SENATE BILL NO. 97–COMMITTEE ON JUDICIARY

FEBRUARY 12, 2003

Referred to Committee on Judiciary

SUMMARY—Makes various changes concerning actions for malpractice against providers of health care, removes certain restrictions by insurers on providers of health care and makes various other changes concerning providers of health care. (BDR 1-248)

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

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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 health care; establishing screening panels for claims for medical malpractice or dental malpractice; increasing the limitation on the amount of noneconomic damages that may be awarded in an action for medical malpractice or dental malpractice in certain circumstances; requiring an investigation of a physician who has had three claims of malpractice reported to the licensing board; making various changes relating to the reporting of claims of medical malpractice; prohibiting an insurer from retaliating against a physician or dentist who indicates a desire to settle a claim during a settlement conference; requiring managed care organizations to enter into contracts for the provision of services with any willing provider in certain circumstances; requiring a temporary reduction in the premiums of malpractice insurance; providing a penalty; and providing other matters properly relating thereto.

WHEREAS, The provision of quality medical care is essential to the general health and welfare of the residents of this state; and

WHEREAS, The practice of medicine is a mixture of art and science and is a dynamic and changing discipline based to a great

extent on concepts of probability rather than on absolute certainty; and

WHEREAS, Regardless of the advances in the practice of medicine, unanticipated medical outcomes may occur during medical treatment because of the unavoidable effects of a disease or the unavoidable result of appropriate medical care; and

WHEREAS, Unanticipated medical outcomes do not automatically give rise to liability for damages; and

WHEREAS, Tens of thousands of patients are unfortunately injured each year as a result of inappropriate medical care; and

WHEREAS, This state is experiencing a health care crisis because increasing costs of malpractice insurance premiums have resulted in a potential breakdown in the delivery and quality of health care in this state; and

WHEREAS, Certain measures must be taken to provide protection for both the providers of health care and their patients to improve the quality of health care in this state; and

WHEREAS, A system for screening claims of malpractice by professionals with specialized training and experience will provide such protection for those providers and their patients and will eliminate frivolous claims and resolve meritorious claims; and

WHEREAS, Reasonable limitations on certain types of damages in malpractice actions will fairly balance the rights of those providers and their patients; and

WHEREAS, A system for reporting and investigating claims of medical malpractice will provide protection to the public by removing incompetent physicians from the medical profession; and

WHEREAS, A system for reducing premiums for malpractice insurance will ensure that competent physicians will continue to provide quality medical care in this state; now, therefore,

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

Section 1. This act may be cited as the "Keep Quality Medical Care in Nevada Act."

Sec. 1.5. The Legislature hereby finds and declares that:

1. The 18th Special Session of the Nevada Legislature was held in 2002 to address the State's emerging medical malpractice crisis.

2. The Nevada Legislature recognized that the difficulty experienced in this state in attracting and maintaining a sufficient network of physicians to meet the needs of the residents of this state posed a serious threat to the health, welfare and safety of those residents.

3. The Nevada Legislature unanimously approved broad tort reforms during the 18th Special Session to provide stability and predictability to Nevada's civil justice system and insurance market while protecting the legal remedies available to injured patients.

4. The reforms passed by the Nevada Legislature during the 18th Special Session included:

(a) A $350,000 limitation on the amount that may be awarded for noneconomic damages in a medical malpractice action, which was carefully crafted to limit a physician's liability and provide compensation to an injured patient;

(b) A $50,000 limitation on the amount of damages that may be awarded in a medical malpractice action for emergency care received in hospitals;

(c) Immunity from liability for certain providers of health care who provide treatment gratuitously at a health care facility of a governmental entity or nonprofit organization;

(d) Protection of the right to consider collateral sources of payment to a patient and to elect to receive future damages awarded in periodic payments;

(e) Several liability for noneconomic damages awarded in an action for medical malpractice so that a physician is only liable for such damages in an amount equal to the percentage of negligence attributable to him;

(f) Increasing the efficiency of the civil justice system by providing a shorter period within which to commence a medical malpractice action, making changes concerning pretrial settlement conferences and requiring certain district judges to receive certain training concerning medical malpractice actions;

(g) Stricter requirements concerning reporting information concerning medical malpractice to state licensing boards; and

(h) Requiring the reporting of medical errors and protecting "whistle blowers" who report medical errors or potential medical malpractice.

5. The Nevada Legislature responded to the crisis in 2002 and proposes the additional protections to consumers of medical care in this state as set forth in this act.

Sec. 2. Chapter 630 of NRS is hereby amended by adding thereto a new section to read as follows:

1. If, within the immediately preceding 7 years, a physician has made three reports or has had three reports made concerning him pursuant to NRS 630.3067, a committee designated by the Board and consisting of members of the Board shall review the reports and conduct an investigation to determine whether it is necessary or appropriate to initiate disciplinary action pursuant to this chapter against the physician.

2. If, after conducting the investigation, the committee determines that it is necessary or appropriate to initiate disciplinary action pursuant to this chapter against the physician, the committee shall file a formal complaint with the Board.

