MINUTES OF JOINT HEARING

SENATE AND ASSEMBLY JUDICIARY COMMITTEE

FEBRUARY 15, 1977

Senate Members present:	Assembly Members present:
Chairman Close	Chairman Barengo
Senator Bryan	Assemblyman Hayes
Senator Ashworth	Assemblyman Banner
Senator Foote	Assemblyman Coulter
Senator Gojack	Assemblyman Polish
Senator Sheerin	Assemblyman Price
Senator Dodge	Assemblyman Ross
	Assemblyman Sena
	Assemblyman Wagner

The meeting was called to order by Senator Close at 8:06 a.m. This was a continuation of the meeting on February 14, 1977 which covered the medical malpractice legislation before these committees.

Bill Isaeff of the Attorney General's office handed out a proposed amendment to SB 185 which he had discussed at yesterday's meeting. This proposed amendment was read to the committee and is attached as Exhibit A. A brief discussion on this followed considering this and possible alternatives.

Peter Newman of the Nevada Trial Lawyers Association asked if SB 185 would prohibit a patient from access to his own records for ten days. Mr. Isaeff stated that it would not, that this was only in regard to official investigations and not to patient access.

Fred Hillerby of the Nevada Hospital Association questioned if the bill could be amended so that not just everyone could request the records of the patients to be copied. Senator Close stated this could be drafted into sections a and b on page 2, section 7.

Senator Bryan asked Mr. Hillerby what he felt as to the costs of copying, in the hospitals, of patient's records. Mr. Hillerby stated he wasn't familiar with those costs. Mr. Barengo stated he has a bill being drafted at this time which concerns rates for duplication of records. Mr. Hillerby stated he would check into what was currently being charged in the hospitals for duplicating records.

SB 187: Peter Newman stated that his association is opposed to the concept of SB 187 on a number of grounds. Their primary objection to this bill is that they felt that it would render and deliver into the hands of the casualty insurance company involved in the case of medical negligence, the rights of the plaintiff to determine his own destinty with that that is rightfully his or hers. He stated this would only add to the vast powers already used by the insurance companies and allow them to benefit from the interest on this money as well as make the plaintiff have to go to the insurance on a regular basis, and be at their mercy, for their payments. They felt it would be a tremendous windfall and bonanza to the casualty insurance company if this bill passes. He stated also that he felt this bill was founded on good intentions, however, that a good lawyer could take this settlement and advise his client as to the proper investments to make to insure this money would be

Continuing Mr. Newman's testimony on SB 187:
safe and available for future expenses without allowing the insurance companies to retain it and benefit from the interest on that money. He pointed out that though the insurance companies argue that if this method is followed there will be a reduction in costs of insurance, they have not come forward with the statistics to support this contention. He then gave to the committee a newspaper article concerning the premiums versus the claims of the Argonaut Insurance Company which is attached as Exhibit B. After discussing the article, he stated that it was the associations contention that the insurance companies should not be able to hold on to this money and dole it out without allowing for the interest they have made on that money. And, indeed, the insurance companies would not have to go broke by doing so on settlements that delt with "future damages". Senator Close asked Mr. Newman to explain "future damages". Mr. Newman explained "future damages" in any case are generally the most important damages to the claimant. They are such things as future loss of earnings, future loss of medical bills and sometimes, more importantly, future disability or pain and suffering. These damages can be economical or non-economical and depend greatly on the age of the person involved and how much longer they might live with what has happened to them.

Senator Dodge asked if this bill only applied to the economical losses of the injured party. Mr. Newman stated that it had been amended to include only the economical aspects, yes. Senator Dodge and Mr. Newman then discussed how an early death in relation to the estimated life span on settlement might effect the insurance company as a windfall if the insurance company was allowed to keep this money and administer its disbursement. Mr. Newman then explained why he felt that the money in a settlement belonged to the client and his heirs and should not be allowed to benefit the insurance company on structured payments. Senator Dodge then asked if Mr. Newman didn't feel that by allowing these unpaid expenses to remain with the insurance companies, rather than paying them to the heirs, that this would be an effective was to, indeed, reduce premiums. Mr. Newman said that it might be if it were tightly controlled and monitored, however, 99% of the insurance of the insurance problems are not subject to this kind of monitoring because there is no mechanism at this point to find out what the insurance companies are doing with the money.

Senator Sheerin asked Mr. Newman, if this bill were passed, if there wouldn't be three separate awards in each case; one for special damages, doctor bills, loss of wages and other economic losses and one for general damages which would be the intangible pain and suffering (both covering things in the past and would be paid in one lump sum) and lastly, future damages for the economic future losses, including medical care, care and custody and and the replacement of income). In other words, the jury would have to be given instructions for all three awards. Mr. Newman said that this was true. That the award would have to be by special verdict.

