PATIENT COMPENSATION FUND

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

OCTOBER 20, 2021

1:02 P.M.

ZOOM VIDEOCONFERENCE

A P P E A R A N C E S

WILLIAM RITCHIE, CHAIR, PCF, (remote)

KATHLEEN LOVE, VICE CHAIR, PCF, (remote)

RAY VARGAS, MEMBER, PCF (remote)

TROY CLARK, MEMBER, PCF, (remote)

KAREN CARSON, MEMBER, PCF, (remote)

MIKE DEKLEVA, MEMBER, PCF, (remote)

ERZA SPITZER, MEMBER, PCF (remote)

ALBEN MARTINEZ, MEMBER, PCF (remote)

RUSSEL TOAL, SUPERINTENDENT, OSI, (remote)

BEFORE: KIM KAY SHOLLENBARGER, RPR
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I N D E X

CHAIR RITCHIE: Let's get started. This is the 2021 Rate Hearing for the PCF Fund for the rates beginning 2022. People have already submitted their exhibits and I will put these -- I don't know the order they came in, so just as we come across them or as people request.

This is basically a fact finding hearing to discuss the Milliman Study that was begun to evaluate/recommend perhaps the rate setting, as well as there are exhibits and information from the Office of the Superintendent of Insurance with their own evaluation and recommendations and all this information will go to Superintendent Toal, he is the one that makes the final decision on rates. The Committee and Board will give him a recommendation between now and the end of the month. The rates are, by statute, supposed to be set by the end of the month.

To begin, I think we introduce people. The Board is assigned as the Hearing Officer, at least for this hearing. I was going to try to keep things organized and running, and we do want to hear from the people who have submitted a request to speak, or to enter exhibits, and then we will have a time for people to ask additional questions of both people from Milliman as well as the people from the Superintendent's Office. Mr. Toal, he is not going to be testifying, but he will be listening in and his role will be to gather in recommendations and the information people have given in

their testimony before he makes his decision.

To begin, where we start, is with the Milliman Study. I would like to hear both presentation from representatives from Milliman, if they will please identify themselves and their positions and what they do, and then give us a brief synopsis on what Milliman did and what their bottom line recommendations were, please.

VICE CHAIR LOVE: Excuse me, Dr. Ritchie, may I just interject and ask, do you think it would be worthwhile to do a quick roll call to determine on the record who is present and serving as a Hearing Officer today.

CHAIR RITCHIE: I'm sorry, yes, to enter that into the record, thank you. That's why we have attorneys on the Board, to keep us going. Obviously Ms. Love and myself are here. The other Board Members, please speak up and signify that you are present.

MEMBER VARGAS: Hi, this is Ray Vargas. I'm present today.

MEMBER CLARK: Troy Clark, present.

MEMBER DEKLEVA: Mike Dekleva, present.

MEMBER CARSON: Karen Carson, present.

MEMBER MARTINEZ: Alben Martinez, present.

MEMBER SPITZER: Ezra Spitzer, present.

CHAIR RITCHIE: I believe that serves as a quorum and certainly we can act as a Hearing Officer. Thank you

very much for correcting me on that.

Now, representatives from the Milliman Foundation, please identify yourselves and let me know if you have any exhibits to enter and let's get started.

MR. BARAN: Dr. Ritchie, if I may. This is Todd Baran, I am the counsel for the Superintendent of Insurance in his capacity as Custodian of the Patient Compensation Fund.

Traditionally in these rate hearings we work on developing a record through the question and answer format, and my representative from Milliman, Mr. Ashenbrenner, has been prepared to answer questions about his report. But for purposes of developing a record that could serve as a foundation for an appeal and for the Superintendent's review, I would like to request that we proceed with the question and answer format. Of course during that, as part of that format, the Board can ask questions as it feels necessary.

CHAIR RITCHIE: So he has presented -- or Milliman has submitted an Executive Summary. In the past you have not presented that Executive Summary at all, we've just gone straight to the questions and answers?

MR. BARAN: Correct. The Executive Summary was prepared as a demonstrative exhibit to guide the testimony, we will be going through that and hitting the key points of the report and expanding on the analysis underlying the

conclusions in the report using that as a guide.

CHAIR RITCHIE: Thank you very much. This is a very new setup for the PCF, so I appreciate that. That's what happens when you have a surgeon as a Hearing Officer.

Then, please, the questions will come from the Board and then others who have submitted. I will open it up to the Board initially for questions, and I would like to address them first to Milliman, and then to the Office of Superintendent of Insurance to try to maintain some sort of organization, particularly since these are different records.

I will take prerogative and not start. I believe that Ms. Love and Mr. Vargas have questions, certainly as does Ms. Carson. And so, if someone will put up their hand to start with any questions they have.

Ms. Love.

VICE CHAIR LOVE: This is not a question, per say, but I believe that we have someone presenting on behalf of the intervenor, The Doctors Company, today. Is that true?

MR. O'BRIEN: No.

VICE CHAIR LOVE: Since we have an intervenor who is not presenting, do we have an intervenor who intends to do any cross-examination or any questioning or counter-presentations related to the Milliman Report? No.

MEMBER DEKLEVA: Chairman Ritchie, may I make a suggestion?

CHAIR RITCHIE: Yes.

MEMBER DEKLEVA: Typically how this works, and what I saw with regard to the previous rate hearings, is that Mr. Baran, I think, presents evidence into the record through the testimony of Mr. Ashenbrenner using demonstrative aides and exhibits, where appropriate. And as the record is developed, and I think we, as the Hearing Officer or Members, I guess, of the PCF Advisory Board, will get opportunities to ask questions as evidence is developed.

The reason I'm bringing it up, if we just proceed to the questions of the Board, I'm concerned that we don't have an adequate factual record to base a decision on. So respectfully, I would suggest that we proceed kind of as the previous hearings have unfolded where the OSI puts on the evidence and then we do what questioning we deem appropriate as the hearing unfolds, if that makes sense.

CHAIR RITCHIE: Mr. Baran, that seems a little bit counter to what you described earlier.

MR. BARAN: No, I believe that's exactly what I was trying to describe. Thank you for clarifying anything that I might have confused. We do like to present our case essentially and develop the evidentiary record that is required under the procedures act and our rules to support a decision by the Superintendent.

So we generally proceed with the swearing of the

witness, what I will call the direct examination. Since we don't have any other parties there would be no cross, but the Board can ask its questions either at the end or during the --

VICE CHAIR LOVE: We have this flag going up from the court reporter.

(discussion by court reporter)

CHAIR RITCHIE: Thank you. Please do remember to identify yourself before speaking. Mr. Baran, thank you, I did not understand the point you were making initially with me. It sounded like you suggested going straight to question and answer, that's what has been done in the past, but I didn't realize that it starts with you beginning to make the case for the OSI and then we begin with questions and answers. So if that is what has been done in the past, please proceed.

MR. BARAN: Again, the Executive Summary will be the outline of the presentation. And again, questions are welcomed at any point in time during this presentation or at the end. I would ask at this point for the court reporter to swear in the witness. The Superintendent calls Carl Ashenbrenner.

CARL ASHENBRENNER,

(being duly sworn, testified as follows)

DIRECT EXAMINATION

BY MR. BARAN:

Q. Mr. Ashenbrenner, can you please spell your name for the record, first and last.

A. Carl, C-a-r-l. Ashenbrenner, A-s-h-e-n-b-r-e-n-n-e-r.

Q. Thank you. Bear with me one second while I get to your CV. Mr. Ashenbrenner, do you recognize this document that's on the screen?

A. Yes, I do.

Q. What is this?

A. This is my....what we call a Bio. It's just kind of a resume of my experience, work experience, and education.

Q. Let me ask you a couple of questions. What do you do for a living?

A. I'm sorry, I didn't hear that.

Q. What do you do for a living?

A. I'm a consulting actuary with the firm Milliman, Incorporated.

Q. In a nutshell, what does a consulting actuary do at Milliman?

A. They provide actuarial services to various clients all over the world.

Q. What is your educational background relative to your current job duties?

A. I graduated from the University of Wisconsin with a Bachelors Degree in Actuarial Science. I passed the Casualty

Actuarial Society exams, so I have my Fellowship of Casualty Actuarial Society. I'm also a member of the American Academy of Actuaries. I have 25 years experience providing actuarial services for insurance companies and part of that is providing actuarial services for medical professional liability clients.

Q. On your CV it says your area of expertise is ratemaking and loss reserve analysis for property and casualty insurance. What's involved in doing actuarial work in the ratemaking and loss reserve arena for property and casualty insurers?

A. So that basically looks at the amount of -- estimating the amount of losses that, say, an insurance company or a fund pay out for the policies that they have with other parties or with themselves, and then estimating what we call funding or ratemaking estimating, what the cost should be in the subsequent year or years to cover the costs, all the costs of those contracts or those policies.

Q. Is that similar to the work you were asked to do on behalf of the PCF?

A. Yes, that is what I was asked to do, yes.

Q. How does the PCF compare to, let's say, a medical malpractice insurer and how the two try to forecast losses and set rates?

A. There isn't a lot of differences. I would say it's

essentially similar. The underlying word is similar.

Q. Let me step back. What were the requirements for obtaining the MAAA designation?

A. That is a membership. The requirements are that you are a member of an actuarial association in the United States. When I became a Fellow, or actually an Associate, of the Casualty Actuary Society, I was eligible to become a member of the American Academy of Actuaries.

Q. What were the requirements for getting the FCAS designation?

A. For that you need to pass roughly ten exams focused on actuarial information. Similar to the bar exam or other exams.

Q. Do you have to have a certain number of hours of experience before you can qualify to take those exams or get that designation?

A. You can take those exams without any experience, but you do need a recommendation from a member to gain entrance into the society.

Q. How long have you been a Fellow?

A. Since 2000.

Q. And what proportion of your work since becoming an actuary has involved casualty insurance?

A. Most of it. 95 to 99 percent.

Q. What proportion of your work has involved medical

professional liability analysis?

A. Probably, in my history, about one-third. 33 percent maybe.

MR. BARAN: At this point I would like to move this CV into evidence as Exhibit Number A, or letter A.

VICE CHAIR LOVE: Hearing no objections, I think it should be admitted. Is that okay, Dr. Ritchie?

CHAIR RITCHIE: Thank you very much.

MR. BARAN: I don't know if I heard, was it admitted?

CHAIR RITCHIE: Yes, I concur with Ms. Love. She recommended it.

Q. (Mr. Baran) Now I will ask you to look at your report. Do you recognize this document, Mr. Ashenbrenner?

A. I do.

Q. What is this document?

A. This is the report that we submitted to the PCF for the actuarial analysis that we performed.

Q. What was your role in preparation of this report?

A. I directed and was responsible for the entire report.

Q. On Page 4 of the report there's a Scope of Work. Can you explain what this section of the report communicates?

A. This section describes what was performed in the report. This follows the description provided by the PCF of what we were engaged to do for the report.

Q. Down at Item Number 4, 5, 6, 7, 8, 9 and 10, did you perform the work reflected in the report concerning those items?

A. Yes, I did.

Q. Does your training and experience as a property and casualty actuary enable you to do each of those items?

A. Yes, it does.

MR. BARAN: At this time I would like to offer Mr. Ashenbrenner as a qualified actuarial expert on the subjects summarized in 4 through 10 of his report, and offer expert testimony concerning those items.

CHAIR RITCHIE: Is there any objection?

VICE CHAIR LOVE: I just have a couple of questions, if I may, of Mr. Ashenbrenner about this topic. You were asked questions about how a PCF compares to a medical malpractice carrier and you said that they are essentially similar. Could you tell us in what ways they are different.

MR. ASHENBRENNER: Probably the largest difference is, they don't compete, per say, with another PCF. I know New Mexico is different than some of the other ones. Some of them are mandatory. That's one of the issues. The other one is the rates are -- they don't have as much -- like the primaries can have -- primary insurance can have what's called a debit or credit based on certain judgments by the underwriters, and the PCF doesn't have that in their rating

mechanism, mostly because it's a judgment call or a type of -- I would say it's a judgment call. Those are two biggest differences. The insurance companies have to have a certain amount of solvency. They're regulated by the states. They also need to maintain a certain amount of solvency to operate in that state.

VICE CHAIR LOVE: Have you done actuarial analyses of Patient Compensation Funds or similar funds in other states?

MR. ASHENBRENNER: I personally haven't performed PCF studies. Our firm here has. We have done work in my office here.

VICE CHAIR LOVE: The information that you have to gather in order to do an artuarial study for a Patient Compensation Fund, is that the same as what you would do as a private insurance company?

MR. ASHENBRENNER: Yes.

VICE CHAIR LOVE: I don't have any objection, Dr. Ritchie, to this witness being admitted as an expert.

MEMBER VARGAS: I have a couple of follow-up questions. Mr. Ashenbrenner, you mentioned that one of the differences is that the primary insurer has to maintain a certain level of solvency. Is that something that's referred to the industry as maintaining adequate claims reserves?

MR. ASHENBRENNER: No. It's maintaining solvency

like a surplus.

MEMBER VARGAS: Original insurer would have reserves adequate to cover the claims and then a surplus on top of that, correct?

MR. ASHENBRENNER: That's correct, yes.

MEMBER VARGAS: And the required surplus varies from state, as I understand it, but also affects the rates that are charged of its customers; isn't that correct?

MR. ASHENBRENNER: Yes, so there's a -- basically there's a formula that most states follow. I think all the states follow, from the National Association of Insurance Commissioners that, I don't want to say sets that amount, but it's the -- obviously the really small company doesn't need as much money as a really large company, so that's kind of what the difference is there.

MEMBER VARGAS: And because the PCF is not required to have that surplus that's not factored into your evaluation; is that correct?

MR. ASHENBRENNER: Yes.

MEMBER VARGAS: Those are all the questions I have, thank you.

MEMBER DEKLEVA: Mike Dekleva, I don't have any questions of the witness, but I concur with Ms. Love in having no objection to this witness testifying as an expert.

CHAIR RITCHIE: Are there any more comments from the

Board regarding the witness's ability to testify?

MEMBER CLARK: This is Troy Clark. I have no objections.

MEMBER CARSON: Karen Carson. No objections.

MEMBER SPITZER: Erza Spitzer. No objections.

CHAIR RITCHIE: Hearing no objections, then Mr. Ashenbrenner is admitted to testify. Mr. Baran, do you have any more questions to help develop your case, questions of Mr. Ashenbrenner, before the Board begins their questions?

MR. BARAN: Yes. We are now going to move through the Executive Summary. Before I get to that I would like to move to have the report, the Milliman Report, admitted as Exhibit B.

MEMBER DEKLEVA: This is Mike Dekleva. I have no objection.

CHAIR RITCHIE: Are there any objections?

MEMBER CLARK: Troy Clark. No objection.

CHAIR RITCHIE: Very well. Please enter it, and proceed.

MR. BARAN: Thank you.

Q. (Mr. Baran) Do you recognize the document that is now on the screen, Mr. Ashenbrenner?

A. I do.

Q. What is this?

A. This is a presentation. It's essentially a summary of

the report that is easier to follow than the report for this hearing today.

Q. Did you prepare this document?

A. Yes, I did, with help from my staff.

Q. On page 2 is the Outline of the Presentation. So you will be testifying about each of those bullet point items?

A. Yes.

Q. Starting with the Selection of Ultimate Loss by Accident Year.

A. Yes.

Q. Let's jump to that. What does that mean, Selection of Ultimate Loss by Accident Year?

A. Generally in an actuarial study you need to estimate what the ultimate losses are by a year by some type of time period and in this we need accident year. So that's kind of the first step of the actuarial process, is organize and gather the data and then perform actuarial indications and analysis on the numbers to select the ultimate loss by accident year.

Q. Is this a forecast or a projection of what the PCF can expect to pay out in the future on a year-by year basis?

A. Yes. For all of the occurrences the PCF would be responsible for prior to December 31st, 2020.

Q. You list on this slide, page 4, different actuarial methods. Without getting into details of what those methods

are, what is the function of these methods? What is the purpose of employing these methods?

A. These are, as I mentioned, generally-accepted actuarial indications. Most of our analyses use these methods or at least several of these methods depending on the type of data you have. Each one of them estimates the ultimate loss by accident year. We would say they were indication of the ultimate loss by accident year.

Q. Did you or people working under your direction use each of these methods to determine or project ultimate losses by accident year?

A. Yes.

Q. You didn't just rely on one of these?

A. No.

Q. Going to page 5, what does this chart depict?

A. The purpose of this chart is to show the actual indication of the actuarial methods for the last five accident years for the ultimate number of occurrences for physicians and surgeons. And then our selection is the light blue column, or bar there. And the reason why we put this together was to show the Board what we are looking at when we select these numbers.

Q. What is reflected on the vertical axis, exactly?

A. Those will be the number of occurrences paid by the PCF. The ultimate number of occurrences paid by the PCF.

Q. This isn't the number of malpractice claims that are filed in New Mexico for those years, is it?

A. No, it's not.

Q. It's not even a reflection of the number that's going to be handled by the PCF, correct?

A. It's a number that would be paid by the PCF. Yeah, number that would ultimately be paid by the PCF.

Q. And this is for P&S, physicians and surgeons?

A. Yes, sir.

Q. Do you have another chart showing occurrences for hospitals?

A. I do.

Q. In generating this chart was it important to have a concept of what an occurrence would be?

A. Yes.

Q. What was the concept that was used in the modeling?

A. The PCF provided what I will call a claims list that was by occurrence and by claims. If there was more than one defendant there would be more than one claim in the occurrence. We relied on that document to estimate the number of occurrences.

Q. You said the light blue was your selection. How did Milliman select the number of occurrences?

A. There's actuarial judgment involved with this. So you take the pros and cons of each indication, each method, and

you select your ultimate based on that. There's not, per say, a mathematical formula used. It's more, what's better or worse in selecting that. As you can see most of them are somewhat in the average of the indications.

Q. We are now on slide 5. What is this chart depicting?

A. This shows the indications for the ultimate loss by accident year for physicians and surgeons and the indications. Now, some of the indications don't have numbers in earlier years, so we don't -- there's not necessarily an indication from each method in each accident year, so that's why some of those are blank.

Q. What is reflected in the vertical axis?

A. That would be the ultimate loss paid by the PCF, ultimately paid for each accident year. So for all of the occurrences within that accident year that the PCF pays out.

Q. Do these numbers reflect actual payments or do they include both actual and projected payments?

A. Actual and projected, yes.

Q. How did you project what the payments would be?

A. We know what the paid is when we did the analysis. The projection is based on, as you mentioned, the ultimate loss indications.

CHAIR RITCHIE: Mr. Ashenbrenner, the statute says that you are supposed to be provided with data going back eight years from the hospital certainly, and data from the

individual physicians and surgeons would be available that far back, but your graph only goes back approximately four years. Did you request more data, was it not available? Certainly even going back three or four years you began to develop for that.

MR. ASHENBRENNER: Sorry. This is just an example. We projected loss. There's an exhibit in the back of the presentation that showed the rest of the years. I didn't want to put 15 years of data on here because it would be hard to see. It's more of, we're trying to show how this was done rather than show every single point of data on here. Does that make sense?

CHAIR RITCHIE: Thank you.

Q. (Mr. Baran) Looking at slide 7, is this the number of occurrences you're projecting will be paid by the PCF on behalf of hospitals?

A. Yes, sir.

Q. And the methodology for deriving those projections was the same as what you used for projecting physicians and surgeons?

A. Yes.

Q. Slide 8, is this ultimate loss that you are projecting will be paid by the PCF on behalf of hospitals in each of those accident years?

A. Yes.

Q. Again, you used the same methodology for these projections as you used for physicians and surgeons?

A. Yes.

Q. Now that we have the projections for occurrences and projections for ultimate losses, what is the next step in the process of trying to determine surcharges?

A. As we saw before, those are the accident year 2020 and prior, so we need to estimate what the losses would be for accident year 2022, so all the occurrences that happened in 2022 that are covered by the PCF in 2022. It could be an incident happens in 2022 and it may not be reported for two years, reported as in a claim, so there is a significant lag in that. But this is to estimate all the occurrences in 2022.

Q. This slide says Calculation of Estimated Surcharge Rate Change. Why surcharge rate change?

A. In our analysis, and this is common in actuarial rate changes, you look at what the prior rates are and then you estimate how much the rates change from those amounts rather than building them up by scratch. Essentially it's the same issue, but it's easier. That's the way that most rate filings are done for state insurance departments, they say the rate change is X percent.

Q. How did you project the losses that will be paid by the PCF for the 2022 coverage year?

A. If we can go down to the next slide. As I mentioned, we have to estimate for 2022, so we know that there's inflation in the world and in the United States and in New Mexico and that inflation we estimate to be four percent per year based on the history of the PCF data. We need to estimate the number of occurrences divided by the surcharge, what we call the frequency, and then the ultimate severity of each occurrence, so that would be the ultimate loss divided by the number of occurrences. The next chart shows those selections. Then we review the ultimate ratio based on those selections. So we're essentially selecting the frequency and severity and then reviewing the loss ratio to see how it looks based on the other ones. I think the prior actuary selects the ultimate loss ration. We did it a little bit different.

Q. You're selecting frequency and severity for events that may not have occurred and certainly haven't been reported, correct?

A. Definitely haven't occurred yet because it would start January 1st, 2022.

Q. What is the foundation for making those projections?

A. For those projections, again the ultimate losses per accident year is the seed of the starting point for that.

Q. How does the data from 2020 that we saw earlier impact the projection of what's going to transpire in 2022?

A. We would use that to select our number of occurrences and the severity of those occurrences in a 2022 year basis.

Q. Are there certain assumptions underlying those projections with respect to participation, provider participation configuration in the fund, the types of claims that can be asserted, the value of claims? What assumptions might underlie those projections?

A. For this purpose we assumed participation in the fund would stay the same and there wouldn't be any differences in the types of claims from the history.

Q. I will call this stuff that's above the line added additional PCF cost. The projections are really based on what you identified as the frequency and severity up to 2020?

A. Yes, that's true.

Q. There's no projection of increased frequency or increased severity underlying your analysis?

A. Not at this point. Since the PCF attachment changed we did make an adjustment for that, but that was on the second step there.

Q. Looking at the chart on page 11, what does this depict?

A. This is what we call the Trended On-Level Loss Ratio, and then the selection you can see in green. Trended on-level means, again, the losses were brought to a 2022 level from an inflationary standpoint. The surcharges were also adjusted to the surcharge amounts as of 2021.

Q. What is the loss ratio?

A. I'm sorry, the loss ratio is total losses paid out by the PCF divided by total surcharges collected by the PCF in those accident years. Again, this is on an accident year basis.

Q. What does it mean that in 2020 the loss ratio is above 100 percent?

A. That means we expect there will be more losses paid out ultimately than what the surcharge is collected.

Q. What does it mean that in 2011 it's above 200 percent?

A. Again, that means more than twice as much losses were paid out than surcharges were collected.

Q. Is the data from 2011 based on projections or mostly on actual payouts?

A. 2011 would be all payouts, I believe. Actually all paid out. The vast majority of it would be paid out by now.

Q. That's not a projected loss ratio from 2011, that's pretty close to an actual loss ratio?

A. That is correct.

CHAIR RITCHIE: Mr. Ashenbrenner, what you're saying then is with one year selected in the past few years, that the PCF has been taking in slightly more than they have been paying out in losses.

MR. ASHENBRENNER: You have to look at the 100 percent, not the red bar. They haven't paid out the losses

yet for the most recent years. We expect them to pay out more than what the surcharges were.

CHAIR RITCHIE: That's based on the 100 percent we're supposed to be looking at for that?

MR. ASHENBRENNER: Yes.

CHAIR RITCHIE: Tell me again, what is the red bar representing?

MR. ASHENBRENNER: That's just a weighted average of all those blue bars. So all the losses summed up -- leveled losses divided by all the surcharges.

CHAIR RITCHIE: So over a period of time we're actually a little bit below the losses, on average.

MR. ASHENBRENNER: Yes. The surcharges collected, yes, were lower than what we expect to pay on on the losses.

CHAIR RITCHIE: Thank you.

Q. (Mr. Baran) I'm hearing an answer to a different question, Mr. Ashenbrenner. As I look at this chart, it shows that the weighted average loss ratio is above 100 percent, so on a weighted average over this period of time the PCF paid out more than it collected. Is that a fair reading of this chart?

A. These are all estimated ultimate losses. We would estimate that the PCF will pay out more than the surcharges collected, yes.

CHAIR RITCHIE: Excuse me once again. In 2011, 2010

and 2007 when there's these much higher payouts, do we have an answer on what caused those?

MR. ASHENBRENNER: There just was more claims. These do not include the batch claims, which were separated from this analysis. Significantly more claims in those years.

CHAIR RITCHIE: And do not represent the batch claims.

MR. ASHENBRENNER: Do not.

CHAIR RITCHIE: Okay.

MEMBER CLARK: Mr. Chair, this is Troy Clark, I've got a question or two.

CHAIR RITCHIE: Please.

MEMBER CLARK: To be clear, the amounts shown by each bar represent the actual amount paid out, plus the projected amount to still pay out. And as you referred to a question earlier, I believe it was on calendar year 2011, the further back we go in time the higher proportion of that would have been actually paid, lower portion to be projected. And as we get to the right-hand side of the graph of 2020 it is mostly projection and very little actual. Is that a fair depiction?

MR. ASHENBRENNER: Yes, that's correct.

MEMBER CLARK: The second question is, this is simply presenting a ratio of expenditures or payouts or

projected payouts compared to surcharges collected, but is not adjusted in any way in the total amount of surcharges, so there is also volatility in the total size of what those surcharges collected were, so a two percent deviation in 2009 could be very different than a two percent deviation in 2018?

MR. ASHENBRENNER: Yes. So this is relative to each year.

MEMBER CLARK: No further questions at this time.

CHAIR RITCHIE: Go ahead.

Q. (Mr. Baran) This is for physicians and surgeons only, correct?

A. Yes.

Q. Now jumping to slide 12, what is depicted on that graph?

A. This is selecting what we call on-level frequency, which is the ultimate number of occurrences divided by the surcharge at current rate level. Re-rate all the policies in, say, 2010 at the 2021 rates or surcharge levels, the number of occurrences divided by that.

Q. How does this help you determine the required rate change or the recommended rate change?

A. This is a piece to the puzzle. The more number of occurrences is, the higher the rate change, is the simple answer.

Q. This also is for physicians and surgeons only?

A. Yes.

Q. Going to the chart on page 13, what is this depicting?

A. This is depicting the ultimate severity per number of occurrences. You take the ultimate losses by accident year and divide it by the ultimate number of occurrences in each accident year and you bring that up to 2022 for inflation. So you increase the amount, as I mentioned, four percent a year based on inflation.

Q. What is the number on the vertical axis telling us?

A. That would be the average occurrence -- I'm sorry, the average severity, which is the -- the average cost to the PCF for each occurrence. Now, there's a lot of volatility in that number for each occurrence that the PCF pays out. So this is the average of that amount.

Q. So now we're on page 14.

MEMBER CLARK: Mr. Chair and Mr. Baran, may I interject with one more question.

CHAIR RITCHIE: Go ahead.

MEMBER CLARK: This is Troy Clark. Again, just making sure we're consistent with previous graphs that you had noted. Do these numbers exclude any claims and payouts related to the batch claims?

MR. ASHENBRENNER: They are all excluded.

MEMBER CLARK: Thank you.

MEMBER VARGAS: Mr. Chair, this is Ray Vargas, I

have one quick question.

CHAIR RITCHIE: Please.

MEMBER VARGAS: The data is for physicians and surgeons only, but do we know or were we able to determine whether any of those physicians and surgeons were employed by hospitals during these time frames that you looked at?

MR. ASHENBRENNER: Yes. This is a different discussion. This includes the employed physicians and their claims.

MEMBER VARGAS: Thank you.

MEMBER CLARK: Mr. Chair, this is Troy again. I have a question just to clarify.

CHAIR RITCHIE: Yes, please.

MEMBER CLARK: So these claims noted as P&S, physicians and surgeons, are inclusive of both employed and independent.

MR. ASHENBRENNER: That is correct.

MEMBER CLARK: Thank you.

VICE CHAIR LOVE: Chairman Ritchie, this is Kathy Love, one other question so I understand the chart. The numbers on -- I'm looking at the projected loss costs, the numbers there, are these total payouts or are they Patient Compensation Fund liabilities? In other words, this does not include the $200,000 of threshold insurance.

MR. ASHENBRENNER: No, this is only the amount the

PCF is expected to pay out.

VICE CHAIR LOVE: Thank you.

Q. (Mr. Baran) I want to follow up on Mr. Clark's question. Why have you included both employed and independent physicians and surgeons in your calculation of the surcharge rate change requirements for 2022?

A. The data provided to me for this analysis did not separate the surcharges by employed physicians and surgeons for this report that I performed. I have subsequently estimated how to allocate this -- a few days ago I received a file that had -- from the PCF, that had the surcharges split between employed and independent physicians. Since it was subsequent to my report I was not able to use it in my report.

Q. So I'm jumping ahead a little bit here, because we haven't gotten to the recommended hospital surcharge changes. How are the physician rates going to impact the amount the hospitals pay under the rating plan?

A. They wouldn't impact what the hospitals are paying.

Q. I read you report to say that the hospitals are going to be charged for the amount calculated under the rating plan and then the additional amount for each employed provider. Did I read that wrong?

A. I'm sorry, the hospitals, effective 2022, will need to -- the same as they do now, pay for each employed physician,

surgeon, under the PCF using the rates that we're providing.

Q. Given --

A. Similar to how it's done now.

Q. Given those circumstances, does that have some bearing on why in the calculation of the physician and surgeon charges you did not break out the employed physicians and surgeons?

A. Yes, that's true.

Q. How so?

A. We didn't split the -- as I mentioned, we didn't have the surcharges split between those two different groups when we performed the analysis.

CHAIR RITCHIE: Mr. Ashenbrenner, then you are assuming the same risk liability for employed physicians as independent physicians, it just depends on who is paying the bill, but the PCF component surcharge will be the same whether they're employed or independent?

MR. ASHENBRENNER: That is correct.

Q. (Mr. Baran) Do you believe that's a reasonable assumption?

A. I do.

Q. Why do you believe that's a reasonable process and assumption?

A. I believe that a doctor, regardless of their employment, would have the same risk if they perform the same

services.

MEMBER VARGAS: This is Ray Vargas. I would like to ask some clarification on that. Mr. Ashenbrenner, did you in your study or your consideration of assumptions consider whether the claims experience of a hospital-employed physician might differ from the claims experience of an independent physician?

MR. ASHENBRENNER: I considered that. The PCF would not have enough data to support separating that between the two.

MEMBER VARGAS: What data would be required to have that? And the reason I ask, is that antidotally in my practice I have observed, and whether this is supported by evidence or not, that the claims frequency and severity tends to be higher in hospital-employed settings. What data would we need to get to test that?

MR. ASHENBRENNER: Well, there's also the hospital having to pay the claim as well, that's another issue, is when claims are paid on behalf of the hospital, they don't separate it whether the hospital paid it or whether the employed physician paid it. It's usually paid on behalf of them.

MEMBER VARGAS: I saw there was an assumption of 50/50, right?

MR. ASHENBRENNER: Yes.

MEMBER VARGAS: If we had, for example, just put employed physicians in with the hospital and did not treat them separately, could we then more accurately assess the claims experience of hospital-employed physicians?

MR. ASHENBRENNER: There's very little independent data from the PCF that would support it.

MEMBER VARGAS: What data could we ask for to learn that?

MR. ASHENBRENNER: Again, the issue is that the hospitals, when a hospital pays a claim they don't essentially allocate it between the employed physicians and the hospital.

MEMBER VARGAS: What I'm getting at is, how can we figure out if, on a whole, hospital-employed physicians have a different claims experience from independent physicians? And by claims experience, I mean can we determine whether they have a hire frequency of claims and/or a higher severity of claims.

MR. ASHENBRENNER: Again, the hospital's data, loss data, is combined. You almost have to push the hospital into a separate, and the employed physicians, in a separate category so then you don't have the issue of trying to allocate claims between employed physicians and the hospital.

MEMBER VARGAS: How do we do that going forward when under the new Act we have included all hospital employees as

potential qualified healthcare providers, and not just the physicians?

MR. ASHENBRENNER: What I understand, that would be covered under the hospital coverage.

MEMBER VARGAS: So going forward we're going to include the hospital payout as any employee that's not a physician, is that your understanding?

MR. ASHENBRENNER: I'm not sure I understand the question. If the hospital is covered by the PCF they would be covered by that. If it was on behalf of one of their -- it's what the PCF would pay out on behalf of the hospital or the contract the hospital has.

MEMBER VARGAS: What do you mean by contract? Contract with who?

MR. ASHENBRENNER: I'm sorry, with the PCF or the underlying insurance provider.

MEMBER VARGAS: And I guess my concern with this is, we have now added entire categories of employees, including parent corporations subsidiaries, into the definition of hospital and I want to make sure that we are accurately attributing those claim losses to hospitals versus individual physicians, and I'm wondering how can we do that? How can we be accurate instead of just creating these categories and saying, "yeah, a surgeon is a surgeon, a primary care doctor is a primary care doctor," it doesn't matter where they work

when, in fact, it may matter.

MR. ASHENBRENNER: As I mentioned, there's few losses in the PCF from hospitals that have physicians associated with those. As I mentioned, we did receive early this week the surcharges by employed physicians, so we could recommend splitting, now that we have that information, there's still a few issues with the information that I would question. I would recommend them splitting that out in between hospitals and independent physicians, especially since the PCF would be -- especially since the hospital's in it, would no longer be in the PCF after five years.

MEMBER VARGAS: Is that something that you can do relatively easily with your existing formulas or algorithms?

MR. ASHENBRENNER: Well, I'm not that confident in the surcharge amount, there's a question in a few years. One year was negative, so it didn't make any sense. And one year didn't look like it was accurate, but I wasn't -- you know what I mean. I only saw the aggregate number, so I have no way of knowing...it wouldn't impact the overall recommended changes.

MEMBER VARGAS: It might give us different numbers, though, right?

MR. ASHENBRENNER: Potentially, yes.

MEMBER VARGAS: Going back to my earlier question, if you, let's say, threw out those two outliers that you

mentioned, could you plug those numbers into your algorithm or formulas and calculate the different numbers that we would potentially see?

MR. ASHENBRENNER: Yes.

MEMBER VARGAS: Those are all the questions I have. Thank you.

MEMBER CLARK: Mr. Chair, this is Troy, I've got questions.

CHAIR RITCHIE: Okay.

MEMBER CLARK: To clarify, the data that you were missing was surcharge, not loss ratios, but it was the surcharges broken out by provider or by hospital; is that correct?

MR. ASHENBRENNER: That is correct, yes.

MEMBER CLARK: One other question, just to clarify. On page 8 of your actual report, not the presentation, there is a sentence that says, "for this allocation, we are assuming employed providers were charged 50 percent of the hospital surcharges," but there's on additional phrase, "prior to 2016." Is that 50/50 allocation only applied to prior to 2016?

MR. ASHENBRENNER: Yes.

MEMBER CLARK: Thank you. No further questions.

VICE CHAIR LOVE: Chairman Ritchie, this is Kathy Love, may I ask a question.

CHAIR RITCHIE: Please.

VICE CHAIR LOVE: I want to be clear about the data that you were looking at when you were determining the future loss expectation. As I understand it, you looked at prior years of PCF data; is that correct?

MR. ASHENBRENNER: Yes.

VICE CHAIR LOVE: Did you take into account -- we know that CHRISTUS St. Vincent entered the PCF in 2009. If we look at the payouts on behalf of hospitals between 2009 and 2016 when other hospitals joined the PCF, it looks like for the first couple of years there were no payouts on behalf of CHRISTUS St. Vincent, and then in 2013 there was a payout of 280,000, and then after that there was a million, and then back down to 790 and 350 in 2016, for a total of two million seven ninety-five on behalf of CHRISTUS which, again, entered the PCF in 2009, which suggests that what we know antidotally is true, which is, it takes a while for a hospital's claims to mature. Once they've entered into the fund it takes a while for those claims to be mature; in other words, to be filed and to be evaluated so that the PCF can determine whether or not -- what to allocate for that case. So I would like to know, when you're looking back and relying on these past years of data for the hospitals, did you take into account that you only had data going back to 2016, which is the first year that the 14 other hospitals started getting

involved in the Patient Compensation Fund? And did you evaluate what impact that has on your projections going forward for what the losses are going to be for the hospitals?

MR. ASHENBRENNER: Yes, that definitely is what we looked at. I don't know where your numbers came from, but I'm not sure what I have for the hospitals in those years.

VICE CHAIR LOVE: Well, just for CHRISTUS St. Vincent.

MR. ASHENBRENNER: There may be something -- there may be a different one or more, because I believe we have more paid losses, than what you mentioned, in those years. So, yes, we know there's a small amount of hospitals in the fund. It was our understanding actuarial firms performed analyses on behalf of the hospitals to set the PCF surcharges in 2019 and 2020 as well, and Milliman did that, I wasn't involved in it. There's also an expectation that those were done and also provided estimation of losses that we considered, that those were done on behalf of those hospitals.

VICE CHAIR LOVE: If that was done on behalf of hospitals that didn't start entering the Fund until 2016, then we've only got, at best, 2017, '18, '19 and '20 of data to look at for lost history. And we know that it takes sometimes four to five years for a hospital claim to mature.

So my question is, was there any other data that you considered in evaluating the risks the hospital presents? And then secondly, what information needs to be evaluated going forward so that we can make sure that the rates are properly set?

MR. ASHENBRENNER: We were provided hospital loss runs that were in the PCF as of in 2020, and we looked through the data, summarized it, and determined we couldn't use it directly in our analysis because the losses weren't stated at the PCF level. In other words, they didn't have the benefit of limits in those claims. We believe the actual PCF experience is more reliable than those claims data. But you're correct; in that, the last four years is when most of the hospitals started current little paid data to support the overall rates from that, but that's why we also took the assumption that the surcharges were set at an adequate level based on the actuarial studies that were performed.

VICE CHAIR LOVE: And we don't have in front of us, in this hearing as evidence, any information about what was taken into account when those actuarial studies were done, do we?

MR. ASHENBRENNER: No.

VICE CHAIR LOVE: That's an assumption that's being made?

MR. ASHENBRENNER: Yes.

VICE CHAIR LOVE: Would you tell us, please, what information you did gather. You said there was some information that was gathered from the hospitals about losses that you decided that you weren't able to use that because it didn't transfer properly into the Patient Compensation Fund experience. What data did you receive from the hospitals, and also I'd like to know, was it consistent among all of the hospitals?

MR. ASHENBRENNER: I received the data from the PCF. This data was made consistent, I would say, by someone in the PCF, as good as they could. Again, the issue isn't -- most of the data isn't underneath the umbrella or the limits of the PCF. And the other issue I had was, I couldn't match claims. So I thought I could go in there and say, "okay, here's a PCF claim from hospital X, and here it is on the data run," I couldn't find them. I didn't know what to do at that point either. It seemed like they were missing.

VICE CHAIR LOVE: Did you, though, have in front of me for each of the hospitals the number of claims that had been made against them for a period of at least eight years, as well as the payouts that they had made on those claims?

MR. ASHENBRENNER: Yes.

VICE CHAIR LOVE: Is there any way you could have just extrapolated that had they been in the fund they would have paid the cap?

MR. ASHENBRENNER: No, it's not that easy, because the medical is unlimited in the Fund, that's the biggest issue. That's what we started to do until we realized that the medical is unlimited and there's really no way to estimate. We thought there would be too much vol -- well, you'd have to make a lot of assumptions to estimate. And I'm not saying you can't do it, but you'd have to start making a lot of assumptions as to what would be considered medical and what would be considered non-medical. There's also the issue of, when there's a limit the plaintiff attorneys know what limit is and when they settle they know what those limits are, so that's a factor. If there's not a limit, they would try to get more, obviously from different sources if they could. But once there's a limit, they know that limit exists and that -- in other words, that influences the decisions. It influences the settlements.

VICE CHAIR LOVE: If you were to be in a position where you had to advise the Patient Compensation Fund about what information you need to do a fair and thorough assessment, a risk assessment, on the hospitals, what information would you ask the hospitals to provide to you? I want you to assume that you can have whatever information you want, what information would you ask for?

MR. ASHENBRENNER: You would ask for the claims listing and you would also ask for the exposures for those

hospitals, historical, that somewhat match the same years as what the claims would, so the same exposures that the PCF uses. We've done in this other places and it's a very time-consuming exercising to even estimate for each individual claim, what the difference in medical and non-medical damages that they would associate, because a lot of claims are just simply settled and they don't differentiate that in the settlement necessarily.

VICE CHAIR LOVE: It would be more accurate, though, wouldn't it? Even though it's time consuming.

MR. ASHENBRENNER: If they could do it, yes, it would be more accurate, yes. We have done studies for insurance companies, either did a sample of them or went through a lot of them and we made assumptions from that, so it's possible, yes.

VICE CHAIR LOVE: Thank you. That's all I have for now.

MEMBER CLARK: Mr. Chair, this is Troy, just a couple of questions.

CHAIR RITCHIE: Yes.

MEMBER CLARK: Mr. Ashenbrenner, is it accurate to say -- I just want to clarify my understanding here. The claims that you -- the data that you received from the hospitals that you excluded, you excluded it because the situation that they were in, not being subject to a cap at

that time prior to 2016, changed or would have a different outcome potentially if they were under the cap. So you said it's not relevant, it would skew the data one way or the other, but it would not be inappropriate use of historical data to project the future.

MR. ASHENBRENNER: That's somewhat accurate. You also have to try to get the best of the most credible actuarial data that you can. Yes, I would say that's fairly accurate, yes.

MEMBER CLARK: And then one further question. On the date that you did receive, you talk about having to make assumptions in the allocation between hospital and physician, and absent a third party making a decision on that, it would be arbitrary to have the hospital make that allocation between how much is related to the physician and how much related is to the hospital. Or conversely, it would be arbitrary for the physician to make that allocation between the two, you really need something independent to have happened back in time when the settlement or adjudication occurred.

MR. ASHENBRENNER: Yes, I would agree, yes.

MEMBER CLARK: Thank you. No further questions at this time.

MR. BARAN: If I can proceed, if there are no more questions from the Board.

CHAIR RITCHIE: Please, go ahead.

Q. (Mr. Baran) Circling back to where we broke off, my question concerned the reasonableness of including both the hospital-employed and the independent physician and surgeons in the rating calculation, basically putting them in the same bucket. You received some questions from Mr. Vargas about whether there was a way to determine whether there's a different risk associated with employed physicians either in terms of frequency or magnitude, and I want to see if we can piece that out a little bit. I will refer you to Exhibit 2, page 67 of Exhibit E. Give me a second to get that up here. I'm going to ask you some questions about this exhibit. On the far left there's a column that has the heading ISO code. What is that?

A. ISO is a rating bureau that provides services for the insurance industry and they -- you see the next column, specialty. They group specialties into various codes. For each type of physician and surgeon they have a separate code for that.

Q. If you look six columns for the right there's a column headed MedPro Relativity. What is MedPro?

A. MedPro is a medical protective insurance company. I think they're the second largest physician and surgeon writer in the State of New Mexico. They are also a countrywide medical professional liability insurer.

Q. How did you access information on the MedPro Relativity?

A. That would be found in their publicly available rate filing.

Q. So in the MedPro publicly available rate filing, MedPro, the second largest medical malpractice issuer is using the ISO codes to determine base rates?

A. Medical protective has their own rating plan, but based on that I would assume they are using the ISO codes to differentiate them. So, yes.

Q. If you look at the specialty associated with codes you will see some specialties that encompass providers that can practice independently or in the hospital; isn't that correct?

A. Yes.

Q. For example, psychiatry and radiology, those could be both in a hospital or outside of a hospital, correct?

A. Yes.

Q. And numerous ones on there can practice independently or in a hospital, correct?

A. Yes.

Q. Are there separate ISO codes, to your knowledge, for those types of practices that say that there should be different ratings or relativities depending on whether that provider is practicing in a hospital as opposed to

independently?

A. They do not have that. They do split -- usually the biggest category is surgery. The first one is minor surgery, and somewhere down the line there's one that has major surgery. There's differences between the care they provide.

Q. At least with respect to something like psychiatry, ISO didn't view the exposures as sufficiently differentiated to have a psychiatry in-hospital code versus psychiatry out-of-hospital code, correct?

A. Yes, they don't differentiate between those.

Q. Does that support your conclusion that it was reasonable to put all of the providers, whether hospital-employed versus independent, into a common pool for purposes of determining the relativities, risks, frequency and magnitude?

A. Yes.

Q. Thank you.

CHAIR RITCHIE: I have a follow-up on this. With the changes in the in-patient only list by CMS, et cetera, there are surgeries that are considered major that are certainly being done outpatient. I don't see where MedPro takes that into account. I don't know that what you're asking, Mr. Baran, is irrelative from a clinical point of view. It's a rating point of view whether you do surgery or not, but it doesn't have any bearing on whether you're at the

hospital or not or employed or not.

MR. BARAN: My question to the witness earlier was whether he felt it was reasonable to include both hospital-employed providers and independent providers in the calculation of the surcharges applicable to providers. The point that this exhibit seems to make is that where a risk is differentiated, such as obstetrical surgery, there is a separate rating code for that enhanced risk. But where the risk is not differentiated such as for psychiatry, there is no separate ISO code for hospital-employed psychiatrists. I believe the witness testified that it supported his conclusion that it's reasonable to include everybody in a common pool, because the ISO codes make the differentiations where there are higher risks or higher frequency claims, such as for surgery.

CHAIR RITCHIE: I think the point is, there's no differentiation, again, between surgery being associated with the hospital necessarily or surgery being associated with being employed at a hospital or not.

MR. BARAN: Correct, the risk is the nature of the practice, not the practice location, according to these ISO codes.

CHAIR RITCHIE: I don't think that it says that. I think that that's an assumption.

Q. (Mr. Baran) Mr. Ashenbrenner, what is your

understanding of how these specialty codes are used in the industry to differentiate risks?

A. We have how they're used here, how they differentiate. I mean, there's issues with, as you mentioned, provided physicians and then physicians with privileges in hospitals as well, so there could be that as well. There's not two separate ones that -- the independent physician never enters a hospital, but there's -- this is the way the industry does it and this is the assumptions that they make.

Q. Are the assumptions that you made consistent with the industry practices?

A. Yes, sorry, that is what I was trying to say.

Q. Okay.

MEMBER CARSON: Dr. Ritchie, can I ask a quick question of Mr. Ashenbrenner.

CHAIR RITCHIE: Please.

MEMBER CARSON: Mr. Ashenbrenner, I'm Dr. Carson and I am a pediatrician who performs surgeries. Do I work in a hospital, am I employed, or am I a private practitioner?

MR. ASHENBRENNER: I believe you're an independent provider unless you're employed by a hospital.

MEMBER CARSON: So what you're telling me is you really can't make that distinction based on that chart that says I'm a pediatrician that performs surgery.

MR. ASHENBRENNER: Yes, that's what I'm saying.

MEMBER CARSON: So your assumption when you look at all of these numbers is that perhaps these physicians that perform surgery or -- and I think this is what Dr. Ritchie was getting at, may actually be independent physicians or they may be employed physicians, but employed by the hospital where their medical malpractice payments are made by the hospital not by them personally, and so you can't get those differentiations based on this list; is that correct?

MR. ASHENBRENNER: Yes.

MEMBER CARSON: Thank you.

CHAIR RITCHIE: Go ahead, Mr. Baran.

Q. (Mr. Baran) Going back to your presentation, we're looking at page 14. Can you walk us through what is behind each of these numbers and how that impacts your determination of the indicated surcharge level change for physicians and surgeons.

A. This is what the change to the surcharge level effective 2022 is from the current rate, so from the 2021 rates. We have what is called a projected loss ratio, so that includes what we looked at previously, is what the ultimate losses would be divided by the current surcharges, but that also includes a load for claim handling expense and on-going medical expense that the PCF needs to pay. We added those two amounts to that and they were about two or three percent each.

Q. Let me make sure I understand that. If the surcharges remain the same at 2020 levels for 2021 based on your projected liabilities of the PCF associated with those claims, the PCF would be paying out 116 cents for every dollar?

A. Yes.

Q. What is line 2?

MEMBER CLARK: One clarification question, Mr. Chair. 2020 rates for 2021, aren't we talking about projected rates for 2022? If we collected the 2020 rates, or 2021 rates I should say against 2022 expected losses, or am I off?

MR. ASHENBRENNER: It would be the 2021 rates.

MEMBER CLARK: Against the 2022 expected losses.

MR. ASHENBRENNER: Yes.

MEMBER CLARK: Just make sure we got the record correct.

Q. (Mr. Baran) What is the discount factor to reflect anticipated investment income account for?

A. The surcharges would be collected in 2022, but the losses wouldn't be paid out until subsequent years generally. We assess that they can earn investment income on those funds held until they pay out the claims, and that was again using the PCF information, I believe. The investment return was three-and-a-half percent based on historical amounts. So

that's an offset because there's investment income falling into the PCF.

Q. Is line 3 an adjustment to the loss ratio to account for that?

A. Yes, that would be one multiplied by two.

Q. Again, assuming no changes in the 2021 rates for the 2022 plan year, then the PCF would be collecting -- or paying out 98 cents for every dollar it collects in surcharges?

A. Yes, if you offset it with the investment income. Loss minus investment income, yes.

Q. What is line 4?

A. HB75 changed both the attachment point and the limits of the PCF for a non-medical damages. It increased from 200,000 per occurrence to 250,0000 per occurrence, and the limit increased by $100,000. We built a statistical model to estimate what that impact would be. We estimated it would cost eight percent more due to that change.

Q. Line 5.

A. Line 5 would be the projected 2022 surcharge at currency level at the 2021 surcharges. This was provided by the PCF to essentially all the participants in the PCF multiplied by their surcharge times the ten percent corporation charge and everything. That's the total amount from 2022.

Q. And line 6.

A. Line 6 would just be, essentially, three times four times five, so that would be the projected discounted losses for 2022. That, again, would be the ultimate losses in accident year 2022, subtract the anticipated investment income.

Q. Line 7.

A. Line 7 is, again the PCF has to pay some office expenses, and that was provided by the PCF the last five or six years. I think HB75 has a PCF management company, I'm not sure that's the correct term, but they're anticipating that cost will increase because of the payment that they will have to make for the management company of the PCF. I believe it hasn't been awarded, so we don't know what that cost is. We attempted to provide a provision for that amount here.

Q. Where did you get five percent as a number for that?

A. We looked at the historical amount and we looked at rate filings in New Mexico and made a selection based on that. Again, once that number is known, say in 2023, it could be replaced by that number, but we don't know what that actual amount is at this point.

Q. What is the 8?

A. As mentioned before, the batch claims, which were excluded from our previous analysis, the PCF started buying insurance to cover those claims. It's my --

(Zoom feed for Mr. Ashenbrenner lost)

MEMBER CLARK: Did he lose connection or is it just me?

CHAIR RITCHIE: We lost connection with the witness.

MEMBER VARGAS: I think Mr. Ashenbrenner lost his connection.

CHAIR RITCHIE: Right.

