



October 20, 2004

Name
CEO
Hospital
Address
City, ST, ZIP

Subject: Physician Involvement in Risk Retention Groups and Other Alternative Insurance Structures

Dear CEO:

OHA's Medical Malpractice Task Force continues to examine the insurance market and to study solutions and alternatives to the medical malpractice insurance crisis. One alternative that physicians are increasingly presenting to hospitals for acceptance is physician malpractice coverage provided by a risk retention group, off-shore captive or other alternative insurance structure.

Risk retention groups and captives are self-insurance vehicles in which physicians rely on their own financial resources to pay claims and expenses. Risk retention groups and captives generally are not licensed or regulated by the Ohio Department of Insurance and are not covered by the Ohio Insurance Guaranty Association in the event they become insolvent.

Attached is a checklist of questions and documentation designed to assist in assessing risk retention groups. Similar issues apply to off-shore captive insurance vehicles. Also enclosed is a detailed letter from Bricker & Eckler, LLP outlining many of the challenges and issues of potential concern with physician risk retention groups. While each hospital must also weigh the sensitivity of the local environment and the needs of the community, the accompanying materials will assist the hospital in making an informed evaluation of alternative physician risk financing.

We continue to advocate and work on behalf of Ohio's hospitals in tackling the medical malpractice insurance crisis. If you have any questions or comments, do not hesitate to call.

Sincerely,

A handwritten signature in black ink, appearing to read 'James R. Castle'.

James R. Castle
President & CEO

Enclosures

Checklist for Risk Retention Group/Captive Evaluation

Organization

- ✓ Is the RRG registered in Ohio?
- ✓ Is the RRG rated by A.M. Best or another rating agency?*
- ✓ Who is on the management team?*
- ✓ Who is on the governing board?*
- ✓ Does the board and management have experience in the insurance industry?
- ✓ Are there independent directors on the board?

Capitalization

- ✓ What is the level of capitalization?*
- ✓ What is the ratio of surplus to premiums?*
- ✓ Are the policies assessable against the physician?
- ✓ Is there access to additional capital if needed?

Reinsurance

- ✓ Does the RRG have reinsurance with a rated carrier?*
- ✓ What is the level of risk retained by the RRG?
- ✓ Is the reinsurance premium fixed or is there a retroactive adjustment?
- ✓ Is there aggregate stop-loss coverage?*

Actuarial Support

- ✓ Are the actuaries experienced, reputable?
- ✓ What assumptions are being used?*
- ✓ What confidence level is being used to determine the premium structure?

Underwriting Support

- ✓ Are the underwriters experienced, reputable?
- ✓ What underwriting standards will be used?
- ✓ Is there an active underwriting committee?

Premium and Tail Issues

- ✓ Are the premiums being charged substantially lower than the market?
- ✓ Is there a guarantee that premiums will not increase?
- ✓ Do the physician insureds have tail coverage from their prior carrier?
- ✓ Will the RRG provide tail coverage?
- ✓ Is the premium for tail coverage substantially lower than the market?

Risk Management and Claims Management

- ✓ Are the risk managers and claims managers experienced, reputable?
- ✓ What risk management program will be used?
- ✓ What is the claims management philosophy?
- ✓ Is there an exclusive relationship with one defense firm?

* Attach Documentation



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October 20, 2004

Mary Gallagher, Esq.
Vice President, General Counsel
Ohio Hospital Association
155 East Broad Street, 15th Floor
Columbus, OH 43215

Re: Continuing Medical Malpractice Issues

Dear Mary:

In a letter dated January 16, 2003, we provided guidance to OHA with respect to how hospitals might evaluate various rated and unrated malpractice insurance carriers. Due to the continuing deterioration in the malpractice insurance market, we are seeing insurance company downgrades and a proliferation of alternative proposals for physician insurance coverage. Principally, these alternative proposals are Risk Retention Groups ("RRGs") or Offshore Captive insurers ("OCs"). Pursuant to the OHA's request, the purpose of this letter is to provide additional information and recommendations with respect to hospital analysis of the issues confronting hospitals.

Risk Retention Groups and Offshore Captives

There is an enormous amount of ongoing activity by physicians working with consultants to develop either RRGs or OCs. We have worked with a number of insurance consultants and actuaries to analyze many of these proposals. The issue that consistently creates concern with these proposals is their under-capitalization.

For hospitals, these RRGs or OCs create a number of risks. First and foremost, if and when these alternative carriers fail, the hospital may find itself with many members of its medical staff who sought coverage through the failed RRG or OC to not only be without current coverage, but also be without coverage for previous years when the physician was insured by the

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RRG or OC. These physicians will probably be unable to purchase tail coverage to cover the period of time when the coverage was through the failed RRG or OC. This will increase the hospital's exposure and also will create a risk of personal liability for the physicians and jeopardize the assets of the physicians involved.

Physicians who are insured by licensed domestic carriers have the protection of the Ohio Insurance Guarantee Association ("OIGA"). This will provide up to \$300,000 of coverage in the event a licensed Ohio company fails. RRGs and OCs do not participate in the OIGA, and therefore if they do fail, the physicians will be left without any coverage.

An additional political problem that many hospitals may face is that if these physician-created RRGs and OCs begin to fail and pose a financial risk for the insured doctors, there will probably be significant pressure on the hospital to fund the losses in order to protect its physicians. This is, obviously, fraught with a number of regulatory and tax related issues for hospitals. We are already seeing physician pressure being brought to bear on hospitals to somehow provide financial support to help physicians create these RRGs or OCs or to fund existing malpractice coverage. It is inevitable that the same type of pressure will be applied if the physicians are left with no coverage and prior claims for which they are personally liable.

