MINUTES OF THE
SENATE COMMITTEE ON JUDICIARY

Seventy-third Session
May 3, 2005

The Senate Committee on Judiciary was called to order by Chair Mark E. Amodei at 9 a.m. on Tuesday, May 3, 2005, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Mark E. Amodei, Chair
Senator Maurice E. Washington, Vice Chair
Senator Mike McGinness
Senator Dennis Nolan
Senator Terry Care
Senator Steven Horsford

COMMITTEE MEMBERS ABSENT:

Senator Valerie Wiener (Excused)

STAFF MEMBERS PRESENT:

Nicolas Anthony, Committee Policy Analyst
Bradley Wilkinson, Committee Counsel
Barbara Moss, Committee Secretary

OTHERS PRESENT:

Chip Wallace, Director, Nevada Mutual Insurance Company
S. Daniel McBride, M.D.
Richard C. Bray, Executive Vice President, Director, Nevada Mutual Insurance Company
Michael J. Fischer, M.D.
Isaac Henderson
Bill Bradley, Nevada Trial Lawyers Association

Cliff King, Appeals Panel for Industrial Insurance, Division of Insurance, Department of Business and Industry
Robb Miller, Caladon Health Solutions
David Goldwater, Former Nevada State Assemblyman
Steven A. Gibson, Attorney

CHAIR AMODEI:
The hearing is opened on two informational items. One is the Committee's ongoing desire to remain updated and informed on medical liability insurance issues that were the subject of the 18th Special Session, valid activity and many hearings. Second, in terms of the Committee's continuing oversight regarding litigation matters in which the State is involved, there will be pharmacy issues involving the State Board of Pharmacy.

CHIP WALLACE (Director, Nevada Mutual Insurance Company):
There is a wonderful irony being here today because this is Nevada Mutual Insurance Company's (NMIC) third anniversary. We are at $30 million in premium and insured approximately 1,700 physicians at the end of the year. To my right is Richard Bray, who has over 20 years' experience in the insurance industry with medical malpractice. He sits among the executive staff of our management company, which heralds over 100 years of experience in the industry. Dr. McBride has practiced in Las Vegas for 20 years, successfully managing his business practices, as well as performing competently as a surgeon. We are happy to announce withdrawal of a 7-percent rate increase established last year, as well as offering our insured a 2.5-percent rate reduction.

S. DANIEL MCBRIDE, M.D.:
We are proud of the success of NMIC. Three years ago we had no plans to be in the insurance business; however, times and situations forced us to think in different ways. The physician community in southern Nevada put funds together and solicited funding from hospitals and individuals to allow us to go forward with the venture. Without it, many of us would not be here today.

The success of NMIC is based on excellent management and oversight from the physicians themselves. All the physicians are shareholders in the venture and any profit that comes to the company is returned to the physicians in rate reductions or rebates. We are not to that level yet; the fact we are able to offer a 2-percent reduction, rather than a rate increase, says a great deal. We

stemmed the tide in terms of rates, but actual rollback and return to rates affordable to many people is still years away. Physicians have been supportive and input from the Legislature is appreciated. We hope to go forward toward basic normalcy.

RICHARD C. BRAY (Executive Vice President, Director, Nevada Mutual Insurance Company):
What was originally set out three years ago is on the way to success. As a team with the provider community and all of Nevada, we are doing quite well. We have a broad cross section of insured from the Reno, rural and Las Vegas markets. We are pleased with the success. One of the key components of the structure of the company is its 100-percent ownership by the physicians of Nevada who have put their capital resources into it. We currently have over $5.8 million of capital and surplus in the company, and we are growing. We write insurance for all classes of doctors. Some insurance carriers, prior to pulling out of the State three or four years ago, nitpicked and specialized certain areas, thinking they were more profitable or less risky than others. Our company does not target that.

We are pleased with the rollout and success of our risk-management, loss-prevention programs. The company would not be a success without the participation and ownership of the individual insured who are the physicians. We are happy to celebrate our third year and thankful the Legislature assisted the State in allowing the establishment of NMIC and success for the physicians.

SENATOR CARE:
In the 18th Special Session in August 2002, a number of doctors, largely obstetrician-gynecologists (OB-GYNs) indicated they received medical malpractice insurance increases of 100 percent and higher. Other doctors, who were not OB-GYNs and had no malpractice suits filed against them, received rate increases just because they were in the medical profession and the underwriters did not want to take a chance. My impression was, if we passed A.B. No. 1 of the 18th Special Session (A.B. 1), which we did, lower rates would stem the tide and doctors would stop leaving Nevada. Then came Ballot Question No. 3, Keep Our Doctors in Nevada (KODIN). After the passage of Question No. 3, discussion ensued regarding what the Nevada Supreme Court would do because there would probably be a future case, which would take another 3 or 4 years.

In other words, in the summer of 2002, I thought we were looking at immediate relief; three years later, we are now looking at three or four years down the road again. Do you remember it that way? I do not recall anyone saying if the bill passed, we would still have to wait several years. Admittedly, in summer 2002, no one was committing to reduce rates by x percentage. I am bothered by the fact it looks as if it may be 7 or 8 years after the 18th Special Session before we see anything that allows us to rest assured doctors are here to stay. Please comment on my perception.

DR. MCBRIDE:
I have a slightly different recollection of the discussions at the time. From a physician's point of view, and after discussion with our attorneys, any real effect of the law, as well intended as it was, would still be some distance off. I believe between four and seven years was the expected projection. Many people expected immediate rollback, rate relief or rebates because the law passed, which was never the case. It still is not the case because the challenge has not yet arisen against A.B. 1 and the code initiative that passed Question No. 3 as well. We are hopeful that when the law is tested, it will hold and the efforts and intentions of those actions will be carried forward. It is unrealistic to think we will receive a rollback of significant dollars until three to four years later.