Sec. 3. 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]~~ ***shall*** report to the Board ~~[any action filed or claim]~~ ***:***

(a) Any action for malpractice filed against the physician not later than 45 days after the physician receives service of a summons and complaint for the action;

(b) Any claim for malpractice against the physician that is submitted to arbitration or mediation ~~[for malpractice or negligence against the physician and the]~~ ***not later than 45 days after the claim is submitted to arbitration or mediation; and***

(c) Any settlement, award, judgment or other disposition of ~~[the]~~ ***any*** 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.]~~ ***described in paragraph (a) or (b) not later than 45 days after the settlement, award, judgment or other disposition.***

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. 4. NRS 630.339 is hereby amended to read as follows:

630.339 1. If a committee designated by the Board to conduct an investigation of a complaint ***or conduct an investigation pursuant to section 2 of this act*** decides to proceed with disciplinary action, it shall bring charges against the licensee. If charges are brought, the Board shall fix a time and place for a formal hearing. If the Board receives a report pursuant to subsection 5 of NRS 228.420, such a hearing must be held within 30 days after receiving the report. The Board shall notify the licensee of the charges brought against him, the time and place set for the hearing, and the possible sanctions authorized in NRS 630.352.

2. The Board, a hearing officer or a panel of its members designated by the Board shall hold the formal hearing on the charges at the time and place designated in the notification. If the hearing is

before a panel, at least one member of the Board who is not a physician must participate in this hearing.

Sec. 5. 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,]~~ ***subsections 4 and 5,*** 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.

5. If the Board finds that the physician is not competent to practice medicine, the Board shall revoke his license.

Sec. 6. NRS 630.356 is hereby amended to read as follows:

630.356 1. Any person aggrieved by a final order of the Board is entitled to judicial review of the Board's order.

2. Every order that imposes a sanction against a licensee pursuant to subsection 3 ***,*** ~~[or]~~ 4 ***or 5*** of NRS 630.352 or any regulation of the Board is effective from the date the Secretary-Treasurer certifies the order until the date the order is modified or reversed by a final judgment of the court. The court shall not stay the order of the Board pending a final determination by the court.

3. The district court shall give a petition for judicial review of the Board's order priority over other civil matters which are not expressly given priority by law.

Sec. 7. Chapter 633 of NRS is hereby amended by adding thereto a new section to read as follows:

1. If, within the immediately preceding 7 years, an osteopathic physician has made three reports or has had three reports made concerning him pursuant to NRS 633.526, the Board shall designate a member of the Board to review the reports and conduct an investigation to determine whether it is necessary or appropriate to initiate disciplinary action pursuant to this chapter against the osteopathic physician.

2. If, after conducting the investigation, the member determines that it is necessary or appropriate to initiate disciplinary action pursuant to this chapter against the osteopathic physician, the member shall file a formal complaint with the Board.

Sec. 8. 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]~~ ***shall*** report to the Board ~~[any action filed or claim]~~ ***:***

(a) Any action for malpractice filed against the osteopathic physician not later than 45 days after the osteopathic physician receives service of a summons and complaint for the action;

(b) Any claim for malpractice against the osteopathic physician that is submitted to arbitration or mediation ~~[for malpractice or negligence against the osteopathic physician and the]~~ ***not later than 45 days after the claim is submitted to arbitration or mediation; and***

(c) Any settlement, award, judgment or other disposition of ~~[the]~~ ***any*** 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.]~~ ***described in paragraph (a) or (b) not later than 45 days after the settlement, award, judgment or other disposition.***

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. 9. NRS 633.621 is hereby amended to read as follows:

633.621 If a formal complaint is filed with the Board pursuant to NRS 633.541 ~~[,]~~ ***or section 7 of this act,*** the Secretary of the Board shall fix a time and place for a hearing and cause a notice of the hearing and a formal complaint to be served on the person charged at least 20 days before the date fixed for the hearing. If the Board receives a formal complaint concerning subsection 5 of NRS 228.420, such a hearing must be held within 30 days after receiving the formal complaint.

Sec. 10. 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 subsection 3, 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.

3. If the Board finds that the osteopathic physician is not competent to practice osteopathic medicine, the Board shall revoke his license.

Sec. 11. Chapter 41A of NRS is hereby amended by adding thereto the provisions set forth as sections 12 to 33, inclusive, of this act.

Sec. 12. ***As used in sections 12 to 32, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 13, 14 and 15 of this act have the meanings ascribed to them in those sections.***

Sec. 13. ***"Dentist" means a person licensed to practice dentistry or any special branch of dentistry pursuant to chapter 631 of NRS.***

Sec. 14. ***"Division" means the Division of Insurance of the Department of Business and Industry.***

Sec. 15. ***"Health care records" means any written reports, notes, orders, photographs, X-rays or other written record received or produced by a provider of health care, or any person employed by him, which contains information relating to the medical or dental history, examination, diagnosis or treatment of the patient.***

Sec. 16. ***1. No cause of action involving medical malpractice or dental malpractice may be filed until the medical malpractice or dental malpractice case has been submitted to an appropriate screening panel and a determination has been made by such a panel as provided in sections 12 to 32, inclusive, of this act, and any action filed without satisfying the requirements of those sections is subject to dismissal without prejudice for failure to comply with this section.***

2. Except as otherwise provided in subsection 3, the written findings of the screening panel are admissible in any action concerning that claim which is subsequently filed in district court. No other evidence concerning the screening panel or its deliberations is admissible, and no member of the screening panel may be called to testify in any such action.

3. If the screening panel finds that it is unable to reach a decision on the issue of medical malpractice or dental malpractice, the written findings of the screening panel are not admissible in any action concerning that claim which is subsequently filed in district court.

Sec. 17. ***There are hereby created two tentative screening panels, one to be known as the Northern Panel, from which must be selected screening panels to sit in Reno, Nevada, to hear claims of medical malpractice or dental malpractice arising in the counties of Washoe, Storey, Douglas, Lyon, Churchill, Pershing, Humboldt, Lander, Elko, Eureka, Mineral, White Pine and Carson City, and one to be known as the Southern Panel, from which must be selected screening panels to sit in Las Vegas, Nevada, to hear claims of medical malpractice or dental***

malpractice arising in the counties of Lincoln, Nye, Esmeralda and Clark.

