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January 16, 2003

**VIA TELEFAX AND  
REGULAR U.S. MAIL**

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

**Re: Medical Staff Malpractice Insurance Issues**

Dear Mary:

The OHA Medical Malpractice Task Force asked that we work on developing some guidelines for hospitals with respect to insurance coverages. The specific focus of this request is to give Ohio hospitals some guidance on issues they should consider when addressing changes to Medical Staff bylaw requirements on mandatory physician insurance coverage.

**I. Introduction**

Hospitals are increasingly running into problems regarding physician professional liability insurance. These problems arise from the inability of physicians to obtain any type of coverage; physicians wanting to use low-rated or unrated carriers; physicians forming risk retention groups; etc. The historic bylaws requirement of an A- A.M. Best rated company no longer appears to be a viable option for most hospitals.

The necessity of physicians maintaining adequate coverage has a number of implications for hospitals. First, it could affect the accessibility and cost for the hospital's own malpractice insurance if its medical staff is inadequately insured. Second, virtually all hospitals have bond requirements requiring adequate insurance coverage and if the hospital's insurance is jeopardized by its policies with respect to medical staff insurance coverage, this could ultimately lead to bond defaults. Third, the hospital's policies with respect to medical staff insurance could bring into question a board's meeting its fiduciary duties with respect to management of the hospital assets. Fourth, if the hospital is on notice that a physician is uninsurable, this could lead to claims regarding potential negligent credentialing by virtue of the claims history of the physician. This latter issue could arise even in the presence of the rebuttable presumption under the new Senate Bill 179.

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Within the context of the malpractice issues, there are two subcategories. The first has to do with the amount of coverage that is required. The second has to do with the type of coverage that is maintained by the physician.

## **II. Amount of Insurance**

A number of physicians around the state are currently attempting to reduce their coverage as a means of reducing their premium costs. Most hospitals require a minimum of \$1,000,000 per occurrence with an aggregate of \$1,000,000 or more. Several hospital insurance carriers (including OHIC) have riders on their policies that require that the hospital have in its bylaws a minimum insurance requirement. Thus, any reduction in the amount of coverage may impact a hospital's own insurance. Before a hospital agrees to reduce its coverage below its currently established minimums, the hospital should:

- (i) address this with the hospital's malpractice carrier or excess carrier (in the case of self-insured hospitals);
- (ii) make an assessment as to the hospital's increased exposure resulting from a reduction in insurance coverage required for its medical staff physicians.

Because of its fiduciary obligations, a hospital board should move very cautiously in permitting reduced coverages, unless the board can satisfy itself that it is not exposing the hospital to significant increases in the hospital's own liability or jeopardizing the hospital's insurance.

## **III. Types of Coverage**

### **A. Rated Companies**

Historically, hospitals have required physicians to be insured by a rated company and have used a rating agency such as A.M. Best for this purpose. Many hospitals required at least an A- rating. Under the current circumstances, there are fewer carriers and the carriers that remain are having their ratings reduced because of Ohio's malpractice environment. Therefore, the rating levels that have been traditionally required may no longer be applicable. Our recommendation is that before adopting a specific rating, the hospital should review this issue with its malpractice carrier or excess carrier. In the current environment, a rating of B+

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appears to be the minimum that should be considered, but a hospital may want to go higher.

B. System Self-Insurance

Many of the large health care systems in Ohio maintain self-insurance not only for the hospital, but for employed physicians. Examples of this would include the Cleveland Clinic, OhioHealth, etc. Many of these physicians have privileges not only at their system hospitals, but at other hospitals outside of the systems in which they work. In general, because these large systems have significant debt outstanding and have reinsurance from reputable reinsurers such as ERC, it would appear that the degree of due diligence that is necessary for a non-system hospital to evaluate medical staff applicants who are insured by their system should be fairly minimal. The hospital should confirm in writing that the physician would be covered under the system's self-insurance and reinsurance at the non-system hospital and determine that the reinsurer does review the actuarial soundness of the self-insurance program.

C. Risk Retention Groups

A number of physician groups in Ohio are now discussing the formation of their own risk retention groups as a means of trying to control premium costs. These risk retention groups are being established with minimum capitalization. In many instances, to save capital costs, these groups are not looking to purchase stop-loss insurance. As a consequence, many of these risk retention groups are of questionable financial viability over the long term. Our recommendation with respect to these risk retention groups is that hospitals consider requiring the risk retention group to perform a Risk-Based Capital analysis following the NAIC guidelines to permit the hospital to assess the financial viability of the risk retention group. Ohio normally requires a company to be at 200% of the basic NAIC guidelines. A hospital may elect to go below that level, but in doing so, the hospital should fully examine the risks and understand that as the risk retention group falls further down the scale on the NAIC RBC guidelines, the viability of the risk retention group becomes more questionable.

