government. By setting forth what we intend to do and working with them, they said we will see that this is done. We are really taking a strong stand. I think that you have the authority. If there were a question of constitutionality you would get a letter from the LCB. I do not believe that you have gotten a letter regarding this. There could be some differences, some give and take. But, what do you do if you pass a law, today, and you have a law on your books already that directs the Supreme Court and the courts to do certain things, and they have not been doing them? I have talked to them, and they are certainly going to do them now, and I'm just the Governor.

I respect your concerns because we have three branches of government, and I do not want to tread on their toes or have you tread on mine. I think it is a real give and take. We are a small enough state that they are willing to help us in this case. I do not think any judge will object to this.

I saw Allen Earl the other day at the Reno airport and asked him where he was going and whether he was handling cases here. He said, "Absolutely not. But, I will tell you, I was assigned a construction defect case, and I have no knowledge in that area. So I am going to the Judicial College because I need that help. I need that experience." That is all we are asking them to do. Here is a person with tremendous experience, let alone, one who is young and has come out of a traffic court situation. It is not good for our citizens, the legal profession or the judicial system. Senator Neal, and this is important for all of you to hear, one of the things that was said at the hearings was our judicial system is lacking in some of these training areas. I am only trying to help so that they will better understand. We cannot have one judge come into a situation under pain and suffering for the same incident, and we can find incidences that are extremely different from $100,000 to $800,000, and not understand what it means to have money left over to be put into economic awards. If there is any further information needed, I will certainly get with you and follow up. I will show you the communications that I have been dealing with the Supreme Court. Their response was outstanding.

SENATOR RAWSON:

I was just going to partially answer the question Senator Mathews asked. I believe section 11 dealing with some of the statute of limitation language does deal with health care providers and defines registered nurses. At least, in part of this, the nurse-midwife would be covered.

SENATOR WIENER:

Governor Guinn, you stated in your remarks we need to reduce premiums paid by our health care providers, and later, you made a comment that this should help us lower our medical liability costs. I am curious as to whether this legislation will deliver that. Do we have any assurances we will have lower premiums because of the negotiations that have occurred? You have mentioned the insurance industry. We have not heard a lot from the particular players there. Have they come to the table in your conversations and said, "We will lower premiums if you do this?"

GOVERNOR GUINN:

I think you might hear from them once they see the final bill. I can't speak for other people, but I did meet with the insurance representatives. They indicated that if we passed a bill that had a $250,000 cap on pain and suffering, noneconomic issues, they would lower their premiums over a period of time pretty substantially. I was concerned because I wanted to know if they are going to lower their premiums when they just increased them in the last six months by 200 or 500 percent as opposed to when we did not have this cap and this problem. Now when we have this problem, will they take it back? The doctors and lawyers realize this, and I think, it will be. We will see a bit of movement, but we are a very small market. We only have about three and, maybe, one or two other small insurance companies. That is why this State had to initiate an insurance company. We are in the insurance business, and I would prefer we be out of it. Right now, for an OB/GYN, we are about $16,000 less than what those people are offering.

We have to wait to see if we can draw them in. I looked at every thing that I could think of and wanting something in this bill that would be directly aligned to insurance companies. You cannot force people from the private sector to issue these. They can set underwriting standards higher, and then nobody can qualify for it. They can set their prices. They can come and go. They are not like a regulation under the PUC or utilities. We are at their mercy. If they do not come down, I will be bringing back some other recommendations to you as we move into the legislative session.

SENATOR WIENER:

You mentioned the state plan and you would rather we not be in that business. Until you have some assurances of the movement you alluded to, are we going to continue to provide that insurance coverage?

GOVERNOR GUINN:

Absolutely, it is our lifeline and has been for the last few months. I cannot even count the number of governors who have called saying, "How did you get an insurance company set up and going, get it approved and funded, and start taking doctors for coverage with not only forward concerns but with the past acts, in a month." We just did what we had to do under emergency powers. We have hundreds of doctors. Let me give you an example of what we did. The company that had been insuring the medical school for eight years gave them a bid, and you were going to have to fund more than the $400,000 that I mentioned but much more than that big dollars. We gave them a bid, and the company came down to meet our bid. We said that is what we are here for, go to the private sector. The university was happy. The insurance company was happy, and I was blessed because I didn't have to do that.

SENATOR TITUS:

Governor, I appreciate your comments about the insurance companies. I hoped that would be one of your points, and we could do some insurance reform. I had planned to come with some amendments, but that will not be appropriate at this time. If things don't work out as we are hoping they will, I would like to come back next session with some insurance reforms. I look forward to working with you to bring those back in February.

GOVERNOR GUINN:

Absolutely, we should see some progress being made because I believe this bill will draw not just the people that are here, but people from outside. You see California has thousands of insurance companies. They have a pool of thousands of people and thousands of doctors. We are very small. The insurance company we have, today, has a great deal of potential. If the people don't rise to the occasion from the private sector, I will bring you a recommendation that will show you how we can become self supported, with good prices for our doctors, and we don't like to be in there. We privatized workers' compensation, but when we have to do something like this, we are not paying any dividends, and we don't have to pay taxes. If we get efficient and learn the business the way we should, we will take care of ourselves in terms of insurance, which means we will take care of our people.

SENATOR TITUS:

And, we don't have to have creative auditing practices either.

GOVERNOR GUINN:

No, we will use the Legislative Counsel Bureau audit team.

SENATOR RAGGIO:

Are there any other questions? Governor, we thank you for appearance and we will proceed with our work.

The first order of business should be the adoption of the committee rules.

The rules are as follows:

1. All meetings shall be open to the public.
2. Eleven members constitute a quorum of the committee.
3. A majority of the members present is required to pass or reconsider a bill, budget, or resolution, or to take any other action.

4. Proponents and opponents of each specific proposal before the committee will receive uninterrupted equal but limited time to address the committee on the specific proposal under consideration.

5. Following presentations by proponents and opponents of each specific proposal, the members of the majority party and the members of the minority party will be given equal but limited time to ask questions and make statements about the specific proposal under consideration.

6. Matters not within the Governor's Proclamation or not relevant to the specific topic under consideration will be ruled out of order.

7. There will be a period of public comment within specified limits on each specific proposal then under consideration following the questions and statements of the members of the committee.

8. Following public comment, the committee may vote on the specific proposal then under consideration. The committee will then proceed to consider the next specific proposal.

9. Smoking in the committee room is not allowed. All cellular phones and pagers must be turned off.

10. The Chairman will convene and adjourn each committee meeting. All recesses shall be at the call of the Chair.

11. Although witnesses are presumed to be under oath while testifying, the committee has the option of requiring a witness to be placed under oath.

SENATOR TOWNSEND:

I move to adopt the committee rules.

SENATOR RAGGIO:

In the Committee of the Whole, a second to a motion is not necessary. You have a copy of the rules before you. Is there any discussion on the proposed rules? Hearing none, all in favor indicate, aye; any opposed?

The motion carried unanimously.

The rules will be utilized in the committee's deliberations. A number of members of the committee have indicated a need to make disclosures. Let me begin by indicating the following: I am a shareholder in a law firm, which has represented both plaintiffs and defendants in medical malpractice cases. Personally, I have not represented anyone in a medical malpractice case in over ten years, but as a share holder in a law firm, I have a pecuniary interest in legislative measures that limit the amount of damages a plaintiff may recover in medical or dental malpractice actions because such measures could have a negative effect on revenues of any law firm. Because the detriment accruing to me as a result of the enactment of those measures is not greater than that accruing to any other share holder in a law firm that may represent a plaintiff in either medical or dental malpractice action, I am advised the ethics law allows me to vote and participate fully in the consideration of such measures.

In addition, a registered lobbyist who represents certain medical groups on the issue of medical malpractice rents office space from my law firm. Other than the fixed amount this lobbyist pays for rent, the firm does not receive any other revenue from him, including no revenue from his representation of medical groups. The amount of money a firm receives from the lobbyist for rent does not create a pecuniary interest or commitment in a private capacity to the lobbyist on the part of the firm. The amount of rent and payment of the firm is not contingent on whom the lobbyist represents or on the issues on which he lobbies, and I am advised the ethics law allows me to vote on and participate fully in the consideration of measures relating to medical and dental malpractice.

I am also a member of the board of directors and a shareholder of Sierra Health Services, a publicly traded company, that has several subsidiaries, which include a manage care company, a health and life company, and medical group. As a shareholder, I would have a pecuniary interest in and a commitment in the private capacity to the company regarding legislative measures that limit the amount of damages a plaintiff may recover in any such actions because such actions could limit the liability of the subsidiary. I am advised that because the benefit accruing to me is a result of the enactment of those measures is not greater than that accruing to any other shareholder in a company that includes such subsidiaries' medical group, health and life company, etcetera, the ethics law does allow me to vote on and participate fully in the consideration of those measures. Pursuant to the appropriate statute, I have filed a disclosure in this nature with the Director of the Legislative Counsel Bureau.

Are there any other committee members who need to make a disclosure?

SENATOR RAWSON:

I would also like to make a disclosure, and it will be filed with the Director of the Legislative Counsel Bureau. I have a son who is a radiologist, a son who is a podiatrist, a son who is finishing his neurosurgery residency, a daughter in physical therapy, a daughter in nursing school, a son in dental school and a black sheep in the family finishing law school. As a dentist, I have a pecuniary interest in legislative measures that would limit my potential personal liability for dental malpractice, however, because the benefit accruing to me or to any members of my family as a result of the enactment of those measures is not greater than that accruing to any other health professional the ethics laws me to vote on and participate fully in the consideration of those measures.

SENATOR O'DONNELL:

I too have to disclose, I am a managing partner in two companies, Mirror Image Group, CML and LLC. These two groups are holding companies for real estate. I do have partners that are physicians as well as attorneys. My wife is also the bookkeeper, and I get paid for my services. I will give a response to the Legislative Counsel Bureau so that it will be on file.

SENATOR NEAL:

I did not realize that I might have a conflict until Senator Rawson started mentioning his children. I realized that I should disclose the fact that I have a daughter who is in medical practice, but she doesn't practice here. I also have a daughter who is graduating from law school and will be practicing here. It has me torn between two interest groups that I have to make up my mind as to which way I should go. I balance myself.

SENATOR COFFIN:

I am a licensed group-health insurance broker. The subject we are discussing is a casualty insurance product. I do not sell it and am not licensed to sell it. The clients that I represent do not sell it. I am not certain whether I have a conflict, but I will declare the position I have in the insurance business because some people assume all insurance brokers can sell all products. I will talk to the Director and see if I need to file anything in writing with the Legislative Counsel Bureau.

SENATOR AMODEI:

I apologize for not having any prepared remarks. I will disclose, I am a partner in a law firm, which occasionally does trial work in the area of medical malpractice on the defense side. I am informed and believe, thereon, included, in part, this disclosure, the fact that the effect of the operations of that firm are no different than any other firm in the State.

SENATOR MATHEWS:

I am a licensed registered nurse. I have never practiced as a midwife.

SENATOR JACOBSEN:

I have a practical disclosure. I have been an ambulance driver in Douglas County for 56 years.

SENATOR MILBURN:

My stepson is an attorney and practices law in that field.

SENATOR RAGGIO:

There are 21 Senators who comprise the Committee of the Whole and who are present for this procedure. The first topic we are going to discuss is to establish limits on the amount of noneconomic damages available in medical malpractice cases. If time permits, we will also consider the subject of limiting liability for acts occurring in a governmental or nonprofit center for treatment of trauma. When the agendas were prepared, we were of the impression that there were major differences between those who were negotiating on these issues. It appears to the committee that, at this time, there may be a coming together on these issues. So, instead of favoring the limits or opposing the limits, I am going to invite those who are representatives of the groups that have been in these negotiations to come forward. We will give you an opportunity to make a presentation, uninterrupted. It is now 4:20 p.m. I am going to

ask those of you that are here how much time you feel would be reasonable to hear this portion of the issue. Will someone give us an indication of how much time would be needed?

DEAN HARDY (Nevada Trial Lawyers Association):
We do have a presentation on the issue of caps. Our presentation probably would not take longer than 10 to 12 minutes. We have a video we would like to present.

SENATOR RAGGIO:
Who is here representing the medical group or health providers, anyone? I want to make certain everyone who has to say something has the time. I also have a list of people who indicated they want to testify. Has everyone who wishes to testify signed in? While we are waiting, let me introduce our counsel, from the Legal Division, Brad Wilkinson, and Scott Young is from our Research Division. Both are familiar with this bill and this subject. Both have served the Legislature and the appropriate committees for many sessions on these particular issues. We are fortunate to have them. Also, Jan Needham, Deputy Legal Counsel, is available. They are all available for any questions you might have. Mr. Wilkinson, at this point, give us an overview of what the bill provides and point to the sections on noneconomic damages.

BRADLEY A. WILKINSON (Principal Deputy Legislative Counsel):
The provisions pertaining to caps on noneconomic damages are contained in sections 3, 4 and 5 of the bill. Section 5 establishes a general limitation on the amount of noneconomic damages that can be awarded to a plaintiff, which is $350,000. The exceptions to the $350,000 cap are set forth is subsection 3 and are cases involving: organic brain damage; hemaplegia, paraplegia or quadriplegia; death of a parent, spouse or child; total blindness; actual physical loss of a limb, including a foot or hand; permanent loss or damage to a reproductive organ resulting in sterility; a case in which the conduct of the defendant is determined to constitute gross malpractice; or a case in which, following return of a verdict by the jury, the court determines, by clear and convincing evidence that an award in excess of $350,000 for noneconomic damages is justified under the circumstances. In those circumstances, in which there is an exception to the cap, the plaintiff is able to recover whichever is greater, $350,000 or the amount of money remaining under the malpractice insurance policy limit of the defendant after economic damages are subtracted from that amount. Further, irrespective of the number of individual plaintiffs in the action, no single defendant can be held liable for noneconomic damages in the aggregate, in excess of the policy limits of the defendant.

SENATOR RAGGIO:
In section 18, there is a requirement that a licensed physician shall not practice in the State unless that physician maintains professional liability insurance in the amount of $1 million per person and not less than $3 million per occurrence, is that correct?

MR. WILKINSON:
That is correct. Sections 25 and 27 contain the same requirement pertaining to dentists and osteopathic physicians.

SENATOR RAGGIO:
Are there any representatives of medical or health provider groups? I am trying to establish some time for your presentations since we do not have a situation where there is an opposition to a cap or support for a cap. How much time is reasonable for a presentation by both of these groups? I want to accommodate you. Are you representing the lawyers group?

MR. HARDY:
Our presentation will be between 30 and 45 minutes.

SENATOR RAGGIO:
How about the medical group?

MARK BROWN, M.D. (Chairman of the Nevada Mutual Insurance Company):
We will need about 15 or 20 minutes to give a general overview.

SENATOR RAGGIO:

We will allow each of you 45 minutes. I would like to have both groups seated at the table to make their presentations without interruption. Then we will have questions. It is now 4:30 p.m. We will allow until 6:00 p.m. if you need that much time to make your presentation on this issue. Are there any others who wish to be involved in this original presentation?

MR. HARDY:

There are other presenters from the Nevada Trial Lawyers Association, including several victims of medical malpractice who want to testify.

SENATOR RAGGIO:
Will all that fit within the time allowed?

MR. HARDY:
They will all fit within our 45 minutes.

SENATOR RAGGIO:
Are there some others outside these groups who wish to participate at this point in time?

DR. BROWN:
We would like approximately 15 minutes to make a presentation from the insurance company perspective.

SENATOR RAGGIO:
Is that on this issue?

DR. BROWN:
Yes, on this issue.

SENATOR RAGGIO:
You need 15 minutes, separate and apart from the rest of the presenters?

DR. BROWN:
Our issue will be separate.

SENATOR RAGGIO:
With that in mind, I will allow up until 6:00 p.m. for presentations from all of you. Will that be acceptable? What order do you think would suit your purposes?

DR. BROWN:
We are prepared at this point.

SENATOR RAGGIO:
There will be 1 hour and 15 minutes, divided between the presenters. Please, be as precise as possible.

SENATOR NEAL:
Could we hear from the insurance person? Because those individuals have not been heard.

SENATOR RAGGIO:
Does everyone who wishes to make a presentation have a copy of Senate Bill No. 2? Everyone who appears before the committee, please indicate your name, spelling it if necessary, and your title or affiliation. Please remain after your presentation for any questions that may arise. Testimony before this committee is deemed to be under oath, even though we may not require anyone to take an oath. Please be mindful of your presentation in that regard.

DANIEL S. MCBRIDE, M.D. (Physician, Chairman, Nevada Mutual Insurance Company)
I am here on behalf of the Nevada Mutual Insurance Company and am member of the Physicians Liability Task Force and represent the American College of Surgeons as the president of the Nevada chapter. I have been intimately involved in these negotiations since the original appearance before the Insurance Commissioner on March 4, 2002. Seated next to me is Charles Wallace.

The last thing I thought I would be doing is appearing on behalf of an insurance company. We are here only as a result of this medical crisis. Our company was founded in response to a lack of affordable coverage that all physicians have faced. Myself, personally, and the group were insured by the same insurance company. Our insurance was being terminated in June, and we found ourselves in the same predicament as most of the physicians in Clark County. The insurance premiums quoted to us were double and triple the cost of our previous coverage.

This insurance company was founded by doctors, run by doctors and is for the benefit of doctors. It was not founded to return profits to any company. It is a totally non-profit organization. It is never to be sold as the previous mutual insurance company had been to the St. Paul Company, which has led to some

of the problems we have now. It was also offered to provide some long-term stability the Governor's plan does not provide or was intended to provide. We are here to try to provide a service for the physicians that would be around in the future and provide stability in the market place.

As you are aware, there was not a flood of insurance companies coming to write policies in this State. The soil in Nevada for the insurance industry was as barren as it gets. What we have done is provide coverage for over 300 Nevada physicians. We have policies in place for reinsurance, plans for long-term growth as well as additional coverage for our physicians. We have no record of underwriting or manipulating the market in this State. We are here solely to provide coverage for physicians and provide their stability, but to do that, we need long-term medical liability insurance reform.

CHARLES (CHIP) WALLACE (Nevada Mutual Insurance Company):

I represent over 300 doctors. Three hospital chains have pledged almost $3 million to get this company going. The reinsurance we have in place provides for a second financial stability and viability in the market place and is quite necessary. We put this program together with the virtues Dr. McBride stated, such as, non-profit status and the ideology that will keep this company in place. That is only part of the equation. We are left with some questions. Does this bill meet the needs of the insurers who gave their sworn testimony on March 4, 2002? The insurance industry has already addressed the governing bodies of the State of Nevada. All we need to do is read their testimony. What the insurance companies stated was that MICRA, the California laws, would bring them back into the insurance industry marketplace. Is this bill short of MICRA? Unfortunately, I am not an expert and have not surveyed this question. The bottom line and answer to that question will determine if these private companies come back into this State.

As a citizen, and I think we should recognize all the opinions and concerns, I ask you, are the patients protected under this bill? Can you say this bill will reduce the cost of premiums? If not, we still have a problem. Will this bill reduce premiums by 5 percent because we watered it down, made changes that may well be necessary, but what is the offset going to be? Looking at this in pragmatic terms, is that going to be 5 percent? If you take a physician who was paying a premium of $30,000 a year and is now paying $68,000 a year, which is moderate, and reduce their premium by 5 percent, are we kidding ourselves into thinking we fooled them as well? Are they going to continue practicing medicine in Nevada? We have seen far too many specialist physicians, who serve an acute patient demographic, leave this community. It is paramount you ask those questions. Do trauma surgeons have liability protection or liability equality at the trauma center? If the answer is yes to the trauma center, what about the patient who shows up at the emergency room (ER)? The patient in the ER is in the same condition as the one in the trauma center. Those are hard questions that need to be asked.

On page 5, I have briefly reviewed the joint and several liability containment, I do not believe it goes far enough.

SENATOR RAGGIO:

What subsection are you referring to?

MR. WALLACE:

The complete language referring to joint and several liability on page 5.

SENATOR RAGGIO:

Please confine your remarks to the caps we are talking about. This part of the discussion is on limiting the amount of noneconomic damages. When we take up that issue, you will be welcome to comment on that topic, but at present we are trying to keep focused on this issue.

MR. WALLACE:

I will withdraw at this time and speak to the issue of joint and several liability at another time.

SENATOR RAGGIO:
What about the sections on establishing limits on the amount of noneconomic damages or governmental or nonprofit treatment centers?

MR. WALLACE:
The dollar amounts are absolutely tied to the language such as joint and several liability that leaves gross exposure; therefore, I would not be able to comment on that.

SENATOR RAGGIO:
You are not commenting on that part of it?

MR. WALLACE:
Arbitrarily, the cap is fine. What is the language within this document that protects those values, that protects the solvency of an insurance company or the exposure of liability of any one physician or group of physicians?

SENATOR RAGGIO:
I am not clear on your position. The bill before us has a $350,000 cap proposed on noneconomic damages, which could be exceeded in those cases in subsection 3, and are outlined where there are certain injuries such as; organic brain damage, paraplegia, quadriplegia or a case in which the defendant conduct is determined to constitute gross malpractice or where the jury gives an award higher and the court determines the clear and convincing evidence the amount for economic damages should be higher. Over all, there is a cap of the policy limits. Are you supporting the cap or proposing a change in that language.

MR. WALLACE:
Without having reviewed the document, I will give a conservative answer. If what is contained in this bill, in the section you are questioning, is consistent with the testimony of the insurers, the testimony from March 4, then I would support it.

DR. MCBRIDE:
Senator, may I ask you a question in reference to your questions on the caps? There was a provision regarding caps on services provided voluntarily, in a non-profit facility. You raised the point in your earlier remarks, and I wanted to ask you a question.

SENATOR RAGGIO:
It is not addressed in the bill. I asked the question whether it had been considered. A situation whether a doctor on a pro-bono basis provides some service in a facility, for indigents, for example, and the Governor responded, it was not in the bill, but he may add it to the "call."

DR. MCBRIDE:
I would encourage you, as a member of this panel, to please put that into a bill draft because I would like to speak to the issue at a future point.

SENATOR RAGGIO:
We do not have the authority at this time since it is not in the proclamation.

SENATOR CARE:
When the California Supreme Court considered the constitutionality of the cap of $250,000, one of the things they looked at was the legislative intent, and that is what we are doing with this testimony. We are laying down legislative intent, so we need to hear this. The Supreme Court in upholding the validity of the caps said, there was a rational relationship between the legislation and the state interest in the courts restraining and sometimes reducing medical malpractice insurance premiums. The court in California was interested in that. I did not hear but, at some point I want to hear, if not from you, gentlemen, something in this bill saying we are going to see insurance premiums restrained or reduced. The Governor addressed that a little earlier.

SENATOR TOWNSEND:

In the spirit of Senator Care's question, are you the actuarial expert who can answer actuarial questions or is there someone with you, today, who might be able to answer questions relative to caps?

MR. WALLACE:

No, the corporate line I was prepared to deliver was this. Were MICRA presented 100 percent, today, then the actuaries of this company and the other insurers doing business in this State would applaud and could attest to the fact that there would be a sharp reduction in malpractice premiums for physicians in the State of Nevada.

SENATOR TOWNSEND:

I would like these two gentlemen to get an answer to the following two questions. One is Senator Care's question. What are the premiums for physicians that practice in a trauma center in the areas of OB/GYN? Two, if this bill becomes law with a $350,000 cap on noneconomic damages with the exceptions that would then go to the policy limits, should a plaintiff in a case be willing to accept $50,000 to settle the suit, instantly, and the doctor agrees to that, but you as the insurance carrier say no, then it ends up going to litigation, and you lose to the caps. How do you actuarially account for the difference when you rate that physician at the next premium level?

MR. WALLACE:

We will have them follow up.

SENATOR O'DONNELL:

I have a question on page 5, paragraph (h). How does the court determine by clear and convincing evidence that an award in excess of $350,000 for noneconomic damages is justified? Does that leave the door open for the attorney to make a case to the judge that this case warrants more than the $350,000 cap? Is that per victim or per instance if there are four victims in a wrongful death suit?

MR. WALLACE:

When I brought up page 5, I was referring to the ambiguities in this law from an insurers and business perspective. We are looking at removing these uncertainties. Already there are a few. Therefore, without a concrete answer to the question, we are still in the same boat.

SENATOR RAGGIO:

I believe counsel has the answer to the question. It is per victim?

MR. WILKINSON:

Yes, that is correct. It is $350, 000 per victim.

SENATOR O'DONNELL:

Does counsel have an idea of how the court determines the clear and convincing evidence to warrant awarding an excess of $350,000.

MR. WILKINSON:

The bill, as it is currently drafted, does not provide a specific procedure by which that determination would be made following the verdict of the jury. Unless the jury returned a verdict for a noneconomic damage in excess of the cap amount, the judge would not be in a position to do that in any case. But there is no specific provisions saying how that procedure is going to take place.

SENATOR RAGGIO:

Let me suggest, on that issue, we hear the presentation from the legal and medical groups. After which we can take those questions. We are going to allow 40 minutes for the presentation from the legal profession representatives and 40 minutes from the medical profession. Is that adequate for your purposes?

MR. HARDY:

I would think so. While we are preparing for the video, I would like to introduce Bill Bradley, past president of the Nevada Trial Lawyers Association and current co-chair of our political action committee,

and John Echeverria, a lawyer in both the State of Nevada and State of California who practices in this arena.

SENATOR RAGGIO:
You might mention that Mr. Echeverria's father was a former member of the Senate in Nevada.

MR. HARDY:
Yes, he was a distinguished member and was a lot more than just a member. We also have several victims who will be testifying later.

SENATOR COFFIN:
Are there any people who have been left out of this bill perhaps through lack of representation or some other way as we found out from an e-mail sent from a nurse-midwife. We need to know that in your presentation. Did I make myself clear?

MR. BRADLEY:
Your question was clear. Because the screening panel covered doctors and osteopathic physicians, that is what this bill applies to as well as hospitals.

Video presentation. The following is text of the video is provided by Fierro Communications, Inc., Long Format, Citizens for Justice, Trt:8:15, 7.27.02, the case of Mike Nostro.

WENDE NOSTRO:
He was the guidance counselor at Brindley Middle School and far the favorite. You know, both staff and students alike just loved this man, just an incredible person. I mean loved by everybody and such a dynamic human being. It was a needle biopsy that was supposed to be performed. He was terrified. He was complaining about the pain in his chest, the pressure. He wasn't able to breathe. He just sounded terrified. The doctors response, and I will never forget this as long as I live, was "suck it up Mike, we're almost done." The doctor had punctured his aorta several times, and he couldn't breathe. I was right outside the door listening to my husband die.

Text of the case of Kevin O'Neill

KRISTIE O'NEILL:
He was completely full term. He was 8 pounds, 9 ounces. He was a big boy when he was born, so yeah he was very healthy. I asked my doctor if I could have a c-section, and he said, no. He just wanted to try and induce labor. He didn't even listen to what I had to say. He just said, no, he'd like to try to induce labor. I didn't even know he wasn't going to be there. He wasn't there, once, the entire time I was in labor.

TIM O'NEILL:
We were going to bring Kevin home to his already-made room, and everything was all done. We had all his stuff painted. His bassinet was ready to go. Everything was done just like the other children. Um, we didn't expect this. There was no indication of something was going to be like this. Kevin was perfectly normal. There was nothing wrong with him.

KRISTIE O'NEILL:
When he was born, he was not breathing. He was pretty, I mean, low apscar scores. He had had a seizure because of lack of oxygen.

TIM O'NEILL:
I knew then there were going to be severe problems, and I thought he was dead.

Text of the case of Diane Meyer

DIANE MEYER:

Two weeks before I went into the hospital, I'd had a complete physical, and I was perfectly fine. Everything was good. I mean, totally. I love being outside, and we love going for walks, climbing on paths and marching around at Red Rock. Anywhere you could take me, I wanted to go, and still do.

The first two adventures in that hospital, just Richter-scale bad. They just . . . And you know the sad thing is that we were the only people in the emergency room waiting. I laid there, and I was, at that point, so incredibly sick and so incredibly ill, I couldn't get the attention of anyone to take care of me. They said you have a tiny kidney stone, take this pin medicine and go home. A week and a half later, I'm so sick I don't have legs anymore. Um, at one point, they even considered taking my hands, and it was, thank God, my daughter and son and my husband just refused to let them do that. So for the lack of one simple little prescription, I no longer have legs.

WENDE NOSTRO:

I never thought he would die. I never thought that for a second. I still wake up and can't believe its real.

DIANE MEYER:

There are catastrophic cases that change your life and change your life and disfigure you forever, change every bit of it. It'll never come back. It won't. I hope I live 30 more years, and yet, I'm always going to be the same, nothing is going to grow legs back for me. Nothing is going to give me my independence.

KRISTIE O'NEILL:

There are a lot of great doctors, but I mean the decision that my doctor made, Kevin is going to have to pay for, for the rest of his life.

WENDE NOSTRO:

Originally, I tried to file a complaint with the Nevada State Board of Medical Examiners, and this is the board that licenses the doctors. They are not even policing their own physicians. Physicians are not policing colleagues. There are repeat offenders everywhere, and it so hard for me to have any trust in any doctor of any kind today.

DIANE MEYER:

It's just so hard to put a pretty outfit on and put my legs on, and I try to stand there and look just the way I used to look. I can never stand up straight. I can't stand correctly. There is nothing about me that looks the way I used to look. My whole life has changed, and it's just not going to change back. It's my job to make you comfortable around me because now I feel like a freak. I feel like a freak. It's really tough. It's really tough.

KRISTIE O'NEILL:

Having a child with special needs has changed my entire family.

WENDE NOSTRO:

Not one doctor in Nevada has ever lost his home, his car because of something like this. The insurance companies paid these malpractice claims, not the doctors, out of their personal bank accounts. So what have they lost?

KRISTIE O'NEILL:

We both almost died because of the carelessness of him and the hospital.

WENDE NOSTRO:

If there is any cap on a malpractice case, the incidents of malpractice will rise. They'll feel more protected, more comfortable. More mistakes will be made. Lives will be lost, I know it. In my heart, I know it.

DIANE MEYER:

I deserve the right to be heard by a jury. I deserve that. I deserve that. They need to hear what happened to me. And it will stop a doctor and make him be just a dot more aware of what he's doing and how he's affecting our lives for the rest of our lives.

WENDE NOSTRO:

There will be less accountability if malpractice is capped at $250,000. That will be nothing to them, nothing.

KRISTIE O'NEILL:

I think it's ridiculous because I think doctors and hospitals or anyone who makes the mistake should be held responsible for that mistake.

DIANE MEYER:

Your whole life is rearranged because of an accident that happened, someone's lack of concern for you in the hospital. That's what happened to me.

KRISTIE O'NEILL:

They don't know how much he suffers, and I don't know how they can put a price on that.

How the $250,000 MICRA cap affected one California Victim's lawsuit. David L.'s California physician was found guilty of malpractice for not providing the proper vaccine. As a result of that malpractice, David's hand and legs were amputated. Under MICRA, David was compensated for his loss of income. The insurance pays for the prosthetic legs he walks on, for the hooks he uses in place of hands. For his pain and suffering, David receives less than $12 per day because of the $250,000 cap.

End of video presentation.

MR. HARDY:

The video was brought here not designed to pull at anyone's heartstrings. I tell you that with all sincerity because of what is occurring in this field relative to limitations on people's access to our justice system. It breaks my heart as a trial lawyer when people's access to the justice system is reduced or diminished. Because we are not talking about technicalities, we are talking about people's access to have a jury hear their case and make a decision based upon the facts of that case, which are a constitutional guarantee and not a technicality. I have lived in Nevada for over 31 years. I went to Clark High School and UNLV. If I thought what I do for a living compromised people's access to health care or compromised the physician's opportunity to practice medicine, I would change what I do.

I am not convinced the data supports that malpractice premium increases are being driven by the civil justice system. The number of cases has risen with the population growth at the same level. The size of cases has risen as well. You have heard that testimony and read it in the newspaper. The size of those cases have risen for several reasons part of which has to do with health care costs. Again, we have information that does not support that health care cost increases are being driven by the civil justice system. What occurred at the end of calendar year, 2001, and the beginning of this year is simple, there was an economic downturn. We had one insurance company that had 60 percent of the market share of malpractice insurance in southern Nevada that pulled out of the business across the United States, including those states that have an active limitation on people's access to justice—what we euphemistically calling caps. This company pulled out across the United States for what we think were business decisions based upon their lack of investment return. This company did not achieve a 60 percent market share of underwriting medical malpractice in southern Nevada except for one very good reason; they kept their malpractice rates down. Their malpractice rates only rose 5.4 percent between 1994 and 2001. They ignored their own underwriting criteria. They insured every doctor that filled out an application, some of which had double digit claims against them. Insurance companies are certainly in the business to earn money, and we do not begrudge them that. When those insurance company practices impact people's ability to have appropriate health care, drive them out of the market, drive their competitors out of the market and then blame the justice system, we are asking for one simple thing to show us the data. We have concerns about this. Please show us the support.

You have heard, time and again, the answer to this problem, and I do not call it a crisis. We have a problem that the insurance industry calls a crisis because they call it a crisis. That is the same industry whose auditors, Arthur Anderson, audited those same multi-national corporations that are now in bankruptcy. It is important to note one aspect of this, on Friday, in the State of California that has all the answers for this problem, two of the larger insurers, NORCAL and Medical Insurance Exchange of California (MIEC), asked for double-digit rate increases for medical malpractice insurance. NORCAL asked for a 13 percent rate increase, and MIEC asked for a 10 percent increase. Is that because they need more tort reform in California? I think not. I think it is do to economic conditions, business determinations, and it is not being driven by the civil justice system. I cannot tell you how important this issue is to the State of Nevada. It is extremely important. I cannot tell you that we should ignore a very serious problem. What I can tell you is, if they are asking for insurance rate increases in California on Friday and if you think they did not know this Special Session was going to take place, today, I think we are all wrong. The reason will be answered in the testimony you will hear all through this bill. The answer is not limiting people's access or opportunity to go to our justice system. This is a multi-faceted problem dealing with doctors' reimbursement rates, the economy and a myriad of other problems, and it will not be resolved with a simple, quick fix that limits people's access to justice.

We have some people who would like to testify on the issue of caps. I like the questions that have been asked here, today, and you are going to do a responsible job because I have participated in this process for some time. Do not let the answer to Senator's Care's and Senator Townsend's questions go unanswered. Because, if you enact this legislation, which includes the issue of caps, and we see insurance companies asking for increase in rates, as occurred in California on Friday, then are we going to be here in February, 2003, or 2005 or 2007 seeking more limits on people's access to justice? Our system is being looked at by the world as the cornerstone of our democracy. Do not take what you are doing lightly for you are trampling on sacred documents. Those documents are our United States Constitution and Nevada State Constitution that preserves the right to a trial by jury. Our forefathers understood that to be the best system and remains, 200-plus years later, the best system of justice ever derived. Please do not take this lightly because we are limiting people's access to justice. I understand the political realities as you do. When you eliminate, reduce, diminish an opportunity to seek redress through our courts, you are trampling on the Constitution, and that is a civil guarantee that breaks my heart almost as much as that video.

JOHN ECHEVERRIA (Attorney):

I had the privilege of meeting quite a number of you last year at the legislative session when you honored my father. Little did I know then I would be back here in the special session addressing you on other issues. I was born in Reno and lived there until I decided to go to San Francisco to practice law. I returned to Reno last summer.

