BEFORE THE NEW MEXICO OFFICE OF SUPERINTENDENT OF
INSURANCE AS CUSTODIAN OF THE PATIENT COMPENSATION FUND

IN THE MATTER OF DETERMINING)
NEW PATIENT COMPENSATION FUND) Docket No. 19-00004-PCF
SURCHARGE RATES)

FILED

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Patient's Compensation Fund

Transcript of Determining New Patient Compensation Surcharge Rates hearing before Marilyn S. Hebert, Hearing Officer, Santa Fe, Sante Fe County, New Mexico, held November 18, 2019, at 9:00 a.m., at 1120 Paseo de Peralta, Apodaca Hall, Santa Fe, New Mexico.

REPORTED BY: Rebecca Fella, RPR, New Mexico CCR No. 534
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Page 2

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INDEX
8
WITNESS: SANDRA ROMERO PAGE
9
EXAMINATION BY:
10 Mr. Baran 6
11
PUBLIC COMMENT BY MR. WATSON AND MR. FRESE .. 24
12
WITNESS: ROBERT JAMES WALLING, III
13
EXAMINATION BY:
14 Mr. Baran 33
15 CERTIFICATE OF REPORTER 159
16
EXHIBITS
17
NO. DESCRIPTION IDENTIFIED
18
Exhibit A File 155
19
Exhibit B Table of base surcharges 155
20
Exhibit C Table of surcharges 155
21
Exhibit D Manage transactions 155
22
Exhibit E Table of surcharges 155
23
24
25

Page 3

1 HEARING OFFICER HEBERT: Okay. Good morning.
2 My name is Marilyn Hebert. I am the designated Hearing
3 Officer for this matter, and this is Docket Number
4 19-00004-PCF, in the matter of determining new Patient
5 Compensation Fund surcharge rates, a case pending before
6 the New Mexico Superintendent of Insurance.
7 On September 16th, 2019, the superintendent, in
8 his capacity as the custodian of the New Mexico Patient
9 Compensation Fund -- the PCF -- issued his order opening
10 this docket to consider new PCF surcharge rates pursuant
11 to NMSA 1978, Section 41-5-25, and set an evidentiary
12 hearing for today.
13 On September 30th, 2019, the superintendent
14 issued an order appointing me as Hearing Officer and
15 setting an initial case schedule.
16 On October 10th, 2019, the Hearing Officer
17 issued an order setting October 17th as the deadline for
18 filing motions to intervene, and at this time there have
19 been no motions to intervene in this matter.
20 On October 15th, notice of public hearing of
21 today's hearing was published in the New Mexico Register
22 and the Albuquerque Journal.
23 On October 22nd, a preliminary hearing was held
24 to discuss procedural and scheduling matters. It was
25 attended by staff of the Office of Superintendent.

Page 4

1 At this time the record and the docket contains,
2 in addition to the orders, the following: It contains the
3 2018 actuarial analysis of the NM PCF, July 2019, by
4 Pinnacle Actuarial Resources, Inc. It's attached as
5 Exhibit A to the superintendent's September 16th order.
6 The record also contains staff's written
7 testimony filed on October 7th, 2019.
8 The Office of the Superintendent has received
9 the following public comment: October 16th, 2019, email
10 from D.J. Letherer, and a November 4th, 2019, comment of
11 the New Mexico Hospital Association submitted by Jeff Dye,
12 D-y-e.
13 The hearing is conducted in accordance with the
14 Administrative Procedure Act, NMSA 1978, Sections 12-8-10
15 through 12-8-13, and Section 12-8-15, the Medical
16 Malpractice Act, NMSA 1978, Sections 45-5-1 through
17 45-5-29, and the rules promulgated thereunder, NMAC
18 13.21.4 through 31.21 -- I'm sorry; excuse me -- NMAC
19 13.21.1 through 31.21.4.
20 If there's anybody who would like to comment on
21 this matter at the conclusion of the evidence, they will
22 be allowed to do so, to make public comment.
23 And at this time I'd ask for the attorneys
24 participating in this matter to state their appearance, as
25 well as the name of their witnesses.

Page 5

1 MR. BARAN: I'm Todd Baran for PCF staff. I
2 will be offering testimony from Sandra Romero and Rob
3 Walling.
4 HEARING OFFICER HEBERT: Thank you. Mr. Baran,
5 I don't know if you want to make an opening statement, but
6 you're certainly welcome to do so.
7 MR. BARAN: Do you mind if I, Madam Hearing
8 Officer, sit through these proceedings?
9 HEARING OFFICER HEBERT: No, not at all.
10 MR. BARAN: Okay. We would waive the opening
11 statement and move on to the presentation of evidence --
12 with one procedural matter.
13 I understand that there's one person here who
14 previously filed a comment who wants to make some public
15 comments, but they have a flight to catch, so if it's okay
16 with the Hearing Officer, we've agreed that they would
17 present their comments after Ms. Romero testifies.
18 HEARING OFFICER HEBERT: No, that's perfectly
19 okay.
20 MR. BARAN: Okay. All right. So at this time
21 I'd like to call Ms. Sandra Romero.
22 HEARING OFFICER HEBERT: All right. Thank you.
23 SANDRA ROMERO,
24 having been first duly sworn, testified as follows:
25 EXAMINATION

Page 6

1 BY MR. BARAN:
2 Q. Ms. Romero, by whom are you employed?
3 **A. By the Office of Superintendent of Insurance.**
4 Q. And what is your position with the Office of
5 Superintendent of Insurance?
6 **A. I am the PCF director.**
7 Q. And what --
8 HEARING OFFICER HEBERT: Ms. Romero, could you
9 speak up just a little bit?
10 THE WITNESS: Oh, sure.
11 **A. PCF director.**
12 Q. And what are your general responsibilities as
13 PCF director?
14 **A. I -- I oversee the carriers' part of uploading**
15 **providers' information to qualify for the Patient**
16 **Compensation Fund.**
17 **I edit surcharge amounts to make sure the**
18 **surcharge amounts are correct, the dates are correct. Any**
19 **errors are to be corrected. Basically just overseeing**
20 **the -- the function of the fund.**
21 Q. Okay. And we're here today to ask the Hearing
22 Officer to make a recommendation with respect to base
23 surcharges for physicians, entities, and hospitals and
24 outpatient facilities.
25 What are your -- what is your understanding of

Page 7

1 the relationship between the -- the base surcharges that
2 providers may be assigned and the actual surcharges that
3 are assessed by the PCF?
4 **A. The annual surcharges is what -- what it is.**
5 **It's for an annual surcharge amount, which is a full year.**
6 **That -- that is the same for any -- we have specialty**
7 **codes, which -- which is for specialty -- the specialty**
8 **medicine that doctors practice, and that is the same**
9 **across the board, so you have a yearly surcharge.**
10 **That surcharge can be changed or it can be**
11 **different from different aspects of the -- of the -- of**
12 **the surcharge, which for an example, their claim -- their**
13 **claim experience, that can add an additional surcharge to**
14 **the base surcharge amount.**
15 **We also have discount amounts that can also**
16 **apply to that surcharge that could change the surcharge,**
17 **and also, not all premium is based -- is a yearly**
18 **surcharge. Sometimes providers have a policy for six**
19 **months, five months, seven days.**
20 **So the beginning of a surcharge for a provider**
21 **begins at the yearly rate, and then different -- different**
22 **things can happen to that rate that will change the final**
23 **surcharge amount.**
24 Q. Okay. So you start with the same surcharges for
25 providers in a particular specialty --

Page 8

1 **A. That is correct.**
2 Q. -- correct?
3 **A. Yes, sir.**
4 Q. Okay. And then that might get adjusted by these
5 other factors that you discussed --
6 **A. Yes.**
7 Q. -- correct?
8 **A. Yes.**
9 Q. And those factors include the claims history of
10 that provider, correct?
11 **A. That is true.**
12 Q. And then how long of a period they want the
13 coverage for, correct?
14 **A. That is true, correct.**
15 Q. Okay. And then also whether or not they're full
16 or part-time, correct?
17 **A. Yes, sir.**
18 Q. So you might have a podiatrist that pays the
19 full recommended base surcharge and another podiatrist
20 that pays something less?
21 **A. That is true.**
22 Q. And another one that pays something more?
23 **A. Based on all those different factors you**
24 **mentioned.**
25 Q. Okay. I'm going to ask you to take a look at

Page 9

1 what's been premarked as Exhibit Number C.
2 HEARING OFFICER HEBERT: Thank you.
3 BY MR. BARAN:
4 Q. And can you tell us what Exhibit Number C is?
5 **A. This appears that it is from our old upload**
6 **system that uploaded providers for coverage.**
7 Q. Okay. So what information are we seeing in
8 Exhibit Number C?
9 **A. What we -- we have the policy number of the**
10 **providers. We have the rate class that they would be**
11 **surcharged on. We have the specialty code, which, again,**
12 **is the -- it describes the type of medicine that doctors**
13 **specialize in.**
14 **It has the beginning and ending date of their**
15 **policy. It has the surcharge -- it has the surcharge**
16 **amount, which would be their final surcharge.**
17 **The next column is a base surcharge, and that**
18 **would be for the base surcharge -- the -- the annual**
19 **surcharge would begin.**
20 **We also have the state of licensure -- which**
21 **would be New Mexico -- the gender of the physician, the**
22 **occupational code, which we don't use at this time. We --**
23 **we use specialty codes.**
24 **We have the graduation -- the year the doctor**
25 **graduated from -- from medical school. We have the**

Page 10

1 **description of the policy -- whether it's a renewal, a**
2 **cancellation -- and we have the entity that they're**
3 **related to in any way.**
4 Q. Okay. So if we go to the column that says base
5 surcharge, what number -- what is the significance of the
6 numbers in that column?
7 **A. The base surcharge would be the annual surcharge**
8 **for a policy -- for the premium --**
9 Q. Okay.
10 **A. -- or the surcharge.**
11 Q. Okay. Would that be the surcharge that would be
12 assessed if there was no adjustments?
13 **A. That is correct.**
14 Q. Okay. And then the column to the left of that
15 is surcharge, correct?
16 **A. Yes.**
17 Q. And what is the significance of the number in
18 that column?
19 **A. That surcharge would relate to any of the**
20 **changes of the surcharge amount. It would be if the**
21 **doctor was a part-time doctor, if the doctor had any --**
22 **their claims experience, and also for the amount of time**
23 **that the doctor was covered.**
24 Q. Okay. Are there any indications in this
25 document that any of these particular physicians were

Page 11

1 working part-time?
2 **A. I didn't bring my calculator. I'll try to see.**
3 **Yes. If you look at -- part-time would be kind of hard**
4 **for me just to look at, but if you looked at the third**
5 **row -- or the fourth row on the base surcharge says**
6 **$22,384. There is a final surcharge of $6,625.66. Then**
7 **again, I don't think there's a part-time.**
8 **We have a new system now that would -- that**
9 **would tell us that, but just looking at it based on the**
10 **dates, their policy is only from 9/17/2019, to 6/1/20, so**
11 **that would limit the number of days of that policy.**
12 **So that annual surcharge would be divided by**
13 **however many days and you get a daily rate, and you would**
14 **come out with the surcharge amount.**
15 Q. So that provider may not be working part-time,
16 but is not asking for a full year of coverage; is that --
17 **A. That is true.**
18 Q. Okay. So go down to the number in the column
19 base surcharge $7,008.00.
20 Do you see that one?
21 **A. Yes.**
22 Q. Okay. And then go to the left of that and it
23 says $3,504?
24 **A. Yes.**
25 Q. And then if you look at the beginning date and

Page 12

1 ending date, it appears to be a full-year policy?
2 **A. That is true.**
3 Q. So does that indicate that that provider is
4 working part-time?
5 **A. Yes, I can probably say the base surcharge, it's**
6 **probably a part-time doctor, which is getting the 50**
7 **percent discount, because then the surcharge is $3,504,**
8 **which is half of the base surcharge amount.**
9 Q. Okay. And go further down on the base surcharge
10 where it says $2,920.00.
11 **A. Yes.**
12 Q. Do you see that one?
13 **A. Yes.**
14 Q. And to the left of that it says the actual
15 surcharge is $1,460.00.
16 Do you see that?
17 **A. Yes.**
18 Q. Okay.
19 **A. Yes.**
20 Q. And that also appears to be a full-year policy?
21 **A. That would also state that it would be a**
22 **part-time doctor.**
23 Q. Okay. And then the next column to the right of
24 base surcharge is experience modifier, and what is that?
25 **A. That would be their claim exposure. If a doctor**

Page 13

1 **has been -- there has been a claim against the -- the**
2 **doctor, the PCF and the first -- the PFC charges an**
3 **additional amount for their claim -- for their claim**
4 **experience.**
5 **Based on number of claims, they pay an**
6 **additional surcharge.**
7 Q. Okay. And what does the number one signify in
8 that column?
9 **A. Just, yeah, that it has zero claims.**
10 Q. Okay.
11 **A. If there was a claim, it would have been -- it**
12 **would be a 1.25.**
13 Q. So a provider that had a single claim would pay
14 the base surcharge times 1.25?
15 **A. Yes, sir.**
16 Q. And then that would be adjusted by any part-time
17 or partial year?
18 **A. Yes.**
19 Q. Okay. All right. I'd like to hand you what's
20 been marked Exhibit Number D.
21 Can you tell us what Exhibit Number D is?
22 **A. This is an upload that has -- that a carrier**
23 **uploaded on our new upload system.**
24 Q. Okay. And so is this the same type of system
25 that was reflected in Exhibit Number B?

Page 14

1 **A. No.**
2 Q. Okay. Or sorry; C.
3 COURT REPORTER: I'm sorry; what did you say?
4 MR. BARAN: C.
5 **A. It is not.**
6 Q. Okay. What's changed between them?
7 **A. Our new system no longer allows a carrier to**
8 **input the base surcharge amount or the surcharge -- final**
9 **surcharge amount.**
10 **It has basically the same information. The**
11 **only -- there's -- the difference is it now -- our new**
12 **system has a place to enter for a carrier a part-time**
13 **amount for part-time doctors that lists the discount.**
14 **It has the claim experience modification -- the**
15 **claims experience that you can add in there, and it**
16 **doesn't allow a carrier to put in surcharge amounts to**
17 **kind of manipulate the system.**
18 **So our information is based on the ISO code,**
19 **which they put in all the information, and this system**
20 **does all the calculations.**
21 **It will calculate if you have a claim that has**
22 **been. It will add -- it will add the percentage of the**
23 **claim. It will also discount the -- the discount for**
24 **part-time doctors, and it also takes in the fact of the**
25 **beginning and ending dates of policies.**

Page 15

1 **So no calculation is done on the carrier's part.**
2 **It is fully calculated from our end from a spreadsheet**
3 **that gets uploaded, and so this is -- for no reason that**
4 **we would have to audit every surcharge that was done in**
5 **the past.**
6 Q. Okay. So at the end of this process today, the
7 Hearing Officer is going to be asked to recommend a set of
8 base surcharges.
9 Those will then be loaded into the system?
10 **A. Yes.**
11 Q. And the insurance carriers will not have any
12 opportunity to try to adjust that?
13 **A. They will not.**
14 Q. Okay. And then -- but they will have to put in
15 information that will affect the actual surcharge that
16 their provider pays --
17 **A. Yes.**
18 Q. -- correct?
19 **A. Yes.**
20 Q. Okay. And so if we look at the information at
21 the top of the page, there's a column, number of claims.
22 What does that refer to?
23 **A. That would be -- number of claims would be if**
24 **there was a claim against the doctor for their claim**
25 **exposure.**

Page 16

1 **If they did have a claim against a doctor, that**
2 **they would have to put in one, and then we would charge --**
3 **the system would charge an extra 25 percent of the**
4 **surcharge.**
5 Q. Okay. And then the column to the left of that
6 is part-time percent discount.
7 What does that refer to?
8 **A. That refers to a part-time doctor. If a doctor**
9 **is part-time, based on how many hours, then there is a**
10 **discount amount of -- it could be 20, 30, 40 percent,**
11 **whatever that it may be based on the hours the doctor is**
12 **working.**
13 Q. And is that going to be built in to the system
14 as well?
15 **A. It already is, yes.**
16 Q. Okay. And what is down below in the box that
17 says manage transactions?
18 **A. This is the actual upload from the new system.**
19 Q. Okay. And when you say the actual upload, what
20 does that mean?
21 **A. That means it took the information that you're**
22 **talking about at the top of the page from the Excel**
23 **spreadsheet that the carrier inputs all that information,**
24 **then once it's submitted, then it looks like this in our**
25 **system, that we can go through and verify the information.**

Page 17

1 Q. Okay. So let's walk through -- this is an
2 example, correct?
3 **A. It is.**
4 Q. Okay. So let's walk through Jessica Smith, and
5 we have the license number, the date received, the policy
6 number, then rate class.
7 What does rate class refer to?
8 **A. Rate class -- actually, the rate class, this is**
9 **used a little -- let me see this. This looks different.**
10 **The rate class is the number that the PCF --**
11 **it -- it transfers over from the ISO specialty code.**
12 **All -- all of the specialties have a -- have a specialty**
13 **code based on their practice -- their specialty of**
14 **practice. Then that gets transferred over to a rate**
15 **class -- the PCF rate class.**
16 **So when the ISO code is entered, it**
17 **automatically transfers over to a rate class -- a PCF rate**
18 **class -- which then gives us our base surcharge.**
19 Q. Okay. So the next column is specialty.
20 Is that the specialty code you were just
21 referring to?
22 **A. I am, yes.**
23 Q. Okay. So that specialty code will tell you
24 what -- what practice area that doctor is in?
25 **A. Yes. Specialty of medicine, yes.**

Page 18

1 Q. Okay. And then there's a rate class that's
2 assigned to that particular specialty?
3 **A. By the PCF.**
4 Q. Okay. And there's a -- in the rate class
5 there's a one and a five and a nine.
6 How are those graduated? Is the one the lower
7 base surcharge and the nine the higher?
8 **A. That is true. That's how it works. I don't**
9 **know how it began, but if you look at our list of**
10 **surcharges, one is usually the lower surcharge, going on**
11 **up to probably a higher specialty of medicine.**
12 Q. Okay. So now we go over to the column that says
13 base surcharge.
14 Is that the base surcharge that applies to that
15 specialty code and that rate class?
16 **A. It is, yes.**
17 Q. Okay. And then the final surcharge would be the
18 one that's adjusted for claims history and whether they're
19 part-time?
20 **A. Discounts.**
21 Q. Okay.
22 **A. Anything else involved, yes, that's correct.**
23 Q. And whether's it's a partial-year policy?
24 **A. Yes.**
25 Q. Okay.

Page 19

1 HEARING OFFICER HEBERT: Excuse me, Mr. Baran.
2 What -- how did you designate Exhibit C? Did you -- did
3 it have a -- the first exhibit, did you have some kind of
4 a title for it or a name for it?
5 MR. BARAN: I -- I did not.
6 HEARING OFFICER HEBERT: Okay. Just Exhibit C?
7 MR. BARAN: Yeah.
8 HEARING OFFICER HEBERT: All right.
9 MR. BARAN: Now I'm going to show you what's
10 been premarked as Exhibit B.
11 HEARING OFFICER HEBERT: Thank you.
12 MR. BARAN: And before I get to that and before
13 I forget, Madam Hearing Officer, this is my client
14 representative, Anna Krylova. She's the chief actuary.
15 HEARING OFFICER HEBERT: Yes, thank you.
16 MR. BARAN: Thank you.
17 BY MR. BARAN:
18 Q. Can you tell us what Exhibit B is?
19 **A. This comes from our website. This is kind of an**
20 **explanation or the requirements of -- to be qualified for**
21 **the PCF.**
22 Q. Okay. And does this kind of outline the process
23 that you just described with respect to Exhibits C and D?
24 **A. It does.**
25 Q. Okay. And down at the bottom, it looks like it

Page 20

1 starts, table of base surcharges, and then continues on
2 the next page.
3 What is -- if you were looking at the website,
4 what information would you see in that table of base
5 surcharges?
6 **A. It would give you the rate class for the**
7 **specialty of doctors, and it would also give you the**
8 **surcharge amount for those class rates.**
9 Q. Okay. And then down below it says, rules for
10 experience-rating base surcharges, and what is that --
11 **A. This --**
12 Q. -- piece of the process?
13 **A. -- this information, that's -- that's -- doctors**
14 **or carriers know that --**
15 COURT REPORTER: I'm sorry; could you -- doctors
16 know what?
17 THE WITNESS: The -- they would let them know
18 the experience rating and what we would charge for an
19 additional claim, so it does let them know what the
20 percentage of an additional surcharge would -- additional
21 charge to the surcharge would be.
22 BY MR. BARAN:
23 Q. Okay. And so the column on the left says,
24 during the last five years, and then there's a one, two,
25 and three.

Page 21

1 Is that number of claims?
2 **A. Yes, it is.**
3 Q. And then over on the right it says, debit, 25,
4 50, and 75 percent.
5 Is that the increase --
6 **A. That is.**
7 Q. -- for the number of claims during the last five
8 years?
9 **A. Yes.**
10 Q. Okay. And that's consistent with what you were
11 testifying to earlier about Exhibits C and D?
12 **A. That is correct.**
13 Q. Okay. And how long has that system been in
14 place?
15 **A. Are you talking about the surcharge -- the --**
16 **the claim amount experience?**
17 Q. Correct.
18 **A. I can't tell -- I can't tell you how long. I**
19 **started in 2016, but I think it was there a lot prior -- I**
20 **think it's been there since the beginning, but I**
21 **couldn't --**
22 Q. Okay. So it's been there as long as you've been
23 there?
24 **A. Yes.**
25 Q. Okay. And then the next page, at the top,

Page 22

1 indicates what type of claims will result in an increase
2 in the surcharge; is that correct?
3 **A. Yes.**
4 Q. Okay. And then below that there's the
5 classification table.
6 What information are we seeing here?
7 **A. This actually gives you the specialty of the**
8 **doctors, outlines all the specialties that we accept, and**
9 **it also has the ISO code that -- that -- that references**
10 **those specialties, and it also gives us our rate class for**
11 **the PFC on each specialty.**
12 Q. All right. So I see that the acupuncture is in
13 a class one.
14 Do you see that?
15 **A. Yes, sir.**
16 Q. And then aerospace medicine/medical director is
17 also in a class one, correct?
18 **A. Yes.**
19 Q. Does that mean that an acupuncturist would have
20 the same base surcharge as the aerospace medicine/medical
21 director?
22 **A. That's exactly what it says, yes.**
23 MR. BARAN: Okay. Those are all the questions I
24 have for you, Ms. Romero.
25 THE WITNESS: Great.

Page 23

1 MR. BARAN: Does the Hearing Officer have any
2 questions?
3 HEARING OFFICER HEBERT: Well, I don't think I
4 do -- except on -- on Exhibit D. That was this second
5 one, I believe.
6 THE WITNESS: Uh-huh.
7 HEARING OFFICER HEBERT: Did you testify that
8 this was the former upload -- example of a former upload
9 or is it the current?
10 THE WITNESS: No, it's the current. The -- the
11 top part is what is entered into an Excel spreadsheet.
12 This once it gets submitted, the -- on the bottom, that is
13 what it will look like.
14 HEARING OFFICER HEBERT: All right. Thank you.
15 THE WITNESS: Okay. You're welcome.
16 MR. BARAN: Thank you very much.
17 THE WITNESS: Thank you.
18 COURT REPORTER: Could you spell your last name?
19 THE WITNESS: Romero, R-o-m-e-r-o.
20 COURT REPORTER: Thank you.
21 THE WITNESS: Uh-huh.
22 HEARING OFFICER HEBERT: Thank you, Ms. Romero.
23 THE WITNESS: Sure. Thank you.
24 HEARING OFFICER HEBERT: This is the public
25 comment --

Page 24

1 MR. BARAN: Yes, it is.
2 HEARING OFFICER HEBERT: -- is that correct?
3 MR. BARAN: Yes.
4 HEARING OFFICER HEBERT: Okay. Good morning.
5 MR. WHITMORE: Good morning.
6 HEARING OFFICER HEBERT: There's -- there's no
7 need to swear these gentlemen because it's public comment.
8 Just introductions.
9 MR. WHITMORE: Thank you. My name is Bruce
10 Whitmore. I'm a senior consultant with Willis Towers
11 Watson, Global Captive and Health Care Practices.
12 MR. FRESE: I'm Richard Frese. I'm a principal
13 and consulting actuary with Milliman.
14 MR. WHITMORE: We work with the New Mexico
15 Hospital Association and the New Mexico Hospital Risk
16 Purchasing Group and been involved with the program since
17 the physicians -- since the majority of the hospitals
18 joined the Patient Compensation Fund in 2016.
19 We -- the New Mexico Hospital Association had
20 submitted some written commentary --
21 HEARING OFFICER HEBERT: Yes.
22 MR. WHITMORE: -- and we just wanted to make
23 sure that some of these points, if they needed to be
24 clarified, would be so clarified.
25 HEARING OFFICER HEBERT: Yes, I appreciate that.

Page 25

1 I -- I believe it would have been more helpful if the
2 staff actuary or the -- Mr. Walling could address those
3 issues.
4 MR. WHITMORE: Well --
5 MR. BARAN: Mr. Walling will be addressing those
6 issues.
7 HEARING OFFICER HEBERT: As to their comments?
8 MR. BARAN: Yeah, as such -- yeah --
9 HEARING OFFICER HEBERT: Okay.
10 MR. BARAN: -- and anything that comes out
11 during the --
12 HEARING OFFICER HEBERT: Yes. And I have read
13 those comments, and if you would just like to give -- give
14 us the high points of -- of the comments that the
15 Association had.
16 MR. WHITMORE: Certainly. You know, first of
17 all, we do believe that there is a -- given the size and
18 complexity of the hospitals involved, that the New Mexico
19 Hospital Association should have an advocacy role to
20 ensure that both actuarially fair and equitable surcharges
21 for the hospitals are applied by the PCF.
22 And Richard, I'm going to encourage you to chime
23 in as we go along.
24 MR. FRESE: Okay. Sure.
25 MR. WHITMORE: A couple of things stood out in

Page 26

1 our mind was that when we saw the Section 41-5-25(B) of
2 the New Mexico Medical Malpractice Act, it specifically
3 refers to, the superintendent should use data obtained
4 from New Mexico experience if available.
5 The work that Richard does includes the actual
6 loss experience of the hospitals within the state.
7 Richard, would you want to provide some more
8 commentary, please?
9 MR. FRESE: Correct. So part of the process of
10 creating the actuarial report -- report for the RPG is
11 that we go ahead and gather all the losses from the
12 members that are participating in the RPG, and that
13 includes ground-up losses and that includes all known
14 losses, which include -- which is case reserves and paid
15 losses, and then we also collect the payment data from the
16 OSI as well too, so we are using a full set of data in the
17 actuarial calculation for the RPG.
18 MR. WHITMORE: I believe that -- that same
19 information would also apply to the other hospitals who
20 are accessing the Patient Compensation Fund outside of the
21 Risk Purchasing Group.
22 So in effect, they are looking at all available
23 loss information, including the losses below the Patient
24 Compensation Fund layer, as well as even losses that
25 were -- would be above the Patient Compensation Fund layer

Page 27

1 as well -- for example, for hospitals and their losses
2 prior to participating in the Patient Compensation Fund.
3 So the long and the short of it is, the
4 actuarial work that has been historically done by the
5 hospitals has been done each and every year, has been
6 adjusted based upon actuarial experience that would not
7 normally be contemplated by Mr. Walling's work just
8 because he looks at Patient Compensation Fund only
9 experience as opposed to the client's individual loss
10 experience below the layer and above the layer.
11 HEARING OFFICER HEBERT: I'm sorry; could you
12 just -- could you clarify that again?
13 MR. WHITMORE: Sure.
14 HEARING OFFICER HEBERT: I didn't understand
15 that.
16 MR. WHITMORE: So Mr. Walling's work is looking
17 at paid loss data. By definition, because those claims
18 take time to be litigated and ultimately be paid out --
19 HEARING OFFICER HEBERT: Uh-huh.
20 MR. WHITMORE: -- it's kind of like, if you
21 will, driving a car by looking at the back window.
22 HEARING OFFICER HEBERT: Uh-huh.
23 MR. WHITMORE: And this -- this is -- this is
24 the challenge that all actuaries have.
25 HEARING OFFICER HEBERT: Uh-huh.

Page 28

1 MR. WHITMORE: By comparison, the actuarial work
2 that the hospitals are currently doing looks at incurred
3 losses before the claims are ever paid. They look at
4 reserves -- i.e., dollars that are expected to be paid out
5 into the future -- and so it is -- it is adjusted on a
6 more real-time basis.
7 HEARING OFFICER HEBERT: By incurred losses, do
8 you mean anticipated incurred losses, because prior to
9 their being resolved, are those --
10 MR. WHITMORE: That -- that can mean, for
11 example -- well, Richard, why don't you, as the expert --
12 MR. FRESE: Sure. So that's -- the definition
13 of the incurred losses that we're using is the combination
14 or the total of payments plus case reserves, and case
15 reserves are basically a provision that's set aside for
16 any known claim of what will be paid in the future.
17 HEARING OFFICER HEBERT: Anticipated --
18 MR. FRESE: Anticipated --
19 HEARING OFFICER HEBERT: -- claim?
20 MR. FRESE: Correct. That would be anticipated,
21 correct.
22 HEARING OFFICER HEBERT: Okay. I'm sorry.
23 MR. WHITMORE: No, I'm -- I'm glad to be able to
24 clarify.
25 I think the other point that we would make is

Page 29

1 that Pinnacle's rate level indication suggests an increase
2 of 13.8 percent on an expected-value basis; you know, the
3 hospitals are lower.
4 Historically, the PCF has implemented increases
5 in the Patient Compensation Fund over a phased-in level.
6 I believe it was, for example -- if my memory serves me
7 correctly -- like 8.75 percent in one year and another
8 8.75 percent in a second year.
9 We would simply ask that if the hospital rates
10 are going to be increased, that they would be phased in in
11 a likewise manner to the physicians -- to be treated, if
12 you will, fairly with the same phase-in effect.
13 I will also say that the -- that just based upon
14 what we saw in Mr. Walling's report, we did not have
15 clarity as far as what the -- the definition of a claim
16 is.
17 I saw it elsewhere in some additional
18 documentation, but we're not entirely clear at this point,
19 for example, what is truly considered a claim for the sake
20 of calculation -- calculating the experience modification
21 factor.
22 So is that, for example, a claim that goes
23 through the Medical Review Commission and is found to have
24 merit? Is that a -- simply a new notice of litigation
25 against an insured?

Page 30

1 The hospitals will commonly post losses
2 themselves based upon what they know about a medical
3 misadventure, but it appears that that -- that definition
4 of a claim does not apply to the physicians, so we just
5 would like to get some clarity on that.
6 I think the -- the other significant comment --
7 there's actually two, but the other significant comment I
8 would say is that it was proposed that the experience
9 modification for hospitals should -- would only apply to
10 accounts that paid the PCF more than one and a half
11 million dollars.
12 Our feeling on this is that if there is an
13 experience modification factor that is applied to
14 individual physicians based upon their individual losses,
15 then hospitals should be able to have an experience
16 modification that would apply to them all the way down
17 and not be limited only to accounts that pay the Patient
18 Compensation Fund a million and a half dollars.
19 MR. FRESE: We actually think that due to the
20 way hospitals have risk management practices and they
21 handle their losses, that their loss data -- and then
22 eventually what would be going into their manual rate --
23 is actually more credible than any individual physician.
24 MR. WHITMORE: And I think that the last
25 significant issue we would like to point out is that the

Page 31

1 PCF should clarify how it will allocate losses between
2 hospitals and physician providers.
3 So, for example, it's very common for a claim to
4 be made against a hospital and a physician -- maybe even
5 multiple physicians --
6 HEARING OFFICER HEBERT: Uh-huh.
7 MR. WHITMORE: -- so under those circumstances,
8 if you count that claim against physician A, physician B,
9 physician C, and against the hospital when calculating
10 experience rate and surcharges, you're effectively
11 counting the same claim four times --
12 HEARING OFFICER HEBERT: Uh-huh.
13 MR. WHITMORE: -- so then it becomes, arguable,
14 a very complicated issue of, was that claim actually
15 caused by the individual provider; was it caused by, for
16 example, an infection issue within the hospital itself?
17 There can be, obviously, conflicting --
18 conflicting circumstances or just circumstances that
19 compound where the physician failed to, for example, make
20 a proper diagnosis, but the nurse also failed to pick up
21 on it as well, so then how do we get into a question -- it
22 becomes a question of, how do we allocate those --
23 HEARING OFFICER HEBERT: Uh-huh.
24 MR. WHITMORE: -- and is that issue too complex?
25 It's, very simply, questions that we find hard

Page 32

1 for ourselves to resolve.
2 Richard, any comment?
3 MR. FRESE: I think the key is -- is that we
4 want to make sure that the PCF is funded in -- in whole
5 and is sound in whole, and at least our understanding
6 right now is that the physicians will be rated
7 individually and the hospitals will be rated individually.
8 Compared to, at least, how the hospitals have
9 been presenting the actual numbers in the past and how we
10 present the numbers in RPGs, we actually combine any
11 employed physicians within the hospital and the actual
12 hospital's losses itself and we do one combined number,
13 and then later there will be an allocation.
14 But the key is that the total funding that goes
15 to the PCF is based upon both the employed physicians and
16 the hospital, so it's a total number, and then how you
17 allocate it later isn't necessarily as important.
18 What's important, though, is that you have a
19 total sum number, and that -- that's the advantage of the
20 actuarial calculation being done in total is, you don't
21 have to worry about the allocation issues.
22 HEARING OFFICER HEBERT: Uh-huh.
23 MR. WHITMORE: So with that, I believe that
24 concludes our -- our comments.
25 HEARING OFFICER HEBERT: Thank you very much.

Page 33

1 MR. WHITMORE: Thank you.
2 HEARING OFFICER HEBERT: Mr. Baran, do you want
3 to call your next witness?
4 MR. BARAN: Yes. So at this time I would like
5 to call Mr. Rob Walling.
6 ROBERT JAMES WALLING, III,
7 having been first duly sworn, testified as follows:
8 EXAMINATION
9 BY MR. BARAN:
10 Q. Mr. Walling, can you please state your name and
11 address for the record?
12 **A. Sure. Robert James Walling, III, 2109 Woodbine,**
13 **W-o-o-d-b-i-n-e, Road, Bloomington, Illinois.**
14 Q. Okay. And I've asked you to come in today and
15 provide some expert testimony regarding work you did on
16 behalf of the New Mexico PCF.
17 Do you have a copy of Exhibit A in front of you?
18 **A. I do.**
19 MR. BARAN: Okay. Madam Hearing Officer, we
20 went ahead and marked this so everyone can refer to these
21 page numbers --
22 HEARING OFFICER HEBERT: All right.
23 MR. BARAN: -- in the hearing today.
24 HEARING OFFICER HEBERT: Thank you very much.
25 BY MR. BARAN:

1 Q. On page five of Exhibit A, there's a summary of
2 the scope of your assignment, and are those the tasks that
3 you are going to be testifying about today?
4 **A. The -- yes, the scope is listed there. I will**
5 **point out the first two of those items within the scope**
6 **are related to the unpaid claims liabilities, so the work**
7 **product from those two elements of the scope is the**
8 **underpinning for what I'll be testifying about today, but**
9 **it isn't directly within the scope of the testimony today.**
10 Q. Okay. So what experience do you have that
11 allows you to provide expert testimony or that qualifies
12 you to provide expert testimony on the issues within this
13 scope?
14 **A. I think the easiest place to see that is**
15 **actually page 19 of Exhibit A. I'll start there and --**
16 **and kind of work through it. This is my curriculum vitae.**
17 **I'll start in the middle of page 19.**
18 **I am a member of the -- of the Casualty**
19 **Actuarial Society -- a fellow -- and also a member of the**
20 **American Academy of Actuaries. Those two organizations**
21 **oversee the credentialing, professional oversight,**
22 **professional standards, continuing education of actuaries**
23 **in the U.S.**
24 Q. So before you move on from that --
25 **A. Sure.**

1 Q. -- point, can you give us a thumbnail sketch of
2 what exactly a casualty actuary does?
3 **A. Sure. An actuary -- a casualty actuary deals**
4 **with a myriad of aspects of property/casualty insurance**
5 **that are statistical or mathematical in nature primarily.**
6 **It may be pricing an insurance product, which is**
7 **part and parcel of what we're talking about today. It may**
8 **be determining unpaid claims liabilities for claims that**
9 **have occurred but haven't been settled. It could be**
10 **enterprise risk management, looking at all of the risks of**
11 **an enterprise.**
12 **There's a number of different types of skills**
13 **that -- that property/casualty actuaries are qualified to**
14 **do.**
15 **Data analytics, looking at large data sets and**
16 **seeing how the -- the loss experience for a heart surgeon**
17 **differs from a spinal surgeon.**
18 **So anything that deals with looking at**
19 **property/casualty insurance data oftentimes falls into**
20 **the -- the -- the venue or the purview of a**
21 **property/casualty actuary.**
22 Q. Is the PCF an insurance company?
23 **A. I'm going to describe it as a government**
24 **insurance program. So it is not an admitted insurance**
25 **company in the sense that State Farm is, but it certainly**

1 **produces insurance policies.**
2 **It behaves in very much the manner that an**
3 **insurance company does, but is regulated differently, is**
4 **managed differently.**
5 **So it has a lot of the same characteristics of**
6 **an admitted insurance company, but I think it's more --**
7 **more correctly described as a government insurance**
8 **program.**
9 Q. Okay. And what type of insurance product would
10 the -- what the PCF does be analogous to?
11 **A. It actually attaches and -- and kind of follows**
12 **form with medical professional liability insurance**
13 **policies and hospital professional liability insurance**
14 **policies that are the underlying coverage.**
15 Q. And are those considered casualty policies?
16 **A. Correct.**
17 Q. Okay. And do companies that issue those types
18 of casualty policies generally use actuarial studies in
19 determining their rates?
20 **A. They're required to.**
21 Q. Okay. So I interrupted. Please continue with
22 your experience.
23 **A. There's lots of other interesting stuff in here,**
24 **but at the bottom of the page, I did want to point out**
25 **that I did start a three-year term on the CAS board of**

1 **directors. That's the -- the -- the board provides the**
2 **kind of strategic oversight for the CAS and is an**
3 **important leadership position.**
4 **If you flip over to the next page, on page 20,**
5 **you can see some of the other professional activities I've**
6 **had, many of them related to ratemaking, many of them**
7 **related to medical professional liability.**
8 **In the professional publications I'll point out**
9 **the fourth publication, which is The Case for Birth Injury**
10 **Funds.**
11 **That's an analysis we did looking specifically**
12 **at primarily the birth injury funds in New York, Virginia,**
13 **and Florida that are kind of like special-purpose patient**
14 **comp funds. They only deal with birth-related**
15 **neurological injury claims, but in all other aspects**
16 **behave just like a PCF does in terms of being a medical**
17 **professional liability government insurance program.**
18 **I'll flip back a couple of more pages. You can**
19 **certainly see the companies that I've worked for -- many**
20 **of them medical professional liability carriers -- and the**
21 **places I presented.**
22 **But if you go back to page 24, you'll see a list**
23 **of -- of situations where I've provided expert reports and**
24 **expert testimony, and in terms of my qualifications, this**
25 **is kind of an important place to park for a minute.**

Page 38

1 The work I did for the Florida Office of Public
2 Policy and Governmental Accountability is specifically
3 related to NICA, the Florida Neurological Injury
4 Compensation Association.
5 The work I did in Indiana for the State Medical
6 Association is specifically related to the Indiana Patient
7 Compensation Fund.
8 The work I did for the Maryland legislature is
9 specifically related to a proposal to form a Patient
10 Compensation Fund in Maryland.
11 The work I've done in New Mexico since 2002 is
12 specifically related to the Patient Comp Fund here.
13 The Medical Indemnity Fund in New York, which is
14 a little interesting, it's a birth injury fund, but
15 instead of being no fault, it still operates within the
16 tort system. I helped the State of New York form that
17 fund and have continued to serve it since then.
18 The work for the Ohio Medical Malpractice
19 Commission in 2003 was specifically related to Ohio
20 considering forming a PCF.
21 I will point out in that study I produced a
22 summary of all patient compensation funds in the United
23 States, identifying their enabling legislation, how
24 they're organized, board representation, and so on.
25 That document we've kept up to date, and a

Page 39

1 number of other states have used that as a reference in
2 their legislative documents when they were considering
3 patient comp funds, so it's a fairly important document
4 for patient comp funds generally.
5 The Virginia Birth-Related Neurological Injury
6 Compensation Program and the Virginia State Corporation
7 Commission, all of that work since 2003 is related to the
8 Virginia Birth Fund.
9 And finally, the Wisconsin Injured Patient and
10 Families Compensation Fund is a client that Pinnacle has
11 served since 2007. We had a brief hiatus, and we actually
12 gained them back as a client in 2019.
13 The work with them and with the Assembly
14 Committee on Insurance and the Wisconsin Medical Society
15 and Hospital Association is all related to the Wisconsin
16 Patient Compensation Fund.
17 Candidly, you're going to be hard-pressed to
18 find an actuary with more experience in patient comp funds
19 than I have.
20 Q. So going to that, how many states, to your
21 knowledge, either have a patient compensation fund or
22 something similar, a birth injury fund or the like?
23 A. It depends on how you keep score. There's
24 somewhere between seven and twelve, and I -- I kind of
25 give you that range because some states have insurers of

Page 40

1 last resort.
2 They're not really patient comp funds, but they
3 are a mechanism for health care providers that can't get
4 coverage in the admitted market to get coverage. They do
5 behave like government insurance programs, but they're not
6 technically patient comp funds.
7 Q. And so how many of those states that have these
8 types of programs have you provided actuarial analysis and
9 work for?
10 A. Over the years, all but two or three.
11 Q. Okay. And what is your relationship to Pinnacle
12 Actuarial Resources, Inc.?
13 A. I'm one of the five owners. I am one of the
14 founders of the firm in 2003.
15 Q. Okay. So going back to the scope of assignment,
16 can you just give us a thumbnail sketch of how your
17 experience as an actuary working for patient compensation
18 funds relates to each of the tasks in the scope of the
19 assignment?
20 A. Sure. So the -- the first two tasks within the
21 scope are related to evaluating the claims experience of
22 the -- the PCF and using that to estimate what the
23 additional claims payments, claims benefits, that will be
24 paid in the future for claims that have already happened
25 is going to be.

Page 41

1 I take a little bit of umbrage with
2 Mr. Whitmore's characterization of looking out the back
3 window. I think it's more like trying to estimate how big
4 an iceberg is by -- by extrapolating it from the part you
5 can see.
6 So the idea here is to try and estimate the
7 financial condition of the PCF by figuring out what
8 additional benefits payments we're going to see for claims
9 that happened in 2018 and prior.
10 Now, as -- as Bruce did -- did rightly point
11 out, sometimes it takes a while to get those claims
12 solved -- to get them resolved, to -- to get the
13 settlements paid, and so there are claims that have
14 already been incurred, that are already in existence, that
15 need to reasonably be estimated by an actuary to figure
16 out what those future benefits payments are going to be.
17 And the idea is -- quite accurately -- that
18 we -- we assume that the way the claims have been resolved
19 in the past is predictive of how they're going to be paid
20 in the future.
21 Q. So have you done that type of work on behalf of
22 the New Mexico Compensation -- Patient Compensation Fund
23 and on behalf of other states' similar funds?
24 A. I have.
25 Q. Okay. And then item number two?

Page 42

1 **A. So item -- item two then is just simply**
2 **comparing those expected claims payments to the funds**
3 **available to pay claims.**
4 **It's -- it's balancing the checkbook. It's --**
5 **it's looking at all the assets of the Patient Comp Fund**
6 **and comparing them to all the liabilities of the -- the**
7 **PCF, and estimating whether there's -- there's money left**
8 **over --**
9 Q. Okay.
10 **A. -- and whether there's enough money to pay all**
11 **of those claims.**
12 Q. And have you done that type of work on behalf of
13 the New Mexico Patient Compensation Fund in the past and
14 on behalf of other states' similar funds?
15 **A. I have.**
16 Q. Okay. How about item number three?
17 **A. Item number three is related to then taking**
18 **those estimates of what ultimate claims obligations are**
19 **going to be and using that to estimate what surcharge**
20 **levels need to be for the PCF to have enough money to pay**
21 **the claims for the 2019 year.**
22 **So the idea here is that if we make a reasonable**
23 **estimate of the claims that will be incurred in 2019, then**
24 **we can use that and the expenses of the PCF to estimate**
25 **what total surcharge levels are going to be, and if we**

Page 43

1 **know what total surcharge levels are going to be, we know**
2 **how they need to change from the current surcharge level.**
3 Q. And have you performed that type of analytical
4 work on behalf the New Mexico Patient Compensation Fund in
5 the past?
6 **A. I have.**
7 Q. And on behalf of other states' similar funds?
8 **A. Yes.**
9 Q. Okay. How about item number four?
10 **A. Item number four -- and actually, I'll -- I'll**
11 **throw five in here as well -- deals with what the first**
12 **expert's testimony was dealing with a little bit, this**
13 **idea that the surcharge in the PCF layer for a**
14 **non-surgical class -- for an ear, nose, and throat doctor,**
15 **for a general practitioner -- should inherently be**
16 **different than the PCF surcharge for a heart surgeon, for**
17 **an OB/GYN doing high-risk deliveries, that the different**
18 **physician specialties have fundamentally different**
19 **underlying large loss propensities.**
20 **And so number four is getting those**
21 **relationships right. It's -- it's making sure that, based**
22 **on all of the available information, we've grouped those**
23 **physicians' specialties correctly and that we're charging**
24 **actuarially reasonable relativities between these groups**
25 **of specialties.**

Page 44

1 Q. Okay. And have you performed that type of
2 analytical work in the past for the New Mexico Patient
3 Compensation Fund?
4 **A. I have.**
5 Q. And have you done that for other states that
6 have similar programs?
7 **A. Yes.**
8 Q. Okay. And then item number six, what does that
9 relate to?
10 **A. Item six then is related to creating the rating**
11 **plan for the hospitals.**
12 **In -- in the past, the approach we've used on**
13 **the hospitals is -- as the representatives from the**
14 **Hospital Association stated -- to rely on the actual**
15 **experience of the hospitals, to use that in a very**
16 **detailed, very experience-rated approach to produce**
17 **indicated surcharges for the hospitals.**
18 **Both Milliman, on -- on behalf of the RPG, and**
19 **Pinnacle, on behalf of two of the large hospitals, have**
20 **performed these studies.**
21 **The new regulations regarding the PCF**
22 **necessitate that the surcharges be determined by PCF**
23 **staff.**
24 **To do that, what we've done is created a rating**
25 **methodology that looks and feels an awful lot like the**

Page 45

1 **physician rating, where you have a base surcharge and you**
2 **apply a series of factors and, finally, an experience**
3 **modification to determine the final surcharge.**
4 **So what we've created in -- in the new hospital**
5 **rating plan is a rating plan that follows form and is**
6 **consistent with the methodology already in place for the**
7 **physicians and surgeons and other health care providers.**
8 Q. And have you performed that kind of work for
9 other PCF-type organizations in the past?
10 **A. We have. It's new here in New Mexico, but I**
11 **have in other states.**
12 Q. Okay. And then number seven, what does that
13 relate to?
14 **A. I'm sorry; the description I just gave was**
15 **actually for seven.**
16 Q. Okay.
17 **A. I flipped them. I apologize.**
18 **Number six is the overall rate change, and the**
19 **issue here is, just like we did with the physicians, we're**
20 **taking the historical surcharges and the historical losses**
21 **and comparing them as a way of trying to project what the**
22 **surcharge need is for next year.**
23 **With the hospitals we've done the exact same**
24 **thing, and -- and again, I'll take a little umbrage with**
25 **the Hospital Association comments.**

Page 46

1 Our approach is actually to use all of the
2 hospitals' experience together, not just the RPG members,
3 so we're actually including not only the RPG members, but
4 also the other two stand-alone hospitals that are -- that
5 are in the PCF to produce a single estimate of what the
6 total surcharge level needs to be.
7 HEARING OFFICER HEBERT: Excuse me, Mr. Walling.
8 THE WITNESS: Yes.
9 HEARING OFFICER HEBERT: RPG --
10 THE WITNESS: Oh, sorry; Risk Purchasing Group.
11 HEARING OFFICER HEBERT: Okay. Thank you.
12 A. So the work that Milliman does -- and -- and
13 please correct me if I misstate, but -- is a -- think of
14 it as a cooperative process to purchase insurance
15 collectively.
16 HEARING OFFICER HEBERT: Okay.
17 A. So in the process of consolidating the data for
18 several hospitals to create a larger, more robust data
19 source, they are able to produce a single premium estimate
20 and then allocate that back to the members.
21 Interestingly, that's exactly what we're doing.
22 We're just able to actually include two more major
23 hospitals in -- in the data.
24 So the process then is to take all of the PCF
25 experience for all of the hospitals -- whether they're in

Page 47

1 the Risk Purchasing Group or stand-alone members of the
2 Patient Comp Fund -- and look at it in its entirety to
3 determine what the overall surcharge level needs to be for
4 all of the hospitals, and -- and so that approach, again,
5 very much follows form with what we do on the physicians.
6 And then the rating plan that we've developed is
7 simply a means of allocating that overall surcharge level
8 to the individual hospitals based on their ratable
9 exposures -- the number of acute care beds, the number of
10 outpatient surgeries, and so on.
11 It also creates a mechanism for outpatient
12 surgery centers that aren't in the PCF yet, so by
13 developing this kind of rating plan, we're actually making
14 it much more inclusive of all of the facilities that are
15 eligible for coverage -- even some of the smaller
16 outpatient facilities.
17 Q. Have you performed that type of analytical work
18 for other PCFs?
19 A. Yes.
20 Q. Okay. And what type of training and education
21 do you need to become a CAS?
22 A. So when I went through the exams, it was a
23 series of ten actuarial exams, some of which were
24 partitioned into parts.
25 These exams -- I think I actually describe it --

Page 48

1 so on page 19 again of Exhibit A, estimated study time
2 exceeding 4,000 hours necessary to complete the qualifying
3 exams for membership. That is simply the first step in
4 meeting the qualification standards.
5 There are also continuing education standards.
6 There are years of service standards to qualify for the
7 American Academy of Actuaries, and so annually now you
8 have to attest to continuing to maintain the continuing
9 education standards.
10 Actually, when I was on the board of directors,
11 I had to provide the documentation of my continuing ed, so
12 I -- I -- I can tell you I'm a member in good standing of
13 both the -- the CAS and the American Academy of Actuaries
14 and qualified to do this work.
15 Q. Are there any actuarial standards or principles
16 that govern the work that was in the scope of your
17 assignment?
18 A. There are, and I'm glad you asked -- you brought
19 that up, because I think it's important to understanding
20 how an actuary looks at a project like this one.
21 If you go back to page nine of Exhibit A, I list
22 on the bottom of the page there just a few of the
23 statements and principles and the standards of practice
24 that apply to work product like this.
25 And -- and you can see, actuaries being

Page 49

1 actuaries, we -- we codify a lot of -- of what we do, and
2 we provide guidance to actuaries. I actually served for a
3 time on the Actuarial Standards Board that writes these
4 standards.
5 The idea is to provide guidance to actuaries, a
6 road map to how they ought to be conducting their
7 business, and -- and a safety net, if you will.
8 And -- and so here at the bottom of page five
9 and -- and rolling over to the top of page six you'll see
10 the CAS statement of principles regarding
11 property/casualty ratemaking, and ASOP -- which is
12 shorthand for actuarial standard of practice -- 12 on risk
13 classification.
14 Q. You meant nine and ten, correct? You said five
15 and six.
16 A. Yes.
17 Q. Okay. Thank you.
18 A. ASOP 12 deals with risk classification, so
19 things like the physician specialty relativities; 17,
20 expert testimony; 20, discounting.
21 We recognize the time value of money for the
22 time that the PCF holds those surcharges until claims are
23 paid, and because it does take a while, there is an
24 opportunity for investment income; 20 speaks to that.
25 ASOP 23 on data quality; 29 on expenses. The

Page 50

1 **PCF is actually very lean and mean when it comes to**
2 **expenses. Both their -- their claims handling expenses**
3 **and their operating expenses are less than three percent**
4 **of surcharges, but those two expense categories do need to**
5 **be reflected in the surcharges.**
6 **ASOP 30 on profit and contingencies, this is all**
7 **about the risk margins that we include in our analysis and**
8 **I'm sure we'll be getting to later.**
9 **ASOP 41 on -- on actuarial communications is all**
10 **about the quality of our reports and what we have to**
11 **document in our reports.**
12 **Fifty-three has to do with the future loss**
13 **provisions, a really fundamental part of ratemaking. I --**
14 **I helped write that ASOP when I was on the committee at**
15 **that time.**
16 **So as you can see, there's a lot that goes into**
17 **kind of a principles-based approach to ratemaking and**
18 **actuarial work.**
19 Q. So just for the clarity of the record, ASOP
20 refers to actuarial standard of practice?
21 **A. Yes.**
22 Q. And you've given us the captions for those
23 standards of practice.
24 Do you actually understand the substance or know
25 the substance of each of those standards without

Page 51

1 reference?
2 **A. Yes.**
3 Q. Okay.
4 **A. It's -- it's important, and -- and as a**
5 **consulting actuary, I find myself -- maybe more and more**
6 **as I get older and wiser -- spending more time in the**
7 **ASOPs than I did when I was younger.**
8 Q. And what is item number ten on page ten? It's
9 CAS code of professional conduct.
10 **A. That's just simply some guidance on how**
11 **actuaries are supposed to behave. We're supposed to play**
12 **nice with others. We're supposed to behave ethically.**
13 **We're supposed to behave in a manner that**
14 **doesn't tarnish the brand of the -- the Casualty Actuarial**
15 **Society. If we know of another actuary that is behaving**
16 **in a manner that tarnishes the reputation, we -- we are**
17 **required to report them.**
18 **So there's -- it's -- it's a fairly standard**
19 **code of conduct.**
20 Q. Okay. And you followed and applied these
21 standards and ethical guidelines in formulating the
22 opinions that are articulated in your report?
23 **A. I have.**
24 Q. And in the opinions that you're going to share
25 with us today?

Page 52

1 **A. Yes.**
2 MR. BARAN: So at this time I'd like to offer
3 Mr. Walling as a qualified expert on each of the matters
4 within the scope of his assignment.
5 HEARING OFFICER HEBERT: He is a qualified
6 expert.
7 MR. BARAN: Okay. Thank you.
8 BY MR. BARAN:
9 Q. So let's go through these one by one, and
10 reference as much of your report as you need to to educate
11 us on what your opinions were and the bases of those
12 opinions.
13 So item number one here is figuring out the loss
14 and loss reserves for unpaid claims obligations. Walk us
15 through what exactly that means. You gave us a summary,
16 but if you can now drill down into the details, that would
17 be great.
18 **A. Sure. So we were provided by the OSI staff**
19 **detailed claims data for the Patient Comp Fund, individual**
20 **claims detail identifying when the claim happened, what**
21 **the -- the value of that claim was, and then when those**
22 **benefits were paid out.**
23 **From that we were able to assemble essentially a**
24 **history of when the claims were reported, when they were**
25 **settled, and the timing of the benefits payments. Those**

Page 53

1 **then formed the basis for a series of triangles.**
2 **So I -- without getting too deep into the weeds,**
3 **I'll -- I'll just point you to page 66 of -- of Exhibit A.**
4 **Page 66 has some microscopic numbers, because that's what**
5 **actuaries do.**
6 THE WITNESS: Madam Hearing Officer, if you'd --
7 never mind.
8 MR. WHITMORE: Yes, I found it; I can't read it.
9 **A. But I -- I guess ignoring the detail of the**
10 **numbers for a moment, what I -- what I want to just try**
11 **and -- and communicate and -- and emphasize here is that**
12 **we were able then, with a pretty detailed look, to see the**
13 **timing of when losses were paid; on the next page, the**
14 **timing of when claims were closed.**
15 **That information allows us the ability to**
16 **project the rest of the 2017 year, the rest of the 2018**
17 **year, on the presumption or on the assumption that claims**
18 **are going to be closed and paid with timing that is**
19 **similar to the timing we've seen in the past.**
20 **Now, if we're aware of a significant operational**
21 **change or a significant judicial change that is going to**
22 **affect that timing or is going to affect the size of those**
23 **numbers, then we would be required by your own**
24 **professional standards to consider that change in how we**
25 **do our analysis.**

Page 54

1 Q. So is there an exhibit that reflects your
2 opinion and your analytical conclusions with respect to
3 loss and loss reserves for unpaid claims?
4 **A. Sure. I think -- I think what I'd like to do**
5 **is -- is start on page 47 of Exhibit A. Page 47 is where**
6 **we actually go through the process of selecting the**
7 **ultimate loss values for each of the previous accident**
8 **years.**
9 **The idea here in columns four through seven is**
10 **that we use four different methodologies for different**
11 **ways of looking at the data as a means of making an**
12 **actuarial estimate of what we think the ultimate loss**
13 **experience is going to be for incidents that happened in**
14 **each of these accident years.**
15 **And so you can see the four methods, and I --**
16 **I -- I don't know that it's necessarily germane unless**
17 **you'd like me to dive deeper into them, but --**
18 Q. Let me ask you --
19 **A. Please.**
20 Q. -- to just explain, when you say loss, what
21 types of claims are we talking about?
22 **A. So these are -- are losses within the Patient**
23 **Compensation Fund layer of coverage.**
24 Q. Okay. And that's medical malpractice claims
25 then?

Page 55

1 **A. Correct.**
2 Q. Okay.
3 **A. And -- and hospital professional liability.**
4 Q. Okay.
5 **A. From that we -- we select those ultimate losses,**
6 **and then we compare those selected ultimate losses to**
7 **the -- the surcharges, and so you can see kind of how my**
8 **ultimate loss estimates compare to the historical**
9 **surcharges that have actually been collected.**
10 **If you go forward a page, you get a little bit**
11 **of a look at -- at how the current analysis compares to**
12 **last year's.**
13 **Largely, these -- the ultimate loss estimates**
14 **are coming down a little bit. The reserves are coming**
15 **down, but that's intuitive because we're actually paying**
16 **out claims.**
17 Q. Okay. Now, you're on Exhibit A, page 48?
18 **A. Exhibit A, page 46.**
19 Q. Forty-six, okay.
20 **A. Sorry.**
21 Q. Sorry.
22 **A. So this is just a comparison of my selected**
23 **ultimates from this year to my selected ultimates from**
24 **last year.**
25 Q. Okay.

Page 56

1 **A. That gives you some perspective on kind of how**
2 **we're doing.**
3 Q. All right. So why don't we start with the last
4 row on page 46, 2017, and just kind of walk us across that
5 row and tell us what each of those numbers reflect.
6 **A. So the first column, under 12/31 of '18, the**
7 **ultimate excess losses are the -- my selection of ultimate**
8 **from this year's analysis --**
9 Q. And what is that?
10 **A. -- for claims that happened during 2017.**
11 Q. Okay.
12 **A. So I'm estimating that there are almost**
13 **$41 million worth of claims payments that will be**
14 **ultimately paid out on a nominal basis, so on an**
15 **undiscounted basis.**
16 HEARING OFFICER HEBERT: Excuse me.
17 THE WITNESS: Please.
18 HEARING OFFICER HEBERT: Those are estimates
19 based on claims made in 2017?
20 THE WITNESS: Actually, it's -- they're claims
21 that occurred during 2017, and --
22 HEARING OFFICER HEBERT: And by claims that
23 occurred, does that mean ones that have gone through the
24 medical review, the ones that have gone through court, the
25 ones that --

Page 57

1 THE WITNESS: Actually, the way we identify the
2 day is the accident date, so the date of treatment.
3 HEARING OFFICER HEBERT: Okay.
4 THE WITNESS: So -- and that's important.
5 I'm -- I'm glad you asked that question.
6 When we're talking about accident year here,
7 we're organizing the data into cohorts by date of
8 treatment rather than any of the dates related to the --
9 the legal or claims proceeding.
10 BY MR. BARAN:
11 Q. So are these numbers based on claims that have
12 actually been reported but have not gone through the
13 system or is this a projected number of claims and
14 obligations on those claims?
15 **A. This is an estimate of all the claims that we**
16 **think ultimately are going to be within the PCF for**
17 **coverage, so --**
18 HEARING OFFICER HEBERT: And do you derive those
19 from reports from individual physicians and the hospitals?
20 THE WITNESS: Yes.
21 HEARING OFFICER HEBERT: How --
22 THE WITNESS: I mean, basically from the data
23 that's provided by the PCF.
24 BY MR. BARAN:
25 Q. So these are projections?

Page 58

1 **A. Yes.**
2 Q. Okay.
3 **A. That's what actuaries do.**
4 Q. Okay. We -- we're -- we're -- we're trying to
5 get to, is this the actual claims that have been reported
6 or is this projected claims based on past experiences?
7 **A. It's projection based a past experience.**
8 **Actually, if you go back to page 47, you can see that in**
9 **kind of great detail.**
10 **The paid losses for the PCF are in column three,**
11 **and so you'll see that on accidents that -- or treatments**
12 **that occurred, negative patient outcomes that occurred, in**
13 **accident year 2018, we have no paid claims yet, but**
14 **because of the -- the volume of surcharges we have**
15 **collected because of what we know about the past, we're**
16 **projecting that ultimately there are going to be**
17 **twenty-four and a half million dollars worth of -- of**
18 **losses paid out on those claims.**
19 **As you go back in time -- go back to, say, 2012,**
20 **so we're back seven years -- there's 12.7 -- or**
21 **$10.7 million worth of paid losses in column three, and**
22 **we're projecting that to settle out at about 11.6 after**
23 **all of the claims related to -- to treatments that**
24 **occurred during that accident year, so we think there's**
25 **still about $1 million worth of unpaid claims obligations**

Page 59

1 **related to claims from 2012.**
2 **This goes back to that triangle we were looking**
3 **at and trying to look at those patterns of how claims**
4 **behave over time.**
5 Q. So --
6 **A. And -- and you can go back even further. Go**
7 **back to 2000. There's paid losses to date of**
8 **$6.56 million, and we think the ultimate loss obligation**
9 **for that year is $6.56 million. Well, thank goodness we**
10 **finally got them all settled.**
11 HEARING OFFICER HEBERT: So that figure does not
12 include the continuing medical care issue for patients who
13 may have 30 years of continuing medical care that -- that
14 is provided for in our Medical Malpractice Act?
15 THE WITNESS: To the extent that there are still
16 ongoing medical payments, that will show up on our
17 triangles, and we will put additional IBNR on it, so --
18 BY MR. BARAN:
19 Q. Explain IBNR.
20 **A. Oh, I'm sorry; incurred but not reported, so**
21 **additional reserves.**
22 **So we are taking the position that those first**
23 **three years are actually full and finally closed. The**
24 **first year where we're showing any IBNR is actually the**
25 **2003 year where we've got a little bit of IBNR or of**

Page 60

1 **additional reserve playing through.**
2 **Also, it's important to point out -- there was a**
3 **comment made during the Hospital Association's comments**
4 **about case reserves.**
5 **The PCF does not post case reserves on**
6 **individual claims. They have in the past, but as a matter**
7 **of process, they've identified that it's -- it's**
8 **appropriate for them not to put a reserve on what they**
9 **think a known claim is.**
10 **So they get first report of a claim and they**
11 **know about a claim, but they don't necessarily put a case**
12 **reserve estimate on what they think the claim is going to**
13 **be worth, so that just is simply an operational decision**
14 **that the PCF has chosen to make.**
15 Q. So going back to page 46, what is the -- in line
16 2017, what is reflected in the number in the column NM PCF
17 discounted reserves?
18 **A. So that's just simply taking that $40.9 million,**
19 **subtracting out the -- the limited amount of paid losses,**
20 **and then using a three and a half percent annual interest**
21 **rate, figuring out how much money is needed today to pay**
22 **out those claims -- those remaining claims obligations**
23 **over time.**
24 **The -- the idea here is just simply a reflection**
25 **of the time value of money. I only need $36.3 million to**

Page 61

1 **pay out the remaining claims obligations, so it's just**
2 **discounting for the time value of money.**
3 Q. So dropping down to the line 2018, what's
4 reflected in the two numbers that appear adjacent to that
5 line?
6 **A. Same thing. So our estimate for 2018 is that**
7 **ultimate claims obligations will be $45.8 million. As I**
8 **just pointed out, there haven't been any losses paid out**
9 **for accidents that occurred in 2018 yet, so we simply**
10 **cash-flowed out that $25.8 million (sic) over time,**
11 **discounted it for the time value of money, so that the**
12 **current need to fund those claims benefits is just over**
13 **$40 million.**
14 Q. Okay. And how does that analysis relate to the
15 rest of the work that you were asked to do with respect to
16 determining surcharges?
17 **A. Sure. So we're using those same ultimate loss**
18 **estimates in our rate level indications, so we're using**
19 **those same projections based on historical claims**
20 **experience to estimate what the surcharge need is for the**
21 **fund.**
22 Q. So that's the -- the target number for funding
23 the fund?
24 **A. Correct.**
25 Q. Okay.

