

STATE OF OHIO)
) SS:
CUYAHOGA COUNTY)

IN THE COURT OF COMMON PLEAS
CASE NO. 326887

REGINA RUSHDAN)
)
Plaintiff,)
)
vs.)
)
DAVID C. BARINGER, M.D., et al.,)
)
Defendants.)
)

OPINION AND JOURNAL ENTRY

Boyko, J.

This matter comes before the Court on cross motions for summary judgment filed by Plaintiff, Regina Rushdan, and Defendant Ohio Insurance Guaranty Association. While the material facts in the case are not in dispute, the issues presented are of first impression and have been exhaustively briefed by both parties. After careful consideration of the facts and applicable law, for the following reasons the Court grants Plaintiff's motion for summary judgment and overrules Defendant's motion for summary judgment.

I. Introduction and Procedural History.

The present controversy arises from Plaintiff's medical malpractice lawsuit filed in 1997 against Defendant David Baringer, M.D. ("Dr. Baringer") regarding treatment rendered to the Plaintiff during the years 1994 and 1995.¹ Dr. Baringer had in effect at this time two separate

¹While the decision of the issues presented herein does not require a recitation of the facts surrounding Plaintiff's treatment, the Court notes that the Plaintiff underwent a total of fourteen

“claims made” malpractice insurance policies issued by the Physicians Insurance Exchange Mutual Insurance Company (“P.I.E.”). Specifically, Dr. Baringer had a Primary Policy, policy number PM34-95F-15036 (“Primary Policy”) that provided coverage up to \$1,000,000 per claim/\$3,000,000 in the aggregate, and an Excess Policy, policy number PM34-95G-11660 (“Excess Policy”) which provided coverage above the Primary Policy up to an additional \$1,000,000. In 1998, P.I.E. was declared insolvent and ordered into liquidation by the Franklin County Common Pleas Court. As a result, pursuant to the Ohio Insurance Guaranty Act (the “Act”), codified in R.C. Ch. 3955, the Ohio Insurance Guarantee Association (“OIGA”) assumed the defense of medical malpractice claims--including the Plaintiff’s--then existing against P.I.E. insureds.

In an effort to resolve the underlying lawsuit, the parties agreed to enter into settlement discussions. Due to P.I.E.’s insolvency, both the OIGA and the P.I.E. Liquidator took part in the settlement process. Eventually, the parties reached a settlement agreement wherein a “reasonable settlement value” for Plaintiffs’ claim against Dr. Baringer was established at \$1,300,000.² With regard to P.I.E.’s liability for the claim, the parties acknowledged that the agreed value “would have been payable by The P.I.E. Mutual Insurance Company, if said insurance company had not been found insolvent.” OIGA agreed to pay Plaintiff \$300,000 pursuant to its statutory obligations arising under Dr. Baringer’s Primary Policy, and further

corrective surgeries which resulted in over \$280,000 in medical expenses alone.

²Per the agreement, any unpaid portions of the settlement value become Class II claims against the liquidation estate of P.I.E. The parties dispute the precise method by which the ultimate value of the Class II claim will be calculated, with regard to which the Plaintiff has filed a separate motion to enforce settlement.

consented to the Plaintiff bringing a separate declaratory judgment action for a determination as to the Plaintiff's right to receive an additional \$300,000 under the Act by virtue of Dr. Baringer's Excess Policy.

Pursuant to the agreement, the Plaintiff filed an amended complaint to include a second count for declaratory judgment, adding OIGA as a new-party defendant. In her amended complaint, the Plaintiff alleged that under the terms of the settlement and in accordance with the established value of her claim, she was entitled to an additional \$300,000 payment from OIGA. OIGA answered and denied any additional obligation under the Act. Both parties filed motions for summary judgment, attaching the policies at issue, the settlement agreement, a stipulation as to the veracity of the policies and settlement agreement, as well as various affidavits.³

The gravamen of both parties' motions is whether the settlement amount of Plaintiff's malpractice complaint presents one or two "covered claims" under the Act: if the Plaintiff has only one "covered claim," then the OIGA would have fulfilled its statutory obligations through its payment of \$300,000, and thus be entitled to summary judgment; if, however, the Plaintiff has two "covered claims," then the OIGA would be required to pay the Plaintiff an additional \$300,000 and the Plaintiff would be entitled to summary judgment. Under the clear provisions of the Act, the Court concludes that the Plaintiff has two "covered claims" and is entitled to an additional \$300,000 payment from the OIGA.

