New Mexico Patient's Compensation Fund

Actuarial Review of PCF Structural Considerations

New Mexico Patient's Compensation Fund

November 5, 2020

risk&regulatory CONSULTING
www.riskreg.com

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November 5, 2020

Dear Ms. Krylova,

Risk & Regulatory Consulting, LLC ("RRC") has completed its review of potential structural considerations for the New Mexico Patient's Compensation Fund, as outlined in the scope of our engagement letter dated June 2, 2020.

We very much appreciate the support you provided us throughout this project. Please let us know if you would like discuss any aspects of this report.

Very truly yours,

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BACKGROUND

The New Mexico Patient's Compensation Fund (PCF) was established in 1976 by the New Mexico Medical Malpractice Act NMSA 1978, § 41-5-1, et seq. The purpose of the PCF is to promote the availability of coverage for medical professional liability (MPL) to health care providers practicing in New Mexico. The PCF also ensures that funds are available to pay for all past and future medical care for patients injured by an act of medical malpractice committed by a member healthcare provider.

SCOPE

As part of a review commissioned by the New Mexico Office of Superintendent of Insurance, Risk and Regulatory Consulting, LLC (RRC or "we") was engaged to help answer the four questions below:

1. Whether, and how, expanding or narrowing the types of providers who can participate in the PCF may impact the availability and cost of healthcare in New Mexico, the cost of healthcare insurance, and the financial viability of the PCF;

2. Whether, and how, increasing the damages cap under the New Mexico Medical Malpractice Act (MMA), or increasing the amount of underlying coverage a Qualified Healthcare Provider (QHP) must maintain, may impact the availability and cost of healthcare in New Mexico, the cost of healthcare insurance, and the financial viability of the PCF;

3. Whether, and how, expanding or narrowing the types of providers who can participate in the PCF, increasing the damages cap under the MMA, or increasing the amount of underlying coverage a QHP must maintain, will impact QHP surcharges; and

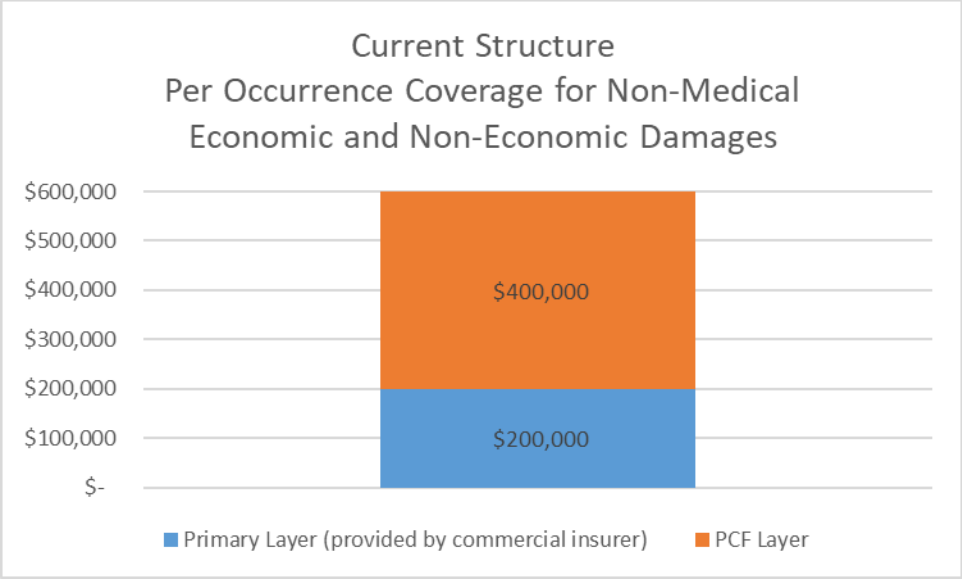
4. The viability of separate PCF funds for different provider types.

PCF PROGRAM DESCRIPTION

The PCF provides QHPs medical professional liability per occurrence coverage of up to $400,000 for economic and non-economic damages (excluding punitive damages) and unlimited coverage for past and future medical costs. QHPs participating in the PCF must purchase medical malpractice occurrence policies with limits of $200,000 per claim and $600,000 in the annual aggregate (although Hospitals are not subject to the $600,000 aggregate) from an OSI authorized insurer. The underlying limits of $200,000 and $600,000 were set in 1995 and have not been revised since. The authorized insurers collect (1) premium for the primary $200,000 layer, and (2) the PCF surcharge from the healthcare provider and remit the surcharge to the PCF. There are

currently 12 authorized MPL insurers in the state of New Mexico. The authorized insurers also have the responsibility to defend the medical malpractice claims throughout the life of a claim.

The current PCF structure is illustrated in the chart below:



A key feature of the current structure, as noted above, is that the limits apply only to non-medical costs. Medical costs are covered by the PCF on an unlimited basis. We also note that the MMA cap of $600,000 per occurrence includes both economic damages (for example, loss of past and future earnings) and non-economic damages (for example, pain and suffering). Punitive damages are excluded from PCF coverage. PCF participation by a QHP limits their exposure to economic and non-economic damages, i.e., participating QHPs do not have exposure above PCF limits.