This issue has arisen, and I have been asked to talk to you about the impact caps have played in California. I have spent my career representing injured people as did my father for a large part of his career. I am doing it in both Nevada and California. I have litigated under both legal systems and under the limitations that have been placed in California and have seen the effect of limitations on economic damages. As a lawyer, representing injured persons, I am unalterably opposed to the caps on any noneconomic or economic damages. I, as well as many other members of the NTLA (Nevada Trial Lawyers Association) and members of this legislative body, belong to an organization called ABTA (American Board of Trial Advocates) which is a group of lawyers, nationwide, who are invited to belong to the group, composed of insurance defense lawyers and plaintiff lawyers. It is one of the most highly respected groups of lawyers who represent litigants in this field in the country. The ABTA's position is that they are on both sides of this fence and are unalterably opposed to the limitation on the recovery of noneconomic damages in any form. The guiding principal of the organization is, and we firmly believe in, the right of a trial by jury. Limitations on damages, limitations on access to the courts, limitations on what are commonly termed as tort reform, deny litigants the right to the fundamental constitutional right of a trial by jury on all issues.

Limitations on the amount of money a victim of medical negligence can recover have a very pernicious effect. Its stated purpose, without proof of these limitations, is to make insurance affordable. I have been practicing under the system in California for over 25 years since MICRA was enacted and

have not seen a significant effect in insurance premiums nor, have I heard any testimony that limiting someone's right to general damages will lower premiums. To me what is more important is, doctors have taken the position they want more affordable insurance. The purpose of these proposals is apparently to create affordable insurance, which is something beyond just reducing premiums from where they are today. I urge you in considering what I am going to discuss as the implication and impingement on the victims of medical negligence rights to access to the court that you ask for and receive very committed, documented assurances that enactments such as you are considering, which change people's rights and limit their amounts of recovery will accomplish the goal of making health care accessible to Nevadans.

In my opinion the real reason these types of limitations are asked for in these crises is to give an advantage to the insurance industry in situations of medical negligence. I say that because of my experience in watching how litigation arises, how it is pursued, how it is defended, and what happens. Limitations on noneconomic damages discriminate against those people that do not have large economic damages such as a housewife whose injured and has no earnings loss in the open market place, who has healthcare covered by insurance, who may have lost both of her legs, fingers and parts of her hands and has little or no economic damage. In that situation the person's recovery is $250,000, which is discriminatory to me against someone else in a similar situation but may have some large economic damages. The injury is the same and the suffering is the same. In my experience and practice in representing people under the California system it drives a great number of victims into bankruptcy because part of the concept of general damages is to compensate them for those things for which they are not otherwise out of pocket. Economic damage compensates them for loss of earnings, their medical bills not covered by insurance under the California system, and basically tries to make them whole again in terms of their out of pocket losses but the limitations on general damages does nothing to help them deal with their issues and other aspects of their life. To that extent those economic damages do not cover many of the tangibles and victims very often have to go into bankruptcy or are placed on the limitations of the welfare system of our country. Then we have transferred the medical negligent actor to the victim and ultimately to the taxpayer, which is a very pernicious act. Before you begin enacting legislation like this you should assure yourselves that it will accomplish the goal of getting affordable insurance.

More importantly, what a cap on limitations of damages does is deny access to the courtrooms. There are economic realities and practicalities in the handling of a medical negligence case. The insurance industry knows it and that is why they seek and pursue these caps on limitations. Cases like this cannot be handled for anything under less than $30,000, $50,000, $60,000 or $70,000 and in a complex case it would not be unusual for us on behalf of our clients to spend $100,000. That money if we are going to pursue our client's rights in a very egregious case such as I have previously described becomes unaffordable because the cases are so expensive to pursue, and the risk of recovery or loss makes it almost impossible. In my experience and in my office on very many unfortunate occasions I have had to tell people because of the limitations on recovery in California we cannot undertake your case because economically it is not viable and justified. Make no mistake, in my view that is the reason why caps are requested. It destroys the ability of a large segment of our population and victims, I have seen this and watched it since 1976 when MICRA came into California, and you cannot understand the number of times I tell this to people who I believe have been wronged but who cannot get redress in the court system which creates an anger because they believe in our system we all have the right to justice and they would if it were not limited. That is what caps do and that is the most pernicious effect of caps on damages in a large number of cases.

In some respects what you are considering is a very important issue and is done under extreme pressure. I recognize and understand the pressure. It is the same thing we went through in California. The same kind of urgency and the same pressures but we have some experience in looking back and seeing whether what is being requested really works. In my view they do not, they deny access. I understand the political realities but I would suggest before you make a decision to limit people's access, deny them compensation for general damages or limit their recovery you get some assurance that it will produce the anticipated benefit. I have seen it work to the disadvantage of many in California.

J. R. CROCKETT (Attorney, Nevada Trial Lawyers Association):

I have lived in Nevada for 50 years. My career has been exclusively devoted to representing injured people. There have been some great questions posed by Senators Wiener, Care, and Townsend that are

the focus of the subject I will discuss□constitutionality of the law. We are a government of the people, by the people and for the people. We are not a government of the insurance industry, by the insurance industry and for the insurance industry, and I hope we will not become so. Whenever you pass a law that impairs an individual's constitutional rights where the clear and unequivocal body of law in our country says that if you are going to impair individual rights, there must be a rational relationship between what you are doing to impair their rights and the public good you are attempting to accomplish. If you cannot establish a rational relationship and you have not used the least, drastic means to accomplish you goal, then the law, however well intentioned, is unconstitutional and will be stricken by the courts. In terms of its rational relationship, we distributed a publication titled *The Reality About Medical Malpractice Law* to the members of the Legislature. The first graph on page 2 shows the impact tort reform has had on insurance premiums in the United States.

The graph shows the 2001 insurance rates for states without caps on damages for a general surgeon were $26,144, and the rates in states with caps on damages were $26,746 a year. It was $600 a year more expensive to buy medical malpractice insurance in states with caps on damages□caps you are being asked to enact today. What is the real connection between rates and the insurance industry?

We have distributed two handouts, which are extremely important. Both carry the NTLA stamp in the corner for identification. One of them is a federal court decision. As you will see, the federal court said it is not a matter of excessive verdicts that are causing the problem; it is the cause of excessive malpractice. The court said the absurdity of the situation that the insurance companies are asking for these rate increases when in fact they are losing money on Wall Street would be analogous to a car manufacturer requesting and receiving a limitation on liability because of low sales in a previous year.

The second page quotes insurance industry representatives. Donald J. Zuke, who is the insurance chief executive for a California medical malpractice insurance company, says, "I don't like to hear insurance-company executives say it is the tort injury-law system. It is self inflicted." Sherman Joyce, who is the president of the American Tort Reform Association, says, "we would not tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." Victor Schwartz, a partner with Schuck, Hardy and Bacon, a leading tort-reform advocate, said, "Many tort-reform advocates do not contend that restricting litigation will lower insurance rates. I have never said that in 30 years." And, as final proof of the fact the insurance industry is the culprit, Governor Guinn, who testified here, instructed the attorneys for the State of Nevada to sue the St. Paul Insurance Company for creating the medical malpractice insurance crisis in the State of Nevada. Governor Guinn said the St. Paul Insurance Company under priced the market. They gave illegal kickbacks to the state medical association, and they have the premiums dangerously low, below acceptable rates. Govern Guinn, on behalf of the State of Nevada, sued St. Paul saying they caused the crisis. Congress has instructed the General Accounting Office to investigate the accounting practices of the insurance industry to see if they created this insurance crisis. There has to be a connection between the two. That great invisible giant, the insurance companies, will not even come and tell you, if you do this, we will do that. In failing to do that, they are building a constitutional infirmity into this law, therefore, making your process a futile act of passing a law that turns out to be unconstitutional. Allow us to continue to live in a state that is governed of, by and for the people and not of, by and for the insurance industry. Thank you.

JAMES DE ROCHE (Attorney):

I am not only a lawyer but also a parent of a child who was subjected to medical malpractice. The reason I have been asked to come here by the NTLA is because I find myself in a unique situation of not being able to retain a lawyer to represent my family because of the malpractice to my son. I will not go into the details of the malpractice, but the issue is that he was a "special needs" child. It is a wrongful death claim, and it is not worth a lawyer's time in the State of California to represent our interests. The reason is that the cost of a medical malpractice case□the expert laden aspect of it, in conjunction with the fact that the cases are often "defensed," juries tend to believe doctors because they are technical and tend to be above a jury's understanding which is why so many experts are needed. A "special needs" child is not going to shower his parents with money when they enter their old age so the value of the case is just not worth a lawyer's time. I have talked to several lawyers about it, but they all say the same thing, and I can fully appreciate what they are saying. The California statute has a lot of problems because of the cap, and I am pursuing this in the courts. My first amendment right is being infringed upon. The United

States Supreme Court and the California Supreme Court has said that as citizens of this country, we have the right to petition the three branches of government. My right to petition the Legislature is being exercised right now but also to exercise the Executive branch and the Judicial branch and that includes "a meaningful right to be heard," which in a complex litigation matter means a right to counsel.

I heard one Senator talk about a California Supreme Court case. They did not address that particular issue. In fact, Justice Kaus specifically mentioned it but said there was no evidence put forth at the trial court level so they were not going to consider it. As a consequence, I think you should be very wary of setting a fixed cap. A fixed cap reminds me of Sybil in Greek mythology. There was a beautiful young woman who the god Apollo, or someone, was smitten by her, and he came down and said, "I will grant you any wish you want." She said, "I want to live forever." Apollo immediately knew that was a mistake because she did not say, "I want to live as a young, beautiful woman forever." As the decades and years rolled on, she became more and more decrepit. The problem with MICRA, at the $250,000 cap, is that times change. There is no provision for allowing the cap to fluctuate based upon the economy, lawyers rates or the standard of living.

As a consequence, the cap, today, based upon the consumer index, is about $84,000. You can imagine what that is worth. As a consequence, I feel that as time has gone on, the cap has become more and more restrictive in 2002 dollars to where it is a first amendment issue. It is unreasonable, and there are a lot of people who are not getting access to the court for their grievances. Most doctors try their best, even the bad ones try their best, but the point is the bad ones are out there and do commit malpractice. When that happens, there needs to be redress, not just in the civil cases but also before the license board, so that the bad are separated from the good.

ROBERT MCBEATH, M.D. (Nevada Medical Liability Physicians Task Force):

I graduated from Clark High School and obtained my undergraduate degree at UNR and my medical degree at the University of Nevada School of Medicine. After a six year Nevada residency, I returned to Las Vegas in 1994 to practice.

This issue ultimately requires us to reevaluate our medical-injury compensation system. We seek to create a new balance between the need to protect the injured patient in an act of medical negligence with the ability of our community to have access to quality, stable medical care. In February of this year, in response to the most significant threat to the stability of our community's health care system that we have seen, nine separate physicians' organizations including the Clark County OB/GYN Society, the Clark County Medical Society, the American College of Surgeons, the American College of Emergency Room Physicians, the Nevada Orthopedic Society, the American College of Physicians in Internal Medicine, Physicians of Nevada, the Nevada State Medical Association and also our liaison came together to form the Nevada Medical Liability Physicians Task Force. Through this organization, the physicians have worked hard to find a solution to reform our severely broken medical-injury compensation system based on California's MICRA legislation. Our position is clear. Our patients and people of our community are at significant risk of losing access to their physicians and other vital health care services.

In 1975, Nevada and California were both experiencing a crisis in their medical liability in health care systems. Our neighbor state enacted meaningful reforms called MICRA while Nevada created the screening panel. Since that time, California has enjoyed a stable medical-injury compensation system providing them the foundation to build a world-class health care system. We are now experiencing our fourth malpractice crisis in 27 years. Our current system is severely ill, but we have the diagnosis, and we know the cure. In the last 2 years, alone, jury awards have increased by over 800 percent, and over the last 15 years, the average, closed-claim costs have increase by 630 percent far outpacing all other medical or wage inflations by more than a factor of 5. This result has been a dramatic increase in premium rates for, primarily, Clark County physicians, some approaching 500 percent. Also, it is combined with the marked reduction in the availability of insurance companies willing to provide and write policies in our State. The good news is there is a time-tested cure to what ails this system. This prestigious body might take some comfort in the knowledge that the MICRA reform package, which the physicians are abdicating in line with what our Governor has presented and similar legislation was adopted 27 years ago by California, has been successful in stabilizing and creating a healthy competitive environment for the malpractice insurers to operate. It has kept physicians malpractice premium rates at affordable levels, and most importantly, it has insured fair compensation to injured patients as a result of

medical negligence, at the same time, maintaining access to high quality health care to all of their citizens. It is this type of reform package, which the Nevada Medical Liability Physicians Task Force urges you to consider and adopt this important legislation and breathe new life into the medical community and guarantee continued access to quality and affordable health care for all our citizens.

IKRAM U. KHAN, M.D. (General Surgery):

I am a practicing general surgeon for the last 24 years, member of the Nevada Medical Liability Physicians' Task Force and serve as the Governor's liaison to this task force. I am also serving as a member of a federal medical advisory board to the United States Secretary of Defense and have had the privilege of serving on the Nevada Board of Medical Examiners for eight years.

I would like to thank the Governor for calling this special session of the Nevada Legislature to debate and vote for a long-term solution of this unprecedented, monumental crisis of skyrocketing premiums for medical liability insurance, which has shattered and shaken the foundation of health-care access and is poised to threaten the entire infrastructure of health-care delivery systems, not only in Clark County but in the entire State.

We in the medical profession owe the Governor a debt of gratitude for making medical liability insurance available in record time, and now with his leadership and the leadership of the Legislature, a meaningful, effective and durable resolution can be achieved.

The Governor's bill introduced, today, with bipartisan support is a tremendous and bold beginning. What you accomplish over the next few days in consolidating this bill could go in the annals of history as a legacy of daring and courageous leadership for the right cause. Each of you represents thousands of constituents, who have high hopes and expectations. The decision you make here will reaffirm their belief in the democratic values and principals and will go a long way in helping them have uninterrupted access to one of the best heath care systems in the world.

This is not an issue about doctors. Doctors have become the football in the game of soccer. You can kick the ball around the court. But, if you kick the ball out of the court, the game stops and the team has to regroup. The game has stopped. It is time for us all to regroup and get the ball back in the court so the game can reconvene, and the people of Nevada, once again , can have access to their doctors.

Given the current medical liability crisis, the doctors cannot protect their family's financial future. The endless and limitless jury awards in verdicts have engulfed the doctors and their families, exposing them to financial ruin. Doctors must, therefore, leave for a safe haven.

We have laws to protect animals in the forest from unforgiving, relentless hunters. We have laws for the protection of the environment. We also limit the number of animals that can be hunted to protect those animals from extinction. Ironically, there are almost no laws to protect the medical professional from extinction.

Like all other professionals, a doctor's first and foremost obligation, religiously, ethically and morally, is to his spouse and children. To expect doctors under their Hippocratic oath to abandon their responsibilities and obligations to their families is grossly irresponsible and inherently unfair. Based on clear and convincing data available from several states, the doctors have concluded the only way to protect their families and have an economically viable practice in Nevada is to have a meaningful, comprehensive tort reform based on the principles of MICRA.

Any effort to dilute, modify or delete any component of MICRA have resulted in minimal impact on medical liability insurance premiums in other states. Texas is a glaring example. Texas has only three out of seven components of MICRA. They are going through a crisis of their own, today, and the governor of Texas is calling for MICRA reforms. The State of Ohio tried to implement caps but was overturned by the courts in 1985, and their malpractice insurance rates have risen.

It has been concluded in several independent, objective national studies, Harvard, Stanford, American Academy of Actuaries and the Congressional budget office studies, that MICRA of California is the gold standard for long-term, affordable, sustainable stability in medical liability insurance premiums. It has also been firmly established that the most crucial and pivotal component is a cap on noneconomic damages, and caps on attorney's fees is an integral and inseparable component of it. The trial attorneys, for self interest, have aggressively and vociferously opposed these caps.

We watched a video earlier concerning the rights of victims, we are all for the rights of the victims. We are also protecting the rights of the victims. In fact, we recommend we go a step further, give the

victims more then they receive under current Nevada law. It is sad to see those victims in the video that had to defer up to 40 percent of their awards in legal fees. Under California law, the victims of an adverse medical outcome receive 17 percent more then they do elsewhere because of those caps.

All doctor's fees are capped. Medicare and Medicaid cap doctors and privately managed care companies. The supposed savings from these caps are to be passed on to the consumer. There are also caps on utilities and power. Then, why is there an objection to cap attorney's fees? The medical profession has become the most regulated profession in this country.

This debate is about injured people, a minority of a few hundred versus the 2 million whose right of access to health care is being denied. The injured person must be made whole for past, present and future economic losses and an additional $250,000 cap in California for pain and suffering. Under our Governors' plan, the cap will be $350,000.

Unfortunately, it is the unrestricted guarantees to handsome rewards that the defenders of these victims retain most of those awards that denies them their real right to that access. We also heard testimony about offering the civil justice system. This is not about the civil justice system at all. The civil justice system has been sound and safe in California for 27 years, and 33 million people are reaping the benefits of it. The civil justice system is not compromised in Utah, Indiana, Montana or Colorado. All have caps of $250,000, and 24 other states have caps of some sort. Their civil justice system is not compromised. How, then, will Nevada's civil justice system be compromised with our meager population of only 2 million people. We believe the civil justice system will be strengthened and streamlined, and more money will be going to the victim. If such legislation is not passed, we cannot sleep with a clear conscience or look in the eyes of pregnant mothers, children with cancer or senior citizens who have no access to medical care.

Insurance industry data suggest to us that a cap of $500,000 in noneconomic damages, by estimate, could reduce insurance premiums by a meager 15 percent over 3 to 8 years. Whereas, a cap of $250,000 for noneconomic damages is expected to reduce the premiums from 30 to 40 percent over the same period. A cap of $350,000, as the Governor has proposed will reduce premiums about 25 percent for the doctor. Imagine a doctor with a 100 to 300 percent increase in premiums hanging his hopes on a meager 15 percent reduction in insurance premiums in 3 to 8 years if the cap were $500,000.

While a cap of $500,000 on noneconomic damages may be a "feel-good number," the people of Nevada expect a "do-good number." We feel the $500,000 number is not a "do-good number" but $350,000 is a good beginning.

If legislation does not evolve from this special session, the doctors will continue to leave. This is a painful reality. I to am seriously considering leaving Nevada in March of 2003. My insurance went up 100 percent this last year with no payments made on my behalf for over 15 years. I have had a 100-percent increase in my insurance premiums, and my insurance carrier has applied for a raise to the Insurance Commissioner. If this raise is even one percent more, I will not be able to sustain myself and my family in this community. This is a painful decision because Nevada and Nevadans have been very kind and gracious to us. We have established our roots here. Our children grew up in Las Vegas and went to public schools and to UNLV. I have done my share of community service and have fulfilled my civic duties. Unfortunately, I cannot sacrifice the well being and financial security of my family and shall move to where my family's future is protected.

Do not abandon our beliefs, our principles and our values to make a policy that we will live to regret. The citizens of Nevada will never forgive us for denying them their constitutional right to the pursuit of happiness and their right to protect their families from harm.

FLORENCE JAMESON, M.D. (OB/GYN Physician):

I moved here in 1985. I was born and raised in San Diego, California. I went to UCSD as an undergraduate and attended UCLA Medical School and residency. I am licensed to practice medicine in California, but I choose to come to Nevada. Since 1985, Nevada has been my home. I have been very blessed with a wonderful practice beyond my dreams, hopes and expectations. I have had wonderful relationships, challenges and the richest joy that anyone could hope to have in their career. However, things have changed. When I first came to Nevada, so many of my patients went to Santa Barbara or elsewhere for their checkups, but through the years, we have won their confidence, and they stayed with our local doctors. We have seen specialists come into the city and have watched an incredible medical

care system develop. Now, I am watching this care system implode, like one of our casinos. It has been devastating because at least one dozen of my colleagues have left in the last few months. In the last year, some have filed bankruptcy, and most of them have made an average loan from the bank of $60,000 to continue practicing and have experienced many months without paychecks.

When I came here in 1985, I received more for a delivery than I do today. My overhead is higher than when I arrived. It is true I am not a businessperson, but my husband is an accountant, and no matter how we try to skimp, he says, "There is no fat or fluff, dear, to take off any more. You really cannot continue." He has been extremely patient. I started 18 years ago seeing approximately 26 patients a day and had 12 deliveries a month. In order not to sacrifice quality time with the patients, I have now extended my hours from about 7:00 a.m. to 7:00 p.m. In order to keep my doors open, I need to see 45 or more patients a day and the number of deliveries have risen to 20 a month. I cannot, humanly, do more to keep a practice going. From all my consultants and advisers, I do not know how I can make it viable.

A colleague said her son-in-law who is 23 years old with a high school degree and is a plumber makes more than she did last year as an OB/GYN physician. After 12 years in training and only 8 years in practice, she said, "I quit." The joy is gone. Another friend told me, "I had a medical malpractice case and I am not insurable. I cannot get an insurance I can afford."

The bottom line is, my insurance has risen so high, there really is no way I can afford it at this time. My insurance premiums have risen from $28,000 to $32,000 to $42,000, and this year it is $137,00. I have never gone to court, paid a claim or settled. How am I supposed to pay that amount when last year I made only $47,000? We are all hoping that our managed-care companies will reimburse us. I am here for the duration. I do not plan to return to California where I have a license. Nevada is my home. If laws are not enacted to protect me so that I can have affordable insurance and practice without the risk of losing everything, I will simply no longer be able to practice. After all these years of education and practice, did I move to the wrong state? All my friends say I did, but this is my home. I need a really good act of this Legislature to keep me in business. I am not any different from so many of the other physicians. Without reform, it will not work.

Mother Theresa said, "You, that practice in the city, have a much more difficult time. I chose to practice in the country where there are the poor and the dying. I can feed the poor and help the dying, die with dignity. You who have chosen to serve in the inner city have a lot more politics." I never understood what she meant, until the last 6 months. I always thought even if I did not make money, I could barter a chicken or whatever and continue my passion and walk that healing journey with my patients. But, I do not know anymore.

SENATOR RAGGIO:
What was your insurance premium raised to?

DR. JAMESON:
$137,000.

JOHN COTTON (Attorney):
I am here in Carson City to help with the negotiations and with the language of the bill you have in front of you.

SENATOR RAGGIO:
So far, we have not heard testimony of any compromise that has been accepted by both sides.

MR. COTTON:
No compromise language has been accepted by both sides at this time. The position of the NTLA would be to attack any bill with a cap at some point. The Governor has presented a plan that is workable, and we hope will solve the problem that has clearly caused a crisis in this State.

I am a trial attorney who represents doctors. There are a lot of great doctors in this State. The practical reality is we are losing them. Everyday, I get calls from doctors not able to get insurance in this State. One of the witnesses testified that this is a multi-faceted problem, and I agree. The fact that it is multi-faceted does not mean that we do not address the facet we have in front of us. The simple fact is

we are not going to have any insurance carriers to regulate in this State if we do not adopt meaningful tort reform.

What we attempted to do is to adopt something that was a little bit different, had some different wrinkles in it than in other states. We have a larger cap than California. You must understand that many of these things are not necessarily palatable to my clients but are things that will be workable within the system. We adopted some exceptions but also gave some certainty to the insurance industry. When you see videos as we saw here, today, and I look at them with compassion, having had my father die at the age of 52 from malpractice, the fact is no amount of money can replace a person. No amount is too little or too much. The problem is we have a crisis that has to be confronted. For every person you saw on that video, I have 15 to 20 cases juries looked at and threw out. I have another 25 to 30 cases, in the last two years, that have approached trial, after having expended significant amount of time and effort, which get dismissed without payment. There are 20 to 30 cases for every one you may see like that, which is creating the crisis in this State because there is a system that is allowing it to occur. Unlike statements that have been made here, today, under this bill, no one is depriving anyone of a trial by jury.

For the brain-damaged baby cases and the paralyzed cases, for economic losses, for losses of income, and for the medical expenses incurred, there are no caps for those in this bill. Those are provable in a court of law before a jury. What is being capped is the nebulous damage that prevent the insurance carriers from coming into this State and helping my clients and this community. You cannot quantify pain and suffering. You cannot plug it into an underwriting program. States around the country have found the only method of giving any stability to the insurance industry, to help the doctors stay in their states is to give something they can quantify and put numbers on.

Senator Townsend and Senator Care had some questions regarding the impact of what is being proposed. Mr. Wadhams has the data. I will defer to him, and I stand ready to answer any questions regarding the substantive aspects of this bill.

LONNIE L. HAMMARGREN, M.D. (Neurosurgical Associates of Nevada):

I have been serving the trauma center, which was a county hospital, for over 31 years. I operated on a blood clot in the head of a patient on the night the trauma center closed.

I will give you a short case and how it applies to caps. I was sued in 1994, shortly, before Christmas. I was in the operating room at University Hospital and a chronic-back patient walked into St. Rose Dominican Hospital-Rose De Lima Campus. They supposedly called me. There is no record of the contact, but my name was on the chart. The doctor the person saw decided he did not need to be admitted into the hospital so was sent to a nursing home over Christmas. Consequently, that person became a paraplegic. You would think it would be easy to get out of that lawsuit because I had never talked with them. I was miles away and am not authorized to take care of an HMO patient. It is the hospital's responsibility, but because it is an HMO, they could not sue. They saw my name on the chart.

It has taken seven years and $56,000 in attorney's fees to be taken out of the lawsuit. A lot of it is not the monetary award, it is the legal morass that we go through. Remember he would have been transferred to University Hospital. Does the cap apply to the trauma patients or the other patients who come through the emergency room? Many people are transferred from other hospitals. So, would the $50,000 cap apply for treating that patient or would it fit in the exclusion of the $350,000 for noneconomic damages because it is a neurological problem? If you look at all the exceptions, half of them are neurological and some are OB/GYN. If you end up being sterile, then you can sue, and the caps do not apply. How about your heart? Does that make a difference too? There is no logic to these exceptions other than they are high-value lawsuits.

Yes, it is a multifaceted problem, but it is just stunning that the doctors are of one voice in this matter, supporting MICRA, and the attorneys are their own worst enemy. You have three attorneys testifying; two saying MICRA does not work, and the third attorney stated he could not get an attorney in California to support his malpractice suit because of MICRA.

SENATOR RAGGIO:

At this time, I would like to have a couple testifiers from the doctors' group and attorneys' group and others available if there are questions. We are on this issue of limited damages. We have heard testimony from the lawyers' group who generally are in opposition to any cap. We have heard testimony from the

doctors who have essentially said we should be adopting MICRA. We just finished a press conference where everybody said they were on board with the bill before us. We are told we have negotiated this; we feel comfortable with this bill; and we can support it. But this body has heard no testimony of that kind. Are we being lead astray? Are you ready to talk about the bill that is before us on this issue of limiting the liability, in sections 3, 4 and 5 of the bill? We would like to hear testimony as to whether this language is appropriate, if there is a need for any change in it or whether there has been some agreement in these negotiations.

BILL BRADLEY (Attorney, Nevada Trial Lawyers Association):
As of 8:30 a.m., there still was some language that was not quite right. We have reviewed it with the Governor's staff and with each other. There are a few minor areas where clarification needs to be made.

SENATOR RAGGIO:
We are addressing sections 3, 4, and 5 of the bill. Will you gentlemen indicate whether this language has been agreed to or are there areas where we have been given inappropriate information? Where are we on this issue?

DR. MCBEATH:
From the physicians standpoint we begin to get a comfort level at the cap number that the Governor has put forward. Our whole presentation has been that our reform package be meaningful and by meaningful reform we are looking for two primary and one tertiary things. The two primary things are: the medical malpractice insurance market be stabilized and our premiums rates be reduced. This is very important to us. We have seen 300 to 500 percent increases in our malpractice premiums. Meaningful reform to us is not a 5 or 10 percent reduction.

SENATOR RAGGIO:
This bill does not mandate any reduction in premiums. This committee needs to know if the language before us is the language your groups have agreed to for this purpose.

MR. COTTON:
The Nevada Trail Lawyers Association with whom we have been having discussions with all day to work out some of the language, much like the American Trial Lawyers Association, has a concept that they can never in principal agree to caps because their clients who theoretically have to agree to it.

SENATOR RAGGIO:
Is this language what has resulted from your negotiations?

MR. COTTON:
It is, Mr. Chairman. Other than a few small, technical wrinkles, which we have agreed to insert in the bill, it is the language we have agreed upon.

SENATOR RAGGIO:
What are the wrinkles? The Governor indicated this was an agreed-upon version of the bill.

MR. COTTON:
It is more technical than just taking some words out that do not make sense in the context of the way they are worded and adding a couple of words that represent the agreed upon version. There are just one or two word additions and two or three word subtractions that need to be done for clerical purposes.

SENATOR RAGGIO:
For the purpose of the record, we are looking at the printed bill, Senate Bill No. 2. Then we can look at the page and the line.

MR. BRADLEY:
Page 3, section 3, line 10, when it says, "loss of earnings," the last three words, "or loss of earnings capacity."

SENATOR RAGGIO:
That should read, "loss of earning capacity?"

MR. HARDY:
It should read both "loss of earnings or loss of earning capacity."

SENATOR RAGGIO:
You would add, "or loss of earning capacity." If these are not agreed to, we need to know that as we go through them.

MR. BRADLEY:
Section 5, line 17; "damages awarded to each plaintiff." On line 16, should be followed by "from each defendant."

SENATOR RAGGIO:
Is that an agreement?

MR. BRADLEY:
Yes, sir.
Let me read the whole sentence. "Except as otherwise provided in subsection 3, in an action for damages for medical malpractice or dental malpractice, the noneconomic damages awarded to each plaintiff from each defendant must not exceed $350,000."

SENATOR RAGGIO:
That is agreed to. What is the next one?

MR. BRADLEY:
In paragraph 2, on line 18, where it starts, "In an action for damages for medical malpractice or dental malpractice in the circumstances and types of cases described in subsection 3, the noneconomic damages awarded to a plaintiff from each defendant."

SENATOR RAGGIO:
That is not covered by the previous change?

MR. BRADLEY:
We thought it should be consistent throughout.

SENATOR RAGGIO:
Is that agreeable?

MR. HARDY:
Yes, it is.

MR. BRADLEY:
(continuing) "must not exceed" and the next words, "the greater of $350,000 or" is deleted.

SENATOR RAGGIO:
You are deleting "the greater of $350,000 or?"

MR. BRADLEY:
Starting with the word "the greater" and including the word "or."

SENATOR RAGGIO:
It would then read "must not exceed the amount of money remaining." Is that agreed upon?

MR. BRADLEY:
Yes. Section 5, the end of subsection 2, "This section is not intended to limit the responsibility of any defendant for the economic damages awarded."

SENATOR RAGGIO:
Is that change agreed upon also?

MR. BRADLEY:
I need to get some clarification on that one change.

SENATOR RAGGIO:
We will hold that one aside. That would go at the end of subsection 2.

MR. BRADLEY:
That is the extent of the technical wrinkles.

SENATOR RAGGIO:
Are there any others in sections 3, 4 or 5?

MR. BRADLEY:
No.

SENATOR NEAL:
What is the importance of the change?

SENATOR RAGGIO:
What is the importance of adding this language, "This section is not intended to limit the responsibility of any defendant or economic damages awarded."

MR. BRADLEY:
Regarding economic damages, the defendant will be responsible for the economic damages awarded.

SENATOR RAGGIO:
That is distinguished from noneconomic damages. You are going to look at these changes rapidly and give us either an acceptance or a non-acceptance so we will know where there is an agreement.

MR. COTTON:
Yes.

JAN NEEDHAM (Principal Deputy Legislative Counsel):
May I get a clarification on that last sentence where it says, "this section," is that all of section 5 or only subsection 2?

SENATOR RAGGIO:
Does it apply to section 5 or just to subsection 2?

MR. BRADLEY:
It applies to section 5.

MR. WILKINSON:
Mr. Bradley, as I understand it, this change is being made because lines 24 through 26 do not specifically identify that the limitation applies to noneconomic damages, is that correct?

MR. BRADLEY:
It is not intended to apply to economic damages.

MR. WILKINSON:
Another way of clarifying that issue would be to amend the existing language to indicate that, "in no event would a single defendant be liable for noneconomic damages to the plaintiffs in the aggregate in excess of the professional liability insurance policy." In hearing the remarks, it occurred to me that issue might be clarified by adding a reference to noneconomic damages in the previous sentence rather than tacking on another sentence.

MR. BRADLEY:
You may be correct. These have been such difficult negotiations, and we are very careful about what we read.

DR. MCBEATH:
The point of clarification for the physicians as they understood it did involve the economic damages. There is an issue that the joint and several and the joint liability still be maintained for the economic

damages. We want to discuss this. As Mr. Bradley indicated, we just received this portion, and it has been explained two different ways. We would like a little more explanation.

SENATOR RAGGIO:
Will you come back to us before we finish this evening?

DR. MCBEATH:
If we could get our presentation together, we were trying to do that when we were called back in for testimony. We were trying to get this ironed out with our larger caucus.

SENATOR RAGGIO:
Other than that issue, is there any thing else that needs to be changed in sections 3, 4 and 5 or anything that pertains to limits on liability.

MR. HARDY:
At no time, during any of the negotiations to try to reach an agreement, was there a discussion that suggested any caps on economic damages. They were always referred to as noneconomic damages. That is the lynchpin of the Governor's proposal. All costs, medical expenses, lost earnings would be reimbursed if they are provable damages. To come to this table and not understand that is in my estimation almost disingenuous.

SENATOR RAGGIO:
Is there some issue on that, now?

MR. COTTON:
I need to discuss this with my clients. I do not know that using terms like disingenuous is profitable here. I will have a response by the end of the evening.

SENATOR CARE:
I want to be sure I heard what the parties intended as to section 3, line 9, page 3. "Economic damages includes damages for medical treatment, care or custody, loss of earnings, and loss of earning capacity, not "or."

MR. COTTON:
"And/or," may be more appropriate because it may be both or one or the other.

SENATOR CARE:
Is that your understanding?

MR. COTTON:
You are correct, Senator Care. It is "and."

SENATOR O'DONNELL:
I do not want you to feel that you are going to agree, and we are going to rubber stamp it. What do you mean by the capacity to determine this $350,000 cap? As I understand it, the judge can lift the cap if you make the case that there is gross or egregious negligence. I am speaking about paragraph (h), subsection 3, section 5. Where do you see that coming into effect?

MR. BRADLEY:
When a judge sits in a courtroom for two or three weeks and listens to the evidence, and despite the fact this particular plaintiff's case does not fit within these exceptions, that under circumstances where someone is catastrophically injured the judge is convinced by a higher standard, after listening to all the evidence, this plaintiff is entitled to something more than $350,000.

SENATOR O'DONNELL:
Is he going to make that determination by himself or are you going to request it?

MR. BRADLEY:
A jury returns a verdict and goes home. A week later, the defense will make a motion to reduce the verdict pursuant to this new statute. At that time, if in the plaintiff's lawyers opinion there is clear and convincing evidence that this was another type of catastrophic injury, the plaintiff's lawyer will make a motion requesting the judge to consider the circumstances if the evidence was clear and convincing that the plaintiff is entitled to something above the $350,000 cap.

SENATOR O'DONNELL:
In the cases that have been filed in the courts, eight states have stricken the caps. California's has been upheld several times, is that true?

MR. BRADLEY:
I do not know about several times. I certainly know about the leading case that upheld it.

SENATOR O'DONNELL:
Do you feel as though this particular bill is constitutionally sound, or is it challengeable?

MR. BRADLEY:
Senator O'Donnell, I hope you do not think I am ducking your question but I have enough trouble keeping up with the specialties of law in which I specialize. I am not a constitutional lawyer, and I cannot answer the question for you.

SENATOR O'DONNELL:
Is it your intention, or the lawyers' intention to challenge this?

MR. BRADLEY:
You do not take this statute to a court right now and ask whether it is constitutional. You must go through a case and have this statute applied to a case and have it work its way up through the judicial system, At that time, if that lawyer who is involved in that case feels that way, then, that lawyer has the option to make that request.

SENATOR O'DONNELL:
Section 13, subsection 3, paragraph (b).

SENATOR RAGGIO:
This is the section on periodic payments. Please reserve those questions until we discuss that area of the bill.

