New Mexico Hospital Association

November 4, 2019

Patient Compensation Fund
Attention: Kourtnie Polanco, PCF Docketing Manager
1120 Paseo de Peralta, PO box 1689
Santa Fe, NM 87504-1689
Kourtnie.Polanco@state.nm.us

Re: Docket No. 19-0004-PCF

Dear Ms. Polanco,

In advance of the public hearing set for November 18, 2019, the New Mexico Hospital Association (NMHA), on behalf of all hospitals currently admitted to the Patient Compensation Fund, submits the attached comments on the proposed Patient Compensation Fund surcharges that are at issue in Docket No. 19-0004-PCF. These comments have been coordinated and compiled with all our members and represent the views of all PCF hospitals.

Position: NMHA strongly believes there is a need for the Office of the Superintendent of Insurance (OSI) to allow for hospital advocacy to ensure actuarially fair and equitable surcharges for hospitals in the state. While actuaries may disagree from time to time, actuarial science is sufficiently developed that actuaries on differing sides of any given transaction should agree on ultimate loss funding within relatively narrow range once all sides of a given issue are considered.

Initial Conclusions: The proposed rating methodology for determining the surcharges of hospitals and providers appears not to be unreasonable. However, the NMHA believes that the procedure as currently published can and should be enhanced. Our recommended enhancements will increase confidence and credibility in the Patient Compensation Fund (PCF) surcharge process.

This is especially relevant since it appears that the PCF is proposing to use only paid loss data within the PCF loss layer as opposed to open claim data including loss reserves in both the primary ($0 – 200,000) and the PCF layers. Including that additional data in the analysis will benefit the PCF by providing additional insight into the loss experience which may otherwise be overlooked.

We have broken down the issues into overarching themes as follows:

- **§ 41-5-25 (B) of the New Mexico Medical Malpractice Act states "To create the patient's compensation fund, an annual surcharge shall be levied on all health care providers qualifying under Paragraph (1) of Subsection A of Section 41-5-5 NMSA 1978 in New Mexico. The surcharge shall be determined by the superintendent based upon sound actuarial principles, *using data obtained from New Mexico experience if available.*" (emphasis added)** - Currently, all hospitals enrolled in the PCF

have submitted actuarial surcharge recommendations based on their New Mexico claims experience. In our opinion, this results in recommendations that are in compliance with the language contained in the Act. By comparison, the hospital rates as proposed by the PCF's actuary, appear to be based primarily on industry data and extrapolations of paid loss data for claims solely in the PCF layer which represent only a small number of claims. Such an approach risks producing inaccurate surcharges, does not include all available New Mexico experience, and seems to conflict with the statute.

Therefore, we propose that the existing hospital actuarial data be utilized so the PCF will follow the Medical Malpractice Act and the surcharges will be as accurate as possible. OSI's current practice of maintaining confidentiality of proprietary hospital actuarial data should be continued.

- **Surcharges (rates) should be calculated on all available loss information rather than only payments in the PCF layer** – Currently, the PCF only tracks payments and does not establish case-by-case claim reserves. By only utilizing indemnity payments in developing surcharges, the information utilized is very outdated due the lag time in reporting, settling, litigating and paying claims.

  When it comes to hospitals, we propose that loss data (including indemnity and defense reserves) in the underlying loss layer be utilized. That information can easily be provided to the PCF by member hospitals. This additional information will reflect shorter term, more current trends and portray a more comprehensive picture of hospital loss experience. Hospitals routinely track this information and have the sophistication to post relevant claim reserves (unlike individual physicians).

- **Pinnacle's prospective rate level indication for physicians and surgeons suggests an increase of 13.8% on an expected value basis. By comparison, Pinnacle's prospective rate level indication for hospitals suggests a decrease of 4.5%.** – The report also states that stable hospital loss ratios in the three most recent years support keeping hospital assessments level. This indicates hospitals have historically paid appropriate surcharges to the PCF using the existing methodologies. Elsewhere in the Pinnacle report, it appears to suggest a 19.3% increase for physicians and an 8% increase for hospitals to fund at an 80% confidence level. Historically, physician surcharge increases have been phased in over time.

  Therefore, we propose that, to the extent hospitals surcharges are ultimately increased, they also should be phased in over time in the same manner as the physician surcharge increases.

- **PCF experience modification-based claim frequency requires defined claim terminology** - The proposed experience modification is based solely of claim frequency. It is unclear at this point whether the calculation will be based on paid claims, include claims that have been reviewed by the Medical Review Commission (MRC), or include incidents and open claims on hospital loss runs. Further, hospitals define claims differently, as some consider incidents as "claims" while others exclude them until such time as a written demand for compensation is received, and yet others wait until litigation is filed. Therefore, the definition of a claim for the purposes of the experience modifier calculations requires clarification both as to the term and the source of the data that will be used.

