DISCLAIMER

Electronic versions of the exhibits in these minutes may not be complete.

This information is supplied as an informational service only and should not be relied upon as an official record.

Original exhibits are on file at the Legislative Counsel Bureau Research Library in Carson City.

Contact the Library at (775) 684-6827 or library@lcb.state.nv.us.

ASSEMBLY BILL 320

Brief History
Development of the Medical Malpractice Crisis in Nevada

- In 2002, a medical malpractice liability insurance crisis of availability and affordability began to occur in Nevada and many other areas of the country. Because of skyrocketing insurance premiums, many Nevada physicians indicated they would have to close their practices or leave the state. Faced with an escalating concern about critical medical care, Governor Kenny C. Guinn called a special session of the Legislature to begin on July 29, 2002. His proclamation called for lawmakers to consider 11 different issues contributing to the malpractice insurance crisis.

- Medical care is an essential component to maintain a high quality of life. A community without adequate access to physicians may be expected to experience health care problems, which could include unnecessary suffering, poor health, and premature deaths. Any threat to the availability of medical care must be addressed promptly and vigorously.

- The time line and experience of Nevada is similar to that of many other states. Beginning in May of 2001, trauma physicians in Southern Nevada reported significant increases in malpractice insurance premiums, in some cases doubling the amount charged the previous year. The St. Paul Company, which insured approximately 60 percent of Nevada's doctors, filed for an 83.6 percent rate hike that was subsequently reduced by the Insurance Commissioner to 70 percent.

- Despite approval of the huge rate increase, St. Paul announced in September 2001 that it would not renew coverage for certain categories of physicians. By December 2001, the company had decided to exit the medical malpractice market nationwide. Shortly thereafter, physicians in Southern Nevada began announcing they would have to close their practices or leave the state due to the high cost of insurance coverage. Many of these physicians were obstetricians/gynecologists (OB/GYNs), who deliver nearly 12,000 babies a year in the state.

- The Nevada Legislature responded to the threatened shortage of heath care providers by establishing an interim subcommittee on malpractice insurance to study its causes and examine possible solutions.

- Meanwhile, the Division of Insurance, Nevada's Department of Business and Industry, held a public hearing and determined that conditions existed to justify

the creation of a Nevada Essential Insurance Association. On March 15, 2002, the Governor and the Insurance Commissioner issued an emergency regulation authorizing formation of a joint underwriting association that became known as the Medical Liability Association of Nevada (MLAN).

- After arduous study and debate, the Legislature enacted **Assembly Bill 1** (Chapter 3, *Statutes of Nevada 2002 Special Session*), which addresses some of the major issues involving our court system that have been identified as contributing factors in the unstable medical malpractice insurance environment. These changes include the imposition of a $350,000 cap on noneconomic damages, which is one of the lowest in the nation among those states that have such a cap.

ASSEMBLY BILL 320
(As Introduced)

OVERVIEW BY TOPIC

Following is an overview of the topics included in **Assembly Bill 320**. The topics are presented in the order in which they first appear in the bill.

PROHIBITION ON FEES FOR INCLUSION ON A PANEL OF PROVIDERS OF HEALTH CARE

If an organization establishes a panel of health care providers and makes the panel available for an insurer to use when offering health care services, or if an insurer establishes such a panel, **Assembly Bill 320** prohibits the organization from charging a fee to the insurer or the provider of health care for including the provider's name on the panel.[1]

If an organization violates this prohibition, it must pay the insurer or provider of health care twice the amount of the fee. In addition, a court must award costs and attorney's fees to the prevailing party.

Finally, **Assembly Bill 320** specifies that, in addition to any other relief, if an organization violates this chapter and an insurer offering health care services has a contract with or uses the services of the organization, the Division of Insurance must require the insurer to suspend performance under the contract or stop using those services until the organization complies with the prohibition on charging panel fees and refunds the panel fees to the providers of health care.

> ***Sections of the bill:*** This provision is included under the following sections of **Assembly Bill 320**. The affected *Nevada Revised Statutes* (NRS) chapter is indicated in parentheses.
>
> - **Section 1** (NRS Chapter 679A – General Provisions for Title 57 [Insurance])
> - **Section 40** (NRS Chapter 616B – Industrial Insurance: Insurers; Liability for Provision of Coverage)

CONTRACTS BETWEEN INSURERS AND PROVIDERS OF HEALTH CARE

Section 2 of **Assembly Bill 320** requires certain individuals and entities who contract with a provider of health care to provide health care to an insured under Chapter 683A (Administrators, Agents and Producers of Insurance) to include in the contract a schedule

---

[1] This section is similar to other prohibitions on panel fees under *Nevada Revised Statutes* (NRS) 689A.035 (Individual Health Insurance), 689B.015 (Group and Blanket Health Insurance), 689C.435 (Health Insurance for Small Employers), 695A.095 (Fraternal Benefit Societies), 695B.035 (Nonprofit Corporations for Hospital, Medical and Dental Services), 695C.125 (Health Maintenance Organizations), and 695G.270 (Managed Care).

setting forth the payments required to be made to the provider under the contract. This provision applies to an administrator; managing general agent or producer of insurance; and a health maintenance organization or nonprofit corporation for hospital or medical services authorized to act as an administrator of a program of health insurance.