Sec. 18. ***1. For cases involving medical malpractice or dental malpractice, the Board of Governors of the Nevada Trial Lawyers Association may designate 40 of its members to serve on the Northern Tentative Screening Panel and 60 of its members to serve on the Southern Tentative Screening Panel. Each person so designated shall serve for a term of 1 year.***

2. For cases involving medical malpractice, the Executive Council of the Nevada State Medical Association may designate 40 of its members to serve on the Northern Tentative Screening Panel and 60 of its members to serve on the Southern Tentative Screening Panel. Each person so designated shall serve for a term of 1 year.

3. For cases involving medical malpractice, the Nevada Hospital Association may designate 40 administrators of hospitals and other persons employed by hospitals in management positions to serve as nonvoting members of the tentative screening panels. Each person so designated shall serve for a term of 1 year.

4. For cases involving dental malpractice, the Nevada Dental Association may designate 40 of its members to serve on the Northern Tentative Screening Panel and 40 of its members to serve on the Southern Tentative Screening Panel. Each person so designated shall serve for a term of 1 year.

Sec. 19. ***1. The Commissioner of Insurance shall arrange for courses of instruction in the rules of procedure and substantive law appropriate for members of a screening panel.***

2. Each person designated to serve on a tentative screening panel shall attend the instruction provided pursuant to subsection 1 before serving on a particular screening panel.

Sec. 20. ***1. The members of a screening panel shall elect one member to serve as chairman.***

2. A screening panel is a state agency. The rules adopted pursuant to section 22 of this act apply to all screening panels.

Sec. 21. ***The provisions of chapter 241 of NRS do not apply to any meeting of a screening panel.***

Sec. 22. ***The Division, through the Commissioner of Insurance:***

1. Shall maintain a list of the names of the attorneys, physicians, dentists, administrators of hospitals and persons employed by hospitals in management positions on the Northern Tentative Screening Panel and on the Southern Tentative Screening Panel;

2. Shall select the members of the screening panels;

3. Shall schedule the hearings for the screening panels;

4. Shall obtain, before or after the filing of a claim, such health care records, statements of policy and procedure and other materials as may be required by a screening panel in connection with the claim;

5. Shall charge and collect a reasonable fee for copying materials produced under subpoena;

6. Shall adopt regulations prescribing the fees to be paid to the Division by any party that is not a governmental entity in an amount sufficient to pay:

(a) All administrative costs incurred to create the tentative screening panels, train the members of the tentative screening panels, appoint members to the screening panels and enable such members to carry out the duties of the screening panels; and

(b) Any other costs reasonably incurred in carrying out the purposes of sections 12 to 32, inclusive, of this act;

7. For good cause shown, may authorize a continuance for the proceedings involving a screening panel; and

8. May adopt such rules of practice and procedure as are necessary to carry out its duties pursuant to sections 12 to 32, inclusive, of this act.

Sec. 23. *Any money received by the Division pursuant to the provisions of sections 12 to 32, inclusive, of this act must be deposited with the State Treasurer for credit to the account for the Division of Insurance in the State General Fund. The administrative costs of the screening panels must be paid from the account.*

Sec. 24. *1. A matter which allegedly involves medical malpractice or dental malpractice is properly presented to a screening panel by filing a claim with the Division and paying any required fee.*

2. The claim must include the following, and no other information:

(a) A clear and concise statement of the facts of the matter, showing the persons involved and the dates and circumstances, so far as they are known, of the alleged medical malpractice or dental malpractice. The claim must not contain any statement of fact that is not included within the health care records of the claimant or any statement about the standard of care that was provided to the claimant.

(b) One or more affidavits from medical or dental experts, as appropriate, providing opinions concerning the appropriate standard of care, the breach of the standard of care, how the breach caused the injury and a description of the injury. A screening panel may dismiss a claim if the claim is filed without such an affidavit.

3. The person against whom a claim is made must, within 90 days after receipt of the claim, file an answer with the Division and pay any required fee. The answer may only include:

(a) A clear and concise statement of the facts of the matter, showing the persons involved and the dates and circumstances, so far as they are known, of the medical or dental care provided. The answer must not contain any statement of fact that is not included within the health care records of the claimant or any statement about the standard of care that was provided to the claimant.

(b) One or more affidavits from medical or dental experts, as appropriate, providing opinions concerning the appropriate standard of care, whether there was a breach of the standard of care, whether the breach of that standard of care caused the injury and a description of the injury.

4. The Division may authorize an extension of the time in which an answer must be filed only if all parties to the matter stipulate to the extension. If an answer is not timely filed with the Division, the respondent who failed to file the answer may not participate in any conference held pursuant to section 25 of this act.

5. The claimant may file a written response to the answer with the Division within 30 days after he receives the answer. The response must not contain any statement of fact that is not included within the health care records of the claimant or any statement about the standard of care provided to the claimant. The screening panel shall disregard any portion of the response that does not address a statement in the answer or an affidavit accompanying the answer. One or more additional affidavits from medical or dental experts may be included with the response providing opinions concerning the appropriate standard of care, whether there was a breach of the standard of care, whether the breach of that standard of care caused the injury and a description of the injury. No fee may be charged or collected by the Division for the filing of the response.

6. The Division may authorize an extension of the time in which a response may be filed only if all parties to the matter stipulate to the extension. Unless otherwise stipulated to by all the parties to the matter, the Division may not accept any response that is not timely filed.