MR. ASHENBRENNER: I just got word that I lost my network. Can you hear me now?

Q. (Mr. Baran) You were explaining the batch claim load line item.

A. It's my understanding that PCF purchasing batch claims and we also looked at what those claims would be based on the amount paid and we estimated that to be five percent.

CHAIR RITCHIE: Mr. Ashenbrenner, what is your understanding of what batch claims represented?

MR. ASHENBRENNER: There was, I believe, two or three, we call them systemic claims in the industry that were paid out from the PCF based on one or two physicians, I don't know the specific details, that were somewhat unique. And typically when that happens in an actuarial analysis you don't necessarily include those in your study, but you include a load for that. For example, like hurricane losses in Florida, you would not say in the last three years we didn't have any hurricanes, we don't have to pay for

hurricanes, but you can have a hurricane hit at some point. Basically it's to smooth out the cost of those systemic claims. Insurance companies have been buying systemic claims, it's kind of a cost to offset these unique issues.

VICE CHAIR LOVE: This is Kathy Love. What is your definition of a systemic claim or a batch claim? How many claims does one individual doctor have to have to qualify as batch claim?

MR. ASHENBRENNER: That would be dependent on the actual insurance contract, not just talking about industry level. Depending on how they want to structure it, would be dependent on that. It would be multiple occurrences of a similar event. It might be a medical device, it may be a prescription for -- some type of prescription. In the PCF history there were two or three of them and they were fairly obvious because it was under one or two physicians and there were several of them, 15 or 20 claims under each of them.

VICE CHAIR LOVE: In other words, for it to be a systemic claim or a batch claim it has to have a nexus in terms of what the allegations of the malpractice were?

MR. ASHENBRENNER: Yes, exactly.

VICE CHAIR LOVE: The only two batch claims that were excluded from the analysis, from the numbers that you provided, were Bryant and Klonis; is that right?

MR. ASHENBRENNER: I believe that was the name. I

don't want to be on the record that those were the names, but I believe so.

VICE CHAIR LOVE: Okay.

MR. ASHENBRENNER: There was about $20.1 million paid out from the PCF on behalf of the batch claims. And those are excluded. The PCF didn't provide those in the claim listing that we had, but rather a summary of those, that's why I don't know all the details of them.

CHAIR RITCHIE: Mr. Ashenbrenner, are you aware that the way that the Act, the Malpractice Act is written, that independent physicians are allowed three occurrences per year, hospitals have no limit to the number of occurrences per year. These batch claims were more than three occurrences, although may have been spread over several years, but still when you take -- start doing your studies, do you take that into account that physicians losses should be, by statute anyway, confined to three occurrences per year and hospitals unlimited occurrences per year?

MR. ASHENBRENNER: We didn't take that -- so again, the five percent load, we didn't specifically take that into account when selecting that five percent load.

CHAIR RITCHIE: Do you feel like it might make a difference if you did take that into account?

MR. ASHENBRENNER: I guess I'm not sure when that change was made, was that in HB75?

CHAIR RITCHIE: No, that's actually been the whole time. In fact, represents even going back to when CHRISTUS St. Vincent came in in 2009 or whatever, that has been the way it's been adjudicated.

MR. ASHENBRENNER: But there's still three occurrences that could compensable from the PCF.

CHAIR RITCHIE: For independent physicians, but unlimited for hospitals and presumably for employed physicians.

MR. ASHENBRENNER: We didn't make an adjustment for that. I was unaware of that.

MEMBER CLARK: Mr. Chair, just to clarify. That distinction would have been a limitation of three occurrences for physicians as rated up until the new recent change of HB75; is that correct? Where the employed physician is now coupled with the hospital.

CHAIR RITCHIE: I believe so, but I'm going to have to defer to Ms. Love or one of the attorneys that have argued that before the Court.

VICE CHAIR LOVE: This is Kathy Love. I think Dr. Ritchie's statement is accurate and that is, the law has always provided a limited of three occurrences for physicians, but unlimited occurrences for hospitals and that, to my knowledge, did not change in HB75.

MEMBER CLARK: That was my understanding. Thank

you.

MR. BARAN: I would like to try and clear this one up.

Q. (Mr. Baran) Line item number 8, Mr. Ashenbrenner, my understanding is that is the cost of the reinsurance coverage, not an estimation of what payments would be on batch claims, correct?

A. Yes, that's what it's based on. There's the other assumption is if they can't get reinsurance, they should still have some cost associated with those claims.

Q. But this one is based on the historical practice of purchasing batch claims insurance.

A. That's correct.

Q. What is line item 9?

A. Line item 9, we recommended some class plan recommendations, just a few. And we don't need to go through these. But essentially lowered the relativity for certain specialties based on comparing Medical Protective Company and The Doctors Company relativities in New Mexico with what the PCF currently was having. Since we lowered those we need to offset that by increasing the overall rates by 1.8 percent. Some physicians will have a lower surcharge based on that.

Q. And line item 10.

A. Line item 10 just shows what we call income requirements. That's a break-even point if the participation

in the PCF stayed the same from 2020 to 2022 based on the cost level at 2022. So the cost at 2022.

Q. Line 11.

A. Line 11 is ten divided by five minus one, so that's the amount that the 2021 surcharge needs to be increased in order to capture the $25 million requirements there based on a consistent PCF participation.

Q. Let's talk about that a little bit. If I'm understanding your testimony, the $25 million projected income requirements assumes that the PCF participation in 2022 will be the same as in 2021, correct?

A. Yes, as in 2020, because we don't -- when we were doing this analysis we don't have the full roster of 2021. In other words, somebody can leave the state and then get pro-rata out. Everything was done as of 2020, yes.

Q. That's why I was confused a little bit earlier. So obviously the participation in the PCF can vary year to year, correct?

A. Yes, that is correct.

Q. If there is an increased participation level with the projected income requirements then line 10 remain the same or would that possibly increase?

A. It would increase pro-rata based on how many physicians left or came in.

Q. What is the relationship between that $25 million and

the surcharges that are ultimately going to be assessed to a specific provider, what is the relationship between those?

A. Again, if we look at all the head counts of the PCF and the different relativities, class relativities, you would basically add those all up and divide it by that amount.

Q. Let's get to that slide. Now we're looking at slide number 16, what is reflected this?

A. The first column is the class, so the PCF class. Each specialty is assigned a class. Based on those calculations for the 19.3 percent is multiplied by the 2021 PCF surcharge charge for each class and that's the 2022 PCF surcharge.

Q. What is the Entity 51, 52, 53 in reference to?

A. Those are entities like a corporation owned by a physician that is also insured by the PCF, be included under the PCF. This is very similar to the primary insurance companies. It would also list their entity, if they have one, a physician.

Q. What is the ten percent?

A. Ten percent would be ten percent of the physician surcharge. They're charged a hundred dollars they would get an extra $10 to charge that.

Q. What is the foundation for the ten percent number?

A. I looked at some primary insurance companies rate filings in New Mexico and they were using ten percent. It's somewhat in the industry is kind of what they're using, ten

percent. I didn't do a separate analysis on that.

Q. It's your recommendation to the Superintendent that the surcharges reflected in column 2 be assessed for each member in each of the classes represented in column 1, the 2022 PCF plan year?

A. Yes.

Q. That ten percent of the aggregate surcharge for each, for the providers in each practice group be assessed for the entity coverage?

A. That's correct.

CHAIR RITCHIE: Mr. Ashenbrenner.

MR. ASHENBRENNER: Yes.

CHAIR RITCHIE: Can you just take me through one line and I'll pick one I'm familiar with. So in class number 9, what you're saying is that the 2022 PCF surcharge you recommend is $32,192. That if you are an independent surgeon who is in that class, then the fund assessment would be an additional $17,255.

MR. ASHENBRENNER: Yes.

CHAIR RITCHIE: If you're an employed surgeon, additional assessment for the fund deficit is only $1,592.

MR. ASHENBRENNER: That's correct.

CHAIR RITCHIE: What are you basing that greater than 90 percent, if my math is correct, difference between independent and employed surgeons on?

MR. BARAN: If I may, Dr. Ritchie. We're going to be getting into considerable detail on how the deficit was allocated. I don't know if we want to jump to that now and then circle back to this or -- it is our plan to answer that precise question.

CHAIR RITCHIE: That's fine. It's just an opportunity to see in it black and white laid out here. We certainly can get to it later, but I think that's a big part of the meat of this hearing as well.

MR. BARAN: Right. I'm going to move very quickly, now that we've seen the methodology, through the hospital base surcharges, how those were determined, and then get into the deficit discussion.

Q. (Mr. Baran) I want to ask a couple of quick questions about the base surcharges. Can you at this point, Mr. Ashenbrenner, explain the confidence level concept, and then which confidence level you employed to determine the surcharges in column 2.

A. The confidence level would be basically the probability that the ultimate losses are greater or lesser than the surcharge amount. If it was 50/50 obviously we have 50 percent chance higher, 50 percent chance lower. We do our analysis, we call it an actuarial central estimate, what we call the mean value, which is approximately the 50 percent confidence level. Those are what the 2020 base rates base

surcharges are based on in actuarial central estimate. You can think about it as a 50 percent confidence level. We also were asked to provide changes at different confidence levels and we provided those in our report.

Q. Showing you Exhibit A2, which is page 37 of your report. Are those the other indications that you testified you were asked to provide?

A. Yes.

Q. What does it mean to a risk-bearing entity such as the PCF to assess surcharges at a central confidence level as opposed to, say, a 70 percent confidence level?

A. Typically, as we discussed before, an insurance company or a self-insured trust would have a surplus to offset the volatility of the results of their insurance. Typically when you would start a trust or an insurance company you would either collect a surplus or you would charge at a greater confidence level so that you would have a surplus to offset the volatility of that. Over time you would adjust that based on how the actual results turned out and how long you want to have that set at, if that makes any sense.

Q. If a risk-bearing entity such as PCF wanted to minimize the potential for a future deficit, what should they do?

A. If they wanted to lower it they would fund at a higher level, at a higher confidence level.

Q. I should have said, what if they want to prevent the

possibility or prevent a deficit from occurring, would your recommendation be to set surcharges at the central level or at a higher confidence level?

A. It would be at a higher confidence level.

Q. So setting rates at the central confidence level presents a risk of deficit accumulation?

A. That's true.

Q. Based on this chart, if the PCF wanted to set rates at those higher confidence level, these would be the percentage increases that would be indicated by your analysis?

A. That's correct.

Q. Page 17, we looked at this earlier as page 67. Correct?

A. Yes, these are different exhibits, but it's the same layout. It's ISO code by class and then the 2022 surcharges.

Q. I'm going to jump to the hospital surcharge setting analysis, page 24 of your summary. It appears to go through the same processes that you went through for setting physician and surgeon rates. Is there any differences?

A. The only differences, we were projecting, if you see, row 3 is the rate change from 2020 to 2021. The premium was at 2020 level, so that's a minor change there, because they did have a rate increase of 300 percent so that was an adjustment there. But the largest differences were recommending removing the experience rating plan and that

will have an impact to the rates. I can discuss that if you want.

Q. I think your report covers why you recommend removing the experience rating plan in great detail and I don't want to cover that here, but I would like to have a synopsis of that's causing a 12.3 percent decrease in the hospital rates for 2022.

A. If you could go to the next slide. In 2020 the impact of the experience rating plan, the $3.2 million reduction in hospital surcharges overall. I believe each hospital that qualified for the ERP had a reduction in surcharge. If we removed it in 2020 you would obviously collect $3.2 million in 202, so you don't need to collect that $3.2 million again. I hope that makes sense. You're taking away a discount, an overall discount, so we don't need to charge for that here.

Q. So what I'm hearing is that if the ERP had not been in existence in the past, the 2020 collections would have been $3.2 million higher, correct?

A. That's correct.

Q. And you're using the 2020 rates as the baseline for the percentage increase, correct, for 2022 or are you using 2021?

A. We did analysis as 2020 premiums, but then we adjusted to get to 2021.

Q. You're looking to 2022 as a percentage increase over 2021, correct?

A. Yes.

Q. So if we eliminate the ERP, the 2021 rates would have been essentially 12.3 percent higher, or at least the surcharges would have been 12.3?

A. Yes, the overall collected surcharges would have been $3.2 million higher, yes.

Q. So the percentage increase does not need to be as great for the hospitals as it does for the individual providers, because the individual providers did not have this discount built into their 2020 rate, correct?

A. Yes. If we go forward with this the hospitals will still have an 18 percent increase, I believe.

Q. Let me go back.

A. If that's the right number.

Q. So all things being equal, the hospitals are at 18.1 percent at the central confidence level versus the 19.3 for the providers?

A. Yes.

Q. And it's only because of the elimination of the rating plan factor that your recommended increase is only 3.6 percent at the central confidence level?

A. That's correct. And I do put a statement down there that if the experience plan isn't removed, this is in the next slide, if it's decided to not remove it, then you must remove that adjustment for the surcharges. You can't

continue with ERP and reduce the rates because we removed it, if that makes sense.

Q. So if they continue with the ERP, it's 18.1?

A. Yes.

Q. Again, this is at the central confidence level?

A. Yes.

Q. And your report included different percentage increases at the different confidence levels, correct?

A. Yes.

Q. Just for the record, that's Exhibit E2 on page 45?

A. That's correct.

Q. One last thing on the surcharge analysis, and that's the newly eligible participants. You also determined surcharges for potential new entrants, correct?

A. That's correct.

Q. How did you do that?

A. The new eligible providers are nurses, certain specialties and nurses. We looked at four different rate filings in New Mexico, looked at their relativity based on the family practice, no surgery, and then made a selection based on those four different relativities, and then we recommend to use that same relativity for the PCF.

Q. And those recommendations are captured in your summary?

A. I don't believe they're on here, unfortunately.

Q. Where did you put those?

A. They would be --

Q. Oh, on page 16 of your summary.

A. One of the specialties, certified nurse midwife, would be a class 3.

Q. To close it out, page 26 is the recommended rates for the 2022 hospital rating plan, correct?

A. Yes, interchange rates and surcharges, yes. Recommended surcharges, if the experience rating plan is eliminated.

Q. In addition to what would be owed using this hospital rating plan, the surcharge or rate that would be generated using this, the hospital, I believe you testified earlier, would pay the additional amount allocable to each type of provider it employs, or each provider it employes?

A. Yes, that's correct.

Q. Let's shift focus to the deficit. Now, on page 28 of your summary, what is this reflecting and how does this help you determine who is responsible for what portion of the deficit?

A. As I mentioned before, we calculated the ultimate losses by accident year, as we discussed before. Here it shows from 2006 and subsequent. We assume that all the losses prior to 2006 have been paid so there's no need to have a liability for those accident years. You can see the ultimate, selected ultimate and the paid, and then

subtraction gives you the unpaid. Look at column 10 at the bottom, $182 million of unpaid losses as of December 31st, 2020. The PCF is also responsible for ongoing medical payments for certain claims that have already occurred that they're paying, we estimated that amount to be three percent, so they need to put away money for that as well. That was determined to be 5.5 million. The overall unpaid amount is 187 million.

Q. That's line 13?

A. That's correct.

Q. Line 14.

A. Line 14 is the estimated fund balance as of December 31st, 2020, that was provided by the PCF. The 120 million. To calculate the deficit, simply subtract 13 from 14, and that's $66.8 million.

Q. If at the end of 2021 the PCF ceased operations, or ceased allowing new participation and claims from 2020 on would be within the MMA or the PCF, the total amount that would be owed that could not be funded is $66.8 million?

A. Yes, that's the difference. There would also be investment income earned by the Fund, but also probably expenses paid out by the Fund. If you put any into run-off there's usual what's called run-off, and costs associated with that as well.

MEMBER CLARK: Mr. Chair, one question. Is the

$66.8 million number undiscounted?

MR. ASHENBRENNER: Yes, that's what I was trying to say, yes.

MEMBER CLARK: Theoretically, if it was closed out by everybody simultaneously settling, normal process of settling would discount any future cash flows brought to current year dollars, so shouldn't that be a discounted number to really reflect what the dollar in today's dollars would be?

MR. ASHENBRENNER: This is the way that we calculated the Fund deficit. When we calculate how to recover that we have the estimated investment income in that amount. I'm not sure that answered your question.

MEMBER CLARK: So you didn't discount it because you're assuming the repayment or the making the Fund whole is going to be paid out of both current and future dollars, not just all out of today's dollars. If we were to look at it, like I said, simultaneously settle everything today, you would discount that. Everybody would take a net present value of future dollars. What you're saying is, you use this as the way to correct the deficit and that correction is going to take place out of current and future dollars so you don't discount it.

MR. ASHENBRENNER: Yes.

Q. (Mr. Baran) So that tells us the amount that the PCF is

in deficit. You also determined how that should be recouped moving forward over the next five years and how that should be -- what portion of that was attributable to the hospitals, correct?

A. Yes.

Q. Let's talk about how you determined the hospital share of the deficit, let's focus on that first.

A. Okay. As I mentioned before, and again this was before we were provided the employed-physician surcharges. We estimated, and we were actually fairly close to what the numbers given by the PCF were. But if we can just move on from there. So we --

Q. Well, let's stay there for one second. In order to determine the hospital share of the deficit did you endeavor to determine how much of that deficit was allocable to employed physicians and surgeons?

A. Yes, so we included -- so under our definition of hospitals is the employed physicians as well.

Q. Okay.

CHAIR RITCHIE: So allocated the employed physicians as 50 percent of the total for hospitals?

MR. ASHENBRENNER: Yes.

Q. (Mr. Baran) Now, after you did that estimation did you learn or was other information available to help estimate the percentage allocable to employed physicians and surgeons?

A. Yes.

Q. What did you learn subsequently?

A. I was provided a file the beginning of this week that had, from the PCF, that had what they believed were the employed physicians surcharges based on underlying primary insurance carrier, I believe.

Q. Was there a difference between your 50/50 split and what was determined to be an appropriate split using that alternative data?

A. There was a difference. I would say it wasn't significant.

Q. Do you believe that the methodology that uses the newly available information has more actuarial value than your methodology?

A. Good question. There was two years that I'm still hesitant about, one of them is 2014 and one of them is 2019. Actually, when I looked at that I estimated what 2019 would be, so we're still estimating what those numbers would be for 2019. 2014 didn't look like it was accurate to me, but I don't have any way right now of saying.

Q. If you use the new data and information were you able to determine what the impact on your overall conclusions would be?

A. If we use those numbers specifically that was provided by the PCF and number that I estimated for 2019, it lowered

the independent physician and surgeon surcharge and that caused a deficit for the independent physicians to increase by about a million dollars.

Q. We would take a million out of the deficit that your report currently allocates to hospitals and move that to the bucket for the independent physicians and surgeons?

A. Yes, that would be correct.

CHAIR RITCHIE: Mr. Ashenbrenner, excuse me. Was one of the assumptions made for this that the number of employed physicians remains stable throughout this time period?

MR. ASHENBRENNER: Yes.

CHAIR RITCHIE: If the number of employed physicians were going up every year and then a contrary decrease in the number of independent physicians each year, would that change your numbers here and your recommendations?

MR. ASHENBRENNER: We estimated that the independent physicians number had changed from 2016 to 2020, and then the hospital surcharge was just a difference of that number. There would be an impact, but I believe it would be minor.

CHAIR RITCHIE: Are you sure of that? What data would you need to be more accurate in that statement?

MR. ASHENBRENNER: Well, we were provided a surcharge, the employed physician surcharge, and we did our analysis and it didn't significantly change the outcome.

CHAIR RITCHIE: Were you provided the independent physician surcharges per year?

MR. ASHENBRENNER: Yes, they were split between the two.

CHAIR RITCHIE: Did you see a decline in the independent physician surcharges or did they remain stable or did they go up?

MR. ASHENBRENNER: I believe they went down.

CHAIR RITCHIE: Did you attribute that to a decline in the number of independent physicians?

MR. ASHENBRENNER: Yes.

CHAIR RITCHIE: Thank you.

Q. (Mr. Baran) If I understand, your methodology didn't necessarily rely on head counts, it relied on the split in the surcharges?

A. Yes.

Q. But at the end of the day it was relatively consistent with the numbers that were generated through actual head counts as provided by the PCF?

A. As actual surcharges provided.

Q. Which would be a product of head counts times the rates?

A. Yes.

Q. We are now on page 31.

MR. BARAN: Before we move into this, Chair, would

it be possible to take ten minutes?

CHAIR RITCHIE: I think we've been at this long enough, I believe a ten minute break would be reasonable. We will come back at 3:40, I believe.

(Recess at 3:28 p.m. to 3:40 p.m.)

CHAIR RITCHIE: Welcome back, everyone. It is 1540. Mr. Baran, I see you're back. Please get the show back on the road.

Q. (Mr. Baran) Mr. Ashenbrenner, moving on from the split. Going to slide 31, tell us what the analysis is here and what it shows. How you created it and what it reflects.

A. As I mentioned previously, the analysis was done by the combined physician and surgeon basis. The purpose of this exhibit was to split the surcharge between employed physicians and independent physicians.

Q. What were your conclusions as to what that split should be and why?

A. Well, we didn't have information when we performed this, but we essentially looked at how much the physician and surcharge changed when the hospitals, when the majority of the hospitals were brought in, and kind of assumed that the increase in that amount was due to those. That's how we selected the 50 percent of the hospital surcharge for that.

Q. Did you draw some conclusion about the extent of the deficit attributable to the hospitals independent of what

would be caused by the employed physicians and surgeons?

A. Yes, we have that, yes.

Q. Why is that in your summary?

A. Just for the hospital separately?

Q. Correct.

A. I don't believe we have that, let me look. I don't have that in this packet.

Q. On this one, though, the combined -- this is showing the surcharge differentials and how did those surcharge differentials impact your analysis?

A. These were what we used to calculate the deficit between the hospitals and the physicians.

CHAIR RITCHIE: I have a question. Excuse me for interrupting. When you looked at the hospital deficit, or hospital liabilities, did you take into account, since they have not previously been covered, the midlevels, the nurse practitioners, the PAs, the other categories that are now going to be covered, were present in the past, but were not specifically named and covered? And did you also take into account the increase in use of midlevels for hospitals over times particularly as number of physicians have declined?

MR. ASHENBRENNER: We didn't specifically take that into account, but my understanding is that a lot of those providers don't have separate insurance policies, so the hospital pays on behalf all of the members, so it would be

included in the historical data.

CHAIR RITCHIE: For the hospital, but not under independent physicians or reported to the PCF. Certainly in the past, before hospitals came under the PCF.

MR. ASHENBRENNER: I'm sorry, I don't understand your question.

CHAIR RITCHIE: I just was curious, those entities were there, they would be paid out under the hospital and not named, particularly before the hospitals fell under the PCF in those years of data provided prior to when the hospitals came into the PCF.

MR. ASHENBRENNER: Yes.

CHAIR RITCHIE: Thank you.

Q. (Mr. Baran) So jumping to slide 33, can you walk us through your analysis that's reflected in this exhibit and what conclusions you were able to draw from that analysis.

A. This is how we derive the PCF deficit between independent physicians and hospitals. And what we did here was look at the ultimate losses by accident year and subtracted the surcharge collected in that year and then calculated the deficit in that year, which is column 3. You can see in accident year 2007 the ultimate losses were 19.1 and these include the additional batch claims and the independent physicians, subtract the PCF surcharge of 8.8 million that was collected, so the deficit was $10.3 million

there, and then we cumulated that for each accident year on the bottom there.

Q. So the cumulative deficit is column 4?

A. Yes, for independent physicians and surgeons, yes.

Q. How much of the deficit accumulated before CHRISTUS entered the fund in 2009?

A. It would be about 19 million.

Q. How much of the deficit accumulated before the other hospitals joined the Fund?

A. In 2016, about 35 million.

CHAIR RITCHIE: Excuse me. And how much could you attribute that since you include the batch claims, could you break it out, though? How much of that was the batch claim before CHRISTUS came in and how much were batch claims after CHRISTUS came in?

MR. ASHENBRENNER: So the batch claims in total were 20 million. CHRISTUS came in in 2009, so subsequent to 2009 the batch claims were about five-and-a-half million. So about 15 million.

CHAIR RITCHIE: In total between the two before and after?

MR. ASHENBRENNER: So there's 15 million batch claims paid in accident years prior to 2009, and about five million paid after 2009. Accident year.

CHAIR RITCHIE: So 15 million of the 19 million

deficit in 2009, or 20 million deficit in 2009, 15 million of that was for batch claims?

MR. ASHENBRENNER: 2009 and prior, yes.

CHAIR RITCHIE: Thank you.

Q. (Mr. Baran) Walking through the bottom line, you determined the ultimate loss attributable to independent physicians and surgeons, and that's the methodology, that same methodology for determining that ultimate loss that you used for determining the ultimate loss for the surcharge calculations, correct?

A. Yes.

Q. And then you aggregated in the second column the total amount of surcharges that were paid by independent physicians and surgeons, or on behalf of, during that period of time?

A. Yes.

Q. So column 3 is 2 minus 1 and column 4 is 3 plus 4. So why are 3 and 4 the same?

A. Three would just be the individual accident year deficit number and four is the cumulative number. The cumulative amount.

Q. And then you went through the same methodology for hospitals?

A. Including employed physicians, yes.

CHAIR RITCHIE: Excuse me again, Mr. Ashenbrenner. How did you -- please run through it again, how you came up

with the numbers? I'm sorry, let me rephrase that. How can you be sure that none of the claims attributed to independent physicians are not attributable to employed physicians? How sure are you that they were actually independent and not employed, did you have the data to make that call accurately?

MR. ASHENBRENNER: We did that based on the claims listing. If a hospital was named as a defendant, any other physician would be included in that, as an employed physician. If there was a physician that was listed separately without the hospital, we assumed that they were independent physicians.

CHAIR RITCHIE: So it would be possible for someone to name an employed physician without naming the hospital and they would be counted as an independent physician even if they were employed?

MR. ASHENBRENNER: It's possible. Typically the hospital would be named as well in the lawsuit because they are their employer. They were doing it underneath the hospital. I don't want to speculate, but I don't think that that would be -- it might get missed in the claims listing, but I would doubt that. Plaintiffs attorneys name everybody they can in any suit, so I would be shocked if they didn't the name hospital if they were provided by the hospital.

CHAIR RITCHIE: Thank you.

MEMBER CLARK: I have a question. This is Karen

Carson. I'm trying to figure out, why did you estimate the ultimate losses? You included the batch claims and then you took out the batch claims. What I see, there's about -- when I look at those two numbers, 250 million minus 205, so we end up with 40 million that are just batch claims in that final amount, and that's all attributed to the independent physicians, not to the hospitals. Why was it done in that way? Why did you include and then take those out?

MR. ASHENBRENNER: The batch claims are about 20 million. Overall, 21 million paid out.

MEMBER CARSON: On the exhibit that I have on page 31, the final report that included the allocation, that included the batch claims, the ultimate was 250,113,483, and then when you -- the next page, it looks like those were taken out and we ended up with 205 million. I was trying to figure that out. It looks like the batch claims were taken out at that point.

MR. BARAN: Can I try to help?

MEMBER CARSON: Please.

Q. (Mr. Baran) Mr. Ashenbrenner, is it correct that you removed the batch claims for purposes of calculating surcharges?

A. Yes.

Q. Is it correct that you included the batch claims for purposes of allocating the deficit?

A. Yes.

Q. Why did you exclude batch claims for purposes of calculating surcharges, but include them for purposes of allocating deficit?

MR. BARAN: Does that help, Dr. Carson?

MEMBER CARSON: Yes.

MR. BARAN: Okay.

MR. ASHENBRENNER: As I explained before, the batch claims were somewhat unique, so we took those out. The other reason is, the PCF was purchasing reinsurance for those, so we could use a cost of that rather than trying to estimate what the cost for those would be. So we just simply used what the cost would be of the reinsurance in the surcharge rate. We don't want to double count those anywhere. But when we get to the deficit, if we're looking for what caused a deficit, obviously the $20 million paid out was a major cause of the deficit. So that's why we included it there.

CHAIR RITCHIE: As a continuation to that, if you pay the extra five percent for reinsurance would that not cover the batch losses and so they shouldn't increase the deficit or would that not have prevented them from being part of the deficit if there had been reinsurance?

MR. ASHENBRENNER: If they were paying reinsurance, yes, but they would have had to pay for that somehow. So even the surcharges would have had to be increased to pay

that reinsurance.

Q. (Mr. Baran) I'm going to try help again. My understanding is that the reinsurance was not put in place until after the payouts of the batch claims. Given those facts, Mr. Ashenbrenner, does that change or support your prior testimony?

A. That's accurate. Yes, it doesn't change my...

Q. There was no reinsurance in place to pay the batch claims that contributed to the deficit, is that your understanding?

A. Yes.

CHAIR RITCHIE: To continue on, then is it Milliman's recommendation then to adding that five percent to the surcharge, that reinsurance be purchased or maintained in the future for this reason?

MR. ASHENBRENNER: I'm not going to make a recommendation because the price of the reinsurance could change. I don't know what it is. I don't want to make a recommendation on what the PCF should do with the reinsurance. That's between the PCF and the broker, I think.

CHAIR RITCHIE: For a price, but would you recommend there be some sort of reinsurance?

MR. ASHENBRENNER: Again, you've got to pay to it and evaluate whether it's worth it or not.

CHAIR RITCHIE: Thank you.

VICE CHAIR LOVE: May I ask a question, Chairman.

CHAIR RITCHIE: Yes.

VICE CHAIR LOVE: This is Kathy Love. Mr. Ashenbrenner, am I correct that you started looking at the deficit numbers beginning in 2010, since in 2009 the PCF had $2 million surplus?

MR. ASHENBRENNER: Where do you see that, I'm sorry? Are you talking about calendar year?

VICE CHAIR LOVE: Well, my understanding is, at the end of 2009 there was a $2 million surplus in the PCF and then the deficit sort of began increasing. Am I correct that you looked at settlements claims going back to -- through 2010?

MR. ASHENBRENNER: Todd, do you mind going back to the report on page 30, just so everybody can look at what Kathy is talking about.

MR. BARAN: Okay, hold on one second.

MR. ASHENBRENNER: Otherwise, I think it will be confusing going back and forth.

MR. BARAN: Am I showing you the right thing?

MR. ASHENBRENNER: Yes. If you look at column 8, you see $2 million there. I don't know where that number came from, other than it was provided by the PCF, how it was estimated. So it looks like at the end of 2009 it was believed to be a $2 million surplus from the PCF, and then

again in 2011 there was a small deficit of a million dollars, so that was in 2011. Those years wouldn't have been paid out. I don't know when the batch claims are notified, but eventually there was some notification and they were ultimately paid out in 2015. So you can see when they increased the deficit from the 2 million to 39 million in 2015. So you're asking why do we start when we started, is because --

VICE CHAIR LOVE: Well, I'm asking first, when did you start?

MR. ASHENBRENNER: Well, we started in 2006, I believe, was the first year that we looked at. And the reason why we did it that way was because there was no prior deficit to that, or surplus. It was essentially flat. It was either a million or two million either way. In other words, there wasn't a large surplus or a deficit prior to those years, and that's when we determined to look at that.

VICE CHAIR LOVE: So essentially you're looking at each year, all of the payouts from the Fund for each different year from 2006 through 2020.

MR. ASHENBRENNER: Yes.

VICE CHAIR LOVE: For each of those years you looked at the settlement payouts -- well, settlement payouts were made on behalf of doctors, particularly before 2009 when CHRISTUS St. Vincent was in the Fund, it was pretty easy

calculation. A settlement was paid out on behalf of a doctor, so that went into the independent doctor bucket. Is that fair to say?

MR. ASHENBRENNER: Yes.

VICE CHAIR LOVE: For 2006 through 2010, if I'm correct, there weren't any payouts on behalf of CHRISTUS St. Vincent in that year, all settlements went into the independent doctor bucket for your analysis about the deficit; is that right?

MR. ASHENBRENNER: Yes, I believe so.

VICE CHAIR LOVE: And then after the hospitals came into the Fund, CHRISTUS in 2009 and the others started coming in in 2016, after that when there was a settlement, if there was a settlement where there was a hospital and a doctor that was sued, you have taken that amount of money and you have put half of that settlement into the employed doctor bucket and half of that settlement into the hospital bucket; is that right?

MR. ASHENBRENNER: Yes, that's correct.

VICE CHAIR LOVE: Okay.

MEMBER CARSON: This is Karen Carson. I just have a quick question following along with that. Were the batch claims also put half and half or were they all included in the physician and surgeon buckets?

MR. ASHENBRENNER: They are all included in

surgeons. It's my understanding that those were independent physicians.

VICE CHAIR LOVE: Mr. Ashenbrenner, for cases where an employed doctor was sued, but the hospital wasn't participating in the Patient Compensation Fund, the employed doctor's settlement went into the independent doctor bucket.

MR. ASHENBRENNER: I don't believe that employed physicians were in the PCF at that point. I don't know that as a factual basis.

VICE CHAIR LOVE: So if there was a physician who was a qualified healthcare provider under the Act, but the hospital wasn't included in the Fund, and that physician was sued, then that physician's settlement would go into the independent doctor bucket because the hospitals weren't even in it yet.

MR. ASHENBRENNER: I don't want to not answer your question, but I'm not sure that I can answer that question. I don't believe that employed physicians were included in the PCF, other than certain hospitals in the past.

VICE CHAIR LOVE: So your assumption is that if a physician was employed by a hospital that they would not have been a qualified healthcare provider under the Act?

MR. ASHENBRENNER: I can't answer that, I don't know that.

VICE CHAIR LOVE: Let's say there is an employed

physician before the hospitals were in the Fund. If you have an employed physician who did qualify as a healthcare provider and there was a settlement payout by the Patient Compensation Fund on behalf of that doctor, that would have gone into the independent doctor bucket; is that right?

MR. ASHENBRENNER: If they were included in the PCF and employed, that would be true.

VICE CHAIR LOVE: Okay.

MR. ASHENBRENNER: But I don't believe that they were.

CHAIR RITCHIE: As a follow along to that, I think where Ms. Love was going to, is one of those batch claims that was included under this PCF with a very large payout was responsible for a lot of that batch money. The hospital was sued as well, but they did not fall under the Act. So their liability, while not incurring deficit to the PCF, would it not have been included in the rate setting for the future for hospitals, in the data that was used to set the rates in the future for the hospitals?

MR. ASHENBRENNER: It could be. I didn't do that work, so I don't know if that was included or excluded or what hospital it was.

MEMBER CLARK: Mr. Chair, let me ask a question, because I thought he answered differently earlier that clarified that. Did you include in your rate settings, so

not the deficit, in the rating setting, a similar percentage, and the slide is not up here in front of me, for hospitals for the batch claims where you used a percentage in lieu of an actual amount, did you apply that to hospitals as well?

MR. ASHENBRENNER: Yes.

MEMBER CLARK: So you did that earlier, I believe you stated, as a surrogate for using the actual dollar amount, but in an effort to spread that across the years, I think was the phrase that you used.

MR. ASHENBRENNER: Yes, that's correct.

MEMBER CLARK: So indirectly, there is an estimate for the batch claims attributable to hospitals in the past to raise surrogate of an amount included in the rate setting for the hospitals.

MR. ASHENBRENNER: Yes, that's accurate.

MEMBER CARSON: My understanding was that you had eight years of data from the hospitals that you didn't use because the numbers did not have a cap to them. So I don't understand, where did you to -- where you had a percentage for including a batch claim if you didn't use that data.

MR. ASHENBRENNER: The batch claim load in the surcharges is based on the reinsurance costs by the PCF. So there is a load from that.

CHAIR RITCHIE: In continuing with what Mr. Clark said, would that amount that you added for batch claims, but

to the hospitals, there was also another physician named who wasn't an employed physician, but did not fall under the Act, would that account for the payouts to him in rate setting for him as an employed physician for the future?

MR. ASHENBRENNER: Yes, I believe so.

CHAIR RITCHIE: I know that's a step back, I'm sorry, we're on the deficit. Sorry.

MR. BARAN: Whatever adds clarity.

Q. (Mr. Baran) I want to go back where the question started, Mr. Ashenbrenner, and that is, what did you include in the deficit column, item number 3? Well, let me step back. For 2007 you've got fully developed claims and payments, correct?

A. Yes.

Q. So that's the actual payout, correct?

A. Yes.

Q. So that number, is that money that was necessarily paid in 2007 or is that money that was paid on behalf of claims that triggered 2007 coverages?

A. Yes, that would be the losses paid from the policies in 2007, for the coverage in 2007.

Q. So that's not the amount necessarily paid in 2007, that's the amount paid on behalf of policyholders and participates for claims arising from events in 2007?

A. Yes.

Q. Why did you do it that way?

A. That's how the PCF coverage attaches. When you set surcharges you're setting surcharges for that coverage, that type of coverage.

Q. How does that compare to what's done in the commercial market, or medically?

A. Actually, a lot coverage is on a claims-made basis, so it's not when actually occurred, but when the claim is made, but those have what's called a retroactive date, which goes back to cover those accident years. So there's a little bit difference, but not -- there is some occurrence coverage in the medical professional insurance in the industry. So a lot of it is on claims-made basis but some of it is on occurrence basis.

Q. So given those dynamics that the numbers in column 1 reflect payments that may have been made in later years, is it possible that the books of the PCF, the actual ledger, would show a positive balance, even though the liabilities would give rise to a deficit?

A. The ultimate liabilities did give rise to a deficit, and when it was estimated in 2007 it looks like it didn't anticipate that when the study was performed. Most likely because it didn't anticipate the batch claims.

CHAIR RITCHIE: Mr. Ashenbrenner, what is your understanding of the type of insurance claims made versus

occurrence that is present under the Act, at least prior to House Bill 75 and what is covered or what is included going forward?

MR. ASHENBRENNER: I believe everything is under occurrence or accident year basis.

CHAIR RITCHIE: In the past. What about going forward?

MR. ASHENBRENNER: I believe it's on an accident year basis.

CHAIR RITCHIE: Mr. Baran, I don't know if you have the answer to that, that's not in my reading of House Bill 75, that there's an option going forward. And if there was an option going forward, Mr. Ashenbrenner, to switch to claims made, would that change your numbers?

MR. ASHENBRENNER: If there was an option to go to claims made, you would need to redo the analysis for the surcharge calculation.

Q. (Mr. Baran) And why is that, Mr. Ashenbrenner?

A. Because when you switch from an occurrence-basis policy to a claims made, you would only be responsible -- because you have coverage in the prior years, have coverage in 2020 and 2021, they would only be responsible for occurrences that occurred in 2022 for claims reported in 2022.

Q. Would your opinion change if there was an indefinite tail under that claims made policy?

A. Well, that would be the issue. So there also needs to cover the tail liability for those occurrences.

Q. I'll represent to the Board, Mr. Ritchie, that the PCF will be requiring for those QHPs that are eligible to use claims-made coverages that their policies have indefinite tails. So anything that happened during the term of that policy will essentially be picked up by insurer even if the policy terminates. So it operates functionally equivalent to occurrence coverage. Given that representation, Mr. Ashenbrenner, do you believe your analysis needs to be changed?

A. Well, no, because the coverage is on an accident basis, or like you mentioned, claims-made plus the tail, which would be the same coverage.

Q. Thank you.

MEMBER DEKLEVA: Mr. Chairman, this is Mike Dekleva, I'm not sure if Todd Baran is going to move on from this exhibit, but I just had a couple of questions I wanted to ask Mr. Ashenbrenner about this, just to make sure I have it clear in my own mind. Mr. Ashenbrenner, just so I understand, we're looking at accident year 2007, and I think that I understand the numbers in those first three columns related to physicians and surgeons, but wanted to make sure. And they do include batch claims, is that true, sir?

MR. ASHENBRENNER: That is correct, yes.

MEMBER DEKLEVA: But if I'm reading it correctly, the selected ultimate column of 19 million, roughly 19 million, would be the amounts actually paid out on claims for that year, is that true?

MR. ASHENBRENNER: Yes, for occurrences in that year, yes.

MEMBER DEKLEVA: And then the PCF surcharges taken in for the physicians and surgeons in that particular year was just short of nine million, correct?

MR. ASHENBRENNER: Yes.

MEMBER DEKLEVA: And the third column, the cumulative deficit then, would be $9.3 million, meaning that the claims paid were essentially $9.3 million more than the surcharges taken in for the physicians and surgeons; is that correct?

MR. ASHENBRENNER: That is correct, yes.

MEMBER DEKLEVA: I just wanted to make sure I understood. Thank you.

MR. ASHENBRENNER: Okay.

MEMBER CLARK: One clarification. This is Troy, can -- if you're okay with that, Mr. Chair.

CHAIR RITCHIE: Yes.

MEMBER CLARK: I believe for the math to work on that last one it's not just the difference in 19 million and the 8.8, you have to take in, because that's a cumulative

deficit, the 900,000 surplus that existed in the prior year. We're on another chart you have, you have the individual year. This is the cumulative. So it would be column 2 minus column 1, plus the previous year surplus or deficit.

MEMBER DEKLEVA: So it would be fair to say then -- thank you for that clarification, Troy. So it would be fair to say that in year 2007 -- well, let me ask it this way. In year 2006 it looks like that there was a surplus of just a little less than a million dollars, is that true?

MR. ASHENBRENNER: Yes.

MEMBER DEKLEVA: And then as a result of claims paid versus the surcharges paid in the year 2007, not only was that surplus of nearly a million dollars wiped out, but the Fund was actually in debt because of those claims to the tune of about $10 million; is that correct?

MR. ASHENBRENNER: Yes.

MEMBER DEKLEVA: Thank you.

Q. (Mr. Baran) Going back to your presentation. Going to slide 34, what is depicted here?

A. This is just a graphical depiction of the prior slide. This is accident years on the bottom. This just shows kind of accumulation of the deficit by accident year is estimated between independent physicians and hospitals.

Q. What does this graph tell you? What do you want it to communicate in terms of the relative contributions to the

deficit?

A. The deficit in 2011, the contribution to the deficit was caused -- 40 million of that by accident years 2011 and prior, but it also shows that the deficit continued to accrue for both independent physicians and hospitals in the resulting years, so kind of continuing to go because the surcharges weren't high enough. Or the losses were higher than the surcharges, I should say.

Q. And that kind of leads to my question, what fundamentally causes the deficit?

A. We estimate them to pay out more claims than they collect in surcharge. Either pay out or their estimated payouts are greater than the collections.

Q. With respect to the batch claims was that a forecasting issue, do you think? How did they contribute to the --

A. They definitely contributed to the problem. As I mentioned in another part, typically self-insurance trusts or funds set aside some type of surplus or fund at a higher level to take into account either the volatility of the fund or the unknown unknowns of the fund of what they're covering. So there's usually some type of surplus so that there isn't a deficit accrued over time.

Q. Are you aware of any information to suggest that prior to 2019 any of the QHPs were being asked to -- or that the surcharges were being set at a confidence level greater than

central?

A. I don't know that. I don't know that.

Q. Does the experience that you have seen in the relationship between ultimate loss and surcharges suggest that that may be the case?

A. In hindsight you could argue that that would be the case, that's using hindsight.

Q. There's no evidence that the deficit was attributable to surcharges being assessed and not paid?

A. I don't have any -- I don't believe so. I don't have any evidence that would support that.

CHAIR RITCHIE: Mr. Ashenbrenner, are there entities you're aware of that establish this as a trust fund as well that maintain a high enough -- or established with a high enough balance so that the income from the Fund helps make up deficits and provides a cushion against large swings in the payouts or the surcharges?

MR. ASHENBRENNER: If you're talking about income, it's investment income?

CHAIR RITCHIE: Correct.

MR. ASHENBRENNER: Yes, that is a -- there's another benefit of a surplus, is you have additional assets that you can collect investment income on and hold over time and that contributes to the overall surplus of the fund. As long as the investments are higher than what you're anticipating in

calculating the surcharge and the rates from.

MEMBER CLARK: Mr. Chair, one question. This is Troy.

CHAIR RITCHIE: Yes.

MEMBER CLARK: Mr. Ashenbrenner, if, and I will start this with a big if to make sure I follow the connection of this visual graph to the last chart. If you were to break out the 20.1 million attributable to the batch claims, am I correct in understanding that that would all come out of the blue line, which is the independent P&S, and predominantly prior to 2013 and thereby show all three lines on here the magnitude of the independent line would be much shallower, if that's the right term. But it would be a lesser amount.

MR. ASHENBRENNER: That's absolutely correct, yes.

Q. (Mr. Baran) Following up on the Chair's question about investments, we know that in some of these years there were market downturns. Is there any evidence that you're aware of that the deficit was contributed to by bad investments that lost value during any of those downturns?

A. We didn't analyze the investments, but we had a summary of what the investment incomes were by year. I guess I don't know what the investments were, but they did lose money in one year, I don't want to speculate what year it was. But overall it didn't seem like there was anything different than what I would expect in a long-term average basis, but I don't

know the individual investment.

Q. It was sufficiently stable for you to use the 3.5 rate of return for your surcharge discount rate, correct?

A. Yes, yes.

Q. Page 35 of your summary, what is this graph telling us?

A. I put this together just to look graphically at the differences in the surcharge, the blue line, and the payouts, and then the estimated payouts, which are the purple lines. I'm sorry, the purple columns. So the red bars are the paid to date. As I mentioned before, years prior to even 2014 or 2015 have been primarily paid out. So you can see -- differentiate between what was paid out and what was expecting to be paid out. Just looking at this you can tell that 2007 through 2011 have already paid out. I guess why I put this together, it's not overestimation of unpaid losses that are primarily causing the deficit, it's more those losses in 2007 and 2011 were the primary cause of the overall deficit.

Q. Page 36, what is this graph telling us?

A. This is the same graph for the hospitals, including the employed physicians. And again, the purpose of this is just to show the difference between the surcharge and the estimated, both the paid and the estimated unpaid loss. What we're trying to highlight here is, there's a lot of estimated unpaid loss, because that would be the purple line column and

the blue column in this chart. So you can see the majority of the losses are estimated for the hospitals at this point.

Q. Slide 38, what are we moving on to now?

A. This is how we estimated the deficit assessment, so this goes back to answer the Chairman's question a while ago, I believe.

Q. Can you walk us through the second bullet point.

A. We took the overall deficit of 66.8 million and essentially allocated that between independent physicians and hospitals. This is our understanding of how HB75 asks how the deficit is cured in five years. Essentially the deficit between the independent physicians and hospitals and then calculate what that number is to eliminate the deficit after five years, including investment income on those assessments. So you take a percentage of the indicated surcharge. We assume the surcharge increase four percent per year, but you're not paying more in 2022 than you are in 2026 as a percent of your surcharge, assume a consistent exposure base that nobody leaves or joins the PCF and then include credit for investment income.

Q. What about Mr. Clark's earlier question about discounting the deficit, why don't we see that in here?

A. That's a good point. We are including a credit for the anticipated investment income, but we don't include a -- we calculate the deficit at a nominal basis or a discounted

basis of 66.8 million. I don't believe HB75 defines how to calculate a deficit. We're calculating it on a nominal basis as an insurance company would, a property and casualty insurance company typically does. They typically don't discount their reserves, but sometimes trust or funds do discount their reserve. And hence, if you discount the reserves, hence you discount the deficit.

Q. The bullet point at the bottom, can you expand on that a little bit?

A. We calculated the assessment charge based on HB75 to eliminate the deficit in five years. We just did the math to do that. I'm not providing an opinion on that. But it's important to note that the calculation assumes a consistent membership in the PCF for the next five years. So if it would change either way, the deficit or the amount to cure the deficit would change. The potential issue the PCF would have is if a significant number of physicians drop out of the PCF they wouldn't be able to collect that money to offset the deficit. And then if you recalculate it or recalibrate it every year, you go into kind of a spiral that would cause that cost to go even higher. In other words, if you took half of the independent physicians dropped out after a year, you'd have to -- the way that HB75 is written, you'd have to collect that balance from the remaining members in the PCF.

Q. So with respect to the surcharges, you testified

earlier that there can be fluctuations in the participation levels in the PCF and the surcharges are going to account for that, correct?

A. Yes.

Q. That's not true here?

A. No, not the way that the HB75 is laid out.

Q. Was there any actuarially sound way to meet the requirements of HB75 without assuming or requiring a stable participation rate?

A. In hindsight there is, but not that I'm aware of. That wasn't under my scope of the project that we did, so we didn't -- HB75 kind of required...

Q. Right. So my question is, given the constraints of HB75, is there an actuarially sound way to extinguish the deficit accounting for the possibility of ferreting levels of participation in the fund?

A. There could be. From what I understand, the PCF membership is voluntary, so I believe people can drop out of it.

Q. That's correct, it's not mandatory.

A. Some states PCF is mandatory. So there is a difference.

Q. So given that there can be and likely will be varying levels of participation year over year, is there any actuarially sound method of extinguishing this deficit with

precision in five years?

A. It would depend on a lot of factors, outside factors. I understand your question, potentially. I know that's not a yes or no answer.

Q. So do you have a concept in mind?

A. I have not explored that.

CHAIR RITCHIE: Let me ask too, in your full note and client report, under one of the bullet points, I'm sorry, the page numbers don't come through, but right before the 2022 rate change table it says, "members in PCF remain the same. One of the assumptions was the number of members the PCF remaining the same as in 2020. If a significant number of members leave the PCF, additional assessments will not be adequate to cover the current deficit. This could cause a spiral of assessments if the assessments are recalibrated each year and the PCF expenses and/or investor return the assumptions use the surcharge calculations, either expenses or investment returns are higher or lower than surcharges, this will impact the deficit as well." So that spiral of assessments is that increase in assessment that more physicians leave and the burden falls on the lesser number and if you recalibrate that each year, then the surcharges go up each year, correct?

MR. ASHENBRENNER: That is what a spiral is, yes, it's an insurance -- it's happened in other insurance

programs where people have dropped out because costs were too high or did something else and by somewhat mandating the participants within that pool, it became a spiral basically.

CHAIR RITCHIE: Thank you.

MR. ASHENBRENNER: I think we wanted to include that as a warning.

Q. (Mr. Baran) To wrap things up a little bit. You were asked some questions about the data that you had and the data that you did not have, many of those questions revolved around the issue of allocating responsibility for past losses to specific QHP participants, whether it's an employed provider, a hospital or an independent provider. Certainly there may have been, or in an ideal world perhaps all of that data would materialize. But given the data that you have, do you believe that your analysis, your findings, your conclusions, your recommendations, are actuarially sound?

A. Yes, I do.

Q. Now we go to other considerations.

A. These are just caveats. We can go through them if you like. One of the caveats, and I'm sure everyone on the call understands, these are estimates and the actual results will differ from that, either higher or lower based on events that occurred subsequent to our analysis.

Q. It's not an exact science, is it?

A. It is not, no.

Q. Let's talk about assumptions. Your analysis depends on assumptions, correct?

A. Yes.

Q. If the assumptions are established or found to be fundamentally wrong that can affect the validity of your conclusions, correct?

A. Yes.

Q. One of the key data points underlying most of your analysis was the number of occurrences that are projected to trigger PCF obligations in the future, correct?

A. Yes.

Q. What assumptions did you make as to what constitutes an occurrence for purposes of a PCF claim?

A. An occurrence would be a medical incident that the provider/claimant is ultimately liable for, found liable for, the PCF needs to pay out the medical incident.

