REQUIRES TWO-THIRDS MAJORITY VOTE (§§ 27, 28, 38, 40)

S.B. 250

SENATE BILL NO. 250–SENATORS TOWNSEND AND O'CONNELL

MARCH 10, 2003

Referred to Committee on Commerce and Labor

SUMMARY—Revises various provisions relating to regulated businesses and professions. (BDR 57-835)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to regulated businesses and professions; revising the provisions governing the filing and approval of rates of certain insurers; authorizing certain insurers in a competitive market to change rates under certain circumstances without prior review by the Commissioner of Insurance; requiring the Commissioner to review and approve certain rates before the rates become effective; providing for the issuance by the Commissioner of orders to discontinue a rate; requiring insurers to describe in certain policies of malpractice insurance the formula or method used to determine the premiums for tail coverage; requiring insurers under certain circumstances to provide for a reduction in the premiums for certain policies of malpractice insurance; authorizing certain providers of health care to recover benefit penalties from insurers that unreasonably reject certain settlement offers in malpractice actions; requiring the district courts and the Court Administrator to compile and report certain information concerning attorney's fees and sanctions; revising the authority of the courts to award attorney's fees; making various changes regarding procedure and the statute of limitations in malpractice actions; authorizing certain monetary sanctions in malpractice actions; making various changes regarding the licensure of certain physicians; clarifying the jurisdiction of certain regulatory boards; imposing reporting requirements on certain

physicians; requiring certain regulatory boards to impose disciplinary action against certain physicians; requiring certain physicians to undergo tests for competency in certain circumstances; establishing an advisory panel to study certain issues relating to malpractice insurance; requiring the Commissioner of Insurance to hold public hearings on certain issues relating to malpractice insurance; providing penalties; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 686B.070 is hereby amended to read as follows:

686B.070 ***1.*** Every authorized insurer and every rate service organization licensed under NRS 686B.130 which has been designated by any insurer for the filing of rates under subsection 2 of NRS 686B.090 shall file with the Commissioner all:

~~[1.]~~ ***(a)*** Rates and proposed increases thereto;

~~[2.]~~ ***(b)*** Forms of policies to which the rates apply;

~~[3.]~~ ***(c)*** Supplementary rate information; and

~~[4.]~~ ***(d)*** Changes and amendments thereof,

made by it for use in this state.

2. Except as otherwise provided in this section and NRS 686B.110, if a proposed increase or decrease in the rate of any kind or line of insurance does not change by more than 7 percent the total average premium required to be paid by persons insured by the insurer for that particular line or kind of insurance during the 12 months immediately preceding the proposed increase or decrease, the insurer shall file the information required by subsection 1 and the supporting data required to be filed pursuant to NRS 686B.100 on or before the date on which the changes are to become effective. The provisions of this subsection do not apply if the Commissioner has determined that the market is not competitive or if the Commissioner has made any of the other determinations described in subsection 1 of NRS 686B.110.

3. In a competitive market, if the Commissioner determines that the rates of an insurer require closer supervision by the Commissioner because of the financial condition of the insurer or because the insurer has engaged in rating practices which are unfairly discriminatory, the Commissioner may require the insurer to file the information required by subsection 1 and the supporting data required to be filed pursuant to NRS 686B.100 at

least 60 days before the rates become effective or may subject the rates to review pursuant to NRS 686B.110.

4. The Commissioner shall review filings made pursuant to this section as soon as practicable to:

(a) Ensure the sufficiency of the financial condition of the insurer; and

(b) Determine whether the insurer has engaged in rating practices which are unfairly discriminatory.

5. Rates for title insurance, surety insurance and liability insurance for medical malpractice must be approved by the Commissioner pursuant to NRS 686B.110 before the insurer may use the rates.

Sec. 2. NRS 686B.110 is hereby amended to read as follows:

686B.110 1. ~~[The]~~ ***If the Commissioner has determined that:***

(a) The market is not competitive;

(b) Pursuant to NRS 686B.180, essential insurance coverage is not readily available in a voluntary market;

(c) Pursuant to NRS 686B.070, the rates of the insurer require closer supervision and that the rates are subject to review pursuant to this section;

(d) A proposed increase or decrease in the rate of any kind or line of insurance changes by more than 7 percent the total average premium required to be paid by persons insured by the insurer for that particular line or kind of insurance during the 12 months immediately preceding the proposed increase or decrease; or

(e) The rate is for title insurance, surety insurance or liability insurance for medical malpractice,

the Commissioner shall consider each proposed increase or decrease in the rate of any kind or line of insurance or subdivision thereof filed with him pursuant to NRS 686B.070. If the Commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050, he shall disapprove the proposal. The Commissioner shall approve or disapprove each proposal ~~[no]~~ ***not*** later than 60 days after it is determined by him to be complete pursuant to subsection 4. If the Commissioner fails to approve or disapprove the proposal within that period, the proposal shall be deemed approved.

2. Whenever an insurer has no legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner shall ***,*** on request ***,*** specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him. When new rates become legally effective, the Commissioner shall order the escrowed ~~[funds]~~ ***money***

or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis must not be required.

3. If the Commissioner disapproves a proposed rate and an insurer requests a hearing to determine the validity of his action, the insurer has the burden of showing compliance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive. Any such hearing must be held:

(a) Within 30 days after the request for a hearing has been submitted to the Commissioner; or

(b) Within a period agreed upon by the insurer and the Commissioner.

If the hearing is not held within the period specified in paragraph (a) or (b), or if the Commissioner fails to issue an order concerning the proposed rate for which the hearing is held within 45 days after the hearing, the proposed rate shall be deemed approved.

