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

IN THE MATTER OF DETERMINING PATIENT'S COMPENSATION FUND SURCHARGE RATES	))))	**Docket No. 21-0004-PCF**

PROPOSED FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

FINDINGS OF FACT:

1. On October 20, 2021, a quorum of the Advisory Board of the New Mexico Patient's Compensation Fund ("PCF") conducted a duly noticed public hearing to receive evidence and comment on proposed surcharges to be levied pursuant to NMSA (1978), § 41-5-25(D).

2. Mr. Carl X. Ashenbrenner testified at the hearing as a qualified casualty actuary. Exhibits A through D were admitted into the record.

3. The obligations of the PCF are funded by annual surcharges collected from every qualified healthcare provider ("QHP") admitted into the PCF pursuant to NMSA (1978), § 41-5-5. NMSA (1978), § 41-5-25(D).

4. Commencing January 1, 2022 the PCF will collect surcharges from four classes of QHPs: (a) individual providers; (b) entities (such as corporations, partnerships or limited liability companies) organized by one or more individual providers; (3) hospitals; and (4) outpatient health care facilities. NMSA (1978), § 41-5-3.

5. NMSA (1978), § 41-5-25(D) requires the PCF Custodian to determine the surcharges based on sound actuarial principles.

6. NMSA (1978), § 41-5-25(D) requires the PCF Custodian to contract for an annual independent actuarial study of the PCF. Among other purposes, the actuarial study is used to determine the annual surcharge payable by each QHP. Pursuant to NMSA (1978), § 41-5-25(E), surcharges "shall be set with the intention of bringing the fund to solvency with no projected deficit," and "[a]ll qualified and participating hospitals and outpatient health care facilities shall cure any fund deficit attributable to hospitals and outpatient health care facilities" by December 31, 2026.

7. The PCF Custodian contracted with the consulting actuarial firm Milliman to conduct an independent actuarial study of the PCF as of December 31, 2020. Mr. Ashenbrenner was the lead Milliman actuary on the actuarial study and prepared the study report. Ex. A.

8. As part of the actuarial study, Milliman (a) estimated the unpaid PCF claim liabilities, separately, for "Physicians & Surgeons" and "Hospitals"; (b) determined the amount of the current PCF deficit (i.e., difference between PCF fund balance and unpaid claim liability estimate) that is attributable to past fund participation by hospitals (including employed qualifying provider types); (c) developed an appropriate annual assessment on hospitals (including employed qualifying provider types) to eliminate their share of the existing Fund deficit by January 1, 2027; (d) developed an appropriate annual assessment on all qualified healthcare providers that will allow the deficit to be eliminated by January 1, 2027; (e) reviewed the current hospital experience rating plan ("ERP") and recommend termination; (f) reviewed the ISO provider code classification relativities and recommend appropriate updates by selected provider types; (g) developed proposed surcharge increases by QHP and provider type at different confidence levels; and (h) developed proposed surcharged rates for newly eligible PCF provider types. Ex. B, p. 4. Milliman's actuarial study was admitted into the record as Ex. B. A summary and demonstrative illustrations of Milliman's key findings was admitted into the record as Exhibit C.

9. Based on the application of sound actuarial principles, the projected losses to be paid for all PCF claims occurring prior to December 31, 2020 is reasonably projected to be $182.1 million. The PCF's obligation to fund ongoing medical payments is expected to add an additional $5.5 million to the PCF's funding obligations. The estimated PCF fund balance as of December 31, 2020 was $120.8 million, resulting in a fund deficit of $66.8 million as of that date. Ex. C, p. 28.

10. Based on the application of sound actuarial principles, the projected 2022 discounted losses attributable to individual QHPs is $22,401,994 at the central confidence level. Ex. C, p. 14.

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

A. Surgery -- gastroenterology (ISO 80104) – Move from class 9 to class 6.

B. Surgery – colon and rectal (ISO 80115) – Move from class 9 to class 6.

C. Surgery – general practice or family practice (ISO 80117) – Move from class 9 to class

D. Pulmonary diseases (ISO 80269) – Move from class 2 to class 4A.

E. Otorhinolaryngology – minor surgery (ISO 80291) – Move from class 3 to class 4.

F. Pediatrics – minor surgery (ISO 80293) – Move from class 6 to class 3.

G. Pulmonary diseases – no surgery (ISO 84269) – Move from class 2 to class 4a.

Ex. B, p. 68.

12. The projected income requirements to fund the projected 2022 losses attributable to individual QHPs, at the central confidence level, is $25,319,827, after adjusting for expenses, discount rates, reinsurance expenses and ISO code classification changes. Ex. C, p. 14.

13. If 2021 surcharge rates for individual provider QHPs were carried forward to 2022, and individual provider participation levels remained constant, the PCF would collect $21,146,700 in surcharges in 2022, which would result in an underfunding of projected losses by $4,173,127. *Id*. To eliminate the projected underfunding at the central confidence level, individual provider surcharge rates would need to increase by 19.7 percent for the 2022 PCF plan year. *Id.*

14. The PCF surcharge payable by an individual provider is based on the provider's practice specialty. Each practice specialty is assigned to a rating class. A surcharge applies to each rating class. The PCF assigns practice specialties to one of 11 rating classes as reflected in Exhibit C on pages 17 through 20. A 19.7 percent increase over 2021 rating class surcharges produces the rating class surcharges reflected in Exhibit C, at page 16.

15. Effective January 1, 2022 certified nurse practitioners, clinical nurse specialists and certified nurse-midwifes will be newly eligible to participate in the PCF. NMSA (1978), § 41-5-3(C). Based on New Mexico rate filings for commercial medical malpractice insurance, class relatives for these newly eligible providers were determinable. Ex. B, p. 12. Using those relativities, certified nurse practitioners and clinical nurse specialists are assigned to a new rating class "CN", and certified nurse midwives are assigned to rating class 3. Ex. B, p. 72.

16. The insurance industry standard practice is to increase premiums paid by individual insured providers by an additional 10 percent to provide coverage for an entity under which the insured provider(s) practice. Using this standard practice, the PCF surcharge payable by an entity QHP is 10 percent of the aggregate surcharges for the individual QHPs who practice in the entity. Ex. C, p. 16.

17. Based on the application of sound actuarial principles, the projected 2022 discounted losses attributable to hospitals is $25,528,348. Ex. C, p. 24.

18. The projected income requirements to fund the projected 2022 losses attributable to hospitals, at the central confidence level, is $28,355,926, after adjusting for expenses, discount rates and reinsurance expenses. Ex. C., p. 24.

19. If 2021 surcharge rates for hospital QHPs were carried forward to 2022, and hospital QHP participation levels remained constant, the PCF would collect $24,007,800 in surcharges in 2022, which would result in an underfunding of projected losses by $4,348,126. Ex. C, p. 24. To eliminate the projected underfunding, at the central confidence level, hospital QHP surcharge rates would need to increase by 18.1 percent for the 2022 PCF plan year, assuming all other rating factors remained unchanged. *Id.*

20. Commencing in 2020, the PCF rating plan for hospitals included an experience rating plan ("ERP") component. Ex. B, pp. 22-23. The ERP operated to reduce the total surcharges paid in 2020 and 2021 by larger hospitals and resulted in the PCF collecting 12.3 percent fewer (less in???) surcharges from hospitals in 2021 than would have been collected had the ERP not been implemented. Ex. B, p. 69; Ex. C., p 24.

21. The ERP should be eliminated for these reasons:

a. ERPs are usually designed for "ground-up" rating plans and split the losses between primary and excess to mitigate the impact of large claims, which are less predictive.

b. There is an incentive for the ERP eligible hospitals to decrease the number of reported claims by either assigning the claim to an employed physician or setting case reserves lower than the PCF attachment point.

c. Due to the reporting pattern of claims, the number of claims is both immature and volatile for the previous five years.

d. The resulting ERP discount should be added back to the overall premium level. This is difficult to project and set correctly in the rates.

e. Only 5 of the hospitals qualified for the ERP and it is unclear how the $1.5 manual premium threshold was set.

f. The available data to calculate the ERP parameters are volatile and hospitals will be ineligible for the PCF beginning January 1, 2027.

g. The ERP creates an additional burden to the administration of the PCF. Ex. B, p.

22. If 2021 surcharge rates for hospital QHPs were carried forward to 2022, hospital QHP participation levels remained constant, and the ERP were eliminated, the PCF would collect $26,960,759 in surcharges in 2022, which would result in an underfunding of projected losses by

$1,395,167. Ex. C, p. 24. To eliminate the projected underfunding, at the central confidence level, hospital QHP surcharge rates would need to increase by 3.6 percent for the 2022 PCF plan year. *Id.* Applying a 3.6 percent surcharge increase to the 2021 hospital rating plan exposure factors yields the rates per-exposure reflected in the column headed "2022 PCF Rates" on page 26 of Exhibit C.

23. With respect to casualty loss rate setting, the term "confidence level" refers to the probability that rates will generate sufficient income to cover projected losses. Rates set at the central confidence level are inadequate to ensure adequate funding for future losses because of natural volatility in loss experience. In addition to natural volatility, judicial constructions of the Medical Malpractice Act in pending cases could increase the funding obligations of the PCF. Because of expected volatility, PCF surcharges should be set above the central confidence level.

24. Indicated surcharge increase percentages at different confidence levels are shown for individual QHPs on page 37 of Exhibit 2, and for hospitals on page 45 of Exhibit 2.

25. In addition to paying surcharges calculated based on the hospital rating plan shown in Exhibit C, page 26, hospital QHPS must pay the aggregate individual provider surcharges for each employed provider.