Q. Did you assume that an occurrence is confined to one injury, to one patient, or did you account for the possibility that an injury to a patient caused by multiple acts of negligence by multiple providers can constitute multiple occurrences, each of which would trigger a PCF obligation?

A. Occurrence would be the historical definition of occurrence in the State of New Mexico.

Q. And what is that?

A. As I mentioned, a medical incident that causes a loss. I'm not an attorney, I don't want to speak like one.

Q. If a court were to say that an occurrence historically would be any act of malpractice that attributes in any part to an injury to a patient, thereby allowing the possibility that the PCF would own several limits for a claim by a single patient, will you stand by your numbers in that scenario or would you need to revisit them?

A. If the number of occurrences or the number of defendants -- okay, we have an occurrence and it has three defendants, we can say that those are all one occurrence currently under the PCF, you're suggesting if those three defendants will be treated as separate occurrences under the PCF?

Q. Correct?

A. How would that impact the PCF.

Q. How that impacted your evaluation and your conclusions and your recommendations.

A. Since the PCF is an excess carrier, in this example, those three occurrences are longer combined, but are separate amounts. What impact the PCF, it would increase the costs to the primary insurer because they would have to pay for and defend each individual case before they took the PCF limit. So the impact to the PCF would be whether those amounts are greater in total than the occurrence, because they would have

to be combined to hit the amount. So it would depend on the overall value of the claim, if that makes sense.

CHAIR RITCHIE: As a quick corollary to that. In your opinion would it be more likely that that scenario would occur in a hospital or to independent physicians, or which numbers would it affect the most, whose bucket?

MR. ASHENBRENNER: This is my opinion without doing an analysis, so it's not -- it could be in a hospital because of the different providers and different people, people interact with in a hospital during the course of their treatment. They could be multiple, multiple providers in a hospital setting, which may not be the case in an office setting, independent physician office setting.

MEMBER CLARK: Would that have any impact upon the deficit or only upon the rate?

MR. ASHENBRENNER: Good question. That would only impact the future surcharge unless it could be retroactively assigned to the claims that have not been paid yet. The occurrences that haven't been paid.

CHAIR RITCHIE: By New Mexico statute some of those claims can go back 18 or 19 years in the case of a minor, theoretically. So claims in hospitals, or independent, could go back even to 2002, 2003. So would that change your opinion on whether they could affect the deficit?

MR. ASHENBRENNER: Yes, it could, yes. Again,

there's volatility in the numbers and there's a lot of different contingencies and issues that could impact our calculation, our estimates.

Q. (Mr. Baran) Let me see if I can bring it down to boots on the ground kind of perspective. If a court said that every physician that touches a patient is entitled to their own -- that every time a physician negligently touches a patient, and I'm using 'touch' to encompass negligent or actual affirmative harm. Even if all of the touches attribute to a single injury, multiple limits would be in play, can we rely on the surcharges that you are recommending?

A. If there is a significant change to the number of occurrences you would want to provide an estimate of what the impact would be.

Q. You would need more data and you would need to revisit your calculations of ultimate lost, correct?

A. You would need to make assumptions. I'm not sure you would have data, but you would have to make some assumptions in whatever a court would determine. First of all you'd have to understand what they determined and then you'd have to make certain assumptions.

MEMBER DEKLEVA: Chairman Ritchie, if I could, just follow up with a couple of questions to your questions a minute ago. Mr. Ashenbrenner, with regard to the idea that a

multi-occurrence case would be more likely to occur in a hospital-related case, that's not really something that you can speak to about some degree of speculation; isn't that true?

MR. ASHENBRENNER: Yes, that's what I was trying to say. I don't have information, nor did I...

MEMBER DEKLEVA: In fact, it would really involve the facts of the case, wouldn't it? I mean, there would be scenarios perhaps that would evolve where a series of independent physicians might get sued in a case where the allegations made by the plaintiff's lawyer would be that there would be multiple occurrences in that setting, true? I mean, that's possible, right?

MR. ASHENBRENNER: Yes.

MEMBER DEKLEVA: Equally possible I suppose would be a scenario where there was a hospital-related case with a series of hospital-employed physicians that all touched the patient where the allegations in the complaint allege multiple occurrences in that setting, correct? That's a possibility.

MR. ASHENBRENNER: That's a possibility, yes.

MEMBER DEKLEVA: As you sit here today, either with the advance training and experience that you have as an actuary, you're not in a position to tell us one way or the another whether those multi-occurrence claims would be likely

to arise at a hospital setting versus in an independent provider setting; isn't that true?

MR. ASHENBRENNER: As I mentioned when I answered the question originally I was speculating when I answered the question, because I haven't performed an analysis.

MEMBER DEKLEVA: Thanks.

VICE CHAIR LOVE: I'd just like to state for the record, if I was the sole hearing officer, which obviously I am not, and it makes it a little awkward when we're doing a group hearing officer thing, Mr. Ashenbrenner was offered as an expert witness in actuarial studies, not in the analysis of the bill or how it will play out or speculation about how the courts will interpret that. So I would ask that the Committee discuss disregarding any testimony along those lines, keep it only to the actuarial analysis.

MR. BARAN: Mr. Chairman, in response to that, it's litigation currently in the courts where parties are advocating for changes in interpretation of the MMA and how it interacts with the PCF's obligations. One of those cases, or a couple of those cases, involve what constitutes an occurrence. Leading to my next question, there's cases that -- there is a case that addresses the issue of what damages are compensable and payable by the PCF. If the law of the land changes, as advocated by the plaintiffs in any of those cases, I want the Board to know and the Superintendent to

know whether those changes would impact the reliability of Mr. Ashenbrenner's analysis. So I think these questions are fair game, because I'm simply trying to establish whether there's anything that could possibly undermine the report that Mr. Ashenbrenner and the PCF are asking this Board to recommend adoption of to the Superintendent.

MEMBER CLARK: Mr. Chair, if I can add on to Ms. Love's comment. I think you're trying to establish that there are other variables that could cause these numbers in the future to change, but that could include changes to who qualifies or is declared a QHP amongst other things. There are variations that, yes, tomorrow and forward there are a number of things that could happen that would change the estimates. And based on the way HB75 was written and what statute is in place today, I think is what Mr. Ashenbrenner is answering to, right. You're just trying to make us aware that there's the potential that tomorrow things may change in the adjudication of cases that could change the estimates, is that what the attempt is?

MR. BARAN: That's the basic question. There's the theoretical changes that would require some legislative action, but these are live issues in the courts and we could have decisions in the very near future. We already have trial court decisions and we could have appellate court decisions and it's important to know whether these issues

that Mr. Ashenbrenner evaluated, these questions, would need to be revisited.

VICE CHAIR LOVE: Well, and I think that that is true every single year that this hearing has happened, that there are always issues being litigated around the interpretation of any law. And I think this Committee can understand that if something changes with the law, whether it be statutorily or in the courts, that certainly affects these numbers.

CHAIR RITCHIE: Right, and we are speaking of setting rates and those decisions can affect rates in the next year. I think they are the purview of at least discussion here, because that's what we're here for, is for setting rates with the best available data and best available actuarial study.

Q. (Mr. Baran) Mr. Ashenbrenner, if I alluded to at least one trial court has determined that the PCF is obligated to reimburse medical expenses at the provider's billed rate, not at the actual paid rate, do you understand the difference between billed rate and paid rate, for the cost of medical expenses?

A. Yes, typically the billed rate is significantly higher than the paid rate.

Q. Would it be important to your analysis and conclusions to know whether it was the billed rate or the paid rate that

the PCF is obligated to reimburse?

A. Yes, that's important.

Q. Is there a possibility that if the law, if the courts declared that the law is that the PCF has to pay the billed rate and not the paid rate, is there a possibility that the surcharges you're recommending would be inadequate to cover the potential obligations of the PCF?

A. Yes. All else equal, yes, because the billed rates are greater than the paid rates, yes, definitely.

MR. BARAN: As housekeeping, I would like to offer the executive summary as Exhibit C.

CHAIR RITCHIE: Is that all you have for additional exhibits for housekeeping, because I have one further question.

MR. BARAN: No, there is one more exhibit and it was attached to the initial exhibit list, we haven't discussed it. But I would like to, either now or after your question, Mr. Chair, lay foundation and move for admission of that document as well.

CHAIR RITCHIE: I don't know if this is included in that new exhibit, it was the previous exhibit, and as you mentioned, we were going to get to it later. When I went through a specific line of the different fees per specialty and the estimated increase to cover both the surcharge increase and to cover the deficit and I was comparing that

independent physician versus employed physician. And I don't believe we ever got a true explanation of why the increase for the independent physician with several multiples of the increase for the employed physician. And my question is, what about a physician who was covered under the Act as an independent physician, then discovered that his insurance became too high and chose to become an employed physician and so he became an employed physician, the rates immediately dropped and his repayment of the deficit was presumably accumulated while he was an independent physician is now not being covered by him, and if that's a possibility. That was another version of that table, and I gave the example of class 9, which is surgeons.

MR. ASHENBRENNER: I know we didn't cover the actual map to get to the deficit assessment, but as we saw that the majority of the assessment is attributable based on the way that HB75 required us to calculate that to the independent physicians rather than the hospitals, so that's why there's a large difference between the assessments there. But to point out what you mentioned is, if the independents become employed, then we'd run into the same problem as I mentioned before, that we wouldn't be collecting enough assessments to eliminate the deficit in five years, because that's a participation issue that we've discussed. I'm trying to answer your question.

CHAIR RITCHIE: And they are still participating, they're just participating under a different category, so to speak, and that relieves them of substantial liability.

MR. ASHENBRENNER: I think you're questioning the fairness of it, correct?

CHAIR RITCHIE: Well, as you understand it with the numbers, can that occur?

MR. ASHENBRENNER: Yes, I believe so. In different states a lot of hospitals have picked up employed physicians to cover their cost of insurance. I'm not talking about New Mexico, but there's been an increase in employed physicians in some states just to kind of offset, or there's a carrot to have the physician come work. There's definitely differences in the participation on the demographics of the physicians that can impact this as well.

VICE CHAIR LOVE: This is Kathy Love. That's different than my understanding recently, from talking to the people at the Patient Compensation Fund, and so I would like to make sure that we have an absolute correct understanding. You're saying now, if an independent physician becomes an employed physician, then the PCF will no longer collect the same amount of a surcharge for that doctor?

MR. ASHENBRENNER: On the assessment.

VICE CHAIR LOVE: The deficit assessment.

MR. ASHENBRENNER: Yes.

VICE CHAIR LOVE: Thank you. I understand, thank you.

MR. ASHENBRENNER: Sorry I was unclear.

MEMBER CARSON: I have a question. This is Karen Carson. I was just wondering about the outpatient healthcare facilities. Where are they in the surcharge bucket? Did they get lumped, so people who work, I guess that would be in an outpatient surgical center, those numbers were changed with this amendment. And so, where did those numbers go to? Where were those surcharges placed? Or were they even looked at?

MR. ASHENBRENNER: I believe they would be included -- I'm not sure if I'm answering your question. I believe they would be included in the hospital, but it would depend on the type of entity, I believe.

MEMBER CARSON: My understanding is, that a group of physicians that runs an outpatient health care facility, so a large group that maybe performs minor surgery in an outpatient setting, has changes to their cap, but I didn't know where they were placed in that grouping. You assume that they were placed into hospital grouping, not into the independent physician grouping? Or were they even split out at all? Was there even a split?

Q. (Mr. Baran) Let me see if I can help again. If an entity falls within the definition of an outpatient

healthcare facility under the MMA, are they going to do the ten percent entity surcharge or are they going to be subject to the hospital rating plan surcharge?

A. That's a good question. It would depend on what was defined as a hospital. I think that's something the PCF will have to determine. I just want to be clear, I didn't look, as was mentioned, I didn't look through all of HB75 and evaluate it and look at it. So there may be some facilities that need to be determined where they fit based on what they do. I didn't classify every single possible entity and facility out there, that really wasn't the purpose.

MEMBER CARSON: So these facilities may not have been placed into a certain deficit bucket either, looking back over these past years. They were placed maybe in the -- maybe with hospitals, maybe with physicians and surgeons, but there was no breakout?

MR. ASHENBRENNER: It would just be how it was provided to me by the PCF. I mean, was specifically called hospitals or specifically called something else, so that's how we split it out. So what you're saying is the change is now called the hospital or vice-versa, how does that impact? My response is, I don't really look at that. And if there's issues, the PCF will need to decide how to determine on a case-by-case basis, I would assume.

CHAIR RITCHIE: I believe, as far as, say, a group,

you had down on one of your tables that the physician group, the organization was liable for a ten percent increase to each of the buckets. They're classified under independent, but it was a ten percent increase to their surcharge to cover the deficit in the surcharge. It appears that's what that table said.

MR. ASHENBRENNER: Yes, the ten percent, that's been the...

CHAIR RITCHIE: Right.

MR. ASHENBRENNER: Additional rating charge there.

CHAIR RITCHIE: Ten percent of the cumulative surcharges for the entities that are employed by that organization, correct?

MR. ASHENBRENNER: Yes, I believe so.

CHAIR RITCHIE: You are then assigning also the deficit repayment to them at the same proportion.

MR. ASHENBRENNER: Yes.

CHAIR RITCHIE: But that also includes hospitals and hospitals-employed physicians and surgeons, then they also pay back for the fund deficit, that ten percent of all the cumulative surcharges for all the employed entities are covered under the Act and they're going to pay an additional ten percent to cover the deficit.

MR. ASHENBRENNER: If I understand your question, when we calculated the assessment we included all surcharges,

including the entity. So it would be ten percent of the assessment as well.

CHAIR RITCHIE: As far as what defines them, that is something separate and that is, I don't believe, I don't know that HB75 truly addresses that and the definition seems to be very vague under state statute. Unless someone else has a different interpretation than what I have been able to discover.

MR. BARAN: Let's go through the presentation a little bit and see if we can add some clarity around this. Is everyone seeing page 16? Mr. Ashenbrenner?

MR. ASHENBRENNER: Yes.

Q. (Mr. Baran) Following up on the Chair's questions, it appears that for entities, we'll get to the definition of that in a minute, but for entities they're responsible for ten percent of the aggregate surcharge for their participating QHPs. So under the umbrella of the entity there may be ten QHP providers, that aggregate of the surcharges for those ten providers times ten percent is what that entity owes for their surcharge, correct?

A. Yes.

Q. And that's the same methodology for determining the deficit assessment owed by that entity, correct?

A. That's correct, yes.

Q. So under this exhibit, if that entity is a hospital,

that hospital will be paying an additional ten percent of the surcharges for its employed providers to help extinguish the deficit, correct?

A. I believe so. I'm not -- I can't think of an example of how that would work but, yes.

Q. Well, we're trying to understand your exhibit here, because we have to operationalize this instruction.

A. Well, I think what you're asking me is, as an employed physician and surgeon, I don't believe they would have an entity, so they wouldn't have the ten percent.

Q. So an entity that is not a hospital, let's say they have ten doctors and their aggregate surcharge is a hundred thousand dollars, they're going to owe $10,000 as the surcharge for participation in the PCF and they're going to owe $10,000 as part of their share of the deficit, if I'm reading this chart correct; is that right?

A. It would be ten percent, yes, of the surcharge, and ten percent of the assessment.

Q. When you say, "ten percent of the assessment," what is the assessment that that ten percent is being derived from, is it the aggregate surcharges for those providers or is it ten percent...

A. Ten percent of the assessment.

CHAIR RITCHIE: The Fund deficit assessment?

MR. ASHENBRENNER: Yes.

CHAIR RITCHIE: Okay.

Q. (Mr. Baran) So give us a concrete example of how this would work. Let's say you have an entity that's not a hospital that has ten class 1 providers in it.

A. Ten class 1 providers, the surcharge would be 41,000. Ten percent of that is 4,000. Ten independent physicians for the assessment would be 22,000, roughly. The assessment would be 2,000. So it would be ten percent, the sum of that.

Q. That's clear, and that's the same thing when we get to employed physicians and surgeons as well. If a hospital has ten class ones they're going to owe $200?

A. The employed would be -- I don't believe that ten percent -- the employed would have to own some entity that would be covered underneath some policy. I don't know if that's what happened. It could be, so I guess that's why we have it. It's potentially there.

Q. So if we look at what the hospitals have to pay.

A. I think it's slide 26.

Q. Slide 26. So the hospitals, and this is how I read it and you can correct us if I read it incorrectly. The hospitals under the rating plan are paying a share of the deficit based on exposures, the number of care beds, the number of psychiatric beds, the number of inpatient surgeries, correct?

A. Yes.

Q. So we take those numbers, ten beds, ten births, ten surgeries and multiple that by the deficit assessment number you put in this chart, correct?

A. Yes.

Q. For the surcharges you testified that the hospitals have to pay what's reflected -- or the number generated from -- times the rating plan that we see here, correct?

A. Yes.

Q. And they would have to pay for the surcharges of the employed providers.

A. Yes.

Q. So logically it seemed to me, if we go back to this analysis, the hospital should also pay for a portion of the deficit allocable to their employed providers.

A. Yes, that's true.

Q. So isn't that what the last column of this chart enables the PCF to calculate?

A. Yes, that's true.

MR. BARAN: Does that add clarity, Mr. Chair?

CHAIR RITCHIE: Yes, I think that answers it. That last column was what I started the question with, but then the entity question definitely was brought on afterwards. The definition of a code entity is beyond the scope of the actuarial study, I believe.

MR. BARAN: Right.

Q. (Mr. Baran) Let's go back to the rating plan. If the particular entity was creating exposure to the PCF for these types of classifications, is it your recommendation that this rating plan be applied to that entity rather than the ten percent?

A. I believe the way to do it is to follow how it's currently in practice by the primary insurance companies. I can't speculate on every type of outpatient differences there are, so I think you would follow what they're doing there. Or you're saying if somebody goes into a doctor's office owned by one doctor, should they be charged an outpatient visit. I would say no.

Q. I think you've misunderstood my question. Let's say we have an entity that is only doing dermatology. We have ten dermatologists practicing in an entity, Albuquerque Dermatology Group. Dermatology is not on this rating plan, correct?

A. Well, it's not on here, no.

Q. Let's say we have an entity that's doing nothing but outpatient surgeries, ten doctors, all surgeons, and that's the service they're providing. Shouldn't that facility or that entity be rated based on these rates rather than the ten percent entity surcharge that we saw on slide 14?

A. I think we have to follow what the industry is doing, for your examples.

CHAIR RITCHIE: Would it make a difference on who owned the facility?

MR. ASHENBRENNER: I'm not sure what the question is. Every provider is required to buy insurance from a primary, so I'm suggesting that they follow whatever methodology they're using to rate....

Q. (Mr. Baran) So the primary carrier is using ten percent of the provider's insurer, you're saying the PCF should use the ten percent entity surcharge methodology? But if the primary insurer is using an exposure basis to calculate the underlying rate for that -- the rate for the underlying coverage, then the PCF should follow that practice and use this rating plan?

A. Yes, that's what I was...yes.

MR. BARAN: So as Exhibit C, which is the summary report, has been admitted? This is housekeeping now.

CHAIR RITCHIE: That is Exhibit C or 3?

MR. BARAN: It would be C.

CHAIR RITCHIE: C. That sounds appropriate.

MEMBER CLARK: This is Troy. I have no objection.

MEMBER DEKLEVA: This is Mike Dekleva. I have no objection.

MEMBER VARGAS: Ray Vargas. I have no objection.

MEMBER CARSON: Karen Carson. No objection.

Q. (Mr. Baran) So the last exhibit that was prefiled is a

compilation of documents, Mr. Ashenbrenner, ten pages starting with the physicians and surgeons mixture and some excepts of the exhibits from your report. Do you recognize this packet of materials?

A. Yes, I do.

Q. Are those documents that you prepared?

A. Yes.

Q. And do they summarize parts of your analysis in your conclusion?

A. Yes.

Q. And the page that we're looking at here, the first page of the exhibit, page 001, is this information that you prepared?

A. Yes.

Q. What was the purpose of preparing this package of materials?

A. As I understood it, there was a deadline to provide information to the advisory board, so we put this together fairly quickly to provide additional information. After that deadline passed I prepared the presentation, the summary that we went through today, that is essentially the same, other than this first page and so it's -- I would suggest that this, other than the first page, which just defines things a little bit better, would kind of be ignored other than the first page, because those are -- the presentation is a better

-- it's a better presentation than these.

MR. BARAN: Move for admission of page 001 of this package of materials to be admitted as Exhibit D and to not admit the remaining, or not to include the remaining nine pages in the exhibit.

MEMBER DEKLEVA: This is Mike Dekleva. I have no objection.

MEMBER CLARK: This is Troy. I have no objection.

MEMBER VARGAS: This is Ray. No objection.

VICE CHAIR LOVE: Kathy Love. No objection.

MEMBER CARSON: Karen Carson. No objection.

MEMBER MARTINEZ: Alben Martinez. No objection.

CHAIR RITCHIE: No objection from me.

MR. BARAN: With that, the custodian rests. That is our case.

CHAIR RITCHIE: I have questions, though. Mr. Ashenbrenner, on this one page here, Exhibit 8, this reconciliation of claim data provide, PCF, 2011, the employed physicians/surgeons, 50 percent of loss but hospital is also listed. I know we discussed this before, but do you have any data to support that the payouts when a physician and a hospital are named in a suit, if they can be assigned on a 50/50 basis? And I realize that the physician's employed, that makes a difference. And if a physician is independent, that makes a difference. Were you given enough data to make

a decision in those three scenarios where -- two scenarios, I'm sorry, where a hospital is listed with a physician and the physician is employed and a hospital is listed with a physician and he is independent and how to allocate the losses?

A. From the PCF we were provided with what we have. We weren't -- I don't think the information, the data provided to come up with that 50 percent was credible from that amount. That's an assumption that we made. Typically, as I mentioned, when we had the loss runs from the hospital, the listing of losses from the hospital, they don't split that out. It was just an estimation, so that's an assumption that we made, I would say.

CHAIR RITCHIE: And you decided to make the same assumption whether the physician was employed or whether they were independent.

MR. ASHENBRENNER: From this we assume that the way that they were employed. In other words, they didn't have an employer independent physician -- so we assumed that any claim that was with a hospital was an employed physician.

CHAIR RITCHIE: If they were not employed, they were independent, would that change any of the numbers you have given us so far, and recommendations?

MR. ASHENBRENNER: If they were independent it would slightly increase the independent losses, because they would

have more paid loss to them.

CHAIR RITCHIE: If you maintain 50 percent split.

MR. ASHENBRENNER: Yes.

CHAIR RITCHIE: But you don't have any data to determine that 50 percent split.

MR. ASHENBRENNER: That was an assumption we made.

CHAIR RITCHIE: Okay.

MEMBER DEKLEVA: Mr. Chairman, if I may. Mr. Ashenbrenner, in making that assumption, the 50 percent assumption that you've been talking about and have been asked questions about today, in making that assumption did you base that on sound actuarial principles? In other words, are making those assumptions, such as what you've described, something that actuaries typically do in preparing their reports and doing their analysis?

MR. ASHENBRENNER: Yes, we typically have to make assumptions when you don't have data to support the assumption that you're trying to make.

MEMBER DEKLEVA: And in doing that, in this case do you feel that that was an actuarially sound or an actuarially reasonable thing to do?

MR. ASHENBRENNER: Yes, I believe it was actuarially reasonable to do that, yes.

MEMBER DEKLEVA: Thank you.

CHAIR RITCHIE: In follow up. You don't have any

evidence to that affect, it's still an assumption, correct?

MR. ASHENBRENNER: Yes, that's true.

VICE CHAIR LOVE: Mr. Chairman, may I ask a question. This is Kathy Love.

CHAIR RITCHIE: Yes.

VICE CHAIR LOVE: Mr. Ashenbrenner, did you do anything different than what Milliman has done in the past to evaluate the appropriate surcharges?

MR. ASHENBRENNER: This was the first time that Milliman has performed the surcharge for the New Mexico PCF. I know we did it a long time ago. I believe we did it in the '90s, I believe. We didn't do anything different because we didn't do it before, but did we do anything different than what we would have done for other projects? No, we wouldn't have done anything different, other than there's always certain issues such as the employed physicians or just issues that you have to make assumptions for and just deal with whatever those issues are in any actuarial analysis.

VICE CHAIR LOVE: Did you go through and look at any past actuarial analyses toward rate setting to determine whether or not you were doing anything different than had been done in past years for rate setting in New Mexico?

MR. ASHENBRENNER: Yes, we reviewed the two prior reports that were placed on the website, we reviewed those. We didn't do anything significantly different. We may have

added a different actuarial method or used different assumptions, but there wasn't anything done significantly different than the previous actuaries did.

VICE CHAIR LOVE: In reviewing those previous studies and also looking at all the data that you looked at, are you able to tell us whether you have any opinion as to whether or not this deficit was caused by a failure with regard to the risk assessment or some other reason? Do you have any opinions about that?

MR. ASHENBRENNER: That's a good question. As we discussed previously, a lot of the deficit was due to prior years in light of what was due to the batch claims, so that would be -- the previous reports wouldn't have been done -- I don't look at the reports that project the losses. So I didn't -- if we would do anything, I'm not sure -- we didn't see anything -- I didn't see anything dras -- different than -- we would change assumptions a little bit, but there isn't anything drastically different.

VICE CHAIR LOVE: The big question for us as we're deliberating over this and making a recommendation to the Superintendent of Insurance is, other than the 20 million, which I think is an easy analysis of the batch claims, that's still leaves a significant deficit. And if we're not doing anything differently this year than has been done in the past, how can we be assured that the estimates are not going

to lead to further deficit problems?

MR. ASHENBRENNER: That's a good question. As I discussed previously, you would -- setting up, you would want to fund it at a higher confidence level to address those issues. Once you get in these situations where there's a deficit, you're trying to recover the deficit, it becomes a lot more difficult to do that. I think to say, what can we do differently? Well, in hindsight you would go back and fund at a higher confidence level, so that kind of assumes that you should be doing that in the future as well.

VICE CHAIR LOVE: You mean in hindsight they could have funded at higher surcharges? Higher rates.

MR. ASHENBRENNER: Yes. Again, I don't know what was selected and what was proposed, other than in the actuarial reports that we provided in the last two years.

VICE CHAIR LOVE: So you wouldn't be able to give us that historical data?

MR. ASHENBRENNER: No, I wouldn't have that information. Other than the two actuarial reports on the website, I don't have any other explanation.

VICE CHAIR LOVE: Thank you.

CHAIR RITCHIE: Any other questions or comments?

MR. BARAN: I might have something that will help clarify some of the follow-up questions. Let me put this document on the screen here. Going back to your report,

Exhibit 2, page number 30, you were asked some questions about if you had any data to do this estimate of 50/50 split. Does the fact that the PCF surcharges paid by physicians and surgeons essentially double between 2016 and 2017, the year that the hospitals came into the Fund, provide any support for your assumption that 50/50 was the reasonable split?

A. That's one piece of information that we looked at, yes.

Q. Why is that a piece of information you looked at?

A. Well, we were trying to determine, if you have a hospital with employed physicians, how much would be paid by the employed physician and how much by the hospital. If it was performed on a combined basis for the hospital.

Q. So if you have a history, as reflected in column 2, of roughly $10 million in surcharges and then a doubling of the surcharges for physicians and surgeons after the hospitals come into the Fund, what does that suggest?

A. I think we're answering two different questions. One of them is, that was for the surcharge, that was 50 percent of the hospitals. But then there's also, why do we allocate the claims 50/50 --

Q. 50/50.

A. -- are the questions that we're answering here. Those don't necessarily have to be same the number, but that was how it turned out.

MR. BARAN: That was all I had. Thank you.

CHAIR RITCHIE: If there's no more comments or questions from the Board or presenters, I thank everyone, particularly Mr. Baran and Mr. Ashenbrenner, thank you very much for your patience and willingness to answer all the questions. Thank you very much to the Board for participating and asking questions. Thank you very much everyone else for attending and listening and contributing interrogatories or anything ahead of time, and I call an end to this and Board.

(Meeting adjourned at 5:40 p.m.)

REPORTER'S CERTIFICATE

I, Kim Kay Shollenbarger, Registered Professional Reporter, do hereby certify that I reported the foregoing proceedings in stenographic shorthand via Zoom and that the foregoing pages are a transcript of those proceedings that were reduced to printed form by me to the best of my ability.

/Kim Shollenbarger

Kim Kay Shollenbarger, RPR

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Carl is a principal and consulting actuary with the Milwaukee office of Milliman. He joined the firm in 2000.

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Prior to joining Milliman, Carl spent six years with a major insurance company and an actuarial consulting firm. His area of expertise is ratemaking and loss reserve analysis for property and casualty insurance. He has experience in many lines of business, with a special emphasis in:

- Aerospace insurance
- Agriculture
- Asbestos liability
- Commercial auto
- Crop insurance (federal MPCI and private programs)
- Directors and officers liability
- Environmental liability (intended coverage and legacy)
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- Fiduciary liability
- General liability
- Marine insurance
- Medical Professional Liability
- Surety
- Umbrella
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Carl's clients include self-insured entities, captives, insurance companies, reinsurers, run-off entities, and underwriting pools. He also serves as an expert witness regarding reinsurance disputes.

PRESENTATIONS AND PUBLICATIONS

"Taming the Turbulent Cycle of Aviation Insurance," *Milliman Global Insurance*, January 2005

"Getting a grip on GRIP—Estimating Loss Ratios for Reserve Analyses," Milliman white paper, June 2008

"Forecasting Asbestos Claims in the Aviation Market," *P&C Perspectives*, October 2009

"Crop Insurance Reserving," Casualty Actuarial Society E-Forum, Fall 2010

"Drones: Emerging commercial potential, emerging liabilities" – *Milliman Insight*, June 2015

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MILLIMAN CLIENT REPORT

New Mexico Patient's Compensation Fund

Actuarial Analysis as of December 31, 2020

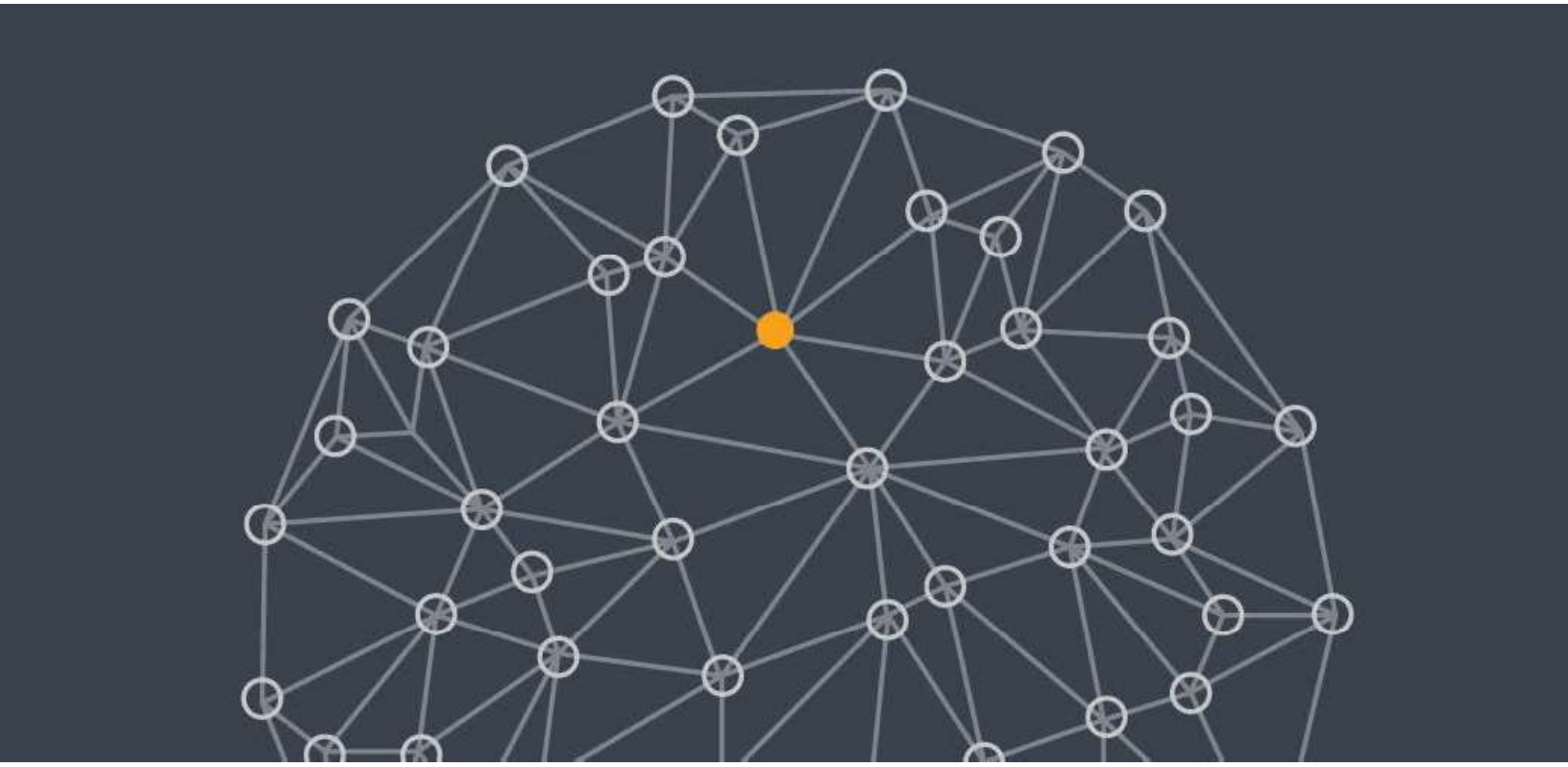
Prepared for: New Mexico Office of the Superintendent of Insurance

Professional Services Contract: #22-440-5000-00003

State Purchasing Price Agreement: #11-44000-21-00112

September 21, 2021

Carl X. Ashenbrenner, FCAS, MAAA
Principal and Consulting Actuary



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Introduction and Background

The New Mexico Patient's Compensation Fund ("PCF"), which was established by the New Mexico Medical Malpractice Act of 1976 ("MMA"), provides an excess layer of professional liability coverage for its member healthcare providers. The following changes to the Act were made by HB75, signed into law in 2021:

- Additional types of providers (e.g. nurse practitioners) will now qualify to participate in the PCF.
- Beginning 1/1/22, qualifying provider types employed by Hospitals and Outpatient Health Care Facilities ("OHCF") will qualify under the "Hospitals" category and will not be required to purchase individual coverage. However, these individual providers will be rated the same surcharges as independent providers. The additional assessment to cure the deficit attributable to the hospitals (and employed qualifying provider types) will be added to these surcharges.
- Hospital and OHCF eligibility for the PCF ends on 12/31/2026. This includes individual providers employed by the Hospital or OHCF.
- Required underlying coverage limit (i.e., PCF attachment point) increases from $200K to $250K.
- For independent providers, the cap on non-medical damages increases from $600K to $750K for injuries occurring in 2022, and inflation-adjusted annually thereafter.
- For Hospitals and OHCFs (including employed individual providers), the PCF portion of the non-medical damages for claims is the layer between $250K and $750K until 2027 when they become ineligible to participate. The overall cap on non-medical damages for claims against Hospitals and OHCFs become substantially higher than for independent providers beginning in 2022.
- The current PCF deficit should be eliminated by 1/1/2027. Any fund deficit attributable to hospitals and outpatient health care facilities (including employed qualifying provider types) shall be cured by those hospitals and healthcare facilities by 12/31/2026.
- The fund will need to pay for the operation of the advisory board and a third party administrator who will be responsible for all operations, including legal, accounting, claim administration and budgeting.

Throughout this report Physicians and Surgeons are referred to as "P&S" while Hospitals and OHCFs are referred to as "Hospitals".

Scope of Work

The scope of work follows the "Professional Services Contract" #22-440-5000-00003 and "State Purchasing Price Agreement" #11-44000-21-00112". The scope includes reviewing the revised MMA statute ((§§ 41-5-1 to -29 NMSA 1978, as amended, or "HB75")) and developing rates for the following categories:

1. Newly eligible types of providers for which the PCF does not have any prior history/data.
2. Existing types of providers for which the PCF does have prior history/data.
3. Hospitals and OHCF for which the PCF has limited prior history/data.

The newly developed rates shall contemplate the increased underlying PCF attachment and layer specified in the statute. Recommended rates will be provided at various confidence levels (between central estimate and 90th percentile confidence level). HB75 requires surcharges to be based on New Mexico experience to the extent that this data is fully credible. Where consistent with the statutory mandate, assumptions may be based on multi-state data for credibility purposes.

In addition, the scope of work will include the following:

4. Estimate the unpaid claim liability, separately, for "Physicians & Surgeons" and "Hospitals" as of a recent accounting date. Physicians & Surgeons include the employed physicians of Hospitals as the PCF is not able to spit out this exposure.
    a) Provide the unpaid claim liability estimates at nominal, discounted and 90th percentile risk level bases.
5. Determine the amount of the current fund 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).
6. Develop an appropriate annual assessment on hospitals (including employed qualifying provider types) to eliminate their share of the existing Fund deficit, as determined in item 5, by January 1, 2027.
7. Excluding the amount of deficit that will be cured by assessments per item 6, develop an appropriate annual assessment on all other qualified healthcare providers that will allow the remaining deficit to be eliminated by January 1, 2027.
8. Review the Hospital experience rating plan ("ERP") and recommend changes as necessary.
9. Review the ISO code classification list and recommend appropriate updates.
10. Present the findings to the Advisory Board, testify at the rate hearing and evaluate/respond to any conflicting actuarial analysis offered into evidence at that hearing.

Disclosures

Reserves

The use of the term “reserves” is common in the insurance industry. All references to the Milliman estimated reserves in this report indicate the Milliman estimated liability for unpaid loss amounts and should not be construed as indicating a value carried on the company financial statements. The amounts carried on the company financial statements are referred to herein as the “carried” or “booked” reserves.

Reserve and Rate Provisions

Our reserve estimates include provisions for loss and future medical payments and does not include any provision for other future expenses. Allocated loss adjustment expenses such as defense counsel and expert witness fess are paid by the primary insurance provider. The indicated rates include the following projected amounts:

- Losses paid by the PCF
- Calendar year loss adjustment expenses
- Calendar year office expenses
- Calendar year cost of “Batch” insurance or a provision for this exposure within the losses
- “On-going” medical payments paid by the PCF
- Offsetting investment income on invested funds held

“On-going” medical payments are attributable to claims that have settled but require the PCF to pay for all future medical care due to the underlying injury. According to the PCF, there are approximately six of these claims and it is possible these claims will settle in the future. These payments are not included in the loss history provided by the PCF and therefore an additional load is added to the rate calculation.

Scenarios

The impact of the key variables for alternative scenarios in the analysis was considered. Alternative development factor or apriori loss ratio assumptions could change the results of this analysis materially, resulting in either greater or lesser estimated reserves depending upon the manner in which the variable is changed.

Reinsurance

The PCF has purchased reinsurance to limit liability for losses. The reinsurance only covers “batch” claims which refer to multiple “related incidents” and was effective September 1, 2017 on a claims-made basis. We are not aware of any incidents that would qualify for this reinsurance at this time and therefore, have not estimated a provision for these contracts. Our results, net of reinsurance, assume that all reinsurance is valid and collectible. An assessment of the potential for uncollectible reinsurance is outside the scope of

our assignment. We have not anticipated any contingent liabilities that could arise if the reinsurers do not meet their obligations to the PCF as reflected in the data and other information provided to us.

Future Investment Return and Financial Condition of the PCF

In estimating the PCF's discounted loss reserves and surcharge requirements, we used an annual effective interest rate of 3.5%. This is based on the historical returns of the PCF which were provided by the PCF.

Future rates of return are not guaranteed and may exceed or fall below the assumed rate. Also, the actual timing of loss payments is subject to variability. Differences between actual and expected rates of return and timing of payments from those underlying our estimates, may have a material effect on the amount of the discount. Further, our projections assume the existence of valid assets underlying the unpaid claim liabilities and that these assets have scheduled maturities that are appropriate to meet the cash flow needs of the PCF. We have not reviewed the held assets.

The scope of our review was only with respect to the PCF's unpaid claim liabilities and future surcharge estimates. We did not review and are not expressing any opinion as to the overall financial condition of the PCF as of December 31, 2020.

Actuarial Central Estimates

Our estimates presented in this report can be characterized as actuarial central estimates. Each estimate represents an expected value over a range of reasonably possible outcomes. They do not reflect all conceivable extreme events where the contribution of such events to an expected value is not reliably estimable. The estimates are not defined by a precise statistical measure (i.e., mean, median, mode, etc.), but are selected from multiple indications produced by a variety of generally accepted actuarial methods that are intended to respond to various drivers of ultimate claim liabilities.

Variability

Actuarial estimates are subject to uncertainty from various sources, including changes in claim reporting patterns, claim settlement patterns, judicial decisions, legislation, economic conditions, etc. It is necessary to project future loss payments while estimating both unpaid losses and future losses. It is certain that actual future loss will not develop exactly as projected and may, in fact, significantly vary from the projections.

Our estimates make no provision for extraordinary future emergence of new classes of losses or types of losses not sufficiently represented in the PCF's historical databases or that are not yet quantifiable, including the potential impact of the COVID-19 pandemic. There is substantial uncertainty regarding the impact of COVID-19 on the level and nature of business activity. Exposures, claim frequency, and claim severity will likely be affected in ways we cannot currently estimate. It is important to recognize that actual losses may emerge significantly higher or lower than the estimates in this analysis.

It is unknown how the COVID-19 pandemic may affect the availability and timeliness of medical treatment (whether or not COVID-19 related). This may affect the amount and timing of future claim payments.

The assumptions included within this report assume the same participation as of the evaluation date. If the participation decreases in the future, the amounts set to eliminate the PCF deficit will be inadequate. If the assessment to eliminate the deficit is recalibrated every year, then a decreasing population could cause a spiral (increasing assessments on a decreasing participation) within the calculation.

Qualification

Carl X. Ashenbrenner is a Fellow of the Casualty Actuarial Society and a member of the American Academy of Actuaries (“AAA”) and meets the Qualifications Standards of the AAA to render the actuarial opinion contained herein.

Limitations on Distribution

Milliman's work is prepared solely for OSI, as custodian of the PCF, and for the PCF advisory board, for purposes of meeting the requirements of Section 41-5-25 NMSA 1978 of the MMA. This work, and the data supporting this work, shall not be disclosed, or relied upon other than as authorized in the MMA.

Milliman's work is not to be distributed to third parties except as otherwise agreed in writing. Milliman does not intend to benefit any third party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

In the event Milliman consents to release its work product, it must be provided in its entirety. Milliman recommends that any third party recipient have its own actuary or other qualified professional review the work product to ensure that the party understands the assumptions and uncertainties inherent in the estimates. No third party recipient of Milliman's work product should rely upon Milliman's work product.

Notwithstanding the above, Milliman consents to the following:

(a) OSI may provide a copy of Milliman's work to its auditor to be used solely for audit purposes. In the event the audit reveals any error or inaccuracy in the data underlying Milliman's work, Milliman requests the Auditor or OSI notify Milliman as soon as possible.

(b) OSI may provide a copy of Milliman's work to governmental entities, as required by law.

Any reader of this report agrees that they shall not use Milliman's name, trademarks or service marks, or refer to Milliman directly or indirectly in any third party communication without Milliman's prior written consent for each such use or release, which consent shall be given in Milliman's sole discretion.

Executive Summary

Unpaid Claim Liabilities

The following table and Summary Exhibits 1 and 2 display our estimated unpaid claim liabilities as of December 31, 2020 for each provider type and on-going medical costs:

New Mexico PCF
Unpaid Claim Liabilities
($ M)

Provider Type / On-Going Medical	Actuarial Central Estimate		90% CL	
	Undiscounted	Discounted	Undiscounted	Discounted
Physicians and Surgeons	$98.6	$89.9	$126.2	$115.1
Hospitals	$83.6	$76.2	$106.9	$97.5
On-going Medical	$5.5	$5.0	$7.0	$6.4
Total	**$187.6**	**$171.1**	**$240.1**	**$219.0**

The discounted amounts are calculated using an annual investment return assumption of 3.5%. This assumption was calculated based on the previous five historical years average investment gains divided by the "Total PCF Funds" in the PCF financial summary worksheet. This calculation is shown on Exhibit C7.

PCF Surplus/Deficit

Based on the estimated unpaid claim liabilities in the above table we can calculate the PCF Surplus/(Deficit) as of December 31, 2020. The PCF Fund Balance was provided by the PCF. These amounts are displayed in the following table.

New Mexico PCF
Unpaid Claim Liabilities
($ M)

	Actuarial Central Estimate		90% CL	
Provider Type	Undiscounted	Discounted	Undiscounted	Discounted
PCF Fund Balance	$120.8	$120.8	$120.8	$120.8
Unpaid Claim Liability	$187.6	$171.1	$240.1	$219.0
PCF Surplus/(Deficit)	$(66.8)	$(50.3)	$(119.4)	$(98.2)

The estimated deficit on an undiscounted basis shown in the previous actuarial report was $65.2 million. Therefore, the PCF deficit increased by $1.6M over the 2020 calendar year. It should be noted this deficit is only calculated as the difference between undiscounted unpaid claim liabilities and the PCF fund balance and does not include other potential expenses or investment income in the future that isn't offset by future PCF surcharges.

PCF Surplus/Deficit by Provider Type

The scope of our work included an allocation of the PCF deficit between P&S and Hospitals. For this exercise, we calculated the difference between the surcharges and the estimated ultimate losses by accident year since 2006 by provider type. We also allocated the deficit between independent P&S and employed P&S (who are included in the hospitals). This difference is approximately $6.1 million lower than the overall deficit, and is due to additional PCF expenses as well as timing issues of payments. Therefore, we allocated this additional amount between providers as shown in the following table:

New Mexico PCF
Deficit by Provider Type
($ M)

Provider Type	Surcharge minus Ultimate Losses	Allocated Deficit
Independent P&S	$(51.5)	$(56.6)
Hospitals	$(5.2)	$(8.1)
Employed P&S	$(4.1)	$(2.1)
Hospitals and Emp P&S	$(9.3)	$(10.2)
Total	**$(60.7)**	**$(66.8)**

PCF Deficit Assessment by Provider Type

The scope of our work also includes estimating an appropriate annual assessment for each provider type to eliminate their share of the existing deficit by January 1, 2027. For this exercise, we first need to allocate the P&S ultimate losses between independent and employed providers. This information was not provided by the PCF as we understand it does not exist. For this allocation, we are assuming employed providers were charged 50% of the hospital surcharges prior to 2016. We assumed that the independent provider membership remained steady from 2016 through 2020, whereby the only changes in surcharges were due to rate changes. This is shown on Summary Exhibit 5. From this surcharge amount we allocated the estimated unpaid losses, pro-rata, between independent and employed providers. We then added the paid loss to date to these unpaid loss estimates.

In order to calculate the assessment, we calculated the projected "normal" PCF surcharges effective January 1, 2022 as shown on Exhibits A1 and B1. These amounts assume no change in PCF membership. Using these amounts, we calculated an additional four years of "normal" surcharges, using an annual inflation rate of 4%. We then allocated the PCF deficit for each provider type by year based on the overall expected surcharges, and then calculated the additional percentage required to eliminate the fund balance by January 1, 2027, as shown on Summary Exhibit 7. It should be noted that this is based on:

- The estimated ultimate losses as of December 31, 2020. These amounts are likely to change as claims are settled and paid by the PCF and could increase or decrease depending on the actual settlement values. This is normal in most actuarial estimates;
- The projected rate change of 4% used in the future surcharges. The actual future experience will also vary, and this will impact the deficit in future years;
- The additional assessments earning investment income at an annual rate of 3.5%. It is likely the investment returns will vary over the next five years;
- The number of members in the PCF remaining the same as in 2020. If a significant number of members leave the PCF, the additional assessment will not be adequate to cover the current deficit. This could cause a "spiral" of assessments if the assessments are recalibrated each year; and
- The PCF expenses and/or investment returns are similar to the assumptions used in the surcharge calculations. If either expenses or investment returns are higher or lower than the accruals in the surcharges, this will impact the deficit.

2022 Rate Change

The following table displays the overall rate change for each provider type as of January 1, 2022. These amounts do not include the additional assessment to eliminate the PCF deficit. These include an estimated provision for the change in the PCF attachment and limit. The details of these calculation are displayed on Exhibits A2 and B2.

New Mexico PCF
Estimated Rate Change by Provider Type
As of January 1, 2022

Provider Type	Central	70% CL	80% CL	90% CL
P&S	19.7%	28.1%	37.7%	53.3%
Hospitals	3.6%	10.8%	19.1%	32.6%

Impact of Attachment Point and Limit Change

HB75 changed both the cap and limit the PCF is responsible for, for occurrences on or after January 1, 2022. The current MMA caps the overall non-medical damages to $600,000 per occurrence. HB75 increases this amount to $750,000 for P&S and $4,000,000 for Hospitals. These caps are increased in future years. The PCF is responsible for all medical (past and future) damages after the attachment point is eroded. The following table displays these amounts:

New Mexico PCF
ATTACHMENT POINTS AND LIMITS FOR NON-MEDICAL DAMAGES

Limits	Current PCF	HB75 PCF
Attachment	$200,000	$250,000
PCF Limit	$400,000	$500,000
Overall Limit	$600,000	$750,000

Previously the PCF limit and cap for non-medical damages were the same for both P&S and Hospitals. With HB75, the hospital will be responsible for any non-medical damage above the PCF limit of $500,000 (up to a cap of $4,000,000 in 2022).

We have estimated the impact of these changes on rates and discuss in a subsequent section.

ISO Class Code Recommendations

We reviewed the most recent classification plans for two large P&S writers in New Mexico and compared their relativities for each ISO class codes to the PCF rating plan. For the ISO class code relativities that are significantly different we recommended using different class codes. Exhibit E1 and E2 provide our analysis of each ISO class code relative to the two large P&S writers, while Exhibit E3 summarizes only the ISO codes where we are recommending a modification. We also included an offset to the 2022 rate change to account for this change, as shown on Exhibit A1.

Newly Eligible Providers

Several health care providers are now eligible to participate in the PCF due to the changes made to HB 75. These include certified nurse practitioners, clinical nurse specialists and certified nurse-midwifes. For these newly eligible providers we reviewed New Mexico rate filings and selected appropriate rating relativities to be included in the class plan, as shown on Exhibit G1. It is our understanding based on conversations with the PCF that the newly eligible providers are not required to pay any assessment for the current PCF deficit.

Hospital Experience Rating Review

We reviewed the recently adopted hospital experience rating methodology and would recommend terminating it for several reasons. A detailed discussion of our recommendation is included in a separate section.