MR. WALLACE:
I recall the days of the 18th Special Session and elements of my testimony with regard to A.B. 1. Based on the advisory I received, I attempted to point out it was falling short. Specific details of A.B. 1 are present in today's law. The actuarial opinions received were more supportive of today's version than A.B. 1. I agree with Dr. McBride that we all have good intentions and understand today's laws provide more protection and do the job.

CHAIR AMODEI:
Nothing here today is a debate of the relative merit, or lack thereof, of people's opinions of A.B. 1 versus Question No. 3. Question No. 3 is the law of the land; could of, would of and should of is not relevant. What do you see as the prognosis for relief for physicians practicing in this State in the liability insurance context and the atmosphere as a result of Question No. 3? Please speculate on time frames as well.

MR. BRAY:
We recognize the work done by this Legislature to pass Question No. 3 and, from a liability perspective, the issues that needed to be resolved. As an insurance company, we constantly analyze the position of the company in regard to its reserves and pricing. We are governed to an extent by mathematical science. Three years ago, everyone was talking about actuaries and their determinations. Actuaries are paid to be wrong; they are either high or low but provide a range of accuracy for rating and pricing. Actuaries also determine whether adequate loss reserves have been posted. Actuaries get less involved in the tort situation, but more involved with historic cash flow and trends in inflation, which might be noneconomic and more societal. Although actuaries argue it is a science, there is much guesswork involved. Unfortunately, from a regulatory perspective, insurance companies must rely on actuarial information because it is the working basis and benchmark.

The NMIC has taken almost no rate action since 2001. Prior to Legislative changes, our actuary recommended a rate increase. A lot of it deals with medical trends. The NMIC is still too young in its development. There are 225 claims on its books at this time and no cases have gone to trial yet. Cases with merit were resolved with patients and providers. From an actuarial perspective, until tested, does NMIC give full credits that could be applied? The range is anticipated at another 15 percent to 20 percent when possible.

Regardless of medical inflation each year since 1991, NMIC did not take any rate action. In essence, there was a rate decrease because there was no action to increase. The data used to first file rates in 2001 was based on industry data which was chaotic at the time. What were the St. Paul Insurance Companies, Inc. doing with their losses, or were they just settling cases in order to leave the industry? What were other carriers, that are no longer writing business, doing with their loss reserves or premiums? The NMIC did a filing based off their rates. With each year, the NMIC has become more comfortable with the adequacy of the base rate it came out with in 2001 which has been confirmed through the Division of Insurance. The NMIC has worked closely with the Division of Insurance regarding pricing, medical malpractice, rates, reforms, structure and policy language, as well as a good understanding of where the medical malpractice industry is and where it is going.

When will rate relief occur? As soon as legislation was approved, NMIC consulted with the actuaries. The actuarial study indicated a range of

somewhere between nothing and 4 percent. The Board of Directors conservatively chose to reduce rates approximately 2.5 percent after taking 7 percent off the table resulting in a reduction of approximately 9.5 percent. The physicians never saw the 7-percent increase because it was filed and approved but never implemented. The good news was it was frozen before it was implemented. The NMIC pushed to get early reductions but hope to see larger reductions down the line. This does not offer much hope, but it took ten years for the Medical Injury Compensation Reform Act (MICRA) in California to recognize their reduction and the legislative body to provide enforcement. We test it every six months and discuss it quarterly at board meetings. There are ongoing actuarial studies throughout the year regarding ratings, reserves and/or adequacy.

SENATOR CARE:
Medical inflation is not just the cost of insurance, it is the cost of anything associated with the practice of medicine. I suppose it is a factor that must be considered in the rates at some point.

MR. BRAY:
Yes, it is. Workers' Compensation is based on company payroll, which is directly impacted by inflation. Inflation is considered by the insurance industry as a component of the pricing because it is already priced off an inflationary number. Therefore, inflationary trends are not taken into the rating because they are reflected in paid salaries. This is not the case with medical malpractice. The medical industry deals with actual claim development and medical trends that occur in the industry. Rates are not charged based on a physician's salary. Product liability, for example, is based off receipts of companies that monitor sales which are inflationary and already incorporated medical malpractice is not.

SENATOR CARE:
I am unsure whether any hard or convincing numbers were ever produced regarding doctors who threatened to leave due to the cost of medical malpractice insurance, or those who left for other reasons. The information I received was woefully inconsistent. If rates have not changed that much, how many doctors are leaving because they cannot afford to wait three or four years? Some doctors did not stay because of the latest increase, as opposed to doctors who gave A.B. 1 and Question No. 3 the benefit of the doubt and remained for another three or four years despite the fact they could not afford

the premium. Generally, how have doctors reacted and are they still considering leaving or remaining in Nevada?

DR. MCBRIDE:
Based on the trend and uncertainty at the time, a number of doctors departed, considered early retirement or reduced the level of their services. When A.B. 1 passed, there was a sense of relief that perhaps the madness had ceased. The doctors thought if they received a 40-percent increase the year before, they would not receive another 40 percent. They did not know how high the rates would go because it seemed the sky was the limit. Doctors could not adjust their practice patterns or receive insurance reimbursement from payers who offset the cost of the medical malpractice insurance increase. We worked in various ways to account for the sudden increases, which hit most practices hard, particularly OB-GYN and surgical. The situation has stabilized; however, $140,000 a year for insurance is an incredible amount of overhead. The difficulty is not doctors departing Nevada, it is recruiting and convincing them to remain. All the residents in the obstetrical department at the University of Nevada, Las Vegas (UNLV) left last year and moved to other places because the cost to practice in Nevada was exorbitant. We are having difficulty tracking surgical and subspecialist care which does not match the rate of growth in the State. On a national basis, the passage of KODIN and A.B. 1 puts Nevada in the forefront as a proactive State in dealing with the issue.