Page 62

1 HEARING OFFICER HEBERT: Could you -- could you
2 state that number, just for the record?
3 THE WITNESS: I'm sorry; which number?
4 HEARING OFFICER HEBERT: The -- the target
5 number that you were just testifying about -- the last
6 number.
7 THE WITNESS: I'm -- I'm going to ask --
8 HEARING OFFICER HEBERT: Well, maybe we can get
9 Rebecca to repeat the question that Mr. Baran asked him.
10 I might have confused you.
11 THE WITNESS: Because -- because this has both
12 the physicians and the hospitals combined --
13 HEARING OFFICER HEBERT: Uh-huh.
14 THE WITNESS: -- we're -- we're in a little
15 apples and oranges situation, because when we're talking
16 about the rates, you've got the physicians' and surgeons'
17 ultimate losses and the hospital's separate.
18 HEARING OFFICER HEBERT: Uh-huh.
19 THE WITNESS: So the numbers as they roll into
20 the rate analysis are categorized as either hospitals or
21 physicians and surgeons.
22 HEARING OFFICER HEBERT: What about that third,
23 that entities, that -- you know, which is --
24 THE WITNESS: The entities coverage is within
25 the physicians and surgeons coverage.

Page 63

1 HEARING OFFICER HEBERT: Okay.
2 THE WITNESS: So when we -- when the first
3 expert was going through the rating rules, the rating
4 rules for physicians, surgeons, and other health care
5 professionals includes that rule about entity coverage, so
6 that does follow form and it travels with the docs.
7 BY MR. BARAN:
8 Q. So if I might help here, this analysis that we
9 just looked at and the conclusions -- especially on
10 line -- the 2018 line -- that's just the first step --
11 **A. Correct.**
12 Q. -- of a larger analysis of determining the rates
13 and surcharges?
14 **A. Yes.**
15 Q. Okay. But that number there is reflective of
16 what the anticipated ultimate net losses are going to be
17 for 2018, reduced by the time value of money?
18 **A. Uh-huh.**
19 Q. Yes?
20 **A. Yes.**
21 Q. Okay.
22 HEARING OFFICER HEBERT: Okay. Thank you.
23 BY MR. BARAN:
24 Q. All right.
25 **A. And -- and just to -- to be more clear or maybe**

Page 64

1 **more complete, if you go back to pages 58 and 64, where**
2 **we're getting into the rate analysis itself, the projected**
3 **ultimate losses that we show here in column -- in column**
4 **three of -- of Exhibit 10 and column three of Exhibit**
5 **14 --**
6 Q. Reference the page number.
7 **A. I'm sorry; pages 58 and 64.**
8 Q. Okay. Thank you.
9 **A. I did.**
10 **Those flow out of the same reserve analysis that**
11 **we were just citing. It's just segregated between the --**
12 **the physicians and surgeons and the hospitals.**
13 Q. Okay. So let's walk through that. On page 58
14 and page 64?
15 **A. Yep.**
16 Q. Okay. There should be two numbers then that add
17 up to that roughly $40 million?
18 **A. Yes.**
19 Q. Okay. Which two numbers are those?
20 **A. I'm sorry; just give me a second.**
21 Q. Okay.
22 **A. Okay. So we -- the number we had over on page**
23 **46 was $45.8 million for -- for accident year 2018. That**
24 **is composed of the $24.6 million in page 48, column three,**
25 **and the $21 million of page 64, column three.**

Page 65

1 Q. All right. So would now be a good time to move
2 to pages 58 and 65 and explain what analysis is reflected
3 in these documents?
4 **A. Yes.**
5 Q. Okay. So let's start with page 58 and explain
6 what analysis is reflected here and how that analysis was
7 performed.
8 **A. Sure. I guess what I'd like to do -- with --**
9 **with a little latitude -- is walk back to the standards**
10 **for a second.**
11 Q. Sure.
12 **A. If you go back to page 12, there's a very**
13 **specific reason that I cited this CAS statement of**
14 **principles on property/casualty ratemaking first in terms**
15 **of those principles and standards.**
16 **It -- it is the primary guidance not only for**
17 **actuaries, but for most state insurance departments when**
18 **it comes to property/casualty ratemaking.**
19 **And in particular, I'm going to point you to**
20 **principle number four, which is kind of the conclusion of**
21 **this statement.**
22 **It says, a rate is reasonable -- and reasonable**
23 **has a very specific meaning in actuarial science -- and**
24 **not excessive, inadequate, or unfairly discriminatory --**
25 **which is the same criteria that is in most state insurance**

Page 66

1 **department guidelines on -- on property/casualty rates --**
2 **if it's an actuarially sound estimate of the expected**
3 **value of all future costs associated with an individual**
4 **risk transfer.**
5 **So I -- I just want you to file that in -- in**
6 **the back of your brain, put a -- put a sticky note on it,**
7 **because everything we're doing here is -- is with the goal**
8 **of producing an actuarially reasonable rate, to produce a**
9 **rate that is neither excessive nor inadequate, is kind of**
10 **in that kind of sweet spot between a rate that's --**
11 **that's, you know, obviously excessive and obviously**
12 **inadequate, it's not -- it's -- it's not unfairly**
13 **discriminatory -- and I apologize for the double**
14 **negative.**
15 **But the idea here is that each physician, each**
16 **hospital, each risk is priced in a way that doesn't**
17 **subsidize any other insured risk, nor does it receive a**
18 **subsidy from -- from anybody else.**
19 **And so that not unfairly discriminatory is**
20 **something that comes into play by physician specialty and**
21 **also between the physicians and the hospitals.**
22 Q. So let's flesh that out a little bit.
23 It's essentially trying to make sure that
24 everybody pays their fair share?
25 **A. Yeah --**

Page 67

1 Q. Okay.
2 **A. -- it has to do with fairness and equity.**
3 **And finally, it's associated with the future**
4 **costs -- all future costs -- emphasis added -- so that**
5 **means the operational expenses of the PCF, the claims**
6 **handling expenses of the PCF, but also the anticipated**
7 **investment income of the PCF, and a margin to reflect risk**
8 **and -- and to, you know, provide for a contingency margin.**
9 Q. Okay.
10 **A. So this principle four really does guide my hand**
11 **in -- it's woven into every page of this analysis and**
12 **guides the actuary's steps.**
13 Q. So let's go back to page 58, and if you can --
14 **A. Sure.**
15 Q. -- walk us through that.
16 **A. So if we're going to use the experience of the**
17 **PCF over the last ten years to project what it's going to**
18 **look like for the next year, we need to make some**
19 **adjustments, because it's no longer 2009. I'm -- I'm no**
20 **longer -- no longer 44, my kids are no longer in -- in**
21 **junior high, but also, claims are handled differently.**
22 **And so what we've done is taken the experience**
23 **of the PCF for the last decade and restated it as if it**
24 **was happening next year.**
25 **Let me explain what that means. We've taken all**

Page 68

1 **of these surcharges actually collected by the PCF for the**
2 **last decade and restated them on the current surcharge**
3 **schedule. The idea here is that we're trying to create a**
4 **apples-to-apples comparison.**
5 **If we're going to state the losses as if they**
6 **were happening next year, then we need to bring all those**
7 **premiums to the current level as well.**
8 Q. Okay. So let me make sure I am understanding
9 that.
10 If we look at the line that begins 2009 and we
11 go to the next column, $14,303,000, that $14,303,000 was
12 not the actual surcharges that were assessed in 2009; that
13 is those surcharges brought up to -- what those surcharges
14 would be at your proposed levels today?
15 **A. Correct.**
16 Q. Okay.
17 **A. And I -- did you provide the Hearing Officer**
18 **with the history of the rate changes? This might be a**
19 **good time to do that.**
20 Q. Well, then let's do that. Let me --
21 MR. BARAN: This one or that one? I think
22 this --
23 MS. KRYLOVA: This one has --
24 MR. BARAN: -- one, yeah.
25 MS. KRYLOVA: -- that.

Page 69

1 MR. BARAN: Yeah.
2 MS. KRYLOVA: Do we need to use that?
3 MR. BARAN: Pardon?
4 MS. KRYLOVA: Do we want to put that in?
5 MR. BARAN: Let's do this one. Okay.
6 Exhibit E.
7 HEARING OFFICER HEBERT: Thank you.
8 BY MR. BARAN:
9 Q. All right. I've put in front of you what's been
10 marked as Exhibit E.
11 **A. Right.**
12 Q. Can you explain what this document is?
13 **A. So on the left-hand side of this exhibit, what**
14 **you're going to see is the rate changes that have actually**
15 **been implemented for physicians, surgeons, and other**
16 **health care professionals since the creation of the fund,**
17 **and you'll see that there typically is kind of a lull of a**
18 **year or two between rate changes.**
19 **We've been able, between 2009 and 2016, to make**
20 **no changes in the surcharges.**
21 **In the bottom right is a history of the**
22 **surcharge levels for CHRISTUS St. Vincent and Presbyterian**
23 **separately, and then collectively the RPG or Risk**
24 **Purchasing Group hospitals, so you can see how the**
25 **hospital surcharges have been changing over the last**

Page 70

1 **several years as well.**
2 **The idea and -- and the reason I asked for this**
3 **to be admitted into evidence at this moment is, the rate**
4 **changes in 2009, 2016, and 2017 have all been applied to**
5 **the historical surcharges to bring them to the current**
6 **surcharge level.**
7 **If you want to think of it this way, we're**
8 **taking the actual number of docs by specialty and**
9 **full-time, part-time, and all of those other rating**
10 **elements and applying today's surcharges to those**
11 **historical exposures.**
12 **So if we re-rated the -- the physicians and**
13 **surgeons and health care professionals from 2014 using**
14 **today's surcharges, here's -- here's how much surcharge**
15 **revenue it would produce.**
16 Q. Okay. Let's go through the notes on Exhibit E,
17 page one.
18 The first note says, back in 1976, when the PCF
19 was established, its surcharges were set to equal 33
20 percent of the premium charged by carriers for their
21 underlying layer of coverage.
22 Is that an actuarial-sound methodology for
23 determining the PCF surcharges?
24 **A. Sure. Essentially it's akin to a common**
25 **practice known as an increased limits factor. So the idea**

Page 71

1 **is, if I -- if I can price the underlying premium and then**
2 **apply a factor of 35 -- 33 percent to include the PCF**
3 **coverage.**
4 **We see this commonly used in commercial auto**
5 **liability, general liability, yeah, even medical**
6 **professional liability in other states, so a very common**
7 **approach to pricing excess layers.**
8 Q. So why aren't we doing that now?
9 **A. Essentially we are. Essentially what we're**
10 **doing is converting that into a dollar amount.**
11 Q. Okay. And that's what's reflected in the third
12 note?
13 **A. Exactly. So back in early '90s, there were some**
14 **growing pains, and -- and that -- it -- there was -- I**
15 **guess I'll call it a medical liability crisis nationally**
16 **in -- in this part of the '90s, and so this spike in PCF**
17 **surcharges is entirely consistent with what we saw in a**
18 **lot of other states at that moment.**
19 **But in '92, '93, there was a decision made to**
20 **convert from a percentage of premiums, because you had a**
21 **moving target here.**
22 **You had the underlying premiums moving and the**
23 **percentage moving, so it ended up being unnecessarily**
24 **complicated, and so we shifted over to an approach where**
25 **the surcharges were dollar amounts and really stood on**

Page 72

1 **their own.**
2 Q. Okay. Anything else that we'd like to --
3 **A. No.**
4 Q. -- review on that document?
5 **A. I -- I guess I -- I would point out, you know,**
6 **for the last 20 years, our approach has been to kind of**
7 **take a fairly balanced approach to surcharge increases.**
8 **You'll see, you know, some -- some high**
9 **single-digit increases. Even in situations where the**
10 **indicated increase was a -- was a larger amount -- in**
11 **particular, 2016 and '17 was actually a phased**
12 **implementation of a double-digit increase over two years,**
13 **so it was simply an approach to -- to get that increase**
14 **in -- in a more gradual, phased-in manner.**
15 MR. BARAN: All right. So Madam Hearing
16 Officer, before we move back into page 58 --
17 **A. Actually, I -- I guess I would add, the**
18 **second --**
19 Q. Oh, we can circle back to it. I will circle
20 back to that.
21 **A. Okay.**
22 MR. BARAN: Can we take our quick morning break?
23 HEARING OFFICER HEBERT: Sure. Let's do. Let's
24 have a break for a few minutes.
25 MR. BARAN: Ten minutes?

Page 73

1 (Recess was held from 10:32 a.m. until
2 10:46 a.m.)
3 HEARING OFFICER HEBERT: All right. We're back
4 on the record now.
5 Mr. Barren, if you would continue with your
6 examination.
7 BY MR. BARAN:
8 Q. All right. Mr. Walling, where we stopped we
9 were going to get through -- or have you walk us through
10 Exhibit A, page 58, and what's reflected in the analysis
11 and what conclusions are to be drawn from this analysis.
12 **A. Sure. So we've gotten through getting the**
13 **surcharges to the current surcharge level. We've gotten**
14 **through getting the projected ultimate losses pulled over**
15 **from the reserve analysis, and those tie to the numbers**
16 **that we selected as part of our unpaid claims liability**
17 **estimates.**
18 **Now, to get those to a current cost basis,**
19 **because, you know, medical benefits and all those other --**
20 **you know, wheelchairs and all the medical equipment in**
21 **2009 don't cost what they cost today, and so we need to**
22 **adjust those for inflationary costs.**
23 **We've trended those forward at an inflation rate**
24 **of five percent annually to the current year, so you'll**
25 **see the -- the $12 million in 2009 in today's dollars,**

Page 74

1 **with today's benefit levels, would be $19.6 million.**
2 **So now we've got both the surcharges and the**
3 **losses stated on a current cost basis. We'll see how**
4 **we've done. Let's see how -- what the relationship is**
5 **between the losses and the revenues that we have available**
6 **to pay those claims.**
7 **That's what's in column five. Column five is**
8 **simply the ratio of the trended ultimate losses divided by**
9 **the current level surcharges.**
10 Q. What does it mean on line 2009 that it's 137.1?
11 **A. So we paid out 137 percent, roughly, of the**
12 **surcharges we collected. So over -- you know, over time,**
13 **we have where we will -- because some of these aren't paid**
14 **yet -- pay out 137 percent of the surcharges collected in**
15 **future benefits.**
16 Q. So you paid out more than we took in -- we paid
17 out more than we took in?
18 **A. Correct.**
19 Q. Okay.
20 HEARING OFFICER HEBERT: For that year?
21 THE WITNESS: For that year.
22 HEARING OFFICER HEBERT: Okay.
23 THE WITNESS: And actually, for every year
24 during this decade except for 2013.
25 BY MR. BARAN:

Page 75

1 Q. And what drove that discrepancy of paying out
2 more than we took in?
3 **A. The largest component here is the -- for these**
4 **long-tailed casualty lines, running a loss ratio in excess**
5 **of 100 percent may be okay if you're generating enough**
6 **investment income.**
7 **So if you're generating 15 percent of -- of the**
8 **surcharges, for example, in investment income over time**
9 **before the claims are paid, then having a projected**
10 **ultimate loss ratio of 115 percent might be okay, because**
11 **you're going to -- you're going to fund those additional**
12 **benefits payments out of investment income, not out of**
13 **revenues, so that investment income is a secondary source**
14 **of income.**
15 Q. So for 2010 and 2011, we're not even close to
16 115?
17 **A. No, and it's --**
18 Q. We're over more than double what we took in?
19 **A. Yeah, but it's --**
20 Q. What's --
21 **A. -- it's important to point out, 2010 and '11 are**
22 **two -- I guess I'll call them batch claims or contagion**
23 **claims that -- that -- where there were a number of**
24 **claimants related to one sustained or a pair of sustained**
25 **acts of behavior.**

Page 76

1 **So 2010 and '11, I'm not going to call it a**
2 **black swan event, but it's as extreme a catastrophic**
3 **claim, I think, maybe as I've ever seen.**
4 **It was dozens of spinal fusions that all failed,**
5 **so you're literally talking about -- I forget the exact**
6 **number, but it's like 80, 85 spinal fusions.**
7 HEARING OFFICER HEBERT: Just this is a
8 curiosity. Did you see that across the nation or was that
9 just here --
10 THE WITNESS: This was an act of a single
11 provider --
12 HEARING OFFICER HEBERT: I see.
13 THE WITNESS: -- in a single hospital.
14 MS. KRYLOVA: Two providers.
15 THE WITNESS: Oh, two providers. I'm sorry.
16 HEARING OFFICER HEBERT: I see. Okay.
17 THE WITNESS: So it was a isolated incident, and
18 candidly, it's very rare to see those correlated claims
19 like that that create that much -- I mean, it's not
20 uncommon to see, you know, a cluster of claims from a
21 sustained behavior, but to see 80 of them --
22 HEARING OFFICER HEBERT: Uh-huh.
23 THE WITNESS: -- is -- is certainly catastrophic
24 by anybody's definition.
25 BY MR. BARAN:

Page 77

1 Q. Okay. So why don't we walk through lines six
2 through fourteen, and just give us a thumbnail sketch --
3 **A. Sure.**
4 Q. -- of what's reflected here.
5 **A. So in six, I -- I created four different**
6 **aggregations or -- or subtotals of the ten years of data**
7 **provided, and ultimately, line six is my selection of what**
8 **I think next year's loss ratio is going to be at current**
9 **surcharges levels, so I have judgmentally selected the**
10 **119.5 percent based on the 2016 back to 2012 years, so**
11 **just five of the ten years.**
12 **A couple of reasons for that. One, if you'll**
13 **recall from the earlier testimony, we don't know an awful**
14 **lot about the 2017 or '18 claims, so I didn't want to rely**
15 **on that.**
16 **And -- and candidly, we've addressed the issue**
17 **that presented itself in 2010 and '11 through the purchase**
18 **of reinsurance. We -- we've purchased what's called batch**
19 **reinsurance, which is intended to address exactly the**
20 **issue we saw in 2010 and '11, so we've addressed that**
21 **issue through reinsurance rather than through rate.**
22 **So my judgmental selection here, based on all of**
23 **the information available, is that I think the program is**
24 **running about a 119 loss ratio at the current surcharge**
25 **levels.**

Page 78

1 Q. Is that -- is that a sustainable loss ratio?
2 **A. No.**
3 Q. Okay. So going down to --
4 **A. So --**
5 Q. -- line seven --
6 **A. -- seven then, we just simply pull forward.**
7 **We're assuming no change in exposures, and assuming that**
8 **if we made no other change, assessments wouldn't change.**
9 **Row eight then is just the 119.5 percent times**
10 **the surcharges to create an estimate of the ultimate loss**
11 **dollars for the coming year.**
12 Q. So let's -- let me make sure I understand that.
13 If we didn't change the rates or the surcharges,
14 we'd take in an estimated $21,929,000; is that correct?
15 **A. Correct.**
16 Q. And we would pay out an estimated $26,211,000;
17 is that correct?
18 **A. Correct.**
19 Q. Okay. So what's line nine?
20 **A. And let me just add --**
21 Q. Okay.
22 **A. -- I'm -- I'm going to skip ahead a second.**
23 Q. Let me --
24 **A. Okay.**
25 Q. -- let me make one clarifying --

Page 79

1 **A. Sorry.**
2 Q. And this is just for physicians and surgeons?
3 **A. Correct.**
4 Q. Okay.
5 **A. Line nine then is an additional provision for**
6 **the claims handling expenses that the PCF incurs, so**
7 **that's going to increase the losses by another 2.7**
8 **percent.**
9 **Line ten then is a reflection of the time value**
10 **of money, so for every dollar that we're going to pay out,**
11 **you only need 85 cents at the -- at the beginning of the**
12 **policy period.**
13 **So if you look at that $26.2 million, basically**
14 **what that suggests is that the time value of money is**
15 **worth about $4 million. Okay? It's about 15 percent of**
16 **that $26 million.**
17 **But even at $4 million, you're still talking**
18 **about needing $22.2 million plus the loss adjustment**
19 **expenses to break even, so there's still not a sustainable**
20 **rate level.**
21 **Row 11 then shows the additional overhead from**
22 **the -- the OSI.**
23 **It's important to point out that loss adjustment**
24 **expenses and the office expenses are both really low --**
25 **dramatically lower than you would see in commercial**

Page 80

1 **insurance, and -- and candidly, one of the big reasons why**
2 **PCFs are so valuable is that they do what they do so**
3 **efficiently. The vast majority of the dollars that go out**
4 **of the PCF go to pay benefits.**
5 **When you're talking about 2.7 on -- on loss**
6 **adjustment and another 2.7 on overhead, you're literally**
7 **suggesting that something on the order of six percent of**
8 **total revenue is covering something besides benefits.**
9 **That's an extraordinarily efficient mechanism**
10 **where 94 percent or more of the total revenues and**
11 **investment income actually go to paying benefits. It's**
12 **one of the huge advantages of a PCF.**
13 Q. What's line 12?
14 **A. Line 12 is the cost for the -- the clash**
15 **coverage, the -- the batch coverage that we were talking**
16 **about to deal with 2010 and '11.**
17 **So then line 13 is the aggegation of rows eight**
18 **through twelve. It's a way of rolling all of that**
19 **together algebraically into a number that says, we need**
20 **$24.945 million to buy the reinsurance, to cover the**
21 **overhead, to pay the loss adjustment expenses, to pay the**
22 **claims, even reflecting the investment income.**
23 **So when you get to the bottom of the -- the --**
24 **the balance sheet and you draw your double line, the**
25 **number we need -- the revenue we need to generate to**

Page 81

1 **handle all of the obligations we're taking on in 2019-20**
2 **is $24.945 million.**
3 **We're estimating that we're only going to**
4 **generate $21.929 million, so there's a $3 million**
5 **shortfall.**
6 Q. Okay. So what's reflected on page 59, it looks
7 like most of the numbers are the same except you have a
8 new line 11.
9 Tell us about the difference between --
10 **A. Sure.**
11 Q. -- the analysis we're looking at on page 58 and
12 the analysis we're looking at on page 59.
13 **A. So for the last 17 years -- and presumably**
14 **before that -- the request has been that we produce a**
15 **central estimate, a best estimate. That's what's shown on**
16 **page 58.**
17 **It's going to be enough probably about 55**
18 **percent of the time, so in -- in 55 percent of the**
19 **possible claims scenarios, what's shown on page 58 is**
20 **going to be enough.**
21 **The problem is, that means in 45 percent of the**
22 **scenarios it's not going to be enough, so you're looking**
23 **at roughly a coin flip of having scenarios where**
24 **additional deficit is created if you only take the 13.8**
25 **percent increase suggested on page 58.**

Page 82

1 Q. It's not --
2 **A. If --**
3 Q. Oh, let me step back there.
4 So it's not a certainty that that additional --
5 that a deficit will be created, but it is a 45 percent
6 possibility --
7 **A. Yes. It's a risk.**
8 Q. -- that a deficit will be created?
9 **A. And -- and in a lot of those scenarios it's not**
10 **a very large risk, but it is a risk that is presented by**
11 **adopting the expected scenario.**
12 Q. Okay. So what's on page 59 --
13 **A. So 59 --**
14 Q. -- and how does that --
15 **A. -- then --**
16 COURT REPORTER: How does that what?
17 BY MR. BARAN:
18 Q. And how does that differ from what we see on
19 page 58?
20 **A. Fifty-nine then, we add an explicit risk margin.**
21 **Again, based on the actuarial standards, when you discount**
22 **for the time value of money, it is strongly suggested --**
23 **I'm not going to say required, but it's strongly suggested**
24 **that you add an explicit risk margin in.**
25 **And so what we've done for the last 17 years is**

Page 83

1 **provided a second version of the indicated rate change at**
2 **a 90 percent confidence level.**
3 **The idea here is that nine times out of ten, out**
4 **of all of the uncertainty, out of all of the negative**
5 **patient outcomes and do they turn into a claim and do they**
6 **blow into the PCF layer, that nine times out of ten, a 37**
7 **percent increase is enough.**
8 **Now, in a lot of those scenarios it's going to**
9 **be more than enough, and the -- the underwriting income**
10 **that is generated by that rate level is -- is going to be**
11 **available to fund.**
12 **But the idea here is that at this 90 percent**
13 **confidence level, your rates -- your surcharges are enough**
14 **90 percent of the time.**
15 Q. So PCF staff has asked the Hearing Officer to
16 recommend an 80 percent confidence level.
17 What -- what do you feel about the 80 percent
18 confidence level as it applies to the New Mexico PCF?
19 **A. I -- I -- broadly -- and -- and I guess what**
20 **I'll do for the Hearing Officer's benefit, if you go back**
21 **to page 105 of -- of Exhibit A, we were asked to provide**
22 **as a supplemental exhibit the indicated surcharge changes**
23 **from our central estimate on page 58 to our 90 percent**
24 **confidence level estimate on page 59.**
25 **And so what you'll see here is a series of risk**

Page 84

1 **margins in row four that produce different indicated**
2 **funding needs, you know, from the $24.945 million that we**
3 **identified all the way to up to $30 million and then**
4 **provides some indication on what the -- the surcharge**
5 **increase would need to be.**
6 **I will caution you that row nine here is after**
7 **the reflection of two additional sources of revenue -- the**
8 **changes in the class plan and the changes in the entity**
9 **coverage -- so they're not comparable to row fifteen of**
10 **page 58, so --**
11 Q. Let me ask a couple of questions --
12 **A. Yeah.**
13 Q. -- and we'll get back to that part of the
14 analysis, but is the -- for a fund like the PCF, which is
15 a government -- essentially -- insurance program, is an 80
16 percent confidence level more reasonable than, say, a
17 central or a 90 percent?
18 **A. I -- I -- I think it's certainly more reasonable**
19 **than the central when the central is on a discounted**
20 **basis.**
21 HEARING OFFICER HEBERT: Okay. Excuse me again.
22 What are you using -- what is central? What is that? Is
23 that --
24 THE WITNESS: So it's just page 58.
25 HEARING OFFICER HEBERT: That was the --

Page 85

1 THE WITNESS: Roughly 55 --
2 HEARING OFFICER HEBERT: -- 13.8 percent figure?
3 THE WITNESS: Yeah, overall.
4 HEARING OFFICER HEBERT: And that was when you
5 were saying it was a 55 percent, 45 percent?
6 THE WITNESS: Correct. So it's -- it's -- it's
7 equivalent to a 55 percent confidence level.
8 HEARING OFFICER HEBERT: Okay.
9 THE WITNESS: I -- I would say it's an average,
10 but actuaries are always inherently a little conservative,
11 so we always tend to be more like 55 percent confidence
12 than just 50.
13 HEARING OFFICER HEBERT: Uh-huh.
14 **A. And -- and so what we've done by -- by**
15 **discounting those ultimate losses and reflecting the time**
16 **value of money, we've removed a risk margin. We've**
17 **removed, as I identified, about $4 million worth of**
18 **cushion.**
19 **What we're talking about doing is putting that**
20 **$4 million cushion back in, and it turns out that going to**
21 **the 80 percent confidence level actually puts about --**
22 **well, $3.3 million of cushion back in, so it actually has**
23 **the effect of kind of undoing or offsetting the -- the --**
24 **the effect of the time value of money.**
25 **So an 80 percent confidence level is an**

Page 86

1 **appropriate risk margin. It's something that's supported**
2 **by actuarial standards and produces a reasonable surcharge**
3 **level for the PCF.**
4 Q. Okay. So while we're on this exhibit, when you
5 look at page 58, line 14, the indicated level change for
6 the central confidence level is 13.8 percent, and then
7 when we get to page 105, the indicated assessment level
8 for the central is 5.5 percent.
9 Can you explain --
10 **A. Sure.**
11 Q. -- how we dropped from 13.8 on page 58 to 5.5
12 on --
13 **A. Sure.**
14 Q. -- page 105?
15 **A. So -- and it's important to focus on row 13 of**
16 **page 58 here. Row 13 says that you need to generate**
17 **$24.945 million of revenue to cover the losses and**
18 **expenses, so I need to generate $24.945 million.**
19 **How I do that is still subject to negotiation.**
20 **If I took a 13.8 percent across-the-board increase in all**
21 **surcharges, I would generate $24.9 million.**
22 **Based on reviewing a couple of other elements of**
23 **the rating plan, we're actually proposing a different**
24 **approach. We're proposing a number of changes in the**
25 **class plan; individual specialties where we identified**

Page 87

1 **that the surcharges were too high or too low and are**
2 **recommended making explicit changes to, you know, either a**
3 **specific specialty or a group of specialties.**
4 **The net effect of that is to produce an**
5 **additional -- somewhere between $229,000 and $276,000. It**
6 **depends largely on what confidence level you fund the base**
7 **surcharge at.**
8 **The second change is the approach taken to the**
9 **entity coverage. This is a phenomenon we're actually**
10 **seeing a lot of nationally where the corporate entity is**
11 **being found to be liable more and more often in medical**
12 **professional liability cases.**
13 **This has to do with practice guidelines that are**
14 **issued by the corporate entity. It has to do with**
15 **coverage for other employees that, even though they're not**
16 **separately surcharged in the PCF, do have an exposure, and**
17 **that exposure for those not-specifically-identified**
18 **employees rolls into the coverage, so we're -- we're**
19 **finding nationally that there's a need to provide a more**
20 **actuarially reasonable funding for that corporate entity**
21 **coverage.**
22 **And -- and it's -- it's resulting in a fairly**
23 **substantial increase in the surcharge revenue associated**
24 **with the entity coverage -- here between $1.57 million and**
25 **$1.89 million -- simply because the approach that's been**

Page 88

1 **used historically in the PCF is just woefully antiquated**
2 **and -- and needs to reflect the new normal where the**
3 **corporate entity does have a substantial amount of**
4 **exposure.**
5 HEARING OFFICER HEBERT: This is the question I
6 was wondering. The entity, we're talking about
7 organizations composed of health providers -- we'll call
8 them health providers.
9 THE WITNESS: Uh-huh.
10 HEARING OFFICER HEBERT: All right. So how --
11 how is that -- what has that been -- how have you
12 determined the entity amount? Is it just by the number of
13 physicians and their classifications --
14 THE WITNESS: So --
15 HEARING OFFICER HEBERT: -- and then --
16 THE WITNESS: I'm sorry.
17 HEARING OFFICER HEBERT: -- an amount over that
18 or --
19 THE WITNESS: The way the industry does this
20 typically is a surcharge -- a percentage surcharge, kind
21 of like the 33 percent we were talking about the PCF doing
22 in the -- in the old days.
23 HEARING OFFICER HEBERT: Yes, just a flat --
24 THE WITNESS: It's just a flat percentage.
25 HEARING OFFICER HEBERT: Uh-hum.

Page 89

1 THE WITNESS: And in -- in certain situations
2 it's a two percent surcharge, and in many more situations
3 it's a ten percent surcharge on the otherwise
4 applicable --
5 HEARING OFFICER HEBERT: On the cumulative
6 amount of the --
7 THE WITNESS: Exactly.
8 HEARING OFFICER HEBERT: Okay.
9 THE WITNESS: That's exactly right.
10 HEARING OFFICER HEBERT: Okay.
11 BY MR. BARAN:
12 Q. So how has the New Mexico PCF been surcharging
13 entities?
14 **A. The way that New Mexico has done it historically**
15 **and -- and for as long as I can remember -- so probably**
16 **back to '02 -- there's been a charge for the first**
17 **physician and then a smaller charge for each additional**
18 **physician.**
19 Q. Do you know what the charges are roughly?
20 **A. Off the top of my head, no.**
21 Q. So did you do any kind of analysis of whether or
22 not the current charges -- whatever they may be -- are
23 reasonably reflective of the risk presented by the
24 entities?
25 **A. In -- in our competitive benchmarking, the**

Page 90

1 **comparison between -- and I want to say it's like a $341**
2 **charge for the first doctor or something like that --**
3 **is -- is woefully inadequate compared to what we see in**
4 **the marketplace, which is that ten percent surcharge.**
5 **And -- and -- it's -- it's -- it really goes**
6 **back to that issue of, are we -- do we have an element of**
7 **our rating plan, do we have an element of our rates that**
8 **is unfairly discriminatory, and the answer is yes.**
9 **We're not charging enough for the entity**
10 **coverage based on -- on everything we -- we saw in our**
11 **competitive benchmarking based on kind of the current**
12 **status quo in the U.S. health care industry and -- and**
13 **medical professional liability market.**
14 **Basically the physician surcharges have been**
15 **subsidizing the entity coverage, and so to get a more**
16 **actuarially sound, more actuarially reasonable rating**
17 **plan, we recommend a fairly substantial change to the**
18 **entity coverage.**
19 Q. So going back to page 105, that would be
20 reflective in the $1.57 million number on line seven?
21 **A. Correct.**
22 Q. Okay.
23 **A. And again, that number moves a little bit based**
24 **on how much of a base surcharge change you make.**
25 Q. Okay. And then we go to line six, which is also

Page 91

1 an increased revenue source, and that relates to changing
2 the classifications.
3 So why don't we walk through very quickly --
4 **A. Actually, if I can --**
5 Q. -- page --
6 **A. -- one more thing before you leave --**
7 Q. Okay.
8 **A. -- 105.**
9 Q. Okay.
10 **A. So row eight then is the remaining surcharge**
11 **need after those two changes.**
12 **So in the central scenario, what was a $24.945**
13 **million need, after you make the adjustment in the class**
14 **plan and after you make the adjustment in the entity**
15 **coverage, there's now a remaining need of only**
16 **$23.1 million. You've created $1.8 million of -- of**
17 **revenue, and so you don't need to increase that base**
18 **surcharge as much.**
19 **So the idea here is, we're still going to**
20 **produce $24.945 million of revenue; we're just doing it a**
21 **little differently.**
22 **And so an ear, nose, and throat doctor that is**
23 **not a part of an entity and is not in a class that's --**
24 **that's being modified by the class change is only going to**
25 **see an assessment increase of 5.5 percent.**

Page 92

1 Q. At the central?
2 **A. At the central. At the 80 percent, it -- you**
3 **know, what -- what was -- or at the 90 percent, what was a**
4 **37 percent increase is now only a 27 percent increase,**
5 **because we generated revenue from these two other sources.**
6 **So the idea is still producing that -- that**
7 **indicated actuarially sound level of revenue. We're just**
8 **not doing it in a single, across-the-board rate change.**
9 **We're doing it in a way that tilts the scales a little**
10 **bit. Sorry.**
11 Q. So now we want to explain in a little bit more
12 detail the change reflected in line six --
13 **A. Yep.**
14 Q. -- on page 105, and does that refer back to
15 pages 79, 80, and 81 --
16 **A. It does.**
17 Q. -- of the same exhibit?
18 **A. Yes, sir.**
19 Q. All right. So what are we seeing in 79, 80, and
20 81, and how does that relate to line six on page 105?
21 **A. So if you were The Doctors Company or Medical**
22 **Protective and you were --**
23 Q. What are those? What are those?
24 **A. Oh, sorry. Which are big admitted medical**
25 **professional liability insurers.**

Page 93

1 Q. Okay.
2 **A. They would use a big data set with lots -- you**
3 **know, tens of thousands of claims in it to figure out what**
4 **these relativities ought to be by physician specialty.**
5 Q. And what's a relativity?
6 **A. So we've selected a group of specialties, which**
7 **we've identified here as class two or group two, to be**
8 **our, quote, unquote, base class.**
9 **This approach is the same way that your**
10 **homeowners insurance works. It's the same way that**
11 **your -- your auto insurance works, that there is a --**
12 **there is a 25-year-old single female driver who drives a**
13 **Ford Escort who is identified as the base class, and a**
14 **54-year-old in an Audi with a speed -- but a good credit**
15 **score and two prior claims is priced differently based on**
16 **relativities to that base class.**
17 Q. Okay.
18 **A. So what we do here is that the specialty of**
19 **the -- the health care provider moves the surcharge up or**
20 **down based on their relative claims propensity.**
21 **But there's just simply not enough granular**
22 **claims detail in the PCF -- thank goodness -- to do this**
23 **on an experience-based basis, so we've got to use**
24 **competitive benchmarking.**
25 **The idea here is that because the Indiana and**

Page 94

1 **Wisconsin Patient Comp Funds go through a regulatory**
2 **process and -- and candidly, have larger claims volume and**
3 **because The Doctors Company and Medical Protective are**
4 **very large, leading medical professional liability**
5 **carriers in New Mexico, all four of those provide**
6 **reasonable benchmarks, reasonable information to guide our**
7 **decision making about what the relativities by specialty**
8 **ought to be for the New Mexico PCF.**
9 **So what page 79 and subsequent shows you is a**
10 **comparison by specialty for each and every ISO-based --**
11 **we -- the first expert talked about ISO. ISO is Insurance**
12 **Services Office.**
13 **ISO serves two roles. They serve as a**
14 **statistical agent that gather data from insurance**
15 **companies and provide it to state insurance departments.**
16 **They also serve as a rating bureau, so they**
17 **create classification plans. They also create actuarial**
18 **work products, increased limits factors and class factors**
19 **and loss costs and all sorts of good things.**
20 Q. So we heard Ms. Romero testify about a base
21 surcharge per class.
22 **A. Right.**
23 Q. And how many classes are in -- used in the PCF
24 in your analysis?
25 **A. There's a total of north of 12 and -- and shy of**

Page 95

1 **20. You've got like 13 for the physicians and surgeons,**
2 **and then some additional classes for the allied health**
3 **professionals and physician extenders, so it's -- it's**
4 **just shy of 20.**
5 Q. So as part of your project, you identified which
6 providers should be in which class based on their
7 relativities; is that correct?
8 **A. Correct, and -- and whether a move to a**
9 **different class was indicated and whether the surcharge**
10 **relativities currently used by the PCF were -- continue to**
11 **be reasonable.**
12 Q. And based -- some providers moved down a class;
13 is that correct?
14 **A. Correct.**
15 Q. And some providers moved up a class?
16 **A. Correct.**
17 Q. Or some specialties, I should say.
18 **A. And some groups, the relativity changed in total**
19 **for that whole group --**
20 Q. Okay.
21 **A. -- so the whole cohort of specialties moved up**
22 **or down.**
23 Q. So then going back to page 105, after those
24 changes were accounted for and projected, that is the --
25 that's where the additional revenue --

Page 96

1 **A. Yep.**
2 Q. -- is coming from?
3 **A. Yes, sir, and --**
4 Q. You took all the -- the increases and subtracted
5 the decreases and reached $229,411 for the central
6 confidence level?
7 **A. Correct.**
8 Q. Okay.
9 **A. And -- and the easiest -- and in my actual**
10 **written report, if -- if you want to see a detail of all**
11 **those changes, the detail of all those changes starts on**
12 **page 75, and it just simply gives you an itemized list.**
13 **That's maybe a little bit easier to wrap your -- your**
14 **brain around.**
15 **There are individual classes identified first.**
16 **So radiation therapy goes up. Gynecology, minor surgery**
17 **goes up. Intensive care goes up. Nephrology actually**
18 **comes down, as does podiatry. Cardiac surgery goes up.**
19 **Nephrology goes up. Obstetrics goes up. Pediatrics goes**
20 **up.**
21 **And then class 5-A -- well, 5-A goes up as a**
22 **group from a relativity of 1.6 to 1.7. Class seven**
23 **actually comes down substantially, from 4.0 to 3.5, and**
24 **class ten increases somewhat, from 6.25 to 6.5.**
25 **So the idea here is to itemize for you in an**

Page 97

1 **easier-to-kind-of-wrap-your-brain-around manner all of**
2 **the -- the details that are going on in pages 79 and**
3 **subsequent.**
4 Q. Okay. So now let's look at pages 82 and 83.
5 **A. Yep.**
6 Q. And we heard Ms. Romero testify about how the
7 system that she administers is going to have the base
8 surcharge or base rate built in and that it -- from that
9 number, the adjustments would be made to determine the
10 actual surcharge for a particular provider.
11 **A. Uh-huh.**
12 Q. What in this -- what on these pages would
13 reflect that number that's going to be built in to the
14 system as the base surcharge?
15 **A. So the two columns in the center of the page --**
16 **current rate and proposed rate -- are those surcharges by**
17 **class or -- or by specialty group, if you'd prefer to**
18 **think of that way.**
19 **There are some rounding errors between the**
20 **current surcharges and the proposed, and these also don't**
21 **reflect any change in base surcharge, which is important.**
22 **So if -- if the idea is that we're going to**
23 **pass, you know, even a ten percent surcharge through, that**
24 **would be in addition to what we're showing as these**
25 **proposed rates, so these just reflect the impact of the**

Page 98

1 **class change.**
2 Q. Okay. So at what confidence level are these
3 reflected on these pages?
4 **A. Well, that -- I mean, it's hard to state these**
5 **at a confidence level, per se. Because we're looking at**
6 **class plan, I -- I guess I would describe them as**
7 **expected, but they're not as well suited to statistical**
8 **confidence as the base rates are.**
9 Q. Okay. So if the Hearing Officer agreed with
10 staff's proposal to utilize an 80 percent confidence level
11 and increase the surcharges accordingly, how are the base
12 surcharges for each class going to be determined?
13 **A. So basically, you're going -- if you look at**
14 **page 105, it says that the remaining assessment level**
15 **change that needs to happen across the board is 19.3**
16 **percent --**
17 Q. Okay. So --
18 **A. -- so you're going to apply that to the changes**
19 **here in Exhibit 2 that reflect the class changes.**
20 Q. So you say Exhibit 2. We're talking about --
21 **A. Oh, I'm sorry; page 82.**
22 Q. Okay. So we would take the current rate and
23 multiply that by 1.193?
24 **A. Correct.**
25 Q. Okay.

Page 99

1 **A. Another way to think of this is, if -- if class**
2 **two is my base class, then we would take that $3,889 base**
3 **class surcharge, right --**
4 Q. Uh-huh.
5 **A. -- at the bottom of page 82 --**
6 Q. Yes.
7 **A. -- we would increase that by 19.3 percent to get**
8 **the new base class surcharge, then we would apply the**
9 **proposed relativities.**
10 **So it's -- it's -- this whole process of**
11 **determining the final surcharge is -- is -- is -- it's**
12 **simply an algebraic formula. It's -- it's this times this**
13 **times this gets you to the final surcharge.**
14 Q. Okay. So because we do not know what confidence
15 level the Hearing Officer will settle upon, we at least
16 have the formulas and the methodology in here to determine
17 what those base surcharges are going to be?
18 **A. Correct. And -- and the multiplicative effect**
19 **of the base rate surcharge shown on page 105 and the**
20 **proposed class changes will be an 80 percent confidence**
21 **level rating plan in total.**
22 Q. Okay. All right. Well, I think that covers
23 105.
24 So in your opinion, based on the application of
25 sound actuarial principles and having advised the New

Page 100

1 Mexico PCF and other PCFs, what confidence level would you
2 recommend be adopted for the physicians and surgeons rate
3 increases for 2019?
4 **A. My recommendation would be to -- to adopt the 80**
5 **percent confidence level. It -- it's prudent given the**
6 **current experience of the program. It's prudent given the**
7 **methodology we've used here. I -- I think it's an**
8 **actuarially sound result.**
9 Q. Okay. Is the PCF currently experiencing an
10 issue with a surplus deficit?
11 **A. Yes, it is.**
12 Q. And what's the issue there?
13 **A. If you compare the present value of all of those**
14 **unpaid claims obligations that -- that we talked about in**
15 **the reserve study to the current fund balance, which is a**
16 **representation of the available assets to pay claims,**
17 **there's a shortfall. You can see that actually in**
18 **Exhibit 1, page --**
19 Q. Exhibit A, page --
20 **A. I'm sorry. So Exhibit A, page 44.**
21 Q. Okay.
22 **A. And the easiest place to see this is column ten.**
23 HEARING OFFICER HEBERT: I'm sorry; what page?
24 THE WITNESS: Page 44.
25 **A. And again, I apologize for the four-point font,**

Page 101

1 **but column ten shows -- if you take all of those future**
2 **claims obligations for accidents that have already**
3 **occurred that we believe the PCF is ultimately going to**
4 **have an obligation to pay on, that number in total on a**
5 **discounted basis reflecting the time value of money is**
6 **about $118 million, $119 million.**
7 **So the idea here is that there's a need over the**
8 **next maybe 30 years, maybe 50 years, to pay out another**
9 **$119 million on claims related to accidents that occurred**
10 **in 2018 and prior years.**
11 **The fund balance as of year-end 2018 for the PCF**
12 **was $87.1 million, so the total amount of funds available**
13 **to pay those benefits was $87 million, suggesting a**
14 **shortfall of almost $32 million, so there's an unfunded**
15 **liability from the PCF's perspective of just shy of**
16 **$32 million.**
17 **If this were a statutory insurance company, it**
18 **would be technically insolvent. Fortunately, government**
19 **insurance programs aren't held to that standard and can**
20 **continue their operations in a surplus deficit position.**
21 **Some government insurance programs go all the**
22 **way to being kind of pay as you go, which I would**
23 **strongly, strongly, strongly caution you against.**
24 **So the good news here is, there's $87 million to**
25 **pay benefits. You can pay benefits for a lot of years out**

Page 102

1 **of $87 million and generate investment income on that**
2 **$87 million.**
3 **The problem is, there's still $32 million of**
4 **additional benefits for claims that have already occurred**
5 **that is unfunded at this time.**
6 Q. So you've done work for the New Mexico PCF in
7 the past and performed and provided opinions similar to
8 what we're looking at today, correct?
9 **A. I have.**
10 Q. Has the New Mexico PCF always adopted your
11 opinions?
12 **A. No.**
13 Q. And what's been your experience with respect to
14 whether they've -- the New Mexico PCF has rejected
15 certain -- did they reject proposals to increase
16 surcharges by a greater amount than was ultimately
17 adopted?
18 **A. Generally, the -- the practice has been to adopt**
19 **either something akin to our central estimate or something**
20 **less than that.**
21 Q. Have you done any kind of assessment as to what
22 the surplus deficit position would be if the New Mexico
23 PCF had adopted your -- all of your recommendations for
24 increases in surcharges?
25 **A. It's hard to string it together, because each of**

Page 103

1 **those additional increases would have affected the next**
2 **analysis. Remember, we went through that process of**
3 **bringing all those surcharges to current level. It may**
4 **have forced our hand to implement some decreases in**
5 **subsequent years.**
6 **So it's -- it's hard to say, but a consistent**
7 **behavior of implementing rate changes of less than the**
8 **indication can't help but have an effect of impacting**
9 **the -- the profitability or the -- the -- the surplus**
10 **deficit position of the fund.**
11 **It would have been better if we'd been adopting**
12 **something more in line with my actuarial recommendations.**
13 Q. Okay. And your report as it's been offered
14 doesn't address how to resolve the surplus deficit
15 situation; is that correct?
16 **A. Correct. It's important to recognize ratemaking**
17 **is prospective, and -- and so for the purpose of setting**
18 **next year's surcharges, it -- it really doesn't fit into**
19 **the idea of an actuarially sound rate to say, we're going**
20 **to increase surcharges by five percent simply as a means**
21 **of starting to -- to fill in that hole of the unfunded**
22 **liability that's out there.**
23 **Certainly there are approaches that do that, but**
24 **that's really outside the bailiwick of -- of the rate**
25 **level indications for trying to determine what the**

Page 104

1 **surcharges would be.**
2 **It's certainly something reasonable to do. It's**
3 **the only way that most government insurance programs have**
4 **of addressing those deficits is either funding at a higher**
5 **confidence level or explicitly charging an assessment, if**
6 **you will, to start funding that unfunded liability.**
7 Q. So I just want to be clear that I understand
8 that this proposal as presented here is not a proposal to
9 charge what is actuarially sound and reasonable for
10 prospective surcharges and to resolve the surplus deficit
11 situation.
12 It's only the former, not the latter?
13 **A. Correct.**
14 Q. Okay. So I think we've gone through your
15 analysis with respect to the proposed rate -- surcharge
16 rate changes for physicians and surgeons.
17 Is there anything else that you think the
18 Hearing Officer needs to know on that?
19 **A. I don't think so.**
20 THE WITNESS: But I -- I guess, I'll ask, do you
21 have questions about the physicians' piece of this?
22 HEARING OFFICER HEBERT: I do. You said you
23 participated in earlier surcharge proceedings --
24 THE WITNESS: Yes.
25 HEARING OFFICER HEBERT: -- in New Mexico.

Page 105

1 THE WITNESS: Since 2002.
2 HEARING OFFICER HEBERT: Since 2002. So at the
3 time of the change in 2016 that was allocated over two
4 different years --
5 THE WITNESS: Uh-huh.
6 HEARING OFFICER HEBERT: -- I guess the proposal
7 must have been over 16, 17 percent?
8 THE WITNESS: Actually, Anna, do you have that
9 number of what the indication was?
10 MS. KRYLOVA: Yes, it's on there.
11 HEARING OFFICER HEBERT: I was just looking at
12 it from Exhibit E. In 2016 --
13 THE WITNESS: Thank you.
14 HEARING OFFICER HEBERT: -- E shows --
15 THE WITNESS: Yep.
16 HEARING OFFICER HEBERT: But -- and -- and I
17 think you testified that that was done over two years
18 instead of one year?
19 THE WITNESS: There was an agreement to
20 implement that as -- as a series of two annual increases.
21 We were doing the actuarial work every other year, and so
22 the idea was to implement half of it immediately and half
23 of it --
24 HEARING OFFICER HEBERT: Yes.
25 THE WITNESS: -- the year subsequent.

Page 106

1 HEARING OFFICER HEBERT: Yes. So when that was
2 done, what was at that time the confidence level that was
3 being sought?
4 THE WITNESS: That was actually --
5 HEARING OFFICER HEBERT: Was it the --
6 THE WITNESS: That was actually --
7 HEARING OFFICER HEBERT: -- was it --
8 THE WITNESS: -- the central. If you look at --
9 HEARING OFFICER HEBERT: The central?
10 THE WITNESS: So the central at that point in
11 time was plus 18, and the 90 percent confidence level
12 estimate was 46.8.
13 HEARING OFFICER HEBERT: So has that been, as
14 far as you know, the experience with this fund all along?
15 It's been based at a central confidence level?
16 THE WITNESS: I would say, or less.
17 HEARING OFFICER HEBERT: Or less?
18 THE WITNESS: If you go back to 2009, for
19 example -- actually, let's go back to 2007. The central
20 was plus 19, and we implement 9.5.
21 In 2009, the central was plus 16, and we
22 implemented plus 9.5.
23 There were increases -- small increases, just
24 2.3 to 2.8 -- in the 2012 and '14 studies that were chosen
25 not to be implemented.

Page 107

1 And -- and so again, if -- if an approach of --
2 of funding something somewhere between the central and
3 that 90 percent confidence level, pretty much time and
4 time again over the last -- over the last decade,
5 surcharges levels would have been 13 to 15 percent higher
6 than they were.
7 Now, think about what that means. What that
8 means is that we would have been generating $1.5 million
9 of additional surcharges each and every one of those
10 years --
11 HEARING OFFICER HEBERT: Uh-huh.
12 THE WITNESS: -- $15 million of additional
13 surcharges over the decade. That cuts the surplus deficit
14 in half.
15 HEARING OFFICER HEBERT: Uh-huh.
16 THE WITNESS: So if we had been prudently
17 adopting a position somewhere between that 90 percent
18 confidence level and the central -- like the 80 percent
19 we're recommending here -- it would have certainly
20 defrayed a substantial part of the deficit that we're
21 facing right now if we had done so.
22 And I would suggest another fairly substantial
23 part of that deficit are the -- the catastrophic claims
24 from 2010 and '11. That's another --
25 HEARING OFFICER HEBERT: But you testified that

Page 108

1 the fund had taken out reinsurance on those.
2 THE WITNESS: And -- and -- absolutely.
3 HEARING OFFICER HEBERT: So far as you know, is
4 that the only reinsurance the fund has taken out?
5 THE WITNESS: It is --
6 BY MR. BARAN:
7 Q. Just to clarify --
8 THE WITNESS: -- as far as I know.
9 Q. -- the reinsurance came in after those were
10 paid?
11 **A. Correct.**
12 Q. So it's for -- future claims will be reinsured,
13 but those claims were not reinsured?
14 **A. Yeah. I -- I would characterize the**
15 **reinsurance -- the reinsurance was purchased in 2016 or**
16 **'17 and was really based on the catastrophic claims from**
17 **2000 and '10 and a perceived concern that bringing the**
18 **hospitals in more fully to the PCF was going to increase**
19 **the exposure of these batch claims to the PCF.**
20 HEARING OFFICER HEBERT: Uh-hum.
21 **A. So it was really, I would say, proactive risk**
22 **management based on bringing the hospitals in, and**
23 **reactive risk management to the -- the catastrophic claims**
24 **from '09 and '10.**
25 HEARING OFFICER HEBERT: Would you think that it

Page 109

1 would be prudent if you -- if you -- if the superintendent
2 were to accept the 80 percent confidence level --
3 THE WITNESS: Uh-huh.
4 HEARING OFFICER HEBERT: -- do you think it
5 would be prudent for him to do so also over a two-year
6 period rather than a one-year period?
7 THE WITNESS: You know, one of the challenges of
8 being an actuary is oftentimes the -- the -- the right
9 answer or the best answer isn't really an actuarial
10 question.
11 I, over the years, have served as a product
12 manager and -- and owns the -- the results of a program or
13 a product, and I -- I think there's certainly a lot of
14 compelling business reasons why phasing a -- the adoption
15 of the 80 percent confidence level in over a period of
16 time would certainly be prudent.
17 I -- there's a natural reaction. There's a
18 natural sticker shock --
19 HEARING OFFICER HEBERT: Uh-huh.
20 THE WITNESS: -- associated with taking very
21 large rate actions.
22 HEARING OFFICER HEBERT: Well, particularly in
23 light of the fact that the fund up to this date had been
24 at a so much lower confident level.
25 THE WITNESS: Agreed.

Page 110

1 HEARING OFFICER HEBERT: I still have a little
2 bit of question about the entity -- about how -- the
3 entity composed of, say, four doctors and then they have
4 the entity that they are employed by.
5 I still have a little problem with how much
6 exposure to risk does that entity add to just the
7 individual physicians themselves.
8 I -- I think you -- you explained it, but I
9 don't think I understood what --
10 MR. BARAN: Let -- let me ask a follow-up
11 question that might help tease that out.
12 HEARING OFFICER HEBERT: All right.
13 BY MR. BARAN:
14 Q. Okay. So when doctors practice in a group, do
15 they have ancillary staff that also perform services that
16 could give rise to a medical malpractice claim?
17 **A. Sure, more than ever, and -- and in an age where**
18 **telemedicine is growing and the use of physician extenders**
19 **is growing, more and more of the care is being provided by**
20 **employees in a health care practice maybe that aren't**
21 **explicitly rated in the PCF rating plan as it's currently**
22 **stated.**
23 Q. And in your experience, are the provider groups
24 liable for the errors and omissions of those non-qualified
25 providers?

Page 111

1 **A. They are. They're also liable for any best**
2 **practices that they dictate to their staff, and so if they**
3 **have a way of treating -- you know, in -- in behavioral**
4 **medicine cases or in the prescription of -- of opioids,**
5 **sometimes those practice guidelines that are dictated by**
6 **the corporate entity have also been found to be a source**
7 **of liability, so both of those risks present themselves.**
8 Q. So as doctors join forces and form entity groups
9 and practice out of those groups, the risk of claims that
10 would be covered by the PCF increases?
11 **A. Yes. And -- and that trend towards larger**
12 **practice groups both within, you know, being W-2 employees**
13 **of the hospital and being stand-alone physicians groups --**
14 **either single specialty or multi-specialty -- is -- is**
15 **pretty clearly the direction health care is going.**
16 **In Wisconsin -- it's the only state I know the**
17 **number -- there are less than 300 sole practitioners left,**
18 **so the idea of -- of -- of, you know, the country doctor**
19 **driving to do house calls in his buggy is just simply not**
20 **how -- how health care is being practiced.**
21 **The -- the small physician groups don't have the**
22 **financial wherewithal even to invest in the technology**
23 **necessary, whether that's electronic medical records or**
24 **just the -- the diagnostic equipment that the larger**
25 **physician groups have, the -- the financial wherewithal to**

Page 112

1 **invest in.**
2 THE WITNESS: Does that address --
3 HEARING OFFICER HEBERT: Yes. Yes, it does,
4 uh-huh. Those are -- those are my questions up to this
5 point.
6 BY MR. BARAN:
7 Q. Okay. So let's turn to the hospitals.
8 What were you asked to do with respect to
9 determining surcharges for the hospitals?
10 **A. So there's two aspects to the hospitals that --**
11 **that need to be addressed.**
12 **The -- the first is, we've got enough data for**
13 **the hospitals for recent years to start forming some --**
14 **some individual opinions, and -- and so we were asked to**
15 **produce a rate level indication for the hospitals in terms**
16 **of the indicated revenue that needed to be generated by**
17 **the hospitals.**
18 **But with the changes in -- in regulation of the**
19 **PCF and the need for the PCF staff to be able to determine**
20 **the surcharges as compared to stand-alone actuarial**
21 **studies, we also needed to develop a rating plan, a rating**
22 **methodology, a rating algorithm that functions in a manner**
23 **similar to what the physicians and surgeons and health**
24 **care providers do --**
25 Q. So let me --

Page 113

1 **A. -- so two elements.**
2 Q. -- let me talk about that aspect of it. We
3 heard comments earlier this morning about using
4 stand-alone actuarial studies, and you testified just a
5 second ago about regulatory changes that require PCF staff
6 to actually be able to determine the appropriate
7 surcharges.
8 Expand on that concept a little bit, if you
9 could. What's the difference between that stand-alone
10 actuarial study versus what you're proposing for PCF staff
11 to implement under this?
12 **A. Sure. When it comes to property/casualty**
13 **insurance products, there's two generally accepted**
14 **methodologies for determining premium.**
15 **One is called exposure rating. It's the idea**
16 **that you take a business's work comp payroll times a rate**
17 **times, you know, a rating factor based on their prior**
18 **experience or the underwriter's discretion and produce a**
19 **premium. It's entirely based on the ratable exposures.**
20 **This is predominately how your homeowners and**
21 **personal auto work, that it's -- it's your vehicle count**
22 **or the insured values of your house times the territorial**
23 **relativity times your credit score times, times, times,**
24 **times, to get to a rate, but it's based on the exposures**
25 **almost to the exclusion of experience.**

Page 114

1 **That is largely what we do with the docs. Other**
2 **than the -- the claim surcharge, everything we do with the**
3 **docs is exposure rating. It's the doctor -- number of**
4 **doctors times the -- the surcharge times the specialty**
5 **relativity times the full-time, part-time charge gets you**
6 **to the final surcharge.**
7 **The other type of -- of rating methodology is**
8 **experience rating. This is what you see on large**
9 **commercial accounts.**
10 **If I'm doing the work for Johns Hopkins**
11 **Hospital, they're a large enough organization that they've**
12 **got detailed claims experience on which I can assign full**
13 **credibility and reliability to determine what next year's**
14 **premium ought to be.**
15 **The idea here is that for large commercial**
16 **accounts that are very commercially insurance savvy, a**
17 **methodology that relies on the claims experience can be**
18 **relied upon.**
19 **Most commercial insurance products are hybrids.**
20 **They start with an exposure rate, and then they apply an**
21 **experience modification -- very much like what we do with**
22 **the physicians. We start with an exposure rate, and then**
23 **as the very last step we apply a very simple experience**
24 **surcharge when the claims experience is bad.**
25 **Larger commercial accounts use more**

Page 115

1 **sophisticated experience rating plans where that exposure**
2 **rate is modified up or down based on how the individual**
3 **risk compares to the class.**
4 **So if I'm doing work comp for a steel mill, I**
5 **start with the payroll and the loss cost by class, but**
6 **then I look at the last three to five years of experience**
7 **for that steel mill and compare it to the experience I**
8 **would have expected to see for a steel mill, and I produce**
9 **an experience modification factor that can move the**
10 **premiums up or down.**
11 **That hybrid approach, where you start with an**
12 **experience rate and then you apply a -- or sorry; an**
13 **exposure rate and then you apply an experience rate at the**
14 **end is where the lion's share of kind of medium-size**
15 **commercial accounts have their premiums determined.**
16 HEARING OFFICER HEBERT: Okay.
17 **A. So that's really what we're dealing with here is**
18 **the right combination of exposure rating to get us to a**
19 **starting point and then experience rate to -- to -- to**
20 **modify the -- the -- the surcharges up or down when we**
21 **think the experience is credible enough to move the**
22 **needle.**
23 Q. So how have hospitals been determining their --
24 how -- how have hospital surcharges been determined
25 historically in the PCF, and how are you proposing that

Page 116

1 they be determined under the new program?
2 **A. So the prior approach was pure experience**
3 **rating. It was purely looking at the -- the loss**
4 **experience of one or a group of hospitals, comparing it --**
5 **you know, looking at it over a five-year period, and using**
6 **that to project what next year's surcharge ought to be.**
7 HEARING OFFICER HEBERT: And that is just for
8 New Mexico you're speaking to?
9 THE WITNESS: Correct.
10 HEARING OFFICER HEBERT: Okay.
11 **A. The -- the previous legislation actually**
12 **required that.**
13 HEARING OFFICER HEBERT: Uh-huh.
14 **A. A qualified actuary developed essentially a**
15 **funding study based on the prior claims experience of --**
16 **of the hospital, or in the case of the Risk Purchase**
17 **Group, a group of hospitals.**
18 **What we're shifting to, because it's -- it's not**
19 **reasonable to ask PCF staff to develop those types of**
20 **actuarial work products, is something that is much more**
21 **consistent with the physicians and surgeons program where**
22 **we work up an exposure-based manual premium and then**
23 **modify it with an exposure -- or sorry; an experience**
24 **modification factor.**
25 Q. So can you walk us through -- first of all,

Page 117

1 let's -- let's -- in order to implement that new rating
2 plan --
3 **A. Uh-huh.**
4 Q. -- you need to know what surcharges -- what --
5 what the -- what the exposures are, correct?
6 **A. Yep.**
7 Q. Okay. So let's start with your analysis of what
8 those exposures are and then move to the rating plan.
9 **A. Sure.**
10 Q. Okay.
11 **A. If you -- if you don't mind, I'm going to do**
12 **that in -- a little bit backwards to what you just**
13 **asked --**
14 Q. Okay.
15 **A. -- if -- if you'll grant me a little latitude.**
16 Q. Whatever is going to make it most understandable
17 for us.
18 **A. So let's start with how much -- how much revenue**
19 **the PCF needs to generate from the hospitals. I think**
20 **that's the right place to start is, what's -- how much**
21 **revenue is required to cover the claims obligations for**
22 **the -- for the coming policy term for the hospitals.**
23 **The approach we used is identical to what we did**
24 **on the physicians and surgeons. And so I'm going to have**
25 **you flipping between exhibits again, and I apologize for**

Page 118

1 that, but I'm going to have you flipping between page 64
2 and page 106.
3 Page 64 looks an awful lot like page -- I think
4 it's 56 where the doctors were.
5 MS. KRYLOVA: Fifty-eight.
6 THE WITNESS: Fifty eight?
7 MS. KRYLOVA: I think so.
8 A. It's -- that's intentional. We intended to use
9 the same exact methodology.
10 And -- and I guess this is maybe a good place
11 to -- to point out or address the -- the issue of the
12 losses between the physicians and the hospitals.
13 There were concerns raised this morning about
14 the allocation of -- of the claims between the physicians
15 and hospitals, and -- and candidly, I don't share that
16 concern.
17 There is a process at settlement that when --
18 when that information comes back to the PCF, they are
19 given an assignment allocating the claims between the
20 responsibility of the hospital and the responsibility of
21 the physician.
22 I -- I don't know that that -- that process is
23 broken, and I certainly didn't see any evidence that it's
24 broken within the data that I was provided.
25 So what you see on page 64 is a rate level

Page 119

1 indication identical to what we did on the physicians.
2 The challenge here, candidly, is that for those
3 early years, only CHRISTUS St. Vincent was participating
4 in the program, and so those loss ratios from those early
5 years are limited to a single facility or group of
6 facilities, and it was only when we rolled the Risk
7 Purchasing Group and Presbyterian in in 2016 and '17 that
8 we really saw the -- the increase in the hospital
9 surcharge revenue.
10 That makes this a little tricky in that I don't
11 have as much historical surcharge revenue. I don't have
12 as much paid claims experience, but the experience to date
13 is pretty good.
14 The experience to date for the hospitals in
15 terms of the claims emergence that we've seen looks like
16 we're slightly outperforming the physicians and surgeons.
17 I would also add -- and -- and this isn't
18 included in my analysis, but there is evidence in other
19 states to suggest that W-2-employed physicians of
20 hospitals tend to be slightly better PCF risks than
21 non-hospital-employed physicians, and this has to do with
22 the coordination of coverage between the hospital and the
23 physician, the -- the combined defense and -- and all of
24 this.
25 There's nothing currently in the rating plan to

Page 120

1 reflect any differential between a W-2 employee of a -- of
2 a hospital and a stand-alone physician or a physician in a
3 group.
4 Q. So going to line number six --
5 A. Yep.
6 Q. -- the undiscounted loss ratio for the
7 hospital --
8 COURT REPORTER: The what? I'm sorry.
9 MR. BARAN: Line number six.
10 Q. -- the undiscounted loss ratio for hospitals is
11 100.4 percent, so that means roughly a dollar in and a
12 dollar out?
13 A. Correct --
14 Q. And that's significant --
15 A. -- which means we're actually making some money
16 on the investment part.
17 Q. Okay. And then for the doctors it was 119.5
18 percent?
19 A. Correct.
20 Q. So you're losing some money on the doctors?
21 A. Right.
22 Q. Okay.
23 A. The other thing you'll note here -- and I'll --
24 I'll point this out now -- is that 100.4 percent ultimate
25 loss ratio selection that I made in row six is based on

Page 121

1 all of the years.
2 Candidly, it's a little different from what I
3 did on the -- on the physicians, but I'm dealing with a
4 smaller data set, it's less credible, and so -- and the
5 hospital data isn't as influenced by the -- the -- the
6 large claims in 2009 and '10.
7 And so candidly, the -- the judgment to use all
8 of the years as compared to the -- the smaller experience
9 period on the -- on the physicians is really trying to
10 squeeze as much information out of the hospital data as
11 possible.
12 Q. So if we go to line 14 for the hospitals, the
13 indicated assessment level change would be minus 4.5
14 percent at the central confidence level; that's correct?
15 A. Correct. So the -- the assessments from last
16 year were 22 -- just $22.176 million. The indication is
17 21.1, so actually, a reduction of about $1 million, give
18 or take, in -- in the revenue needed.
19 Q. Okay. And then if we look at page 65, the
20 indicated assessment level on line 15 is 15.2 percent, and
21 that's at the 90 percent confidence level?
22 A. Correct, and $25.45 million of revenue.
23 Q. Okay.
24 HEARING OFFICER HEBERT: Excuse me. At the
25 which confidence level?