Change from Last Year

A comparison of our current estimated ultimate loss to the prior[1] estimated ultimate loss as of December 31, 2019 is shown on Summary Exhibit 8 and in the following table:

New Mexico PCF
Change in Milliman's Estimated Ultimate Loss to Prior Actuarial Report
From December 31, 2019 to December 31, 2020
($000's)

Accident Year	P&S	Hospitals	Difference
2014 and Prior	$(1.0)	$2.4	$1.4
2015	$(3.3)	$0.2	$(3.1)
2016	$(0.8)	$(2.9)	$(3.6)
2017	$0.3	$(2.7)	$(2.4)
2018	$(0.3)	$2.1	$1.8
2019	$(1.2)	$1.4	$0.3
Total	**$(6.3)**	**$0.6**	**$(5.7)**

As can be seen in the above table, the estimated ultimate loss decreased by $5.7 million since last year-end. This decrease was primarily due to favorable experience in the 2015 through 2017 accident years. These amounts do not include the batch claims (which are discussed in more detail in the following section), which were paid prior to December 31, 2019 and therefore had no impact on the 2020 calendar year change. Detailed calculations are provided on Summary Exhibit 8.

[1] "New Mexico Patient's Compensation Fund – 2019 Actuarial Analysis"; Merlinos & Associates, Inc; November 2020

Discussion of Reserve Analysis

We have estimated ultimate loss for P&S and Hospitals separately using standard actuarial methods and using an accounting date as of December 31, 2020. The claim data was provided as of July 27, 2021, and we did not use the provided 2021 calendar year data directly in our analysis. However, we reviewed this additional information while making our selections. Our analysis included development of ultimate closed-with-payment ("CWP") claims for each segment. Claims counts are highly predictive of loss payments and we believe their development and use in an actuarial analysis is particularly important for a high severity / low frequency line of business such as Medical Professional Liability ("MPL") coverage. In developing our indicated ultimate loss estimate, we rely in part on our indicated projections of ultimate CWP claim counts.

For the methods below that rely on development factors, it should be noted that the selected factors were derived using combined P&S and Hospital data. This approach was taken to maintain credibility within the development triangles, as well as remain consistent with the prior actuary.

It should also be noted that we have removed all batch claims from both the triangles and the development methods. The batch claims were two separate groupings of large claims, where batch #1 occurred in the 2006 to 2009 accident years, while batch #2 occurred between the 2005 and 2010 accident years. These batch claims have not been factored into our reserve analysis due to the reinsurance purchased to cover this potential exposure. A summary of the batch claims can be found on Summary Exhibit 1.

The following methods are used in developing ultimate loss, and are explained below using P&S exhibits as a guide:

- Paid development method;
- Paid Generalized Cape Cod ("GCC") method;
- Paid Bornhuetter-Ferguson ("B-F") method;
- Frequency-Severity method; and
- Loss Ratio method.

Exhibit H1 presents our estimates of ultimate loss by accident year and derives the associated unpaid loss.

Exhibit H2 summarizes the various projection methods and displays our selection of ultimate loss and by accident year.

The paid development method uses historical relationships between loss payments at given months of development for each accident year as a predictor of future development patterns. This method assumes that historical payment patterns are consistent from year to year. Should there be changes in the way claims are settled, the historical patterns would lose some predictive accuracy without adjustments first being made to the historical data. The paid development indications are displayed on Exhibit H3.

Exhibit H4 presents the derivation of ultimate loss by a GCC method, based on paid development patterns. The GCC method provides a formula to determine the apriori estimate of ultimate loss that is then used to calculate the indicated ultimate loss. Under the GCC method, the apriori expected loss used for each accident year is the weighted average of the trended and exposure adjusted development method ultimate where the average is taken over all available years. The GCC method uses weights to calculate the weighted average. The weights have the following properties:

- They are positively proportional to the exposure in any year. In our application of the GCC method, the exposure used is earned surcharges as an approximation for the volume of exposure. Thus, the higher surcharges a given accident year has, the more weight that year is given;
- They are inversely proportional to the magnitude of the development factor applicable for a year. That is, the larger the development factor is for a given year, the less weight that year receives. This has the effect of giving more weight to older, more mature accident years, and less weight to younger, less mature years; and
- They are inversely proportional to the length of time between years, based on the decay ratio. For example, when determining the apriori ultimate losses for accident year 2015, more weight is given to the years closest to 2015.

Once we have the apriori expected loss, Column (9), we calculate the expected unpaid loss plus the actual paid loss to estimate the ultimate for a given accident year.

Exhibit H5 presents the derivation of ultimate loss based on a paid B-F method. The paid B-F method estimates ultimate loss based on paid loss to date and an estimate of expected loss yet to be paid. The loss expected to be paid is calculated from our apriori ultimate loss, based on our selected frequency-severity indication, and the percentage of loss unpaid.

Exhibits H6 and H7 present the derivation of ultimate loss based on a frequency-severity method. Exhibit H6 derives an ultimate CWP severity for each accident year, and trends that severity forward to future accident years. A selected severity based on historical indications is then selected for each accident year. Exhibit H7 multiplies the selected severities by the indicated ultimate CWP claim counts to derive an indication of ultimate loss.

Exhibits H8 and H9 present the derivation of ultimate loss based on a loss ratio method. Exhibit H8 derives an ultimate loss ratio for each accident year, and trends that loss ratio forward to future accident years. A selected loss ratio based on historical indications is then selected for each accident year. Exhibit H9 multiplies the selected loss ratio by the on-level surcharges to derive an indication of ultimate loss.

The following methods are used in developing CWP claim counts, and are also explained below using P&S exhibits as a guide:

- CWP chain ladder development;
- GCC method;
- BF method; and
- Ultimate frequency (relative to on-level surcharges).

Exhibit I1 presents our estimates of ultimate claim counts by accident year and derives the associated claims yet to CWP.

Exhibit I2 summarizes the various projection methods and displays our selection of ultimate claim counts by accident year.

The CWP claim development method projects CWP claim counts to their ultimate value, based on historical development patterns. Changes in claim closure patterns can affect the accuracy of this method. The CWP claim count development indications are displayed on Exhibit I3.

The GCC method relies on similar methodology as the loss method to develop indicated ultimate CWP counts. The indications are displayed on Exhibit I4.

The claim count B-F method is similar to the loss B-F method, except it uses CWP claim counts in lieu of paid loss and an estimate of the percentage of ultimate claims unreported in lieu of the percent of ultimate loss unreported. Exhibit I5 displays the paid B-F method.

Exhibits I6 and I7 display the ultimate frequency method. Exhibit I6 derives an ultimate CWP frequency for each accident year, and then trends the frequency forward to future accident years. A selected frequency based on historical indications is then selected for each accident year. Exhibit I7 multiplies the selected frequencies by the on-level surcharges to derive an indication of ultimate CWP counts.

Analogous exhibits for Hospitals can be found in Exhibits J and K.

As stated above, the development factors utilized in the methods were derived using combined P&S and Hospitals data. The loss and count triangles, along with the selected development factors, can be found on Exhibits L1 and L2.

Discussion of Rating Analysis

Methodology

The overall rate change for P&S is shown on Exhibit A1. The projected loss ratio at current rates, line (1), is calculated on Exhibit A3. This includes an amount for both unallocated loss adjustment expenses ("ULAE") as shown on Exhibit C3 and on-going medical expenses which are displayed on Exhibit C6. The projected loss ratio is the product of the projected severity and projected frequency, shown on Exhibit A5 and Exhibit A6, respectively. These amounts have been trended to the midpoint of the annual rate change period which is July 1, 2022. A comparison to the trended on-level loss ratios is shown on Exhibit A4.

The projected loss ratio is discounted to reflect anticipated investment income and based on a projected payout pattern shown on Exhibit C1. The adjustment for changes in the attachment point and limit is shown on line (4). This amount is multiplied to the projected discounted loss ratio for 2022. This loss ratio is multiplied by the current assessment level to calculate the projected discounted losses for 2022. This amount is further loaded for the following items:

- Office expenses (displayed on Exhibit C4);
- Batch reinsurance costs and/or a load for potential batch claims (displayed on Exhibit C5); and
- Adjustment to reflect the ISO class plan changes (displayed on Exhibit E2).

The projected total amount is then compared to the current rate level and an overall change is calculated. The overall rate change is shown for different confidence levels on Exhibit A2.

The rate change for Hospitals follows the same approach and is shown on Exhibits B1 through B6. We included an offset for the elimination of the ERP for hospitals (derived on Exhibit F1). For hospitals, we also needed to factor in the rate change in 2021 since the surcharges were not restated at current rate levels.

We also included summaries of base rates by class for each provider type, and a separate column displays the additional assessment by class. For P&S, this summary is provided for Independent P&S and Employed P&S on Exhibit A7 and A8, respectively. The summary for Hospitals is provided on Exhibit B7.

Assumptions

The following assumptions were used in the proposed rate change and are shown on Exhibit C1-C7. These assumptions were derived using the historical averages. If differences are anticipated in the future, these should be adjusted to the forecasted amount during 2022.

The discount factor calculation is shown on Exhibit C1. This is based off the projected payout of losses displayed on Exhibit C2. The selected investment income ratio is shown on Exhibit C7 and is based off the previous five-year net investment income compare to the total PCF funds.

The loads for ULAE and office expenses are shown on Exhibit C3 and Exhibit C4, respectively. It is our understanding the PCF is planning to hire an administrator and therefore the office expenses should be greater in 2022 compared to prior years. We attempted to account for this by reviewing the fixed expense loads of a MPL insurer from New Mexico as provided in a rate filing. Once the administrator is hired, the actual costs should be considered in future rate reviews.

Beginning in 2017, the PCF purchased reinsurance for batch claims. It is unknown at this time whether the PCF will continue to purchase this reinsurance into 2022. However, the batch losses were excluded from the rating assumptions. As such, either the cost of the reinsurance or the expected value of batch claims should be included in the rate calculation. Exhibit C5 displays the cost of the reinsurance and the ratio of batch losses to projected ultimate losses for accident years 2000 through 2020. Based on these two calculations, a load for batch claims is selected.

Exhibit C6 displays the calculation for the on-going medical payments. This amount is not included elsewhere in the rate calculation.

Discussion of PCF Attachment Point and Limit Change

Exhibit D1 summarizes the estimated impact to rates due to the change in the PCF attachment point and limit, as provided by HB75.

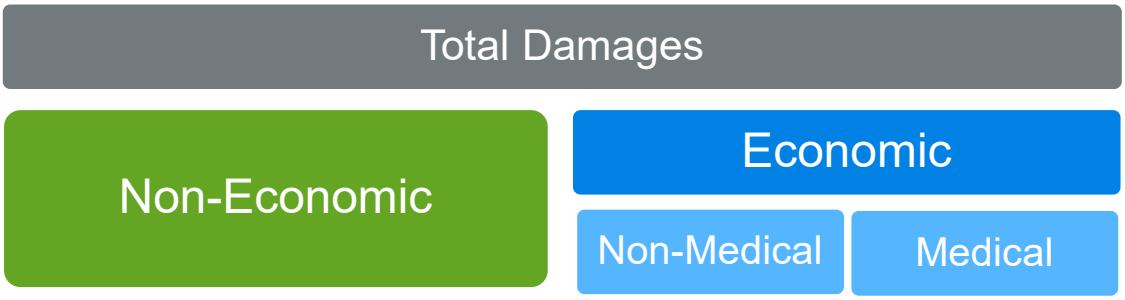
Damages in MPL Cases

Damages awarded to a patient injured from a medical event can be separated into economic and non-economic components. Economic damages compensate the injured party for the financial impact of the injury. These damages are typically quantifiable and can be separated into medical and non-medical losses. Non-medical economic losses include items such as lost wages.

Non-economic damages are more difficult to quantify as there are no specific monetary amounts from which to calculate. Non-economic damages include items such as pain and suffering, loss of consortium, etc. The sum of the economic and non-economic components is the total amount awarded to the injured party.

In regards to the damages that are subject to the attachment point and limit, HB75 states "*Except for punitive damages and past and future medical care and related benefits…".* It is our understanding that punitive damages are not paid by the PCF and therefore we have excluded consideration of these damages in this analysis. Therefore, our analysis considers two categories of damages: medical losses and non-medical losses (including the non-medical portion of economic damages and all non-economic damages).

Components of Total Damages in a MPL Case



HB 75 Attachment Point and Limit Changes

As provided by HB75, the attachment point and limit the PCF provides is changing effective January 1, 2022. The attachment point is increasing from $200,000 to $250,000 per occurrence while the limit is increasing from $400,000 to $500,000. The limit does not apply to medical damages; hence the PCF will pay for all medical damages as long as the combined amounts exceed the attachment point. HB 75 also increased the cap for non-medical damages to $750,000 from $600,000 for P&S. The cap increased from $600,000 to $4 million for hospitals, although the PCF is not responsible for any non-medical damages above the PCF limit of $500,000.

Simulation Discussion

We modeled the changes to the PCF by using a Monte-Carlo simulation model. This model calculated the difference between the current PCF attachment and limit and the HB75 attachment and limit for 2022. The difference between the loss costs was calculated as an adjustment to the rates, which were discussed in a previous section. The simulation model uses many assumptions. The assumptions were made using New Mexico specific data, as required by the MMA, except for certain assumptions that required additional data. Professional judgement was also incorporated into these assumptions. These assumptions are summarized on Exhibit D2 and further described below:

1. **Average Severity per Occurrence Paid by the PCF:** This amount was derived in the rating analysis for each provider type. The model simulates claim-level results, so the average severity per occurrence is transformed to an average unlimited severity per claim on Exhibit D3.
2. **Hospital Claims as Percent of All Claims:** Exhibit D4
3. **Number of Claims per Occurrence:** This represents the number of PCF insureds that are named in the lawsuit or case. This assumption was calculated for each provider type, shown on Exhibit D5.
4. **Medical Loss as Percent of Total Loss:** This assumption is used to derive an estimated medical and non-medical severity per claim. The calculation of this assumption is shown on Exhibit D6 and relies on PCF claims data as well as assumptions from a prior Milliman analysis, which is publicly available on the New Mexico PCF website[2]. Because of the structure of the PCF, all occurrences with payments excess of the $400,000 limit were assumed to be medical damages.
5. **Loss Distribution:** Since the non-medical severity amounts have been capped by the $600,000 limit, we need to adjust this amount to an “unlimited” severity using a fitted distribution. We selected a lognormal distribution which, as shown on Exhibit D7, is the best fit. Lognormal distributions are typically used to model MPL claims.
6. **Coefficient of Variation:** For this model, we simulated the medical and non-medical damages separately for each claim. We fit the historical PCF data to a lognormal distribution on Exhibit D8 and then selected a coefficient of variation (“CV”) for each claim type. With this CV, we then calculated the “unlimited” per claim severity to be used in our simulation model as shown on Exhibit D3 for non-medical damages. Since the medical damages are not capped no adjustment is needed. We then ran several simulations using various CV assumptions and compared the resulting CV to the historical PCF data CV and selected the CV that best fit the underlying PCF data.

We ran 80,000 separate occurrences and calculated the PCF payout for both the current and HB75 attachment points and limits. The trial results were recorded separately for both P&S and hospitals. The average severity and frequency under the current attachment point and limit and the HB75 attachment point and limit are calculated across all trials. The change between these scenarios, calculated on Exhibit D1, is the resulting adjustment used in the rate development analysis discussed previously.

We performed scenario testing by running simulations using different CV assumptions for the claims. We also tested the sensitivity of the medical loss as percent of total loss by running simulations using various selected percentages.

[2] https://pcf.osi.state.nm.us/wp-content/uploads/2020/11/Milliman-TDC-PCF-Cap-Analysis-Report-.pdf

The following table displays the differences between claim CV assumptions. The table shows that the differences due to CV assumptions (and resulting rate change adjustments) are modest in our model.

New Mexico PCF
Adjustments using Alternative CV Assumptions

Input Claim CV	P&S Adjustment	Hospital Adjustment	Difference from CV 1.0	
			P&S	Hospital
0.75	7.0%	1.4%	-0.9%	-1.7%
1.00	8.0%	3.2%	0.0%	0.0%
1.25	8.7%	4.4%	0.6%	1.2%
1.50	9.1%	5.3%	1.0%	2.0%
2.00	9.7%	6.4%	1.5%	3.1%
4.00	10.8%	8.2%	2.5%	4.9%

We also compared the difference between medical damage percentages assumptions as shown in the following table. It is important to understand that we are only measuring the difference between the current and HB75 attachment point and limit. If the percentage of medical damages would increase in future claims, the overall cost to the PCF would increase since the medical is unlimited.

New Mexico PCF
Adjustments using Alternative Medical Damage Percentages

Medical Percentage	P&S Adjustment	Hospital Adjustment	Difference from 35%	
			P&S	Hospital
0.35	8.0%	3.2%	0.0%	0.0%
0.40	5.2%	0.8%	-2.7%	-2.3%
0.50	0.7%	-2.9%	-6.7%	-5.9%

Discussion of Hospital Experience Rating Methodology

A hospital rating plan[3] was established for the PCF and was implemented in 2020. Included in this rating plan was an adjustment to the manual rates based on each hospital's own experience. This is referred to as an Experience Rating Plan ("ERP") and is commonly used within the rating structures of many casualty exposures[4]. In a typical ERP, adjustments are made to lower the impact of large volatile claims. We reviewed the hospital experience rating plan of UMIA Insurance, Inc. which was filed[5] in the state of New Mexico. This plan uses the last five years of incurred loss history, excluding the most recent year. The UMIA ERP caps losses at $350,000 "to reduce the impact of a single large loss on the final experience modification."

The PCF Hospital ERP uses the number of claims which exceed the $200,000 attachment in the most recent five accident year history, excluding the most recent year. The PCF ERP does not use the incurred loss amounts, only the frequency, to adjust the manual premium.

We reviewed the impact the ERP had for the 2020 year. We were provided the experience plan calculation for each hospital insured by the PCF. Hospitals were eligible for the ERP if the manual surcharge was greater than $1.5 million. It was unclear how this amount was selected when the ERP was designed. There was a total of 15 hospitals within the PCF during 2020. Of these, 5 qualified for ERP because their manual surcharge was greater than $1.5 million. These eligible hospitals accounted for 81% of the manual surcharge overall. We then calculated the difference between the manual surcharge and the adjusted surcharge. The adjusted surcharge was 12% lower than the manual surcharge, as displayed on Exhibit F1. None of the hospitals received a debit from the ERP. All else equal, the overall premium level should be increased by this amount to offset for the reduced premium level.

The PCF ERP calculates the experience modification using reported claims above $200,000. For each hospital it compares the actual number of claims to the expected and calculates the experience mod using these amounts. We summarized these amounts for each hospital on Exhibit F2. The hospitals are only required to provide claim counts if they are eligible for the ERP. The number of claims reported by the hospitals was 56% of the expected number of claims compared to 81% of the manual premium. Since we have a limited amount of data it is difficult to test whether the hospitals not eligible for ERP have worse experience than eligible hospitals.

One issue with using hospital loss experience is employed physician claims. For many MPL claims that occurred within a hospital both a physician(s) and the hospital are named as a defendant. According to the PCF, there is usually little attempt to split the loss between providers when both are covered under the same insurance scheme. The PCF placed a data call for the hospital PCF members. However, it is not clear how the physician claims were accounted for in the data, and it is possible that the data was provided differently between hospitals.

[3] "New Mexico PCF Hospital & Outpatient Health Care Facility Rating Plan"; Pinnacle Actuarial Resources, Inc. – October 2019
[4] https://www.ncci.com/Articles/Documents/UW_ABC_Exp_Rating.pdf
[5] SERFF Tracking #: PERR-131385463

After reviewing the ERP and the resulting discounts provided by the PCF we would recommend discontinuing the ERP for 2022. These are the major reasons for this recommendation:

1. 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.
2. 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.
3. Due to the reporting pattern of claims, the number of claims is both immature and volatile for the previous five years.
4. The resulting ERP discount should be added back to the overall premium level. This is difficult to project and set correctly in the rates.
5. Only 5 of the hospitals qualified for the ERP and it is unclear how the $1.5 manual premium threshold was set.
6. The available data to calculate the ERP parameters are volatile and hospitals will be ineligible for the PCF beginning January 1, 2027.
7. The ERP creates an additional burden to the administration of the PCF.

Confidence Levels of Rates and Reserves

The scope of our analysis included estimating confidence levels for the future rate requirements and reserves. The confidence level factors were selected from a simulation model that simulated the payout of the reserves. This simulation was a separate model than the one used to estimate the change in loss costs between the current and HB75 PCF attachment points and limits. The confidence level represents the overall reserve base estimated as of December 31, 2021.

The range of values displayed in the exhibits (in particular the 90th percentile) does not represent the highest possible values of the discounted loss liabilities. Potential variation above this value exists, both due to uncertainty with respect to the amount, as well as timing of future payments.

Reliance on Data

The data used in our analysis was valued as of December 31, 2020 with additional information provided through August 31, 2021. Our actuarial analyses relied upon data and related information provided by the PCF, OSI, and other publicly available information. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. In that event, the results of our analysis may not be suitable for the intended purpose.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

In performing this evaluation, we have assumed that the PCF (a) used their best efforts to supply accurate and complete data, and (b) did not knowingly provide any inaccurate data.

We note there is a difference between the financial statements and the paid claims provided by the PCF. According to the OSI, this can be attributed to differences between when settlements are recorded in the loss run and when the actual payments are made from the fund.

We were provided the following files from the PCF that were used in our analysis:

1. **PCF Claim Settlements** – This file included PCF paid claims that settled starting on or around 2011. This file excluded the Batch claims and any medical payments. It is our understanding this file was different than the previous file used for the prior actuarial report. This latest file allocated hospital claims 50/50 between the hospital and P&S if both parties were named as a defendant in the case. Therefore, we recast the 12/31/19 data using this latest file. Since the file did not include all the historical claims, we needed to add these back. From this data we added the incremental payments for calendar year 2020. We also show the calendar year 2021 through July 27, 2021. These loss amounts were used in the projection files to calculate the ultimate losses. This is displayed on Summary Exhibit 9.
2. **Summary of PCF Surcharges and Losses by Hosp vs Phys** - This file contained the calendar surcharges by year. Using this file, we calculated the “on-level” surcharges using historical rate changes. This was used in both the ultimate loss projection as well as the rate change indications.
3. **PCF Participation Stats 2019-2021** - This file contained detailed information for each member of the PCF including ISO Code and rating class. We utilized this file in the ISO Class Code analysis.
4. **NM PCF Financial Summary** – This file contained the balance sheet of the PCF for the last seven years. We used this file to calculate the rating assumptions and the PCF fund balance. This file also contained the historical rate changes.
5. **Hospital Experience Plan Rating Files** – These files contained each hospitals experience rating plan for 2020. We utilized these files to evaluate the hospital experience rating plan.
6. **Hospital Data Call Combined** - This file contained the historical claims for each hospital in the PCF. This file was of limited value because the claims included both hospital and employed physician claims and our analysis was split.

Closing

We appreciate the opportunity to be of service to The New Mexico Patient's Compensation Fund and the New Mexico Office of Superintendent of Insurance. If you have any comments or questions, please let us know.

Sincerely,

Carl X. Ashenbrenner, FCAS, MAAA
Principal and Consulting Actuary

CXA/sbs

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New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Summary of Loss

	(1)	(2)	(3) (1) - (2)	(4)	(5)	(6) (4) - (5)	(7)	(8)	(9) (7) - (8)	(10) (3) + (6) + (9)
	Physicians & Surgeons			Hospitals			Batch Claims			
Accident Year	Selected Ultimate	Paid @ 12/31/20	Unpaid	Selected Ultimate	Paid @ 12/31/20	Unpaid	Selected Ultimate	Paid @ 12/31/20	Unpaid	Combined Unpaid
Prior	NA	NA	0	NA	NA	0	NA	NA	0	0
2006	6,328,725	6,328,725	0	0	0	0	1,811,904	1,811,904	0	0
2007	13,190,829	13,164,500	26,329	0	0	0	5,881,469	5,881,469	0	26,329
2008	11,732,218	11,662,152	70,066	0	0	0	7,736,024	7,736,024	0	70,066
2009	8,080,562	7,992,342	88,220	2,097,904	2,075,000	22,904	3,825,362	3,825,362	0	111,124
2010	16,573,610	16,262,567	311,043	1,493,020	1,465,000	28,020	1,642,339	1,642,339	0	339,064
2011	20,495,740	19,911,969	583,771	1,971,143	1,915,000	56,143	0	0	0	639,915
2012	10,221,686	9,734,408	487,278	2,167,872	2,075,000	92,872	0	0	0	580,149
2013	8,605,723	7,962,544	643,179	1,646,106	1,544,693	101,413	0	0	0	744,592
2014	15,747,095	14,364,565	1,382,530	6,895,231	6,244,130	651,101	0	0	0	2,033,631
2015	6,656,137	4,027,500	2,628,637	1,999,712	1,437,868	561,844	0	0	0	3,190,481
2016	13,987,152	5,840,000	8,147,152	4,616,582	2,010,000	2,606,582	0	0	0	10,753,734
2017	26,821,644	9,950,000	16,871,644	14,283,213	2,497,184	11,786,029	0	0	0	28,657,673
2018	25,449,620	2,721,023	22,728,597	23,342,004	2,372,500	20,969,504	0	0	0	43,698,101
2019	24,303,532	720,000	23,583,532	22,696,570	550,000	22,146,570	0	0	0	45,730,101
2020 [1]	21,022,111	0	21,022,111	24,828,117	300,000	24,528,117	0	0	0	45,550,228
Total	229,216,385	130,642,295	98,574,090	108,037,471	24,486,374	83,551,097	20,897,098	20,897,098	0	182,125,187

[1] Reflects a full year of earned exposure

(11) On-Going Medical Payments Percentage	3.0%
(12) On-Going Medical Payments Unpaid Amounts; [(10) total x (11)]	5,463,756
(13) Total Unpaid (Including On-Going Medical Payments provision); [(10) total + (12)]	187,588,942
(14) Estimated 12/31/20 Fund Balance	120,750,188
(15) Fund Deficit; [(14) - (13)]	(66,838,754)

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Confidence Level of Reserves

Summary of Loss

	(1)	(2)	(3) (1) x (2)	(4)	(5) (3) x (4)	(6)	(7) (3) x (6)	(8)	(9) (3) x (8)
				70% Confidence Level		80% Confidence Level		90% Confidence Level	
Accident Year	Combined Unpaid	Discount Factor at 3.5%	Discounted Combined Unpaid	Indicated Factor	Discounted Unpaid	Indicated Factor	Discounted Unpaid	Indicated Factor	Discounted Unpaid
Prior	NA	NA	0	1.070	0	1.150	0	1.280	0
2006	0	1.000	0	1.070	0	1.150	0	1.280	0
2007	26,329	1.000	26,329	1.070	28,172	1.150	30,278	1.280	33,701
2008	70,066	1.000	70,066	1.070	74,971	1.150	80,576	1.280	89,685
2009	111,124	1.000	111,124	1.070	118,902	1.150	127,792	1.280	142,238
2010	339,064	0.983	333,281	1.070	356,611	1.150	383,273	1.280	426,600
2011	639,915	0.966	618,366	1.070	661,652	1.150	711,121	1.280	791,509
2012	580,149	0.958	555,955	1.070	594,872	1.150	639,349	1.280	711,623
2013	744,592	0.945	703,572	1.070	752,822	1.150	809,108	1.280	900,572
2014	2,033,631	0.941	1,913,549	1.070	2,047,498	1.150	2,200,582	1.280	2,449,343
2015	3,190,481	0.968	3,088,727	1.070	3,304,937	1.150	3,552,035	1.280	3,953,570
2016	10,753,734	0.961	10,333,799	1.070	11,057,165	1.150	11,883,869	1.280	13,227,263
2017	28,657,673	0.943	27,010,429	1.070	28,901,159	1.150	31,061,993	1.280	34,573,349
2018	43,698,101	0.924	40,363,461	1.070	43,188,904	1.150	46,417,980	1.280	51,665,230
2019	45,730,101	0.901	41,204,094	1.070	44,088,380	1.150	47,384,708	1.280	52,741,240
2020 [1]	45,550,228	0.873	39,766,028	1.070	42,549,649	1.150	45,730,932	1.280	50,900,515
Total	182,125,187	0.912	166,098,780		177,725,694		191,013,597		212,606,438
[1] Reflects a full year of earned exposure									
(10) On-Going Medical Payments Percentage			3.0%						
(11) On-Going MedPay Unpaid; [Total by C.I. x (10)]			4,982,963		5,331,771		5,730,408		6,378,193
(12) Total Unpaid (Incl MedPay); [Total by C.I. + (11)]			171,081,743		183,057,465		196,744,005		218,984,631
(13) Estimated 12/31/20 Fund Balance			120,750,188						
(14) Fund Deficit; [(13) - (12)]			(50,331,555)		(62,307,277)		(75,993,817)		(98,234,443)

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Derivation of Discount Factor

Age in Months	(1) Selected Cumulative Payment Pattern	(2) (1) - (1) prior Incremental Payment Pattern	(3) Wtd Avg Discount Factor	(4) Accident Year	(5) Current MOD	(6) Discount Factor @ 12/31/20
0	0.0%	0.0%	0.844	2020	12	0.873
12	0.1%	0.1%	0.873	2019	24	0.901
24	2.3%	2.2%	0.901	2018	36	0.924
36	11.5%	9.3%	0.924	2017	48	0.943
48	27.5%	16.0%	0.943	2016	60	0.961
60	46.2%	18.7%	0.961	2015	72	0.968
72	75.1%	28.9%	0.968	2014	84	0.941
84	95.0%	19.9%	0.941	2013	96	0.945
96	97.0%	2.0%	0.945	2012	108	0.958
108	98.0%	1.0%	0.958	2011	120	0.966
120	99.0%	1.0%	0.966	2010	132	0.983
132	99.5%	0.5%	0.983	2009	144	1.000
144	100.0%	0.5%	1.000	2008	156	1.000
156	100.0%	0.0%	1.000	2007	168	1.000
168	100.0%	0.0%	1.000	2006	180	1.000
180	100.0%	0.0%	1.000			

(3) Based on 3.50% assumed yield (derived on Exhibit C7) and selected payment pattern from column (2), assuming mid-year payments
(6) Linearly interpolated from column (3)

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Comparison between PCF Fund Deficit by Calendar Year and Accident Year Deficit

	(1)	(2)	(3) (2) - (1) + (3) prior	(4)	(5)	(6) (5) - (4) + (6) prior	(7) (3) + (6)	(8) Provided by PCF
	Physicians & Surgeons (Including Batch Claims)			Hospitals			Combined	
Accident Year	Selected Ultimate	PCF Surcharge	Cumulative Deficit	Selected Ultimate	PCF Surcharge	Cumulative Deficit	Cumulative Deficit	Calendar Year Fund Deficit
Prior	NA	NA	0	NA	NA	0	0	
2006	8,140,629	9,067,465	926,836	0	0	0	926,836	
2007	19,072,298	8,810,595	(9,334,867)	0	0	0	(9,334,867)	(1,600,000)
2008	19,468,242	9,696,249	(19,106,860)	0	0	0	(19,106,860)	
2009	11,905,924	11,113,554	(19,899,230)	2,097,904	1,130,000	(967,904)	(20,867,134)	2,000,000
2010	18,215,949	11,293,496	(26,821,683)	1,493,020	1,130,000	(1,330,924)	(28,152,607)	
2011	20,495,740	10,798,897	(36,518,527)	1,971,143	1,175,200	(2,126,867)	(38,645,394)	(1,100,000)
2012	10,221,686	10,498,870	(36,241,342)	2,167,872	1,099,542	(3,195,197)	(39,436,539)	
2013	8,605,723	10,330,574	(34,516,491)	1,646,106	1,250,000	(3,591,302)	(38,107,794)	(5,300,000)
2014	15,747,095	10,838,627	(39,424,959)	6,895,231	1,350,000	(9,136,533)	(48,561,492)	
2015	6,656,137	10,536,745	(35,544,351)	1,999,712	1,350,000	(9,786,245)	(45,330,596)	(39,900,000)
2016	13,987,152	11,706,286	(37,825,217)	4,616,582	9,476,474	(4,926,353)	(42,751,570)	
2017	26,821,644	19,718,779	(44,928,082)	14,283,213	18,644,316	(565,249)	(45,493,332)	(36,600,000)
2018	25,449,620	21,435,425	(48,942,278)	23,342,004	21,596,277	(2,310,976)	(51,253,254)	(44,400,000)
2019	24,303,532	20,518,662	(52,727,148)	22,696,570	21,523,811	(3,483,735)	(56,210,882)	(65,200,000)
2020	21,022,111	18,198,537	(55,550,722)	24,828,117	23,123,811	(5,188,040)	(60,738,762)	
Total	250,113,483	194,562,762	(55,550,722)	108,037,471	102,849,431	(5,188,040)	(60,738,762)	

Note: Differences between accident year and calendar year deficits are due to reestimation of ultimate losses as well as other PCF expense and investment items

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Allocation of P&S between Independent Providers and Employed

	(1)	(2)	(3)	(4)	(5)	(6) [(1) - (3) - (4)] x [(5) / (2)]	(7) (3) + (6)	(8) (2) - (5)	(9) (1) - (7)
	Physicians & Surgeons (Including Batch Claims)				Estimated Independent Provider P&S			Estimated Employed P&S	
Accident Year	Selected Ultimate	PCF Surcharge	Independent Paid Loss	Employed Paid Loss	PCF Surcharge	Allocated Unpaid Loss	Selected Ultimate	PCF Surcharge	Selected Ultimate
Prior	NA	NA	0	0	NA	0	NA	NA	0
2006	8,140,629	9,067,465	6,328,725	0	9,067,465	1,811,904	8,140,629	0	0
2007	19,072,298	8,810,595	13,164,500	0	8,810,595	5,907,798	19,072,298	0	0
2008	19,468,242	9,696,249	11,662,152	0	9,696,249	7,806,090	19,468,242	0	0
2009	11,905,924	11,113,554	7,992,342	0	10,548,554	3,714,620	11,706,962	565,000	198,962
2010	18,215,949	11,293,496	16,122,567	140,000	10,728,496	1,855,657	17,978,224	565,000	237,725
2011	20,495,740	10,798,897	19,279,469	632,500	10,211,297	552,007	19,831,475	587,600	664,265
2012	10,221,686	10,498,870	8,334,408	1,400,000	9,949,099	461,761	8,796,169	549,771	1,425,516
2013	8,605,723	10,330,574	6,900,000	1,062,545	9,705,574	604,266	7,504,266	625,000	1,101,457
2014	15,747,095	10,838,627	13,920,435	444,130	10,163,627	1,296,430	15,216,865	675,000	530,230
2015	6,656,137	10,536,745	3,815,000	212,500	9,861,745	2,460,242	6,275,243	675,000	380,894
2016	13,987,152	11,706,286	5,165,000	675,000	9,889,584	6,882,793	12,047,793	1,816,702	1,939,359
2017	26,821,644	19,718,779	8,900,000	1,050,000	10,512,783	8,994,874	17,894,874	9,205,996	8,926,770
2018	25,449,620	21,435,425	1,668,523	1,052,500	11,393,122	12,080,455	13,748,978	10,042,303	11,700,643
2019	24,303,532	20,518,662	720,000	0	11,658,519	13,399,951	14,119,951	8,860,143	10,183,581
2020 [1]	21,022,111	18,198,537	0	0	12,059,845	13,930,977	13,930,977	6,138,692	7,091,134
Total	250,113,483	194,562,762	123,973,121	6,669,175	154,256,554	81,759,825	205,732,946	40,306,208	44,380,538

[1] Reflects a full year of earned exposure
(3), (4) Provided by the PCF
(5) Estimated Surcharge Premium for 2009-2015 estimated as 50% of Hospital surcharge
Estimated Surcharge Premium for 2016-2020 uses 2015 as a base (all independent P&S) and is adjusted for future rate changes

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
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Derivation of Existing Fund Deficit % By Healthcare Provider Based on Surcharge Deficit

	(1)	(2)	(3) (2) - (1)	(4)	(5)	(6) (5) - (4)	(7) (1) + (4)	(8) (2) + (5)	(9) (8) - (7)	(10) (6) / (9)
	Independent Physicians & Surgeons			Hospitals plus Employed P&S			Total			
Accident Year	Selected Ultimate	PCF Surcharge	Deficit	Selected Ultimate	PCF Surcharge	Deficit	Selected Ultimate	PCF Surcharge	Deficit	Hospital % of Deficit
Prior	NA	NA	0	NA	NA	0	NA	NA	0	NA
2006	8,140,629	9,067,465	926,836	0	0	0	8,140,629	9,067,465	926,836	0.0%
2007	19,072,298	8,810,595	(10,261,703)	0	0	0	19,072,298	8,810,595	(10,261,703)	0.0%
2008	19,468,242	9,696,249	(9,771,993)	0	0	0	19,468,242	9,696,249	(9,771,993)	0.0%
2009	11,706,962	10,548,554	(1,158,408)	2,296,866	1,695,000	(601,866)	14,003,828	12,243,554	(1,760,274)	34.2%
2010	17,978,224	10,728,496	(7,249,728)	1,730,745	1,695,000	(35,745)	19,708,970	12,423,496	(7,285,474)	0.5%
2011	19,831,475	10,211,297	(9,620,178)	2,635,408	1,762,800	(872,608)	22,466,883	11,974,097	(10,492,786)	8.3%
2012	8,796,169	9,949,099	1,152,930	3,593,388	1,649,313	(1,944,075)	12,389,557	11,598,412	(791,145)	245.7%
2013	7,504,266	9,705,574	2,201,307	2,747,562	1,875,000	(872,562)	10,251,829	11,580,574	1,328,745	-65.7%
2014	15,216,865	10,163,627	(5,053,237)	7,425,461	2,025,000	(5,400,461)	22,642,326	12,188,627	(10,453,698)	51.7%
2015	6,275,243	9,861,745	3,586,503	2,380,606	2,025,000	(355,606)	8,655,849	11,886,745	3,230,897	-11.0%
2016	12,047,793	9,889,584	(2,158,209)	6,555,941	11,293,176	4,737,235	18,603,734	21,182,760	2,579,026	183.7%
2017	17,894,874	10,512,783	(7,382,091)	23,209,982	27,850,312	4,640,329	41,104,857	38,363,095	(2,741,762)	-169.2%
2018	13,748,978	11,393,122	(2,355,856)	35,042,647	31,638,580	(3,404,066)	48,791,624	43,031,702	(5,759,922)	59.1%
2019	14,119,951	11,658,519	(2,461,432)	32,880,151	30,383,954	(2,496,197)	47,000,101	42,042,473	(4,957,628)	50.4%
2020 [1]	13,930,977	12,059,845	(1,871,132)	31,919,251	29,262,503	(2,656,748)	45,850,228	41,322,348	(4,527,880)	58.7%
Total	205,732,946	154,256,554	(51,476,392)	152,418,009	143,155,639	(9,262,370)	358,150,954	297,412,193	(60,738,762)	15.2%
									Select	15.2%

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Additional Annual Assessment to Eliminate Fund Deficit

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8) SUM [(1):(7)]
Fund Deficit	(66,838,754)							
				As Of				
Provider Type	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025	12/31/2026	Total
Hospital								
Selected % of Fund Deficit	15.2%							
Allocated Fund Deficit	(8,054,386)							
Allocated Assessment Per Year			1,598,871	1,606,865	1,610,877	1,614,899	1,622,974	8,054,487
Discounted Assessment			1,369,562	1,424,584	1,478,126	1,533,681	1,595,296	7,401,250
Surcharge	23,123,811		28,355,926	29,490,164	30,669,770	31,896,561	33,172,423	
Assessment as % of Surcharge			4.8%	4.8%	4.8%	4.8%	4.8%	
Employed Physicians & Surgeons								
Allocated Fund Deficit	(2,138,203)							
Allocated Assessment Per Year			424,453	426,575	427,641	428,708	430,852	2,138,230
Discounted Assessment			363,579	378,185	392,399	407,147	423,504	1,964,814
Surcharge	6,138,692		7,350,113	7,644,117	7,949,882	8,267,877	8,598,592	
Assessment as % of Surcharge			4.9%	4.9%	4.9%	4.9%	4.9%	
Independent Physicians & Surgeons								
Allocated Fund Deficit	(56,646,165)							
Allocated Assessment Per Year			11,244,792	11,301,016	11,329,233	11,357,521	11,414,308	56,646,869
Discounted Assessment			9,632,075	10,019,043	10,395,602	10,786,313	11,219,653	52,052,686
Surcharge	12,059,845		17,969,714	18,688,503	19,436,043	20,213,484	21,022,024	
Assessment as % of Surcharge			53.6%	53.6%	53.5%	53.4%	53.4%	
Total								
Discounted Assessment			11,365,215	11,821,813	12,266,127	12,727,141	13,238,454	61,418,750
Investment Earned on Assessments to 12/31/2026			1,902,900	1,512,643	1,101,624	673,988	229,681	5,420,835
Surcharge	41,322,348		53,675,753	55,822,783	58,055,695	60,377,922	62,793,039	
Assessment as % of Surcharge			21.2%	21.2%	21.1%	21.1%	21.1%	
							Total Assessments Plus Investment Income:	66,839,585

Note: Investment Returns utilize assumed yield of 3.50%
Methodology assumes no change to fund deficit in the prospective periods and the indicated rate changes are taken
Prospective Period Surcharges trended at 4.00%

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Change in Estimated Ultimate Loss

	(1)	(2)	(3) (1) - (2)	(4)	(5)	(6) (4) - (5)	(7) (1) + (4)	(8) (2) + (5)	(9) (7) - (8)
	Physicians & Surgeons (Excluding Batch Claims)			Hospitals			Combined (Excluding Batch Claims)		
Accident Year	12/31/2020 Selected Ultimate	12/31/2019 Selected Ultimate	Change in Estimates	12/31/2020 Selected Ultimate	12/31/2019 Selected Ultimate	Change in Estimates	12/31/2020 Selected Ultimate	12/31/2019 Selected Ultimate	Change in Estimates
Prior	NA	NA		NA	NA		NA	NA	0
2006	6,328,725	6,328,725	0	0	NA	NA	6,328,725	6,328,725	0
2007	13,190,829	13,268,531	(77,702)	0	NA	NA	13,190,829	13,268,531	(77,702)
2008	11,732,218	11,788,976	(56,758)	0	NA	NA	11,732,218	11,788,976	(56,758)
2009	8,080,562	8,174,638	(94,076)	2,097,904	2,090,000	7,904	10,178,466	10,264,638	(86,172)
2010	16,573,610	16,257,661	315,949	1,493,020	1,550,000	(56,980)	18,066,631	17,807,661	258,970
2011	20,495,740	19,500,000	995,740	1,971,143	2,075,000	(103,857)	22,466,883	21,575,000	891,883
2012	10,221,686	11,250,000	(1,028,314)	2,167,872	1,000,000	1,167,872	12,389,557	12,250,000	139,557
2013	8,605,723	9,300,000	(694,277)	1,646,106	1,025,000	621,106	10,251,829	10,325,000	(73,171)
2014	15,747,095	16,100,000	(352,905)	6,895,231	6,100,000	795,231	22,642,326	22,200,000	442,326
2015	6,656,137	10,000,000	(3,343,863)	1,999,712	1,800,000	199,712	8,655,849	11,800,000	(3,144,151)
2016	13,987,152	14,750,000	(762,848)	4,616,582	7,500,000	(2,883,418)	18,603,734	22,250,000	(3,646,266)
2017	26,821,644	26,500,000	321,644	14,283,213	17,000,000	(2,716,787)	41,104,857	43,500,000	(2,395,143)
2018	25,449,620	25,750,000	(300,380)	23,342,004	21,250,000	2,092,004	48,791,624	47,000,000	1,791,624
2019	24,303,532	25,500,000	(1,196,468)	22,696,570	21,250,000	1,446,570	47,000,101	46,750,000	250,101
Total	208,194,274	214,468,531	(6,274,257)	83,209,355	82,640,000	569,355	291,403,628	297,108,531	(5,704,903)

New Mexico Patient's Compensation Fund

Reconciliation of Paid Loss Data

	Prior Actuary 12/31/19		Data as of 12/31/19		Difference in Data		ReCast as of 12/31/19	
AY	P&S x Batch	Hospitals	P&S x Batch	Hospitals	P&S x Batch	Hospitals	P&S x Batch	Hospitals
2000	6,560,000	-	-	-	-	-	6,560,000	-
2001	9,261,652	-	-	-	-	-	9,261,652	-
2002	9,309,500	-	-	-	-	-	9,309,500	-
2003	6,596,189	-	-	-	-	-	6,596,189	-
2004	5,482,500	-	-	-	-	-	5,482,500	-
2005	8,791,254	-	1,050,000	-	-	-	8,791,254	-
2006	6,328,725	-	950,000	-	-	-	6,328,725	-
2007	13,164,500	-	5,277,500	-	-	-	13,164,500	-
2008	11,662,152	-	6,897,500	-	-	-	11,662,152	-
2009	7,992,342	2,075,000	5,123,775	2,075,000	-	-	7,992,342	2,075,000
2010	16,067,567	1,535,000	15,412,567	1,465,000	70,000	(70,000)	16,137,567	1,465,000
2011	18,932,165	2,041,563	19,058,728	1,915,000	126,563	(126,563)	19,058,728	1,915,000
2012	10,824,408	955,000	9,654,408	2,075,000	(1,120,000)	1,120,000	9,704,408	2,075,000
2013	8,571,321	935,916	7,962,545	1,544,693	(608,777)	608,777	7,962,544	1,544,693
2014	13,391,619	888,826	13,036,315	1,244,130	(355,304)	355,304	13,036,315	1,244,130
2015	3,240,000	1,162,868	3,165,000	1,237,868	(75,000)	75,000	3,165,000	1,237,868
2016	3,705,000	1,125,000	3,705,000	1,125,000	-	-	3,705,000	1,125,000
2017	2,137,500	1,877,500	1,900,000	2,115,000	(237,500)	237,500	1,900,000	2,115,000
2018	-	650,000	-	650,000	-	-	-	650,000
2019	-	-	-	-	-	-	-	-
2020								
Total	162,018,394	13,246,673	93,193,338	15,446,690	(2,200,017)	2,200,017	159,818,377	15,446,690

	2020 CY Incremental		ReCast as of 12/31/20		2021 CY as of 7/27/21		ReCast as of 7/27/21	
AY	P&S x Batch	Hospitals	P&S x Batch	Hospitals	P&S x Batch	Hospitals	P&S x Batch	Hospitals
2000	-	-	6,560,000	-			6,560,000	-
2001	-	-	9,261,652	-			9,261,652	-
2002	-	-	9,309,500	-	-	-	9,309,500	-
2003	-	-	6,596,189	-	-	-	6,596,189	-
2004	-	-	5,482,500	-	-	-	5,482,500	-
2005	-	-	8,791,254	-	-	-	8,791,254	-
2006	-	-	6,328,725	-	-	-	6,328,725	-
2007	-	-	13,164,500	-	-	-	13,164,500	-
2008	-	-	11,662,152	-	-	-	11,662,152	-
2009	-	-	7,992,342	2,075,000	-	-	7,992,342	2,075,000
2010	125,000	-	16,262,567	1,465,000	-	-	16,262,567	1,465,000
2011	853,241	-	19,911,969	1,915,000	-	-	19,911,969	1,915,000
2012	30,000	-	9,734,408	2,075,000	-	-	9,734,408	2,075,000
2013	-	-	7,962,544	1,544,693	-	-	7,962,544	1,544,693
2014	1,328,250	5,000,000	14,364,565	6,244,130	-	-	14,364,565	6,244,130
2015	862,500	200,000	4,027,500	1,437,868	1,200,000	-	5,227,500	1,437,868
2016	2,135,000	885,000	5,840,000	2,010,000	2,350,000	315,000	8,190,000	2,325,000
2017	8,050,000	382,184	9,950,000	2,497,184	5,010,000	-	14,960,000	2,497,184
2018	2,721,023	1,722,500	2,721,023	2,372,500	1,669,748	4,947,248	4,390,770	7,319,748
2019	720,000	550,000	720,000	550,000	141,250	241,250	861,250	791,250
2020	-	300,000	-	300,000	-	-	-	300,000
Total	16,825,014	9,039,684	176,643,390	24,486,374	10,370,998	5,503,498	187,014,388	29,989,872

New Mexico Patient's Compensation Fund

Physicians & Surgeons
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Derivation of Indicated Surcharge Level Change, Effective January 1, 2022

(1)	Projected Loss Ratio	116.2%
(2)	Discount Factor to Reflect Anticipated Investment Income	84.4%
(3)	Discounted Projected Loss Ratio	98.1%
(4)	Indicated Increased Limits Factor to reflect change in PCF limits	1.080
(5)	Projected 2022 Surcharges at Current Fee Level	21,146,700
(6)	Projected 2022 Discounted Losses	22,401,994
(7)	Load for Office Expenses	5.0%
(8)	Load for Batch Claim Reinsurance	5.0%
(9)	Adjustment to reflect ISO Class Plan Recommendations	1.018
(10)	Projected 2022 Income Requirements	25,319,827
(11)	**Indicated Surcharge Level Change on January 1, 2022**	**19.7%**

Notes:

(1)	From Exhibit A3	(7)	From Exhibit C4
(2)	From Exhibit C1	(8)	From Exhibit C5
(3)	(1) x (2)	(9)	From Exhibit E3
(4)	From Exhibit D1	(10)	[(6) x (9)] / [1 - (7) - (8)]
(5)	Based on current surcharge level	(11)	(10) / (5) - 1
(6)	(3) x (4) x (5)		

New Mexico Patient's Compensation Fund

Physicians & Surgeons
Occurrence Coverage Evaluated as of December 31, 2020
Confidence Level of Surcharge Change

Confidence Level of Indicated Surcharge Level Changes, Effective January 1, 2022

		Central	70% CL	80% CL	90% CL
(1)	Confidence Level Factor	1.000	1.070	1.150	1.280
(2)	Discounted Projected Loss Ratio -- Based on Actuarial Central Estimate	98.1%	98.1%	98.1%	98.1%
(3)	Indicated Increased Limits Factor to reflect change in PCF limits	1.080	1.080	1.080	1.080
(4)	Projected 2022 Surcharges at Current Fee Level	21,146,700	21,146,700	21,146,700	21,146,700
(5)	Projected 2022 Discounted Losses	22,401,994	23,970,134	25,762,294	28,674,553
(6)	Load for Office Expenses	5.0%	5.0%	5.0%	5.0%
(7)	Load for Batch Claim Reinsurance	5.0%	5.0%	5.0%	5.0%
(8)	Adjustment to reflect ISO Class Plan Recommendations	1.018	1.018	1.018	1.018
(9)	Projected 2022 Income Requirements	25,319,827	27,092,214	29,117,801	32,409,378
(10)	**Indicated Surcharge Level Change on January 1, 2022**	**19.7%**	**28.1%**	**37.7%**	**53.3%**

Notes:

(1) Derived from simulation modeling
(2) From Exhibit A1
(3) From Exhibit D1
(4) Based on current surcharge level
(5) (1) x (2) x (3) x (4)
(6) From Exhibit C4
(7) From Exhibit C5
(8) From Exhibit E3
(9) [(5) x (8)] / [1 - (6) - (7)]
(10) (9) / (4) - 1

New Mexico Patient's Compensation Fund

Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Derivation of Loss Ratio, Effective January 1, 2022

(1)	Projected Loss Severity	746,300
(2)	Projected Ultimate CWP Frequency	0.15%
(3)	Projected On-Level Loss Ratio	109.8%
(4)	Load for ULAE	2.75%
(5)	Load for Medical Payments	3.00%
(6)	Projected Loss Ratio	116.2%