In addition, **Assembly Bill 320** prohibits insurers from contracting with providers of health care unless the following requirements are met:

- ***Standard form for information regarding credentials***—The insurer must use the forms prescribed by the Commissioner of Insurance to obtain any information related to the credentials of a provider of health care.

- ***Disclosure of payment schedule***—The insurer must include in the contract a schedule setting forth the payments required to be made to the health care provider under the contract.

- ***Changes of material terms***—The contract must not contain any provision authorizing an insurer to amend the material terms of the contract unless the provider agrees to the amendment or the amendment is necessary to comply with state or federal law or accreditation requirements. If such an amendment is necessary, the provider may terminate the contract.

- ***Advance notice of certain programs***—The contract must not contain any provision requiring the provider to comply with quality improvement or utilization management programs or procedures unless the requirement is fully disclosed to the provider 15 days before the contract is executed. An exception is also provided if the amendment is necessary to comply with state or federal law or accreditation requirements. If such an amendment is necessary, the provider may terminate the contract.

- ***Patient information***—The contract must not contain any provision that requires or permits access to information related to an insured in violation of state or federal law concerning the confidentiality of such information.

Provisions waiving or conflicting with the above requirements are prohibited, and a contract that contains any provision in violation of the requirements is void.

Sections of the bill: These provisions are included under the following sections of **Assembly Bill 320**. The affected NRS chapter is indicated in parentheses.

- **Section 10** (Chapter 689A – Individual Health Insurance)
- **Section 14** (Chapter 689B – Group and Blanket Health Insurance)
- **Section 16** (Chapter 689C – Health Insurance for Small Employers)

- **Section 23** (Chapter 695A – Fraternal Benefit Societies)
- **Section 25** (Chapter 695B – Nonprofit Corporations for Hospital, Medical and Dental Services)
- **Section 30** (Chapter 695C – Health Maintenance Organizations)
- **Section 34** (Chapter 695G – Managed Care)

REVOCATION OF LICENSURE OR CERTIFICATION FOR FAILURE TO PAY CERTAIN PERCENTAGE OF CLAIMS

Under **Assembly Bill 320**, the Commissioner of Insurance must require evidence demonstrating that certain individuals or entities pay at least 95 percent of approved claims within 30 days after the date of approval and 90 percent of the total dollar amount for approved claims within the same time frame.

If the Commissioner, after a hearing, determines the individual or entity is not in compliance, the Commissioner must revoke their license or certificate of registration or authority. In addition, if revocation is required, a lesser form of penalty, such as a fine or a suspension, must not be substituted in lieu of the revocation.

Sections of the bill: This provision is added to existing statutes regarding the time frame for approval or denial of claims under the following sections of **Assembly Bill 320**. The affected NRS chapter is indicated in parentheses.

- **Section 3** (NRS Chapter 683A – Administrators, Agents and Producers of Insurance.)
- **Section 12** (NRS Chapter 689A – Individual Health Insurance)
- **Section 15** (NRS Chapter 689B – Group and Blanket Health Insurance)
- **Section 17** (NRS Chapter 689C – Health Insurance for Small Employers)
- **Section 26** (NRS Chapter 695B – Nonprofit Corporations for Hospital, Medical and Dental Services)
- **Section 31** (NRS Chapter 695C – Health Maintenance Organizations)

UNFAIR PRACTICES

Section 4 of **Assembly Bill 320** specifies that failing to comply with the provisions of NRS Chapter 695G (Managed Care) is considered to be an unfair practice under NRS Chapter 686A (Trade Practices and Frauds; Financing of Premiums).

INTERVENTION IN RATE FILING PROCESS

Currently, every authorized insurer must file with the Commissioner of Insurance all rates and proposed increases to those rates; the forms and policies to which the rates apply; supplementary rate information; and changes and amendments to that information (NRS 686B.070). **Section 5** of **Assembly Bill 320** provides that if such a filing is made that pertains to insurance covering the liability of certain health care practitioners[2], any interested person or entity may intervene as a matter of right in any hearing or proceeding conducted to determine whether the applicable rate or proposed increase complies with statutory standards and should be approved or disapproved.

In addition, **Section 7** of **Assembly Bill 320** prohibits the Commissioner of Insurance from exempting an insurer from certain rate-related provisions of Chapter 686B (Rates and Essential Insurance) with regard to insurance covering the liability of the health care practitioners.

APPROVAL OR DISAPPROVAL OF CHANGES IN INSURANCE RATES

Currently, NRS 686B.110 requires the Commissioner to consider each proposed increase or decrease in a line of insurance that is filed with the Division of Insurance. The Commissioner must disapprove the proposal if the Commissioner finds that a proposed increase will result in rates that do not comply with Nevada's standards for rates, including that those rates are not excessive, inadequate or unfairly discriminatory.

Section 8 of **Assembly Bill 320** revises these provisions to require the Commissioner to disapprove any proposal for an increase or decrease in rates that does not comply with Nevada's standards.

In addition, **Section 8** requires the Commissioner to disapprove proposals to increase the rate of insurance for certain licensed practitioners if the Commissioner finds the proposal is necessitated by any of the following:

- **Imprudent investment of money**—The insurer has experienced or is reasonably likely to experience capital losses, or diminished dividends, returns or income or any other financial loss as a result of the imprudent investment of money.

