Ohio Administrative Code

Rule 3901-1-64 Medical liability data collection.

Effective: November 10, 2014

(A) Purpose

The purpose of this rule is to establish procedures and requirements for the reporting of specific medical, dental, optometric and chiropractic claims data to the Ohio department of insurance.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under sections 3901.041 and 3929.302 of the Revised Code.

(C) Definitions

(1) "Medical, dental, optometric and chiropractic claims" include those claims asserted against a risk located in this state that either:

(a) Meet the definition of "medical claim," "dental claim," "optometric claim," or "chiropractic claim" in section 2305.113 of the Revised Code, or

(b) Have not been asserted in any civil action, but that otherwise meet the definition of "medical claim," "dental claim," "optometric claim," or "chiropractic claim" in section 2305.113 of the Revised Code.

(2) "Risk retention group" has the same meaning as in section 3960.01 of the Revised Code.

(3) "Surplus lines insurer" means an insurer that is not licensed to do business in this state, but is nonetheless approved by the department to offer insurance because coverage is not available through licensed insurers.

(4) "Self-insurer" means any person or persons who set aside funds to cover liability for future medical, dental, optometric or chiropractic claims or that otherwise assume their own risk or potential loss for such claims. "Self-insurer" includes captives.

(D) Each authorized insurer, surplus lines insurer, risk retention group, self-insurer, the medical liability underwriting association if created under section 3929.63 of the Revised Code, or any other entity that offers medical malpractice insurance to, or that otherwise assumes liability to pay medical, dental, optometric or chiropractic claims for, risks located in this state, shall report at least annually to the superintendent of insurance, or to the superintendent's designee, information regarding any medical, dental, optometric, or chiropractic claim asserted against a risk located in this state, if the claim resulted in:

(1) A final judgment in any amount,

(2) A settlement in any amount, or

(3) A final disposition of the claim resulting in no indemnity payment on behalf of the covered person or persons.

(E) The report required by paragraph (D) of this rule shall include for each claim:

(1) The name, address and specialty coverage of each covered person;

(2) The insured's policy number, if applicable;

(3) The date of the occurrence that created the claim;

(4) The name and address of the injured person;

(5) The date the claim was reported and the claim number;

(6) The injured person's age and sex;

(7) If the medical, dental, optometric, or chiropractic claim was filed with the court, the case number and the name and location of the court;

(8) In the case of a judgment, the date and amount of the judgment and, if the judgment is subject to the itemization requirements in division (B) of section 2323.43 of the Revised Code, a description of the portion of the judgment that represents economic loss, non-economic loss and punitive damages, if any;

(9) In the case of a settlement, the date and amount of the settlement and, if known, the injured person's incurred medical expense, wage loss, and other expenses;

(10) Any loss adjustment expenses allocated to the claim or, if known, the amount allocated to each covered person;

(11) The loss adjustment expense, broken down between fees and expenses, paid to defense counsel;

(12) The date and reason for final disposition, if no judgment or settlement, and the type of disposition;

(13) Unless disclosure is otherwise prohibited by state or federal law, a summary of the occurrence which created the claim which shall include:

(a) The name of the institution, if any, and the location at which the injury occurred;

(b) The operation, diagnosis, treatment, procedure or other medical event or incident giving rise to the alleged injury;

(c) A description of the principal injury giving rise to the claim.

(F) Frequency

The report(s) required by this rule shall be filed with the superintendent, or the superintendent's designee, on or before May first of each year, and shall contain information for the previous calendar

year.

(G) Noncompliance

Any person listed in paragraph (D) of this rule that fails to timely submit the report required under this section shall be subject to a fine not to exceed five hundred dollars.

(H) Confidentiality

Information reported to the superintendent or the superintendent's designee pursuant to this rule shall be confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information provided under this section is not subject to discovery or subpoena and shall not be made public by the superintendent or any other person, including any rating organizations or other agencies designated by the superintendent to gather and/or compile the information.

(I) The requirements of this rule do not apply to reinsurers, reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.

(J) Severability

If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and effect.