Continuing Mr. Newman's testimony on SB 187:
Mr. Newman stated that an economist in these cases is brought in to testify as to how much should be awarded to the injured party as to the future projected costs. Senator Sheerin then asked if it wouldn't be better to simply put this on the basis of whatever medical costs, etc. would be needed in the future, and living costs, would be paid by the insurance company, thus taking out the intangibles. Mr. Newman replied that this would in effect make the insurance company into a disbursement agency which would have to rule on each separate request and there would never be and end to these cases. He stated one of the best points of the current tort law is that when the cases is over it is finished and you have disposed of that particular piece of legal business. Mr. Newman said he believed that it is hard enough to deal with the insurance companies and get them to pay one time now, and that it would be extremely difficult to contend with working with them on an item by item basis if it were allowed to be the determining agency in this type of a situation.

Mr. Ross brought out what happens in the situation where the injured party outlives what the jury has estimated as far as the settlement amount is concerned. Mr. Newman stated that this was one of the risks that was run and that if this did happen, it would be a windfall to the insurance company and the injured party had no recourse for additional payment.

Seantor Bryan then asked if there would be a difficulty, in a structured payment system, proving to an insurance company who was handling disbursement of these funds, if the medical bills which were submitted would be directly related back to the original injury or if the insurance company would try to relate them, perhaps, to a recent medical problem. Mr. Newman replied that it would, indeed, be difficult to sometimes prove that a current treatment was a side effect of the original injury and that some doctors might be very hard to pin down even if they had stated to the injured party that they believed the problem to be related to the original injury. In his opinion this would only lead to more litigation between the insurance company and the injured party.

Mr. Barengo asked why the benefit can be decreased but never increased in a settlement of this sort. Mrs. Hayes stated that she did not remember covering this point in the Interim Committee. Seantor Close suggested this be reviewed by the Interim Committee to make sure the bill before the committees are the same as the Committee had proposed.

Dr. John Callister was next to speak on SB 187. He stated this is one of the pieces of legislation which has been proposed which will attract the private insurance industry back into writing negligence insurance in Nevada. He stated he did not feel that the insurance companies had as much control over settlements of this type as Mr. Newman had indicated they did. He stated, in addition, that there should be some kind of interest concession for interest earned if the insurance companies have benefit of the monies.

Continuing Dr. Callister's testimony on SB 187:
Mr. Ross asked Dr. Callister if he felt, rather that relating the compensation to the interest factor, if it could be related to the inflationary factors prevalent during the time of payment. Dr. Callister stated that this would be satisfactory perhaps, but, that if it made it so arbitrary that the actuarial tables could not be used accurately that it would defeat the purpose of the bill, to attract companies back to underwriting. Discussion on this continued briefly.

Mrs. Wagner asked the doctor if other states which had this type of legislation had indicated any significant changes in the attitudes of the insurance companies to carry malpractice insurance. The doctor stated there were no indications to date but, that he did not feel they had been in effect for a long enough period to know. He stated thirteen states have introduced periodic payment type legislation and the feed back from the insurance companies indicate this is valuable to them in those instances, although the end result cannot be estimated at this time.

A brief discussion of the ability to increase monthly payments ensued and it was brought out that the court costs to increase the monthly allowance amount would be awarded to the successful party however, once the maximum settlement was reached, that would end the payments regardless of how much the installment was.

Robert Byrd, President of the Nevada Medical Liability Insurance Association, was next to speak on SB 187. He stated he felt the insurance companies could basically live with this bill. The one point he brought out that, he felt, would weaken the position of of the insurance company in a court settlement was that in section 3, paragraph 1, of this bill the if the defendant is insured against liability for such future damages, the order shall not be entered until his insurer is made a party of the action. Senator Close asked Mr. Byrd how the insurance company could be made to make settlement if they were not brought into the case. Mr. Byrd replied that he did not object to being a part of the settlement or the agreement but, he did object to being made a party to the actual action in court. Being named a defendant defeated the position of the insurance company. Senator Close pointed out that the way the bill read, that the insurance company would not be brought into the case until after the suit had been tried and the order is about to be entered. Mr Byrd said at that point they would have no problem.

Senator Close then asked Mr. Byrd what he felt would be sufficient security to guarantee a $100,000 judgement, payable over twenty years. Mr. Byrd replied that in the medical malpractice field he felt there should be $100,000 in cash or securities set aside in a trust or however the court orders. Continuing in this area, Senator Ashworth questioned Mr. Byrd as to how the insurance companies set up their reserves for these payments. Mr. Byrd stated that the entire settlement amount was set up as a bookkeeping reserve.