- **Fraud or willful misconduct**—The insurer, or any director, partner, officer, employee, agent or contractor of the insurer has engaged in:
  - Any fraudulent accounting practice;
  - Any form of corporate fraud or securities fraud; or

[2] **Sections 5 and 7** apply to practitioners licensed under NRS Chapters 630 (Physicians, Physician Assistants and practitioners of Respiratory Care); 631 (Dentistry and Dental Hygiene); 632 (Nursing); or 633 (Osteopathic Medicine).

- Any willful misconduct or wrongdoing that violates the laws or regulations of the United States, this state, or any other state.

- **Certain decisions involving litigation**—The insurer has experienced or is reasonably likely to experience losses or expenses as a result of the insurer or any director, partner, officer, employee, agent or contract of the insurer having engaged in litigation unreasonably or vexatiously after one or more opposing parties have made a reasonable offer to settle.

- **Decisions to insure practitioners with multiple judgments**—The insurer has experienced losses or expenses as a result of providing insurance to certain practitioners for whom the insurer has paid not less than 10 judgments or settlements with regard to the practitioner's breach of duty to the patient and a total of $5 million with regard to the judgments and settlements involved in these cases.

The Commissioner must adopt regulations, as necessary to carry out the provisions governing the approval or disapproval of proposals for changes in rates.

CONTINUING COVERAGE FOR CERTAIN PATIENTS WHEN A PROVIDER'S CONTRACT IS TERMINATED

Assembly Bill 320 requires that policies of health insurance must include certain provisions allowing treatment for an insured's medical condition to continue when a health care provider's contract with the insurer is terminated. These provisions are the following:

- The insured may continue to obtain medical treatment for the medical condition from a health care provider; and

- The health care provider is entitled to receive reimbursement from the insurer for the treatment provided at the same rate and under the same conditions as before the contract was terminated.

- *Time frame for coverage*—The required coverage must be provided until the later of either: (1) the 180th day after the date the contract is terminated; or (2) if the medical condition is pregnancy, the 45th day after the date of delivery, or if the pregnancy does not end in delivery, the date of the end of the pregnancy.

- *Exceptions*—An exception is provided if the contract was terminated because of the incompetence or misconduct of the health care provider and the insurer did not enter into another contract with that provider after the contract was terminated for these reasons.

- *Applicability*—Policies delivered, issued, or renewed on or after October 1, 2003, have the legal effect of including this required coverage, and any provision under the policy or its renewal that is in conflict is void.

- *Regulations*—The Commissioner of Insurance must adopt regulations to carry out these provisions.

  Sections of the bill: This provision is included under the following sections of **Assembly Bill 320**. The affected NRS chapter is indicated in parentheses.

  - **Sections 9 and 11** (689A – Individual Health Insurance)
  - **Section 13** (Chapter 689B – Group and Blanket Health Insurance)
  - **Section 24** (Chapter 695B – Nonprofit Corporations for Hospital, Medical and Dental Services)
  - **Sections 27, 28, and 32** (Chapter 695C – Health Maintenance Organizations)
  - **Section 33** (Chapter 695G – Managed Care)
  - **Sections 38 and 39** (Chapter 287 – Programs for Public Employees)

PROHIBITIONS ON CANCELING, REFUSING TO RENEW, OR INCREASING THE PREMIUMS FOR RENEWAL BASED UPON CERTAIN CLAIMS UNDER THE POLICY

Sections 18 and 19 of Assembly Bill 320 prohibits an insurer from canceling, refusing to renew, or increasing the premium for renewal of an insurance policy covering the liability of certain practitioners[3] for a breach of professional duty toward a patient under specified circumstances. Such action is prohibited as a result of a claim against the practitioner if the insurer:

- o Makes a payment with respect to the claim in an amount that exceeds the limit of the coverage under the policy;

- o Had the opportunity to settle the claim for an amount equal to or less than the limit of coverage under the policy; and

- o Did not settle the claim for an amount equal to or less than the limit of coverage under the policy.

[3] **Section 19** applies to practitioners licensed under NRS Chapters 630 (Physicians, Physician Assistants and practitioners of Respiratory Care); 631 (Dentistry and Dental Hygiene); 632 (Nursing); or 633 (Osteopathic Medicine).

REQUIRED DISCLOSURE OF CERTAIN UNDERWRITING DECISIONS

Upon request, **Section 20** of **Assembly Bill 320** requires an insurer to disclose to a practitioner the reasons the insurer declined to issue a policy covering the practitioner's liability for breach of professional duty toward a patient.[4]

Section 21 requires an insurer to disclose, upon the request of the practitioner, the reasons an insurer sets a premium for a policy at a rate that is higher than the applicable average rate, as determined by the Commissioner of Insurance. The section requires the Commissioner of Insurance to determine the average rate for the premiums, and authorizes the Commissioner to determine different average rates applicable to different types of policies, types and specialties of practitioners, and geographic areas of the State. The Commissioner must review and update the average rates not less than once every two years.

NOTICE OF WITHDRAWAL FROM THE MARKET IN NEVADA

Section 22 of **Assembly Bill 320** requires an insurer with more than 40 percent of the market in Nevada for a particular category of practitioner to comply with certain requirements before withdrawing from the market. At least 120 days before withdrawing, the insurer must give written notice to the Commissioner of Insurance and each practitioner within the applicable category. The insurer must also submit a written plan to the Commissioner providing for the insurer's orderly withdrawal from the market so as to minimize the effect of the withdrawal on the public generally and on the practitioners in the applicable category.