Notes:

(1)	From Exhibit A5	(4)	From Exhibit C3
(2)	From Exhibit A6	(5)	From Exhibit C6
(3)	{ [(1) x (2)] } / 1,000	(6)	[(3) x [1 + (4)] x [1 + (5)]

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Loss Ratio

Accident Year	(1) Full Year Surcharges at CRL	(2) Ultimate Loss	(3) (2) / (1) Ultimate Loss Ratio	(4) Ultimate Loss Ratio Trended to 1/1/2022 [2]
2006	15,441,893	6,328,725	41.0%	76.8%
2007	14,828,231	13,190,829	89.0%	160.2%
2008	15,242,503	11,732,218	77.0%	133.3%
2009	17,192,668	8,080,562	47.0%	78.3%
2010	16,352,982	16,573,610	101.3%	162.3%
2011	15,345,233	20,495,740	133.6%	205.6%
2012	14,918,894	10,221,686	68.5%	101.4%
2013	14,679,745	8,605,723	58.6%	83.4%
2014	15,401,689	15,747,095	102.2%	139.9%
2015	14,972,715	6,656,137	44.5%	58.5%
2016	16,587,807	13,987,152	84.3%	106.7%
2017	26,285,132	26,821,644	102.0%	124.1%
2018	26,365,573	25,449,620	96.5%	112.9%
2019	24,663,432	24,303,532	98.5%	110.8%
2020 [1]	21,146,700	21,022,111	99.4%	107.5%
			WA	117.0%
			WA L7	110.4%
			WA L5	113.2%
			WA L3	110.6%
			Select	109.8%

[1] Reflects a full year of earned exposure
[2] Trended at 4.0% per annum

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Loss Severity

Accident Year	(1) Ultimate CWP Claims	(2) Ultimate Loss	(3) (2) / (1) Ultimate Loss Severity	(4) Ultimate Loss Severity Trended to 1/1/2022 [2]
2006	17	6,328,725	372,278	697,344
2007	31	13,190,829	425,511	766,423
2008	35	11,732,218	335,206	580,500
2009	21	8,080,562	384,789	640,753
2010	39	16,573,610	424,964	680,455
2011	33	20,495,740	621,083	956,257
2012	23	10,221,686	444,421	657,887
2013	18	8,605,723	478,096	680,534
2014	27	15,747,095	583,226	798,270
2015	12	6,656,137	554,678	730,017
2016	27	13,987,152	518,043	655,524
2017	37	26,821,644	724,909	882,034
2018	39	25,449,620	652,554	763,478
2019	37	24,303,532	656,852	738,969
2020 [1]	31	21,022,111	678,133	733,508
			WA	738,564
			WA L7	764,305
			WA L5	761,349
			WA L3	746,320
			Select	746,300

[1] Reflects a full year of earned exposure
[2] Trended at 4.0% per annum

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

CWP Frequency

Accident Year	(1) ($000) Surcharges at CRL	(2) Ultimate CWP Claims	(3) (2) / (1) Ultimate CWP Frequency	(4) Ultimate CWP Frequency Trended to 1/1/2022 [2]
2006	15,442	17	0.11%	0.11%
2007	14,828	31	0.21%	0.21%
2008	15,243	35	0.23%	0.23%
2009	17,193	21	0.12%	0.12%
2010	16,353	39	0.24%	0.24%
2011	15,345	33	0.22%	0.22%
2012	14,919	23	0.15%	0.15%
2013	14,680	18	0.12%	0.12%
2014	15,402	27	0.18%	0.18%
2015	14,973	12	0.08%	0.08%
2016	16,588	27	0.16%	0.16%
2017	26,285	37	0.14%	0.14%
2018	26,366	39	0.15%	0.15%
2019	24,663	37	0.15%	0.15%
2020 [1]	21,147	31	0.15%	0.15%
			WA	0.16%
			WA L7	0.14%
			WA L5	0.15%
			WA L3	0.15%
			Select	0.15%

[1] Reflects a full year of earned exposure
[2] Trended at 0.0% per annum

New Mexico Patient's Compensation Fund
Independent Physicians & Surgeons
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Summary of Rates ("Surcharges") by Class

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Class	2020 Estimated Counts [1]	Class Relativity	2020 PCF Rates	2021 PCF Rates	2022 PCF Rates	2022 Fund Deficit Assessment [2]
1	466	1.000	3,208	3,507	4,199	2,251
2	503	1.334	4,278	4,676	5,599	3,001
3	140	1.600	5,133	5,611	6,718	3,601
4A	98	2.000	6,417	7,014	8,398	4,502
4	126	2.400	7,700	8,416	10,077	5,401
5A	375	2.267	7,272	7,949	9,518	5,102
5	8	2.934	9,411	10,287	12,317	6,602
6	45	3.467	11,123	12,157	14,556	7,802
7A	20	4.001	12,834	14,027	16,795	9,002
7	59	4.667	14,973	16,365	19,594	10,503
8	36	6.334	20,320	22,210	26,593	14,254
9	187	7.668	24,598	26,886	32,192	17,255
10	112	8.668	27,806	30,392	36,390	19,505
99	0	0.800	2,567	2,805	3,359	1,800
CRNA	99	0.333	1,069	1,169	1,400	750
PA-1	240	0.453	1,454	1,590	1,904	1,020
PA-2	31	0.600	1,925	2,104	2,519	1,350
PA-3	83	0.720	2,310	2,525	3,023	1,621
CN		0.200			840	

Entity	2020 Estimated Counts	Percentage of PCF Surcharge			
51	471	10%	10%	10%	10%
52	5	10%	10%	10%	10%
53	1	10%	10%	10%	10%

[1] Provided by the PCF, calculated as premium by class divided by class rate
[2] Based on projected additional assesment as % of surcharge ratio of 53.6%

New Mexico Patient's Compensation Fund
Employed Physicians & Surgeons
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Summary of Rates ("Surcharges") by Class

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Class	2020 Estimated Counts [1]	Class Relativity	2020 PCF Rates	2021 PCF Rates	2022 PCF Rates	2022 Fund Deficit Assessment [2]
1	466	1.000	3,208	3,507	4,199	208
2	503	1.334	4,278	4,676	5,599	277
3	140	1.600	5,133	5,611	6,718	332
4A	98	2.000	6,417	7,014	8,398	415
4	126	2.400	7,700	8,416	10,077	498
5A	375	2.267	7,272	7,949	9,518	471
5	8	2.934	9,411	10,287	12,317	609
6	45	3.467	11,123	12,157	14,556	720
7A	20	4.001	12,834	14,027	16,795	831
7	59	4.667	14,973	16,365	19,594	969
8	36	6.334	20,320	22,210	26,593	1,315
9	187	7.668	24,598	26,886	32,192	1,592
10	112	8.668	27,806	30,392	36,390	1,800
99	0	0.800	2,567	2,805	3,359	166
CRNA	99	0.333	1,069	1,169	1,400	69
PA-1	240	0.453	1,454	1,590	1,904	94
PA-2	31	0.600	1,925	2,104	2,519	125
PA-3	83	0.720	2,310	2,525	3,023	150
CN		0.200			840	

Entity	2020 Estimated Counts	Percentage of PCF Surcharge			
51	471	10%	10%	10%	10%
52	5	10%	10%	10%	10%
53	1	10%	10%	10%	10%

[1] Provided by the PCF, calculated as premium by class divided by class rate
[2] Based on projected additional assesment as % of surcharge ratio of 4.9%

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Hospitals
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Derivation of Indicated Surcharge Level Change, Effective January 1, 2022

(1)	Projected Loss Ratio	126.8%
(2)	Discount Factor to Reflect Anticipated Investment Income	84.4%
(3)	Rate Change from 2020 to 2021	103.8%
(4)	Discounted Projected Loss Ratio	103.0%
(5)	Indicated Increased Limits Factor to reflect change in PCF limits	1.032
(6)	Projected 2022 Surcharges at 2021 Fee Level	24,007,800
(7)	Projected 2022 Discounted Losses	25,528,348
(8)	Load for Office Expenses	5.0%
(9)	Load for Batch Claim Reinsurance	5.0%
(10)	Projected 2022 Income Requirements	28,355,926
(11)	**Indicated Surcharge Change from 2021 on January 1, 2022 Prior to ERP Adjustment**	**18.1%**
(12)	Experience Rating Plan Removal Factor	(12.3)%
(13)	**Indicated Surcharge Level Change from 2021 on January 1, 2022**	**3.6%**

Notes:

(1)	From Exhibit B3	(8)	From Exhibit C4
(2)	From Exhibit C1	(9)	From Exhibit C5
(4)	Provided by PCF	(10)	(7) / [1 - (8) - (9)]
(4)	[(1) x (2)] / (3)	(11)	(10) / (6) - 1
(5)	From Exhibit D1	(12)	From Exhibit F1
(6)	Based on current surcharge level	(13)	[1 + (11)] x [1 + (12)] - 1
(7)	(4) x (5) x (6)		

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Confidence Level of Surcharge Change

Confidence Level of Indicated Surcharge Level Changes, Effective January 1, 2022

		Central	70% CL	80% CL	90% CL
(1)	Confidence Level Factor	1.000	1.070	1.150	1.280
(2)	Discounted Projected Loss Ratio -- Based on Actuarial Central Estimate	103.0%	103.0%	103.0%	103.0%
(3)	Indicated Increased Limits Factor to reflect change in PCF limits	1.032	1.032	1.032	1.032
(4)	Projected 2022 Surcharges at 2021 Fee Level	24,007,800	24,007,800	24,007,800	24,007,800
(5)	Projected 2022 Discounted Losses	25,528,348	27,315,333	29,357,600	32,676,286
(6)	Load for Office Expenses	5.0%	5.0%	5.0%	5.0%
(7)	Load for Batch Claim Reinsurance	5.0%	5.0%	5.0%	5.0%
(8)	Projected 2022 Income Requirements	28,355,926	30,340,841	32,609,315	36,295,586
(9)	**Indicated Surcharge Level Change on January 1, 2022**	**18.1%**	**26.4%**	**35.8%**	**51.2%**
(10)	Experience Rating Plan Removal Factor	-12.3%	-12.3%	-12.3%	-12.3%
(11)	**Indicated Rate Level Change on January 1, 2022**	**3.6%**	**10.8%**	**19.1%**	**32.6%**

Notes:

(1) Derived from simulation modeling
(2) From Exhibit B1
(3) From Exhibit D1
(4) Based on current surcharge level
(5) (1) x (2) x (3) x (4)
(6) From Exhibit C4
(7) From Exhibit C5
(8) (5) / [1 - (6) - (7)]
(9) (8) / (4) - 1
(10) From Exhibit F1
(11) [1 + (10)] x [1 + (11)] - 1

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Hospitals

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Derivation of Loss Ratio, Effective January 1, 2022

(1)	Projected Loss Severity	545,900
(2)	Projected Ultimate CWP Frequency	0.22%
(3)	Projected On-Level Loss Ratio	119.8%
(4)	Load for ULAE	2.75%
(5)	Load for Medical Payments	3.00%
(6)	Projected Loss Ratio	126.8%

Notes:

(1)	From Exhibit B5	(4)	From Exhibit C3
(2)	From Exhibit B6	(5)	From Exhibit C6
(3)	{ [(1) x (2)] } / 1,000	(6)	[(3) x [1 + (4)] x [1 + (5)]

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Loss Ratio

Accident Year	(1) Surcharges	(2) Ultimate Loss	(3) (2) / (1) Ultimate Loss Ratio	(4) Ultimate Loss Ratio Trended to 1/1/2022 [2]
2006	0	0	NA	NA
2007	0	0	NA	NA
2008	0	0	NA	NA
2009	1,130,000	2,097,904	185.7%	309.1%
2010	1,130,000	1,493,020	132.1%	211.5%
2011	1,175,200	1,971,143	167.7%	258.2%
2012	1,099,542	2,167,872	197.2%	291.9%
2013	1,250,000	1,646,106	131.7%	187.4%
2014	1,350,000	6,895,231	510.8%	699.0%
2015	1,350,000	1,999,712	148.1%	194.9%
2016	9,476,474	4,616,582	48.7%	61.6%
2017	18,644,316	14,283,213	76.6%	93.2%
2018	21,596,277	23,342,004	108.1%	126.4%
2019	21,523,811	22,696,570	105.4%	118.6%
2020 [1]	23,123,811	24,828,117	107.4%	116.1%
			WA	125.9%
			WA L7	118.5%
			WA L5	109.1%
			WA L3	120.3%
			Select	119.8%

[1] Reflects a full year of earned exposure
[2] Trended at 4.0% per annum

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Loss Severity

Accident Year	(1) Ultimate CWP Claims	(2) Ultimate Loss	(3) (2) / (1) Ultimate Loss Severity	(4) Ultimate Loss Severity Trended to 1/1/2022 [2]
2006	0	0	NA	NA
2007	0	0	NA	NA
2008	0	0	NA	NA
2009	3	2,097,904	699,301	1,164,482
2010	6	1,493,020	248,837	398,438
2011	10	1,971,143	197,114	303,489
2012	4	2,167,872	541,968	802,288
2013	5	1,646,106	329,221	468,622
2014	4	6,895,231	1,723,808	2,359,403
2015	6	1,999,712	333,285	438,640
2016	16	4,616,582	288,536	365,110
2017	45	14,283,213	317,405	386,202
2018	51	23,342,004	457,686	535,486
2019	45	22,696,570	504,368	567,422
2020 [1]	50	24,828,117	496,562	537,111
			WA	528,412
			WA L7	529,906
			WA L5	497,199
			WA L3	545,886
			Select	545,900

[1] Reflects a full year of earned exposure
[2] Trended at 4.0% per annum

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CWP Frequency

Accident Year	(1) ($000s) Surcharges	(2) Ultimate CWP Claims	(3) (2) / (1) Ultimate CWP Frequency	(4) Ultimate CWP Frequency Trended to 1/1/2022 [2]
2006	0	0	NA	NA
2007	0	0	NA	NA
2008	0	0	NA	NA
2009	1,130	3	0.27%	0.27%
2010	1,130	6	0.53%	0.53%
2011	1,175	10	0.85%	0.85%
2012	1,100	4	0.36%	0.36%
2013	1,250	5	0.40%	0.40%
2014	1,350	4	0.30%	0.30%
2015	1,350	6	0.44%	0.44%
2016	9,476	16	0.17%	0.17%
2017	18,644	45	0.24%	0.24%
2018	21,596	51	0.24%	0.24%
2019	21,524	45	0.21%	0.21%
2020 [1]	23,124	50	0.22%	0.22%
			WA	0.24%
			WA L7	0.22%
			WA L5	0.22%
			WA L3	0.22%
			Select	0.22%

[1] Reflects a full year of earned exposure
[2] Trended at 0.0% per annum

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Hospitals

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Summary of Rates ("Surcharges") by Class

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Class	2020 Exposures	Class Relativity	2020 PCF Rates	2021 PCF Rates	2022 PCF Rates	2022 Fund Deficit Assessment [1]
Acute Care Bed	1,790	1.000	4,774	4,957	5,135	248
Psychiatric Care Bed	76	1.000	4,774	4,957	5,135	248
Extended Care Bed	0	0.100	477	496	514	25
Skilled Nursing Care Bed	0	0.350	1,671	1,735	1,797	87
Personal Care Bed	0	0.150	716	744	771	37
Physical Rehab Bed	82	0.500	2,387	2,479	2,568	124
Chemical Dep. Rehab Bed	0	0.250	1,193	1,239	1,283	62
Births	17,499	0.050	239	248	257	12
Inpatient Surgeries (000)s	316	1.750	8,354	8,675	8,986	434
Outpatient Surgeries (000)s	896	0.200	955	991	1,027	50
ER visits (000)s	6,570	0.150	716	744	771	37
Other Outpatient visits (000)s	19,002	0.050	239	248	257	12
Home Healthcare (000)s	1,415	0.050	239	248	257	12

[1] Based on projected additional assesment as % of surcharge ratio of 4.8%

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Medical Professional Liability
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Derivation of Discount Factor

Year	(1) Selected Cumulative Payment Pattern [1]	(2) Incremental Payment Pattern	(3) Discounted Incremental Payment Pattern [2]
1	0.1%	0.1%	0.1%
2	2.3%	2.2%	2.1%
3	11.5%	9.3%	8.5%
4	27.5%	16.0%	14.1%
5	46.2%	18.7%	16.0%
6	75.1%	28.9%	23.9%
7	95.0%	19.9%	15.9%
8	97.0%	2.0%	1.5%
9	98.0%	1.0%	0.7%
10	99.0%	1.0%	0.7%
11	99.5%	0.5%	0.3%
12	100.0%	0.5%	0.3%
13	100.0%	0.0%	0.0%
14	100.0%	0.0%	0.0%
15	100.0%	0.0%	0.0%
		Discount Factor	84.4%

[1] From Exhibit C2
[2] Based on a 3.50% assumed yield (dervied on Exhibit C7)

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Derivation of Payment Pattern

Accident Year	Ultimate Loss	Paid by Month of Development 12	24	36	48	60	72	84	96	108	120	132	144	156	168	180
2006	6,328,725	0	0	628,725	4,253,725	5,228,725	5,378,725	5,628,725	5,928,725	6,328,725	6,328,725	6,328,725	6,328,725	6,328,725	6,328,725	6,328,725
2007	13,190,829	0	0	1,250,000	4,937,000	7,887,000	12,067,000	12,717,000	13,164,500	13,164,500	13,164,500	13,164,500	13,164,500	13,164,500	13,164,500	
2008	11,732,218	0	0	2,163,652	4,764,652	6,542,152	9,204,652	11,262,152	11,662,152	11,662,152	11,662,152	11,662,152	11,662,152	11,662,152		
2009	10,178,466	0	495,000	2,868,567	3,368,567	4,203,567	8,242,342	8,242,342	8,367,342	8,367,342	8,367,342	10,067,342	10,067,342			
2010	18,066,631	0	775,000	3,511,000	6,138,000	9,688,000	16,177,567	16,502,567	16,902,567	16,902,567	17,602,567	17,727,567				
2011	22,466,883	0	1,325,000	1,925,000	4,753,000	9,950,312	17,226,228	19,358,728	20,973,728	20,973,728	21,826,969					
2012	12,383,580	0	50,000	850,000	2,614,408	4,324,408	7,529,408	11,629,408	11,779,408	11,809,408						
2013	10,267,438	0	450,000	750,000	875,000	4,575,000	6,407,148	9,507,237	9,507,237							
2014	22,435,751	0	480,000	2,370,000	4,945,000	7,573,261	14,280,446	20,608,696								
2015	8,687,554	0	0	1,112,868	1,977,868	4,402,868	5,465,368									
2016	20,574,198	0	700,000	2,625,000	4,830,000	7,850,000										
2017	47,061,307	0	675,000	4,015,000	12,447,184											
2018	49,569,739	0	650,000	5,093,523												
2019	49,799,867	0	1,270,000													
2020	49,039,745	300,000														

Accident Year	Paid as a Percentage of Ultimate 12-24	24-36	36-48	48-60	60-72	72-84	84-96	96-108	108-120	120-132	132-144	144-156	156-168	168-180	180-ult
2006	0.0%	0.0%	9.9%	67.2%	82.6%	85.0%	88.9%	93.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2007	0.0%	0.0%	9.5%	37.4%	59.8%	91.5%	96.4%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	
2008	0.0%	0.0%	18.4%	40.6%	55.8%	78.5%	96.0%	99.4%	99.4%	99.4%	99.4%	99.4%	99.4%		
2009	0.0%	4.9%	28.2%	33.1%	41.3%	81.0%	81.0%	82.2%	82.2%	82.2%	98.9%	98.9%			
2010	0.0%	4.3%	19.4%	34.0%	53.6%	89.5%	91.3%	93.6%	93.6%	97.4%	98.1%				
2011	0.0%	5.9%	8.6%	21.2%	44.3%	76.7%	86.2%	93.4%	93.4%	97.2%					
2012	0.0%	0.4%	6.9%	21.1%	34.9%	60.8%	93.9%	95.1%	95.4%						
2013	0.0%	4.4%	7.3%	8.5%	44.6%	62.4%	92.6%	92.6%							
2014	0.0%	2.1%	10.6%	22.0%	33.8%	63.7%	91.9%								
2015	0.0%	0.0%	12.8%	22.8%	50.7%	62.9%									
2016	0.0%	3.4%	12.8%	23.5%	38.2%										
2017	0.0%	1.4%	8.5%	26.4%											
2018	0.0%	1.3%	10.3%												
2019	0.0%	2.6%													
2020	0.6%														
Wtd Avg	0.1%	2.3%	11.5%	27.5%	46.2%	75.1%	90.9%	94.0%	94.6%	96.3%	99.1%	99.5%	99.7%	99.9%	100.0%
Avg x H/L	0.0%	2.1%	11.6%	28.2%	47.0%	75.0%	91.5%	94.6%	96.3%	98.4%	99.4%	99.6%	99.8%	NA	NA
Wtd Avg L7	0.1%	2.0%	9.8%	22.5%	42.1%	72.1%	90.3%	94.0%	94.6%	NA	NA	NA	NA	NA	NA
Wtd Avg L5	0.1%	1.9%	10.3%	23.0%	38.6%	66.8%	90.6%	92.0%	93.2%	96.0%	99.1%	NA	NA	NA	NA
Wtd Avg L3	0.2%	1.8%	10.0%	25.2%	38.4%	63.2%	92.6%	93.7%	93.9%	94.3%	98.7%	99.4%	99.7%	NA	NA
Select	0.1%	2.3%	11.5%	27.5%	46.2%	75.1%	95.0%	97.0%	98.0%	99.0%	99.5%	100.0%	100.0%	100.0%	100.0%

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Calculation of ULAE Load

Calendar Year	(1) Paid Losses [1]	(2) Paid ULAE [1]	(3) (2) / (1) Indicated ULAE Load
2006			
2007			
2008			
2009			
2010			
2011			
2012			
2013			
2014	18,123,993	340,007	1.9%
2015	27,429,472	501,647	1.8%
2016	11,851,645	432,432	3.6%
2017	18,100,094	418,033	2.3%
2018	15,469,183	586,750	3.8%
2019	23,265,051	557,981	2.4%
2020	33,473,168	815,092	2.4%
Total	147,712,607	3,651,943	2.5%
Last 7	147,712,607	3,651,943	2.5%
Last 5	102,159,142	2,810,289	2.8%
Last 3	72,207,402	1,959,823	2.7%
(4) Selected ULAE Load			2.8%

[1] Provided by NMPCF

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Calculation of Office Expenses Load

Calendar Year	(1) Participant Surcharges [1]	(2) Office Expenses [1]	(3) (2) / (1) Indicated Office Expenses Load
2006			
2007			
2008			
2009			
2010			
2011			
2012			
2013			
2014	12,188,627	6,000	0.0%
2015	11,886,745	701,916	5.9%
2016	21,182,760	754,120	3.6%
2017	38,363,095	788,944	2.1%
2018	43,031,702	803,196	1.9%
2019	42,042,473	764,164	1.8%
2020	41,322,348	1,095,288	2.7%
Total	210,017,751	4,913,629	2.3%
Last 7	210,017,751	4,913,629	2.3%
Last 5	185,942,379	4,205,713	2.3%
Last 3	126,396,524	2,662,648	2.1%

(4) Selected Office Expenses Load	5.0%

[1] Provided by NMPCF

Fixed Expense Load: 8.9%
Derived from NM SERRF Tracking #: MDPC-132566743

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Calculation of Batch Claim Reinsurance Load

Calendar Year	(1) Participant Surcharges [1]	(2) Batch Claim Reinsurance [1]	(3) (2) / (1) Indicated Batch Claim Reinsurance Load
2006			
2007			
2008			
2009			
2010			
2011			
2012			
2013			
2014	12,188,627	0	0.0%
2015	11,886,745	0	0.0%
2016	21,182,760	0	0.0%
2017	38,363,095	1,399,296	3.6%
2018	43,031,702	2,975,445	6.9%
2019	42,042,473	1,868,175	4.4%
2020	41,322,348	2,072,251	5.0%
Total	210,017,751	8,315,167	4.0%
Last 7	210,017,751	8,315,167	4.0%
Last 5	185,942,379	8,315,167	4.5%
Last 3	126,396,524	6,915,871	5.5%
(4) Selected Batch Claim Reinsurance Load			5.0%

[1] Provided by NMPCF

Ultimate Losses x Batch	Batch Losses	Indicated Batch %
397,784,027	21,882,501	5.5%

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Calculation of On-Going Medical Payments Load

Calendar Year	(1) Paid Losses [1]	(2) Medical Payments [1]	(3) (2) / (1) Indicated Medical Payments Load
2006			
2007			
2008			
2009			
2010			
2011			
2012			
2013			
2014	18,123,993	808,822	4.5%
2015	27,429,472	1,066,646	3.9%
2016	11,851,645	477,039	4.0%
2017	18,100,094	1,030,260	5.7%
2018	15,469,183	472,660	3.1%
2019	23,265,051	365,188	1.6%
2020	33,473,168	262,725	0.8%
Total	147,712,607	4,483,340	3.0%
Last 7	147,712,607	4,483,340	3.0%
Last 5	102,159,142	2,607,872	2.6%
Last 3	72,207,402	1,100,573	1.5%
(4) Selected On-Going Medical Payments Load			3.0%

[1] Provided by NMPCF

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Medical Professional Liability
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Calculation of Investment Income Ratio

Calendar Year	(1) Total PCF Funds [1]	(2) Net Investment Income [1]	(3) (2) / (1) Indicated Investment Ratio
2016	43,455,311	2,215,484	5.1%
2017	64,285,006	3,272,469	5.1%
2018	87,104,681	(951,307)	-1.1%
2019	109,398,646	5,115,965	4.7%
2020	120,750,188	4,475,515	3.7%
Total	424,993,832	14,128,126	3.3%
Last 7	424,993,832	14,128,126	3.3%
Last 5	424,993,832	14,128,126	3.3%
Last 3	317,253,515	8,640,173	2.7%
(4) Selected Investment Income Ratio			3.5%

[1] Provided by NMPCF

New Mexico Patients' Compensation Fund
Milliman Analysis of Effect on Loss Costs
Increase in PCF Limit and Retention

Indicated Increase in Loss Costs Under New Attachment and Limits

	(1)	(2)	(3) (2) / (1)
	Severity		
Provider Type	Prior Caps/Limits	New Caps/Limits	Percentage Change
Hospitals	537,178	563,571	4.9%
Physicians and Surgeons	673,169	730,473	8.5%
	Frequency[1]		
Provider Type	Prior Caps/Limits	New Caps/Limits	Percentage Change
Hospitals	48,837	48,036	-1.6%
Physicians and Surgeons	30,483	30,348	-0.4%

	Percentage Change
Overall Change in Loss Cost - Hospitals	3.2%
Overall Change in Loss Cost - Physicians and Surgeons	8.0%

[1] Calculated as change in count of simulated occurrences (out of 80,000 trials) where the loss amount exceeds the PCF attachment point.

New Mexico Patients' Compensation Fund
Milliman Analysis of Effect on Loss Costs
Increase in PCF Limit and Retention

Summary of Parameters

Parameter	Mean Value	Distribution	Reference
Unlimited Non-Medical Loss per Claim - Physicians & Surgeons	1,314,287	Lognormal -- CV of 1.00	Exhibit D3
Unlimited Non-Medical Loss per Claim - Hospitals	800,888	Lognormal -- CV of 1.00	Exhibit D3
Unlimited Future Medical Loss per Claim - Physicians & Surgeons	288,004	Lognormal -- CV of 1.00	Exhibit D3
Unlimited Future Medical Loss per Claim - Hospitals	248,633	Lognormal -- CV of 1.00	Exhibit D3
Hospital Occurrences as a percentage of all Occurrences	62.0%	N/A	Exhibit D4
P&S Claims Per Occurrence	1.150	Zero-truncated Poisson	Exhibit D5
Hospital Claims Per Occurrence	1.050	Zero-truncated Poisson	Exhibit D5

New Mexico Patients' Compensation Fund
Milliman Analysis of Effect on Loss Costs
Increase in PCF Limit and Retention

Calculation of Medical and Non-Medical Unlimited Loss Severity

		Physicians & Surgeons	Hospitals
(1)	Projected Per Occurrence Loss Severity trended to March 1, 2022	746,300	545,900
(2)	Per Occurrence Attachment Point	200,000	200,000
(3)	Claims per Occurrence	1.150	1.050
(4)	Selected Percent PCF Non-Medical	65.0%	65.0%
(5)	Medical Loss Severity Per Claim	288,004	248,633
(6)	Non-Medical Loss Severity Per Claim	534,865	461,748
(7)	Unlimited Medical Loss Severity per Claim	288,004	248,633
(8)	Unlimited Non-Medical Loss Severity Per Claim	1,314,287	800,888
(9)	Total Unlimited Loss Severity per Claim	1,602,291	1,049,521

(1) Loss Severity under current limits from rate analysis Exhibit A3 and Exhibit B3
(3) From Exhibit D5
(4) From Exhibit D6

(7) Equal to (5) since medical payments are not considered within current PCF limits
(8) Estimated using lognormal distribution

New Mexico Patients' Compensation Fund
Milliman Analysis of Effect on Loss Costs
Increase in PCF Limit and Retention

Estimated Hospital Claims as Percent of All Claims

		Physicians & Surgeons	Hospitals
(1)	PCF Frequency per $1000 on-level surcharge	0.15%	0.22%
(2)	PCF 2020 on-level surcharge $(000)	21,147	23,124
(3)	PCF Estimated 2020 claims	31	51
(4)	Estimated Hospital Claim as Percent of All Claims:	62.0%	

(1) From rate analysis Exhibit A6 and Exhibit B6
(2) From rate analysis Exhibit A4 and Exhibit B4
(3) = (1) x (2)

New Mexico Patients' Compensation Fund
Milliman Analysis of Effect on Loss Costs
Increase in PCF Limit and Retention

Calculation of Average Claims per Occurrence

	Physician and Surgeons			Hospitals		
Closed Year	Closed Claims	Closed Occurrences	Closed Claims per Occurrence	Closed Claims	Closed Occurrences	Closed Claims per Occurrence
2011	1	1	1.000	0	0	
2012	27	24	1.125	0	0	
2013	26	25	1.040	1	1	1.000
2014	28	28	1.000	5	5	1.000
2015	35	31	1.129	2	2	1.000
2016	20	19	1.053	2	2	1.000
2017	24	22	1.091	8	8	1.000
2018	24	22	1.091	8	8	1.000
2019	23	21	1.095	15	15	1.000
2020	20	20	1.000	16	16	1.000
2021	17	12	1.417	11	9	1.222
Total	245	225	1.089	68	66	1.030
Last 5	108	97	1.113	58	56	1.036
Last 3	60	53	1.132	42	40	1.050
		Selected:	1.150		Selected:	1.050

New Mexico Patients' Compensation Fund
Milliman Analysis of Effect on Loss Costs
Increase in PCF Limit and Retention

Calculation of Medical Damages Percentage

Closed Year	Total PCF Payments	XS PCF Payments	Percent XS PCF
2011	40,000	-	0.0%
2012	11,328,500	4,415,000	39.0%
2013	8,174,500	1,582,000	19.4%
2014	14,571,775	4,638,775	31.8%
2015	14,696,287	5,066,720	34.5%
2016	11,450,916	5,760,916	50.3%
2017	13,825,368	4,392,868	31.8%
2018	15,900,408	6,145,408	38.6%
2019	23,193,765	11,351,265	48.9%
2020	24,242,702	13,008,018	53.7%
2021	12,955,000	5,975,000	46.1%
Total	150,379,220	62,335,970	41.5%
Last 5	90,117,242	40,872,559	45.4%
Last 3	60,391,466	30,334,283	50.2%
		Selected:	45%

		Claim Percentage	Medical Percentage
(1)	Selected XS of PCF Limits:	28%	100%
(2)	Within PCF Limits:	34%	19% [1]
(3)	Below PCF Limits:	38% [1]	0% [1]
(4)	Indicated Medical percentage of loss:		35%
(5)	Selected Medical percentage of loss:		35%

[1] From "Increase in New Mexico Cap on Damages"; Milliman, Inc.
https://pcf.osi.state.nm.us/wp-content/uploads/2020/11/Milliman-TDC-PCF-Cap-Analysis-Report-.pdf
(4) = Sumproduct[(1), (2), (3)]

New Mexico Patients' Compensation Fund
Milliman Analysis of Effect on Loss Costs
Increase in PCF Limit and Retention

Goodness of Distribution Fit Tests
New Mexico PCF Closed Claims Data

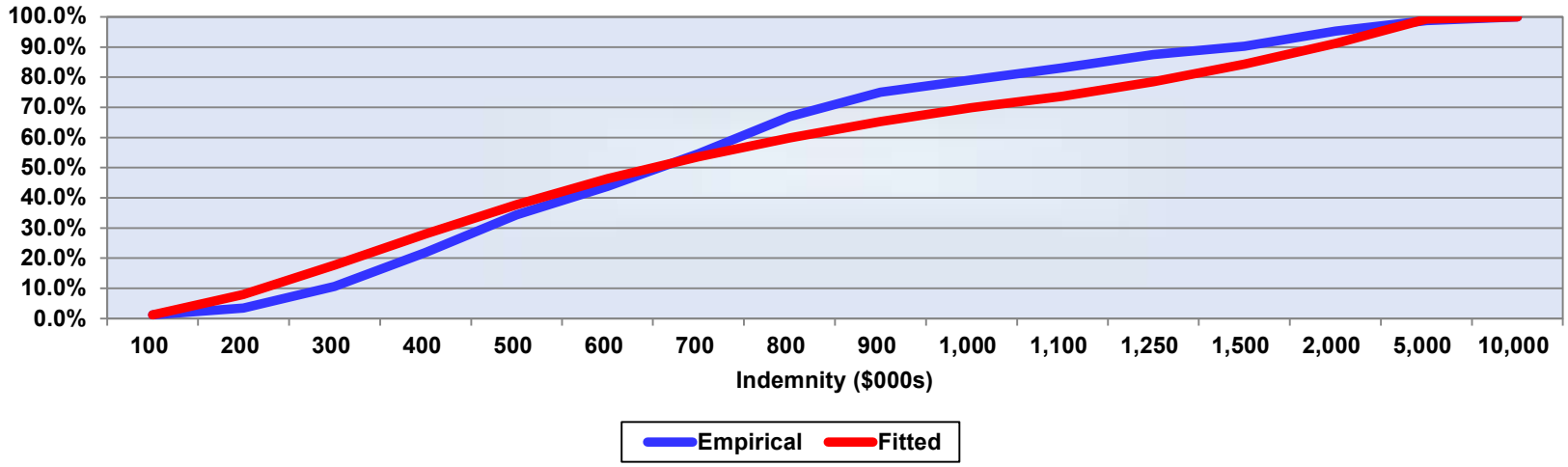
		Goodness of Fit Test					
		Kolmogorov-Smirnov		Anderson-Darling		Chi-Square	
Indemnity Data Source:	**Fit**	Distribution	Test Statistic	Distribution	Test Statistic	Distribution	Test Statistic
NM PCF	Best	Lognormal	0.0701	Lognormal	2	Lognormal	29.2
	Second	Max Extreme	0.1035	Max Extreme	5	Max Extreme	42.8
	Third	Gamma	0.1160	Gamma	6	Gamma	56.2

Selected Indemnity Distribution: Lognormal

Note: Underlying indemnity has been trended at 4.0% per annum to 3/1/2022.

New Mexico Patients' Compensation Fund
Milliman Analysis of Effect on Loss Costs
Increase in PCF Limit and Retention

Based on all Closed With Indemnity Claims, Trended at 4.0% to Closed Year 3/1/2022
New Mexico Closed Claim Data - 2011 to 2020 Closed Years
Cumulative Distribution Function



New Mexico Patient's Compensation Fund
Physicians Professional Liability
Occurrence Coverage Effective March 1, 2022

Derivation of Overall Average Class Plan Factors

ISO Code	Specialty	CY 2020 Surcharges	Percentage of Total Surcharge	NMPCF Current Relativity	MedPro Relativity	TDC Relativity	NMPCF MedPro Relativity	NMPCF TDC Relativity	NMPCF Recommeded Class	NMPCF Rate Change	NMPCF New Surcharge
80102	Emergency Medicine - no major surgery	1,793,307	9.6%	2.934	2.571	3.008	0.876	1.025		1.00	1,793,307
80104	Surgery - gastroenterology	514,528	2.8%	7.668	1.785	1.831	0.233	0.239	6	0.45	232,665
80106	Surgery - laryngology	10,384	0.1%	3.467	1.879	2.854	0.542	0.823		1.00	10,384
80108	Surgery - nephrology	10,384	0.1%	3.467	1.785	NA	0.515	NA		1.00	10,384
80114	Surgery - ophthalmology	122,680	0.7%	1.600	1.000	1.504	0.625	0.940		1.00	122,680
80115	Surgery - colon and rectal	54,487	0.3%	7.668	2.571	2.846	0.335	0.371	6	0.45	24,638
80117	Surgery - general practice or family practice	37,150	0.2%	7.668	1.879	1.831	0.245	0.239	6	0.45	16,799
80120	Urology - minor surgery	12,013	0.1%	1.600	1.597	NA	0.998	NA		1.00	12,013
80134	Preventive Medicine - no surgery - Occupational Medicine	12,916	0.1%	1.000	0.667	NA	0.667	NA		1.00	12,916
80135	Preventive Medicine - no surgery - Public/General Health Medicine	1,875	0.0%	1.000	0.777	NA	0.777	NA		1.00	1,875
80141	Surgery - cardiac	20,387	0.1%	6.334	4.300	NA	0.679	NA		1.00	20,387
80143	Surgery - general (no general/family practice)	1,750,990	9.4%	7.668	4.300	5.881	0.561	0.767		1.00	1,750,990
80144	Surgery - thoracic	245,282	1.3%	7.668	4.300	5.852	0.561	0.763		1.00	245,282
80145	Surgery - urological	207,055	1.1%	3.467	1.989	2.678	0.574	0.772		1.00	207,055
80146	Surgery - vascular	128,314	0.7%	7.668	4.515	5.852	0.589	0.763		1.00	128,314
80150	Surgery - cardiovascular disease	228,887	1.2%	8.668	4.300	5.852	0.496	0.675		1.00	228,887
80151	Anesthesiology	252,914	1.4%	4.001	1.344	2.070	0.336	0.517		1.00	252,914
80152	Surgery - neurology - including child	202,000	1.1%	8.668	6.219	8.735	0.718	1.008		1.00	202,000
80153	Surgery - obstetrics - gynecology	2,475,933	13.3%	8.668	4.730	6.930	0.546	0.800		1.00	2,475,933
80154	Surgery - orthopedic	1,513,412	8.1%	7.668	3.630	4.643	0.473	0.606		1.00	1,513,412
80155	Surgery - plastic - otorhinolaryngology	26,629	0.1%	6.334	2.210	3.880	0.349	0.613		1.00	26,629
80156	Surgery - plastic - N.O.C.	174,300	0.9%	6.334	2.210	3.880	0.349	0.613		1.00	174,300
80157	Emergency Medicine - including major surgery	10,547	0.1%	3.467	3.300	3.008	0.952	0.868		1.00	10,547
80159	Surgery - otorhinolaryngology	150,506	0.8%	3.467	1.879	2.854	0.542	0.823		1.00	150,506
80163	Radiation Therapy - employed phys/surg involved w/ major surgery	152	0.0%	1.334	1.050	NA	0.787	NA		1.00	152
80164	Surgery – oncology	107,392	0.6%	6.334	2.210	NA	0.349	NA		1.00	107,392
80165	Radiation Therapy - insured phys/surg involved w/ major surgery	250	0.0%	1.000	1.050	NA	1.050	NA		1.00	250
80167	Surgery - gynecology	291,882	1.6%	6.334	2.571	2.033	0.406	0.321		1.00	291,882
80169	Surgery - hand	36,013	0.2%	3.467	2.210	3.757	0.637	1.084		1.00	36,013
80170	Surgery - head and neck	10,122	0.1%	3.467	2.571	5.881	0.742	1.696		1.00	10,122
80171	Surgery - traumatic	32,878	0.2%	7.668	4.515	5.881	0.589	0.767		1.00	32,878
80180	Surgery - pediatric	59,715	0.3%	6.334	2.210	NA	0.349	NA		1.00	59,715
80181	Anesthesiology - Critical Care Medicine	3,235	0.0%	4.001	1.344	NA	0.336	NA		1.00	3,235
80182	Anesthesiology - Pain Management	84,845	0.5%	1.334	1.344	2.173	1.008	1.630		1.00	84,845
80183	Anesthesiology - All Other	564,746	3.0%	4.001	1.344	NA	0.336	NA		1.00	564,746
80204	Sports Medicine - minor surgery	3,762	0.0%	2.000	1.344	NA	0.672	NA		1.00	3,762
80205	Sports Medicine - no surgery	4,023	0.0%	1.334	0.855	NA	0.641	NA		1.00	4,023
80208	Physical Medicine and Rehabilitation - Pain Management	8,388	0.0%	1.334	1.344	NA	1.008	NA		1.00	8,388
80209	Physical Medicine and Rehabilitation - All Other	17,862	0.1%	1.000	0.667	NA	0.667	NA		1.00	17,862
80222	Hospitalists	408,889	2.2%	1.334	1.597	NA	1.198	NA		1.00	408,889
80224	Addiction Psychiatry	835	0.0%	1.000	0.667	NA	0.667	NA		1.00	835
80226	Child and Adolescent Psychiatry	4,493	0.0%	1.000	0.667	NA	0.667	NA		1.00	4,493
80229	Psychiatry - All Other	25,096	0.1%	1.000	0.667	NA	0.667	NA		1.00	25,096
80231	General Preventive Medicine - no surgery	3,647	0.0%	1.000	0.914	1.378	0.914	1.378		1.00	3,647
80235	Physiatry	16,872	0.1%	1.000	0.855	1.185	0.855	1.185		1.00	16,872
80238	Endocrinology - no surgery	31,135	0.2%	1.000	0.567	0.749	0.567	0.749		1.00	31,135
80239	Family Practice- no surgery	317,260	1.7%	1.000	1.000	NA	1.000	NA		1.00	317,260
80241	Gastroenterology - no surgery	16,093	0.1%	1.600	1.597	1.831	0.998	1.144		1.00	16,093
80242	General Practice- no surgery	2,995	0.0%	1.000	1.000	NA	1.000	NA		1.00	2,995
80243	Geriatrics - no surgery	5,142	0.0%	1.000	0.960	1.000	0.960	1.000		1.00	5,142
80244	Gynecology - no surgery	4,268	0.0%	1.000	0.960	1.000	0.960	1.000		1.00	4,268
80245	Hematology - no surgery	6,819	0.0%	1.000	1.000	1.197	1.000	1.197		1.00	6,819
80246	Infectious Diseases - no surgery	30,436	0.2%	1.000	1.344	0.764	1.344	0.764		1.00	30,436
80249	Psychiatry - including child	93,161	0.5%	1.000	0.667	1.185	0.667	1.185		1.00	93,161
80252	Rheumatology - no surgery	64,176	0.3%	1.000	0.667	0.764	0.667	0.764		1.00	64,176
80253	Radiology - diagnostic - no surgery	224,400	1.2%	1.334	1.879	1.602	1.409	1.201		1.00	224,400
80254	Allergy	25,493	0.1%	1.000	0.500	0.717	0.500	0.717		1.00	25,493
80255	Cardiovascular Disease - no surgery	91,306	0.5%	1.334	1.344	1.602	1.008	1.201		1.00	91,306
80256	Dermatology - no surgery	88,315	0.5%	1.334	0.667	0.749	0.500	0.562		1.00	88,315
80257	Internal Medicine - no surgery	703,113	3.8%	1.334	1.129	1.378	0.847	1.033		1.00	703,113
80260	Nephrology - no surgery	123,015	0.7%	1.334	1.050	0.764	0.787	0.573		1.00	123,015
80261	Neurology - including child - no surgery	45,507	0.2%	1.334	1.452	1.500	1.089	1.125		1.00	45,507
80263	Opthalmology - no surgery	11,022	0.1%	1.000	0.667	0.742	0.667	0.742		1.00	11,022
80265	Otorhinolaryngology - no surgery	3,945	0.0%	1.000	0.914	1.000	0.914	1.000		1.00	3,945
80266	Pathology - no surgery	12,154	0.1%	1.000	1.000	1.145	1.000	1.145		1.00	12,154
80267	Pediatrics - no surgery	793,551	4.3%	2.000	0.777	1.408	0.388	0.704		1.00	793,551
80268	Physicians - no surgery - N.O.C.	102,463	0.6%	1.600	1.000	1.000	0.625	0.625		1.00	102,463
80269	Pulmonary Diseases - no surgery	65,407	0.4%	1.334	1.785	2.812	1.339	2.108	4A	1.50	98,110
80272	Endocrinology - minor surgery	55,509	0.3%	1.600	0.914	0.749	0.571	0.468		1.00	55,509
80273	Family Practice minor surgery	76,489	0.4%	2.267	1.344	2.729	0.593	1.204		1.00	76,489
80274	Gastroenterology - minor surgery	111,827	0.6%	2.000	1.700	1.831	0.850	0.915		1.00	111,827
80275	General Practice- minor surgery	74,089	0.4%	2.934	1.344	NA	0.458	NA		1.00	74,089
80277	Gynecology - minor surgery	60,508	0.3%	2.400	1.700	2.033	0.708	0.847		1.00	60,508
80278	Hematology - minor surgery	37,711	0.2%	1.600	1.050	1.197	0.656	0.748		1.00	37,711
80280	Radiology - diagnostic - minor surgery	383,972	2.1%	2.934	2.210	2.882	0.753	0.982		1.00	383,972

New Mexico Patient's Compensation Fund
Physicians Professional Liability
Occurrence Coverage Effective March 1, 2022

Derivation of Overall Average Class Plan Factors

ISO Code	Specialty	CY 2020 Surcharges	Percentage of Total Surcharge	NMPCF Current Relativity	MedPro Relativity	TDC Relativity	NMPCF MedPro Relativity	NMPCF TDC Relativity	NMPCF Recommeded Class	NMPCF Rate Change	NMPCF New Surcharge
80281	Cardiovascular Disease - minor surgery	391,325	2.1%	2.400	1.700	1.145	0.708	0.477		1.00	391,325
80282	Dermatology - minor surgery	889	0.0%	1.600	0.914	1.514	0.571	0.946		1.00	889
80283	Intensive Care Medicine	186,518	1.0%	1.600	1.700	1.378	1.063	0.861		1.00	186,518
80284	Internal Medicine - minor surgery	47,541	0.3%	2.400	1.597	1.378	0.665	0.574		1.00	47,541
80287	Nephrology - minor surgery	25,794	0.1%	2.400	1.452	0.764	0.605	0.318		1.00	25,794
80288	Neurology - including child - minor surgery	9,512	0.1%	3.467	1.597	1.500	0.461	0.433		1.00	9,512
80289	Opthalmology - minor surgery	3,534	0.0%	1.334	0.960	1.185	0.720	0.889		1.00	3,534
80291	Otorhinolaryngology - minor surgery	5,644	0.0%	1.600	1.452	2.854	0.907	1.784	4	1.50	8,467
80293	Pediatrics - minor surgery	50,787	0.3%	3.467	1.344	1.408	0.388	0.406	3	0.46	23,437
80294	Physicians - minor surgery - N.O.C.	25,274	0.1%	1.600	1.344	1.419	0.840	0.887		1.00	25,274
80296	Dermatopathology	3,232	0.0%	1.600	0.667	1.603	0.417	1.002		1.00	3,232
80297	Dermatology - All Other	40,935	0.2%	1.600	0.667	NA	0.417	NA		1.00	40,935
80298	Neurology - including child - no surgery - Pain Management	65,223	0.4%	1.334	1.452	NA	1.089	NA		1.00	65,223
80299	Neurology - including child - no surgery - All Other	43,127	0.2%	1.334	1.452	NA	1.089	NA		1.00	43,127
80301	Oncology – minor surgery	45,635	0.2%	2.934	1.050	NA	0.358	NA		1.00	45,635
80302	Oncology – no surgery	128,570	0.7%	1.334	1.000	NA	0.750	NA		1.00	128,570
80307	Pathology - All Other	100,110	0.5%	1.000	1.000	NA	1.000	NA		1.00	100,110
80321	Physicians - No Surgery - Full time teaching	6,071	0.0%	1.000	1.000	NA	1.000	NA		1.00	6,071
80358	Radiology - therapeutic - minor surgery	0	0.0%	2.934	2.210	NA	0.753	NA		1.00	0
80359	Radiology - therapeutic - no surgery	3,889	0.0%	1.334	1.879	NA	1.409	NA		1.00	3,889
80360	Radiology - interventional	32,066	0.2%	2.934	1.879	NA	0.641	NA		1.00	32,066
80410	Chiropractors	1,156	0.0%	0.800	0.500	NA	0.625	NA		1.00	1,156
80420	Family Physicians or General Practitioners-no surgery	573,177	3.1%	1.000	1.000	1.000	1.000	1.000		1.00	573,177
80421	Family Physicians or General Practitioners - minor surgery	76,250	0.4%	1.600	1.344	1.419	0.840	0.887		1.00	76,250
80422	Physicians no major surgery: - Angiography	0	0.0%	2.400	2.210	1.145	0.921	0.477		1.00	0
80425	Physicians no major surgery: - Lasers - used in Therapy	36,291	0.2%	2.934	1.344	2.067	0.458	0.705		1.00	36,291
80443	Colonoscopy	4,643	0.0%	1.600	1.597	NA	0.998	NA		1.00	4,643
80804	Neonatal / Perinatal Medicine	120,613	0.6%	2.934	1.344	NA	0.458	NA		1.00	120,613
84102	Emergency Medicine - no major surgery	222,728	1.2%	2.934	2.571	3.008	0.876	1.025		1.00	222,728
84134	Preventive Medicine - no surgery - Occupational Medicine	2,928	0.0%	1.000	0.667	NA	0.667	NA		1.00	2,928
84143	Surgery - general (no general/family practice)	112,003	0.6%	7.668	4.300	5.881	0.561	0.767		1.00	112,003
84145	Surgery - urological	16,329	0.1%	3.467	1.989	2.678	0.574	0.772		1.00	16,329
84151	Anesthesiology	14,351	0.1%	4.001	1.344	2.070	0.336	0.517		1.00	14,351
84153	Surgery - obstetrics - gynecology	206,866	1.1%	8.668	4.730	6.930	0.546	0.800		1.00	206,866
84154	Surgery - orthopedic	215,359	1.2%	7.668	3.630	4.643	0.473	0.606		1.00	215,359
84155	Surgery - plastic - otorhinolaryngology	16,271	0.1%	6.334	2.210	3.880	0.349	0.613		1.00	16,271
84156	Surgery - plastic - N.O.C.	19,106	0.1%	6.334	2.210	3.880	0.349	0.613		1.00	19,106
84157	Emergency Medicine - incl. major surgery	588	0.0%	3.467	3.300	3.008	0.952	0.868		1.00	588
84167	Surgery - gynecology	23,827	0.1%	6.334	2.571	2.033	0.406	0.321		1.00	23,827
84182	Anesthesiology - Pain Management	2,791	0.0%	1.334	1.344	2.173	1.008	1.630		1.00	2,791
84183	Anesthesiology - All Other	44,469	0.2%	4.001	1.344	NA	0.336	NA		1.00	44,469
84209	Physicial Medicine and Rehabilitation - All Other	16,453	0.1%	1.000	0.667	NA	0.667	NA		1.00	16,453
84222	Hospitalists	17,648	0.1%	1.334	1.597	NA	1.198	NA		1.00	17,648
84249	Psychiatry - including child	9,106	0.0%	1.000	0.667	1.185	0.667	1.185		1.00	9,106
84253	Radiology - diagnostic - no surgery	5,729	0.0%	1.334	1.879	1.602	1.409	1.201		1.00	5,729
84254	Allergy	4,291	0.0%	1.000	0.500	0.717	0.500	0.717		1.00	4,291
84255	Cardiovascular Disease - no surgery	1,113	0.0%	1.334	1.344	1.602	1.008	1.201		1.00	1,113
84257	Internal Medicine - no surgery	74,003	0.4%	1.334	1.129	1.378	0.847	1.033		1.00	74,003
84263	Ophthalmology - no surgery	(94)	0.0%	1.000	0.667	0.742	0.667	0.742		1.00	(94)
84267	Pediatric - no surgery	58,213	0.3%	2.000	0.777	1.408	0.388	0.704		1.00	58,213
84268	Physicians - no surgery - N.O.C.	22,663	0.1%	1.600	1.000	1.000	0.625	0.625		1.00	22,663
84269	Pulmonary Diseases - no surgery	6,457	0.0%	1.334	1.785	2.812	1.339	2.108	4A	1.50	9,686
84274	Gastroenterology - minor surgery	580	0.0%	2.000	1.700	1.831	0.850	0.915		1.00	580
84278	Hematology - minor surgery	4,796	0.0%	1.600	1.050	1.197	0.656	0.748		1.00	4,796
84280	Radiology - diagnostic - minor surgery	11,957	0.1%	2.934	2.210	2.882	0.753	0.982		1.00	11,957
84283	Intensive Care Medicine	19,161	0.1%	2.400	1.700	1.378	0.708	0.574		1.00	19,161
84284	Internal Medicine - minor surgery	2,257	0.0%	2.400	1.597	1.378	0.665	0.574		1.00	2,257
84289	Ophthalmology - minor surgery	(870)	0.0%	1.334	0.960	1.185	0.720	0.889		1.00	(870)
84297	Dermatology - All Other	0	0.0%	1.600	0.667	NA	0.417	NA		1.00	0
84298	Neurology - including child - no surgery - Pain Management	2,521	0.0%	1.334	1.452	NA	1.089	NA		1.00	2,521
84299	Neurology - including child - no surgery - All Other	3,956	0.0%	1.334	1.452	NA	1.089	NA		1.00	3,956
84306	Pathology - Cytopathology - no surgery	586	0.0%	1.000	1.000	NA	1.000	NA		1.00	586
84307	Pathology - all other	6,660	0.0%	1.000	1.000	NA	1.000	NA		1.00	6,660
84360	Radiology - interventional	5,801	0.0%	2.934	1.879	NA	0.641	NA		1.00	5,801
84420	Family Physicians or General Practitioners - no surgery	83,225	0.4%	1.000	1.000	1.000	1.000	1.000		1.00	83,225
84421	Family Physicians or General Practitioners - minor surgery	13,812	0.1%	1.600	1.344	1.419	0.840	0.887		1.00	13,812
Total		**18,598,709**	**100.0%**	**4.801**	**2.672**	**3.298**					**18,278,051**