Continuing Mr. Byrd's testimony:
Senator Ashworth then asked what ratio of money had to be liquid assets available for payment. Mr. Byrd stated only enough to meet, say, six months payments. He felt this was proper so long as the reserves were set up in the accounting system properly. Senator Ashworth then stated that because these reserves are gaining interest that there should be some provision for the injured party to benefit, at least in part, from these increases. Mr. Byrd said that in most structured settlements there is some provision for this type of thing. Senator Ashworth asked Mr. Byrd if he felt this bill could be improved (because it does not provide for this) by putting a proportionate amount, of the return of the insurance company, toward increasing the award of the injured party. Mr. Byrd answered that he felt this was the way that they are being settled presently even though this particular bill may not set it out as such.

Senator Dodge of Mr. Byrd if there would be any objection to putting the entire settlement into a separate trust, to protect the injured party against the insurance company going out of business. Mr. Byrd stated that under the trustee, that the balance would still revert back to the insurance company and that was better that paying it out in a lump sum payment and they would not object to the trust.

Mr. Byrd and Senator Close then discussed who would handle the investments of these trusts, whether it would be a broker or other agent or the insurance company. Mr. Byrd stated that if the insurance company did not control the investments and the fund went broke they would not want the injured party trying to collect the balance of the award from the insurance company. It was thought that this point was not covered well in the bill as it is now.

Mr. Ross discussed with Mr. Byrd what happens when the injured party dies before the limits of the settlement are reached. And after this discussion Mr. Ross made the observation that the ultimate impact of this was to protect the insurance company from having to pay the full settlement if the injured party died and no longer needed sustenance payments. And, on the other hand, it does not provide for the additional benefits which would be needed if the injured party outlived that estimated in the original settlement. Mr. Byrd stated that this was correct. In continuing, Mr. Ross, asked Mr. Byrd if it were not correct that as it stands now, both parties bear the risk of a windfall to the other party and as it is proposed, the new bill would take the risks away from the insurance companies (guarding them from having to pay full settlements in the event of death), yet, leave that risk of future uncovered expenses with the injured parties. Mr. Byrd said that, yes, that was stating it fairly.

Testimony on SB 188 was heard next. Mr. Isaeff pointed out that this particular bill was not covered in the 77-1 bulletin and not a part of the package.

Continuing Mr. Isaeff's testimony on SB 188:
He stated that in his opinion SB 188 was a step backward from the mandate previously sent forth. He stated that this change in the term "community" would make it exceptionally difficult to bring in expert witnesses in malpractice investigations. This would change it from the area from which a patient may choose to the particular area in which the physician practices. He added that the "similar locality" languarge of this bill is very vague and, indeed, it would be difficult in the state to find two "similar" towns. He said he felt what is suggested in the bill is, if SB 188 is accepted as written, that you want the investigations to continue, but you are going to make it as difficult as possible to get expert witnessess to testify in these matters. And, he stated, it difficult enough already.

Senator Hilbrecht that this was discussed in the committee and that the doctors wanted to limit the importation of experts from places like the Mayo Clinic, etc. The committee was unwilling to accept that modification because it felt that there were certain procedures that the rural physician should not undertake, rather, they should be refered to a facility that had the proper equipment to handle these cases. He stated that approximately 20 per cent of the testimony before the committee was from people in the remote areas, that their medical care was deteriorating because doctors were aprehensive to practice there because if anything went wrong, they would be compared to doctors in larger cities. He stated that the idea of this bill was to insure a level of medical care in the rural areas and at the same time maintaining the protections for the public that are available in the more populous area.

Mr. Isaeff stated that he did not feel that Senator Hilbrecht's explanation of this bill reflected SB 188 as it was before them. He stated that as far as the medical malpractice area was concerned, that the definition of comunity be left as is and if there needs to be some broadening as far as civil issues were concerned, then there should be another bill addressed to that area. And, as this bill is now, they would urge it's defeat.

J. W. Callister, State Medical Association, was next to speak. He also stated his association thought this bill to be a setback to rural medicine. His association recommended that this bill not be approved as it is written.

Mr. Newman stated the Trial Lawyer's Association concurred with Mr. Isaeff's statements concerning this bill. He additionally pointed out that the jury in these cases were there to use local standards in application to these cases. He stated the existing language is difficult enough to work with and the new language would make it more strict. He stated further, that 40 states have abolished the locality standard completely.

Mr. Price asked if the doctors were willing to help clean up their profession by testifying at malpractice hearings, but, on the other hand, were reluctant to testify in civil damage suits. Mr. Newman said that this did seem to be the case.