SENATOR TITUS:
We have heard compelling testimony concerning the reason that we need to put these caps in place is to try to reduce insurance premiums, and we need to do that in order to save our doctors. We, secondarily, heard that if we do not show the linkage between saving doctors, which is good public policy, and reducing the premium, perhaps, it would be a constitutional question. We should put an amendment in the bill that provides that linkage rather than leaving it to chance and the good will of the insurance industry and say roll back those rates. Then, we know we will have that linkage. I would purpose an amendment that says, "roll back the rates 20 percent." I would offer that to this body.

SENATOR RAGGIO:
That question was raised initially, and it is my understanding that it is outside the Governor's call. Therefore, it would not be an appropriate amendment.

SENATOR RAWSON:
Can we look at the issue in section 1 and to whom this applies.

SENATOR RAGGIO:
That would be appropriate because it deals with caps.

SENATOR RAWSON:
I would like to suggest an amendment that podiatrists be added.

SENATOR RAGGIO:
What is the line and section?

SENATOR RAWSON:
Section 1, subsection 1, paragraph ®, line 13 or 14. Line 13 lists, "A physician or dentist licensed under the provisions of chapter 630, 631,or 633."

SENATOR RAGGIO:
Would not a podiatrist come under the definition of a physician?

SENATOR RAWSON:
They have their own chapter 635, and they are listed in several places in the NRS as being appropriately called physicians, NRS.040 and .060.

SENATOR RAGGIO:
Let me ask staff. Would that be appropriate?

MR. WILKINSON:
If there were a desire to include podiatrists under the terms of medical malpractice, that would be appropriate.

SENATOR RAWSON:
It is not my intention to open this up to every group under the sun, but they are listed as physicians. They can practice in hospitals, and they are subject to other provisions in this bill under health care providers. Being able to practice in hospitals, if they are left out of this, will be a tremendous disadvantage to them.

SENATOR RAGGIO:
When it comes time to vote on that issue, then, it would be an appropriate suggestion for an amendment.

SENATOR NEAL:
Let us go back and address this cap language on noneconomic damages as stated in the bill. Let me preface my question with these remarks. There has been a lot of discussion this evening relative to the caps being unconstitutional. Different caps bring different results across the nation, and the caps are not going to reduce the premiums. I have another side to this. Could you tell me whether the caps devalue a human being?

MR. BRADLEY:
Yes.

SENATOR NEAL:
No further explanation? What about the doctors' side?

MR. COTTON:
I do not feel it devalues a human being. It is almost impossible to quantify the types of losses we are talking about. Whether it is $1, $350,000 or $500,000, the losses are not quantifiable. There are quantifiable losses that do go towards devaluing a human being by not providing adequate medical care, not providing for loss of income to their families, those are the economic damages.

SENATOR NEAL:
Are you saying that, when you look at me as a whole person, I am only worth $350,000.

MR. COTTON:
No more than I would say you are worth $1 or $5 million. I cannot say what you are worth. It is such a speculative number, and this is part of the problem. I have tried a number of cases, and I have had juries give awards all across the board for similar types of injuries. It is not something that has a value in my mind one way or the other I generally leave that up to a jury. The practical problem is, without some quantification, we are in a stage where we are not going to get new carriers writing insurance nor providing sufficient coverage for doctors to stay in this State. Mr. Wadhams was going to be here, and I do not have actual numbers. I have been quoted some, but I do not want to quote mistaken numbers. He has represented that there will be significant decreases in the premiums and the ability to keep doctors here. I offset that with, are we devaluing the people who are here who do need medical care? There is the lady who has to drive to Bullhead City. I cannot quantify what that is worth to her for her anxiety to have to leave this State to receive medical care. I think that situation is going to repeat itself in gross fashion if we do not have some solution.

SENATOR NEAL:
As I understand your explanation, the essence of the cap is to keep doctors here. It has nothing to do with the pain and suffering of the individual.

MR. COTTON:
It puts a value on those that will support someone being able to make a business decision as to whether they will win or lose money here. St. Paul has been sent out as a whipping boy. The simple fact is that CNA, MICOWA, NORCAL, MIEC, none of them are writing in this State. It cannot be that large or system-wide of a conspiracy causing them not to write in this State. There are quantifiable numbers here that it is a loser in this State to write business for less than what these doctors are paying right now. They are paying out a significant amount more in damages than they are collecting in premiums, and that is at the current rates. Something has to be done to address the other side of the equation, or we are not going to have an insurance company to regulate.

SENATOR NEAL:

If I lose an arm or a leg, then, quantifying that in terms of cost has to be something that would be provable to the doctors to keep them in this State.

MR. COTTON:

As opposed to caps in most states, what we have under our system on the loss of a limb, or other catastrophic injuries, is that if you had $100,000 of medical expenses, you could recover up to $900,000 worth of pain and suffering in noneconomic damages. We do have increased amounts. The practical problem I was dealing with here is a lot of offsetting concerns, concerns of people who can not get medical care. Doctors are leaving, doctors who can not get policies and are charged a dollar amount for coverage that has a significant impact on our ability to keep our physicians in this State. It is such a tough balancing contest. I do not envy your job in the slightest nor do I intend to tell you how to do it. I would love it if you adopted a lower cap because I think that would keep more doctors here. But the practical matter is, there is a balance, and there gets to be a breaking point, and we are almost there. Where there is any significant savings, and more importantly where people can persuade more insurance carriers to come in and reinsurance carriers to underwrite them, so that we can get some competition back into this State. I would love you to have 20 insurance carriers to regulate. That would be an ideal situation not just for you but also for the citizens of this State.

SENATOR NEAL:

I gather from your remarks that it is not a devaluation of the human being. You do not believe that?

MR. COTTON:

No, Senator, I do not believe that. I did personalize that with my father. There is no amount of money that could replace him. You cannot put a value on his life. I lost him in a malpractice situation. If someone said I would give you $350,000, it would not bring him back. But, in that circumstance, if someone said to me, your mother is going to be deprived of the ability to survive; we are not going to give her economic damages; we are not giving her anything at all; that would bother me. Under these circumstances, you try to find a balance where society's interests and needs for medical care in this community are offset against an extremely small minority of people. That is the balance test. With a crisis like this, the needs of society versus the need to maintain a free-floating level of damages without a statement as to valuing life, because no one can place a value on life.

SENATOR NEAL:

I find your comments to my question quite interesting, which leads me to make this comment. Are we now looking to grow body parts? Will we create a drug store on the corner where we can purchase an arm or have a farm of individuals that can supply body parts for other people? Are we headed in that direction since we cannot put a value on these things? It seems to me the human being is becoming less and less in the whole sphere of things. That troubles me.

MR. COTTON:

There are other methods of addressing those problems. Other states have compensation funds but is not something that is addressed here. The simple fact is, and it is a sad situation because there are people in our community that lose their arms, their legs, the ability to breathe, not by anyone's fault and I have a great deal of sympathy for those people too, they do not get to sue anyone. They live with it the rest of their lives. It is a happenstance that someone in this case loses legs and they are going to blame it on a doctor. The simple fact I have found in my practice, which has been fairly extensive in defending cases over the years, is most of the time I do not find a doctor responsible for someone's injuries. It is very small percentage of cases where the doctor is held responsible or where I look at a case and determine that somebody did something wrong and should pay. As a consequence, all of the medical industry is confronted with the problem of not being able to practice medicine. This is the solution that has been attempted in most states. It has been effective, statistically, in most states. It has worked to make a viable system work in most states. I would expect every single person in your position has had to anguish over the decision because it is not an easy thing to do.

SENATOR NEAL:

Have you ever thought there might be something other than the cap?

MR. COTTON:

There have been a number attempts to address this issue, as I have indicated, in other systems. The problem is we have run into these traps, and you are in the trap much more than I am with taxation. There are systems that tried to put a tax on medical services and raise monies to create patient compensation funds for those damages that might exceed a cap such as this. But, those are political decisions. There is only so much money to go around. They are tough decisions, and it becomes "that is your problem there, and the doctor's problem over here," and we have the doctor's sharing the burden, entirely, for society as opposed to any real spread of it. In my opinion, it is not a legal issue; it is a social issue. The determination has to be made by this Legislature not by lawyers.

SENATOR TOWNSEND:

Based on the testimony about the constitutional issue, I would recommend we put a provision in this bill concerning several liability so that whatever does pass some of it might stand if it is challenged. The other thing I am puzzled by is this, one side says the crisis is defined as an increase in medical malpractice premiums, the answer to which is a cap. The other side is talking about constitutional and protection issues. We do not have the people to give us the answer. If a cap is passed, whatever level that may be, what does that do for the premium of a doctor who is practicing in the field of either OB/GYN or trauma in southern Nevada? I find it most amusing that we do not have anyone here who is going to stand up and represent the insurance industry to give us specific answers. Now, we are all aware that we only control a certain amount of the insurance side of this issue because of federal protection, and we are precluded from doing things. I do not have an answer from the people who are going to respond to the proponents who say they have a problem. That is what I am wrestling with.

MR. COTTON:

As Mr. Bradley indicated, to get these things down into quantifiable form in sections 3, 4 and 5 was not an easy task. The NTLA has been extremely cooperative and worked hard to do so. I have spent the better part of the day on that point getting some confirmation in my own mind before I would recommend to my clients that there is a significant benefit from an insurance standpoint. We have gotten information developed. I have been told that there will be some people here tomorrow to testify to that issue. It is a critical issue for you to hear.

SENATOR TOWNSEND:

Am I confused, Mr. Chairman, or are we the only 500 people in the State that heard about the special session and what it was about? Why are they not here?

MR. BRADLEY:

As you know, as part of the subcommittee you are a member of, today is July 29. We had a hearing scheduled for today where we for the first time, despite numerous requests, thought there would be some insurers at the subcommittee meeting. We also know that, other than Mr. Wallace, we had no members at any of the subcommittee meetings despite the request from you as well as other legislators at the first meeting of the subcommittee regarding this exact issue. As you can see from the debate you are hearing, as part of the Governor's committee in attempting to discuss the issues across the table, we could not get any answers to the questions you are asking.

SENATOR CARE:

In the interest of legislative intent, I would like to hear what both parties have to say regarding the scope of these caps. We do have NRS 41A.097 that gives a definition of a health care provider, but there was some discussion earlier about midwives, and there was a suggestion that podiatrist would come in to NRS 630, 631, 633. If you look at what happened in California, there is a lot of case law about exactly who is covered□military hospitals, blood banks, transporters of patients from one hospital to another. I would like to hear who you think will enjoy the shield of caps. I am assuming it would include the doctors, the hospitals and their employees. I do not know about independent contractors.

MR. BRADLEY:

This whole debate was driven by a crisis we contend was caused by insurance companies involving physicians. With all due respect to Senator Rawson, we did not hear in the last six months of a crisis in the area of podiatric medicine with availability and affordability of insurance rates. You should proceed with caution with regard to adding additional professionals that did not experience a crisis. From reading the bill, there is a difference at the trauma center regarding who is covered and who is covered at a non-trauma center. The intent was to cover the hospitals, the doctors. Independent contractors are different because of the trauma centers or non-trauma centers, and it is a very complicated question to answer. Previously, the screening panel covered physicians, hospitals and osteopaths. That is where the crisis was in 1985 when the screening panel was created. In all our discussions, midwives and things such as that were never a part of our discussions.

SENATOR CARE:
In the catastrophic case, does that include hospitals?

MR. BRADLEY:
Yes, it does. There is something important that needs to be said, some people have talked about the cap going up to $1 million. In the catastrophic case, the cap does not go up to $1 million, Senator Care. This bill provides, in a noneconomic catastrophic case, the noneconomics awarded against either a physician or a hospital go up to the limits of that particular individual or hospital's professional liability limit. I wish to be perfectly clear. That is not $1 million in many cases. That was the intent.

SENATOR RAGGIO:
The bill does require that doctors carry a $1 million policy.

MR. BRADLEY:
Actually, the bill requires $1 million per incident and $3 million per occurrence. There is also a "self-consuming clause." This is where defense fees are taken off the limits. If you are in three years of litigation and you started off with a $1 million cap and you have a lot of lawyers working on your side, by the time your case is settled, your limit might be down.

SENATOR RAGGIO:
In some cases, the policies do not go that high, but they will be required under this bill.

MR. BRADLEY:
My point was, there are not any self-consuming policies sold now, but if they were, the intent was $1 million per incident and $3 million per occurrence available to the victims of medical negligence. That is in respect to the physician, but the hospitals carry much higher policy limits, and that would be the limit with respect to a hospital.

SENATOR RAWSON:
I love preambles because they help to create rational relationships. We could strengthen this preamble. Looking at page 1 of the bill, following line 7, we add another phrase "and aggrieved patients are afforded appropriate access to jury consideration for redress," or something of that nature. In order to state that, we see there is a problem. We have to do something about that problem. This will adequately protect their constitutional rights. That would help the overall process.

SENATOR RAGGIO:
That is a potential amendment to the preamble, is that what you are saying?

SENATOR RAWSON:
Yes.

SENATOR COFFIN:

Senator Townsend made a good point about several liability. I do not know if it is in the later part of the bill where it usually resides, but it should be in there. One of the things that will help this bill and maintain the caps is the language on page 3 which does allow a judge to pierce that cap. That will help the constitutionality because there are some catastrophic things that will occur that are not on a list. Whenever you build a list, you automatically leave things out. In subsequent sessions, we will be visiting this part of the law adding new acts, which should be catastrophic based upon a legal decision by the courts. It is a good idea to have this in the bill to protect the caps, and it may prevent having a several liability clause. Seeing a list like this always makes me nervous because of what is left out. But, the judge does have flexibility, and I do not think it will drive the premium rates up.

MR. WILKINSON:

NRS 0.020 already provides "if any provision of the NRS is held invalid, that invalidity will not effect the other provisions." Basically, several liability is already built into every statute. Subsection 2 of NRS 0.020 also provides that the inclusion of express declaration of several liability in a bill does not enhance the several liability of the provision or detract from the several liability of it.

CHARLES LAWS (Green Party, Candidate for Governor):

I am a retired environmental engineer and am familiar with systems analysis. When we are dealing with very complex interacting systems within a system we have to do a great deal of diagnosis to get a better grasp of what the relationships are and how when you pull on one end the other responds. I would like to describe our system as I see it as being totally supported and motivated by the needs of our residents for secure medical practice. What we have serving them is insurance systems which somewhat dictate to the physicians and other caregivers what they can provide. We have a system of service to the caregivers to protect them from accidents and injury to their clients, which has a continuing relationship, and then we have a relationship with all of you, here, to the administration, and the regulatory and licensing boards. At the moment, we have a conflict between two insurance sectors. The insurance companies who provide health insurance do not want to let the doctors do things which would protect the doctors from malpractice events. The malpractice insurers do not want the doctors to do anything but be protected from malpractice cases. Therefore, we have a conflict that goes on behind the scenes.

What Governor Guinn presented, today, is an excellent first step, and he recognized it is going to be a continuing set of steps. I think he went out of his bounds in suggesting that he would be the one to work with you in the Legislature in 2003. Senator Neal and myself would also enjoy the opportunity to sign into legislation a bill. What I am really asking you to undertake is, in regard to caps, the recognition that economic means cannot be used to balance or to award noneconomic losses. They are out of sync. If we were to say it would be possible to mandate that people who have suffered loss receive those services which benefit them in the transition from their loss, this would be a very useful thing and is beyond the scope of what Governor Guinn is recommending you limit yourself to. I know there are things within the system that may need to be looked at in the future. This bill may serve well as a Band-Aid and aspirin to keep things under wraps. But, it does not deal with the sources and causes of what has precipitated the crisis. We must move beyond crisis into some kind of management and development of what the future needs to have in order to provide security to me and the other residents of the state.

MR. WALLACE:

Senator Townsend and Senator Care, I would say the $350,000 cap is quite sellable, but section 5 contains language which attempts to narrow it, but, in the scope of probabilities and the uncertainty of loss, with regard to paragraph (h), as was pointed out by Senator O'Donnell, "you could drive a truck through it." In sections 31 through 37, which of those cases on the video would have breached the $350,000 cap? We know that severity is an issue facing this community, and if this were passed, today, those cases on the video, looking at their malpractice issues, very well would have surpassed the $350,000 cap. I appreciate both sides of the argument. Is there something we can do besides caps? That would be wonderful, but there has been nothing provided to show that there would be a fix without caps. That is why we keep hanging our hat on MICRA.

ROBERT SCHRECK, M.D. (President,Nevada Medical Association):

I came, today, to specifically talk about section 5, subsection 3, paragraph (h) to which Senator O'Donnell talked about earlier.

It reads, "A case in which, following return of a verdict by the jury, the court determines by clear and convincing evidence, that an award in excess of $350,000 for noneconomic damages is justified under the circumstances." The question is what circumstances? Mr. Bradley testified to catastrophic injuries, and it was mentioned several times that they are talking, specifically, about catastrophic injuries. I think that wording should be looked at as a possible addition to the paragraph and possibly even further recommendations might bring it into a meaningful sentence. It just ends in the air stating "circumstances" because you really do not know what circumstances are being talked about in this paragraph.

SENATOR RAGGIO:
Is the group representing the medical profession considering that?

DR. SCHRECK:
They are discussing some of these issues now. I bring it up because Senator O'Donnell said this body is going to use their own thought processes and intelligence.

SENATOR RAGGIO:
We were trying to ferret out what had been agreed to and whether there were any changes that were required by what has been agreed to. We have the opportunity and the right to add whatever we want that is germane to the Governor's proclamation. Your suggestion is, regardless whether that has been agreed to, that we should look at that language also because it is too general. Is that what you are saying?

DR. SCHRECK:
I am saying that it is something Mr. Bradley said and was repeated. I assume the trial lawyers are in favor of that language, but I do not know whether it has been discussed.

SENATOR RAGGIO:
Do you have any specific suggestions? Are you saying it should be catastrophic?

DR. SCHRECK:
I would suggest catastrophic circumstances.

SENATOR RAWSON:
Before I actually saw language, I was under the impression that paragraph (h) under subsection 3 would be in the case of gross malpractice. I am wondering whether the parties would consider putting an "and" on line 39, so that if it is a case of gross malpractice, "and" there is clear and convincing evidence.

SENATOR RAGGIO:
We will make a note of that suggestion. Is there any other public testimony?

SUSAN ROE (Registered Nurse):
I lost my son three years ago due to medical negligence. We are at the point in the case where we are going to the medical screening panel. I would like to speak about caps. While it is true that no amount of money will make up for the loss of my son, I do feel that what I have experienced, our society understands. We understand litigation. Physicians understand judgments against them. To put the cap at a low enough point that you cannot get a lawyer to take your case is really doing a disservice to my son and everyone else who has been injured or died because of medical malpractice. I hope you will keep that in mind. The loss of a son is something that we will never get over. There are so many intangibles things that enter into this. My husband is unable to work, and his heath has significantly deteriorated since our son's death. It is a total devastation of our lives, and I would ask you to please bear that in mind when you make your decisions.

SENATOR O'DONNELL:
Where was the hospital located, in northern or southern Nevada?

MRS. ROE:
It was in southern Nevada.

SENATOR O'DONNELL:
Was it at private hospital or public hospital?

MRS. ROE:
It was at a private hospital.

SENATOR O'DONNELL:
If your son was injured in a public hospital, say you had chosen UMC, would you think it would be fair that you would have less compensation then if you went to Sunrise or some other hospital? Do you think $50,000 is good enough at one hospital and $350,000 is okay at another hospital?

MRS. ROE:
No, $5 billion at any hospital would not be enough. The disparity there would be tough to take.

SENATOR RAGGIO:
The only issue we have that is still pending is the suggested language that was to be added to subsection 2. Tomorrow we are going to start with joint and several liability.

SCOTT YOUNG (Principal Research Analyst):
That would be section 1 in the present bill, "liability for acts in a government or nonprofit center." The next item that we had tentatively listed was the "several liability's standard," which is in section 6. After that, we had listed reviewing the medical and dental screening panels to revise existing procedures or change the composition of the panels. Those provisions are largely repealed, but they were addressed in sections 24, 35 and 38. The other item we had tentatively scheduled was strengthening the reporting requirements regarding disciplinary actions, claims settlements and/or awards against physicians, which is contained, now, in sections 14, 19 through 23, and 28 through 34.

SENATOR RAGGIO:
We will recess until 8:30 p.m. They will come back with that information. We will then conclude our deliberations and vote on this part of the bill.

The committee will please come to order. In order to do justice to the issue before us, it is the Chair's intention to recess the committee this evening. The Senate will have to go back into session, into the Chamber and adjourn formally. This committee will resume at 8:00 a.m. tomorrow. At which time, we will hear any final testimony or input. We will then deliberate and vote on the issues in sections 3, 4 and 5 of Senate Bill No. 2.

Senator Raggio moved that the Senate rise and return to the Senate Chamber.

Motion carried.

18th Special Legislative Session
Senate
7-29-02

SENATE COMMITTEE OF THE WHOLE

DATE: July 29, 2002
TIME: 1:00 p.m.
Room 1214

AGENDA

1:00 p.m.- 1:45 p.m.	Presentation by the Governor outlining Senate Bill No. 2.
	Adoption of Committee Rules
1:50 p.m.	Establishing Limits on the Amount of NON-ECONOMIC DAMAGES Available in Medical Malpractice Cases
	Presentations in FAVOR of Such Limits
	Presentations OPPOSING Such Limits
	Questions and Statements by Members of the Committee
	*Public Comment
	Vote on Proposals
	If time permits, the committee may consider the following item as well:
	Limiting Liability for ACTS OCCURRING IN A GOVERNMENTAL OR NON-PROFIT CENTER for Treatment of Trauma

*The public is invited to testify but testimony may be limited.

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PLEASE PRINT

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Guest List for Committee of the Whole ~~Committee~~ Date July 29, 2002

PLEASE LEAVE A COPY OF PREPARED HANDOUTS WITH THE COMMITTEE SECRETARY

❖ PLEASE PRINT ❖

Name / Title	Representing	Phone No.	Bill No.	For	Against	Neutral	✓ If Speaking
CHARLES LAWS	CITIZEN/CANDIDATE FOR GOVERNOR	775 787-8935				✓	✓
DELL WILLIAMS	SILVER ROSE MANOR	775 423-4131					✓
STEVE KOETSIER	CARSON VALLEY RES. CARE	775 265 1400					✓
Susan L Roe	Henderson NV	7025647132					✓
LONNIE HAMMARGREN	LAS VEGAS	702-596-6669					✓
[redacted]	[redacted]	[redacted]					✓
James Kilber	Desert Radiologists	460-3200					✓
Michelle Keys	[redacted]	760 530-1578					✓
Dianne Meyer	Self	702 363-0468					
L. DEAN HARDY	NTLA	8833577					✓
Jim Crockett	NTLA	8833577					
Chip Wallace et al	NMIC	768-6777					✓
[redacted]							

ORIGINAL—Secretary; YELLOW COPY—Chairman

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(Rev. 9-00)

EXHIBIT B

(O) 425

Guest List for: SENATE MEDICAL MALPRACTICE **Date** 07/29/02

PLEASE LEAVE COPY OF PREPARED HANDOUTS WITH THE COMMITTEE SECRETARY

**** PLEASE PRINT CLEARLY ****

Name/Title	Representing	Phone No.	Bill No.	For	Against	Neutral	Check this box if Speaking
Thelma Clark		702-453-345[redacted]					X

NOTE: This meeting was video-conferenced to the Legislative Counsel Bureau, Las Vegas Office.

Sign in Sheet for Testimony: 7-29-02

- S. Daniel McBride, M.D.
  - Physician – Chairman Nevada Mutual Insurance Co.
- Lonnie Hammargren
  - Doctor
- Florence Jameson
  - OB/Gyn
- Dean Hardy
  - Attorney – NTLA
- James De Roche
  - Attorney – NTLA
- Jim Crockett
  - Attorney – NTLA
- Charles Laws
  - Candidate for Governor
- Keith Munro
  - Office of the Governor – General Counsel
- Susan L. Roe
  - Malpractice victim's mother
- Chip Wallace
  - Founder – Nevada Mutual Insurance Co.
- Dell Williams
  - Administrator – Owner
- Stephen J. Koetsler
  - Carson Valley Residential Care Center
- James Kilber
  - Chief Operating Office
- Dianne Meyer
- Nawnelle Keys
- Larry Spitler
  - Associate State Director – AARP

SB2

JUL 2 9 2001

Raggio

SUMMARY—Makes various changes related to medical and dental malpractice. (BDR 3-13)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State: No.

AN ACT relating to malpractice; limiting the liability of certain medical providers for negligent acts under certain circumstances; establishing a limitation on the amount of noneconomic damages that may be awarded in an action for medical malpractice or dental malpractice; providing for several liability of a defendant for noneconomic damages in an action for medical malpractice; making various changes concerning the payment of future economic damages in actions for medical malpractice; providing for the mandatory dismissal of an action for medical malpractice or dental malpractice under certain circumstances; repealing the provisions pertaining to the use of screening panels for an action for medical malpractice or dental malpractice; revising the statute of limitations for filing an action for medical malpractice or dental malpractice; making various other changes concerning actions for medical malpractice or dental malpractice; requiring certain district judges to receive training concerning the complex issues involved in medical malpractice litigation; requiring courts to impose certain sanctions on attorneys in certain circumstances; making various changes relating to the reporting of claims of malpractice or negligence; and providing other matters properly relating thereto.

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* 3 - 1 3 *

* Same as introduced bill - SB 2

SENATE COMMITTEE OF THE WHOLE

COMMITTEE RULES
EIGHTEENTH SPECIAL SESSION

1. All meetings shall be open to the public.

2. Eleven members constitute a quorum of the committee.

3. A majority of the members present is required to pass or reconsider a bill, budget, or resolution, or to take any other action.

4. Proponents and opponents of each specific proposal before the committee will receive uninterrupted equal but limited time to address the committee on the specific proposal under consideration.

5. Following presentations by proponents and opponents of each specific proposal, the members of the majority party and the members of the minority party will be given equal but limited time to ask questions and make statements about the specific proposal under consideration.

6. Matters not within the Governor's Proclamation or not relevant to the specific topic under consideration will be ruled out of order.

7. There will be a period of public comment within specified limits on each specific proposal then under consideration following the questions and statements of the members of the committee.

8. Following public comment, the committee may vote on the specific proposal then under consideration. The committee will then proceed to consider the next specific proposal.

9. Smoking in the committee room is not allowed. All cellular phones and pagers must be turned off.

10. The Chairman will convene and adjourn each committee meeting. All recesses shall be at the call of the Chair.

11. Although witnesses are presumed to be under oath while testifying, the committee has the option of requiring a witness to be placed under oath.

Jim Crockett

The Reality About Medical Malpractice Law

Presented by

NEVADA TRIAL LAWYERS ASSOCIATION

July 2002

ADVOCATES FOR JUSTICE

NEVADA TRIAL LAWYERS ASSOCIATION

July 29, 2002

Members of the Legislature:

We find ourselves amidst an insurance crisis due to the actions of the insurance industry.

The Nevada Trial Lawyers association believes it is necessary that the Legislature preserve Nevada citizen's access to justice. We are extremely concerned that some of the current proposals will significantly limit a citizen's access to our civil justice system.

The attached position paper addresses each of these proposals. It shows why they will significantly interfere with; 1) a citizens's access to our justice system, 2) a victim's right to receive full compensation, and 3) the right of a jury to evaluate and assess damages based upon the evidence produced at trial.

Nevada must resist the temptation to punish future victims of medical negligence based on a crisis created by the insurance industry today. We must work together to preserve our civil justice system while ensuring continued access to quality health care.

If we can be of any assistance during the special session, please contact one of our members or contact our office at 883-3577.

Sincerely,

Bill Bradley
Co-Chair, Citizens For Justice

Dean A. Hardy, Esq.
Co-Chair, Citizens For Justice

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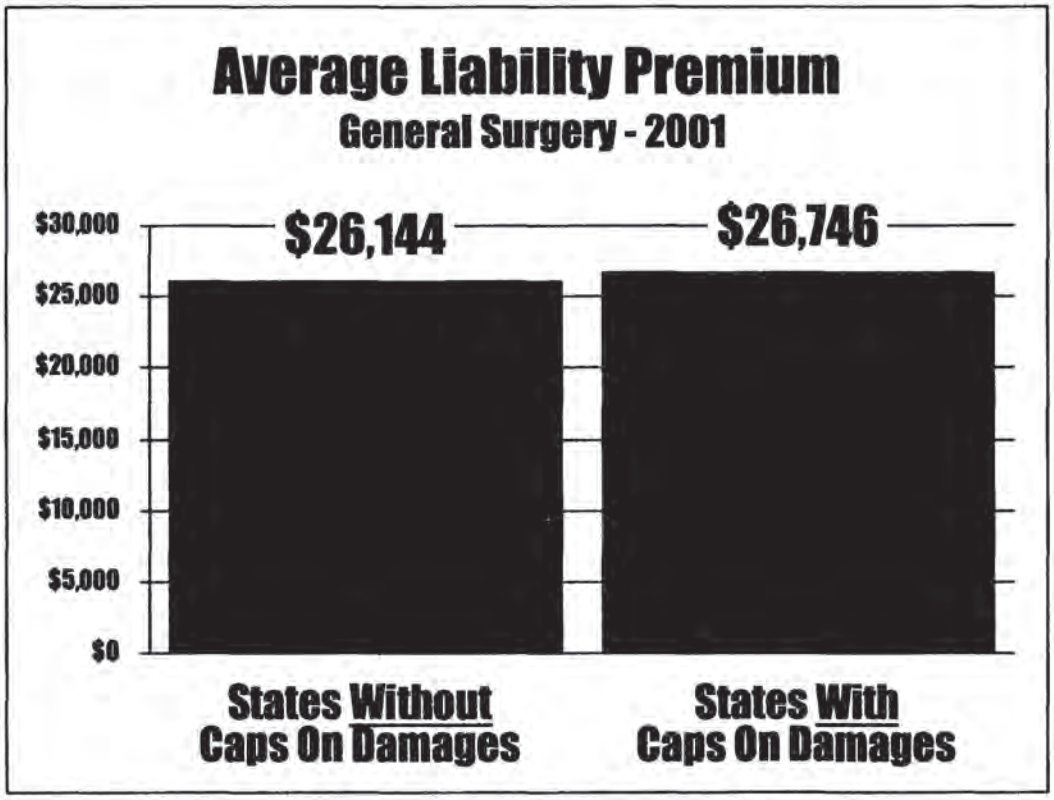
Advocates for Justice

Medical Malpractice Insurance

Do Caps Reduce Malpractice Premiums?



- **Insurance Premiums For General Surgeons Are 2.3% Higher In States With Caps On Damages**
- **Caps Do Not Bring Down Malpractice Premiums**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

•Derived from data provided by Medical Liability Monitor (vol 26, #10 – Oct 2001) A state's average premium is calculate as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a "cap" when there exists a general noneconomic damage cap that affect medical malpractice or a broad medical malpractice specific cap on noneconomic damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases.

CAPS FOR NON-ECONOMIC DAMAGES

In California, the law imposes a limitation on non-economic damages of 250,000.

Non-economic damages are damages for pain, suffering, inconvenience, physical impairment, disfigurement, and other non-pecuniary damages.

Those damages include the loss of a loved one like a spouse or child.

The cap applies to all past, present and future non-economic damages.

- Caps unfairly single out senior citizens, homemakers and children, people who do not earn wages to base economic damages on. By law, their economic value is virtually zero. Their contributions to their families are priceless.
- In many of these cases the effect of the cap will deny the victims and their family access to the civil justice system. They will simply be forced to accept the offer of the insurance company.
- Caps on damages reduce accountability for medical negligence. Caps don't reduce medical negligence, they reduce penalties for malpractice.
- Caps have not reduced the premiums for medical malpractice insurance in states that have enacted such limits.
- Arbitrary caps for compensation of non-economic damages further punish the victim of medical negligence.

"We wouldn't tell you or anyone that the reason to pass tort reform (ie. caps on damages) would be to reduce insurance rates."
(Sherman Joyce, American Tort Reform Association President to Liability Week July 19, 1999.)

JOINT AND SEVERAL LIABILITY

The purpose of Joint and Several Liability is to ensure that the innocent victim of medical negligence is fully compensated. Joint and several liability is a long standing legal doctrine which only arises in cases where there are multiple responsible parties. The doctrine means that any wrongdoer is legally responsible for all of the damages sustained by the innocent victim of medical negligence.

A hypothetical example –

- A doctor performs surgery at a surgical center. Both the doctor and the surgical center commit medical negligence. The doctor is determined to be 70% responsible. The hospital is 30% responsible. The doctor and surgical center are both fully responsible for all damages but the operators of the surgical center declare bankruptcy before the victim can collect. But because the innocent victim's rights supersede the rights of all others, the doctor will be held to be responsible for the entire judgement. If the innocent victim does recover the full amount of the damages from the doctor, the doctor can seek reimbursement from the other wrongdoer.

- The innocent victim of medical negligence should be fully compensated for any damages sustained as a result of medical negligence.

- The innocent victim of medical negligence should not bear the responsibility for an insolvent or inadequately insured medical wrongdoer.

- An innocent defendant cannot be held financially responsible for the acts of the medical wrongdoer.

- Joint liability does not apply if the injured victim of medical negligence bears any degree of responsibility.

PERIODIC PAYMENTS

If enacted into law, periodic payments would allow the medical wrongdoer and his insurance company to pay compensation to the innocent victim of medical negligence over the course of time.

A hypothetical example –

- A jury awards $75,000 to a victim of medical negligence. That $75,000 is paid out over the life expectancy of innocent victim. If victim of medical negligence is a 5 year old child, the $75,000 will be paid $1,000 every year for life. The medical wrongdoer is not responsible for the payment of the $75,000. At the same time, the insurance company for the medical wrongdoers retains use and control of the $75,000.

- Wrongdoers profit from their own wrongdoing as they can invest and profit from the use of the victim's money.

- Payments stop if the innocent victim of medical negligence dies and victim's family receives nothing.

- Periodic payments do not consider inflation or increased costs of medical care: In this hypothetical example, the thousand dollars per year received when victim has grown to adulthood is worth a tiny fraction of the thousand dollars per year awarded when the victim was a small child.

- Periodic payments are not secured if the insurance company becomes insolvent. In California, Executive Life Insurance Co. of Los Angeles was a major insurer and seller of annuities. Executive Life Insurance Co. went bankrupt. Since the medical wrongdoers were not responsible for guaranteeing the payment of the annuity, the insolvency of Executive Life Insurance Co. left many victims of medical negligence without any compensation.

- Innocent victims of medical negligence should be fully and immediately compensated for any damages sustained as a result of medical negligence.

COLLATERAL SOURCE RULE - NRS 42.020

In cases involving medical negligence, Nevada law already gives the medical wrongdoer an offset for collateral sources. For example, if an innocent victim of medical negligence has health insurance for the medical bills, any award for medical negligence must be reduced by the amount that health insurance company has paid for medical care of the victim. The only exception to this when the innocent victim has agreed in writing before the court to pay his health insurance company back.

- Nevada's collateral source reimbursement applies to all insurance including private disability policies.

Under California MICRA, the defendant may elect to introduce insurance payments to cover any economic damages. When the defendant makes the election, the insurance company's right of reimbursement is eliminated. The innocent victim of medical negligence is relieved of the obligation to pay back his health insurance company. Additionally, the innocent victim of medical negligence may introduce payments of insurance premiums. Furthermore, the jury is not required to reduce its verdict by payments made by the insurance company.

Insurers' Price Wars Contributed To Doctors Facing Soaring Costs; Lawsuits Alone Didn't Inflate Malpractice Premiums; Reserves at St. Paul Distorted Pricing Picture in 1990s
Wall Street Journal
June 24, 2002

By RACHEL ZIMMERMAN and CHRISTOPHER OSTER

As medical-malpractice premiums skyrocket in about a dozen states across the country, obstetricians and doctors in other risky specialties, such as neurosurgery, are moving, quitting or retiring. Insurers and many doctors blame the problem on rising jury awards in liability lawsuits.