ISO Code Change Offset: **1.018**

Notes: MedPro Relativity based on Filing# MDPC-1322566734 -- Effective 5-1-2021
TDC Relativity based on Filing# DCTR-132364328 -- Effective 8-1-2021

New Mexico Patient's Compensation Fund
Physicians Professional Liability
Occurrence Coverage Effective March 1, 2022

Recommended ISO Class Updates

ISO Code	Specialty	CY 2020 Surcharges	NMPCF Current Class	NMPCF Recommeded Class	NMPCF Rate Change	NMPCF New Surcharge
80104	Surgery - gastroenterology	514,528	9	6	0.45	232,665
80115	Surgery - colon and rectal	54,487	9	6	0.45	24,638
80117	Surgery - general practice or family practice	37,150	9	6	0.45	16,799
80269	Pulmonary Diseases - no surgery	65,407	2	4A	1.50	98,110
80291	Otorhinolaryngology - minor surgery	5,644	3	4	1.50	8,467
80293	Pediatrics - minor surgery	50,787	6	3	0.46	23,437
84269	Pulmonary Diseases - no surgery	6,457	2	4A	1.50	9,686
Total		**734,460**				**413,802**

New Mexico Patient's Compensation Fund
Hospitals & Outpatient Facilities

Summary of Hospital Providers Surcharges and Adjustments - 2020

Hospital	Experience Rated?	Manual Surcharge	Adjusted Surcharge	Experience Discount
1	N	744,728	744,728	-
2	N	452,641	452,641	-
3	N	164,248	164,248	-
4	Y	2,783,745	2,783,745	-
5	N	52,515	52,515	-
6	N	646,812	646,812	-
7	Y	4,095,387	4,095,387	-
8	N	241,428	241,428	-
9	N	1,049,555	1,049,555	-
10	Y	1,631,127	1,435,392	(195,735)
11	N	164,946	164,946	-
12	Y	11,057,718	8,293,288	(2,764,430)
13	N	1,122,857	1,122,857	-
14	N	276,424	276,424	-
15	Y	1,882,171	1,599,845	(282,326)
	Total	26,366,303	23,123,812	(3,242,491)
			Overall amount of Discount:	-12.3%
	Experience Rated Only:	21,450,148	18,207,657	
	Percentage Experience Rated:	81%	79%	

New Mexico Patient's Compensation Fund
Hospitals & Outpatient Facilities

Summary of Hospital Providers Claims - 2020

Hospital	Experience Rated?	2018	2017	2016	2015	2014	Total
1	N	0	0	0	0	0	0
2	N	0	0	0	0	0	0
3	N	0	0	0	0	0	0
4	Y	2	1	8	5	2	18
5	N	0	0	0	0	0	0
6	N	0	0	0	0	0	0
7	Y	7	5	5	14	8	39
8	N	0	0	0	0	0	0
9	N	0	0	0	0	0	0
10	Y	0	2	3	2	2	9
11	N	0	0	0	0	0	0
12	Y	1	9	11	21	19	61
13	N	0	0	0	0	0	0
14	N	0	0	0	0	0	0
15	Y	1	1	1	3	2	8
	Total	11	18	28	45	33	135
Used in Experience Rating Modification:		22	52	50	67	48	239
Percentage of Reported Claims:		50%	35%	56%	67%	69%	56%
						Percentage of Manual Premium that is Experience Rated:	81%

New Mexico Patient's Compensation Fund
Hospitals & Outpatient Facilities

Summary of Hospital Exposures - 2020

	Hospital															
Exposure Type	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Relativity
Acute Care Bed	28	10	-	120	-	28	290	45	28	113	6	940	55	9	117	1.000
Psychiatric Care Bed	-	-	-	-	-	-	-	-	20	-	-	51	-	-	5	1.000
Extended Care Bed	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.100
Skilled Nursing Care Bed	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.350
Personal Care Bed	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.150
Physical Rehab Bed	-	-	63	-	-	-	-	-	6	-	-	-	-	-	13	0.500
Chemical Dep. Rehab Bed	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.250
Births	302	297	-	1,120	-	527	4,000	-	527	1,247	107	7,749	316	103	1,204	0.050
Inpatient Surgeries (000)s	6	4	-	34	-	6	57	-	9	33	2	124	12	1	29	1.750
Outpatient Surgeries (000)s	31	13	-	116	55	18	156	-	55	76	20	223	51	8	73	0.200
ER visits (000)s	236	144	-	511	-	206	1,103	-	297	389	78	2,672	298	156	480	0.150
Other Outpatient visits (000)s	1,216	787	60	4,963	-	729	1,431	111	1,299	700	90	4,194	1,752	320	1,350	0.050
Home Healthcare (000)s	-	-	-	-	-	-	-	-	116	-	-	1,299	-	-	-	0.050
Acute Care Bed Equivalent	156	95	34	583	11	135	858	51	220	342	35	2,316	235	58	394	

New Mexico Patient's Compensation Fund

Newly Eligible Providers Professional Liability

Occurrence Coverage Effective March 1, 2022

Recommended New Eligible Provider Relativities

	Relativity to Family Practice - No Surgery Base Rate					
Specialty	MedPro	NORCAL	TDC	UMIA	NMPCF Selected	NMPCF Proposed Class
Ceritifed Nursing Practitioner	0.051	0.125	0.224	0.287	0.200	CN
Certified Nurse Midwife	1.411	1.575	1.240	1.964	1.600	3
Clinical Nurse Specialist	0.051			0.287	0.200	CN

Other company relativities based on:

MedPro Filing: Filing# MDPC-132182122 -- Effective 5-1-2020

NORCAL Filing: Filing# NCMC-131349568 -- Effective 1-18-2018

TDC Filing: Filing# DCTR-132364328 -- Effective 8-1-2021

UMIA Filing: Filing# PERR-131385463 -- Effective 3-5-2018

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Summary of Loss

Accident Year		(1) Selected Ultimate	(2) Paid @ 12/31/20	(3) (1) - (2) Unpaid
Prior		NA	NA	0
2006		6,328,725	6,328,725	0
2007		13,190,829	13,164,500	26,329
2008		11,732,218	11,662,152	70,066
2009		8,080,562	7,992,342	88,220
2010		16,573,610	16,262,567	311,043
2011		20,495,740	19,911,969	583,771
2012		10,221,686	9,734,408	487,278
2013		8,605,723	7,962,544	643,179
2014		15,747,095	14,364,565	1,382,530
2015		6,656,137	4,027,500	2,628,637
2016		13,987,152	5,840,000	8,147,152
2017		26,821,644	9,950,000	16,871,644
2018		25,449,620	2,721,023	22,728,597
2019		24,303,532	720,000	23,583,532
2020	[1]	21,022,111	0	21,022,111
Total		229,216,385	130,642,295	98,574,090

[1] Reflects a full year of earned exposure
[2] Judgmentally selected

New Mexico Patient's Compensation Fund

Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Selection of Ultimate Loss

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Indicated Ultimate Based on:						
Accident Year	Paid @ 12/31/20	Paid Chain Ladder	Paid Generalized Cape Cod	Paid Bornhuetter-Ferguson	Frequency-Severity	Ratio to Surcharge	Prior Actuary Selected @ 12/31/19	Selected Ultimate
2006	6,328,725	6,328,725	6,328,725	NA	NA	NA	6,328,725	6,328,725
2007	13,164,500	13,190,829	13,185,083	NA	NA	NA	13,268,531	13,190,829
2008	11,662,152	11,732,218	11,728,168	NA	NA	NA	11,788,976	11,732,218
2009	7,992,342	8,080,562	8,133,286	NA	NA	NA	8,174,638	8,080,562
2010	16,262,567	16,573,610	16,511,997	NA	NA	NA	16,257,661	16,573,610
2011	19,911,969	20,495,740	20,285,261	NA	NA	NA	19,500,000	20,495,740
2012	9,734,408	10,170,095	10,273,277	NA	NA	NA	11,250,000	10,221,686
2013	7,962,544	8,485,305	8,726,141	NA	NA	NA	9,300,000	8,605,723
2014	14,364,565	15,862,416	15,631,774	NA	NA	NA	16,100,000	15,747,095
2015	4,027,500	5,601,237	7,711,037	NA	NA	NA	10,000,000	6,656,137
2016	5,840,000	13,413,353	14,560,952	NA	NA	NA	14,750,000	13,987,152
2017	9,950,000	43,069,112	30,400,332	27,387,865	22,676,735	NA	26,500,000	26,821,644
2018	2,721,023	27,355,734	27,725,776	24,813,728	24,532,951	23,809,357	25,750,000	25,449,620
2019	720,000	37,696,221	27,279,655	24,559,890	24,304,100	24,302,964	25,500,000	24,303,532
2020 [1]	0	0	24,030,236	21,109,949	21,177,364	20,866,859	NA	21,022,111
Total	130,642,295	238,055,158	242,511,698	NA	NA	NA	NA	229,216,385
2006-2017	127,201,272	173,003,203	163,476,031	NA	NA	NA	163,218,531	158,441,121
2018-2020	3,441,023	65,051,954	79,035,666	70,483,567	70,014,415	68,979,180	NA	70,775,264

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund

Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Chain Ladder Indications of Ultimate Loss

	(1)	(2)	(3)	(4) (1) x (3)
	Based on Paid Development			
Accident Year	Paid @ 12/31/20	Development Factor Select	Development Factor Cumulative	Indicated Ultimate
2006	6,328,725	1.000	1.000	6,328,725
2007	13,164,500	1.002	1.002	13,190,829
2008	11,662,152	1.004	1.006	11,732,218
2009	7,992,342	1.005	1.011	8,080,562
2010	16,262,567	1.008	1.019	16,573,610
2011	19,911,969	1.010	1.029	20,495,740
2012	9,734,408	1.015	1.045	10,170,095
2013	7,962,544	1.020	1.066	8,485,305
2014	14,364,565	1.036	1.104	15,862,416
2015	4,027,500	1.259	1.391	5,601,237
2016	5,840,000	1.651	2.297	13,413,353
2017	9,950,000	1.885	4.329	43,069,112
2018	2,721,023	2.323	10.053	27,355,734
2019	720,000	5.208	52.356	37,696,221
2020 [1]	0	6.000	314.135	0

[1] Reflects a full year of earned exposure

Note: Development factors based on Physicians & Surgeons and Hospitals combined data

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Generalized Cape Cod Indications of Ultimate Loss

	(1)	(2)	(3)	(4)	(5)	(6) Min [(1), (1)x(5)]	(7)	(8)	(9)	(10) (5)	(11) (3)x(10) + (9)x[1-(10)]
			Based on Paid Development								
Accident Year	Surcharges at CRL	Selected Exposure Period Weight	Paid Chain Ladder Indication	Paid @ 12/31/20	% Paid	Used-Up Surcharges at CRL	Trended Developed Ratio to Surcharge	Expected Ratio to Surcharge	A Priori Ultimate for Paid GCC Method	Selected Weight	Indicated Ultimate
2006	15,441,893	1	6,328,725	6,328,725	100.0%	15,441,893	71.0%	110.6%	9,861,888	100.0%	6,328,725
2007	14,828,231	1	13,190,829	13,164,500	99.8%	14,798,634	148.1%	115.8%	10,312,181	99.8%	13,185,083
2008	15,242,503	1	11,732,218	11,662,152	99.4%	15,151,473	123.2%	116.1%	11,054,069	99.4%	11,728,168
2009	17,192,668	1	8,080,562	7,992,342	98.9%	17,004,967	72.4%	115.6%	12,909,886	98.9%	8,133,286
2010	16,352,982	1	16,573,610	16,262,567	98.1%	16,046,079	150.0%	120.3%	13,290,616	98.1%	16,511,997
2011	15,345,233	1	20,495,740	19,911,969	97.2%	14,908,161	190.1%	121.6%	13,105,975	97.2%	20,285,261
2012	14,918,894	1	10,170,095	9,734,408	95.7%	14,279,769	93.3%	115.4%	12,578,641	95.7%	10,273,277
2013	14,679,745	1	8,485,305	7,962,544	93.8%	13,775,358	76.1%	111.1%	12,394,471	93.8%	8,726,141
2014	15,401,689	1	15,862,416	14,364,565	90.6%	13,947,343	130.3%	110.3%	13,419,883	90.6%	15,631,774
2015	14,972,715	1	5,601,237	4,027,500	71.9%	10,765,945	45.5%	106.5%	13,110,424	71.9%	7,711,037
2016	16,587,807	1	13,413,353	5,840,000	43.5%	7,222,116	94.6%	108.9%	15,445,894	43.5%	14,560,952
2017	26,285,132	1	43,069,112	9,950,000	23.1%	6,072,497	184.3%	113.8%	26,594,241	23.1%	30,400,332
2018	26,365,573	1	27,355,734	2,721,023	9.9%	2,622,534	112.2%	113.9%	27,766,649	9.9%	27,725,776
2019	24,663,432	1	37,696,221	720,000	1.9%	471,073	159.0%	114.2%	27,076,823	1.9%	27,279,655
2020 [1]	21,146,700	1	0	0	0.3%	67,317	0.0%	114.0%	24,106,977	0.3%	24,030,236

[1] Reflects a full year of earned exposure

(5) Inverse of the cumulative development factors on the exhibit titled "Chain Ladder Indications of Ultimate Loss"
(7) Equal to (4) / (6) and trended at 4.0% per annum to December 31, 2020
(8) Calculated from (2), (6), (7), and a decay ratio of 0.75
(9) Equal to (1) x (8) and detrended at 4.0% per annum from December 31, 2020

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Bornhuetter-Ferguson Indications of Ultimate Loss

	(1)	(2)	(3)	(4)	(5)	(6)
				1 / (3)	(4)	(2)x(5) + (1)x[1-(5)]
		Based on Paid Development				
Accident Year	A Priori [2] Ultimate for BF Method	Paid Chain Ladder Indication	Cumulative Development Factor	% Paid	Selected Weight	Indicated Ultimate
2006	NA	6,328,725	1.000	100.0%	100.0%	NA
2007	NA	13,190,829	1.002	99.8%	99.8%	NA
2008	NA	11,732,218	1.006	99.4%	99.4%	NA
2009	NA	8,080,562	1.011	98.9%	98.9%	NA
2010	NA	16,573,610	1.019	98.1%	98.1%	NA
2011	NA	20,495,740	1.029	97.2%	97.2%	NA
2012	NA	10,170,095	1.045	95.7%	95.7%	NA
2013	NA	8,485,305	1.066	93.8%	93.8%	NA
2014	NA	15,862,416	1.104	90.6%	90.6%	NA
2015	NA	5,601,237	1.391	71.9%	71.9%	NA
2016	NA	13,413,353	2.297	43.5%	43.5%	NA
2017	22,676,735	43,069,112	4.329	23.1%	23.1%	27,387,865
2018	24,532,951	27,355,734	10.053	9.9%	9.9%	24,813,728
2019	24,304,100	37,696,221	52.356	1.9%	1.9%	24,559,890
2020 [1]	21,177,364	0	314.135	0.3%	0.3%	21,109,949

[1] Reflects a full year of earned exposure
[2] From frequency-severity indication

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Frequency-Severity Loss Projection

Accident Year	Ultimate CWP Severity	Ultimate Severity per CWP Claim (Excluding Most Recent Evaluation), Trended at 4.0% per Annum to 2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
2006	372,278	644,665	619,870	596,029	573,105	551,062	529,868	509,488	489,892	471,050	452,933	435,513	418,762	402,656	387,169	
2007	425,511	708,506	681,256	655,054	629,860	605,634	582,341	559,943	538,407	517,699	497,787	478,642	460,232	442,531		
2008	335,206	536,676	516,035	496,187	477,103	458,753	441,109	424,143	407,830	392,144	377,061	362,559	348,614			
2009	384,789	592,364	569,581	547,674	526,610	506,356	486,880	468,154	450,148	432,835	416,187	400,180				
2010	424,964	629,051	604,857	581,593	559,224	537,716	517,034	497,148	478,027	459,641	441,963					
2011	621,083	883,995	849,995	817,303	785,868	755,642	726,579	698,634	671,763	645,926						
2012	444,421	608,221	584,828	562,334	540,706	519,910	499,913	480,686	462,198							
2013	478,096	629,141	604,944	581,677	559,304	537,793	517,108	497,220								
2014	583,226	737,967	709,583	682,292	656,050	630,817	606,555									
2015	554,678	674,851	648,895	623,937	599,940	576,865										
2016	518,043	606,037	582,728	560,315	538,764											
2017	724,909	815,424	784,062	753,906												
2018	652,554	705,803	678,657													
2019	656,852	683,126														
2020																
Wtd Avg		683,141	656,868	629,050	589,160	571,610	549,377	521,406	503,456	489,277	435,699	416,682	404,671	428,409	387,169	
Avg x H/L		669,596	642,660	614,481	575,951	558,269	534,243	502,106	483,734	470,306	437,028	417,846	418,762	NA	NA	
Wtd Avg L7		703,977	669,383	674,051	612,885	590,365	545,855	522,419	503,456	NA	NA	NA	NA	NA	NA	
Wtd Avg L5		706,802	691,247	656,217	579,093	624,149	580,888	539,408	497,808	491,225	435,699	NA	NA	NA	NA	
Wtd Avg L3		734,272	691,374	664,609	597,868	590,083	546,808	581,901	541,493	519,689	412,354	413,003	404,671	NA	NA	
Trended Select		683,142	654,212	637,400	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Select		683,141	656,868	629,050	612,885	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Frequency-Severity Indicated Ultimate Loss

Accident Year	(1) Selected Ultimate CWP Claim Counts	(2) Selected Ultimate Severity per CWP Claim	(3) (1) x (2) Indicated Ultimate
2006	17	NA	NA
2007	31	NA	NA
2008	35	NA	NA
2009	21	NA	NA
2010	39	NA	NA
2011	33	NA	NA
2012	23	NA	NA
2013	18	NA	NA
2014	27	NA	NA
2015	12	NA	NA
2016	27	NA	NA
2017	37	612,885	22,676,735
2018	39	629,050	24,532,951
2019	37	656,868	24,304,100
2020 [1]	31	683,141	21,177,364

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Loss Ratio to Surcharge Projection

Accident Year	Ultimate Ratio to CRL Surcharges	Ultimate Ratio to CRL Surcharges (Excluding Most Recent Evaluation), Trended at 4.0% per Annum to 2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
2006	41.0%	71.0%	68.2%	65.6%	63.1%	60.7%	58.3%	56.1%	53.9%	51.9%	49.9%	47.9%	46.1%	44.3%	42.6%	
2007	89.0%	148.1%	142.4%	136.9%	131.7%	126.6%	121.7%	117.1%	112.6%	108.2%	104.1%	100.1%	96.2%	92.5%		
2008	77.0%	123.2%	118.5%	113.9%	109.6%	105.3%	101.3%	97.4%	93.6%	90.0%	86.6%	83.3%	80.0%			
2009	47.0%	72.4%	69.6%	66.9%	64.3%	61.8%	59.5%	57.2%	55.0%	52.9%	50.8%	48.9%				
2010	101.3%	150.0%	144.3%	138.7%	133.4%	128.2%	123.3%	118.6%	114.0%	109.6%	105.4%					
2011	133.6%	190.1%	182.8%	175.8%	169.0%	162.5%	156.3%	150.2%	144.5%	138.9%						
2012	68.5%	93.8%	90.2%	86.7%	83.4%	80.2%	77.1%	74.1%	71.3%							
2013	58.6%	77.1%	74.2%	71.3%	68.6%	65.9%	63.4%	61.0%								
2014	102.2%	129.4%	124.4%	119.6%	115.0%	110.6%	106.3%									
2015	44.5%	54.1%	52.0%	50.0%	48.1%	46.2%										
2016	84.3%	98.6%	94.9%	91.2%	87.7%											
2017	102.0%	114.8%	110.4%	106.1%												
2018	96.5%	104.4%	100.4%													
2019	98.5%	102.5%														
2020																
Wtd Avg		109.0%	105.5%	102.1%	97.5%	94.8%	96.2%	91.2%	91.6%	91.2%	78.8%	69.1%	73.8%	67.9%	42.6%	
Avg x H/L		107.1%	103.4%	99.7%	95.2%	92.4%	93.2%	87.5%	89.3%	90.2%	80.5%	66.1%	80.0%	NA	NA	
Wtd Avg L7		99.8%	94.8%	100.9%	101.3%	93.8%	98.0%	96.2%	91.6%	NA	NA	NA	NA	NA	NA	
Wtd Avg L5		98.7%	98.5%	90.3%	80.9%	93.6%	106.0%	92.1%	95.1%	98.9%	78.8%	NA	NA	NA	NA	
Wtd Avg L3		107.3%	102.8%	87.3%	84.0%	74.7%	82.6%	95.8%	110.3%	98.9%	80.3%	76.0%	73.8%	NA	NA	
Trended Select		102.5%	93.9%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Select		98.7%	98.5%	90.3%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

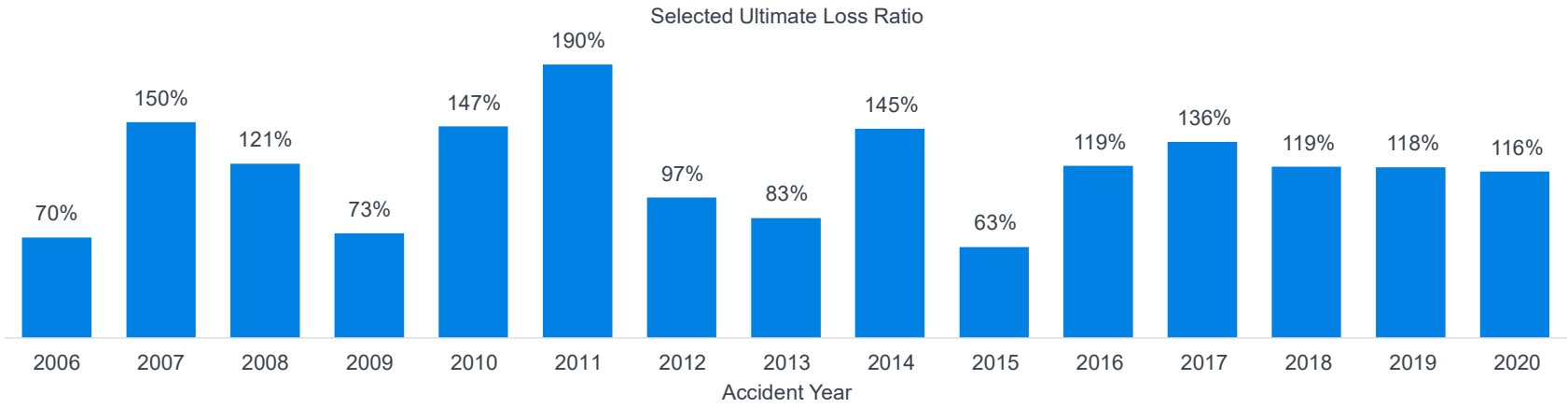
Ratio to Surcharge Indicated Ultimate Loss

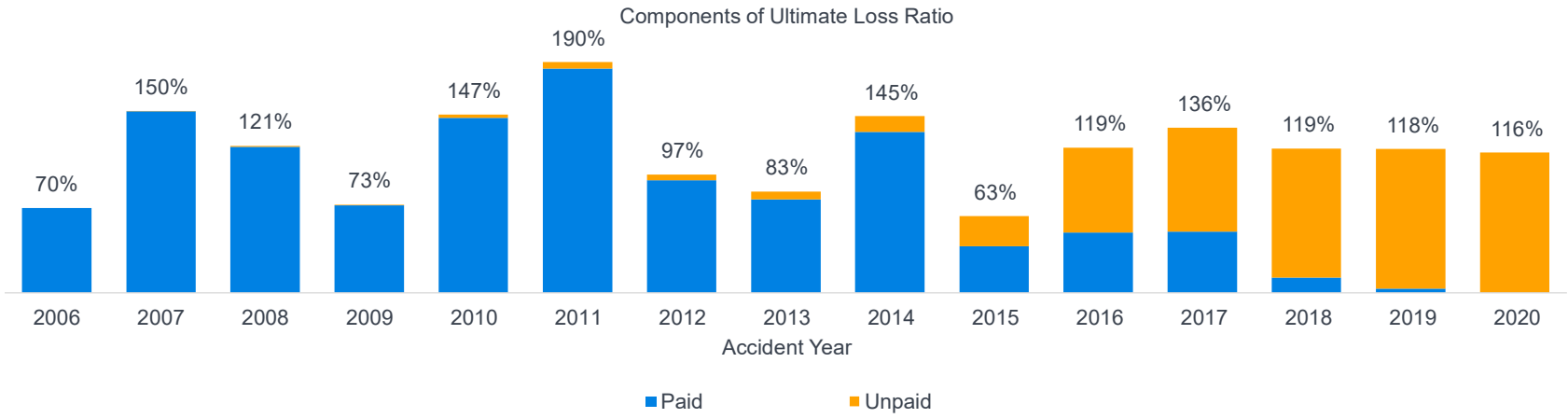
Accident Year		(1) Surcharges at CRL	(2) Selected Ratio to Surcharge	(3) (1) x (2) Indicated Ultimate
2006		15,441,893	NA	NA
2007		14,828,231	NA	NA
2008		15,242,503	NA	NA
2009		17,192,668	NA	NA
2010		16,352,982	NA	NA
2011		15,345,233	NA	NA
2012		14,918,894	NA	NA
2013		14,679,745	NA	NA
2014		15,401,689	NA	NA
2015		14,972,715	NA	NA
2016		16,587,807	NA	NA
2017		26,285,132	NA	NA
2018		26,365,573	90.3%	23,809,357
2019		24,663,432	98.5%	24,302,964
2020	[1]	21,146,700	98.7%	20,866,859

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Diagnostic Charts





New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Summary of Claim Counts

Accident Year	(1) CWP @ 12/31/20	(2) Selected Ultimate CWP	(3) (2) - (1) Yet-to-be-CWP
2006	17	17	0
2007	30	31	1
2008	34	35	1
2009	20	21	1
2010	38	39	1
2011	32	33	1
2012	22	23	1
2013	17	18	1
2014	24	27	3
2015	10	12	2
2016	17	27	10
2017	12	37	25
2018	8	39	31
2019	1	37	36
2020 [1]	0	31	31
Total	282	427	145

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Selection of Ultimate CWP Claim Counts

	(1)	(2)	(3)	(4)	(5)	(6)
		Indicated Ultimate Based on:				
Accident Year	CWP @ 12/31/20	CWP Chain Ladder	Generalized Cape Cod	Bornhuetter-Ferguson	Ultimate CWP Frequency	Selected Ultimate
2006	17	17	17	NA	NA	17
2007	30	30	30	NA	NA	31
2008	34	34	34	NA	NA	35
2009	20	20	20	NA	NA	21
2010	38	38	38	NA	NA	39
2011	32	32	32	NA	NA	33
2012	22	23	23	NA	NA	23
2013	17	18	18	NA	NA	18
2014	24	27	26	NA	NA	27
2015	10	12	14	NA	NA	12
2016	17	30	28	28	25	27
2017	12	34	37	36	37	37
2018	8	49	41	38	36	39
2019	1	26	37	36	37	37
2020 [1]	0	0	31	31	31	31
Total	282	390	428	NA	NA	427
2006-2017	273	314	318	NA	NA	320
2018-2020	9	75	110	105	104	107

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Chain Ladder Indicated Ultimate CWP Claim Counts

Accident Year		(1) CWP @ 12/31/20	(2) Selected Development Factor	(3) Cumulative Development Factor	(4) (1) x (3) Indicated Ultimate
2006		17	1.000	1.000	17
2007		30	1.000	1.000	30
2008		34	1.000	1.000	34
2009		20	1.000	1.000	20
2010		38	1.005	1.005	38
2011		32	1.010	1.015	32
2012		22	1.015	1.030	23
2013		17	1.020	1.051	18
2014		24	1.053	1.106	27
2015		10	1.119	1.238	12
2016		17	1.411	1.747	30
2017		12	1.598	2.792	34
2018		8	2.203	6.153	49
2019		1	4.225	25.992	26
2020	[1]	0	4.000	103.969	0

[1] Reflects a full year of earned exposure
Note: Development factors based on Physicians & Surgeons and Hospitals combined data

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Generalized Cape Cod Indicated Ultimate CWP Claim Counts

Accident Year	(1) ($000) Surcharges at CRL	(2) Selected Exposure Period Weight	(3) CWP Chain Ladder Indication	(4) CWP @ 12/31/20	(5) % CWP	(6) Min [(1), (1)x(5)] Used-Up ($000) Surcharges at CRL	(7) Trended Developed Frequency	(8) Expected Frequency	(9) A Priori Ultimate for GCC Method	(10) (3)x(5) + (9)x[1-(5)] Indicated Ultimate
2006	15,442	1	17	17	100.0%	15,442	0.11%	0.17%	26	17
2007	14,828	1	30	30	100.0%	14,828	0.20%	0.17%	26	30
2008	15,243	1	34	34	100.0%	15,243	0.22%	0.18%	27	34
2009	17,193	1	20	20	100.0%	17,193	0.12%	0.17%	30	20
2010	16,353	1	38	38	99.5%	16,272	0.23%	0.18%	29	38
2011	15,345	1	32	32	98.5%	15,118	0.21%	0.17%	26	32
2012	14,919	1	23	22	97.1%	14,480	0.15%	0.17%	25	23
2013	14,680	1	18	17	95.2%	13,969	0.12%	0.16%	23	18
2014	15,402	1	27	24	90.4%	13,923	0.17%	0.16%	24	26
2015	14,973	1	12	10	80.8%	12,095	0.08%	0.15%	23	14
2016	16,588	1	30	17	57.2%	9,494	0.18%	0.15%	25	28
2017	26,285	1	34	12	35.8%	9,413	0.13%	0.15%	40	37
2018	26,366	1	49	8	16.3%	4,285	0.19%	0.15%	40	41
2019	24,663	1	26	1	3.8%	949	0.11%	0.15%	37	37
2020 [1]	21,147	1	0	0	1.0%	203	0.00%	0.15%	32	31

[1] Reflects a full year of earned exposure

(5) Inverse of the cumulative development factors on the exhibit titled "Chain Ladder Indicated Ultimate CWP Claim Counts"
(7) Equal to (4) / (6) and trended at 0.0% per annum to December 31, 2020
(8) Calculated from (2), (6), (7), and a decay ratio of 0.75
(9) Equal to (1) x (8) and detrended at 0.0% per annum from December 31, 2020

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Bornhuetter-Ferguson Indicated Ultimate CWP Claim Counts

Accident Year		(1) A Priori [2] Ultimate for BF Method	(2) CWP Chain Ladder Indication	(3) Cumulative Development Factor	(4) 1 / (3) % CWP	(5) (4) Selected Weight	(6) (2)x(5) + (1)x[1-(5)] Indicated Ultimate
2006		NA	17	1.000	100.0%	100.0%	NA
2007		NA	30	1.000	100.0%	100.0%	NA
2008		NA	34	1.000	100.0%	100.0%	NA
2009		NA	20	1.000	100.0%	100.0%	NA
2010		NA	38	1.005	99.5%	99.5%	NA
2011		NA	32	1.015	98.5%	98.5%	NA
2012		NA	23	1.030	97.1%	97.1%	NA
2013		NA	18	1.051	95.2%	95.2%	NA
2014		NA	27	1.106	90.4%	90.4%	NA
2015		NA	12	1.238	80.8%	80.8%	NA
2016		25	30	1.747	57.2%	57.2%	28
2017		37	34	2.792	35.8%	35.8%	36
2018		36	49	6.153	16.3%	16.3%	38
2019		37	26	25.992	3.8%	3.8%	36
2020	[1]	31	0	103.969	1.0%	1.0%	31

[1] Reflects a full year of earned exposure
[2] From frequency indication

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Ultimate CWP Frequency Projection

Accident Year	Ultimate CWP Frequency	Ultimate CWP Frequency per ($000) Surcharges at CRL (Excluding Most Recent Evaluation), Trended at 0.0% per Annum to 2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
2006	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	0.11%	
2007	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%	0.21%		
2008	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%	0.23%			
2009	0.12%	0.12%	0.12%	0.12%	0.12%	0.12%	0.12%	0.12%	0.12%	0.12%	0.12%					
2010	0.24%	0.24%	0.24%	0.24%	0.24%	0.24%	0.24%	0.24%	0.24%	0.24%						
2011	0.22%	0.22%	0.22%	0.22%	0.22%	0.22%	0.22%	0.22%	0.22%							
2012	0.15%	0.15%	0.15%	0.15%	0.15%	0.15%	0.15%	0.15%								
2013	0.12%	0.12%	0.12%	0.12%	0.12%	0.12%	0.12%									
2014	0.18%	0.18%	0.18%	0.18%	0.18%	0.18%										
2015	0.08%	0.08%	0.08%	0.08%	0.08%											
2016	0.16%	0.16%	0.16%	0.16%												
2017	0.14%	0.14%	0.14%													
2018	0.15%	0.15%	0.15%													
2019	0.15%	0.15%														
2020																
Wtd Avg		0.16%	0.16%	0.16%	0.17%	0.17%	0.18%	0.17%	0.18%	0.19%	0.18%	0.17%	0.18%	0.16%	0.11%	
Avg x H/L		0.16%	0.16%	0.16%	0.17%	0.17%	0.18%	0.18%	0.19%	0.19%	0.19%	0.17%	0.21%	NA	NA	
Wtd Avg L7		0.14%	0.14%	0.15%	0.17%	0.16%	0.18%	0.18%	0.18%	NA	NA	NA	NA	NA	NA	
Wtd Avg L5		0.14%	0.14%	0.14%	0.14%	0.15%	0.18%	0.17%	0.19%	0.20%	0.18%	NA	NA	NA	NA	
Wtd Avg L3		0.15%	0.15%	0.13%	0.14%	0.13%	0.15%	0.16%	0.20%	0.19%	0.19%	0.18%	0.18%	NA	NA	
Trended Select		0.15%	0.14%	0.14%	0.15%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Select		0.15%	0.15%	0.14%	0.14%	0.15%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

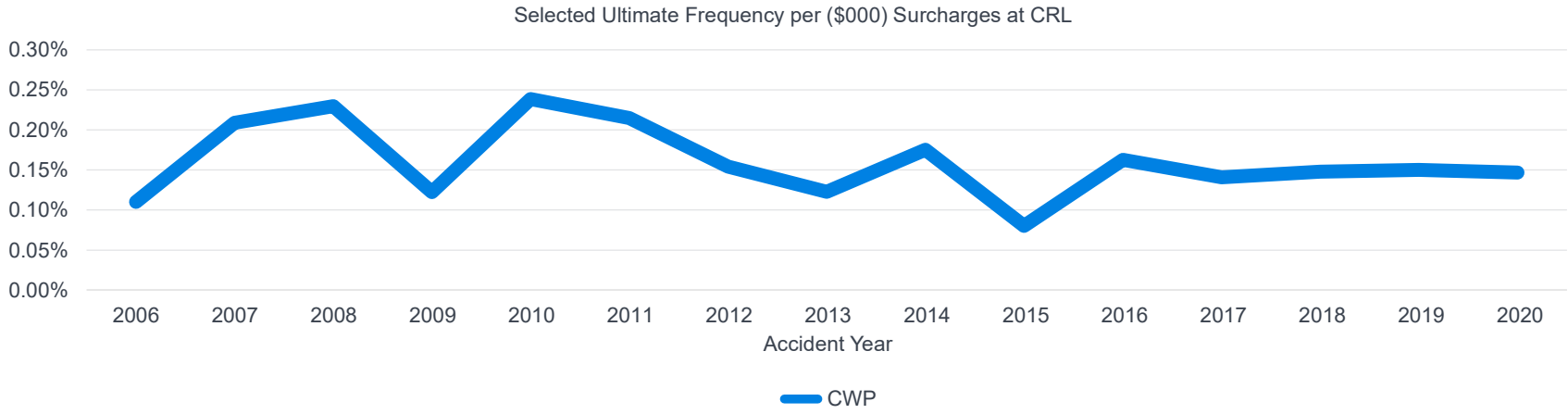
Frequency Indicated Ultimate CWP Claim Counts

Accident Year		(1) ($000) Surcharges at CRL	(2) Selected CWP Frequency	(3) (1) x (2) Indicated Ultimate
2006		15,442	NA	NA
2007		14,828	NA	NA
2008		15,243	NA	NA
2009		17,193	NA	NA
2010		16,353	NA	NA
2011		15,345	NA	NA
2012		14,919	NA	NA
2013		14,680	NA	NA
2014		15,402	NA	NA
2015		14,973	NA	NA
2016		16,588	0.15%	25
2017		26,285	0.14%	37
2018		26,366	0.14%	36
2019		24,663	0.15%	37
2020	[1]	21,147	0.15%	31

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund
Physicians & Surgeons (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Diagnostic Charts



New Mexico Patient's Compensation Fund
Hospitals
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Summary of Loss

Accident Year	(1) Selected Ultimate	(2) Paid @ 12/31/20	(3) (1) - (2) Unpaid
Prior	NA	NA	0
2006	0	0	0
2007	0	0	0
2008	0	0	0
2009	2,097,904	2,075,000	22,904
2010	1,493,020	1,465,000	28,020
2011	1,971,143	1,915,000	56,143
2012	2,167,872	2,075,000	92,872
2013	1,646,106	1,544,693	101,413
2014	6,895,231	6,244,130	651,101
2015	1,999,712	1,437,868	561,844
2016	4,616,582	2,010,000	2,606,582
2017	14,283,213	2,497,184	11,786,029
2018	23,342,004	2,372,500	20,969,504
2019	22,696,570	550,000	22,146,570
2020 [1]	24,828,117	300,000	24,528,117
Total	108,037,471	24,486,374	83,551,097

[1] Reflects a full year of earned exposure
[2] Judgmentally selected

New Mexico Patient's Compensation Fund

Hospitals

Occurrence Coverage Evaluated as of December 31, 2020

PCF Loss

Actuarial Central Estimate

Selection of Ultimate Loss

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
		Indicated Ultimate Based on:						
Accident Year	Paid @ 12/31/20	Paid Chain Ladder	Paid Generalized Cape Cod	Paid Bornhuetter-Ferguson	Frequency-Severity	Ratio to Surcharge	Prior Actuary Selected @ 12/31/19	Selected Ultimate
2006	0	0	NA	NA	NA	NA	NA	0
2007	0	0	NA	NA	NA	NA	NA	0
2008	0	0	NA	NA	NA	NA	NA	0
2009	2,075,000	2,097,904	2,092,834	NA	NA	NA	2,090,000	2,097,904
2010	1,465,000	1,493,020	1,495,910	NA	NA	NA	1,550,000	1,493,020
2011	1,915,000	1,971,143	1,965,021	NA	NA	NA	2,075,000	1,971,143
2012	2,075,000	2,167,872	2,146,616	NA	NA	NA	1,000,000	2,167,872
2013	1,544,693	1,646,106	1,661,682	NA	NA	NA	1,025,000	1,646,106
2014	6,244,130	6,895,231	6,440,730	NA	NA	NA	6,100,000	6,895,231
2015	1,437,868	1,999,712	1,937,371	NA	NA	NA	1,800,000	1,999,712
2016	2,010,000	4,616,582	7,995,153	NA	NA	NA	7,500,000	4,616,582
2017	2,497,184	10,809,194	17,757,231	NA	NA	NA	17,000,000	14,283,213
2018	2,372,500	23,851,867	24,041,766	26,536,884	26,833,457	21,596,277	21,250,000	23,342,004
2019	550,000	28,795,724	25,295,173	25,113,781	25,042,087	21,523,811	21,250,000	22,696,570
2020 [1]	300,000	94,240,552	28,774,095	28,446,840	28,236,728	23,123,811	NA	24,828,117
Total	24,486,374	180,584,906	NA	NA	NA	NA	NA	108,037,471
2006-2017	21,263,874	33,696,763	NA	NA	NA	NA	NA	37,170,781
2018-2020	3,222,500	146,888,143	78,111,034	80,097,506	80,112,272	66,243,899	NA	70,866,690

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund

Hospitals

Occurrence Coverage Evaluated as of December 31, 2020

PCF Loss

Actuarial Central Estimate

Chain Ladder Indications of Ultimate Loss

	(1)	(2)	(3)	(4) (1) x (3)
	Based on Paid Development			
Accident Year	Paid @ 12/31/20	Development Factor Select	Development Factor Cumulative	Indicated Ultimate
2006	0	1.000	1.000	0
2007	0	1.002	1.002	0
2008	0	1.004	1.006	0
2009	2,075,000	1.005	1.011	2,097,904
2010	1,465,000	1.008	1.019	1,493,020
2011	1,915,000	1.010	1.029	1,971,143
2012	2,075,000	1.015	1.045	2,167,872
2013	1,544,693	1.020	1.066	1,646,106
2014	6,244,130	1.036	1.104	6,895,231
2015	1,437,868	1.259	1.391	1,999,712
2016	2,010,000	1.651	2.297	4,616,582
2017	2,497,184	1.885	4.329	10,809,194
2018	2,372,500	2.323	10.053	23,851,867
2019	550,000	5.208	52.356	28,795,724
2020 [1]	300,000	6.000	314.135	94,240,552

[1] Reflects a full year of earned exposure

Note: Development factors based on Physicians & Surgeons and Hospitals combined data

New Mexico Patient's Compensation Fund
Hospitals
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Generalized Cape Cod Indications of Ultimate Loss

	(1)	(2)	(3)	(4)	(5)	(6) Min [(1), (1)x(5)]	(7)	(8)	(9)	(10) (5)	(11) (3)x(10) + (9)x[1-(10)]
			Based on Paid Development								
Accident Year	Surcharges	Selected Exposure Period Weight	Paid Chain Ladder Indication	Paid @ 12/31/20	% Paid	Used-Up Surcharges	Trended Developed Ratio to Surcharge	Expected Ratio to Surcharge	A Priori Ultimate for Paid GCC Method	Selected Weight	Indicated Ultimate
2006	0	0	0	0	100.0%	0	NA	NA	NA	100.0%	NA
2007	0	0	0	0	99.8%	0	NA	NA	NA	99.8%	NA
2008	0	0	0	0	99.4%	0	NA	NA	NA	99.4%	NA
2009	1,130,000	1	2,097,904	2,075,000	98.9%	1,117,663	285.8%	222.5%	1,633,540	98.9%	2,092,834
2010	1,130,000	1	1,493,020	1,465,000	98.1%	1,108,793	195.6%	215.7%	1,646,981	98.1%	1,495,910
2011	1,175,200	1	1,971,143	1,915,000	97.2%	1,141,727	238.7%	212.7%	1,756,184	97.2%	1,965,021
2012	1,099,542	1	2,167,872	2,075,000	95.7%	1,052,438	269.8%	208.1%	1,671,699	95.7%	2,146,616
2013	1,250,000	1	1,646,106	1,544,693	93.8%	1,172,990	173.3%	199.9%	1,898,946	93.8%	1,661,682
2014	1,350,000	1	6,895,231	6,244,130	90.6%	1,222,523	646.3%	195.1%	2,082,013	90.6%	6,440,730
2015	1,350,000	1	1,999,712	1,437,868	71.9%	970,701	180.2%	160.2%	1,777,831	71.9%	1,937,371
2016	9,476,474	1	4,616,582	2,010,000	43.5%	4,125,934	57.0%	130.9%	10,600,453	43.5%	7,995,153
2017	18,644,316	1	10,809,194	2,497,184	23.1%	4,307,285	65.2%	119.7%	19,844,635	23.1%	17,757,231
2018	21,596,277	1	23,851,867	2,372,500	9.9%	2,148,141	119.5%	120.5%	24,062,741	9.9%	24,041,766
2019	21,523,811	1	28,795,724	550,000	1.9%	411,106	139.1%	121.9%	25,227,010	1.9%	25,295,173
2020 [1]	23,123,811	1	94,240,552	300,000	0.3%	73,611	407.5%	123.5%	28,565,027	0.3%	28,774,095

[1] Reflects a full year of earned exposure

(5) Inverse of the cumulative development factors on the exhibit titled "Chain Ladder Indications of Ultimate Loss"
(7) Equal to (4) / (6) and trended at 4.0% per annum to December 31, 2020
(8) Calculated from (2), (6), (7), and a decay ratio of 0.75
(9) Equal to (1) x (8) and detrended at 4.0% per annum from December 31, 2020

New Mexico Patient's Compensation Fund
Hospitals
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Bornhuetter-Ferguson Indications of Ultimate Loss

	(1)	(2)	(3)	(4)	(5)	(6)
				1 / (3)	(4)	(2)x(5) + (1)x[1-(5)]
		Based on Paid Development				
Accident Year	A Priori [2] Ultimate for BF Method	Paid Chain Ladder Indication	Cumulative Development Factor	% Paid	Selected Weight	Indicated Ultimate
2006	NA	0	1.000	100.0%	100.0%	NA
2007	NA	0	1.002	99.8%	99.8%	NA
2008	NA	0	1.006	99.4%	99.4%	NA
2009	NA	2,097,904	1.011	98.9%	98.9%	NA
2010	NA	1,493,020	1.019	98.1%	98.1%	NA
2011	NA	1,971,143	1.029	97.2%	97.2%	NA
2012	NA	2,167,872	1.045	95.7%	95.7%	NA
2013	NA	1,646,106	1.066	93.8%	93.8%	NA
2014	NA	6,895,231	1.104	90.6%	90.6%	NA
2015	NA	1,999,712	1.391	71.9%	71.9%	NA
2016	NA	4,616,582	2.297	43.5%	43.5%	NA
2017	NA	10,809,194	4.329	23.1%	23.1%	NA
2018	26,833,457	23,851,867	10.053	9.9%	9.9%	26,536,884
2019	25,042,087	28,795,724	52.356	1.9%	1.9%	25,113,781
2020 [1]	28,236,728	94,240,552	314.135	0.3%	0.3%	28,446,840

[1] Reflects a full year of earned exposure
[2] From frequency-severity indication

New Mexico Patient's Compensation Fund
Hospitals
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Frequency-Severity Loss Projection

Accident Year	Ultimate CWP Severity	Ultimate Severity per CWP Claim (Excluding Most Recent Evaluation), Trended at 4.0% per Annum to 2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
2006	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
2007	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
2008	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			
2009	699,301	1,076,542	1,035,137	995,324	957,042	920,233	884,839	850,807	818,084	786,619	756,364	727,273				
2010	248,837	368,339	354,172	340,550	327,452	314,858	302,748	291,104	279,907	269,142	258,790					
2011	197,114	280,555	269,765	259,389	249,413	239,820	230,596	221,727	213,199	204,999						
2012	541,968	741,720	713,193	685,762	659,387	634,026	609,640	586,192	563,647							
2013	329,221	433,233	416,570	400,548	385,142	370,329	356,086	342,390								
2014	1,723,808	2,181,167	2,097,276	2,016,611	1,939,049	1,864,470	1,792,760									
2015	333,285	405,492	389,897	374,901	360,481	346,617										
2016	288,536	337,547	324,564	312,081	300,078											
2017	317,405	357,037	343,305	330,101												
2018	457,686	495,034	475,994													
2019	504,368	524,543														
2020																
P&S Select		683,141	656,868	629,050												
Wtd Avg		486,433	456,731	429,623	492,844	551,931	567,719	377,608	370,447	317,089	424,648	727,273	NA	NA	NA	
Avg x H/L		526,610	506,604	491,324	498,264	517,212	538,328	406,562	421,777	269,142	NA	NA	NA	NA	NA	
Wtd Avg L7		486,293	462,454	416,704	465,538	551,931	567,719	377,608	370,447	NA	NA	NA	NA	NA	NA	
Wtd Avg L5		446,328	456,114	423,242	550,960	562,880	534,913	377,608	370,447	317,089	424,648	NA	NA	NA	NA	
Wtd Avg L3		460,410	401,049	329,810	566,167	759,282	876,156	330,210	303,301	317,089	424,648	727,273	NA	NA	NA	
Trended Select		578,750	547,192	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Select		564,735	556,491	526,146	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