Senator Hilbrecht then refered back to SB 187 which he was brought in to clarify. He state that in section 5, page 2, lines 29 and 30, these were included to guard against windfalls which would be due to institutional and medical care which would not be needed if the injured person were to die.

He also stated that this bill would enable the courts to adjust the periodic payments if the costs of treatment or care changed greatly after the settlement was set. He further noted that subsection two encourages the parties to get together so that a formal hearing can be avoided when these changes take place. If the amount of the periodic payment was increased, the settlement would be used up at a faster rate.

Senator Dodge asked Senator Hilbrecht to comment on the rationale of the insurance company being made a part of the court action. Senator Hilbrecht commented that what happens, in most cases, is that the insurance company provides the doctor an attorney for the doctor's defense, reserving their policy defenses. This is done simply to defend themselves. The doctor's attorney (the insurance company's attorney) is the one who is going to ask the judge to implement the act. It is at this point that the policy defenses enter into the case (and the insurance company). If this were not the case, multiple litigation would come in. In other words the judgement would be entered against the doctor and if the insurance company were not made a part at that juncture then two problems would arise. The first problem would be security, and the only way to make sure the insurance company would be responsible, would be to involve them at that point. The second is that, constitutionally, you cannot enforce a judgement on a third party, even if he is obligated under contract, without filing a separate court action to enforce it. He stated he felt the bill could be improved by specifying that at that time, the issues of policy defenses shall be litigated before the order is entered so that the rights and and responsibilities of the insurance company are clear.

Mr. Ross asked Seantor Hilbrecht why future earning were not covered in this bill. Senator Hilbrecht explained that they did not want to completely revise the existing tort law and that the committee tried to address themselves specifically to the problem of rising costs in medical and custodial care and stay away from the broad area of future income.

Senator Close then asked if there was further testimony on SB 189. Peter Newman stated that the Nevada Trial Lawyers Association was against this bill for the reasons stated by the lawyers from Las Vegas, yesterday. Specifically he said if the committee passed this bill, which he hopes they don't, the bill should be amended on page one, line five, so that it reads: "which is based upon a breach of a professional duty towards the patient, the amount of damages, if any, awarded in such action shall be reduced by:--
any non - reimburseable--

Mr. Isaeff testified on behalf of SB 190 stating that this bill, particularly section one, is a very important addition to Chapter 630 of the NRS. It will, by its content, relieve the aprehension and uncertainty usually felt by the lay person in dealing with these investigations and the harassment or civil liabilities that sometime are related to cooperating with these authorities. He did also point out that on page 1, line 5, the term malpractice should be changed to include the four existing areas which are covered by Chapter 630.

His next point on this bill was in conjunction with SB 191 in regard to referals of claims paid, which are refered to the Board of Medical Examiners by the Insurance Commissioner. He recommended on this bill that the Board is aware of the activity in these areas when it receives these reports from the Joint Medical-Legal Screening Panel and the Board can review these reports and see which doctors seem to be having the most activity before the Panel and initiate its own investigation at its own discretion.

Mr. Ross inquired of Mr. Isaeff if he felt that SB 190 would encourage doctors to make payoffs to their clients to avoid their insurance companies becoming involved and having to file a report. Mr Isaeff replied that this does not encourage any out of court settlement of medical malpractice because the doctor knows that even though he has settled out of court, that the Board of Medical Examiners gets that report down the line and the Attorney General will, if SB 191 is passes in conjuction with this bill, be required to do a full scale investigation of him. He has not bought himself out of trouble. He stated he felt this would have an impact on the number of settlements and encourage doctors, instead, to fight all down the line, in the hope that they will win the suit and avoid investigation.

Mr. Isaeff, in continuing, stated he felt that in section one, the inclusion of a governmental entity should be included in the language.

He also pointed out to the committee that it was his feeling that the $2000 threshold could be considerably raised, because a $2000 settlement in a malpractice claim would not tend to indicate to him, in general, that the doctor needed license review of any type. Senator Close asked him what figure he would suggest. Mr. Isaeff said it was difficult for him to say. Senator Close asked him to prepare a recommended amendment to SB 191. Mr. Isaeff stated that it would be a better bill if the bracketed material in section 5, paragraph 1 of SB 191 were left in the bill rather than being deleted as proposed. This would leave a little discretion with the Board of Medical Examiners and not make it mandatory for each case to have to go to the Attorney General.

Mr. Callister was next to speak on SB 190. He stated he was, essentially, in support of the bill. He also favored the corrections that Mr. Isaeff brought out. He stated further that the Medical

Continuing Mr. Callister's testimony on SB 190:
Society did discuss the sum of money and that $5000 would not be objectionable to them. He said he felt the bill would read better if the word committee was inserted after "other medical society" on page 1, line 10.