³Plaintiff also attached as an exhibit a "Trial Brief" bearing no time stamp nor attorney signature. OIGA filed a motion to strike this exhibit. To the extent that this Trial Brief does not constitute proper evidentiary material for a summary judgment motion, the Court grants OIGA's Motion to Strike.

II Law and Analysis

A. Standard for Summary Judgment

Under Civ. R. 56(C), a court shall grant summary judgment if, upon reviewing the pleadings, depositions, answers to interrogatories, written admissions, affidavits, transcripts of evidence, and written stipulations of fact, the court is satisfied that no genuine issue of material fact exists in the case and that the moving party is entitled to judgment as a matter of law. In making this determination, the court is to construe the evidence and stipulations most strongly in the nonmoving party's favor and then decide whether, based upon such evidence and stipulations, reasonable minds can come to but one conclusion, that conclusion being adverse to the nonmoving party.

B. Purpose and Scope of the Act

The General Assembly created the Ohio Insurance Guaranty Association Act, R.C. §§ 3955.01 et seq., as a means to protect insureds and third-party claimants from potentially catastrophic losses due to the insolvency of member insurers. *Lake Hosp. Sys. Inc. v. Ohio Ins. Guar. Assn.* (1994), 69 Ohio St.3d 521, 523. The stated purpose of the Act is to “provide a mechanism for the payment of covered claims under certain insurance policies, avoid excessive delay in payment and reduce financial loss to claimants or policyholders” R.C. § 3955.03. This purpose serves as the guiding principal behind the Act, the provisions of which are to be “liberally construed” to achieve this end. R.C. § 3955.04.

Under the Act, when an insurer is declared insolvent, the OIGA steps into the shoes of the insurer and assumes all of the carrier's obligations to insureds and third-party claimants. *Lake Hosp. Sys. Inc.* at 523 (emphasis added). In this role, the OIGA is deemed the insurer and

becomes obligated on all “covered claims,” to this extent assuming “all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent.” R.C. § 3955.08(A)(1) and (2) (emphasis added). A “covered claim,” as defined by R.C. § 3955.01(B), includes a claim (1) arising during a period for which the insolvent insurer provided coverage and (2) which falls within the scope of claims covered by an insurance policy. *Lake Hosp. Sys. Inc.* at 524. However, before recovery may be had on a “covered claim,” the claimant must first exhaust all possible recovery rights against solvent insurers. R.C. § 3955.13(A); *Vickers v. Howe* (1998), 123 Ohio App.3d 546; *Dickerson v. Thompson* (1993), 89 Ohio App.3d 399.⁴ In no event shall any single “covered claim” exceed three hundred thousand dollars. R.C. § 3955.01(D)(2)(b).

C. Plaintiff’s Claims under the Act.

Given that the parties have (1) stipulated as to the value of plaintiff’s claim against Dr. Baringer (\$1,300,000) and (2) agreed that the full value of the claim would have been payable by P.I.E. pursuant to Dr. Baringer’s policies, the resolution of this case becomes purely one of statutory application, properly decided as a matter of law. As such, analysis begins and ends with a determination as to how many “covered claims” Plaintiff has under the Act. Since OIGA has already tendered one \$300,000 payment to the Plaintiff, thus fulfilling its obligations vis-a-vis the \$1,000,000 limits of Dr. Baringer’s Primary Policy, the only remaining question is whether that portion of Plaintiff’s claim above the Primary Policy’s limits constitutes a separate

⁴In its Motion for Summary Judgment, the OIGA alleged, without evidentiary support, that the Plaintiff failed to demonstrate exhaustion of all other available insurance. However, the Court finds that Plaintiff has provided sufficient evidentiary materials to demonstrate such exhaustion.