Assembly Bill 320 requires the Commissioner of Insurance to do the following under **Section 22**:

- Adopt regulations prescribing the form, content, and method of submission for the insurer's plan for withdrawal;

- Provide a procedure for determining the relative market share in Nevada among insurers with respect to policies of insurance issued to cover the liability of certain licensed practitioners[5] for a breach of professional duty toward a patient;

---

[4] **Sections 20 and 21** apply to practitioners licensed under NRS Chapters 630 (Physicians, Physician Assistants and practitioners of Respiratory Care); 631 (Dentistry and Dental Hygiene); 632 (Nursing); or 633 (Osteopathic Medicine).

[5] **Section 22** applies to practitioners licensed under NRS Chapters 630 (Physicians, Physician Assistants and practitioners of Respiratory Care); 631 (Dentistry and Dental Hygiene); 632 (Nursing); or 633 (Osteopathic Medicine).

- Specify the categories of licensed practitioners. Using data from the previous calendar year, the Commissioner must determine for each category the relative market share in Nevada among insurers. Such a determination is valid from April 1 to March 31 in the following year, without regard to any actual change in market share during that period.

- Provide notice of the applicability of this section to each insurer whom the Commissioner determines to possess more than 40 percent of the market in Nevada within a category of practitioner.

REQUIRE HEALTH MAINTENANCE ORGANIZATIONS TO COMPLY WITH LAWS GOVERNING TRADE PRACTICES, FRAUDS, AND FINANCING OF PREMIUMS

Section 29 of **Assembly Bill 320** amends NRS 695C.055 to specify that Chapter 686A (Trade Practices and Frauds; Financing of Premiums) applies to a health maintenance organization.

ACTIONS FOR DAMAGES FOR MALPRACTICE—DUTIES OF THE INSURER

Section 36 of **Assembly Bill 320** requires the defendant and the insurer to attend any settlement conferences required in actions for damages for malpractice.

In addition, if the defendant receives a settlement demand that is equal to the limits of the defendant's insurance policy, the insurer must inform the defendant of any applicable rights and obligations possessed by the defendant. These rights include, without limitation, the right of the defendant to obtain independent counsel at the insurer's expense.

If the defendant notifies the judge within 15 days of receiving the settlement demand that the defendant wishes to have independent counsel, the judge must appoint independent counsel to represent the defendant within 15 days after receiving the notice. The insurer must pay the fees for the independent counsel.

Section 36 also requires the Commissioner of Insurance to prescribe a form that may be used by an insurer to fulfill the requirement of informing the defendant of any applicable rights and obligations after receiving a settlement demand.

IMPOSITION OF LIABILITY ON AN INSURER FOR DAMAGES AWARDED IN CERTAIN MALPRACTICE CASES

In an action for damages for medical or dental malpractice, **Section 37** of **Assembly Bill 320** provides that an insurer is liable for the entire amount of damages to the same extent the defendant is liable to the plaintiff if:

C 10618

- The plaintiff made a settlement offer within the limits of coverage under the policy;

- The liability of the defendant was reasonably clear when the plaintiff made the settlement offer;

- The insurer, in contravention to the express instructions of the defendant, unreasonably rejected the settlement offer in light of all the surrounding facts and circumstances; and

- The court enters a judgment in favor of the plaintiff that imposes liability on the defendant for damages in an amount that exceeds the limits of coverage under the policy.

The court is authorized to determine the liability of the insurer in the underlying action for malpractice or in a separate proceeding.

Section 37 also specifies that an insurer found to be liable for the entire amount of damages to the same extent that the defendant is liable to the plaintiff is deemed to have acted in bad faith regarding its obligations to provide insurance coverage.

APPLICABILITY OF PROVISIONS AND EFFECTIVE DATE OF THE BILL

Assembly Bill 320 is effective on October 1, 2003. **Section 41** specifies that the amendatory provisions of the act apply to the following:

- A policy of insurance issued or renewed on or after October 1, 2003;

- An offer to issue a policy of insurance communicated to the applicant for the policy on or after October 1, 2003;

- A decision with regard to the issuance of a policy of insurance communicated to the applicant for the policy on or after October 1, 2003; and

- A cause of action that accrues on or after October 1, 2003.