Senator Bryan commented to Mr. Callister that one of the major problems in looking into this area last session was the extreme lack of statistical information and/or the lack of cooperation of the different agencies in supplying this information to the committee. Further, that due to this inability to collect the information there was an amendment to the statute to enable the Insurance Commissioner to collect the data which was not forthcoming.

Mr. Callister responded by saying that he understood the information the Commissioner needed was in the area of rate setting. And, that it was his opinion that if every insurance company reports every threat of suit, anytime the doctor contacts the insurance company and says that a possible claim may result from this, there will not only becoming an enormous amount of paperwork (which really doesn't give an idea of what's going on) but, may actually create a black list against physicians. He stated that in his ten years experience on the screening panel, many of the actions involving these doctors have never gone to court because the attorney withdrew the action because it was without sufficient merit to continue. Mr. Callister then handed out an amendment proposed for this and it is attached and marked Exhibit C.

Dr. Rottman was next to speak on SB 190. Mr. Close asked his ideas concerned with page 2, section 3, the reporting requirement.

Dr. Rottman stated that the primary information needed by his office is the closed claims. He stated he felt that reporting of the claims that are merely reported to the carrier would create additional reporting and paperwork which would not contribute to the understanding of the malpractice problem. He stated that the amendment submitted by Mr. Callister was co-authored by himself and it was pointed at reducing any unnecessary paperwork because he felt reporting for the sake of reporting, with no objective, was ridiculous.

Senator Dodge asked Dr. Rottman to comment regarding the $2000 threshold. Dr. Rottman stated that he felt the reason the $2000 figure was used was that there was the feeling that this would give a handle on the small claims to see if there was a problem. However, he stated, that for these purposes he felt $5000 might do just as well.

Dr. Rottman then handed out a proposed amendment which is attached and marked as Exhibit D. This concerned itself with maximum limits of liability insurance with regard to professional policies and the uncertain upper limits thereof.

Continuing Dr. Rottman's testimony:
In closing, Dr. Rottman commended the Interim Committee on the work they did. And, he stated he would be available to the committees, in the future, if they needed information from him.

Andy Grose of the LCB, pointed out to the committee that the thinking of the Interim Committee on the $2000 threshold is explained in the bulletin on page 30, section 2, line 11.

Senator Dodge asked Mr. Callister if, from the standpoint of policing the profession, there is any way to develop knowledge of those small claims without this low threshold and, if not, would it be better to file these claims with the Board of Medical Examiners. Mr. Callister said that they did not have any objections to it being filed with the Board of Medical Examiners. And in answer to the first question however, they already require that the Medical Legal Screening Panel report the small claims to the County Society as well as Board of Medical Examiners. A discussion followed on the reporting of possible claims and threats of claims in the high-risk professions such as cosmetic surgery etc. And, Mr. Callister stated, finally, that he did not necessarily agree with the thoughts of the Interim Committee with regard to page 30.

SB 191: Mr. Bryce Rhodes of the Board of Medical Examiners was the first to speak on SB 191. He stated that the Board of Medical Examiners was in oposition to the deletion on page 5, line 36. He stated further, that this section provides that when a written allegation of gross or repeated malpractice or professional incompetence is filed against any holder of a license, the Board may require the person to submit to a mental or physical examination. He stated that they felt this was good law and should be retained. Mr. Rhodes said he felt the new language in section 7, beginning on line 21, page 5, which states "when the Board has determined to proceed with administrative action on an allegation reported to it by the Attorney General, the Board may require the person charged in the allegation, to submit to a mental or physical examination.", was not as good as what they are working with currently. And,that the present law be retained because it may be that in the time the Attorney General has completed the investigation, maybe weeks or months, that the Board should have the power, if a written allegation is filed, to require the mental or physical examination at that time to protect the public and not wait until an investigation is completed. In addition to leaving in the section(NRS 630.315), that a new section should be added to the effect that in the event the Board shall determine, following said mental or physical examination, that the physician lacks the ability to safely practice medicine, the Board may suspend the physician's license to practice medicine until there has been a hearing on the allegation. He stated he felt this would be in the best interest of the public.

Discussion on the time limits for bringing a doctor to a hearing followed. The main point brought out in this discussion, by Senator Bryan, was that the hearing should be called immediately because, during this time, you are depriving the doctor of his livelyhood.

Mr. Rhodes' prepared comments are attached and marked Exhibit E.

Senator Dodge asked both Mr. Callister and Mr. Isaeff if they felt 60 days would be sufficient time to conduct preparations for a hearing and they both replied that 60 days would be a period of time they could work within.