“covered claim” under Dr. Baringer’s Excess Policy, for which the OIGA is separately obligated up to an additional \$300,000. In other words, does the remaining \$300,000 (that portion of the settlement value exceeding the Primary Policy’s \$1,000,000 limits) also meet the statutory definition of “covered claim,” i.e., is it also a claim (1) arising out of and (2) is within the coverage of an insurance policy?

In making this determination, the Court must look to the provisions of the policies at issue, particularly the Excess Policy, and analyze whether the Excess Policy by its terms provides separate and distinct coverage as to that portion of the settlement agreement exceeding \$1,000,000. To the extent that the provisions of the P.I.E. policies at issue are clear and unambiguous, such analysis is properly undertaken via summary judgment. *Leber v. Smith* (1994), 70 Ohio St.3d 553, 558; see *Latina v. Woodpath Development Corp.* (1991), 57 Ohio St.3d 212.

According to the Declarations, Dr. Baringer’s Primary Policy provided “each claim” limits of \$1 million with an annual aggregate of \$3 million. With regard to the “each claim” limits, the policy limited liability as follows:

[T]he limit of The Company’s liability for all damages because of any one claim or suit or all claims or suits first made during the Policy period because of injury to or death of any one person

Pursuant to the Excess Policy, P.I.E. agreed “to indemnify [Dr. Baringer], in accordance with the applicable provisions of the Underlying Insurance for the amount of Loss which is in excess of the applicable limits of the Underlying Insurance”⁵ The Excess Policy defines

⁵The Declarations page of the Excess Policy identified the Underlying Insurance as Dr. Baringer’s Primary Policy.

“Loss” as, inter alia, “sums paid as damages in settlement of a claim . . .” The term “claim” is defined as “a notification to an Insured by a third party or by means of a civil proceeding, alleging injury to which this coverage applies and which is reported to The Company during the Policy period.” “Coverage” is defined as “the protection afforded [Dr. Baringer] under the terms and conditions of this Policy” (emphasis added throughout).

In Ohio, courts construe insurance contracts in accordance with the same rules as other written contracts. *Rhoades v. Equitable Life Assurance Society* (1978), 54 Ohio St.2d 45. One of the cardinal principles of contract construction is to give reasonable effect to every provision in the agreement. *Stone v. National City Bank* (1995), 106 Ohio App.3d 221. To this end, a court must give meaning to every paragraph, clause, phrase, and word, omitting nothing as meaningless or surplusage, *Affiliated FM Insurance Co. v. Owens-Corning Fiberglass Co.* (C.A. 6 1994), 16 F.3d 684, citing *Heifner v. Swaney* (Aug. 27, 1992), Allen Cty. App. No. 1-91-82, 1992 WL 198120, and affording due consideration to the subject matter, nature, and purpose of the agreement. *Blosser v. Carter* (1990), 67 Ohio App.3d 215; *Bennett v. Heidinger* (1986), 30 Ohio App.3d 267.

The provisions of the Excess Policy will be construed according to these principles. Fundamentally, the very fact that the Excess Policy contains its own definition of “claim” is clear indication that the policy envisions separate claims made against it. To conclude otherwise would render the entire definition of “claim” within the policy to be mere surplusage. Furthermore, it is inconceivable that the Excess Policy would not recognize a “scope” of claims separate and distinct from those brought under the Primary Policy, when by its very terms the Excess Policy defines a “claim” as “injury to which this coverage applies.” Finally, the

“protection afforded” by the Excess Policy covers precisely the kind of situation presented here, where Dr. Baringer’s liability exceeds the limits of his underlying Primary Policy. Indeed, this is the very nature and purpose of excess insurance: to provide coverage once other sources of compensation have been exhausted. *Demetry v. Kim* (1991), 72 Ohio App.3d 692, 698.