DATA ON PLAINTIFF VERDICTS
CLARK COUNTY, NEVADA
TRIAL DATES 1996-2001

COURT CASE INFORMATION					MEDICAL MALPRACTICE SCREENING PANEL (Provided by the Division of Insurance and the NTLA[1])							DATA FROM EIGHTH JUDICIAL DISTRICT COURT'S JURY VERDICT FORMS AND MINUTES May 31, 2002[2] (If more than one plaintiff awarded damages, noted by "P1," "P2," etc.)									
	Case Name (Eighth Judicial District Court Case Number)[3]	Date Filed	Trial Date	Nature of the Case (Provided by NTLA)[4]	Panel No.	Date Filed	Date Decided	Panel Findings[5]	Results of Mandatory Settlement Conference (From the NTLA[6]) Judge's Evaluation	Plaintiff Demand	Defense Offer	Total Award	Total Economic Damages[7]	Total Pain & Suffering Award	Other (As Specified)	Past Wage Loss	Past Medical Expenses	Past Pain and Suffering	Future Wage Loss	Future Medical Expenses	Future Pain and Suffering
1	Brooks vs. HCA Health Svcs of NV (A335569)	July 94	Nov. 96		695	3/4/93	6/17/94	Does I-X: Jurisdiction Mesevista Hospital: No Nilsen: No Weisner: Undecided	N/A			P1: $75,000 P2: $75,000 Total: $150,000 According to minutes, jury found Weisner and Mesevista Hospital negligent in treatment of Brooks	Not specified		[redacted]	P1: $37,500 P2: $37,500 Total: $75,000			P1: $37,500 P2: $37,500 Total: $75,000		
2	Ross vs. Sparkhul (A312211)	Oct. 92	March 97	Penis erroneously injected with acid rather than Lidocaine; required reconstructive surgery	497	7/26/91	9/2/92	Sparkhul: Undecided Universal Health Svcs dba Valley Hospital: No	N/A	$300,000	$100,000	$379,926 According to special verdict form, jury found against Universal Heath Services, d/b/a Valley Hospital and Medical Center. Jury did not find against Sparkuh	$29,926	$350,000	[redacted]	$3,840	$26,086	$250,000	$0	$0	$100,000
3	Schmitz Jr. V. Ebert III, M.D. (A347451)	June 95	Nov. 98		826	2/17/94	4/26/95	Ebert: Undecided	N/A			$250,000 No specifics on negligence of parties	Not specified		[redacted]	$100,000			$150,000	
4	Estate of MaCrae vs. Jonak (A385143)	Feb. 98	Feb. 99		1301	4/15/97	1/27/98	Jonak: Yes				Verdict Sealed								

Compiled by the Research Division
Nevada Legislative Counsel Bureau
July 26, 2002

C Box 18

DATA ON PLAINTIFF VERDICTS
CLARK COUNTY, NEVADA
TRIAL DATES 1996-2001

COURT CASE INFORMATION					MEDICAL MALPRACTICE SCREENING PANEL (Provided by the Division of Insurance and the NTLA)							DATA FROM EIGHTH JUDICIAL DISTRICT COURT'S JURY VERDICT FORMS AND MINUTES May 31, 2002 (If more than one plaintiff awarded damages, noted by "P1," "P2," etc.)									
	Case Name (Eighth Judicial District Court Case Number)	Date Filed	Trial Date	Nature of the Case (Provided by NTLA)	Panel No.	Date Filed	Date Decided	Panel Findings	Results of Mandatory Settlement Conference (From the NTLA)			Total Award	Total Economic Damages	Total Pain & Suffering Award	Other (As Specified)	Past Wage Loss	Past Medical Expenses	Past Pain and Suffering	Future Wage Loss	Future Medical Expenses	Future Pain and Suffering
									Judge's Evaluation	Plaintiff Demand	Defense Offer										
5	Burney vs. Kramer (A330489)	Feb. 94	May 99	Permanent injury to baby at birth	652	11/16/92	1/18/94	Kramer: Yes Obstetrics & Gynecology: Jurisdiction Roe Corporations I-X[2]: Jurisdiction Women's Hospital: No		$1 Million	$200,000	P1: 5,350,000 P2: 171,000 Totals $5,521,000 Jury verdict form specifies recovery from Kramer with no reference to other defendants	$350,000	$5,171,000	[redacted]	$0	$0	P1: $1 Million P2: $171,000	$0	P1: $350,000	P1: $1 million
6	Cleveland vs. Capanna (A354647)	Jan. 96	June 99	Spine surgery at wrong level	939	11/16/94	12/7/95	Capanna: Undecided Granilich: No	N/A	$325,000	$0	$450,000 Adjusted Total: $405,000 Reduced by 10% for plaintiff's comparative negligence	Not specified		[redacted]	$100,000 Adjusted Total: 390,000 Reduced by 10% for plaintiff's comparative negligence			$350,000 Adjusted Total: $315,000 Reduced by 10% for plaintiff's comparative negligence		
7	Schrader vs. Swain (A320120)	June 93	July 99	Failure to recognize internal bleeding leading to death of 61 year old woman	724	6/11/93	6/16/94	Roe Corp 6-10[3]: Jurisdiction Brewers dba Heart Institute of NV: Jurisdiction Does I-5[3]: Jurisdiction Pauli: Yes Swain: Yes Thomas: No	$900,000	$900,000	$100,000	$4,250,000 Jury found Swain, Thomas, and Heart Institute of Nevada negligent	$2 Million Not specified	$2 Million	$2 Million Pain & Suffering	P1: $421,857 P2: $421,857 P3: $421,857 Total: $1,265,625			P1: $328,125 P2: $328,125 P3: $328,125 $984,375		
8	Puckett vs. Valley Hosp. Med. Ctr. (A376883)	Aug. 97	Dec. 99	Death of 70 year old man when negligently inserted breathing tube	1178	6/12/96	7/10/97	Valley Hospital Med Ctr: Yes Does I-X[2]: Jurisdiction Roe Corporations I-X[2]: Jurisdiction	$100,000	$225,000	$200,000	$1,169,000 Jury found against only defendant named in caption: Valley Hospital Medical Center	$0	$983,000	$186,000 Prejudgment Interest	$0	$0	$766,000	$0	$0	$217,000
9	Marquez vs. S. West Med. Associates (A352612)	Nov. 95	March 00	Failure to timely diagnose facial fractures resulting in permanent nerve damage and complex surgical repair	1268	1/21/97	1/8/98	Roberts: Yes Lin: Undecided Tan: Undecided	$650,000	$650,000	$200,000	$1.2 million No specifics on negligence of parties	Not specified		[redacted]	$400,000			$800,000		

