Aggregate Retention: An Innovative Model for Medical Malpractice Insurance

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In 2003 Wenatchee Valley Medical Center evaluated a number of different approaches to medical malpractice insurance. Because of the decision we made, the Medical Center is able to better align physician incentives, control and manage malpractice claims, ease administrative expenses, and ultimately, improve our relationship with the community. While our solution may not be right for every practice, this is the story of what worked for us.

Background

Wenatchee Valley Medical Center, established in 1940, is a rural, multispecialty healthcare delivery system in central Washington State, with a regional service area of about 12,000 square miles. Wenatchee Valley Medical Center is the second-largest multispecialty clinic in the Pacific Northwest with more than 180 physicians and 65 midlevel providers delivering comprehensive medical, surgical, and ancillary services. Our physicians provide primary care to area residents and also draw patients from throughout the region for specialty care. Our 20-bed hospital is a general medical, surgical, and rehabilitation facility.

From its founding, the group had purchased first dollar medical malpractice insurance policies, one for each physician. The hardening of the malpractice marketplace that was occurring around 2003 caused us to look at alternatives in order to control costs. Generally, the alternatives seemed to be either to find a new malpractice insurance carrier that would provide the same first dollar coverage as in the past but at a lower price; to buy a per-claim deductible policy to lower the premium; or to go self-insured and take the leap into the land of captive insurance companies.

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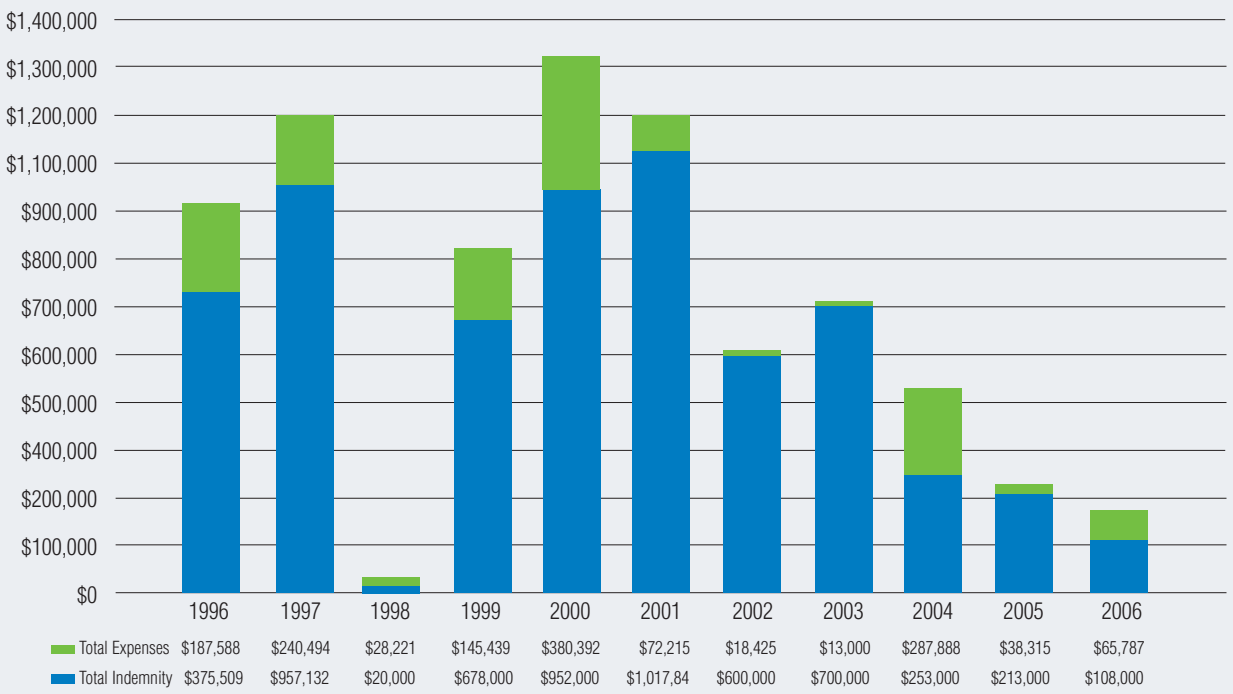
A Good Malpractice Program

As we more closely examined these and other alternatives, we began to delineate what we needed in a malpractice program. We recognized that a good malpractice program has three important elements:

- The first element is insurance coverage for negligent acts, or the allegation of negligent acts. All medical malpractice policies are designed to provide this coverage and our new approach would be no different.
- The second element is service. We wanted such things such as same-day certificates of insurance and the ability to add a physician without insurance company approval and without immediate premium charge, as well as dedicated claims and risk management. When we developed our

FIGURE 1

Malpractice 10 Year Indemnity and Claims Expense History



program, we found that we were able to get all of this with the bonus of real financial savings while cutting staff involvement.