It cannot be doubted that but for the P.I.E. insolvency, the Plaintiff would have pursued two claims, one against Dr. Baringer’s Primary Policy and one against the Excess Policy. Or, looking from P.I.E.’s perspective, the \$1.3 million settlement would have been paid pursuant to both of Dr. Baringer’s policies, the Primary up to \$1 million, and the Excess for the remaining \$300,000. If two claims would have existed but for P.I.E.’s insolvency, two “covered claims” exist pursuant to the Act. Therefore, Plaintiff is entitled to a second \$300,000 payment from OIGA.

Having found that Dr. Baringer’s Excess Policy gives the Plaintiff second “covered claim” under the Act, the Court must now address OIGA’s argument that payment under the Excess Policy is not triggered unless and until the Plaintiff actually receives \$1,000,000. The crux of OIGA’s argument is that since the Plaintiff has received from OIGA only \$300,000 of the \$1,000,000 covered by the Primary Policy, the Excess Policy is not implicated because the actual loss under the Primary Policy does not exceed \$1 million. In support of this assertion, OIGA points to the provisions of the Excess Policy wherein P.I.E. agreed to indemnify Dr. Baringer for “the amount of Loss in excess of the applicable limits of the Underlying Insurance. . . .” Because the Excess Policy defines “Loss” as, inter alia, “sums paid as damages in settlement,” OIGA argues that the excess policy is triggered only when the limits of the underlying coverage have actually been paid.

While OIGA's arguments may appear logical on their face, they fail because they ignore the statutory requirement that the OIGA assume all obligations of the insurer, to the extent of covered claims, as if the insurer had not become insolvent. R.C. 3955.08(A)(2). The fallacy of OIGA's position lies in the fact that the OIGA is seeking to construe the provisions of the Excess Policy in light of P.I.E.'s insolvency. This it cannot do. The OIGA must assume all of the obligations created under the provisions of the Excess Policy, to the extent of their status as "covered claims," as if P.I.E. had not become insolvent. In other words, the OIGA must meet P.I.E.'s obligations under the Excess Policy as if the full limits of the Primary Policy had been available for payment. OIGA's attempt to use P.I.E. insolvency to shield its obligations under the Excess Policy is not permissible under the Act. Indeed, OIGA has already acknowledged that the full 1.3 million "settlement value" would have been payable by P.I.E. but for its insolvency. Thus, OIGA is obligated under the terms of the Excess Policy as if the Plaintiff had been paid the full \$1 million under the Primary Policy.

Finally, the OIGA devotes a portion of its brief to a public policy rationale for limiting the Plaintiff to one "covered claim," in effect asking this Court to limit Plaintiff to one claim so as to protect against the depletion of OIGA funds. However, the OIGA is statutorily bound to comply with the clear provisions of the Act that define its powers and duties. As such, this court will not employ equitable principals to circumvent valid legislative enactments. *Lake Hosp. Sys. Inc.* at 526. While maintaining the integrity of the OIGA insurance fund is certainly a laudable goal, limiting claims in the manner suggested by OIGA is not in keeping with the statutory scheme. Indeed, the \$300,000 "covered claim" limitation, as well as the requirement of exhaustion, are the statutory safeguards currently in place to protect against unnecessary

depletion of OIGA funds. See *PIE Mut. Ins. Co. v. Ohio Ins. Guar. Assn.* (1993), 66 Ohio St.3d 209, 215; *Vickers v. Howe* (1998), 123 Ohio App.3d 456, 462-463. For this court to place any further limitations on payment would contravene the very stated purpose of the Act. The Ohio General Assembly is the proper body to address OIGA's concerns.

III. Conclusion

Based upon the foregoing, this Court concludes that Plaintiff has a second "covered claim" under R.C. § 3955.01(D) and is entitled to an additional \$300,000 payment from the OIGA pursuant to R.C. § 3955.08. Accordingly, Plaintiff's motion for summary judgment is GRANTED and OIGA's motion for summary judgment is OVERRULED.

IT IS SO ORDERED.


CHRIS BOYKO, JUDGE

Date: July 25, 2000

CERTIFICATE OF SERVICE

A copy of the foregoing Opinion has been sent by regular U.S. Mail this 26th day of

July, 2000 to the following:

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