4. The Commissioner shall by regulation specify the documents or any other information which must be included in a proposal to increase or decrease a rate submitted to him pursuant to ~~[subsection 1.]~~ ***NRS 686B.070.*** Each such proposal shall be deemed complete upon its filing with the Commissioner, unless the Commissioner, within 15 business days after the proposal is filed with him, determines that the proposal is incomplete because the proposal does not comply with the regulations adopted by him pursuant to this subsection.

5. If the Commissioner finds that a rate no longer meets the requirements of this chapter, the Commissioner may order the discontinuance of the rate. An order for the discontinuance of a rate may be issued only after a hearing with at least 10 days' notice for all insurers and rate organizations that would be affected by such an order. The order must be in writing and include, without limitation:

(a) The grounds pursuant to which the order was issued;

(b) The date on which the order to discontinue the rate becomes effective; and

(c) The date, within a reasonable time after the date on which the order becomes effective, on which the order will expire.

An order for the discontinuance of a rate does not affect any contract or policy made or issued before the date on which the order becomes effective.

Sec. 3. Chapter 690B of NRS is hereby amended by adding thereto the provisions set forth as sections 4 to 11, inclusive, of this act.

Sec. 4. ***As used in NRS 690B.050 and sections 4 to 11, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 5 to 8, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 5. ***"Action for malpractice" means an action for malpractice that is subject to the provisions of chapter 41A of NRS.***

Sec. 6. ***"Policy of malpractice insurance" means a policy of insurance covering the liability of a provider of health care for injury or death based upon professional negligence.***

Sec. 7. ***"Professional negligence" means a negligent act or omission to act by a provider of health care in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death. The term does not include services that are outside the scope of services for which the provider of health care is licensed or services for which any restriction has been imposed by the applicable regulatory board or health care facility.***

Sec. 8. ***"Provider of health care" or "provider" means a physician licensed under chapter 630 or 633 of NRS, dentist, licensed nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, or a licensed hospital and its employees.***

Sec. 9. ***1. In each policy of malpractice insurance that includes tail coverage, an insurer shall describe, in at least 10-point bold type, the formula or method that is used by the insurer to determine the premiums for the tail coverage.***

2. For the purposes of this section, the Commissioner shall adopt by regulation a definition of tail coverage.

Sec. 10. ***1. In each policy of malpractice insurance, an insurer shall include provisions that provide for a reduction in the premiums for the malpractice insurance if the provider of health care implements a qualified risk management system. The reduction in the premiums must equal 5 percent of the total premiums to be paid under the policy or $10,000, whichever amount is greater.***

2. A qualified risk management system must:

(a) Include a system to capture electronically the interaction between the provider and the patient at the point of care; and

(b) Comply with all other requirements established by the Commissioner.

3. The Commissioner shall adopt regulations to:

(a) Establish the requirements for a qualified risk management system; and

(b) Carry out the provisions of this section.

4. The provisions of this section apply to any policy of malpractice insurance if any part of the term of the policy provides coverage to a provider of health care on or after October 1, 2004. If the term of the policy begins before October 1, 2004, and ends on or after October 1, 2004, the Commissioner shall establish a formula or method for prorating a reduction in the premiums pursuant to this section for the portion of the term that provides coverage on or after October 1, 2004.

5. The Commissioner may exempt an insurer, in whole or in part, from the provisions of this section if such an exemption is necessary under the Constitution of the United States or of this state to provide a fair and reasonable return to the insurer or to avoid a confiscatory result.

Sec. 11. *1. A provider of health care who is insured by a policy of malpractice insurance is entitled to a benefit penalty that must be paid to the provider by the insurer that issued the policy if:*

(a) An action for malpractice is brought against the provider in the district court;

(b) The plaintiff in the malpractice action makes a settlement offer that is within the limits of coverage under the policy;

(c) The insurer, in contravention of the express instructions of the provider, unreasonably rejects the settlement offer in light of all the surrounding facts and circumstances; and

(d) The district court enters a judgment in favor of the plaintiff that imposes liability on the provider for damages in an amount that exceeds the limits of coverage under the policy and the judgment of the district court becomes final and binding on the parties.

2. To collect the benefit penalty, the provider must file with the Commissioner a claim for the benefit penalty not later than 1 year after the judgment of the district court becomes final and binding on the parties.

3. If the provider files a claim for a benefit penalty, the Commissioner shall:

(a) Provide the insurer with notice of the claim; and

(b) Hold a hearing on the claim.

4. At the hearing on the claim, if the provider presents evidence that the judgment of the district court imposes liability on the provider for damages in an amount that exceeds the limits of coverage under the policy and that the insurer rejected the

settlement offer in contravention of the express instructions of the provider, there is a rebuttable presumption that the insurer unreasonably rejected the settlement offer. To rebut this presumption, the insurer must present clear and convincing evidence that its decision to reject the settlement offer was reasonable in light of all the surrounding facts and circumstances.

5. If the Commissioner finds that the provider is entitled to a benefit penalty pursuant to this section, the Commissioner shall order the insurer to pay to the provider:

(a) The benefit penalty in an amount equal to the difference between the damages for which the provider is liable under the judgment of the district court and the limits of coverage under the policy, except that the benefit penalty may not exceed $150,000; and

(b) Reasonable attorney's fees and costs incurred by the provider to bring and prosecute the claim for the benefit penalty.

6. For the purposes of this section, a judgment of the district court becomes final and binding on the parties when all rights to appeal the judgment have been exhausted or waived by the parties.

7. The provisions of this section do not create an exclusive remedy and do not abrogate or limit any other action or remedy that is available to a provider pursuant to any other statute or the common law.