Compiled by the Research Division
Nevada Legislative Counsel Bureau
July 26, 2002

C 14 of 18

DATA ON PLAINTIFF VERDICTS
CLARK COUNTY, NEVADA
TRIAL DATES 1996-2001

COURT CASE INFORMATION					MEDICAL MALPRACTICE SCREENING PANEL (Provided by the Division of Insurance and the NTLA)							DATA FROM EIGHTH JUDICIAL DISTRICT COURT'S JURY VERDICT FORMS AND MINUTES May 31, 2002 (If more than one plaintiff awarded damages, noted by "P1," "P2," etc.)									
	Case Name (Eighth Judicial District Court Case Number)	Date Filed	Trial Date	Nature of the Case (Provided by NTLA)	Panel No.	Date Filed	Date Decided	Panel Findings	Results of Mandatory Settlement Conference (From the NTLA)			Total Award	Total Economic Damages	Total Pain & Suffering Award	Other (As Specified)	Past Wage Loss	Past Medical Expenses	Past Pain and Suffering	Future Wage Loss	Future Medical Expenses	Future Pain and Suffering
									Judge's Evaluation	Plaintiff Demand	Defense Offer										
10	Gainey vs. Valley Hospital (A381935)	Dec. 97	March 00		1272	1/31/97	11/5/97	Valley Hospital Med Ctr: Yes Does I-X[3]: Jurisdiction Roe Corporations I-X[2]: Jurisdiction	$35,000	$120,000	$22,000	P1: $5,000 P2: $50,000 Total: $55,000 No specifics on negligence of defendants Valley Hospital Medical Center, Does I-X and Roe Corps I-X	Not specified		P1: $5,000 P2: $50,000 No breakdown	No breakdown			No breakdown		
11	Ruppert vs. Buzard (A347725)	June 95	April 00		890	7/28/94	5/10/95	Buzzard: No The Shearing eye Institute: Jurisdiction Shearing: Jurisdiction Reyes: Jurisdiction	N/A			$2 million No specifics on negligence of parties	Not specified		$2 Million No breakdown	No breakdown: No jury verdict form provided by court. Source: Minutes			No breakdown: No jury verdict form provided by court. Source: Minutes		
12	Makuch vs. Fremont Med. Ctr. (A387463)	April 98	April 00	Lost biopsy with potential diagnosis for malignancy in foot	1334	6/27/97	3/26/98	Nichoff: No Associated Pathologists Laboratory: Jurisdiction Fremont Medical Center: Jurisdiction	N/A			$130,000 Jury found against Fremont Medical Center, but in favor of Associated Pathologists Laboratories against the plaintiff	$64,000	$66,000	[redacted]	$4,000	$5,000	$33,000	$50,000	$5,000	$33,000
13	Rice vs. Torres (A357782)	April 96	July 00	"Botched" C-Section on 32 year old woman, first child, with post-op bleeding resulting in hysterectomy	973	2/22/95	3/25/96	Torres: No St. Rose Dominican Hosp: No Roe Corporations I-X[2]: Jurisdiction Does I-X[3]: Jurisdiction	N/A	$80,000	$0	$298,000 Jury found against Torres, but no specifics on any findings regarding Does I-XX or Roe Corps I-XX	$205,000	$0	$93,000 Prejudgment Interest	$0	$205,000	$0	$0	$0	$0

Compiled by the Research Division
Nevada Legislative Counsel Bureau
July 26, 2002

DATA ON PLAINTIFF VERDICTS
CLARK COUNTY, NEVADA
TRIAL DATES 1996-2001

	COURT CASE INFORMATION				MEDICAL MALPRACTICE SCREENING PANEL (Provided by the Division of Insurance and the NTLA)							DATA FROM EIGHTH JUDICIAL DISTRICT COURT'S JURY VERDICT FORMS AND MINUTES May 31, 2002 (If more than one plaintiff awarded damages, noted by "P1," "P2," etc.)									
	Case Name (Eighth Judicial District Court Case Number)	Date Filed	Trial Date	Nature of the Case (Provided by NTLA)	Panel No.	Date Filed	Date Decided	Panel Findings	Results of Mandatory Settlement Conference (From the NTLA)			Total Award	Total Economic Damages	Total Pain & Suffering Award	Other (As Specified)	Past Wage Loss	Past Medical Expenses	Past Pain and Suffering	Future Wage Loss	Future Medical Expenses	Future Pain and Suffering
									Judge's Evaluation	Plaintiff Demand	Defense Offer										
14	Fowler vs. Egedar (A352025)	Oct. 95	Sep. 00	Failure to timely diagnose femur fracture resulting in ischemia to lower leg with resulting nerve damage	901	8/23/94	9/26/95	Egedar: Yes University Medical Center: No Does 1-X[2]: Jurisdiction	$450,000	$450,000	$0	$1,237,220 Jury found against Egedar, who the only party named in the caption of the case	$284,720	$952,500	[redacted]	$174,720	$0	$140,000	$110,000	$0	$812,500
15	Supries vs. Poon (A385787)	March 98	Sep. 00	Adult circumcision with removal of 1" from center of penis	1344	7/21/97	3/9/98	Poon: Yes	$1 Million	$1 Million	$200,000	$515,000 Jury found against Poon, who the only party named in the caption of the case	$100,000	$415,000	[redacted]	$0	$0	$65,000	$0	$100,000	$350,000
16	Watts vs. Reliable Med. Care (A361891)	July 96	Feb. 01	Baby injured at birth with permanent brain damage leaving boy 9 months old mentally with need for lifelong care	Case No. 1: 1197 Case No. 2: 1410	Case No. 1: 7/31/96 Case No. 2: 12/17/97	Case No. 1: 7/29/97 Case No. 2: 7/23/98	Case No. 1: Turner: Yes Rogers: No Levy: No Cappiello: No Roe Corporations I-X[2]: Jurisdiction Does I-X[2]: Jurisdiction Christopher Rogers LTD: Jurisdiction Hooper: Jurisdiction Reliable Medical Center: Jurisdiction Mirchou: Jurisdiction Case No 2: Yin: No	$3.5 Million	$3.5 Million	$2 Million	$6 Million Jury found St. Ass Birthing Center and Hooper, R.N. 90% negligent, Turner, M.D. 5% negligent, and Levy, M.D. 5% negligent. Jury found Christopher Rogers, LTD and Yin not negligent	$5 Million	$1 Million	[redacted]	$0	$0	$500,000	$500,000	$4.5 Million	$500,000