QHPs may participate in the PCF subject to the superintendent's determination of base coverage and PCF surcharges for each individual provider or entity. The PCF currently groups physicians and surgeons into 13 classes based on their Insurance Services Office (ISO) specialty code, with three additional classes for physician assistants, and one class each for certified registered nurse anesthetists (CRNAs) and chiropractors. In addition, the PCF covers business entities comprised of PCF eligible groups including physician, podiatrist and chiropractor practice groups. Hospitals and outpatient facilities are rated according to a rating plan based on facility exposures. Exposures include number of beds, number of births, number of surgeries, and number of visits. An updated rating plan was adopted on December 27, 2019. The PCF is funded solely through the surcharges paid by its participants. The coverage offered by the PCF is on an occurrence basis and the underlying coverage must also be on an occurrence basis.

When compared to MPL insurance offered by commercial insurers in New Mexico, QHPs participating in the PCF have the following key characteristics:

- Monetary awards: $600,000 limit on economic and non-economic damages (compared to unlimited for commercial insurers);

And

- Mandatory panel review of claims for QHPs participating in the PCF.

APPROACH

To help answer the questions posed by Superintendent Toal, RRC took the following steps:

1. Assessed the potential PCF growth opportunity by estimating:
   a. The total number of providers in New Mexico compared to the number of providers in the PCF
   b. The additional premium volume "available" in New Mexico to the PCF
2. Identified provider types not currently present or with a limited presence in the PCF
3. Estimated the potential profitability of potential new PCF provider types
4. Evaluated the benefits of adding provider types to the PCF
5. Compared and contrasted MPL loss costs in New Mexico with other states
6. Identified areas for further exploration

RRC also conducted an interview with an insurance agent, recommended by Independent Insurance Agents of New Mexico, who places MPL coverage for QHPs in New Mexico and an interview with a representative of Wisconsin's PCF Fund. Our findings are described in the Observations section below.

LIMITATIONS AND USE

As part of our review of the MPL market in New Mexico, RRC made use of publicly available data because certain important data elements were not available from the PCF. For example, size-of-loss data for QHPs was not available.

In addition, we made a number of assumptions based on the publicly available data. Some of those assumptions have a material impact on our recommendations. To the extent this data is not reflective of the PCF's risk characteristics, our findings may be impacted.

Detailed data on demographic trends, cost of healthcare insurance plans, provider trends, statistics on access to healthcare, and other data points specific to New Mexico is needed to quantify some elements of this analysis.

RRC did not perform any rate analyses to estimate the premium volume available in New Mexico. Rather, we used a top down approach using publicly available data and leveraging actuarial analysis already performed for the PCF and rate filings from The Medical Protective Company (MedPro) and The Doctors Company (TDC). While we have estimated impacts of certain changes (e.g. provider expansion, limit and damages cap increases, etc.) to the PCF in some instances, fully quantifying estimates of the potential impact of various changes to the PCF will require additional data and further analysis.

Estimates of future loss and loss adjustment expense are based on certain assumptions and are subject to the occurrence or non-occurrence of future contingent events. Such estimates are

therefore subject to uncertainty. Actual results may vary, perhaps substantially, from estimates. Given the relative paucity of data available for our review from the PCF, there is significant uncertainty in our estimates.

This report was prepared for the exclusive use of New Mexico Office of Superintendent of Insurance to assist in the evaluation of potential structural changes to the PCF. It is not intended nor is it necessarily appropriate for any other purpose. We understand that this report is to be made publicly available. While no third parties shall rely on this report for any reason, we understand that stakeholders may consider this report as part of assessing the advantages and disadvantages of potential changes to the PCF's structure. Access to this report will not create any duty nor liability to RRC.

DATA AND MATERIALS

RRC reviewed the following information provided by the PCF:

1. Pinnacle Actuarial Resources, Inc.'s (Pinnacle's) 2018 Actuarial Analysis of the New Mexico Patients Compensation Fund
2. Pinnacle's Actuarial Report Addendum: New Mexico Patient's Compensation Fund Class Plan and Entity Coverage Review, October 2019
3. Pinnacle's Actuarial Report Addendum: New Mexico Patient's Compensation Fund Hospital & Outpatient Health Care Facility Rating Plan
4. New Mexico Patient's Compensation Fund 2019 Surcharge Public Hearing Written Testimony
5. Merlinos' Second Opinion Actuarial Review of the October 2019 Actuarial Analysis of the New Mexico Patient Compensation Fund's Loss Reserves and Surcharge Estimate – February 20, 2020

RRC also reviewed the following publicly available data:

Data Source	**Information extracted**
Bureau of Labor Statistics[1]	Number of healthcare providers in New Mexico as of May 2019
American Hospital Directory[2]	Name, number of beds and type of hospital for hospitals in New Mexico
National Practitioner DataBank (NPDB)[3]	Medical malpractice claims
American Hospital Association[4]	Number of community hospitals in New Mexico
Advisory article[5]	Percentage of hospitals that use self-insurance
New Mexico psychologists[6]	Number of psychologists in New Mexico
MedPro rate filing[7]	Medical malpractice rates for physicians and allied providers
Doctors Company rate filing[8]	Medical malpractice rates for physicians and allied providers

1 https://www.bls.gov/oes/current/oes_NM.htm#29-0000
2 https://www.ahd.com/list_cms.php?mstate%5B%5D=NM&listing=1&viewmap=0#
3 https://www.npdb.hrsa.gov/
4 https://www.aha.org/statistics/2020-01-07-archived-fast-facts-us-hospitals-2019
5 https://www.advisory.com/daily-briefing/2011/10/26/hospitals-consider-self-insurance-for-medical-malpractice
6 https://www.psychologydegree411.com/licensure/new-mexico/
7 S&P Global Market Intelligence
8 S&P Global Market Intelligence

OBSERVATIONS

We organized the questions posed by the Superintendent in a matrix and created a qualitative impact map as shown below.