Page 122

1 MR. BARAN: Ninety percent confidence level --
2 HEARING OFFICER HEBERT: Ninety percent.
3 MR. BARAN: -- as indicated in line 11 on page
4 65.
5 BY MR. BARAN:
6 Q. So this might be a good point for me to ask
7 if -- if --
8 **A. Actually, if you don't mind, we've got a**
9 **comparable summary then of various confidence levels from**
10 **the central up to the 90 percent showing on page 106.**
11 **Again, I want there to be equivalence between**
12 **what we're doing with the physicians and surgeons and what**
13 **we're doing with the hospitals.**
14 Q. So that was going to be my next question.
15 If the Hearing Officer concluded that the 80
16 percent confidence level was reasonable for the physicians
17 and surgeons, would it be reasonable for the Hearing
18 Officer to apply a different confidence level to the
19 hospitals?
20 **A. Again, I'm going to go back to those actuarial**
21 **standards and principles again, and I'm sorry to wear out**
22 **that -- that old saw, but for -- for a rating plan to be**
23 **actuarially sound, to be reasonable, it's got to be not**
24 **unfairly discriminatory.**
25 **I -- I think a decision to implement a different**

Page 123

1 **confidence level for the hospitals and outpatient**
2 **facilities as compared to the physicians and surgeons**
3 **would actually create a potential bias. It -- it would**
4 **create a potential opportunity to introduce something that**
5 **is unfairly discriminatory.**
6 **If you're going to fund the hospitals at --**
7 **at -- or the physicians and surgeons at 80 percent**
8 **confidence, then I -- I think that the actuarially**
9 **reasonable decision would be to fund the hospitals and**
10 **outpatient facilities at the same 80 percent confidence**
11 **level.**
12 Q. Okay. So turning to page 106 of Exhibit A, is
13 this reflective of the same analysis you did for
14 physicians and surgeons with respect to hospitals showing
15 what the indicated assessment level should be at the
16 different confidence levels?
17 **A. It is.**
18 Q. Okay. So then how does that work or dovetail
19 with the rating plan that you are proposing?
20 **A. So the rating plan then becomes this -- this**
21 **giant puzzle.**
22 **If I select a base surcharge for an acute care**
23 **bed and then I look at all of the ratable exposures that a**
24 **hospital has -- actually, let me -- I'm waving my arms**
25 **around instead of showing you numbers.**

Page 124

1 **Let's look at page 95. I think this is a good**
2 **place to kind of walk you through the approach we've**
3 **taken.**
4 **In -- in a review of a number of hospital**
5 **professional liability rating plans for patient comp funds**
6 **and for commercial insurance carriers, we identified these**
7 **exposure types shown in column one as a generally accepted**
8 **list of exposures that hospitals' premiums are determined**
9 **based on -- acute care beds, psychiatric care beds,**
10 **extended care, so on and so forth.**
11 **You'll note that unlike the physicians and**
12 **surgeons, where the rating is based on**
13 **full-time-equivalent docs, here some of the exposures --**
14 **inpatient and outpatient surgeries, ER visits, and so**
15 **on -- are actually based on per-100 procedures, per-100**
16 **visits.**
17 **Again, this is consistent with how the hospital**
18 **professional liability insurance industry determines**
19 **premiums.**
20 Q. Okay.
21 **A. The idea is, if I select that acute care bed**
22 **rate or surcharge, which we've dropped in here as -- as**
23 **$4,957 in column three, and then allow all the different**
24 **relativities to work -- so the idea is that a personal**
25 **care bed or a skilled nursing bed -- care bed is not as**

Page 125

1 **risky as an acute care bed from the PCF's perspective, and**
2 **the, you know, $248, again, is based on a relativity to**
3 **the acute care bed rate.**
4 **But if I allow all those relativities to work**
5 **and all of the existing exposures insured by the PCF to**
6 **work, then that $4,957 base rate or base surcharge**
7 **produces in this case the $23,861,000 premium or surcharge**
8 **that is consistent with the 80 percent confidence level**
9 **shown on page 106.**
10 Q. Okay.
11 **A. So the idea -- you're kind of backing into the**
12 **number, so you basically have to get that $4,947 in base**
13 **surcharge to produce the overall level of surcharges for**
14 **the hospitals.**
15 Q. So if the Hearing Officer determined that it was
16 reasonable to go with a different confidence level --
17 either higher or lower -- then you can still back into the
18 numbers on page 95?
19 **A. Correct.**
20 Q. Okay.
21 **A. Basically, you would -- you would identify what**
22 **that total surcharge revenue number needed to be, and --**
23 **and then you would --**
24 Q. It's a -- is it a straight-line percentage --
25 **A. -- you would --**

Page 126

1 COURT REPORTER: I'm sorry?
2 MR. BARAN: I'm sorry.
3 **A. You would just -- you would revise that base**
4 **surcharge for the acute care beds, and all the other**
5 **surcharges would change.**
6 Q. And that would be a straight-line percentage
7 decrease?
8 **A. Correct.**
9 Q. Thanks.
10 HEARING OFFICER HEBERT: Mr. Walling, I'm
11 missing something on this exhibit, page 95. I -- how --
12 how did we get to the figures in -- in column four on page
13 94?
14 THE WITNESS: So those are the -- the
15 exposures -- do we have that? If you go back two pages to
16 page 97, the previous actuarial work products produced by
17 Pinnacle and by Milliman provided listings of the covered
18 exposures.
19 And so the way you -- and I apologize; that
20 should have been presented on Exhibit 1 better -- but
21 the -- for the acute care beds, we have a total of -- of
22 1,508 acute care beds covered by the PCF --
23 HEARING OFFICER HEBERT: For all the -- the
24 hospitals?
25 THE WITNESS: For all the covered hospitals.

Page 127

1 HEARING OFFICER HEBERT: Okay.
2 THE WITNESS: -- times that $4,900 surcharge --
3 HEARING OFFICER HEBERT: I see. Okay.
4 THE WITNESS: -- gets you the $7.4 million of
5 revenue.
6 HEARING OFFICER HEBERT: All right. Thank you.
7 **A. And how you get the -- the relative differences**
8 **in column three is actually shown on page 96.**
9 **Again, we don't have enough hospital data to**
10 **indicate what the relationship ought to be between a**
11 **skilled care bed and an acute care bed, so we went and**
12 **looked at publicly available rate filings and then made**
13 **selections based on our actuarial judgment and our**
14 **experience with hospital professional liability programs**
15 **that we believe produces an actuarially reasonable rating**
16 **plan.**
17 Q. So now, how do we integrate the information on
18 page 96 with -- and 95 into the rating plan, which is 99
19 through --
20 **A. Sure. So what you see in --**
21 Q. -- 99 through 104?
22 **A. So what you see in pages 95, 6, and 7 are**
23 **fundamentally the rates. What you don't have yet are the**
24 **rating rules.**
25 **Typically insurance products have at least three**

Page 128

1 **components. They've got rates, they've got rating rules,**
2 **and they've got forms. The coverage forms are the -- the**
3 **legal contracts, and so the rates and the rating rules**
4 **are -- are really the bailiwick of actuaries.**
5 **And so what shows up on page 99 and subsequent**
6 **pages are simply the rules. It's a codification of -- of**
7 **how you do the math, of -- of how you determine what gets**
8 **multiplied by what. It's -- it's the rules for the rating**
9 **algorithm.**
10 **Again, the approach we've taken here is to lift**
11 **this from other insurance programs' rating rules for**
12 **hospital professional liability -- either at PCFs or at**
13 **leading hospital professional liability insurers -- and**
14 **then craft it to suit the needs of -- of the New Mexico**
15 **PCF.**
16 **But it literally is just laying out how to**
17 **compute the -- the indicated surcharges for a hospital --**
18 **to the point that it actually shows a sample rating**
19 **calculation of -- of the algorithm on the bottom of page**
20 **101.**
21 Q. So is this a program that you contemplate PCF
22 staff would be able to implement based on some raw data or
23 risk analysis presented by the hospitals?
24 **A. Yes. And -- and these rating rules actually**
25 **codify this in such a way that if this were an admitted**

Page 129

1 **insurance company, then OSI staff could come in and**
2 **perform a market conduct exam to make sure that PCF staff**
3 **are actually applying these rating rules accurately in**
4 **producing what the surcharges are. That's why the rating**
5 **rules are so important.**
6 Q. You -- you heard Ms. Romero testify about the
7 program that is being used now to determine ultimate
8 surcharges paid by physicians.
9 Would it be possible to implement a similar
10 system under this rating plan?
11 **A. Absolutely.**
12 Q. Okay.
13 **A. And -- and again, these rating rules would help**
14 **the people writing that program make sure that they're**
15 **producing accurate surcharges based on these rules.**
16 Q. Okay. Based on your analysis of both the
17 surcharges for hospitals and for the physicians, do you
18 have an opinion as to what would occur if the hospitals
19 were to not be participating in the PCF?
20 **A. The approach we've taken to determining the rate**
21 **needed is to determine those indicated surcharge changes**
22 **on a stand-alone basis, and so the recommendations we make**
23 **about the physicians and surgeons is -- is sufficient to**
24 **get them to an actuarially reasonable position in and of**
25 **itself.**

1 Q. Okay.
2 **A. Similarly, the recommendations for the hospitals**
3 **are intended to produce actuarially reasonable surcharges**
4 **for the hospitals and outpatient facilities in and of**
5 **themselves.**
6 **However, the early indications are that the**
7 **hospitals are producing very profitable results right now.**
8 **So this isn't a prospective statement but a retrospective**
9 **one: The addition of the hospitals and their physicians**
10 **and surgeons -- their W-2 employees -- to the Patient**
11 **Compensation Fund has been very successful. It -- it has**
12 **produced experience so far that has outperformed the PCF**
13 **prior to the hospitals joining.**
14 Q. But the goal of this new proposal will be to
15 make sure that prospectively everyone is paying their fair
16 share in a non-discriminatory manner?
17 **A. I -- I want to be clear. That's the goal every**
18 **time.**
19 Q. Okay.
20 **A. The -- the goal every time we do this is, when**
21 **we're doing the experience rating of the individual**
22 **hospitals, when Milliman is doing the pricing for the Risk**
23 **Purchasing Group, when we're doing the analysis of the**
24 **indicated surcharges for the physicians and surgeons, it's**
25 **always to produce an actuarially reasonable surcharge**

1 **level for all of the participants.**
2 **That's -- that's part and parcel of -- of what**
3 **standard of being not excessive, not inadequate, and not**
4 **unfairly discriminatory is all about.**
5 HEARING OFFICER HEBERT: Mr. Walling --
6 THE WITNESS: Yeah.
7 HEARING OFFICER HEBERT: -- if the historical
8 basis for doing this was just on the, I think you've said,
9 pure experience rating, if that's resulted in what seems
10 to be adequate funding for the fund, then why would they
11 want to change it to adding in the exposure factor?
12 THE WITNESS: I -- I don't know that the
13 hospitals want to change it. I don't know that I want to
14 change it.
15 HEARING OFFICER HEBERT: I'm sorry; why would
16 the superintendent want to change it?
17 THE WITNESS: I'm not sure the superintendent
18 wanted to change it.
19 I -- I think the issue here is that the -- the
20 change in regulation of the PCF is necessitating a shift
21 to the PCF doing the rating rather than having a qualified
22 actuary to do so.
23 MR. BARAN: May I --
24 THE WITNESS: I -- I would --
25 MR. BARAN: -- interject --

1 THE WITNESS. -- let me add if you --
2 MR. BARAN: Let me interject some context first.
3 HEARING OFFICER HEBERT: Yes, I think that would
4 be helpful.
5 MR. BARAN: Okay. So we had a lawsuit filed by
6 certain groups in District Court saying that the hospital
7 should not have been admitted to the fund, and in a ruling
8 in that case, Judge Thompson indicated that the
9 superintendent has a statutory obligation to perform risk
10 assessments for each hospital and outpatient facility and
11 use those risk assessments to determine a surcharge.
12 That process that has been directed by Judge
13 Thompson is inconsistent with what has historically been
14 done --
15 HEARING OFFICER HEBERT: I see.
16 MR. BARAN: -- and we're trying to comply with
17 his order --
18 HEARING OFFICER HEBERT: Okay. Yes.
19 MR. BARAN: -- and that's what's driving this.
20 HEARING OFFICER HEBERT: I understand.
21 MR. BARAN: Okay.
22 HEARING OFFICER HEBERT: Yeah, I -- I believe
23 Melissa Martinez had provided me that -- the particular
24 decision.
25 MR. BARAN: Yes.

1 HEARING OFFICER HEBERT: All right.
2 MR. BARAN: Okay.
3 THE WITNESS: I -- I would also add, this works
4 really well -- the -- the current approach works really
5 well when you're looking at the claims experience of
6 Presbyterian or CHRISTUS St. Vincent or the amalgamation
7 of four to six hospitals in the Risk Purchasing Group.
8 This makes big, hefty dollars and claims volume to deal
9 with.
10 It's a lot harder when you're dealing with a
11 smaller outpatient facility, and so the -- the approach we
12 had been using and -- and that was in the statute of
13 having an actuary do an actuarial analysis of each and
14 every one doesn't lend itself very well to opening up the
15 PCF to smaller facilities that can't really experience
16 rate in the same way.
17 And so this shift in methodology, beyond still
18 remaining actuarially reasonable, should also be more
19 attractive and more usable for the -- the smaller
20 facilities that have not come into this PCF in the same
21 way.
22 HEARING OFFICER HEBERT: I see. And are they
23 participating -- do you know whether they're participating
24 at this time or --
25 THE WITNESS: Not to the best of my knowledge,

Page 134

1 no.
2 HEARING OFFICER HEBERT: They're not?
3 THE WITNESS: (Shakes head.)
4 HEARING OFFICER HEBERT: Okay.
5 THE WITNESS: Now, right now it's CHRISTUS
6 St. Vincent, Presbyterian, and the Risk Purchasing Group.
7 MR. BARAN: The outpatient facilities have been
8 combined with hospitals, so the same system has to be used
9 with both, and do we contemplate that outpatient
10 facilities will start moving in.
11 We've -- we've had contact, and they'll start
12 moving in once we have a system that allows them to move
13 in.
14 HEARING OFFICER HEBERT: I see, yes.
15 Okay. Mr. Baran, would this be a good time to
16 ask if you think we can wrap this up in the next 45
17 minutes?
18 MR. BARAN: Oh, I think we --
19 THE WITNESS: Easily.
20 MR. BARAN: -- most definitely.
21 HEARING OFFICER HEBERT: Okay.
22 MR. BARAN: We may want to take five minutes --
23 HEARING OFFICER HEBERT: I just didn't want
24 everyone to be starving.
25 MR. BARAN: -- just for -- just for -- I want to

Page 135

1 wrap up Mr. Walling's testimony on his report, and then
2 we'll just go and have a critique of the comments, and
3 then we'll be done, and I'm ready to go to that next step.
4 HEARING OFFICER HEBERT: All right. Let's do
5 it.
6 MR. BARAN: Okay.
7 BY MR. BARAN:
8 Q. So Mr. Walling, can you turn to page six of
9 Exhibit A?
10 **A. Yes, I can. Yep.**
11 Q. All right. And that's the summary of your
12 expert opinions?
13 **A. It is.**
14 Q. And that's a concise recitation of what you
15 testified to today?
16 **A. It is.**
17 Q. And is it your recommendation, based on the
18 application of sound actuarial principles and your
19 opinion, that these opinions should be adopted and that
20 the surcharges at the 80 percent confidence level for both
21 the hospitals and the physicians and surgeons should be
22 adopted by the Hearing Officer?
23 **A. It is.**
24 Q. Okay. And that the hospital rating plan should
25 be implemented and recommended by the Hearing Officer?

Page 136

1 **A. Yes.**
2 MR. BARAN: Okay. That's all I have for that
3 part of it, and we're -- we're going to turn to response
4 to comments, but if we could take five minutes before we
5 do that.
6 HEARING OFFICER HEBERT: Certainly.
7 MR. BARAN: Okay. Thank you.
8 (Recess was held from 12:09 p.m. until
9 12:12 p.m.)
10 HEARING OFFICER HEBERT: We can go back on the
11 record.
12 Mr. Baran, if you would continue, please.
13 BY MR. BARAN:
14 Q. Mr. Walling, do you have a copy of the
15 November 4th, 2019, comments submitted by the New Mexico
16 Hospital System?
17 **A. I do.**
18 Q. All right. I believe that those written
19 comments echo some of what we heard this morning.
20 I also believe that you have responded to some
21 of them already, but if we could just kind of go through
22 and have some concise responses to these comments --
23 **A. Sure.**
24 Q. -- one by one, that would be helpful, starting
25 with the comment that appears on the bottom of page one

Page 137

1 regarding the data used in the -- your analysis.
2 **A. So the comment here has to do with using non-PCF**
3 **data for the purpose of -- of PCF program ratemaking.**
4 **There's a couple of problems with this, and --**
5 **and -- and full disclosure: Back in -- when I first**
6 **started doing this work, this was the only way for us to**
7 **do PCF-level ratemaking.**
8 **We would go to AIG and to Medical Protective and**
9 **the leading PFC insurers at the time and they would send**
10 **us loss runs, and -- and we would use their data to**
11 **extrapolate the experience of the PCF.**
12 **It's -- it's not a preferred approach, but it is**
13 **a generally accepted approach kind of when -- when needs**
14 **warrant.**
15 **A couple of challenges here. One is getting**
16 **that prior claims experience from all of the hospitals**
17 **prior to their joining.**
18 **Similarly, if you're going to do it for the**
19 **hospitals, you also presumably would want the experience**
20 **for new physicians and surgeons that join the program for**
21 **the first time.**
22 **So the -- the technical challenge of getting**
23 **those -- those loss runs from prior to a health care**
24 **facility or a health care provider joining the PCF is --**
25 **is always going to be a technical challenge.**

Page 138

1 **You can issue data calls, but the data is in a**
2 **bunch of different formats. It's -- it's a nontrivial**
3 **exercise to get this additional data they're -- they're**
4 **suggesting.**
5 **It's also not -- not necessarily predictive of**
6 **what the claims experience is going to be like once a**
7 **provider or a facility joins the PCF.**
8 **The -- the dynamics in a courtroom when the PCF**
9 **is in play are different than when it's just a hospital's**
10 **insurance program at play.**
11 **We've seen this in a number of states that --**
12 **that the view of -- of a settlement or a verdict in a**
13 **large medical professional liability claim change when**
14 **it's a government insurance program as compared to when**
15 **it's, you know, the -- the hospital who has their -- their**
16 **insurance program.**
17 **The third issue, candidly, is, sometimes you get**
18 **counterintuitive results out of relying on that data in**
19 **that primary insurance layer.**
20 **A hospital working really hard to avoid large**
21 **losses and -- and contain them, control them to lower**
22 **severity, may actually be pulling claims out of the PCF**
23 **layer and restricting them to the retained layer, and you**
24 **may actually not see much of a change in the primary layer**
25 **even though they're making substantive changes in the PCF**

Page 139

1 **layer.**
2 **So I -- I worry a little bit that using non-PCF**
3 **data may actually give you some -- some mixed signals**
4 **or -- or some signals that are counterintuitive to what --**
5 **what hospitals are really doing in the excess layer.**
6 **I think for that reason I'd really rather lean**
7 **on the data for all of the hospitals together -- as you**
8 **saw in the rate level indications -- but restrict it to**
9 **the PCF layer.**
10 **There's always a bit of a disconnect about the**
11 **-- the data in that primary layer not being perfectly**
12 **correlated to what's going on in the excess layer.**
13 Q. So the second comment is very related to that.
14 Surcharge rates should be calculated on all available loss
15 information rather than only payments in the PCF layer.
16 What is your response to that?
17 **A. It's the same issue.**
18 Q. Okay. And then --
19 **A. Oh, actually, the one thing that is mentioned**
20 **here is the issue of the case reserves. I've got a real**
21 **problem with that, because you've got a bunch of different**
22 **third-party administrators and claims departments handling**
23 **these claims. They all have different philosophies of**
24 **what the case reserves need to be.**
25 **I -- I -- candidly, what we have found in the**

Page 140

1 **PCF data back when they were assigning case reserves was**
2 **that the paid loss data was actually more stable and more**
3 **predictable than the case reserves just because some of**
4 **these verdicts on the PCF layer claims are -- are**
5 **extremely volatile, and the case reserves add more noise**
6 **than they do signal.**
7 Q. Okay. The next comment, the concluding
8 sentence, I believe you've already addressed this.
9 **A. I have.**
10 Q. We propose that any phased-in surcharges be the
11 same for -- in terms of the phasing -- for hospitals and
12 for physician and surgeons.
13 So if the Hearing Officer concludes that they
14 should be phased in, you would agree that it should be
15 phased in equally for both?
16 **A. I agree.**
17 Q. Okay. Next comment, PCF experience
18 modification-based claim frequency requires defined claim
19 terminology, and this gets back to what I heard in the
20 oral comments about, what is a claim.
21 What is your response to this?
22 **A. There are notification requirements for PCF**
23 **coverage eligibility, and so the gatekeeper here on**
24 **whether a claim is a PCF layer claim is exactly that**
25 **criteria.**

Page 141

1 **So if we have notice of a claim that the**
2 **primary-layer carrier believes is potentially in the PCF**
3 **layer, I -- I think we do have a stable and consistent way**
4 **of defining what the -- what claims go into this**
5 **experience rating methodology --**
6 Q. Okay.
7 **A. -- so I think there's a way to do this.**
8 Q. And has that already been -- is that already
9 factored into your analysis?
10 **A. Yes.**
11 Q. Okay.
12 **A. And -- and that's what's shown in the -- that**
13 **data that's used in our experience rating plan analysis.**
14 Q. Okay. The next comment is, PCF experience
15 modifiers only based on claim frequency may lag actual
16 experience.
17 What's your response to that comment?
18 **A. I -- I strongly disagree with the idea that**
19 **lag -- remember what an experience rating plan is -- is**
20 **intended to do. It's intended to produce a more accurate**
21 **estimate of what next year's surcharges ought to be or**
22 **what next year's claims might be.**
23 **The problem with getting experience rating right**
24 **for a hospital or for anybody in the PCF layer is those --**
25 **those large claims are -- are very volatile and very**

Page 142

1 **unpredictable.**
2 **And so we actually tested a number of different**
3 **experience rating methodologies, several that looked at**
4 **the -- the loss dollars in the PCF layer, and candidly,**
5 **what we found was the loss dollars approach was too**
6 **volatile and it overreacted to prior claims.**
7 **It's noteworthy that work comp is the same way.**
8 **If you look at a workers' compensation experience rating**
9 **plan in almost every state in the union, it limits the**
10 **dollars of loss from each and every work comp claim.**
11 **So instead of doing that, instead of limiting**
12 **the dollars of loss and using a dollar approach, we**
13 **actually found that using the number of claims produced**
14 **something that was more predictive.**
15 **The idea here is that a hospital that is doing a**
16 **good job of controlling or mitigating those large losses,**
17 **that are putting the safety procedures in place, that**
18 **have, you know, loss control practices that are really**
19 **constraining those large claims, they don't see frequency,**
20 **and I want to reward that. I -- I want the experience**
21 **rating plan to reward that behavior that avoids claim**
22 **frequency in -- in the PCF layer.**
23 **To some extent, the severity of the PCF layer**
24 **claims for a hospital is -- is out of their control.**
25 **It's -- it's -- I -- I don't want to say it's entirely out**

Page 143

1 **of their control, but there's an element of volatility in**
2 **those settlement values that isn't something that a**
3 **hospital, with all the best intentions, can control.**
4 **So what I'd rather do is, if -- if I've got a**
5 **hospital whose frequency is substantially lower than**
6 **expected, I'd like to reward that.**
7 **Even if one of the -- one of the claims they**
8 **have had has had a very large value, I'm still seeing a**
9 **pattern of sustained behavior that helps me predict what**
10 **next year's surcharges ought to be, and it's that**
11 **sustained pattern of behavior I want the experience rating**
12 **plan to reward --**
13 Q. Okay.
14 **A. -- and that's frequency.**
15 **And -- and I guess I'll add to that I -- I find**
16 **the -- the idea of -- of frequencies lagging dollars**
17 **really misleading. Frequency is actually a leading**
18 **indicator of experience, not a lagging indicator.**
19 **Frequency will give you signal, but while those**
20 **loss -- you know, the -- the ultimate settlement values of**
21 **the claims may still be ten years away, so an experience**
22 **rating methodology based on claim counts actually gets you**
23 **to the right answer a lot faster than doing it on dollars**
24 **would.**
25 Q. Okay. And just for the record, what is the PCF

Page 144

1 layer?
2 **A. I don't remember right now.**
3 MS. KRYLOVA: Two hundred.
4 **A. I'm sorry; it's -- it's in excess of $200,000.**
5 Q. There we go.
6 THE WITNESS: Thank you.
7 BY MR. BARAN:
8 Q. So the next comment, experience modification
9 should not be limited to those with manual surcharges
10 greater than $1,500,000, and this pertains to the rating
11 plan in which there can be an experience rating benefit
12 for certain larger facilities.
13 What's your response to this comment?
14 **A. So work comp experience rating plans**
15 **nationally -- and actually, general liability and auto**
16 **liability experience rating plans as well -- either have**
17 **an eligibility requirement or they have a minimum**
18 **threshold to qualify for experience rating.**
19 **So this approach of using an eligibility**
20 **standard is something that is -- is commonly seen in**
21 **commercial insurance -- commercial casualty insurance**
22 **products.**
23 **Another way of thinking of this is that for a**
24 **small stand-alone outpatient facility, their data just**
25 **simply isn't credible enough to -- to warrant getting**

Page 145

1 **experience modification.**
2 **So if we applied some kind of credibility**
3 **methodology here, the indicated experience modifier would**
4 **always be one, that there just simply isn't enough data to**
5 **warrant a material experience modification.**
6 Q. Is it possible that as outpatient facilities
7 come into the plan and we get more data on those that the
8 plan could be amended for accounting for more credible
9 data?
10 **A. Sure, and I -- but I guess I would add, you're**
11 **only going to -- you're -- you're only going to see small**
12 **modifications in the indicated premium for those smaller**
13 **outpatient facilities just because the data isn't very**
14 **credible.**
15 Q. Okay. Next comment, the PCF needs to clarify
16 how it will allocate claims between hospitals and
17 physicians to avoid double charging. I also heard that in
18 comments this morning.
19 What is your response to this?
20 **A. And I -- I -- I disagree with the statement.**
21 **I -- I think there is already a process.**
22 **When the claim comes back from the courts, when**
23 **it comes back from the settlement, the documentation that**
24 **the PCF receives includes a clear and unambiguous**
25 **allocation of the dollars to the hospital and to the --**

Page 146

1 **any and all providers that are involved.**
2 HEARING OFFICER HEBERT: Mr. Walling --
3 THE WITNESS: Yeah.
4 HEARING OFFICER HEBERT: -- you -- you keep
5 referring to the W-2, the employees of the hospitals --
6 THE WITNESS: Correct.
7 HEARING OFFICER HEBERT: -- the physicians.
8 So in -- in that answer you just gave, are you
9 distinguishing between the hospital and non-employee
10 doctors?
11 THE WITNESS: Oh, I was just using that as an
12 example.
13 If you're having a settlement that -- that comes
14 out that names a hospital and an unaffiliated physician,
15 I -- I believe the verdict also assigns it that way for
16 the purpose of the two insurance programs coming into play
17 as well.
18 HEARING OFFICER HEBERT: Okay.
19 BY MR. BARAN:
20 Q. So the remainder of the comments reference
21 specific parts of your report, and page 16, there is a
22 comment concerning the exposure presented by physician
23 groups.
24 And I believe you've already covered this, but
25 if you want to comment on this additionally, that might be

Page 147

1 helpful.
2 **A. You know, it's -- it's interesting that there's**
3 **some question stated in this comment about whether the ten**
4 **percent charge is too high. I'm actually concerned that**
5 **it's too low, and -- and the concern here is that the**
6 **entity coverage makes it easier to breach the PCF layer.**
7 **And so when you're adding in the errors and**
8 **omissions of non-named health care providers, when you're**
9 **adding that corporate coverage when they dictate practice**
10 **guidelines, the chances of a claim breaching the layer**
11 **actually increased.**
12 **So if anything, a ten percent surcharge in the**
13 **primary layer -- which is fairly common -- may actually**
14 **suggest a surcharge of more than ten percent in the excess**
15 **layer, not less.**
16 Q. Okay. Page 17, there's a comment concerning the
17 shortfall.
18 Can you address that?
19 **A. We believe the PCF should charge adequate rates;**
20 **I agree. We believe they should collect surcharges at**
21 **expected levels to reduce future deficits; I disagree.**
22 **I don't -- I don't think the expected level is a**
23 **strategy that -- that allows you to reduce future**
24 **deficits. There's -- there's too much of a potential for**
25 **the actual losses to be higher than the collected**

Page 148

1 **surcharges.**
2 Q. Can you flesh that out a little bit? Does that
3 relate to the surplus deficit position discussion that you
4 were testifying about earlier?
5 **A. Not really. I mean, I guess to the extent that**
6 **funding at a higher confidence level increases the**
7 **likelihood that you're going to generate an underwriting**
8 **profit in a future accident year, that does increase the**
9 **chance of reducing the deficit in future years, but that's**
10 **not why you're doing it.**
11 Q. Okay. Page 31, another comment about data.
12 Can you respond to that?
13 **A. It really speaks to that same issue of using the**
14 **non-PCF layer data. There are benefits that I -- I think**
15 **I've already gotten on to the record.**
16 **You've got more claims volume, and you can kind**
17 **of marry what's going on in the primary layer to what's**
18 **going on in the PCF layer.**
19 **Conversely, the lack of consistency in the**
20 **underlying data, the differences in claims handling**
21 **methodologies, and the -- the cross signals of -- of**
22 **organizations doing a better job of restricting claims to**
23 **the primary layer all increase the volatility and -- and**
24 **offset the benefits.**
25 Q. Okay. And then on page 64, there's a comment

Page 149

1 concerning the 100.4 percent --
2 **A. I've already explained that.**
3 Q. Okay.
4 **A. That's -- I need all of the years of the data**
5 **for the hospital program because it's got less**
6 **credibility, it's got less predictive accuracy than the**
7 **physicians do.**
8 **I very intentionally omitted the 2009 and '10**
9 **physicians data for a very sound reason. I -- I think my**
10 **selections of the expected loss ratios for both programs**
11 **are reasonable and internally consistent.**
12 Q. Okay. And is that the same response to the
13 comment concerning your opinions on 66 and 67?
14 **A. No. Well, sort of. The approach we've taken**
15 **for the reserve analysis and for the funding analysis is**
16 **to look at all of the PCF claims data in total in terms of**
17 **getting the timing of the claim closures, the timing of**
18 **the claim reporting, the timing of the claim payments.**
19 **Right now the hospitals don't have sufficient**
20 **data for us to develop a stand-alone loss development**
21 **pattern for the hospitals.**
22 **I don't have any reason to believe that the**
23 **hospitals and -- and the providers have materially**
24 **different loss development behaviors, so until I've got**
25 **more credible data, it's -- it's -- it's more important to**

Page 150

1 **increase the credibility of the data by combining it than**
2 **it is to increase the homogeneity of the data by -- by**
3 **separating it.**
4 Q. Okay. The next comment concerns the
5 relativities proposed on page 96.
6 Do you have a response to that comment?
7 **A. Just because there's variability in the**
8 **competitive benchmarks we use doesn't in any way infer**
9 **that our selections aren't reasonable.**
10 **If you go pull State Farm, Allstate, and GEICO**
11 **filings for personal auto, they all have a different**
12 **opinion of -- of how safe or dangerous a Tesla is. They**
13 **all have different opinions about how dangerous or safe**
14 **personal auto insurance in Taos is.**
15 **And so the fluctuations that we saw in that**
16 **competitive benchmarking weren't unexpected, they weren't**
17 **unreasonable, and they don't affect the actuarial**
18 **soundness of my selections.**
19 Q. Okay. Page 98.
20 **A. Candidly, the issue here has entirely to do with**
21 **how green, how undeveloped 2017 and '18 are. It's just**
22 **simply that while you're within the statute of**
23 **limitations, it takes a while sometimes for those claims**
24 **to be reported.**
25 **We've made the decision in a lot of places in**

Page 151

1 **our analysis to limit the role that 2017 and '18 play in**
2 **our analysis because there's so little we know.**
3 **Early in my testimony we identified that zero**
4 **dollars had been paid on accident year 2018 claims, and**
5 **only half a million dollars had been paid on accident year**
6 **2017 claims by the end of 2018.**
7 **It's exactly that lag -- that reporting lag,**
8 **that settlement lag, that is causing us to -- to not lean**
9 **very heavily on the 2017 or '18 years.**
10 **It's also important to -- to recognize -- and**
11 **I -- I -- I was kind of mystified when I saw this -- the**
12 **expected claims per -- per exposure being too high here**
13 **would actually be to the hospital's benefit.**
14 **This is the standard we're holding the hospitals**
15 **to. If -- if my number is too high, then the hospitals**
16 **are going to realize experience credits, so I'm -- I'm not**
17 **quite sure why -- why they're worried about that my -- my**
18 **selection here being too high.**
19 **If anything, they ought to be worried about it**
20 **being too low. Me selecting a frequency number that is**
21 **too high is actually to the hospital's benefit.**
22 Q. Okay. So on page number 104, I believe you've
23 already addressed this, the difference between frequency
24 and magnitude in the experience rating, but if you want to
25 touch on that again.

Page 152

1 **A. Yeah, I've got nothing to add on that.**
2 Q. Okay. So now, on October 16th --
3 **A. Uh-huh.**
4 Q. -- we received some comments from Donald
5 Letherer.
6 Do you have any response to his comments?
7 **A. I -- well, let's -- let's take these apart.**
8 **Comment one, where he's talking about experience rating**
9 **plans, I'm -- I'm not sure he's really -- I'm not sure**
10 **what he's getting at in -- in number one. I -- I don't**
11 **know that I have any response to it.**
12 **Number two, I have a real problem with the**
13 **allegation that this is on a cash basis or a pay-as-you-go**
14 **basis. The PCF is -- is on an accrual basis, and any move**
15 **towards cash basis treatment of the Patient Comp Fund I've**
16 **got a real problem with.**
17 **Cash basis programs inherently always end up**
18 **being kind of hand to mouth, having just enough money to**
19 **pay this year's claims, and -- and oftentimes build up**
20 **huge unfunded liabilities.**
21 **The New Mexico Medical Indemnity Fund currently**
22 **has billions -- with a B -- dollars worth of unfunded**
23 **benefits payments that they have promised to families**
24 **of -- of injured infants, and they've got nothing but a**
25 **promise that there will be money in the budget to pay that**

Page 153

1 **20 years from now, so I -- I have real concerns about the**
2 **idea of -- of any kind of pay-as-you-go program.**
3 Q. All right.
4 **A. Is there anything else in there that --**
5 Q. I think that was it. So --
6 **A. I also disagree with the statement that Indiana**
7 **is pay-as-you-go. I -- I don't believe it is.**
8 MR. BARAN: And -- and just for the record, I
9 wanted to clarify that although this appears to be from
10 Ms. Carlova and the PCF staff, it was a forwarded message
11 from Mr. Letherer, so it is Mr. Letherer's comments and
12 not the comments of PCF staff.
13 HEARING OFFICER HEBERT: Yes.
14 BY MR. BARAN:
15 Q. All right. So we had an earlier scheduling
16 hearing, and during that hearing the Hearing Officer was
17 asked -- asked us to let her know how many carriers are
18 currently in the PCF.
19 If you'd take a look at page two of Exhibit E,
20 and is that the current list, as you understand it, of
21 participating underlying carriers?
22 **A. So -- so the list here I -- I -- I believe to be**
23 **a fair and accurate representation of the carriers that**
24 **are contributing to the PCF or -- or have -- have insured**
25 **risks that are eligible for PCF coverage.**

Page 154

1 **I -- I do want to point something out here.**
2 **It's -- it's hard within the context of this list to**
3 **identify how much risk is coming from each of these**
4 **sources.**
5 **You'll see a number of -- of carriers listed**
6 **here that are risk retention groups. Those risk retention**
7 **groups are federally regulated insurance companies that**
8 **are outside the regulatory purview of -- of the New Mexico**
9 **State Office of the Superintendent of Insurance. They**
10 **tend to be smaller.**
11 **You'll also see some regional carriers. I'll**
12 **identify MagMutual, which is Georgia and the Carolinas**
13 **predominately, Norcal, which is Northern California, and a**
14 **few others here that don't contribute very much risk in**
15 **terms of the number of -- of insureds into the program.**
16 **Conversely, you'll see Medical Protective and --**
17 **and The Doctors Company. The Doctors Company, when they**
18 **purchased AP Capital a number of years ago, took over a**
19 **very large program from AP Capital, and Medical Protective**
20 **has always been a very large carrier within the PCF -- or**
21 **at least for the last 17 years.**
22 **Finally, number four, National Union Fire is a**
23 **statutory company within AIG, and again, AIG has been a**
24 **carrier contributing to the PCF for a lot of years.**
25 Q. So we're asking the Hearing Officer to approve a

Page 155

1 rate increase.
2 Whether or not -- if there is a rate increase
3 proposed to the superintendent, would it be reasonable to
4 allow 60 days for carriers, providers, and hospitals to --
5 before those new rates would go into effect?
6 **A. At -- at least. We're going to have to look at**
7 **the insurance contracts themselves and make sure that we**
8 **respond to the mandatory notification lead times and so**
9 **on.**
10 **I mean, a lot of commercial insurance policies**
11 **have either 60 or 90-day notice requirements for letting**
12 **them know that there's going to be an increase --**
13 Q. Okay.
14 **A. -- so if we're going to follow form with what**
15 **commercial carriers do, yeah, I think that's absolutely**
16 **prudent.**
17 MR. BARAN: Okay. At this point I would like to
18 offer Exhibits A through E into the record.
19 HEARING OFFICER HEBERT: Exhibits A through E
20 are admitted.
21 (Exhibits A through E admitted into evidence.)
22 HEARING OFFICER HEBERT: And Mr. Baran, I -- I
23 know you gave me the exhibits, but you didn't give the
24 court reporter the exhibits. I would like to keep the
25 exhibits.

Page 156

1 MR. BARAN: Okay.
2 HEARING OFFICER HEBERT: Can you get another
3 set --
4 MR. BARAN: We will --
5 HEARING OFFICER HEBERT: -- for the court
6 reporter?
7 MR. BARAN: -- we will get a set for the court
8 reporter.
9 HEARING OFFICER HEBERT: Okay. Thank you. And
10 before we conclude this, I would like -- do you happen to
11 have the order of September 30th with you?
12 MR. BARAN: I did not bring that.
13 HEARING OFFICER HEBERT: Okay. I'm just going
14 to -- I'm just going to then just -- that order identified
15 that the written testimony that you filed on October 7th
16 was to cover six -- six issues, and I believe we have --
17 MR. BARAN: I believe we have.
18 HEARING OFFICER HEBERT: -- but I just want to
19 confirm that it's your understanding that we have covered
20 the six issues identified in that order --
21 MR. BARAN: It is my understanding --
22 HEARING OFFICER HEBERT: -- correct?
23 MR. BARAN: -- that we have.
24 HEARING OFFICER HEBERT: Okay.
25 MR. BARAN: Thank you.

Page 157

1 HEARING OFFICER HEBERT: Great. All right. So
2 I believe at this time, if you have no other witnesses to
3 call -- do you have any?
4 MR. BARAN: I -- I do not have any additional
5 witnesses and that's all our housekeeping, so --
6 HEARING OFFICER HEBERT: It is all of our
7 housekeeping.
8 Under the APA -- the Administrative Procedures
9 Act -- findings of facts and conclusions of law are
10 required, so I would ask that you provide those.
11 And I don't -- ten days, would that be adequate
12 time? Will you --
13 MR. BARAN: It would not.
14 HEARING OFFICER HEBERT: Well, we have
15 Thanksgiving; is that --
16 MR. BARAN: Yes. I'll be out from the 22nd
17 through the 1st, so I'd be looking at mid-December at the
18 earliest.
19 HEARING OFFICER HEBERT: Okay. Now, I think
20 there was some concern about getting a recommended
21 decision to the superintendent by the end of the year. I
22 think that can still be done --
23 MR. BARAN: Okay.
24 HEARING OFFICER HEBERT: -- but if -- if you
25 were to get the findings of facts by December 12th. I

Page 158

1 don't know what dat that is. Is that a weekday? Weekend?
2 Would that give you enough time?
3 THE WITNESS: The 12th is a Thursday.
4 MR. BARAN: Can we go to the 13th?
5 HEARING OFFICER HEBERT: The 13th it is.
6 If there's no one else -- anyone in this room
7 who wants to make a comment on this matter? If not, we
8 will conclude this hearing.
9 Thank you all for your attendance and your
10 testimony.
11 MS. KRYLOVA: Thank you.
12 MR. BARAN: Thank you.
13 (Proceedings concluded at 12:41 p.m.)
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Page 159

1 REPORTER'S CERTIFICATE.
2
3 I, REBECCA FELLA, NM CCR #534, DO HEREBY CERTIFY
4 THAT I did, in stenographic shorthand, transcribe the
5 proceedings set forth herein, and the foregoing pages are
6 a true and correct transcription to the best of my
7 ability.
8 I FURTHER CERTIFY that I am neither employed by
9 nor related to nor contracted with (unless excepted by the
10 rules) any of the parties or attorneys in this matter, and
11 that I have no interest whatsoever in the final
12 disposition of this matter,
13
14
15
16 REBECCA FELLA, NM CCR #534
17
18
19
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23
24
25

A

a.m 1:14 73:1,2
ability 53:15 159:7
able 28:23 30:15 46:19,22 52:23 53:12 69:19 112:19 113:6 128:22
absolutely 108:2 129:11 155:15
Academy 34:20 48:7,13
accept 22:8 109:2
accepted 113:13 124:7 137:13
accessing 26:20
accident 54:7,14 57:2,6 58:13,24 64:23 148:8 151:4,5
accidents 58:11 61:9 101:2,9
Accountability 38:2
accounted 95:24
accounting 145:8
accounts 30:10,17 114:9,16,25 115:15
accrual 152:14
accuracy 149:6
accurate 129:15 141:20 153:23
accurately 41:17 129:3
across-the-board 86:20 92:8
act 4:14,16 26:2 59:14 76:10 157:9
actions 109:21
activities 37:5
acts 75:25
actual 7:2 12:14 15:15 16:18,19 26:5 32:9,11 44:14 58:5 68:12 70:8 96:9 97:10 141:15 147:25
actuarial 4:3,4 26:10,17 27:4,6 28:1 32:20 34:19 36:18 40:8,12 47:23 48:15 49:3,12 50:9,18,20 51:14 54:12 65:23 82:21 86:2 94:17 99:25 103:12 105:21 109:9 112:20 113:4,10 116:20 122:20 126:16 127:13 133:13 135:18 150:17
actuarial-sound 70:22
actuarially 25:20 43:24 66:2,8 87:20 90:16,16 92:7 100:8 103:19 104:9 122:23 123:8 127:15 129:24 130:3,25 133:18
actuaries 27:24 34:20,22 35:13 48:7,13,25 49:1,2,5 51:11 53:5 58:3 65:17 85:10 128:4
actuary 19:14 24:13 25:2 35:2,3 35:3,21 39:18 40:17 41:15 48:20 51:5,15 109:8 116:14 131:22 133:13
actuary's 67:12
acupuncture 22:12
acupuncturist 22:19
acute 47:9 123:22 124:9,21 125:1 125:3 126:4,21,22 127:11
add 7:13 14:15,22,22 64:16 72:17 78:20 82:20,24 110:6 119:17 132:1 133:3 140:5 143:15 145:10 152:1
added 67:4
adding 131:11 147:7,9
addition 4:2 97:24 130:9
additional 7:13 13:3,6 20:19,20 20:20 29:17 40:23 41:8 59:17 59:21 60:1 75:11 79:5,21 81:24 82:4 84:7 87:5 89:17 95:2,25 102:4 103:1 107:9,12 138:3 157:4
additionally 146:25
address 25:2 33:11 77:19 103:14 112:2 118:11 147:18
addressed 77:16,20 112:11 140:8 151:23
addressing 25:5 104:4
adequate 131:10 147:19 157:11
adjacent 61:4
adjust 15:12 73:22
adjusted 8:4 13:16 18:18 27:6 28:5
adjustment 79:18,23 80:6,21 91:13,14
adjustments 10:12 67:19 97:9
administers 97:7
Administrative 4:14 157:8
administrators 139:22
admitted 35:24 36:6 40:4 70:3 92:24 128:25 132:7 155:20,21
adopt 100:4 102:18
adopted 100:2 102:10,17,23 135:19,22
adopting 82:11 103:11 107:17
adoption 109:14
advantage 32:19
advantages 80:12
advised 99:25
advocacy 25:19
aerospace 22:16,20
affect 15:15 53:22,22 150:17
age 110:17
agent 94:14
aggegation 80:17
aggregations 77:6
ago 113:5 154:18
agree 140:14,16 147:20
agreed 5:16 98:9 109:25
agreement 105:19
ahead 26:11 33:20 78:22
AIG 137:8 154:23,23
akin 70:24 102:19
Albuquerque 1:21 3:22
algebraic 99:12
algebraically 80:19
algorithm 112:22 128:9,19
allegation 152:13
allied 95:2
allocate 31:1,22 32:17 46:20 145:16
allocated 105:3
allocating 47:7 118:19
allocation 32:13,21 118:14 145:25
allow 14:16 124:23 125:4 155:4
allowed 4:22
allows 14:7 34:11 53:15 134:12 147:23
Allstate 150:10
amalgamation 133:6
amended 145:8
American 34:20 48:7,13
amount 7:5,14,23 9:16 10:20,22 11:14 12:8 13:3 14:8,9,13 16:10 20:8 21:16 60:19 71:10 72:10 88:3,12,17 89:6 101:12 102:16
amounts 6:17,18 7:15 14:16 71:25
analogous 36:10
analysis 4:3 37:11 40:8 50:7 53:25 55:11 56:8 61:14 62:20 63:8,12 64:2,10 65:2,6,6 67:11 73:10,11,15 81:11,12 84:14 89:21 94:24 103:2 104:15 117:7

119:18 123:13 128:23 129:16 130:23 133:13 137:1 141:9,13 149:15,15 151:1,2
analytical 43:3 44:2 47:17 54:2
analytics 35:15
ancillary 110:15
Anna 19:14 105:8
annual 7:4,5 9:18 10:7 11:12 60:20 105:20
annually 48:7 73:24
answer 90:8 109:9,9 143:23 146:8
anticipated 28:8,17,18,20 63:16 67:6
antiquated 88:1
anybody 4:20 66:18 141:24
anybody's 76:24
AP 154:18,19
APA 157:8
apart 152:7
Apodaca 1:15
apologize 45:17 66:13 100:25 117:25 126:19
appear 61:4
appearance 4:24
appears 9:5 12:1,20 30:3 136:25 153:9
apples 62:15
apples-to-apples 68:4
applicable 89:4
application 99:24 135:18
applied 25:21 30:13 51:20 70:4 145:2
applies 18:14 83:18
apply 7:16 26:19 30:4,9,16 45:2 48:24 71:2 98:18 99:8 114:20 114:23 115:12,13 122:18
applying 70:10 129:3
appointing 3:14
appreciate 24:25
approach 44:12,16 46:1 47:4 50:17 71:7,24 72:6,7,13 86:24 87:8,25 93:9 107:1 115:11 116:2 117:23 124:2 128:10 129:20 133:4,11 137:12,13 142:5,12 144:19 149:14
approaches 103:23
appropriate 60:8 86:1 113:6
approve 154:25
area 17:24
arguable 31:13
arms 123:24
articulated 51:22
aside 28:15
asked 15:7 33:14 48:18 57:5 61:15 62:9 70:2 83:15,21 112:8 112:14 117:13 153:17,17
asking 11:16 154:25
ASOP 49:11,18,25 50:6,9,14,19
ASOPs 51:7
aspect 113:2
aspects 7:11 35:4 37:15 112:10
assemble 52:23
Assembly 39:13
assessed 7:3 10:12 68:12
assessment 86:7 91:25 98:14 102:21 104:5 121:13,20 123:15
assessments 78:8 121:15 132:10 132:11
assets 42:5 100:16
assign 114:12
assigned 7:2 18:2
assigning 140:1
assignment 34:2 40:15,19 48:17 52:4 118:19
assigns 146:15
Associate 2:3
associated 66:3 67:3 87:23 109:20
Associates 1:20
Association 4:11 24:15,19 25:15 25:19 38:4,6 39:15 44:14 45:25
Association's 60:3
assume 41:18
assuming 78:7,7
assumption 53:17
attached 4:4
attaches 36:11
attendance 158:9
attended 3:25
attest 48:8
attorneys 4:23 159:10
attractive 133:19
Audi 93:14
audit 15:4
auto 71:4 93:11 113:21 144:15 150:11,14
automatically 17:17
available 26:4,22 42:3 43:22 74:5 77:23 83:11 100:16 101:12 127:12 139:14
average 85:9
avoid 138:20 145:17
avoids 142:21
aware 53:20
awful 44:25 77:13 118:3

B

B 2:19 13:25 19:10,18 31:8 152:22
back 27:21 37:18,22 39:12 40:15 41:2 46:20 48:21 58:8,19,19,20 59:2,6,7 60:15 64:1 65:9,12 66:6 67:13 70:18 71:13 72:16 72:19,20 73:3 77:10 82:3 83:20 84:13 85:20,22 89:16 90:6,19 92:14 95:23 106:18,19 118:18 122:20 125:17 126:15 136:10 137:5 140:1,19 145:22,23
backing 125:11
backwards 117:12
bad 114:24
bailiwick 103:24 128:4
balance 80:24 100:15 101:11
balanced 72:7
balancing 42:4
Baran 2:5,10,14 5:1,1,4,7,10,20 6:1 9:3 14:4 19:1,5,7,9,12,16,17 20:22 22:23 23:1,16 24:1,3 25:5 25:8,10 33:2,4,9,19,23,25 52:2 52:7,8 57:10,24 59:18 62:9 63:7 63:23 68:21,24 69:1,3,5,8 72:15 72:22,25 73:7 74:25 76:25 82:17 89:11 108:6 110:10,13 112:6 120:9 122:1,3,5 126:2 131:23,25 132:2,5,16,19,21,25 133:2 134:7,15,18,20,22,25 135:6,7 136:2,7,12,13 144:7 146:19 153:8,14 155:17,22 156:1,4,7,12,17,21,23,25 157:4 157:13,16,23 158:4,12
Barren 73:5
base 2:19 6:22 7:1,14 8:19 9:17 9:18 10:4,7 11:5,19 12:5,8,9,24

13:14 14:8 15:8 17:18 18:7,13 18:14 20:1,4,10 22:20 45:1 87:6 90:24 91:17 93:8,13,16 94:20 97:7,8,14,21 98:8,11 99:2,2,8 99:17,19 123:22 125:6,6,12 126:3
based 7:17 8:23 11:9 13:5 14:18 16:9,11 17:13 27:6 29:13 30:2 30:14 32:15 43:21 47:8 56:19 57:11 58:6,7 61:19 77:10,22 82:21 86:22 90:10,11,23 93:15 93:20 95:6,12 99:24 106:15 108:16,22 113:17,19,24 115:2 116:15 120:25 124:9,12,15 125:2 127:13 128:22 129:15,16 135:17 141:15 143:22
bases 52:11
basically 6:19 14:10 28:15 57:22 79:13 90:14 98:13 125:12,21
basis 28:6 29:2 53:1 56:14,15 73:18 74:3 84:20 93:23 101:5 129:22 131:8 152:13,14,14,15 152:17
batch 75:22 77:18 80:15 108:19
Bean 1:20
bed 123:23 124:21,25,25,25 125:1,3 127:11,11
beds 47:9 124:9,9 126:4,21,22
began 18:9
beginning 7:20 9:14 11:25 14:25 21:20 79:11
begins 7:21 68:10
behalf 33:16 41:21,23 42:12,14 43:4,7 44:18,19
behave 37:16 40:5 51:11,12,13 59:4
behaves 36:2
behaving 51:15
behavior 75:25 76:21 103:7 142:21 143:9,11
behavioral 111:3
behaviors 149:24
believe 23:5 25:1,17 26:18 29:6 32:23 101:3 127:15 132:22 136:18,20 140:8 146:15,24 147:19,20 149:22 151:22 153:7 153:22 156:16,17 157:2
believes 141:2
benchmarking 89:25 90:11 93:24 150:16
benchmarks 94:6 150:8
benefit 74:1 83:20 144:11 151:13 151:21
benefits 40:23 41:8,16 52:22,25 61:12 73:19 74:15 75:12 80:4,8 80:11 101:13,25,25 102:4 148:14,24 152:23
best 81:15 109:9 111:1 133:25 143:3 159:6
better 103:11 119:20 126:20 148:22
beyond 133:17
bias 123:3
big 41:3 80:1 92:24 93:2 133:8
billions 152:22
birth 37:9,12 38:14 39:8,22
birth-related 37:14 39:5
bit 6:9 41:1 43:12 55:10,14 59:25 66:22 90:23 92:10,11 96:13 110:2 113:8 117:12 139:2,10 148:2
black 76:2
Bloomington 33:13
blow 83:6
board 7:9 36:25 37:1 38:24 48:10 49:3 98:15
bottom 19:25 23:12 36:24 48:22 49:8 69:21 80:23 99:5 128:19 136:25
box 2:4 16:16
brain 66:6 96:14
brand 51:14
breach 147:6
breaching 147:10
break 72:22,24 79:19
brief 39:11
bring 11:2 68:6 70:5 156:12
bringing 103:3 108:17,22
broadly 83:19
broken 118:23,24
brought 48:18 68:13
Bruce 24:9 41:10
budget 152:25
buggy 111:19
build 152:19
built 16:13 97:8,13
bunch 138:2 139:21
bureau 94:16
business 49:7 109:14
business's 113:16
buy 80:20

C

C 2:1,20 9:1,4,8 14:2,4 19:2,6,23 21:11 31:9
calculate 14:21
calculated 15:2 139:14
calculating 29:20 31:9
calculation 15:1 26:17 29:20 32:20 128:19
calculations 14:20
calculator 11:2
California 154:13
call 5:21 33:3,5 71:15 75:22 76:1 88:7 157:3
called 77:18 113:15
calls 111:19 138:1
cancellation 10:2
candidly 39:17 76:18 77:16 80:1 94:2 118:15 119:2 121:2,7 138:17 139:25 142:4 150:20
capacity 3:8
Capital 154:18,19
captions 50:22
Captive 24:11
car 27:21
Cardiac 96:18
care 24:11 40:3 45:7 47:9 59:12 59:13 63:4 69:16 70:13 90:12 93:19 96:17 110:19,20 111:15 111:20 112:24 123:22 124:9,9 124:10,21,25,25 125:1,3 126:4 126:21,22 127:11,11 137:23,24 147:8
Carlova 153:10
Carolinas 154:12
carrier 13:22 14:7,12,16 16:23 141:2 154:20,24
carrier's 15:1
carriers 15:11 20:14 37:20 70:20 94:5 124:6 153:17,21,23 154:5 154:11 155:4,15
carriers' 6:14
CAS 36:25 37:2 47:21 48:13

49:10 51:9 65:13
case 3:5,15 26:14 28:14,14 37:9 60:4,5,11 116:16 125:7 132:8 139:20,24 140:1,3,5
cases 87:12 111:4
cash 152:13,15,17
cash-flowed 61:10
casualty 34:18 35:2,3 36:15,18 51:14 75:4 144:21
catastrophic 76:2,23 107:23 108:16,23
catch 5:15
categories 50:4
categorized 62:20
caused 31:15,15
causing 151:8
caution 84:6 101:23
CCR 1:20 159:3,16
center 97:15
centers 47:12
central 81:15 83:23 84:17,19,19 84:22 86:6,8 91:12 92:1,2 96:5 102:19 106:8,9,10,15,19,21 107:2,18 121:14 122:10
cents 79:11
certain 89:1 102:15 132:6 144:12
certainly 5:6 25:16 35:25 37:19 76:23 84:18 103:23 104:2 107:19 109:13,16 118:23 136:6
certainty 82:4
CERTIFICATE 2:15 159:1
CERTIFY 159:3,8
challenge 27:24 119:2 137:22,25
challenges 109:7 137:15
chance 148:9
chances 147:10
change 7:16,22 43:2 45:18 53:21 53:21,24 78:7,8,8,13 83:1 86:5 87:8 90:17,24 91:24 92:8,12 97:21 98:1,15 105:3 121:13 126:5 131:11,13,14,16,18,20 138:13,24
changed 7:10 14:6 95:18
changes 10:20 68:18 69:14,18,20 70:4 83:22 84:8,8 86:24 87:2 91:11 95:24 96:11,11 98:18,19 99:20 103:7 104:16 112:18 113:5 129:21 138:25
changing 69:25 91:1
characteristics 36:5
characterization 41:2
characterize 108:14
charge 16:2,3 20:18,21 89:16,17 90:2 104:9 114:5 147:4,19
charged 70:20
charges 13:2 89:19,22
charging 43:23 90:9 104:5 145:17
checkbook 42:4
chief 19:14
chime 25:22
chosen 60:14 106:24
CHRISTUS 69:22 119:3 133:6 134:5
circle 72:19,19
circumstances 31:7,18,18
cited 65:13
citing 64:11
claim 7:12,13 12:25 13:1,3,3,11 13:13 14:14,21,23 15:24,24 16:1 20:19 21:16 28:16,19 29:15,19,22 30:4 31:3,8,11,14 52:20,21 60:9,10,11,12 76:3 83:5 110:16 114:2 138:13 140:18,18,20,24,24 141:1,15 142:10,21 143:22 145:22 147:10 149:17,18,18
claimants 75:24
claims 8:9 10:22 13:5,9 14:15 15:21,23 18:18 21:1,7 22:1 27:17 28:3 34:6 35:8,8 37:15 40:21,23,23,24 41:8,11,13,18 42:2,3,11,18,21,23 49:22 50:2 52:14,19,20,24 53:14,17 54:3 54:21,24 55:16 56:10,13,19,20 56:22 57:9,11,13,14,15 58:5,6 58:13,18,23,25 59:1,3 60:6,22 60:22 61:1,7,12,19 67:5,21 73:16 74:6 75:9,22,23 76:18,20 77:14 79:6 80:22 81:19 93:3,15 93:20,22 94:2 100:14,16 101:2 101:9 102:4 107:23 108:12,13 108:16,19,23 111:9 114:12,17 114:24 116:15 117:21 118:14 118:19 119:12,15 121:6 133:5,8 137:16 138:6,22 139:22,23
140:4 141:4,22,25 142:6,13,19 142:24 143:7,21 145:16 148:16 148:20,22 149:16 150:23 151:4 151:6,12 152:19
clarified 24:24,24
clarify 27:12 28:24 31:1 108:7 145:15 153:9
clarifying 78:25
clarity 29:15 30:5 50:19
clash 80:14
class 9:10 17:6,7,8,8,10,15,15,17 17:18 18:1,4,15 20:6,8 22:10,13 22:17 43:14 84:8 86:25 91:13 91:23,24 93:7,8,13,16 94:18,21 95:6,9,12,15 96:21,22,24 97:17 98:1,6,12,19 99:1,2,3,8,20 115:3,5
classes 94:23 95:2 96:15
classification 22:5 49:13,18 94:17
classifications 88:13 91:2
clear 29:18 63:25 104:7 130:17 145:24
clearly 111:15
client 19:13 39:10,12
client's 27:9
close 75:15
closed 53:14,18 59:23
closures 149:17
cluster 76:20
code 9:11,22 14:18 17:11,13,16 17:20,23 18:15 22:9 51:9,19
codes 7:7 9:23
codification 128:6
codify 49:1 128:25
cohort 95:21
cohorts 57:7
coin 81:23
collect 26:15 147:20
collected 55:9 58:15 68:1 74:12 74:14 147:25
collectively 46:15 69:23
column 9:17 10:4,6,14,18 11:18 12:23 13:8 15:21 16:5 17:19 18:12 20:23 56:6 58:10,21 60:16 64:3,3,4,24,25 68:11 74:7 74:7 100:22 101:1 124:7,23 126:12 127:8

columns 54:9 97:15
combination 28:13 115:18
combine 32:10
combined 32:12 62:12 119:23 134:8
combining 150:1
come 11:14 33:14 129:1 133:20 145:7
comes 19:19 25:10 50:1 65:18 66:20 96:18,23 113:12 118:18 145:22,23 146:13
coming 55:14,14 78:11 96:2 117:22 146:16 154:3
comment 2:11 4:9,10,20,22 5:14 23:25 24:7 30:6,7 32:2 60:3 136:25 137:2 139:13 140:7,17 141:14,17 144:8,13 145:15 146:22,25 147:3,16 148:11,25 149:13 150:4,6 152:8 158:7
commentary 24:20 26:8
comments 5:15,17 25:7,13,14 32:24 45:25 60:3 113:3 135:2 136:4,15,19,22 140:20 145:18 146:20 152:4,6 153:11,12
commercial 71:4 79:25 114:9,15 114:19,25 115:15 124:6 144:21 144:21 155:10,15
commercially 114:16
Commission 29:23 38:19 39:7
committee 39:14 50:14
common 31:3 70:24 71:6 147:13
commonly 30:1 71:4 144:20
communicate 53:11
communications 50:9
comp 37:14 38:12 39:3,4,18 40:2 40:6 42:5 47:2 52:19 94:1 113:16 115:4 124:5 142:7,10 144:14 152:15
companies 36:17 37:19 94:15 154:7
company 35:22,25 36:3,6 92:21 94:3 101:17 129:1 154:17,17,23
comparable 84:9 122:9
compare 55:6,8 100:13 115:7
compared 32:8 90:3 112:20 121:8 123:2 138:14
compares 55:11 115:3
comparing 42:2,6 45:21 116:4
comparison 28:1 55:22 68:4 90:1 94:10
compelling 109:14
compensation 1:1,3,11 3:5,9 6:16 24:18 26:20,24,25 27:2,8 29:5 30:18 38:4,7,10,22 39:6,10 39:16,21 40:17 41:22,22 42:13 43:4 44:3 54:23 130:11 142:8
competitive 89:25 90:11 93:24 150:8,16
complete 48:2 64:1
complex 31:24
complexity 25:18
complicated 31:14 71:24
comply 132:16
component 75:3
components 128:1
composed 64:24 88:7 110:3
compound 31:19
compute 128:17
concept 113:8
concern 108:17 118:16 147:5 157:20
concerned 147:4
concerning 146:22 147:16 149:1 149:13
concerns 118:13 150:4 153:1
concise 135:14 136:22
conclude 156:10 158:8
concluded 122:15 158:13
concludes 32:24 140:13
concluding 140:7
conclusion 4:21 65:20
conclusions 54:2 63:9 73:11 157:9
condition 41:7
conduct 51:9,19 129:2
conducted 4:13
conducting 49:6
confidence 83:2,13,16,18,24 84:16 85:7,11,21,25 86:6 87:6 96:6 98:2,5,8,10 99:14,20 100:1 100:5 104:5 106:2,11,15 107:3 107:18 109:2,15 121:14,21,25 122:1,9,16,18 123:1,8,10,16 125:8,16 135:20 148:6
confident 109:24
confirm 156:19
conflicting 31:17,18
confused 62:10
conservative 85:10
consider 3:10 53:24
considered 29:19 36:15
considering 38:20 39:2
consistency 148:19
consistent 21:10 45:6 71:17 103:6 116:21 124:17 125:8 141:3 149:11
consolidating 46:17
constraining 142:19
consultant 24:10
consulting 24:13 51:5
contact 134:11
contagion 75:22
contain 138:21
contains 4:1,2,6
contemplate 128:21 134:9
contemplated 27:7
context 132:2 154:2
contingencies 50:6
contingency 67:8
continue 36:21 73:5 95:10 101:20 136:12
continued 38:17
continues 20:1
continuing 34:22 48:5,8,8,11 59:12,13
contracted 159:9
contracts 128:3 155:7
contribute 154:14
contributing 153:24 154:24
control 138:21 142:18,24 143:1,3
controlling 142:16
Conversely 148:19 154:16
convert 71:20
converting 71:10
cooperative 46:14
coordination 119:22
copy 33:17 136:14
corporate 87:10,14,20 88:3 111:6 147:9
Corporation 39:6
correct 6:18,18 8:1,2,7,10,13,14 8:16 10:13,15 15:18 17:2 18:22 21:12,17 22:2,17 24:2 26:9 28:20,21 36:16 46:13 49:14