"The real sickness is people sue at the drop of a hat, judgments are going up and up and up, and the people getting rich out of this are the plaintiffs' attorneys," says David Golden of the National Association of Independent Insurers, a trade group. The American Medical Association says Florida, Nevada, New York, Pennsylvania and eight other states face a "crisis" because "the legal system produces multimillion-dollar jury awards on a regular basis."

But while malpractice litigation has a big effect on premiums, **insurers' pricing and accounting practices have played an equally important role**. Following a cycle that recurs in many parts of the business, a price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims.

Price Slashing

Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year.

"I don't like to hear insurance-company executives say it's the tort [injury-law] system -- it's self-inflicted," says Donald J. Zuk, chief executive of Scpie Holdings Inc., **a leading malpractice insurer in California.**

What's more, the litigation statistics most insurers trumpet are incomplete. The statistics come from Jury Verdict Research, a Horsham, Pa., information service, which reports that since 1994, jury awards for medical-malpractice cases have jumped 175%, to a median of $1 million in 2000. During that seven-year period, the median award for negligence in childbirth was $2,050,000 -- the highest for all types of medical-malpractice cases, Jury Verdict Research says. (In any group of figures, half fall above the median, and half fall below.)

Gaps in Database

But Jury Verdict Research says its 2,951-case malpractice database has large gaps. It collects award information unsystematically, and it can't say how many cases it misses. It says it can't calculate the percentage change in the median for childbirth-negligence cases. More important, the database excludes trial victories by doctors and hospitals -- verdicts that are worth zero

dollars. That's a lot to ignore. Doctors and hospitals win about 62% of the time, Jury Verdict Research says. A separate database on settlements is less comprehensive.

A spokesman for Jury Verdict Research, Gary Bagin, confirms these and other holes in its statistics. He says the numbers nevertheless accurately reflect trends. The company, which sells its data to all comers, has reported jury information this way since 1961. "If we changed now, people looking back historically couldn't compare apples to apples," Mr. Bagin says.

Some doctors are beginning to acknowledge that the conventional focus on jury awards deflects attention from the insurance industry's behavior. **The American College of Obstetricians and Gynecologists for the first time is conceding that carriers' business practices have contributed to the current problem,** says Alice Kirkman, a spokeswoman for the professional group. "We are **admitting it's a much more complex problem than we have previously talked about," she says.**

Scrambling for Doctors

The upshot is beyond dispute: Pregnant women across the country are scrambling for medical attention. Kimberly Maugaotega of Las Vegas is 13 weeks pregnant and hasn't seen an obstetrician. When she learned she was expecting, the 33-year-old mother of two called the doctor who delivered her second child but was told he wasn't taking any new pregnant patients. Dr. Shelby Wilbourn plans to leave Nevada because of soaring medical-malpractice insurance rates there. Ms. Maugaotega says she called 28 obstetricians but couldn't find one who would take her.

Frustrated, she called the office of Nevada Gov. Kenny Guinn. A staff member gave her yet another name. She made an appointment to see that doctor today but says she is skeptical about the quality of care she will receive.

In the Las Vegas area, doctors say some 90 obstetricians have stopped accepting new patients since St. Paul Cos., formerly the country's leading provider of malpractice coverage, quit the business in December. St. Paul had insured more than half of Nevada's 240 obstetricians. Carriers still offering coverage in the state have raised rates by 100% to 400%, physicians say.

Dr. Wilbourn says his annual malpractice premium was due to jump to $108,000 next month, from $33,000. The 41-year-old solo practitioner says the increase would come straight out of his take-home pay of between $150,000 and $200,000 a year. In response, he is moving to Maine this summer.

Dr. Wilbourn mourns having "to pick up and leave the patients I cared for and the practice I built up over 12 years." But in Maine, he has found a $200,000-a-year position with an insurance premium of only $9,800 for the first year, although the rate rises significantly after that. Premiums in Maine are relatively low because a dominant doctor owned insurance cooperative there hasn't pushed to maximize rates, the heavily rural population isn't notably litigious and its court system employs an expert panel to screen out some suits, says Insurance Commissioner Alessandro Iuppa.

Until the 1970s, few doctors faced big-dollar suits. Malpractice coverage was a small specialty. As courts expanded liability rules, malpractice suits became more common. Dozens of doctor-owned insurance cooperatives, or "bedpan mutuals," formed in response. Most stuck to their home states.

St. Paul, a mid-sized national carrier named for its base in Minnesota, saw an opportunity. An insurer of Main Street businesses, St. Paul became the leader in the malpractice field. By 1985, it had a 20% share of the national market. Overall, the company had revenue of $8.9 billion last year, with about 10% of its premium dollars coming from malpractice coverage.

The frequency and size of doctors' malpractice claims rose steadily in the early 1980s, industry officials say. St. Paul and its competitors raised rates sharply during the 1980s.

Expecting malpractice awards to continue rising rapidly, St. Paul increased its reserves. But the company miscalculated, says Kevin Rehnberg, a senior vice president. Claim frequency and size leveled off in the late 1980s, as more than 30 states enacted curbs on malpractice awards, Mr. Rehnberg says. The combination of this so-called tort reform and the industry's rate increases turned malpractice insurance into a very lucrative specialty.

A standard industry accounting device used by St. Paul and, on a smaller scale, by its rivals, made the field look even more attractive. Realizing that it had set aside too much money for malpractice claims, St. Paul "released" $1.1 billion in reserves between 1992 and 1997. The money flowed through its income statement and boosted its bottom line.

St. Paul stated clearly in its annual reports that excess reserves had enlarged its net income. But that part of the message didn't get through to some insurers -- especially bedpan mutuals -- dazzled by St. Paul's bottom line, according to industry officials.

In the 1990s, some bedpan mutuals began competing for business beyond their original territories. New Jersey's Medical Inter-Insurance Exchange, California's Southern California Physicians Insurance Exchange (now known as Scpie Holdings), and Pennsylvania Hospital Insurance Co., or Phico, fanned out across the country. Some publicly traded insurers also jumped into the business.

With St. Paul seeming to offer a model for big, quick profits, "no one wanted to sit still in their own backyard," says Scpie's Mr. Zuk. "The boards of directors said, 'We've got to grow.' " Scpie expanded into Connecticut, Florida and Texas, among other states, starting in 1997.

As they entered new areas, smaller carriers often tried to attract customers by undercutting St. Paul. The price slashing became contagious, and premiums fell in many states. The mutuals "went in and aggravated the situation by saying, 'Look at all the money St. Paul is making,' " says Tom Gose, President of MAG Mutual Insurance Co., which operates mainly in Georgia. "They came in late to the dance and undercut everyone."

The newer competitors soon discovered, however, that "the so-called profitability of the '90s was the result of those years in the mid-80s when the actuaries were predicting the terrible trends," says Donald J. Fager, president of Medical Liability Mutual Insurance Co., a bedpan mutual

started in 1975 in New York. Except for two mergers in the past two years, his company mostly has held to its original single-state focus.

The competition intensified, even though some insurers "knew rates were inadequate from 1995 to 2000" to cover malpractice claims, says Bob Sanders, an actuary with Milliman USA, a Seattle consultancy serving insurance companies.

Alleged Fraud

In at least one case, aggressive pricing allegedly crossed the line into fraud. Pennsylvania regulators last year filed a civil suit in state court in Harrisburg against certain executives and board members of Phico. The state alleges the defendants misled the company's board on the adequacy of Phico's premium rates and funds set aside to pay claims. On the way to becoming the nation's seventh-largest malpractice insurer, the company had suffered mounting losses on policies for medical offices and nursing homes as far away as Miami.

Pennsylvania regulators took over Phico last August. The company filed for bankruptcy-court protection from its creditors in December. A trial date hasn't been set for the state fraud suit. Phico executives and directors have denied wrongdoing.

In the late 1990s, the size of payouts for malpractice awards increased, carriers say. By 2000, many companies were losing money on malpractice coverage. Industrywide, carriers paid out $1.36 in claims and expenses for every premium dollar they collected, says Mr. Golden, the trade-group official.

The losses were exacerbated by carriers' declining investment returns. Some insurers had come to expect that big gains in the 1990s from their bond and stock portfolios would continue, industry officials say. **When the bull market stalled in 2000, investment gains that had patched over inadequate premium rates disappeared.**

Some bedpan mutuals went home. Scpie stopped writing coverage in any state other than California. "We lost money, and we retreated," says the company's Mr. Zuk.

New Jersey's Medical Inter-Insurance Exchange, now known as MIIX, had expanded into 24 states by the time it had a loss of $164 million in the fourth quarter of 2001. The company says it is now refusing to renew policies for 7,000 physicians outside of New Jersey. It plans to reformulate as a new company operating only in that state.

St. Paul's malpractice business sank into the red. Last December, newly hired Chief Executive Jay Fishman, a former Citigroup Inc. executive, announced the company would drop the coverage line. St. Paul reported a $980 million loss on the business for 2001.

As carriers retrench, competition has slumped and prices in some states have shot up. Lauren Kline, 6_ months pregnant, changed obstetricians when her long-time Philadelphia doctor moved out of state because of rate increases. Now, her new doctor, Robert Friedman, may have to give up delivering babies at his suburban Philadelphia practice. His insurance expires at the end of the month, and he says he is having difficulty finding a carrier that will sell him a policy at any price.

Last year, Dr. Friedman says he paid $50,000 for coverage. If he gets a policy for next year, it will cost $90,000, he predicts, based on his broker's estimate. "I can't pass a single bit of that off to my patients," because managed-care companies don't allow it, he says.

Dr. Friedman says he is considering dropping the obstetrics part of his practice. Generally, delivering babies is seen as posing greater risks than most gynecological treatment. As a result, insurers offer less-expensive policies to doctors who don't do deliveries.

Mr. Golden of the insurers' association argues that whatever role industry practices may play, the current turmoil stems from lawsuits. The association says that from 1995 through 2000, total industry payouts to cover losses and legal expenses jumped 52%, to $6.9 billion. "That says there are more really huge verdicts," Mr. Golden says. Even in the majority of cases in which doctors and hospitals win -- the zero-dollar verdicts -- there are still legal expenses that insurers have to pick up, he adds.

Industry critics point to different sets of statistics. Bob Hunter, director for insurance at Consumer Federation of America, an advocacy group in Washington, prefers numbers generated by A.M. Best Co. The insurance-rating agency estimates that once all malpractice claims from 1991 through 2000 are resolved -- which will take until about 2010 -- the average payout per claim will have risen 47%, to $42,473. That projection includes legal expenses and suits in which doctors or hospitals prevail.

While the statistical debate rages, pregnant women adjust to new limits and inconveniences. Kelly Biesecker, 35, spent many extra hours on the highway this spring, driving from her home in Villanova, Pa., to Delran, N.J., so she could continue to use her obstetrician. Dr. Richard Krauss says he moved the obstetrics part of his practice from Philadelphia because malpractice rates had skyrocketed in Pennsylvania. Ms. Biesecker, who gave birth to a healthy boy on June 5, says Dr. Krauss was the doctor she trusted to guard her health and the health of her baby: "You stick with that guy no matter what the distance."

Dr. Krauss, 53, left Philadelphia last year only after his malpractice premium rose to $54,000, from $38,000, and then was canceled by a carrier getting out of the business, he says. After getting quotes of about $80,000 on a new policy, he moved. New Jersey hasn't been a panacea, however. His policy there expires July 1, and the carrier refuses to renew it. The doctor says he hopes to go to work for a hospital that will pay for his coverage.

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Report: CDC Off on Infection Deaths

.c The Associated Press

CHICAGO (AP) - About 103,000 deaths were linked to hospital infections in 2000 - a figure 14 percent higher than government estimates - and nearly 75 percent of the deaths were preventable, the Chicago Tribune reported.

The national Centers for Disease Control and Prevention last year calculated 90,000 deaths in 2000 were linked to hospital infections, the fourth leading cause of death in the United States behind heart disease, cancer and strokes.

Many of the deaths were caused by unsanitary facilities, germ-laden instruments and unwashed hands, the newspaper said in early Sunday editions distributed Saturday.

According to the report, infection rates are soaring nationally, exacerbated by hospital cutbacks and carelessness by doctors and nurses, and serious violations of infection-control standards have been found in the majority of hospitals.

Since 1995, more than 75 percent of all hospitals have been cited for serious cleanliness and sanitation violations.

Hospitals are not required to disclose infection rates, and most do not. Doctors are not required to tell patients about risk or exposure to hospital germs.

To document the rising rate of infection-related deaths, the newspaper analyzed records from 75 federal and state agencies, as well as internal hospital files, patient databases and court cases around the country.

CDC officials said they believe most hospital infections are preventable, but the agency has not arrived at a precise number.

The American Hospital Association said the last decade of unprecedented cost-cutting and financial instability has impacted all areas of hospital care.

``It's had an effect on infection control and it's had an effect on our ability to recruit and retain workers. It's had an effect on our ability to invest in new and updated equipment as much as we would like to," said Rick Wade, spokesman for the AHA.

``It's also a question in front of society. How much do you want to invest in high-quality, safe medical care?"

Among recent incidents in which hospital-linked infections were cited, the newspaper noted a 1998 case in which eight children died at a Chicago pediatric medical center; a 1997 Detroit case in which four babies died in 1997; and an infection at a West Palm Beach, Fla., hospital where 13 people cardiac patients died in the late 1990s.

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WSJ.com THE WALL STREET JOURNAL. ONLINE

April 11, 2002

PAGE ONE

Businesses' Insurance Costs Surge, But They Shouldn't Blame Sept. 11

By CHRISTOPHER OSTER
Staff Reporter of THE WALL STREET JOURNAL

TULSA, Okla. -- When Bennett Steel Inc., a small construction firm based here, went to renew its insurance coverage shortly after Sept. 11, President Dave Bennett got a shock. The total bill shot up more than $185,000 from a year earlier because of higher premiums for various policies: a 122% increase in umbrella-liability rates, 66% more for liability at job sites, and 51% more for vehicle coverage.

Already dealing with the impact of the economic slowdown, Mr. Bennett increased the number of employees he was planning to lay off, to 15, or 10% of his work force.

Dave Bennett

Businesses across the country have been forced to make similar adjustments in recent months as they confront rate increases of 100% or more on their insurance premiums. And that threatens to damp job growth at smaller businesses -- which traditionally create most of the nation's new jobs -- and thus possibly slow the economic recovery.

Insurers point to the estimated $50 billion in claims from the Sept. 11 attacks as a big reason for the rate increases. But Mr. Bennett and other business owners strain to see the connection. "It just doesn't make sense that it would hit us like that," Mr. Bennett says.

COMPANIES

Dow Jones, Reuters

Berkshire Hathaway Inc. Cl A (BRKA)	
PRICE	71200.00
CHANGE	300.00
U.S. dollars	11:28 a.m.
Chubb Corp. (CB)	
PRICE	77.01
CHANGE	0.01
U.S. dollars	11:34 a.m.
American International Group Inc. (AIG)	
PRICE	73.59
CHANGE	0.79
U.S. dollars	11:35 a.m.
American Financial Group Inc. (AFG)	
PRICE	29.20
CHANGE	0.00
U.S. dollars	11:32 a.m.
St. Paul Cos. (SPC)	
PRICE	49.07
CHANGE	-0.13
U.S. dollars	11:35 a.m.

* At Market Close

He's right. The higher premiums many small and midsize businesses hundreds of miles from New York City now face are the legacy of a decade of imprudence among insurers -- a period that combined a relentless price war with aggressive risk-taking. From 1993 to 2000, underwriters slashed rates, sometimes as much as 40%, and fought for customers by loosening terms on all types of business policies -- from directors-and-officers' liability coverage to medical-malpractice packages to workers' compensation insurance. For many businesses, that meant a boost to already-growing profits in a strong economy. (Rates for consumers dropped in the '90s, too, and have been rising lately, but the swings haven't been nearly as pronounced because of closer regulatory scrutiny.)

Insurers eventually reached the limit. By 1999, they were paying out, on average, $1.07 in

claims and related expenses for every $1 of premium received on business coverage. During the bull market of the '90s, insurers could sustain these losses on underwriting because the shortfalls were more than offset by investment income the insurers earned on premiums.

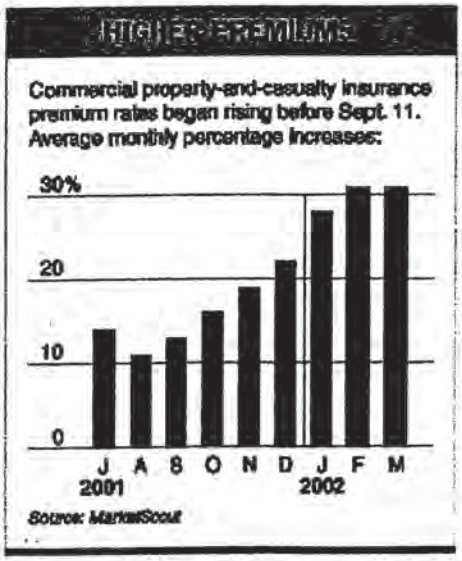
Now financial markets have soured, and so have insurers' investment yields. The companies have also been hurt because claims on the cheap policies they wrote in recent years have come in much higher than they originally estimated -- optimistically, in the eyes of some critics. And all this was happening before Sept. 11. Some insurers haven't survived it all. And others are paying a steep price: For the fourth quarter, more than three dozen insurers reported a total of $5.4 billion in charges, mostly related to restructuring or boosting the amount of money set aside to cover claims beyond the impact of Sept. 11.

This mass action is an "industrywide confessional and rush to atone" for the aggressive practices of the '90s, says Alice Schroeder, a property-casualty insurance analyst with Morgan Stanley.

Indeed, risky lines of business that appealed to insurers several years ago now haunt them. For example, Cologne Re, a unit of Warren Buffett's **Berkshire Hathaway** Inc., took a $225 million charge in 1999 for losses on workers' compensation business it obtained through a complicated premium-sharing system. It involved one insurer after another taking a slice of the insurance pool, then passing a big piece of it along, each successive insurer receiving less premium and more risk. At the time, a Berkshire executive said the practice provided a classic example of an insurer operating "outside its area of expertise."

Selling to Enron

More recently, **Chubb** Corp. Chairman Dean O'Hare lamented $143 million in losses the insurer suffered on surety bonds it sold to guarantee delivery of natural gas by Enron Corp. "What happened with Enron is that our folks ... didn't know what they were writing," Mr. O'Hare wrote in a December letter to employees to help explain why they would be receiving no year-end bonuses. A Chubb spokesman says the company is disputing whether it is required to pay on some of the bonds it sold to Enron.



Now, the higher cost of insurance in more sober times is adding to pressure on businesses when they least need it. In a recent survey by the National Federation of Independent Business, rising insurance costs tied with taxes as the biggest problem facing small businesses. And these businesses feel the pain more than bigger ones. Among businesses with less than $100 million in annual revenue, about 3% of revenue goes to insurance, according to a study by the Risk and Insurance Management Society, which represents corporate-risk managers. For companies with more than $5 billion in annual revenue, the proportion is a much smaller 0.5% of revenue.

Rising insurance rates pose particular problems for places such as Tulsa. Today, the skyline of this city of nearly 400,000 people is dominated by the Bank of Oklahoma tower, designed by the architect who built the World Trade Center. The city once billed itself as the oil capital of the world, and the area was home to J. Paul Getty and Frank Phillips, founders of what became two of the world's largest energy companies.

Oil has remained a mainstay, but in the past decade, Tulsa shifted part of its economic focus to technology. That meant strong growth in the 1990s. Now, it means layoffs such as the 500 workers **Williams Communications Group** Inc. has shed since the start of the year amid a glut of fiber-optic capacity. Tulsa's unemployment rate stands at 4.5%, up from 2.8% at the start of 2001, though nearly a full percentage point below the national average.

A Sudden Switch

Among the many local businesses that benefited from low insurance rates in the '90s was Bennett Steel. Mr. Bennett's workers' compensation insurer, **American International Group** Inc., had been lowering its rates for several years. Then, in 1999, he switched to the Reliance Insurance Co. unit of Reliance Group Holdings Inc. for the coverage. It offered a premium that was $100,000, or 25%, less than his AIG premium.

Mr. Bennett's insurance broker of 15 years, Wally Bryce, of Arthur J. Gallagher & Co., tried to steer Mr. Bennett away from Reliance, arguing that it was weaker financially than other options. "That was the first time in umpteen years of doing business together that he didn't take my advice," Mr. Bryce says.

But Mr. Bennett had plans for the money he saved on insurance. He spent more than $50,000 on new trucks for Bennett Steel.

In 1999, Reliance, which had been as aggressive as the rest in cutting its rates and was now on shaky ground, promised Mr. Bennett a renewal quote but never got back to him. So Mr. Bennett turned to the state-sponsored workers' compensation insurer. He ended up paying premiums 30% higher than the Reliance coverage but still less than what AIG was now offering.

In 2000, the Reliance holding company, long controlled by financier Saul Steinberg, tottered after years of extravagant spending and big dividend payouts. Ratings of the Reliance Insurance unit's financial strength plunged, and Pennsylvania insurance regulators began to exert control over it, eventually announcing in October that they would liquidate its operations. It was part of a small shakeout among less-stable insurers. The same year, Superior National Insurance Co., a workers' compensation specialist, was seized by California regulators, and Pennsylvania regulators last year took control of medical-malpractice specialist Phico Insurance Co.

As weaker insurers fell, stronger ones were freed to raise rates without fear of losing market share. Last fall, Mr. Bryce delivered the news that Mr. Bennett would have to pay much higher rates to Tulsa-based Mid-Continent Insurance Co., which for more than 10 years has been Mr. Bennett's insurer for all coverage except workers' compensation. Mr. Bennett told the broker to show him something better. But only Mid-Continent, a unit of **American Financial Group** Inc., had submitted a serious bid. Most others simply declined the opportunity.

'Grossly Underpriced'

Mike Coon, a Tulsa-based senior vice president for Mid-Continent who handles Mr. Bennett's account, says part of the rate increase was due to claims Mr. Bennett filed last year. He adds that hefty rate increases aren't uncommon. Some new customers, he says, are being asked to pay more than triple the premiums they paid to their previous insurers. "There are companies who had rate levels that were 15% to 20% of what we would have charged," Mr. Coon says. "A lot of that business was non-renewed because it's been so grossly underpriced."

Mr. Bennett, a weathered 48-year-old Tulsa native with the meaty forearms of a fourth-generation iron worker, started his business in 1980 with four employees, "a bumper jack and a pry bar," he says. Now, it has 135 employees, including his wife and three of his sons, and

operates a fleet of 21 cranes -- some valued at more than $1 million -- that erect university buildings, offices and warehouses. Annual revenue is now around $18 million.

The layoffs, the biggest in the company's history, hurt. "If I've got 150 people working for me, it's 600 people," he says, noting that a typical employee has several dependents.

In addition to letting go of 15 people shortly after Thanksgiving, Mr. Bennett cut some of his remaining workers' hours to 30 a week. Business had slowed. A construction contract with American Airlines fell through soon after Sept. 11. And the 32% rise in its insurance rates, Mr. Bennett says, made the cuts all the more necessary -- and deeper.

Throughout Tulsa, businesses public and private are trying to cope with the higher insurance expenses. Brad Frank, president of Tulsa Tube Bending, which bends metal pipes for industrial use, says his rates for property, product-liability and umbrella-liability coverage increased more than 20% when the company renewed Dec. 31. Mr. Frank has tried to absorb the cost increases by preaching efficiency to employees. He says a profit-sharing program at Tulsa Tube will motivate employees to, among other things, pay more attention to workplace safety.

"We were thinking about adding another person," Mr. Frank says. "But that's not part of our plan anymore."

Lloyd Snow, school superintendent for Sand Springs, a small town just outside of Tulsa, got news last July that rates would jump to $280,000 from $160,000. "Schools are seeing increases of 70% to 250%," Mr. Snow says. "It's been phenomenal."

Brent LaGere, chairman and chief executive of National American Insurance Co., which insures most of Oklahoma's school districts, says his company was passing on higher premiums from its reinsurer, a firm that helps insurers spread their risk. Mr. LaGere anticipates his company will need to increase rates further as reinsurers try to recoup losses from Sept. 11 and Enron's collapse.

The rate increases come as the state of Oklahoma is eliminating $194,000 from the roughly $15 million a year it sends to the Sand Springs school district as part of statewide budget cuts. "There will be services to kids that are reduced or lost," Mr. Snow says. Up to 87% of the district's budget goes to salaries of teachers, administrators and support staff, he says, so "increasing costs like insurance means cutting payroll." Sand Springs already has had to delay the purchase of school buses and desktop computers and has canceled an increase in the textbook budget.

Strength in Numbers

Mr. Snow says the rate increases have hit Oklahoma's school systems so hard that school districts are working on a plan to pool their insurance premiums and risks to make insurance more affordable. If that doesn't come together, "we're being told that we're looking at another 50% to 150% increase," Mr. Snow says.

Businesses and institutions that haven't yet paid higher insurance premiums are bracing for them. Valley View Regional Hospital, south of Tulsa in Ada, Okla., has a liability-insurance policy that runs until summer. But in December, Phil Fisher, the hospital's president, received notice that Valley View's insurer, **St. Paul** Cos., wouldn't be able to renew the hospital's medical-liability coverage.

St. Paul, the nation's largest writer of medical-malpractice insurance, with a 10% market share, decided to shutter its medical business altogether, after losing $940 million on it last year. St. Paul's medical-malpractice problems were emblematic of the impact of the insurance price war

of the 1990s. Medical-malpractice insurance was the industry's most profitable line 10 years ago, and so many companies piled into it that they began underpricing their coverage. Then came rising jury verdicts in malpractice suits and higher health-care inflation. A St. Paul spokesman says the company is leaving the business because it doesn't believe it can make the line of business profitable.

Valley View's Mr. Fisher isn't sure who the hospital's insurer will be after its St. Paul policy expires next year, nor how much the insurance will cost. "Everyone is very reluctant to talk about that," he says. "But we need something. We need a marker somewhere along the line."

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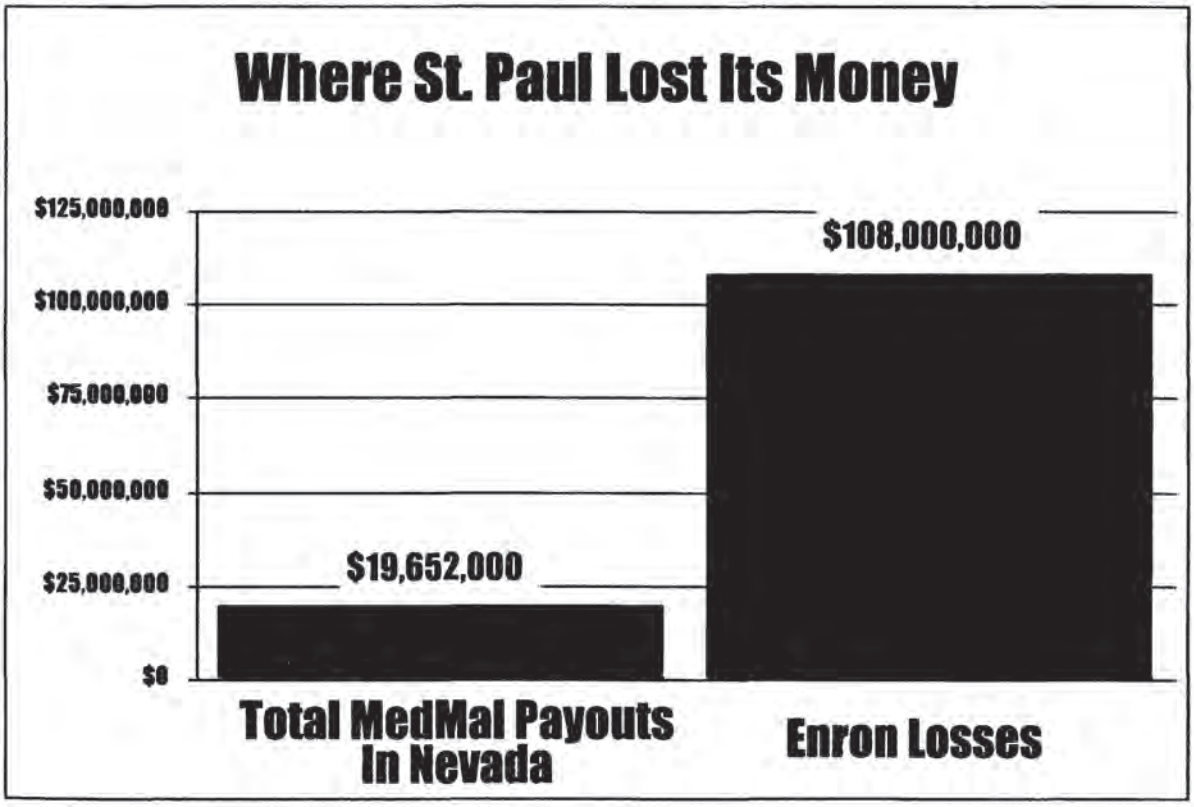
Updated April 11, 2002 12:54 p.m. EDT

Medical Malpractice Caps

Is Medical Malpractice Really St. Paul's Problem?



- **St. Paul Lost Over Five Times More Money In The Enron Fiasco Than In Nevada Malpractice Claims**
- **Bad Investments Are St. Paul's Real Problem**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Source: Nevada Medmal payments for 2000 as reported in the AM Best State/Line Report, Format A3. St. Paul announced on December 4, 2001, an exposure of $85 million after taxes due to the Enron bankruptcy. Additionally, they have reported that they hold $23 million par value on Enron Corporate Senior Unsecured debt.

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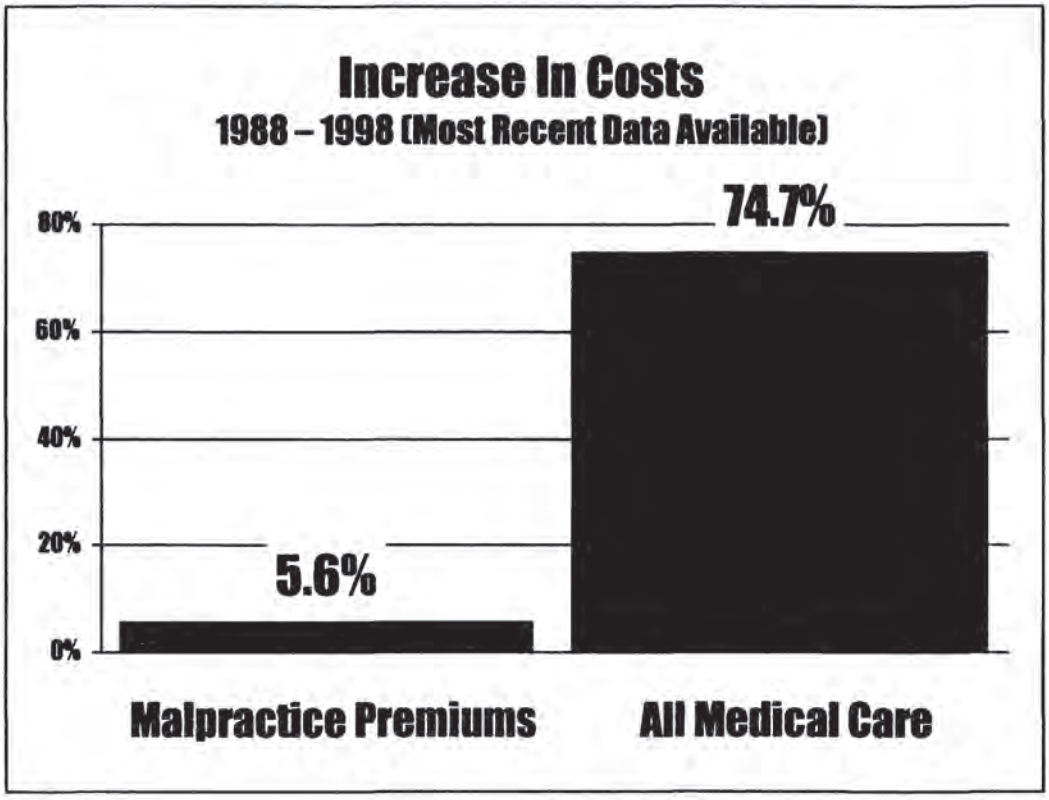
Medical Malpractice

Are Malpractice Costs Out Of Control?

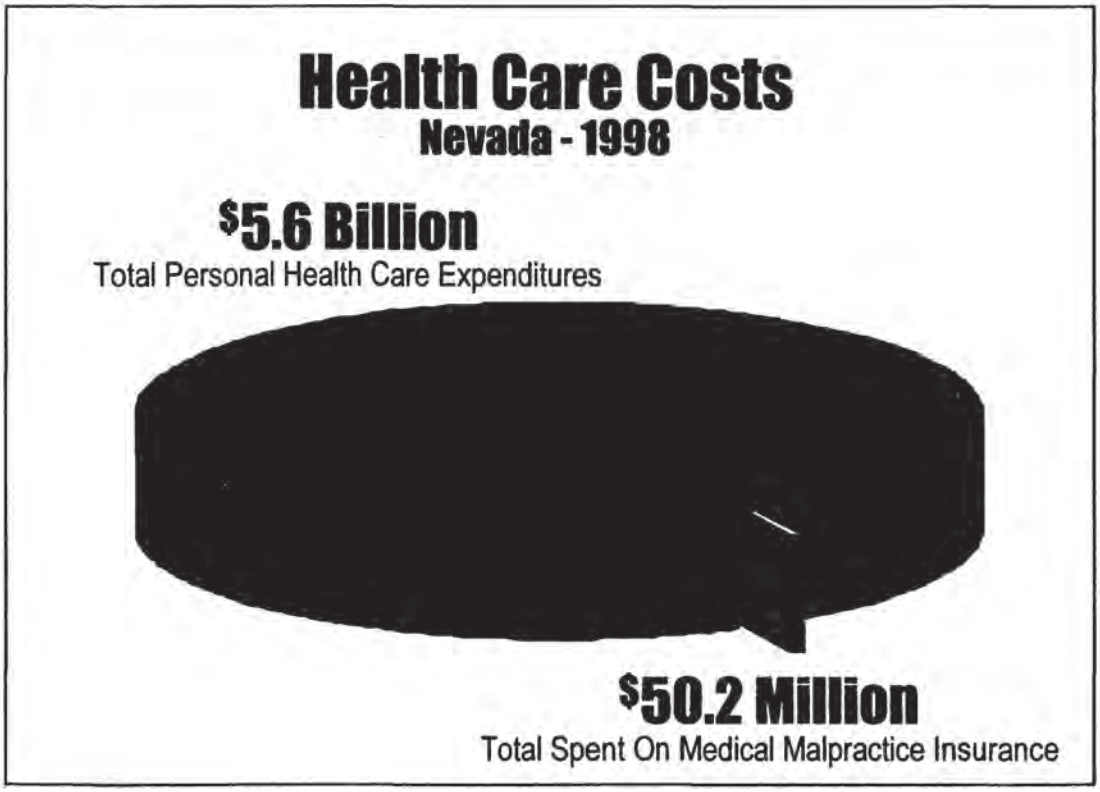


- **Medical Care Costs Rose Thirteen Times Faster Than Malpractice Costs From 1988-1998**
- **There Is No Evidence That Malpractice Costs Have Contributed To Overall Rising Medical Costs**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Sources: malpractice data from the American Medical Association, Socioeconomic Characteristics of Medical Practice. Medical care costs calculated from the Consumer Price Index Home Page: http://stats.bls.gov/cpihome.htm

Medical Malpractice Insurance

Do Malpractice Premiums Drive Up Medical Costs?