As fiduciaries, hospital boards need to carefully evaluate these proposed RRGs and OCs to determine whether they are adequately capitalized and whether they are being operated in an actuarially sound manner. The failure of one of these companies without OIGA backup could have significant adverse financial consequences for the hospital as well as the physicians.

A number of hospitals have been struggling with how to evaluate these alternative programs. The fact that an RRG is licensed in Nevada, for example, does not assure that it is adequately capitalized. Most of these RRGs are formed in states that have capitalization requirements that are substantially lower than Ohio's. Under federal law, a state must recognize an RRG which is licensed in another state, even if the capitalization and regulatory requirements of that state are far less rigorous than Ohio's. A medical malpractice insurer would be required to have at least \$5 million of capital in addition to the premium that it receives in order to be licensed in Ohio. RRGs are typically located in states with far lower capitalization requirements, and may be required to have only \$500,000 in capital under the law of the domicile state. Similarly, off shore jurisdictions where OCs are typically located may have even lower capitalization requirements than RRGs. Thus, the fact that an RRG is licensed in another state or an OC is licensed by a governmental oversight board in the jurisdiction where the company is formed does not in any way assure that the RRG or OC is either adequately capitalized or that it is actuarially sound.

One of the problems for both hospital management and boards is that they do not have the expertise or resources to be able to adequately evaluate many of these companies. In addition, the risk-based capital calculations that I referenced in my letter of January 16, 2003, are only applicable to insurance companies domiciled in a state that has adopted the risk-based

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capital model, and that have been in operation for a period of time. Most of these proposed companies are based in states which have not adopted the risk-based capital model, and they are also new, so the risk-based capital calculations would not be applicable. Many hospitals are relying upon outside consultants to assist them in evaluating the viability of these proposed companies. Some factors hospitals may want to consider when doing an analysis of an RRG or OC include:

1. Who are the actuaries that are doing the actuarial analysis, and what are the assumptions that are being used? What confidence level is being used to determine the premium structure? Are assumptions being made based upon optimistic projections as to claims experience? We have seen some hospitals requiring a 75% confidence level based upon the best estimate of expected losses and the variability of the expected losses. This is more stringent than the confidence level being used by many of these RRGs and OCs.
2. Does the entity have reinsurance with a rated reinsurance carrier? If so, what is the level of risk retained by the company and what is the level that is ceded to the reinsurer? Is the payment for the reinsurance by a fixed premium or is there a retroactive adjustment against the assets of the RRG or OC based upon the actual performance? Is there aggregate stop-loss coverage?
3. What is the level of capitalization? A rule of thumb for a financially sound organization would be to have a surplus that would be equal to the amount of the mature premium that the organization retains after reinsurance. (Surplus is defined as excess of assets over projected claim liabilities and administrative expenses, and is in addition to reserves to pay projected claims.) Are the premiums assessable against the physicians if the RRG or OC needs additional capital? If not, what will be the source if additional capital is required?
4. Who manages the organization? Do they have experience in operating insurance companies? Is the board comprised of individuals who are knowledgeable in the insurance industry? Is the board comprised of only insured physicians, or are there independent directors with expertise relevant to the insurance industry?
5. What arrangements have the physicians made for tail coverage if they are leaving a carrier to become insured by this new entity? Is the new entity going to provide the tail coverage? If so, has that been adequately factored into its capital and premium structure?
6. Is the new entity offering premiums that are substantially lower than current market premiums? Insurers in Ohio are still experiencing claims losses or combined ratios that are unprofitable at the current premium level. A new company offering substantially reduced premiums should be considered suspect.

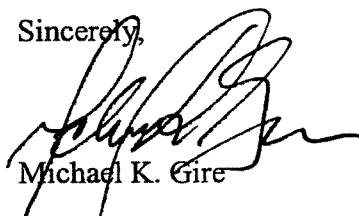
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7. Who will be doing the underwriting? What underwriting standards will be utilized?
8. Who will be handling risk management and claims management? What is their prior experience?
9. If the carrier is an RRG, is it registered in Ohio. Although Ohio may not, under federal law, impose its capitalization or other regulatory requirements on an RRG which is licensed in another state, Ohio does register RRGs, and an RRG which is not registered is operating illegally in Ohio. Registration does not assure any greater financial soundness; however failure to register is a sign of inexperience in the management of the RRG, and is one more red flag.
10. Is the RRG or OC itself rated by either Best or one of the other recognized insurance rating agencies? Although it is rare that an RRG or OC is rated, there are a few that have been in existence for some time, and that are rated.

Any one of the above items is not, in and of itself, determinative of the viability of the RRG or OC. All of these items will have an impact on the long-term viability. The one issue that we have seen that has consistently been the biggest negative on the ability of these organizations to become viable and, for that reason, to obtain reinsurance, is the undercapitalization. Without adequate capitalization or a guaranteed source of standby capitalization (other than the hospital), a hospital should be very concerned about approving an RRG or OC as an acceptable insurer.

Mary, I hope this additional information is of some help as hospitals continue to try to be supportive, yet prudent, in dealing with physician malpractice carrier issues. Obviously, Ohio continues to be a difficult malpractice insurance market for physicians. Nonetheless, boards still have fiduciary duties with respect to the hospitals. Please let me know if I can provide any additional information.

Sincerely,



Michael K. Gire

klr