- The third element is cost. Malpractice is at heart a financial transaction: the payment of money (the premium) for the promise that a claim (if it ever happens) will be paid sometime in the future. With our new model, the transformation in this area was profound. We reduced our costs by not buying the first and most expensive layer of insurance; we were able to better align our physician financial incentives; we were able to take advantage of pricing swings in the malpractice market; and we gained a tremendous amount of control, all without giving up any coverage.

The Aggregate Retention Model

In 2004, we adopted the Aggregate Retention model for our malpractice insurance program. The alternative that we selected has a large self-insurance element, but with the security of traditional insurance. We are self-insured up to our expected annual loss level, and carry traditional insurance for losses that exceed that level. The group is underwritten as a whole, not as a collection of individuals, but each physician has a separate limit of insurance. This allows us to control our own financial future but without the costs associated with captives. In addition, it provides for the all-important professional claims and risk management services, avoiding the need to build an internal staff and incur additional administrative costs and headaches.

The Aggregate Retention model promotes increased risk management activity and oversight by the covered group and, through the use of concrete and measurable financial incentives, improves a group's malpractice loss experience. As a result, premium costs are reduced. Figures 1 and 2 represent the financial gain for our group after we adopted the Aggregate Retention model in 2004. The total costs of insurance dropped dramatically, while our escrow residual has grown each year.

Organizing Principles

The Aggregate Retention model approach is based on a few organizing principles.

- **First Principle:** A group knows that claims are going to occur and can, with reasonable accuracy, estimate what that annual cost is going to be. Therefore, it makes no financial sense to pay those premium dollars to an insurance carrier, only to have them turn around and pay claims that you know are inevitable. Insurance carriers charge extra for that "service."
- **Second Principle:** The "first dollar" of insurance costs the most. The insurance carrier knows that it is likely to be paying out the first dollar of coverage for claims, and so it will charge more than a dollar for that first dollar of protection. The entire insurance industry operates on this simple

premise. However, since the insurance company knows that most likely it will not pay out the "millionth dollar" of coverage in claims, it is in a position to charge much less for protection at that level.

- **Third Principle:** The medical malpractice marketplace is constantly in flux. At times, the premiums are high relative to the actual risk; at times, they are low. When premiums are high, it makes sense that the clinic should increase the amount of risk it retains. Conversely, when the marketplace shifts and premiums are low relative to risk, it is sensible to have the insurance carrier "buy" losses by lowering the amount of risk retained by the group.

- **Fourth Principle:** This is perhaps the simplest. Claims have two parts: "claims management," a sophisticated process requiring a professional to handle claims and manage them through their entire cycle; and "claims payment," where the expertise required is mainly the ability to write a check.