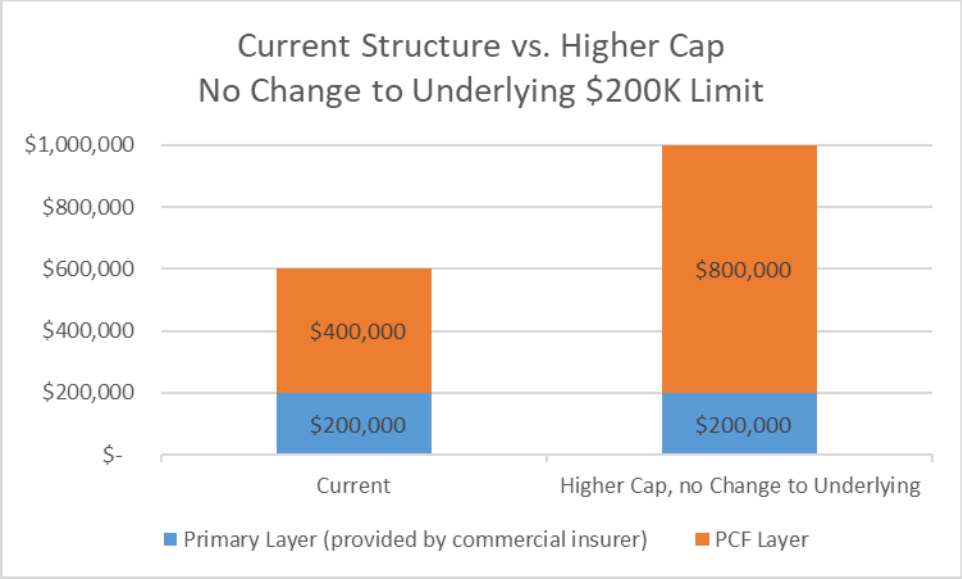
	Anticipated impact on		
Questions posed	**Cost of medical professional liability insurance***	**Financial viability of the PCF**	**QHP surcharges***
Expanding provider types	**Positive**	**Positive**	**Neutral**
Increasing damages cap	**Negative**	**Neutral**	**Negative**
Increasing underlying coverage	**Neutral**	**Neutral**	**Positive**
Increasing damages cap & increasing underlying coverage	**Neutral**	**Positive**	**Positive**
Separating the PCF	**Negative**	**Negative**	**Negative**

** for cost of healthcare insurance and QHP surcharges, positive is equivalent to lower cost and negative is equivalent to higher cost*

RATIONALE

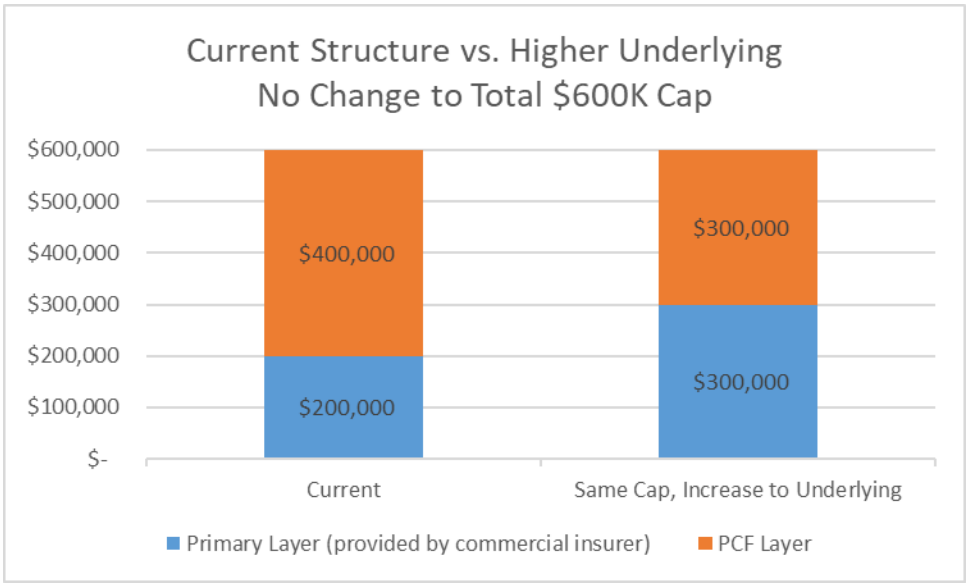
Expanding provider types would be expected to have a positive impact on the cost of MPL insurance because new providers to the PCF will benefit from the damages cap. In addition, we expect that the financial strength of the PCF will improve if the new providers are priced appropriately relative to the exposure because the additional volume of business generated would reduce volatility in the PCF financial results. Though the types of providers may introduce more or less volatility to the PCF on their own depending on the nature of the services provided, from the perspective of the PCF as a whole, more participation should lead to lower volatility in the long run.

Increasing the damages cap alone (with no commensurate increase in the underlying coverage of MPL insurance) would not be expected to have a positive impact on the PCF. This option is illustrated below, using the example of increasing the total non-medical damages cap to $1,000,000 with no change to the underlying $200,000 limit provided by commercial insurance:



Such a structural change would increase the limits of insurance provided by the PCF and therefore the total amount of insurance premium inclusive of the QHP surcharges will also increase. Increasing the damages cap should not have an impact on the financial viability of the PCF, if the higher limits are priced appropriately relative to the exposure. However, higher limits would be expected to create additional volatility to the PCF's financial results.