26. The projected PCF deficit reflects the difference between paid losses and administrative expenses, plus projected losses and administrative expenses, less current assets which consist entirely of collected surcharges and earnings. Because the deficit is largely the product of under-assessment of surcharges, the share of the deficit attributable to hospitals can be determined by subtracting the total surcharges paid by hospitals from the claim losses attributable to hospitals, taking appropriate discounts and adjustments for anticipated earnings on collected but unpaid surcharges and inflation. Ex. B, pp. 10,

27. Historically, hospital QHPs paid surcharges on behalf of their employed providers. Because the PCF did not separately log employed provider surcharge amounts, total hospital surcharge payments were estimated to be 50 percent of total hospital surcharge remissions. Ex. D, p. 1. The accuracy of this estimation was largely corroborated by underwriting data provided by issuers of primary coverage. Historically, the PCF did not attempt to divide loss payments made on behalf of a hospital and employed provider based on respective shares of fault. Instead, the entire claim loss amount was allocated to the hospitals. To determine the deficit attributable to hospitals, 50 percent of loss payments made on claims involving a hospital and employed

provider(s) were allocated to the hospital. *Id.* These estimates were reasonable approximations and did not impact the actuarial soundness of the deficit allocation performed by Milliman.

28. Based on the surcharge and loss estimates, hospitals are responsible for $ 8.1 million of the deficit. Ex. B, p. 10.

29. The plan to have the hospitals extinguish their share of the deficit, as mandated by Section 41-5-25(E), contemplates assessing the hospitals a proportionate share of a fraction of the deficit for each of the next five PCF plan years, after making appropriate adjustments in the fractional amount for projected PCF fund investment income and for inflation. Ex. B, pp. 10-11. The gross and discounted amount of each annual assessment is depicted on page 33 of Exhibit B. The proportionate distribution will follow the exposure rating plan used to set base surcharges for hospitals that is reflected on page 26 of Exhibit C.

30. The remaining $58.7 million of the PCF deficit is allocable to individual provider QHPs, both employed and independent, and to the entities owned and operated by those providers. Ex. B, p. 10. The plan to extinguish this remaining deficit amount in five years contemplates applying the same methodology as the hospital deficit reduction plan. The cumulative deficit allocable to individual providers will be divided into five shares that will be proportionally assessed during each of the next five PCF plan years based on the provider surcharge class proportionalities. Ex. B, p. 33; Ex. C, p. 16. A QHP entity will be assessed 10 percent of the aggregate deficit assessment surcharge of its PCF participating providers. *Id.* Because hospital surcharges will be based, in part, on the aggregate amount of the individual surcharge amounts for its employed providers, a hospital will also pay the fund deficit assessment allocable to employed providers by rating class. Ex. C, p. 16.

31. The deficit reduction plans are predicated on the assumption that provider and hospital participation in the PCF will remain stable over the next five years. Ex. B, p. 11. A material decrease in participation will result in inadequate surcharge assessments to extinguish the deficit. *Id.* That development would require reallocation of a larger deficit share to a smaller provider group using the proposed proportionate allocation plan, or development of a deficit reduction plan based on more sophisticated modeling.

32. Milliman's development of proposed surcharge rates, deficit allocations, deficit reduction assessments, rating classes for newly eligible provider types and rating class changes was based on the application of sound actuarial principles, and its recommended allocations, surcharges, classifications and assessments are actuarially sound.

BASED ON THESE FINDINGS, THE PCF ADVISORY BOARD, ACTING AS THE HEARING OFFICER, SHOULD CONCLUDE AND RECOMMEND:

A. The PCF should eliminate the ERP;

B. PCF surcharges should be assessed at the 80 percent confidence level for all QHPs, resulting in a 37.7 percent increase in surcharges for individual providers and provider owned entities, and a 19.1 percent increase for hospitals and outpatient facilities;

C. The risk classifications for individual providers set out on pages 16 through 20 of Exhibit C should be adopted for use by the PCF;

D. The PCF should adopt the proposed deficit reduction plans and apply the deficit reduction assessments recommended on pages 16 and 26 of Exhibit C.

E. PCF surcharges for provider owned entities should be assessed at 10 percent of the cumulative individual QHP surcharges for all individual QHPs who practice within the entity, and deficit assessments should be assessed at 10 percent of the aggregate deficit assessment amounts recommended on page 16 of Exhibit C;

F. Hospital/Outpatient QHP surcharges should be assessed according to the rating plan that appears on page 26 of Exhibit C, plus the surcharges and deficit reduction amounts for employed providers as proposed on page 16 of Exhibit C; and

G. These changes shall become effective January 1, 2022.

DATED this 25th day of October, 2021

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing *Proposed Findings, Conclusions, and Recommendations* was sent by email to the following individuals, as indicated below, on this 25th day of October, 2021.

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