7. A copy of any claim, answer or response filed with the Division pursuant to this section must be delivered by the party, by certified or registered mail or by personal service, to each opposing party or, if he is represented in the proceedings of the screening panel by counsel, to his attorney.

Sec. 25. *1. Within 35 days after the expiration of the time in which to answer a claim of medical malpractice or dental malpractice, the Division shall hold a conference to resolve any issues as to challenges for cause. For good cause shown, the Division may continue the conference once, for a period not to exceed 7 days. A party may challenge any person on the tentative screening panel for cause on any of the grounds provided by NRS 16.050 for the challenge of jurors.*

2. The Division shall determine whether cause exists to excuse any member of the tentative screening panel and shall notify each party of the excused members no later than the completion of the conference required by subsection 1.

3. Except as otherwise provided in this subsection, each party is entitled to not more than:

(a) Two peremptory challenges from the list of attorneys in cases involving medical malpractice or dental malpractice;

(b) Two peremptory challenges from the list of physicians in cases involving medical malpractice; and

(c) Two peremptory challenges from the list of dentists in cases involving dental malpractice.

In any case in which there are two or more claimants or respondents, they are collectively entitled to not more than four peremptory challenges from the list of members selected for the tentative screening panel. Each party asserting a peremptory challenge shall notify the Division of the challenge at the conference required by subsection 1. If several parties are represented by the same attorney, those parties shall be deemed to be one party for the purpose of determining the distribution of peremptory challenges.

4. In cases involving medical malpractice, the Division shall randomly select, from the list of members of the tentative screening panel who have not been excused for cause or by a peremptory challenge, the names of two physicians, two attorneys and, if a hospital is also named in the claim submitted to the Division, one administrator of a hospital or person employed by a hospital in a management position, to serve on the screening panel for review of a claim of medical malpractice, but the representative of a hospital may not vote on any claim before the screening panel.

5. In cases involving dental malpractice, the Division shall randomly select, from the list of members of the tentative screening panel who have not been excused for cause or by a peremptory challenge, the names of two dentists and two attorneys to serve on the screening panel for review of the claim of dental malpractice.

6. The Division shall notify the parties and the members selected to serve on the screening panel immediately after it has made the selections. If any member so selected declines to serve, the Division shall immediately and randomly select a replacement from the list. The Division shall not release or disclose to any person the names of the members selected.

7. If, because of the exercise of challenges for cause or peremptory challenges or any other reason, no attorney, dentist, physician, administrator of a hospital or other person employed by a hospital in a managerial position designated pursuant to section 18 of this act remains available to serve on the screening panel, the Division shall immediately notify the Nevada Trial Lawyers Association, the Nevada State Medical Association, the Nevada Dental Association or the Nevada Hospital Association, as appropriate, and that association shall immediately designate a replacement from among its members. No person who is not so designated may serve on the screening panel.

Sec. 26. *1. The Division may, by certified or registered mail, issue subpoenas, as may be required by the screening panel, to compel the attendance of medical or dental experts, as appropriate, who may testify only with regard to the health care records of the claimant, and, as may be required by the parties or the screening panel, to compel the production of books, papers, health care records, statements of policy and procedure or other materials.*

2. The Division shall keep the material so produced and make it available to the parties, upon request, for inspection or copying. If the material is reasonably capable of being copied, the Division shall provide a copy to the parties, upon request and receipt of a fee for the copying.

3. If the health care record of a claimant is illegible or difficult to read, the claimant may request an explanation of the health care record from the provider of health care who created the record. If the provider of health care fails or refuses to provide a satisfactory explanation, the claimant may request the Division to issue a subpoena to compel the provider of health care to provide a satisfactory explanation.

4. If any medical or dental expert refuses to attend or testify or if any person refuses to produce any materials as required by a subpoena, the Division may report to the district court by petition, setting forth that:

(a) Due notice has been given of the time and place of attendance of the medical or dental expert or for the production of the materials;

(b) The medical or dental expert or the person required to produce the materials has been subpoenaed by the Division pursuant to this section; and

(c) The medical or dental expert has failed or refused to attend or the person has failed or refused to produce the materials required by the subpoena, or has refused to answer questions propounded to him,

and asking for an order of the court compelling the medical or dental expert to attend and testify or the other person to produce the materials.

5. Upon receiving such a petition, the court shall enter an order directing the medical or dental expert or other person to appear before the court at a time and place to be fixed by the court in its order, the time to be not more than 10 days after the date of the order, and show cause why he has not attended or testified or produced the materials. A certified copy of the order must be served upon the medical or dental expert or other person.

6. If it appears to the court that the subpoena was regularly issued by the Division, the court shall enter an order that the medical or dental expert or other person appear at the time and place fixed in the order and testify or produce the required materials, and upon his failure to obey the order, the medical or dental expert or other person must be dealt with as for contempt of court.

Sec. 27. ***1. A claim must be heard by a screening panel within 30 days after the panel is selected.***

2. The screening panel shall consider all the documentary material, including the claim, answer and response, health care records and records of a hospital or office and the testimony of any medical or dental experts provided by the parties that the panel considers necessary, and shall determine only, from that evidence, whether there is a reasonable probability that the acts complained of constitute medical malpractice or dental malpractice and that the claimant was injured thereby. Except for the issue of whether there is a reasonable probability of medical malpractice or dental malpractice and whether the claimant was injured thereby, the screening panel shall not consider any pleading or paper to the extent that it addresses a legal issue presented by the claim or a legal argument of a party. The screening panel shall not consider challenges concerning any relevant statute of limitation relating to a claim before the panel.