8. If the Commissioner orders an insurer to pay a benefit penalty pursuant to this section, no insurer doing business in this state may use the judgment of the district court that imposes liability on the provider or the benefit penalty as a factor, criteria or component in:

(a) Determining whether to issue a policy of malpractice insurance to the provider;

(b) Making any underwriting decision concerning the provider with regard to a policy of malpractice insurance, including, without limitation, determining the risk associated with issuing a policy of malpractice insurance to the provider; or

(c) Calculating the amount of any premium for a policy of malpractice insurance that is issued to the provider.

9. If the Commissioner orders an insurer to pay a benefit penalty pursuant to this section:

(a) The benefit penalty is not a loss, an expense or a cost of service for the insurer;

(b) The insurer shall not include any portion of the benefit penalty in any application for a rate adjustment or rate increase; and

(c) The Commissioner shall not allow the insurer to recover any portion of the benefit penalty from its policyholders.

10. If the Commissioner orders an insurer to pay a benefit penalty pursuant to this section on two or more occasions within a period of 3 years, the Commissioner shall hold a hearing pursuant to chapter 680A of NRS to determine whether to suspend, limit or revoke the insurer's certificate of authority. At the hearing, the imposition of the benefit penalties pursuant to this section shall be deemed to be sufficient grounds, standing alone, for the Commissioner to exercise the power to suspend, limit or revoke the insurer's certificate of authority pursuant to chapter 680A of NRS.

Sec. 12. NRS 690B.050 is hereby amended to read as follows:

690B.050 1. ~~[Each insurer which]~~ ***If an insurer*** issues a policy of ***malpractice*** insurance ~~[covering the liability of]~~ ***to a provider of health care who is*** a physician licensed under chapter 630 ~~[of NRS or an osteopathic physician licensed under chapter]~~ ***or*** 633 of NRS ~~[for a breach of his professional duty toward a patient]~~ ***, the insurer*** shall report to the Commissioner ***,*** within 30 days ***,*** each settlement or award made or judgment rendered by reason of a claim, giving the name and address of the claimant and ~~[physician]~~ ***the provider of health care*** and the circumstances of the case.

2. The Commissioner shall report to the Board of Medical Examiners or the State Board of Osteopathic Medicine, as applicable, within 30 days after receiving the report of the insurer, each claim made and each settlement, award or judgment.

Sec. 13. NRS 3.243 is hereby amended to read as follows:

3.243 ***1.*** In the time and manner prescribed by the Supreme Court, the chief judge of the judicial district or, if the district has no chief judge, a district judge designated by mutual consent of the district judges of that district, shall submit to the Court Administrator a report of the statistical information required pursuant to this section and such other statistical information as prescribed by the Supreme Court. The report must include, without limitation, statistical information concerning:

~~[1.]~~ ***(a)*** Those cases which are pending and undecided and the judge to whom each case has been assigned;

~~[2.]~~ ***(b)*** The type and number of cases each judge considered during the preceding month;

~~[3.]~~ ***(c)*** The number of cases submitted to each judge during the preceding month;

~~[4.]~~ ***(d)*** The number of cases decided by each judge during the preceding month; and

~~[5.]~~ ***(e)*** The number of full judicial days in which each judge appeared in court or in chambers in performance of his duties during the preceding month.

2. In addition to the information required by subsection 1, the report must include the following information:

(a) The number of cases in the judicial district in which a court awarded attorney's fees pursuant to NRS 7.085 or paragraph (b) of subsection 2 of NRS 18.010 and, for each such case, the amount of the attorney's fees awarded and whether the case was an action for malpractice; and

(b) The number of cases in the judicial district in which a court imposed sanctions pursuant to NRS 41A.081 or Rule 11 of the Nevada Rules of Civil Procedure and, for each such case, the type of sanctions imposed, the amount of the sanctions if they were monetary sanctions and whether the case was an action for malpractice.

3. The provisions of subsection 2 apply only to attorney's fees that are awarded by a court or sanctions that are imposed by a court on or after January 1, 2004.

4. As used in this section, "action for malpractice" means an action for malpractice that is subject to the provisions of chapter 41A of NRS.

Sec. 14. NRS 7.085 is hereby amended to read as follows:

7.085 ***1.*** If a court finds that an attorney has:

~~[1.]~~ ***(a)*** Filed, maintained or defended a civil action or proceeding in any court in this state and such action or defense is not well-grounded in fact or is not warranted by existing law or by an argument for changing the existing law that is made in good faith; or

~~[2.]~~ ***(b)*** Unreasonably and vexatiously extended a civil action or proceeding before any court in this state,

the court shall require the attorney personally to pay the additional costs, expenses and attorney's fees reasonably incurred because of such conduct.

2. The court shall liberally construe the provisions of this section in favor of awarding costs, expenses and attorney's fees in all appropriate situations. It is the intent of the Legislature that the court award costs, expenses and attorney's fees pursuant to this section and impose sanctions pursuant to Rule 11 of the Nevada Rules of Civil Procedure in all appropriate situations to punish for and deter frivolous or vexatious claims and defenses because such claims and defenses overburden limited judicial resources, hinder the timely resolution of meritorious claims and increase the costs of engaging in business and providing professional services to the public.

Sec. 15. NRS 18.010 is hereby amended to read as follows:

18.010 1. The compensation of an attorney and counselor for his services is governed by agreement, express or implied, which is not restrained by law.

