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
)

FILED
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Patient's Compensation Fund

STAFF'S PROPOSED FINDINGS OF FACT AND
RECOMMENDED CONCLUSIONS OF LAW

THIS MATTER, came before the New Mexico Superintendent of Insurance, in his capacity as Custodian of the New Mexico Patient Compensation Fund ("Custodian"), pursuant to the statutory mandates of NMSA 1978, § 41-5-25(A), (B) and (H). Based on the docketed filings, administrative notice, and evidence presented at hearing, the Hearing Examiner

FINDS:

1. On September 16, 2019, the Custodian issued his order scheduling a public evidentiary hearing for November 18, 2019 to determine new Patient Compensation Fund ("PCF") surcharges.
2. On September 30, 2019, the Custodian issued an order appointing Marilyn S. Hebert to serve as the Hearing Examiner.
3. Staff filed written testimony on October 7, 2019.
4. On October 10, 2019, the Hearing Examiner issued an order setting deadlines for intervention, discovery, and testimony.
5. A notice of Public Hearing was published with the New Mexico Register and the Albuquerque Journal on October 15, 2019.
6. The Hearing Examiner conducted a preliminary hearing on October 22, 2019.
7. Mr. Don Letherer submitted public comment on October 16, 2019.
8. On October 23, 2019, the Hearing Examiner issued an order vacating settlement conference.
9. November 4, 2019, Mr. Jeff Dye submitted comments as President and CEO of the New Mexico Hospital Association.

10. All filings were made available on the Patient's Compensation Fund website and sent out to a list of interested persons via the Patient's Compensation Fund Newsletter.
11. A public hearing was conducted on November 18, 2019. Ms. Sandra Romero and Mr. Robert J. Walling, III, testified at the hearing. Public comments were received from Richard Frese and Bruce Whitmore on behalf of the New Mexico Hospital Association and the New Mexico Hospital Risk Purchasing Group. PCF Staff exhibits A through E were admitted into the record.
12. The obligations of the PCF are funded by annual premium surcharges collected from every qualified healthcare provider ("QHP") admitted into the PCF pursuant to NMSA (1978), § 41-5-5(A) & (B). NMSA (1978), § 41-5-25(B).
13. The PCF currently collects surcharges from three classes of QHPs: (a) individual providers; (b) entities (such as corporations, partnerships or limited liability companies) organized by one or more individual providers; and (3) hospitals. TR 8; 89; 116. The risks and funding requirements relating to an entity QHP are included with those relating to individual QHPs. TR 62.
14. The PCF surcharge payable by an individual QHP is determined through a formula. The foundation of the formula is the base surcharge that applies to the rate classification for the provider practice specialty. TR 6-8. All provider practice specialties are assigned to a rate classification. TR 17. The rate classifications are based on the risk exposure presented by each practice specialty, relative to each other practice specialty. TR 17-18. The annual base surcharge will increase from 25 to 75 percent depending on the number of past malpractice claims paid on behalf of the provider. TR 12-13. The base surcharge will decrease if the provider works less than full time or seeks QHP status for less than an annual term. TR 11-13. To determine the actual surcharge due, a provider, or the provider's representative, will transmit to the PCF pertinent information concerning the provider's practice specialty, coverage term, time status, and claims experience. TR 14-15. The PCF uses an automated process to generate an actual surcharge amount, using the base annual surcharge as the foundation for the calculation. *Id.*
15. The PCF surcharge payable by an entity QHP is currently determined by assessing a $341.00 fixed fee for the first physician in the entity, and an additional $86.00 fee for each additional

physician who practices in the entity. Ex. A, p. 77; TR 89-90. As individual physicians have migrated into entity provider groups, the malpractice claim risks presented by such groups have increased. TR 110-112. The current PCF surcharge rate formula that applies to entity provider groups is woefully inadequate to account for the risks to the PCF attributable to those groups. TR 90.

16. NMSA (1978), § 41-5-25(B) requires the Custodian to determine the surcharges based on sound actuarial principals.

17. NMSA (1978), § 41-5-25(H) requires the Custodian to contract for an independent actuarial study of the PCF not less than once every two years. Among other purposes, the actuarial study is used to determine the annual surcharge payable by each QHP.

18. PCF surcharges for individual physicians are currently based on the risk presented by the exposure of the particular physician specialty, and then applying an experience rating surcharge enhancement for past claims of a particular physician QHP. TR 115. This type of rating process is used by commercial medical malpractice liability insurers to determine rates. TR 115.

19. The Custodian contracted with Pinnacle Actuarial Resources, Inc. ("Pinnacle") to conduct an actuarial study of the PCF as of December 31, 2018. Ex. A, p. 6. Pinnacle was contracted to determine (a) loss and loss reserves for unpaid claims obligations of the PCF as of December 31, 2018; (b) the PCF fund balance as of December 31, 2018 based on the projected loss reserves; (c) the overall indicated percentage change indicated for surcharge levels applicable to QHPs; (d) PCF surcharge relativities by class for individual QHPs; (e) PCF surcharges for entity QHPs; and (f) the overall indicated percentage change for surcharge levels applicable to hospital/outpatient facility QHPs. Pinnacle was also contracted to develop an actuarially sound rating plan for determining surcharges for hospital/outpatient facility QHPs. *Id.* Pinnacle's actuarial study was published on October 7, 2019, and admitted into the record as Ex. A.