3. Copies of the original claim and of the findings of the screening panel with regard to each matter considered by the panel must be forwarded to:

(a) In cases involving medical malpractice:

(1) The Board of Medical Examiners;

(2) The State Board of Osteopathic Medicine; and

(3) The county medical society of the county in which the alleged malpractice occurred.

(b) In cases involving dental malpractice, the Board of Dental Eaminers of Nevada.

4. The Commissioner of Insurance shall mail to the parties a copy of the findings of the screening panel concerning the claim.

5. The written findings of the screening panel must be based upon a vote of the members of the screening panel made by written ballot, must be rendered within 5 days after the review and must be in substantially the following form:

(a) Based upon a review of the materials submitted by the parties and expert testimony (if any) we find that there is a reasonable probability of medical malpractice or dental malpractice and that the claimant was injured thereby;

(b) Based upon a review of the materials submitted by the parties and expert testimony (if any) we find that there is no reasonable probability of medical malpractice or dental malpractice; or

(c) Based upon a review of the materials submitted by the parties and expert testimony (if any) we are unable to reach a decision on the issue of medical malpractice or dental malpractice.

6. Whenever three members of the screening panel are unable to find that there is a reasonable probability of medical malpractice or dental malpractice and that the claimant was injured thereby or that there is no reasonable probability of medical malpractice or dental malpractice, the screening panel shall be deemed unable to reach a decision on the issue and shall make a finding to that effect.

Sec. 28. *1. If a claimant is 70 years of age or older or suffers from an illness or condition which raises a substantial medical doubt that the claimant will survive until a determination is made by a screening panel, the claimant may file a written request with the Division to give preference in scheduling the hearing of the claim filed by the claimant. The request must set forth facts showing that the claimant is 70 years of age or older or suffers from an illness or condition which raises a substantial medical doubt that the claimant will survive until a determination is made by a screening panel.*

2. The Division shall schedule the hearing of claims for which preference has been granted pursuant to subsection 1 based on the order in which the Division received the requests for preference.

Sec. 29. *1. Upon the request of the Division or counsel for a patient, a custodian of any health care records shall not allow any person to review any of those records relevant to a claim filed with the Division before those records are transferred to a requesting party or the authority issuing the subpoena.*

2. A violation of this section is punishable as a misdemeanor.

Sec. 30. *1. If a screening panel finds in favor of a claimant and a cause of action involving medical malpractice or dental malpractice is thereafter filed by the claimant in district court, a settlement conference must be held as provided in NRS 41A.081.*

2. If the determination of the screening panel is not in favor of the claimant, the claimant may file an action in court. If the claimant does not obtain a judgment in his favor in court, the defendant must be awarded reasonable costs and attorney's fees incurred after the date of filing the action in court.

3. If the screening panel is unable, for any reason, to reach a decision, the claimant may file a civil action or proceed no further with the claim.

4. If the claimant files a civil action in district court, a person may not be named as a party in the action unless the person was named as a party in the claim which was filed with the Division and considered by the screening panel.

Sec. 31. *1. Unless the written findings of a screening panel are not admissible pursuant to subsection 3 of section 16 of this act, in any action for medical malpractice tried before a jury, the following instructions must be given:*

(a) If testimony of an expert was given at the review by the screening panel:

During the course of this trial certain evidence was admitted concerning the findings of a screening panel. The findings of the panel were based upon a review of the medical records of the claimant and the testimony of medical experts based upon the review by the experts of those records. These findings are to be given the same weight as any other evidence, but are not conclusive on your determination of the case.

(b) If testimony of an expert was not given at the review by the screening panel:

During the course of this trial certain evidence was admitted concerning the findings of a screening panel. The findings of the panel were based solely upon a review of the medical records of the claimant. These findings are to be given the same weight as any other evidence, but are not conclusive on your determination of the case.

2. Unless the written findings of a screening panel are not admissible pursuant to subsection 3 of section 16 of this act, in

any action for dental malpractice tried before a jury, the following instructions must be given:

(a) If testimony of an expert was given at the review by the screening panel:

During the course of this trial certain evidence was admitted concerning the findings of a screening panel. The findings of the panel were based upon a review of dental records of the claimant and the testimony of experts based upon the review by the experts of those records. These findings are to be given the same weight as any other evidence, but are not conclusive on your determination of the case.

(b) If testimony of an expert was not given at the review by the screening panel:

During the course of this trial certain evidence was admitted concerning the findings of a screening panel. The findings of the panel were based solely upon a review of the dental records of the claimant. These findings are to be given the same weight as any other evidence, but are not conclusive on your determination of the case.

Sec. 32. *A screening panel or any of its members acting pursuant to sections 12 to 32, inclusive, of this act that initiates or assists in any proceeding concerning a claim of medical malpractice or dental malpractice against a physician or dentist is immune from any civil action for that initiation or assistance or any consequential damages if the panel or members acted without malicious intent.*

Sec. 33. *1. Except as otherwise provided in subsection 2 and except as further limited in subsection 3, in an action for damages for medical malpractice or dental malpractice where the alleged malpractice occurred on or after the effective date of this act, the noneconomic damages awarded to each plaintiff from each defendant must not exceed $350,000, except that if the plaintiff is not entitled to receive economic damages for lost wages the noneconomic damages awarded must not exceed $500,000.*

2. In an action for damages for medical malpractice or dental malpractice where the alleged malpractice occurred on or after the effective date of this act, the limitation on noneconomic damages set forth in subsection 1 does not apply in the following circumstances and types of cases:

(a) A case in which the conduct of the defendant is determined to constitute gross malpractice; or

(b) A case in which, following return of a verdict by the jury or a finding of damages in a bench trial, the court determines, by clear and convincing evidence admitted at trial, that an award in excess of the limits on the amount of noneconomic damages that

may be awarded to a plaintiff is justified because of exceptional circumstances.