Increasing the underlying coverage of insurance (with no commensurate increase in damages cap) would be expected to have both positive and negative impacts on the PCF. This option is illustrated below, using the example of increasing the underlying limit to $300,000 with no change to the total cap of $600,000:



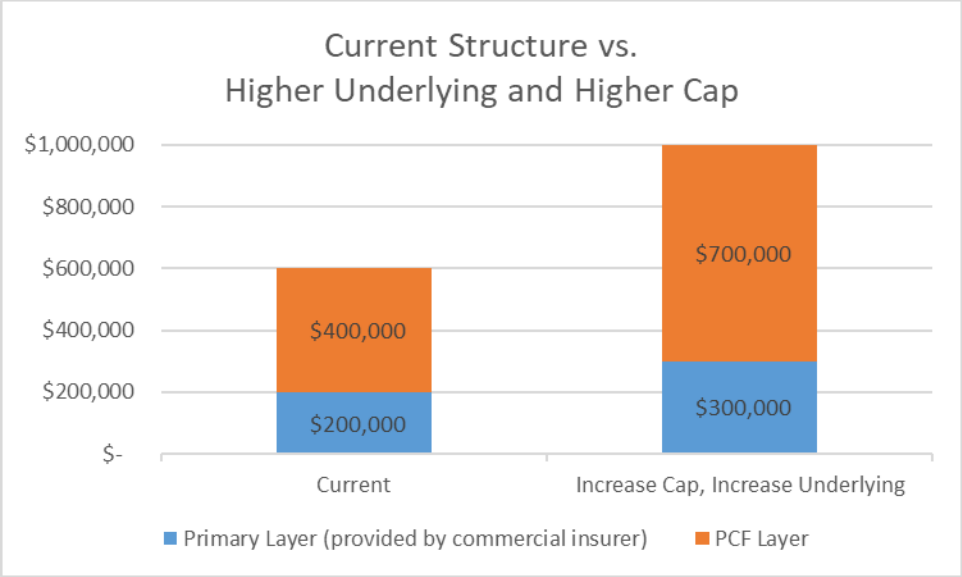
Such a structural change would not be expected to materially impact the overall cost of MPL insurance, though it would reduce the QHP surcharges, as the PCF covers less than it does under

the current structure. A disadvantage of this option is that it would increase volatility to the PCF, as it would insure losses in a higher excess layer. In addition, the PCF would have lower revenue as a result of lower surcharges, which could have a negative impact on the PCF's financial stability. An increase in the coverage the insurer must provide will increase the insurer's stake in claims settlement, which may reduce overall costs to the PCF.

Increasing both the underlying coverage and the damages cap in tandem would be expected to have a positive impact on the financial viability of the PCF, assuming that the higher limits are priced appropriately relative to the exposure. Such a structural change could increase the attractiveness of the PCF to commercial insurers, since the increase in amount of coverage would increase premium available to those insurers. This in turn could benefit the QHP's by increasing the availability of MPL insurance in New Mexico.

We believe that this option has the most potential to improve the cost and availability of both MPL insurance and healthcare in New Mexico, since we believe it will draw more participants in the market.

This option is illustrated below, using the example of increasing the total non-medical damages cap from $600,000 to $1,000,000 and increasing the underlying limit provided by commercial insurance from $200,000 to $300,000:



We conducted an analysis of physician MPL claims in New Mexico based on publicly available data from the NPDB. This analysis demonstrated that approximately 10% of total losses and 26% of New Mexico MPL physician claims are in the layer from $200,000 to $300,000. The presence of a relatively significant number of claims and loss dollars in this layer suggests that $300,000 may be a viable underlying coverage limit. **We therefore recommend that the PCF consider increasing the underlying per occurrence limit of coverage**. In addition, we recommend that the PCF consider an increase in the total non-medical cap. This is in recognition of the fact that

the $600,000 cap was established 25 years ago, and an increase to recognize inflation over that time appears to be appropriate.

Separating the PCF funds into separate legal entities will likely have a negative impact on the PCF because additional capital would be needed for the funds, and additional expenses would be incurred to manage the multiple funds. This will likely result in higher surcharges for the QHPs, due to increased risk and expense margins.

In addition, we believe that any changes to the PCF that would positively impact the cost and availability of medical malpractice in New Mexico would also have a positive impact the availability and cost of healthcare in New Mexico. This is because it would encourage more providers to establish their practices in New Mexico, more providers to permanently move to New Mexico, and more insurers to offer underlying MPL. Based on the market feedback we received, we believe this could help reverse a trend New Mexico is seeing with healthcare providers leaving the state due at least in part to concerns with the MPL market as it currently stands.

ANALYSIS

Expanding Provider Types in the New Mexico PCF

We segmented provider types into three main categories – physicians, allied healthcare providers, and hospitals and outpatient facilities -- and used publicly available data from the Bureau of Labor Statistics (BLS) and the American Hospital Directory to estimate the number of healthcare providers practicing in New Mexico and the number and size of hospitals operating in New Mexico. This information was then used to estimate the additional MPL risks (and premium) available in New Mexico.

Physicians

According to the May 2019 State Occupational Employment from the BLS, the total number of Healthcare Practitioners and Technical Occupations in New Mexico was 47,530. Of those, 3,370 were physicians and an additional 760 were dentists and orthodontists. The table below compares the total number of physicians by PCF class, where possible. The right-most column shows the number of qualified health providers already participating in the PCF as of January 1, 2019.