MR. WALLACE:
I met with chief executive officers of local hospitals in Las Vegas and Reno and observed physicians moving to the school of medicine due to the cost of operating a private practice. In particular, OB-GYNs, left the State and retired. A carrier in northern Nevada that insured quite a few physicians departed the State. Physicians in their 50s at the prime of their careers retired early because of tail cost. An encumbrance of $150,000 to pay for tail costs puts physicians in a position where they must consider how long they will continue to practice. If doctors go with a new insurance company, they know they will be hit with tail costs. If they retire now, they will save $150,000 which is conservative when considering crucial specialties. Things have eroded in southern Nevada. We meet with physicians, develop programs and segregate hospital, campus, general, surgical and emergency room calls. That is just one specialty. Physicians are retiring, leaving the State and private practice and moving into the school of medicine system.

DR. MCBRIDE:
One of the positive aspects of A.B. 1, which was almost a peripheral issue, was the establishment of trauma care under the same liability when there was a $150,000 cap. It allowed the establishment of a second trauma center at Sunrise Hospital and Medical Center in Las Vegas. The physicians and hospital practicing under that cap can now afford to provide a level of service so desperately needed in southern Nevada. The cap provided an element of protection not there before. Without the cap, there would be no way a private hospital could have a financially liable trauma center compared to one under the university or State system with a cap. Caps have worked every place they have been implemented. The law has not been tested yet, but establishment of the program is testimony to the wisdom of the Legislature.

SENATOR CARE:
County Line, a Clark County Medical Society newsletter, indicated the number of lawsuits rose each month from 2002 to 2003, in part, because of the way A.B. 1 was written. It allowed plaintiffs to leave the screening panel program and go directly to district court, and the number of lawsuits tapered off after that. The monthly comparison between 2003 and 2004 showed fewer lawsuits were filed the previous year, and fewer the first few months of 2005, compared with 2004. It appears fewer lawsuits are being filed in Clark County.

What is the reason? Part of me wants to say the plaintiff is thinking what his or her attorney is thinking that because of the new law, there is no point in a lawsuit and you should settle for what you can get. I would like to disclose that I am an attorney. I am not a plaintiff's attorney and do not do medical malpractice; nevertheless, I would like to know why fewer lawsuits are filed.

MR. BRAY:
Medical malpractice is known as a long-tail program wherein claims continue to come in up to 16 years later. In the case of infants, statutorily, it could come up 17 or 18 years later. The tail is unknown, and there is no way to predict how many claims could come in. In the first year of an insured, typically only 33 percent to 40 percent of claims are known and may not even be filed yet, but an incident may have occurred at that point. Senator Care is referring to gross numbers. Nobody can specifically say what causes people to file a lawsuit at a certain time versus another.

After looking at statistical data, actuaries indicated the frequency doubled in 2002 and 2003, which more than tripled 2001, before settling back to 233 percent of the 2001 frequency. From the actuarial perspective, the concern was whether they adequately priced for the increase in claims in 2001, 2002 and 2003. Did they need to make up the difference regardless of whether the claims started to decrease in one given year? We felt there might have been a rush to get some things in at the last minute. I do not know. We cannot speculate or answer the question; the issue was taken into account with the actuarial analysis to arrive at the rate decreases approved by the Division of Insurance.

DR. MCBRIDE:
The climate has changed. I am not sure how it is measured, but there is a sense of relief that legislation passed and things are not spiraling out of control. The physicians are patient and NMIC has not been badgered by the shareholders for immediate relief and huge reductions in rates. They understand it will be a while coming. The fact it has not gone the other direction has calmed the medical community as well as the legal community.

MR. BRAY:
The NMIC is running a 98 to 99-percent renewal with the physicians in the company which is phenomenal. In addition, NMIC insures over 70 OB-GYNs. The insured recognize and support the direction of the company under Dr. McBride and the Board of Directors. The biggest fear is giving too much back too quickly. We must avoid having to collect capital from a base because we made a mistake. We analyze the situation on a quarterly basis at the Board of Directors' level. We are asked tough questions. It is the doctors' money, they are Nevada doctors, and we want to be sure it is managed correctly. We do not want to go back to them and ask for more money. It is a balancing act, and, so far, we are doing well. We receive negative feedback from a small number of outside doctors who are not insured, but receive favorable feedback from current insured who say, "It is my money in the company, be careful with it."

MR. WALLACE:
Two weeks ago we had a roundtable discussion with our panel of attorneys. The consensus was the jury culture has changed to some degree, and they are now looking at the motor vehicle accident arena.

SENATOR CARE:
It seems to me the jury culture is still as scary and unpredictable as always. Dr. McBride probably cringes when he reads about claims against a doctor in the newspaper. I have the same reaction in regard to lawyers. A few months ago, an older graduate student at UNLV filed suit because he received a B grade instead of an A. The theory of his damages was it would hinder him from receiving additional scholarships and grants. I asked myself, what kind of an attorney would represent somebody like that?

There was a provision in A.B. 1 regarding frivolous lawsuits; that term is heard all the time. A fast-food obesity bill came before the Committee and frivolous lawsuits were introduced by respectable Legislators. Are you aware of any cases since A.B. 1 was passed in which a court found a lawsuit frivolous and the attorney had no basis in fact or law in filing the suit?

DR. MCBRIDE:
I cannot speak to that directly, but I will say getting a judge to say a lawsuit is frivolous is always a stretch, even if a case has no merit and would not go to trial. Cases have been filed that were outside the statute of limitations and clearly frivolous because they did not meet the standard, but those have been allowed to stand and go forward for a year or so of proceedings. That was an aside to the bill, and there was not much to it. The prospect of suing an attorney for bringing a frivolous case is not something most physicians want to pursue.