3. Except as otherwise provided in subsection 4, in an action for damages for medical malpractice or dental malpractice where the alleged malpractice occurred on or after the effective date of this act, in the circumstances and types of cases described in subsections 1 and 2, the noneconomic damages awarded to each plaintiff from each defendant must not exceed the amount of money remaining under the professional liability insurance policy limit covering the defendant after subtracting the economic damages awarded to that plaintiff. Irrespective of the number of plaintiffs in the action, in no event may any single defendant be liable to the plaintiffs in the aggregate in excess of the professional liability insurance policy limit covering that defendant.

4. The limitation set forth in subsection 3 does not apply in an action for damages for medical malpractice or dental malpractice unless the defendant was covered by professional liability insurance at the time of the occurrence of the alleged malpractice and on the date on which the insurer receives notice of the claim, in an amount of:

(a) Not less than $1,000,000 per occurrence; and

(b) Not less than $3,000,000 in the aggregate.

5. This section is not intended to limit the responsibility of any defendant for the total economic damages awarded.

6. For the purposes of this section, "gross malpractice" means failure to exercise the required degree of care, skill or knowledge that amounts to:

(a) A conscious indifference to the consequences which may result from the gross malpractice; and

(b) A disregard for and indifference to the safety and welfare of the patient.

Sec. 34. NRS 41A.031 is hereby amended to read as follows:

41A.031 1. Except as otherwise provided in subsection 2 and except as further limited in subsection 3, in an action for damages for medical malpractice or dental malpractice ~~[,]~~ ***where the alleged malpractice occurred on or after October 1, 2002, but before the effective date of this act,*** the noneconomic damages awarded to each plaintiff from each defendant must not exceed $350,000.

2. In an action for damages for medical malpractice or dental malpractice ~~[,]~~ ***where the alleged malpractice occurred on or after October 1, 2002, but before the effective date of this act,*** the limitation on noneconomic damages set forth in subsection 1 does not apply in the following circumstances and types of cases:

(a) A case in which the conduct of the defendant is determined to constitute gross malpractice; or

(b) A case in which, following return of a verdict by the jury or a finding of damages in a bench trial, the court determines, by clear and convincing evidence admitted at trial, that an award in excess of $350,000 for noneconomic damages is justified because of exceptional circumstances.

3. Except as otherwise provided in subsection 4, in an action for damages for medical malpractice or dental malpractice ~~[,]~~ ***where the alleged malpractice occurred on or after October 1, 2002, but before the effective date of this act,*** in the circumstances and types of cases described in subsections 1 and 2, the noneconomic damages awarded to each plaintiff from each defendant must not exceed the amount of money remaining under the professional liability insurance policy limit covering the defendant after subtracting the economic damages awarded to that plaintiff. Irrespective of the number of plaintiffs in the action, in no event may any single defendant be liable to the plaintiffs in the aggregate in excess of the professional liability insurance policy limit covering that defendant.

4. The limitation set forth in subsection 3 does not apply in an action for damages for medical malpractice or dental malpractice unless the defendant was covered by professional liability insurance at the time of the occurrence of the alleged malpractice and on the date on which the insurer receives notice of the claim, in an amount of:

(a) Not less than $1,000,000 per occurrence; and

(b) Not less than $3,000,000 in the aggregate.

5. This section is not intended to limit the responsibility of any defendant for the total economic damages awarded.

6. For the purposes of this section, "gross malpractice" means failure to exercise the required degree of care, skill or knowledge that amounts to:

(a) A conscious indifference to the consequences which may result from the gross malpractice; and

(b) A disregard for and indifference to the safety and welfare of the patient.

Sec. 35. 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 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) In any action governed by the provisions of sections 12 to 32, inclusive, of this act from the date on which a claimant files a claim for review by a screening panel until 30 days after the date on which the screening panel notifies the claimant, in writing, of its findings. The provisions of this paragraph apply to an action against the provider of health care and to an action against any person or governmental entity that is alleged by the claimant to be liable vicariously for the medical malpractice or dental malpractice of the provider of health care, if the provider, person or governmental entity has received notice of the filing of a claim for review by a screening panel within the limitation of time provided in subsection 1.

Sec. 36. NRS 49.245 is hereby amended to read as follows:

49.245 There is no privilege under NRS 49.225 or 49.235:

1. For communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the doctor in the course

of diagnosis or treatment has determined that the patient is in need of hospitalization.

2. As to communications made in the course of a court-ordered examination of the condition of a patient with respect to the particular purpose of the examination unless the court orders otherwise.

3. As to written medical or hospital records relevant to an issue of the condition of the patient in any proceeding in which the condition is an element of a claim or defense.

4. In a prosecution or mandamus proceeding under chapter 441A of NRS.

5. As to any information communicated to a physician in an effort unlawfully to procure a dangerous drug or controlled substance, or unlawfully to procure the administration of any such drug or substance.

6. As to any written medical or hospital records which are furnished in accordance with the provisions of NRS 629.061.

7. As to records that are required by chapter 453 of NRS to be maintained.

8. If the services of the physician are sought or obtained to enable or aid a person to commit or plan to commit fraud or any other unlawful act in violation of any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS which the person knows or reasonably should know is fraudulent or otherwise unlawful.