Occupation code	Bureau of Labor Statistics Occupation Title	Total Employees
29-1215	Family Medicine Physicians	710
29-1223	Psychiatrists	100
Subtotal		**810**
29-1216	General Internal Medicine Physicians	130
29-1221	Pediatricians, General	140
29-1081	Podiatrists	70
29-1211	Anesthesiologists	0
29-1218	Obstetricians and Gynecologists	100
29-1228	Physicians, All Other; and Ophthalmologists, Except Pediatric	2,120
29-1248	Surgeons, Except Ophthalmologists	0
29-1021-23-2	Dentists and Orthodontists	760
Total		**4,130**

There were 2,981 QHP's in the PCF as of January 1, 2019. This compares to 4,130 total in the state, and 3,370 in the state excluding Dentists and Orthodontists.

From this analysis we estimate that nearly 90% of physicians (excluding dentists and orthodontists) practicing in New Mexico - according to the BLS' employment figures - already participate in the PCF. Therefore, approximately 400 additional physicians could join the PCF.

It was suggested that another area be explored with respect to physicians:

- Possibility of offering coverage to QHPs that are transferring from a claims-made to an occurrence coverage. QHP's that are currently on claims-made coverage would need coverage for their unreported claims ("tail" coverage) in order to convert to occurrence coverage as required by the PCF.

Allied Healthcare Providers

According to the BLS, there are more than 40,000 allied healthcare providers and technicians in New Mexico. Not all healthcare professionals purchase stand-alone professional liability insurance. Of the groups that do or can purchase professional liability insurance, the largest classes are nurses, pharmacists, physical therapists, opticians, psychologists, EMT and paramedics, nurse practitioners, and physician assistants. The opportunity for the PCF to include additional allied healthcare providers, along with an order-of magnitude estimate of the premium based on public rate filings, is summarized below.

Allied healthcare providers	Number of providers (from BLS)	MedPro occ rate $200k/$600k	MedPro occ rate $1M/$3M	Doctors occ rate $200k/$600k	Doctors occ rate $1M/$3M	Estimated premium 400k xs 200k (MedPro)***	Estimated premium 400k xs 200k (Doctors)***
Dental hygienists	1,180	44	61	NA	NA	20,060	
Audiologist/speech pathologist	950	58	81				
Registered/vocational nurses & occupational therapists	20,100	67	93			522,600	
Pharmacists	1,500	96	134	NA	NA	57,000	
Physical therapists	1,380	107	149	NA	NA	57,960	
Opticians	440	114	167	NA	NA	23,320	
Paramedic/EMT	1,410	120	167			66,270	
Psychologists*	1,150	283	394	NA	NA	127,650	
Optometrists	200	274	401	416	764	25,400	69,488
Chiropractors**	150	1,788	2,614	9,206	16,892	123,900	1,152,900
Nurse practitioners	1,110	562	781	2,679	4,916	243,090	2,482,793
Nurse midwife	90	15,448	21,485	9,944	18,246	543,330	747,167
Total	**29,660**					**1,810,580**	**4,452,348**

*Estimated from the New Mexico psychologists website (https://www.psychologydegree411.com/licensure/new-mexico/)
***Only three chiropractors are currently in the PCF*
****Calculated as the difference between the $1M/$3M and $200k/$600k rates*

As seen above, and based on the rates from MedPro and TDC, the order of magnitude of additional premium that could be obtained from adding allied healthcare risks is estimated to be approximately $1.8 million to $4.5 million, which is relatively small compared to the size of the MPL markets as a whole in New Mexico. Given this relatively small exposure from a premium standpoint, we believe adding allied healthcare risks to the PCF would be unlikely to create significant risk to PCF's overall financial strength. Nursing represents the largest opportunity within the various allied healthcare provider types above. The rates between MedPro and Doctors Company are quite different, and further analysis using the exact limits is needed in order to determine the appropriate premium for some of these classes.

Healthcare Systems

From the American Hospital directory, we identified 64 hospitals in the state of New Mexico. It is estimated that approximately 75% of hospitals and health care systems in the United States use self-insurance. While a self-insured hospital cannot directly participate in the PCF, they can through a fronting arrangement. An example of such an arrangement would be the purchase of MPL insurance and PCF coverage through a carrier, and then self-insuring through a deductible.

To estimate the magnitude of the opportunity to the PCF of expanding from increased participation of healthcare systems, we listed all hospitals with accompanying information on their type of services and number of beds. We used the rates calculated from the Pinnacle actuarial study (occupied beds by type of hospital) to estimate the premium volume for all hospitals in New Mexico. We then grossed up the premium (using the ratio derived from the hospitals already in the PCF) to obtain an estimate of the additional premium derived from births, procedures, and visits exposures. Note that data about number of births, procedures and visits is not available from public datasets. Also note that this approach only calculates premium from an exposure basis and an experience analysis is not possible given the data available to us for this study. An example of the calculation is shown below:

Hospital Name	Beds	City	State	Hospital type	Rate per occupied bed	Premium estimate (bed estimates only - not procedures)
Santa Fe Indian Hospital	4	Santa Fe	NM	short term acute care	4,957	19,828
Acoma-Canoncito-Laguna Hospital	6	Acoma	NM	short term acute care	4,957	29,742
Advanced Care Hospital of Southern New Mexico	20	Las Cruces	NM	long term	496	9,920
Alta Vista Regional Hospital	46	Las Vegas	NM	short term acute care	4,957	228,022
AMG Specialty Hospital - Albuquerque	25	Albuquerque	NM	long term	496	12,400
Artesia General Hospital	49	Artesia	NM	short term acute care	4,957	242,893
Carlsbad Medical Center	95	Carlsbad	NM	short term acute care	4,957	470,915
Central Desert Behavioral Health Center	26	Albuquerque	NM	psychiatric	4,957	128,882

The total potential premium related to occupied beds for all NM hospitals is approximately $22.9 million. We estimate that occupied beds comprise approximately 32% of the total and procedures represent the remaining 68% based on exposure and surcharge data provided by the PCF.