CHAIR AMODEI:
I have been corrected. This issue is not medical malpractice, it is medical liability. For purposes of this hearing, we will refer to medical malpractice as medical liability.

Recruiting and retention of doctors is a national problem. Federal legislation has been proposed, and other states are struggling with the issue. It is not just a Nevada problem. In terms of the atmosphere in Nevada, the Legislature, the Governor and the professional community responded, and legislation and initiative petitions were passed. No jurisdiction in the nation has been more proactive in its attempt to resolve the problem. The message has been positive in the last 48 months, and the issue has been at the top of the radar screen. Is there still concern that Nevada cares whether or not physicians remain, depart or want to come here?

MR. WALLACE:
Nevada is one of the most proactive states in the nation, but recruiting is not one of NMIC's core competencies. We gently boasted about the things we do well, and a couple members of our executive branch provided some technical advisory. There is still downward pressure on physicians coming into the State, including the tail burden and other issues affecting physicians. We try to assist when we can and, hopefully, the climate will improve.

DR. MCBRIDE:
I serve as Governor of the American College of Surgeons for the Nevada Chapter and, on a national level, am active with organizations that represent 60,000 surgeons of all types across the country. Medical liability is still the No. 1 issue with that body. Nevada was an example to the country in the last election because we passed our initiative with a 20- to 30-percent majority. Oregon had a similar ballot measure that lost due to one county near Portland. The country is still divided on the issue. Nevada was fortunate to have passed the initiative. Nevada is still an expensive place to practice. Although the climate has stabilized, it is not cheaper to practice in Nevada. It is still cheaper to go to California, Indiana and other states with tort reform.

CHAIR AMODEI:
Why is Nevada more expensive? Is it due to the size of your rating pool? Please give us more explicit reasons why Nevada is more expensive.

DR. MCBRIDE:
Clark County is twice as expensive to buy liability insurance than Washoe County. Does this mean doctors are twice as bad in Las Vegas than Reno? Are surgical complications higher? Is there a difference? The answer is the climate of personal injury attorneys and the feeding frenzy that went on for quite awhile which did not occur in northern Nevada or other parts of the country. A certain amount of regional difference exists. There is no reason why Nevada should not be an equal pool with equal rates across the board, but it is not.

MR. BRAY:
Speaking globally from having visited the reinsurance industry outside the State, the industry looks at Nevada from an investment perspective, and there are strong supporters of NMIC and its success. Attitudes have changed. Three years ago, the insurance industry was afraid to come into Nevada. They felt

they would be guaranteed massive losses because everyone was leaving, and it would not be worthwhile to come here. The reinsurers with whom we work and the support we have received over the last three years has gradually and substantially improved our reinsurance coverage and structure. Reinsurers in the industry consider Las Vegas separately from the rest of the State. They have no problem with rural Nevada or the Reno area nor does NMIC. We are in the business of paying claims which is the purpose of an insurance company. There is an interesting dynamic when dealing with a rapidly growing urban community. It causes stress on the physician community. If it was a perfect liability community, there still would be stress because of the number of new doctors required to keep up with the population trends. From an insurance industry perspective, the work being done will produce more competition and growth.

CHAIR AMODEI:
What percent of the market does NMIC have at this time?

MR. WALLACE:
We speculate NMIC has approximately 47 percent to 52 percent of the market.

CHAIR AMODEI:
Is it at that level throughout rural, northern and southern Nevada?

MR. WALLACE:
Northern Nevada has a stronger ratio of physicians insured than southern Nevada which is pleasing from a risk position.

MR. BRAY:
We track and analyze the market, and, at last report, NMIC was right on in regard to the split of doctors by percent in specialty between Las Vegas and Reno. If 60 percent of the doctors were in Las Vegas and 40 percent in Reno, that was also the premium split. We were pleased with that conclusion.

CHAIR AMODEI:
What is the interrelationship between capital and premium? You said if you missed on rates, you would have to return for more capital. I am trying to get a feel for relief in medical liability insurance premiums for doctors practicing in the State. If those are sources of keeping the company solvent or within guidelines set by the Division of Insurance, how does it work in terms of capital versus rate or premium?

MR. BRAY:
It is extremely important. Capital is the rainy day and mistake fund. Rates are developed based on a 70- to 73-percent loss ratio. The actuary develops the price charged within credits and debits based on the practice and individual feel. The underwriters understand the specialties and how medical practices differ; therefore, they may get credits or debits. More specifically, a practice may have two or three claims and not receive full claim-free discounts. Pricing is established with some fluctuation. Seventy-three cents of every dollar goes into the claims fund and is used to pay claims if the actuary is correct. If the actuary is wrong and there are no extra funds, the money comes from capital surplus of the company. If the actuary is correct, or wrong in the sense that less claims were paid out than expected, the money goes into capital surplus.

As capital surplus numbers increase, the funds become dividends and reduction of rates for the insured. Those funds are called redundancies in both claims and reserves and are tracked. There are a couple of components of capital. The industry regulates insurance companies on how much capital they must have to write a certain amount of premium. If we write $30 million of premium volume with $5.8 million of capital and purchase no reinsurance, it would not be a good thing. However, because we buy reinsurance, the regulations consider insurers liable for the risk exposures they assume. We take the gross premium of $30 million and lower that number when we look at our ratios.