9. In a review before a screening panel pursuant to sections 12 to 32, inclusive, of this act.

Sec. 37. Chapter 690B of NRS is hereby amended by adding thereto a new section to read as follows:

An insurer shall not take any retaliatory action, including, without limitation, cancelling or failing to renew a policy of insurance or renewing a policy of insurance with altered policy or contract terms, against a physician or dentist who, during a settlement conference held pursuant to NRS 41A.081, indicates his desire to settle the claim for or within his policy limits.

Sec. 38. NRS 690B.045 is hereby amended to read as follows:

690B.045 Except as more is required in NRS 630.3067 and 633.526:

1. Each insurer which issues a policy of insurance covering the liability of a practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS for a breach of his professional duty toward a patient shall report to the board which licensed the practitioner within ~~[30]~~ ***45*** days each settlement or award made or judgment rendered by reason of a claim, if the settlement, award or judgment is for more than $5,000, giving the name and address of the claimant and the practitioner and the circumstances of the case.

2. A practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS who does not have insurance covering liability for a breach of his professional duty toward a patient shall report to the board which issued his license within ~~[30]~~ ***45*** days of each settlement or award made or judgment rendered by reason of a claim, if the settlement, award or judgment is for more than $5,000, giving his name and address, the name and address of the claimant and the circumstances of the case.

3. These reports are public records and must be made available for public inspection within a reasonable time after they are received by the licensing board.

Sec. 39. NRS 690B.050 is hereby amended to read as follows:

690B.050 1. Each insurer which issues a policy of insurance covering the liability of a physician licensed under chapter 630 of NRS or an osteopathic physician licensed under chapter 633 of NRS for a breach of his professional duty toward a patient shall report to the Commissioner within ~~[30]~~ ***45*** days each settlement or award made or judgment rendered by reason of a claim, giving the name and address of the claimant and physician 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. 40. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 3, each health care plan offered or issued by a managed care organization that contracts with providers of health care for the provision of health care services to insureds must provide that the managed care organization will enter into a contract with any provider of health care for the provision of covered health care services to its insureds if:

(a) The provider of health care is qualified under the laws of this state to provide such care; and

(b) The provider of health care agrees to accept the rates, terms and conditions established for other providers of health care by the managed care organization.

2. An evidence of coverage for a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after the effective date of this act has the legal effect of including the provisions required by this section, and any provision of the evidence of coverage or renewal thereof that is in conflict with this section is void.

3. The provisions of this section do not apply to any plan for providing welfare benefits for employees of more than one employer as described in NRS 679B.139.

Sec. 41. NRS 41A.071 is hereby repealed.

Sec. 42. Sections 12 to 32, inclusive, of this act do not apply to an action involving medical malpractice or dental malpractice filed before the effective date of this act.

Sec. 43. 1. Until the Division of Insurance of the Department of Business and Industry collects sufficient fees to pay for the administrative costs of the screening panels established pursuant to sections 12 to 32, inclusive, of this act, the Division shall apportion such administrative costs among the Board of Medical Examiners, the State Board of Osteopathic Medicine and the Board of Dental Examiners of Nevada as follows:

(a) The Board of Medical Examiners shall pay a portion of the administrative costs based on the ratio of the number of physicians licensed pursuant to chapter 630 of NRS to the total number of physicians, osteopathic physicians and dentists licensed pursuant to the provisions of chapters 630, 631 and 633 of NRS.

(b) The State Board of Osteopathic Medicine shall pay a portion of the administrative costs based on the ratio of the number of osteopathic physicians licensed pursuant to chapter 633 of NRS to the total number of physicians, osteopathic physicians and dentists licensed pursuant to the provisions of chapters 630, 631 and 633 of NRS.

(c) The Board of Dental Examiners of Nevada shall pay a portion of the administrative costs based on the ratio of the number of dentists licensed pursuant to chapter 631 of NRS to the total number of physicians, osteopathic physicians and dentists licensed pursuant to the provisions of chapters 630, 631 and 633 of NRS.

2. Any money received by the Division of Insurance pursuant to the provisions of this section must be deposited with the State Treasurer for credit to the account for the Division of Insurance in the State General Fund. The administrative costs of the screening panels must be paid from the account.

3. If a board fails to pay its apportioned share of the administrative costs required by this section, the Commissioner of Insurance may refer the nonpayment to the Office of the Attorney General for collection of the apportioned share and any costs incurred.

4. For the purposes of this section, "administrative costs" means:

(a) All costs incurred to create the tentative screening panels, train the members of the tentative screening panels, appoint

members to the screening panels and enable such members to carry out the duties of the screening panels; and

(b) Any other costs reasonably incurred in carrying out the purposes of sections 12 to 32, inclusive, of this act.

Sec. 44. 1. For a policy of insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of his professional duty toward a patient that is issued or renewed on or after the effective date of this act, the insurer shall reduce the premium for the policy to an amount which:

(a) Must be determined by the Commissioner of Insurance; and

(b) Must be less than the premium for the same coverage in effect on the effective date of this act.

2. If, on or after the effective date of this act, a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS applies for the first time for a policy of insurance covering the liability of the practitioner for a breach of his professional duty toward a patient, the premium for the policy:

(a) Must be determined by the Commissioner of Insurance; and

(b) Must be less than the premium for similarly situated risks in effect on the effective date of this act.

3. Any separate affiliate of an insurer, established after the effective date of this act, is subject to the provisions of this section and shall reduce its premiums to amounts which:

(a) Must be determined by the Commissioner of Insurance; and

(b) Must be less than the insurer's premiums in effect on the effective date of this act.

