

# MEDICAL PROFESSIONAL LIABILITY INSURANCE MANDATORY REPORTING OF DETAILED CLAIM INFORMATION

## GENERAL INSTRUCTIONS AND INFORMATION FREQUENTLY ASKED QUESTIONS

Most Recent Update: January 6, 2014

### **Background:**

#### Screening Panel Report RSA 519-B

With the passage of SB 419 in 2014 and RSA 519-B:16, the New Hampshire Legislature reauthorized the insurance commissioner to collect data from medical malpractice insurers and report on that data to the Medical Malpractice Panel and Insurance Oversight Committee comprised of eight legislators. The purpose of the Committee is to review and analyze information provided by the administrative office of the courts and the insurance department related to medical injury liability claim activity in order to determine the effectiveness of mandatory screening panels. Part of their review is to analyze whether or not medical malpractice insurance premiums have been affected by the use of screening panels.

In 2014 the insurance department adopted Ins 3800, the rules that provide the guidelines to be used to report detailed claim information to help in this analysis. We are the conduit by which summary data is provided to the legislature, and we assist and guide the analytical process of comparing individual claim settlement activity with statewide premium trends. It is important to remember that the primary purpose for collecting and analyzing claims data is to study the impact of the screening panel process in NH on the cost structure associated with medical malpractice insurance for NH healthcare providers (obtained from insurers or through self-insurance mechanisms).

#### Early Offer Report RSA 519-C

A second report is required of insurers—the report of any “early offer” claims. RSA 519-C authorizes the collection of claims information from insurers or self-insured entities with regard to “early offer” claims. According to the statute an “early offer” is “an offer to pay an injured person's economic loss related to a medical injury, and reasonable attorney's fees and costs incurred in representing the injured person.” Ins 4900 was established in 2014 to create a process for collecting this information.

To help facilitate your reporting under both RSA 519-B and RSA 519-C, the Department is providing you with the following information.

**General Instructions and Information:** The department intends to update this document on a regular basis to reflect current procedures and questions received from reporting entities. It would be worthwhile to check the department’s website regularly for updates.

- Ins 3800, as amended and effective January 1, 2015, specifies that an annual report is due at the department on or before August 1 of each year. The prior rule provided for reports to be filed quarterly on January 10th, April 10th, July 10th, and October 10th. The new rule also states that this report should include claims made against NH insureds that have been opened, modified, or closed during the preceding 12-month period July through June. Therefore, if you submitted a quarterly report on October 10, 2014, which included the months of July and August, 2014, then your 2015 report (due on August 1, 2015) only need include activity for a ten month period from September 1, 2014 through June 30, 2015.
- Ins 4900 explains the procedure for the annual reporting of “early offer” claims. These reports must be filed annually on October 15. All claims that have resulted in an early offer need to be reported even if the offer was not accepted or responded to.
- For both screening panel reports made under RSA 519-C (and Ins 4900) and early offer reports made under RSA 519-B (and Ins 3800), submissions should be provided in an excel workbook with two spreadsheets. The first sheet is a “Claim Summary” which should list the claims being reported and a brief comment on why they are each included in the report (opened, modified, or closed). The second sheet should provide the claim detail which includes complete answers to a series of questions about each claim in the report. It is very important that all questions are answered for each claim.

Please note that some questions for the screening panel report under RSA 519-C have changed slightly.

- Question 14 now requires one total dollar amount for payment made. This is the total amount paid by your company to the claimant. All payments for the claims refer to the actual amount paid to the claimant, even if you received reimbursement from the insured or reinsurer. Do not report on claims for which you act as a reinsurer.
- Question 11 refers to the claim’s screening panel status. Please take care to complete this response correctly. There cannot be a screening panel unless a suit has been filed, so, if there is not yet a suit, the correct code here is (01). Once a suit has been filed, the screening panel process has officially been initiated. If the claim closes before the panel presentations, and before having officially bypassed the screening panel, we ask that you enter code (02). It is not acceptable to enter an NA here or leave this question blank.
- Similarly the required responses to question 12 (Settlement code) has been updated. Again you may not leave this question blank or submit “NA”. If a claim is not yet closed, only (00) can be entered and if a claim is closed then (00) cannot be entered. It is not

acceptable to respond “I don’t know” as your response to this question. It is the responsibility of the respondent to obtain the information required.

- The required response to Question 13 has not changed. This question addresses the status of court proceedings. If no suit was filed, enter (00). If a suit was filed, you cannot enter (00). Also, it is the responsibility of the respondent to inquire of knowledgeable counsel as to the appropriate codes.

### **Questions and Answers:**

Q. We are an insurance company licensed in New Hampshire, but we do not write Professional Liability or Medical Malpractice insurance. Do we have to submit summary reports, indicating this to be the case?

*A. No reporting is required.*

Q. Should we report on claims where we act as a reinsurer?

*A. No only primary insurers should report on claims. However they must present all amounts paid to the claimant even if they will cede some or all of the loss to a reinsurer.*

Q. Should we report dollar amounts before or after a deductible?

*A. You should report what is paid to the claimant on behalf of the insured. This is before consideration of recovery in the form of deductible, reinsurance or subrogation.*

Q. Where can we find the Act or Omission codes?

*A. You will use the 3-digit codes published by the National Practitioner Data Bank in the old form. They can found at <http://www.npdb.hrsa.gov/software/CodeLists.pdf>. The applicable codes are in Tables 122 – 131 on pages 43-44.*

Q. How should we report a claim that involves multiple insureds?

*A. Suppose a claim is settled for \$1,000,000, payments are made on behalf of 2 doctors (\$250,000 each) and a hospital (\$500,000). Suppose you insure both doctors, but the hospital is self-insured. You would report 2 claims (one for each doctor) and the \$250,000 paid for each. The hospital would report the \$500,000 claim.*

Q. We are a medical provider who self-insures. Do we need to submit a report?

*A. Yes*

Q. How often do we have to update information about a claim?

*A. Reports are due annually and you only need to update information about a claim previously reported in your annual report. A claim should first be reported when a reserve is established by the insurer (item 9a should have a non-zero value). Once you have reported the claim, you would only need to report on that claim if there is*

- a material change to the information already supplied to department,*
- the indemnity or expense reserve is modified,*
- a payment is made, or*
- the claim is closed.*

Q. If there is no activity in the past year on any claims; does an insurer have to notify the department of that?

*A. There is no need for such notification.*

Q. If I submit a screening panel report in January, 2015, can I just report activity since that report?

*A. No, the rule governing screening panel reports which is in effect as of January 1, 2015, provides for an annual reporting date of August 1 and you may no longer file quarterly reports. Any submissions made in January will be rejected.*

*If you filed no quarterly report in 2014, but file a report on August 1, 2015, that report should include activity for the reporting period July 1, 2014 through June 30, 2015. If you filed a quarterly report in October of 2014, then your August 1, 2015 report should report activity from September 1, 2014 to June 30, of 2015.*

Q. For a screening panel report, if we filed a suit and the screening panel process has not started, what code should we use to answer question 11?

*A. The screening panel process begins when a suit is filed with the court. So if a suit is filed and the paperwork for bypassing the screening panel has not been submitted then use code (02).*

Q. If we do not know which screening panel code to use, out what should we do?

*A. Speak with the claim handler or lawyers overseeing the case. They must be aware of the status of screening panel. You must enter the correct code.*

The department contacts to whom questions and comments should be directed and to whom reports should be sent are:

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