We operate NMIC at a conservative ratio regulated by the Division of Insurance. We recently completed audits in which the Division of Insurance perused our claims, accounting, reinsurance structures and the whole program. They were comfortable with everything. Capital is important. If the capital fund reaches zero, you hope your actuary was wrong and what was set aside for reserves actually has some fat. To use a gambling phrase, you let it ride, hoping tort reform and other issues have a positive financial impact in order to get redundancies in the reserves. It is preparation for the worst-case scenario.

CHAIR AMODEI:
Am I correct in saying the difference between NMIC, as a mutual entity, as opposed to a regular insurance entity, is that NMIC has the capital option to make sure things are financially healthy, while the regular entity must do it through rates?

MR. BRAY:
That is correct. If there is no capital or surplus, the entity must rely on rates. The redundancy must be built on fluff or something for protection in the event things go wrong, or else take the risk and charge rates without capital, surplus or backup funds. A stock company is different because it is for profit; even when extra funds are set aside in reserve losses, we are talking about trading 30 percent annually which is money for people who put in capital. Under our structure, every nickel in the company is owned by the individuals insured. The extra fluff returns to the doctors in reduced rates as soon as we are able to bring down reserves from the first years. Within another couple of years, the actuary will know how many claims there were in the first year. The claims are "x" to a certain degree, and all the money sitting against those claims will not be required. Because there is more money than needed, the capital can be brought down; whereas a stock company, for a profit, will take it down and distribute it as profits.

SENATOR HORSFORD:
Testimony indicated a proposal to increase rates 7 percent, but then it was lowered to a 2-percent decrease. Where is the decrease? I understand the doctors with NMIC were saying to go slow and do not give a reduction now, based upon other issues occurring in the market. Please clarify that for me.

MR. BRAY:
The rate reduction of 2.5 percent was effective May 1. All renewals and new physicians are being quoted with the new rates. Some classes will have larger rate reductions, others less, based on where they are in the overall. Basically, the overall rate reduction for the entire group is 2.5 percent.

SENATOR HORSFORD:
Is that an average among doctors in Nevada?

MR. BRAY:
Not every doctor will qualify for every credit, just as every doctor will not qualify for every debit. There is always a plus or minus; our group has enough critical mass that our doctors will receive a rate decrease of 2.5 percent. Some doctors may have rate increases driven from either a change in their practice or claim scenarios that impacted their entity and resulted in losing a credit they

had before. In any event, the base rate everything starts from has been reduced immediately. At the end of the day, that rate reduction goes across the board for everyone.

SENATOR HORSFORD:
Are decreased rates the same in southern Nevada as northern Nevada? Based upon the dynamics, northern Nevada has fewer risks and you are able to pass on savings to those doctors. Does the decrease positively affect doctors in the south?

MR. BRAY:
Absolutely.

SENATOR HORSFORD:
What portion of the profit that NMIC receives from Nevada doctors is taken out of the State?

MR. WALLACE:
The NMIC is domiciled in the State of Nevada and owned by the doctors for the doctors. There has been rapid growth over the last three years based on values. The NMIC does not write foreign risk, and the profits remain with the State in this not-for-profit company. Likewise, built into the charter is the intent to keep the company going on through time in that it cannot be sold or turned into a for-profit entity.

SENATOR HORSFORD:
Is NMIC wholly owned as a Nevada corporation?

MR. WALLACE:
Yes, it is 100 percent wholly owned by the physicians.

SENATOR HORSFORD:
When you referenced the physicians in your group who do not want you to provide too much of a rate reduction too fast, were those the doctors to whom you were referring?

DR. MCBRIDE:
As chairman of the company, I am the one who used the term profit, which is a euphemism for excess money the physicians paid into the company for

start-up and to ensure solvency for years to come. It was not a one-shot deal to help a few people, nor was it designed to provide a source of income for any particular physician. The profits, as such, are returned to the physicians in terms of reductions over a period of years. We are patient. When deciding on the 2.5-percent decrease, we could have gone to 4 percent. Rather than going to the maximum, we felt it better to split it down the middle, reconsider it in six months or a year and bring down the rates incrementally. We want to be conservative and responsive to our insured who are us.

SENATOR HORSFORD:
As a not-for-profit corporation, if there is any money left over for a year that is not passed on to the doctors in the group in premium savings, what is done with that revenue?

MR. BRAY:
The money, which would be considered profit for a nonprofit entity, would go into the capital and surplus of the company. At the direction of the Board of Directors and shareholders, the money can be distributed in the form of dividends or rate reductions. Traditionally, companies that do this sort of thing tend to do it in the form of rate reduction because it becomes complicated to determine individual stock value for all the insured. The doctors would also have individual tax issues in receiving dividends. In any event, the doctors will probably prefer rate reductions.

MICHAEL J. FISCHER, M.D.:
I will present my written testimony (Exhibit C). In reference to a question regarding the OB-GYN specialty, 33.33 percent of OB-GYN residencies are filled across the board around the United States. Nevada is not the only state that has problems recruiting OB-GYNs, it is a problem nationwide. When only 33.33 percent of residency programs are filled around the nation, there will be a problem 5 years later. From the standpoint of the Nevada State Medical Association, there appears to be significant stabilization of physicians. I do not think the loss of physicians is taking place at the rate seen in 2001. Some physicians retired because it was time to retire, not because of medical liability. We are optimistic that Nevada will take heed to what happened in states such as California and Indiana. Testimony at today's hearing is encouraging.

Nevada has done an amazing thing in the process of dealing with the medical liability issue. We happen to be the benchmark for the country. There is a big

problem in 19 states, and Nevada was one of the crisis states. The question is whether or not Nevada will be removed from the crisis situation. I believe it will.

SENATOR CARE:
Did you mean to suggest that fewer medical students are coming out of medical school with the intent of going into OB-GYN? For example, in spite of MICRA, is California having the same problem recruiting OB-GYNs?