Compiled by the Research Division
Nevada Legislative Counsel Bureau
July 26, 2002

C 16 of 18

DATA ON PLAINTIFF VERDICTS
CLARK COUNTY, NEVADA
TRIAL DATES 1996-2001

COURT CASE INFORMATION					MEDICAL MALPRACTICE SCREENING PANEL (Provided by the Division of Insurance and the NTLA)							DATA FROM EIGHTH JUDICIAL DISTRICT COURT'S JURY VERDICT FORMS AND MINUTES May 31, 2002 (If more than one plaintiff awarded damages, noted by "P1," "P2," etc.)									
	Case Name (Eighth Judicial District Court Case Number)	Date Filed	Trial Date	Nature of the Case (Provided by NTLA)	Panel No.	Date Filed	Date Decided	Panel Findings	Results of Mandatory Settlement Conference (From the NTLA) Judge's Evaluation	Plaintiff Demand	Defense Offer	Total Award	Total Economic Damages	Total Pain & Suffering Award	Other (As Specified)	Past Wage Loss	Past Medical Expenses	Past Pain and Suffering	Future Wage Loss	Future Medical Expenses	Future Pain and Suffering
17	Spradlin vs. Hito (A379411)	Sep. 97	March 01	Failure to rule out cauda equina syndrome resulting in decompression of disc and permanent nerve damage	1235	11/1/96	9/16/97	Hito: Yes Goebel: Yes St. Rose Hospital: Undecided	$1 Million	$300,000	$0	$1.5 Million Adjusted Total: $765,000 Reduced by 49% for plaintiff's comparative negligence	$450,000	$1,050,000	[redacted]	$30,000	$0	$250,000	$220,000	$200,000	$800,000
18	Fithaber vs. Slavis (A408739)	Sep. 99	March 01	Failure to diagnose cancer	1844	2/7/00	5/23/00	Slavis: Yes Roe Corporations I-X[2]: Jurisdiction Does I-X[2]: Jurisdiction	$750,000	$500,000	$0	$1,300,000 Adjusted Total: $650,000 Reduced by 50% for plaintiff's comparative negligence	$300,000 Adjusted Total: $150,000 Reduced by 50% for plaintiff's comparative negligence	P1: $250,000 P2: $100,000 $350,000 Adjusted Total: P1: $125,000 P2:$50,000 Reduced by 50% for plaintiff's comparative negligence	P2: $100,000 Loss of Consortium Adjusted Total: P2: $50,000 Reduced by 50% for plaintiff's comparative negligence	$0	P1: $200,000 Adjusted Total: P1: $100,000 Reduced by 50% for plaintiff's comparative negligence	P1: $200,000 Adjusted Total: P1: $100,000 Reduced by 50% for plaintiff's comparative negligence	$0	P1: 100,000 Adjusted Total: P1: $50,000 Reduced by 50% for plaintiff's comparative negligence	P1: $50,000 Adjusted Total: P1: $25,000 Reduced by 50% for plaintiff's comparative negligence
19	Ablock vs. Sunrise Hospital & Medical (A412884)	Dec. 99	May 01	Retained sponge requiring four follow-up needle aspirations	1668	4/20/99	11/29/99	Paugh: Yes Sunrise Hospital: Yes	$50,000	$30,000	$25,000	$78,047 Jury found against Sunrise Hospital and Medical Center, the only defendant named in the caption of the case	$3,047	$75,000	[redacted]	$0	$3,047	$75,000	$0	$0	$0

Compiled by the Research Division
Nevada Legislative Counsel Bureau
July 26, 2002

