Readopt with amendment, Ins 3800, effective 12-01-06 (Doc. #8754), to read as follows:

CHAPTER Ins 3800 MEDICAL PROFESSIONAL LIABILITY INSURANCE

Statutory Authority: RSA 400-A;15, I.; RSA 412:43; RSA 519-B:12 II.

PART Ins 3801 MANDATORY REPORTING OF DETAILED CLAIM INFORMATION

Ins 3801.01 Purpose. The purpose of this chapter is to identify the rules and guidelines to be used to report detailed claim information applicable to medical professional liability insurance.

Ins 3801.02 Scope. This chapter shall apply to all insurers writing medical professional liability insurance in this state.

Ins 3801.03 Definitions.

(a) "Act or omission code" means the old format MMPR Act or Omission Codes from the National Practitioner's Data Bank Code Lists that identifies the type of loss category related to:

(1) Diagnosis;

(2) Anesthesia;

(3) Surgery;

(4) Medication;

(5) Intravenous and blood products;

(6) Obstetrics;

(7) Monitoring;

(8) Biomedical;

(9) Equipment/Product; and

(10) Miscellaneous.

(b) "Claim" means a request for indemnification submitted by a health care provider pursuant to a medical professional liability insurance policy for which an insurer has established a loss or loss adjustment expense reserve amount at any point in time.

(c) "Claim number" means a unique identifying code assigned to each claim by the insurer.

(d) "Closed claim" means a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on behalf of the insured.

(e) "Commissioner" means the insurance commissioner of the state of New Hampshire.

(f) "Common statistical base classification code" means the Insurance Services Office's 5-digit code used to identify professional liability risk classifications.

(g) "Companion claim" means a separate claim for each named defendant that is covered under the policy, whether or not they are the named insured on the policy or covered employees or agents of a corporation, association or trust.

(h) "Court code" means the 2-digit code identifying the result of court proceedings.

(i) "Date of payment or closure" means the date on which the insurer closed the claim.

(j) "Health care provider" means:

(1) In the case of a natural person, a person, licensed or approved by the state to provide health care or professional services, including, but not limited to:

a. Acupuncturists;

b. Allied health professionals;

c. Chiropractors;

d. Dentists and dental hygienists;

e. Emergency medical care provider;

f. Licensed dietitians;

g. Mental health practitioners;

h. Midwives;

i. Naturopaths;

j. Nurses;

k. Occupational therapists;

l. Optometrists;

m. Pharmacists;

n. Physical therapists;

o. Physician assistants;

p. Physicians and surgeons; and

q. Podiatrists;

(2) In the case of an institution:

a. Ambulance or other corporation;

b. Ambulatory care clinic;

c. Health maintenance organization;

d. Hospital;

e. Long-term care facility;

f. Pharmacy;

g. Residential care facility;

h. Facility or entity licensed by the state to provide health care services; or

i. An officer, employee or agent of any such person or institution acting in the course and scope of his employment; and

(3) Where the context so permits, both persons and institutions as listed in (1) and (2) above.

(k) "Insurance Services Office (ISO)" means the property and casualty, for-profit insurance advisory entity that assists insurers in the collection of statistical information and ratemaking-related activities.

(l) "Insured" means the policyholder and any named defendants covered under a medical professional liability insurance policy.

(m) "Insurer" means every:

(1) Insurance company authorized to transact insurance business in this state;

(2) Unauthorized insurance company transacting business pursuant to RSA 406-B;

(3) Risk retention group;

(4) Insurance company issuing insurance to or through a purchasing group;

(5) Captive insurance company;

(6) Self-insured person or entity; and

(7) Other person providing insurance in this state.

(n) "License number" means the number assigned by the state professional licensing board associated with the applicable health care provider, or the federal identification number.

(o) "Loss adjustment expense" means the dollars expended to defend, manage, or otherwise process a claim on behalf of the insured health care provider.

(p) "MMPR" means the medical malpractice payer report.

(q) "Medical professional liability insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as a result of the negligence or malpractice in rendering professional service by any health care provider.

(r) "MMPR act or omission code" means the old format MMPR published by the national practitioner's data bank.

(s) "NAIC group and company code" means the NAIC - assigned 9-digit code beginning with the group 4-digit code followed by the company 5-digit code or the assigned NAIC alien number.

(t) "National Practitioner's Data Bank" means the data maintained by the U.S. Department of Health and Human Services and established by the Health Care Quality Improvement Act of 1986, Title IV of Public Law 99-660 as amended.

(u) "Open claim" means a claim that has yet to be settled, or otherwise disposed of, where the insurer expects to make future indemnity and expense payments on behalf of the insured.

(v) “Open claim ID number” means the original identification number used when the claim was previously filed with the department.

(w) “Practice code” means the 2-digit code identifying the kind of practice for an insured when it is a physician or other medical professional.

(x) “Profession code” means the 2-digit code identifying the medical specialty practiced by the health care provider.

(y) “Reserve” means the dollar value established by the insurer as their best estimate of the dollar amount needed to cover future loss and loss adjustment expense payments.

(z) “Screening panel code” means the numeric code used to identify the status or outcome of the screening panel process.

(aa) “Settlement code” means the 2-digit code used to identify when in the legal process the claim has been closed or settled.

(ab) “Severity of injury code” means the 2-digit code that identifies the relative degree or severity of injury, covering a range from "emotional only" to "death."

(ac) “Specialty code” means the 5-digit code established by the ISO to define a common statistical base classification code used for underwriting.

Ins 3801.04 Detailed Reporting Requirements.

(a) As a condition of doing business in this state, each insurer providing medical professional liability insurance coverage to a New Hampshire health care provider, and every health care provider who maintains professional liability coverage through a plan of self insurance, shall submit to the commissioner a report of all open and/or closed claims and companion claims made against any New Hampshire insureds during the preceding year.

(b) Every report shall contain the following detailed information:

(1) A summary, listing the individual claim reports included with the particular submission; and

(2) A separate form titled "Medical Professional Liability Insurance Claim Report" dated January 2015 filed for each individual claim newly opened, modified or closed since the previous report, and for which the following mandatory fields shall be completed:

a. When reporting an open claim**,** items 1 through 9b; and

b. When reporting a closed claim**,** items 1 through 19.

Ins 3801.05 Report Dates. The report shall be sent to the department by August 1st of each year.

Ins 3801.06 Penalty. Failure to file a completed report in accordance with the provisions outlined in this rule shall result in the application of the penalty provisions of RSA 412:40.

Ins 3801.07 Confidentiality. All information collected under Ins 3801.04 regarding individual claims, loss adjustment and other expenses, reserves, indemnity payments, or other financial information that is not otherwise reported to the commissioner or available to the public, shall be treated as examination material under RSA 400-A:37, kept confidential, and not subject to RSA 91-A.

APPENDIX

RULE	STATUTE
3801.01	519-B:16, II.; 412:13; 412:14; 412:16
3801.02	519-B:16, II.; 412:13; 412:14; 412:16
3801.03	519-B:16, II.; 412:13; 412:14; 412:16
3801.04	519-B:16, II.; 412:13; 412:14; 412:16
3801.05	519-B:16, II.; 412:13; 412:14; 412:16
3801.06	519-B:16, II.; 412:40
3801.07	400-A;15, I.; 519-B:16, II