20. Based on the application of sound actuarial principals, the projected losses to be paid for all PCF claims occurring prior to December 31, 2018 is reasonably projected to be $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 discounted reserves reflect a risk margin to increase the statistical confidence to 90%. Ex. A, p. 6.

21. Based on the application of sound actuarial principals, the PCF balance as of December 31, 2018 is a deficit of $44.4 million when unpaid claim 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. Ex. A, p. 6.

22. Based on the application of sound actuarial principals, the projected 2019-2020 undiscounted losses attributable to individual and entity QHPs is $26,211,763.00. The projected 2019-2020 income requirements to fund those losses, at the central confidence level, is $24,945,200.00, after adjusting for expenses, discount rates, and reinsurance expenses. Ex. A, p. 58.

23. The assessment level required to fund the projected losses attributable to individual and entity QHP's will be impacted by PCF revenue increases or decreases attributable to any changes in physician specialty rating classifications. TR 93-96. Based on the application of sound actuarial principals, the ratings for these physician specialties should be changed as indicated:

    A. Radiation Therapy and Shock Therapy (ISO 80163, 80165 and 80431) Move from class 1 to class 2.

    B. Otorhinolaryngology – Minor Surgery (ISO 80291) – Move from class 2 to class 3.

    C. Gynecology – Minor Surgery (ISO 80277) – Move from class 3 to class 4.

    D. Intensive Care Medicine (ISO 80283) – Move from class 3 to class 4.

    E. Nephrology – No surgery (ISO 80260) – Move from class 3 to class 2.

    F. Podiatrists/Chiropodists – No surgery (ISO 80993-N) – Move from class 5 to class 4.

    G. Cardiac Surgery (ISO 80141) – Move from class 6 to class 8.

    H. Nephrology – Including Child – Minor Surgery (ISO 80288) – Move from class 6 to class 4.

    I. Obstetrics Surgery (c-sections only) (ISO 80168) – Move from class 6 to class 8.

    J. Pediatrics – Minor Surgery (ISO 80293) – Move from class 6 to class 4.

    Ex. A, pp. 75-76.

24. The assessment level required to fund the projected losses attributable to individual and entity QHP's will also be impacted by PCF revenue increases or decreases attributable to any changes in class relativities. Based on the application of sound actuarial principals, these class relativities should be changed as indicated:
    A. Class 5A – Increase from 1.60 to 1.70.
    B. Class 7 – Reduce from 4.00 to 3.50.
    C. Class 10 – Increase from 6.25 to 6.5.
    D. CRNA – Increase from 0.20 to 0.25. Ex. A, p. 76.
25. The class and relativity changes identified in the preceding two paragraphs will result in a net PCF revenue increase of $229,411.00 at the central confidence level, and an increase of $259,371.00 at the 80 percent confidence level. Ex. A, p. 105.
26. The assessment level required to fund the projected losses attributable to individual and entity QHP's will also be impacted by revenue generated from entity QHP's. TR 87-91. Based on the application of sound actuarial principals, entity QHP's should be assessed 10 percent of the individual QHP surcharge for each physician who practices in the entity. Ex. A, p. 77. This assessment more accurately accounts for the loss risk attributable to the entity form of practice. TR 110-112. Assessing entity QHP's at 10 percent of the cumulative surcharge assessed to the individual QHPs that practice in the entity will generate $1,570,142.00 of additional surcharge at the central confidence level, and $1,775,192.00 of additional surcharge at the 80 percent confidence level. Ex. A, p. 105.
27. After offsetting additional income to be derived from class changes, and entity QHP surcharge increases, the projected 2019-2020 income requirements for individual QHPs, at the central confidence level is $23,145,646.00, and $26,168,310.00 at the 80 percent confidence level. Ex. A, p. 105. The indicated individual QHP base surcharge level change required to meet the PCF income requirement at the central confidence level is 5.5 percent, and 19.3 percent at the 80 percent confidence level. Ex. A, p. 105.
28. Based on the application of sound actuarial principals, the projected 2019-2020 undiscounted losses attributable to hospital and outpatient QHPs is $22,176,471.00. Ex. A, p. 64. The projected 2019-2020 income requirements to fund those losses, at the central confidence level, is $21,104,895.00, and $23,861,051.00 at the 80 percent confidence level, after

adjusting for expenses, discount rates, and reinsurance expenses. Ex. A, pp. 64 & 106. The indicated hospital/outpatient facility base surcharge level change required to meet the PCF income requirement at the central confidence level is -4.5 percent, and 8.0 percent at the 80 percent confidence level. Ex. A, p. 106.