New Mexico Patient's Compensation Fund
Hospitals
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Frequency-Severity Indicated Ultimate Loss

Accident Year		(1) Selected Ultimate CWP Claim Counts	(2) Selected Ultimate Severity per CWP Claim	(3) (1) x (2) Indicated Ultimate
2006		0	NA	NA
2007		0	NA	NA
2008		0	NA	NA
2009		3	NA	NA
2010		6	NA	NA
2011		10	NA	NA
2012		4	NA	NA
2013		5	NA	NA
2014		4	NA	NA
2015		6	NA	NA
2016		16	NA	NA
2017		45	NA	NA
2018		51	526,146	26,833,457
2019		45	556,491	25,042,087
2020	[1]	50	564,735	28,236,728

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund
Hospitals
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Loss Ratio to Surcharge Projection

Accident Year	Ultimate Ratio to Surcharges	Ultimate Ratio to Surcharges (Excluding Most Recent Evaluation), Trended at 4.0% per Annum to 2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
2006	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
2007	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
2008	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			
2009	185.7%	285.8%	274.8%	264.2%	254.1%	244.3%	234.9%	225.9%	217.2%	208.8%	200.8%	193.1%				
2010	132.1%	195.6%	188.1%	180.8%	173.9%	167.2%	160.8%	154.6%	148.6%	142.9%	137.4%					
2011	167.7%	238.7%	229.5%	220.7%	212.2%	204.1%	196.2%	188.7%	181.4%	174.4%						
2012	197.2%	269.8%	259.5%	249.5%	239.9%	230.7%	221.8%	213.2%	205.0%							
2013	131.7%	173.3%	166.6%	160.2%	154.1%	148.1%	142.4%	137.0%								
2014	510.8%	646.3%	621.4%	597.5%	574.5%	552.4%	531.2%									
2015	148.1%	180.2%	173.3%	166.6%	160.2%	154.1%										
2016	48.7%	57.0%	54.8%	52.7%	50.7%											
2017	76.6%	86.2%	82.9%	79.7%												
2018	108.1%	116.9%	112.4%													
2019	105.4%	109.7%														
2020																
Wtd Avg		119.0%	117.7%	116.2%	148.2%	247.2%	254.6%	182.8%	187.9%	175.4%	169.1%	193.1%	NA	NA	NA	
Avg x H/L		184.0%	185.9%	188.8%	199.1%	200.1%	203.4%	185.5%	193.2%	174.4%	NA	NA	NA	NA	NA	
Wtd Avg L7		111.2%	110.6%	109.2%	141.1%	247.2%	254.6%	182.8%	187.9%	NA	NA	NA	NA	NA	NA	
Wtd Avg L5		100.2%	106.2%	100.3%	132.8%	262.2%	258.3%	182.8%	187.9%	175.4%	169.1%	NA	NA	NA	NA	
Wtd Avg L3		105.1%	90.3%	75.0%	120.9%	288.3%	307.9%	178.0%	178.2%	175.4%	169.1%	193.1%	NA	NA	NA	
Trended Select		104.0%	104.0%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Select		100.0%	100.0%	100.0%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

New Mexico Patient's Compensation Fund

Hospitals

Occurrence Coverage Evaluated as of December 31, 2020

PCF Loss

Actuarial Central Estimate

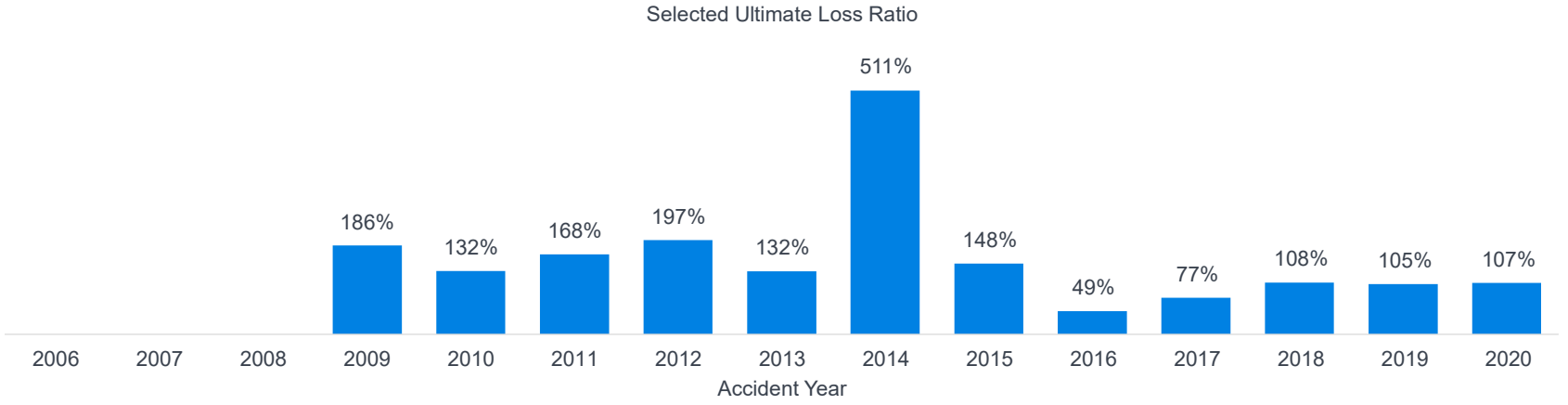
Ratio to Surcharge Indicated Ultimate Loss

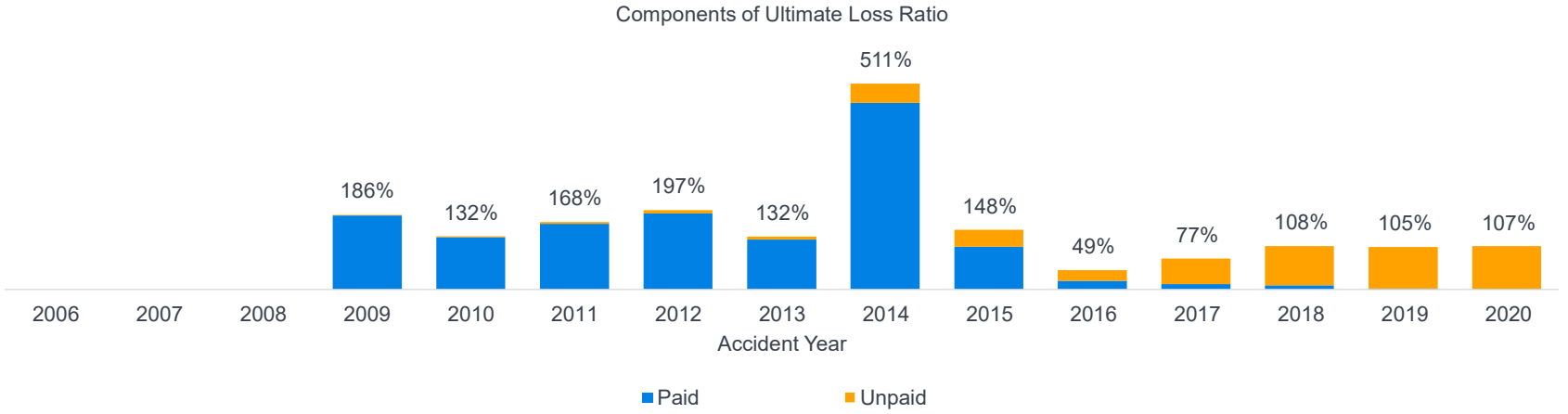
Accident Year		(1) Surcharges	(2) Selected Ratio to Surcharge	(3) (1) x (2) Indicated Ultimate
2006		0	NA	NA
2007		0	NA	NA
2008		0	NA	NA
2009		1,130,000	NA	NA
2010		1,130,000	NA	NA
2011		1,175,200	NA	NA
2012		1,099,542	NA	NA
2013		1,250,000	NA	NA
2014		1,350,000	NA	NA
2015		1,350,000	NA	NA
2016		9,476,474	NA	NA
2017		18,644,316	NA	NA
2018		21,596,277	100.0%	21,596,277
2019		21,523,811	100.0%	21,523,811
2020	[1]	23,123,811	100.0%	23,123,811

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund
Hospitals
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Diagnostic Charts





New Mexico Patient's Compensation Fund

Hospitals

Occurrence Coverage Evaluated as of December 31, 2020

Actuarial Central Estimate

Summary of Claim Counts

Accident Year	(1) CWP @ 12/31/20	(2) Selected Ultimate CWP	(3) (2) - (1) Yet-to-be-CWP
2006	0	0	0
2007	0	0	0
2008	0	0	0
2009	2	3	1
2010	5	6	1
2011	9	10	1
2012	3	4	1
2013	4	5	1
2014	3	4	1
2015	5	6	1
2016	5	16	11
2017	9	45	36
2018	8	51	43
2019	1	45	44
2020 [1]	1	50	49
Total	55	245	190

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund

Hospitals

Occurrence Coverage Evaluated as of December 31, 2020

Actuarial Central Estimate

Selection of Ultimate CWP Claim Counts

	(1)	(2)	(3)	(4)	(5)	(6)
		Indicated Ultimate Based on:				
Accident Year	CWP @ 12/31/20	CWP Chain Ladder	Generalized Cape Cod	Bornhuetter-Ferguson	Ultimate CWP Frequency	Selected Ultimate
2006	0	0	NA	NA	NA	0
2007	0	0	NA	NA	NA	0
2008	0	0	NA	NA	NA	0
2009	2	2	2	NA	NA	3
2010	5	5	5	NA	NA	6
2011	9	9	9	NA	NA	10
2012	3	3	3	NA	NA	4
2013	4	4	4	NA	NA	5
2014	3	3	3	NA	NA	4
2015	5	6	6	NA	NA	6
2016	5	9	12	23	42	16
2017	9	25	30	45	56	45
2018	8	49	41	55	57	51
2019	1	26	38	48	48	45
2020 [1]	1	104	43	53	53	50
Total	55	246	NA	NA	NA	245
2006-2017	45	67	NA	NA	NA	99
2018-2020	10	179	122	156	158	146

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund

Hospitals

Occurrence Coverage Evaluated as of December 31, 2020

Actuarial Central Estimate

Chain Ladder Indicated Ultimate CWP Claim Counts

Accident Year		(1) CWP @ 12/31/20	(2) Selected Development Factor	(3) Cumulative Development Factor	(4) (1) x (3) Indicated Ultimate
2006		0	1.000	1.000	0
2007		0	1.000	1.000	0
2008		0	1.000	1.000	0
2009		2	1.000	1.000	2
2010		5	1.005	1.005	5
2011		9	1.010	1.015	9
2012		3	1.015	1.030	3
2013		4	1.020	1.051	4
2014		3	1.053	1.106	3
2015		5	1.119	1.238	6
2016		5	1.411	1.747	9
2017		9	1.598	2.792	25
2018		8	2.203	6.153	49
2019		1	4.225	25.992	26
2020	[1]	1	4.000	103.969	104

[1] Reflects a full year of earned exposure

Note: Development factors based on Physicians & Surgeons and Hospitals combined data

New Mexico Patient's Compensation Fund
Hospitals
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Generalized Cape Cod Indicated Ultimate CWP Claim Counts

Accident Year	(1) ($000) Surcharges	(2) Selected Exposure Period Weight	(3) CWP Chain Ladder Indication	(4) CWP @ 12/31/20	(5) % CWP	(6) Min [(1), (1)x(5)] Used-Up ($000) Surcharges	(7) Trended Developed Frequency	(8) Expected Frequency	(9) A Priori Ultimate for GCC Method	(10) (3)x(5) + (9)x[1-(5)] Indicated Ultimate
2006	0	0	0	0	100.0%	0	NA	NA	NA	NA
2007	0	0	0	0	100.0%	0	NA	NA	NA	NA
2008	0	0	0	0	100.0%	0	NA	NA	NA	NA
2009	1,130	1	2	2	100.0%	1,130	0.18%	0.30%	3	2
2010	1,130	1	5	5	99.5%	1,124	0.44%	0.32%	4	5
2011	1,175	1	9	9	98.5%	1,158	0.78%	0.32%	4	9
2012	1,100	1	3	3	97.1%	1,067	0.28%	0.28%	3	3
2013	1,250	1	4	4	95.2%	1,189	0.34%	0.25%	3	4
2014	1,350	1	3	3	90.4%	1,220	0.25%	0.23%	3	3
2015	1,350	1	6	5	80.8%	1,091	0.46%	0.21%	3	6
2016	9,476	1	9	5	57.2%	5,424	0.09%	0.18%	17	12
2017	18,644	1	25	9	35.8%	6,677	0.13%	0.17%	33	30
2018	21,596	1	49	8	16.3%	3,510	0.23%	0.18%	39	41
2019	21,524	1	26	1	3.8%	828	0.12%	0.18%	39	38
2020 [1]	23,124	1	104	1	1.0%	222	0.45%	0.18%	42	43

[1] Reflects a full year of earned exposure

(5) Inverse of the cumulative development factors on the exhibit titled "Chain Ladder Indicated Ultimate CWP Claim Counts"
(7) Equal to (4) / (6) and trended at 0.0% per annum to December 31, 2020
(8) Calculated from (2), (6), (7), and a decay ratio of 0.75
(9) Equal to (1) x (8) and detrended at 0.0% per annum from December 31, 2020

New Mexico Patient's Compensation Fund

Hospitals

Occurrence Coverage Evaluated as of December 31, 2020

Actuarial Central Estimate

Bornhuetter-Ferguson Indicated Ultimate CWP Claim Counts

Accident Year	(1) A Priori [2] Ultimate for BF Method	(2) CWP Chain Ladder Indication	(3) Cumulative Development Factor	(4) 1 / (3) % CWP	(5) (4) Selected Weight	(6) (2)x(5) + (1)x[1-(5)] Indicated Ultimate
2006	NA	0	1.000	100.0%	100.0%	NA
2007	NA	0	1.000	100.0%	100.0%	NA
2008	NA	0	1.000	100.0%	100.0%	NA
2009	NA	2	1.000	100.0%	100.0%	NA
2010	NA	5	1.005	99.5%	99.5%	NA
2011	NA	9	1.015	98.5%	98.5%	NA
2012	NA	3	1.030	97.1%	97.1%	NA
2013	NA	4	1.051	95.2%	95.2%	NA
2014	NA	3	1.106	90.4%	90.4%	NA
2015	NA	6	1.238	80.8%	80.8%	NA
2016	42	9	1.747	57.2%	57.2%	23
2017	56	25	2.792	35.8%	35.8%	45
2018	57	49	6.153	16.3%	16.3%	55
2019	48	26	25.992	3.8%	3.8%	48
2020 [1]	53	104	103.969	1.0%	1.0%	53

[1] Reflects a full year of earned exposure

[2] From frequency indication

New Mexico Patient's Compensation Fund
Hospitals
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Ultimate CWP Frequency Projection

Accident Year	Ultimate CWP Frequency	Ultimate CWP Frequency per ($000) Surcharges (Excluding Most Recent Evaluation), Trended at 0.0% per Annum to 2020	2019	2018	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006
2006	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
2007	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA		
2008	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA			
2009	0.27%	0.27%	0.27%	0.27%	0.27%	0.27%	0.27%	0.27%	0.27%	0.27%	0.27%	0.27%				
2010	0.53%	0.53%	0.53%	0.53%	0.53%	0.53%	0.53%	0.53%	0.53%	0.53%	0.53%					
2011	0.85%	0.85%	0.85%	0.85%	0.85%	0.85%	0.85%	0.85%	0.85%	0.85%						
2012	0.36%	0.36%	0.36%	0.36%	0.36%	0.36%	0.36%	0.36%	0.36%							
2013	0.40%	0.40%	0.40%	0.40%	0.40%	0.40%	0.40%	0.40%								
2014	0.30%	0.30%	0.30%	0.30%	0.30%	0.30%	0.30%									
2015	0.44%	0.44%	0.44%	0.44%	0.44%	0.44%										
2016	0.17%	0.17%	0.17%	0.17%	0.17%											
2017	0.24%	0.24%	0.24%	0.24%												
2018	0.24%	0.24%	0.24%													
2019	0.21%	0.21%														
2020																
Wtd Avg		0.24%	0.26%	0.27%	0.30%	0.45%	0.45%	0.48%	0.51%	0.55%	0.40%	0.27%	NA	NA	NA	
Avg x H/L		0.33%	0.35%	0.36%	0.38%	0.41%	0.40%	0.43%	0.45%	0.53%	NA	NA	NA	NA	NA	
Wtd Avg L7		0.23%	0.24%	0.26%	0.30%	0.45%	0.45%	0.48%	0.51%	NA	NA	NA	NA	NA	NA	
Wtd Avg L5		0.22%	0.23%	0.24%	0.24%	0.47%	0.48%	0.48%	0.51%	0.55%	0.40%	NA	NA	NA	NA	
Wtd Avg L3		0.23%	0.23%	0.23%	0.21%	0.38%	0.35%	0.54%	0.59%	0.55%	0.40%	0.27%	NA	NA	NA	
Trended Select		0.23%	0.26%	0.30%	0.45%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Select		0.23%	0.23%	0.26%	0.30%	0.45%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

New Mexico Patient's Compensation Fund

Hospitals

Occurrence Coverage Evaluated as of December 31, 2020

Actuarial Central Estimate

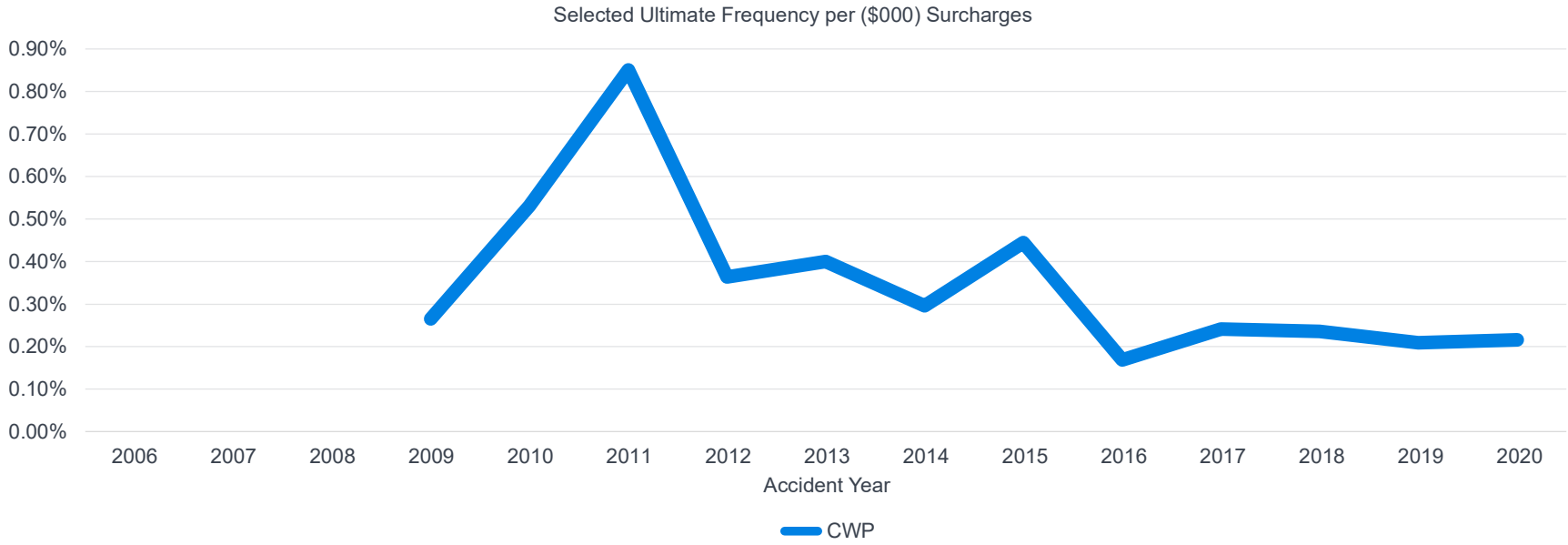
Frequency Indicated Ultimate CWP Claim Counts

Accident Year		(1) ($000) Surcharges	(2) Selected CWP Frequency	(3) (1) x (2) Indicated Ultimate
2006		0	NA	NA
2007		0	NA	NA
2008		0	NA	NA
2009		1,130	NA	NA
2010		1,130	NA	NA
2011		1,175	NA	NA
2012		1,100	NA	NA
2013		1,250	NA	NA
2014		1,350	NA	NA
2015		1,350	NA	NA
2016		9,476	0.45%	42
2017		18,644	0.30%	56
2018		21,596	0.26%	57
2019		21,524	0.23%	48
2020	[1]	23,124	0.23%	53

[1] Reflects a full year of earned exposure

New Mexico Patient's Compensation Fund
Hospitals
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

Diagnostic Charts



New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate

Paid Loss Chain Ladder Projection

Accident	**Paid by Month of Development**														
Year	12	24	36	48	60	72	84	96	108	120	132	144	156	168	180
2006	0	0	628,725	4,253,725	5,228,725	5,378,725	5,628,725	5,928,725	6,328,725	6,328,725	6,328,725	6,328,725	6,328,725	6,328,725	6,328,725
2007	0	0	1,250,000	4,937,000	7,887,000	12,067,000	12,717,000	13,164,500	13,164,500	13,164,500	13,164,500	13,164,500	13,164,500	13,164,500	
2008	0	0	2,163,652	4,764,652	6,542,152	9,204,652	11,262,152	11,662,152	11,662,152	11,662,152	11,662,152	11,662,152	11,662,152		
2009	0	495,000	2,868,567	3,368,567	4,203,567	8,242,342	8,242,342	8,367,342	8,367,342	8,367,342	10,067,342	10,067,342			
2010	0	775,000	3,511,000	6,138,000	9,688,000	16,177,567	16,502,567	16,902,567	16,902,567	17,602,567	17,727,567				
2011	0	1,325,000	1,925,000	4,753,000	9,950,312	17,226,228	19,358,728	20,973,728	20,973,728	21,826,969					
2012	0	50,000	850,000	2,614,408	4,324,408	7,529,408	11,629,408	11,779,408	11,809,408						
2013	0	450,000	750,000	875,000	4,575,000	6,407,148	9,507,237	9,507,237							
2014	0	480,000	2,370,000	4,945,000	7,573,261	14,280,446	20,608,696								
2015	0	0	1,112,868	1,977,868	4,402,868	5,465,368									
2016	0	700,000	2,625,000	4,830,000	7,850,000										
2017	0	675,000	4,015,000	12,447,184											
2018	0	650,000	5,093,523												
2019	0	1,270,000													
2020	300,000														

Accident	**Development Factors**														
Year	12-24	24-36	36-48	48-60	60-72	72-84	84-96	96-108	108-120	120-132	132-144	144-156	156-168	168-180	180-ult
2006	NA	NA	6.766	1.229	1.029	1.046	1.053	1.067	1.000	1.000	1.000	1.000	1.000	1.000	
2007	NA	NA	3.950	1.598	1.530	1.054	1.035	1.000	1.000	1.000	1.000	1.000	1.000		
2008	NA	NA	2.202	1.373	1.407	1.224	1.036	1.000	1.000	1.000	1.000	1.000			
2009	NA	5.795	1.174	1.248	1.961	1.000	1.015	1.000	1.000	1.203	1.000				
2010	NA	4.530	1.748	1.578	1.670	1.020	1.024	1.000	1.041	1.007					
2011	NA	1.453	2.469	2.093	1.731	1.124	1.083	1.000	1.041						
2012	NA	17.000	3.076	1.654	1.741	1.545	1.013	1.003							
2013	NA	1.667	1.167	5.229	1.400	1.484	1.000								
2014	NA	4.938	2.086	1.531	1.886	1.443									
2015	NA	NA	1.777	2.226	1.241										
2016	NA	3.750	1.840	1.625											
2017	NA	5.948	3.100												
2018	NA	7.836													
2019	NA														
Wtd Avg	NA	5.208	2.323	1.662	1.584	1.196	1.036	1.005	1.020	1.032	1.000	1.000	1.000	1.000	
Avg x H/L	NA	4.923	2.342	1.659	1.576	1.199	1.029	1.001	1.010	1.002	1.000	1.000	NA	NA	
Geo Avg	NA	4.606	2.306	1.770	1.533	1.199	1.032	1.010	1.013	1.039	1.000	1.000	1.000	1.000	
Wtd Avg L5	NA	6.074	2.306	1.885	1.651	1.259	1.035	1.000	1.022	1.032	NA	NA	NA	NA	
Wtd Avg L3	NA	5.794	2.484	1.687	1.580	1.479	1.044	1.001	1.034	1.048	1.000	1.000	NA	NA	
Select	6.000	5.208	2.323	1.885	1.651	1.259	1.036	1.020	1.015	1.010	1.008	1.005	1.004	1.002	1.000

New Mexico Patient's Compensation Fund
Medical Professional Liability (Excluding Batch Claims)
Occurrence Coverage Evaluated as of December 31, 2020
Actuarial Central Estimate

CWP Claim Counts Chain Ladder Projection

Accident Year	**CWP by Month of Development** 12	24	36	48	60	72	84	96	108	120	132	144	156	168	180
2006	0	0	2	7	11	13	15	16	17	17	17	17	17	17	17
2007	0	0	2	13	20	26	28	30	30	30	30	30	30	30	
2008	0	0	6	15	21	27	33	34	34	34	34	34	34		
2009	0	2	7	9	13	20	20	21	21	21	22	22			
2010	0	2	9	16	24	38	40	41	41	42	43				
2011	0	1	4	10	20	28	33	37	37	38					
2012	0	1	3	8	12	19	22	23	24						
2013	0	1	2	3	10	15	18	18							
2014	0	1	6	12	17	24	26								
2015	0	0	2	5	10	13									
2016	0	2	7	14	21										
2017	0	2	9	18											
2018	0	1	12												
2019	0	2													
2020	1														

Accident Year	**Development Factors** 12-24	24-36	36-48	48-60	60-72	72-84	84-96	96-108	108-120	120-132	132-144	144-156	156-168	168-180	180-ult
2006	NA	NA	3.500	1.571	1.182	1.154	1.067	1.063	1.000	1.000	1.000	1.000	1.000	1.000	
2007	NA	NA	6.500	1.538	1.300	1.077	1.071	1.000	1.000	1.000	1.000	1.000	1.000		
2008	NA	NA	2.500	1.400	1.286	1.222	1.030	1.000	1.000	1.000	1.000	1.000			
2009	NA	3.500	1.286	1.444	1.538	1.000	1.050	1.000	1.000	1.048	1.000				
2010	NA	4.500	1.778	1.500	1.583	1.053	1.025	1.000	1.024	1.024					
2011	NA	4.000	2.500	2.000	1.400	1.179	1.121	1.000	1.027						
2012	NA	3.000	2.667	1.500	1.583	1.158	1.045	1.043							
2013	NA	2.000	1.500	3.333	1.500	1.200	1.000								
2014	NA	6.000	2.000	1.417	1.412	1.083									
2015	NA	NA	2.500	2.000	1.300										
2016	NA	3.500	2.000	1.500											
2017	NA	4.500	2.000												
2018	NA	12.000													
2019	NA														
Wtd Avg	NA	5.462	2.203	1.598	1.411	1.119	1.053	1.010	1.011	1.014	1.000	1.000	1.000	1.000	
Avg x H/L	NA	4.143	2.294	1.608	1.415	1.129	1.048	1.009	1.006	1.008	1.000	1.000	NA	NA	
Geo Avg	NA	4.225	2.333	1.685	1.402	1.123	1.051	1.015	1.008	1.014	1.000	1.000	1.000	1.000	
Wtd Avg L5	NA	6.000	2.000	1.667	1.435	1.121	1.053	1.006	1.012	1.014	NA	NA	NA	NA	
Wtd Avg L3	NA	5.600	2.056	1.548	1.405	1.138	1.068	1.010	1.020	1.021	1.000	1.000	NA	NA	
Select	4.000	4.225	2.203	1.598	1.411	1.119	1.053	1.020	1.015	1.010	1.005	1.000	1.000	1.000	1.000

New Mexico Patient's Compensation Fund

Actuarial Analysis
As of December 31, 2020

Carl X. Ashenbrenner, FCAS, MAAA

OCTOBER 20, 2021

Milliman

EXHIBIT C

Outline of Presentation

- Selection of Ultimate Loss by Accident Year (AY) – 2006 to 2020
  - Physician and Surgeons (“P&S”)
  - Hospital
- Estimate indicated surcharge “rate” change as of January 1, 2022
  - Account for change to PCF limits
  - Adjust for changes to class plan
  - Adjust for elimination of the Hospital Experience Rating Plan (“ERP”)
- Estimated Unpaid Losses as of December 31, 2020
  - Add provision for on-going medical losses
  - Calculate overall PCF deficit
- Allocate PCF deficit to P&S and Hospital
  - Allocate ultimate losses between Independent and Employed P&S
- Estimate indicated “assessment” to eliminate PCF deficit in five years
- Other Considerations and Limitations on Distribution

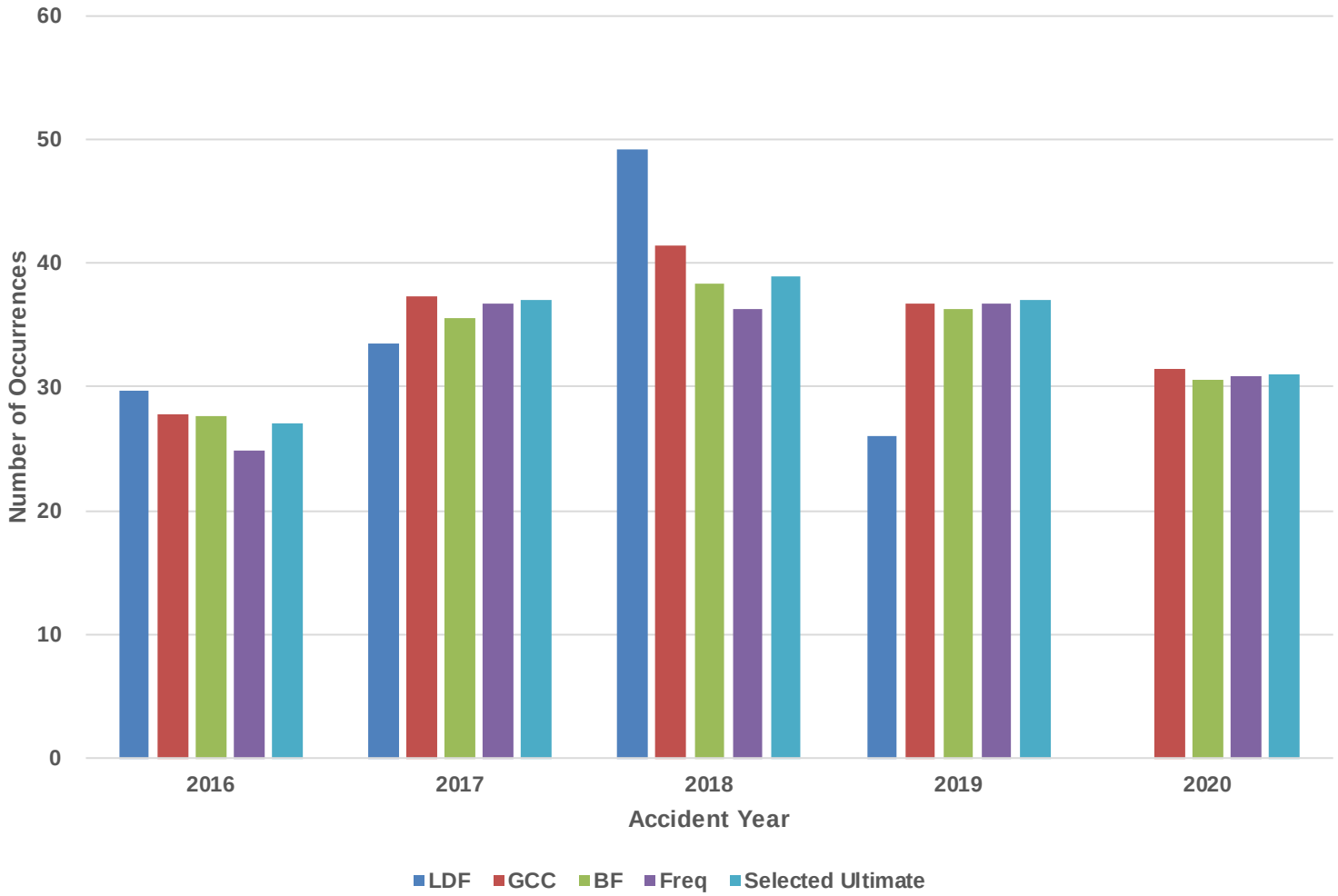
Selection of Ultimate Loss by Accident Year as of December 31, 2020

Selection of Ultimate Loss by Accident Year

- Estimate indicated ultimate for each AY using various generally accepted actuarial indications (split between P&S and Hospitals)
  - Ultimate indicated number of occurrences
  - Ultimate indicated loss
- Select Ultimate Loss by AY based on merits of indications and actuarial judgment
- Actuarial Methods Include:
  - LDF = “Loss Development Method”
  - GCC = “Generalized Cape Cod Method”
  - BF = “Bornhuetter – Ferguson Method”
  - Freq = “Frequency” (Occurrence indication only)
  - FS = “Frequency – Severity” (Loss indication only)
  - Ratio = “Losses divided by Surcharge” (Loss indication only)
- Subsequent charts show AY 2016 – 2020 which comprise majority of unpaid losses

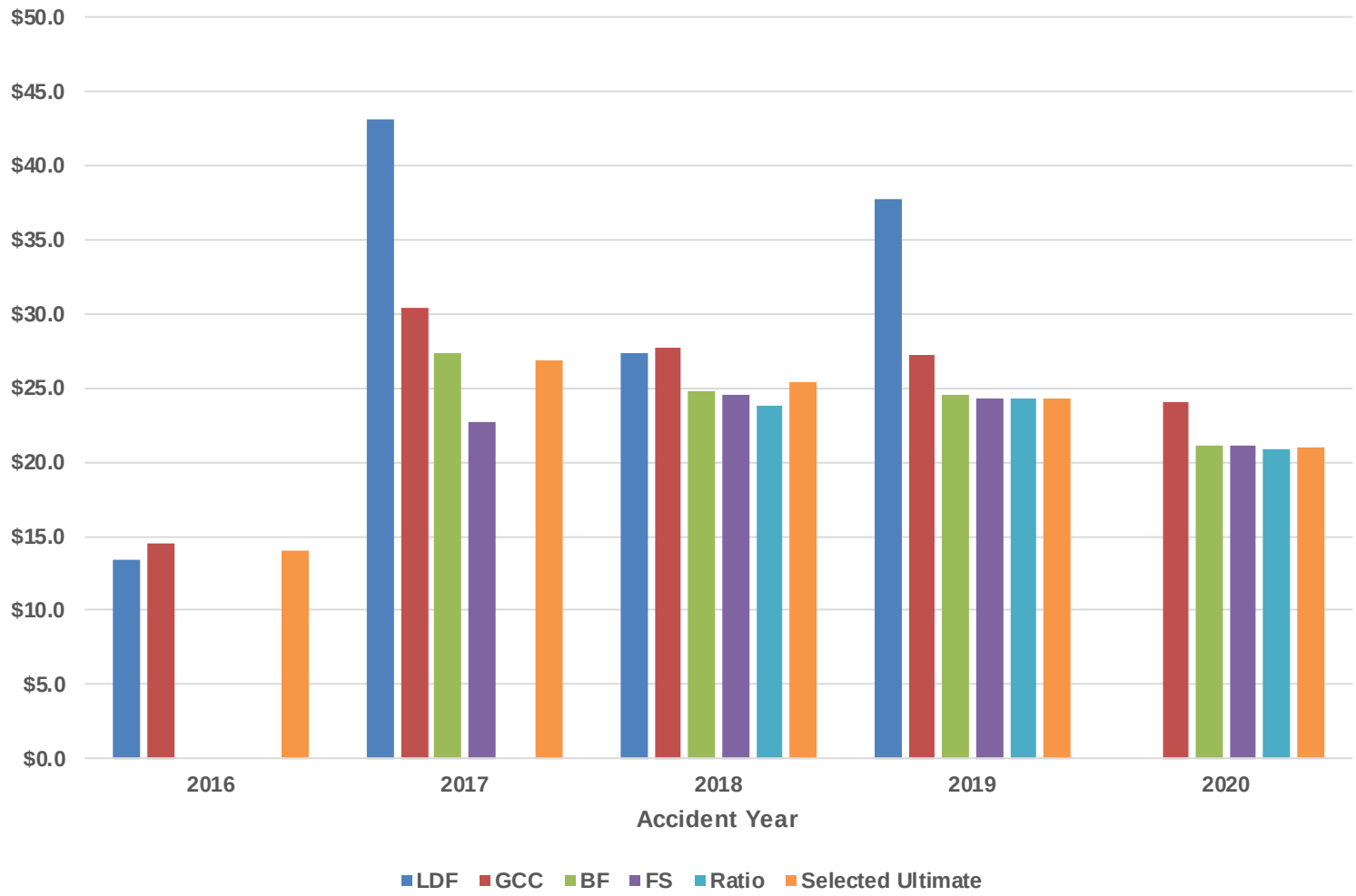
Analysis Details

P&S Indicated and Selected Ultimate Number of Occurrences



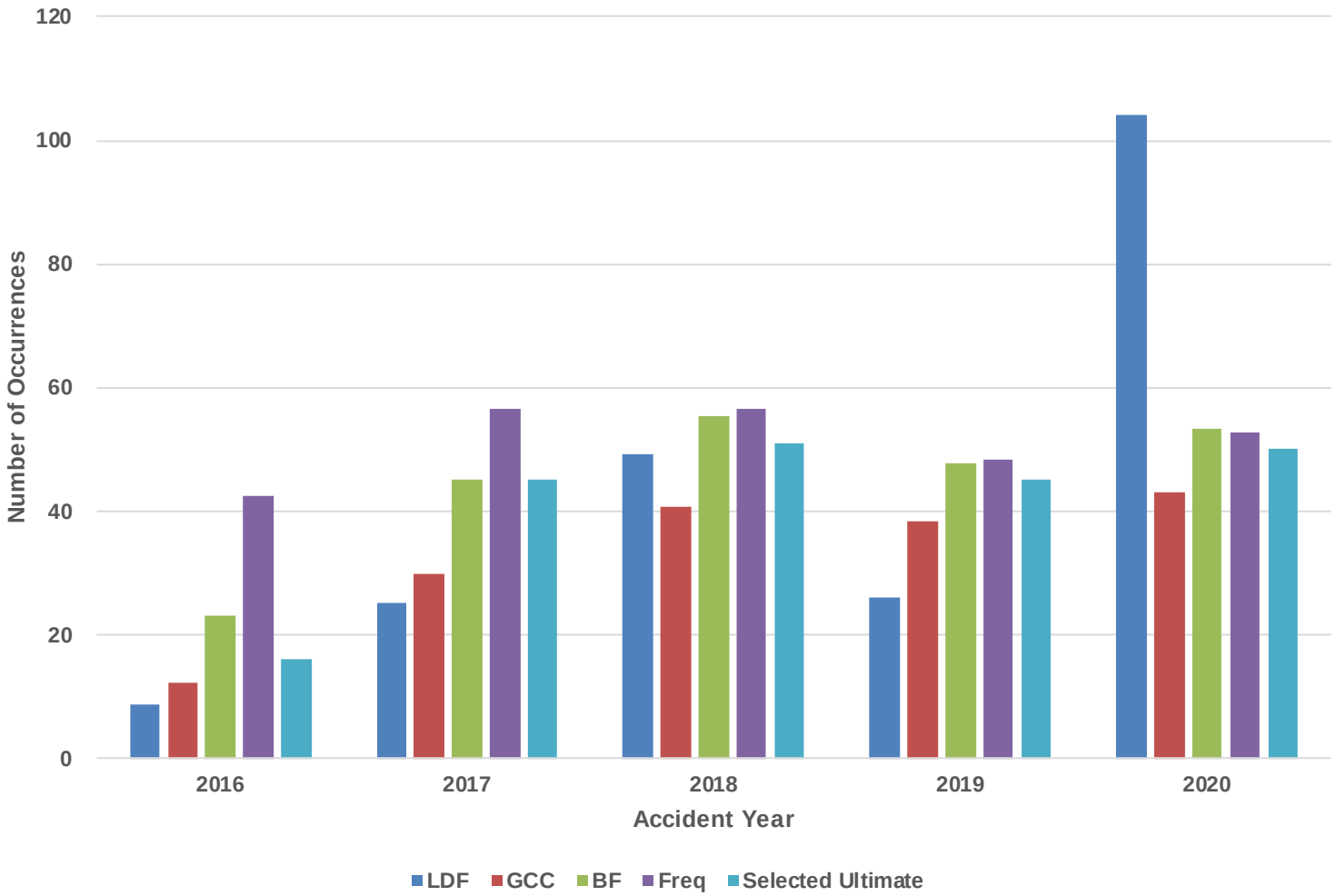
Analysis Details

P&S Indicated and Selected Ultimate Loss (In $Millions)



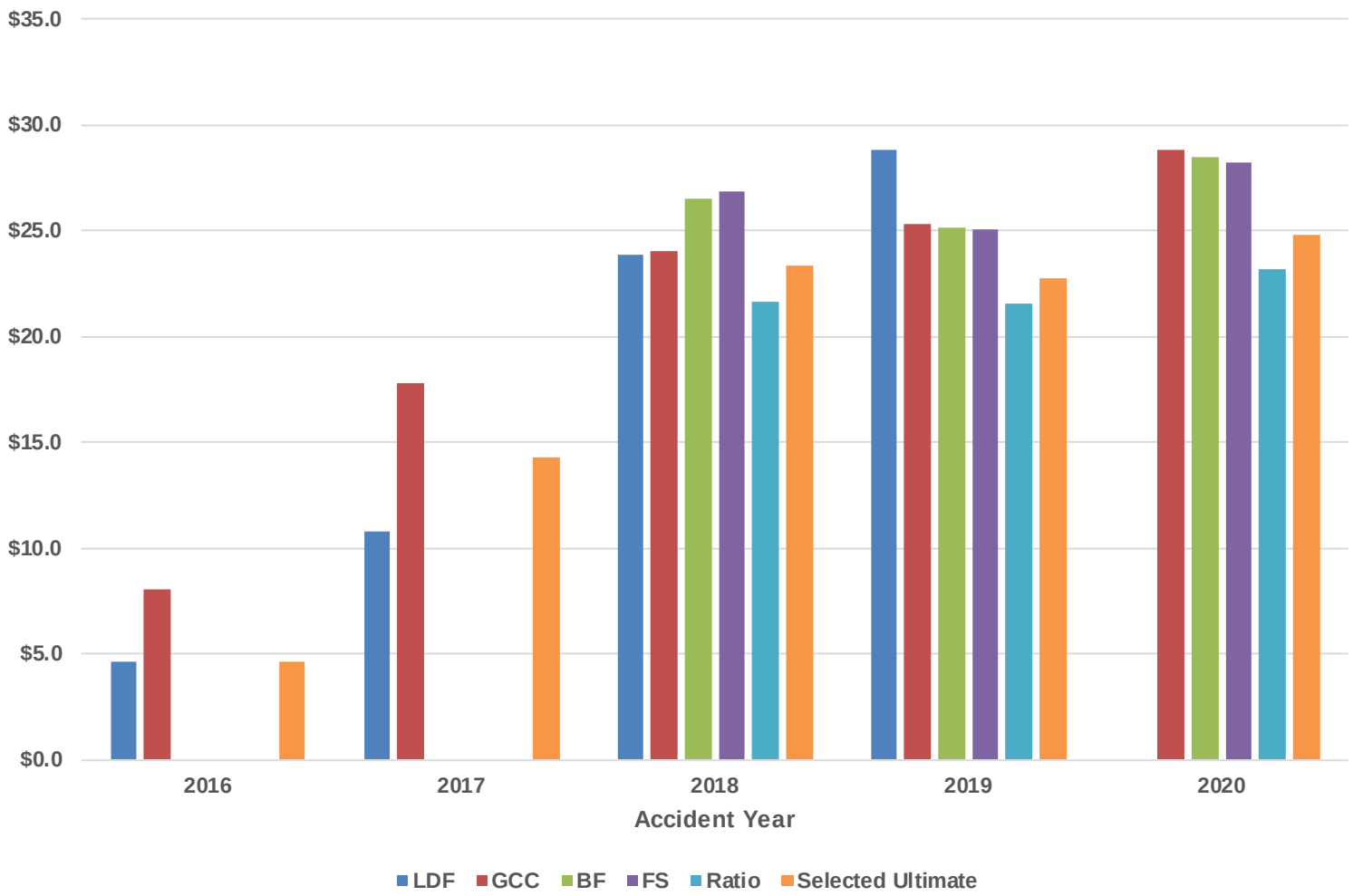
Analysis Details

Hospital Indicated and Selected Ultimate Number of Occurrences



Analysis Details

Hospital Indicated and Selected Ultimate Loss (In $Millions)



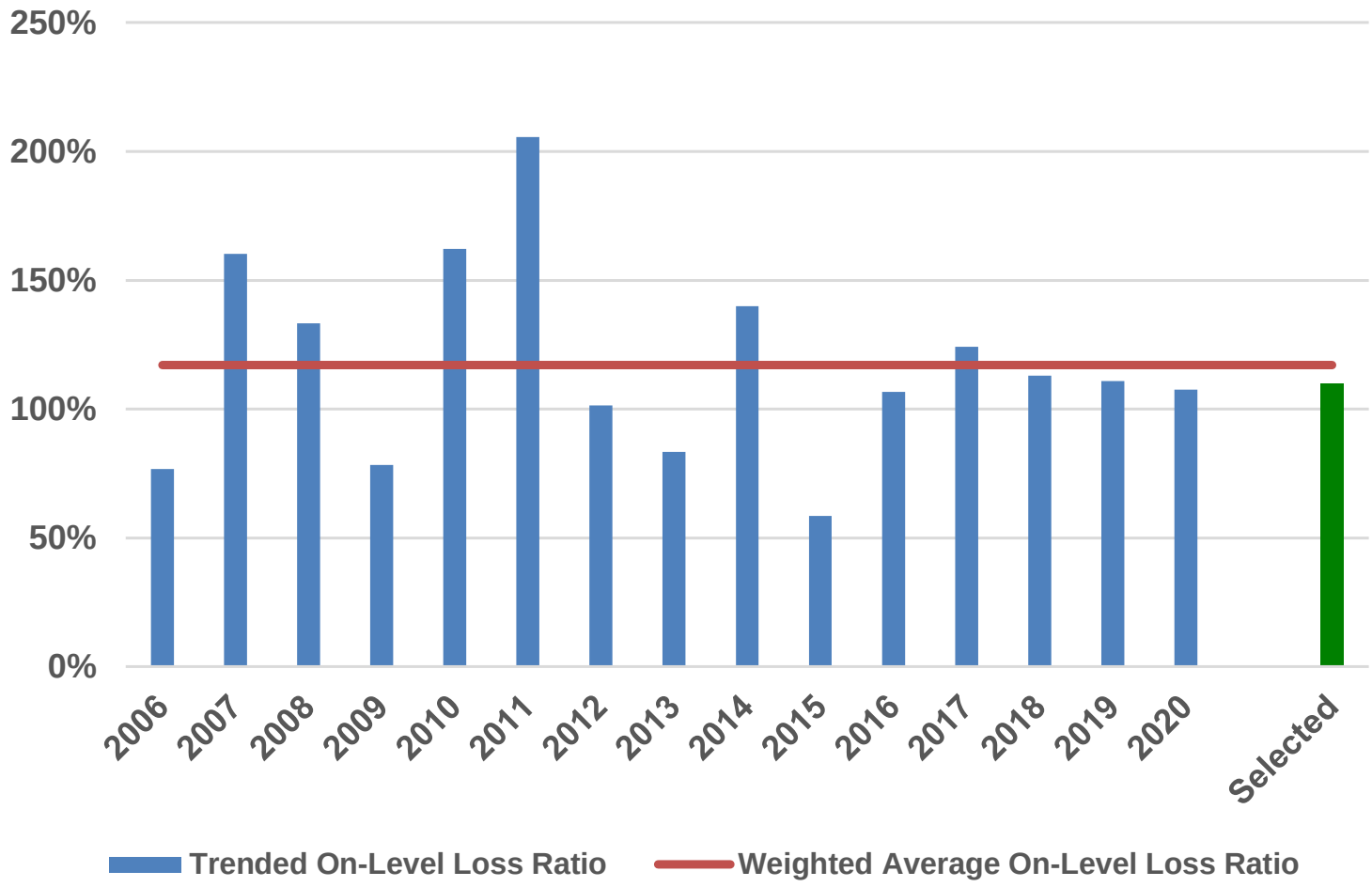
Calculation of Estimated Surcharge Rate Change Effective January 1, 2022

Indication of Surcharge Rate Changes

- Using previously estimated ultimate for each AY (split between P&S and Hospitals):
  - Adjust losses to effective date of January 1, 2022, for claim inflation (4% per year)
  - Select ultimate frequency (number of occurrences divided by surcharge)
  - Select ultimate severity (loss divided by number of occurrences)
  - Review ultimate loss ratio based on these selections
- Add additional PCF costs:
  - ULAE = “Unallocated Loss Adjustment Expenses”
  - On-Going Medical Costs as these costs are not included in losses
  - Credit for Anticipated Investment Income
  - Office Expenses
  - Reinsurance Costs or load for “batch” claims
  - Adjustment to different PCF attachment point and limit
  - Adjustment for changes to class plan and removal of Hospital ERP