Senator Dodge, after discussion, asked Mr. Rhodes if 60 days for investigation, 20 days for a hearing and 10 days for determination would be acceptable. Mr. Rohodes said this would be good.

Senator Close stated that the Senate was about to convene and the meeting would have to be continued. He stated those wishing to be notified of the time and date of the next meeting, leave their names with the secretary. The meeting was adjourned at 10:59 a.m.

Attached is Exhibit F which applies to testimony by Jo Powell at the February 14 meeting regarding AB 267.

Respectfully submitted,

Linda D Chandler
Linda D. Chandler, Secretary

APPROVED:

SENATOR MELVIN D. CLOSE, JR., CHAIRMAN

ASSEMBLYMAN ROBERT R. BARENGO, CHAIRMAN

EXHIBIT A

FROM A.G.'s office

shifts the

PROPOSED AMENDMENT TO SUBSECTION 1 of SEC. 6 IN S.B. 185

Whenever health care records are requested by the Board of Medical Examiners or the Attorney General pursuant to this section, the secretary of the board or the Attorney General, as may be appropriate, shall concurrently notify the patient in writing that such a request has been made and that the patient may, within 10 days of the receipt of said notice, petition the district court for an order prohibiting the inspection or copying of the patient's health care records. No such order shall be entered by a district court except upon a specific finding that the interests of the patient in the particular case outweigh the interest of the Board of Medical Examiners or the Attorney General to inspect and copy such records in connection with an investigation conducted pursuant to NRS 630.330 or 630.343. During any proceeding under this section, the name of the physician who is the subject of an investigation shall be kept confidential by the patient and all other parties. Notice to the patient as required by this section shall not constitute a breach of confidence under the provisions of NRS 630.341.

THE NEW YORK TIMES, TUESDAY, JUNE 17, 1975

Argonaut's Malpractice Premiums in '74 Amounted to $35-Million, Claims $24,000

By DAVID BIRD

The president of the Argonaut Insurance Company, in one of the rare cases where it has testified publicly, said yesterday that while it took in $35 million in doctors' malpractice insurance premiums in the last year and so far has paid out only $24,000 in claims, it decided to abandon the field here July 1. The reason for leaving, he said, was that Argonaut estimated that eventually it would have to have $69-million in reserve to meet claims arising out of the current insurance.

The testimony was given here at a meeting of the Congressional Subcommittee on Health and the Environment that is looking into whether the Federal Government should take a stronger role in malpractice insurance that so far is a state problem.

Lawrence C. Baker, Argonaut's new president, said the company made an unwise move when it entered the malpractice insurance business in New York State last July 1.

Asked by Representative Paul G. Rogers, the subcommittee chairman why the company went into the business if it was such an unprofitable line, Mr. Baker said he had no idea.

"I can't speak for the people who made that decision," Mr. Baker said. "Those people are no longer with the company."

That remark drew the only burst of laughter at the day-long hearing at 26 Federal Plaza, but it left the committee members still unclear on the workings of Argonaut whose actions precipitated the malpractice problem here.

Mr. Baker has been president of Argonaut only since last Friday. He joined the company last Jan. 20 after leaving his post as Chief Deputy Insurance Commissioner of California.

Argonaut is a wholly owned subsidiary of the Teledyne Financial Corporation, a California conglomerate that bought Argonaut in 1969. Mr. Baker said that Argonaut's income tax return was combined with Teledyne's.

Representative Rogers asked if the subcommittee could study the tax returns. Mr. Baker replied that they were not made public, but he would carry the request back to Teledyne.

It was Argonaut's announcement last December that it was going to triple malpractice insurance premiums here that stirred the intense concern over the problem that has since led to new legislation.

On the eve of a hearing by the State Insurance Department to inquire into the need for such a steep rate rise Argonaut said it would rescind the rate increase, but that it would cease writing doctors' malpractice insurance next July 1.

Because Mr. Baker shed no light on why Argonaut went in and out of doctors malpractice insurance here so rapidly, Representative Rogers said it probably would be necessary to call other members of Teledyne who had been around at the time.

Some former high officials of Argonaut have said privately that they saw no reason based on claims for malpractice for the company in December to demand such a large rate increase. They suggested that it was other company losses that might have been the basis for the rise.

Mr. Baker's testimony came late in the day. He did not detail how his company arrived at the $69-million figure and subcommittee members did not question him as to its accuracy.

GRAIN FUTURES UP; SOYBEANS IN RISE

Price Jumps Also Shown by Pork Bellies and Cattle

By ELIZABETH M. FOWLER

Continued strength in meat prices on the Chicago Mercantile Exchange influenced traders to take a new look at recently weak grain and soybean prices, and they did some active buying. As a result, grain and soybean prices on the neighboring Chicago Board of Trade rose yesterday.