29. NMSA (1978), § 41-5-5(B), requires the Custodian to determine the PCF surcharge for a hospital or outpatient based on a risk assessment.

30. Historically, the PCF surcharge payable by a hospital, or hospital group, QHP (collectively "the hospitals"), has been determined by independent actuarial studies that utilized experience (claim history) ratings. TR 115-116. This process, which is used by commercial malpractice liability insurers, resulted in a virtual dollar-for-dollar (100.4), or break-even, loss ratio for the hospitals. TR 120. PCF staff cannot independently determine surcharges for the hospitals using an experienced based rating methodology. TR 116.

31. The PCF currently does not have a process for determining the surcharge payable by an outpatient facility. TR 133. Because of the limited claims experience of smaller outpatient facilities, it is not practical, or accurate, to determine a PCF surcharge for an outpatient facility using an experience rating-based risk assessment. TR 133.

32. To comply with the mandate of NMSA (1978), § 41-5-5(B), to provide a rating methodology for outpatient facilities, and to enable PCF staff to perform a risk assessment that will generate an actuarially sound surcharge for a hospital or outpatient facility QHP, Pinnacle generated a hospital/outpatient facility rating plan. TR 116; Ex. A, p. 18.

33. The rating plan incorporates an exposure model that uses rates based on unit of exposure. Ex. A, p. 18. The ratable exposures are commonly used by hospital professional liability insurers and reflect the relative loss potential of the exposures. The surcharges by exposure were selected so that the targeted overall surcharge would generate cumulative surcharges from the hospitals consistent with the 80 percent confidence level, or $23,861,051.00. Ex. A, pp. 18; 99-104.

34. The hospital/outpatient facility rating plan incorporates an experience rating that modifies the surcharges of larger hospitals. The experience rating is based on a comparison of the number of PCF layer claims during a five year period compared to the expended number of PCF layer claims for the risk given the ratable exposures for the hospital or outpatient

facility. The approach will be responsive to larger 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. Ex. A, p. 18.

35. PCF staff can implement the Pinnacle hospital/outpatient rating plan to generate actuarially sound surcharges for hospitals and outpatient facilities without the need for an independent actuarial study for each facility. TR 128-130.

36. The term "confidence level" refers to the probability that rates will generate sufficient income to cover projected losses. TR 83. Historically, the Custodian has set surcharge rates at the central confidence level or below. TR 102. The central confidence level is approximately 55 percent. TR 85. The PCF currently has a deficit of $31,858,505.00 in discounted reserves. Ex. A, p. 44. This deficit reflects unfunded future payment obligations. TR 100. Setting surcharges at the central confidence level or below has contributed to the deficit. TR 103.

37. Setting surcharges at the 80 percent confidence level produces an actuarially sound result and an adequate risk margin that will be less likely to add to the current PCF deficit. TR 86; 100.

38. Actuarial standard of practice number 4 directs that rates/surcharges should be reasonable, not excessive, adequate and not discriminatory. Ex. A, p. 12. A rate/surcharge is discriminatory if it is priced in a way that requires one insured to subsidize the risk of another insured. TR 66-67. Applying difference confidence levels to the determination of surcharge assessments for individual physicians and hospitals/outpatient facilities would result in a discriminatory rate/surcharge. TR 66-68.

39. It would be reasonable to defer the effective date of any rate increase by at least 60 days. TR 155.

BASED ON THESE FINDINGS, THE HEARING OFFICER CONCLUDES AND RECOMMENDS:

40. PCF surcharges should be assessed at the 80 percent confidence level for all QHPs;

41. The cumulative surcharges to be collected from all QHPs for the 2020 plan year are $50,029,361.00 at the 80 percent confidence level;

42. $26,168,310 of the cumulative surcharges are allocable to individual and entity QHPs. The remaining $23,861,051.00 are allocable to hospital/outpatient facility QHPs;
43. The risk classifications for individual providers set out on pages 79 through 81 of Exhibit A are actuarially sound and should be adopted for use by the PCF;
44. The classification factors by assigned class that appear on page 85 of Exhibit A are actuarially sound and should be adopted for use by the PCF;
45. Current individual QHP surcharges should be increased 19.3 percent by class;
46. Entity QHP surcharges should be assessed at 10 percent of the cumulative individual QHP surcharges for all individual QHPs who practice within the entity;
47. Hospital/Outpatient QHP surcharges should be assessed according to the rating plan that appears in Exhibit A at pages 99 through 104;
48. The record contains no evidence to support imposition of a special assessment and, therefore, no such assessment should be imposed based on the evidence currently in the record.
49. Increased surcharge assessments should be effective 60 days from entry of an order adopting these findings, conclusions and recommendations.

/s/ *Todd S. Baran*

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

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of *Staff's Proposed Findings of Fact and Recommended Conclusions of Law* was sent by email to the following individuals, as indicated below, on this 11th day of December, 2019.

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