DATA ON PLAINTIFF VERDICTS
CLARK COUNTY, NEVADA
TRIAL DATES 1996-2001

COURT CASE INFORMATION					MEDICAL MALPRACTICE SCREENING PANEL (Provided by the Division of Insurance and the NTLA)							DATA FROM EIGHTH JUDICIAL DISTRICT COURT'S JURY VERDICT FORMS AND MINUTES May 31, 2002 (If more than one plaintiff awarded damages, noted by "P1," "P2," etc.)									
	Case Name (Eighth Judicial District Court Case Number)	Date Filed	Trial Date	Nature of the Case (Provided by NTLA)	Panel No.	Date Filed	Date Decided	Panel Findings	Results of Mandatory Settlement Conference (From the NTLA)			Total Award	Total Economic Damages	Total Pain & Suffering Award	Other (As Specified)	Past Wage Loss	Past Medical Expenses	Past Pain and Suffering	Future Wage Loss	Future Medical Expenses	Future Pain and Suffering
									Judge's Evaluation	Plaintiff Demand	Defense Offer										
20	Banks vs. Sunrise Hospital (A373928)	May 97	July 01	51 year old now in persistent vegetative state; $14,000/per month life care	1148	4/24/96	5/2/97	Kinavan: Undecided Sunrise Hospital: No Manning: No Re Corporations I-X': Jurisdiction Does I-X': Jurisdiction	N/A	$1 million	$500,000 Sunrise	$5,412,031 No specifics on negligence of parties	Not specified		$5,412,031 No breakdown	No breakdown: No jury verdict form provided by court. Source: Minutes			No breakdown: No jury verdict form provided by court. Source: Minutes		
21	Conn vs. Schiff (A415376)	Feb. 00	Aug. 01	Failure to diagnose myocardial infarction; sent home and died of cardiac rupture	1589	12/1/98	2/2/00	Schiff: Yes	$500,000	$500,000	$100,000	$2 million No specifics on negligence of parties	Not specified		$2 Million No breakdown	No breakdown: No jury verdict form provided by court. Source: Minutes			No breakdown: No jury verdict form provided by court. Source: Minutes		
22	Kay vs. Eftaiha (A385204)	March 98	Oct. 01	Sphincter damaged resulting in permanent incontinence; now wears diapers	1298	4/10/97	2/3/98	Eftaiha: Undecided	N/A			$1,520,800 Jury found against Eftaiha, the only defendant named in caption of case	$20,000	$1.5 million	[redacted]	$0	$0	$1 Million	$0	$20,000	$500,000
23	Debourg vs. SoWest Medical (A403525)	May 99	Oct. 01	Failure of nurse practitioner to diagnose cervical cord compression causing permanent damage to nerves in upper and lower extremities	Nursing case - No panel				N/A	$500,000	$500,000 10 days before trial	$4,564,128 Jury found Southwest Medical Associates, Inc. and Carol Jones negligent	$1,339,128	$3,225,000	[redacted]	$35,287	$0	$225,000	$700,000	$603,841	$3 Million
											TOTALs:	$39,329,352	$8,145,821	$17,137,500	Explanation of Difference: There is a $14,046,031 difference between the total for economic damages ($8,246,221) and the total for the pain/suffering awards ($20,037,100) versus the total award amount ($42,329,352) for the following reasons: (1) In many cases, the jury did not break out the award to specify economic and noneconomic damages; and (2) some of the awards involved prejudgment interest.								

C 117 of 18

Compiled by the Research Division
Nevada Legislative Counsel Bureau
July 26, 2002

DATA ON PLAINTIFF VERDICTS
CLARK COUNTY, NEVADA
TRIAL DATES 1996-2001

---

[1] Source: Nevada Trial Lawyers Association (NTLA).

[2] The Eighth Judicial District Court compiled the information in the chart from the jury verdict forms. In some cases, the jury did not break the award out between economic and noneconomic damages. In some cases, the award is only broken out in the general categories of future damages and past damages.

[3] The 1998 case of Fox vs. Donner (Court Case No. A327222) is not included in this cart as it involved an alleged intentional act, which is not generally covered by a medical malpractice carrier.

[4] Source: Nevada Trial Lawyers Association (NTLA).

[5] In providing the data regarding the findings of the panels, the Division of Insurance noted the following:

Jurisdiction – Means "no jurisdiction" in that case; that the named respondent was not a physician licensed under chapter 630 or 633 of NRS or a hospital licensed under chapter 449 or a dentist licensed under chapter 630 of NRS. Often parent corporations, medical clinics, nurses or physician assistants not employed by a hospital are named in the caption of the case. The MDLSP (Medical Dental Legal Screening Panel] was not given "jurisdiction" over those parties, so a "no jurisdiction' means that they are not subject to the provisions of chapter 41A of NRS. A legislative act is limited to its terms. We are very careful not to exceed our authority/jurisdiction.

Yes – Based upon a review of the materials submitted by the parties and the testimony of medical experts (if any were called), the panel finds that there is a reasonable probability of medical malpractice by the respondent and that the claimant was injured thereby.

No - Based upon a review of the materials submitted by the parties and the testimony of medical experts (if any were called), the panel finds that there is NO reasonable probability of medical malpractice by the respondent.

Undecided - Based upon a review of the materials submitted by the parties and the testimony of medical experts (if any were called), the panel finds that they are UNABLE to reach a decision on the issue of medical malpractice by the respondent.

In addition "Does" refers to unnamed (or "Doe") individuals, and "Roe" refers to unnamed corporations.

[6] Source: Nevada Trial Lawyers Association (NTLA).

[7] "Economic damages" includes wage loss and medical expenses.

C 18 of 18