The gross up calculation of the premium to reflect the additional potential premium generated for births, procedures, and visits is shown below:

Premium from beds in NM	22,857,860
Gross up factors	68.4%
Total available premium	72,304,027
Premium written by PCF	23,868,130
Total estimated premium	48,435,897

Hospital systems clearly represent the largest opportunity for the PCF in terms of expanding its size and in turn potentially enhancing its long-term financial stability. In addition, healthcare organizations now employ more physicians with approximately 50% of physicians employed when compared to physician-owners, a trend that is unlikely to be reversed. Therefore, with the changing landscape of physicians' employment, and the large number of hospitals in New Mexico, further exploring how to recruit profitable hospitals may have a significant positive impact on the PCF.

Increasing the Underlying Coverage or Damages Cap

RRC did not have access to ground-up size-of-loss data from either the PCF or commercial insurers to analyze the impact of increasing the underlying limit of $200,000 or the damages cap of $600,000 for economic damages. RRC therefore used the National Practitioner DataBank as a data source. The NPDB was established by the Health Care Quality Improvement Act of 1986 (HCQIA), Title IV of Public Law 99-660. The NPDB Public Use Data File discloses certain information on the professional competence and conduct of physicians, dentists, and other health care practitioners including medical malpractice payments, adverse actions, clinical privileges actions, and more.

RRC selected the following criteria to filter the relevant loss data:

- Practicing state: New Mexico
- Accident years: 2005 to 2016

- Record type: Malpractice payment

Note that RRC was not able to accurately separate payments from the PCF versus payments from commercial insurers. Therefore RRC used the full dataset including both losses from PCF payments and commercial insurer payments. RRC indexed the losses using a 2% inflation rate (indexed to 2019 for consistency with the rest of the data valuation points). We note that the NPDB only contains data on physicians' claims and therefore medical malpractice claims against a hospital are not part of the NPDB.

The figure below illustrates the percentage of losses and percentage of claim counts in tranches of $100,000, starting at $200,000.

[1] https://www.ama-assn.org/press-center/press-releases/employed-physicians-outnumber-self-employed
1 https://www.npdb.hrsa.gov/

NPDB New Mexico % losses per layer			
Lower limit	Upper limit	% payments in layer*	% counts in layer*
0	200,000	37%	45%
200,000	300,000	10%	26%
300,000	400,000	7%	4%
400,000	500,000	6%	4%
500,000	600,000	5%	4%
600,000	700,000	4%	4%
700,000	800,000	3%	2%
800,000	900,000	3%	1%
900,000	1,000,000	2%	2%
1,000,000	Unlimited	24%	8%

** All NPDB medical malpractice losses in NM regardless of type of payer for accident years 2006 to 2015*

In the figure above, we observe:

- 37% of loss payments are less than $200,000 AND 24% of loss payments are above $1,000,000
- 45% of claim counts are less than $200,000 AND 26% of claim counts settle between $200,000 and $300,000, a high frequency layer.

The data suggests that raising the underlying coverage to up to $300,000 or $350,000 may benefit the PCF, commercial insurers and healthcare providers. Commercial insurers would collect relatively more premium and would have an increased stake in claims settlement, which may reduce overall costs to the PCF, and the PCF may see a commensurate reduction in losses (albeit surcharges would be reduced). As per our conversation with an insurance agent, healthcare providers may also feel more confident that insurers are incentivized to defend their claims given the increase in their exposure to loss from the increase in underlying limit.

Another consideration is the large percentage of losses above $1,000,000 which may inform the decision on increasing the damages cap. Below are some comparative tables with other PCF states.

Voluntary; 200/600 underlying, 350/1000 cap

Practicing state is **South Carolina**

Accident years 2006 to 2015

Inflation rate of 2%

NPDB South Carolina % losses per layer			
Lower limit	Upper limit	% payments in layer*	% counts in layer*
0	200,000	41%	48%
200,000	300,000	11%	24%
300,000	400,000	7%	6%
400,000	500,000	6%	5%
500,000	600,000	5%	4%
600,000	700,000	4%	2%
700,000	800,000	3%	1%
800,000	900,000	3%	1%
900,000	1,000,000	2%	1%
1,000,000	Unlimited	18%	7%

** All NPDB medical malpractice losses regardless of type of payer for accident years 2006 to 2015*

AY	number of claims	total payments	average claim size
2010	118	41,301,802	350,015
2011	112	31,514,415	281,379
2012	118	34,467,462	292,097
2013	113	38,100,609	337,174
2014	118	43,258,990	366,602
2015	89	40,857,484	459,073
average 2010-2014	116	38,250,127	**347,723**
state population	5,210,095		
frequency	2.22%		

Mandatory; 100/300 underlying, 500 cap

Practicing state is **Louisiana**

Accident years 2006 to 2015

Inflation rate of 2%

NPDB Louisiana % losses per layer			
Lower limit	Upper limit	% payments in layer*	% counts in layer*
0	200,000	45%	66%
200,000	300,000	11%	9%
300,000	400,000	8%	6%
400,000	500,000	6%	6%
500,000	600,000	4%	3%
600,000	700,000	3%	2%
700,000	800,000	3%	2%
800,000	900,000	2%	1%
900,000	1,000,000	2%	1%
1,000,000	Unlimited	15%	4%