Reflecting tight current supplies and good consumer demand despite high prices, cattle futures for nearby delivery jumped sharply. August was up almost the 1½ cent-a-pound daily limit, closing at 50.77 cents a pound, up from 49.40. During the session it made a new contract high of 50.80.

Pork bellies, the raw material for bacon, also showed some limit jumps, with August closing at 79.32 cents a pound, up 1½ cents, and a new contract high. Bacon, in short supply, has been selling at record price levels with some branded bacon retailing at around $2 a pound.

Willing and Able

With surging meat prices, some traders were inspired to sell beef, hog or pork belly futures and buy grain contracts on the theory that animal raisers would be willing and able to pay higher grain prices. Also there has been some talk that wheat prices appear low enough to attract purchases for feeding cattle and poultry. July wheat closed at $3.04½ a bushel, up 7½ cents, and July corn ended at $2.82, up about 4 cents.

Recently strong potato prices attracted new buying during the session on the New York Mercantile Exchange, but when the previous contract high for May of 9.20 cents

Silver Talks

By GENE SMITH

[illegible] the doldrums.

Domestic refined production through the first four months of 1975 totaled 5[illegible].42 million Troy ounces, off 8.1 per cent from the 1974 level. At the same time, production in Canada, Australia, Latin America, Europe and Asia edged ahead by only two-tenths of 1 per cent to 37.7 million Troy ounces.

In 1974, according to the United States Bureau of Mines, production from mines in this country fell sharply to 33.8 million ounces from 37.8 million ounces in 1973. Last June the Silver Institute forecast 1974 mine production in the United States at 39.9 million ounces.

Modiano Publishing Research & Consulting, Inc., recently forecast for this year "a slight increase in primary [or mine] production of silver in the non-Communist world" with domestic output rising from 33.8 million to 34 million Troy ounces.

Optimism Over Coinage

Although industry officials have indicated optimism over potential silver usage in solar-energy applications, water purification and other [illegible]

Suspect Pleads Guilty to Killing Of 24 in '74 Discotheque Fire

By MARY BREASTED

Almost a year after he broke into a Port Chester bowling alley to steal money and cigarettes and set a diversionary fire, which killed 24 persons in an adjoining discotheque, Peter J. Leonard yesterday pleaded guilty to causing those deaths.

He stood with his head bowed, sobbing, before State Supreme Court Justice George Beisheim Jr. in White Plains, as his lawyer entered the plea to 24 counts of felony murder.

Original document is of poor quality

SERVICE NORMAL AT BROOKLYN GAS

Company Reports Business as Usual Despite Job Dispute

By WOLFGANG SAXON

The Brooklyn Union Gas Company reported business as usual for its more than one million customers yesterday, the first day of what its 2,600 [illegible] workers call a lockout and the company calls a work stoppage.

Nearly 900 people in supervisory jobs, most of them work-

Argonaut's Malpractice Premiums in '74 Amounted to $35-Million, Claims $24,000
By DAVID BIRD
New York Times (1857-Current file); Jun 17, 1975; ProQuest Historical Newspapers The New York Times (1851 - 200
pg. 41

Argonaut's Malpractice Premiums in '74 Amounted to $35-Million, Claims $24,000

By DAVID BIRD

The president of the Argonaut Insurance Company, in one of the rare cases where it has testified publicly, said yesterday that while it took in $35-million in doctors' malpractice insurance premiums in the last year and so far has paid out only $24,000 in claims, it decided to abandon the field here July 1. The reason for leaving, he said, was that Argonaut estimated that eventually it would have to have $69-million in reserve to meet claims arising out of the current insurance.

The testimony was given here at a meeting of the Congressional Subcommittee on Health and the Environment that is looking into whether the Federal Government should take a stronger role in malpractice insurance that so far is a state problem.

Lawrence C. Baker, Argonaut's new president, said the company made an unwise move when it entered the malpractice insurance business in New York State last July 1.

Asked by Representative Paul G. Rogers, the subcommittee chairman why the company went into the business if it was such an unprofitable line, Mr. Baker said he had no idea.

"I can't speak for the people who made that decision," Mr. Baker said. "Those people are no longer with the company."

That remark drew the only burst of laughter at the daylong hearing at 26 Federal Plaza, but it left the committee members still unclear on the workings of Argonaut whose actions precipitated the malpractice problem here.

Mr. Baker has been president of Argonaut only since last Friday. He joined the company last Jan. 20 after leaving his post as Chief Deputy Insurance Commissioner of California.