DR. FISCHER:
It is my understanding California does not have a problem with OB-GYNs, due to liability premiums OB-GYNs pay in California where MICRA has existed since the 1970s. The premium rates in the Los Angeles area were approximately $43,000 to $44,000 per year; there was a different number in the Las Vegas area. My statement was about residency programs, not in any one state, but the residency pool for the entire country. The number of medical graduates becoming OB-GYNs has decreased to a problem level, which is one of the reasons the American Medical Association has been fighting diligently to solve the problem nationwide. The whole country will have a problem, particularly in the 19 states where doctors do not want to practice OB-GYN due to the cost of liability insurance. In 2001, we saw an exodus of OB-GYNs from Nevada and assumed they were moving to states such as California or Indiana that have tort reform and a better marketplace insofar as the actual cost of medical liability premium for the year.

ISAAC HENDERSON:
Life and death is in the power of doctors who have control of lives and the medication it takes for us to live longer. Let them know medicine does not discriminate whether they are OB-GYNs, nurses, police officers, judges, or any jurisdiction or easement for a human being to get medicine. Let us not limit the decisions you make to only Nevada, but make them for the whole world. We must not look at the laws as nonprofit organizations. If the insurance companies say they have stock in the medical field and it is not public, tell them to bring it public so they can get more money to be financed so there will be no lack of funds to pay the insurance. If the insurance company does not want to take the nonprofit money and they have their own money and stock, let them reveal their stock to the medical field.

BILL BRADLEY (Nevada Trial Lawyers Association):
I submitted a packet of information for the Committee's perusal regarding the medical liability insurance issue (Exhibit D).

I would like to bring a different perspective to the discussion. It is a happy day for the insurance industry because they are making money. It is interesting that a doctor in Nevada 2 years ago, who said he or she had to leave Nevada because of a $100,000 premium, is now paying $9,750 and is happy. I find it disingenuous and I maintain, as many studies will show, that the crisis created was not a real crisis, and history will bear that out.

From the standpoint of the plaintiff, the injured victim, you must remember Question No. 3 did not limit their rights, it eliminated their rights. Respectable lawyers who used to do medical negligence will no longer do it. I have been asked how many cases I reviewed and took in a year. I probably took 1 or 2 cases out of 60 I reviewed in a year. Since passage of Question No. 3, I have been approached by four people in this Legislative Building to review medical malpractice cases. I told all four I could not help them because their case occurred after passage of Question No. 3. One was the wrongful death of a 57-year-old retired man, one was the death of a child and one was a significant injury to a housewife. Those cases are gone.

I was hoping to find out more about trends. There have been 43 defense verdicts in a row. I question the changing climate. I submit to you that since the closing of the trauma center, it is virtually impossible to get a verdict against a hospital or physician in Clark County. It is worse in Clark County than Washoe County. The trends should be positive for the insurance industry over the next couple of years because peoples' rights and the ability of a lawyer to take a case have been eliminated.

Is the size of the risk pool limited? We know if there is more in the risk pool, there is a better chance of spreading a significant risk among the larger percentage. Had the doctors in Nevada chosen to follow MICRA, they could have pooled with California and had a massive risk pool. Remember, in Question No. 3, joint and several liability was abolished. Even California did not abolish joint and several liability. Frankly, the doctors in Nevada are more at risk for personal and excess judgments than doctors in California. An insurance company in California that insures doctors would not want to take the same risk.

A comment was made that we must wait for constitutional issues to be decided. Big business did not wait for constitutional issues to be decided. Big business built a second trauma center in Clark County. Perhaps it was built on the back of Question No. 3, perhaps on A.B. 1, I am not sure. The fact of the matter is, big business did the same analysis and was comfortable with a $100-million or $200-million investment in a trauma center. However, until they get the word from the Nevada Supreme Court, insurance companies will hold off and provide incremental decreases.

Finally, I would like to discuss the perception of a 16-year tail. I have listened to that for the last 20 years in this Legislature and am frustrated by it. If we look at *Nevada Revised Statute* (NRS) 41A.097, every claim is cut off at the age of 10 years for people in Nevada, except for the rare occasion where a person is sterilized, wherein they have 2 years after the sterilization is discovered. In the 24 years I have practiced, I never read about a case at birth, I never was asked to handle such a case, and I wonder why we keep discussing the 16-year tail. If they are charging a 16-year tail, it is worth looking at to find how to shorten that tail. What would it do to take some pressure off the tail?

I do not feel like celebrating today. I am glad the doctors received a 2.5-percent increase. Considering peoples' rights have been abolished in this State, I would think it would be a more significant increase. I hope the Committee will continue to be active and ask about the trends, which are decreasing jury verdicts and medical expenses, and Las Vegas defense firms letting lawyers go because there are no claims. It is similar to the worker's compensation system which was balanced on the backs of injured people. You saw how it worked with worker's compensation; when the system became healthy, the benefits were restored.

If this becomes the predicted profit driver, you will restore patients' rights. Two years ago, the insurance industry was telling you they were running at 102-, 104- and 108-percent loss ratios, but were still able to make a profit on their investments. The NMIC just told you they are running at a 70- to 72-percent loss ratio. If that continues—and there is no reason to think it will not continue because of the draconian effect of these laws—there will be plenty of surplus to spread around.

SENATOR CARE:
The argument is the rates could be further reduced but for the uncertainty and constitutionality of the deprivation of right to trial by jury in A.B. 1 and Question No. 3. Attorneys want to take cases like this or juries are more inclined to go with the defense than the plaintiff. How and when would the Nevada Supreme Court get a case? Obviously, the Supreme Court would have to have a case before it could make a decision.