D. Offshore, Captive Insurers

There are certain offshore insurers that are by definition financially sound because of the way in which they require the risk to be covered. An example of this is Providers Re, SPC (which was established by the OHA)

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which requires that for any insurance written through Providers Re, SPC that there must be either sufficient capital in the account to cover the claims, or that there must be capital and a letter of credit from an acceptable bank to cover the risk. Therefore, a provider, physician group or physician who has a policy written by a company like Providers Re, SPC should be accepted. The nature of these offshore companies needs to be determined by the hospital. There are some brokers, such as Marsh and Aon, who also have access to offshore captives that may be similarly structured that should also be acceptable. Hospitals should be able to work through Aon or Marsh or Providers Re, SPC to determine whether such offshore captives are viable and would provide acceptable coverage.

E. Offshore, Unrated Insurers

Offshore, unrated insurers that are not provider-controlled or maintained by brokers such as Aon and Marsh are of greatest concern. The viability of these companies is questionable, and the validity of the financial information is subject to speculation. If a hospital has physicians who will attempt to meet their insurance requirements through these types of companies, the hospitals have to be very critical in their analysis. It should also be noted that Cayman Island and Bermuda Island companies may have more regulatory oversight than other offshore companies. The hospitals may want to consider requiring that the company become registered in Ohio. It may require that the insurer subject itself to an NAIC RBC analysis by an acceptable accounting firm. Hospital boards will have to move very cautiously in this area because of the inability to monitor these companies and the poor track record that has occurred over the years with these types of companies being able to pay claims long term.

**III. Evaluation Criteria**

To determine whether or not to accept an entity that is not an admitted and licensed insurer in Ohio, the following criteria should be considered:

- 1) Is the entity admitted in any jurisdiction in the U.S. if not Ohio?
- 2) Is the entity an authorized surplus lines insurer?
- 3) Is the entity rated by any recognized rating bureau (*i.e.*, A.M. Best, Moody's, etc.)

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- 4) Does the entity prepare financial statements in conformance with statutory accounting principles? Does it, or can it, prepare a statutory blank as if it were admitted to a state?
- 5) Can the entity compute its Risk Based Capital (RBC) numbers? The figures necessary to determine RBC of the entity is derived from schedules and calculations from the statutory annual statement referred to in item 4 above.
- 6) Is there an actuarial opinion regarding the reserves for the entity? Is the actuary who gave the opinion an associate or fellow of the Casualty Actuarial Society?
- 7) Does the entity have audited financial statements? Were the statements prepared under U.S. standards of accounting?
- 8) Who is the auditor? CPA? Experienced in insurance or actuarial matters?
- 9) If assets are pledged to the entity, does the entity have first lien and is there a current and accurate evaluation of the asset based on the type of asset?

The listing of the above factors is intended to stimulate the thought process of the person(s) or committee who will decide whether or not to accept the alternate insuring entity. The absence or presence of any one item is not intended to be the deciding factor. The decision should be made after analyzing all the available information, with an understanding that there is no risk-free transaction.

Generally, the more that an entity can satisfy the criteria above, the more likely that the promoters of the entity have thought out the issues and are prepared to meet the obligations assumed by the entity. Likewise, the less that an entity can satisfy the criteria above, the more likely the risk stays with the hospital.

The above is a summary of information that hospitals may want to consider as they modify their bylaws requirements. To give hospitals maximum flexibility, our recommendation is that the language of Medical Staff bylaws be drafted to give the Board discretion in determining whether a physician has an acceptable level of coverage. The proposed OHA model Medical Staff bylaws incorporate such language:

- (a) Has professional liability insurance of such kind, in such amount, and underwritten by such insurers as required or approved from time to time by the Board after consultation with the MEC. The requirement that a particular Appointee maintain professional liability insurance may, in the sole discretion of the Board, be waived or modified if the Board determines, consistent with policies of insurance maintained by the

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Hospital, community need, and the Hospital's mission, that such waiver or modification is in the best interests of the patient care.

If we can provide any additional information, please let me know.

Sincerely,

Michael K. Gire