- **PCF experience modifiers only based on claim frequency may lag actual experience**

  If the experience modifiers will only utilize closed claims or claims that have been deemed worthy of pursuit by the MRC, the data will be so outdated as to be of reduced value. Malpractice claims in New Mexico are commonly brought years after the incident occurs and take years to litigate or settle. This is especially true for cases brought during a time when the validity of the caps are being litigated. Relying on paid claim data that is within a five-year window (as is done with the physicians) will therefore be less responsive and less reliable. Improving or degrading loss trends will take years to be reflected in the experience modifier. We believe it would be better to incorporate loss information in the underlying layer (inclusive of reserves) which would be more predictive of actual PCF losses. Hospitals can easily provide such data.

- **Experience modification should <u>not</u> be limited to those with manual surcharges greater than $1,500,000** – Currently, the PCF levies surcharges against individual doctors depending on the number of claims (more information regarding those surcharges can be found at https://pcf.osi.state.nm.us/index.php/carriers/). Therefore, we believe that limiting the experience modification factor to those hospitals with a PCF manual surcharge of $1,500,000 or higher is both inconsistent and unreasonable. Hospitals have active risk management practices in place and are positioned to better control losses compared to individual physicians. Hence, the incurred and paid loss experience of hospitals is more credible than that of individual physicians and should therefore be utilized in the development of experience modification factors.

- **The PCF needs to clarify how it will assign (allocate) claims between hospitals and physicians to avoid any "double charging"** – Historically, there have been limitations in the data collected regarding assignment of claims and losses between the hospitals and the physicians. Allocating legal responsibility for losses is complicated. Employed physician losses are commonly paid by the hospital since any given patient injury is usually influenced by a combination of circumstances involving actions (or inactions) of physicians and other care providers.

  Pinnacle recognizes these limitations in the last bullet on Page 28 of the aforementioned study which states "…some payments originally attributed to hospitals were actually made on behalf of physicians, not the hospital. This resulted in a shifting of some payments from our prior analysis."

  This dichotomy creates a challenge in estimating surcharges separately for physicians and hospitals based on data that was not completely allocated in the past.

  We support the process of calculating the surcharge for the entire risk based on combined loss histories (including both the employed providers and hospital). Individual employed providers should be enrolled using PCF published rates. Finally, any remaining surcharge should be allocated to the facilities. By so doing, the total risk posed by the hospital and its employed providers is fully funded regardless of allocations and hence actuarially sound. This is also consistent with the section of the Act requiring use of New Mexico data as previously discussed.

It should be noted that the PCF claim cost for any given claim will be the same regardless of the number of defendants. Since the proposed experience modification is based solely of claim frequency, counting any given claim against a hospital and multiple provider defendants would result in over-counting and excessive experience-based surcharges.

To resolve this, the PCF (in actuality, the enrolling carriers) would have to allocate claims to both the hospital and providers appropriately. This would result in partial claim counts which must, in total, match one full claim. This would be further complicated by the fact that physicians and hospitals may be insured by different carriers, who would be unaware of all the other defendants and/or the MRC status of those defendants. It should be noted that the same issue of double counting appears to potentially affect the development of base rates as well.

We therefore propose that, while the base rates would be established by the PCF's actuary, the hospital's experience modifiers should be jointly developed by the hospital's and the PCF's actuary to ensure timely and relevant New Mexico data is incorporated in determining appropriate hospital surcharges ultimately collected by the PCF.

Detailed Comments: The following are additional comments of key pages (page numbers refer to the 106 page .pdf file of PCF Staff's Written Testimony for Docket 19-00004-PCF) of the actuarial report which provide more background to our position:

Page 16 – Section 4 states a charge of 10% of the applicable PCF surcharges for each covered physicians, surgeons and other participating healthcare providers within a qualifying business entity seeking PCF coverage provides an actuarially sound surcharge for this coverage. This surcharge amount and approach is stated to be derived from leading medical professional liability insurers' practices and a review of rate filings. The exposure to the PCF does not increase since coverage and limits are not increased by having additional physicians, surgeons and other participating healthcare providers within a qualifying business entity. Therefore, we believe this charge does not apply since the PCF pays claims on a per accident basis regardless of the number of defendants.