MR. BRADLEY:
That is an excellent question. The people who deserve the right to have that question decided are denied representation. There are only two kinds of cases in Nevada that justify involving a lawyer. One is a young person who is catastrophically injured with huge, lifetime medical expenses. Part of the fee of any lawyer who takes such a case will come out of the child's medical expenses because pain and suffering is now limited to $350,000. Second is the case of a substantial wage earner who is equally catastrophically injured. I do not know how cases involving the death of a child, a housewife or a retired person will get to the Nevada Supreme Court for a decision. The combination of fee limitations, the limitation on pain and suffering and the fact that the wrongdoer gets the benefit of the victim's health insurance makes it impossible to take those cases anymore.

A case should arise out of the trauma issue because it takes a cap of $50,000 to get the benefit of a sovereign immunity cap in a trauma center. From personal experience, it is hard to understand, but the Legislature did it. Resolving the constitutional issues will be difficult. It will take a unique case and somebody willing to say this is wrong and, regardless of the economics, the court must look at it. The initiative process and how it politicizes the judiciary greatly concerns me.

CHAIR AMODEI:
Please submit something in one page or less with respect to trends from the plaintiff's perspective.

MR. BRADLEY:
I will be happy to do that.

CLIFF KING (Appeals Panel for Industrial Insurance, Division of Insurance, Department of Business and Industry):
I will present my written testimony regarding the effect of tort reform on medical malpractice rates (Exhibit E).

CHAIR AMODEI:
Please relay the Committee's appreciation to the Commissioner of the Division of Insurance for doing as we asked; we will leave the Attorney General discussion for another day.

The informational hearing on medical malpractice insurance rates is closed and the informational hearing on pharmacy issues and related litigation is opened.

SENATOR CARE:
The Legislature is not restricted to examining, passing or rejecting legislation, and Committees are free to explore subjects of concern to the Legislature. Two years ago, it was an examination of who controls the dairy industry in the State. Earlier this year, an item was agendized to discuss litigation between the Colorado River Commission of Nevada and Nevada Power which came off the calendar because the case settled the day before the hearing. There is precedence for this sort of thing.

A year ago I attended a Legislative Commission meeting as an alternate. I knew nothing about the issue, but there was litigation between a wholesaler and the State Board of Pharmacy. It was unusual due to the fact that a deputy attorney general, who had been named in his personal capacity, was represented by private counsel and not the Attorney General. I thought that was unusual and brought it to the attention of the Chair. I do not know who is right or wrong in the litigation, but the situation is unusual enough to warrant a hearing. Keith W. Macdonald and Fred L. Hillerby, representing the State Board of Pharmacy, visited me in my office after the hearing some months ago and I also talked with Robb Miller on two or three occasions. I thought this was something the Legislature should address.

CHAIR AMODEI:
Since the Senate Committee on Judiciary is responsible for civil, criminal, administrative and juvenile procedure jurisdictionally, any litigation involving the

State should be pursued by the Legislature. This is strictly in a litigation context regarding due process procedures and things within the jurisdiction of this Committee.

ROBB MILLER (Caladon Health Solutions):
I am the president of Caladon Health Solutions since its inception in 1997. I am a pharmaceutical wholesaler and drug distributor licensed by the Nevada State Board of Pharmacy. I purchase about 95 percent of the products I distribute for manufacturers or major wholesalers and sell them to mail-service pharmacies and chains. Recently, we started selling through the local surgery center market in Las Vegas.

Caladon Health Solutions is a self-funded organization; the company does not have large lines of credit. I utilize distributors in Nevada and other states to extend terms to the big chain stores and those that require terms beyond what I can extend. I have gone above the letter of the law in terms of regulatory compliance and passed every state inspection, as well as every inspection by the U.S. Drug Enforcement Administration, with flying colors. I have never faced a formal investigation by the State Board of Pharmacy, nor any kind of administrative action. I am here today because of what I consider rogue actions on the part of Louis Ling, General Counsel, and Keith W. Macdonald, Executive Secretary of the State Board of Pharmacy.

I employed seven employees, but currently have four. The reason I cut employees was because I had to fund expensive litigation. I feel I have been harassed and interfered with beyond what is considered normal regulatory control. It became so severe I had to litigate to put an end to it. Because the State has unlimited resources and indemnified the general counsel and executive secretary, my settlement attempts have been ignored.

It is a complicated case, and I will not go into details; however, I will briefly relay the history of the case. I worked with the Board from July 2002 to January 2003, and supported their efforts to protect public health, which was a reflection on my business and industry. A regulation was proposed that I considered bad for my business. I began to negotiate with the general counsel and executive secretary. In January 2003, after seven months and several

thousand dollars in legal fees, Mr. Ling, General Counsel, decided he was tired, did not want to further negotiate and encouraged the Board to enforce the particular regulation.

Within a few weeks, with the permission of the general counsel, Mr. Macdonald, Executive Secretary, sent a letter to Cardinal Health, one of the major wholesalers who supplied approximately 30 percent of my products. The letter claimed I did not comply with State regulations which put me on a black list. I lost the account which resulted in lost customers. I feel it was a renegade action because there was no investigation, no accusation and no administrative action. I was never accused of wrongdoing, but appeared on a list of those who potentially might not be complying with Nevada regulations. In my opinion, Messrs. Ling and Macdonald ran loose with the law and showed little respect for State law.

After much red tape, Cardinal Health performed a site inspection and reevaluated Caladon Health Solutions which the Board never did outside of annual inspections. After inspecting my business, Cardinal Health decided Messrs. Ling and Macdonald were wrong and my account was reestablished.

I litigated because I was afraid they would send more letters of a similar nature to other vendors, and I would lose my business. What should they have done before sending letters of this nature? They should have investigated my company and filed the appropriate administrative action. In my opinion, they acted outside regulatory authority.