2. In addition to the cases where an allowance is authorized by specific statute, the court may make an allowance of attorney's fees to a prevailing party:

(a) When he has not recovered more than $20,000; or

(b) Without regard to the recovery sought, when the court finds that the claim, counterclaim, cross-claim or third-party complaint or defense of the opposing party was brought ***or maintained*** without reasonable ground or to harass the prevailing party. ***The court shall liberally construe the provisions of this paragraph in favor of awarding attorney's fees in all appropriate situations. It is the intent of the Legislature that the court award attorney's fees pursuant to this paragraph and impose sanctions pursuant to Rule 11 of the Nevada Rules of Civil Procedure in all appropriate situations to punish for and deter frivolous or vexatious claims and defenses because such claims and defenses overburden limited judicial resources, hinder the timely resolution of meritorious claims and increase the costs of engaging in business and providing professional services to the public.***

3. In awarding attorney's fees, the court may pronounce its decision on the fees at the conclusion of the trial or special proceeding without written motion and with or without presentation of additional evidence.

4. Subsections 2 and 3 do not apply to any action arising out of a written instrument or agreement which entitles the prevailing party to an award of reasonable attorney's fees.

Sec. 16. Chapter 41A of NRS is hereby amended by adding thereto the provisions set forth as sections 17, 18 and 19 of this act.

Sec. 17. ***"Professional negligence" means a negligent act or omission to act by a provider of health care in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death. The term does not include services that are outside the scope of services for which the provider of health care is licensed or services for which any restriction has been imposed by the applicable regulatory board or health care facility.***

Sec. 18. ***"Provider of health care" means a physician licensed under chapter 630 or 633 of NRS, dentist, licensed nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, or a licensed hospital and its employees.***

Sec. 19. ***1. Except as otherwise provided in subsection 4, at least 90 days before a plaintiff files an action for injury or death against a provider of health care based upon professional***

negligence, the plaintiff must provide a notice of his intent to file the action to:

(a) Each defendant against whom the action is brought; and

(b) If the defendant is a physician licensed pursuant to chapter 630 or 633 of NRS, the Board of Medical Examiners or the State Board of Osteopathic Medicine, as applicable.

2. The notice must inform each defendant of the legal basis for the action and the type of loss sustained and must include, without limitation:

(a) The date and location of each alleged act of professional negligence;

(b) A detailed description of each alleged act of professional negligence; and

(c) A detailed description of the injuries suffered from each alleged act of professional negligence.

3. The notice may be served in the manner provided by law and the Nevada Rules of Civil Procedure for the service of process.

4. The provisions of this section do not apply to any defendant whose name is unknown to the plaintiff at the time the plaintiff files the complaint and who is identified therein by a fictitious name, as provided in N.R.C.P. 10.

5. Failure to comply with the provisions of this section shall not invalidate any proceedings of any court in this state, nor shall it affect the jurisdiction of a court in this state to render a judgment therein.

6. Failure by an attorney to comply with the provisions of this section is grounds for professional discipline. The State Bar of Nevada shall investigate and take appropriate action in any such case brought to its attention.

Sec. 20. NRS 41A.003 is hereby amended to read as follows:

41A.003 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 41A.004 to 41A.013, inclusive, ***and sections 17 and 18 of this act*** have the meanings ascribed to them in those sections.

Sec. 21. NRS 41A.081 is hereby amended to read as follows:

41A.081 1. In an action for medical malpractice or dental malpractice, all the parties to the action, the insurers of the respective parties and the attorneys of the respective parties shall attend and participate in a settlement conference before a district judge, other than the judge assigned to the action, to ascertain whether the action may be settled by the parties before trial.

2. The judge before whom the settlement conference is held:

(a) May, for good cause shown, waive the attendance of any party.

(b) Shall decide what information the parties may submit at the settlement conference.

3. The judge shall notify the parties of the time and place of the settlement conference.

4. The failure of any party, his insurer or his attorney to participate in good faith in the settlement conference is grounds for sanctions ***, including, without limitation, monetary sanctions,*** against the party or his attorney, or both. ***The judges of the district court shall liberally construe the provisions of this subsection in favor of imposing sanctions in all appropriate situations. It is the intent of the Legislature that the judges of the district court impose sanctions pursuant to this subsection in all appropriate situations to punish for and deter conduct which is not undertaken in good faith because such conduct overburdens limited judicial resources, hinders the timely resolution of meritorious claims and increases the costs of engaging in business and providing professional services to the public.***

Sec. 22. NRS 41A.097 is hereby amended to read as follows:

41A.097 1. Except as otherwise provided in subsection 3, an action for injury or death against a provider of health care may not be commenced more than 4 years after the date of injury or 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first, for:

(a) Injury to or the wrongful death of a person occurring before October 1, 2002, based upon alleged professional negligence of the provider of health care;

(b) Injury to or the wrongful death of a person occurring before October 1, 2002, from professional services rendered without consent; or

(c) Injury to or the wrongful death of a person occurring before October 1, 2002, from error or omission in practice by the provider of health care.

2. Except as otherwise provided in subsection 3, an action for injury or death against a provider of health care may not be commenced more than 3 years after the date of injury or ~~[2 years]~~ ***1 year*** after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first, for:

(a) Injury to or the wrongful death of a person occurring on or after October 1, 2002, based upon alleged professional negligence of the provider of health care;

(b) Injury to or the wrongful death of a person occurring on or after October 1, 2002, from professional services rendered without consent; or

(c) Injury to or the wrongful death of a person occurring on or after October 1, 2002, from error or omission in practice by the provider of health care.

3. This time limitation is tolled ~~[for]~~ ***:***

(a) For any period during which the provider of health care has concealed any act, error or omission upon which the action is based and which is known or through the use of reasonable diligence should have been known to him.

(b) If a notice required pursuant to section 19 of this act is served within 90 days before this time limitation, for 90 days after the notice is served.

4. For the purposes of this section, the parent, guardian or legal custodian of any minor child is responsible for exercising reasonable judgment in determining whether to prosecute any cause of action limited by subsection 1 or 2. If the parent, guardian or custodian fails to commence an action on behalf of that child within the prescribed period of limitations, the child may not bring an action based on the same alleged injury against any provider of health care upon the removal of his disability, except that in the case of:

(a) Brain damage or birth defect, the period of limitation is extended until the child attains 10 years of age.

(b) Sterility, the period of limitation is extended until 2 years after the child discovers the injury.

~~[5. As used in this section, "provider of health care" means a physician licensed under chapter 630 or 633 of NRS, a dentist, registered nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, or a licensed hospital as the employer of any such person.]~~

Sec. 23. Chapter 630 of NRS is hereby amended by adding thereto the provisions set forth as sections 24 to 28, inclusive, of this act.

Sec. 24. ***1. In addition to the other requirements for licensure, an applicant for a license to practice medicine shall submit to the Board information describing:***

(a) Any claims made against the applicant for malpractice within the 5 years immediately preceding the filing of the application for a license, whether or not a civil action was filed concerning the claim;

(b) Any complaints filed against the applicant with a licensing board of another state and any disciplinary action taken against the applicant by a licensing board of another state within the 5 years immediately preceding the filing of the application for a license; and

(c) Any complaints filed against the applicant with a hospital, clinic or medical facility or any disciplinary action taken against the applicant by a hospital, clinic or medical facility within the 5 years immediately preceding the filing of the application for a license.

2. The Board shall not issue a license to the applicant until it has received all the information required by this section.

Sec. 25. *1. In addition to the other requirements for licensure, if an applicant for a license to practice in this state has never been licensed to practice in any state, the applicant shall submit to the Board a letter of recommendation from the person who is the head of the residency program where the applicant received training.*

2. The Board shall not issue a license to the applicant until it has received the letter of recommendation required by this section.

3. If the person who is the head of the residency program where the applicant received training has recommended the applicant for licensure by the Board, the person is immune from civil liability for his actions and any consequences of his actions unless, when the person recommended the applicant for licensure by the Board, the person acted without any reasonable grounds to support the recommendation.

4. If the person who is the head of the residency program where the applicant received training has refused to recommend the applicant for licensure by the Board or has disclosed to the Board any adverse information concerning the abilities, qualifications, attributes or character of the applicant, the person is immune from civil liability for his actions and any consequences of his actions unless:

(a) When the person refused to recommend the applicant for licensure by the Board, the person acted without any reasonable grounds to support the refusal; or

(b) When the person disclosed the adverse information to the Board, the person acted without any reasonable grounds to believe that the adverse information was accurate.

Sec. 26. *The expiration of a license by operation of law or by order or decision of the Board or a court, or the voluntary surrender of a license by a licensee, does not deprive the Board of jurisdiction to proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.*

Sec. 27. *1. A physician shall report to the Board any action filed or claim submitted to arbitration or mediation for malpractice or negligence against the physician and the*

settlement, award, judgment or other disposition of the action or claim within 10 days after:

(a) The action was filed or the claim was submitted to arbitration or mediation; and

(b) The disposition of the action or claim.

2. If the Board finds that a physician has violated the provisions of this section, the Board shall impose a fine of $5,000, in addition to any other fines or penalties permitted by law.

Sec. 28. *1. If the Board receives a report pursuant to the provisions of NRS 630.3067, 690B.045, 690B.050 or section 27 of this act that a judgment has been rendered by reason of a claim of malpractice or negligence against a physician, regardless of any appeal of the judgment, the Board shall conduct a hearing to determine whether to impose disciplinary action against the physician for violation of the provisions of subsection 4 of NRS 630.301 or subsection 12 of NRS 630.306.*

2. The results of any examination of the physician conducted pursuant to the provisions of subsection 2 of NRS 630.318 must be considered a part of the record of the hearing before the Board.

3. If, after conducting the hearing, the Board finds that a violation of the provisions of subsection 4 of NRS 630.301 or subsection 12 of NRS 630.306 has occurred, the Board shall by order:

(a) Place the physician on probation for a specified period on any of the conditions specified in the order;

(b) Administer to him a public reprimand;

(c) Impose a fine not to exceed $5,000;

(d) Require him to perform community service without compensation;

(e) Require him to fulfill certain training or educational requirements; and

(f) Require him to pay all costs incurred by the Board relating to his disciplinary proceedings.

4. The provisions of subsection 3 do not limit the authority of the Board to:

(a) Limit the practice of the physician or exclude one or more specified branches of medicine from his practice;

(b) Require supervision of his practice;

(c) Require him to participate in a program to correct alcohol or drug dependence or any other impairment;

(d) Suspend his license for a specified period or until further order of the Board; or

(e) Revoke his license to practice medicine. If the Board revokes the license to practice medicine, the Board is not required to take any disciplinary action set forth in subsection 3 that would

be inconsistent with the revocation of the license to practice medicine.

5. The Board shall not remove any restrictions imposed on a physician pursuant to this section until the physician has successfully completed the training or educational requirements ordered by the Board. If the person who provides the training or educational instruction to the physician issues a certificate of satisfactory completion, the certificate shall be deemed to be proof that the physician satisfactorily completed the training or educational requirements ordered by the Board.

Sec. 29. NRS 630.130 is hereby amended to read as follows:

630.130 1. In addition to the other powers and duties provided in this chapter, the Board shall:

(a) Enforce the provisions of this chapter;

(b) Establish by regulation standards for licensure under this chapter;

(c) Conduct examinations for licensure and establish a system of scoring for those examinations;

(d) Investigate the character of each applicant for a license and issue licenses to those applicants who meet the qualifications set by this chapter and the Board; and

(e) Institute a proceeding in any court to enforce its orders or the provisions of this chapter.