55:1 61:24 63:11 68:15 74:18 78:14,15,17,18 79:3 85:6 90:21 95:7,8,13,14,16 96:7 98:24 99:18 102:8 103:15,16 104:13 108:11 116:9 117:5 120:13,19 121:14,15,22 125:19 126:8 146:6 156:22 159:6
corrected 6:19
correctly 29:7 36:7 43:23
correlated 76:18 139:12
cost 73:18,21,21 74:3 80:14 115:5
costs 66:3 67:4,4 73:22 94:19
Counsel 2:3
count 31:8 113:21
counterintuitive 138:18 139:4
counting 31:11
country 111:18
counts 143:22
County 1:13
couple 25:25 37:18 77:12 84:11 86:22 137:4,15
court 14:3 20:15 23:18,20 56:24 82:16 120:8 126:1 132:6 155:24 156:5,7
courtroom 138:8
courts 145:22
cover 80:20 86:17 117:21 156:16
coverage 8:13 9:6 11:16 36:14 40:4,4 47:15 54:23 57:17 62:24 62:25 63:5 70:21 71:3 80:15,15 84:9 87:9,15,18,21,24 90:10,15 90:18 91:15 119:22 128:2 140:23 147:6,9 153:25
covered 10:23 111:10 126:17,22 126:25 146:24 156:19
covering 80:8
covers 99:22
craft 128:14
create 46:18 68:3 76:19 78:10 94:17,17 123:3,4
created 44:24 45:4 77:5 81:24 82:5,8 91:16
creates 47:11
creating 26:10 44:10
creation 69:16
credentialing 34:21
credibility 114:13 145:2 149:6 150:1
credible 30:23 115:21 121:4 144:25 145:8,14 149:25
credit 93:14 113:23
credits 151:16
crisis 71:15
criteria 65:25 140:25
critique 135:2
cross 148:21
cumulative 89:5
curiosity 76:8
current 23:9,10 43:2 55:11 61:12 68:2,7 70:5 73:13,18,24 74:3,9 77:8,24 89:22 90:11 97:16,20 98:22 100:6,15 103:3 133:4 153:20
currently 28:2 95:10 100:9 110:21 119:25 152:21 153:18
curriculum 34:16
cushion 85:18,20,22
custodian 1:1 3:8
cuts 107:13

D

D 2:21 13:20,21 19:23 21:11 23:4
D-y-e 4:12
D.J 4:10
daily 11:13
dangerous 150:12,13
dat 158:1
data 26:3,15,16 27:17 30:21 35:15,15,19 46:17,18,23 49:25 52:19 54:11 57:7,22 77:6 93:2 94:14 112:12 118:24 121:4,5,10 127:9 128:22 137:1,3,10 138:1 138:1,3,18 139:3,7,11 140:1,2 141:13 144:24 145:4,7,9,13 148:11,14,20 149:4,9,16,20,25 150:1,2
date 9:14 11:25 12:1 17:5 38:25 57:2,2,7 59:7 109:23 119:12,14
dates 6:18 11:10 14:25 57:8
day 57:2
days 7:19 11:11,13 88:22 155:4 157:11
de 1:14 2:4
deadline 3:17
deal 37:14 80:16 133:8
dealing 43:12 115:17 121:3 133:10
deals 35:3,18 43:11 49:18
debit 21:3
decade 67:23 68:2 74:24 107:4 107:13
December 157:25
decision 60:13 71:19 94:7 122:25 123:9 132:24 150:25 157:21
decrease 126:7
decreases 96:5 103:4
deep 53:2
deeper 54:17
defense 119:23
deficit 81:24 82:5,8 100:10 101:20 102:22 103:10,14 104:10 107:13,20,23 148:3,9
deficits 104:4 147:21,24
defined 140:18
defining 141:4
definitely 134:20
definition 27:17 28:12 29:15 30:3 76:24
defrayed 107:20
deliveries 43:17
department 66:1
departments 65:17 94:15 139:22
depends 39:23 87:6
derive 57:18
describe 35:23 47:25 98:6
described 19:23 36:7
describes 9:12
description 2:17 10:1 45:14
designate 19:2
designated 3:2
detail 52:20 53:9 58:9 92:12 93:22 96:10,11
detailed 44:16 52:19 53:12 114:12
details 52:16 97:2
determine 45:3 47:3 97:9 99:16 103:25 112:19 113:6 114:13 128:7 129:7,21 132:11
determined 44:22 88:12 98:12 115:15,24 116:1 124:8 125:15
determines 124:18
determining 1:3,11 3:4 35:8 36:19 61:16 63:12 70:23 99:11

112:9 113:14 115:23 129:20
develop 112:21 116:19 149:20
developed 47:6 116:14
developing 47:13
development 149:20,24
diagnosis 31:20
diagnostic 111:24
dictate 111:2 147:9
dictated 111:5
differ 82:18
difference 14:11 81:9 113:9 151:23
differences 127:7 148:20
different 7:11,11,21,21 8:23 17:9 35:12 43:16,17,18 54:10,10 77:5 84:1 86:23 95:9 105:4 121:2 122:18,25 123:16 124:23 125:16 138:2,9 139:21,23 142:2 149:24 150:11,13
differential 120:1
differently 36:3,4 67:21 91:21 93:15
differs 35:17
directed 132:12
direction 111:15
directly 34:9
director 6:6,11,13 22:16,21
directors 37:1 48:10
disagree 141:18 145:20 147:21 153:6
disclosure 137:5
disconnect 139:10
discount 7:15 12:7 14:13,23,23 16:6,10 82:21
discounted 60:17 61:11 84:19 101:5
discounting 49:20 61:2 85:15
Discounts 18:20
discrepancy 75:1
discretion 113:18
discriminatory 65:24 66:13,19 90:8 122:24 123:5 131:4
discuss 3:24
discussed 8:5
discussion 148:3
disposition 159:12
distinguishing 146:9
District 132:6
dive 54:17
divided 11:12 74:8
docket 1:3 3:3,10 4:1
docs 63:6 70:8 114:1,3 124:13
doctor 9:24 10:21,21,21,23 12:6 12:22,25 13:2 15:24 16:1,8,8,11 17:24 43:14 90:2 91:22 111:18 114:3
doctors 7:8 9:12 14:13,24 20:7 20:13,15 22:8 92:21 94:3 110:3 110:14 111:8 114:4 118:4 120:17,20 146:10 154:17,17
document 10:25 38:25 39:3 50:11 69:12 72:4
documentation 29:18 48:11 145:23
documents 39:2 65:3
doing 28:2 43:17 46:21 56:2 66:7 71:8,10 85:19 88:21 91:20 92:8 92:9 105:21 114:10 115:4 122:12,13 130:21,22,23 131:8 131:21 137:6 139:5 142:11,15 143:23 148:10,22
dollar 71:10,25 79:10 120:11,12 142:12
dollars 28:4 30:11,18 58:17 73:25 78:11 80:3 133:8 142:4,5 142:10,12 143:16,23 145:25 151:4,5 152:22
Donald 152:4
double 66:13 75:18 80:24 145:17
double-digit 72:12
dovetail 123:18
dozens 76:4
dramatically 79:25
draw 80:24
drawn 73:11
drill 52:16
driver 93:12
drives 93:12
driving 27:21 111:19 132:19
dropped 86:11 124:22
dropping 61:3
drove 75:1
due 30:19
duly 5:24 33:7
Dye 4:11
dynamics 138:8

E

E 2:1,1,22 69:6,10 70:16 105:12 105:14 153:19 155:18,19,21
ear 43:14 91:22
earlier 21:11 77:13 104:23 113:3 148:4 153:15
earliest 157:18
early 71:13 119:3,4 130:6 151:3
easier 96:13 147:6
easier-to-kind-of-wrap-your-b... 97:1
easiest 34:14 96:9 100:22
Easily 134:19
echo 136:19
ed 48:11
edit 6:17
educate 52:10
education 34:22 47:20 48:5,9
effect 26:22 29:12 85:23,24 87:4 99:18 103:8 155:5
effectively 31:10
efficient 80:9
efficiently 80:3
eight 78:9 80:17 91:10 118:6
either 39:21 62:20 87:2 102:19 104:4 111:14 125:17 128:12 144:16 155:11
electronic 111:23
element 90:6,7 143:1
elements 34:7 70:10 86:22 113:1
eligibility 140:23 144:17,19
eligible 47:15 153:25
email 4:9
emergence 119:15
emphasis 67:4
emphasize 53:11
employed 6:2 32:11,15 110:4 159:8
employee 120:1
employees 87:15,18 110:20 111:12 130:10 146:5
enabling 38:23
encourage 25:22
ended 71:23
ensure 25:20
enter 14:12
entered 17:16 23:11

enterprise 35:10,11
entirely 29:18 71:17 113:19 142:25 150:20
entirety 47:2
entities 6:23 62:23,24 89:13,24
entity 10:2 63:5 84:8 87:9,10,14 87:20,24 88:3,6,12 90:9,15,18 91:14,23 110:2,3,4,6 111:6,8 147:6
equal 70:19
equally 140:15
equipment 73:20 111:24
equitable 25:20
equity 67:2
equivalence 122:11
equivalent 85:7
ER 124:14
errors 6:19 97:19 110:24 147:7
Escort 93:13
especially 63:9
essentially 52:23 66:23 70:24 71:9,9 84:15 116:14
established 70:19
estimate 40:22 41:3,6 42:19,23 42:24 46:5,19 54:12 57:15 60:12 61:6,20 66:2 78:10 81:15 81:15 83:23,24 102:19 106:12 141:21
estimated 41:15 48:1 78:14,16
estimates 42:18 55:8,13 56:18 61:18 73:17
estimating 42:7 56:12 81:3
ethical 51:21
ethically 51:12
evaluating 40:21
event 76:2
eventually 30:22
everybody 66:24
evidence 4:21 5:11 70:3 118:23 119:18 155:21
evidentiary 3:11
exact 45:23 76:5 118:9
exactly 22:22 35:2 46:21 52:15 71:13 77:19 89:7,9 140:24 151:7
exam 129:2
examination 2:9,13 5:25 33:8 73:6
example 7:12 17:2 23:8 27:1 28:11 29:6,19,22 31:3,16,19 75:8 106:19 146:12
exams 47:22,23,25 48:3
exceeding 48:2
Excel 16:22 23:11
excepted 159:9
excess 56:7 71:7 75:4 139:5,12 144:4 147:14
excessive 65:24 66:9,11 131:3
exclusion 113:25
excuse 4:18 19:1 46:7 56:16 84:21 121:24
exercise 138:3
exhibit 2:18,19,20,21,22 4:5 9:1 9:4,8 13:20,21,25 19:2,3,6,10 19:18 23:4 33:17 34:1,15 48:1 48:21 53:3 54:1,5 55:17,18 64:4 64:4 69:6,10,13 70:16 73:10 83:21,22 86:4 92:17 98:19,20 100:18,19,20 105:12 123:12 126:11,20 135:9 153:19
exhibits 2:16 19:23 21:11 117:25 155:18,19,21,23,24,25
existence 41:14
existing 125:5
Expand 113:8
expected 28:4 42:2 66:2 82:11 98:7 115:8 143:6 147:21,22 149:10 151:12
expected-value 29:2
expense 50:4
expenses 42:24 49:25 50:2,2,3 67:5,6 79:6,19,24,24 80:21 86:18
experience 7:13 10:22 12:24 13:4 14:14,15 20:18 21:16 26:4,6 27:6,9,10 29:20 30:8,13,15 31:10 34:10 35:16 36:22 39:18 40:17,21 44:15 45:2 46:2,25 54:13 58:7 61:20 67:16,22 100:6 102:13 106:14 110:23 113:18,25 114:8,12,17,21,23,24 115:1,6,7,9,12,13,19,21 116:2,4 116:15,23 119:12,12,14 121:8 127:14 130:12,21 131:9 133:5 133:15 137:11,16,19 138:6 140:17 141:5,13,14,16,19,23 142:3,8,20 143:11,18,21 144:8 144:11,14,16,18 145:1,3,5 151:16,24 152:8
experience-based 93:23
experience-rated 44:16
experience-rating 20:10
experiences 58:6
experiencing 100:9
expert 28:11 33:15 34:11,12 37:23,24 49:20 52:3,6 63:3 94:11 135:12
expert's 43:12
explain 54:20 59:19 65:2,5 67:25 69:12 86:9 92:11
explained 110:8 149:2
explanation 19:20
explicit 82:20,24 87:2
explicitly 104:5 110:21
exposure 12:25 15:25 87:16,17 88:4 108:19 110:6 113:15 114:3 114:20,22 115:1,13,18 116:23 124:7 131:11 146:22 151:12
exposure-based 116:22
exposures 47:9 70:11 78:7 113:19,24 117:5,8 123:23 124:8 124:13 125:5 126:15,18
extended 124:10
extenders 95:3 110:18
extent 59:15 142:23 148:5
extra 16:3
extraordinarily 80:9
extrapolate 137:11
extrapolating 41:4
extreme 76:2
extremely 140:5

F

facilities 6:24 47:14,16 119:6 123:2,10 130:4 133:15,20 134:7 134:10 144:12 145:6,13
facility 119:5 132:10 133:11 137:24 138:7 144:24
facing 107:21
fact 14:24 109:23
factor 29:21 30:13 70:25 71:2 113:17 115:9 116:24 131:11
factored 141:9
factors 8:5,9,23 45:2 94:18,18

facts 157:9,25
failed 31:19,20 76:4
fair 25:20 66:24 130:15 153:23
fairly 29:12 39:3 51:18 72:7 87:22 90:17 107:22 147:13
fairness 67:2
falls 35:19
families 39:10 152:23
far 29:15 106:14 108:3,8 130:12
Farm 35:25 150:10
faster 143:23
fault 38:15
Fe 1:13,13,15 2:5
federally 154:7
feel 83:17
feeling 30:12
feels 44:25
Fella 1:20 159:3,16
fellow 34:19
female 93:12
fifteen 84:9
Fifty 118:6
Fifty-eight 118:5
Fifty-nine 82:20
Fifty-three 50:12
figure 41:15 59:11 85:2 93:3
figures 126:12
figuring 41:7 52:13 60:21
file 2:18 66:5
filed 4:7 5:14 132:5 156:15
filing 3:18
filings 127:12 150:11
fill 103:21
final 7:22 9:16 11:6 14:8 18:17 45:3 99:11,13 114:6 159:11
finally 39:9 45:2 59:10,23 67:3 154:22
financial 41:7 111:22,25
find 31:25 39:18 51:5 143:15
finding 87:19
findings 157:9,25
Fire 154:22
firm 40:14
first 5:24 13:2 19:3 25:16 33:7 34:5 40:20 43:11 48:3 56:6 59:22,24 60:10 63:2,10 65:14 70:18 89:16 90:2 94:11 96:15 112:12 116:25 132:2 137:5,21
fit 103:18
five 7:19 18:5 20:24 21:7 34:1 40:13 43:11 49:8,14 73:24 74:7 74:7 77:11 103:20 115:6 134:22 136:4
five-year 116:5
flat 88:23,24
flesh 66:22 148:2
flight 5:15
flip 37:4,18 81:23
flipped 45:17
flipping 117:25 118:1
Florida 37:13 38:1,3
flow 64:10
fluctuations 150:15
focus 86:15
follow 63:6 155:14
follow-up 110:10
followed 51:20
following 4:2,9
follows 5:24 33:7 36:11 45:5 47:5
font 100:25
forced 103:4
forces 111:8
Ford 93:13
foregoing 159:5
forget 19:13 76:5
form 36:12 38:9,16 45:5 47:5 63:6 111:8 155:14
formats 138:2
formed 53:1
former 23:8,8 104:12
forming 38:20 112:13
forms 128:2,2
formula 99:12
formulas 99:16
formulating 51:21
forth 124:10 159:5
Fortunately 101:18
Forty-six 55:19
forward 55:10 73:23 78:6
forwarded 153:10
found 29:23 53:8 87:11 111:6 139:25 142:5,13
founders 40:14
four 31:11 43:9,10,20 54:9,10,15 65:20 67:10 77:5 84:1 94:5 110:3 126:12 133:7 154:22
four-point 100:25
fourteen 77:2
fourth 11:5 37:9
frequencies 143:16
frequency 140:18 141:15 142:19 142:22 143:5,14,17,19 151:20 151:23
Frese 2:11 24:12,12 25:24 26:9 28:12,18,20 30:19 32:3
front 33:17 69:9
full 7:5 8:15,19 11:16 26:16 59:23 114:12 137:5
full-time 70:9 114:5
full-time-equivalent 124:13
full-year 12:1,20
fully 15:2 108:18
function 6:20
functions 112:22
fund 1:1,3 3:5,9 6:16,20 24:18 26:20,24,25 27:2,8 29:5 30:18 38:7,10,12,13,14,17 39:8,10,16 39:21,22 41:22 42:5,13 43:4 44:3 47:2 52:19 54:23 61:12,21 61:23 69:16 75:11 83:11 84:14 87:6 100:15 101:11 103:10 106:14 108:1,4 109:23 123:6,9 130:11 131:10 132:7 152:15,21
fundamental 50:13
fundamentally 43:18 127:23
funded 32:4
funding 32:14 61:22 84:2 87:20 104:4,6 107:2 116:15 131:10 148:6 149:15
funds 37:10,12,14 38:22 39:3,4 39:18 40:2,6,18 41:23 42:2,14 43:7 94:1 101:12 124:5
further 12:9 59:6 159:8
fusions 76:4,6
future 28:5,16 40:24 41:16,20 50:12 66:3 67:3,4 74:15 101:1 108:12 147:21,23 148:8,9

G

gained 39:12
gatekeeper 140:23
gather 26:11 94:14
GEICO 150:10
gender 9:21

general 2:3 6:12 43:15 71:5 144:15
generally 36:18 39:4 102:18 113:13 124:7 137:13
generate 80:25 81:4 86:16,18,21 102:1 117:19 148:7
generated 83:10 92:5 112:16
generating 75:5,7 107:8
gentlemen 24:7
Georgia 154:12
germane 54:16
getting 12:6 43:20 50:8 53:2 64:2 73:12,14 137:15,22 141:23 144:25 149:17 152:10 157:20
giant 123:21
give 20:6,7 25:13,13 35:1 39:25 40:16 64:20 77:2 110:16 121:17 139:3 143:19 155:23 158:2
given 25:17 50:22 100:5,6 118:19
gives 17:18 22:7,10 56:1 96:12
glad 28:23 48:18 57:5
Global 24:11
go 10:4 11:18,22 12:9 16:25 18:12 25:23 26:11 37:22 48:21 52:9 54:6 55:10 58:8,19,19 59:6 59:6 64:1 65:12 67:13 68:11 70:16 80:3,4,11 83:20 90:25 94:1 101:21,22 106:18,19 121:12 122:20 125:16 126:15 135:2,3 136:10,21 137:8 141:4 144:5 150:10 155:5 158:4
goal 66:7 130:14,17,20
goes 29:22 32:14 50:16 59:2 90:5 96:16,17,17,18,19,19,19,21
going 8:25 15:7 16:13 18:10 19:9 25:22 29:10 30:22 34:3 35:23 39:17,20 40:15,25 41:8,16,19 42:19,25 43:1 51:24 53:18,21 53:22 54:13 57:16 58:16 60:12 60:15 62:7 63:3,16 65:19 67:16 67:17 68:5 69:14 73:9 75:11,11 76:1 77:8 78:3,22 79:7,10 81:3 81:17,20,22 82:23 83:8,10 85:20 90:19 91:19,24 95:23 97:2,7,13,22 98:12,13,18 99:17 101:3 103:19 108:18 111:15 117:11,16,24 118:1 120:4 122:14,20 123:6 136:3 137:18 137:25 138:6 139:12 145:11,11 148:7,17,18 151:16 155:6,12,14 156:13,14
good 3:1 24:4,5 48:12 65:1 68:19 93:14 94:19 101:24 118:10 119:13 122:6 124:1 134:15 142:16
goodness 59:9 93:22
gotten 73:12,13 148:15
govern 48:16
government 35:23 36:7 37:17 40:5 84:15 101:18,21 104:3 138:14
Governmental 38:2
gradual 72:14
graduated 9:25 18:6
graduation 9:24
grant 117:15
granular 93:21
great 22:25 52:17 58:9 157:1
greater 102:16 144:10
green 150:21
ground-up 26:13
group 24:16 26:21 46:10 47:1 69:24 87:3 93:6,7 95:19 96:22 97:17 110:14 116:4,17,17 119:5 119:7 120:3 130:23 133:7 134:6
grouped 43:22
groups 43:24 95:18 110:23 111:8 111:9,12,13,21,25 132:6 146:23 154:6,7
growing 71:14 110:18,19
guess 53:9 65:8 71:15 72:5,17 75:22 83:19 98:6 104:20 105:6 118:10 143:15 145:10 148:5
guidance 49:2,5 51:10 65:16
guide 67:10 94:6
guidelines 51:21 66:1 87:13 111:5 147:10
guides 67:12
Gynecology 96:16

H

half 12:8 30:10,18 58:17 60:20 105:22,22 107:14 151:5
Hall 1:15
hand 13:19 67:10 103:4 152:18
handle 30:21 81:1
handled 67:21
handling 50:2 67:6 79:6 139:22 148:20
happen 7:22 98:15 156:10
happened 40:24 41:9 52:20 54:13 56:10
happening 67:24 68:6
hard 11:3 31:25 98:4 102:25 103:6 138:20 154:2
hard-pressed 39:17
harder 133:10
head 89:20 134:3
health 24:11 40:3 45:7 63:4 69:16 70:13 88:7,8 90:12 93:19 95:2 110:20 111:15,20 112:23 137:23,24 147:8
heard 94:20 97:6 113:3 129:6 136:19 140:19 145:17
hearing 1:12,12 3:1,2,12,14,16 3:20,21,23 4:13 5:4,7,9,16,18 5:22 6:8,21 9:2 15:7 19:1,6,8,11 19:13,15 23:1,3,7,14,22,24 24:2 24:4,6,21,25 25:7,9,12 27:11,14 27:19,22,25 28:7,17,19,22 31:6 31:12,23 32:22,25 33:2,19,22 33:23,24 46:7,9,11,16 52:5 53:6 56:16,18,22 57:3,18,21 59:11 62:1,4,8,13,18,22 63:1,22 68:17 69:7 72:15,23 73:3 74:20,22 76:7,12,16,22 83:15,20 84:21 84:25 85:2,4,8,13 88:5,10,15,17 88:23,25 89:5,8,10 98:9 99:15 100:23 104:18,22,25 105:2,6,11 105:14,16,24 106:1,5,7,9,13,17 107:11,15,25 108:3,20,25 109:4 109:19,22 110:1,12 112:3 115:16 116:7,10,13 121:24 122:2,15,17 125:15 126:10,23 127:1,3,6 131:5,7,15 132:3,15 132:18,20,22 133:1,22 134:2,4 134:14,21,23 135:4,22,25 136:6 136:10 140:13 146:2,4,7,18 153:13,16,16,16 154:25 155:19 155:22 156:2,5,9,13,18,22,24 157:1,6,14,19,24 158:5,8
heart 35:16 43:16
heavily 151:9
Hebert 1:12 3:1,2 5:4,9,18,22 6:8

9:2 19:1,6,8,11,15 23:3,7,14,22 23:24 24:2,4,6,21,25 25:7,9,12 27:11,14,19,22,25 28:7,17,19 28:22 31:6,12,23 32:22,25 33:2 33:22,24 46:7,9,11,16 52:5 56:16,18,22 57:3,18,21 59:11 62:1,4,8,13,18,22 63:1,22 69:7 72:23 73:3 74:20,22 76:7,12,16 76:22 84:21,25 85:2,4,8,13 88:5 88:10,15,17,23,25 89:5,8,10 100:23 104:22,25 105:2,6,11,14 105:16,24 106:1,5,7,9,13,17 107:11,15,25 108:3,20,25 109:4 109:19,22 110:1,12 112:3 115:16 116:7,10,13 121:24 122:2 126:10,23 127:1,3,6 131:5,7,15 132:3,15,18,20,22 133:1,22 134:2,4,14,21,23 135:4 136:6,10 146:2,4,7,18 153:13 155:19,22 156:2,5,9,13 156:18,22,24 157:1,6,14,19,24 158:5
hefty 133:8
held 1:13 3:23 73:1 101:19 136:8
help 63:8 103:8 110:11 129:13
helped 38:16 50:14
helpful 25:1 132:4 136:24 147:1
helps 143:9
hiatus 39:11
high 25:14 67:21 72:8 87:1 147:4 151:12,15,18,21
high-risk 43:17
higher 18:7,11 104:4 107:5 125:17 147:25 148:6
historical 45:20,20 55:8 61:19 70:5,11 119:11 131:7
historically 27:4 29:4 88:1 89:14 115:25 132:13
history 8:9 18:18 52:24 68:18 69:21
holding 151:14
holds 49:22
hole 103:21
homeowners 93:10 113:20
homogeneity 150:2
Hopkins 114:10
hospital 4:11 24:15,15,19 25:19 29:9 31:4,9,16 32:11,16 36:13 39:15 44:14 45:4,25 55:3 60:3 66:16 69:25 76:13 111:13 114:11 115:24 116:16 118:20 119:8,22 120:2,7 121:5,10 123:24 124:4,17 127:9,14 128:12,13,17 132:6,10 135:24 136:16 138:15,20 141:24 142:15,24 143:3,5 145:25 146:9 146:14 149:5
hospital's 32:12 62:17 138:9 151:13,21
hospitals 6:23 24:17 25:18,21 26:6,19 27:1,5 28:2 29:3 30:1,9 30:15,20 31:2 32:7,8 44:11,13 44:15,17,19 45:23 46:4,18,23 46:25 47:4,8 57:19 62:12,20 64:12 66:21 69:24 108:18,22 112:7,9,10,13,15,17 115:23 116:4,17 117:19,22 118:12,15 119:14,20 120:10 121:12 122:13,19 123:1,6,9,14 125:14 126:24,25 128:23 129:17,18 130:2,4,7,9,13,22 131:13 133:7 134:8 135:21 137:16,19 139:5,7 140:11 145:16 146:5 149:19,21 149:23 151:14,15 155:4
hospitals' 46:2 124:8
hours 16:9,11 48:2
house 111:19 113:22
housekeeping 157:5,7
huge 80:12 152:20
hundred 144:3
hybrid 115:11
hybrids 114:19

I

i.e 28:4
IBNR 59:17,19,24,25
iceberg 41:4
idea 41:6,17 42:22 43:13 49:5 54:9 60:24 66:15 68:3 70:2,25 83:3,12 91:19 92:6 93:25 96:25 97:22 101:7 103:19 105:22 111:18 113:15 114:15 124:21 124:24 125:11 141:18 142:15 143:16 153:2
identical 117:23 119:1
identified 2:17 60:7 84:3 85:17 86:25 93:7,13 95:5 96:15 124:6 151:3 156:14,20
identify 57:1 125:21 154:3,12
identifying 38:23 52:20
ignoring 53:9
III 2:12 33:6,12
Illinois 33:13
immediately 105:22
impact 97:25
impacting 103:8
implement 103:4 105:20,22 106:20 113:11 117:1 122:25 128:22 129:9
implementation 72:12
implemented 29:4 69:15 106:22 106:25 135:25
implementing 103:7
important 32:17,18 37:3,25 39:3 48:19 51:4 57:4 60:2 75:21 79:23 86:15 97:21 103:16 129:5 149:25 151:10
inadequate 65:24 66:9,12 90:3 131:3
incident 76:17
incidents 54:13
include 8:9 26:14 46:22 50:7 59:12 71:2
included 119:18
includes 26:5,13,13 63:5 145:24
including 26:23 46:3
inclusive 47:14
income 49:24 67:7 75:6,8,12,13 75:14 80:11,22 83:9 102:1
inconsistent 132:13
increase 21:5 22:1 29:1 72:10,12 72:13 79:7 81:25 83:7 84:5 86:20 87:23 91:17,25 92:4,4 98:11 99:7 102:15 103:20 108:18 119:8 148:8,23 150:1,2 155:1,2,12
increased 29:10 70:25 91:1 94:18 147:11
increases 29:4 72:7,9 96:4,24 100:3 102:24 103:1 105:20 106:23,23 111:10 148:6
incurred 28:2,7,8,13 41:14 42:23 59:20
incurs 79:6

Indemnity 38:13 152:21
INDEX 2:7
Indiana 38:5,6 93:25 153:6
indicate 12:3 127:10
indicated 44:17 72:10 83:1,22 84:1 86:5,7 92:7 95:9 112:16 121:13,20 122:3 123:15 128:17 129:21 130:24 132:8 145:3,12
indicates 22:1
indication 29:1 84:4 103:8 105:9 112:15 119:1 121:16
indications 10:24 61:18 103:25 130:6 139:8
indicator 143:18,18
individual 27:9 30:14,14,23 31:15 47:8 52:19 57:19 60:6 66:3 86:25 96:15 110:7 112:14 115:2 130:21
individually 32:7,7
industry 88:19 90:12 124:18
infants 152:24
infection 31:16
infer 150:8
inflation 73:23
inflationary 73:22
influenced 121:5
information 6:15 9:7 14:10,18,19 15:15,20 16:21,23,25 20:4,13 22:6 26:19,23 43:22 53:15 77:23 94:6 118:18 121:10 127:17 139:15
inherently 43:15 85:10 152:17
initial 3:15
injured 39:9 152:24
injury 37:9,12,15 38:3,14 39:5 39:22
inpatient 124:14
input 14:8
inputs 16:23
insolvent 101:18
insurance 1:1 2:2,3 3:6 6:3,5 15:11 35:4,6,19,22,24,24 36:1,3 36:6,7,9,12,13 37:17 39:14 40:5 46:14 65:17,25 80:1 84:15 93:10,11 94:11,14,15 101:17,19 101:21 104:3 113:13 114:16,19 124:6,18 127:25 128:11 129:1 138:10,14,16,19 144:21,21 146:16 150:14 154:7,9 155:7,10
insured 29:25 66:17 113:22 125:5 153:24
insureds 154:15
insurers 39:25 92:25 128:13 137:9
integrate 127:17
intended 77:19 118:8 130:3 141:20,20
Intensive 96:17
intentional 118:8
intentionally 149:8
intentions 143:3
interest 60:20 159:11
interesting 36:23 38:14 147:2
Interestingly 46:21
interject 131:25 132:2
internally 149:11
interrupted 36:21
intervene 3:18,19
introduce 123:4
introductions 24:8
intuitive 55:15
invest 111:22 112:1
investment 49:24 67:7 75:6,8,12 75:13 80:11,22 102:1 120:16
involved 18:22 24:16 25:18 146:1
ISO 14:18 17:11,16 22:9 94:11 94:11,13
ISO-based 94:10
isolated 76:17
issue 30:25 31:14,16,24 36:17 45:19 59:12 77:16,20,21 90:6 100:10,12 118:11 131:19 138:1 138:17 139:17,20 148:13 150:20
issued 3:9,14,17 87:14
issues 25:3,6 32:21 34:12 156:16 156:20
item 41:25 42:1,1,16,17 43:9,10 44:8,10 51:8 52:13
itemize 96:25
itemized 96:12
items 34:5

J

James 2:12 33:6,12
Jeff 4:11
Jessica 17:4
job 142:16 148:22
Johns 114:10
join 111:8 137:20
joined 24:18
joining 130:13 137:17,24
joins 138:7
Journal 3:22
Judge 132:8,12
judgment 121:7 127:13
judgmental 77:22
judgmentally 77:9
judicial 53:21
July 4:3
junior 67:21

K

keep 39:23 146:4 155:24
kept 38:25
key 32:3,14
kids 67:20
kind 11:3 14:17 19:3,19,22 27:20 34:16 36:11 37:2,13,25 39:24 45:8 47:13 50:17 55:7 56:1,4 58:9 65:20 66:9,10 69:17 72:6 85:23 88:20 89:21 90:11 101:22 102:21 115:14 124:2 125:11 136:21 137:13 145:2 148:16 151:11 152:18 153:2
know 5:5 18:9 20:14,16,17,19 25:16 29:2 30:2 43:1,1 50:24 51:15 54:16 58:15 60:11 62:23 66:11 67:8 72:5,8 73:19,20 74:12 76:20 77:13 84:2 87:2 89:19 92:3 93:3 97:23 99:14 104:18 106:14 108:3,8 109:7 111:3,12,16,18 113:17 116:5 117:4 118:22 125:2 131:12,13 133:23 138:15 142:18 143:20 147:2 151:2 152:11 153:17 155:12,23 158:1
knowledge 39:21 133:25
known 26:13 28:16 60:9 70:25
Krylova 19:14 68:23,25 69:2,4 76:14 105:10 118:5,7 144:3 158:11

L

lack 148:19
lag 141:15,19 151:7,7,8
lagging 143:16,18
large 35:15 43:19 44:19 82:10 94:4 109:21 114:8,11,15 121:6 138:13,20 141:25 142:16,19 143:8 154:19,20
largely 55:13 87:6 114:1
larger 46:18 63:12 72:10 94:2 111:11,24 114:25 144:12
largest 75:3
latitude 65:9 117:15
law 157:9
lawsuit 132:5
layer 26:24,25 27:10,10 43:13 54:23 70:21 83:6 138:19,23,23 138:24 139:1,5,9,11,12,15 140:4,24 141:3,24 142:4,22,23 144:1 147:6,10,13,15 148:14,17 148:18,23
layers 71:7
laying 128:16
lead 155:8
leadership 37:3
leading 94:4 128:13 137:9 143:17
lean 50:1 139:6 151:8
leave 91:6
left 10:14 11:22 12:14 16:5 20:23 42:7 111:17
left-hand 69:13
legal 57:9 128:3
legislation 38:23 116:11
legislative 39:2
legislature 38:8
lend 133:14
let's 17:1,4 52:9 64:13 65:5 66:22 67:13 68:20 69:5 70:16 72:23 72:23 74:4 78:12 97:4 106:19 112:7 117:1,1,7,18 124:1 135:4 152:7,7
Letherer 4:10 152:5 153:11
Letherer's 153:11
letting 155:11
level 29:1,5 43:2 46:6 47:3,7 61:18 68:7 70:6 73:13 74:9 79:20 83:2,10,13,16,18,24 84:16 85:7,21,25 86:3,5,6,7 87:6 92:7 96:6 98:2,5,10,14 99:15,21 100:1,5 103:3,25 104:5 106:2,11,15 107:3,18 109:2,15,24 112:15 118:25 121:13,14,20,21,25 122:1,16,18 123:1,11,15 125:8,13,16 131:1 135:20 139:8 147:22 148:6
levels 42:20,25 43:1 68:14 69:22 74:1 77:9,25 107:5 122:9 123:16 147:21
liabilities 34:6 35:8 42:6 152:20
liability 36:12,13 37:7,17,20 55:3 71:5,5,6,15 73:16 87:12 90:13 92:25 94:4 101:15 103:22 104:6 111:7 124:5,18 127:14 128:12 128:13 138:13 144:15,16
liable 87:11 110:24 111:1
license 17:5
licensure 9:20
lift 128:10
light 109:23
likelihood 148:7
likewise 29:11
limit 11:11 151:1
limitations 150:23
limited 30:17 60:19 119:5 144:9
limiting 142:11
limits 70:25 94:18 142:9
line 60:15 61:3,5 63:10,10 68:10 74:10 77:7 78:5,19 79:5,9 80:13 80:14,17,24 81:8 86:5 90:20,25 92:12,20 103:12 120:4,9 121:12 121:20 122:3
lines 75:4 77:1
lion's 115:14
list 18:9 37:22 48:21 96:12 124:8 153:20,22 154:2
listed 34:4 154:5
listings 126:17
lists 14:13
literally 76:5 80:6 128:16
litigated 27:18
litigation 29:24
little 6:9 17:9 38:14 41:1 43:12 45:24 55:10,14 59:25 62:14 65:9 66:22 85:10 90:23 91:21 92:9,11 96:13 110:1,5 113:8 117:12,15 119:10 121:2 139:2 148:2 151:2
loaded 15:9
long 8:12 21:13,18,22 27:3 89:15
long-tailed 75:4
longer 14:7 67:19,20,20,20
look 8:25 11:3,4,25 15:20 18:9 23:13 28:3 47:2 53:12 55:11 59:3 67:18 68:10 79:13 86:5 97:4 98:13 106:8 115:6 121:19 123:23 124:1 142:8 149:16 153:19 155:6
looked 11:4 63:9 127:12 142:3
looking 11:9 20:3 26:22 27:16,21 35:10,15,18 37:11 41:2 42:5 54:11 59:2 81:11,12,22 98:5 102:8 105:11 116:3,5 133:5 157:17
looks 16:24 17:9 19:25 27:8 28:2 44:25 48:20 81:6 118:3 119:15
losing 120:20
loss 26:6,23 27:9,17 30:21 35:16 43:19 50:12 52:13,14 54:3,3,7 54:12,20 55:8,13 59:8 61:17 75:4,10 77:8,24 78:1,10 79:18 79:23 80:5,21 94:19 115:5 116:3 119:4 120:6,10,25 137:10 137:23 139:14 140:2 142:4,5,10 142:12,18 143:20 149:10,20,24
losses 26:11,13,14,15,23,24 27:1 28:3,7,8,13 30:1,14,21 31:1 32:12 45:20 53:13 54:22 55:5,6 56:7 58:10,18,21 59:7 60:19 61:8 62:17 63:16 64:3 68:5 73:14 74:3,5,8 79:7 85:15 86:17 118:12 138:21 142:16 147:25
lot 21:19 36:5 44:25 49:1 50:16 71:18 77:14 82:9 83:8 87:10 101:25 109:13 118:3 133:10 143:23 150:25 154:24 155:10
lots 36:23 93:2
low 79:24 87:1 147:5 151:20
lower 18:6,10 29:3 79:25 109:24 125:17 138:21 143:5
lull 69:17

M

Madam 5:7 19:13 33:19 53:6 72:15
MagMutual 154:12
magnitude 151:24
maintain 48:8
major 46:22
majority 24:17 80:3
making 43:21 47:13 54:11 87:2 94:7 120:15 138:25
malpractice 4:16 26:2 38:18 54:24 59:14 110:16
manage 2:21 16:17
managed 36:4
management 30:20 35:10 108:22 108:23
manager 109:12
mandatory 155:8
manipulate 14:17
manner 29:11 36:2 51:13,16 72:14 97:1 112:22 130:16
manual 30:22 116:22 144:9
map 49:6
margin 67:7,8 82:20,24 85:16 86:1
margins 50:7 84:1
Marilyn 1:12 3:2
marked 13:20 33:20 69:10
market 40:4 90:13 129:2
marketplace 90:4
marry 148:17
Martinez 132:23
Maryland 38:8,10
material 145:5
materially 149:23
math 128:7
mathematical 35:5
matter 1:3 3:3,4,19 4:21,24 5:12 60:6 158:7 159:10,12
matters 3:24 52:3
mean 16:20 22:19 28:8,10 50:1 56:23 57:22 74:10 76:19 98:4 148:5 155:10
meaning 65:23
means 16:21 47:7 52:15 54:11 67:5,25 81:21 103:20 107:7,8 120:11,15
meant 49:14
mechanism 40:3 47:11 80:9
medical 4:15 9:25 26:2 29:23 30:2 36:12 37:7,16,20 38:5,13 38:18 39:14 54:24 56:24 59:12 59:13,14,16 71:5,15 73:19,20 87:11 90:13 92:21,24 94:3,4 110:16 111:23 137:8 138:13 152:21 154:16,19
medicine 7:8 9:12 17:25 18:11 111:4
medicine/medical 22:16,20
medium-size 115:14
meeting 48:4
Melissa 132:23
member 34:18,19 48:12
members 26:12 46:2,3,20 47:1
membership 48:3
memory 29:6
mentioned 8:24 139:19
merit 29:24
message 153:10
methodologies 54:10 113:14 142:3 148:21
methodology 44:25 45:6 70:22 99:16 100:7 112:22 114:7,17 118:9 133:17 141:5 143:22 145:3
methods 54:15
Mexico 1:1,13,15,20,21 2:3,5 3:6 3:8,21 4:11 9:21 24:14,15,19 25:18 26:2,4 33:16 38:11 41:22 42:13 43:4 44:2 45:10 83:18 89:12,14 94:5,8 100:1 102:6,10 102:14,22 104:25 116:8 128:14 136:15 152:21 154:8
microscopic 53:4
mid-December 157:17
middle 34:17
mill 115:4,7,8
Milliman 24:13 44:18 46:12 126:17 130:22
million 30:11,18 56:13 58:17,21 58:25 59:8,9 60:18,25 61:7,10 61:13 64:17,23,24,25 73:25 74:1 79:13,15,16,17,18 80:20 81:2,4,4 84:2,3 85:17,20,22 86:17,18,21 87:24,25 90:20 91:13,16,16,20 101:6,6,9,12,13 101:14,16,24 102:1,2,3 107:8 107:12 121:16,17,22 127:4 151:5
mind 5:7 26:1 53:7 117:11 122:8
minimum 144:17
minor 96:16
minus 121:13
minute 37:25
minutes 72:24,25 134:17,22 136:4
misadventure 30:3
misleading 143:17
missing 126:11
misstate 46:13
mitigating 142:16
mixed 139:3
modification 14:14 29:20 30:9 30:13,16 45:3 114:21 115:9 116:24 144:8 145:1,5
modification-based 140:18
modifications 145:12
modified 91:24 115:2
modifier 12:24 145:3
modifiers 141:15
modify 115:20 116:23
moment 53:10 70:3 71:18
money 42:7,10,20 49:21 60:21,25 61:2,11 63:17 79:10,14 82:22 85:16,24 101:5 120:15,20 152:18,25
months 7:19,19
morning 3:1 24:4,5 72:22 113:3 118:13 136:19 145:18
motions 3:18,19
mouth 152:18
move 5:11 34:24 65:1 72:16 95:8 115:9,21 117:8 134:12 152:14
moved 95:12,15,21
moves 90:23 93:19
moving 71:21,22,23 134:10,12
multi-specialty 111:14
multiple 31:5
multiplicative 99:18
multiplied 128:8
multiply 98:23
myriad 35:4
mystified 151:11

N

N 2:1
name 3:2 4:25 19:4 23:18 24:9 33:10
names 146:14
nation 76:8
National 154:22
nationally 71:15 87:10,19 144:15
natural 109:17,18
nature 35:5
necessarily 32:17 54:16 60:11 138:5
necessary 48:2 111:23
necessitate 44:22
necessitating 131:20
need 24:7 41:15 42:20 43:2 45:22 47:21 50:4 52:10 60:25 61:12 61:20 67:18 68:6 69:2 73:21 79:11 80:19,25,25 84:5 86:16 86:18 87:19 91:11,13,15,17 101:7 112:11,19 117:4 139:24 149:4
needed 24:23 60:21 112:16,21 121:18 125:22 129:21
needing 79:18
needle 115:22
needs 46:6 47:3 84:2 88:2 98:15 104:18 117:19 128:14 137:13 145:15
negative 58:12 66:14 83:4
negotiation 86:19
neither 66:9 159:8
Nephrology 96:17,19
net 49:7 63:16 87:4
neurological 37:15 38:3 39:5
never 53:7
new 1:1,3,11,13,15,20,21 2:3,5 3:4,6,8,10,21 4:11 9:21 11:8 13:23 14:7,11 16:18 24:14,15 24:19 25:18 26:2,4 29:24 33:16 37:12 38:11,13,16 41:22 42:13 43:4 44:2,21 45:4,10,10 81:8 83:18 88:2 89:12,14 94:5,8 99:8 99:25 102:6,10,14,22 104:25 116:1,8 117:1 128:14 130:14 136:15 137:20 152:21 154:8 155:5
news 101:24
NICA 38:3
nice 51:12
nine 18:5,7 48:21 49:14 78:19 79:5 83:3,6 84:6
Ninety 122:1,2
NM 4:3 60:16 159:3,16
NMAC 4:17,18
NMSA 3:11 4:14,16
noise 140:5
nominal 56:14
non-discriminatory 130:16
non-employee 146:9
non-hospital-employed 119:21
non-named 147:8
non-PCF 137:2 139:2 148:14
non-qualified 110:24
non-surgical 43:14
nontrivial 138:2
Norcal 154:13
normal 88:2
normally 27:7
north 94:25
Northern 154:13
Northwest 1:21
nose 43:14 91:22
not-specifically-identified 87:17
note 66:6 70:18 71:12 120:23 124:11
notes 70:16
noteworthy 142:7
notice 3:20 29:24 141:1 155:11
notification 140:22 155:8
November 1:14 4:10 136:15
number 3:3 9:1,4,8,9 10:5,17 11:11,18 13:5,7,20,21,25 15:21 15:23 17:5,6,10 21:1,7 32:12,16 32:19 35:12 39:1 41:25 42:16 42:17 43:9,10,20 44:8 45:12,18 47:9,9 51:8 52:13 57:13 60:16 61:22 62:2,3,5,6 63:15 64:6,22 65:20 70:8 75:23 76:6 80:19,25 86:24 88:12 90:20,23 97:9,13 101:4 105:9 111:17 114:3 120:4 120:9 124:4 125:12,22 138:11 142:2,13 151:15,20,22 152:10 152:12 154:5,15,18,22
numbers 10:6 32:9,10 33:21 53:4 53:10,23 56:5 57:11 61:4 62:19 64:16,19 73:15 81:7 123:25 125:18
nurse 31:20
nursing 124:25

O

OB/GYN 43:17
obligation 59:8 101:4 132:9
obligations 42:18 52:14 57:14 58:25 60:22 61:1,7 81:1 100:14 101:2 117:21
Obstetrics 96:19
obtained 26:3
obviously 31:17 66:11,11
occupational 9:22
occur 129:18
occurred 35:9 56:21,23 58:12,12 58:24 61:9 101:3,9 102:4
October 3:16,17,20,23 4:7,9 152:2 156:15
offer 52:2 155:18
offered 103:13
offering 5:2
office 1:1 2:2,3 3:25 4:8 6:3,4 38:1 79:24 94:12 154:9
Officer 1:13 3:1,3,14,16 5:4,8,9 5:16,18,22 6:8,22 9:2 15:7 19:1 19:6,8,11,13,15 23:1,3,7,14,22 23:24 24:2,4,6,21,25 25:7,9,12 27:11,14,19,22,25 28:7,17,19 28:22 31:6,12,23 32:22,25 33:2 33:19,22,24 46:7,9,11,16 52:5 53:6 56:16,18,22 57:3,18,21 59:11 62:1,4,8,13,18,22 63:1,22 68:17 69:7 72:16,23 73:3 74:20 74:22 76:7,12,16,22 83:15 84:21,25 85:2,4,8,13 88:5,10,15 88:17,23,25 89:5,8,10 98:9 99:15 100:23 104:18,22,25 105:2,6,11,14,16,24 106:1,5,7,9 106:13,17 107:11,15,25 108:3 108:20,25 109:4,19,22 110:1,12 112:3 115:16 116:7,10,13 121:24 122:2,15,18 125:15 126:10,23 127:1,3,6 131:5,7,15 132:3,15,18,20,22 133:1,22 134:2,4,14,21,23 135:4,22,25 136:6,10 140:13 146:2,4,7,18 153:13,16 154:25 155:19,22

156:2,5,9,13,18,22,24 157:1,6 157:14,19,24 158:5
Officer's 83:20
offset 148:24
offsetting 85:23
oftentimes 35:19 109:8 152:19
Oh 6:10 46:10 59:20 72:19 76:15 82:3 92:24 98:21 134:18 139:19 146:11
Ohio 38:18,19
okay 3:1 5:10,15,19,20 6:21 7:24 8:4,15,25 9:7 10:4,9,11,14,24 11:18,22 12:9,18,23 13:7,10,19 13:24 14:2,6 15:6,14,20 16:5,16 16:19 17:1,4,19,23 18:1,4,12,17 18:21,25 19:6,22,25 20:9,23 21:10,13,22,25 22:4,23 23:15 24:4 25:9,24 28:22 33:14,19 34:10 36:9,17,21 40:11,15 41:25 42:9,16 43:9 44:1,8 45:12 45:16 46:11,16 47:20 49:17 51:3,20 52:7 54:24 55:2,4,17,19 55:25 56:11 57:3 58:2,4 61:14 61:25 63:1,15,21,22 64:8,13,16 64:19,21,22 65:5 67:1,9 68:8,16 69:5 70:16 71:11 72:2,21 74:19 74:22 75:5,10 76:16 77:1 78:3 78:19,21,24 79:4,15 81:6 82:12 84:21 85:8 86:4 89:8,10 90:22 90:25 91:7,9 93:1,17 95:20 96:8 97:4 98:2,9,17,22,25 99:14,22 100:9,21 103:13 104:14 110:14 112:7 115:16 116:10 117:7,10 117:14 120:17,22 121:19,23 123:12,18 124:20 125:10,20 127:1,3 129:12,16 130:1,19 132:5,18,21 133:2 134:4,15,21 135:6,24 136:2,7 139:18 140:7 140:17 141:6,11,14 143:13,25 145:15 146:18 147:16 148:11 148:25 149:3,12 150:4,19 151:22 152:2 155:13,17 156:1,9 156:13,24 157:19,23
old 9:5 88:22 122:22
older 51:6
omissions 110:24 147:8
omitted 149:8
once 16:24 23:12 134:12 138:6
one-year 109:6
ones 56:23,24,25
ongoing 59:16
opening 3:9 5:5,10 133:14
operates 38:15
operating 50:3
operational 53:20 60:13 67:5
operations 101:20
opinion 54:2 99:24 129:18 135:19 150:12
opinions 51:22,24 52:11,12 102:7 102:11 112:14 135:12,19 149:13 150:13
opioids 111:4
opportunity 15:12 49:24 123:4
opposed 27:9
oral 140:20
oranges 62:15
order 3:9,14,17 4:5 80:7 117:1 132:17 156:11,14,20
orders 4:2
organization 114:11
organizations 34:20 45:9 88:7 148:22
organized 38:24
organizing 57:7
OSI 26:16 52:18 79:22 129:1
ought 49:6 93:4 94:8 114:14 116:6 127:10 141:21 143:10 151:19
outcomes 58:12 83:5
outline 19:22
outlines 22:8
outpatient 6:24 47:10,11,16 123:1,10 124:14 130:4 132:10 133:11 134:7,9 144:24 145:6,13
outperformed 130:12
outperforming 119:16
outside 26:20 103:24 154:8
overall 45:18 47:3,7 85:3 125:13
overhead 79:21 80:6,21
overreacted 142:6
oversee 6:14 34:21
overseeing 6:19
oversight 34:21 37:2
owners 40:13
owns 109:12

P

P 2:1,1
p.m 136:8,9 158:13
P.O 2:4
page 2:8 15:21 16:22 20:2 21:25 33:21 34:1,15,17 36:24 37:4,4 37:22 48:1,21,22 49:8,9 51:8 53:3,4,13 54:5,5 55:10,17,18 56:4 58:8 60:15 64:6,13,14,22 64:24,25 65:5,12 67:11,13 70:17 72:16 73:10 81:6,11,12 81:16,19,25 82:12,19 83:21,23 83:24 84:10,24 86:5,7,11,14,16 90:19 91:5 92:14,20 94:9 95:23 96:12 97:15 98:14,21 99:5,19 100:18,19,20,23,24 118:1,2,3,3 118:25 121:19 122:3,10 123:12 124:1 125:9,18 126:11,12,16 127:8,18 128:5,19 135:8 136:25 146:21 147:16 148:11,25 150:5 150:19 151:22 153:19
pages 37:18 64:1,7 65:2 92:15 97:2,4,12 98:3 126:15 127:22 128:6 159:5
paid 26:14 27:17,18 28:3,4,16 30:10 40:24 41:13,19 49:23 52:22 53:13,18 56:14 58:10,13 58:18,21 59:7 60:19 61:8 74:11 74:13,16,16 75:9 108:10 119:12 129:8 140:2 151:4,5
pains 71:14
pair 75:24
parcel 35:7 131:2
Pardon 69:3
park 37:25
part 6:14 15:1 23:11 26:9 35:7 41:4 50:13 71:16 73:16 84:13 91:23 95:5 107:20,23 120:16 131:2 136:3
part-time 8:16 10:21 11:1,3,7,15 12:4,6,22 13:16 14:12,13,24 16:6,8,9 18:19 70:9 114:5
partial 13:17
partial-year 18:23
participants 131:1
participated 104:23
participating 4:24 26:12 27:2

119:3 129:19 133:23,23 153:21
particular 7:25 10:25 18:2 65:19 72:11 97:10 132:23
particularly 109:22
parties 159:10
partitioned 47:24
parts 47:24 146:21
Paseo 1:14 2:4
pass 97:23
patient 1:1,3,11 3:4,8 6:15 24:18 26:20,23,25 27:2,8 29:5 30:17 37:13 38:6,9,12,22 39:3,4,9,16 39:18,21 40:2,6,17 41:22 42:5 42:13 43:4 44:2 47:2 52:19 54:22 58:12 83:5 94:1 124:5 130:10 152:15
patients 59:12
pattern 143:9,11 149:21
patterns 59:3
pay 13:5,13 30:17 42:3,10,20 60:21 61:1 74:6,14 78:16 79:10 80:4,21,21 100:16 101:4,8,13 101:22,25,25 152:19,25
pay-as-you-go 152:13 153:2,7
paying 55:15 75:1 80:11 130:15
payment 26:15
payments 28:14 40:23 41:8,16 42:2 52:25 56:13 59:16 75:12 139:15 149:18 152:23
payroll 113:16 115:5
pays 8:18,20,22 15:16 66:24
PCF 3:9,10 4:3 5:1 6:6,11,13 7:3 13:2 17:10,15,17 18:3 19:21 25:21 29:4 30:10 31:1 32:4,15 33:16 35:22 36:10 37:16 38:20 40:22 41:7 42:7,20,24 43:13,16 44:21,22 46:5,24 47:12 49:22 50:1 57:16,23 58:10 60:5,14,16 67:5,6,7,17,23 68:1 70:18,23 71:2,16 79:6 80:4,12 83:6,15,18 84:14 86:3 87:16 88:1,21 89:12 93:22 94:8,23 95:10 100:1,9 101:3,11 102:6,10,14,23 108:18 108:19 110:21 111:10 112:19 112:19 113:5,10 115:25 116:19 117:19 118:18 119:20 125:5 126:22 128:15,21 129:2,19 130:12 131:20,21 133:15,20 137:3,11,24 138:7,8,22,25 139:9,15 140:1,4,17,22,24 141:2,14,24 142:4,22,23 143:25 145:15,24 147:6,19 148:18 149:16 152:14 153:10,12,18,24 153:25 154:20,24
PCF's 101:15 125:1
PCF-level 137:7
PCF-type 45:9
PCFs 47:18 80:2 100:1 128:12
Pediatrics 96:19
pending 3:5
people 129:14
per-100 124:15,15
Peralta 1:14 2:4
perceived 108:17
percent 12:7 16:3,6,10 21:4 29:2 29:7,8 50:3 60:20 70:20 71:2 73:24 74:11,14 75:5,7,10 77:10 78:9 79:8,15 80:7,10 81:18,18 81:21,25 82:5 83:2,7,12,14,16 83:17,23 84:16,17 85:2,5,5,7,11 85:21,25 86:6,8,20 88:21 89:2,3 90:4 91:25 92:2,3,4,4 97:23 98:10,16 99:7,20 100:5 103:20 105:7 106:11 107:3,5,17,18 109:2,15 120:11,18,24 121:14 121:20,21 122:1,2,10,16 123:7 123:10 125:8 135:20 147:4,12 147:14 149:1
percentage 14:22 20:20 71:20,23 88:20,24 125:24 126:6
perfectly 5:18 139:11
perform 110:15 129:2 132:9
performed 43:3 44:1,20 45:8 47:17 65:7 102:7
period 8:12 79:12 109:6,6,15 116:5 121:9
person 5:13
personal 113:21 124:24 150:11 150:14
perspective 56:1 101:15 125:1
pertains 144:10
PFC 13:2 22:11 137:9
phase-in 29:12
phased 29:10 72:11 140:14,15
phased-in 29:5 72:14 140:10
phasing 109:14 140:11
phenomenon 87:9
philosophies 139:23
physician 9:21 30:23 31:2,4,8,8,9 31:19 43:18 45:1 49:19 66:15 66:20 89:17,18 90:14 93:4 95:3 110:18 111:21,25 118:21 119:23 120:2,2 140:12 146:14 146:22
physicians 6:23 10:25 24:17 29:11 30:4,14 31:5 32:6,11,15 45:7,19 47:5 57:19 62:12,21,25 63:4 64:12 66:21 69:15 70:12 79:2 88:13 95:1 100:2 104:16 110:7 111:13 112:23 114:22 116:21 117:24 118:12,14 119:1 119:16,19,21 121:3,9 122:12,16 123:2,7,14 124:11 129:8,17,23 130:9,24 135:21 137:20 145:17 146:7 149:7,9
physicians' 43:23 62:16 104:21
pick 31:20
piece 20:12 104:21
Pinnacle 4:4 39:10 40:11 44:19 126:17
Pinnacle's 29:1
place 14:12 21:14 34:14 37:25 45:6 100:22 117:20 118:10 124:2 142:17
places 37:21 150:25
plan 44:11 45:5,5 47:6,13 84:8 86:23,25 90:7,17 91:14 98:6 99:21 110:21 112:21 117:2,8 119:25 122:22 123:19,20 127:16,18 129:10 135:24 141:13,19 142:9,21 143:12 144:11 145:7,8
plans 94:17 115:1 124:5 144:14 144:16 152:9
play 51:11 66:20 138:9,10 146:16 151:1
playing 60:1
please 26:8 33:10 36:21 46:13 54:19 56:17 136:12
plus 28:14 79:18 106:11,20,21,22
podiatrist 8:18,19
podiatry 96:18
point 28:25 29:18 30:25 34:5 35:1 36:24 37:8 38:21 41:10

53:3 60:2 65:19 72:5 75:21 79:23 106:10 112:5 115:19 118:11 120:24 122:6 128:18 154:1 155:17
pointed 61:8
points 24:23 25:14
policies 14:25 36:1,13,14,15,18 155:10
policy 7:18 9:9,15 10:1,8 11:10 11:11 12:1,20 17:5 18:23 38:2 79:12 117:22
position 6:4 37:3 59:22 101:20 102:22 103:10 107:17 129:24 148:3
possibility 82:6
possible 81:19 121:11 129:9 145:6
post 30:1 60:5
potential 123:3,4 147:24
potentially 141:2
practice 7:8 17:13,14,24 48:23 49:12 50:20,23 70:25 87:13 102:18 110:14,20 111:5,9,12 147:9
practiced 111:20
practices 24:11 30:20 111:2 142:18
practitioner 43:15
practitioners 111:17
predict 143:9
predictable 140:3
predictive 41:19 138:5 142:14 149:6
predominately 113:20 154:13
prefer 97:17
preferred 137:12
preliminary 3:23
premarked 9:1 19:10
premium 7:17 10:8 46:19 70:20 71:1 113:14,19 114:14 116:22 125:7 145:12
premiums 68:7 71:20,22 115:10 115:15 124:8,19
Presbyterian 69:22 119:7 133:6 134:6
prescription 111:4
present 5:17 32:10 100:13 111:7
presentation 5:11
presented 37:21 77:17 82:10 89:23 104:8 126:20 128:23 146:22
presenting 32:9
presumably 81:13 137:19
presumption 53:17
pretty 53:12 107:3 111:15 119:13
previous 54:7 116:11 126:16
previously 5:14
price 71:1
priced 66:16 93:15
pricing 35:6 71:7 130:22
primarily 35:5 37:12
primary 65:16 138:19,24 139:11 147:13 148:17,23
primary-layer 141:2
principal 24:12
principle 65:20 67:10
principles 48:15,23 49:10 65:14 65:15 99:25 122:21 135:18
principles-based 50:17
prior 21:19 27:2 28:8 41:9 93:15 101:10 113:17 116:2,15 130:13 137:16,17,23 142:6
proactive 108:21
probably 12:5,6 18:11 81:17 89:15
problem 81:21 102:3 110:5 139:21 141:23 152:12,16
problems 137:4
procedural 3:24 5:12
Procedure 4:14
procedures 124:15 142:17 157:8
proceeding 57:9
proceedings 5:8 104:23 158:13 159:5
process 15:6 19:22 20:12 26:9 46:14,17,24 54:6 60:7 94:2 99:10 103:2 118:17,22 132:12 145:21
produce 44:16 46:5,19 66:8 70:15 81:14 84:1 87:4 91:20 112:15 113:18 115:8 125:13 130:3,25 141:20
produced 38:21 126:16 130:12 142:13
produces 36:1 86:2 125:7 127:15
producing 66:8 92:6 129:4,15 130:7
product 34:7 35:6 36:9 48:24 109:11,13
products 94:18 113:13 114:19 116:20 126:16 127:25 144:22
professional 34:21,22 36:12,13 37:5,7,8,17,20 51:9 53:24 55:3 71:6 87:12 90:13 92:25 94:4 124:5,18 127:14 128:12,13 138:13
professionals 63:5 69:16 70:13 95:3
profit 50:6 148:8
profitability 103:9
profitable 130:7
program 24:16 35:24 36:8 37:17 39:6 77:23 84:15 100:6 109:12 116:1,21 119:4 128:21 129:7,14 137:3,20 138:10,14,16 149:5 153:2 154:15,19
programs 40:5,8 44:6 101:19,21 104:3 127:14 146:16 149:10 152:17
programs' 128:11
project 45:21 48:20 53:16 67:17 95:5 116:6
projected 57:13 58:6 64:2 73:14 75:9 95:24
projecting 58:16,22
projection 58:7
projections 57:25 61:19
promise 152:25
promised 152:23
promulgated 4:17
propensities 43:19
propensity 93:20
proper 31:20
property/casualty 35:4,13,19,21 49:11 65:14,18 66:1 113:12
proposal 38:9 98:10 104:8,8 105:6 130:14
proposals 102:15
propose 140:10
proposed 30:8 68:14 97:16,20,25 99:9,20 104:15 150:5 155:3
proposing 86:23,24 113:10 115:25 123:19

prospective 103:17 104:10 130:8
prospectively 130:15
Protective 92:22 94:3 137:8 154:16,19
provide 26:7 33:15 34:11,12 48:11 49:2,5 67:8 68:17 83:21 87:19 94:5,15 157:10
provided 37:23 40:8 52:18 57:23 59:14 77:7 83:1 102:7 110:19 118:24 126:17 132:23
provider 7:20 8:10 11:15 12:3 13:13 15:16 31:15 76:11 93:19 97:10 110:23 137:24 138:7
providers 7:2,18,25 9:6,10 31:2 40:3 45:7 76:14,15 88:7,8 95:6 95:12,15 110:25 112:24 146:1 147:8 149:23 155:4
providers' 6:15
provides 37:1 84:4
provision 28:15 79:5
provisions 50:13
prudent 100:5,6 109:1,5,16 155:16
prudently 107:16
psychiatric 124:9
public 2:11 3:20 4:9,22 5:14 23:24 24:7 38:1
publication 37:9
publications 37:8
publicly 127:12
published 3:21
pull 78:6 150:10
pulled 73:14
pulling 138:22
purchase 46:14 77:17 116:16
purchased 77:18 108:15 154:18
Purchasing 24:16 26:21 46:10 47:1 69:24 119:7 130:23 133:7 134:6
pure 116:2 131:9
purely 116:3
purpose 103:17 137:3 146:16
pursuant 3:10
purview 35:20 154:8
put 14:16,19 15:14 16:2 59:17 60:8,11 66:6,6 69:4,9
puts 85:21
putting 85:19 142:17
puzzle 123:21

Q

qualification 48:4
qualifications 37:24
qualified 19:20 35:13 48:14 52:3 52:5 116:14 131:21
qualifies 34:11
qualify 6:15 48:6 144:18
qualifying 48:2
quality 49:25 50:10
question 31:21,22 57:5 62:9 88:5 109:10 110:2,11 122:14 147:3
questions 22:23 23:2 31:25 84:11 104:21 112:4
quick 72:22
quickly 91:3
quite 41:17 151:17
quo 90:12
quote 93:8

R

R 2:1
R-o-m-e-r-o 23:19
radiation 96:16
raised 118:13
range 39:25
rare 76:18
ratable 47:8 113:19 123:23
rate 7:21,22 9:10 11:13 17:6,7,8 17:8,10,14,15,17,17 18:1,4,15 20:6 22:10 29:1 30:22 31:10 45:18 60:21 61:18 62:20 64:2 65:22 66:8,9,10 68:18 69:14,18 70:3 73:23 77:21 79:20 83:1,10 92:8 97:8,16,16 98:22 99:19 100:2 103:7,19,24 104:15,16 109:21 112:15 113:16,24 114:20,22 115:2,12,13,13,19 118:25 124:22 125:3,6 127:12 129:20 133:16 139:8 155:1,2
rated 32:6,7 110:21
ratemaking 37:6 49:11 50:13,17 65:14,18 103:16 137:3,7
rates 1:4,12 3:5,10 20:8 29:9 36:19 62:16 63:12 66:1 78:13 83:13 90:7 97:25 98:8 127:23 128:1,3 139:14 147:19 155:5
rating 20:18 44:10,24 45:1,5,5 47:6,13 63:3,3 70:9 86:23 90:7 90:16 94:16 99:21 110:21 112:21,21,22 113:15,17 114:3,7 114:8 115:1,18 116:3 117:1,8 119:25 122:22 123:19,20 124:5 124:12 127:15,18,24 128:1,3,8 128:11,18,24 129:3,4,10,13 130:21 131:9,21 135:24 141:5 141:13,19,23 142:3,8,21 143:11 143:22 144:10,11,14,16,18 151:24 152:8
ratio 74:8 75:4,10 77:8,24 78:1 120:6,10,25
ratios 119:4 149:10
raw 128:22
re-rated 70:12
reached 96:5
reaction 109:17
reactive 108:23
read 25:12 53:8
ready 135:3
real 139:20 152:12,16 153:1
real-time 28:6
realize 151:16
really 40:2 50:13 67:10 71:25 79:24 90:5 103:18,24 108:16,21 109:9 115:17 119:8 121:9 128:4 133:4,4,15 138:20 139:5,6 142:18 143:17 148:5,13 152:9
reason 15:3 65:13 70:2 139:6 149:9,22
reasonable 42:22 43:24 65:22,22 66:8 84:16,18 86:2 87:20 90:16 94:6,6 95:11 104:2,9 116:19 122:16,17,23 123:9 125:16 127:15 129:24 130:3,25 133:18 149:11 150:9 155:3
reasonably 41:15 89:23
reasons 77:12 80:1 109:14
Rebecca 1:20 62:9 159:3,16
recall 77:13
receive 66:17
received 4:8 17:5 152:4
receives 145:24
Recess 73:1 136:8
recitation 135:14
recognize 49:21 103:16 151:10

recommend 15:7 83:16 90:17 100:2
recommendation 6:22 100:4 135:17
recommendations 102:23 103:12 129:22 130:2
recommended 8:19 87:2 135:25 157:20
recommending 107:19
record 4:1,6 33:11 50:19 62:2 73:4 136:11 143:25 148:15 153:8 155:18
records 111:23
reduce 147:21,23
reduced 63:17
reducing 148:9
reduction 121:17
refer 15:22 16:7 17:7 33:20 92:14
reference 39:1 51:1 52:10 64:6 146:20
references 22:9
referring 17:21 146:5
refers 16:8 26:3 50:20
reflect 56:5 67:7 88:2 97:13,21 97:25 98:19 120:1
reflected 13:25 50:5 60:16 61:4 65:2,6 71:11 73:10 77:4 81:6 92:12 98:3
reflecting 80:22 85:15 101:5
reflection 60:24 79:9 84:7
reflective 63:15 89:23 90:20 123:13
reflects 54:1
regarding 33:15 44:21 49:10 137:1
regional 154:11
Register 3:21
regulated 36:3 154:7
regulation 112:18 131:20
regulations 44:21
regulatory 94:1 113:5 154:8
reinsurance 77:18,19,21 80:20 108:1,4,9,15,15
reinsured 108:12,13
reject 102:15
rejected 102:14
relate 10:19 44:9 45:13 61:14 92:20 148:3
related 10:3 34:6 37:6,7 38:3,6,9 38:12,19 39:7,15 40:21 42:17 44:10 57:8 58:23 59:1 75:24 101:9 139:13 159:9
relates 40:18 91:1
relationship 7:1 40:11 74:4 127:10
relationships 43:21
relative 93:20 127:7
relativities 43:24 49:19 93:4,16 94:7 95:7,10 99:9 124:24 125:4 150:5
relativity 93:5 95:18 96:22 113:23 114:5 125:2
reliability 114:13
relied 114:18
relies 114:17
rely 44:14 77:14
relying 138:18
remainder 146:20
remaining 60:22 61:1 91:10,15 98:14 133:18
remember 89:15 103:2 141:19 144:2
removed 85:16,17
renewal 10:1
repeat 62:9
report 26:10,10 29:14 51:17,22 52:10 60:10 96:10 103:13 135:1 146:21
reported 1:20 52:24 57:12 58:5 59:20 150:24
reporter 2:15 14:3 20:15 23:18 23:20 82:16 120:8 126:1 155:24 156:6,8
REPORTER'S 159:1
reporting 149:18 151:7
reports 37:23 50:10,11 57:19
representation 38:24 100:16 153:23
representative 19:14
representatives 44:13
reputation 51:16
request 81:14
require 113:5
required 36:20 51:17 53:23 82:23 116:12 117:21 157:10
requirement 144:17
requirements 19:20 140:22 155:11
requires 140:18
reserve 60:1,8,12 64:10 73:15 100:15 149:15
reserves 26:14 28:4,14,15 52:14 54:3 55:14 59:21 60:4,5,17 139:20,24 140:1,3,5
resolve 32:1 103:14 104:10
resolved 28:9 41:12,18
resort 40:1
Resources 4:4 40:12
respect 6:22 19:23 54:2 61:15 102:13 104:15 112:8 123:14
respond 148:12 155:8
responded 136:20
response 136:3 139:16 140:21 141:17 144:13 145:19 149:12 150:6 152:6,11
responses 136:22
responsibilities 6:12
responsibility 118:20,20
rest 53:16,16 61:15
restated 67:23 68:2
restrict 139:8
restricting 138:23 148:22
result 22:1 100:8
resulted 131:9
resulting 87:22
results 109:12 130:7 138:18
retained 138:23
retention 154:6,6
retrospective 130:8
revenue 70:15 80:8,25 84:7 86:17 87:23 91:1,17,20 92:5,7 95:25 112:16 117:18,21 119:9 119:11 121:18,22 125:22 127:5
revenues 74:5 75:13 80:10
review 29:23 56:24 72:4 124:4
reviewing 86:22
revise 126:3
reward 142:20,21 143:6,12
Richard 24:12 25:22 26:5,7 28:11 32:2
right 5:20,22 12:23 13:19 19:8 21:3 22:12 23:14 32:6 33:22 43:21 56:3 63:24 65:1 69:9,11

69:21 72:15 73:3,8 88:10 89:9 92:19 94:22 99:3,22 107:21 109:8 110:12 115:18 117:20 120:21 127:6 130:7 133:1 134:5 135:4,11 136:18 141:23 143:23 144:2 149:19 153:3,15 157:1
rightly 41:10
rise 110:16
risk 24:15 26:21 30:20 35:10 46:10 47:1 49:12,18 50:7 66:4 66:16,17 67:7 69:23 82:7,10,10 82:20,24 83:25 85:16 86:1 89:23 108:21,23 110:6 111:9 115:3 116:16 119:6 128:23 130:22 132:9,11 133:7 134:6 154:3,6,6,14
risks 35:10 111:7 119:20 153:25
risky 125:1
road 33:13 49:6
Rob 5:2 33:5
Robert 2:12 33:6,12
robust 46:18
role 25:19 151:1
roles 94:13
roll 62:19
rolled 119:6
rolling 49:9 80:18
rolls 87:18
Romero 2:8 5:2,17,21,23 6:2,8 22:24 23:19,22 94:20 97:6 129:6
room 2:4 158:6
roughly 64:17 74:11 81:23 85:1 89:19 120:11
rounding 97:19
row 11:5,5 56:4,5 78:9 79:21 84:1,6,9 86:15,16 91:10 120:25
rows 80:17
RPG 26:10,12,17 44:18 46:2,3,9 69:23
RPGs 32:10
RPR 1:20
rule 63:5
rules 4:17 20:9 63:3,4 127:24 128:1,3,6,8,11,24 129:3,5,13,15 159:10
ruling 132:7
running 75:4 77:24
runs 137:10,23

S

S 1:12 2:1,5
safe 150:12,13
safety 49:7 142:17
sake 29:19
sample 128:18
Sandra 2:8 5:2,21,23
Santa 1:13,15 2:5
Sante 1:13
savvy 114:16
saw 26:1 29:14,17 71:17 77:20 90:10 119:8 122:22 139:8 150:15 151:11
saying 85:5 132:6
says 10:4 11:5,23 12:10,14 16:17 18:12 20:9,23 21:3 22:22 65:22 70:18 80:19 86:16 98:14
scales 92:9
scenario 82:11 91:12
scenarios 81:19,22,23 82:9 83:8
schedule 3:15 68:3
scheduling 3:24 153:15
school 9:25
science 65:23
scope 34:2,4,5,7,9,13 40:15,18,21 48:16 52:4
score 39:23 93:15 113:23
se 98:5
second 23:4 29:8 64:20 65:10 72:18 78:22 83:1 87:8 113:5 139:13
secondary 75:13
Section 3:11 4:15 26:1
Sections 4:14,16
see 11:2,20 12:12,16 17:9 20:4 22:12,14 34:14 37:5,19,22 41:5 41:8 48:25 49:9 50:16 53:12 54:15 55:7 58:8,11 69:14,17,24 71:4 72:8 73:25 74:3,4 76:8,12 76:16,18,20,21 79:25 82:18 83:25 90:3 91:25 96:10 100:17 100:22 114:8 115:8 118:23,25 127:3,20,22 132:15 133:22 134:14 138:24 142:19 145:11 154:5,11,16
seeing 9:7 22:6 35:16 87:10 92:19 143:8
seen 53:19 76:3 119:15 138:11 144:20
segregated 64:11
select 55:5 123:22 124:21
selected 55:6,22,23 73:16 77:9 93:6
selecting 54:6 151:20
selection 56:7 77:7,22 120:25 151:18
selections 127:13 149:10 150:9 150:18
send 137:9
senior 24:10
sense 35:25
sentence 140:8
separate 62:17
separately 69:23 87:16
separating 150:3
September 3:7,13 4:5 156:11
series 45:2 47:23 53:1 83:25 105:20
serve 38:17 94:13,16
served 39:11 49:2 109:11
serves 29:6 94:13
service 48:6
services 94:12 110:15
set 3:11 15:7 26:16 28:15 70:19 93:2 121:4 156:3,7 159:5
sets 35:15
setting 3:15,17 103:17
settle 58:22 99:15
settled 35:9 52:25 59:10
settlement 118:17 138:12 143:2 143:20 145:23 146:13 151:8
settlements 41:13
seven 7:19 39:24 45:12,15 54:9 58:20 78:5,6 90:20 96:22
severity 138:22 142:23
Shakes 134:3
share 51:24 66:24 115:14 118:15 130:16
sheet 80:24
shift 131:20 133:17
shifted 71:24
shifting 116:18
shock 109:18
short 27:3

shortfall 81:5 100:17 101:14 147:17
shorthand 49:12 159:4
show 19:9 59:16 64:3
showing 59:24 97:24 122:10 123:14,25
shown 81:15,19 99:19 124:7 125:9 127:8 141:12
shows 79:21 94:9 101:1 105:14 128:5,18
shy 94:25 95:4 101:15
sic 61:10
side 69:13
signal 140:6 143:19
signals 139:3,4 148:21
significance 10:5,17
significant 30:6,7,25 53:20,21 120:14
signify 13:7
similar 39:22 41:23 42:14 43:7 44:6 53:19 102:7 112:23 129:9
Similarly 130:2 137:18
simple 114:23
simply 29:9,24 31:25 42:1 47:7 48:3 51:10 60:13,18,24 61:9 72:13 74:8 78:6 87:25 93:21 96:12 99:12 103:20 111:19 128:6 144:25 145:4 150:22
single 13:13 46:5,19 76:10,13 92:8 93:12 111:14 119:5
single-digit 72:9
sir 8:3,17 13:15 22:15 92:18 96:3
sit 5:8
situation 62:15 103:15 104:11
situations 37:23 72:9 89:1,2
six 7:18 44:8,10 45:18 49:9,15 77:1,5,7 80:7 90:25 92:12,20 120:4,9,25 133:7 135:8 156:16 156:16,20
size 25:17 53:22
sketch 35:1 40:16 77:2
skilled 124:25 127:11
skills 35:12
skip 78:22
slightly 119:16,20
small 106:23 111:21 144:24 145:11
smaller 47:15 89:17 121:4,8 133:11,15,19 145:12 154:10
Smith 17:4
Society 34:19 39:14 51:15
sole 111:17
solved 41:12
somewhat 96:24
sophisticated 115:1
sorry 4:18 14:2,3 20:15 27:11 28:22 45:14 46:10 55:20,21 59:20 62:3 64:7,20 76:15 79:1 88:16 92:10,24 98:21 100:20,23 115:12 116:23 120:8 122:21 126:1,2 131:15 144:4
sort 149:14
sorts 94:19
sought 106:3
sound 32:5 66:2 90:16 92:7 99:25 100:8 103:19 104:9 122:23 135:18 149:9
soundness 150:18
source 46:19 75:13 91:1 111:6
sources 84:7 92:5 154:4
speak 6:9
speaking 116:8
speaks 49:24 148:13
special-purpose 37:13
specialize 9:13
specialties 17:12 22:8,10 43:18 43:23,25 86:25 87:3 93:6 95:17 95:21
specialty 7:6,7,7,25 9:11,23 17:11,12,13,19,20,23,25 18:2 18:11,15 20:7 22:7,11 49:19 66:20 70:8 87:3 93:4,18 94:7,10 97:17 111:14 114:4
specific 65:13,23 87:3 146:21
specifically 26:2 37:11 38:2,6,9 38:12,19
speed 93:14
spell 23:18
spending 51:6
spike 71:16
spinal 35:17 76:4,6
spot 66:10
spreadsheet 15:2 16:23 23:11
squeeze 121:10
St 69:22 119:3 133:6 134:6
stable 140:2 141:3
staff 3:25 5:1 25:2 44:23 52:18 83:15 110:15 111:2 112:19 113:5,10 116:19 128:22 129:1,2 153:10,12
staff's 4:6 98:10
stand-alone 46:4 47:1 111:13 112:20 113:4,9 120:2 129:22 144:24 149:20
standard 49:12 50:20 51:18 101:19 131:3 144:20 151:14
standards 34:22 48:4,5,6,9,15,23 49:3,4 50:23,25 51:21 53:24 65:9,15 82:21 86:2 122:21
standing 48:12
start 7:24 34:15,17 36:25 54:5 56:3 65:5 104:6 112:13 114:20 114:22 115:5,11 117:7,18,20 134:10,11
started 21:19 137:6
starting 103:21 115:19 136:24
starts 20:1 96:11
starving 134:24
state 4:24 9:20 12:21 26:6 33:10 35:25 38:5,16 39:6 62:2 65:17 65:25 68:5 94:15 98:4 111:16 142:9 150:10 154:9
stated 44:14 74:3 110:22 147:3
statement 5:5,11 49:10 65:13,21 130:8 145:20 153:6
statements 48:23
states 38:23 39:1,20,25 40:7 44:5 45:11 71:6,18 119:19 138:11
states' 41:23 42:14 43:7
statistical 35:5 94:14 98:7
status 90:12
statute 133:12 150:22
statutory 101:17 132:9 154:23
steel 115:4,7,8
stenographic 159:4
step 48:3 63:10 82:3 114:23 135:3
steps 67:12
sticker 109:18
sticky 66:6
stood 25:25 71:25
stopped 73:8
straight-line 125:24 126:6
strategic 37:2

strategy 147:23
Street 1:21
string 102:25
strongly 82:22,23 101:23,23,23 141:18
studies 36:18 44:20 106:24 112:21 113:4
study 38:21 48:1 100:15 113:10 116:15
stuff 36:23
subject 86:19
submitted 4:11 16:24 23:12 24:20 136:15
subsequent 94:9 97:3 103:5 105:25 128:5
subsidize 66:17
subsidizing 90:15
subsidy 66:18
substance 50:24,25
substantial 87:23 88:3 90:17 107:20,22
substantially 96:23 143:5
substantive 138:25
subtotals 77:6
subtracted 96:4
subtracting 60:19
successful 130:11
sufficient 129:23 149:19
suggest 107:22 119:19 147:14
suggested 81:25 82:22,23
suggesting 80:7 101:13 138:4
suggests 29:1 79:14
suit 128:14
Suite 1:21
suited 98:7
sum 32:19
summary 34:1 38:22 52:15 122:9 135:11
superintendent 1:1 2:2,3 3:6,7 3:13,25 4:8 6:3,5 26:3 109:1 131:16,17 132:9 154:9 155:3 157:21
superintendent's 4:5
supplemental 83:22
supported 86:1
supposed 51:11,11,12,13
surcharge 1:4,12 3:5,10 6:17,18 7:5,9,10,12,13,14,16,16,18,20 7:23 8:19 9:15,15,16,17,18,19 10:5,7,7,10,11,15,19,20 11:5,6 11:12,14,19 12:5,7,8,9,15,24 13:6,14 14:8,8,9,16 15:4,15 16:4 17:18 18:7,10,13,14,17 20:8,20,21 21:15 22:2,20 42:19 42:25 43:1,2,13,16 45:1,3,22 46:6 47:3,7 61:20 68:2 69:22 70:6,14 72:7 73:13 77:24 83:22 84:4 86:2 87:7,23 88:20,20 89:2 89:3 90:4,24 91:10,18 93:19 94:21 95:9 97:8,10,14,21,23 99:3,8,11,13,19 104:15,23 114:2,4,6,24 116:6 119:9,11 123:22 124:22 125:6,7,13,22 126:4 127:2 129:21 130:25 132:11 139:14 147:12,14
surcharged 9:11 87:16
surcharges 2:19,20,22 6:23 7:1,2 7:4,24 15:8 18:10 20:1,5,10 25:20 31:10 44:17,22 45:20 49:22 50:4,5 55:7,9 58:14 61:16 63:13 68:1,12,13,13 69:20,25 70:5,10,14,19,23 71:17,25 73:13 74:2,9,12,14 75:8 77:9 78:10,13 83:13 86:21 87:1 90:14 97:16,20 98:11,12 99:17 102:16,24 103:3,18,20 104:1,10 107:5,9,13 112:9,20 113:7 115:20,24 117:4 125:13 126:5 128:17 129:4,8,15,17 130:3,24 135:20 140:10 141:21 143:10 144:9 147:20 148:1
surcharging 89:12
sure 6:10,17 23:23 24:23 25:24 27:13 28:12 32:4 33:12 34:25 35:3 40:20 43:21 50:8 52:18 54:4 61:17 65:8,11 66:23 67:14 68:8 70:24 72:23 73:12 77:3 78:12 81:10 86:10,13 110:17 113:12 117:9 127:20 129:2,14 130:15 131:17 136:23 145:10 151:17 152:9,9 155:7
surgeon 35:16,17 43:16
surgeons 45:7 62:21,25 63:4 64:12 69:15 70:13 79:2 95:1 100:2 104:16 112:23 116:21 117:24 119:16 122:12,17 123:2 123:7,14 124:12 129:23 130:10 130:24 135:21 137:20 140:12
surgeons' 62:16
surgeries 47:10 124:14
surgery 47:12 96:16,18
surplus 100:10 101:20 102:22 103:9,14 104:10 107:13 148:3
sustainable 78:1 79:19
sustained 75:24,24 76:21 143:9 143:11
swan 76:2
swear 24:7
sweet 66:10
sworn 5:24 33:7
system 9:6 11:8 13:23,24 14:7,12 14:17,19 15:9 16:3,13,18,25 21:13 38:16 57:13 97:7,14 129:10 134:8,12 136:16

T

table 2:19,20,22 20:1,4 22:5
take 8:25 27:18 41:1 45:24 46:24 49:23 72:7,22 78:14 81:24 98:22 99:2 101:1 113:16 121:18 134:22 136:4 152:7 153:19
taken 67:22,25 87:8 108:1,4 124:3 128:10 129:20 149:14
takes 14:24 41:11 150:23
talk 113:2
talked 94:11 100:14
talking 16:22 21:15 35:7 54:21 57:6 62:15 76:5 79:17 80:5,15 85:19 88:6,21 98:20 152:8
Taos 150:14
target 61:22 62:4 71:21
tarnish 51:14
tarnishes 51:16
tasks 34:2 40:18,20
tease 110:11
technical 137:22,25
technically 40:6 101:18
technology 111:22
telemedicine 110:18
tell 9:4 11:9 13:21 17:23 19:18 21:18,18 48:12 56:5 81:9
ten 47:23 49:14 51:8,8 67:17 72:25 77:6,11 79:9 83:3,6 89:3 90:4 96:24 97:23 100:22 101:1

143:21 147:3,12,14 157:11
tend 85:11 119:20 154:10
tens 93:3
term 36:25 117:22
terminology 140:19
terms 37:16,24 65:14 112:15 119:15 140:11 149:16 154:15
territorial 113:22
Tesla 150:12
tested 142:2
testified 5:24 33:7 105:17 107:25 113:4 135:15
testifies 5:17
testify 23:7 94:20 97:6 129:6
testifying 21:11 34:3,8 62:5 148:4
testimony 4:7 5:2 33:15 34:9,11 34:12 37:24 43:12 49:20 77:13 135:1 151:3 156:15 158:10
thank 5:4,22 9:2 19:11,15,16 23:14,16,17,20,22,23 24:9 32:25 33:1,24 46:11 49:17 52:7 59:9 63:22 64:8 69:7 93:22 105:13 127:6 136:7 144:6 156:9 156:25 158:9,11,12
Thanks 126:9
Thanksgiving 157:15
therapy 96:16
thereunder 4:17
thing 45:24 61:6 91:6 120:23 139:19
things 7:22 25:25 49:19 94:19
think 11:7 21:19,20 23:3 28:25 30:6,19,24 32:3 34:14 36:6 41:3 46:13 47:25 48:19 54:4,4,12 57:16 58:24 59:8 60:9,12 68:21 70:7 76:3 77:8,23 84:18 97:18 99:1,22 100:7 104:14,17,19 105:17 107:7 108:25 109:4,13 110:8,9 115:21 117:19 118:3,7 122:25 123:8 124:1 131:8,19 132:3 134:16,18 139:6 141:3,7 145:21 147:22 148:14 149:9 153:5 155:15 157:19,22
thinking 144:23
third 1:21 11:4 62:22 71:11 138:17
third-party 139:22
Thompson 132:8,13
thousands 93:3
three 20:25 40:10 42:16,17 50:3 58:10,21 59:23 60:20 64:4,4,24 64:25 115:6 124:23 127:8,25
three-year 36:25
threshold 144:18
throat 43:14 91:22
throw 43:11
thumbnail 35:1 40:16 77:2
Thursday 158:3
tie 73:15
tilts 92:9
time 3:18 4:1,23 5:20 9:22 10:22 27:18 33:4 48:1 49:3,21,22 50:15 51:6 52:2 58:19 59:4 60:23,25 61:2,10,11 63:17 65:1 68:19 74:12 75:8 79:9,14 81:18 82:22 83:14 85:15,24 101:5 102:5 105:3 106:2,11 107:3,4 109:16 130:18,20 133:24 134:15 137:9,21 157:2,12 158:2
times 13:14 31:11 78:9 83:3,6 99:12,13 113:16,17,22,23,23,23 113:23,24 114:4,4,5 127:2 155:8
timing 52:25 53:13,14,18,19,22 149:17,17,18
title 19:4
today 3:12 6:21 15:6 33:14,23 34:3,8,9 35:7 51:25 60:21 68:14 73:21 102:8 135:15
today's 3:21 70:10,14 73:25 74:1
Todd 2:5 5:1
Todd.baran@state.nm.us 2:6
top 15:21 16:22 21:25 23:11 49:9 89:20
tort 38:16
total 28:14 32:14,16,19,20 42:25 43:1 46:6 80:8,10 94:25 95:18 99:21 101:4,12 125:22 126:21 149:16
touch 151:25
Towers 24:10
training 47:20
transactions 2:21 16:17
transcribe 159:4
Transcript 1:11
transcription 159:6
transfer 66:4
transferred 17:14
transfers 17:11,17
travels 63:6
treated 29:11
treating 111:3
treatment 57:2,8 152:15
treatments 58:11,23
trend 111:11
trended 73:23 74:8
triangle 59:2
triangles 53:1 59:17
tricky 119:10
true 8:11,14,21 11:17 12:2 18:8 159:6
truly 29:19
try 11:2 15:12 41:6 53:10
trying 41:3 45:21 58:4 59:3 66:23 68:3 103:25 121:9 132:16
turn 83:5 112:7 135:8 136:3
turning 123:12
turns 85:20
twelve 39:24 80:18
twenty-four 58:17
two 20:24 30:7 34:5,7,20 40:10 40:20 41:25 42:1 44:19 46:4,22 50:4 61:4 64:16,19 69:18 72:12 75:22 76:14,15 84:7 89:2 91:11 92:5 93:7,7,15 94:13 97:15 99:2 105:3,17,20 112:10 113:1,13 126:15 144:3 146:16 152:12 153:19
two-year 109:5
type 9:12 13:24 22:1 36:9 41:21 42:12 43:3 44:1 47:17,20 114:7
types 35:12 36:17 40:8 54:21 116:19 124:7
typically 69:17 88:20 127:25

U

U.S 34:23 90:12
uh-huh 23:6,21 27:19,22,25 31:6 31:12,23 32:22 62:13,18 63:18 76:22 85:13 88:9 97:11 99:4 105:5 107:11,15 109:3,19 112:4 116:13 117:3 152:3
Uh-hum 88:25 108:20

ultimate 42:18 54:7,12 55:5,6,8 55:13 56:7,7 59:8 61:7,17 62:17 63:16 64:3 73:14 74:8 75:10 78:10 85:15 120:24 129:7 143:20
ultimately 27:18 56:14 57:16 58:16 77:7 101:3 102:16
ultimates 55:23,23
umbrage 41:1 45:24
unaffiliated 146:14
unambiguous 145:24
uncertainty 83:4
uncommon 76:20
underlying 36:14 43:19 70:21 71:1,22 148:20 153:21
underpinning 34:8
understand 5:13 27:14 50:24 78:12 104:7 132:20 153:20
understandable 117:16
understanding 6:25 32:5 48:19 68:8 156:19,21
understood 110:9
underwriter's 113:18
underwriting 83:9 148:7
undeveloped 150:21
undiscounted 56:15 120:6,10
undoing 85:23
unexpected 150:16
unfairly 65:24 66:12,19 90:8 122:24 123:5 131:4
unfunded 101:14 102:5 103:21 104:6 152:20,22
union 142:9 154:22
United 38:22
unnecessarily 71:23
unpaid 34:6 35:8 52:14 54:3 58:25 73:16 100:14
unpredictable 142:1
unquote 93:8
unreasonable 150:17
upload 9:5 13:22,23 16:18,19 23:8,8
uploaded 9:6 13:23 15:3
uploading 6:14
usable 133:19
use 9:22,23 26:3 36:18 42:24 44:15 46:1 54:10 67:16 69:2 93:2,23 110:18 114:25 118:8 121:7 132:11 137:10 150:8
usually 18:10
utilize 98:10

V

valuable 80:2
value 49:21 52:21 60:25 61:2,11 63:17 66:3 79:9,14 82:22 85:16 85:24 100:13 101:5 143:8
values 54:7 113:22 143:2,20
variability 150:7
various 122:9
vast 80:3
vehicle 113:21
venue 35:20
verdict 138:12 146:15
verdicts 140:4
verify 16:25
version 83:1
versus 113:10
view 138:12
Vincent 69:22 119:3 133:6 134:6
Virginia 37:12 39:5,6,8
visits 124:14,16
vitae 34:16
volatile 140:5 141:25 142:6
volatility 143:1 148:23
volume 58:14 94:2 133:8 148:16

W

W-2 111:12 120:1 130:10 146:5
W-2-employed 119:19
W-o-o-d-b-i-n-e 33:13
waive 5:10
walk 17:1,4 52:14 56:4 64:13 65:9 67:15 73:9 77:1 91:3 116:25 124:2
Walling 2:12 5:3 25:2,5 33:5,6 33:10,12 46:7 52:3 73:8 126:10 131:5 135:8 136:14 146:2
Walling's 27:7,16 29:14 135:1
want 5:5 8:12 26:7 32:4 33:2 36:24 53:10 66:5 69:4 70:7 77:14 90:1 92:11 96:10 104:7 122:11 130:17 131:11,13,13,16 134:22,23,25 137:19 142:20,20 142:25 143:11 146:25 151:24 154:1 156:18
wanted 24:22 131:18 153:9
wants 5:14 158:7
warrant 137:14 144:25 145:5
Watson 2:11 24:11
waving 123:24
way 10:3 30:16,20 41:18 45:21 57:1 66:16 70:7 80:18 84:3 88:19 89:14 92:9 93:9,10 97:18 99:1 101:22 104:3 111:3 126:19 128:25 133:16,21 137:6 141:3,7 142:7 144:23 146:15 150:8
ways 54:11
we'll 50:8 74:3 84:13 88:7 135:2 135:3
we're 6:21 28:13 29:18 35:7 41:8 43:23 45:19 46:3,21,22 47:13 51:11,12,13 53:20 55:15 56:2 57:6,7 58:4,4,4,15,20,22 59:24 61:17,18 62:14,14,15 64:2 66:7 67:16 68:3,5 70:7 71:9 73:3 75:15,18 78:7 79:10 81:1,3,3,11 81:12 85:19 86:4,23,24 87:9,18 87:18 88:6 90:9 91:19,20 92:7,9 97:22,24 98:5,20 102:8 103:19 107:19,20 115:17 116:18 119:16 120:15 122:12,13 130:21,23 132:16 136:3,3 151:14 154:25 155:6,14
we've 5:16 38:25 43:22 44:12,24 45:4,23 47:6 53:19 59:25 67:22 67:25 69:19 73:12,13,23 74:2,4 77:16,18,20 82:25 85:14,16,16 93:6,7,23 100:7 104:14 112:12 119:15 122:8 124:2,22 128:10 129:20 134:11,11 138:11 149:14 150:25
wear 122:21
website 19:19 20:3
weeds 53:2
weekday 158:1
Weekend 158:1
welcome 5:6 23:15
went 33:20 47:22 103:2 127:11
weren't 150:16,16
whatsoever 159:11
wheelchairs 73:20
wherewithal 111:22,25
whether's 18:23

Whitmore 24:5,9,10,14,22 25:4 25:16,25 26:18 27:13,16,20,23 28:1,10,23 30:24 31:7,13,24 32:23 33:1 53:8
Whitmore's 41:2
Willis 24:10
window 27:21 41:3
Wisconsin 39:9,14,15 94:1 111:16
wiser 51:6
witness 2:8,12 6:10 20:17 22:25 23:6,10,15,17,19,21,23 33:3 46:8,10 53:6 56:17,20 57:1,4,20 57:22 59:15 62:3,7,11,14,19,24 63:2 74:21,23 76:10,13,15,17 76:23 84:24 85:1,3,6,9 88:9,14 88:16,19,24 89:1,7,9 100:24 104:20,24 105:1,5,8,13,15,19 105:25 106:4,6,8,10,16,18 107:12,16 108:2,5,8 109:3,7,20 109:25 112:2 116:9 118:6 126:14,25 127:2,4 131:6,12,17 131:24 132:1 133:3,25 134:3,5 134:19 144:6 146:3,6,11 158:3
witnesses 4:25 157:2,5
woefully 88:1 90:3
wondering 88:6
Woodbine 33:12
work 24:14 26:5 27:4,7,16 28:1 33:15 34:6,16 38:1,5,8,11,18 39:7,13 40:9 41:21 42:12 43:4 44:2 45:8 46:12 47:17 48:14,16 48:24 50:18 61:15 94:18 102:6 105:21 113:16,21 114:10 115:4 116:20,22 123:18 124:24 125:4 125:6 126:16 137:6 142:7,10 144:14
worked 37:19
workers' 142:8
working 11:1,15 12:4 16:12 40:17 138:20
works 18:8 93:10,11 133:3,4
worried 151:17,19
worry 32:21 139:2
worth 56:13 58:17,21,25 60:13 79:15 85:17 152:22
wouldn't 78:8
woven 67:11
wrap 96:13 134:16 135:1
write 50:14
writes 49:3
writing 129:14
written 4:6 24:20 96:10 136:18 156:15

X

Y

yeah 13:9 19:7 25:8,8 66:25 68:24 69:1 71:5 75:19 84:12 85:3 108:14 131:6 132:22 146:3 152:1 155:15
year 7:5 9:24 11:16 13:17 27:5 29:7,8 42:21 45:22 53:16,17 55:23,24 57:6 58:13,24 59:9,24 59:25 64:23 67:18,24 68:6 69:18 73:24 74:20,21,23 78:11 105:18,21,25 121:16 148:8 151:4,5 157:21
year's 55:12 56:8 77:8 103:18 114:13 116:6 141:21,22 143:10 152:19
year-end 101:11
yearly 7:9,17,21
years 20:24 21:8 40:10 48:6 54:8 54:14 58:20 59:13,23 67:17 70:1 72:6,12 77:6,10,11 81:13 82:25 101:8,8,10,25 103:5 105:4,17 107:10 109:11 112:13 115:6 119:3,5 121:1,8 143:21 148:9 149:4 151:9 153:1 154:18 154:21,24
Yep 64:15 92:13 96:1 97:5 105:15 117:6 120:5 135:10
York 37:12 38:13,16
younger 51:7

Z

zero 13:9 151:3

0

02 89:16
09 108:24

1

1 58:25 100:18 121:17 126:20
1,460.00 12:15
1,500,000 144:10
1,508 126:22
1.193 98:23
1.25 13:12,14
1.5 107:8
1.57 87:24 90:20
1.6 96:22
1.7 96:22
1.8 91:16
1.89 87:25
10 64:4 108:17,24 121:6 149:8
10.7 58:21
10:32 73:1
10:46 73:2
100 75:5
100.4 120:11,24 149:1
101 128:20
104 127:21 151:22
105 83:21 86:7,14 90:19 91:8 92:14,20 95:23 98:14 99:19,23
106 118:2 122:10 123:12 125:9
10th 3:16
11 75:21 76:1 77:17,20 79:21 80:16 81:8 107:24 122:3
11.6 58:22
1120 1:14 2:4
115 75:10,16
118 101:6
119 77:24 101:6,9
119.5 77:10 78:9 120:17
12 49:12,18 65:12 73:25 80:13,14 94:25
12-8-10 4:14
12-8-13 4:15
12-8-15 4:15
12.7 58:20
12/31 56:6
12:09 136:8
12:12 136:9
12:41 158:13
12th 157:25 158:3
13 80:17 86:15,16 95:1 107:5
13.21.1 4:19
13.21.4 4:18
13.8 29:2 81:24 85:2 86:6,11,20
137 74:11,14
137.1 74:10

13th 158:4,5
14 64:5 86:5 106:24 121:12
14,303,000 68:11,11
15 75:7 79:15 107:5,12 121:20
15.2 121:20
155 2:18,19,20,21,22
159 2:15
15th 3:20
16 105:7 106:21 146:21
1630 1:21
1699 2:4
16th 3:7 4:5,9 152:2
17 49:19 72:11 81:13 82:25 105:7 108:16 119:7 147:16 154:21
17th 3:17
18 1:14 56:6 77:14 106:11 150:21 151:1,9
19 34:15,17 48:1 106:20
19-00004-PCF 1:3 3:4
19.3 98:15 99:7
19.6 74:1
1976 70:18
1978 3:11 4:14,16
1st 157:17

2

2 98:19,20
2,920.00 12:10
2.3 106:24
2.7 79:7 80:5,6
2.8 106:24
20 16:10 37:4 49:20,24 72:6 95:1 95:4 153:1
200,000 144:4
2000 59:7 108:17
2002 38:11 105:1,2
2003 38:19 39:7 40:14 59:25
2007 39:11 106:19
2009 67:19 68:10,12 69:19 70:4 73:21,25 74:10 106:18,21 121:6 149:8
201 1:21
2010 75:15,21 76:1 77:17,20 80:16 107:24
2011 75:15
2012 58:19 59:1 77:10 106:24
2013 74:24
2014 70:13
2016 21:19 24:18 69:19 70:4 72:11 77:10 105:3,12 108:15 119:7
2017 53:16 56:4,10,19,21 60:16 70:4 77:14 150:21 151:1,6,9
2018 4:3 41:9 53:16 58:13 61:3,6 61:9 63:10,17 64:23 101:10,11 151:4,6
2019 1:14 3:7,13,16 4:3,7,9,10 39:12 42:21,23 100:3 136:15
2019-20 81:1
21 64:25
21,929,000 78:14
21.1 121:17
21.929 81:4
2109 33:12
22 121:16
22,384 11:6
22.176 121:16
22.2 79:18
229,000 87:5
229,411 96:5
22nd 3:23 157:16
23 49:25
23,861,000 125:7
23.1 91:16
24 2:11 37:22
24.6 64:24
24.9 86:21
24.945 80:20 81:2 84:2 86:17,18 91:12,20
248 125:2
25 16:3 21:3
25-year-old 93:12
25.45 121:22
25.8 61:10
26 79:16
26,211,000 78:16
26.2 79:13
27 92:4
276,000 87:5
29 49:25

3

3 81:4
3,504 11:23 12:7
3,889 99:2
3.3 85:22
3.5 96:23
30 16:10 50:6 59:13 84:3 101:8
300 111:17
30th 3:13 156:11
31 148:11
31.21 4:18
31.21.4 4:19
32 101:14,16 102:3
33 2:14 70:19 71:2 88:21
341 90:1
35 71:2
36.3 60:25
37 83:6 92:4

4

4 79:15,17 85:17,20
4,000 48:2
4,900 127:2
4,947 125:12
4,957 124:23 125:6
4.0 96:23
4.5 121:13
40 16:10 61:13 64:17
40.9 60:18
41 50:9 56:13
41-5-25 3:11
41-5-25(B) 26:1
44 67:20 100:20,24
45 81:21 82:5 85:5 134:16
45-5-1 4:16
45-5-29 4:17
45.8 61:7 64:23
46 55:18 56:4 60:15 64:23
46.8 106:12
47 54:5,5 58:8
48 55:17 64:24
4th 4:10 136:15

5

5-A 96:21,21
5.5 86:8,11 91:25
50 12:6 21:4 85:12 101:8
510 2:4
534 1:20 159:3,16
54-year-old 93:14
55 81:17,18 85:1,5,7,11
56 118:4
58 64:1,7,13 65:2,5 67:13 72:16

73:10 81:11,16,19,25 82:19 83:23 84:10,24 86:5,11,16
59 81:6,12 82:12,13 83:24

6

6 2:10 127:22
6,625.66 11:6
6.25 96:24
6.5 96:24
6.56 59:8,9
6/1/20 11:10
60 155:4,11
64 64:1,7,14,25 118:1,3,25 148:25
65 65:2 121:19 122:4
66 53:3,4 149:13
67 149:13

7

7 127:22
7,008.00 11:19
7.4 127:4
75 21:4 96:12
79 92:15,19 94:9 97:2
7th 4:7 156:15

8

8.75 29:7,8
80 76:6,21 83:16,17 84:15 85:21 85:25 92:2,15,19 98:10 99:20 100:4 107:18 109:2,15 122:15 123:7,10 125:8 135:20
81 92:15,20
82 97:4 98:21 99:5
83 97:4
85 76:6 79:11
87 101:13,24 102:1,2
87.1 101:12
87102 1:21
87504-1689 2:5

9

9.5 106:20,22
9/17/2019 11:10
9:00 1:14
90 83:2,12,14,23 84:17 92:3 106:11 107:3,17 121:21 122:10
90-day 155:11
90s 71:13,16
92 71:19
93 71:19
94 80:10 126:13
95 124:1 125:18 126:11 127:18 127:22
96 127:8,18 150:5
97 126:16
98 150:19
99 127:18,21 128:5

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Patient's Compensation Fund

BEFORE THE NEW MEXICO SUPERINTENDENT OF INSURANCE
AS CUSTODIAN OF THE PATIENT COMPENSATION FUND

IN THE MATTER OF DETERMINING	)	
NEW PATIENT COMPENSATION FUND	)	
SURCHARGE RATES	)	**Docket No. 19-00004-PCF**
	)	

PCF STAFF'S WRITTEN TESTIMONY

Pursuant to Paragraph 2 of the Order Appointing Hearing Officer and Setting Initial Case Schedule, PCF Staff respectfully submit the attached written testimony.

/s/ Todd S. Baran

Todd S. Baran
Associate General Counsel
Office of Superintendent of Insurance
Of Counsel for PCF Staff

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing pleading and evidence were sent by email to the following individuals, as indicated below, on this 7th day of October, 2019.

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Office of Superintendent of Insurance

New Mexico Patient's Compensation Fund

2019 Surcharge Rate Hearing

Report of

Robert J. Walling III, FCAS, MAAA, CERA

Prepared by
Pinnacle Actuarial Resources, Inc.

October 7, 2019

Commitment Beyond Numbers

Table of Contents

Section | *Page*

Section I. *Scope of Assignment* *1*

Section II. *Summary of Expert Opinions* *2*

Section III. *Qualifications* *3*

Section IV. *Data and Materials Reviewed* *5*

Section V. *Background* *6*

- *a) Exposure versus Experience Rating* *6*
- *b) CAS Statement of Principles Regarding Property and Casualty Insurance Ratemaking* *7*

Section VI. *Opinions and Basis for Opinions* *9*

EXHIBITS

Curriculum Vitae – Robert J. Walling III, FCAS, MAAA, CERA

I. Scope of Assignment

Pinnacle Actuarial Resources, Inc. (Pinnacle) has been retained by the New Mexico Office of the Superintendent of Insurance (OSI) to conduct an actuarial review of the New Mexico Patient's Compensation Fund (PCF). This review examines several aspects of the PCF including analyses of indicated reserves for unpaid losses and appropriate assessment surcharges for the upcoming policy period using data evaluated as of December 31, 2018. This year, the scope of the analysis included projections of:

1. Loss and loss reserves for unpaid claims obligations of the PCF as of December 31, 2018. These reserve estimates were stated on a nominal (undiscounted) basis as well as on a discounted basis, reflecting a 3.5% discount rate, and at a 90% level statistical confidence.
2. The PCF Fund balance as of December 31, 2018 based on the projected loss reserves.
3. The overall indicated percentage change indicated for surcharge levels applicable to physicians, surgeons and other participating healthcare providers. These projections were provided both on an undiscounted and discounted basis and stated at several different levels of statistical confidence.
4. PCF surcharge relativities by class for physicians, surgeons and other participating healthcare providers.
5. PCF surcharges for business entities.
6. The overall indicated percentage change indicated for surcharge levels applicable to hospitals and outpatient facilities. These projections were provided both on an undiscounted and discounted basis and stated at several different levels of statistical confidence.
7. An actuarially sound rating plan for PCF surcharges for hospitals and outpatient facilities.

II. Summary of Expert Opinions

Through a review of information associated with this matter, which are listed in Part IV of this report, I have come to a number of key findings. These findings are based on my experience as an actuary, my experience as a regulatory consulting actuary serving patient compensation funds and other medical professional liability government insurance programs, my experience in the insurance industry generally and with medical professional liability insurance in particular, and my review of the available documents. My key findings are as follows:

1. Pinnacle projects the amount of losses still to be paid for all PCF claims occurring prior to December 31, 2018 to be approximately $131.5 million on a nominal basis, $119.0 million on a discounted basis using a 3.5% discount rate, and $143.5 million when the discounted reserves reflect a risk margin to increase the statistical confidence to 90%.
2. The PCF Fund balance as of December 31, 2018 is a deficit of $44.4 million when unpaid claims reserves are stated on a nominal basis. This deficit is reduced to $31.9 million when unpaid claims reserves are discounted at an annual rate of 3.5%. When discounted reserves are stated at a 90% level of statistical confidence, the PCF deficit is $56.4 million.
3. The proposed changes in PCF surcharge relativities for physicians, surgeons and other participating healthcare providers by provider specialty or class groups including multiple specialties improve the actuarial soundness of the PCF surcharges.
4. 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.
5. After reflecting the additional surcharge income derived from the PCF surcharge relativities and the business entity coverage, the proposed increase in overall surcharges for physicians, surgeons and other participating healthcare providers is 19.3% at the 80% confidence level and reflecting a 3.5% discount rate.
6. The proposed overall increase in surcharges for hospitals and outpatient facilities is 8.0% at the 80% confidence level and reflecting a 3.5% discount rate.

7. The proposed hospital and outpatient rating plan provides an actuarially sound means of determining the indicated surcharges for each participating facility.

III. Qualifications

My name is Robert J. Walling III. I am a Principal and Consulting Actuary with Pinnacle Actuarial Resources, Inc. Pinnacle is an independent property and casualty insurance actuarial consulting firm. By property and casualty, I mean insurance risk other than life, health and pensions. For the last twenty-two years, I have worked as an independent actuarial consultant. My clients include insurance regulators, admitted insurance companies, captive insurance companies and risk retention groups, captive managers, insurance agents and brokers, self-insured public and private entities, agencies of state governments, government insurance programs, industry associations and law firms. Many of these engagements have involved medical professional liability (MPL) insurance generally, and specifically government insurance companies providing MPL insurance coverage. A significant amount of this work has been related to establishing or reviewing expected loss and premium estimates and estimating unpaid loss and loss adjustment expenses.

I am a Fellow of the Casualty Actuarial Society (CAS), a member of the American Academy of Actuaries (AAA), and a Chartered Enterprise Risk Analyst or Actuary (CERA). The CAS is a professional organization for property/casualty actuaries in the U.S., Canada and internationally. The CAS establishes membership requirements, codes of professional conduct, and statements of actuarial principles. I achieved membership in the CAS by passing ten rigorous tests covering a range of topics: calculus and probability, interest theory, economics and finance, applied statistics, risk theory, ratemaking, loss reserving, insurance accounting, reinsurance, annual financial statements, taxation, insurance law and regulation, investments, solvency, and advanced ratemaking topics. I meet the continuing education requirements of the CAS and am a member in good standing with both organizations.

I have satisfied all the qualification requirements of my profession to render a prescribed statement of actuarial opinion and have previously participated in hearings, testified or provided depositions and actuarial reports as an expert actuary in a variety of venues. A more detailed summary of my education, training, experience, presentations and publications is set forth in my Curriculum Vitae which is attached.

From 2015 to 2017, I served as a member of the CAS Board of Directors. I have previously served the CAS as Chairman of the Ratemaking Seminar Committee, Chairman of the Risk and Capital Management Seminar Committee, Chairman of the New Fellows Committee, and faculty member of the Limited Attendance Seminar on Dynamic Financial Analysis. I am a frequent author and speaker on issues related to pricing, product development, loss reserving, costing of legislative changes, and captive and other alternative risk transfer mechanisms for a wide variety of property and casualty insurance products and coverages. I also serve as an instructor for the International Council for Captive Insurance Education. Finally, I have served as an actuarial expert to state insurance regulators in states including Connecticut, Florida, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Missouri, New Mexico, New York, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, and Wisconsin. I have work on assignments related to patient compensation funds and other MPL government insurance programs, such as birth injury funds, in seven of these states.

The materials that I considered in preparing this report are listed in the ***Data and Materials Reviewed*** section of this report. Exhibits supporting my findings are also attached.

IV. Data and Materials Reviewed

A number of data sources were used in the development of this analysis. To assist in the performance of this review, Pinnacle has been provided with or reviewed:

1) "2018 Actuarial Analysis of the New Mexico Patients Compensation Fund," dated July 10, 2019.
2) "Actuarial Report Addendum: New Mexico Patient's Compensation Fund Class Plan and Entity Coverage Review," dated October 7, 2019.
3) "Actuarial Report Addendum: New Mexico Patient's Compensation Fund Hospital & Outpatient Health Care Facility Rating Plan," dated October 7, 2019.
4) "New Mexico Patient's Compensation Fund Indicated Rate Change Effective 9/1/19 through 9/1/20 – Physicians & Surgeons," dated October 7, 2019
5) "New Mexico Patient's Compensation Fund Indicated Rate Change Effective 9/1/19 through 9/1/20 – Hospitals & Outpatient Facilities," dated October 7, 2019

I have also reviewed a number of the applicable actuarial standards and statements of principles relevant to this case. These include:

1) CAS Statement of Principles Regarding Property and Casualty Insurance Ratemaking
2) Actuarial Standard of Practice No. 12, *Risk Classification (for All Practice Areas)*
3) Actuarial Standard of Practice No. 17 *Expert Testimony by Actuaries*
4) Actuarial Standard of Practice No. 20 *Discounting of Property/ Casualty Unpaid Claim Estimates*
5) Actuarial Standard of Practice No. 23, *Data Quality*
6) Actuarial Standard of Practice No. 29, *Expense Provisions in Property/Casualty Insurance Ratemaking*
7) Actuarial Standard of Practice No. 30, *Treatment of Profit and Contingency Provisions and the Cost of Capital in Property/Casualty Insurance Ratemaking*
8) Actuarial Standard of Practice No. 41, *Actuarial Communications*

9) Actuarial Standard of Practice No 53, *Estimating Future Costs for Prospective Property/Casualty Risk Transfer and Risk Retention*

10) CAS Code of Professional Conduct

V. Background

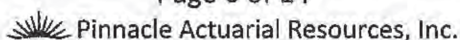
There are a couple of fundamental issues related to property-casualty ratemaking for commercial enterprises that are relevant background information supporting my findings.

Exposure versus Experience Rating

All personal insurance products and all but very large commercial insureds cannot estimate premiums solely based on the experience of the insured. As a result, exposure rating, which relies on a rate developed from aggregate data for similar insureds, is an essential element of premium development for most property casualty insurance. The need for exposure rating has its foundations in the law of large numbers and the closely related concepts of credibility and statistically independent exposure units.

The publicly available rate filings of large insurance companies and rating bureaus provide much larger, more credible sources of benchmark data to use in the ratemaking process. However, there may be differences between the exposures, coverages and/or claims in this data, relative to the individual risk being priced that must be reflected using adjustments to the benchmarks.

The CAS Statement of Principles Regarding Property and Casualty Insurance Ratemaking section on "Credibility" states: "Credibility is a measure of the predictive value that the actuary attaches to a particular body of data. Credibility is increased by making groupings more homogeneous or by increasing the size of the group analyzed. A group should be large enough to be statistically reliable. Obtaining homogeneous groupings requires refinement and partitioning of the data. There is a point at which partitioning divides data into groups too small



to provide credible patterns. Each situation requires balancing homogeneity and the volume of data."

The reason that rating bureaus and "me too" filings benchmarked off of large insurers are not only permitted but common practice is that without them most insurance companies, including captive insurance companies, would not have data of sufficient credibility to estimate expected losses with sufficient actuarial confidence.

Conversely, many commercial risks have sufficient experience that is predictive of their expected loss experience relative to the exposure rating plan to justify an adjustment to their indicated exposure rated premiums. Therefore, many commercial insurance products that utilize exposure rating also have an experience rating plan to reflect the predictive accuracy added to the projected premiums attributable to the claims experience of the individual insured.

CAS Statement of Principles Regarding Property and Casualty Insurance Ratemaking

Since its adoption by the CAS Board of Directors in May of 1988, CAS Statement of Principles Regarding Property and Casualty Insurance Ratemaking has arguably been one of the most important sources of guidance to U.S. property and casualty actuaries engaged in ratemaking. Many elements of this document are pertinent in this situation and will be cited throughout my expert report. As background information, the principles themselves are foundational to an understanding of how property-casualty actuaries determine rates. The principles are quoted below:

> **II. Principles**
> Ratemaking is prospective because the property and casualty insurance rate must be developed prior to the transfer of risk.
>
> **Principle 1: A rate is an estimate of the expected value of future costs.**

Ratemaking should provide for all costs so that the insurance system is financially sound.

Principle 2: A rate provides for all costs associated with the transfer of risk.

Ratemaking should provide for the costs of an individual risk transfer so that equity among insureds is maintained. When the experience of an individual risk does not provide a credible basis for estimating these costs, it is appropriate to consider the aggregate experience of similar risks. A rate estimated from such experience is an estimate of the costs of the risk transfer for each individual in the class.

Principle 3: A rate provides for the costs associated with an individual risk transfer.

Ratemaking produces cost estimates that are actuarially sound if the estimation is based on Principles 1, 2, and 3. Such rates comply with four criteria commonly used by actuaries: reasonable, not excessive, not inadequate, and not unfairly discriminatory.

Principle 4: A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer.

There are several important elements of the actuarial aspects of property casualty ratemaking contained within these four principles. Among them:

- The rates used to develop premiums are prospective, that is they provide for expected future costs.
- The rates used to develop premiums must provide for all prospective costs.
- The rates used to develop premiums must provide for all prospective costs related to the specific, individual risk transfer.
- Using actuarial methods and assumptions consistent with Principles 1, 2, and 3 results in actuarially sound rates and by extension premium that are not excessive, not inadequate and not unfairly discriminatory.

VI. Opinions and Basis for Opinions

The following is some extended discussion of each of my opinions. Additional discussion can be found in the applicable actuarial reports.

1. **Pinnacle projects the amount of losses still to be paid for all PCF claims occurring prior to December 31, 2018 to be approximately $131.5 million on a nominal basis, $119.0 million on a discounted basis using a 3.5% discount rate, and $143.5 million when the discounted reserves reflect a risk margin to increase to the statistical confidence to 90%.**

   Pinnacle's analysis of the projected unpaid claims liabilities as of December 31, 2018 was based on data provided by OSI, including detailed claims payment data as of the December 31, 2018 valuation date and summarized PCF surcharge data by accident year. Organizing data by accident year is a commonly used actuarial approach which summarizes claims that occur during a common period to facilitate the projection of ultimate losses. The accident year data was organized into loss development triangles which allowed the estimation of development patterns that facilitated the estimation of development patterns for paid losses, claim counts, and claim severities.

   Based on this data, Pinnacle developed four estimates or projections of ultimate losses by accident year. The four methods used: (Paid) Loss Development, Expected Loss Ratio, (Paid) B-F Method, and Frequency and Severity Method (this method was used only for Physicians and Surgeons) are commonly used and generally accepted actuarial methodologies. Pinnacle's central estimate of ultimate losses by year were then based on these four methodologies by year. These methods were applied separately to data for 1) physicians, surgeons and other healthcare providers, and 2) hospitals and outpatient facilities. Indicated unpaid claims obligations on a nominal (undiscounted basis) were computed as the projected ultimate losses less paid amounts through the December 31, 2018 accounting date.

In order to state the project unpaid claim liabilities on a present value basis, that is reflecting the potential time value of money, projections were made of future loss payments for the unpaid loss amounts. These payments were then discounted using a 3.5% annual discount rate to the accounting date of December 31, 2018.

However, stating the unpaid loss obligation on a discounted basis removes an implicit risk margin from the stated reserves as the full nominal amount is not required as of the accounting to fulfill the future claims payment obligations, if the insurance program is able to derive investment income on invested assets until the payments are made. Therefore, an explicit risk margin is needed to protect the PCF from potential adverse claims development. Consistent with previous analyses and the requested scope of work, Pinnacle developed risk margins for the unpaid claims obligations at the 90% level of statistical confidence. This risk margin was developed using a stochastic simulation model of the expected number of unpaid claims and their severity.

2. **The PCF Fund balance as of December 31, 2018 is a deficit of $44.4 million when unpaid claims reserves are stated on a nominal basis. This deficit is reduced to $31.9 million when unpaid claims reserves are discounted at an annual rate of 3.5%. When discounted reserves are stated at a 90% level of statistical confidence, the PCF deficit is $56.4 million.**

The PCF's stated Fund balance prior to the reflection of unpaid claims obligations was $87,104,681. Therefore, once the estimated unpaid claims liabilities are applied, the indicated Fund deficit of $44.4 million on a nominal basis, $31.9 million after discounting, and $56.4 million discounted and at the 90% confidence level.

This is not to suggest in any way that the PCF is at risk of being unable to pay their claims obligations. We estimate that annual claims payments will be between $20 to $27 million per year in the next five years. These payments can be met with the current PCF assets and the additional surcharge collections from these years. Rather, it suggests that there is a

long term unfunded liability associated with the claims occurring prior to December 31, 2018 that will need to be funded at some point.

3. **The proposed changes in PCF surcharge relativities for physicians, surgeons and other participating healthcare providers by provider specialty or class groups including multiple specialties improve the actuarial soundness of the PCF surcharges.**

Based on a detailed analysis of rating relativities for physicians, surgeons and other participating healthcare providers for admitted carriers in New Mexico and patient compensation funds in other states, Pinnacle proposes a number of changes in rating relativities for individual specialties and some class groups that include multiple specialties. The proposed changes include:

- Radiation Therapy and Shock Therapy (80163, 80165, and 80431) - Move from class 1 to class 2.
- Otorhinolaryngology – Minor Surgery (80291) - Move from class 2 to class 3.
- Gynecology – Minor Surgery (80277) - Move from class 3 to class 4.
- Intensive Care Medicine (80283) - Move from class 3 to class 4.
- Nephrology – No Surgery (80260) - Move from class 3 to class 2.
- Podiatrists/Chiropodists – No Surgery (80993-N) - Move from class 5 to class 4.
- Cardiac Surgery (80141) - Move from class 6 to class 8.
- Nephrology – Including Child – Minor Surgery (80288) - Move from class 6 to class 4.
- Obstetrics Surgery (c-sections only) (80168) - Move from class 6 to class 8.
- Pediatrics – Minor Surgery (80293) - Move from class 6 to class 4.
- Class 5A: Increase the relativity from 1.60 to 1.70.
- Class 7: Reduce the relativity from 4.00 to 3.50.
- Class 10: Increase the relativity from 6.25 to 6.50.

Because the admitted primary medical professional liability insurers and the patient compensation funds in other states are all larger and possess more credible, that is larger and more predictive, databases of exposures and losses, the information in their filed and approved

class relativities is useful in estimating differences in expected loss experience for the PCF by specialty. Therefore, the revised surcharge relativities are more in line with expected claims experience and thus result in more actuarially sound rates. This is because the proposed relativities are less likely to be "unfairly discriminatory."

In total, the proposed changes in specialty and class group relativities result in approximately $201,673 in additional surcharges.

4. **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.**

   Pinnacle reviewed publicly available, filed and approved rate filings for leading medical professional liability insurers to assess the indicated surcharge for business entity coverage. The generally accepted approach is a percentage surcharge of the medical professional liability insurance premiums of the physicians, surgeons and other participating healthcare providers insured by the policy. Based on my years of reviewing these rate filings, a 10% surcharge is widely used for the business entity premium rate.

   The PCF does not have sufficient data to support a credible analysis of the indicated business entity surcharge. Further, the approach of benchmarking off of the filed and approved rates and rating plans of large commercial carriers allows the PCF to leverage off of the large and credible data sets these carriers possess. Further, because these rates and rating rules have been filed and approved, they have been found to be actuarially sound, that is no excessive, inadequate or unfairly discriminatory by the governing state insurance regulators. Therefore, we believe that following the generally accepted industry practice is appropriate.

This change will generate approximately $1.57 million in additional surcharges and thereby reduce the indicated change in surcharges for physicians, surgeons and other participating healthcare providers.

5. **After reflecting the additional surcharge income derived from the PCF surcharge relativities and the business entity coverage, the proposed increase in overall surcharges for physicians, surgeons and other participating healthcare providers is 19.3% at the 80% confidence level and reflecting a 3.5% discount rate.**

At the current surcharge levels, we anticipate approximately $21.929 million in surcharges for the upcoming policy period. We also estimate losses for the accident year from 9/1/19 through 9/1/20 to be approximately $24.945 million on a discounted basis, resulting in a shortfall of just over $3 million. At higher levels of statistical confidence, this shortfall increases. At the 80% confidence level, the anticipated losses are $28.203 million, resulting in an anticipated shortfall almost $6.3 million. However, the proposed class plan changes for physicians, surgeons, and other participating healthcare providers and the proposed change to business entity surcharges produce an additional $2.035 million in additional surcharges, reducing the indicated percentage change in surcharges to 19.3% at the 80% confidence level.

6. **The proposed overall increase in surcharges for hospitals and outpatient facilities is 8.0% at the 80% confidence level and reflecting a 3.5% discount rate.**

In the actuarial report issued to OSI and the PCF in July, Pinnacle projected indicated changes to the overall surcharge levels for hospitals and outpatient facilities discounted at 3.5% and reflecting both the actuarial central estimate of ultimate losses and also at the 90% level of statistical confidence. OSI requested that we produce an additional exhibit stating the indicated surcharge changes at the 65%, 70%, 75% and 80% confidence levels. At these confidence levels, the indicated surcharge increases are +0.9%, +3.0%, +5.3% and

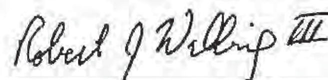
+8.0% respectively. The risk margins at these additional confidence levels are based on the same stochastic simulation model that produced the 90% confidence level in the initial actuarial report.

7. **The proposed hospital and outpatient rating plan provides an actuarially sound means of determining the indicated surcharges for each participating facility.**

In order to facilitate OSI performing the underwriting and premium determination for hospitals and outpatient facilities participating in the PCF, Pinnacle developed an exposure rating model. This rating model utilizes rates per unit of exposure. The ratable exposures included in the model are commonly used by hospital professional liability insurers and reflect the relative loss potential of these exposures. The surcharges by exposure were also selected so that the targeted overall surcharge increase of +8.0% at the 80% confidence level would be realized.

An experience rating plan that modifies the surcharges of larger hospitals (those with more than $1.5 million of indicated surcharges) is proposed. The experience rating plan is based on a comparison of the number of PCF layer claims during a five year period compared to the expected number of PCF layer claims for the risk given their current ratable exposures. This approach will be responsive to large hospitals and outpatient facilities whose PCF claims frequency is better or worse than expected, but will also provide surcharges that do not overreact to a single large PCF claim.

This report submitted by Robert J. Walling III.



October 7, 2019
Date

Robert J. Walling III, FCAS, MAAA, CERA

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	Certification in Secondary Mathematics Education	
CONTINUING EDUCATION	Estimated study time exceeding 4,000 hours necessary for completion of qualifying exams for membership in Casualty Actuarial Society (CAS) Meets and exceeds all annual requirements of the Casualty Actuarial Society (CAS) and the American Academy of Actuaries (AAA).	
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	Fellow	2001
	Associate Member	1995
	American Academy of Actuaries	1995
	Chartered Enterprise Risk Analyst	2013
	Midwestern Actuarial Forum	1989
	American Society for Healthcare Risk Management	2011
	Public Risk Management Association	
	Risk and Insurance Management Society	
	Vermont Captive Insurance Association	
	South Carolina Captive Insurance Association	
EMPLOYMENT HISTORY	Pinnacle Actuarial Resources, Inc.	2003 – Present
	Miller, Herbers, Lehmann, & Associates, Inc.	1997 – 2002
	Shelby Insurance Company / Anthem Casualty	1992 – 1997
	Providence Washington Insurance Companies	1991 – 1992
	Great American Insurance Group	1989 – 1991
PROFESSIONAL ACTIVITIES	American Academy of Actuaries	
	Retained Risk Working Group	2016 - Present
	Government Insurance Task Force	2017 - Present
	International Center for Captive Insurance Education (ICCIE)	
	Instructor	2016 - Present
	Self-Insurance Institute of America (SIIA)	
	Captive Committee	2016 - Present
	CAS Finance Committee	2015 – Present
	Actuarial Standards Board Casualty Committee	2014 – Present
	CAS University Liaison – Miami University	1999 – Present
	CAS Board of Directors	2014 – 2017
	Vermont Captive Insurance Association	
	Conference Committee	2009 – 2015

PROFESSIONAL ACTIVITIES (cont.)	CAS Leadership Development Committee	2012 – 2014
	Captive Insurance Company Association Actuary/Consultant Best Practices Committee	2009 – 2010
	AAA Medical Professional Liability Subcommittee	2009 – 2010
	Actuarial Review Editorial Board	2003 – 2008
	CAS Ratemaking and Product Management Seminar Committee	2008 – 2009
	CAS Ratemaking Seminar Committee	1997 – 2002, 2004 – 06
	Vice Chairperson for CAS Ratemaking Seminar	2000 – 2001
	Chairperson for CAS Ratemaking Seminar	2001 – 2002
	CAS Task Force on ACAS Voting Rights	2004
	CAS Working Group on Executive Level Decision Making Using DFA	2004
	Chairperson, CAS Risk & Capital Mgmt. Seminar	2002
	Chairperson, CAS DFA Seminar	2000 – 2001
	Vice Chairperson, CAS DFA Seminar	2000
	Faculty Member, CAS Limited Attendance Seminars on Dynamic Financial Analysis	1998 – 1999, 2001 – 04
	Chairperson, CAS New Fellows Committee	2003 – 2006
	Vice Chairperson, CAS New Fellows Committee	2003
	CAS Committee on Health and Managed Care Issues	1996 – 2001

PROFESSIONAL PUBLICATIONS

"The Future of ERC Captives," *Best's Review Issues & Answers,* August 2017

"The Actuary's Role in Captive Formation," *Captive Review – How to Start a Captive Report 2017*

"Common Ground With The IRS?" *Captive Review Domiciles,* April 2017

"The Case for Birth Injury Funds," *Pinnacle Actuarial Resources Monograph Program,* March 2017

"A Guide to Actuarial Reports," *International Risk Management Institute,* March 2017

"Diversification in the Medical Professional Liability Market," *Inside Medical Liability*, PIAA, First Quarter 2017 (Also published in *Pinnacle Actuarial Resources Monograph Program,* January 2017)

"Puerto Rico: The Right Place, the Right Time?" *Captive Review*, November 2016

"Workers Comp: Approaches That Work," with Jing Liu, FCAS, MAAA, *Captive Review*, October 2016

"Will Captives Capitalize on Analytics?" *IRMI Captive Insurance Company Reports*, October 2016

"How Do Actuaries Preserve Their Market Value?" *Actuarial Review*, September/October 2016

"Your Results May Vary," with Erich A. Brandt, FCAS, MAAA, and Gregory W. Fears, Jr., ACAS, MAAA, ARM, *Risk Retention Reporter* (Also published in *Pinnacle Actuarial Resources Monograph Program,* September 2016)

"Captive Expertise," *Best's Review Issues & Answers,* August 2016

"The Actuary's Expanding Role in the Era of Big Data," *Captive Review – Captive Start-Up Report 2016* (Also published in *Pinnacle Actuarial Resources Monograph Program,* September 2016)

"The Benefits of Automated Underwriting," *Pinnacle Actuarial Resources Monograph Program,* May 2016
"More Than Insurance, Homegrown Vermont RRG Protects Land that Americans Love," VCIA Newsletter: *The Captive Chronicle*, May 2016
"A Deep Dive into the Casualty Group Captive Space," *TerrillConnect* Interview, March 2016
"Healthcare Provider Captives: An Alternative Approach to Evolving Coverages," *Inside Medical Liability*, PIAA, First Quarter 2015
"Expert Captive Analysis," *Best's Review Issues & Answers,* August 2014
"Innovative Uses of Captives for Health Care Providers," *Pinnacle Actuarial Resources Monograph Program,* August 2014
"Using the Hospital Medicare Licensee Database for Analytics," *Pinnacle Actuarial Resources Monograph Program,* October 2013
"Effects of Loss Reserve Margins on Calendar Year Results – Balcarek Expanded," with Erich A. Brandt, FCAS, MAAA, *CAS Forum*, Fall 2013
"External Peer Review," *Pinnacle Actuarial Resources Monograph Program,* January 2013
"DD&R Reserves for Claims-Made Professional Liability Coverage," with Jessica Lasher, CPA, *Johnson & Lambert Industry Insights*, September 2011 (Also published in *Pinnacle Actuarial Resources Monograph Program*)
"Improving Commercial Casualty Claims Handling with Predictive Analytics," *Pinnacle Actuarial Resources Monograph Program,* October 2010
"How I Became a Negative Patient Outcome Statistic – and What I Learned," *Physician Insurer*, Second Quarter 2010
"Underwriting Power Tools for Small Business Insurance," *Pinnacle Actuarial Resources Monograph Program,* September 2008 (reprinted in National Association of Mutual Insurance Companies (NAMIC) Farm Forum in 2009)
"Medical Malpractice Predictive Modeling: A Push-Me-Pull-You Proposition" *Physician Insurer*, First Quarter 2008
"Commercial Auto Predictive Modeling: The Time Is Now," *Pinnacle Actuarial Resources Monograph Program,* September 2007 (Reprinted in Best's Review October 2007 as "Rules of the Road: Predictive Modeling Can Help Commercial Insurers Set Premiums")
"Having to Say You're Sorry: A More Efficient Medical Malpractice Insurance Model" Contingencies, November/December 2006
"I Like You as a Neighbor, But We're Not Sharing Checkbooks (Opportunities and for public entity groups)" *Public Risk Magazine,* June/July 2006
"What Makes an Effective Captive Application: Actuarial Do's and Don'ts" *Captive Chronicle,* June/July 2006
"Medical Malpractice Insurance: A Call for Efficiency" *Pinnacle Actuarial Resources Monograph Program,* May 2006
"The Case of the Medical Malpractice Crisis: A Classic Who Dunnit," *CAS Forum,* Summer 2004
"Are You Ready to Unlock the Power Hidden in Your BOP Application," *Pinnacle Actuarial Resources Monograph Program,* July 2003
"A Dynamic Approach to Modeling Free Tail Coverage," *CAS Forum*, Fall 1999
"Customizing the Public Access Model Using Publicly Available Data," *CAS Forum,* Summer 1999

"Using the Public Access DFA Model: A Case Study," *CAS Forum,* Summer 1998

CURRENTLY APPOINTED ACTUARY

American Risk Management Risk Retention Group	2016 - Present
Asset Protection Program Risk Retention Group	2014 – Present
Aviation Alliance Insurance Risk Retention Group, Inc.	2012 – Present
Blackshield Indemnity International Insurer	2017 - Present
C.A.R. Risk Retention Group, Inc.	2016 – Present
Cedar Rapids Insurance Ltd.	2003 – Present
Continuing Care Risk Retention Group	2015 – Present
Emergency Medicine Professional Assurance Co. RRG	2016 - Present
Florida Lawyers Mutual Insurance Company	2010 – Present
FS Preferred Insurance Company	2004 – Present
Great Plains Casualty, Inc.	2007 – Present
Highland Fidelity Limited	2014 - Present
Madison International Insurance Company, I.I.	2016 - Present
Madison RE, International Insurer	2015 – Present
Missouri Doctors Mutual Insurance Company	2015 - Present
Pamlico Insurance Company Limited	2016 - Present
PCH Mutual Insurance Co., Inc., A Risk Retention Group	2016 - Present
Peninsula Insurance Company, Ltd.	2008 – Present
PIA Professional Liability Insurance Company, RRG	2013 – Present
Romulus Insurance Risk Retention Group	2015 – Present
SCRUBS Mutual Assurance Co. Risk Retention Group	2016 - Present
Spencer Re Insurance Company	2017 - Present
Terra Firma Risk Retention Group	2014 – Present
The Captive Advantage for Human Services	2012 - Present
Traders and Merchants Insurance Company, Ltd.	2015 - Present

Currently provides statements of actuarial opinion for scores of captive insurance companies not required to file NAIC annual financial statements.

PROFESSIONAL PRESENTATIONS

Numerous interviews and presentations at educational seminars conducted by the CAS and other industry organizations on topics including:

- Captives and Alternative Markets Pricing and Loss Reserving
- Dynamic Financial Analysis and Enterprise Risk Management (ERM)
- Ratemaking and Loss reserving for Workers Compensation, Professional Liability, Commercial Automobile, Business Owners Policy (BOP) and Commercial Specialty Lines
- Predictive Analytics for Commercial Lines Insurance
- Loss Reserving issues specific to Medical Professional Liability
- Self-Insured Funding and Reserving for Individual and Group Programs
- Legislative Costing for Medical Professional Liability, Workers' Compensation, Commercial Auto Liability, Contractors Liability
- Workers Compensation Managed Care
- Actuarial Professionalism

PROFESSIONAL PRESENTATIONS

Presentations at actuarial, captive insurance and property and casualty educational seminars include:

- American Association of Insurance Services (AAIS) Conference
- Bermuda Captive Conference
- British Virgin Islands Captive Insurance Educational Conference
- Captive Alternatives Annual Meeting
- Captive Insurance Companies Association (CICA) Annual Meeting
- Casualty Actuarial Society (CAS)
    - Casualty Loss Reserve Seminar (CLRS)
    - Central States Actuarial Forum
    - Midwestern Actuarial Forum
    - Ratemaking Seminar
    - Ratemaking and Product Management (RPM) Seminar
    - Special Interest Seminars
    - Spring and Fall Annual Meetings
    - Webinar Program
- Farm Bureau Actuaries Conference
- Illinois State University – Katie School of Insurance – Financial Regulators Program
- Insurance Managers Association of Cayman (IMAC)
    - Annual Meeting
    - Summer Educational Conference
- Insurance Regulatory Examiners Society (IRES)
- International Center for Captive Insurance Education (ICCIE) Webinars
- Montana Captive Insurance Association Annual Conference
- National Association of Insurance Commissioners (NAIC) Quarterly Meeting
- National Association of Mutual Insurance Companies (NAMIC)
    - Commercial Lines Underwriting Seminar
    - Annual Meeting
- North Carolina Captive Insurance Association Meeting
- Oxford Risk Partners Annual Conference
- Property Casualty Insurers Association of America (PCI) Joint Marketing and Underwriting Seminar
- Physician Insurers Association of America (PIAA) Annual Meeting
- Public Risk Management Association (PRIMA) Annual Meeting
- Risk and Insurance Managers Society (RIMS) Conference
- Self-Insurance Association of America (SIAA)
    - Annual Conference
    - International Conference
- Society of State Filers
- South Carolina Captive Insurance Association Meeting
- Tennessee Captive Insurance Association Conference
- USA Risk Annual Conference
- Vermont Captive Insurance Association Annual Conference
- Western Regional Captive Insurance Conference (WRCIC)
- Willis Re Healthcare Reinsurance Forum

EXPERT TESTIMONY/ REPORTS

Florida Office of Public Policy and Governmental Accountability, 2004-07
Florida Office of Insurance Regulation, 2014
Illinois Department of Insurance, 2010
Indiana State Medical Association, 2014, 2016
Maine Joint Standing Committee on Insurance and Financial Services, 2004
Maryland Insurance Administration, 2013
Maryland Legislature, 2014-2017
Massachusetts Division of Insurance, 2012
Michigan Office of Insurance and Financial Regulation, 2007-2008
Missouri Division of Workers Compensation, 2009-2012
Missouri Second Injury Fund, 2011-2013, 2017
New Mexico Patients Compensation Fund, 2002 - 2017
New York Department of Financial Services, 2010 - 2017
New York Medical Indemnity Fund, 2011-2017
Ohio Medical Malpractice Commission, 2003
Oregon Medical Association, 2005
Oregon Prof. Panel for Analysis of Medical Professional Liability Ins., 2004
Oregon Construction Claims Task Force, 2006
Republican Governors Association, An Analysis of the Impact of Workers' Compensation Reform in Nevada, 2005
Virginia Birth Related Neurological Injury Compensation Program, 2003 - 2010
Virginia State Corporation Commission, Bureau of Insurance, 2011 - 2016
Virginia Medical Society, 2008
Wisconsin Assembly Committee on Insurance, 2005
Wisconsin Injured Patients and Families Compensation Fund, 2007 - 2016
Wisconsin Medical Society and Wisconsin Hospital Association, 2005, 2007

Numerous written and oral testimonies in support of arbitrations, mediations, and litigations associated with commercial lines insurance issues in numerous venues including the U.S. Tax Court, U.S. Bankruptcy Court, U.S. District Courts, and state courts.

2018 Actuarial Analysis of the

New Mexico Patients Compensation Fund

July 2019

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Commitment Beyond Numbers

Table of Contents

Section	*Page*
Executive Summary	1
Unpaid Claims Liabilities	1
PCF Surplus/Deficit	2
Expected Surcharge Levels	2
Background	3
Data Sources	4
PCF Financial Statement Data	4
Industry Rate Filings	5
PCF Claims Data	5
Discussion and Analysis	6
Estimated Unpaid Claims Liabilities as of December 31, 2018	6
Methodology	7
PCF Surplus/Deficit	10
Expected Surcharge Levels	10
Glossary of Terms & Abbreviations	11
Legal Disclosures	14
Distribution and Use	14
Reliances and Limitations	14

Exhibits

2018 Actuarial Analysis of the New Mexico Patients Compensation Fund

Executive Summary [1]

The New Mexico Patients Compensation Fund (PCF) serves a vital role in supporting the overall health of the medical professional liability insurance (MPLI) system in New Mexico. The PCF provides excess coverage that stabilizes the operating results of participating insurers and encourages competition which leads to greater availability and affordability of coverage. In New Mexico and other states, a competitive MPLI market tends to attract new physicians leading to greater access to care. The coverage provided by the PCF requires the use of an occurrence coverage form, preferred by healthcare providers, with limits that provide comprehensive coverage to ensure that injured patients receive appropriate compensation for their injuries. As a result, all stakeholders in the New Mexico healthcare system benefit in some way from a healthy PCF.

One way that the New Mexico Office of Superintendent of Insurance (OSI) ensures the ongoing health of the PCF is to conduct a periodic actuarial review. This review examines several aspects of the PCF including analyses of indicated reserves for unpaid losses and appropriate assessment surcharges for upcoming policy periods.

Through a review of a number of both publicly available and proprietary data sources, Pinnacle has come to a number of key conclusions regarding a number of aspects of the PCF. The highlights of our findings regarding the various issues include:

Unpaid Claims Liabilities

- Pinnacle estimates the amount of losses still to be paid for all claims occurring prior to December 31, 2018 to be approximately $131.5 million on a nominal basis, $119.0 million on a discounted basis using a 3.5% discount rate, and $143.5 million when the discounted reserves reflect a risk margin to increase to the statistical confidence to 90%. These are all increases from the values as of December 31, 2017 of $100.9 million (nominal), $91.2 million (discounted) and $109.9 million (discounted at 90% confidence).

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[1] Third parties receiving only this Executive Summary should recognize that the furnishing of this summary is not a substitute for their own due diligence and should place no reliance on this summary that would result in the creation of any duty or liability by Pinnacle to the third party. Pinnacle is available to answer any questions regarding the information contained in the Executive Summary.

PCF Surplus/Deficit

- The current PCF Fund balance of approximately $87.1 million as of December 31, 2018, when compared to Pinnacle's estimate of indicated nominal loss reserves of approximately $131.5 million, suggests a Fund deficit position of $44.4 million, or just over 50% of the current Fund balance. This is an improvement of $11.0 million since our analysis as of December 31, 2017.
- Reflecting reserves on a present value basis, using a 3.5% discount rate, results in a Fund deficit of approximately $31.9 million. This is an improvement of $13.7 million since our analysis as of December 31, 2017.
- If discounted loss reserves are increased to the 90% confidence level, the resulting reserves indicate a $56.4 million PCF surplus deficit.

Expected Surcharge Levels

- Pinnacle's prospective rate level indication for physicians & surgeons suggests an increase of +13.8% on an expected value basis. If adjusted to a 90% level of statistical confidence, an indicated increase of +37.2% results. This estimate only reflects expected future losses and does not contemplate funding to reduce the indicated Fund deficit.
- Given the magnitude of the current indicated Fund deficit, a small additional increase in surcharges to begin reducing the deficit would be reasonable from an actuarial perspective.
- Pinnacle's rate level indication for hospitals suggests a decrease of -4.5% on an expected value basis. At a 90% level of statistical confidence, the indicated increase is +15.2%. Stable loss ratios in the three most recent years support keeping in assessments level.
- We received a more accurate breakdown of losses for this analysis detailing the split of PCF payments when both a physician and hospital were named as providers on a claim. This breakdown showed that 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.

Background

The PCF was established in 1976 to provide for the payment of claims in excess of a primary limit of $100,000 per incident which was provided by private insurers. This resulted in the PCF providing coverage with a non-medical indemnity limit of $400,000 per incident (to reach the state damage cap on non-medical damages), plus unlimited medical benefits. Effective July 1, 1991, the primary limit was increased to $150,000 on new and renewal policies, thereby reducing the PCF's liability limit to $350,000 non-medical indemnity, plus unlimited medical. The PCF's liability was further reduced to $300,000 effective April 1, 1992 when the primary limit was increased to $200,000. Most recently, an increase in the maximum non-medical indemnity amount to $600,000 effective April 1, 1995 increased the PCF liability retention to $400,000 non-medical indemnity, plus unlimited medical.

The unlimited medical feature of the New Mexico PCF presents significant risk for the PCF and additional variability in estimating the current liabilities and prospective rates. Since the detailed data available to estimate the unpaid claims liabilities and indicated surcharge levels only goes back to calendar year 2000, some adjustments are required to this data. These adjustments, as well as the methods and assumptions used to estimate indicated loss reserves and PCF surcharges are detailed later in the report and in the attached exhibits.

Pinnacle Actuarial Resources, Inc. (Pinnacle) has been retained by the New Mexico Office of Superintendent of Insurance (OSI) to conduct a comprehensive actuarial analysis of the New Mexico Patients Compensation Fund (PCF). This analysis will contain several components including evaluation of:

- the estimated ultimate liabilities for losses incurred by the New Mexico Patients Compensation Fund (PCF) as of December 31, 2018, and
- recommended PCF assessment surcharges to fund the operations of the PCF for the effective date of September 1, 2019.

Pinnacle is an Illinois corporation that has been in property and casualty actuarial consulting since 1984. Our actuarial consultants make Pinnacle one of the largest property/casualty actuarial consulting firms in the U.S. We specialize in insurance pricing, loss reserving, alternative markets, legislative costing, market analysis and financial risk modeling.

Pinnacle has established a reputation as a provider of unbiased, independent, actuarially sound analyses and reports. This reputation is demonstrated in the variety of clients that have engaged us for projects similar to this one. Clients that have engaged Pinnacle in areas of medical professional liability

including governmental insurance programs, legislative costing and market evaluation have included healthcare industry associations (e.g. American Medical Association, Oregon Medical Association, Medical Society of Virginia), insurance departments and governmental panels (e.g. Connecticut, Florida, Illinois, Indiana, Maine, Michigan, New York, Ohio, Oregon), and government insurance programs, (e.g. Florida Neurological Injury Compensation Association, New Mexico Patient Compensation Fund, New York Medical Indemnity Fund, Virginia Birth Related Neurological Injury Compensation Program, Wisconsin Patients Compensation Fund). Pinnacle may be unique in the breadth of parties involved in the medical professional liability insurance system that have engaged us.

Data Sources

Our analyses use a number of data sources. The data sources are categorized as follows:

1. PCF Financial Statement Data
2. Industry Rate Filings
3. PCF Claims Data

A brief description of the data sources utilized in each area along with a description of the key data elements and potential limitations of the data follows for each category.

PCF Financial Statement Data

Unlike insurance companies who are required to provide extensive, detailed financial information annually that complies with a standardized format prescribed by the National Association of Insurance Commissioners (NAIC), most governmental insurance programs, such as the PCF, have much simpler financial reporting requirements.

Pinnacle was provided a single document, one page in length, related to and supporting the financial statements of the PCF. While in analyses prior to 2015 monthly cash flows in and out of the PCF were provided dating back to 1996 (including surcharge collections, loss payments, interest earned, underwriting expenses and claims handling expenses), for this analysis as well as the 2015 and 2017 analyses we were provided only with loss, expense and operating payments; surcharges; and the total PCF funds for calendar years 2014 through 2018. However, for this analysis we were also provided with categories of operating expenses to consider in the surcharge evaluation as well as significantly revised PCF total funds.

Industry Rate Filings

Insurance company rate filings provide valuable insights into individual insurance company perceptions of prospective claim trends. Many of these filings include rigorous actuarial analyses of claim frequency, severity and pure premium trends. Due to data limitations, these trend analyses are often performed on countrywide data to increase statistical credibility. Pinnacle reviewed several publicly available filings for medical professional liability insurance (MPLI) providers and government insurance programs in New Mexico and other states to assess trends in the MPLI marketplace and for MPLI excess insurance programs in particular. Pinnacle relied on this information without independent review or verification. However, given that information had been through regulatory scrutiny, we are comfortable that the information is appropriate for the limited role it plays in our analysis.

PCF Claims Data

The enabling statute for the PCF (41-5-25) requires that the PCF surcharges be based on data obtained from New Mexico experience if available. When Pinnacle began performing these studies for OSI, credible New Mexico loss data in the PCF layer was only available on a calendar year basis which is not appropriate for reserving or ratemaking. As a result, prior analyses relied on New Mexico data for losses limited to $100,000 from the two major primary insurers in New Mexico that participate in the PCF.

Starting with our 2010 study, OSI has been able to provide detailed claim data for most claims paid since 2000. Most of this data had valid loss dates and payment dates as well. In addition, a table of open claims with loss date information was also provided. These databases enabled Pinnacle to develop a much more direct approach to estimating indicated loss reserves as well as prospective assessment surcharge levels. However, for the 2015 analysis, only calendar year 2014 and 2015 aggregate loss payments were provided. We were again provided with detailed claim data for the 2017 and current analyses, which show that the prior estimated calendar year 2014 and 2015 payments were much too high. We have relied upon the individual claim data provided to us for the current analysis and prior analyses.

Starting with the 2017 analysis and continuing in the current analyses, significant effort has gone into improving the loss database provided to us by OSI. These improvements now allow us to sort payments by hospital/provider more precisely. We anticipate that this improvement to the database going forward will provide material insights into the PCF payments.

We were also provided with specific information regarding two large groups of claims. For the first group (Batch #1), we understand that early in 2012, a group of approximately 69 claims associated with a single physician and medical center were all settled. Most of these claims occurred in the 2007-

2009 period. It has been represented to us that the settlement paid by the PCF on Batch #1 claims is $11.7 million. We were provided the approximate number of claims per accident year by the department and have reflected this settlement across accident years 2006-2009, allocating the settlement by the number of claims falling in each accident year.

The second group of claims (Batch #2) were made for a single physician and associated corporations for a total of 31 incidents in accident years 2005-2010. These claims were settled for $10,182,000. We have allocated this amount based on the claim counts in each accident year from 2005 through 2010.

Please note that for the purposes of this report, the accounting date and the valuation date was December 31, 2019. The review date (the cutoff date for including information to the actuary) was May 22, 2019.

Discussion and Analysis

Estimated Unpaid Claims Liabilities as of December 31, 2018

Pinnacle estimates the amount of losses still to be paid for all claims occurring prior to December 31, 2018 to be approximately $131.5 million on a nominal basis, $119.0 million on a discounted basis using a 3.5% discount rate, and $143.5 million when the discounted reserves reflect a risk margin to increase to the statistical confidence to 90%. These results are summarized in Exhibit 1. These amounts represent estimates of the losses that remain to be paid from the current Fund balance if the PCF had ceased operations as of December 31, 2018. These are all increases from the values as of December 31, 2017 of $100.9 million (nominal), $91.2 million (discounted) and $109.9 million (discounted at 90% confidence).

The present value as of December 31, 2018, assuming a 3.5% annual discount rate, of unpaid losses on claims occurring through December 31, 2018 is estimated as $119.0 million. The $31.9 million difference between the discounted losses and the estimated December 31, 2018 PCF Fund balance ($87.1 million) represents the present value of the expected deficit between the currently available funds and the funds needed to meet all outstanding claim obligations as of December 31, 2018. The current PCF Fund balance is also $44.4 million lower than the nominal reserve estimate. If discounted loss reserves are increased to the 90% confidence level, the resulting reserves indicate a $56.4 million PCF surplus deficit.

Methodology

Pinnacle's estimates of ultimate losses for the PCF were developed based on four actuarial methods for the physician data and three methods for the hospital data. The methods used are paid loss development, expected loss ratio method, paid loss Bornhuetter-Ferguson (B-F) method, and average paid claim development (also known as a frequency and severity or counts and averages method; this method was not used with the hospital data). These methods are among the most commonly used methods and would be considered generally accepted actuarial methods. The intended measure of this approach is an actuarial central estimate of the ultimate losses and indicated loss reserves. The calculations and assumptions underpinning these methods are documented in Exhibits 3 through 8 for the physician data and Exhibits 12 through 13 for the hospital data.

The paid loss development method uses historical loss payment patterns to project actual payments to an ultimate settlement basis. Estimates of the percentage of additional development expected during a given interval between valuations (link ratios or age-to-age factors) based on historical development of the combined physician and hospital experience are used to estimate the expected amount of ultimate loss that is paid as of a given valuation. These factors "to ultimate" are applied to the latest paid loss data for each accident year to compute an estimate of ultimate losses. Estimates produced using this method are not affected by changes in case reserve adequacy or open claim frequency that might have occurred during the review period. The inability to respond to the presence or absence of large outstanding claims is a significant weakness of this method. This method may also be susceptible to changes in claims settlement philosophy and/or payment speed. The results of the paid loss development method are summarized in Exhibits 4 and 13. The paid loss development triangles and selected age-to-age factors are shown in Exhibit 15.

The expected loss ratio method assumes that over the long run the ratio of ultimate losses to earned premiums, or in this case assessment surcharges, will remain stable. The long term loss ratio for the physician segment is assumed to be 115.0% for the 2000 and subsequent years based on the historical experience of the program, up from 110.0% in the 2017 analysis, and the loss ratio for the hospital segment is assumed to be 98.0%, a significant drop from the 120.0% assumed in the 2017 analysis reflecting the shift in losses paid from the hospital to physician segment. The estimates of ultimate losses are computed as the assessments for each year times this long term average loss ratio. The results of this method are shown in Exhibits 3 and 12, Page 2.

The B-F method estimates ultimate losses using a combination of a priori expected losses and loss development techniques. If we define:

A = Paid Losses
B = Expected Percentage of Ultimate Losses Reported
C = *a priori* Expected Losses, equal to historical assessments times long term loss ratio of 115.0% or 98.0% depending on the segment

then the estimated ultimate losses using the B-F technique are:

$$A + [C \times (1 - B)].$$

B-F ultimate loss estimates have the advantage of stability. This is important for coverages with long periods of loss development like MPLI. This stability means the method's estimates do not over-react to short term or one-time changes in development patterns that do not impact long-term development expectations. They also do not overreact to the presence or absence of large losses early in the development of a portfolio of claims. Conversely, B-F estimates have the disadvantage of being slow to respond to real changes in underlying loss development behavior. The a priori losses were based on the expected loss ratio method previously described. This method is summarized in Exhibits 3 and 12, Page 1.

The counts and averages method estimates ultimate losses by multiplying an estimate of the ultimate number of claims by a selected average cost per claim. This method was only used on the physician segment as the hospital data is not yet robust enough to support the method. The results of this method are contained in Exhibits 5 through 8 and summarized in Exhibit 5. The supporting development patterns are contained in Exhibit 16.

The estimated number of claims has been selected based on three methods: a closed claim development method, a B-F method, and a frequency method looking at the long term ratio of claims closed with payment to assessment revenues. Similarly, average claim costs (severities) have been estimated using paid claim severity development and applying a smoothing approach to adjust for volatility between years.

These four methods are standard actuarial reserving techniques for estimating claim liabilities. Selected ultimate loss estimates for the PCF layer of coverage by year were then made based on the results of these four methods for each segment (three methods for the hospitals segment). These estimates rely heavily on the B-F method and expected loss ratio method in the more recent years.

Exhibit 1, Page 3 contains a detailed comparison of the selected ultimate losses compared to the results of our previous study. Estimated ultimate losses for years 2004 and prior have all produced reductions since the last study, while the estimates for 2005 through 2012 all increased (in the case of 2012, the increase was $3.8 million, or 42% of the prior estimate). Estimates for 2013 – 2017 decreased somewhat, except for 2015 which saw a modest increase.

Because of the often significant delay between the occurrence of a PCF claim and its payment, a material discount to bring the ultimate claim payments to a present value reflecting the time value of money exists. Exhibit 1, Page 2 contains the analysis developing estimates of the PCF present value factors based on a 3.5% rate of return and the estimated PCF excess payment pattern. This analysis assumes claim payments are made mid-year on average.

The financial operations of the PCF are similar to a commercial insurer, but one major difference is that the PCF does not maintain a large capital/surplus account. However, in any given year, the actual experience of the PCF can deviate widely from the expected experience. Unanticipated changes in the social, legal or economic environments can also adversely affect PCF experience. An insurer's capital/surplus can assist in withstanding such deviations in experience. By adding a margin for the risk of adverse deviation to indicated loss reserve (and also funding levels), the PCF can be protected in a similar manner.

There are various rules of thumb used in the insurance industry (some mandated by state regulations) that specify the size of the required risk margin (surplus). One state, for example, requires a margin sufficient to assure that funds will be sufficient to meet all claims obligations under 90% of all claims scenarios on a discounted basis. While there are a number of methods for estimating a risk margin, a reasonable margin can be estimated via a simulation model.

We constructed a simulation model that randomly generated possible aggregate loss outcomes for each of the PCF's projected unpaid claims that will ultimately result in payments. Each random outcome generated by a model is called a trial. A trial consists of simulating the individual and aggregate claim results for the PCF for the coming years. We generated 10,000 trials for each model and produced a distribution of aggregate PCF losses. We then compared the average outcome with the outcome at the 90th percentile to compute the risk margin for the 90% confidence level. Exhibit 1, Page 1 summarizes Pinnacle's selected ultimate losses and ultimate loss reserves as of December 31, 2018. These selected reserves are then adjusted for discounting at 3.5% annually and a risk margin to increase statistical confidence to the 90% level. A similar simulation model was created for the risk margin applied to the prospective rate level indication and a similar approach was used to develop the rate indication at the 90% confidence level.

PCF Surplus/Deficit

The current PCF Fund balance appears to be approximately $87.1 million as of December 31, 2018. When compared to Pinnacle's estimate of indicated loss reserves of approximately $131.5 million, this would suggest a Fund deficit position of $44.4 million as of December 31, 2018. The indicated Fund position remains a deficit of approximately $31.9 million when losses are considered on a discounted basis using a 3.5% discount rate.

However, it is imperative to understand that the application of discounting to these unpaid claims liabilities strongly indicates the need to add an explicit risk margin. For example, section 3.6 of Actuarial Standard of Practice No. 20 promulgated by the Actuarial Standards Board entitled, "Discounting of Property/Casualty Unpaid Claim Estimates" states that, "The actuary should be aware of the relationship between discounting unpaid claim estimates and risk margins. Discounting an unpaid claim estimate diminishes the [implicit] margin in an undiscounted unpaid claim estimate."

The standard allows both implicit margins (such as the nominal reserve estimate) and explicit margins (such as the 90% risk margin developed by Pinnacle). If discounted reserves are increased to the 90% confidence level, the resulting reserves of $143.5 million indicate a $56.4 million PCF surplus deficit.

Expected Surcharge Levels

A table of current and recommended PCF surcharges by physician class is shown in Exhibit 9. Recommended surcharges were computed based on both an expected value basis and a 90% confidence level. The indicated percentage rate level changes are derived in Exhibit 10. On an expected value basis the indicated surcharge change is an increase of +13.8%, while at the 90% confidence level an indicated increase of +37.2% is indicated. Including the risk margin improves the likelihood that rates will be sufficient to cover all claims liabilities for the upcoming exposure year.

Investment income as an offset to the otherwise required revenue is recognized in both sets of rates using a 3.5% annual discount rate. Loss ratios were selected based on historical results and reflect recent loss ratio deterioration. The rates include provisions for other expenses, such as administration and medical/legal panels, as well as losses. However, since allocated loss adjustment expenses (ALAE) have historically been paid by the primary carrier, no ALAE provision is included in the PCF rates. Exhibit 17 shows selected ratios of expenses to either losses or surcharge revenues based on the PCF's historical paid expenses and losses. There is also no provision for profit and contingencies in the rate level indications, other than the risk margin.

Glossary of Terms & Abbreviations

The definitions included in this glossary are intended to be practical definitions to assist non-technical readers in understanding the key technical contents of this report.

Accident Year – A method of organizing insurance loss and loss adjustment expense data according to the year in which the accident or event occurred.

Annual Statement – A detailed financial report of an insurance company, required to be filed with state insurance regulators in a specified format using insurance-specific accounting rules.

Calendar Year – A method of organizing insurance loss and loss adjustment expense data according to the year in which the financial transaction (e.g., a loss payment or reserve increase) occurred.

Case Reserves – A financial provision for the potential liability associated with known, unpaid claims.

Claims-Made Coverage – An insurance coverage form that provides reimbursement for claims reported during the coverage period.

Damage Cap – An amount imposed as a limit on claim damages. In New Mexico, this cap applies only to non-medical indemnity payments.

DCC – Defense and Cost Containment, loss adjustment expenses specifically attributable to the defense of a claim or cost containment procedures. Also called DCCE.

Earned Premium – The portion of an insurance policy's premium for which the coverage has been provided.

Experience Rating – A method of adjusting insured premium derived from manual rates for insured historical loss experience to the extent that it is predictive of future loss results.

Frequency – The number of claims per unit of exposure, such as physicians or beds.

Incurred but not Reported (IBNR) reserves – A provision for unpaid claims liabilities intended to provide a provision for both unknown/unreported claims events and additional development on known claims.

Incurred Loss – Paid losses plus Case Reserves.

Indemnity – The sum paid by the insurer to the insured by way of compensation for a particular loss suffered by the insured.

LAE – Loss Adjustment Expenses; insurance company expenses associated with settling claims. LAE includes both unallocated loss adjustment expenses (ULAE, which is similar to Adjusting and Other Expense, AOE) and allocated loss adjustment expenses (ALAE, which is similar to DCC).

Limit – The most the insurer is obligated to pay for loss in any one occurrence.

Loss Cost – The ratio of actual losses to a company's subject matter exposure for the same period.

Loss Ratio – The ratio of some measure of losses (typically paid or incurred) to some measure of premium.

Patient Compensation Fund (PCF) - a medical malpractice insurance mechanism, created by state law, designed to increase professional liability coverage availability and/or affordability primarily by providing coverage for a specific type of injury or an excess layer of coverage.

Primary Carrier – The insurance company issuing the insurance policy to the insured and typically providing the lowest or primary layer of coverage. This is compared to a reinsurer or excess carrier providing coverage to the primary insurer for higher loss limits.

Pure Premium – The provision in the rate per exposure unit to pay losses.

Rate – The price per exposure unit for insurance coverage.

Reinsurance – A mechanism by which an insurance company can transfer some of their insurance risk to another insurer.

Report Year – A method of organizing insurance loss and loss adjustment expense data according to the year in which the accident or event was reported to the insurer, regardless of when it occurred.

Risk Margin – A factor added to indicated ultimate losses, loss reserves or funding estimates to increase statistical confidence to a higher level.

Severity – The average cost or payment amount of a claim.

Surcharges – For the PCF, assessments paid by insureds to fund benefits payments. Akin to premiums, these surcharges are added to the premiums charged by primary insurers so insureds can make a single payment for both primary and PCF coverage.

Territory – The geographic area within which a carrier provides coverage.

Trend – The direction and amount that rates, premium, or losses tend to move over time.

Written Premium – The entire amount of premium on a policy contract.

Legal Disclosures

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This report is being provided to the OSI solely for their internal use. It is understood that this report may also be distributed to representatives of the New Mexico Medical Society, New Mexico Bar Association, as well as other makers of public policy and various stakeholders in the healthcare industry in the State of New Mexico. Distribution to these parties is granted on the conditions that the entire report be distributed rather than any excerpts and that all recipients be made aware that Pinnacle is available to answer any questions regarding the report. In the event our report is distributed to other parties due to statute or regulations, or by agreement of Pinnacle and the OSI, we require that the report and supporting exhibits be distributed in their entirety. Pinnacle advises that any recipient have their own actuary review the work. Pinnacle does not intend to benefit any third party recipient of its work product or create any legal duty from Pinnacle to a third party even if Pinnacle consents to the release of its work product to such third party.

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Reliances and Limitations

Judgments as to conclusions, recommendations, methods and data contained in this report should be made only after studying the report in its entirety. It should be understood that the exhibits, graphs and figures are integral elements of the report. These sections have been prepared so that our actuarial assumptions and judgments are documented. Pinnacle is available to answer any questions that may arise regarding this report. We assume that the user of this report will seek such explanation on any matter in question.

We have relied upon a great deal of publicly available and proprietary data, without audit or verification. Pinnacle reviewed as many elements of this data and information as practical for reasonableness and consistency with our knowledge of the insurance industry. It is possible that the historical data used to make our estimates may not be predictive of future experience in New Mexico. We have not anticipated any extraordinary changes to the legal, social or economic environment which might affect the size or frequency of medical malpractice claims beyond those contemplated in the proposed legislative changes.

Our analysis is based on closed and open claims information provided by OSI in prior analyses as well as closed claim information for the years 2012 through 2018. In the data provided for prior analyses, there were a small number of claims that did not contain accurate loss dates. In addition, there were a small number of claims handled in 2000-2001 by a secondary third party administrator (TPA) that were not contained in the data we were provided. However, we believe the methods and assumptions incorporated into our analysis effectively recognize these shortcomings in the data. If it is subsequently discovered that the underlying data or information provided to us is materially in error, the calculations and conclusions herein will not be correct and will need to be revised. We expect OSI to notify us promptly if any such data issues are subsequently discovered.

The payment pattern used in our analysis for deriving PCF's present value factor and estimated unpaid losses is based on the data available from PCF claims payments for most claims since 2000 through 2018. We also reviewed a variety of external databases for other PCFs and MPLI reinsurance to validate the reasonableness of the payment pattern for the PCF excess layer. The volatility of the payment patterns for this layer of coverage on a relatively small portfolio of claims introduces additional risk into the estimation process.

Many actuarial estimates, including loss and loss adjustment expense reserves, future premium level estimates and potential legislative impacts, are subject to potential errors of estimation due to the fact that the ultimate liability for claims is subject to the outcome of events yet to occur, e.g., jury decisions, judicial interpretations of statutory changes and attitudes of claimants with respect to settlements. Pinnacle has employed techniques and assumptions that we believe are appropriate, and we believe the conclusions presented herein are reasonable, given the information currently available. It should be recognized that future loss emergence will likely deviate, perhaps substantially, from our estimates.

A source of variation is introduced in estimating outstanding liabilities on a discounted basis. That is, besides the risk of underestimating or overestimating the overall amount of nominal loss liabilities, there is the additional risk that the future yield on the underlying assets will differ from our assumed

discount rate. Actual loss payments could occur materially more rapidly or more slowly than projected, due to random variations and the timing of large claim payments. The yield on assets supporting the liabilities may be affected by capital gains or losses, or significant changes in economic conditions. The 3.5% interest rate used in the discounting calculation was provided to us by the OSI and we are expressing no opinion on the appropriateness of this interest rate.
The mathematical techniques underlying our estimate of the risk margin are intended to provide an approximation of the potential variation in loss costs. It should be noted that this estimate reflects only the potential "process" variation (i.e., the random variation inherent in the claim process) based on the assumed loss distributions and the selected parameters. Additional "parameter" variation exists due to the risk that the selected theoretical loss distributions and their parameters will not be predictive of the actual loss distributions. Of particular concern is the potential for unexpected increases in the inflation of the losses.

A simulation model of this type cannot possibly capture all or completely describe any of the dynamic forces that impact medical professional liability losses. Such a model, however, can provide considerable insight into the range of potential fluctuation of losses.

Pinnacle is not qualified to provide formal legal interpretations of state legislation. The elements of this report that require legal interpretation should be recognized as reasonable interpretations of the available statutes, regulations, and administrative rules. State governments and courts are also constantly in the process of changing and reinterpreting these statutes.

Exhibits and Appendices

Estimated Unpaid Claims Liabilities & Surcharge Levels

Exhibit 1. Reserve Summary; Calculation of Discount Factor; Compare (pages 1-3)

Exhibit 2. Physicians & Surgeons - Selected Ultimate Losses

Exhibit 3. Physicians & Surgeons - B-F and Expected Loss Ratio Methods

Exhibit 4. Physicians & Surgeons - Paid Loss Development Method

Exhibit 5. Physicians & Surgeons - Frequency and Severity Method

Exhibit 6. Physicians & Surgeons - Paid Claim Projection Based on B-F Method

Exhibit 7. Physicians & Surgeons - Paid Claim Projection Based on Frequency Method

Exhibit 8. Physicians & Surgeons - Paid Claim Development Method

Exhibit 9. Development of Physician Surcharge Estimates

Exhibit 10. Physicians & Surgeons – Indicated Rate Change

Exhibit 11. Hospitals - Selected Ultimate Losses

Exhibit 12. Hospitals - B-F and Expected Loss Ratio Methods

Exhibit 13. Hospitals - Paid Loss Development Method

Exhibit 14. Hospitals - Indicated Rate Change

Exhibit 15. Combined - Historical Loss Experience

Exhibit 16. Combined - Historical Claim Experience

Exhibit 17. Expense Analysis

New Mexico Patients' Compensation Fund

Reserves as of 12/31/2018

Reserve Summary

Exhibit 1

Page 1

Accident Year	Physician & Surgeons: Selected Ultimate Losses	Physician & Surgeons: Paid Losses	Physician & Surgeons: Selected Ultimate Reserves	Hospitals: Selected Ultimate Losses	Hospitals: Paid Losses	Hospitals: Selected Ultimate Reserves	Combined Selected Ultimate Reserves	Discount Factor	Estimated Discounted Reserves	Indicated Risk Margin @ 90%	Estimated Discounted Reserves @ 90%
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
2000	6,560,000	6,560,000	0				0	0.000	0	1.206	0
2001	9,261,652	9,261,652	0				0	0.000	0	1.206	0
2002	9,309,500	9,309,500	0				0	0.983	0	1.206	0
2003	6,602,760	6,596,189	6,572				6,572	0.983	6,460	1.206	7,790
2004	5,497,464	5,482,500	14,964				14,964	0.970	14,513	1.206	17,503
2005	9,807,180	9,776,657	30,523				30,523	0.955	29,139	1.206	35,142
2006	8,185,026	8,140,629	44,397				44,397	0.945	41,948	1.206	50,589
2007	19,120,000	19,005,969	114,031				114,031	0.938	106,994	1.206	129,035
2008	19,580,000	19,398,176	181,824				181,824	0.934	169,798	1.206	204,776
2009	12,040,000	11,817,704	222,296	388,421	375,000	13,421	235,717	0.931	219,405	1.206	264,602
2010	18,140,000	17,709,906	430,094	862,277	835,000	27,277	457,372	0.929	424,726	1.206	512,220
2011	19,610,000	18,972,165	637,835	2,106,190	2,041,563	64,627	702,462	0.923	648,120	1.206	781,633
2012	11,630,000	10,674,408	955,592	1,040,513	955,000	85,513	1,041,105	0.938	976,850	1.206	1,178,081
2013	8,760,000	5,781,250	2,978,750	858,816	625,898	232,918	3,211,668	0.950	3,052,627	1.206	3,681,468
2014	14,340,000	7,484,434	6,855,566	753,652	88,826	664,826	7,520,391	0.959	7,208,299	1.206	8,693,208
2015	11,140,000	1,240,000	9,900,000	2,114,649	737,868	1,376,782	11,276,782	0.943	10,631,150	1.206	12,821,167
2016	13,950,000	1,700,000	12,250,000	9,286,945	925,000	8,361,945	20,611,945	0.923	19,028,487	1.206	22,948,355
2017	22,676,596	500,000	22,176,596	18,271,430	175,000	18,096,430	40,273,026	0.902	36,320,907	1.206	43,803,013
2018	24,650,739	0	24,650,739	21,164,351	0	21,164,351	45,815,090	0.875	40,083,764	1.206	48,341,019
Total	250,860,917	169,411,138	81,449,779	56,847,243	6,759,154	50,088,089	131,537,868		118,963,186		143,469,603
(13) Estimated 12/31/2018 Fund Balance							87,104,681		87,104,681		87,104,681
(14) Difference							-$44,433,187		-$31,858,505		-$56,364,921

Column/Row	Note
(2)	Exhibit 2, Col (8)
(3), (6)	Provided by client
(4)	Col (2) - Col (3)
(5)	Exhibit 11, Col (7)
(7)	Col (5) - Col (6)
(8)	Col (4) + Col (7)
(9)	Exhibit 1, Page 2
(10)	Col (8) x Col (9)
(11)	Based on simulation analysis of future closed claims
(12)	Col (10) x Col (11)
(13)	Provided by client
(14)	Row (13) - Column totals

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Calculation of Discount Factor

Accident Year	Indicated Reserve	Months	Unpaid Percentage	Payments made at: 07/01/19	07/01/20	07/01/21	07/01/22	07/01/23	07/01/24	07/01/25
2000	-	228	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2001	-	216	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2002	-	204	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2003	6,572	192	0.1%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2004	14,964	180	0.2%	60.6%	39.4%	0.0%	0.0%	0.0%	0.0%	0.0%
2005	30,523	168	0.3%	38.4%	37.3%	24.3%	0.0%	0.0%	0.0%	0.0%
2006	44,397	156	0.5%	37.1%	24.1%	23.5%	15.3%	0.0%	0.0%	0.0%
2007	114,031	144	0.7%	36.3%	23.6%	15.4%	15.0%	9.7%	0.0%	0.0%
2008	181,824	132	1.2%	35.7%	23.3%	15.2%	9.9%	9.6%	6.3%	0.0%
2009	235,717	120	1.8%	35.4%	23.1%	15.1%	9.8%	6.4%	6.2%	4.0%
2010	457,372	108	2.8%	35.0%	23.0%	15.0%	9.8%	6.4%	4.2%	4.0%
2011	702,462	96	3.9%	29.7%	24.7%	16.2%	10.6%	6.9%	4.5%	2.9%
2012	1,041,105	84	8.1%	51.2%	14.5%	12.0%	7.9%	5.2%	3.4%	2.2%
2013	3,211,668	72	19.0%	57.5%	21.8%	6.2%	5.1%	3.4%	2.2%	1.4%
2014	7,520,391	60	50.3%	62.2%	21.8%	8.2%	2.3%	1.9%	1.3%	0.8%
2015	11,276,782	48	71.1%	29.3%	43.9%	15.4%	5.8%	1.6%	1.4%	0.9%
2016	20,611,945	36	85.7%	17.1%	24.3%	36.4%	12.8%	4.8%	1.4%	1.1%
2017	40,273,026	24	96.2%	10.9%	15.2%	21.6%	32.5%	11.4%	4.3%	1.2%
2018	45,815,090	12	99.3%	3.2%	10.5%	14.7%	21.0%	31.4%	11.0%	4.2%
Total	131,537,868			20,317,720	23,839,791	25,939,878	26,573,688	20,592,662	7,486,968	2,911,808

Accident Year	07/01/26	07/01/27	07/01/28	07/01/29	07/01/30	07/01/31	07/01/32	07/01/33	07/01/34	07/01/35	07/01/36	07/01/37	Acc Yr Discount
2000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.000
2001	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.000
2002	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.983
2003	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.983
2004	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.970
2005	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.955
2006	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.945
2007	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.938
2008	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.934
2009	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.931
2010	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.929
2011	2.8%	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.923
2012	1.4%	1.4%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.938
2013	0.9%	0.6%	0.6%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.950
2014	0.5%	0.4%	0.2%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.959
2015	0.6%	0.4%	0.2%	0.2%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.943
2016	0.7%	0.5%	0.3%	0.2%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.923
2017	1.0%	0.7%	0.4%	0.3%	0.2%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.902
2018	1.2%	1.0%	0.6%	0.4%	0.3%	0.2%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.875
Total	1,283,127	931,768	607,153	395,668	255,740	168,363	117,615	82,268	33,650	0	0	0	

Row		Interest Rate	07/01/19	07/01/20	07/01/21	07/01/22	07/01/23	07/01/24	07/01/25
(1)	Annual Discount Factors	3.5%	0.983	0.950	0.918	0.887	0.857	0.828	0.800
		4.5%	0.978	0.936	0.896	0.857	0.820	0.785	0.751
		5.5%	0.974	0.923	0.875	0.829	0.786	0.745	0.706
(2)	Discounted Values	3.5%	19,971,229	22,640,808	23,802,198	23,559,204	17,639,283	6,196,323	2,328,362
		4.5%	19,875,444	22,316,599	23,236,848	22,779,533	16,892,316	5,877,144	2,187,293
		5.5%	19,781,023	22,000,054	22,690,120	22,032,726	16,183,648	5,577,216	2,055,994

Row		Interest Rate	07/01/26	07/01/27	07/01/28	07/01/29	07/01/30	07/01/31	07/01/32	07/01/33	07/01/34	07/01/35	07/01/36	07/01/37
(1)	Annual Discount Factors	3.5%	0.773	0.746	0.721	0.697	0.673	0.650	0.628	0.607	0.587	0.567	0.548	0.529
		4.5%	0.719	0.688	0.658	0.630	0.603	0.577	0.552	0.528	0.505	0.484	0.463	0.443
		5.5%	0.669	0.634	0.601	0.570	0.540	0.512	0.485	0.460	0.436	0.413	0.392	0.371
(2)	Discounted Values	3.5%	991,328	695,529	437,890	275,713	172,180	109,520	73,921	49,957	19,743	0	0	0
		4.5%	922,354	640,943	399,662	249,235	154,156	97,117	64,922	43,456	17,009	0	0	0
		5.5%	858,769	591,101	365,090	225,517	138,164	86,217	57,089	37,850	14,675	0	0	0

Row		Interest Rate	Discounted Totals
(3)	Discounted Totals	3.5%	118,963,186
		4.5%	115,754,030
		5.5%	112,695,253

(4)

Overall Discount Factors	Rate	Factor
	3.5%	0.904
	4.5%	0.880
	5.5%	0.857

Row	Note
(1)	1 / (1 + Discount Factor) ^ (Payments made at date - 12/31/18) Assumes payments are made uniformly throughout the policy period, starting six months subsequent to the loss evaluation date.
(2)	Annual Discount Factor x Payments made at date
(3)	Sum across all years
(4)	(3) / Total Reserves

New Mexico Patients' Compensation Fund

Reserves as of 12/31/2018

Compare

Accident Year	as of 12/31/18 NMPCF Ultimate Excess Losses	as of 12/31/18 NMPCF Discounted Reserves	as of 12/31/17 NMPCF Ultimate Excess Losses	as of 12/31/17 NMPCF Discounted Reserves	Difference NMPCF Ultimate Excess Losses		Difference NMPCF Discounted Reserves	
2000	6,560,000	0	6,562,409	2,368	-2,409	0%	-2,368	-100%
2001	9,261,652	0	9,269,230	7,349	-7,578	0%	-7,349	-100%
2002	9,309,500	0	9,324,379	14,272	-14,879	0%	-14,272	-100%
2003	6,602,760	6,460	6,619,260	21,933	-16,499	0%	-15,474	-71%
2004	5,497,464	14,513	5,512,224	27,885	-14,760	0%	-13,372	-48%
2005	9,807,180	29,139	8,843,727	48,841	963,453	11%	-19,702	-40%
2006	8,185,026	41,948	6,566,583	63,291	1,618,444	25%	-21,343	-34%
2007	19,120,000	106,994	17,530,000	153,848	1,590,000	9%	-46,853	-30%
2008	19,580,000	169,798	17,690,000	242,613	1,890,000	11%	-72,815	-30%
2009	12,428,421	219,405	10,229,829	310,615	2,198,592	21%	-91,210	-29%
2010	19,002,277	424,726	17,665,524	709,209	1,336,754	8%	-284,482	-40%
2011	21,716,190	648,120	20,948,280	1,451,884	767,910	4%	-803,763	-55%
2012	12,670,513	976,850	8,914,500	1,676,988	3,756,013	42%	-700,138	-42%
2013	9,618,816	3,052,627	10,107,387	5,294,947	-488,571	-5%	-2,242,321	-42%
2014	15,093,652	7,208,299	15,405,894	9,871,492	-312,243	-2%	-2,663,193	-27%
2015	13,254,649	10,631,150	12,855,815	10,860,637	398,834	3%	-229,487	-2%
2016	23,236,945	19,028,487	24,830,088	21,819,050	-1,593,143	-6%	-2,790,563	-13%
2017	40,948,026	36,320,907	43,983,204	38,591,812	-3,035,178	-7%	-2,270,905	-6%
Subtotal	261,893,071	78,879,423	252,858,332	91,169,033	9,034,739	4%	-12,289,611	-13%
2018	45,815,090	40,083,764						
Total	307,708,161	118,963,186						

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Physicians & Surgeons
Including Batch Claims
Selected Ultimate Losses

Accident Year	Practitioner Surcharges	Paid Losses	Indicated Ultimate Losses: B-F Method	Indicated Ultimate Losses: Expected Loss Ratio Method	Indicated Ultimate Losses: Paid Development Method	Indicated Ultimate Losses: Frequency/ Severity Method	Selected Ultimate Losses	Loss Ratio
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
2000	8,238,309	6,560,000	6,560,000	9,474,056	6,560,000	4,546,643	6,560,000	79.6%
2001	9,181,946	9,261,652	9,261,652	10,559,238	9,261,652	8,040,380	9,261,652	100.9%
2002	9,421,675	9,309,500	9,309,500	10,834,926	9,309,500	6,859,449	9,309,500	98.8%
2003	9,924,688	6,596,189	6,604,516	11,413,391	6,601,005	7,202,421	6,602,760	66.5%
2004	9,283,270	5,482,500	5,502,261	10,675,761	5,492,667	6,689,941	5,497,464	59.2%
2005	9,151,210	9,776,657	9,808,258	10,523,892	9,806,102	9,773,132	9,807,180	107.2%
2006	9,067,465	8,140,629	8,190,390	10,427,585	8,179,663	7,375,660	8,185,026	90.3%
2007	8,810,595	19,005,969	19,081,838	10,132,184	19,149,358	19,866,181	19,120,000	217.0%
2008	9,696,249	19,398,176	19,528,100	11,150,686	19,626,862	26,162,750	19,580,000	201.9%
2009	11,113,554	11,817,704	12,048,053	12,780,587	12,034,608	13,364,216	12,040,000	108.3%
2010	11,293,496	17,709,906	18,070,257	12,987,521	18,215,307	17,150,743	18,140,000	160.6%
2011	10,798,897	18,972,165	19,461,982	12,418,731	19,751,187	13,506,210	19,610,000	181.6%
2012	10,498,870	10,674,408	11,650,029	12,073,701	11,612,785	9,454,347	11,630,000	110.8%
2013	10,330,574	5,781,250	8,040,108	11,880,160	7,138,553	9,475,834	8,760,000	84.8%
2014	10,838,627	7,484,434	13,747,977	12,464,421	15,044,503	14,213,752	14,340,000	132.3%
2015	10,536,745	1,240,000	9,852,507	12,117,257	4,287,153	11,442,070	11,140,000	105.7%
2016	11,706,286	1,700,000	13,239,382	13,462,229	11,902,036	15,148,306	13,950,000	119.2%
2017	19,718,779	500,000	22,312,873	22,676,596	13,127,245	24,681,291	22,676,596	115.0%
2018	21,435,425	0	24,487,449	24,650,739	0	25,915,356	24,650,739	115.0%
Total	211,046,660	169,411,138	246,757,134	242,703,660	207,100,187	250,868,685	250,860,917	118.9%
2009-18	128,271,253	75,879,867	152,910,619	147,511,941	113,113,378	154,352,126	156,937,334	122.3%

Column	Note
(2), (3)	Based on data provided by client
(4)	Exhibit 3, Page 1, Col (6)
(5)	Exhibit 3, Page 2, Col (6)
(6)	Exhibit 4, Col (5)
(7)	Exhibit 5, Page 1, Col (4)
(8)	Judgmental selection based on Cols (4) - (7)
(9)	Col (8) / Col (2)

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Physicians & Surgeons
Including Batch Claims
B-F Method

Accident Year (1)	Practitioner Surcharges (2)	Expected Loss Ratio (3)	Paid Loss (4)	Percentage Of Ultimate Paid (5)	Indicated Ultimate Losses (6)
2000	8,238,309	115.0%	6,560,000	100.0%	6,560,000
2001	9,181,946	115.0%	9,261,652	100.0%	9,261,652
2002	9,421,675	115.0%	9,309,500	100.0%	9,309,500
2003	9,924,688	115.0%	6,596,189	99.9%	6,604,516
2004	9,283,270	115.0%	5,482,500	99.8%	5,502,261
2005	9,151,210	115.0%	9,776,657	99.7%	9,808,258
2006	9,067,465	115.0%	8,140,629	99.5%	8,190,390
2007	8,810,595	115.0%	19,005,969	99.3%	19,081,838
2008	9,696,249	115.0%	19,398,176	98.8%	19,528,100
2009	11,113,554	115.0%	11,817,704	98.2%	12,048,053
2010	11,293,496	115.0%	17,709,906	97.2%	18,070,257
2011	10,798,897	115.0%	18,972,165	96.1%	19,461,982
2012	10,498,870	115.0%	10,674,408	91.9%	11,650,029
2013	10,330,574	115.0%	5,781,250	81.0%	8,040,108
2014	10,838,627	115.0%	7,484,434	49.7%	13,747,977
2015	10,536,745	115.0%	1,240,000	28.9%	9,852,507
2016	11,706,286	115.0%	1,700,000	14.3%	13,239,382
2017	19,718,779	115.0%	500,000	3.8%	22,312,873
2018	21,435,425	115.0%	0	0.7%	24,487,449
Total	211,046,660		169,411,138		246,757,134
2010-18	117,157,699		64,062,163		140,862,565

Column	Note
(2), (4)	Based on data provided by client
(3)	Exhibit 3, Page 2, Col (5)
(5)	Exhibit 15
(6)	Col (2) x Col (3) x [1 - Col (5)] + Col (4)

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Physicians & Surgeons
Including Batch Claims
Expected Loss Ratio Method

Accident Year (1)	Practitioner Surcharges (2)	Indicated Ultimate Losses From Paid Loss Dev Method (3)	Indicated Loss Ratio (4)	Expected Loss Ratio (5)	Indicated Ultimate Losses (6)
2000	8,238,309	6,560,000	79.6%		9,474,056
2001	9,181,946	9,261,652	100.9%		10,559,238
2002	9,421,675	9,309,500	98.8%		10,834,926
2003	9,924,688	6,601,005	66.5%		11,413,391
2004	9,283,270	5,492,667	59.2%		10,675,761
2005	9,151,210	9,806,102	107.2%		10,523,892
2006	9,067,465	8,179,663	90.2%		10,427,585
2007	8,810,595	19,149,358	217.3%		10,132,184
2008	9,696,249	19,626,862	202.4%		11,150,686
2009	11,113,554	12,034,608	108.3%		12,780,587
2010	11,293,496	18,215,307	161.3%		12,987,521
2011	10,798,897	19,751,187	182.9%		12,418,731
2012	10,498,870	11,612,785	110.6%		12,073,701
2013	10,330,574	7,138,553	69.1%		11,880,160
2014	10,838,627	15,044,503	138.8%		12,464,421
2015	10,536,745	4,287,153	40.7%		12,117,257
2016	11,706,286	11,902,036	101.7%		13,462,229
2017	19,718,779	13,127,245	66.6%		22,676,596
2018	21,435,425	0	0.0%		24,650,739
Total	211,046,660	207,100,187	98.1%	115.0%	242,703,660
2000-13	136,810,798	162,739,250	119.0%		
2009-15	75,410,763	88,084,097	116.8%		

Column	Note
(2)	Based on data provided by client
(3)	Exhibit 4, Col (5)
(4)	Col (3) / Col (2)
(5)	Judgment
(6)	Col (2) x Col (5)

Exhibit 4

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Physicians & Surgeons
Including Batch Claims
Paid Loss Development Method

Accident Year	Paid Losses	Month of Development	Cumulative Development Factor	Indicated Ultimate Losses
(1)	(2)	(3)	(4)	(5)
2000	6,560,000	228	1.000	6,560,000
2001	9,261,652	216	1.000	9,261,652
2002	9,309,500	204	1.000	9,309,500
2003	6,596,189	192	1.001	6,601,005
2004	5,482,500	180	1.002	5,492,667
2005	9,776,657	168	1.003	9,806,102
2006	8,140,629	156	1.005	8,179,663
2007	19,005,969	144	1.008	19,149,358
2008	19,398,176	132	1.012	19,626,862
2009	11,817,704	120	1.018	12,034,608
2010	17,709,906	108	1.029	18,215,307
2011	18,972,165	96	1.041	19,751,187
2012	10,674,408	84	1.088	11,612,785
2013	5,781,250	72	1.235	7,138,553
2014	7,484,434	60	2.010	15,044,503
2015	1,240,000	48	3.457	4,287,153
2016	1,700,000	36	7.001	11,902,036
2017	500,000	24	26.254	13,127,245
2018	0	12	150.963	0
Total	169,411,138			207,100,187

Column	Note
(2)	Based on data provided by client
(4)	Exhibit 15
(5)	Col (2) x Col (4)

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Physicians & Surgeons
Including Batch Claims
Frequency and Severity Method

Accident Year	Selected Ultimate Claims Closed with Payment	Selected Ultimate Severity	Indicated Ultimate Losses
(1)	(2)	(3)	(4)
2000	19	239,297	4,546,643
2001	32	251,262	8,040,380
2002	26	263,825	6,859,449
2003	26	277,016	7,202,421
2004	23	290,867	6,689,941
2005	32	305,410	9,773,132
2006	23	320,681	7,375,660
2007	59	336,715	19,866,181
2008	74	353,551	26,162,750
2009	36	371,228	13,364,216
2010	44	389,790	17,150,743
2011	33	409,279	13,506,210
2012	22	429,743	9,454,347
2013	21	451,230	9,475,834
2014	30	473,792	14,213,752
2015	23	497,481	11,442,070
2016	29	522,355	15,148,306
2017	45	548,473	24,681,291
2018	45	575,897	25,915,356
Total	642		250,868,685

Column	Note
(2)	Exhibit 5, Page 3, Col (6)
(3)	Exhibit 5, Page 2, Col (10)
(4)	Col (2) x Col (3)

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Physicians & Surgeons
Including Batch Claims
Severity Trend for Paid Losses Excess of Retention

Accident Year (1)	Paid Loss (2)	Claims Closed With Payment (3)	Paid Severity (4)	Indicated Trend (5)	R^2 (6)	Selected Trend (7)	Trended Severity to 2018 (8)	Selected Severity (9)	Detrended Severity (10)
2000	6,560,000	19	345,263				830,917		239,297
2001	9,261,652	32	289,427				663,371		251,262
2002	9,309,500	26	358,058				781,595		263,825
2003	6,596,189	26	253,700				527,423		277,016
2004	5,482,500	23	238,370				471,955		290,867
2005	9,776,657	32	305,521				576,105		305,410
2006	8,140,629	23	353,940				635,626		320,681
2007	19,005,969	59	322,135				550,960		336,715
2008	19,398,176	74	262,138				426,994		353,551
2009	11,817,704	36	328,270				509,254		371,228
2010	17,709,906	43	411,858				608,502		389,790
2011	18,972,165	32	592,880				834,242		409,279
2012	10,674,408	20	533,720				715,236		429,743
2013	5,781,250	14	412,946				527,036		451,230
2014	7,484,434	17	440,261				535,140		473,792
2015	1,240,000	4	310,000				358,864		497,481
2016	1,700,000	5	340,000				374,850		522,355
2017	500,000	1	500,000				525,000		548,473
2018	0	0	0				0		575,897
Total	169,411,138	486	348,583				586,160		
2006-15	120,224,641	322	373,368	3.1%	0.135	5.0%	565,634	575,897	

Column	Note
(2), (3)	Based on data provided by client
(4)	Col (2) / Col (3)
(8)	Col (4) trended forward with selected trend in Col (7)
(10)	Selected severity in Col (9) detrended with selected trend in Col (7)

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Physicians & Surgeons
Including Batch Claims
Closed With Payment Projection Summary

Accident Year	Claims Closed With Payment	Indicated Ultimate Claims Closed With Payment			Selected Ultimate Closed With Payment
		B-F Method	Frequency Method	Claim Development Method	
(1)	(2)	(3)	(4)	(5)	(6)
2000	19	19	27	19	19
2001	32	32	29	32	32
2002	26	26	28	26	26
2003	26	26	30	26	26
2004	23	23	28	23	23
2005	32	32	27	32	32
2006	23	23	27	23	23
2007	59	59	26	59	59
2008	74	74	27	74	74
2009	36	36	30	36	36
2010	43	44	29	44	44
2011	32	33	27	33	33
2012	20	22	26	22	22
2013	14	19	26	17	21
2014	17	29	27	30	30
2015	4	21	26	12	23
2016	5	29	29	30	29
2017	1	45	46	23	45
2018	0	45	46	0	45
Total	486	637	561	561	642

Column	Note
(2)	Based on data provided by client
(3)	Exhibit 6, Col (5)
(4)	Exhibit 7, Col (7)
(5)	Exhibit 8, Col (5)
(6)	Judgmental selection based on Cols (3) - (5)

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Physicians & Surgeons
Including Batch Claims
Paid Claim Projection Based on B-F Method

Accident Year	Claims Closed With Payment	Frequency Mtd. Indicated Ultimate Claims Closed With Payment	Percent of Ultimate Closed With Payment	Indicated Ultimate Closed With Payment
(1)	(2)	(3)	(4)	(5)
2000	19	27	100.0%	19
2001	32	29	100.0%	32
2002	26	28	100.0%	26
2003	26	30	100.0%	26
2004	23	28	100.0%	23
2005	32	27	100.0%	32
2006	23	27	100.0%	23
2007	59	26	100.0%	59
2008	74	27	99.7%	74
2009	36	30	99.2%	36
2010	43	29	98.2%	44
2011	32	27	96.3%	33
2012	20	26	91.2%	22
2013	14	26	81.4%	19
2014	17	27	56.1%	29
2015	4	26	34.6%	21
2016	5	29	16.5%	29
2017	1	46	4.4%	45
2018	0	46	1.1%	45
Total	486	561		637

Column	Note
(2)	Based on data provided by client
(4)	Exhibit 16
(3)	Exhibit 7, Col (7)
(5)	Col (2) + Col (3) x [1 - Col (4)]

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Physicians & Surgeons
Including Batch Claims
Paid Claim Projection Based on Frequency Method

Accident Year (1)	Claims Closed With Payment (2)	Development Mtd. Indicated Ultimate Claims Closed With Payment (3)	Practitioner Surcharges at Current Rate Level (4)	Indicated Ultimate Claim Frequency Per $1M in Surcharges (5)	Selected Frequency (6)	Indicated Ultimate Claims Closed With Payment (7)
2000	19	19	12,878,190	1.48		27
2001	32	32	13,452,186	2.38		29
2002	26	26	13,347,977	1.95		28
2003	26	26	14,060,611	1.85		30
2004	23	23	13,151,894	1.75		28
2005	32	32	12,964,801	2.47		27
2006	23	23	12,846,157	1.79		27
2007	59	59	12,335,754	4.78		26
2008	74	74	12,682,723	5.83		27
2009	36	36	14,303,427	2.52		30
2010	43	44	13,606,370	3.23		29
2011	32	33	12,759,642	2.59		27
2012	20	22	12,405,139	1.77		26
2013	14	17	12,206,286	1.39		26
2014	17	30	12,806,586	2.34		27
2015	4	12	12,449,891	0.96		26
2016	5	30	13,794,281	2.17		29
2017	1	23	21,867,098	1.05		46
2018	0	0	21,929,056	0.00		46
Total	486	561	265,848,068	2.11	2.12	561
2009-15	166	194	90,537,341	2.14		

Column	Note
(2)	Exhibit 8, Col (1)
(3)	Exhibit 8, Col (5)
(4)	Based on data provided by client
(5)	Col (3) / Col (4) x 1,000,000
(7)	Col (4) x Col (6) / 1,000,000

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Physicians & Surgeons
Including Batch Claims
Closed With Payment Claim Development Method

Accident Year (1)	Claims Closed With Payment (2)	Month of Development (3)	Cumulative Development Factor (4)	Indicated Ultimate Claims Closed With Payment (5)
2000	19.0	228	1.000	19
2001	32.0	216	1.000	32
2002	26.0	204	1.000	26
2003	26.0	192	1.000	26
2004	23.0	180	1.000	23
2005	32.0	168	1.000	32
2006	23.0	156	1.000	23
2007	59.0	144	1.000	59
2008	74.0	132	1.003	74
2009	36.0	120	1.008	36
2010	43.0	108	1.018	44
2011	32.0	96	1.038	33
2012	20.0	84	1.097	22
2013	14.0	72	1.229	17
2014	17.0	60	1.782	30
2015	4.0	48	2.886	12
2016	5.0	36	6.061	30
2017	1.0	24	22.729	23
2018	0.0	12	90.914	0
Total	486.0			561

Column	Note
(2)	Based on data provided by client
(4)	Exhibit 16
(5)	Col (2) x Col (4)

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Development of Physician Surcharge Estimates

NMPCF Indicated Surcharge
Physicians and Surgeons

		Discounted Estimated Surcharges	
	NMPCF	9/1/19-20 Rate Level	
Class	Current Surcharge	Expected Value	Risk Loaded Value
(1)	(2)	(3)	(4)
1	$2,920	$3,322	$4,006
2	3,889	4,424	5,335
3	4,676	5,319	6,415
4A	5,843	6,647	8,016
4	7,008	7,972	9,614
5A	6,214	7,069	8,525
5	8,562	9,740	11,746
6	10,122	11,514	13,886
7A	11,678	13,284	16,021
7	15,569	17,710	21,359
8	18,494	21,038	25,371
9A	18,876	21,472	25,896
9	22,384	25,463	30,708
10	24,334	27,681	33,383
51	341	388	468
52	341	388	468
53	234	266	321
99	2,325	2,645	3,190
CRNA	774	880	1,062
PA-1	1,319	1,500	1,810
PA-2	1,760	2,002	2,414
PA-3	2,119	2,410	2,907
(9) Class 1 Rate	$2,920	$3,322	$4,006
(10) Indicated Percent of Change		13.8%	37.2%

Column/Row	Note
(2)	Provided by NMPCF
(3)-(4)	Based on indicated surcharge changes in Exhibit 10

New Mexico Patients' Compensation Fund

Reserves as of 12/31/2018
Indicated Rate Change Effective 9/1/19 through 9/1/20
Using Expected Value Losses
Physicians & Surgeons

Accident Year	Practitioner Surcharges @ 12/31/18 Level	Projected Ultimate Losses	Trended Ultimate Loss	Trended Ultimate Loss Ratio
(1)	(2)	(3)	(4)	(5)
2009	14,303,427	12,040,000	19,611,891	137.1%
2010	13,606,370	18,140,000	28,141,094	206.8%
2011	12,759,642	19,610,000	28,972,901	227.1%
2012	12,405,139	11,630,000	16,364,578	131.9%
2013	12,206,286	8,760,000	11,739,238	96.2%
2014	12,806,586	14,340,000	18,301,878	142.9%
2015	12,449,891	11,140,000	13,540,740	108.8%
2016	13,794,281	13,950,000	16,148,869	117.1%
2017	21,867,098	22,676,596	25,000,947	114.3%
2018	21,929,056	24,650,739	25,883,276	118.0%
All Years	148,127,775	156,937,334	203,705,411	137.5%
2009 - 2016	104,331,622	109,610,000	152,821,188	146.5%
2012 - 2016	63,662,184	59,820,000	76,095,302	119.5%
2014 - 2016	39,050,759	39,430,000	47,991,486	122.9%

Row	Description	Value
(6)	Projected 2019-2020 Undiscounted Loss Ratio (Selected Based on Col (4))	119.5%
(7)	Projected 2019-2020 Assessments at Current Fee Level	21,929,056
(8)	Projected 2019-2020 Undiscounted Losses	26,211,763
(9)	Projected Loss Adjustment Expenses as a Percentage of Losses Paid	2.7%
(10)	Discount Factor at 3.5% Yield	0.846
(11)	Projected Office Expenses as a Percentage of Surcharges Collected	2.7%
(12)	Projected Reinsurance Expense as a Percentage of Surcharges Collected	6.0%
(13)	Projected 2019-2020 Income Requirements	24,945,200
(14)	Indicated Assessment Level Change on September 1, 2019	13.8%

Column / Row	Note
(2), (9), (10), (11), (12)	Based on data provided by client
(3)	Exhibit 2, Col (8)
(4)	Col (3) x [1 + Selected trend rate of 5%] ^ (2019 - Col (1))
(5)	Col (4) / Col (2)
(7)	Most current Assessment
(8)	Row (6) x Row (7)
(13)	[Row (8) x [1 + Row (9)] x Row (10)] / [1 - Row (11) - Row (12)]
(14)	Row (13) / Row (7) - 1

New Mexico Patients' Compensation Fund

Reserves as of 12/31/2018

Indicated Rate Change Effective 9/1/19 through 9/1/20
Using Expected Value Losses with Risk Load
Physicians & Surgeons

Accident Year	Practitioner Surcharges @ 12/31/18 Level	Projected Ultimate Losses	Trended Ultimate Loss	Trended Ultimate Loss Ratio
(1)	(2)	(3)	(4)	(5)
2009	14,303,427	12,040,000	19,611,891	137.1%
2010	13,606,370	18,140,000	28,141,094	206.8%
2011	12,759,642	19,610,000	28,972,901	227.1%
2012	12,405,139	11,630,000	16,364,578	131.9%
2013	12,206,286	8,760,000	11,739,238	96.2%
2014	12,806,586	14,340,000	18,301,878	142.9%
2015	12,449,891	11,140,000	13,540,740	108.8%
2016	13,794,281	13,950,000	16,148,869	117.1%
2017	21,867,098	22,676,596	25,000,947	114.3%
2018	21,929,056	24,650,739	25,883,276	118.0%
All Years	148,127,775	156,937,334	203,705,411	137.5%
2009 - 2016	104,331,622	109,610,000	152,821,188	146.5%
2012 - 2016	63,662,184	59,820,000	76,095,302	119.5%
2014 - 2016	39,050,759	39,430,000	47,991,486	122.9%

(6)	Projected 2019-2020 Undiscounted Loss Ratio (Selected Based on Col (4))	119.5%
(7)	Projected 2019-2020 Assessments at Current Fee Level	21,929,056
(8)	Projected 2019-2020 Undiscounted Losses	26,211,763
(9)	Projected Loss Adjustment Expenses as a Percentage of Losses Paid	2.7%
(10)	Discount Factor at 3.5% Yield	0.846
(11)	Risk Margin Factor at 90% Confidence Level	1.206
(12)	Projected Office Expenses as a Percentage of Surcharges Collected	2.7%
(13)	Projected Reinsurance Expense as a Percentage of Surcharges Collected	6.0%
(14)	Projected 2019-2021 Income Requirements @ 90%	30,083,911
(15)	Indicated Assessment Level Change on September 1, 2019	37.2%

Column / Row	Note
(2), (9), (10), (11), (12), (13)	Based on data provided by client
(3)	Exhibit 2, Col (8)
(4)	Col (3) x [1 + Selected trend rate of 5%] ^ (2019 - Col (1))
(5)	Col (4) / Col (2)
(7)	Most current Assessment
(8)	Row (6) x Row (7)
(14)	[Row (8) x [1 + Row (9)] x Row (10) x Row (11)] / [1 - Row (12) - Row (13)]
(15)	Row (14) / Row (7) - 1

New Mexico Patients' Compensation Fund

Reserves as of 12/31/2018
Hospitals
Selected Ultimate Losses

Accident Year	Hospital Surcharges	Paid Losses	Indicated Ultimate Losses: B-F Method	Indicated Ultimate Losses: Expected Loss Ratio Method	Indicated Ultimate Losses: Paid Development Method	Selected Ultimate Losses	Loss Ratio
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2009	1,130,000	375,000	394,959	1,107,400	381,883	388,421	34.4%
2010	1,130,000	835,000	865,726	1,107,400	858,829	862,277	76.3%
2011	1,175,200	2,041,563	2,086,987	1,151,696	2,125,392	2,106,190	179.2%
2012	1,099,542	955,000	1,042,072	1,077,551	1,038,953	1,040,513	94.6%
2013	1,250,000	625,898	858,816	1,225,000	772,844	858,816	68.7%
2014	1,350,000	88,826	753,652	1,323,000	178,550	753,652	55.8%
2015	1,350,000	737,868	1,678,208	1,323,000	2,551,090	2,114,649	156.6%
2016	9,476,474	925,000	8,885,465	9,286,945	6,476,108	9,286,945	98.0%
2017	18,644,316	175,000	17,750,494	18,271,430	4,594,536	18,271,430	98.0%
2018	21,596,277	0	21,024,156	21,164,351	0	21,164,351	98.0%
Total	58,201,809	6,759,154	55,340,536	57,037,773	18,978,185	56,847,243	97.7%

Column	Note
(2), (3)	Based on data provided by client
(4)	Exhibit 12, Page 1, Col (6)
(5)	Exhibit 12, Page 2, Col (6)
(6)	Exhibit 13, Col (5)
(7)	Judgmental selection based on Cols (4) - (6)
(8)	Col (8) / Col (2)

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Hospitals
B-F Method

Accident Year (1)	Hospital Surcharges (2)	Expected Loss Ratio (3)	Paid Loss (4)	Percentage Of Ultimate Paid (5)	Indicated Ultimate Losses (6)
2009	1,130,000	98.0%	375,000	98.2%	394,959
2010	1,130,000	98.0%	835,000	97.2%	865,726
2011	1,175,200	98.0%	2,041,563	96.1%	2,086,987
2012	1,099,542	98.0%	955,000	91.9%	1,042,072
2013	1,250,000	98.0%	625,898	81.0%	858,816
2014	1,350,000	98.0%	88,826	49.7%	753,652
2015	1,350,000	98.0%	737,868	28.9%	1,678,208
2016	9,476,474	98.0%	925,000	14.3%	8,885,465
2017	18,644,316	98.0%	175,000	3.8%	17,750,494
2018	21,596,277	98.0%	0	0.7%	21,024,156
Total	58,201,809		6,759,154		55,340,536

Column	Note
(2), (4)	Based on data provided by client
(3)	Exhibit 12, Page 2, Col (5)
(5)	Exhibit 15
(6)	Col (2) x Col (3) x [1 - Col (5)] + Col (4)

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Hospitals
Expected Loss Ratio Method

Accident Year	Hospital Surcharges	Indicated Ultimate Losses From Paid Loss Dev Method	Indicated Loss Ratio	Expected Loss Ratio	Indicated Ultimate Losses
(1)	(2)	(3)	(4)	(5)	(6)
2009	1,130,000	381,883	33.8%		1,107,400
2010	1,130,000	858,829	76.0%		1,107,400
2011	1,175,200	2,125,392	180.9%		1,151,696
2012	1,099,542	1,038,953	94.5%		1,077,551
2013	1,250,000	772,844	61.8%		1,225,000
2014	1,350,000	178,550	13.2%		1,323,000
2015	1,350,000	2,551,090	189.0%		1,323,000
2016	9,476,474	6,476,108	68.3%		9,286,945
2017	18,644,316	4,594,536	24.6%		18,271,430
2018	21,596,277	0	0.0%		21,164,351
Total	58,201,809	18,978,185	32.6%	98.0%	57,037,773
2009-15	8,484,742	7,907,541	93.2%		
2009-17	36,605,532	18,978,185	51.8%		

Column	Note
(2)	Based on data provided by client
(3)	Exhibit 13, Col (5)
(4)	Col (3) / Col (2)
(5)	Judgment
(6)	Col (2) x Col (5)

Exhibit 13

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Hospitals
Paid Loss Development Method

Accident Year	Paid Losses	Month of Development	Cumulative Development Factor	Indicated Ultimate Losses
(1)	(2)	(3)	(4)	(5)
2009	375,000	120	1.018	381,883
2010	835,000	108	1.029	858,829
2011	2,041,563	96	1.041	2,125,392
2012	955,000	84	1.088	1,038,953
2013	625,898	72	1.235	772,844
2014	88,826	60	2.010	178,550
2015	737,868	48	3.457	2,551,090
2016	925,000	36	7.001	6,476,108
2017	175,000	24	26.254	4,594,536
2018	0	12	150.963	0
Total	6,759,154			18,978,185

Column	Note
(2)	Based on data provided by client
(4)	Exhibit 15
(5)	Col (2) x Col (4)

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Indicated Rate Change Effective 9/1/19 through 9/1/20
Using Expected Value Losses
Hospitals

Accident Year	Hospital Surcharges @ 12/31/18 Level	Projected Ultimate Losses	Trended Ultimate Loss	Projected Ultimate Loss Ratio
(1)	(2)	(3)	(4)	(5)
2009	1,454,339	388,421	632,697	43.5%
2010	1,361,421	862,277	1,337,675	98.3%
2011	1,388,580	2,106,190	3,111,801	224.1%
2012	1,299,185	1,040,513	1,464,106	112.7%
2013	1,476,961	858,816	1,150,896	77.9%
2014	1,595,118	753,652	961,872	60.3%
2015	1,595,118	2,114,649	2,570,369	161.1%
2016	11,166,748	9,286,945	10,750,799	96.3%
2017	20,675,574	18,271,430	20,144,251	97.4%
2018	22,093,612	21,164,351	22,222,569	100.6%
All Years	64,106,656	56,847,243	64,347,035	100.4%
2009 - 2016	21,337,470	17,411,462	21,980,215	103.0%
2012 - 2016	17,133,131	14,054,574	16,898,042	98.6%
2014 - 2016	14,356,985	12,155,245	14,283,040	99.5%

Row	Item	Value
(6)	Projected 2019-2020 Undiscounted Loss Ratio (Selected Based on Col (4))	100.4%
(7)	Projected 2019-2020 Assessments at Current Fee Level	22,093,612
(8)	Projected 2019-2020 Undiscounted Losses	22,176,471
(9)	Projected Loss Adjustment Expenses as a Percentage of Losses Paid	2.7%
(10)	Discount Factor at 3.5% Yield	0.846
(11)	Projected Office Expenses as a Percentage of Surcharges Collected	2.7%
(12)	Projected Reinsurance Expense as a Percentage of Surcharges Collected	6.0%
(13)	Projected 2019-2020 Income Requirements	21,104,895
(14)	Indicated Assessment Level Change on September 1, 2019	-4.5%

Column / Row	Note
(2), (9), (10), (11), (12)	Based on data provided by client
(3)	Exhibit 2, Col (8)
(4)	Col (3) x [1 + Selected trend rate of 5%] ^ (2019 - Col (1))
(5)	Col (4) / Col (2)
(7)	Most current Assessment
(8)	Row (6) x Row (7)
(13)	[Row (8) x [1 + Row (9)] x Row (10)] / [1 - Row (11) - Row (12)]
(14)	Row (13) / Row (7) - 1

New Mexico Patients' Compensation Fund

Exhibit 14
Page 2

Reserves as of 12/31/2018
Indicated Rate Change Effective 9/1/19 through 9/1/20
Using Expected Value Losses with Risk Load
Hospitals

Accident Year	Participant Surcharges @ 12/31/18 Level	Projected Ultimate Losses	Trended Ultimate Loss	Projected Ultimate Loss Ratio
(1)	(2)	(3)	(4)	(4)
2009	1,454,339	388,421	632,697	43.5%
2010	1,361,421	862,277	1,337,675	98.3%
2011	1,388,580	2,106,190	3,111,801	224.1%
2012	1,299,185	1,040,513	1,464,106	112.7%
2013	1,476,961	858,816	1,150,896	77.9%
2014	1,595,118	753,652	961,872	60.3%
2015	1,595,118	2,114,649	2,570,369	161.1%
2016	11,166,748	9,286,945	10,750,799	96.3%
2017	20,675,574	18,271,430	20,144,251	97.4%
2018	22,093,612	21,164,351	22,222,569	100.6%
All Years	64,106,656	56,847,243	64,347,035	100.4%
2009 - 2016	21,337,470	17,411,462	21,980,215	103.0%
2012 - 2016	17,133,131	14,054,574	16,898,042	98.6%
2014 - 2016	14,356,985	12,155,245	14,283,040	99.5%

Row	Description	Value
(6)	Projected 2019-2020 Undiscounted Loss Ratio (Selected Based on Col (4))	100.4%
(7)	Projected 2019-2020 Assessments at Current Fee Level	22,093,612
(8)	Projected 2019-2020 Undiscounted Losses	22,176,471
(9)	Projected Loss Adjustment Expenses as a Percentage of Losses Paid	2.7%
(10)	Discount Factor at 3.5% Yield	0.846
(11)	Risk Margin Factor at 90% Confidence Level	1.206
(12)	Projected Office Expenses as a Percentage of Surcharges Collected	2.7%
(13)	Projected Reinsurance Expense as a Percentage of Surcharges Collected	6.0%
(14)	Projected 2019-2021 Income Requirements @ 90%	25,452,503
(15)	Indicated Assessment Level Change on September 1, 2019	15.2%

Column / Row	Note
(2), (9), (10), (11), (12), (13)	Based on data provided by client
(3)	Exhibit 2, Col (8)
(4)	Col (3) x [1 + Selected trend rate of 5%] ^ (2019 - Col (1))
(5)	Col (4) / Col (2)
(7)	Most current Assessment
(8)	Row (6) x Row (7)
(14)	[Row (8) x [1 + Row (9)] x Row (10) x Row (11)] / [1 - Row (12) - Row (13)]
(15)	Row (14) / Row (7) - 1

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018

Paid Losses - Hospital & Practitioner Combined (Excluding Batch Claims)

Accident Year	Months of Development 12	24	36	48	60	72	84	96	108	120	132	144	156	168	180	192	204	216	228	240	252
1995	0	0	0	0	0	2,520,000	2,920,000	2,995,000	2,995,000	2,995,000	2,995,000	4,045,000	4,045,000	4,045,000	4,045,000	4,045,000	4,045,000	4,045,000	4,045,000	4,045,000	4,045,000
1996	0	0	0	0	925,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000	1,590,000
1997	0	0	0	2,060,000	4,360,000	5,162,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000	5,462,000
1998	0	0	600,000	1,255,000	1,895,000	2,005,000	2,305,000	2,305,000	2,305,000	2,305,000	2,305,000	2,730,000	2,730,000	2,730,000	2,730,000	2,730,000	2,730,000	2,730,000	2,730,000	2,730,000	2,730,000
1999	0	125,000	993,000	1,530,500	2,437,000	3,462,000	4,887,000	5,187,000	5,187,000	5,282,000	5,282,000	5,284,209	5,285,956	5,285,956	5,285,956	5,285,956	5,285,956	5,285,956	5,285,956	5,285,956	
2000	0	1,500,000	2,295,000	2,745,000	5,845,000	6,560,000	6,560,000	6,560,000	6,560,000	6,560,000	6,560,000	6,560,000	6,560,000	6,560,000	6,560,000	6,560,000	6,560,000	6,560,000	6,560,000		
2001	125,000	745,000	2,332,152	3,282,152	6,024,152	8,226,652	9,226,652	9,261,652	9,261,652	9,261,652	9,261,652	9,261,652	9,261,652	9,261,652	9,261,652	9,261,652	9,261,652	9,261,652			
2002	290,000	890,000	990,000	2,932,000	4,819,500	6,144,500	8,994,500	9,309,500	9,309,500	9,309,500	9,309,500	9,309,500	9,309,500	9,309,500	9,309,500	9,309,500	9,309,500				
2003	0	275,000	1,950,000	2,997,500	4,137,500	5,032,500	5,707,500	6,196,189	6,596,189	6,596,189	6,596,189	6,596,189	6,596,189	6,596,189	6,596,189	6,596,189					
2004	0	0	1,197,500	1,527,500	2,870,000	4,607,500	4,657,500	5,482,500	5,482,500	5,482,500	5,482,500	5,482,500	5,482,500	5,482,500	5,482,500						
2005	300,000	575,000	1,035,000	1,410,000	4,911,086	6,873,180	7,741,254	8,341,254	8,791,254	8,791,254	8,791,254	8,791,254	8,791,254	8,791,254							
2006	0	0	628,725	4,253,725	5,228,725	5,378,725	5,628,725	5,928,725	6,328,725	6,328,725	6,328,725	6,328,725	6,328,725								
2007	0	0	1,250,000	4,937,000	7,887,000	12,027,000	12,677,000	13,124,500	13,124,500	13,124,500	13,124,500	13,124,500									
2008	0	0	2,163,652	4,764,652	6,542,152	9,204,652	11,262,152	11,662,152	11,662,152	11,662,152	11,662,152										
2009	0	495,000	2,868,567	3,368,567	4,203,567	8,242,342	8,242,342	8,367,342	8,367,342	8,367,342											
2010	0	775,000	3,511,000	6,138,000	9,688,000	16,177,567	16,502,567	16,902,567	16,902,567												
2011	0	1,365,000	1,965,000	4,793,000	9,990,312	17,266,228	19,398,728	21,013,728													
2012	0	50,000	850,000	2,614,408	4,324,408	7,529,408	11,629,408														
2013	0	450,000	750,000	875,000	4,575,000	6,407,148															
2014	0	480,000	2,370,000	4,945,000	7,573,261																
2015	0	0	1,112,868	1,977,868																	
2016	0	700,000	2,625,000																		
2017	0	675,000																			
2018	0																				

Paid Losses - Hospital & Practitioner Combined (Excluding Batch Claims)

Accident Year	Development Factors 12-24	24-36	36-48	48-60	60-72	72-84	84-96	96-108	108-120	120-132	132-144	144-156	156-168	168-180	180-192	192-204	204-216	216-228	228-240	240-252	252-Ult
1995						1.159	1.026	1.000	1.000	1.000	1.351	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
1996					1.719	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
1997				2.117	1.184	1.058	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
1998			2.092	1.510	1.058	1.150	1.000	1.000	1.000	1.000	1.184	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
1999		7.944	1.541	1.592	1.421	1.412	1.061	1.000	1.018	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000		
2000		1.530	1.196	2.129	1.122	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000			
2001	5.960	3.130	1.407	1.835	1.366	1.122	1.004	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000				
2002	3.069	1.112	2.962	1.644	1.275	1.464	1.035	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000					
2003		7.091	1.537	1.380	1.216	1.134	1.086	1.065	1.000	1.000	1.000	1.000	1.000	1.000	1.000						
2004			1.276	1.879	1.605	1.011	1.177	1.000	1.000	1.000	1.000	1.000	1.000	1.000							
2005	1.917	1.800	1.362	3.483	1.400	1.126	1.078	1.054	1.000	1.000	1.000	1.000	1.000								
2006			6.766	1.229	1.029	1.046	1.053	1.067	1.000	1.000	1.000	1.000									
2007			3.950	1.598	1.525	1.054	1.035	1.000	1.000	1.000	1.000										
2008			2.202	1.373	1.407	1.224	1.036	1.000	1.000	1.000											
2009		5.795	1.174	1.248	1.961	1.000	1.015	1.000	1.000												
2010		4.530	1.748	1.578	1.670	1.020	1.024	1.000													
2011		1.440	2.439	2.084	1.728	1.124	1.083														
2012		17.000	3.076	1.654	1.741	1.545															
2013		1.667	1.167	5.229	1.400																
2014		4.938	2.086	1.531																	
2015			1.777																		
2016		3.750																			
2017																					
Avg	3.649	4.748	2.209	1.950	1.435	1.147	1.042	1.012	1.001	1.000	1.041	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
W Avg	12.727	3.737	2.024	1.741	1.483	1.136	1.044	1.011	1.001	1.000	1.018	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
5 yr W Avg		4.588	2.157	1.867	1.697	1.147	1.044	1.007	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000		
7 yr W Avg		3.451	1.840	1.705	1.628	1.125	1.048	1.012	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000				
5 yr Avg x Hi/Lo		3.451	2.101	1.772	1.713	1.122	1.032	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000		
7 yr Avg x Hi/Lo		4.136	1.845	1.644	1.614	1.094	1.045	1.011	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000				
Prior	5.750	3.750	2.000	1.720	1.570	1.084	1.045	1.021	1.010	1.006	1.004	1.003	1.002	1.001	1.001	1.001	1.000	1.000	1.000	1.000	1.000
Selected	5.750	3.750	2.025	1.720	1.628	1.135	1.045	1.012	1.010	1.006	1.004	1.003	1.002	1.001	1.001	1.001	1.000	1.000	1.000	1.000	1.000
LDF to Ultimate	150.963	26.254	7.001	3.457	2.010	1.235	1.088	1.041	1.029	1.018	1.012	1.008	1.005	1.003	1.002	1.001	1.000	1.000	1.000	1.000	1.000
% of Ultimate	0.7%	3.8%	14.3%	28.9%	49.7%	81.0%	91.9%	96.1%	97.2%	98.2%	98.8%	99.3%	99.5%	99.7%	99.8%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018

Exhibit 16

Claims Closed With Payment - Hospital & Practitioner Combined (Excluding Batch Claims)

Accident Year	Months of Development 12	24	36	48	60	72	84	96	108	120	132	144	156	168	180	192	204	216	228	240	252
1995	0	0	0	0	0	3	4	5	5	5	5	6	6	6	6	6	6	6	6	6	6
1996	0	0	0	0	4	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
1997	0	0	0	6	10	13	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14
1998	0	0	2	6	8	10	12	12	12	12	12	13	13	13	13	13	13	13	13	13	13
1999	0	1	3	6	11	15	18	19	19	20	20	20	20	20	20	20	20	20	20	20	
2000	0	3	7	10	16	19	19	19	19	19	19	19	19	19	19	19	19	19	19		
2001	1	5	10	14	22	28	31	32	32	32	32	32	32	32	32	32	32	32			
2002	1	2	3	10	15	21	25	26	26	26	26	26	26	26	26	26	26				
2003	0	1	7	12	18	20	22	25	26	26	26	26	26	26	26	26					
2004	0	0	6	8	14	20	21	23	23	23	23	23	23	23	23						
2005	1	2	4	7	16	23	26	27	29	29	29	29	29	29							
2006	0	0	2	7	11	13	15	16	17	17	17	17	17								
2007	0	0	2	13	20	25	27	29	29	29	29	29									
2008	0	0	6	15	21	27	33	34	34	34	34										
2009	0	2	7	9	13	20	20	21	21	21											
2010	0	2	9	16	24	38	40	41	41												
2011	0	2	5	11	21	29	34	38													
2012	0	1	3	8	12	19	22														
2013	0	1	2	3	10	15															
2014	0	1	6	12	17																
2015	0	0	2	5																	
2016	0	2	7																		
2017	0	2																			
2018	0																				

Claims Closed With Payment - Hospital & Practitioner Combined (Excluding Batch Claims)

Accident Year	Development Factors 12-24	24-36	36-48	48-60	60-72	72-84	84-96	96-108	108-120	120-132	132-144	144-156	156-168	168-180	180-192	192-204	204-216	216-228	228-240	240-252	252-Ult
1995						1.333	1.250	1.000	1.000	1.000	1.200	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
1996					2.250	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
1997				1.667	1.300	1.077	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
1998			3.000	1.333	1.250	1.200	1.000	1.000	1.000	1.000	1.083	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
1999		3.000	2.000	1.833	1.364	1.200	1.056	1.000	1.053	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000		
2000		2.333	1.429	1.600	1.188	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000			
2001	5.000	2.000	1.400	1.571	1.273	1.107	1.032	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000				
2002	2.000	1.500	3.333	1.500	1.400	1.190	1.040	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000					
2003		7.000	1.714	1.500	2.111	1.100	1.136	1.040	1.000	1.000	1.000	1.000	1.000	1.000	1.000						
2004			1.333	1.750	1.429	1.050	1.095	1.000	1.000	1.000	1.000	1.000	1.000	1.000							
2005	2.000	2.000	1.750	2.286	1.438	1.130	1.038	1.074	1.000	1.000	1.000	1.000	1.000								
2006			3.500	1.571	1.182	1.154	1.067	1.063	1.000	1.000	1.000	1.000									
2007			6.500	1.538	1.250	1.080	1.074	1.000	1.000	1.000	1.000										
2008			2.500	1.400	1.286	1.222	1.030	1.000	1.000	1.000											
2009		3.500	1.286	1.444	1.538	1.000	1.050	1.000	1.000												
2010		4.500	1.778	1.500	1.583	1.053	1.025	1.000													
2011		2.500	2.200	1.909	1.381	1.172	1.118														
2012		3.000	2.667	1.500	1.583	1.158															
2013		2.000	1.500	3.333	1.500																
2014		6.000	2.000	1.417																	
2015			2.500																		
2016		3.500																			
2017																					
Avg	3.000	3.295	2.355	1.703	1.406	1.124	1.060	1.011	1.004	1.000	1.022	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
W Avg	9.000	3.720	2.070	1.636	1.380	1.114	1.054	1.011	1.003	1.000	1.008	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
5 yr W Avg		4.000	2.167	1.680	1.513	1.120	1.058	1.007	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000		
7 yr W Avg		3.778	1.882	1.595	1.430	1.117	1.056	1.016	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000				
5 yr Avg x Hi/Lo		3.000	2.233	1.636	1.541	1.128	1.051	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000		
7 yr Avg x Hi/Lo		3.400	1.996	1.554	1.458	1.123	1.052	1.013	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000				
Prior	4.000	3.750	2.050	1.585	1.360	1.120	1.055	1.023	1.010	1.005	1.003	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
Selected	4.000	3.750	2.100	1.620	1.450	1.120	1.056	1.020	1.010	1.005	1.003	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
LDF to Ultimate	90.914	22.729	6.061	2.886	1.782	1.229	1.097	1.038	1.018	1.008	1.003	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
% of Ultimate	1.1%	4.4%	16.5%	34.6%	56.1%	81.4%	91.2%	96.3%	98.2%	99.2%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

New Mexico Patients' Compensation Fund

Reserves as of 12/31/2018

Expense Analysis

Loss Adjustment Expenses as a Percentage of Losses Paid

Calendar Year	NM Med Soc/ Medical Panel Expenses	Contracts and Consultants	Paid Losses
(1)	(2)	(3)	(4)
2014	217,379	122,628	18,123,993
2015	303,346	198,302	27,429,472
2016	228,983	203,449	11,851,645
2017	205,740	212,293	18,100,094
2018	287,476	299,274	15,469,183
Total	1,242,924	1,035,946	90,974,388

Loss Adjustment Expenses as a Percentage of Losses Paid

2014	1.2%	0.7%
2015	1.1%	0.7%
2016	1.9%	1.7%
2017	1.1%	1.2%
2018	1.9%	1.9%
Total	1.4%	1.1%
		Selected Ratio of Expenses to Losses Paid
Average 2014 - 2018	1.4%	1.2%
Total		2.7%

Notes: (2) - (4) Based on data provided by client

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2018
Expense Analysis

Exhibit 17
Page 2

Office Expenses as a percentage of Surcharges collected

Calendar Year	IT Services	PCF Employee Services	Rent	Intra-Agency Transfer	Participant Surcharges
(1)	(2)	(3)	(4)	(5)	(6)
2014			6,000		12,188,627
2015	30,816		6,000	665,100	11,886,745
2016	41,592	41,428	6,000	665,100	21,182,760
2017	44,191	73,653	6,000	665,100	38,363,095
2018	30,785	76,662	6,749	689,000	43,031,702
Total	147,384	191,744	30,749	2,684,300	126,652,929
		Operating Expenses as a Percentage of Premiums			
2014	0.0%	0.0%	0.0%	0.0%	
2015	0.3%	0.0%	0.1%	5.6%	
2016	0.2%	0.2%	0.0%	3.1%	
2017	0.1%	0.2%	0.0%	1.7%	
2018	0.1%	0.2%	0.0%	1.6%	
Total	0.1%	0.2%	0.0%	2.1%	
		Selected Ratio of Expenses to Premiums			
Average 2014 - 2018	0.1%	0.1%	0.0%	2.4%	
Total					2.7%

Notes: (2) - (6) Based on data provided by client

New Mexico Patients' Compensation Fund

Reserves as of 12/31/2018

Expense Analysis

Batch Claim Reinsurance as a Percentage of Surcharges collected

Calendar Year	Batch Claim Reinsurance *	Participant Surcharges	Reinsurance as % of Surcharges	Selected Percentage
(1)	(2)	(3)	(4)	(5)
2014	0	12,188,627	0.0%	
2015	0	11,886,745	0.0%	
2016	0	21,182,760	0.0%	
2017	1,399,296	38,363,095	3.6%	
2018	2,975,445	43,031,702	6.9%	
Total	4,374,741	126,652,929	3.5%	6.0%

Notes: (2) - (5) Based on data provided by client
* applies to both doctors and hospitals

Actuarial Report Addendum:

New Mexico Patient's Compensation Fund Class Plan and Entity Coverage Review

October 2019

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Commitment Beyond Numbers

Table of Contents

Section	*Page*
Purpose and Scope	1
Data Sources	1
PCF Current Class Plan and Exposure Data	2
Industry Rate Filings	2
Methods and Assumptions	2

Exhibits

New Mexico Patient's Compensation Fund
Class Plan and Entity Coverage Review

Purpose and Scope

Pinnacle was requested by the New Mexico Patient Compensation Fund (PCF) to review the current physician and allied health providers class plan as well as current surcharges for entity coverage. Entity coverage provides PCF coverage to a business entity employing one or more physicians. The purpose of this review is to ensure that physicians, allied health providers, and entities are being charged in a manner proportionate to their risk level, i.e. their level of expected losses in the PCF coverage layer.

Using a number of publicly available data sources, Pinnacle has prepared this analysis as an addendum to our report dated July 10, 2019. Relevant background information on Pinnacle and the PCF as well as legal disclosures (including information on distribution, use, reliances, and limitations) can be found in our report dated July 10, 2019.

The Medical Malpractice Act of New Mexico (Chapter 41, Article 5 NMSA 1978) states that health care provider surcharges for the PCF shall be "based on sound actuarial principles, using data obtained from New Mexico experience if available" and "collected on the same basis as premiums". The PCF currently groups physicians and surgeons into thirteen classes based on their specialty ISO code with three additional classes for physician assistants and one code each for certified registered nurse anesthetists (CRNAs) and chiropractors. In addition, business entities comprised of PCF eligible providers may be covered by the PCF, including physician, podiatrist, and chiropractor practice groups. Pinnacle has reviewed these classes as a whole as well as the groupings of specialties into classes against other patient compensation funds and New Mexico medical professional liability insurers to propose adjustments as appear reasonable.

Data Sources

Our analyses use a number of data sources. The data sources are categorized as follows:

1. PCF Current Class Plan and Exposure Data
2. Industry Rate Filings

A brief description of the data sources utilized in each area along with a description of the key data elements and potential limitations of the data follows for each category.

PCF Current Class Plan and Exposure Data

Pinnacle was provided with the PCF current class plan including base surcharges by class and assignment of Insurance Services Office (ISO) codes to PCF class. This information is publicly available on the PCF's website. A list of the physician ISO codes, their current and selected classes, and the corresponding current and selected relativities are shown in Exhibit 1. Class relativities are the ratio of the surcharge for a given class and a selected base class. They allow for an easier comparison of how different rating plans reflect the risk potential of a given specialty by normalizing for differences in base rates. For the PCF surcharges, Class 2 has been selected as the base class. Classes and relativities for allied health providers (physician assistants, CRNAs, and chiropractors) are shown on Exhibit 4.

In addition, we were provided with the number of health care providers with PCF coverage by ISO specialty (for physicians and surgeons) or class (for allied health providers and business entities). These exposure counts enable us to determine the impact of any changes in classes or relativities on the PCF's surcharge levels. Based on the percentage of providers employed by business entities with PCF corporation coverage, a calculation provided by The Doctors Company, we project that 80% of physicians and surgeons, physician assistants, and CRNAs would practice under the form of an entity. Exposures can be found on Exhibit 2 (for physicians and surgeons), Exhibit 4 Page 2 (for allied health providers), and Exhibit 5 (for business entities).

Industry Rate Filings

The PCF loss data is not yet credible enough to calculate new relativities by ISO class. In order to review these relativities, we compiled data from The Doctors Company (TDC, filing submitted 8/11/2014) and The Medical Protective Company (MedPro, filing submitted 12/21/2010), two of the largest medical professional liability carriers in the state of New Mexico. Since these carrier relativities are based on the underlying coverage required by the PCF ($200,000 per occurrence, $600,000 in aggregate occurrence policies), we also compare to the Wisconsin and Indiana patient compensation funds which cover excess layers of medical professional liability similar to the PCF. These relativities are shown on Exhibit 1 and Exhibit 4, Page 1. We also relied on filings by TDC as well as our industry knowledge of medical professional liability coverage in determining the appropriate entity surcharge, shown on Exhibit 5.

Methods and Assumptions

Pinnacle's class plan review was based on two parts: reviewing class assignments by ISO code, and evaluating overall relativities by class. We then calculated the indicated surcharge impact to the PCF based on each suggested change on Exhibit 2.

To review the ISO code class assignments, we compared the current PCF relativities to the other patient compensation fund and primary carrier relativities to determine if any classes appeared to be significantly lower or higher than the industry would indicate and selected new relativities as appropriate. These ISO codes and relativities are found on Exhibit 1, while new class assignments are shown on Exhibit 2.

Based on the class assignment review, we recommend the following adjustments. All ISO codes shown in the following list are for M.D. physicians and surgeons; the same adjustments apply to the corresponding codes for D.O. physicians and surgeons. More detail regarding these numbers is shown in Exhibits 2 and 4.

- Radiation Therapy and Shock Therapy (80163, 80165, and 80431)
  Move from class 1 to class 2. There are no PCF-covered providers with this specialty, so there is no impact to the surcharge.

- Otorhinolaryngology – Minor Surgery (80291)
  Move from class 2 to class 3. There is one PCF-covered provider with this specialty resulting in an indicated surcharge impact of $778.

- Gynecology – Minor Surgery (80277)
  Move from class 3 to class 4. There are twenty one PCF-covered providers with this specialty resulting in an indicated surcharge impact of $48,804.

- Intensive Care Medicine (80283)
  Move from class 3 to class 4. There are thirty-five PCF-covered providers with this specialty resulting in an indicated surcharge impact of $81,340.

- Nephrology – No Surgery (80260)
  Move from class 3 to class 2. There are thirty three PCF-covered providers with this specialty resulting in an indicated surcharge impact of -$25,971.

- Podiatrists/Chiropodists – No Surgery (80993-N)
  Move from class 5 to class 4. There are three PCF-covered providers with this specialty resulting in an indicated surcharge impact of -$4,686.

- Cardiac Surgery (80141)
  Move from class 6 to class 8. There are two PCF-covered providers with this specialty resulting in an indicated surcharge impact of $16,902.

- Nephrology – Including Child – Minor Surgery (80288)
  Move from class 6 to class 4. There is one PCF-covered provider with this specialty resulting in an indicated surcharge impact of -$3,122.

- Obstetrics Surgery (c-sections only) (80168)
  Move from class 6 to class 8. There are no PCF-covered providers with this specialty, so there is no impact to the surcharge.

- Pediatrics – Minor Surgery (80293)
  Move from class 6 to class 4. There are seven PCF-covered providers with this specialty resulting in an indicated surcharge impact of -$21,854.

Once the class assignments were adjusted, we reviewed the overall weighted relativities by class to determine whether the class relativities remained appropriate. Our analysis resulted in the following recommendations and impacts:

- Class 5A: Increase the relativity from 1.60 to 1.70. This class is composed entirely of physicians with ISO code 80273.

- Class 7: Reduce the relativity from 4.00 to 3.50. Only physicians with ISO code 80993-S are included in this class.

- Class 10: Increase the relativity from 6.25 to 6.50. This class includes physicians with ISO codes 80150, 80152, and 80153.

Further details regarding these recommendations are on Exhibit 3. The total impact of the class assignment changes and class relativity changes on the indicated surcharge is $180,915. See Exhibit 2 for more detail regarding this impact.

We also compared PCF relativities for the allied provider types to the other patient compensation fund and insurer relativities, resulting in the following recommendation:

- CRNA: Increase relativity from 0.20 to 0.25.

The indicated surcharge impact of this change is $20,758. More details of this recommendation may be found on Exhibit 4.

The final piece of our analysis was a review of the entity coverage charge for business entities covered by the PCF. The prior entity charge for physician and surgeon entities (including podiatrists/ chiropodists) was $341 for a single physician plus $86 for each additional physician and $42 for each additional CRNA or physician assistant. For a chiropractor business entity, the charge was $234 for a single chiropractor plus $50 for each additional chiropractor. Based on our review of industry rate filings, we found that a typical entity charge is 10% of the premium for each covered provider in the entity. Because individual analysis of practice groups to calculate an appropriate rate would be inefficient, and because there is no indication that the industry standard is unreasonable, we believe that following the industry practice is appropriate. We therefore propose adjusting the entity charge to 10% of the individual provider surcharges in the entity. The actual surcharge will therefore vary based on the individual provider specialty. In order to estimate the funding impact of this change, we relied on a calculation provided by The Doctors Company, showing that 80% of PCF-covered physicians, surgeons, physician assistants, and CRNAs are employed as providers by a business entity. We also used the weighted average provider surcharges for physicians and CRNAs/physician assistants in order to estimate the surcharge impact of this change. This change results in an estimated surcharge impact of $1,570,142. More details of this calculation are available in Exhibit 5.

Exhibits and Appendices

Exhibit 1. Development of Classification Assignments by Specialty – Review of Assigned Factors

Exhibit 2. Surcharge Impact of Classification Assignments

Exhibit 3. Review of Classification Factors by Assigned Class

Exhibit 4. Page 1: Development of Relativities by Allied Class

Page 2: Surcharge Impact of New Relativities by Allied Class

Exhibit 5. Entity Coverage Evaluation

New Mexico Patient's Compensation Fund

Development of Classification Assignments by Specialty - Review of Assigned Factors

ISO Class Code					Current Rate Factors						
			Current	Proposed	Patient Compensation Funds			NM Primary Carriers		Proposed	Indicated
M.D.	D.O.	Specialty	Class	Class	NM	IN	WI	TDC	MedPro	Factor	Change
80437	84437	Acupuncture - Other than Acupuncture Anesthesia	1	1	0.75	N/A	1.80	N/A	N/A	0.75	0.0%
80230		Aerospace Medicine / Medical Director	1	1	0.75	0.70	1.00	N/A	0.67	0.75	0.0%
80254	84254	Allergy/Immunology - No Surgery	1	1	0.75	0.70	1.00	0.52	0.67	0.75	0.0%
80237		Diabetes - No Surgery	1	1	0.75	1.00	1.00	N/A	1.45	0.75	0.0%
80238	84238	Endocrinology - No Surgery	1	1	0.75	1.00	1.00	0.52	0.85	0.75	0.0%
80239		Family Practitioners - No Ob/ No Surgery	1	1	0.75	1.00	N/A	N/A	1.00	0.75	0.0%
80240	84240	Forensic Medicine / Legal Medicine	1	1	0.75	0.70	1.00	N/A	0.67	0.75	0.0%
80242		General Practitioners - No Ob/ No Major Surgery	1	1	0.75	1.00	N/A	N/A	1.70	0.75	0.0%
80420	84420	General Practitioners or Family Physicians - No Surgery - I	1	1	0.75	1.00	1.00	0.66	1.00	0.75	0.0%
80231		General Preventive Medicine - No Surgery / No Ob	1	1	0.75	0.70	1.00	0.66	0.67	0.75	0.0%
80243	84243	Geriatrics - No Surgery	1	1	0.75	1.00	1.00	N/A	0.85	0.75	0.0%
80244	84244	Gynecology - No Surgery	1	1	0.75	1.00	1.00	N/A	0.85	0.75	0.0%
80245	84245	Hematology - No Surgery	1	1	0.75	1.00	1.00	0.83	1.00	0.75	0.0%
80232		Hypnosis	1	1	0.75	N/A	1.00	N/A	N/A	0.75	0.0%
80246		Infectious Diseases - No Surgery	1	1	0.75	1.00	1.00	0.52	1.45	0.75	0.0%
80258		Larynogology - No Surgery	1	1	0.75	1.00	1.00	N/A	N/A	0.75	0.0%
	84801	Manipulator	1	1	0.75	N/A	1.00	N/A	N/A	0.75	0.0%
80259		Neoplastic Diseases - No Surgery	1	1	0.75	1.00	1.00	N/A	N/A	0.75	0.0%
80262	84262	Nuclear Medicine - Excluding Radiation Therapy	1	1	0.75	1.00	1.00	0.85	0.67	0.75	0.0%
80248		Nutrition	1	1	0.75	0.70	1.00	N/A	0.67	0.75	0.0%
80233		Occupational Medicine	1	1	0.75	0.70	1.00	0.52	0.67	0.75	0.0%
80263	84263	Ophthamology - No Surgery	1	1	0.75	0.70	1.00	0.52	0.67	0.75	0.0%
80264		Otology - No Surgery	1	1	0.75	1.00	1.00	N/A	N/A	0.75	0.0%
80265	84265	Otorhinolaryngology - No Surgery	1	1	0.75	1.00	1.00	N/A	0.85	0.75	0.0%
80307	84307	Pathology - All Other	1	1	0.75	1.00	1.00	0.83	N/A	0.75	0.0%
80304	84304	Pathology - Blood Banking/Transfusion Medicine - No Sur	1	1	0.75	1.00	1.00	0.83	N/A	0.75	0.0%
80306	84306	Pathology - Cytopathology - No Surgery	1	1	0.75	1.00	1.00	0.83	N/A	0.75	0.0%
80266		Pathology - No Surgery	1	1	0.75	1.00	1.00	0.83	0.95	0.75	0.0%
80234		Pharmacology - Clinical	1	1	0.75	0.70	1.00	N/A	0.85	0.75	0.0%
80209	84209	Physical Medicine and Rehabilitation - All Other	1	1	0.75	N/A	N/A	0.83	N/A	0.75	0.0%
80235		Physical Medicine and Rehabilitation / Physiatry	1	1	0.75	1.00	1.00	1.00	0.67	0.75	0.0%
80133	84133	Preventive Medicine - No Surgery - Aerospace Medicine	1	1	0.75	N/A	N/A	N/A	N/A	0.75	0.0%
80138	84138	Preventive Medicine - No Surgery - Medical Toxicology	1	1	0.75	N/A	N/A	N/A	N/A	0.75	0.0%
80134	84134	Preventive Medicine - No Surgery - Occupational Medicin	1	1	0.75	N/A	N/A	N/A	N/A	0.75	0.0%
80135	84135	Preventive Medicine - No Surgery - Public/General Health	1	1	0.75	N/A	N/A	N/A	N/A	0.75	0.0%
80139	84139	Preventive Medicine - No Surgery - Undersea/Hyperbaric	1	1	0.75	N/A	N/A	N/A	N/A	0.75	0.0%
80224	84224	Psychiatry - Addiction Psychiatry	1	1	0.75	0.70	1.00	0.83	N/A	0.75	0.0%
80229	84229	Psychiatry - All Other	1	1	0.75	0.70	1.00	0.83	0.67	0.75	0.0%
80226	84226	Psychiatry - Child and Adolescent Psychiatry	1	1	0.75	0.70	1.00	0.83	0.67	0.75	0.0%
80227	84227	Psychiatry - Forensic Psychiatry	1	1	0.75	0.70	1.00	0.83	0.67	0.75	0.0%
80228	84228	Psychiatry - Geriatric Psychiatry	1	1	0.75	0.70	1.00	0.83	0.67	0.75	0.0%
80249	84249	Psychiatry - Including Child	1	1	0.75	0.70	1.00	0.83	0.67	0.75	0.0%
80250		Psychoanalysis	1	1	0.75	0.70	1.00	N/A	N/A	0.75	0.0%
80251	84251	Psychosomatic Medicine	1	1	0.75	0.70	1.00	N/A	N/A	0.75	0.0%
80236		Public Health	1	1	0.75	0.70	1.00	N/A	0.67	0.75	0.0%
80163	84163	Radiation Therapy - by Employed Physicians or Surgeons I	1	2	0.75	1.70	4.00	N/A	1.25	1.00	33.3%
80165	84165	Radiation Therapy - by Insured Physicians or Surgeons Inv	1	2	0.75	N/A	1.80	N/A	1.25	1.00	33.3%
80252	84252	Rheumatology - No Surgery	1	1	0.75	1.00	1.00	0.52	0.95	0.75	0.0%
80247		Rhinology - No Surgery	1	1	0.75	1.00	1.00	N/A	0.85	0.75	0.0%
80431	84431	Shock Therapy	1	2	0.75	1.30	1.00	N/A	1.45	1.00	33.3%
80162	84162	Shock Therapy - by Insured Physicians or Surgeons Involv	1	1	0.75	N/A	1.00	N/A	N/A	0.75	0.0%
80161	84161	Shock Therapy - by Employed Physicians or Surgeons Inv	1	1	0.75	N/A	4.00	N/A	N/A	0.75	0.0%
80321		Teaching Physicians - No Surgery	1	1	0.75	N/A	N/A	N/A	N/A	0.75	0.0%
80121	84121	Urology - No Surgery	1	1	0.75	N/A	1.00	1.88	N/A	0.75	0.0%
80182	84182	Anesthesiology - Pain Management	2	2	1.00	N/A	1.80	1.50	1.25	1.00	0.0%
80255	84255	Cardiovascular Disease - No Surgery	2	2	1.00	1.00	1.00	0.83	1.25	1.00	0.0%
80225		Cardiovascular Disease - No Surgery	2	2	1.00	1.00	1.00	0.83	1.25	1.00	0.0%
80256	84256	Dermatology - No Surgery	2	2	1.00	0.70	1.00	0.52	0.67	1.00	0.0%
80428	84428	Discograms / Myleography / Pneumoencephalography	2	2	1.00	N/A	1.80	N/A	N/A	1.00	0.0%
80222	84222	Hospitalism	2	2	1.00	N/A	1.80	1.25	1.00	1.00	0.0%
80257	84257	Internal Medicine - No Surgery	2	2	1.00	1.00	1.00	N/A	1.00	1.00	0.0%
80440	84440	Laparoscopy (Peritonescopy)	2	2	1.00	N/A	1.80	N/A	N/A	1.00	0.0%
80446	84446	Needle Biopsy	2	2	1.00	N/A	1.80	N/A	N/A	1.00	0.0%
80261		Neurology - Including Child - No Surgery	2	2	1.00	1.30	1.00	1.02	1.45	1.00	0.0%
80299	84299	Neurology - Including Child - No Surgery - All Other	2	2	1.00	N/A	N/A	1.02	N/A	1.00	0.0%

New Mexico Patient's Compensation Fund

Development of Classification Assignments by Specialty - Review of Assigned Factors

ISO Class Code					Current Rate Factors						
			Current	Proposed	Patient Compensation Funds			NM Primary Carriers		Proposed	Indicated
M.D.	D.O.	Specialty	Class	Class	NM	IN	WI	TDC	MedPro	Factor	Change
80298	84298	Neurology - Including Child - No Surgery - Pain Managem	2	2	1.00	N/A	1.80	1.02	1.45	1.00	0.0%
80302	84302	Oncology - No Surgery	2	2	1.00	N/A	1.00	0.83	N/A	1.00	0.0%
80289	84289	Ophthamology - Minor Surgery	2	2	1.00	1.30	1.80	0.83	0.85	1.00	0.0%
80291	84291	Otorhinolaryngology - Minor Surgery	2	3	1.00	1.70	1.80	N/A	1.45	1.20	20.0%
80208	84208	Physical Medicine and Rehabilitation - Pain Management	2	2	1.00	N/A	1.00	1.66	N/A	1.00	0.0%
80269	84269	Pulmonary Diseases - No Surgery	2	2	1.00	1.00	1.00	0.83	1.70	1.00	0.0%
80253	84253	Radiology - Diagnostic - No Surgery	2	2	1.00	1.30	1.00	1.09	1.45	1.00	0.0%
80359	84359	Radiology - Therapeutic - No Surgery	2	2	1.00	N/A	N/A	N/A	N/A	1.00	0.0%
80205	84205	Sports Medicine - No Surgery	2	2	1.00	N/A	N/A	N/A	N/A	1.00	0.0%
80322		Teaching Physicians - Minor Surgery	2	2	1.00	N/A	N/A	N/A	N/A	1.00	0.0%
80101		Broncho-Esophagology	3	3	1.20	2.00	1.80	N/A	N/A	1.20	0.0%
80443	84443	Colonoscopy / Endoscopic Retrograde Cholangiopancreat	3	3	1.20	N/A	1.80	N/A.	N/A	1.20	0.0%
80297	84297	Dermatology - All Other	3	3	1.20	N/A	N/A	1.02	0.85	1.20	0.0%
80295	84295	Dermatology - Clinical and Dermatological Immunology	3	3	1.20	N/A	N/A	1.02	0.85	1.20	0.0%
80296	84296	Dermatology - Dermatopathology	3	3	1.20	N/A	1.80	1.02	0.85	1.20	0.0%
80282		Dermatology - Including X-Ray Therapy / Radiation Thera	3	3	1.20	1.30	1.80	1.02	0.85	1.20	0.0%
80271		Diabetes - Minor Surgery	3	3	1.20	1.70	1.80	N/A	N/A	1.20	0.0%
80272	84272	Endocrinology - Minor Surgery	3	3	1.20	1.70	1.80	N/A	1.25	1.20	0.0%
80241	84241	Gastroenterology - No Surgery	3	3	1.20	1.00	1.00	1.30	1.45	1.20	0.0%
80421	84421	General Practitioners or Family Physicians - Minor Surger	3	3	1.20	1.70	1.80	1.00	2.21	1.20	0.0%
80276	84276	Geriatrics - Minor Surgery	3	3	1.20	1.70	1.80	N/A	1.45	1.20	0.0%
80277	84277	Gynecology - Minor Surgery (including 1st trimester abort	3	4	1.20	2.00	1.80	2.72	1.45	1.80	50.0%
80278	84278	Hematology - Minor Surgery	3	3	1.20	1.70	1.80	N/A	1.70	1.20	0.0%
80279		Infectious Diseases - Minor Surgery	3	3	1.20	1.70	1.80	1.00	1.70	1.20	0.0%
80283	84283	Intensive Care Medicine	3	4	1.20	1.70	1.80	N/A	2.21	1.80	50.0%
80285		Larynogology - Minor Surgery	3	3	1.20	1.70	1.80	N/A	N/A	1.20	0.0%
80286		Neoplastic Diseases - Minor Surgery	3	3	1.20	1.70	1.80	N/A	N/A	1.20	0.0%
80260		Nephrology - No Surgery	3	2	1.20	1.00	1.00	0.52	0.95	1.00	-16.7%
80114		Ophthamology Surgery	3	3	1.20	1.70	1.80	1.09	0.91	1.20	0.0%
80290		Otology - Minor Surgery	3	3	1.20	1.70	1.80	N/A	N/A	1.20	0.0%
80303	84303	Pathology - Blood Banking/Transfusion Medicine - Minor	3	3	1.20	N/A	N/A	N/A	1.45	1.20	0.0%
80305	84305	Pathology - Cytopathology - Minor Surgery	3	3	1.20	N/A	N/A	N/A	1.45	1.20	0.0%
80292		Pathology - Minor Surgery	3	3	1.20	1.30	1.80	N/A	1.45	1.20	0.0%
80294		Physicians - Minor Surgery - No Ob	3	3	1.20	1.70	1.80	N/A	1.45	1.20	0.0%
80268	84268	Physicians - No Surgery / No Ob - Urgent Care Only	3	3	1.20	1.00	1.00	N/A	N/A	1.20	0.0%
80270		Rhinology - Minor Surgery	3	3	1.20	1.70	1.80	N/A	N/A	1.20	0.0%
	84802	Sclerotherapy	3	3	1.20	N/A	N/A	N/A	N/A	1.20	0.0%
80120	84120	Urology - Minor Surgery	3	3	1.20	N/A	1.00	1.88	N/A	1.20	0.0%
80422	84422	Angiography / Arteriography / Catheterization	4	4	1.80	1.70	1.80	N/A	N/A	1.80	0.0%
80281	84281	Cardiovascular Disease - Minor Surgery	4	4	1.80	1.70	1.80	N/A	1.70	1.80	0.0%
80429	84429	Cryosurgery	4	4	1.80	N/A	N/A	N/A	N/A	1.80	0.0%
80284	84284	Internal Medicine - Minor Surgery	4	4	1.80	1.70	1.80	1.15	1.70	1.80	0.0%
80287		Nephrology - Minor Surgery	4	4	1.80	1.70	1.80	N/A	1.45	1.80	0.0%
80449	84449	Radiopaque Dye Injections	4	4	1.80	N/A	1.00	N/A	1.95	1.80	0.0%
80102	84102	Emergency Medicine - No Major Surgery	5	5	2.20	2.75	1.80	2.09	2.57	2.20	0.0%
80275		General Practitioners or Family Physicians - Ob but No Ma	5	5	2.20	1.70	N/A	1.88	N/A	2.20	0.0%
80804	84804	Neonatal/Perinatal Medicine	5	5	2.20	N/A	N/A	1.30	N/A	2.20	0.0%
80301	84301	Oncology - Minor Surgery	5	5	2.20	N/A	1.80	N/A	N/A	2.20	0.0%
80993-N		Podiatrists/Chiropodists - No Surgery	5	4	2.20	0.93	N/A	0.67	N/A	1.80	-18.2%
80425	84425	Radiation Therapy / Lasers - Used in Therapy	5	5	2.20	1.30	1.80	N/A	N/A	2.20	0.0%
80280	84280	Radiology - Diagnostic - Minor Surgery	5	5	2.20	1.30	1.80	2.00	1.95	2.20	0.0%
80360	84360	Radiology - Interventional	5	5	2.20	N/A	N/A	2.00	N/A	2.20	0.0%
80358	84358	Radiology - Therapeutic - Minor Surgery	5	5	2.20	N/A	N/A	1.45	N/A	2.20	0.0%
80141		Cardiac Surgery	6	8	2.60	6.00	4.00	N/A	N/A	4.75	82.7%
80157	84157	Emergency Medicine - Including Major Surgery	6	6	2.60	4.25	4.00	2.09	2.57	2.60	0.0%
80169		Hand Surgery	6	6	2.60	4.25	4.00	2.63	2.39	2.60	0.0%
80170		Head and Neck Surgery	6	6	2.60	4.25	4.00	N/A	2.39	2.60	0.0%
80106		Laryngology Surgery	6	6	2.60	2.75	4.00	N/A	N/A	2.60	0.0%
80107		Neoplastic Surgery	6	6	2.60	2.75	1.80	N/A	N/A	2.60	0.0%
80288	84288	Nephrology - Including Child - Minor Surgery	6	4	2.60	1.70	1.80	N/A	2.21	1.80	-30.8%
80108		Nephrology Surgery	6	6	2.60	2.00	1.80	N/A	N/A	2.60	0.0%
80168		Obstetrics Surgery (c-sections only)	6	8	2.60	7.50	6.60	4.86	N/A	4.75	82.7%
80158		Otology Surgery	6	6	2.60	2.75	4.00	N/A	N/A	2.60	0.0%
80159		Otorhinolaryngology Surgery	6	6	2.60	2.75	4.00	2.00	1.95	2.60	0.0%
80293	84293	Pediatrics - Minor Surgery	6	4	2.60	1.70	1.80	N/A	1.45	1.80	-30.8%

New Mexico Patient's Compensation Fund

Development of Classification Assignments by Specialty - Review of Assigned Factors

ISO Class Code					Current Rate Factors						
			Current	Proposed	Patient Compensation Funds			NM Primary Carriers		Proposed	Indicated
M.O.	D.O.	Specialty	Class	Class	NM	IN	WI	TDC	MedPro	Factor	Change
80160		Rhinology Surgery	6	6	2.60	2.75	4.00	N/A	N/A	2.60	0.0%
80145	84145	Urological Surgery	6	6	2.60	2.00	1.80	N/A	1.70	2.60	0.0%
80993-S		Podiatrists - Surgery	7	7	4.00	1.45	4.25	2.05	N/A	3.50	-12.5%
80167	84167	Gynecology Surgery	8	8	4.75	6.00	4.00	1.39	2.39	4.75	0.0%
80164	84164	Oncology Surgery	8	8	4.75	N/A	N/A	N/A	N/A	4.75	0.0%
80180	84180	Pediatric Surgery	8	8	4.75	N/A	4.00	N/A	6.22	4.75	0.0%
80156	84156	Plastic Surgery	8	8	4.75	4.25	4.00	2.72	2.21	4.75	0.0%
80155	84155	Plastic-otorhino-laryngology Surgery	8	8	4.75	2.75	4.00	2.72	2.21	4.75	0.0%
80166		Abdominal Surgery	9	9	5.75	4.25	4.00	N/A	4.00	5.75	0.0%
80115		Colon and Rectal Surgery	9	9	5.75	2.00	1.80	1.88	2.21	5.75	0.0%
80103		Endocrinology Surgery	9	9	5.75	2.75	1.80	N/A	N/A	5.75	0.0%
80104		Gastroenterology Surgery	9	9	5.75	2.75	1.80	N/A	2.21	5.75	0.0%
80117		General Practice or Family Practice Surgery	9	9	5.75	2.00	1.80	1.30	2.21	5.75	0.0%
80143	84143	General Surgery	9	9	5.75	4.25	4.00	4.10	3.81	5.75	0.0%
80105		Geriatrics Surgery	9	9	5.75	2.75	1.80	N/A	2.39	5.75	0.0%
80154	84154	Orthopedic Surgery	9	9	5.75	6.00	4.00	2.96	3.00	5.75	0.0%
80144	84144	Thoracic Surgery	9	9	5.75	6.00	4.00	4.10	3.48	5.75	0.0%
80171		Traumatic Surgery	9	9	5.75	6.00	4.00	N/A	4.58	5.75	0.0%
80146		Vascular Surgery	9	9	5.75	6.00	4.00	N/A	3.48	5.75	0.0%
80150	84150	Cardiovascular Disease Surgery	10	10	6.25	6.00	4.00	1.09	3.48	6.50	4.0%
80152	84152	Neurology Surgery - Including Child	10	10	6.25	N/A	6.60	5.82	6.22	6.50	4.0%
80153	84153	Obstetrics Surgery / Gynecology Surgery	10	10	6.25	7.50	6.60	4.13	4.00	6.50	4.0%
80274	84274	Gastroenterology - Minor Surgery	4A	4A	1.50	1.70	1.80	N/A	1.70	1.50	0.0%
80434	84434	Lymphangiography / Phlebography	4A	4A	1.50	N/A	1.80	N/A	1.45	1.50	0.0%
80267	84267	Pediatrics - No Surgery	4A	4A	1.50	1.00	1.00	1.02	0.91	1.50	0.0%
80204	84204	Sports Medicine - Minor Surgery	4A	4A	1.50	N/A	N/A	N/A	N/A	1.50	0.0%
80273		General Practitioners or Family Physicians - Ob but No Ma	5A	5A	1.60	1.70	N/A	N/A	N/A	1.70	6.3%
80151	84151	Anesthesiology	7A	7A	3.00	1.70	1.80	1.50	1.25	3.00	0.0%
80183	84183	Anesthesiology - All Other	7A	7A	3.00	1.70	1.80	1.50	N/A	3.00	0.0%
80181	84181	Anesthesiology - Critical Care Medicine	7A	7A	3.00	1.70	1.80	1.50	N/A	3.00	0.0%
80323		Teaching Physicians or Surgeons - Major Surgery	7A	7A	3.00	N/A	N/A	N/A	N/A	3.00	0.0%
80324		Teaching Physicians or Surgeons - Major Surgery	7A	7A	3.00	N/A	N/A	N/A	N/A	3.00	0.0%
80325		Teaching Physicians or Surgeons - Major Surgery	7A	7A	3.00	N/A	N/A	N/A	N/A	3.00	0.0%
80326		Teaching Physicians or Surgeons - Major Surgery	7A	7A	3.00	N/A	N/A	N/A	N/A	3.00	0.0%
80327		Teaching Physicians or Surgeons - Major Surgery	7A	7A	3.00	N/A	N/A	N/A	N/A	3.00	0.0%

New Mexico Patient's Compensation Fund

Surcharge Impact of Classification Assignments

ISO Class Code M.D.	D.O.	Specialty	Current Class	Proposed Class	Exposures	Current Rate	Proposed Rate	Proposed Factor	Indicated Surcharge Impact	% of Surcharge Impact
80437	84437	Acupuncture - Other than Acupuncture Anesthesia	1	1	2	$2,920	$2,917	0.75	-$6	-0.1%
80230		Aerospace Medicine / Medical Director	1	1	0	2,920	2,917	0.75	0	0.0%
80254	84254	Allergy/Immunology - No Surgery	1	1	15	2,920	2,917	0.75	-45	-0.1%
80237		Diabetes - No Surgery	1	1	0	2,920	2,917	0.75	0	0.0%
80238	84238	Endocrinology - No Surgery	1	1	14	2,920	2,917	0.75	-42	-0.1%
80239		Family Practitioners - No Ob/ No Surgery	1	1	131	2,920	2,917	0.75	-393	-0.1%
80240	84240	Forensic Medicine / Legal Medicine	1	1	0	2,920	2,917	0.75	0	0.0%
80242		General Practitioners - No Ob/ No Major Surgery	1	1	3	2,920	2,917	0.75	-9	-0.1%
80420	84420	General Practitioners or Family Physicians - No Surgery - I	1	1	328	2,920	2,917	0.75	-984	-0.1%
80231		General Preventive Medicine - No Surgery / No Ob	1	1	0	2,920	2,917	0.75	0	0.0%
80243	84243	Geriatrics - No Surgery	1	1	2	2,920	2,917	0.75	-6	-0.1%
80244	84244	Gynecology - No Surgery	1	1	3	2,920	2,917	0.75	-9	-0.1%
80245	84245	Hematology - No Surgery	1	1	3	2,920	2,917	0.75	-9	-0.1%
80232		Hypnosis	1	1	0	2,920	2,917	0.75	0	0.0%
80246		Infectious Diseases - No Surgery	1	1	12	2,920	2,917	0.75	-36	-0.1%
80258		Larynogology - No Surgery	1	1	0	2,920	2,917	0.75	0	0.0%
	84801	Manipulator	1	1	0	2,920	2,917	0.75	0	0.0%
80259		Neoplastic Diseases - No Surgery	1	1	0	2,920	2,917	0.75	0	0.0%
80262	84262	Nuclear Medicine - Excluding Radiation Therapy	1	1	0	2,920	2,917	0.75	0	0.0%
80248		Nutrition	1	1	0	2,920	2,917	0.75	0	0.0%
80233		Occupational Medicine	1	1	1	2,920	2,917	0.75	-3	-0.1%
80263	84263	Ophthamology - No Surgery	1	1	11	2,920	2,917	0.75	-33	-0.1%
80264		Otology - No Surgery	1	1	0	2,920	2,917	0.75	0	0.0%
80265	84265	Otorhinolaryngology - No Surgery	1	1	3	2,920	2,917	0.75	-9	-0.1%
80307	84307	Pathology - All Other	1	1	44	2,920	2,917	0.75	-132	-0.1%
80304	84304	Pathology - Blood Banking/Transfusion Medicine - No Sur	1	1	0	2,920	2,917	0.75	0	0.0%
80306	84306	Pathology - Cytopathology - No Surgery	1	1	0	2,920	2,917	0.75	0	0.0%
80266		Pathology - No Surgery	1	1	6	2,920	2,917	0.75	-18	-0.1%
80234		Pharmacology - Clinical	1	1	0	2,920	2,917	0.75	0	0.0%
80209	84209	Physical Medicine and Rehabilitation - All Other	1	1	15	2,920	2,917	0.75	-45	-0.1%
80235		Physical Medicine and Rehabilitation / Physiatry	1	1	6	2,920	2,917	0.75	-18	-0.1%
80133	84133	Preventive Medicine - No Surgery - Aerospace Medicine	1	1	0	2,920	2,917	0.75	0	0.0%
80138	84138	Preventive Medicine - No Surgery - Medical Toxicology	1	1	0	2,920	2,917	0.75	0	0.0%
80134	84134	Preventive Medicine - No Surgery - Occupational Medicin	1	1	7	2,920	2,917	0.75	-21	-0.1%
80135	84135	Preventive Medicine - No Surgery - Public/General Health	1	1	2	2,920	2,917	0.75	-6	-0.1%
80139	84139	Preventive Medicine - No Surgery - Undersea/Hyperbaric	1	1	0	2,920	2,917	0.75	0	0.0%
80224	84224	Psychiatry - Addiction Psychiatry	1	1	0	2,920	2,917	0.75	0	0.0%
80229	84229	Psychiatry - All Other	1	1	20	2,920	2,917	0.75	-60	-0.1%
80226	84226	Psychiatry - Child and Adolescent Psychiatry	1	1	1	2,920	2,917	0.75	-3	-0.1%
80227	84227	Psychiatry - Forensic Psychiatry	1	1	0	2,920	2,917	0.75	0	0.0%
80228	84228	Psychiatry - Geriatric Psychiatry	1	1	0	2,920	2,917	0.75	0	0.0%
80249	84249	Psychiatry - Including Child	1	1	53	2,920	2,917	0.75	-159	-0.1%
80250		Psychoanalysis	1	1	0	2,920	2,917	0.75	0	0.0%
80251	84251	Psychosomatic Medicine	1	1	0	2,920	2,917	0.75	0	0.0%
80236		Public Health	1	1	0	2,920	2,917	0.75	0	0.0%
80163	84163	Radiation Therapy - by Employed Physicians or Surgeons I	1	2	0	2,920	3,889	1.00	0	0.0%
80165	84165	Radiation Therapy - by Insured Physicians or Surgeons Inv	1	2	0	2,920	3,889	1.00	0	0.0%
80252	84252	Rheumatology - No Surgery	1	1	27	2,920	2,917	0.75	-81	-0.1%
80247		Rhinology - No Surgery	1	1	0	2,920	2,917	0.75	0	0.0%
80431	84431	Shock Therapy	1	2	0	2,920	3,889	1.00	0	0.0%
80162	84162	Shock Therapy - by Insured Physicians or Surgeons Involv	1	1	0	2,920	2,917	0.75	0	0.0%
80161	84161	Shock Therapy - by Employed Physicians or Surgeons Inv	1	1	0	2,920	2,917	0.75	0	0.0%
80321		Teaching Physicians - No Surgery	1	1	2	2,920	2,917	0.75	-6	-0.1%
80121	84121	Urology - No Surgery	1	1	0	2,920	2,917	0.75	0	0.0%
80182	84182	Anesthesiology - Pain Management	2	2	23	3,889	3,889	1.00	0	0.0%
80255	84255	Cardiovascular Disease - No Surgery	2	2	24	3,889	3,889	1.00	0	0.0%
80225		Cardiovascular Disease - No Surgery	2	2	1	3,889	3,889	1.00	0	0.0%
80256	84256	Dermatology - No Surgery	2	2	36	3,889	3,889	1.00	0	0.0%
80428	84428	Discograms / Myleography / Pneumoencephalography	2	2	0	3,889	3,889	1.00	0	0.0%
80222	84222	Hospitalism	2	2	121	3,889	3,889	1.00	0	0.0%
80257	84257	Internal Medicine - No Surgery	2	2	244	3,889	3,889	1.00	0	0.0%
80440	84440	Laparoscopy (Peritonescopy)	2	2	0	3,889	3,889	1.00	0	0.0%
80446	84446	Needle Biopsy	2	2	0	3,889	3,889	1.00	0	0.0%
80261		Neurology - Including Child - No Surgery	2	2	12	3,889	3,889	1.00	0	0.0%
80299	84299	Neurology - Including Child - No Surgery - All Other	2	2	17	3,889	3,889	1.00	0	0.0%

New Mexico Patient's Compensation Fund

Surcharge Impact of Classification Assignments

ISO Class Code M.D.	D.O.	Specialty	Current Class	Proposed Class	Exposures	Current Rate	Proposed Rate	Proposed Factor	Indicated Surcharge Impact	% of Surcharge Impact
80298	84298	Neurology - Including Child - No Surgery - Pain Managem	2	2	25	3,889	3,889	1.00	0	0.0%
80302	84302	Oncology - No Surgery	2	2	42	3,889	3,889	1.00	0	0.0%
80289	84289	Ophthamology - Minor Surgery	2	2	1	3,889	3,889	1.00	0	0.0%
80291	84291	Otorhinolaryngology - Minor Surgery	2	3	1	3,889	4,667	1.20	778	20.0%
80208	84208	Physical Medicine and Rehabilitation - Pain Management	2	2	2	3,889	3,889	1.00	0	0.0%
80269	84269	Pulmonary Diseases - No Surgery	2	2	25	3,889	3,889	1.00	0	0.0%
80253	84253	Radiology - Diagnostic - No Surgery	2	2	135	3,889	3,889	1.00	0	0.0%
80359	84359	Radiology - Therapeutic - No Surgery	2	2	3	3,889	3,889	1.00	0	0.0%
80205	84205	Sports Medicine - No Surgery	2	2	2	3,889	3,889	1.00	0	0.0%
80322		Teaching Physicians - Minor Surgery	2	2	0	3,889	3,889	1.00	0	0.0%
80101		Broncho-Esophagology	3	3	0	4,676	4,667	1.20	0	0.0%
80443	84443	Colonoscopy / Endoscopic Retrograde Cholangiopancreat	3	3	1	4,676	4,667	1.20	-9	-0.2%
80297	84297	Dermatology - All Other	3	3	12	4,676	4,667	1.20	-108	-0.2%
80295	84295	Dermatology - Clinical and Dermatological Immunology	3	3	0	4,676	4,667	1.20	0	0.0%
80296	84296	Dermatology - Dermatopathology	3	3	0	4,676	4,667	1.20	0	0.0%
80282		Dermatology - Including X-Ray Therapy / Radiation Thera	3	3	0	4,676	4,667	1.20	0	0.0%
80271		Diabetes - Minor Surgery	3	3	0	4,676	4,667	1.20	0	0.0%
80272	84272	Endocrinology - Minor Surgery	3	3	13	4,676	4,667	1.20	-117	-0.2%
80241	84241	Gastroenterology - No Surgery	3	3	3	4,676	4,667	1.20	-27	-0.2%
80421	84421	General Practitioners or Family Physicians - Minor Surger	3	3	26	4,676	4,667	1.20	-234	-0.2%
80276	84276	Geriatrics - Minor Surgery	3	3	0	4,676	4,667	1.20	0	0.0%
80277	84277	Gynecology - Minor Surgery (including 1st trimester abor	3	4	21	4,676	7,000	1.80	48,804	49.7%
80278	84278	Hematology - Minor Surgery	3	3	9	4,676	4,667	1.20	-81	-0.2%
80279		Infectious Diseases - Minor Surgery	3	3	1	4,676	4,667	1.20	-9	-0.2%
80283	84283	Intensive Care Medicine	3	4	35	4,676	7,000	1.80	81,340	49.7%
80285		Larynogology - Minor Surgery	3	3	0	4,676	4,667	1.20	0	0.0%
80286		Neoplastic Diseases - Minor Surgery	3	3	0	4,676	4,667	1.20	0	0.0%
80260		Nephrology - No Surgery	3	2	33	4,676	3,889	1.00	-25,971	-16.8%
80114		Ophthamology Surgery	3	3	65	4,676	4,667	1.20	-585	-0.2%
80290		Otology - Minor Surgery	3	3	0	4,676	4,667	1.20	0	0.0%
80303	84303	Pathology - Blood Banking/Transfusion Medicine - Minor	3	3	0	4,676	4,667	1.20	0	0.0%
80305	84305	Pathology - Cytopathology - Minor Surgery	3	3	0	4,676	4,667	1.20	0	0.0%
80292		Pathology - Minor Surgery	3	3	0	4,676	4,667	1.20	0	0.0%
80294		Physicians - Minor Surgery - No Ob	3	3	10	4,676	4,667	1.20	-90	-0.2%
80268	84268	Physicians - No Surgery / No Ob - Urgent Care Only	3	3	38	4,676	4,667	1.20	-342	-0.2%
80270		Rhinology - Minor Surgery	3	3	0	4,676	4,667	1.20	0	0.0%
	84802	Sclerotherapy	3	3	0	4,676	4,667	1.20	0	0.0%
80120	84120	Urology - Minor Surgery	3	3	3	4,676	4,667	1.20	-27	-0.2%
80422	84422	Angiography / Arteriography / Catheterization	4	4	1	7,008	7,000	1.80	-8	-0.1%
80281	84281	Cardiovascular Disease - Minor Surgery	4	4	65	7,008	7,000	1.80	-520	-0.1%
80429	84429	Cryosurgery	4	4	0	7,008	7,000	1.80	0	0.0%
80284	84284	Internal Medicine - Minor Surgery	4	4	18	7,008	7,000	1.80	-144	-0.1%
80287		Nephrology - Minor Surgery	4	4	5	7,008	7,000	1.80	-40	-0.1%
80449	84449	Radiopaque Dye Injections	4	4	2	7,008	7,000	1.80	-16	-0.1%
80102	84102	Emergency Medicine - No Major Surgery	5	5	238	8,562	8,556	2.20	-1,428	-0.1%
80275		General Practitioners or Family Physicians - Ob but No M	5	5	11	8,562	8,556	2.20	-66	-0.1%
80804	84804	Neonatal/Perinatal Medicine	5	5	18	8,562	8,556	2.20	-108	-0.1%
80301	84301	Oncology - Minor Surgery	5	5	6	8,562	8,556	2.20	-36	-0.1%
80993-N		Podiatrists/Chiropodists - No Surgery	5	4	3	8,562	7,000	1.80	-4,686	-18.2%
80425	84425	Radiation Therapy / Lasers - Used in Therapy	5	5	3	8,562	8,556	2.20	-18	-0.1%
80280	84280	Radiology - Diagnostic - Minor Surgery	5	5	44	8,562	8,556	2.20	-264	-0.1%
80360	84360	Radiology - Interventional	5	5	1	8,562	8,556	2.20	-6	-0.1%
80358	84358	Radiology - Therapeutic - Minor Surgery	5	5	0	8,562	8,556	2.20	0	0.0%
80141		Cardiac Surgery	6	8	2	10,122	18,473	4.75	16,702	82.5%
80157	84157	Emergency Medicine - Including Major Surgery	6	6	0	10,122	10,111	2.60	0	0.0%
80169		Hand Surgery	6	6	6	10,122	10,111	2.60	-66	-0.1%
80170		Head and Neck Surgery	6	6	1	10,122	10,111	2.60	-11	-0.1%
80106		Laryngology Surgery	6	6	0	10,122	10,111	2.60	0	0.0%
80107		Neoplastic Surgery	6	6	0	10,122	10,111	2.60	0	0.0%
80288	84288	Nephrology - Including Child - Minor Surgery	6	4	1	10,122	7,000	1.80	-3,122	-30.8%
80108		Nephrology Surgery	6	6	1	10,122	10,111	2.60	-11	-0.1%
80168		Obstetrics Surgery (c-sections only)	6	8	0	10,122	18,473	4.75	0	0.0%
80158		Otology Surgery	6	6	0	10,122	10,111	2.60	0	0.0%
80159		Otorhinolaryngology Surgery	6	6	23	10,122	10,111	2.60	-253	-0.1%
80293	84293	Pediatrics - Minor Surgery	6	4	7	10,122	7,000	1.80	-21,854	-30.8%

New Mexico Patient's Compensation Fund

Surcharge Impact of Classification Assignments

ISO Class Code M.D.	D.O.	Specialty	Current Class	Proposed Class	Exposures	Current Rate	Proposed Rate	Proposed Factor	Indicated Surcharge Impact	% of Surcharge Impact
80160		Rhinology Surgery	6	6	0	10,122	10,111	2.60	0	0.0%
80145	84145	Urological Surgery	6	6	24	10,122	10,111	2.60	-264	-0.1%
80993-S		Podiatrists - Surgery	7	7	18	15,569	13,612	3.50	-35,226	-12.6%
80167	84167	Gynecology Surgery	8	8	19	18,494	18,473	4.75	-399	-0.1%
80164	84164	Oncology Surgery	8	8	7	18,494	18,473	4.75	-147	-0.1%
80180	84180	Pediatric Surgery	8	8	5	18,494	18,473	4.75	-105	-0.1%
80156	84156	Plastic Surgery	8	8	13	18,494	18,473	4.75	-273	-0.1%
80155	84155	Plastic-otorhino-laryngology Surgery	8	8	3	18,494	18,473	4.75	-63	-0.1%
80166		Abdominal Surgery	9	9	0	22,384	22,362	5.75	0	0.0%
80115		Colon and Rectal Surgery	9	9	4	22,384	22,362	5.75	-88	-0.1%
80103		Endocrinology Surgery	9	9	1	22,384	22,362	5.75	-22	-0.1%
80104		Gastroenterology Surgery	9	9	27	22,384	22,362	5.75	-594	-0.1%
80117		General Practice or Family Practice Surgery	9	9	2	22,384	22,362	5.75	-44	-0.1%
80143	84143	General Surgery	9	9	90	22,384	22,362	5.75	-1,980	-0.1%
80105		Geriatrics Surgery	9	9	0	22,384	22,362	5.75	0	0.0%
80154	84154	Orthopedic Surgery	9	9	99	22,384	22,362	5.75	-2,178	-0.1%
80144	84144	Thoracic Surgery	9	9	8	22,384	22,362	5.75	-176	-0.1%
80171		Traumatic Surgery	9	9	3	22,384	22,362	5.75	-66	-0.1%
80146		Vascular Surgery	9	9	12	22,384	22,362	5.75	-264	-0.1%
80150	84150	Cardiovascular Disease Surgery	10	10	9	24,334	25,279	6.50	8,505	3.9%
80152	84152	Neurology Surgery - Including Child	10	10	9	24,334	25,279	6.50	8,505	3.9%
80153	84153	Obstetrics Surgery / Gynecology Surgery	10	10	123	24,334	25,279	6.50	116,235	3.9%
80274	84274	Gastroenterology - Minor Surgery	4A	4A	27	5,843	5,834	1.50	-243	-0.2%
80434	84434	Lymphangiography / Phlebography	4A	4A	0	5,843	5,834	1.50	0	0.0%
80267	84267	Pediatrics - No Surgery	4A	4A	201	5,843	5,834	1.50	-1,809	-0.2%
80204	84204	Sports Medicine - Minor Surgery	4A	4A	0	5,843	5,834	1.50	0	0.0%
80273		General Practitioners or Family Physicians - Ob but No Ma	5A	5A	19	6,214	6,611	1.70	7,543	6.4%
80151	84151	Anesthesiology	7A	7A	31	11,678	11,667	3.00	-341	-0.1%
80183	84183	Anesthesiology - All Other	7A	7A	75	11,678	11,667	3.00	-825	-0.1%
80181	84181	Anesthesiology - Critical Care Medicine	7A	7A	0	11,678	11,667	3.00	0	0.0%
80323		Teaching Physicians or Surgeons - Major Surgery	7A	7A	0	11,678	11,667	3.00	0	0.0%
80324		Teaching Physicians or Surgeons - Major Surgery	7A	7A	0	11,678	11,667	3.00	0	0.0%
80325		Teaching Physicians or Surgeons - Major Surgery	7A	7A	0	11,678	11,667	3.00	0	0.0%
80326		Teaching Physicians or Surgeons - Major Surgery	7A	7A	0	11,678	11,667	3.00	0	0.0%
80327		Teaching Physicians or Surgeons - Major Surgery	7A	7A	0	11,678	11,667	3.00	0	0.0%
							Total Surcharge Impact		180,915	

New Mexico Patient's Compensation Fund

Review of Classification Factors by Assigned Class

		Current Rate Factors Evaluated Over Proposed Class*					
	Current	Patient Compensation Funds			NM Primary Carriers		Proposed
Class	Factor	NM	IN	WI	TDC	MedPro	Factor
1	0.75	0.75	0.87	1.09	0.79	0.85	0.75
2	1.00	0.98	1.15	1.47	0.98	1.22	1.00
3	1.20	1.19	1.59	1.69	1.15	1.33	1.20
4A	1.50	1.50	1.35	1.53	1.02	1.36	1.50
4	1.80	1.87	1.65	1.71	1.51	1.77	1.80
5A	1.60	1.60	1.70				1.70
5	2.20	2.20	1.76	1.80	1.79	2.26	2.20
6	2.60	2.60	3.05	3.34	2.24	2.20	2.60
7A	3.00	3.00	1.70	1.80	1.50	1.25	3.00
7	4.00	4.00	1.45	4.25	2.05		3.50
8	4.75	4.14	5.30	4.43	2.92	3.26	4.75
9	5.75	5.75	4.07	3.00	2.87	3.14	5.75
10	6.25	6.25	6.75	5.73	3.68	4.57	6.50

*Incorporates impact of changes in classification for physician classes

New Mexico Patient's Compensation Fund

Development of Relativities by Allied Class

NM Class Code				Relativity to Internal Medicine No Surgery - 80257					Proposed	Indicated
				Patient Compensation Funds			NM Primary Carrier			
M.D.	D.O.	Description	Class	NM	IN	WI	TDC	MedPro	Factor	Change
80410		Chiropractors	99	0.60	N/A	0.40	0.85	N/A	0.60	0.0%
		Nurse Anesthetists	CRNA	0.20	0.45	0.25	0.60	N/A	0.25	25.0%
		Physicians Assistants - Supervised by Non-Invasive Specialists	PA-1	0.34	0.35	0.20	0.25	N/A	0.34	0.0%
80116	84116	Physicians Assistants - Supervised by Specialists Performing Minor Surgery	PA-2	0.45	0.35	0.20	0.25	N/A	0.45	0.0%
		Physicians Assistants - Supervised by Specialists Performing Major Surgery	PA-3	0.54	0.35	0.20	0.25	N/A	0.54	0.0%

New Mexico Patient's Compensation Fund

Surcharge Impact of New Relativities by Allied Class

NM Class Code M.D.	D.O.	Description	Class	Exposures	Current Factor	Proposed Factor	Current Rate	Proposed Rate	Indicated Surcharge Impact	% of Surcharge Impact
80410		Chiropractors	99	3	0.60	0.60	2,333	2,333	0	0.0%
		Nurse Anesthetists	CRNA	107	0.20	0.25	778	972	20,758	24.9%
		Physicians Assistants - Supervised by Non-Invasive Specialists	PA-1	312	0.34	0.34	1,322	1,322	0	0.0%
80116	84116	Physicians Assistants - Supervised by Specialists Performing Minor Surgery	PA-2	59	0.45	0.45	1,750	1,750	0	0.0%
		Physicians Assistants - Supervised by Specialists Performing Major Surgery	PA-3	73	0.54	0.54	2,100	2,100	0	0.0%
								Total	20,758	

New Mexico Patient's Compensation Fund
Entity Coverage Evaluation

NM Class Code M.D.	D.O.	Description	Class	Exposures (1)	Current Rate Per Provider (2)	Current Surcharge (3)	Proposed Rate per Provider (4)	Weighted Average Provider Surcharge (5)	Estimated Rate Per Provider (6)	Estimated Surcharge (7)	Estimated Surcharge Impact (8)	% of Surcharge Impact (9)
80999	84999	Physicians and Surgeons - Corporate or Partnership Liability	51									
		Single doctor		503	$341	$171,523	10% of provider surcharge	$7,766	$777	$390,605	$219,082	127.7%
		Each additional doctor		1,882	86	161,835	10% of provider surcharge	7,766	777	1,461,313	1,299,478	803.0%
		Each additional CRNA or PA		441	42	18,514	10% of provider surcharge	1,403	140	61,841	43,328	234.0%
80943		Podiatrists/Chiropodists - Corporate or Partnership Liability	52									
		Single doctor		23	$341	$7,843	10% of provider surcharge	$7,000	$700	$16,100	$8,257	105.3%
		Each additional doctor		0	86	0	10% of provider surcharge	7,000	700	0	0	
		Each additional CRNA or PA		0	42	0	10% of provider surcharge	1,403	140	0	0	
80412		Chiropractors - Corporate or Partnership Liability	53									
		Single chiropractor		3	$234	$702	10% of provider surcharge	$2,333	$233	$700	-$2	-0.3%
		Each additional chiropractor		0	54	0	10% of provider surcharge	2,333	233	0	0	
					Total	$360,416				Total	$1,570,142	335.6%

Notes
- (1),(2) Provided by New Mexico PCF; estimating 80% of physicians, physician assistants and CRNAs belong to a corporate entity
- (3) Col (1) x Col (2)
- (5) Weighted average of exposures and proposed rate on Exhibit 2 for physicians, Exhibit 4 Page 2 for CRNAs and physician assistants
  For podiatrists/chiropodists and chiropractors, using actual Proposed rate
- (6) Col (5) x 10% (note that actual rate will differ based on individual provider specialty)
- (7) Col (1) x Col (6)
- (8) Col (7) - Col (3)
- (9) Col (8) / Col (3)

Actuarial Report Addendum:

New Mexico Patient's Compensation Fund
Hospital & Outpatient Health Care Facility Rating Plan

October 2019

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Bloomington, IL 61704
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Commitment Beyond Numbers

Table of Contents

Section ***Page***

Purpose and Scope 1

Data Sources 1

Health System Loss and Exposure Data 2

Industry Rate Filings 2

PCF Actuarial Analysis as of December 31, 2018 2

Methods and Assumptions 2

Exhibits

New Mexico Patient's Compensation Fund
Hospital & Outpatient Health Care Facility Rating Plan

Purpose and Scope

In the past, surcharges for hospitals and outpatient health care facilities (QHP facilities) that participate in the New Mexico Patient's Compensation Fund (PCF) have been determined on an individual basis through an independent actuarial review. The purpose of this rating plan is to provide a consistent framework for rating QHP facilities that participate in the PCF. This rating plan includes both exposure and experience rating portions.

Through a review of a number of both publicly available and confidential data sources, Pinnacle has prepared a QHP facility rating plan consistent with the funding recommendations shown in our analysis of the PCF as of December 31, 2018 and is an addendum to our report dated July 10, 2019. Further discussion of the data and assumptions underlying these recommendations as well as relevant background information on Pinnacle and the PCF and legal disclosures (including information on distribution, use, reliances, and limitations) can be found in our report dated July 10, 2019.

Based on the provisions of the Medical Malpractice Act of New Mexico (Chapter 41, Article 5 NMSA 1978), hospitals and outpatient health care facilities may be admitted to the PCF subject to the superintendent's determination of base coverage and PCF surcharges for each facility. The surcharges shall be determined "based upon sound actuarial principles." Pinnacle was approached by the PCF to provide a consistent rating framework for hospitals and outpatient health care facilities.

Data Sources

Our analyses use a number of data sources. The data sources are categorized as follows:

1. Health System Loss and Exposure Data
2. Industry Rate Filings
3. PCF Actuarial Analysis as of December 31, 2018

A brief description of the data sources utilized in each area along with a description of the key data elements and potential limitations of the data follows for each category.

Health System Loss and Exposure Data

Pinnacle was provided with claim counts and exposure information for two New Mexico health systems (Presbyterian Health Services and Christus St. Vincent) with claims evaluated as of 12/31/2018, as well as claim counts and exposure information for the New Mexico Hospital Risk Purchasing Group (RPG) as a whole evaluated as of 3/31/2018. The claim counts are comprised of claims with indemnity over $200,000 (i.e. claims that would pierce the PCF layer). These are summarized by year in Exhibit 4.

Exposures include number of beds (for acute care, psychiatric care, extended care, skilled nursing care, personal care, physical rehab, and chemical dependency rehab beds), number of births, number of surgeries (inpatient and outpatient), and number of visits in hundreds (ER, other outpatient, and home healthcare). These exposures are summarized on Exhibit 3.

Industry Rate Filings

In order to develop PCF rates for the different types of QHP facility loss exposures, e.g. emergency room visits, births, outpatient surgeries, Pinnacle reviewed several publicly available filings for medical professional liability insurance (MPLI) providers and government insurance programs in New Mexico and other states in developing appropriate relativities to the acute care bed base rate (i.e. the occupied bed equivalent or OBE rate). Because these rate filings have been through regulatory scrutiny, we are comfortable that the information is appropriate for use in this analysis. These relativities are shown in Exhibit 2.

PCF Actuarial Analysis as of December 31, 2018

The rating plan is based on the funding recommendation provided in our analysis as of December 31, 2018. Further information on methods, data, and assumptions incorporated in this analysis is discussed in our report dated July 10, 2019.

Methods and Assumptions

Pinnacle's developed PCF surcharges for QHP facilities based on the overall funding need for QHP facilities insured by the PCF. The goal of the analysis was to satisfy the overall surcharge need for the PCF through actuarially sound rates by ratable exposure. First, hospital exposures were collected and summarized. These exposures comprise all the hospital systems currently participating in the PCF. The exposures are summarized in Exhibit 3.

Second, appropriate relativities for each exposure type were selected based a review of relativities for two primary carriers in the state of New Mexico (MMIC Insurance, Inc. and The Continental Insurance Company; these rate filings were accessed as of May 2, 2019) as well as the Indiana Patient Compensation Fund, a state program that offers excess coverage in a similar manner to the PCF. Selections were made based on these relativities. See Exhibit 2 for more detail.

Finally, we calculate the acute care bed base rate by balancing the calculated funding (using the results of Exhibits 2 and 3) to the overall funding recommendation for hospitals in the PCF. In calculating the base rate, we developed the projected 2019-2020 assessments based on an 80% confidence level shown in the hospital funding.

For the experience rating portion of the plan, we used the total hospital claims with over $200,000 in indemnity and current exposures to estimate an estimated frequency of claims per bed. The estimated frequency can then be applied to the OBE exposures of a facility to determine expected claim counts. A facility's ratio of its actual claim counts to expected claim counts over the five years of the experience period is then credibility-weighted using the maximum of statewide claims summarized over the past five years as the full credibility standard to provide an experience modification factor to the facility's surcharge.

Exhibits and Appendices

Exhibit 1. Proposed Hospital & Outpatient Health Care Facility Rates

Exhibit 2. Proposed Hospital & Outpatient Health Care Facility OBE Relativities

Exhibit 3. Current Health System Exposures

Exhibit 4. Expected Claims Estimate

Exhibit 5. Patient's Compensation Fund – Rules and Rating Manual for Owners/Operators of New Mexico Hospitals and Outpatient Health Care Facilities

Supplemental Exhibit Experience Rating Adjustment Example

New Mexico Patient's Compensation Fund

Proposed Hospital & Outpatient Health Care Facility Rates

Exhibit 1

Exposure Type	Exposure Basis	Proposed PCF Rate	Indicated Hospital Premium
(1)	(2)	(3)	(4)
Acute Care Bed	Per bed	4,957	7,473,425
Psychiatric Care Bed	Per bed	4,957	23,150
Extended Care Bed	Per bed	496	13,384
Skilled Nursing Care Bed	Per bed	1,735	-
Personal Care Bed	Per bed	744	-
Physical Rehab Bed	Per bed	2,479	31,874
Chemical Dependency Rehab Bed	Per bed	1,239	-
Births	Per birth	248	4,090,131
Inpatient Surgeries	Per 100 surgeries	8,675	3,447,757
Outpatient Surgeries	Per 100 surgeries	991	781,783
ER visits	Per 100 visits	744	4,831,786
Other Outpatient visits	Per 100 visits	248	3,167,760
Home Healthcare	Per 100 visits	248	-
			23,861,051

Column / Row	Note
(3)	Based on current hospital & outpatient health care facility surcharge indication and proposed relativities from Exhibit 2, Col (3)
(4)	Col (3) x Exhibit 3, Col (6)

Exhibit 2

New Mexico Patient's Compensation Fund

Proposed Hospital & Outpatient Health Care Facility OBE Relativities

Exposure Type	Exposure Basis	Proposed Relativity to Acute Care Beds	MMIC	IN PCF	CNA
(1)	(2)	(3)	(4)	(5)	(6)
Acute Care Bed	Per bed	1.0000	1.0000	1.0000	1.0000
Psychiatric Care Bed	Per bed	1.0000	1.0000	0.5005	0.7000
Extended Care Bed	Per bed	0.1000	0.1501	0.0501	0.1000
Skilled Nursing Care Bed	Per bed	0.3500	0.3000	0.5005	0.5000
Personal Care Bed	Per bed	0.1500	0.1000	0.1996	
Physical Rehab Bed	Per bed	0.5000	0.5000		
Chemical Dependency Rehab Bed	Per bed	0.2500	0.2500		
Births	Per birth	0.0500	0.0501	0.0400	0.0400
Inpatient Surgeries	Per 100 surgeries	1.7500	1.2501	2.0000	1.5997
Outpatient Surgeries	Per 100 surgeries	0.2000	0.4000	0.1000	0.4001
ER visits	Per 100 visits	0.1500	0.1501	0.1000	0.1500
Other Outpatient visits	Per 100 visits	0.0500	0.0501	0.0500	0.0700
Home Healthcare	Per 100 visits	0.0500	0.0125	0.0500	0.0300

Column / Row	Note
(3)	Proposed based on Cols (4) - (6)
(4), (6)	From New Mexico rate filings PERR-131779736 and CNAC-125268857 respectively
(5)	From 2019 surcharges bulletin for Indiana Patient Compensation Fund

New Mexico Patient's Compensation Fund
Current Health System Exposures

Exhibit 3

Exposure Type	Exposure Basis	Hospital RPG	PHS	St. Vincent	Total - All Hospitals
(1)	(2)	(3)	(4)	(5)	(6)
Acute Care Bed	Per bed	795	583	130	1,508
Psychiatric Care Bed	Per bed			5	5
Extended Care Bed	Per bed		27		27
Skilled Nursing Care Bed	Per bed				-
Personal Care Bed	Per bed				-
Physical Rehab Bed	Per bed			13	13
Chemical Dependency Rehab Bed	Per bed				-
					-
Births	Per birth	8,630	6,569	1,303	16,502
Inpatient Surgeries	Per 100 surgeries	245	120	32	397
Outpatient Surgeries	Per 100 surgeries	490	224	75	789
ER visits	Per 100 visits	3,376	2,634	489	6,498
Other Outpatient visits	Per 100 visits	7,338	4,068	1,375	12,781
Home Healthcare	Per 100 visits				-

Column / Row	Note
(3)	From 2018 actuarial study of New Mexico Hospital Risk Purchasing Group
(4), (5)	From 2018 surcharge analyses
(6)	Sum of Cols (3) - (5)

New Mexico Patient's Compensation Fund
Expected Claims Estimate

Policy Year	Hospital RPG PCF Layer Claims	PHS PCF Layer Claims	St. Vincent PCF Layer Claims	Total	5-Year Total
(1)	(2)	(3)	(4)	(5)	(6)
2009	12	15	1	28	
2010	25	19	4	48	
2011	23	20	8	51	
2012	27	33	2	62	
2013	23	17	2	42	231
2014	25	22	0	47	250
2015	15	19	1	35	237
2016	8	11	0	19	205
2017	0	3	0	3	146
2018	0	0	0	0	104
Total (excl. 2017 and 2018)	158	156	18	332	

Row	Description	Value
(7)	Expected Claims per Year (excl. 2017 and 2018)	41.500
(8)	Acute Care Bed Equivalent Exposures	4,813
(9)	Expected Claims per Exposure	0.009

Column / Row	Note
(2)	From 2018 actuarial study of New Mexico Hospital Risk Purchasing Group
(3), (4)	From 2018 surcharge analyses
(5)	Sum of Cols (2) - (4)
(6)	Sum of prior 5 years of Col (5)
(7)	Col (5) Total / 8
(8)	Sum of Exhibit 3, Col (6) x Exhibit 2, Col (3)
(9)	Row (7) / Row (8)

PATIENT'S COMPENSATION FUND

RULES AND RATING MANUAL
FOR OWNERS/OPERATORS OF NEW MEXICO HOSPITALS AND OUTPATIENT HEALTH CARE FACILITIES

INTRODUCTION

This manual contains the rules and rating procedures governing the underwriting of hospitals and outpatient health care facilities (QHP facilities) for participation in the New Mexico Patient Compensation Fund (PCF).

This manual shall be used to calculate PCF surcharges. Any exceptions to this manual must be approved by the Superintendent of Insurance.

PCF COVERAGE TERM

PCF coverage is coextensive with the underlying coverage term, but not to exceed 1 year.

LIMITS OF LIABILITY

A. **Required Underlying Coverage**
   QHP facilities are required to hold professional liability policies covering up to $200,000 per occurrence. Annual aggregate limits are determined on a case-by-case basis by the Superintendent of Insurance.

B. **PCF Coverage**
   The PCF provides coverage excess of the required underlying coverage of $200,000 per occurrence with awards capped at $600,000 per occurrence (excluding medical care costs, which are uncapped). Punitive damages are not covered by the PCF.

RATING

Patient Compensation Fund Surcharge

A. **Basis of Surcharge**
   The surcharge is calculated based on the following:
   1. Occupied Bed: When overnight care is provided, a charge is made for the number of annual average occupied beds, which is defined as the total annual inpatient days divided by 365.

2. Inpatient Surgeries: The total number of surgeries performed for patients who remain in the facility overnight or longer. The rates apply per 100 inpatient surgeries.
3. Outpatient Surgeries: The total number of surgeries performed for patients who do not remain in the facility overnight. The rates apply per 100 outpatient surgeries.
4. Births: Total annual number of births. The rates apply per birth.
5. Visits: The number of ER visits, Other Outpatient visits and Home Health Care visits. The rate apply per 100 visits.

B. Surcharge Calculation

1. Computation
   i. Compute the surcharge at coverage inception using the rules, rates and rating plan in effect at that time. At each renewal, compute the surcharge using the rules, rates and rating plan then in effect.
   ii. Pro-rate the surcharge when coverage is issued for other than a whole year.

2. Exposure Changes
   If there is a change to the exposures of a QHP facility that would result in a surcharge increase of more than 10% of the initial surcharge paid, the revised exposure must be reported to the PCF, and the surcharge restated for the remainder of the coverage period.

SUPPLEMENTARY RULES

A. PCF Experience Rating Plan

Refer to the PCF Experience Rating Plan for details.

B. Surcharge Change Rules

1. Pro-rate all changes requiring additional surcharge.
2. Apply the rates and rules in effect on the effective date of the coverage. Charge the additional surcharge applicable to the change.

C. Coverage Cancellation

1. Compute return surcharge pro-rata, at the rates used to calculate the original surcharge, when coverage is canceled at the request of the QHP facility.
2. Refund checks will not be issued, unless approved by the Superintendent. Return surcharge will be credited.

Patient Compensation Fund Surcharge Rates

Occupied Beds:	Exposure Type	Proposed PCF Rate
Acute Care	Per bed	4,957
Psychiatric Care	Per bed	4,957
Extended Care	Per bed	496
Skilled Nursing Care	Per bed	1,735
Personal Care	Per bed	744
Physical Rehab	Per bed	2,479
Chemical Dependency Rehab	Per bed	1,239
Births	Per birth	248
Inpatient Surgeries	Per 100 surgeries	8,675
Outpatient Surgeries	Per 100 surgeries	991
ER visits	Per 100 visits	744
Other Outpatient visits	Per 100 visits	248
Home Healthcare	Per 100 visits	248

Sample Calculation:
A hospital with 20 acute care beds and 55 births a year that performs 50 inpatient surgeries annually would pay an annual surcharge of:

20 x \$4,957 + 55 x \$248 + (50/100) x \$8,675 = \$117,112

PCF Experience Rating Plan

General Rules and Eligibility

A QHP facility that develops an annual manual surcharge of $1.5 million or more for its rated exposures shall be subject to Experience Rating.

Experience Period

The experience period is determined as the five years immediately preceding the effective date of the coverage period prior to the current coverage period.

Experience Rating Rules

The experience rating modification shall be calculated based on the following formula:

$$\left(\frac{A}{E}\right) * \sqrt{\frac{E}{S}} + 1.0 * \left(1 - \sqrt{\frac{E}{S}}\right)$$

Where

$$A = Actual\ PCF\ Claims\ in\ Experience\ Period$$
$$E = Expected\ Claims\ in\ Experience\ Period$$
$$S = Statewide\ 5 - Year\ Claim\ Maximum$$

For years in the experience period where the QHP facility was not covered by the PCF, actual claims (A) shall be counted as any claims with incurred indemnity in excess of $200,000. Expected claims shall be calculated as

$$0.009 * \ (Experience\ Period\ Occupied\ Bed\ Equivalent\ Exposure)$$

Where the *Occupied Bed Equivalent Exposure* is the acute care bed equivalent exposure for the experience period calculated using the relativities provided in Exhibit 2, Column (3).

Sample Calculation:
An entity with 5 Acute Care beds, 70 Extended Care beds, 600 Inpatient Surgeries and 1,000 ER visits, would have 24 acute-care-equivalent occupied beds:
Occupied Bed Equivalent Exposure =
5 x 1 + 70 x 0.1 + (600/100) x 1.75 + (1,000/100) x 0.15 = 24

The Experience Period Occupied Bed Equivalent Exposure would then be the sum of the Occupied Bed Equivalent Exposures for the five years of the experience period.

The Statewide 5-Year Claim Maximum is calculated as the maximum over the past ten years of the sum of the prior five years of claim counts, as shown in Exhibit 4, Col (6).

New Mexico Patient's Compensation Fund

Supplemental Exhibit

Experience Rating Adjustment Example

Presbyterian Health Services

(1)	Expected Claims (5 years):	80
(2)	Actual Claims (5 years):	102
(3)	Statewide Claims (5 years):	250
(4)	Emod:	1.16
(5)	Manual Surcharge:	8,764,689
(6)	Adjusted Surcharge:	10,167,039
(7)	Difference:	1,402,350

Column / Row	Note
(1)	Exhibit 4, Row (9) x [Sum of Exhibit 3, Col (4) x Exhibit 2, Col (3)]
(2)	Exhibit 4, Col (3) Sum of 2012 - 2016
(3)	Max of Exhibit 4, Col (6)
(4)	[Row (2) / Row (1)] x [Row (1) / Row (3)] ^ 0.5 + 1.0 x {1 - [Row (1) / Row (3)] ^ 0.5}
(5)	Sum of Exhibit 3, Col (4) x Exhibit 1, Col (3)
(6)	Row (5) x Row (4)
(7)	Row (6) - Row (5)

New Mexico Patient's Compensation Fund

Indicated Rate Change Effective 9/1/19 through 9/1/20
Physicians & Surgeons

(1)	Projected 2019-2020 Assessments at Current Fee Level	21,929,056					
(2)	Projected 2019-2020 Income Requirements @ Central Confidence Level	24,945,200					
(3)	Confidence Level	Central	65%	70%	75%	80%	90%
(4)	Risk Margin Factor at Confidence Level	1.000	1.057	1.079	1.102	1.131	1.206
(5)	Projected 2019-2020 Income Requirements @ Confidence Level	24,945,200	26,358,218	26,904,735	27,489,395	28,202,873	30,091,177
(6)	Offset due to Class Plan Change	229,411	242,406	247,432	252,809	259,371	276,737
(7)	Offset due to Entity Coverage Change	1,570,142	1,659,083	1,693,483	1,730,283	1,775,192	1,894,049
(8)	Projected 2019-2020 Income Requirements with Offsets	23,145,646	24,456,729	24,963,819	25,506,302	26,168,310	27,920,391
(9)	Indicated Assessment Level Change on September 1, 2019	5.5%	11.5%	13.8%	16.3%	19.3%	27.3%

Row	Note
(1)	From New Mexico Patient's Compensation Fund reserve analysis as of 12/31/2018, Exhibit 10, Page 1, Row (7)
(2)	From New Mexico Patient's Compensation Fund reserve analysis as of 12/31/2018, Exhibit 10, Page 1, Row (13)
(4)	Based on data provided by client
(5)	= Row (2) x Row (4)
(6), (7)	Based on class plan review provided by Pinnacle
(8)	= Row (5) - Row (6) - Row (7)
(9)	= Row (8) / Row (1) - 1

New Mexico Patient's Compensation Fund

Indicated Rate Change Effective 9/1/19 through 9/1/20
Hospitals & Outpatient Facilities

(1)	Projected 2019-2020 Assessments at Current Fee Level	22,093,612					
(2)	Projected 2019-2020 Income Requirements @ Central Confidence Level	21,104,895					
(3)	Confidence Level	Central	65%	70%	75%	80%	90%
(4)	Risk Margin Factor at Confidence Level	1.000	1.057	1.079	1.102	1.131	1.206
(5)	Projected 2019-2020 Income Requirements @ Confidence Level	21,104,895	22,300,379	22,762,760	23,257,412	23,861,051	25,458,651
(6)	Indicated Assessment Level Change on September 1, 2019	-4.5%	0.9%	3.0%	5.3%	8.0%	15.2%

Row	Note
(1)	From New Mexico Patient's Compensation Fund reserve analysis as of 12/31/2018, Exhibit 14, Page 1, Row (7)
(2)	From New Mexico Patient's Compensation Fund reserve analysis as of 12/31/2018, Exhibit 14, Page 1, Row (13)
(4)	Based on data provided by client
(5)	= Row (2) x Row (4)
(6)	= Row (5) / Row (1) - 1

NM PCF

Home Information for... News Contacts FAQs

CARRIERS

Home | Carriers

1. All insurance carriers that provide the primary layer of medical professional liability coverage for healthcare providers in the Patient's Compensation Fund (PCF) must be licensed and admitted in New Mexico by the Office of Superintendent of Insurance or be a licensed risk retention group. Carriers must provide coverage on occurrence policies at limits prescribed by the New Mexico Medical Malpractice Act. Claims-made policies are not permitted.
2. Admitted carriers and risk retention groups that want to become primary layer carriers in the PCF must apply for approval by:
Submitting a copy of the occurrence policy form(s) that they will be using, including the SERFF filing number(s) showing prior approval of those forms and rates, to the PCF Administrator at osi-pcf@state.nm.us;
3. Agreeing to continue to provide legal defense through settlement for claims that enter the excess PCF layer of coverage
4. The rates and forms used for the primary layer of medical professional liability coverage are subject to prior approval.
5. ISO physician/surgeon specialty codes must be used. The mapping of those ISO codes to PCF rating classes is provided below.
6. A healthcare provider must pay the surcharge to their primary insurer within 30 days of the effective date of coverage. The insurance carrier then has an additional 30 days to remit the PCF surcharge to the PCF administrator.
7. Carriers must upload coverage reports via the PCF Administration Application, which uploads using a batch process with an Excel template which is provided. For additional support using the batch upload contact our PCF Support Team, at OSI-PCF-Support@state.nm.us.

TABLE OF BASE SURCHARGES

(Prior to the Application of Experience Rating Debits)|
Effective October 1, 2017

PDF PRINT

Show 15 entries Search:

PCF Class	Description
1	
2	
3	
4A	
4	
5A	
5	
6	
7A	
7	
8	
9	
10	
51	Doctor Business Entity
	Single physician or surgeon

Showing 1 to 15 of 29 entries Previous Next

RULES FOR EXPERIENCE – RATING BASE SURCHARGES

Effective June 1, 2004

Carriers must debit the base surcharge of each physician or other healthcare provider according to his or her claim experience as described below and include the resulting debit in the total surcharge remitted to the PCF.

Number of Claims Reported During the Last Five Years	Debit
1	25%
2	50%
3	75%

EX. B, Page 2 of 4

4 or more 100%

Include only those claims which resulted in at least one of the following conditions:

- A finding of both negligence and injury by the PCF medical review commission
- A claim settlement requiring payment by the carrier or the
- A trial judgment in favor of the plaintiff

* Do not report as a claim any incident that is overturned or dismissed with no monetary exchange.

Carriers are responsible for maintaining a repository of claim information in sufficient detail for them to calculate accurate debits. This may require carriers to expand their policy application questionnaires and procedures for obtaining information on claims incurred under prior carriers or in other states.

Classification Table

PDF PRINT

Show 25 entries Search:

Specialty	M.D.	D.O.	Class
Abdominal Surgery	80166		9
Acupuncture - Other than Acupuncture Anesthesia	80437	84437	1
Aerospace Medicine / Medical Director	80230		1
Allergy/Immunology - No Surgery	80254	84254	1
Anesthesiology	80151	84151	7A
Anesthesiology - All Other	80183	84183	7A
Anesthesiology - Critical Care Medicine	80181	84181	7A
Anesthesiology - Pain Management	80182	84182	2
Angiography / Arteriography / Catheterization	80422	84422	4
Broncho-Esophagology	80101		3
Cardiac Surgery	80141		6
Cardiovascular Disease - Minor Surgery	80281	84281	4
Cardiovascular Disease - No Surgery	80255	84255	2
Cardiovascular Disease - No Surgery	80225		2
Cardiovascular Disease Surgery	80150	84150	10

EX. B, Page 3 of 4

Specialty	M.D.	D.O.	Class
Chiropractors	80410		99
Chiropractors - Corporate or Partnership Liability	80412		53
Colon and Rectal Surgery	80115		9
Colonoscopy / Endoscopic Retrograde Cholangiopancreatography/ Pneumatic or Mechanical Esophageal Dilation	80443	84443	3
Cryosurgery	80429	84429	4
Dermatology - All Other	80297	84297	3
Dermatology - Clinical and Dermatological Immunology	80295	84295	3
Dermatology - Dermatopathology	80296	84296	3
Dermatology - including X-Ray Therapy / Radiation Therapy	80282		3
Dermatology - No Surgery	80256	84256	2

Showing 1 to 25 of 177 entries

Previous Next

NM PCF

NM Patient's Compensation Fund

Navigate

- FAQs
- Information for...
  - Attorneys
  - Carriers
  - Medical Professionals
  - Hospitals And Outpatient Facilities

Search

Search ...

InsuredName	ReceivedDate	NMPhyLicense	PolicyNumber	RateClass	ISOspecialty	BeginningDate	EndingDate	Surcharge	BaseSurcharge	ExperienceModifier	SSNFEDID	StateofLicense	Gender	OccupationCode	YearGraduated	ProfessionalSchool	DOB	Description	Entity
	6/1/2019		MPLS007	1	80420	6/1/2019	6/1/2020	$ 2,920.00	$ 2,920.00	1		NM	F	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	4	80284	6/1/2019	6/1/2020	$ 7,008.00	$ 7,008.00	1		NM	M	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	PA-3	80116	6/1/2019	6/1/2020	$ 2,119.00	$ 2,119.00	1		NM	M	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	9	80154	9/17/2019	6/1/2020	$ 6,625.66	$ 22,384.00	1		NM	M	n/a	2012			New	n/a
	6/1/2019		MPLS007	1	80420	6/1/2019	6/1/2020	$ 2,920.00	$ 2,920.00	1		NM	F	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	9	80154	6/1/2019	6/1/2020	$ 22,384.00	$ 22,384.00	1		NM	M	n/a	2011			Renew	n/a
	6/1/2019		MPLS007	PA-1	80116	6/1/2019	6/1/2020	$ 1,319.00	$ 1,319.00	1		NM	M	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	1	80420	6/1/2019	6/1/2020	$ 2,920.00	$ 2,920.00	1		NM	F	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	4	80284	6/1/2019	6/1/2020	$ 3,504.00	$ 7,008.00	1		NM	F	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	2	80257	6/1/2019	6/1/2020	$ 3,889.00	$ 3,889.00	1		NM	M	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	2	80257	6/1/2019	6/1/2020	$ 3,889.00	$ 3,889.00	1		NM	M	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	PA-1	80116	6/1/2019	6/30/2019	$ 104.20	$ 1,319.00	1		NM	M	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	1	80420	6/1/2019	6/1/2020	$ 1,460.00	$ 2,920.00	1		NM	F	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	2	84257	6/1/2019	6/1/2020	$ 3,889.00	$ 3,889.00	1		NM	F	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	3	80114	6/1/2019	6/12/2019	$ 140.28	$ 4,676.00	1		NM	M	n/a	n/a			Renew to 6/22/19	n/a
	6/1/2019		MPLS007	PA-3	80116	6/1/2019	6/1/2020	$ 2,119.00	$ 2,119.00	1		NM	M	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	1	80263	6/1/2019	6/1/2020	$ 2,920.00	$ 2,920.00	1		NM	F	n/a	2012			Renew	n/a
	6/1/2019		MPLS007	PA-1	80116	6/1/2019	6/1/2020	$ 1,319.00	$ 1,319.00	1		NM	F	n/a	n/a			Renew	n/a
	6/1/2019		MPLS007	2	80257	6/1/2019	6/1/2020	$ 3,889.00	$ 3,889.00	1		NM	M	n/a	n/a			Renew	n/a

type	dateReceived	businessName	physicianLicenseNumber	firstName	middleName	lastName	dob	gender	stateOfLicensure	professionalSchool	yearGraduated	policyNumber	isoSpecialty
entity	6/15/2018	BsnName											
individual	6/16/2018		321	John		Doe	6/15/1994	male	NM	Univeristy of New Mexico	2016	123	80230

rateClass	partTimePercentDiscount	numberOfClaims	beginningDate	endingDate	transactionType	checkNumber	dba	comments	additionalDoctors	additionalCrna	additionalPa	pcfAssignedEntityNumber
1	5											
	6	1	6/15/2018	6/20/2018	New				1	2	0	2236

type	dateReceived	businessName	physicianLicenseNumber	firstName	middleName	lastName	dob	gender	stateOfLicensure	professionalSchool	yearGraduated	policyNumber	isoSpecialty
individual	6/15/2018		85222	Josh		Baca	12/19/1963	male	NM	UNM	1995	2587521	80425
individual	6/16/2018		321	John		Doe	6/15/1994	male	NM	Univeristy of New Mexico	2016	123	80230
individual	9/15/2019		95158	Jessica		Smith	8/15/1986	female	NM	UNM	2000	75258	80144

rateClass	partTimePercentDiscount	numberOfClaims	beginningDate	endingDate	transactionType	checkNumber	dba	comments	additionalDoctors	additionalCrna	additionalPa	pcfAssignedEntityNumber
	0	0	7/1/2019	12/31/2019	Cancel						0	2236
	0	0	6/15/2018	6/20/2018	New							
	0	0	1/1/2018	1/1/2019	New							

Manage Transactions

TOTAL SURCHARGE AMOUNT
$22,424.00

Back

id	Insured Name	License Num...	Date Received	Policy Number	Rate Class	Specialty	Beginning Da...	Ending Date	Base Surchar...	Final Surchar...	Type
ITRANSACTIO... 2019-425	Jessica Smith	95158	9/15/2019	75258	9	80144	1/1/2018	1/1/2019	$22,384.00	$22,384.00	individual
ITRANSACTIO... 2019-424	John Doe	321	6/16/2018	123	1	80230	6/15/2018	6/20/2018	$2,920.00	$4,332.73	individual
ITRANSACTIO... 2019-423	Josh Baca	85222	6/15/2018	2587521	5	80425	7/1/2019	12/31/2019	$8,562.00	($4,292.73)	individual

1 - 3 of 3 items

NEW MEXICO PATIENTS COMPENSATION FUND

CY	Effective Date	Doctors' Rate Change	Christus Surcharge	Christus Eff. Rate Chg	Presbyterian Surchage	Presbyterian Eff.Rate Chg	RPG Hospitals Surcharge	RPG Hospitals Eff Rate Chg	Total Surcharge	Avg Hospital Rate Change
1986										
1987										
1988										
1989										
1990										
1991	1/1/1991	50.0%								
1992	4/1/1992	22.0%								
1993	4/1/1993	8.0%								
1994										
1995										
1996	4/1/1996	10.0%								
1997										
1998										
1999										
2000	11/1/2000	10.5%								
2001										
2002										
2003										
2004	6/1/2004	N/A								
2005										
2006										
2007	7/1/2007	9.5%								
2008										
2009	9/1/2009	9.5%	1,130,000						1,130,000	
2010			1,130,000	0.0%					1,130,000	0.0%
2011			1,175,200	4.0%					1,175,200	4.0%
2012			1,099,542	-6.4%					1,099,542	-6.4%
2013			1,250,000	13.7%					1,250,000	13.7%
2014			1,350,000	8.0%					1,350,000	8.0%
2015			1,350,000	0.0%					1,350,000	0.0%
2016	10/1/2016	8.7%	1,300,000	-3.7%			8,176,474		9,476,474	-3.7%
2017	10/1/2017	8.7%	1,450,000	11.5%	9,764,899		7,429,417	-9.1%	18,644,316	-5.8%
2018			1,813,682	25.1%	10,485,433	7.4%	9,297,162	25.1%	21,596,277	16.5%
2019										

Notes:

Back in 1976 when the PCF was established, its surcharges were set to equal 33% of the premium charged by carriers for their underlying layer of coverage.

In 1991 this percentage doubled to equal 66% of the underlying carrier premium.

Sometime in 1992 or 1993 the surcharges became fixed dollar amounts per specialty, rather than a percentage of the underlying carrier's premium.

In 2004 the surcharges for anesthesiologists and for CRNAs were reduced and experience rating was introduced. We do not know the overall rate effect of these changes.

Carrier List

1) Carrier #10903
   AEIX: TPA; Premier Insurance Management Services

2) Carrier #12180,
   California Medical Group Insurance Co. (RRG) TPA: Beecher Carlson

3) Carrier #10472,
   Capital Indemnity Corporation: TPA; Professional Risk Management Services, Inc.

4) Carrier #19445,
   National Union Fire: TPA; Contemporary Insurance Services

5) Carrier #34495,
   The Doctor's Company

6) Carrier #11843,
   MedPro Group

7) Carrier #15865
   NCMIC

8) Carrier #36234,
   PPIC/Coverys

9) Carrier #42617,
   Mag-Mutual

10) Carrier #15211,
    Lone Star Alliance (RRG)

11) Carrier #33200,
    Norcal Group

12) Carrier#11598,
    Applied Medico Solutions; TPA: Thorson Insurance

1 REPORTER'S CERTIFICATE.
2
3 I, REBECCA FELLA, NM CCR #534, DO HEREBY CERTIFY
4 THAT I did, in stenographic shorthand, transcribe the
5 proceedings set forth herein, and the foregoing pages are
6 a true and correct transcription to the best of my
7 ability.
8 I FURTHER CERTIFY that I am neither employed by
9 nor related to nor contracted with (unless excepted by the
10 rules) any of the parties or attorneys in this matter, and
11 that I have no interest whatsoever in the final
12 disposition of this matter,
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16 REBECCA FELLA, NM CCR #534
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