DAVID GOLDWATER (Former Nevada State Assemblyman):
Mr. Miller asked me to get involved, and I agreed to do so. I will relate to you a metaphor to help you understand the issue. You, Chair Amodei, are under the jurisdiction of the Commission on Ethics as an elected official. The executive director of the Commission decides you are doing something wrong. Rather than going through proper channels to start an investigation, she goes to your district and tells your most influential constituents, “Senator Amodei may be a shady character,” and then walks away. What would you do? Your only recourse would be to take her to court and pay your own legal costs. A small businessman should not have to take regulatory civil action with every dispute.

This is a State agency; therefore, you have recourse. There are checks and balances and budget oversight, and executive boards can be checked when they are on State time and using State resources. Executive Branch agencies, particularly boards and commissions, have changed. Formerly, there were line item budgets; board and commission budgets are now submitted in a big bucket and the Department of Administration peruses them. Larger items are approved by the State Board of Examiners and rubber stamped.

Approval and rubber stamping is not helpful in these matters. The cost of private litigation for a small businessman against the State is thousands of dollars. This hearing is a citizen's recourse, as well as the check and balance and Legislative oversight.

SENATOR WASHINGTON:
Was Mr. Miller afforded due process or administrative action?

STEVEN A. GIBSON (Attorney):
I submitted a document entitled "Documentation With Respect To Informational Hearings Regarding Pharmaceutical Wholesalers' Action Against Ling/Macdonald" (Exhibit F, original is on file at the Research Library).

I am legal counsel on behalf of Caladon Health Solutions and other plaintiffs that brought action against Louis Ling, General Counsel, and Keith W. Macdonald, Executive Secretary, in their personal capacity. As Mr. Miller eloquently stated, there was no due process, no investigation, no accusation and not even a hint from Messrs. Ling or Macdonald that Caladon Health Solutions did anything wrong.

An interesting aside is, at the time the Cardinal Health communication was made by Mr. Macdonald against Mr. Miller, an action was brought against another of my plaintiff clients, a company named IPD Inc., which was later dismissed by the Board. Subsequently, action was brought against another of my clients, FMC Distributors of Nevada, Inc. (FMC). I went to court on behalf of FMC, and the State court found no wrongdoing on the part of FMC with respect to any contempt action.

We are not here to litigate the case. We put a narrow question before you: can individual employees go outside the system, send out communication to a Fortune 500 company, potentially enable the destruction of a private business in Nevada, the loss of livelihood of employees, then hide behind the State's revenue coffers and conduct a massive defense when citizens of the State are left helpless by that conduct? This is not an action against the State Board of Pharmacy, nor is it an action taken by Messrs. Ling and Macdonald under the authority of the Board because the Board did not know anything about it. This is their private behavior which is indemnified by the State.

We have come before this Committee to say, let us bring rationality to the process. Litigation has its own dynamic. Even if Messrs. Ling and Macdonald believe they only have a 2-percent level of success, they might as well have the State pay for their defense and buy that 2-percent chance to win the day. In our perspective, that is illegitimate with respect to not engaging in a legitimate settlement discussion.

I will give you an example of what occurred in this case in terms of expense. Senior U.S. District Judge Lloyd D. George, District of Nevada, entered a preliminary injunction against Messrs. Ling and Macdonald. After entry of that order, Messrs. Ling and Macdonald wanted to relitigate the entry of the preliminary injunction saying it was inappropriately applied. My client spent a lot of money to relitigate it. Judge George said, no, the preliminary injunction should stand. We are here today with this concise appeal to say there should be a check and balance, as Mr. Goldwater indicated. You are our hope that my clients do not have to spend more money to defend themselves against the rogue behavior of private citizens, Messrs. Ling and Macdonald, acting under the color of State authority, but outside the scope of their employment.

CHAIR AMODEI:
To narrow things for continuance and further assuage anyone's fears, I have perused Exhibit F, and it will be part of the record for this legislative day. We will not attempt to litigate whatever is going on in federal court. The Committee has jurisdiction over chapter 233B of NRS, which is administrative procedures, and will look into whether this was adverse action which is a term used in the chapter. I will request a general briefing from Mr. Wilkinson, Committee Counsel, as to whether the Committee should look into the matter and add to

definitions. This will also dovetail with the presentation of the Attorney General regarding the Colorado River Commission of Nevada. What are the procedures, authorities and protocols for paying outside counsel costs in any context, not specifically this case, but in a global sense? Specific answers can be obtained regarding these types of queries.

The meeting is closed on the informational hearing on pharmacy issues and related litigation.

The hearing is opened on Assembly Bill (A.B.) 421 and A.B. 550. The Chair would entertain a motion to rerefer both bills to the Senate Committee on Transportation and Homeland Security.

ASSEMBLY BILL 421: Provides that once person has been convicted of felony for operating vehicle or vessel while under influence of alcohol or controlled substance, any subsequent violation is treated as felony. (BDR 43-473)

ASSEMBLY BILL 550 (1st Reprint): Makes various changes concerning offenses involving use of intoxicating liquor and controlled substances. (BDR 43-832)

SENATOR WASHINGTON MOVED TO REREFER A.B. 421 AND A.B. 550 TO THE SENATE COMMITTEE ON TRANSPORTATION AND HOMELAND SECURITY.

SENATOR CARE SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR WIENER WAS ABSENT FOR THE VOTE.)

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CHAIR AMODEI:
Having discussed the pharmacy issues and related litigation, there is no further business to come before the Committee; therefore, the hearing is adjourned at 11 a.m.

RESPECTFULLY SUBMITTED:

Barbara Moss,
Committee Secretary

APPROVED BY:

Senator Mark E. Amodei, Chair

DATE: