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MEDICAL
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**Re: In the Matter of Adoption of Rules for the Patient's Compensation Fund, Docket No. 21-0005-PCF**

Dear Superintendent Toal,

The New Mexico Medical Society ("NMMS") respectfully submits the following comments regarding the Office of the Superintendent of Insurance's proposed regulations governing the administration of the Patient's Compensation Fund.

**13.21.1 – PCF GENERAL PROVISIONS**

NMMS respectfully submits that the following subsections of 13.21.1 should be revised as follows:

**13.21.1.8 – Responsibilities of the Third-Party Administrator**

Section 13.21.1.8 transfers a significant amount of the authority and responsibility for the administration of the PCF from the superintendent to the third-party administrator ("TPA"). Although the amendments made to NMSA 1978, § 41-5-25 shift some responsibilities from the superintendent to the TPA, the superintendent remains the "custodian of the fund." NMSA 1978, § 41-5-25(C). As the custodian of the fund, the superintendent should not give the TPA ultimate authority to "negotiate reasonable and appropriate compromises and settlements of the fund's liability respecting any claim against the fund." 13.21.1.8(I) NMAC. Rather, the superintendent should retain ultimate authority over the approval of settlements that involve funds paid from the PCF. To accomplish that goal, Section 13.21.1.8(I) should be revised to read: "negotiate reasonable and appropriate compromises and settlements of the fund's liability respecting any claim against the fund and obtain approval from the superintendent or the superintendent's designee before entering into any agreement involving PCF funds."

As the custodian of the PCF, the superintendent is responsible for determining and levying annual surcharges on qualified health care providers. *See* NMSA 1978, § 41-5-25(D). "Beginning in 2021, the surcharges shall be set with the intention of bringing the fund to solvency with no projected deficit by December 31, 2026." NMSA 1978, § 41-5-25(D). Although the superintendent has the ultimate responsibility to set surcharges, Section 13.21.1.8(M) directs the TPA to "develop [a] methodology for allocating liability for any fund deficit among health care providers." Although NMMS does not take issue with the superintendent delegating that task to the TPA, the rules should make it clear that superintendent retains ultimate authority to allocate liability for the fund's deficit. To do so, 13.21.1.8(M) should be revised to read as follows: "Subject to approval from the superintendent, develop a methodology for allocating liability for any fund deficit among health care providers."

**13.21.1.9 – Expenses of Administration and Defense.**

As written, Section 13.21.1.9 reads as follows: "All expenses incurred for, by, or on behalf of the superintendent or the TPA in the administration, operation, and defense of the fund shall be borne by the fund." The PCF Advisory Board should be added to Section 13.21.1.9 because the Board will incur expenses that will need to be paid by the PCF. For instance, Board members are entitled to per diem and mileage and the Board is in the process of retaining counsel, which will result in legal fees that need to be paid using PCF funds. Accordingly, Section 13.21.1.9 should be revised to read as follows: "All expenses incurred for, by, or on behalf of the superintendent, the TPA, or the PCF advisory board in the administration, operation, and defense of the fund shall be borne by the fund."

**13.21.2 – PCF QUALIFICATIONS AND ADMISSIONS**

NMMS respectfully submits that the following subsections of 13.21.2 should be revised as follows:

**13.21.2.8 – Base Qualifications for Admission to the Fund**

Section 13.21.2.8(C)(1) mandates that "[a]n independent provider that is a business entity … must have at least one qualified health care provider as a member or employee of the entity." The provisions set forth in Section 13.21.2.8(C)(1) are inconsistent with NMSA 1978, § 41-5-3(E), which provides the following definition of the business entities that are considered independent providers under the MMA: "'Independent provider' includes a business entity that is not a hospital or outpatient health care facility that employees or consists of members who are licensed or certified as doctors of medicine, doctors of osteopathy, chiropractors, podiatrists, nurse anesthetists, physician's assistants, certified nurse practitioners, clinical nurse specialists or certified nurse-midwives and the business entity's employees." As can be seen, § 41-5-3(E) only requires a business entity to employ or consist of members who are qualifiable health care providers under the MMA. In other words, the employed health care providers or members of a business entity do not need to be qualified under the Act for the entity to be considered an

independent provider. Therefore, Section 13.21.2.8(C)(1) should be deleted because it is inconsistent with NMSA 1978, § 41-5-3(E).

Next, Section 13.21.2.8(C)(2) would require business entities to have "all qualifiable health care provider members or employees admitted to the fund to have the business entity eligible for fund coverage." Under NMSA 1978, § 41-5-5(A)(1), an independent provider's coverage under the Act is limited to "three separate occurrences." In the rare event that an independent provider employed by a covered business entity had more than three (3) separate occurrences, the entire business entity would lose its MMA coverage based on the requirement proposed in Section 13.21.2.8(C)(2). Similarly, if one independent provider within a large group practice could not gain coverage under the Act for any number of reasons, that would prohibit the entire practice from qualifying for coverage under the MMA. If the Legislature had intended for business entity coverage to be dependent on all of its qualifiable employees participating in the Act, the Legislature would have included that requirement in the Act. That said, without any other restriction, a business entity is entitled to MMA coverage if it meets the definition set forth in NMSA 1978, § 41-5-3(E) and satisfies the qualification requirements set forth in NMSA 1978, § 41-5-5(A). Accordingly, because Section 13.21.2.8(C)(2) is inconsistent with the MMA, it should be deleted.

**13.21.2.11 – Additional Qualifications for Hospitals and Outpatient Health Care Facilities**

Section 13.21.2.11(A) states the following regarding the steps that a non-independent provider must take to qualify for PCF participation:

> The superintendent shall perform a risk assessment for each applicant hospital or outpatient health care facility. If the hospital or outpatient care facility will establish and maintain financial responsibility with medical malpractice liability insurance, the superintendent may consider as the risk assessment the information and documents that the applicant submitted to its insurer, all of which shall be provided to the superintendent by, or on behalf of, the applicant, along with all other information that the superintendent has or requests of the applicant.

The amendments made to the MMA in 2021 included significant changes to the information that hospitals and outpatient health care facility must provide to qualify for coverage under the MMA. Section 13.21.2.11(A) should be revised as follows to comply with NMSA 1978, § 41-5-25(D):

> The superintendent shall perform a risk assessment for each applicant hospital or outpatient health care facility seeking participation in the fund. As part of the risk assessment process, each applicant hospital or outpatient health care facility shall provide, at a minimum, the hospital's or outpatient health care facility's direct and indirect cost information as reported to the federal centers for Medicare and Medicaid services for all self-insured malpractice claims, including claims and paid loss detail, and the claims and paid loss detail for any professional liability

insurance carriers for each hospital or outpatient health care facility and each employed health care provided for the last eight years to the third-party actuary.

The proposed changes to Section 13.21.2.11(A) will ensure that hospitals and outpatient health care facilities are providing the information necessary for accurate surcharges to be assessed.

Section 13.21.2.11(B) provides that, "[t]he superintendent shall arrange for an actuarial study before determining base coverage or deposit and surcharges. If the data available for a hospital or outpatient health care facility is insufficient for actuarial analysis, due to sample size or similar inadequacies, the actuarial study may aggregate data among similar hospitals or outpatient health care facilities to achieve actuarial significance." Pursuant to NMSA 1978, § 41-5-25(D), surcharges for health care providers "shall be based on sound actuarial principles, using data obtained from New Mexico claims and loss experience." In order to account for that new requirement, the second sentence in Section 13.21.2.11(B) should be revised to read as follows: "If the data available for a hospital or outpatient health care facility is insufficient for actuarial analysis, due to sample size or similar inadequacies, the actuarial study may aggregate data from New Mexico claims and loss experience among similar hospitals or outpatient health care facilities to achieve actuarial significance."

Lastly, Section 13.21.2.11(E) requires hospitals and outpatient health care facilities to apply for fund participation "by April 1 of the year prior to their first admission to the fund." In order to provide for additional time to gather the data and information necessary to conduct a complete analysis of the risk presented by a hospital or outpatient health care facility, any hospital or outpatient facility applying for participation should be required to submit its application by "March 1 of the year prior to their first admission to the fund."

**13.21.2.17 - Patient's Compensation Fund Actuary**

In the first sentence of Section 13.21.2.17(A), the words, "may employ or hire" should be revised to read, "shall employ or hire." Similarly, in Section 13.21.2.17(B), "may" should be revised to "shall."

**13.21.5 – PATIENT'S COMPENSATION FUND SURCHARGE RATE HEARINGS**

NMMS respectfully submits that the following subsections of 13.21.5 should be revised as follows:

**13.21.5.9 – Advisory Board as Hearing Office**

Section 13.21.5.9(A) should be revised to allow the PCF Advisory Board to designate a non-Board member to preside as the hearing officer over a surcharge rate hearing based on a majority vote of the Board. To accomplish that revision, NMMS proposes the following revisions to Section 13.21.5.9(A):

> The advisory board is the hearing officer for surcharge rate hearings. The advisory board may conduct any hearing *en banc*, may designate any number of members less than its whole to conduct any hearing, may designate a single member to conduct any hearing, or may designate a non-Board member to preside as the hearing officer.

If OSI accepts NMMS's recommended revisions to Section 13.21.5.9(A), subsequent references to the "advisory board" in its capacity as a hearing officer should be revised to "hearing officer" or the "advisory board or its designee."

Section 13.21.5.9(E) should be revised to capture the Board's responsibilities under NMSA 1978, § 41-5-25.1(E). In short, outside of its potential duties as a hearing officer, the Board has a duty to "advise the superintendent on the surcharges to be set by the superintendent." NMSA 1978, § 41-5-25.1(E). Section 13.21.5.9(E) should be revised as follows to capture the dual role that the Board may potentially play in hearings related to surcharges:

> If the advisory board or any number of its members preside over a surcharge rate hearing, the advisory board, upon the conclusion of the surcharge rate hearing, shall meet to determine the surcharge rates to recommend to the superintendent. The advisory board shall base its determination upon substantial evidence in the whole record. The advisory board shall provide a written recommended decision to the superintendent on or before October 21 of each year. If the advisory board designates a non-board member to preside as the hearing officer over a surcharge rate hearing, the hearing officer shall provide the hearing officer's recommended decision to the advisory board and the superintendent on or before October 11 of each year. The hearing officer shall base his or her determination upon substantial evidence in the whole record. The advisory board shall meet to discuss the hearing officer's recommended decision and provide the superintendent with the advisory board's advice on the surcharges by no later than October 21 of each year.

Lastly, section 13.21.5.10(C) should be revised to read as follows: "The superintendent's initial order shall designate the advisory board or its designee as the hearing officer in the surcharge rate hearing."

Thank you for considering NMMS's comments regarding OSI's proposed rules governing the PCF. If you have any question or concerns, please let me know.

Sincerely,

Annie Jung,
NMMS Executive Director