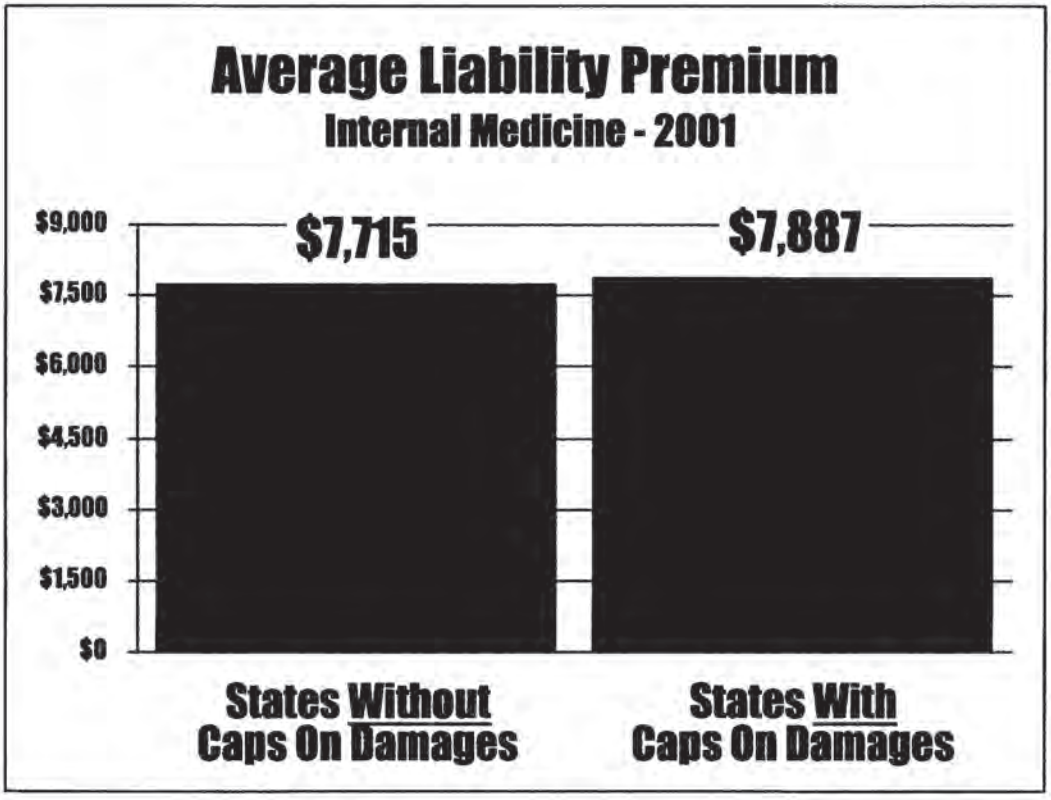


- **Medical Malpractice Insurance Premiums Amount To Less Than 1% Of All Medical Costs**
- **Premiums Cannot Be A Significant Factor**
- **Medical Malpractice Premiums Do Not Contribute To Rising Overall Medical Costs**

Sources: Personal Health Care Expenditures taken from the Health Care Financing Administration (http://www.hcfa.gov/stats/nhe-oact/stateestimates/Tables98). "Total spent on medical malpractice insurance" reflects US total medical malpractice premiums written according to AM Best State Line Report (the insurance industry's leading provider of information and company ratings)

Medical Malpractice Insurance

Do Caps Reduce Malpractice Premiums?



- **Premiums For Doctors Of Internal Medicine Are 2.2% Higher In States With Caps On Damages**
- **Caps Do Not Bring Down Malpractice Premiums**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

*Derived from data provided by Medical Liability Monitor (vol 26, #10 – Oct 2001) A state's average premium is calculate as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a "cap" when there exists a general noneconomic damage cap that affect medical malpractice or a broad medical malpractice specific cap on noneconomic damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases.

ADVOCATES FOR JUSTICE

NEVADA TRIAL LAWYERS ASSOCIATION

August 9, 2002

Patricia Vardakis
Legislative Counsel Bureau
401 S. Carson St.
Carson City, NV 89701-4747

Dear Patricia:

Enclosed are handouts that were used during the 18th Special Session, I was not sure if you had copies of the following or not. Could you please put these with any other documents from NTLA.

- Tort Source - A Publication of the Tort and Insurance Practice Section
- Legal Draft - The People of the State of Nevada, Represented In Senate and Assembly, Do Enact as Follows:
- The Wall Street Journal April 11, 2002
  "Businesses' Insurance Costs Surge, But They Shouldn't Blame Sept. 11"
- Report: CDC Off on Infection Deaths
- Wall Street Journal June 24, 2002
  "Insurers' Price Wars Contributed To Doctors Facing Soaring Costs"
- North Eastern Reporter, 2nd Series - State Ex Rel. Oatl v. Sheward

Thank you,

Victoria Coolbaugh
Deputy Executive Director

Enclosures (6)

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Advocates for Justice

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TortSource

A Publication of the Tort and Insurance Practice Section

American Bar Association

The Insurance Cycle [The Reform Cycle]

Joanne Doroshow

The tort "reform" movement of the last two decades has turned the civil justice system into a battleground. Founded in 1986, the American Tort Reform Association (ATRA), with the backing of 300 corporate, professional, and insurance trade organization members, boasts that most states have enacted some form of tort reform—laws that restrict the rights of injured consumers to sue and be fully compensated for their injuries.

In the mid-1980s, manufacturers, municipalities, doctors, nurse-midwives, daycare centers, nonprofit groups, and many other commercial customers of liability insurance were faced with skyrocketing insurance rates, coverage reductions, and arbitrary policy cancellations. Many could not find coverage at any price.

Insurance companies said costs were being driven up by an "explosion" in litigation and claimed "frivolous lawsuits" and "out of control" juries were forcing them to make insurance unaffordable or even unavailable. They told state legislatures around the country that the only way to ease this crisis was to limit tort laws, to make it more difficult for sick and injured consumers to sue and be compensated by wrongdoers in court.

But what ultimately proved to be the true cause of the "liability insurance crisis" of the mid-1980s was not the legal system at all. Study after study that examined the property/casualty insurance industry found the same result: The "insurance crisis" was actually a self-inflicted phenomenon caused by the mismanaged underwriting practices of the industry itself.

The past few years, when the economy for the most part was booming, have found state court tort filings stable or declining. Only 10 percent of injured people file claims for compensation, and just 2 percent file lawsuits. Nearly eight times as many patients suffer an injury from negligent medical treatment than ever file a claim. Punitive damages are rarely awarded, and liability insurance costs for businesses are minuscule and dropping. The premium-gouging cash-flow underwriting practices of the insurance industry have been widely exposed. With these facts in mind, it may be hard to understand why tort reform remains on the national agenda.

By 1985 interest rates had dropped, and investment income had decreased accordingly. The industry responded by sharply increasing premiums and reducing availability of coverage, creating a "liability insurance crisis." As *Business Week* explained in a January 1987 editorial,

> Even while the industry was blaming its troubles on the tort system, many experts pointed out that its problems were largely self-made. In previous years the industry had slashed prices competitively to the point that it incurred enormous losses. That, rather than excessive jury awards, explained most of the industry's financial difficulties.

The National Association of Attorneys General and state commissions in New Mexico, Michigan, and Pennsylvania reached similar conclusions. Even the insurance industry admitted this internally. In 1986 Maurice R. Greenberg, president and CEO of American International Group, Inc., told an insurance audience in Boston that the industry's problems were due to price cuts taken "to the point of absurdity" in the early 1980s. Had it not been for these cuts, he said, "there would not be 'all this hullabaloo' about the tort system."

Without question, one of the major reasons is the number of conservative, industry-sponsored think tanks, polling companies, and lobbying firms that are setting legislative agendas, devising strategies, and purchasing expensive media to convince the public that the tort system is out of control and needs to be scaled back. Because of the intensity of their efforts, it is sometimes easy to forget that it was the insurance industry that created the "crises" that led to the drive for tort reform in the first place. Given recent indications, the insurance cycle is about to change again.

The insurance industry's profits and underwriting practices are cyclical, often characterized by sharp ups and downs. In fact, these underwriting practices and the insurance cycle caused a similar, less severe "insurance crisis" in the mid-1970s. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars, lowering prices and insuring very poor risks just to get the premium dollars. In the mid-1980s, the cycle's effects were exacerbated by a particularly exaggerated underwriting response to the high interest rates of the early 1980s—characterized by such risky underwriting as insuring the MGM Grand Hotel *months after it burned down in a fire*.

But to the public and to lawmakers, insurers told a different story. In fact, coming out of their bottom year of 1984, insurance companies marketed the idea that the civil justice system is flawed. The goal, in the words of industry leader John J. Byrne, GEICO's chairman, was "to withdraw [from the market] and let the pressure for reform build in the courts and in the state legislatures."

To support this effort, the Insurance Information Institute purchased $6.5 million worth of print and television ads in 1986. Their headlines read "The Lawsuit Crisis Is Bad for Babies," "The Lawsuit Crisis Is Penalizing School Sports," and "Even Clergy Can't Escape the Lawsuit Crisis"; the ads ran in *Readers' Digest, Time, Newsweek*, and Sunday newspaper supplements. Insurance companies and other insurance trade associations complemented the campaign with their own ads.

State legislatures, regulators, and voters in ballot initiative states were told by business and insurance lobbyists (and their PR firms) that the way to bring down insurance rates was to make it more difficult for injured consumers to sue in court. A November 7, 1988, *National Underwriter* editorial entitled "Prepare for the backlash" bluntly conceded, "Let's face it. The only reason tort reform was granted in many states is because people accepted our argument that it was needed to control soaring insurance rates." At the same time, another business trade publication acknowledged "a virtual absence of empirical evidence that tort reform [would] indeed lower liability insurance rates or expand the insurance's availability."

When lobbyists were pushed hard by legislators to provide guarantees that rates would drop, they could not. In state after state, subsequent rate filings with insurance departments confirmed this. For example, in 1986 Washington State enacted what was considered at the time one of the most comprehensive tort reform bills ever. Before it passed, Ted E. Linham, president of the Washington State Physicians Insurance Association, testified that the new law would reduce premiums charged by the association, a mutual company, by 25 to 30 percent within 18 months after the legislation took effect. However, after the law passed, the company asked for a rate *hike*, and state regulators began looking for an explanation.

By the late 1980s, the insurance cycle had flattened out; rates stabilized, and availability improved everywhere. This had nothing to do with tort law restrictions enacted in particular states but was the result of modulations in the insurance cycle everywhere. As Washington's insurance commissioner Dick Marquardt concluded in a 1991 report, it was "impossible to attribute stable insurance rates to tort-law changes or the damages cap" because rates also improved in states that did not pass tort reform.

This fact was confirmed much later in a 1999 Center for Justice & Democracy study, *Premium Deceit—the Failure of "Tort Reform" to Cut Insurance Prices*. After examining liability insurance rates in every state in the country between 1985 and 1997, the study concluded that enactment of tort reform had not succeeded in reducing insurance prices for insurance consumers. Some states that resisted enacting tort reform since 1985 experienced low increases in insurance rates relative to the national trends, and others that enacted major tort reform packages saw high rate increases.

After publication of the report, ATRA spokespeople admitted in published statements that lawmakers who enacted tort reform should not expect insurance rates to drop. ATRA President Sherman Joyce told *Liability Week* on July 19, 1999, "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." Victor Schwartz, ATRA's general counsel and one of D.C.'s principal tort reform lobbyists on behalf of business interests, told *Business Insurance* he thought severe tort reform measures could reduce insurance rates; when pressed, however, he admitted, "more importantly... many tort reform advocates do not contend that restricting litigation will lower insurance rates, and I've never said that in 30 years."

Tort reform has had terrible consequences for many innocent people yet done nothing to improve the affordability or availability of liability insurance for businesses or professions. Insurance companies that claim otherwise are severely misleading the country's lawmakers.❖

Joanne Doroshow is executive director of the Center for Justice & Democracy in New York City.

CENTER FOR JUSTICE & DEMOCRACY
CJ&D

WHITE PAPER

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SHAKEDOWN:

HOW THE INSURANCE INDUSTRY EXPLOITS A NATION IN TIMES OF CRISIS

*By Joanne Doroshow and Emily Gottlieb**

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"Fighting to protect the right to jury trial and an independent judiciary for all Americans."

* Executive Director and Deputy Director, Center for Justice & Democracy

INTRODUCTION

Ten days after the September 11, 2001 terrorist attacks, a delegation of 15 insurance executives met privately with President Bush and Commerce Secretary Donald Evans at the White House in an effort to limit insurance companies' liability exposure for future acts of terrorism.[1] A few days later, Jacques E. DuBois, an executive from Swiss Re, the world's second-largest reinsurance company* but to most people a virtually unknown foreign entity, walked into the White House and told officials that his company would stop providing terrorism coverage to property and casualty insurers, raising fears of a nationwide economic collapse.[2]

These executives were demanding a multi-billion-dollar insurance "backstop," essentially capping the liability of the property/casualty insurance industry, an industry worth hundreds of billions of dollars, in the event of future terrorist attacks. While similar to the demands of a host of other major industries that demonstrated their post-September 11 patriotism by asking to loot the federal treasury, this proposal stood out because the "federal safety net" the insurance executives wanted had the potential to become the most expensive bailout in U.S. history. Without a program in place by the end of 2001, the executives warned, reinsurers would stop providing coverage to property and casualty insurance companies for future terrorist attacks. Without reinsurance, they argued, insurance companies could no longer offer policies with terrorism coverage. And without terrorism insurance, they said, banks would stop lending money, new construction would grind to a halt and businesses would collapse. The blow to the U.S. economy would be crushing.

As of April 2002, a federal insurance bailout had not yet passed, the economy had not crumbled and the insurance industry has actually seen a surge in capital. In fact, by January 23, 2002, the Consumer Federation of America was reporting that the insurance industry was "more strongly capitalized than it was even before September 11," that "banks were lending money to most businesses" and that while certain large businesses and potential targets like skyscrapers and sports arenas were having difficulty getting terrorism coverage (problems that could be solved with alternatives to traditional terrorism coverage), there were "no widespread economic problems related to terrorism insurance."[3] On March 20, 2002, Assistant Secretary of the Treasury for Financial Institutions, Sheila Bair, acknowledged that there has been no "dramatic disruption" in economic activity as a result of Congress' failure to enact bailout legislation.[4]

While the doomsday predictions of September 2001 have not come to pass, the ease with which insurance executives were able to command the nation's attention with promises about the economy's imminent collapse says a great deal about the vast power and economic control that this industry exercises in the United States. History shows that property/casualty insurance

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* Reinsurance is insurance for insurance companies; the insurer pays the reinsurer a premium in exchange for which the reinsurer agrees to share the risk with the insurer. A U.S. insurer's willingness to offer coverage is often determined by the availability of reinsurance. Reinsurers, typically foreign companies like Swiss Re or Lloyd's of London that operate domestically with virtually no regulatory oversight, can dictate rates, terms of coverage and other matters to U.S. companies. Reinsurers also control the amount of business that primary insurers can write, since reinsurance releases funds for further underwriting that the insurer otherwise would keep in reserve to cover potential large losses. Thus, reinsurers have a substantial amount of economic power over primary insurers.

companies have repeatedly threatened to pull the rug out from under the U.S. economy to get what it wants, whether it be a bailout or limits on people's rights to sue, freely intimidating lawmakers and creating an atmosphere of "crisis" to promote its legislative agenda while at the same time escaping any meaningful public scrutiny or regulatory control.

The medical malpractice insurance "crisis" that many states are now experiencing,[†] created by the insurance industry's own pricing errors and lost investment income, is another example of how the industry uses its vast economic clout to pressure lawmakers. Doctors, like all businesses and professions that provide services, depend on adequate and reasonably priced insurance to function. Yet because of scant oversight of insurance industry activities, insurers can, in an effort to raise profits, impose rate hikes that are so astronomical that they threaten the ability of medical clinics to survive even though insurers' own mismanaged underwriting and unchecked power are to blame. Insurance companies and their foreign reinsurers announced, "Don't look at us – blame those lawyers, lawsuits and juries!" With this rhetoric in hand, the industry then uses its economic clout to drive a nationwide campaign to weaken U.S. civil liability laws, some that have protected U.S. citizens for over 200 years. And it's all done with very little scrutiny by policyholders, lawmakers, the media or the public at large.

How can this happen?

MONEY BUYS RESULTS

The property/casualty insurance industry is accountable to no federal agency but rather only to weak state agencies. Moreover, it is subject to virtually no federal regulatory laws, few federal anti-trust laws and no oversight by the Federal Trade Commission.[5] Combine this sorry state of insurance regulation and almost non-existent data disclosure requirements with the industry's massive political influence through enormous financial contributions to key lawmakers, and the result is an industry that can make extraordinary claims and demands on U.S. politicians that go nearly unchallenged.

Weak Regulation and Oversight ...

To understand how the insurance industry can exercise this kind of power in the United States, it is necessary to start with one key observation: the property/casualty insurance industry is one of the least regulated and anti-competitive industries in the country. In 1944, the insurance industry strong-armed Congress into enacting the McCarran-Ferguson Act, which allows insurance companies to fix prices, an anti-competitive practice that for other industries can be punishable

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[†] In many states, as well as Congress, proposals have been introduced to restrict the rights of patients to sue doctors and hospitals for medical negligence, triggered by an insurance "crisis" – astronomical rate increases and cancelled coverage for medical malpractice insurance. As explained later in this report, the "crisis" is caused not by lawsuits but by the property/casualty insurance industry's cyclical downturn and will not be solved by restricting patients rights to sue. Despite this fact, the American Medical Association announced in March 2002 that it planned to lobby lawmakers and courts in at least 25 states for laws to cap the liability of malpracticing doctors and hospitals. On March 14, 2002, the Pennsylvania legislature became the first state this year to approve such a bill.

CENTER FOR JUSTICE & DEMOCRACY

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Studies

To order this study, contact CJ&D

PREMIUM DECEIT:

THE FAILURE OF "TORT REFORM" TO CUT INSURANCE PRICES

EXECUTIVE SUMMARY

From the mid-1980s until today, the nation's largest businesses have been advancing a legislative agenda to limit their liability for causing injuries. One of the principal arguments on which they rely is that laws that make it more difficult for injured people to go to court (*i.e.*, "tort reform") will reduce insurance rates. This report analyzes these claims, and concludes they are invalid.

The "tort reform" movement largely originated in the mid-1980's while the nation was suffering through a severe "liability insurance crisis." Small businesses, doctors, non-profit groups and others were hit with dramatic increases in insurance premiums, reduced coverage and arbitrary policy cancellations. The situation received extensive media attention, such as *Time Magazine*'s 1986 cover story entitled, "Sorry, Your Policy is Cancelled."

The insurance industry and other large corporations blamed the crisis on the legal system and lobbied extensively for what they called "tort reform" --laws that restrict the rights of injured consumers to sue and obtain compensation from corporate lawbreakers and other wrongdoers. They claimed that enactment of "tort reform" would cause insurance rates to stabilize and even fall.

Great pressure was brought to bear on state legislatures around the country to restrict the rights of innocent victims to recover for their injuries and to hold wrongdoers accountable in court. Many states succumbed to this pressure and passed "tort reforms." Moreover, states have continued to adopt these laws. As recently as the spring of 1999, Florida passed an extensive "tort reform" package. And some New York lawmakers are considering a similarly broad proposal.

This study --the most extensive review of insurance rate activity in the wake of the liability insurance crisis ever undertaken --was designed to test the impact on liability insurance rates of "tort reforms," specifically those

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that were passed by state legislators (or voters by ballot initiative) in reaction to the liability insurance crisis of the mid-1980s, and in the years since.

We obtained data on insurance rate and loss cost movement in every state from 1985 through 1998. We then segregated the states into three categories: states that enacted the fewest number of tort law changes over the period; states that passed a mid-range level of tort law limits; and states that enacted the most "tort reform."

The hypothesis we tested was simple: if tort law limits succeed in reducing insurance costs for consumers of insurance, that should be evident in the trends of insurance costs. As tort law limits get more severe, the trends in rates and underlying loss costs should be less.

We tested this hypothesis for the lines of insurance subject to general tort reform and to product liability and medical malpractice separately, since states often enact separate tort law restrictions to be applied just in those areas.

We found that the trends in rates/loss costs do not support the hypothesis that "tort reform" has succeeded in holding down insurance costs or rates. Despite what "tort reform" proponents promised lawmakers, tort law limits enacted since the liability insurance crisis of the mid-1980s have not lowered insurance rates in the ensuing years. States with little or no tort law restrictions have experienced the same level of insurance rates as those states that enacted severe restrictions on victims' rights.

The "liability insurance crisis" of the mid-1980s was ultimately found to be caused not by legal system excesses but by the economic cycle of the insurance industry. Given large rate increases and cut backs in coverage, the insurance cycle soon turned again and prices began to fall. The nation has enjoyed a relatively "soft" insurance market for over a decade now -- with rates of liability insurance not only stable but down.

Just as the liability insurance crisis was found to be driven by the insurance underwriting cycle and not a tort law cost explosion as many insurance companies and others had claimed, the "tort reform" remedy pushed by these advocates failed. As the findings of this report confirm, legal system restrictions are based upon a false predicate. "Tort reforms" do not produce lower insurance costs or rates.

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CENTER FOR JUSTICE & DEMOCRACY

CJ&D

News Releases

For Immediate Release
March 19, 2002

Contact: Joanne Doroshow
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Insurance Industry Admits: Don't Expect "Tort Reform" To Reduce Insurance Rates

New York - In a startling admission, the American Insurance Association (AIA), a major insurance industry trade group, says lawmakers who enact "tort reform" should not expect insurance rates to drop. Specifically, a March 13, 2002 AIA press release, evidently issued to critique the Center for Justice & Democracy's 1999 study Premium Deceit - the Failure of "Tort Reform" to Cut Insurance Prices, leads with an astounding face-saving pronouncement: "[T]he insurance industry never promised that tort reform would achieve specific premium savings."

Said CJ&D Executive Director Joanne Doroshow, "We would like to thank the insurance industry for finally admitting what is already obvious: that they have not cut, and have no plans to cut, insurance premiums for doctors, hospitals or other businesses as a consequence of 'tort reform' - restrictions on consumers' rights to sue wrongdoers in court. AIA's friends at the American Tort Reform Association (ATRA) said this nearly three years ago following Premium Deceit's release. Now that we're all in agreement, can we please recognize 'tort reform' for what it is - an insidious movement that has had terrible consequences for many innocent people, while doing nothing to improve the affordability of liability insurance for businesses or professions."

A medical malpractice insurance "crisis" for doctors is currently driving a national movement to restrict patient's rights to sue malpracticing doctors, on the grounds that these restrictions will reduce doctors' insurance rates.

In 1999, ATRA President Sherman Joyce told Liability Week (July 19, 1999), "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." Victor Schwartz, ATRA's General Counsel, told Business Insurance (July 19, 1999) that "[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'"

Premium Deceit is an exhaustive look at the impact of "tort reform" on nationwide insurance costs between 1985 and 1999. It finds that tort law limits enacted since the mid-1980s have not lowered insurance rates in the ensuing years. States with little or no tort law restrictions have experienced

approximately the same changes in insurance rates as those states that have enacted severe restrictions on victims' rights.

For a copy of CJ&D's full response to AIA's critique of Premium Deceit in pdf format, click here.

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Expert Commentary

Medical Malpractice Insurance Trends? Chaos!
September 2001

by **Charles Kolodkin**
Gallagher Healthcare Insurance Services

A quick examination of the medical malpractice insurance marketplace in the second half of 2001 might lead a dispassionate observer to conclude this segment of the insurance industry is confused, in disarray, and generally in a state of disorder. Premiums are doubling, hospital deductibles are tripling, claims-free physicians are being nonrenewed, insurers are leaving territories en masse. Simply put, the market is in chaos.

Ask an insurance agent or broker specializing in medical malpractice coverage and you will no doubt receive confirmation of this turmoil. Survey a physician or hospital risk manager on this subject, especially one that has recently sought professional liability insurance protection, and you will likely hear a litany of complaints suggesting disgust, bewilderment, and helplessness. The reaction from insurers themselves may come with a wry smile, but they too will agree the market is in a chaotic state. Yet, in a perverse way, the condition of the medical malpractice market is actually quite rationale and not at all surprising.

The Problems of the Past

What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income.

In a perfect world, investment income would cover any deficiencies that might exist in underwriting results and the insurers' aggressive marketing and pricing strategy would prove to be successful. Alas, we do not live in a perfect insurance world and, as competition intensified, underwriting results deteriorated. Regardless of the level of risk management intervention, proactive claims management, or tort reform, the fact remains that if insurance policies are consistently underpriced, the insurer will lose money.

The following table displays the performance of insurers issuing medical malpractice coverage in the United States during the decade of the 1990s.

Year	Net Premiums Written	Combined Ratio*
1990	$4,014,622,000	101.9%
1991	$4,067,803,000	99.0%
1992	$4,133,567,000	123.4%
1993	$4,370,812,000	104.5%
1994	$4,780,537,000	94.2%
1995	$4,800,552,000	96.4%
1996	$4,875,486,000	102.6%
1997	$4,892,496,000	103.5%
1998	$5,145,066,000	111.9%
1999	$5,104,147,000	125.8%
Source: A.M. Best Co.		

It only takes a quick view of insurance companies' results during the past few years to realize how poorly the sector has performed. As bad a year as 1998 was, evidenced by a combined ratio of 112 percent, 1999 results are worse, weakening to 126 percent. Preliminary information indicates the trend deteriorating in 2000 to 140 percent. In other words, for every $1.00 medical malpractice insurers were receiving in 2000 as premium, they will pay out $1.40 in losses and expenses.

Insurers Go Out of Business

Clearly a business cannot continue operating in this fashion indefinitely. Indeed, this has been the case for such long time writers of professional liability insurance as Frontier, Reliance, and P.I.E Mutual. These companies, who suffered through several years of weakening performance, have been liquidated or are otherwise inactive.

In August 2001, the list of impaired medical malpractice insurers got longer as the Pennsylvania Department of Insurance placed PHICO under state rehabilitation. PHICO, one of the ten largest writers of medical malpractice insurance, has been one of the more aggressive underwriters during the late 1990s. The company has seen its surplus decrease dramatically over the past year and half from almost $200 million to under $10 million. Regulatory intervention was necessary as it became obvious PHICO's premiums had been inadequate to cover losses.

The Industry Reacts

In light of these dismal results, the insurance industry realizes it must take action. A top executive of St. Paul Insurance Company, the country's largest writer of medical malpractice insurance, recently stated, healthcare liability "is the most dramatically underperforming segment of the marketplace." In response, the Minnesota based insurer is reevaluating its marketing strategy, examining not only its premium rating structure, but also the territories, product lines, and coverage limits it will offer.

St. Paul is hardly unique. It is safe to say ***every*** insurance company actively insuring hospitals and physicians has gone through an intensive introspection of its marketing strategy during the past 12 months.

Insurance companies are evaluating all aspects of underwriting, and not just premiums. As of 2001, the effects of this introspection by the medical malpractice insurance community remain unclear, although one thing is certain: the aggressiveness of the 1990s characterized by soft pricing is over. Insurers are now examining the territories they will write, the medical specialties to be targeted, the amount of coverage to make available, deductibles required, and the way they make underwriting decisions.

The following are examples of the way medical malpractice underwriting is changing:

Territory:

- **Eastern Pennsylvania:** Principally due to high jury awards, insurers are avoiding this venue. Employers Reinsurance Corporation (ERC), an insurance titan with over $10 billion in assets, has effectively pulled out of this market. Whereas, ERC formerly issued policies above $1 million to $2 million level, they now want to attach at $10 million. Moreover, their premium requirements have increased sometimes by as much as 500 percent.
- **West Virginia:** The premium rates in the state have long lagged behind the loss experience, however the state insurance department has been slow to approve rate increases. Accordingly, most medical malpractice insurers are withdrawing from doing business in the Mountaineer State.
- **South Florida and Texas:** Traditionally these territories have been viewed as problematic for the medical malpractice insurance industry on account of large jury awards. Although rates in these states are significantly higher than those in neighboring states like Georgia or Oklahoma, a number of insurers are choosing to discontinue offering policies in the second and fourth most populous states.

Business Class:

- **Unattractive Medical Specialties:** Many insurers have found certain medical specialties to be either entirely unprofitable or simply difficult to classify. *Primary care physicians* such as family practitioners, pediatricians, and internists are no longer a targeted class of business. This is mainly a result of their relatively low premiums and the fact that managed care has placed more demands on these physicians, in effect increasing their loss exposure. *Emergency medicine* is a medical specialty that few, if any, insurers are eager to write in 2001. The transitional nature of the patient-physician relationship, the potential for catastrophic outcomes if there is a misdiagnosis or premature discharge, and the sector's historically poor claims experience has made this an unappealing business class. Surprising to many, *radiologists* are having difficulty garnering interest in the insurance marketplace. In the past, this group has been categorized as a lower risk group, yet their susceptibility to failure to diagnose claims has many underwriters perplexed about how to properly rate radiologists. Therefore, the simplest solution is to avoid the specialty.
- **Unattractive Healthcare Sectors:** Certain healthcare sectors are increasingly being avoided due to their unfavorable claims history. This is complicated by the insurance industry's inability to project future losses with any degree of confidence. Thus, insurers basically abandon a sector. This has been the case with the well-publicized insurance crisis being experienced by the *nursing home* industry. The *correctional care* sector (clinics serving prisons and jails) is in a similar predicament. *Academic medicine*, encompassing large teaching hospitals usually located in urban settings, falls into this category as well.

Insurance Restructuring:

- **Structured Underwriting:** Several insurers have imposed stricter guidelines on their underwriters by establishing acceptable levels of claims frequency and claims severity an applicant may have. This is usually accomplished through objective standards, such as no more than 1 claim in the past 5 years for physicians. Acceptable claim severity for a potential insured physician might be under $100,000 (exclusive of defense costs) for all settlements, including open cases.
- **Centralized Underwriting:** Insurers are more and more frequently implementing a chain-of-approval process for accepting and rating insureds. The companies' home offices are increasingly requiring to sign-off on the proposals prepared by field offices. SCPIE, an "A"-rated insurer focused exclusively on the healthcare industry, recently closed their regional offices and are centralizing underwriting decisions within their Los Angeles home office.

Forecast for 2002

The immediate prospects for the buyer of hospital professional liability insurance or physician malpractice coverage are not promising. Rates likely will continue to increase, market capacity will further shrink, and insurers will be highly selective about the risks they will write.

Rate Increases Will Continue. Although premium rates started their climb in 2000 and noticeably increased in 2001, most underwriters feel they are still insufficient to cover losses. Indications for 2002 are more rate increases. St. Paul raised rates for large hospitals it has renewed thus far in 2001 by an average of 76 percent. The company's price increases have been even steeper in recent months, with renewal increases in July 2001 up 103 percent from last year. This is not an isolated phenomenon.

Underwriting Standards Will Tighten. During the soft market a prospective insured really was not closely scrutinized when it applied for coverage. This was the case for both institutions as well as physicians. In the quest for market share, insurers would issue a quote in days, if not hours. The information requests of underwriters were hardly exhaustive.

The tide has turned. All insurers insist on a detailed, completed application from the insured with a comprehensive summary of operations. For many hospitals, the insurance company will not prepare a quote without first performing a site visit. In today's world, underwriters require thorough loss information, including a current loss run identifying an insured's open and closed claims. In the event any of these materials are not submitted, it is doubtful an underwriter will release a quotation.

Limited Number of New Players. In view of the woeful operating results in the medical malpractice insurance segment, an influx of new insurers is unlikely in 2002. Most potential risk bearers will await the outcome of the changes that have occurred in 2001, such as higher rates and focused underwriting, before committing capital and resources to the industry. It is important to realize the impact of these changes may take a number of years to be fully understood, particularly since medical malpractice claims are among the slowest in the industry to develop. Thus, additional capacity in the form of new insurance companies entering the medical malpractice environment appears far off.

Reemergence of Alternative Risk Funding Vehicles. One source of possible relief for hospitals and physician groups may be in the reemergence of alternative risk funding vehicles, for example, captive insurance companies, both group and single-parent sponsored; rent-a-captives; risk purchasing pools; risk retention groups; and insurance reciprocals. These structures, popular in both the late 1970s and again in the mid-1980s, lost much of their allure as insurance companies slashed premiums. But with the return of hard market conditions, buyers will seek options outside of the commercial marketplace. These alternative risk funding vehicles promising pricing stability and more control for the insured should again prove increasingly attractive.

Conclusion

To an experienced and keen insurance professional, the dreadful operating results medical malpractice insurers are now suffering are scarcely surprising and are a direct outcome of an inadequately priced product. Although a hardening of the market with significant premium increases has long been anticipated, the extent of the change has surprised many. Insurers have been forced to not only reevaluate their pricing, but their entire business strategy. While this process continues, the medical malpractice insurance industry will remain in upheaval—a state of chaos.

Back to the Top

RESOLUTION NO. 5

A RESOLUTION REGARDING THE MEDICAL MALPRACTICE CRISIS

WHEREAS, the current medical malpractice crisis in Nevada is causing doctors to leave the state, jeopardizing the access and quality of health care for all working men and women; and

WHEREAS, it has been proven in other states like California and Texas that tort reform alone does not bring down medical malpractice rates; and

WHEREAS, the Nevada Medical Examiner's Board does not appropriately discipline doctors who are repeatedly reported for malpractice; and

WHEREAS, serious staffing shortage in hospitals creates an environment which will cause more malpractice cases; and

WHEREAS, the largest provider of services to Nevada's injured workers, Carenet, is forcing doctors to greatly discount rates that have not been raised in two years and creating a serious threat to the care of injured workers and further contribute to the occurrence of malpractice; and

WHEREAS, Nevada hospitals are forcing doctors to pay for the hospital's malpractice insurance coverage while at the same time hospitals are not providing adequate staffing for quality patient care; and

WHEREAS, insurance companies writing malpractice insurance policies in Nevada have never been scrutinized as to the actuarial soundness of their malpractice insurance premiums;

NOW THEREFORE BE IT RESOLVED, the Nevada State AFL-CIO and all of its affiliated unions oppose a $250,000 cap on pain and suffering in medical malpractice court awards; and

BE IT FURTHER RESOLVED, the Nevada State AFL-CIO and all of its affiliated unions support a plan that has multiple solutions to resolve the medical malpractice crisis, including the following:

1. The Nevada Board of Medical Examiners must take corrective action when dealing with doctors who repeated commit medical malpractice.
2. Staffing standards must be enacted to correct the staffing shortage at our hospitals and the fleeing of our nurses from working in Nevada's hospitals.
3. Doctors providing services to Nevada's injured workers must be fairly compensated.
4. Doctors need to be relieved of some of the responsibility of paying for the hospital's malpractice insurance.
5. A government panel must be convened to investigate medical malpractice insurance companies regarding the actuarial soundness of their medical malpractice rates.
6. A system must be enacted to accurately and correctly report medical errors, so that the public can make informed decisions when seeking health care services.

SUBMITTED BY THE EXECUTIVE BOARD
Signatures on file

SO

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Bad Business Decisions By Insurers Reap Havoc on the Insurance Industry

Industry's own analysts admit that lawsuits have NOT caused medical malpractice insurance rates to rise and tort reform will NOT reduce medical malpractice insurance premiums.

Industry analysts explain that insurance companies are experiencing financial difficulties because they engaged in reckless underwriting decisions.

- Carol Brierly Golin, editor of Medical Liability Monitor, an industry newsletter in Chicago writes, "As the economy enjoyed a magic carpet ride in the 1990s, insurers kept rates artificially low because they earned more money investing than by writing policies." RISING MALPRACTICE PREMIUMS HIT FLORIDA DOCTORS HARDEST, Medical Liability Monitor, 12/19/01.

- She explains further, "The insurance companies wouldn't be in this position if they hadn't been so hungry for investment profits and had priced their product appropriately." RISING MALPRACTICE PREMIUMS HIT FLORIDA DOCTORS HARDEST, Medical Liability Monitor, 12/19/01.