Page 17 – Section 5 states projected physician losses for the period of 9/1/19 through 9/1/20 are $24.945 million while the surcharges are $21.929 million resulting in a projected *shortfall* of $3 million. As further detailed, this shortfall might be reduced by $2.035 million but this still leaves an expected shortfall of $1 million for the next policy period. We believe the PCF should charge adequate rates and should collect surcharges at expected level to reduce future deficits.

By comparison, Section 6 discusses the hospital surcharges which are listed as 0.9% at the 65th percentile which indicates that the surcharge increase is essentially flat or slightly negative at the expected level (the 55th to 60th percentile). This is evidence that the hospitals have paid their fair share and continue to pay adequate rates.

Page 31 – The last full paragraph states that the OSI is gathering "better quality" data by improving the database. While this is true, the data that is used in the actuarial calculations for hospitals could be significantly enhanced by incorporating loss data below the PCF layer. A more complete data set would be more predictive than just using paid loss data as it will be more responsive to current trends.

Page 64 –The hospital selected loss ratio in line 6 is 100.4% however this is based on a longer period than used in the physician selected loss ratio. The physician selected loss ratio uses the

years 2012 through 2016 as demonstrated on page 58. A hospital loss ratio based on the same period as the physicians would be 98.6%. A loss ratio below 100% indicates the hospitals paid surcharges equal to or greater than their predicted losses, and have not been undercharged. Further, Column 5 demonstrates that losses are more predictable for the hospitals since the majority of the hospitals joined the PCF in 2016. Since that time, the loss ratios have become more consistent compared to prior years when the loss ratios had more variability and exceeded 100%.

Pages 66 and 67 - The loss development pattern is based on hospitals and practitioners combined. Most hospitals that joined the PCF did so in 2016, and the later years' loss data reflects very little in the way of paid claims, especially when it comes to hospitals. Hence, an assumption has been made that the experience of the hospitals and practitioners in early years is representative of the current exposures. While the PCF is much larger with the inclusion the hospitals (improving credibility), the paid loss data used by the PCF's actuary inclusive of the all hospitals is much "greener", meaning it is less developed.

Page 96 – The proposed relativities as selected in Column 3 are based on industry relativities as shown in Columns 4, 5 and 6. As shown in the exhibit, there is a great deal of variability among the industry sources and hence trying to make a selection in Column 3 based on judgement may indicate that the exposure rating for hospitals may not be as reliable when compared to experience rating.

Page 98 – There is a reduction in the hospital's PCF layer claims in the 2017 and 2018 years which is expected since the hospitals would have had losses limited to $600,000 plus unlimited medical expenses (and would not include punitive damages). This compares to years prior to 2016 when the PCF cap did not apply to most of the hospitals. We note that the selection of the expected claims per year in Row 7 does not give any credit to the 2017 and 2018 years which may be more representative of future exposure. Therefore, the final expected claims per exposure in Row 9 may be too high.

Page 104 – As stated in the last paragraph, the experience rating plan modifier will be based on the number of PCF claims. However, the definition of a claim has not been made clear and should include some common standard involving the MRC. Beyond that, we believe that actual loss experience in the underlying layer (as measured in payments and loss reserves) should be considered since they reflect more current data and trends. Frequency ignores claim severity which has more variability due the PCF covering unlimited medical expenses.

Credibility for the experience rating is proposed to be based on claim frequency. We believe that the credibility formula should give some weight to loss experience as measured in dollars. Further, only members with manual surcharges only over $1,500,000 are eligible for the experience modifier under the proposed structure. If the small members have bad loss experience, this would result in the PCF being underfunded since those surcharges would not be adjusted upwards. This might result in larger members overpaying or the PCF being underfunded. We believe hospitals usually have safety practices in place and should be able to better control losses compared to individual physicians. Hence, loss experience and claim experience of hospitals is more credible and should be utilized.

Finally, the surcharges (rates) against which the experience modifier is being applied are developed using PCF loss payments. Such data is slow to emerge and would not be responsive to current loss activity and trends compared to a comprehensive set of data including paid and reserved losses below the PCF layer which can be obtained from the hospitals.

Summary: The PCF would benefit by having a system of checks and balances including input from its major stakeholders including hospitals and their actuaries. The confidence of all PCF members would be enhanced, and the accuracy and actuarial soundness of the PCF funding would be drastically improved if all reasonably available information is utilized.

If the PCF desires to use the exact same process for physicians and hospitals, then the PCF should at least weigh conclusions contained in independent actuarial reports to ensure that the final rates charged to the hospitals are appropriate and reflect their individual loss experience.

Thank you for this opportunity to submit comments.

Sincerely,

Jeff Dye
President and CEO