2. On or before February 15 of each odd-numbered year, the Board shall submit to the Governor and to the Director of the Legislative Counsel Bureau for transmittal to the next regular session of the Legislature a written report compiling:

(a) Disciplinary action taken by the Board during the previous biennium against physicians for malpractice or negligence; and

(b) Information reported to the Board during the previous biennium pursuant to NRS 630.3067, subsections 2 and 3 of NRS 630.307 and NRS 690B.045 ~~[.]~~ ***and 690B.050 and section 27 of this act.***

The report must include only aggregate information for statistical purposes and exclude any identifying information related to a particular person.

3. The Board may adopt such regulations as are necessary or desirable to enable it to carry out the provisions of this chapter.

Sec. 30. NRS 630.3062 is hereby amended to read as follows:

630.3062 The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.

2. Altering medical records of a patient.

3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.

4. Failure to make the medical records of a patient available for inspection and copying as provided in NRS 629.061.

5. Failure to comply with the requirements of ~~[NRS 630.3067.]~~ ***section 27 of this act.***

6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board.

Sec. 31. NRS 630.3067 is hereby amended to read as follows:

630.3067 1. The insurer of a physician licensed under this chapter ~~[and the physician]~~ must report to the Board any action filed or claim submitted to arbitration or mediation for malpractice or negligence against the physician and the settlement, award, judgment or other disposition of the action or claim within 30 days after:

(a) The action was filed or the claim was submitted to arbitration or mediation; and

(b) The disposition of the action or claim.

2. The Board shall report any failure to comply with subsection 1 by an insurer licensed in this state to the Division of Insurance of the Department of Business and Industry. If, after a hearing, the Division of Insurance determines that any such insurer failed to comply with the requirements of subsection 1, the Division may impose an administrative fine of not more than $10,000 against the insurer for each such failure to report. If the administrative fine is not paid when due, the fine must be recovered in a civil action brought by the Attorney General on behalf of the Division.

Sec. 32. NRS 630.318 is hereby amended to read as follows:

630.318 1. If the Board or any investigative committee of the Board has reason to believe that the conduct of any physician has raised a reasonable question as to his competence to practice medicine with reasonable skill and safety to patients, it may order that the physician undergo a mental or physical examination or an examination testing his competence to practice medicine by physicians or other examinations designated by the Board to assist the Board or committee in determining the fitness of the physician to practice medicine.

2. ***If the Board receives a report pursuant to the provisions of NRS 630.3067, 690B.045, 690B.050 or section 27 of this act that a judgment has been rendered by reason of a claim of malpractice or negligence against a physician, regardless of any appeal of the judgment, the Board shall order that the physician undergo a mental or physical examination or an examination testing his***

competence to practice medicine by physicians or other examinations designated by the Board to assist the Board or any investigative committee of the Board in determining the fitness of the physician to practice medicine.

3. For the purposes of this section:

(a) Every physician who applies for a license or who is licensed under this chapter shall be deemed to have given his consent to submit to a mental or physical examination or an examination testing his competence to practice medicine when ordered to do so in writing by the Board.

(b) The testimony or reports of the examining physicians are not privileged communications.

~~[3.]~~ ***4.*** Except in extraordinary circumstances, as determined by the Board, the failure of a physician licensed under this chapter to submit to an examination when directed as provided in this section constitutes an admission of the charges against him.

Sec. 33. NRS 630.352 is hereby amended to read as follows:

630.352 1. Any member of the Board, except for an advisory member serving on a panel of the Board hearing charges, may participate in the final order of the Board. If the Board, after a formal hearing, determines from a preponderance of the evidence that a violation of the provisions of this chapter or of the regulations of the Board has occurred, it shall issue and serve on the physician charged an order, in writing, containing its findings and any sanctions.

2. If the Board determines that no violation has occurred, it shall dismiss the charges, in writing, and notify the physician that the charges have been dismissed. If the disciplinary proceedings were instituted against the physician as a result of a complaint filed against him, the Board may provide the physician with a copy of the complaint.

3. Except as otherwise provided in subsection 4 ~~[,]~~ ***and sections 27 and 28 of this act,*** if the Board finds that a violation has occurred, it may by order:

(a) Place the person on probation for a specified period on any of the conditions specified in the order;

(b) Administer to him a public reprimand;

(c) Limit his practice or exclude one or more specified branches of medicine from his practice;

(d) Suspend his license for a specified period or until further order of the Board;

(e) Revoke his license to practice medicine;

(f) Require him to participate in a program to correct alcohol or drug dependence or any other impairment;

(g) Require supervision of his practice;

(h) Impose a fine not to exceed $5,000;

(i) Require him to perform community service without compensation;

(j) Require him to take a physical or mental examination or an examination testing his competence;

(k) Require him to fulfill certain training or educational requirements; and

(l) Require him to pay all costs incurred by the Board relating to his disciplinary proceedings.

4. If the Board finds that the physician has violated the provisions of NRS 439B.425, the Board shall suspend his license for a specified period or until further order of the Board.

Sec. 34. Chapter 633 of NRS is hereby amended by adding thereto the provisions set forth as sections 35 to 40, inclusive, of this act.

Sec. 35. ***1. In addition to the other requirements for licensure, an applicant for a license to practice shall submit to the Board information describing:***

(a) Any claims made against the applicant for malpractice within the 5 years immediately preceding the filing of the application for a license, whether or not a civil action was filed concerning the claim;

(b) Any complaints filed against the applicant with a licensing board of another state and any disciplinary action taken against the applicant by a licensing board of another state within the 5 years immediately preceding the filing of the application for a license; and

(c) Any complaints filed against the applicant with a hospital, clinic or medical facility or any disciplinary action taken against the applicant by a hospital, clinic or medical facility within the 5 years immediately preceding the filing of the application for a license.

2. The Board shall not issue a license to the applicant until it has received all the information required by this section.