4. In determining the amount by which premiums must be reduced pursuant to this section, the Commissioner of Insurance shall consider:

(a) Whether the reduction in premiums permits a fair and reasonable return to the insurer; and

(b) Whether the reduction in premiums is otherwise not confiscatory.

5. During the period beginning on the effective date of this act and ending on December 1, 2004:

(a) Premiums reduced pursuant to this section may be increased only in accordance with the provisions of this subsection or chapter 686B of NRS.

(b) An insurer subject to the provisions of this section may apply to the Commissioner of Insurance pursuant to this subsection to increase a premium set pursuant to this section if the premium set pursuant to this section fails to provide a fair and reasonable return to the insurer or is otherwise confiscatory.

(c) An application by an insurer pursuant to this subsection:

(1) Must be in writing;

(2) Must contain a detailed analysis of the reasons the premium set pursuant to this section fails to provide a fair and reasonable return to the insurer or is otherwise confiscatory, including, without limitation, relevant facts and provisions of law; and

(3) Must contain a proposed premium which:

(I) The insurer believes is the minimum premium that provides a fair and reasonable return to the insurer and is otherwise not confiscatory; and

(II) Is equal to or less than the premium charged by the insurer before the reduction pursuant to this section.

(d) After a hearing, the Commissioner of Insurance may approve the application of an insurer pursuant to this subsection, provided that the Commissioner:

(1) Finds that the premium set pursuant to this section fails to provide a fair and reasonable return to the insurer or is otherwise confiscatory; and

(2) Sets the premium at the minimum amount that provides a fair and reasonable return to the insurer and is otherwise not confiscatory.

(e) An insurer who submits an application pursuant to this subsection may charge the premium proposed in the application until the Commissioner of Insurance approves or disapproves the application, provided that:

(1) Upon approval of the application, the insurer immediately begins to charge the premium set by the Commissioner of Insurance pursuant to this subsection and refunds any excess portion of the previously paid premiums, with interest, to the person who paid the premiums; and

(2) Upon disapproval of the application, the insurer immediately begins to charge the premium set pursuant to this section and refunds the excess portion of the previously paid premiums, with interest, to the person who paid the premiums.

(f) If an insurer submits an application pursuant to this subsection, the insurer may not submit another application pursuant to this subsection regarding the same premium until no sooner than 60 days after the date of the decision of approval or disapproval of the Commissioner of Insurance with regard to the first application.

6. Notwithstanding any previous notice of cancellation or renewal, an insurer who has issued a policy of insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of his professional duty toward a patient that is in effect on the effective date of this act, and has a scheduled date for termination of the policy before December 1, 2004, shall not terminate or cancel that policy before December 1,

2004, or refuse to renew or extend that policy through November 30, 2004, for the purpose of avoiding the reduction in premiums required by this section.

7. An insurer who cancels or fails to renew policies of insurance covering the liability of practitioners licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of their professional duty toward patients at a rate that exceeds the insurer's average monthly rate of cancellation or failure to renew, respectively, for the preceding 24 months by more than 10 percent during any 30-day period between the effective date of this act and December 1, 2004, is required to show cause immediately to the Commissioner of Insurance why the insurer is not in violation of this section. Any violation of this section is a violation of the Nevada Insurance Code. If the Commissioner of Insurance determines that the reason for the increase in the rate of cancellation of or failure to renew policies is an attempt to circumvent the reduction in premiums required by this section, the Commissioner may take appropriate disciplinary action.

8. For the purposes of this section:

(a) "Insurer" has the meaning ascribed to it in NRS 679A.100.

(b) "Premium" has the meaning ascribed to it in NRS 679A.115.

Sec. 45. 1. Not later than 90 days after the effective date of this act, an insurer subject to the provisions of section 44 of this act shall submit a proposal to reduce premiums to the lowest amount possible that continues to permit a fair and reasonable return to the insurer and is not otherwise confiscatory, taking into consideration the savings experienced and reasonably anticipated as a result of the passage of Assembly Bill No. 1 of the 18th Special Session of the Nevada Legislature.

2. Until the Commissioner of Insurance determines the amount by which an insurer must reduce premiums, the insurer may continue to charge the current premium. Upon such a determination of the Commissioner of Insurance, the insurer shall immediately begin to charge the premium set by the Commissioner of Insurance and refund any excess portion of the previously paid premiums, with interest, to the person who paid the premiums.

Sec. 46. Section 44 of this act expires by limitation on July 1, 2007.

Sec. 47. 1. At the general election held in 2004, the provisions of this act must be submitted to the registered voters of this state, pursuant to Section 2 of Article 19 of the Nevada Constitution, as a different and competing measure enacted by the Legislature on the same subject contained in the initiative petition that was presented to the Legislature by the Secretary of State on February 3, 2003.

2. If the initiative petition that was presented to the Legislature by the Secretary of State on February 3, 2003, is invalidated or for any other reason is not submitted to the registered voters of this state at the general election held in 2004, the provisions of this act also must not be submitted to the registered voters of this state at that general election and are thereafter void.

3. This act shall become law and take effect in the manner set forth in Section 2 of Article 19 of the Nevada Constitution.

TEXT OF REPEALED SECTION

41A.071 Dismissal of action filed without affidavit of medical expert supporting allegations. If an action for medical malpractice or dental malpractice is filed in the district court, the district court shall dismiss the action, without prejudice, if the action is filed without an affidavit, supporting the allegations contained in the action, submitted by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged malpractice.

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