** All NPDB medical malpractice losses regardless of type of payer for accident years 2006 to 2015*

AY	number of claims	total payments	average claim size
2010	229	46,237,833	201,912
2011	203	48,050,923	236,704
2012	207	52,511,017	253,676
2013	181	55,549,369	306,903
2014	140	32,768,014	234,057
2015	108	30,667,251	283,956
average 2010-2014	192	44,297,401	**252,868**
state population	4,645,184		
frequency	4.13%		

Voluntary; 500/1000 underlying, 1750 cap

Practicing state is **Nebraska**

Accident years 2006 to 2015

Inflation rate of 2%

NPDB Nebraska % losses per layer			
Lower limit	Upper limit	% payments in layer*	% counts in layer*
0	200,000	45%	50%
200,000	300,000	15%	11%
300,000	400,000	12%	7%
400,000	500,000	10%	5%
500,000	600,000	7%	12%
600,000	700,000	3%	7%
700,000	800,000	2%	2%
800,000	900,000	2%	1%
900,000	1,000,000	1%	1%
1,000,000	Unlimited	3%	3%

** All NPDB medical malpractice losses regardless of type of payer for accident years 2006 to 2015*

AY	number of claims	total payments	average claim size
2010	33	12,051,313	365,191
2011	44	13,287,496	301,989
2012	41	12,423,897	303,022
2013	30	9,026,192	300,873
2014	47	15,134,740	322,016
2015	29	7,928,816	273,407
average 2010-2014	39	11,642,076	**311,083**
state population	1,952,570		
frequency	2.00%		

Voluntary; 500/1500 underlying, 1800 cap

Practicing state is **Indiana**

Accident years 2006 to 2015

Inflation rate of 2%

NPDB Indiana % losses per layer			
Lower limit	Upper limit	% payments in layer*	% counts in layer*
0	200,000	47%	51%
200,000	300,000	11%	22%
300,000	400,000	8%	4%
400,000	500,000	7%	3%
500,000	600,000	6%	5%
600,000	700,000	4%	3%
700,000	800,000	4%	1%
800,000	900,000	3%	1%
900,000	1,000,000	3%	1%
1,000,000	Unlimited	5%	8%

** All NPDB medical malpractice losses regardless of type of payer for accident years 2006 to 2015*

AY	number of claims	total payments	average claim size
2010	190	57,567,609	302,987
2011	221	61,471,695	278,152
2012	186	54,224,052	291,527
2013	157	44,951,899	286,318
2014	118	25,182,317	213,409
2015	73	20,292,139	277,975
average 2010-2014	174	43,948,285	**275,061**
state population	6,745,354		
frequency	2.59%		

Mandatory; 1000/3000 underlying, 750 cap

Practicing state is **Wisconsin**

Accident years 2006 to 2015

Inflation rate of 2%

NPDB Wisconsin % losses per layer			
Lower limit	Upper limit	% payments in layer*	% counts in layer*
0	200,000	27%	70%
200,000	300,000	8%	7%
300,000	400,000	6%	4%
400,000	500,000	5%	3%
500,000	600,000	4%	3%
600,000	700,000	3%	3%
700,000	800,000	3%	1%
800,000	900,000	2%	1%
900,000	1,000,000	2%	1%
1,000,000	Unlimited	40%	7%

** All NPDB medical malpractice losses regardless of type of payer for accident years 2006 to 2015*

AY	number of claims	total payments	average claim size
2010	52	12,315,429	236,835
2011	35	14,575,443	416,441
2012	46	17,950,511	390,228
2013	46	8,778,155	190,829
2014	40	12,322,701	308,068
2015	26	6,008,581	231,099
average 2010-2014	44	11,991,803	**295,584**
state population	5,851,754		
frequency	0.75%		

Mandatory; 200/600 underlying, 325 cap

Practicing state is **Kansas**

Accident years 2006 to 2015

Inflation rate of 2%

NPDB Kansas % losses per layer			
Lower limit	Upper limit	% payments in layer*	% counts in layer*
0	200,000	72%	57%
200,000	300,000	11%	36%
300,000	400,000	4%	1%
400,000	500,000	3%	1%
500,000	600,000	2%	1%
600,000	700,000	2%	1%
700,000	800,000	2%	1%
800,000	900,000	1%	0%
900,000	1,000,000	1%	1%
1,000,000	Unlimited	2%	2%

** All NPDB medical malpractice losses regardless of type of payer for accident years 2006 to 2015*

AY	number of claims	total payments	average claim size
2010	78	10,922,549	140,033
2011	67	9,660,332	144,184
2012	93	17,941,953	192,924
2013	81	16,423,671	202,761
2014	75	8,971,485	119,620
2015	56	12,064,518	215,438
average 2010-2014	79	12,664,085	**169,160**
state population	2,910,357		
frequency	2.71%		

The proportion of loss dollars below $200,000 per occurrence varies from 27% to 72% (41% to 47% excluding Wisconsin and Texas), and 48%-70% of claim counts are in this layer. New Mexico's experience (37% of dollars and 45% of claim counts) falls in the lowest end of this range, suggesting that New Mexico's average claim size is higher than in other states.

At $300,000 per occurrence, the other states' proportion of loss dollars below this limit varies from 35% to 83% (52% to 60% excluding Wisconsin and Texas), and 61%-91% of claim counts are $300,000 or less. Again, New Mexico's experience (47% of dollars and 71% of claim counts) reflect a higher average claim size, but also suggest that increasing the underlying coverage limit to $300,000 or higher makes sense.