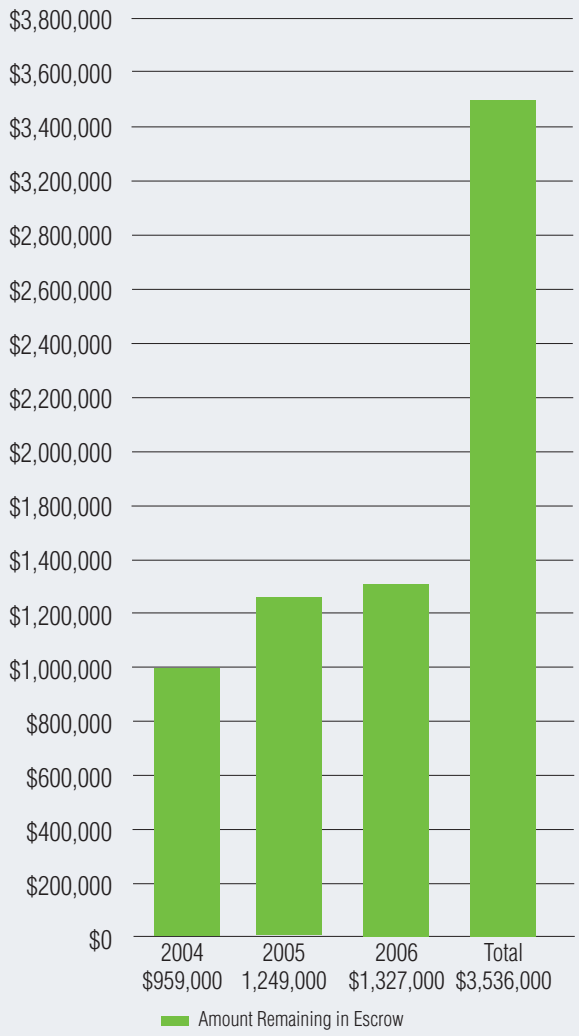
How the Model Works

How does this model work in actual practice? The first key piece of information you'll need is the group's expected annual loss level. While in-house expertise may be able to provide this information, it's probably wise to retain the services of a professional actuarial firm. Once that information is available, the plan details can be formulated.

As an example, if the anticipated annual loss level is $1 million after trending and development, then the suggested self-insured retention (SIR) should be $1 million. The clinic pays the claims and claims expenses, regardless of their source, to the anticipated annual loss level. Everything above that level is insured. The insurer, in exchange for a premium, which is much less than the cost of first dollar insurance, pays all claims and expenses over the $1 million. It also handles all claims management in consultation with the group. If, after all open claims for the year are closed, the group has not dispersed the entire $1 million, it keeps any of the aggregate retention amount not used to pay claims and expenses, along with any interest accrued during that period.

FIGURE 2

Malpractice Insurance Escrow Residual



An Aggressive Risk Management Program

An essential success factor of this plan is an aggressive risk management program. Our physicians are strongly encouraged to report promptly any possible act of negligence or adverse outcome. With each report, our Medical Director and his staff gather and review the facts and are immediately in contact with the patient. Early on, an open discussion with the patient and his or her physician occurs and apologies are extended as appropriate. Concessions such as payment for medical care and lost income may be extended. To further reduce costs, there is a concerted effort to settle small claims early and without the involvement of legal counsel.

Oversight of the program even

extends to details such as active involvement in the selection of the defense attorneys with whom we will be working. This is about real dollars, and that realization quickly focuses the group's attention and efforts.

All risk cases are reviewed by our multidisciplinary Risk Management Committee, which is composed of physicians and administrators. There is a real commitment to make certain that every aspect of the case is thoroughly investigated. Very substantive recommendations are made by the committee including risk assessment, settlement guidelines, and changes in care, with feedback to the physician and department involved.

To develop interactive patient skills, our physicians undergo training in a program that we call "Listening Well." As the title implies, this program aims to enhance the patient/provider dialogue by giving the patient an opportunity to be heard fully by the physician, who has acquired enhanced communication skills. This program was developed in association with a University of Washington professor and has been very rewarding. Both patient and physician satisfaction with the visit is significantly enhanced after such training. We firmly believe that this is a significant element in reducing malpractice risk as well.

Benefits of the Model

Initially, the Aggregate Retention model was designed to reduce insurance costs in a rapidly hardening malpractice marketplace. However, the concept has had an interesting impact on loss control and risk management for the group. With the physician's money at risk, there is greater incentive for proactive claims and loss control management. It should be specifically noted that Aggregate Retention works best in an environment that is aggressively proactive about risk management and loss control. The financial advantage is greatest in those clinics that lower risk and manage losses so that they reach the Aggregate Retention level less than half the time.

So how did we better align physician incentives? The money left in SIR after all the claims have been closed for the year ultimately belongs to the physicians. It pays to have engaged physicians and an active and continuous commitment to risk management. It pays to have the type of patient communication that has been proven to prevent claims in the first place.

How did we improve our relationship with the community? We found that we could handle a lot of things ourselves. We could talk to patients directly; we could provide accommodations where we needed to; and we could even settle some fairly complex claims before any lawyers were involved. It doesn't take much to hurt a reputation for excellent clinical care built over years. Sometimes, bad things happen that shouldn't happen, and by taking care of those cases quickly and fairly, we have only improved our standing in our community.

In summary, the Aggregate Retention model for medical malpractice insurance can significantly reduce costs. However, the model will work only if there is a commitment by the group leadership and physician staff to provide the time, resources, and discipline it will take to make it work.

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