Sec. 36. ***1. In addition to the other requirements for licensure, if an applicant for a license to practice in this state has never been licensed to practice in any state, the applicant shall submit to the Board a letter of recommendation from the person who is the head of the residency program where the applicant received training.***

2. The Board shall not issue a license to the applicant until it has received the letter of recommendation required by this section.

3. If the person who is the head of the residency program where the applicant received training has recommended the applicant for licensure by the Board, the person is immune from

civil liability for his actions and any consequences of his actions unless, when the person recommended the applicant for licensure by the Board, the person acted without any reasonable grounds to support the recommendation.

4. If the person who is the head of the residency program where the applicant received training has refused to recommend the applicant for licensure by the Board or has disclosed to the Board any adverse information concerning the abilities, qualifications, attributes or character of the applicant, the person is immune from civil liability for his actions and any consequences of his actions unless:

(a) When the person refused to recommend the applicant for licensure by the Board, the person acted without any reasonable grounds to support the refusal; or

(b) When the person disclosed the adverse information to the Board, the person acted without any reasonable grounds to believe that the adverse information was accurate.

Sec. 37. *The expiration of a license by operation of law or by order or decision of the Board or a court, or the voluntary surrender of a license by a licensee, does not deprive the Board of jurisdiction to proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.*

Sec. 38. *1. An osteopathic physician shall report to the Board any action filed or claim submitted to arbitration or mediation for malpractice or negligence against the osteopathic physician and the settlement, award, judgment or other disposition of the action or claim within 10 days after:*

(a) The action was filed or the claim was submitted to arbitration or mediation; and

(b) The disposition of the action or claim.

2. If the Board finds that an osteopathic physician has violated the provisions of this section, the Board shall impose a fine of $5,000, in addition to any other fines or penalties permitted by law.

Sec. 39. *1. If the Board receives a report pursuant to the provisions of NRS 633.526, 690B.045, 690B.050 or section 38 of this act that a judgment has been rendered by reason of a claim of malpractice or negligence against an osteopathic physician, regardless of any appeal of the judgment, the Board shall order that the osteopathic physician undergo a mental or physical examination or an examination testing his competence to practice medicine by osteopathic physicians or other examinations designated by the Board to assist the Board or any investigative*

committee of the Board in determining the fitness of the osteopathic physician to practice medicine.

2. For the purposes of this section:

(a) Every osteopathic physician who applies for a license or who holds a license under this chapter shall be deemed to have given his consent to submit to a mental or physical examination or an examination testing his competence to practice medicine when ordered to do so in writing by the Board.

(b) The testimony or reports of the examining osteopathic physician are not privileged communications.

Sec. 40. *1. If the Board receives a report pursuant to NRS 633.526, 690B.045, 690B.050 or section 38 of this act that a judgment has been rendered by reason of a claim of malpractice or negligence against an osteopathic physician, regardless of any appeal of the judgment, the Board shall conduct a hearing to determine whether to impose disciplinary action against the osteopathic physician for violation of the provisions of subsection 4 or 5 of NRS 633.511.*

2. The results of any examination of the osteopathic physician conducted pursuant to the provisions of section 39 of this act must be considered a part of the record of the hearing before the Board.

3. If, after conducting the hearing, the Board finds that a violation of the provisions of subsection 4 or 5 of NRS 633.511 has occurred, the Board shall by order:

(a) Place the osteopathic physician on probation for a specified period on any of the conditions specified in the order;

(b) Administer to him a public reprimand;

(c) Impose a fine not to exceed $5,000;

(d) Require him to perform community service without compensation;

(e) Require him to fulfill certain training or educational requirements; and

(f) Require him to pay all costs incurred by the Board relating to his disciplinary proceedings.

4. The provisions of subsection 3 do not limit the authority of the Board to:

(a) Limit the practice of the osteopathic physician or exclude one or more specified branches of osteopathic medicine from his practice;

(b) Require supervision of his practice;

(c) Require him to participate in a program to correct alcohol or drug dependence or any other impairment;

(d) Suspend his license for a specified period or until further order of the Board; or

(e) Revoke his license to practice osteopathic medicine. If the Board revokes the license to practice osteopathic medicine, the Board is not required to take any disciplinary action set forth in subsection 3 that would be inconsistent with the revocation of the license to practice osteopathic medicine.

5. The Board shall not remove any restrictions imposed on an osteopathic physician pursuant to this section until the osteopathic physician has successfully completed the training or educational requirements ordered by the Board. If the person who provides the training or educational instruction to the osteopathic physician issues a certificate of satisfactory completion, the certificate shall be deemed to be proof that the osteopathic physician satisfactorily completed the training or educational requirements ordered by the Board.

Sec. 41. NRS 633.286 is hereby amended to read as follows:

633.286 1. On or before February 15 of each odd-numbered year, the Board shall submit to the Governor and to the Director of the Legislative Counsel Bureau for transmittal to the next regular session of the Legislature a written report compiling:

(a) Disciplinary action taken by the Board during the previous biennium against osteopathic physicians for malpractice or negligence; and

(b) Information reported to the Board during the previous biennium pursuant to NRS 633.526, subsections 2 and 3 of NRS 633.533 and NRS 690B.045 ~~[.]~~ ***and 690B.050 and section 38 of this act.***

2. The report must include only aggregate information for statistical purposes and exclude any identifying information related to a particular person.

Sec. 42. NRS 633.511 is hereby amended to read as follows:

633.511 The grounds for initiating disciplinary action pursuant to this chapter are:

1. Unprofessional conduct.

2. Conviction of:

(a) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

(b) A felony;

(c) A violation of any of the provisions of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive; or

(d) Any offense involving moral turpitude.

3. The suspension of the license to practice osteopathic medicine by any other jurisdiction.

4. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner.