- In commentary written for International Risk Management Institute, Charles Kolodkin, analyst with Gallagher Healthcare Insurance Services, explains that medical malpractice companies artificially cut premiums to compete for greater market share and more revenue. Kolodkin writes, "Regardless of the level of risk management intervention, proactive claims management, or tort reform, the fact remains that if insurance policies are consistently underpriced, the insurer will lose money." Source: http://www.irmi.com/expert/articles/kolodkin001.asp

- David Schiff, editor of Schiff's Insurance Observer states,"The [premium] increases follow years when carriers underpriced policies in order to gain a competitive edge. Throughout much of the 1990s price wars kept the cost to customers low." TOUGH TIMES FOR INSURERS BOOST COSTS, Denver Post, April 22, 2002.

Tort Reform Proposals Will NOT Reduce Skyrocketing Insurance Premiums

- Sherman Joyce, president of the American Tort Reform Association, states "we wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." STUDY FINDS NO LINK BETWEEN TORT REFORMS AND INSURANCE RATES, Liability Week, July 19, 1999.

- Sherman Joyce, president of the American Tort Reform Association in Washington, stated "tort reform is not just about lower insurance rates." MICHAEL PRINCE, TORT REFORMS DON'T CUT LIABILITY RATES, STUDY SAYS, Business Insurance, July 19, 1999.

- Victor Schwartz, a partner with Shook, Hardy & Bacon L.L.P and a leading tort reform advocate, said "many tort reform advocates do not contend that restricting litigation will lower insurance rates. I've never said that in 30 years.'" MICHAEL PRINCE, TORT REFORMS DON'T CUT LIABILITY RATES, STUDY SAYS, Business Insurance, July 19, 1999.

- In a recent news release (March 13, 2002), Debra Ballen, American Insurance Association's (AIA) executive vice president, eliminated any pretense that caps on damages or other limitations on the legal rights of Americans might result in lower insurance costs by saying "insurers never promised that tort reform would achieve specific PREMIUM savings." AIA CITES FATAL FLAWS IN CRITIC'S REPORT ON TORT REFORM, March 13, 2002.

Deterring medical malpractice is the best way to bring down costs and protect our families.

PLAINTIFF MEDICAL MALPRACTICE VERDICTS
(CLARK COUNTY: 1996 - 2001)

	Date of Verdict	District Ct. Case #	Case Name	Nature of Case	Panel Findings	Results of Mandatory Settlement Conference			Verdicts	Insurance Company
						Judge Evaluation	Plaintiff Demand	Defense Offer		
1	Mar-97	A312211	*Ross v. Sparkhul*	Penis erroneously injected with acid rather than Lidocaine; required reconstructive surgery	No Negligence Unable to Determine		$300,000	$100,000	$545,000	Valley Hospital (100%)
2	Nov-98	A347451	*Schmitz v. Ebert*						$500,000	
3	May-99	A330489	*Burney v. Kramer*	Permanent injury to baby at birth	Negligence		$1,000,000	$200,000	$5,350,000	Doctors Company
4	Jun-99	A354647	*Cleveland v. Capanna*	Spine surgery at wrong level	Negligence		$325,000	$0	$450,000	St. Paul
5	Jul-99	A320120	*Schrader v. Swain*	Failure to recognize internal bleeding leading to death of 61 year old woman	Negligence No Negligence	$900,000	$900,000	$100,000	$3,406,355	CNA Insurance Doctors Company
6	Dec-99	A376883	*Pucket v. Valley Hosp.*	Death of 70 year old man when negligently inserted breathing tube	Negligence	$100,000	$225,000		$983,000	Valley Hospital (100%)
7	Mar-00	A352612	*Marquez v. Southwest Medical*	Failure to timely diagnose facial fractures resulting in permanent nerve damage and complex surgical repair	Negligence	$650,000	$650,000	$200,000	$1,200,000	AIG Insurance
8	Mar-00	A381955	*Gainey v. Valley Hosp.*						$55,000	
9	Apr-00	A347725	*Ruppert v. Buzzard*						$2,000,000	
10	Apr-00	A387463	*Makuch v. Fremont Medical Center*	Lost biopsy with potential diagnosis for malignancy in foot	No Screening Panel				$130,000	Doctors Company
11	Jul-00	A357782	*Rice v. Torres*	Botched C-Section on 32 year old woman, first child, with post-op bleeding resulting in hysterectomy	No Negligence		$80,000	$0	$205,000	Doctors Company
12	Sep-00	A352025	*Fowler v. Egtedar*	Failure to timely diagnose femur fracture resulting in ischemia to lower leg with resulting nerve damage	Negligence	$450,000	$450,000	$0	$1,237,220	No Insurance; Dr. pays monthly
13	Sep-00	A385787	*Suprien v. Poon*	Adult circumcision with removal of 1" from center of penis	Negligence	$1,000,000	$1,000,000	$200,000	$515,000	St. Paul
14	Mar-01	A361891	*Watts v. Reliable Medical Care*	Baby injured at birth with permanent brain damage leaving boy 9 months old mentally with need for lifelong care	Negligence No Negligence	$3,500,000	$3,500,000	$2,000,000	$6,000,000	Judge ordered new trial for other defendants; Professional Underwriters settled $1,000,000 for Dr. Turner

PLAINTIFF MEDICAL MALPRACTICE VERDICTS
(CLARK COUNTY: 1996 - 2001)

	Date of Verdict	District Ct. Case #	Case Name	Nature of Case	Panel Findings	Results of Mandatory Settlement Conference			Verdicts	Insurance Company
						Judge Evaluation	Plaintiff Demand	Defense Offer		
15	Mar-01	A379411	*Spradlin v. Hito*	Failure to rule out cauda equina syndrome resulting in decompression of disc and permanet nerve damage	Negligence	$1,000,000	$300,000	$0	$1,500,000 *(49% cont. negligence reduced verdict to $765,000)*	Doctors Company; St. Paul settled for ER Dr. for $300,000
16	May-01	A412884	*Irving v. Sunrise*	Retained sponge requiring 4 follow-up needle aspirations	Negligence	$50,000	$30,000	$25,000	$78,000	Settled with doctor before trial; verdict against hospital 100%
17	Jul-01	A373928	*Banks v. Sunrise*	51 year old now in persistent vegetative state; $14,000/per month life care	No Negligence Unable to Determine		$1,000,000	Sunrise $500,000	$5,412,031	Doctors Company settled for $1.9 million before trial; verdict against hospital 100% - now on appeal
18	Aug-01	A415376	*Conn v. Schiff*	Failure to diagnose myocardial infarction; sent home and died of cardiac rupture	Negligence	$500,000	$500,000	$100,000	$2,000,000	AIG Insurance
19	Oct-01	A385204	*Kay v. Eftaha*	Sphincter damaged resulting in permanent incontinence; now wears diapers	Unable to Determine				$1,520,000	Doctors Company
20	Oct-01	A403525	*Debourg v. Southwest Medical*	Failure of nurse practitioner to diagnose cervical cord compression causing permanent damage to nerves in upper and lower extremities	Nursing/No Panel		$500,000	$500,000 *(10 days before trial)*	$4,564,128	Firemen's Fund (On Appeal)

CENTER FOR JUSTICE & DEMOCRACY
CJ&D

THE FOUNDATION FOR TAXPAYER AND CONSUMER RIGHTS

For Immediate Release
May 29, 2002

Contact: Jamie Court (310) 392-0522 ext. 327
Joanne Doroshow (212) 267-2801

CALIFORNIA RESTRICTIONS ON MALPRACTICE VICTIMS HAVE NOT AFFECTED MALPRACTICE PREMIUMS

Premium Data Shows California Law Is No Model For The Nation

Data released today by two consumer groups show that California's 22-year experience with the nation's most draconian limits on the rights of medical malpractice victims has failed to slow premium increases for doctors and hospitals. In fact, over the last decade, the average malpractice premium in California has grown *more quickly* than it has in the nation overall.

The California-based Foundation for Taxpayer and Consumer Rights and New York-based Center for Justice & Democracy (CJ&D) hired nationally recognized actuary J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator under Ford and Carter, to compare national malpractice premium trends to those in California. Hunter found that from 1991 to 2000, malpractice premiums in California have stayed close to national premium trends. The 2000 average premium per doctor in California was only 8.2 percent below that of the nation ($7,200.61 vs. $7,843.75) while the average malpractice premium in California between 1991 and 2000 actually grew more quickly (3.5 percent), than it did in the nation overall (1.9 percent.) According to Hunter, "there is not much difference in the rates or the rate of change between California and the nation based on the latest decade of experience."

In the mid-1970s, California enacted severe laws restricting the rights of patients who have been injured by malpractice, allowing them to recover no more than $250,000 in noneconomic compensation no matter how egregious the malpractice or serious the injury. The medical establishment is campaigning to spread this severe cap on damages not only to other states, but to the entire nation in recently introduced federal legislation (H.R. 4600), arguing falsely that this cap has kept premiums dramatically downward.

"If there are savings to limiting the rights and recovery of innocent victims of dangerous and culpable doctors, then insurers have not passed them on to physicians," said Jamie Court, executive director of the Foundation for Taxpayer and Consumer Rights. "California is a failed model for the national restrictions being proposed on patients.

California patients have been denied adequate compensation and representation for their injuries, and California doctors have seen almost no premium savings. Only the insurers have gotten rich in the good times."

"This study disputes one of the most sensationalized fictions driving the movement to limit lawsuits against malpracticing doctors and hospitals —the notion that California's brutal restrictions on patients' rights, enacted in the mid-1970s, have slowed the growth of malpractice premiums," said CJ&D Executive Director Joanne Doroshow. "In fact, the opposite has happened. Over the last 10 years, California's premiums have grown faster than the nation's.

"This analysis has, for the first time, exposed as an insidious public relations scam the notion that California's cruel law has controlled the growth of malpractice insurance premiums. This law has had terrible consequences for many innocent people, while doing nothing to improve the affordability of liability insurance for doctors."

YEAR	CALIFORNIA NUMBER OF DOCTORS IN STATE	U.S.A. NUMBER OF DOCTORS	CALIFORNIA MEDICAL MALPRACTICE PREM EARNED (in thousands)	U.S.A. MEDICAL MALPRACTICE PREM EARNED (in thousands)	AVERAGE MED MAL PREMIUM PER DOCTOR CALIFORNIA	AVERAGE MED MAL PREMIUM PER DOCTOR U.S.A.
1991	76043	631400	529056	4862170	6957.33	7700.62
1992	76367	652100	526496	5138395	6894.29	7879.77
1993	76411	670300	563004	5174055	7368.10	7719.01
1994	77311	684400	576771	5931898	7460.40	8667.30
1995	78169	720300	597660	6080639	7645.74	8441.81
1996	79048	737800	610003	5992394	7716.87	8121.98
1997	80341	756700	628858	5917038	7827.36	7819.53
1998	81762	777900	652601	6195047	7981.72	7963.81
1999	82872	797600	611785	6155241	7382.29	7717.20
2000	84675	812800	609712	6375401	7200.61	7843.75
			1991 to 1999 percent change		3.5	1.9
			1991 to 1999 % change (annualized)		0.4	0.2

Sources: Doctors USA: Statistical Abstract of the United States;
Doctors CA: California Department of Consumer Affairs;
Earned Premiums: NAIC Report On Profit By Line By State

MICRA (Medical Injury Compensation Reform Act of 1975) :

Creates Severe Problems for Californians By Severely Limiting Malpractice Victim's Rights

MICRA is a series of statutes that took effect in 1975 which restrict the legal liability of health care professionals. MICRA's main provisions: (1) place a cap of $250,000 on the amount of compensation paid to malpractice victims for their noneconomic injuries; (2) allow damage awards of over $50,000 to be paid in periodic installments; (3) permit the defense to inform the jury about any other sources of compensation available to the plaintiff ("collateral sources"); (4) mandate arbitration for medical malpractice victims; and (5) establish a sliding scale for attorneys' fees.

I. MICRA'S SEVERE RESTRICTIONS COINCIDE WITH AN INCREASE IN THE LEVEL OF MEDICAL MALPRACTICE IN CALIFORNIA

According to data collected by the National Practitioner Data Bank, a nationwide repository for medical malpractice information, the rate of malpractice in California has increased by almost 45% since 1991.[1]

II. MICRA'S $250,000 CAP HAS A UNFAIR IMPACT ON VICTIMS OF MEDICAL NEGLIGENCE.

Victims of medical negligence in California are limited to $250,000 even when juries award significantly more compensation.

> *Harry Jordan, a Long Beach, California, man was hospitalized to have a cancerous kidney removed, but the surgeon took out his healthy kidney instead. A jury awarded Jordan more than $5 million dollars, but the judge was required to reduce the verdict to $250,000 due to California's cap on noneconomic damages, plus a mere $6,000 in economic costs. Jordan, who currently lives on 10% kidney function, can no longer work though the jury (which lawfully could not be notified about the noneconomic cap) did not take this into account. Jordan's court costs - not including attorney fees - have amounted to more than $400,000, and his medical bills that have increased since trial and are frequently denied by insurers, total more than $500,000.*[2]

MICRA's arbitrary cap on noneconomic compensation unfairly discriminates against the suffering of women - who typically sustain injuries due to medical negligence, such as laceration of the uterus or loss of a new born during child birth, that do not carry high economic price tags but involve significant loss.

> *Terry McBride, of San Andrean, California, lost her unborn baby and her ability to bear more children at the hands of a negligent doctor who had injured at least 25 women before her, causing the unnecessary deaths of their babies and the affliction of Cerebral Palsy to 2 children. California's noneconomic compensation cap restricted McBride to less than $250,000 for the loss of her child's life and her own sterilization. The award was insufficient to cover the cost of an expensive new procedure seeking to restore her fertility.*[3]

MICRA's cap limits liability for egregious medical malpractice to an acceptable cost of doing business, permitting systemic medical negligence to continue undeterred.

> *Colin McCaffery, for instance, was born too large, in a Woodland Hills, California, HMO facility with only a nurse-midwife present - although his parents urged that a physician be there because their other children had been born large. As a cost cutting practice, the HMO does not permit doctors to be present during child birth, except for "high risk" cases. Because the nurse - midwife lacked the skill to properly guide Colin out of the birth canal, he was crippled, losing movement in his arms and torso - a rare condition known as Erbs Palsy which results <u>only</u> from botched deliveries. Due to California's cap on recovery, Colin's family settled for only $250,000 - the MICRA limit, but not enough to compensate Colin or make the HMO in question change its practice.*[4]

III. MICRA'S NONECONOMIC CAP UNFAIRLY IMPACTS WOMEN, THE POOR AND THE ELDERLY - RELEGATING THEM TO SECOND CLASS STATUS IN CALIFORNIA'S COURTS.

By treating economic and noneconomic damages differently, MICRA creates a two-tiered legal system which unfairly discriminates against women, children, the elderly and low wage earners who traditionally do not experience high economic losses, but, rather, experience serious, non-compensable losses when their health and well-being is adversely affected.

Noneconomic losses are the main source of harm to women who have suffered reproductive injuries. Denying or reducing these losses denies justice to injured women.

- Permanently damaging someone's health and well-being has long been viewed by proponents of limitations on damages as injuries that are somehow not real. As a result, women, who have traditionally been associated with these injuries, often have their claims marginalized.

- Capping noneconomic loss is also particularly unfair to children and the elderly. In wrongful death claims, for instance, their value of life is often underestimated because they do not generally have income that can be used to measure their economic worth.

IV. THOUGH HEALTH CARE COSTS HAVE RISEN DRAMATICALLY SINCE 1975, COMPENSATION FOR NONECONOMIC DAMAGES HAS BEEN FROZEN BY MICRA.

The $250,000 MICRA cap, adjusted for inflation according to the Consumer Price Index, WAS worth only around $83,000 by the year 2000.[5] Just to maintain the value of 1975's $250,000 cap, the MICRA limit should have been increased to $753,000 by the year 2000.[6]

V. CAPS DO NOT IMPACT THE NUMBER OF DOCTORS, PARTICULARLY OB/GYNS, IN RURAL AREAS OR OTHER AREAS.

- In 1998, there were 7.6% more OB/GYNs per 100,000 women in states without caps on damages.[7]

Caps do NOT entice doctors to practice in a state. In 1998, there were 1.9% more general/family practice doctors in states without caps.[8]

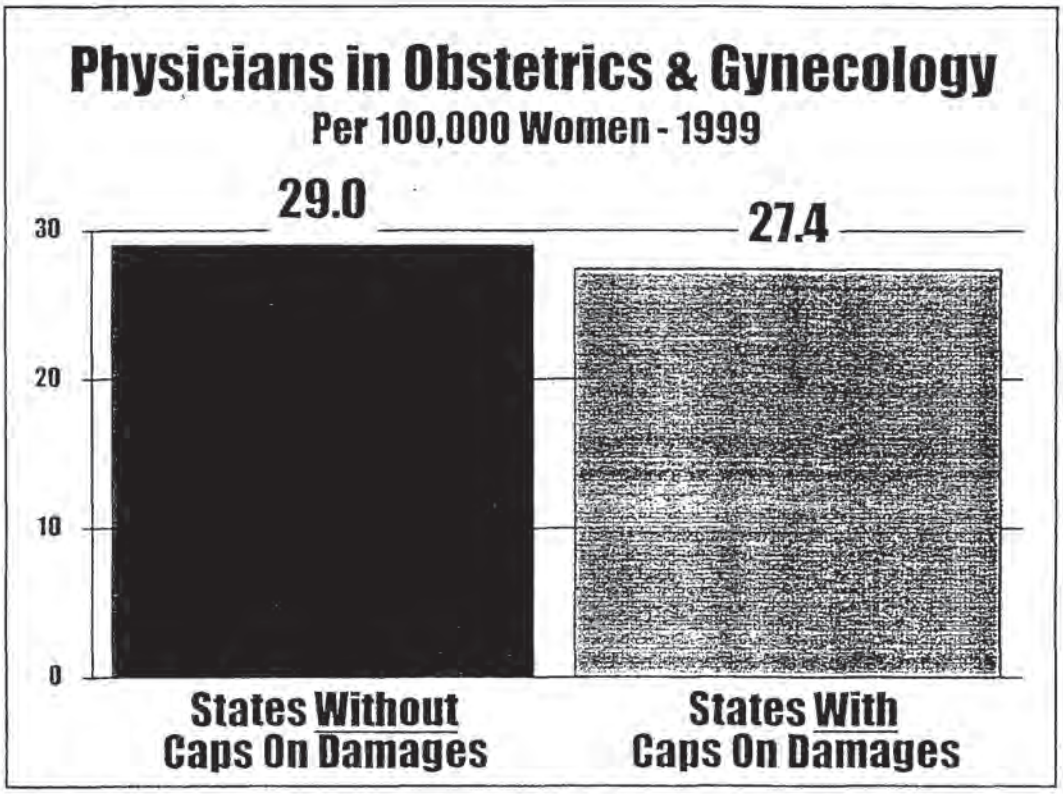
- Cases against OB/GYNs do present higher damages amounts, but that is because the economic damages are often very high. The lifetime of medical care for a catastrophically injured infant or child can be significant.

Under MICRA laws, it is almost impossible for Californians to hold negligent providers fully accountable when egregious injuries occur due to medical negligence.

1.U.S. Dept. of Health and Human Services, *National Practitioner Data Bank 1994 Annual Report,* 1995.
2.Fact sheet, *Capping Medical Malpractice Victims' Compensation Cause Innocent Patients' More Pain And Suffering,* Consumers For Quality Care.
3.*Id.*
4.*Id.*
5.U.S. Dept. of Labor, *Bureau of Labor Statistics - Consumer Price Index, U.S. Cities Average*, All Urban Consumers.
6. *Id.*
7.Morgan Quinto Press, *Health Care State Rankings*, 2000.
8.*Id.*

Medical Malpractice Insurance

Do Caps Reduce Access To Women's Health Care?



- **There Are 5.8% More Ob/Gyn Physicians Per 100,000 Women In States Without Caps**
- **Caps Do Not Attract Doctors**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

* Source: Health Care State Rankings 2001. Morgan Quitn Press. A state is classified as having a "cap" when there exists a general noneconomic damage cap that affect medical malpractice or a broad medical malpractice specific cap on noneconomic damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases. Cap states include: AK, CA, CO, FL, HI, ID, IN, KS, LA, MD, MA, MI, MO, MT, NE, NM, ND, SD, UT, VA, WV and WI.

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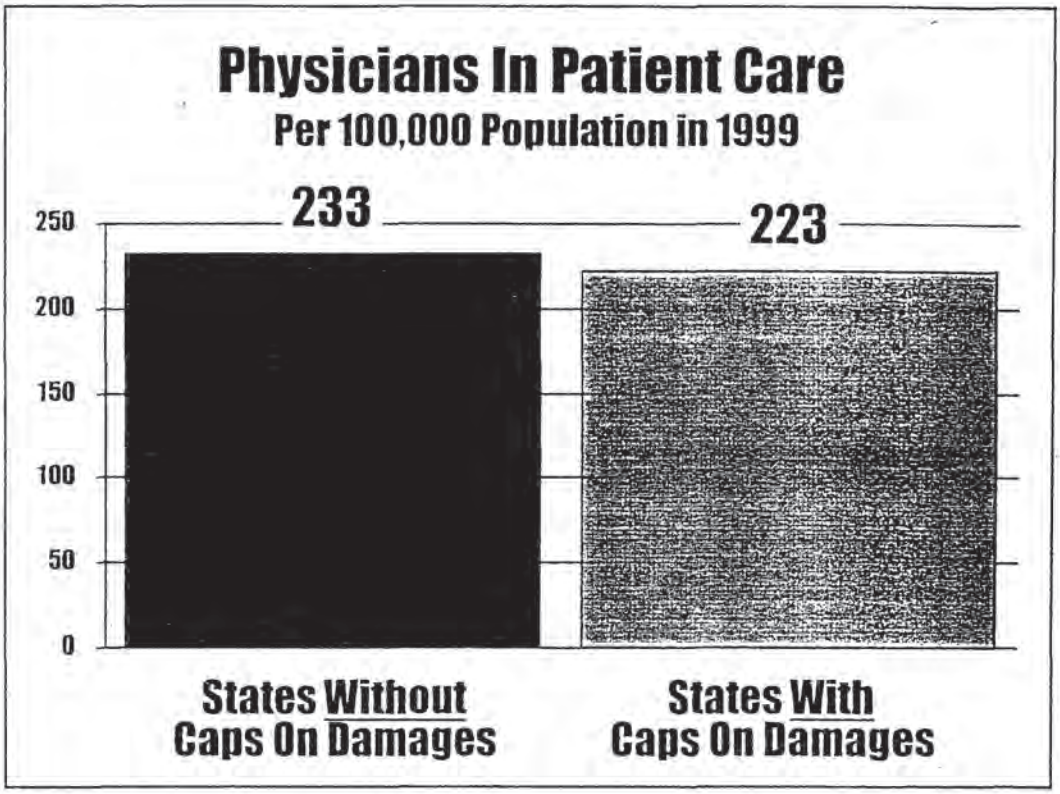
Medical Malpractice Insurance

Do Caps Reduce Access To Family Doctors?

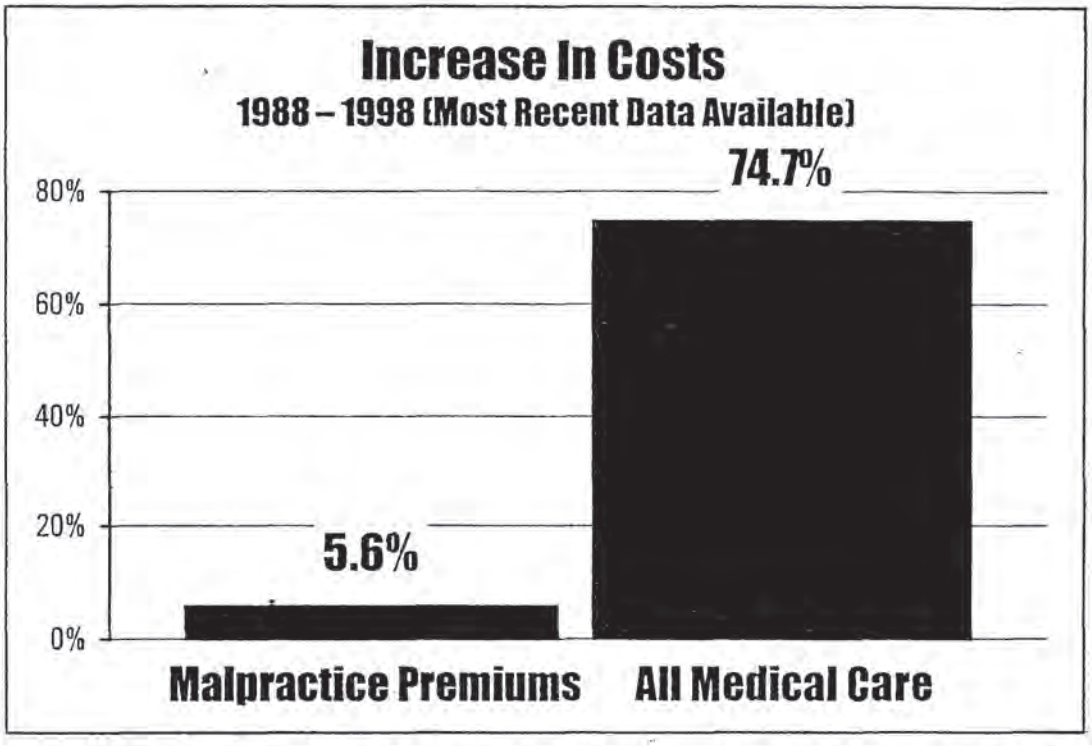


- **There Are 4.4% More Physicians In Patient Care Per 100,000 Population In States Without Caps**
- **Caps Do Not Attract Doctors**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

•Source: American Medical Association Physician Characteristics and Distribution in the US, 2001 Edition. A state is classified as having a "cap" when there exists a general noneconomic damage cap that affect medical malpractice or a broad medical malpractice specific cap on noneconomic damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases. Cap states include: AK, CA, CO, FL, HI, ID, IN, KS, LA, MD, MA, MI, MO, MT, NE, NM, ND, SD, UT, VA, WV and WI.

Medical Malpractice

Are Malpractice Costs Out Of Control?



- **Medical Care Costs Rose Thirteen Times Faster Than Malpractice Costs From 1988-1998**
- **There Is No Evidence That Malpractice Costs Have Contributed To Overall Rising Medical Costs**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

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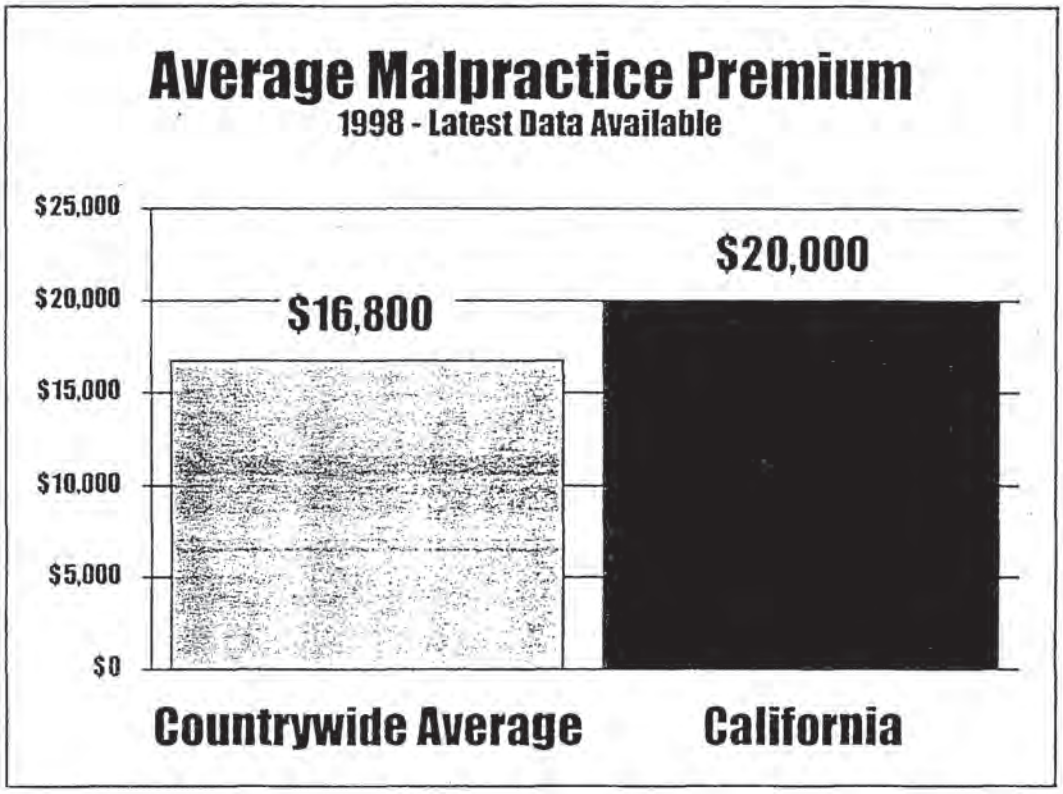
Sources: malpractice data from the American Medical Association, Socioeconomic Characteristics of Medical Practice. Medical care costs calculated from the Consumer Price Index Home Page: http://stats.bls.gov/cpihome.htm

Medical Malpractice Caps

Did Severe Caps Keep Costs Down In California?

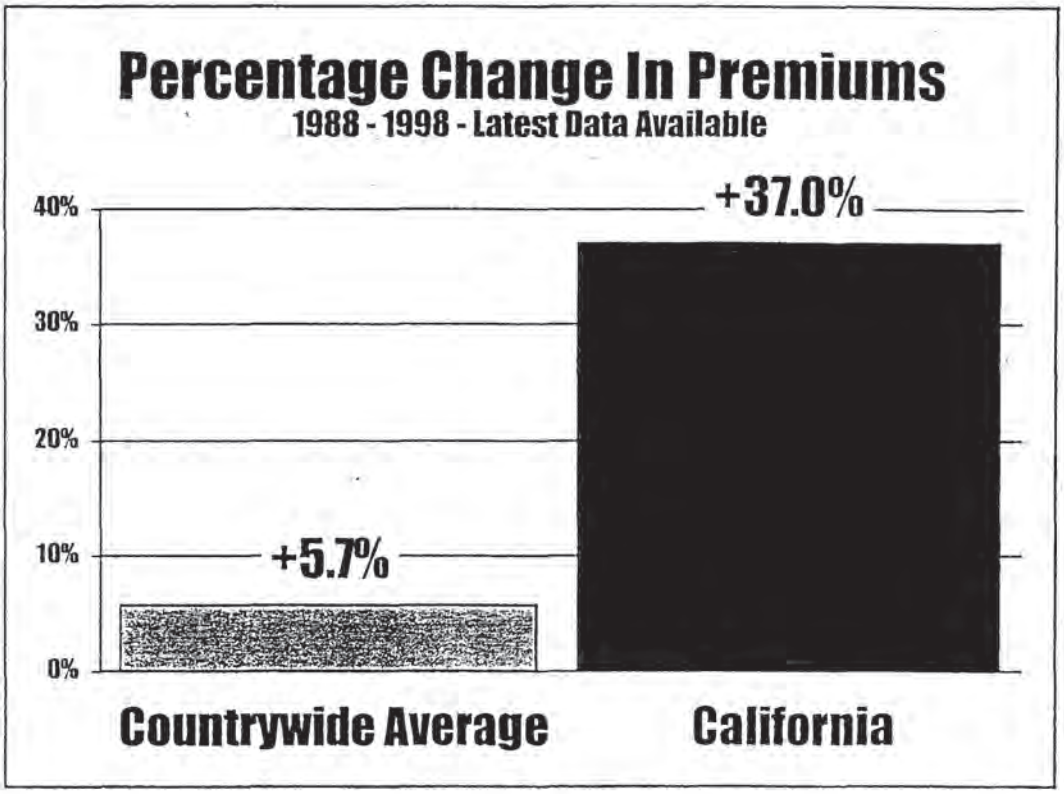


- **California Has The Most Severe Medical Malpractice Restrictions In The Country**
- **Premiums In California Are 19% Higher In California Than In The Country As A Whole**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Source: Center For Justice & Democracy news release 10/16/2001, http://centerid.org. Analysis conducted by J. Robert Hunter, Director of Insurance for the Consumer Federation of America.

Medical Malpractice Caps

Did Severe Caps Keep Costs Down In California?

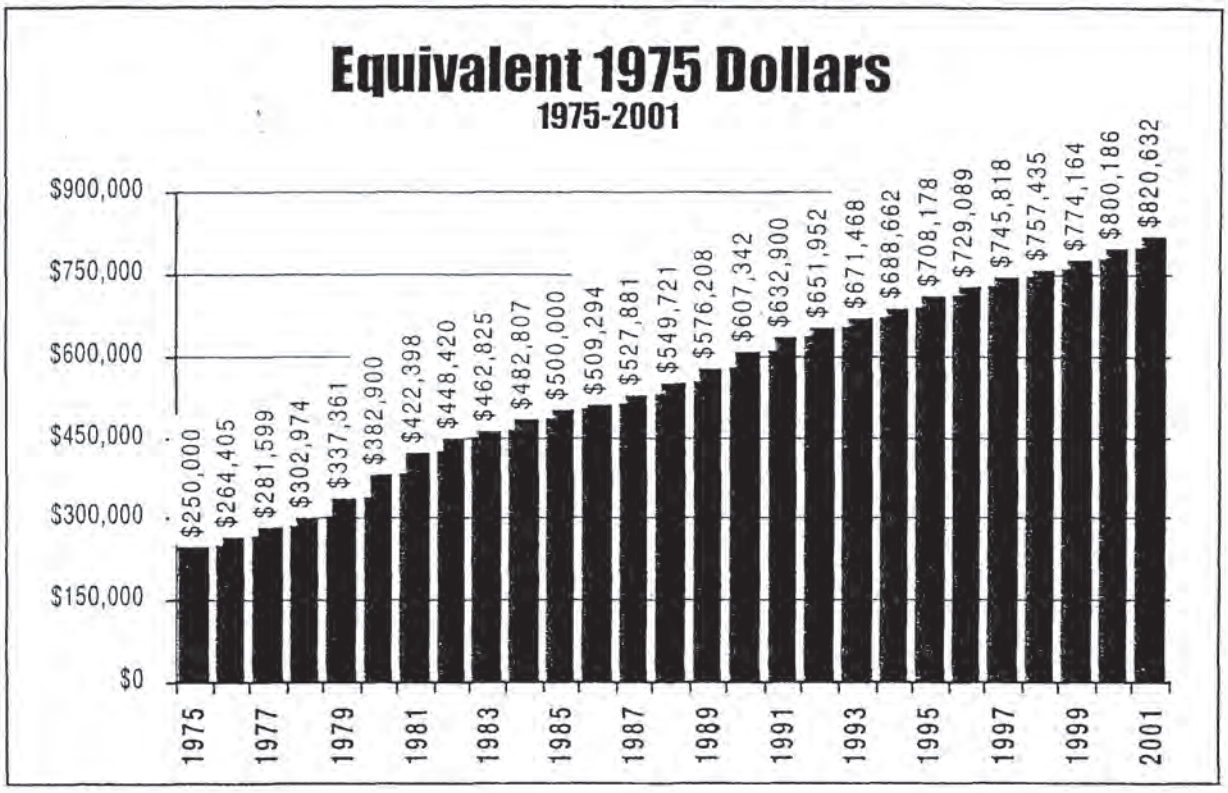


- **California Has The Most Restrictive Medical Malpractice Caps In The Country**
- **Since 1998, Premiums In California Rose 37% While Premiums Countrywide Rose Just 5.7%**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Source: malpractice data from the American Medical Association, Socioeconomic Characteristics of Medical Practice, 2000-2002.

Micra

How Many 2001 Dollars Would You Need?