Over $1,000,000 per occurrence, the proportion of loss dollars varies widely, from 2% to 40% (3% to 18% excluding Wisconsin and Texas), and accounts for 2%-8% of claim counts. New Mexico's proportions of 24% and 8% again speak to a higher average claim severity, and also suggest that raising the cap to at least $1,000,000 should be considered.

Separating the PCF fund by type of provider

RRC does not recommend splitting the PCF into separate funds by provider type because the aggregate capital requirement would be higher for multiple entities than for a single entity due to a reduction in the ability to pool risks.

We do; however, encourage the following practices to alleviate concerns of equity, if any, between provider types:

- The PCF captures ground-up loss data on all its QHPs;
- The PCF provides regular analysis to providers to demonstrate how losses and surcharges are allocated among provider types;
- The PCF conducts an actuarial review of the PCF's current experience rating plans to maximize their impact within the constraints of actuarial principles. For example, should the credibility for a given size of hospital be increased to increase the impact or "swing" of the experience rating adjustment?
- The PCF considers aggregate experience rating by provider type, if possible and permitted. For example, the aggregate experience of all physicians for a recent 3 or 5 year period would directly influence the rates to be charged physicians in the upcoming year.

RECOMMENDATIONS

The PCF plays an important role in New Mexico's healthcare system, access to healthcare, healthcare insurance, and ability to recruit and retain physicians. All stakeholders benefit in some way from a healthy PCF. Based on our analysis, we have identified steps that the PCF can take:

1. **Existing and new provider types (question 1):**
   - 1.1 Consider focusing efforts on recruiting and retaining hospitals in the PCF. Hospitals represent the largest provider type. There is also a trend towards a larger percentage of physicians employed by hospitals; a trend we do not expect to change in the near future;
   - 1.2 Consider adding new provider types to the PCF with emphasis on nursing (nurses, nurse practitioners, nurse midwives) because the number of providers in these positions is increasing. For example, in the US, the number of nurse practitioners increased by 9% between 2018 and 2019.

2. **Underlying limits and damages cap (questions 2 and 3):**

   - 2.1 Consider increasing the underlying limits of insurance a QHP must maintain to position the PCF's attachment point above the frequency layer. $300,000 is a potentially viable alternative to the current $200,000 underlying limit. This could involve changes in QHP premiums to the extent that insurers' pricing for the $100,000 excess $200,000 layer differs from the PCF; we have not quantified this difference as it is outside our scope of work;

[13] https://www.forbes.com/sites/brucejapsen/2019/01/29/number-of-nurse-practitioners-surpasses-270000/#30c10afc19ec

2.2 Obtain ground up loss information from commercial carriers split between allocated loss adjustment expenses (ALAE) and indemnity payments to better support pricing and monitor long term trends in losses;

2.3 Consider increasing the damages cap in line with social inflation and New Mexico's MPL claim severity distribution;

2.4 If choosing to do so, consider moving the underlying coverage limit and damages cap in tandem; this would provide maximum benefit to the PCF;

3. Separation of PCF by provider type (question 4):

3.1 Ensure that providers' concerns about cross-subsidy are heard and answered. Produce regular reports on losses and surcharges to share with providers to alleviate concerns that some groups may subsidize others; and

3.2 Do not separate the PCF by provider type.

COVID 19 Pandemic and Current Environment

Factors in the current environment, namely the COVID-19 pandemic, its impact on the healthcare environment, access to healthcare, healthcare practices, and the resulting low interest rates and market volatility, could have a significant impact on the PCF and uncertain impact to the insurance and healthcare industries as a whole in 2020 and beyond. RRC's analysis has not accounted for the potential impact of these factors.

DISCLOSURES

Lisa Chanzit, Véronique Grenon, David Heppen, and Debbie Rosenberg are associated with RRC and are independent of the New Mexico Office of Superintendent of Insurance. All are Fellows of the Casualty Actuarial Society. Lisa Chanzit, David Heppen, and Debbie Rosenberg are Members of the American Academy of Actuaries. All meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

We performed this review at the level of detail we deemed professionally necessary to render the opinion herein. A full substantive actuarial ratemaking and cost impact analysis, which was outside the scope of this review, may have resulted in other methods or assumptions we consider appropriate.

We relied on information provided by the PCF, MedPro, TDC, and publicly available studies. The work was performed at a level of detail deemed professionally necessary to meet the requested objectives. There may be individual parameters or assumptions which could be considered unreasonable by other actuaries, and which could have or would have been discovered by employing an exhaustive, detailed study of the underlying data and assumptions. Such a study was beyond the scope of our work.

Financial results for entities providing insurance products are subject to certain assumptions about the future and to the occurrence or non-occurrence of future contingent events. Any estimate of future premiums and losses is therefore subject to uncertainty. Ultimate claims may vary in dollar amount, perhaps materially, from amounts estimated. We have utilized generally accepted actuarial standards, procedures and methodologies in completing the tasks outlined in the Scope section. However, we do not guarantee that our conclusions, opinions or estimates provided in this report are accurate in their expressed or implied predictions of future events. Our conclusion is not a guarantee that specific actions taken will produce the desired results under every scenario of future experience; the results reached in this analysis are dependent on the assumptions used.

Véronique Grenon, a contractor with RRC, accepted employment with TDC prior to the conclusion of this study. This did not impact our approach to the study, nor did it affect our findings.

This Report was prepared for the PCF. Any other use or distribution of the Report is not permitted without our prior written consent.

We are available to discuss the contents of this report at a mutually convenient time.