5. Professional incompetence.

6. Failure to comply with the requirements of ~~[~~NRS 633.526.~~]~~ ***section 38 of this act.***

Sec. 43. NRS 633.526 is hereby amended to read as follows:

633.526 1. The insurer of an osteopathic physician licensed under this chapter ~~[~~and the osteopathic physician~~]~~ must report to the Board any action filed or claim submitted to arbitration or mediation for malpractice or negligence against the osteopathic physician and the settlement, award, judgment or other disposition of the action or claim within 30 days after:

(a) The action was filed or the claim was submitted to arbitration or mediation; and

(b) The disposition of the action or claim.

2. The Board shall report any failure to comply with subsection 1 by an insurer licensed in this state to the Division of Insurance of the Department of Business and Industry. If, after a hearing, the Division of Insurance determines that any such insurer failed to comply with the requirements of subsection 1, the Division may impose an administrative fine of not more than $10,000 against the insurer for each such failure to report. If the administrative fine is not paid when due, the fine must be recovered in a civil action brought by the Attorney General on behalf of the Division.

Sec. 44. NRS 633.651 is hereby amended to read as follows:

633.651 1. The person charged in a formal complaint is entitled to a hearing before the Board, but the failure of the person charged to attend his hearing or his failure to defend himself must not delay or void the proceedings. The Board may, for good cause shown, continue any hearing from time to time.

2. ~~[~~If~~]~~ ***Except as otherwise provided in sections 38 and 40 of this act, if*** the Board finds the person guilty as charged in the formal complaint, it may by order:

(a) Place the person on probation for a specified period or until further order of the Board.

(b) Administer to the person a public reprimand.

(c) Limit the practice of the person to, or by the exclusion of, one or more specified branches of osteopathic medicine.

(d) Suspend the license of the person to practice osteopathic medicine for a specified period or until further order of the Board.

(e) Revoke the license of the person to practice osteopathic medicine.

The order of the Board may contain such other terms, provisions or conditions as the Board deems proper and which are not inconsistent with law.

Sec. 45. 1. The Commissioner shall conduct a study concerning insurers that issue policies of malpractice insurance to

providers of health care in this state. The study must include, without limitation, investigation and fact-finding concerning:

(a) Current actuarial practices, including, without limitation:

(1) Bandwidth used in data transmission;

(2) Credits relating to premiums; and

(3) Charges imposed for specific medical or dental specialties;

(b) Procedures relating to and factors used for the underwriting of losses;

(c) The adequacy of standards, practices and procedures relating to the reserves of insurers; and

(d) The strategies used to price policies of malpractice insurance and other products, including, without limitation, the impact of such strategies on the reserves of insurers.

2. For the purposes of this section, the Commissioner shall appoint an advisory panel within the Division of Insurance of the Department of Business and Industry, consisting of:

(a) An actuary;

(b) A person with expertise regarding policy-making and decision-making within the insurance industry; and

(c) A person with expertise regarding policies of malpractice insurance.

3. The advisory panel appointed pursuant to this section shall:

(a) With regard to the available databases containing actuarial information relating to policies of malpractice insurance:

(1) Review all such databases;

(2) Investigate the accuracy of such databases, including, without limitation, the accuracy of data relating to insurers and to specific medical or dental specialties;

(3) Study the feasibility of combining such databases into one database, including, without limitation, the potential accuracy of that one combined database; and

(4) Formulate recommendations for improving the accuracy and accessibility of such databases and, if feasible, for combining such databases into one database;

(b) With regard to policies of malpractice insurance:

(1) Review the forms for such policies and determine whether the forms are properly used; and

(2) Review the adequacy of standards, practices and procedures relating to the reserves of insurers;

(c) Review any other matters as directed by the Commissioner; and

(d) Report all findings, determinations and recommendations required by this subsection to the Commissioner, in the manner prescribed by the Commissioner.

4. The Commissioner shall hold public hearings, at such times and places as the Commissioner deems appropriate, to:

(a) Carry out the study required pursuant to subsection 1;

(b) Review and consider the report of the advisory panel pursuant to subsection 3; and

(c) Afford the general public and representatives of governmental agencies and of organizations interested in insurance the opportunity to present relevant information and recommendations.

5. The Commissioner and the advisory panel may employ any consultants and professional and secretarial staff that the Commissioner deems necessary to carry out fully the requirements of this section.

6. The Commissioner shall assess to the Board of Medical Examiners all costs related to carrying out the requirements of this section. The Board of Medical Examiners shall pay any claim submitted to the Board by the Commissioner pursuant to this section not less than 30 days after such submission.

7. The Commissioner shall submit to the Director of the Legislative Counsel Bureau for distribution to the Legislature a report of his findings and any recommendations for legislation pursuant to this section not later than March 1, 2004.

8. As used in this section:

(a) "Commissioner" means the Commissioner of Insurance.

(b) "Policy of malpractice insurance" has the meaning ascribed to it in section 6 of this act.

(c) "Provider of health care" has the meaning ascribed to it in section 8 of this act.

Sec. 46. 1. The provisions of section 19 of this act do not apply to an action filed before October 1, 2003.

2. The amendatory provisions of section 22 of this act do not apply to a cause of action that accrues before October 1, 2003.

Sec. 47. 1. The provisions of this act become effective upon passage and approval for the purpose of adopting regulations, and on October 1, 2003, for all other purposes.

2. If the Initiative Petition which is commonly known as "Keep Our Doctors in Nevada" is submitted as a question and is approved by a majority of the voters voting on the question at the general election held in 2004, sections 17 to 20, inclusive, and 22 of this act expire by limitation on the date that the Initiative Petition becomes law and takes effect pursuant to Section 2 of Article 19 of the Nevada Constitution.

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