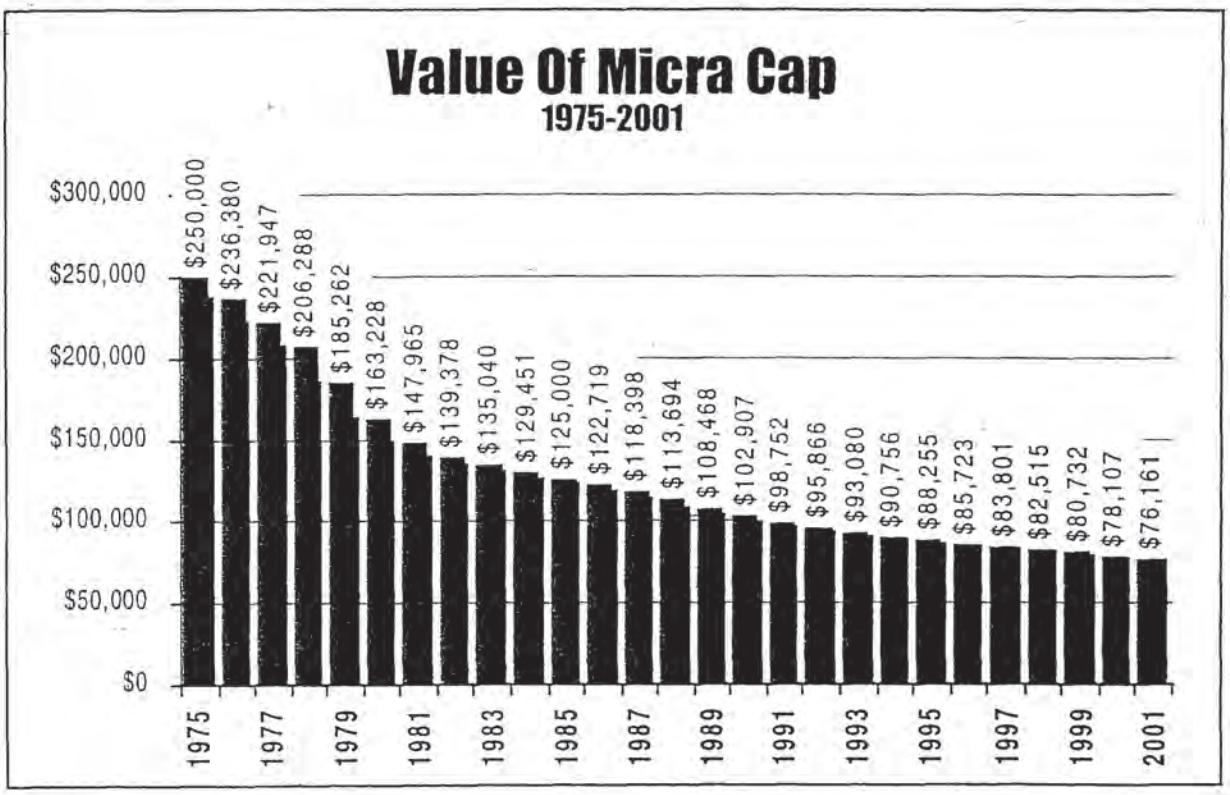


- **Inflation Has Severely Eroded Micra**
- **The Micra Cap Must Be Increased To $820,632 For The Equivalent Of $250,000 In 1975**
- **Caps Must Be Adjusted For Inflation**

The value of $250,000 was adjusted for changes in prices based upon Consumer Price Index - all items - data from The 1975 average to the mid-year 2001 average. Bureau of Labor Statistics: http://stats.bls.gov.

Micra

What Has Inflation Done To The Value Of The Micra Cap?



- **Inflation Has Severely Eroded Micra**
- **Years Of Inflation Make Have Dropped The Value Of The Cap To Just $76,161 By 2001**
- **Caps Must Be Adjusted For Inflation**

The value of $250,000 was adjusted for changes in prices based upon Consumer Price Index - all items - data from The 1975 average to the mid-year 2001 average. Bureau of Labor Statistics: http://stats.bls.gov.

AGENDA ITEM V.A
National Overview of Medical Malpractice Crisis

Statement of Mimi Marchev, Sr. Policy Analyst, National Academy for State Health Policy before the Nevada Legislative Subcommittee to Study Medical Malpractice, July 22, 2002

Rapidly rising medical malpractice insurance premiums and the departure of many insurance companies from the medical malpractice market have created a crisis of affordability and availability of malpractice insurance in certain areas of the country. State efforts to address the emergency are hampered by the paucity of conclusive data on the causes and effective solutions to this problem. While an increased rate of litigation and higher damage awards are often blamed for rising premiums, insurance companies may be equally culpable due to their pricing policies of the 1990s. Furthermore, the move toward more restrictive tort reform does not address the complexity of the problem. Previous rounds of tort reform that followed the malpractice insurance crises of the 1970s and 1980s have not succeeded in preventing periodic and dramatic rises in insurance premiums. And tort reform does not address the important and related issue of patient safety and medical errors.

The conflict among insurance companies, the medical profession and trial lawyers inherent in the debate over solutions to the medical malpractice insurance crisis creates a chilling effect on efforts to improve patient safety. While a full and open disclosure of medical errors is seen as an essential step in addressing the issue of patient safety, doctors and hospitals resist reporting errors for fear of increased malpractice litigation. The wave of the future may be seen in the comprehensive legislative initiative in Pennsylvania, wherein tort and insurance reforms were combined with patient safety initiatives and reporting requirements.

Medical Malpractice Insurance Crisis

- The data are inconclusive as to the causes of rapidly rising medical malpractice insurance premiums. While there are reported increases in frequency and severity of medical malpractice claims, the underpricing of malpractice premiums throughout the 1990s and a downturn in the stock market exacerbated by the attacks of Sept 11th are also to blame.
- The data are inconclusive as to whether there has been an increase in medical malpractice claims greater than that which corresponds to growth in population, an increase in the number of doctors and hospitals, or growth in technological advancements.
- Because of the reluctance to report errors, the data are inconclusive as to whether any increase in malpractice claims corresponds to an increase in incidents of medical malpractice or medical errors.
- The data are inconclusive as to the efficacy of tort reform as remedy for periodic malpractice insurance crises. Previous rounds of tort reform have not prevented periodic malpractice insurance crises. Tort reform does not address the issue of patient safety.
- Medical errors are a serious and costly problem, killing between 44,000 and 98,000 people annually in the United States. Total national cost of medical errors is estimated to be between $17 billion and $29 billion annually.
- Total medical malpractice costs are estimated at 0.55% of U.S. healthcare costs.
- The great majority of patients injured by medical negligence do not file a malpractice claim and of those who do file only a third receive any compensation for their injuries.

Dan Radmacher

AP article misses malpractice mark

Friday July 26, 2002

Thanks to reporter Lawrence Messina — now on his way to The Associated Press, sadly (for the Gazette, anyway) — the Gazette has had some of the most comprehensive and substantive coverage of the medical malpractice insurance crisis in the state, and perhaps in the nation.

Messina's meticulous reporting ignored the rhetoric and claims on all sides of this contentious debate to try to get at the facts that could be verified by the public record. He succeeded brilliantly, debunking claim after claim by the West Virginia Medical Association and insurance companies.

So I was disappointed to see on the Gazette's front page two days after Messina's departure: a lame, superficial report by The Associated Press that repeated many of the myths busted by Messina, and also ignored a blockbuster report by the Wall Street Journal.

The AP story, written by Theresa Agovino, accepted without any real critical examination the contention by insurance companies

and a dwindling number of doctors that rising malpractice insurance premiums are caused solely by "soaring jury awards."

Agovino listed West Virginia as one of the states having such problems.

Messina found that jury awards in West Virginia had fluctuated, but generally held steady between 1993 and 2000. The number of claims filed each year actually decreased. Messina found this out by examining Board of Medicine records that insurance companies are required to file. He looked at nearly 2,300 resolved claims.

As far as I know, no one else in the nation has done such work, so there's no way to tell if West Virginia's experience is similar to other states. But there is no reason to think that trends here would be markedly different than elsewhere.

Agovino goes on to boldly claim that high malpractice rates "are compounded by being charged in states where laws place fewer limits on jury awards." She quotes Medical Liability Monitor, an industry publication out of Chicago to show that rates for obstetricians and gynecologists are set to go up by 40 percent to 81 percent in Pennsylvania, and by as much as 36 percent in West Virginia.

But she missed where the same publication noted that rates in Indiana — which has strict tort reform laws for medical malpractice cases — had rates that increased by 40 percent as well.

The most egregious part of the story was her summary of two insurance companies getting out of the malpractice business. She told of how St. Paul Cos., the second largest provider of malpractice insurance, decided to get out of the business after it lost close to $1 billion on its malpractice line last year.

But she didn't discuss an important Wall Street Journal story that ran three weeks before her article was printed. The Journal noted that "while malpractice litigation has a big effect on premiums, insurers' pricing and accounting practices have played an equally important role."

The article specifically mentions St. Paul, and how the company "released" $1.1 billion in reserves between 1992 and 1997 that could have cushioned its losses. Instead, the released reserves made the company look far more profitable than it was, and encouraged many other companies to get into the malpractice insurance business.

In the resulting flurry of competition, many companies tried to undercut others to win market share. They also were far too indiscriminate in the doctors they signed up, often ignoring previous claims histories.

The results were predictable. Premiums were too low to cover costs. Eventually, the market shook out. Companies failed. Those that remained demanded huge rate increases. It hit some states, like West Virginia, sooner, but the crisis is spreading nationwide.

Even doctors are coming to realize that malpractice lawsuits are not the only cause of their problem, the Journal article noted.

The failure to mention that Wall Street Journal report amounts to journalistic malpractice.

The second company Agovino mentioned was Phico Insurance Co. in Pennsylvania. Here is her paragraph concerning Phico:

"Smaller insurers are also cutting back or leaving the business. Pennsylvania's second-largest malpractice insurer, Phico Insurance Co., failed earlier this year and was liquidated by the state."

The story she didn't tell? Pennsylvania Insurance Commissioner M. Diane Koken sued Phico's top executives and board members, claiming that the company followed a "fundamentally unsound" strategy to under-price competitors and carve out new markets.

That strategy is what led to the financial disaster that prompted a judge to put Phico into receivership under Koken's control.

Though I hate to lose Messina at the Gazette, I'm glad he'll be taking his brand of reporting to The Associated Press. Apparently, at least some AP reporters could use the good example.

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Economic Impact of Medical Tort Reform in California - 1975-1998

It is generally recognized that the medical malpractice liability system in the United States has two principal roles: providing redress to individuals who suffer injuries due to negligence; and creating incentives for doctors to provide appropriate treatment to their patients. Malpractice law seeks to accomplish these goals by penalizing physicians whose negligence causes an adverse patient health outcome, and uses these penalties to compensate the injured patients. Considerable evidence indicates that the current United States malpractice system is neither sensitive nor specific in providing compensation to injured patients. For example, the Harvard Medical Practice Study (1990) found that 16 times as many patients suffered an injury from negligent medical care as received compensation in New York State.

Harvard Medical Malpractice Study (1990)
The 1990 New York legislature commissioned a $3 million study of the State's medical practice problem by specialists at Harvard University to determine whether the existing tort system provided adequate compensation to the medically injured.

1. **The incidence of adverse events**
   One goal was to establish a population-based measure of the incidence of medical injuries which the Study defined as "adverse events," and to determine the percentage of such events that resulted from fault or negligence of the physician or other provider.

   The researchers found that three of every 100 hospital admittees suffered an adverse event and one of the three was a result of negligence. Of interest was the finding that, although the operating room was the situs of the highest fraction of adverse events, relatively few of these were negligent. But 70% of the adverse events in the emergency room resulted from negligence. Although the most common type of adverse event involved the performance of a medical procedure, diagnostic errors and medication errors were more likely to be adjudged negligent and to result in serious liability.

2. **Litigation data**
   The Study determined the percentage of adverse events, both negligent and non-negligent, that led to claims and suits. The report estimated that eight times as many patients suffered an injury from negligence as filed a malpractice claim. The report also points out that the legal system has not yet resolved the fact that many claims (approximately 50%) brought are without ultimate merit and place an added burden on the tort litigation system. Thus according to the Study, few injured by negligence bring a claim while many who were not injured by negligence do file claims.
3. **Economic consequences of medical injury**
   The Study set out to measure the costs of medical expenses, lost wages and lost household production to the victims of medical injuries and to their families, and their compensation for such losses under current arrangements.

   In this portion of the Study, it was determined that the bulk of the disabilities were of short duration: 42% of absences from work were of less than one month and 76% less than six months. As to the longer lasting disabilities, more than 85% of the medical bills were covered by some form of health insurance, but only 20% of the lost earnings and substantially no portion of lost household production were covered or otherwise reimbursed.

4. **Malpractice litigation and deterrence**

Another goal of the Study was to estimate the degree to which variations in the threat of litigation affected the incidence of adverse events.

On the matter of deterrence, the report is mixed - primarily because it appears that physicians do not identify the threat of a malpractice suit as related to their own transgressions. In other words, physicians perceive malpractice suits against them as having arisen from circumstances beyond their control and the threat of the tort system was too broad and lacked specificity. Furthermore, they did not report that they made long-term changes in their practice as a result of a specific suit

Although there was clear evidence of defensive medical practice, it appeared to be more the result of a reaction to societal expectations, as well as to advances in the science and technology of medicine, than to specific steps to avoid a potential malpractice claim.

The direct cost of compensating malpractice claimants is an important source of medical expenditure growth. Compensation paid and the costs of administering that compensation through the legal system account for almost 1% of health care expenditures. U.S. health care expenditures are approximately $1 trillion so direct costs related to compensating malpractice claimants amount to $10 billion each year. U.S. health care costs are expected to double within 10 years to $2 trillion and direct malpractice costs to $20 billion. California health care costs represent approximately 10% of the U.S. total or $1 billion currently. The United States' direct tort system costs are significantly higher than those in other English-speaking countries. For example, in 1994, U.S. tort system costs represented 2.2% of the Gross Domestic Product (GDP), while only 0.7% in Australia and 0.8% in the United Kingdom.

The indirect effects of the malpractice system on physician behavior, have substantial effects on health care costs and outcomes, even though virtually all physicians are fully insured against the financial costs through the purchase of malpractice insurance. Physicians may employ costly precautionary treatments in order to avoid nonfinancial penalties, such as fear of reputational harm, decreased self-esteem from adverse publicity and the time and unpleasantness of defending a claim. Indirect costs are less tangible but estimates are in the range of 3-6% or $30 to $60 billion currently rising to $60 to $120 billion in 10 years. Again California's 10% share of indirect medical malpractice costs amounts to $3 to $6 billion currently and will rise to $6 to 12 billion in 10 years.

On the one hand, these direct and indirect costs for malpractice may deter doctors and other providers from putting patients at excessive risk of adverse health outcomes. On the other hand, these costs may also drive physicians to be too careful - to administer precautionary treatments with minimal expected medical benefit out of fear of legal liability - and thus to practice "defensive medicine." Many physicians and policymakers have argued that the incentive costs of the malpractice system, due to extra tests and procedures ordered in response to the perceived threat of a medical malpractice claim, may account for a substantial portion of the explosive growth in health care costs. The practice of defensive medicine may even have adverse effects on patient health outcomes if doctors forgo risky but beneficial treatment options. For these reasons, defensive medicine is a crucial policy concern. Total direct and indirect costs for California medical malpractice ranges from $4 to $7 billion currently and is expected to rise to $7 to $14 billion in 10 years.

During the past five years a number of important studies have been undertaken to determine the direct and indirect benefits of medical tort reform and to determine whether such benefits, usually in the form of health care cost savings, have any adverse impact on injured victims'

ability to obtain a financial recovery to reasonably compensate them for their injuries.

California's experience with the Medical Injury Compensation Reform Act of 1975 (MICRA) has been of particular importance in evaluating the economic results of a comprehensive package of medical tort reforms. The California medical tort reform package includes a $250,000 cap on noneconomic damages, a modification of the collateral source rule, an eight-year statute of limitations on birth injuries, limits on plaintiff attorneys' fees and mandatory periodic payments. The U.S. Supreme Court declined to review the Fein case in 1985, thereby confirming California court decisions some 10 years after the original statute was enacted. During the 10-year period of uncertainty, the full impact of the tort changes was not reflected in the frequency and severity of judgments. Malpractice premiums remained at 1975 levels. However, the market for malpractice insurance from physician- and hospital-controlled companies was stable.

The California Supreme Court decision in *Fein v. Permanente Medical Group* had a major impact on reported verdicts and settlements. In its annual survey of verdicts and settlements over $50,000 ("large loss"), Medical Insurance Exchange of California, a major physician-sponsored carrier, reported in 1987 that:

- Total large loss indemnity at present value decreased by 31%. Total indemnity for 1987 was lower than any year since 1982.
- Average large loss indemnity also decreased, by 31% from 1986, and by 43% from 1985 to $567,462 per claim.
- The report also indicated that the percentage of cases that were settled increased and that the average elapsed time from incident to settlement or verdict was just under five years, a full year improvement over 1986. Currently, average settlement time has further decreased to less than three years in California.

No medical tort reform has had any immediate impact on reducing premiums. At best a package of medical tort reforms in the short term will moderate the rate of increase in malpractice premiums and, in the long run, stabilize the marketplace. Average indemnity payments will continue to grow as the underlying cost of medical care and living expenses increases with inflation. There are good reasons for this result:

- Current premiums are based upon the current pattern of experience and claims that are in the pipeline;
- Any legislation will be challenged on constitutional and other grounds and many years may pass before these issues are resolved;
- No package of tort reforms is a complete answer to the continued expansion of the liability system by the courts;
- Even if carefully drawn, the legislation may not be retroactive and there will be an immediate rush to file suits or press them to trial prior to its effective date; and
- A prudent insurance carrier is reluctant to expose its capital to the risk of unintended consequences of the legislation.

The American Academy of Actuaries Study (1996)

The American Academy of Actuaries (AAA) is a national, nonpartisan public policy organization that does not take positions on legislation. Academy committees regularly prepare testimony for Congress, provide information to congressional staff and senior elected officials, comment on proposed federal regulations, and work closely with state officials in health and life insurance, property and liability insurance, and pension and employee benefits.

On March 10, 1995, by a communication to Representative Steven Schiff of the U.S. House of Representatives, The Malpractice Reform Work Group of the AAA submitted its report as an objective actuarial input on the potential effects of proposed medical tort reforms associated with projected changes in the cost of medical malpractice insurance. The Medical Malpractice Reform Work Group reviewed the results of the actuarial experience in the States of California, New York and Ohio.

When analyzing medical tort reform proposals, the initial question is whether they work as advertised. Critics of tort reform challenge medical tort reform proponents to demonstrate that lower paid losses resulting from tort reform translates into lower direct costs to physicians in the form of cheaper medical malpractice rates. "Paid losses" are often used as a measure of malpractice insurance costs. Using this measure, several studies have documented the effectiveness of the cap in holding down California's loss costs.

The AAA has analyzed California's share of U.S. loss payments and compared it to New York's and Ohio's. The AAA found that while California "had a relatively stable proportion of the U.S. physician population, its percentage of loss payments (relative to the U.S. total) has dropped dramatically . . . since the inception of its MICRA package of medical tort reform was upheld by the California Supreme Court in the mid-1980s. Prior to medical tort reform in 1975, California's percentage of loss payments had increased faster than their percentage increase or the number of physicians. Since 1981, California has continued to benefit from their MICRA reforms. Loss costs continue to drop as a percent of the total for the US, while the level of growth in the number of physicians remains stable with other states. Exhibit 6 lists the principle conclusions of the AAA Report.

Many opponents of tort reform argue that insurance premiums do not drop after tort reform. It is true that this is difficult to measure since costs and premiums normally go up with inflation and tort reform may only slow down the increases. However, the data shows that premiums declined as losses declined in California. Exhibit 7 shows California premiums compared to U.S. totals 1975 to 1994. Year-to-year fluctuations do occur, but over an extended period, premiums have fallen in a similar proportion to the decline in losses. Competition tends to keep companies at an appropriate profit margin, and any extra profits are normally short-lived or returned to policyholders in the form of premium credits or dividends. NORCAL, for example, did not raise premiums for an eight-year period once the loss trends after the Fein case became apparent. Exhibit 8 demonstrates that a combination of rate reductions and policyholder dividends has held NORCAL premiums from 1987 to 1997 below the growth in CPI. NORCAL's actual premium levels declined when policyholder dividends are considered. Total cost savings are estimated at 30% per year over pre-MICRA levels.

The New York loss experience shows that the medical tort reform measures implemented piecemeal did not improve its experience relative to other states. Exhibit 9 demonstrates that New York's percentage of loss payments do not show any observable pattern of decline or improvement over the 16-year period, despite the various medical tort reform measures adopted. This result supports the merits of a cap on damages, which New York does not have, and the package concept as compared to piecemeal reform. The 1995 study for the Medical Liability Mutual Insurance Company of New York, *Projected Effect on New York Professional Liability Costs of Capping Non-Economic Damages,* by Biondi and Quintilian, projected a 28% savings should New York adopt California's medical tort reform package.

The final example in the AAA Report is Ohio. Exhibit 10 shows a gradual decline in the cost level following medical tort reform, from 1976 through 1982, and a sharp increase during the time the cap was under challenge in the courts with a peak in 1985, when the cap was finally

overturned. Since 1985, costs in Ohio have remained high, with no indication of decreasing. Again, this data appears to support the benefits of a medical tort reform package and the specific benefit from a cap on noneconomic damages, as seen by the increases in costs when the cap was no longer in effect.

The AAA concluded from its findings:

- All else being equal, each state's percent of costs, in terms of paid medical malpractice claims relative to the total for the US, should remain constant over time. The observed changes, or lack thereof, in the state's relative cost level provide an indication of the effectiveness of their medical tort reforms.
- California - The MICRA package of reforms has caused medical malpractice costs to fall substantially as a percent of the U.S. total.
- New York - Several individual reforms were enacted in 1975, 1981, 1985 and 1986. There has been no observable improvement in the state's relative costs. The New York reforms did not include any cap on damages.
- Ohio - Reforms enacted in 1975 included a cap on damages; however, the cap was overturned in 1985. Costs rose dramatically after the cap was overturned and have remained high.

The AAA report also discussed the importance of a comprehensive package of medical tort reforms. Their findings:

- A package of tort reforms is more likely to achieve savings in malpractice losses and insurance premiums (and, to the extent they are related, lower defense medicine costs) rather than one or two reforms.
- An effective reform package should include two components: a cap on awards for noneconomic damages, and some form of mandatory recognition of compensation from collateral sources. The 1993 Congressional Office of Technology Assessment (OTA Impact of Legal Reforms on Medical Malpractice Crises, September 1993) agrees that these are the most effective reforms.
- Other reforms in a reform package that help assure its effectiveness should contain more restrictive statutes of limitations, limits on expert qualifications and frivolous suit penalties. Poorly constructed tort reforms will not result in lower malpractice costs and premiums and may actually increase malpractice costs.

Estimating the Cost of Eliminating MICRA and the Cap on Noneonomic Damages
The AAA Study suggests that eliminating the medical tort reform provisions of MICRA would have the effect of increasing California's share of U.S. medical malpractice premiums to mid-1970s levels. Under this scenario, California premiums would jump from the current 10% of national premiums level to 25% of national premiums. This represents an increase of 150%. The National Association of Insurance Commissioners (NAIC) reports that California medical malpractice premiums are $660 million, and industry observers estimate self-insured and government medical malpractice costs are comparable, resulting in total costs of $1.320 billion in California. Exhibit 11 demonstrates that a 150% increase in costs for insured, self-insured and government would total almost $2 billion. Government costs are estimated as approximately $400 million per year, and a 50% increase will cost approximately $670 million. Whether these costs reach these levels immediately or over a period of years will depend on the triggering event selected by the Legislature for the legislation. For example, cost will be realized quickly if a cap increase bill affects all cases that have not been submitted to a jury on the legislation's effective date, while a bill attaching to incidents occurring after the

legislation's effective date will take several years to be fully realized.

Estimating the cost of altering the cap on noneconomic damages is a more complex task. An increase in the cap on noneconomic damages to $750,000 and adjusting the cap to reflect increases in the CPI will effectively destroy the economic value of the cap. Capping noneconomic damages at such a high level will make it inapplicable to all but a few high value cases. According to the National Practitioners Data Bank (NPDB), the median medical malpractice award was $30,000, while average awards are $120,000. Industry observers believe the elimination of the cap on noneconomic damages will result in premium increases in the range of 30% to 50%. This estimate is consistent with the Hamm Report analysis of studies on the subject. Exhibit 12 demonstrates the cost of increasing California medical malpractice costs by 30% to 50%.

It has been suggested by members of the plaintiff's trial bar that California physician-owned insurers can absorb the cost attributable to an increase of the cap on noneconomic damages from excess surplus funds. According to statistics published by the NAIC from 1988 to 1997, California medical malpractice insurers' return on net worth (measured as a percent of direct premiums earned) has been 20.5% to 15.5% nationwide, or 5% higher than the national average. However, in the last three years, California has averaged 12.8% versus 12.6% nationwide. This can be explained by the fact that medical malpractice rates prior to 1987 were set on the assumption that MICRA would be found unconstitutional or repealed by the Legislature, so no cost saving was assumed. When the California Supreme Court upheld all the major provisions of MICRA in the mid-1980s and the Legislature signaled its reluctance to change MICRA in 1987 with the "napkin agreement," insurers held rates more or less constant; while costs increased until today, annual premiums losses and expenses are back in balance. Accumulated surplus funds have allowed the California "bedpan mutuals" to compete in the current soft market brought on by 10 years of rate inactivity. Should the cap on noneconomic damages be lifted, premiums are likely to rise to actuarially indicated levels tempered by the level of competition, which is in turn dependent on rate adequacy.

To illustrate the point, NORCAL has averaged a year-to-year change in surplus of 7.8% over the past six years. If an increase in the cap resulted in an indicated 30% to 50% premium increase as industry observers believe, NORCAL would be compelled to raise rates in order to avoid a year-to-year negative change in surplus. A negative change in surplus will trigger an adverse result on the NAIC company solvency monitoring system and would likely lead to a downgrade in the claims paying ability rating by A.M. Best. Insurance brokers would be compelled to move business from NORCAL because many credentialing hospitals and medical organizations set insurer acceptance standards based on these criteria. The lethal combination of adverse underwriting results and loss of market share would put NORCAL in a death spiral that would be hard to reverse.

Hamm Study of Medical Malpractice Costs on Availability of Healthcare (1998)
Since the passage of MICRA, California has been a model for state and national medical malpractice reforms. The centerpiece of MICRA is a $250,000 cap on the amount of noneconomic damages, such as pain and suffering, that may be awarded to plaintiffs in medical malpractice lawsuits. The most comprehensive study of MICRA was prepared by Bill Hamm, former California Legislative Budget Analyst. The study, known as the *Hamm Report*, made two principal findings with regard to the $250,000 cap on noneconomic damages limitations:

a. **MICRA has helped to hold down the rate of increase in health care costs in California.**

b. **MICRA is fair to the medically injured.**

The first principal finding determined the following:

- A higher cap on noneconomic damages will lead to increased medical malpractice premiums (30% to 50%).
- Higher malpractice premiums will be passed to health care providers, such as physicians and hospitals.
- To insulate themselves from malpractice suits, health care providers prescribe tests and treatments that are not medically necessary and do not improve outcomes (the practice of so-called "defensive medicine"). Defensive medicine increases health care costs.
- The increase in health care costs drives up health insurance premiums.
- As health insurance premiums rise, access to quality health care suffers because the increase in premiums resulting from the higher cap will discourage some employers from offering health insurance programs to their employees.
- Other employers will shift the increased costs to their employees in the form of higher payroll deductions of insurance, larger deductibles and increased co-payments.
- As the cost of health insurance goes up, some individuals - particularly low-wage workers - will choose to give up their insurance.
- The increase in medical malpractice premiums and litigation will also reduce the availability of quality health care to Californians.
- Physicians and medical students will be discouraged from entering high-risk specialties like obstetrics.
- Physicians and hospitals may choose not to offer certain risky treatment that increases the provider's vulnerability to malpractice lawsuits.
- Other physicians will locate or relocate in areas where medical malpractice insurance premiums do not take such a large bite out of their incomes.
- Some community hospitals will find it even more difficult to cover their costs when malpractice premiums are raised in response to the higher cap.
- The reduced availability of quality health care will be felt most by residents of rural and inner-city areas, since the higher costs incurred by providers will reduce the viability of marginally economic practices serving lower-income families.
- Likely outcomes from increased malpractice costs include:
  - State and county health care expenditures will increase.
  - University and public hospitals will incur increased costs as the higher cap lead to more marginal lawsuits and larger awards.
  - The state's share of publicly funded health care will increase as provider charges and health insurance premiums are raised to cover the increased costs.
  - The number of uninsured Californians requiring publicly funded health care will increase.

In short, empirical research and analysis of health statistics indicate that a higher cap on noneconomic damages would impose significant direct and indirect costs on California's health system. The evidence shows that an increase in the cap could **increase the cost of health care in California by more than $6 billion per year.** The higher costs will ripple through the state's health care system, as the costs are shifted from malpractice insurance companies to providers to health insurers and, ultimately, to individuals, families and government (that is, taxpayers). The evidence also shows that, as the cost of health care goes up, access to quality care suffers.

The second principal conclusion of the *Hamm Report* is that MICRA is fair to the medically

injured. The principal findings were:

- The medically injured bring as many medical malpractice claims per capita today as before enactment of MICRA.
- The medically injured received higher total compensation after enactment the of MICRA than they previously received.

Research confirms that MICRA medical tort reforms, such as caps on damages, help reduce the size of judgments in medical malpractice cases. A model of claims dispositions developed by Danzon and Lillard (1983) indicates that costs appear to influence disposition in the predicted manner . . . ceilings on awards, periodic payments, and elimination of the plaintiff's ad damnum significantly reduce awards and reduce the probability and size of payment in settlement out of court.

Some opponents of MICRA argue that the cap on noneconomic damages has reduced access to the court system. This argument, however, is not supported by the available evidence. First, the cap on noneconomic damages does not prevent claimants from filing suit, although it discourages those with dubious claims from incurring the costs associated with a lawsuit. Second, even with a cap in place most individuals with strong claims still find that the expected jury award from filing suit is sufficient.

Data from California gives no indication that MICRA has reduced access to the court system. A study of estimated medical malpractice filings for California, based on a survey of such filings in Los Angeles County, shows that the frequency of medical malpractice claims has not changed substantially since MICRA was enacted despite the reduced financial incentives to file malpractice claims. Exhibit 13 shows that from 1975 to 1996, estimated per capital filings of medical malpractice cases in California have been relatively flat.

It is also clear that MICRA has not depressed judgments and settlements below the rate of anticipated growth using the CPIas a benchmark. Figures compiled from California physician-owned insurers from 1976 to 1995 amply demonstrate that the size of average awards have been growing at a rate far exceeding anticipated growth compared to the CPI. Exhibit 14 tracks average payments as a result of settlements and judgments from 1976 to 1996. During this 20-year period, the average award has grown from approximately $10,000 to $120,000, or 1200%. Using the CPI as a baseline, the average award would have increased by about 500%. In 1996, average payments were twice as large as would have been expected using the CPI as a benchmark.

Taken together, the two figures indicate that the MICRA cap is fulfilling its purpose - it is reducing the largest claims without decreasing access to the tort system. An increase in the MICRA cap on noneconomic damages would accelerate the rate at which the average paid indemnity claim is growing.

In sum, economic theory and the available evidence indicate that an increase in the cap on noneconomic damages would increase the volume and cost of malpractice-related litigation, particularly the weak or marginal claims.

The *Hamm Report* shows that when a cap is imposed on noneconomic damages, the average size of medical malpractice claims goes down. (This measure of medical malpractice claims is referred to as "severity.") For example, in 1986, Danzon measured the effect of various factors on malpractice claim frequency and severity. She concluded that "[t]he average impact of the various statutes to cap all or part of the plaintiff's recovery has been to reduce average

severity by 23%." Sloan, Mergenhagen and Bovbjerg conclude that caps are the strongest reforms "in terms of their impact on paid claim size." These same researchers also found a significant negative relationship between a cap on noneconomic damages and the severity of malpractice claims. OTA's review of six empirical studies finds a similar outcome: "The one reform consistently shown to reduce malpractice cost indicators is caps on damages."

Caps on noneconomic damages tend to be particularly effective in reducing costs because of the extreme variability of damage awards attributable to pain and suffering. The greater the variation in claims and awards, the more effective a cap on maximum awards. According to one 1984 study, 2.1% of malpractice cases accounted for 64% of the pain and suffering damages awarded. Because the cap in MICRA dramatically reduces the cost of these large cases, it has a large impact on total claims payments. In fact, the cap's effectiveness increases in direct proportion to the tendency of total noneconomic claim payments to be concentrated among a few very large awards.

A survey of large losses finds that the average size of large malpractice claims in California has diminished since MICRA took effect. Following MICRA's implementation, the mean payment for large verdicts in constant (inflation-adjusted) dollars decreased.

Despite the reduction in mean payments on large malpractice claims, industry data shows that the average size of all claims - large and small - has actually increased on an inflation-adjusted basis. Thus, while payments on large malpractice claims - where we would expect to find an impact from the cap - are getting smaller, average malpractice claims are getting larger. Currently the average paid indemnity claim in California grew at twice the rate of inflation.

Congressional Budget Office (CBO) Study of H.R. 4250 (1998)
The most recent study of the direct cost saving benefits of medical tort reform on federal programs was prepared in 1998 by the Congressional Budget Office (CBO) as part of its analysis of the Patient Protection Act of 1998 (H.R. 4250). The CBO is an independent agency which advises the House and Senate regarding the financial impacts of proposed legislation on the federal budget. The CBO study, which only measured direct cost, found medical tort reform would reduce federal spending for Medicare and Medicaid by $1.5 billion over 10 years. The CBO estimates that the medical liability tort reforms would ultimately reduce private health plan premiums annually by 0.3% to 0.5%. The CBO is still considering indirect savings through a reduction of defensive medicine, which studies have shown are three-to-six times the direct savings. When these indirect costs attributable to defensive medicine are factored into the equation, medical liability cost savings in the Medicare and Medicaid programs will rise from $4.5 billion to $9 billion.

The key reform provisions in the Patient Protection Act are based on California's successful MICRA provisions and include:

- a $250,000 cap on noneconomic damages in medical malpractice cases.
- a separate $250,000 cap on punitive damages.
- mandated periodic payment of future losses when they exceed $50,000.
- a defendant's right to admit evidence of collateral source payments.

H.R. 4250 would establish uniform standards for all health care liability actions brought in any state or federal court, except for actions under ERISA and vaccine-related injury cases. The standards would apply to all medical malpractice cases and actions against manufacturers of pharmaceuticals and medical devices. Federal law would preempt inconsistent state laws,

unless they give defendants more rights than would exist under these provisions. In addition to the key provisions set out above, the bill would impose limits on joint and several liability, and restrictions on statutes of limitations. The bill would also prohibit punitive damages altogether for drugs and devices approved by the Food and Drug Administration (FDA) unless the manufacturer was found to have intentionally withheld or misrepresented material information to the FDA.

The CBO Report confirmed studies such as the AAA Report (1996) and the *Hamm Report (1998)* that suggest medical tort reforms substantially reduce medical liability premiums as well as malpractice claims, payments and premiums for medical liability insurance. The CBO found that 65% of the U.S. population lived in states with collateral source offset provisions, and 45% of the population lived in states with caps on noneconomic damages. Those two provisions in particular have been found extremely effective in reducing the amount of claims paid and, ultimately, medical liability premiums.

Lower medical malpractice costs would contribute to slower growth in federal health care spending, because changes in malpractice premiums are used to calculate the measures of inflation, which are used to update payment rates for hospitals, physicians and other providers in the Medicare program. Medicaid spending would also be reduced as states adjust payment rates to reflect lower costs to providers for liability insurance.

The Physician Insurers Association of America (PIAA) has led the effort to convince the CBO to assign a savings value (score) to federal health care liability reforms. Starting with CBO Director Robert Reicher who, four years ago stated that medical tort reform could not be scored, the CBO has increased scoring values each year from a mere $200 million over seven years in 1995 and $600 million over 10 years in 1997, to the current $1.5 billion estimate in 1998. The PIAA expects the scoring estimate to jump dramatically when defensive medicine costs are factored into the calculation.