Argonaut is a wholly owned subsidiary of the Teledyne Financial Corporation, a California conglomerate that bought Argonaut in 1969. Mr. Baker said that Argonaut's income tax return was combined with Teledyne's.

Representative Rogers asked if the subcommittee could study the tax returns. Mr. Baker replied that they were not made public, but he would carry the request back to Teledyne.

It was Argonaut's announcement last December that it was going to triple malpractice insurance premiums here that stirred the intense concern over the problem that has since led to new legislation.

On the eve of a hearing by the State Insurance Department to inquire into the need for such a steep rate rise Argonaut said it would rescind the rate increase, but that it would cease writing doctors' malpractice insurance next July 1.

Because Mr. Baker shed no light on why Argonaut went in and out of doctors malpractice insurance here so rapidly, Representative Rogers said it probably would be necessary to call other members of Teledyne who had been around at the time.

Some former high officials of Argonaut have said privately that they saw no reason based on claims for malpractice for the company in December to demand such a large rate increase. They suggested that it was other company losses that might have been the basis for the rise.

Mr. Baker's testimony came late in the day. He did not detail how his company arried at the $69-million figure and subcommittee members did not question him as to its accuracy.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Callister

EXHIBIT C

Section 3. Chapter 690B of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. Each insurer which issues a policy of insurance covering the liability of a physician licensed under Chapter 630 of NRS for a breach of his professional duty toward a patient shall report in writing to the Commissioner within 30 days, with a simultaneous copy to the board of medical examiners of the State of Nevada, each claim closed under the policy giving the name and address of the claimant and physician, the date and circumstances of each alleged breach so far as known and the settlement agreed upon, award made or judgment rendered by reason of the claim.

EXHIBIT D

Amend NRS 681A.100(6) to read as follows:

6. *This section does not apply to life or health insurance, annuities, title insurance, insurance of wet marine and transportation risks, workmen's compensation insurance, employer's liability coverages, liability insurance, surety, or to any policy or type of coverage as to which the maximum possible loss to the insurer is not readily acertainable on issuance of the policy.*

Rhodes

EXHIBIT E

SENATE BILL NO. 191

COMMITTEE HEARING - FEBRUARY 14, 1977

The Nevada State Board of Medical Examiners recommends:

1. That the new Sec. 7 not be inacted.

2. That NRS 630.315 not be repealed.

3. That NRS 630.315 be amended by adding thereto a new sub-section which will read as follows:

> 5. In the event the Board shall determine, following said mental or physical examination, that the physician lacks the ability to safely practice medicine, the Board may suspend the physician's license to practice medicine until there has been a hearing on the allegation.

It is submitted that the above requested new sub-section is indicated to protect the public health, safety and welfare in the event a physical or mental examination reveals that the physician has impaired physical or mental capabilities or lacks the ability to safely practice medicine due to indulgence in the use of alcohol or drugs, or for any reason revealed by such examination should be suspended from the practice of medicine until there has been a hearing on the allegation of gross or repeated malpractice or incompetency.

4. That SB 191 be amended by the addition of a new section, amending NRS 630.340 by adding thereto the following new sub-section.

> 3. Until the Order of Revocation or Suspension is modified or reversed, as provided in this section, the Court shall not stay the same by temporary restraining order or preliminary injunction.

It is submitted that the above requested new sub-section is indicated to protect the public health safety and welfare pending judicial review. Otherwise, a physician whose license to practice medicine has been revoked or suspended after a full hearing and who has been found to lack the ability to safely practice medicine due to indulgence in the use of alcohol or drugs or who willfully disregards established medical practices or fails to excercise proper care, diligence and skill in the treatment of patients, may be permitted to prey upon the public during a lengthy period of judicial review.

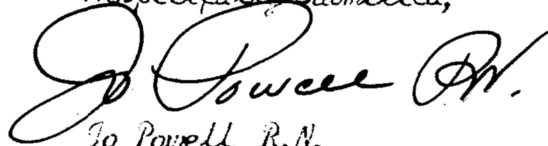
EXHIBIT F

Supplement

Statement to the Committee on Judiciary---------Assembly Bill No. 267

Amend to read that no medical or legal member selected to act as a member of the medical-legal panel, including the chairman, has rendered services, directly or indirectly to the subject or parties before the panel hearing.
Recommend due consideration of Committee on Judiciary to be clearly included in this bill.
Recommend due consideration by the Attorney General of this amendment.

Respectfully Submitted,



Jo Powell, R.N.
Trustee, Washoe Medical Center
President, Nevada Nurses' Association,
District #1 (Washoe County)
Consumer (Personal experience before
the existing medical-legal panel)