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. The Patient Compensation Fund Advisory Board's objective in holding this public hearing is to advise the OSI so that patients are protected, the PCF remains solvent, and QHPs and their practices continue to provide services and remain sustainable.

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

4. 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).

5. 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.

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

7. 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.

8. 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.

9. 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 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 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 recommended using a manual rating system rather than the ERP; (f) reviewed the ISO provider code classification relativities and recommended 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.

10. Based on the application of actuarial principles, the projected losses to be paid for all PCF claims occurring prior to December 31, 2020 is 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.

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

12. The fund deficit is attributable to a long history of mismanagement during prior administrations. The fund deficit grew partly as a result of so-called "batch claims," (multiple claims against one physician that arise out of a similar scheme or type or procedure), partly due to the failure to raise surcharges on independent physicians when recommended, and possibly related to other factors which there is insufficient data to support.

13. The ability to accurately allocate deficit obligations is complicated by the historical failure of fund administrators to track the appropriate allocation of settlement payments among hospitals, hospital employed physicians, and independent physicians.

14. It is assumed that $20.1 million of the individual QHPs' deficit was caused by settlement payouts for so-called "batch claims." That amount should be removed from the overall deficit attributable to individual QHPs and should be segregated, with a separate plan to extinguish that debt. If the amount of the batch claims turns out to be different from $20.1 million, then the amount removed from the overall deficit attributable to individual QHPs should be adjusted accordingly.

15. 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.

16. 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.

17. 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.*

18. 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.

19. 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.

20. 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.

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

22. 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.

23. 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.*

24. 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 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.

25. The Committee found that, for this year, the Milliman recommendation to eliminate the ERP should be followed. However, the decision of whether use the ERP going forward should be made after further study by the OSI and the qualified Third Party Administrator that is to be retained.

26. If 2021 surcharge rates for hospital QHPs are carried forward to 2022, hospital QHP participation levels remain constant, the PCF will collect $26,960,759 in surcharges in 2022, which will 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 which will need to be recalculated based on the ERP.

27. 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. Changing the Confidence Level, the increase in the Base Coverage level, the PCF exposure, and addressing the deficit all in the same year pose a significant threat to the goal of maintaining a stable number of participants in the PCF. Therefore, the PCF Advisory Board does not recommend implementing the recommended change to the confidence level this year but does encourage that recommendation to be considered in future years.

28. 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.

29. 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.

30. 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,

31. 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. This allocation was based on anecdotal evidence that was not by testimony or documents at the hearing. In the future, the PCF should attribute loss payments for employed physicians directly to the hospitals. Further, if a non-employed physician and a hospital are both the subject of a claim, the PCF should endeavor to allocate loss payments made on behalf of the hospital and the non-employed provider based upon a reasonable estimate of comparative fault.

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

33. 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.

34. Based on the evidence presented, including information about the lack of data regarding appropriate allocations between hospital and employed physician settlements, the remaining $58.7 million of the PCF deficit is allocated to individual provider QHPs, both employed and independent, and to the entities owned and operated by those providers. Ex. B, p. 10. Section 41-5-25(E) does not require independent provider QHPs to extinguish their proportionate share of the deficit in any particular time period and are therefore not required to extinguish their share of the deficit in five years. Because hospital surcharges will be based, in part, on the aggregate amount of the individual surcharge amounts for its employed providers, a hospital will pay the fund deficit assessment allocable to employed providers by rating class. Ex. C, p. 16.

35. 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.

BASED ON THESE FINDINGS, THE PCF ADVISORY BOARD, ACTING AS THE HEARING OFFICER, HEREBYCONCLUDES AND RECOMMENDS:

A. The PCF should further study, in conjunction with the OSI and the Third Party Administrator to be retained; whether to eliminate the ERP; the ERP should be eliminated this year, but that decision should be studied and re-evaluated by the OSI and the Third Party Administrator going forward;

B. PCF surcharges should be assessed at the central confidence level for all QHPs, resulting in a 19.7 percent increase in surcharges for individual providers and provider owned entities, and a 3.6 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;

E. The PCF should defer the proposed deficit reduction plan for individual QHPs;

F. It is assumed that $20.1 million of the individual QHP's deficit is due to so-called "batch claims" and should be placed in a separate category of deficit and a separate plan, removed from the physician and surgeon category, to extinguish that deficit. If the amount of the deficit attributable to the so-called "batch claims" is different from the $20.1 million, then the amount placed in the separate category of deficit should be adjusted accordingly;

G. 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;

H. 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;

I. Going forward, the PCF and its actuaries, in conjunction with the selected Third Party Administrator, should collect additional data about claims including, but not limited to, allocating employed providers' settlement payments to hospitals and, in cases of hospitals or hospital employees that include claims against individual QHPs, the PCF should estimate an allocation of comparative fault and allocate the comparative share of any payments appropriately on new settlements; and,

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

DATED this 26th day of October, 2021

/s/ William Ritchie, M.D.
Dr. William Ritchie
PCF Advisory Board Chair

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 26th day of October, 2021.

Bryan E. Brock, General Counsel
Office of Superintendent of Insurance
P.O. Box 1689, Santa Fe, NM 87504-1689
bryan.brock@state.nm.us

Kathleen J. Love, Vice Chair
PCF Advisory Board
kathy@mcginnlaw.com

Troy Clark, Member
PCF Advisory Board
tclark@nmhsc.com

Karen L Carson MD, Member
PCF Advisory Board
ksaltermd@msn.com

Ezra Spitzer, Member
PCF Advisory Board
Ezra.spitzer@gmail.com
Ezra.spitzer@Nmcan.org

Superintendent Russell Toal
Office of Superintendent of Insurance
P.O. Box 1689, Santa Fe, NM 87504-1689
Russell.toal@state.nm.us

William Ritchie, M.D., Chairman
PCF Advisory Board
ritchiewl@nmortho.net

Mr. Ray M. Vargas II, Member
PCF Advisory Board
ray@vargaslawfirmabq.com

Mike Dekleva, Member
PCF Advisory Board
mdekleva@phs.org

Tanya Rodarte, Member
PCF Advisory Board
TanyaRodarte@gmail.com

Alfonso B. Martinez, Jr., Member
PCF Advisory Board
alfonsomrtnz25@gmail.com

Melissa Y. Gutierrez

MELISSA Y. GUTIERREZ, Law Clerk
Office of Legal Counsel
Office of Superintendent of Insurance