For a number of reasons, some not relating to tort reform, getting H.R. 4250 or similar to President Clinton's desk will be most difficult. However, this new level of scoring improves the likelihood that medical tort reform will be included in the next budget reconciliation. A $1.5 billion savings will be more attractive to individual House and Senate Members looking to offset expenditures in other areas. It may also allow the bill to survive the germaneness test of the Byrd Rule, which permits the Senate Parliamentarian to strip provisions out of the budget reconciliation (called Byrd Droppings) which are not deemed to be integral to the federal budget process. The threat of this forced the withdrawal of tort reform provisions in the last two attempts to include them in the budget reconciliations of 1995 and 1997.

Stanford Study of Defensive Medicine (1996)

The most recent empirical study of the indirect costs associated with defensive medicine provides the best evidence we have on how the malpractice exposure affects health care expenditures. The 1996 study, *Do Doctors' Practice Defensive Medicine,* by Stanford Economic Professors Kessler and McClellan, found that malpractice tort reforms, particularly reforms such as caps on noneconomic damages, lead to reductions of 5% to 9% in medical expenditures on cardiac disease without having substantial effects on mortality or medical complications. When Kessler's and McClellan's results are applied to all U.S. cardiac disease expenditures, the savings from malpractice tort reforms amount to $450 million per year for the first two years, and $600 million per year for each year thereafter. Exhibit 15 lists the principle findings of the Kessler and McClellan study.

Kessler and McClellan estimate that, if their results hold true for all procedures, direct tort

reforms could bring about total medical "expenditure reductions of well over $50 billion per year without serious adverse consequences for health outcomes." Given California's share of total U.S. spending on health care, **California consumers' and taxpayers' share of the benefits from tort reform would total approximately $5.8 billion.**

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|Application to MCOs|Conclusion|

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Nevada Trial Lawyers Association
406 North Nevada Street
Carson City, Nevada 89703-4107

LEGAL DRAFT

SUMMARY—none yet (BDR 57-1)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State: Yes.

AN ACT relating to health; ..... 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. Title 57 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 21, inclusive, of this act.

Sec. 2. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 3 to 6, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Carrier" means any entity subject to the provisions of this Title and the regulations adopted pursuant thereto that contracts or offers to contract to provide for, deliver payment for, arrange for payment of, pay for, or reimburse any cost of health care services, including a sickness and accident health service corporation, and any other entity providing a***

THE WALL STREET JOURNAL. ONLINE
April 11, 2002

PAGE ONE

Businesses' Insurance Costs Surge, But They Shouldn't Blame Sept. 11

By CHRISTOPHER OSTER
Staff Reporter of THE WALL STREET JOURNAL

TULSA, Okla. -- When Bennett Steel Inc., a small construction firm based here, went to renew its insurance coverage shortly after Sept. 11, President Dave Bennett got a shock. The total bill shot up more than $185,000 from a year earlier because of higher premiums for various policies: a 122% increase in umbrella-liability rates, 66% more for liability at job sites, and 51% more for vehicle coverage.

Already dealing with the impact of the economic slowdown, Mr. Bennett increased the number of employees he was planning to lay off, to 15, or 10% of his work force.


Dave Bennett

Businesses across the country have been forced to make similar adjustments in recent months as they confront rate increases of 100% or more on their insurance premiums. And that threatens to damp job growth at smaller businesses -- which traditionally create most of the nation's new jobs -- and thus possibly slow the economic recovery.

Insurers point to the estimated $50 billion in claims from the Sept. 11 attacks as a big reason for the rate increases. But Mr. Bennett and other business owners strain to see the connection. "It just doesn't make sense that it would hit us like that," Mr. Bennett says.

COMPANIES

Dow Jones, Reuters

Berkshire Hathaway Inc. Cl A (BRKA)	
PRICE	71200.00
CHANGE	300.00
U.S. dollars	11:28 a.m.
Chubb Corp. (CB)	
PRICE	77.01
CHANGE	0.01
U.S. dollars	11:34 a.m.
American International Group Inc. (AIG)	
PRICE	73.59
CHANGE	0.79
U.S. dollars	11:35 a.m.
American Financial Group Inc. (AFG)	
PRICE	29.20
CHANGE	0.00
U.S. dollars	11:32 a.m.
St. Paul Cos. (SPC)	
PRICE	49.07
CHANGE	-0.13
U.S. dollars	11:35 a.m.

* At Market Close

He's right. The higher premiums many small and midsize businesses hundreds of miles from New York City now face are the legacy of a decade of imprudence among insurers -- a period that combined a relentless price war with aggressive risk-taking. From 1993 to 2000, underwriters slashed rates, sometimes as much as 40%, and fought for customers by loosening terms on all types of business policies -- from directors-and-officers' liability coverage to medical-malpractice packages to workers' compensation insurance. For many businesses, that meant a boost to already-growing profits in a strong economy. (Rates for consumers dropped in the '90s, too, and have been rising lately, but the swings haven't been nearly as pronounced because of closer regulatory scrutiny.)

Insurers eventually reached the limit. By 1999, they were paying out, on average, $1.07 in

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claims and related expenses for every $1 of premium received on business coverage. During the bull market of the '90s, insurers could sustain these losses on underwriting because the shortfalls were more than offset by investment income the insurers earned on premiums.

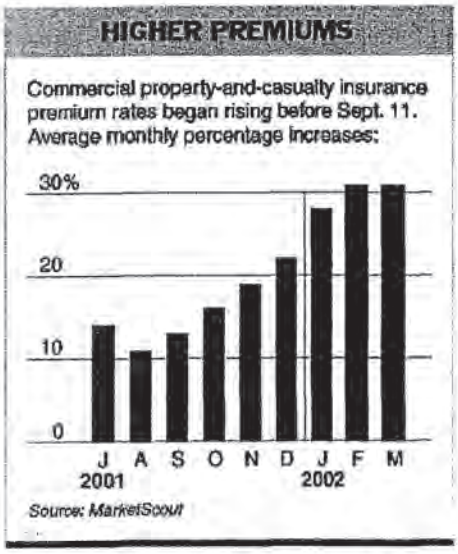
Now financial markets have soured, and so have insurers' investment yields. The companies have also been hurt because claims on the cheap policies they wrote in recent years have come in much higher than they originally estimated -- optimistically, in the eyes of some critics. And all this was happening before Sept. 11. Some insurers haven't survived it all. And others are paying a steep price: For the fourth quarter, more than three dozen insurers reported a total of $5.4 billion in charges, mostly related to restructuring or boosting the amount of money set aside to cover claims beyond the impact of Sept. 11.

This mass action is an "industrywide confessional and rush to atone" for the aggressive practices of the '90s, says Alice Schroeder, a property-casualty insurance analyst with Morgan Stanley.

Indeed, risky lines of business that appealed to insurers several years ago now haunt them. For example, Cologne Re, a unit of Warren Buffett's **Berkshire Hathaway** Inc., took a $225 million charge in 1999 for losses on workers' compensation business it obtained through a complicated premium-sharing system. It involved one insurer after another taking a slice of the insurance pool, then passing a big piece of it along, each successive insurer receiving less premium and more risk. At the time, a Berkshire executive said the practice provided a classic example of an insurer operating "outside its area of expertise."

Selling to Enron

More recently, **Chubb** Corp. Chairman Dean O'Hare lamented $143 million in losses the insurer suffered on surety bonds it sold to guarantee delivery of natural gas by Enron Corp. "What happened with Enron is that our folks ... didn't know what they were writing," Mr. O'Hare wrote in a December letter to employees to help explain why they would be receiving no year-end bonuses. A Chubb spokesman says the company is disputing whether it is required to pay on some of the bonds it sold to Enron.



Now, the higher cost of insurance in more sober times is adding to pressure on businesses when they least need it. In a recent survey by the National Federation of Independent Business, rising insurance costs tied with taxes as the biggest problem facing small businesses. And these businesses feel the pain more than bigger ones. Among businesses with less than $100 million in annual revenue, about 3% of revenue goes to insurance, according to a study by the Risk and Insurance Management Society, which represents corporate-risk managers. For companies with more than $5 billion in annual revenue, the proportion is a much smaller 0.5% of revenue.

Rising insurance rates pose particular problems for places such as Tulsa. Today, the skyline of this city of nearly 400,000 people is dominated by the Bank of Oklahoma tower, designed by the architect who built the World Trade Center. The city once billed itself as the oil capital of the world, and the area was home to J. Paul Getty and Frank Phillips, founders of what became two of the world's largest energy companies.

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Oil has remained a mainstay, but in the past decade, Tulsa shifted part of its economic focus to technology. That meant strong growth in the 1990s. Now, it means layoffs such as the 500 workers **Williams Communications Group** Inc. has shed since the start of the year amid a glut of fiber-optic capacity. Tulsa's unemployment rate stands at 4.5%, up from 2.8% at the start of 2001, though nearly a full percentage point below the national average.

A Sudden Switch

Among the many local businesses that benefited from low insurance rates in the '90s was Bennett Steel. Mr. Bennett's workers' compensation insurer, **American International Group** Inc., had been lowering its rates for several years. Then, in 1999, he switched to the Reliance Insurance Co. unit of Reliance Group Holdings Inc. for the coverage. It offered a premium that was $100,000, or 25%, less than his AIG premium.

Mr. Bennett's insurance broker of 15 years, Wally Bryce, of Arthur J. Gallagher & Co., tried to steer Mr. Bennett away from Reliance, arguing that it was weaker financially than other options. "That was the first time in umpteen years of doing business together that he didn't take my advice," Mr. Bryce says.

But Mr. Bennett had plans for the money he saved on insurance. He spent more than $50,000 on new trucks for Bennett Steel.

In 1999, Reliance, which had been as aggressive as the rest in cutting its rates and was now on shaky ground, promised Mr. Bennett a renewal quote but never got back to him. So Mr. Bennett turned to the state-sponsored workers' compensation insurer. He ended up paying premiums 30% higher than the Reliance coverage but still less than what AIG was now offering.

In 2000, the Reliance holding company, long controlled by financier Saul Steinberg, tottered after years of extravagant spending and big dividend payouts. Ratings of the Reliance Insurance unit's financial strength plunged, and Pennsylvania insurance regulators began to exert control over it, eventually announcing in October that they would liquidate its operations. It was part of a small shakeout among less-stable insurers. The same year, Superior National Insurance Co., a workers' compensation specialist, was seized by California regulators, and Pennsylvania regulators last year took control of medical-malpractice specialist Phico Insurance Co.

As weaker insurers fell, stronger ones were freed to raise rates without fear of losing market share. Last fall, Mr. Bryce delivered the news that Mr. Bennett would have to pay much higher rates to Tulsa-based Mid-Continent Insurance Co., which for more than 10 years has been Mr. Bennett's insurer for all coverage except workers' compensation. Mr. Bennett told the broker to show him something better. But only Mid-Continent, a unit of **American Financial Group** Inc., had submitted a serious bid. Most others simply declined the opportunity.

'Grossly Underpriced'

Mike Coon, a Tulsa-based senior vice president for Mid-Continent who handles Mr. Bennett's account, says part of the rate increase was due to claims Mr. Bennett filed last year. He adds that hefty rate increases aren't uncommon. Some new customers, he says, are being asked to pay more than triple the premiums they paid to their previous insurers. "There are companies who had rate levels that were 15% to 20% of what we would have charged," Mr. Coon says. "A lot of that business was non-renewed because it's been so grossly underpriced."

Mr. Bennett, a weathered 48-year-old Tulsa native with the meaty forearms of a fourth-generation iron worker, started his business in 1980 with four employees, "a bumper jack and a pry bar," he says. Now, it has 135 employees, including his wife and three of his sons, and

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operates a fleet of 21 cranes -- some valued at more than $1 million -- that erect university buildings, offices and warehouses. Annual revenue is now around $18 million.

The layoffs, the biggest in the company's history, hurt. "If I've got 150 people working for me, it's 600 people," he says, noting that a typical employee has several dependents.

In addition to letting go of 15 people shortly after Thanksgiving, Mr. Bennett cut some of his remaining workers' hours to 30 a week. Business had slowed. A construction contract with American Airlines fell through soon after Sept. 11. And the 32% rise in its insurance rates, Mr. Bennett says, made the cuts all the more necessary -- and deeper.

Throughout Tulsa, businesses public and private are trying to cope with the higher insurance expenses. Brad Frank, president of Tulsa Tube Bending, which bends metal pipes for industrial use, says his rates for property, product-liability and umbrella-liability coverage increased more than 20% when the company renewed Dec. 31. Mr. Frank has tried to absorb the cost increases by preaching efficiency to employees. He says a profit-sharing program at Tulsa Tube will motivate employees to, among other things, pay more attention to workplace safety.

"We were thinking about adding another person," Mr. Frank says. "But that's not part of our plan anymore."

Lloyd Snow, school superintendent for Sand Springs, a small town just outside of Tulsa, got news last July that rates would jump to $280,000 from $160,000. "Schools are seeing increases of 70% to 250%," Mr. Snow says. "It's been phenomenal."

Brent LaGere, chairman and chief executive of National American Insurance Co., which insures most of Oklahoma's school districts, says his company was passing on higher premiums from its reinsurer, a firm that helps insurers spread their risk. Mr. LaGere anticipates his company will need to increase rates further as reinsurers try to recoup losses from Sept. 11 and Enron's collapse.

The rate increases come as the state of Oklahoma is eliminating $194,000 from the roughly $15 million a year it sends to the Sand Springs school district as part of statewide budget cuts. "There will be services to kids that are reduced or lost," Mr. Snow says. Up to 87% of the district's budget goes to salaries of teachers, administrators and support staff, he says, so "increasing costs like insurance means cutting payroll." Sand Springs already has had to delay the purchase of school buses and desktop computers and has canceled an increase in the textbook budget.

Strength in Numbers

Mr. Snow says the rate increases have hit Oklahoma's school systems so hard that school districts are working on a plan to pool their insurance premiums and risks to make insurance more affordable. If that doesn't come together, "we're being told that we're looking at another 50% to 150% increase," Mr. Snow says.

Businesses and institutions that haven't yet paid higher insurance premiums are bracing for them. Valley View Regional Hospital, south of Tulsa in Ada, Okla., has a liability-insurance policy that runs until summer. But in December, Phil Fisher, the hospital's president, received notice that Valley View's insurer, **St. Paul** Cos., wouldn't be able to renew the hospital's medical-liability coverage.

St. Paul, the nation's largest writer of medical-malpractice insurance, with a 10% market share, decided to shutter its medical business altogether, after losing $940 million on it last year. St. Paul's medical-malpractice problems were emblematic of the impact of the insurance price war

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of the 1990s. Medical-malpractice insurance was the industry's most profitable line 10 years ago, and so many companies piled into it that they began underpricing their coverage. Then came rising jury verdicts in malpractice suits and higher health-care inflation. A St. Paul spokesman says the company is leaving the business because it doesn't believe it can make the line of business profitable.

Valley View's Mr. Fisher isn't sure who the hospital's insurer will be after its St. Paul policy expires next year, nor how much the insurance will cost. "Everyone is very reluctant to talk about that," he says. "But we need something. We need a marker somewhere along the line."

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Updated April 11, 2002 12:54 p.m. EDT

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Report: CDC Off on Infection Deaths

.c The Associated Press

CHICAGO (AP) - About 103,000 deaths were linked to hospital infections in 2000 - a figure 14 percent higher than government estimates - and nearly 75 percent of the deaths were preventable, the Chicago Tribune reported.

The national Centers for Disease Control and Prevention last year calculated 90,000 deaths in 2000 were linked to hospital infections, the fourth leading cause of death in the United States behind heart disease, cancer and strokes.

Many of the deaths were caused by unsanitary facilities, germ-laden instruments and unwashed hands, the newspaper said in early Sunday editions distributed Saturday.

According to the report, infection rates are soaring nationally, exacerbated by hospital cutbacks and carelessness by doctors and nurses, and serious violations of infection-control standards have been found in the majority of hospitals.

Since 1995, more than 75 percent of all hospitals have been cited for serious cleanliness and sanitation violations.

Hospitals are not required to disclose infection rates, and most do not. Doctors are not required to tell patients about risk or exposure to hospital germs.

To document the rising rate of infection-related deaths, the newspaper analyzed records from 75 federal and state agencies, as well as internal hospital files, patient databases and court cases around the country.

CDC officials said they believe most hospital infections are preventable, but the agency has not arrived at a precise number.

The American Hospital Association said the last decade of unprecedented cost-cutting and financial instability has impacted all areas of hospital care.

``It's had an effect on infection control and it's had an effect on our ability to recruit and retain workers. It's had an effect on our ability to invest in new and updated equipment as much as we would like to," said Rick Wade, spokesman for the AHA.

``It's also a question in front of society. How much do you want to invest in high-quality, safe medical care?"

Among recent incidents in which hospital-linked infections were cited, the newspaper noted a 1998 case in which eight children died at a Chicago pediatric medical center; a 1997 Detroit case in which four babies died in 1997; and an infection at a West Palm Beach, Fla., hospital where 13 people cardiac patients died in the late 1990s.

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WALL STREET JOURNAL

June 24, 2002

PAGE ONE

Insurers' Price Wars Contributed To Doctors Facing Soaring Costs

Lawsuits Alone Didn't Inflate Malpractice Premiums; Reserves at St. Paul Distorted Pricing Picture in 1990s

By RACHEL ZIMMERMAN and CHRISTOPHER OSTER
Staff Reporters of THE WALL STREET JOURNAL

As medical-malpractice premiums skyrocket in about a dozen states across the country, obstetricians and doctors in other risky specialties, such as neurosurgery, are moving, quitting or retiring.
Insurers and many doctors blame the problem on rising jury awards in liability lawsuits.

"The real sickness is people sue at the drop of a hat, judgments are going up and up and up, and the people getting rich out of this are the plaintiffs' attorneys," says David Golden of the National Association of Independent Insurers, a trade group. The American Medical Association says Florida, Nevada, New York, Pennsylvania and eight other states face a "crisis" because "the legal system produces multimillion-dollar jury awards on a regular basis."

But while malpractice litigation has a big effect on premiums, insurers' pricing and accounting practices have played an equally important role. Following a cycle that recurs in many parts of the business, a price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims.

Price Slashing

Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year.

"I don't like to hear insurance-company executives say it's the tort [injury-law] system -- it's self-inflicted," says Donald J. Zuk, chief executive of Scpie Holdings Inc., a leading malpractice insurer in California.

What's more, the litigation statistics most insurers trumpet are incomplete. The statistics come from Jury Verdict Research, a Horsham, Pa., information service, which reports that since 1994, jury

awards for medical-malpractice cases have jumped 175%, to a median of $1 million in 2000. During that seven-year period, the median award for negligence in childbirth was $2,050,000 -- the highest for all types of medical-malpractice cases, Jury Verdict Research says. (In any group of figures, half fall above the median, and half fall below.)

Gaps in Database

But Jury Verdict Research says its 2,951-case malpractice database has large gaps. It collects award information unsystematically, and it can't say how many cases it misses. It says it can't calculate the percentage change in the median for childbirth-negligence cases. More important, the database excludes trial victories by doctors and hospitals -- verdicts that are worth zero dollars. That's a lot to ignore. Doctors and hospitals win about 62% of the time, Jury Verdict Research says. A separate database on settlements is less comprehensive.

A spokesman for Jury Verdict Research, Gary Bagin, confirms these and other holes in its statistics. He says the numbers nevertheless accurately reflect trends. The company, which sells its data to all comers, has reported jury information this way since 1961. "If we changed now, people looking back historically couldn't compare apples to apples," Mr. Bagin says.

Some doctors are beginning to acknowledge that the conventional focus on jury awards deflects attention from the insurance industry's behavior. The American College of Obstetricians and Gynecologists for the first time is conceding that carriers' business practices have contributed to the current problem, says Alice Kirkman, a spokeswoman for the professional group. "We are admitting it's a much more complex problem than we have previously talked about," she says.

Scrambling for Doctors

The upshot is beyond dispute: Pregnant women across the country are scrambling for medical attention. Kimberly Maugaotega of Las Vegas is 13 weeks pregnant and hasn't seen an obstetrician. When she learned she was expecting, the 33-year-old mother of two called the doctor who delivered her second child but was told he wasn't taking any new pregnant patients. Dr. Shelby Wilbourn plans to leave Nevada because of soaring medical-malpractice insurance rates there. Ms. Maugaotega says she called 28 obstetricians but couldn't find one who would take her.

Frustrated, she called the office of Nevada Gov. Kenny Guinn. A staff member gave her yet another name. She made an appointment to see that doctor today but says she is skeptical about the quality of care she will receive.

In the Las Vegas area, doctors say some 90 obstetricians have stopped accepting new patients since St. Paul Cos., formerly the country's leading provider of malpractice coverage, quit the business in December. St. Paul had insured more than half of Nevada's 240 obstetricians. Carriers still offering coverage in the state have raised rates by 100% to 400%, physicians say.

Dr. Wilbourn says his annual malpractice premium was due to jump to $108,000 next month, from $33,000. The 41-year-old solo practitioner says the increase would come straight out of his take-home pay of between $150,000 and $200,000 a year. In response, he is moving to Maine this summer.

Dr. Wilbourn mourns having "to pick up and leave the patients I cared for and the practice I built up over 12 years." But in Maine, he has found a $200,000-a-year position with an insurance premium of only $9,800 for the first year, although the rate rises significantly after that. Premiums in Maine are relatively low because a dominant doctor-owned insurance cooperative there hasn't pushed to maximize rates, the heavily rural population isn't notably litigious and its court system employs an expert panel to screen out some suits, says Insurance Commissioner Alessandro Iuppa.

Until the 1970s, few doctors faced big-dollar suits. Malpractice coverage was a small specialty. As courts expanded liability rules, malpractice suits became more common. Dozens of doctor-owned insurance cooperatives, or "bedpan mutuals," formed in response. Most stuck to their home states.

St. Paul, a mid-sized national carrier named for its base in Minnesota, saw an opportunity. An insurer of Main Street businesses, St. Paul became the leader in the malpractice field. By 1985, it had a 20% share of the national market. Overall, the company had revenue of $8.9 billion last year, with about 10% of its premium dollars coming from malpractice coverage.

The frequency and size of doctors' malpractice claims rose steadily in the early 1980s, industry officials say. St. Paul and its competitors raised rates sharply during the 1980s.

Expecting malpractice awards to continue rising rapidly, St. Paul increased its reserves. But the company miscalculated, says Kevin Rehnberg, a senior vice president. Claim frequency and size leveled off in the late 1980s, as more than 30 states enacted curbs on malpractice awards, Mr. Rehnberg says. The combination of this so-called tort reform and the industry's rate increases turned malpractice insurance into a very lucrative specialty.

A standard industry accounting device used by St. Paul and, on a smaller scale, by its rivals, made the field look even more attractive. Realizing that it had set aside too much money for malpractice claims, St. Paul "released" $1.1 billion in reserves between 1992 and 1997. The money flowed through its income statement and boosted its bottom line.

St. Paul stated clearly in its annual reports that excess reserves had enlarged its net income. But that part of the message didn't get through to some insurers -- especially bedpan mutuals -- dazzled by St. Paul's bottom line, according to industry officials.

In the 1990s, some bedpan mutuals began competing for business beyond their original territories. New Jersey's Medical Inter-Insurance Exchange, California's Southern California Physicians Insurance

Exchange (now known as Scpie Holdings), and Pennsylvania Hospital Insurance Co., or Phico, fanned out across the country. Some publicly traded insurers also jumped into the business.

With St. Paul seeming to offer a model for big, quick profits, "no one wanted to sit still in their own backyard," says Scpie's Mr. Zuk. "The boards of directors said, 'We've got to grow.' " Scpie expanded into Connecticut, Florida and Texas, among other states, starting in 1997.

As they entered new areas, smaller carriers often tried to attract customers by undercutting St. Paul. The price slashing became contagious, and premiums fell in many states. The mutuals "went in and aggravated the situation by saying, 'Look at all the money St. Paul is making,' " says Tom Gose, President of MAG Mutual Insurance Co., which operates mainly in Georgia. "They came in late to the dance and undercut everyone."

The newer competitors soon discovered, however, that "the so-called profitability of the '90s was the result of those years in the mid-80s when the actuaries were predicting the terrible trends," says Donald J. Fager, president of Medical Liability Mutual Insurance Co., a bedpan mutual started in 1975 in New York. Except for two mergers in the past two years, his company mostly has held to its original single-state focus.

The competition intensified, even though some insurers "knew rates were inadequate from 1995 to 2000" to cover malpractice claims, says Bob Sanders, an actuary with Milliman USA, a Seattle consultancy serving insurance companies.

Alleged Fraud

In at least one case, aggressive pricing allegedly crossed the line into fraud. Pennsylvania regulators last year filed a civil suit in state court in Harrisburg against certain executives and board members of Phico. The state alleges the defendants misled the company's board on the adequacy of Phico's premium rates and funds set aside to pay claims. On the way to becoming the nation's seventh-largest malpractice insurer, the company had suffered mounting losses on policies for medical offices and nursing homes as far away as Miami.

Pennsylvania regulators took over Phico last August. The company filed for bankruptcy-court protection from its creditors in December. A trial date hasn't been set for the state fraud suit. Phico executives and directors have denied wrongdoing.

In the late 1990s, the size of payouts for malpractice awards increased, carriers say. By 2000, many companies were losing money on malpractice coverage. Industrywide, carriers paid out $1.36 in claims and expenses for every premium dollar they collected, says Mr. Golden, the trade-group official.

The losses were exacerbated by carriers' declining investment returns. Some insurers had come to expect that big gains in the 1990s from their bond and stock portfolios would continue, industry officials say. When the bull market stalled in 2000, investment gains that had patched over inadequate premium rates disappeared.

Some bedpan mutuals went home. Scpie stopped writing coverage in any state other than California. "We lost money, and we retreated," says the company's Mr. Zuk.

New Jersey's Medical Inter-Insurance Exchange, now known as MIIX, had expanded into 24 states by the time it had a loss of $164 million in the fourth quarter of 2001. The company says it is now refusing to renew policies for 7,000 physicians outside of New Jersey. It plans to reformulate as a new company operating only in that state.

St. Paul's malpractice business sank into the red. Last December, newly hired Chief Executive Jay Fishman, a former Citigroup Inc. executive, announced the company would drop the coverage line. St. Paul reported a $980 million loss on the business for 2001.

As carriers retrench, competition has slumped and prices in some states have shot up. Lauren Kline, 6_ months pregnant, changed obstetricians when her long-time Philadelphia doctor moved out of state because of rate increases. Now, her new doctor, Robert Friedman, may have to give up delivering babies at his suburban Philadelphia practice. His insurance expires at the end of the month, and he says he is having difficulty finding a carrier that will sell him a policy at any price.

Last year, Dr. Friedman says he paid $50,000 for coverage. If he gets a policy for next year, it will cost $90,000, he predicts, based on his broker's estimate. "I can't pass a single bit of that off to my patients," because managed-care companies don't allow it, he says.

Dr. Friedman says he is considering dropping the obstetrics part of his practice. Generally, delivering babies is seen as posing greater risks than most gynecological treatment. As a result, insurers offer less-expensive policies to doctors who don't do deliveries.

Mr. Golden of the insurers' association argues that whatever role industry practices may play, the current turmoil stems from lawsuits. The association says that from 1995 through 2000, total industry payouts to cover losses and legal expenses jumped 52%, to $6.9 billion. "That says there are more really huge verdicts," Mr. Golden says. Even in the majority of cases in which doctors and hospitals win -- the zero-dollar verdicts -- there are still legal expenses that insurers have to pick up, he adds.

Industry critics point to different sets of statistics. Bob Hunter, director for insurance at Consumer Federation of America, an advocacy group in Washington, prefers numbers generated by A.M. Best Co. The insurance-rating agency estimates that once all malpractice claims from 1991 through 2000 are resolved -- which will take until about 2010 -- the average payout per claim will have risen 47%, to $42,473. That projection includes legal expenses and suits in which doctors or hospitals prevail.

While the statistical debate rages, pregnant women adjust to new limits and inconveniences. Kelly Biesecker, 35, spent many extra hours on the highway this spring, driving from her home in Villanova, Pa., to Delran, N.J., so she could continue to use her obstetrician. Dr. Richard Krauss says he moved the obstetrics part of his practice from Philadelphia because malpractice rates had skyrocketed in Pennsylvania. Ms. Biesecker, who gave birth to a healthy boy on June 5, says Dr. Krauss was the doctor she trusted to guard her health and the health of her baby: "You stick with that guy no matter what the distance."

Dr. Krauss, 53, left Philadelphia last year only after his malpractice premium rose to $54,000, from $38,000, and then was canceled by a carrier getting out of the business, he says. After getting quotes of about $80,000 on a new policy, he moved. New Jersey hasn't been a panacea, however. His policy there expires July 1, and the carrier refuses to renew it. The doctor says he hopes to go to work for a hospital that will pay for his coverage.

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Updated June 24, 2002

86 Ohio St.3d 451

The STATE ex rel. OHIO ACADEMY OF TRIAL LAWYERS et al.

v.

SHEWARD, Judge, et al.

No. 97-2419.

Supreme Court of Ohio.

Submitted Sept. 29, 1998.

Decided Aug. 16, 1999.

Organizations and individuals filed original action in prohibition and mandamus, challenging constitutionality of legislative enactment amending statutes and rules relating to tort and other civil actions. The Supreme Court, Alice Robie Resnick, J., held that: (1) action was one to procure enforcement or protection of a public right, in which plaintiff's standing as citizen of State would be sufficient to confer standing; (2) enactment, through which General Assembly sought to reenact provisions previously held unconstitutional by Supreme Court, usurped judicial power in violation of doctrine of separation of powers; and (3) enactment violated one-subject rule of State Constitution, and was unconstitutional in toto.

Writs granted.

Pfeifer, J., concurred separately and filed opinion.

Moyer, C.J., dissented and filed opinion in which Cook and Lundberg Stratton, JJ., joined.

Lundberg Stratton, J., dissented and filed opinion in which Moyer, C.J., and Cook, J., joined.

1. Constitutional Law ⇐70.3(3, 4)

A court has nothing to do with the policy or wisdom of a statute, as that is the exclusive concern of the legislative branch of the government.

2. Constitutional Law ⇐47, 70.3(4)

Only judicial inquiry into the constitutionality of a statute involves the question of legislative power, not legislative wisdom.

3. Constitutional Law ⇐67

Constitutional duty of Supreme Court is to preserve the integrity and independence of the judiciary, and ensure that the judicial power of the State remains vested in the courts.

4. Constitutional Law ⇐67

Power and duty of the judiciary to determine the constitutionality and, therefore, the validity of the acts of the other branches of government is firmly established as an essential feature of the system of separation of powers. Const. Art. 2, § 32.

5. Constitutional Law ⇐52

Supreme Court will entertain a public action in the rare and extraordinary case where relators challenge the constitutionality of a legislative enactment on grounds that it operates, directly and broadly, to divest the courts of judicial power.

6. Mandamus ⇐23(1)
Prohibition ⇐15

Where the object of an action in mandamus and/or prohibition is to procure the enforcement or protection of a public right, the relator need not show any legal or special individual interest in the result to have standing, as it is sufficient that the relator is a citizen of State and as such interested in the execution of laws of State.

7. Action ⇐13

Before a court can consider the merits of a legal claim, the person seeking relief must establish standing to sue.

8. Action ⇐13

Concept of standing embodies general concerns about how courts should function in a democratic system of government.

9. Constitutional Law ⇐67

Judicial power to declare legislative enactments unconstitutional is not a superior power, neither one of veto nor of greater wisdom, but is rather a power burdened with a duty to decide in particular cases whether the Legislature has reached and passed the extreme boundary of legislative power.

10. Constitutional Law ⇐46(1)

Judicial function of determining constitutionality of legislative enactments does not begin until after the legislative process is completed and the void law is about to be enforced against a citizen to his prejudice.

11. Action ⇐13

In the vast majority of cases brought by a private litigant, question of standing depends upon whether the party has alleged such a personal stake in the outcome of the controversy, as to ensure that the dispute sought to be adjudicated will be presented in an adversary context and in a form historically viewed as capable of judicial resolution.

12. Constitutional Law ⇐42(2)

To have standing to attack the constitutionality of a legislative enactment, private litigant must generally show that he or she has suffered or is threatened with direct and concrete injury in a manner or degree different from that suffered by the public in general, that the law in question has caused the injury, and that the relief requested will redress the injury.

13. Federal Civil Procedure ⇐103.2

In federal judicial system, where requirement that injury must exist to confer standing is grounded in requirements of Article III, necessity of showing injury in fact prevails irrespective of whether the complaining party seeks to enforce a private or public right. U.S.C.A. Const. Art. 3, § 2.

14. Action ⇐13

Unlike the federal courts, state courts are not bound by constitutional strictures on standing, and with state courts standing is a self-imposed rule of restraint.

15. Action ⇐13

State courts need not become enmeshed in the federal complexities and technicalities involving standing, and are free to reject procedural frustrations in favor of just and expeditious determination on the ultimate merits.

16. Action ⇐13

When the issues sought to be litigate are of great importance and interest to the public, they may be resolved in a form of action that involves no rights or obligation peculiar to named parties.

17. Municipal Corporations ⇐995(1)

Statutes governing suits to restrain the misapplication of funds by municipal corporations merely codify doctrine allowing suits to enforce a public right without requiring showing that plaintiff has sustained an individualized injury with respect to municipal corporations, as doctrine exists independent of any statute authorizing invocation of the judicial process. R.C. §§ 733.56-733.61.

18. Constitutional Law ⇐42.3(1)

Fact that legislative enactment which amended numerous statutes and rules relating to tort and other civil actions had caused lawyers' organization to lose dues-paying members, and its members to lose fees and clients, did not give organization standing to bring private action challenging constitutionality of enactment.

19. Constitutional Law ⇐42.3(1)

Attorney's diminution in income traceable to legislation does not give attorney standing to bring private action challenging statute as unconstitutional.

20. Mandamus ⇐23(2)
Prohibition ⇐15

Action brought in prohibition and mandamus challenging constitutionality of legislative enactment which amended numerous statutes and rules relating to tort and other civil actions, in which General Assembly reenacted legislation which had previously been determined by Supreme Court to be unconstitutional and/or in conflict with rules promulgated by Supreme Court, was action to procure enforcement or protection of a public right, in which plaintiff's standing as citizen of State would be sufficient to confer standing, with no showing of any legally special individual interest in result required.

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Crowe v. Wigglesworth, M.D.
623 F Supp 699 (D.C. Kan 1985)

On a more fundamental level, this Court is not at all persuaded this discriminatory legislation is needed or that it will achieve its stated goals. Regarding need, defendants cavalierly refer to the "obvious" medical malpractice crisis justifying this legislation. What is apparently so clear to the medical profession, the insurance industry, their respective lobbyists, and the Legislature is a matter of deep and growing concern to this Court as well as a number of commentators and other courts across the country. Lin the legislature's haste to remedy the situation, it has overlooked or, more likely, ignored the fundamental cause of the so-called crisis: it is the unmistakable result not of excessive verdicts, but of excessive malpractice by health care providers.

Citizens of Idaho were treated to the spectacle of medical malpractice insurers insisting on legislative relief in part because of "*abnormally low earnings from investments*."...

The absurdity of that situation is akin to a products manufacturer requesting and receiving a limitation on liability because of low sales in a previous year. In 1976, the Travelers Insurance Companies faced billion dollar litigation instituted by a physicians' council after Travelers demanded a 486% rate increase; the company ultimately returned 50 million dollars in excess premiums. Carlova, *How Doctors Forced a Malpractice Carrier to Refund $50 Million,* Medical Economics, July 20, 1981, at 171, 172.

623 F Supp 699 at 706-707 (Emphasis supplied in original