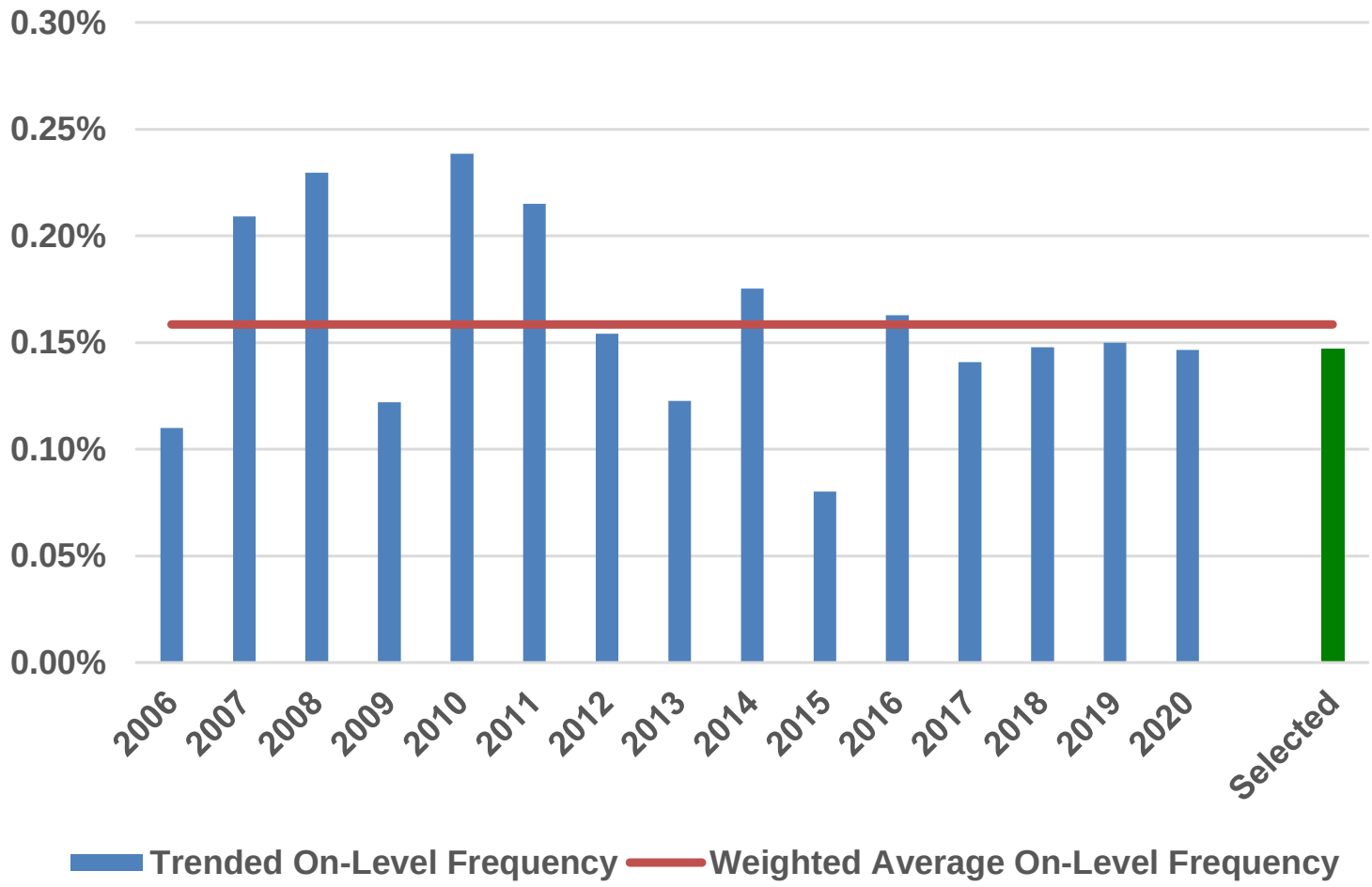
Components of Projected Loss Costs

P&S Estimated Ultimate On-Level Loss Ratio



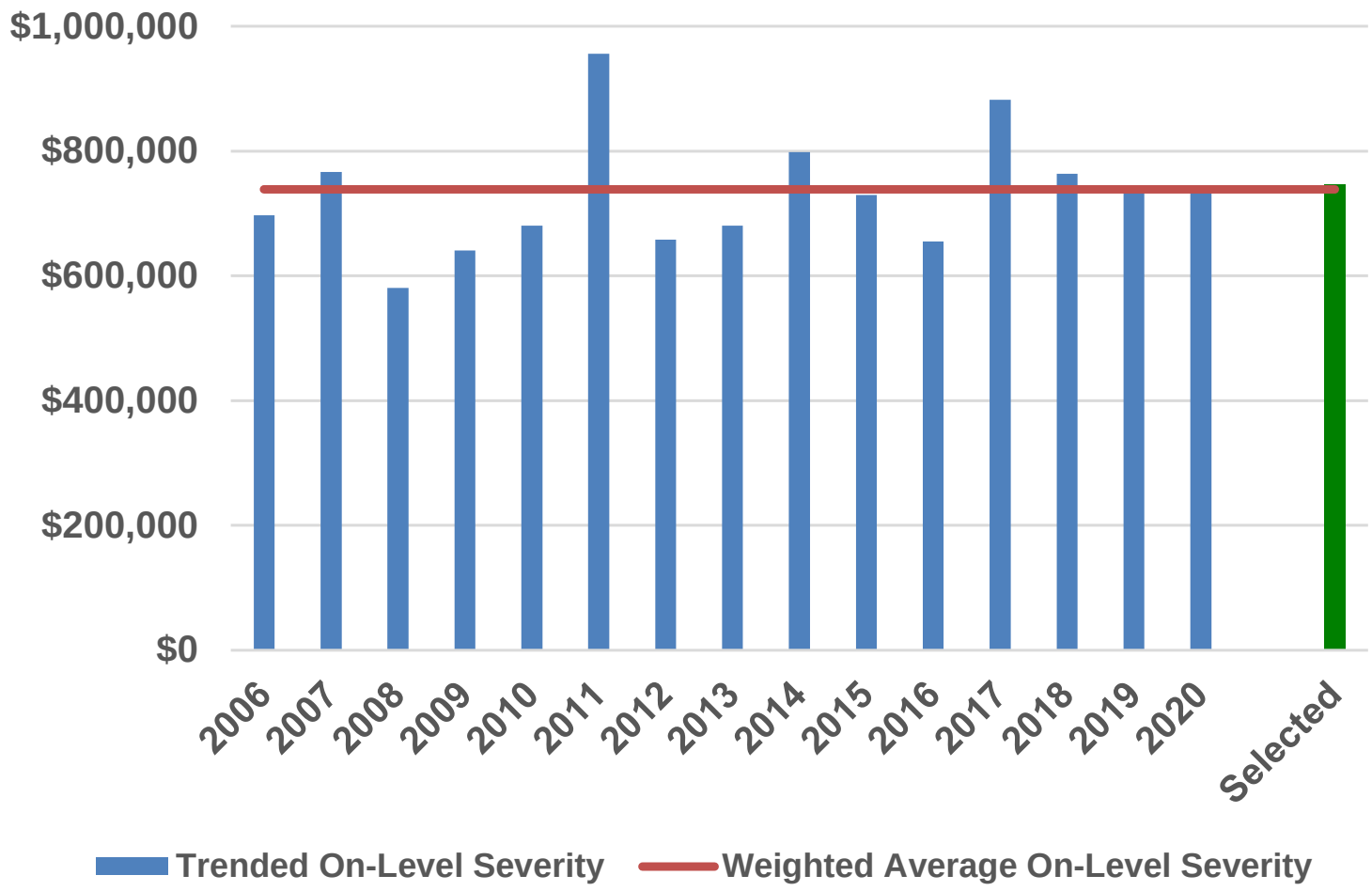
Components of Projected Loss Costs

P&S Estimated Ultimate On-Level Frequency per Surcharge @ Current Rate Level



Components of Projected Loss Costs

P&S Estimated Ultimate On-Level Severity per Number of Occurrences



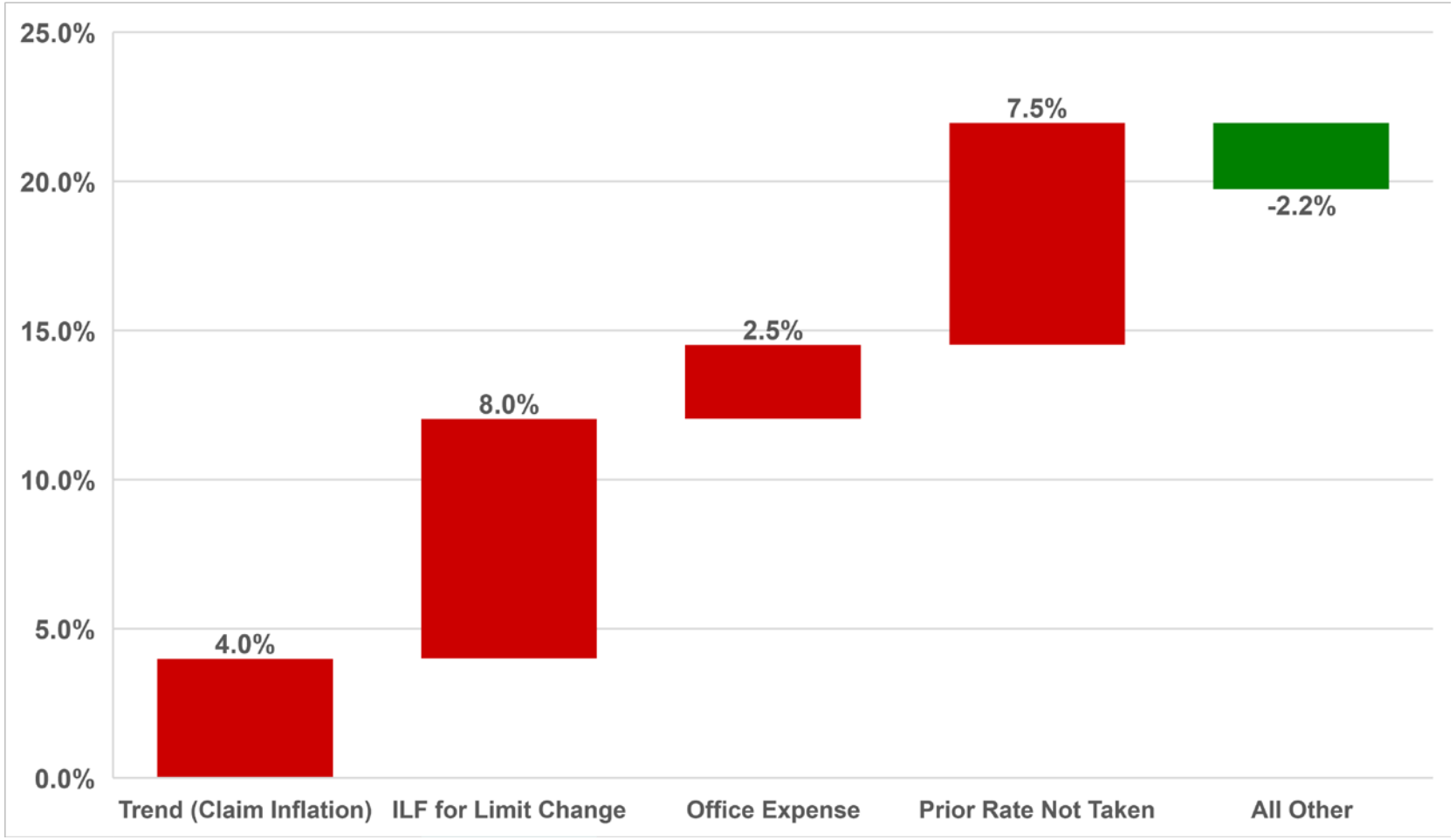
Components of Projected Loss Costs

P&S Derivation of Indicated Surcharge Level Change, Effective January 1, 2022

(1)	Projected Loss Ratio	116.2%
(2)	Discount Factor to Reflect Anticipated Investment Income	84.4%
(3)	Discounted Projected Loss Ratio	98.1%
(4)	Indicated Increased Limits Factor to reflect change in PCF limits	1.080
(5)	Projected 2022 Surcharges at Current Fee Level	21,146,700
(6)	Projected 2022 Discounted Losses	22,401,994
(7)	Load for Office Expenses	5.0%
(8)	Load for Batch Claim Reinsurance	5.0%
(9)	Adjustment to reflect ISO Class Plan Recommendations	1.018
(10)	Projected 2022 Income Requirements	25,319,827
(11)	**Indicated Surcharge Level Change on January 1, 2022**	**19.7%**

Components of Projected Loss Costs

P&S 2022 Rate Change by Cause



Estimated P&S Surcharges and Deficit Assessment

P&S Surcharge and Assessment – Effective January 1, 2022

Class	2022 PCF Surcharge	Fund Deficit Assessment	
		Independent P&S	Employed P&S
1	4,199	2,251	208
2	5,599	3,001	277
3	6,718	3,601	332
4A	8,398	4,502	415
4	10,077	5,401	498
5A	9,518	5,102	471
5	12,317	6,602	609
6	14,556	7,802	720
7A	16,795	9,002	831
7	19,594	10,503	969
8	26,593	14,254	1,315
9	32,192	17,255	1,592
10	36,390	19,505	1,800
99	3,359	1,800	166
CRNA	1,400	750	69
PA-1	1,904	1,020	94
PA-2	2,519	1,350	125
PA-3	3,023	1,621	150
CN	840		
Entity			
51	10%	10%	10%
52	10%	10%	10%
53	10%	10%	10%

Estimated P&S Surcharges and Deficit Assessment

P&S Surcharge and Assessment by Specialty – Effective January 1, 2022

ISO Code	Specialty	NMPCF Class	Surcharge	Independent Assessment	Independent Total	Employed Assessment	Employed Total
80102	Emergency Medicine - no major surgery	5	$12,317	$6,602	$18,919	$609	$12,926
80104	Surgery - gastroenterology	6	$14,556	$7,802	$22,358	$720	$15,276
80106	Surgery - laryngology	6	$14,556	$7,802	$22,358	$720	$15,276
80108	Surgery - nephrology	6	$14,556	$7,802	$22,358	$720	$15,276
80114	Surgery - ophthalmology	3	$6,718	$3,601	$10,319	$332	$7,051
80115	Surgery - colon and rectal	6	$14,556	$7,802	$22,358	$720	$15,276
80117	Surgery - general practice or family practice	6	$14,556	$7,802	$22,358	$720	$15,276
80120	Urology - minor surgery	3	$6,718	$3,601	$10,319	$332	$7,051
80134	Preventive Medicine - no surgery - Occupational Medicine	1	$4,199	$2,251	$6,450	$208	$4,407
80135	Preventive Medicine - no surgery - Public/General Health Medicine	1	$4,199	$2,251	$6,450	$208	$4,407
80141	Surgery - cardiac	8	$26,593	$14,254	$40,847	$1,315	$27,908
80143	Surgery - general (no general/family practice)	9	$32,192	$17,255	$49,447	$1,592	$33,784
80144	Surgery - thoracic	9	$32,192	$17,255	$49,447	$1,592	$33,784
80145	Surgery - urological	6	$14,556	$7,802	$22,358	$720	$15,276
80146	Surgery - vascular	9	$32,192	$17,255	$49,447	$1,592	$33,784
80150	Surgery - cardiovascular disease	10	$36,390	$19,505	$55,895	$1,800	$38,190
80151	Anesthesiology	7A	$16,795	$9,002	$25,798	$831	$17,626
80152	Surgery - neurology - including child	10	$36,390	$19,505	$55,895	$1,800	$38,190
80153	Surgery - obstetrics - gynecology	10	$36,390	$19,505	$55,895	$1,800	$38,190
80154	Surgery - orthopedic	9	$32,192	$17,255	$49,447	$1,592	$33,784
80155	Surgery - plastic - otorhinolaryngology	8	$26,593	$14,254	$40,847	$1,315	$27,908
80156	Surgery - plastic - N.O.C.	8	$26,593	$14,254	$40,847	$1,315	$27,908
80157	Emergency Medicine - including major surgery	6	$14,556	$7,802	$22,358	$720	$15,276
80159	Surgery - otorhinolaryngology	6	$14,556	$7,802	$22,358	$720	$15,276
80163	Radiation Therapy - employed phys/surg involved w/ major surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80164	Surgery – oncology	8	$26,593	$14,254	$40,847	$1,315	$27,908
80165	Radiation Therapy - insured phys/surg involved w/ major surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80167	Surgery - gynecology	8	$26,593	$14,254	$40,847	$1,315	$27,908
80169	Surgery - hand	6	$14,556	$7,802	$22,358	$720	$15,276
80170	Surgery - head and neck	6	$14,556	$7,802	$22,358	$720	$15,276
80171	Surgery - traumatic	9	$32,192	$17,255	$49,447	$1,592	$33,784
80180	Surgery - pediatric	8	$26,593	$14,254	$40,847	$1,315	$27,908
80181	Anesthesiology - Critical Care Medicine	7A	$16,795	$9,002	$25,798	$831	$17,626
80182	Anesthesiology - Pain Management	2	$5,599	$3,001	$8,600	$277	$5,876
80183	Anesthesiology - All Other	7A	$16,795	$9,002	$25,798	$831	$17,626

Estimated P&S Surcharges and Deficit Assessment

P&S Surcharge and Assessment by Specialty – Effective January 1, 2022

ISO Code	Specialty	NMPCF Class	Surcharge	Independent Assessment	Independent Total	Employed Assessment	Employed Total
80204	Sports Medicine - minor surgery	4A	$8,398	$4,502	$12,900	$415	$8,814
80205	Sports Medicine - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80208	Physical Medicine and Rehabilitation - Pain Management	2	$5,599	$3,001	$8,600	$277	$5,876
80209	Physical Medicine and Rehabilitation - All Other	1	$4,199	$2,251	$6,450	$208	$4,407
80222	Hospitalists	2	$5,599	$3,001	$8,600	$277	$5,876
80224	Addiction Psychiatry	1	$4,199	$2,251	$6,450	$208	$4,407
80226	Child and Adolescent Psychiatry	1	$4,199	$2,251	$6,450	$208	$4,407
80229	Psychiatry - All Other	1	$4,199	$2,251	$6,450	$208	$4,407
80231	General Preventive Medicine - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80235	Physiatry	1	$4,199	$2,251	$6,450	$208	$4,407
80238	Endocrinology - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80239	Family Practice- no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80241	Gastroenterology - no surgery	3	$6,718	$3,601	$10,319	$332	$7,051
80242	General Practice- no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80243	Geriatrics - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80244	Gynecology - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80245	Hematology - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80246	Infectious Diseases - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80249	Psychiatry - including child	1	$4,199	$2,251	$6,450	$208	$4,407
80252	Rheumatology - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80253	Radiology - diagnostic - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80254	Allergy	1	$4,199	$2,251	$6,450	$208	$4,407
80255	Cardiovascular Disease - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80256	Dermatology - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80257	Internal Medicine - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80260	Nephrology - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80261	Neurology - including child - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80263	Opthalmology - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80265	Otorhinolaryngology - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80266	Pathology - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80267	Pediatrics - no surgery	4A	$8,398	$4,502	$12,900	$415	$8,814
80268	Physicians - no surgery - N.O.C.	3	$6,718	$3,601	$10,319	$332	$7,051
80269	Pulmonary Diseases - no surgery	4A	$8,398	$4,502	$12,900	$415	$8,814
80272	Endocrinology - minor surgery	3	$6,718	$3,601	$10,319	$332	$7,051
80273	Family Practice minor surgery	5A	$9,518	$5,102	$14,619	$471	$9,988

Estimated P&S Surcharges and Deficit Assessment

P&S Surcharge and Assessment by Specialty – Effective January 1, 2022

ISO Code	Specialty	NMPCF Class	Surcharge	Independent Assessment	Independent Total	Employed Assessment	Employed Total
80274	Gastroenterology - minor surgery	4A	$8,398	$4,502	$12,900	$415	$8,814
80275	General Practice- minor surgery	5	$12,317	$6,602	$18,919	$609	$12,926
80277	Gynecology - minor surgery	4	$10,077	$5,401	$15,478	$498	$10,575
80278	Hematology - minor surgery	3	$6,718	$3,601	$10,319	$332	$7,051
80280	Radiology - diagnostic - minor surgery	5	$12,317	$6,602	$18,919	$609	$12,926
80281	Cardiovascular Disease - minor surgery	4	$10,077	$5,401	$15,478	$498	$10,575
80282	Dermatology - minor surgery	3	$6,718	$3,601	$10,319	$332	$7,051
80283	Intensive Care Medicine	3	$6,718	$3,601	$10,319	$332	$7,051
80284	Internal Medicine - minor surgery	4	$10,077	$5,401	$15,478	$498	$10,575
80287	Nephrology - minor surgery	4	$10,077	$5,401	$15,478	$498	$10,575
80288	Neurology - including child - minor surgery	6	$14,556	$7,802	$22,358	$720	$15,276
80289	Opthalmology - minor surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80291	Otorhinolaryngology - minor surgery	4	$10,077	$5,401	$15,478	$498	$10,575
80293	Pediatrics - minor surgery	3	$6,718	$3,601	$10,319	$332	$7,051
80294	Physicians - minor surgery - N.O.C.	3	$6,718	$3,601	$10,319	$332	$7,051
80296	Dermatopathology	3	$6,718	$3,601	$10,319	$332	$7,051
80297	Dermatology - All Other	3	$6,718	$3,601	$10,319	$332	$7,051
80298	Neurology - including child - no surgery - Pain Management	2	$5,599	$3,001	$8,600	$277	$5,876
80299	Neurology - including child - no surgery - All Other	2	$5,599	$3,001	$8,600	$277	$5,876
80301	Oncology – minor surgery	5	$12,317	$6,602	$18,919	$609	$12,926
80302	Oncology – no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80307	Pathology - All Other	1	$4,199	$2,251	$6,450	$208	$4,407
80321	Physicians - No Surgery - Full time teaching	1	$4,199	$2,251	$6,450	$208	$4,407
80358	Radiology - therapeutic - minor surgery	5	$12,317	$6,602	$18,919	$609	$12,926
80359	Radiology - therapeutic - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
80360	Radiology - interventional	5	$12,317	$6,602	$18,919	$609	$12,926
80410	Chiropractors	99	$3,359	$1,800	$5,159	$166	$3,525
80420	Family Physicians or General Practitioners-no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
80421	Family Physicians or General Practitioners - minor surgery	3	$6,718	$3,601	$10,319	$332	$7,051
80422	Physicians no major surgery: - Angiography	4	$10,077	$5,401	$15,478	$498	$10,575
80425	Physicians no major surgery: - Lasers - used in Therapy	5	$12,317	$6,602	$18,919	$609	$12,926
80443	Colonoscopy	3	$6,718	$3,601	$10,319	$332	$7,051
80804	Neonatal / Perinatal Medicine	5	$12,317	$6,602	$18,919	$609	$12,926
84102	Emergency Medicine - no major surgery	5	$12,317	$6,602	$18,919	$609	$12,926
84134	Preventive Medicine - no surgery - Occupational Medicine	1	$4,199	$2,251	$6,450	$208	$4,407

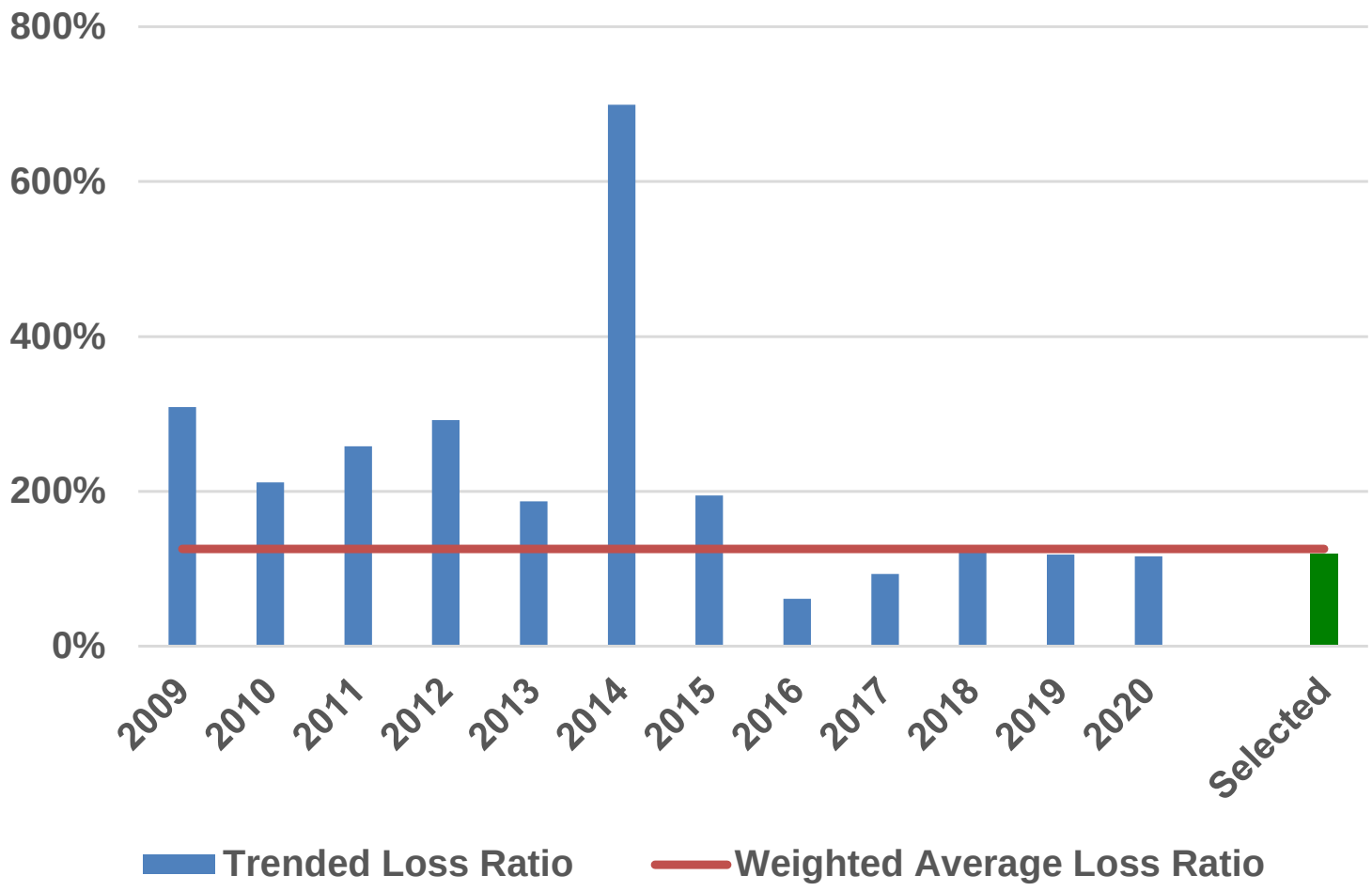
Estimated P&S Surcharges and Deficit Assessment

P&S Surcharge and Assessment by Specialty – Effective January 1, 2022

ISO Code	Specialty	NMPCF Class	Surcharge	Independent Assessment	Independent Total	Employed Assessment	Employed Total
84143	Surgery - general (no general/family practice)	9	$32,192	$17,255	$49,447	$1,592	$33,784
84145	Surgery - urological	6	$14,556	$7,802	$22,358	$720	$15,276
84151	Anesthesiology	7A	$16,795	$9,002	$25,798	$831	$17,626
84153	Surgery - obstetrics - gynecology	10	$36,390	$19,505	$55,895	$1,800	$38,190
84154	Surgery - orthopedic	9	$32,192	$17,255	$49,447	$1,592	$33,784
84155	Surgery - plastic - otorhinolaryngology	8	$26,593	$14,254	$40,847	$1,315	$27,908
84156	Surgery - plastic - N.O.C.	8	$26,593	$14,254	$40,847	$1,315	$27,908
84157	Emergency Medicine - incl. major surgery	6	$14,556	$7,802	$22,358	$720	$15,276
84167	Surgery - gynecology	8	$26,593	$14,254	$40,847	$1,315	$27,908
84182	Anesthesiology - Pain Management	2	$5,599	$3,001	$8,600	$277	$5,876
84183	Anesthesiology - All Other	7A	$16,795	$9,002	$25,798	$831	$17,626
84209	Physicial Medicine and Rehabilitation - All Other	1	$4,199	$2,251	$6,450	$208	$4,407
84222	Hospitalists	2	$5,599	$3,001	$8,600	$277	$5,876
84249	Psychiatry - including child	1	$4,199	$2,251	$6,450	$208	$4,407
84253	Radiology - diagnostic - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
84254	Allergy	1	$4,199	$2,251	$6,450	$208	$4,407
84255	Cardiovascular Disease - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
84257	Internal Medicine - no surgery	2	$5,599	$3,001	$8,600	$277	$5,876
84263	Ophthalmology - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
84267	Pediatric - no surgery	4A	$8,398	$4,502	$12,900	$415	$8,814
84268	Physicians - no surgery - N.O.C.	3	$6,718	$3,601	$10,319	$332	$7,051
84269	Pulmonary Diseases - no surgery	4A	$8,398	$4,502	$12,900	$415	$8,814
84274	Gastroenterology - minor surgery	4A	$8,398	$4,502	$12,900	$415	$8,814
84278	Hematology - minor surgery	3	$6,718	$3,601	$10,319	$332	$7,051
84280	Radiology - diagnostic - minor surgery	5	$12,317	$6,602	$18,919	$609	$12,926
84283	Intensive Care Medicine	4	$10,077	$5,401	$15,478	$498	$10,575
84284	Internal Medicine - minor surgery	4	$10,077	$5,401	$15,478	$498	$10,575
84289	Ophthalmology - minor surgery	2	$5,599	$3,001	$8,600	$277	$5,876
84297	Dermatology - All Other	3	$6,718	$3,601	$10,319	$332	$7,051
84298	Neurology - including child - no surgery - Pain Management	2	$5,599	$3,001	$8,600	$277	$5,876
84299	Neurology - including child - no surgery - All Other	2	$5,599	$3,001	$8,600	$277	$5,876
84306	Pathology - Cytopathology - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
84307	Pathology - all other	1	$4,199	$2,251	$6,450	$208	$4,407
84360	Radiology - interventional	5	$12,317	$6,602	$18,919	$609	$12,926
84420	Family Physicians or General Practitioners - no surgery	1	$4,199	$2,251	$6,450	$208	$4,407
84421	Family Physicians or General Practitioners - minor surgery	3	$6,718	$3,601	$10,319	$332	$7,051

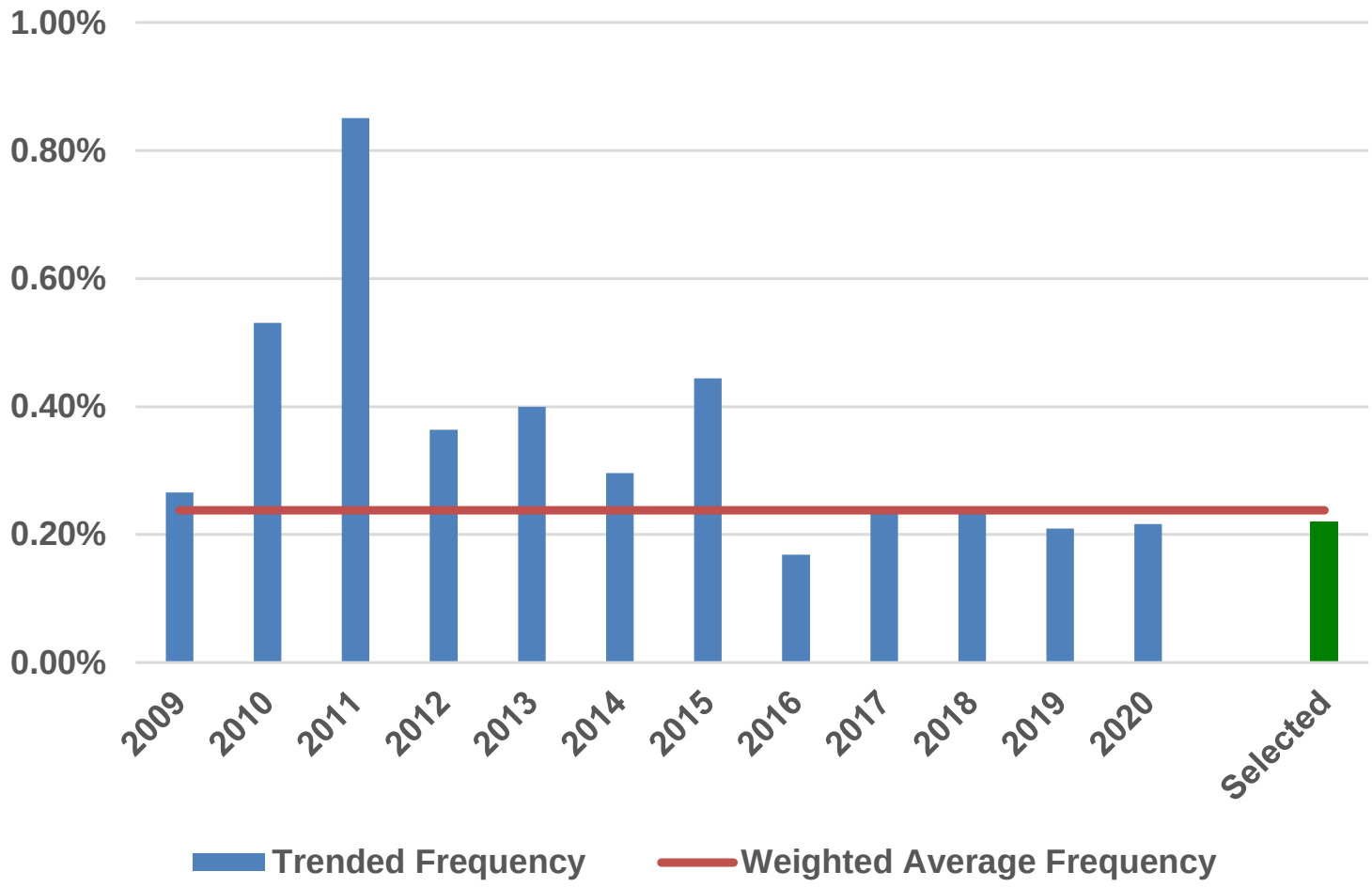
Components of Projected Loss Costs

Hospital Estimated Ultimate On-Level Loss Ratio



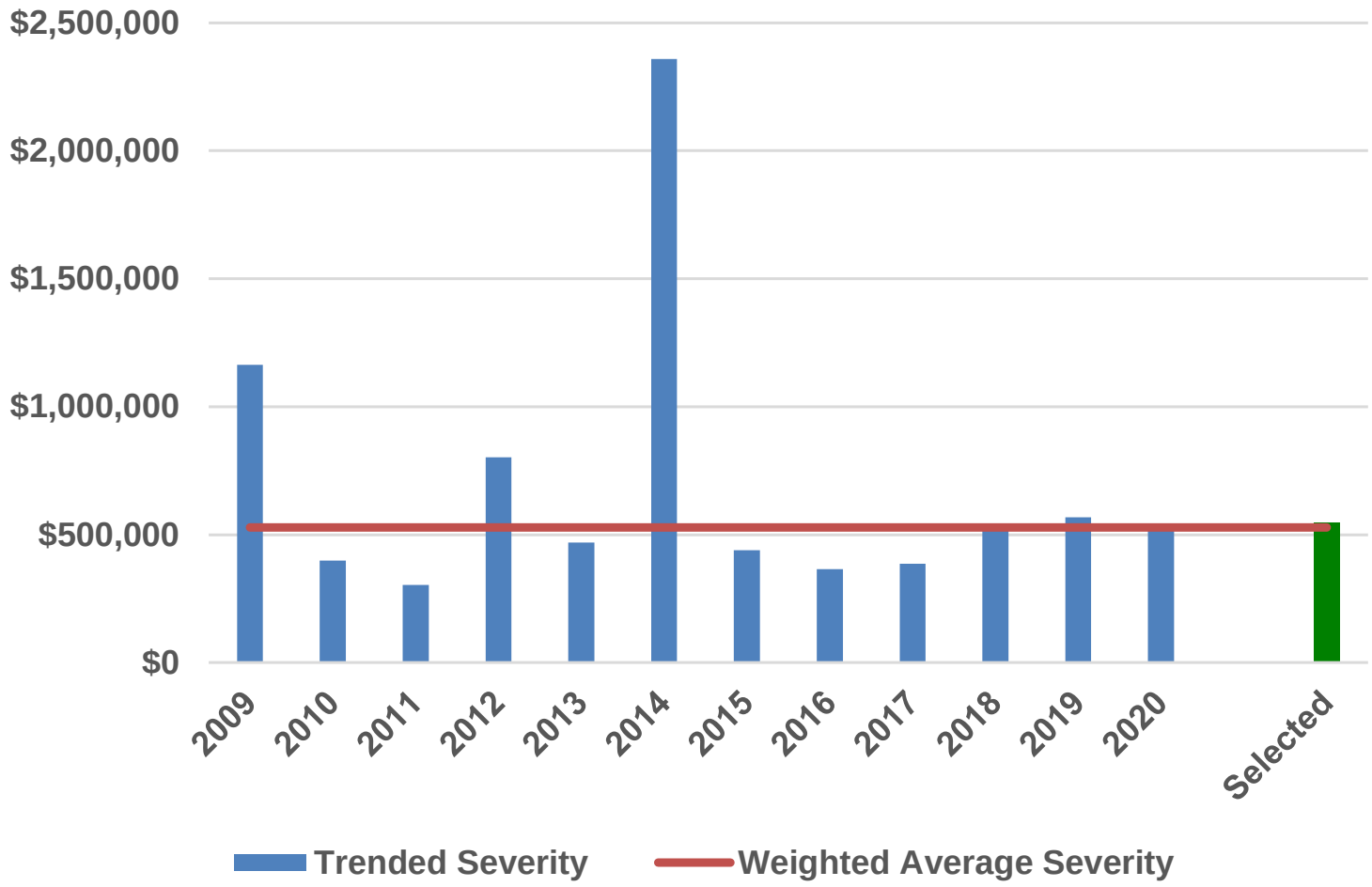
Components of Projected Loss Costs

Hospital Estimated Ultimate Frequency per Surcharge



Components of Projected Loss Costs

Hospital Estimated Ultimate Severity per Number of Occurrences



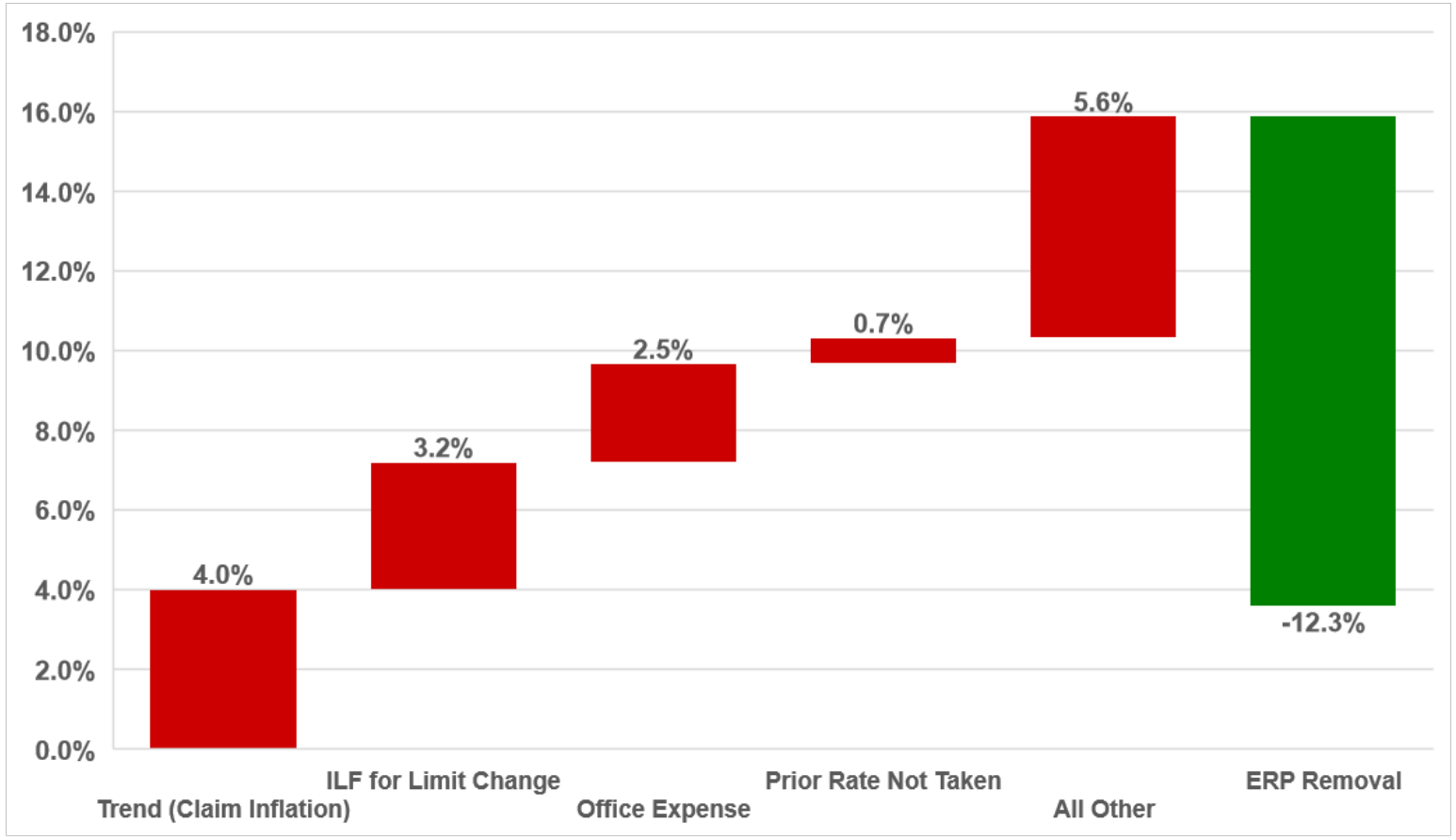
Components of Projected Loss Costs

Hospital Derivation of Indicated Surcharge Level Change, Effective January 1, 2022

(1)	Projected Loss Ratio	126.8%
(2)	Discount Factor to Reflect Anticipated Investment Income	84.4%
(3)	Rate Change from 2020 to 2021	103.8%
(4)	Discounted Projected Loss Ratio	103.0%
(5)	Indicated Increased Limits Factor to reflect change in PCF limits	1.032
(6)	Projected 2022 Surcharges at 2021 Fee Level	24,007,800
(7)	Projected 2022 Discounted Losses	25,528,348
(8)	Load for Office Expenses	5.0%
(9)	Load for Batch Claim Reinsurance	5.0%
(10)	Projected 2022 Income Requirements	28,355,926
(11)	**Indicated Surcharge Change from 2021 on January 1, 2022 Prior to ERP Adjustment**	**18.1%**
(12)	Experience Rating Plan Removal Factor	(12.3)%
(13)	**Indicated Surcharge Level Change from 2021 on January 1, 2022**	**3.6%**

Components of Projected Loss Costs

Hospital 2022 Rate Change by Cause



- In 2020, the overall impact of the ERP was a $3.2 million reduction in surcharge.
- If the PCF removes the ERP for 2022, the overall surcharges should increase approximately $3.2 million.
- An adjustment to the 2022 surcharges was made to account for this change.
- If the ERP is not removed in 2022, this adjustment should be removed from the surcharges.

Estimated Hospital Surcharges and Deficit Assessment

Hospital Surcharge and Assessment – Effective January 1, 2022

Class	2022 PCF Rates	2022 Fund Deficit Assessment
Acute Care Bed	5,135	248
Psychiatric Care Bed	5,135	248
Extended Care Bed	514	25
Skilled Nursing Care Bed	1,797	87
Personal Care Bed	771	37
Physical Rehab Bed	2,568	124
Chemical Dep. Rehab Bed	1,283	62
Births	257	12
Inpatient Surgeries (000)s	8,986	434
Outpatient Surgeries (000)s	1,027	50
ER visits (000)s	771	37
Other Outpatient visits (000)s	257	12
Home Healthcare (000)s	257	12

Estimated Unpaid Loss as of December 31, 2020

Calculation of PCF deficit

Analysis Details

PCF Unpaid Loss and Deficit (in $Millions)

	(1)	(2)	(3) (1) - (2)	(4)	(5)	(6) (4) - (5)	(7)	(8)	(9) (7) - (8)	(10) (3) + (6) + (9)
	Physicians & Surgeons			Hospitals			Batch Claims			
Accident Year	Selected Ultimate	Paid @ 12/31/20	Unpaid	Selected Ultimate	Paid @ 12/31/20	Unpaid	Selected Ultimate	Paid @ 12/31/20	Unpaid	Combined Unpaid
Prior	NA	NA	0.0	NA	NA	0.0	NA	NA	0.0	0.0
2006	6.3	6.3	0.0	0.0	0.0	0.0	1.8	1.8	0.0	0.0
2007	13.2	13.2	0.0	0.0	0.0	0.0	5.9	5.9	0.0	0.0
2008	11.7	11.7	0.1	0.0	0.0	0.0	7.7	7.7	0.0	0.1
2009	8.1	8.0	0.1	2.1	2.1	0.0	3.8	3.8	0.0	0.1
2010	16.6	16.3	0.3	1.5	1.5	0.0	1.6	1.6	0.0	0.3
2011	20.5	19.9	0.6	2.0	1.9	0.1	0.0	0.0	0.0	0.6
2012	10.2	9.7	0.5	2.2	2.1	0.1	0.0	0.0	0.0	0.6
2013	8.6	8.0	0.6	1.6	1.5	0.1	0.0	0.0	0.0	0.7
2014	15.7	14.4	1.4	6.9	6.2	0.7	0.0	0.0	0.0	2.0
2015	6.7	4.0	2.6	2.0	1.4	0.6	0.0	0.0	0.0	3.2
2016	14.0	5.8	8.1	4.6	2.0	2.6	0.0	0.0	0.0	10.8
2017	26.8	10.0	16.9	14.3	2.5	11.8	0.0	0.0	0.0	28.7
2018	25.4	2.7	22.7	23.3	2.4	21.0	0.0	0.0	0.0	43.7
2019	24.3	0.7	23.6	22.7	0.6	22.1	0.0	0.0	0.0	45.7
2020	21.0	0.0	21.0	24.8	0.3	24.5	0.0	0.0	0.0	45.6
Total	229.2	130.6	98.6	108.0	24.5	83.6	20.9	20.9	0.0	182.1

(11) On-Going Medical Payments Percentage	3.0%
(12) On-Going Medical Payments Unpaid Amounts; [(10) total x (11)]	5.5
(13) Total Unpaid (Including On-Going Medical Payments provision); [(10) total + (12)]	187.6
(14) Estimated 12/31/20 Fund Balance	120.8
(15) Fund Deficit; [(14) - (13)]	(66.8)

Allocation of surcharge and losses between Independent and Employed P&S

Allocation between Independent and Employed P&S

- Surcharge data provided by the PCF was not split between Independent and Employed P&S
- In order to calculate the PCF deficit between Independent P&S and Employed P&S we allocated the surcharge and loss between these groups using the following steps:
  - Estimate the surcharge for Employed P&S as 50% of the hospital surcharge for 2015 and prior
  - Estimate the surcharge for Independent P&S using current rates and historical rate changes for 2016 – 2020
  - Estimate ultimate losses between Independent and Employed P&S by allocating unpaid losses using allocated surcharges
  - Calculate PCF deficit between Independent P&S and Hospitals (Including Employed P&S) as of December 31, 2020

Analysis Details

Allocation of Surcharge between Independent Providers and Employed (in $Millions)

Accident Year	(1) P&S PCF Surcharge	(2) Hospital PCF Surcharge	(3) Estimated Employed P&S PCF Surcharge	(4) Estimated Independent P&S PCF Surcharge	(5) Factor to Current Rate Level	(6) Estimated Independent P&S PCF Surcharge	(7) Estimated Independent P&S PCF Surcharge	(8) Estimated Employed P&S PCF Surcharge	(9) Hospital Plus Employed P&S PCF Surcharge
Prior	NA	NA		NA					NA
2006	9.1	0.0		9.1	1.703		9.1	0.0	0.0
2007	8.8	0.0		8.8	1.683		8.8	0.0	0.0
2008	9.7	0.0		9.7	1.572		9.7	0.0	0.0
2009	11.1	1.1	0.6	10.5	1.547		10.5	0.6	1.7
2010	11.3	1.1	0.6	10.7	1.448		10.7	0.6	1.7
2011	10.8	1.2	0.6	10.2	1.421		10.2	0.6	1.8
2012	10.5	1.1	0.5	9.9	1.421		9.9	0.5	1.6
2013	10.3	1.3	0.6	9.7	1.421		9.7	0.6	1.9
2014	10.8	1.4	0.7	10.2	1.421		10.2	0.7	2.0
2015	10.5	1.4	0.7	9.9	1.421		9.9	0.7	2.0
2016	11.7	9.5			1.417	9.9	9.9	1.8	11.3
2017	19.7	18.6			1.333	10.5	10.5	9.2	27.9
2018	21.4	21.6			1.230	11.4	11.4	10.0	31.6
2019	20.5	21.5			1.202	11.7	11.7	8.9	30.4
2020	18.2	23.1			1.162	12.1	12.1	6.1	29.3
Total	194.6	102.8	4.2	98.7		55.5	154.3	40.3	143.2

(1), (2) Provided by the PCF
(3) = 50% of (2)
(4) = (1) - (2)
(5) Provided by the PCF
(6) For 2016, (4) 2015 x (5) Prior / (5) Current; For other years (6) x (5) Prior / (5) Current
(7) = (4) + (6)
(8) = (1) - (7)
(9) = (2) - (8)

Analysis Details

Allocation of P&S between Independent Providers and Employed (in $Millions)

	(1)	(2)	(3)	(4)	(5)	(6) [(1) - (3) - (4)] x [(5) / (2)]	(7) (3) + (6)	(8) (2) - (5)	(9) (1) - (7)
	Physicians & Surgeons (Including Batch Claims)				Estimated Independent Provider P&S			Estimated Employed P&S	
Accident Year	Selected Ultimate	PCF Surcharge	Independent Paid Loss	Employed Paid Loss	PCF Surcharge	Allocated Unpaid Loss	Selected Ultimate	PCF Surcharge	Selected Ultimate
Prior	NA	NA	0	0	NA	0	NA	NA	0
2006	8.1	9.1	8.1	0.0	9.1	0.0	8.1	0.0	0.0
2007	19.1	8.8	19.0	0.0	8.8	0.0	19.1	0.0	0.0
2008	19.5	9.7	19.4	0.0	9.7	0.1	19.5	0.0	0.0
2009	11.9	11.1	11.8	0.0	10.5	0.1	11.9	0.6	0.0
2010	18.2	11.3	17.8	0.1	10.7	0.3	18.1	0.6	0.2
2011	20.5	10.8	19.3	0.6	10.2	0.6	19.8	0.6	0.7
2012	10.2	10.5	8.3	1.4	9.9	0.5	8.8	0.5	1.4
2013	8.6	10.3	6.9	1.1	9.7	0.6	7.5	0.6	1.1
2014	15.7	10.8	13.9	0.4	10.2	1.3	15.2	0.7	0.5
2015	6.7	10.5	3.8	0.2	9.9	2.5	6.3	0.7	0.4
2016	14.0	11.7	5.2	0.7	9.9	6.9	12.0	1.8	1.9
2017	26.8	19.7	8.9	1.1	10.5	9.0	17.9	9.2	8.9
2018	25.4	21.4	1.7	1.1	11.4	12.1	13.7	10.0	11.7
2019	24.3	20.5	0.7	0.0	11.7	13.4	14.1	8.9	10.2
2020 [1]	21.0	18.2	0.0	0.0	12.1	13.9	13.9	6.1	7.1
Total	250.1	194.6	144.9	6.7	154.3	61.1	206.0	40.3	44.1

[1] Reflects a full year of earned exposure

(3), (4) Provided by the PCF

(5), (8) Estimated Surcharge Premium for 2009-2015 estimated as 50% of Hospital surcharge

(5), (8) Estimated Surcharge Premium for 2016-2020 uses 2015 as a base (all independent P&S) and is adjusted for future rate changes

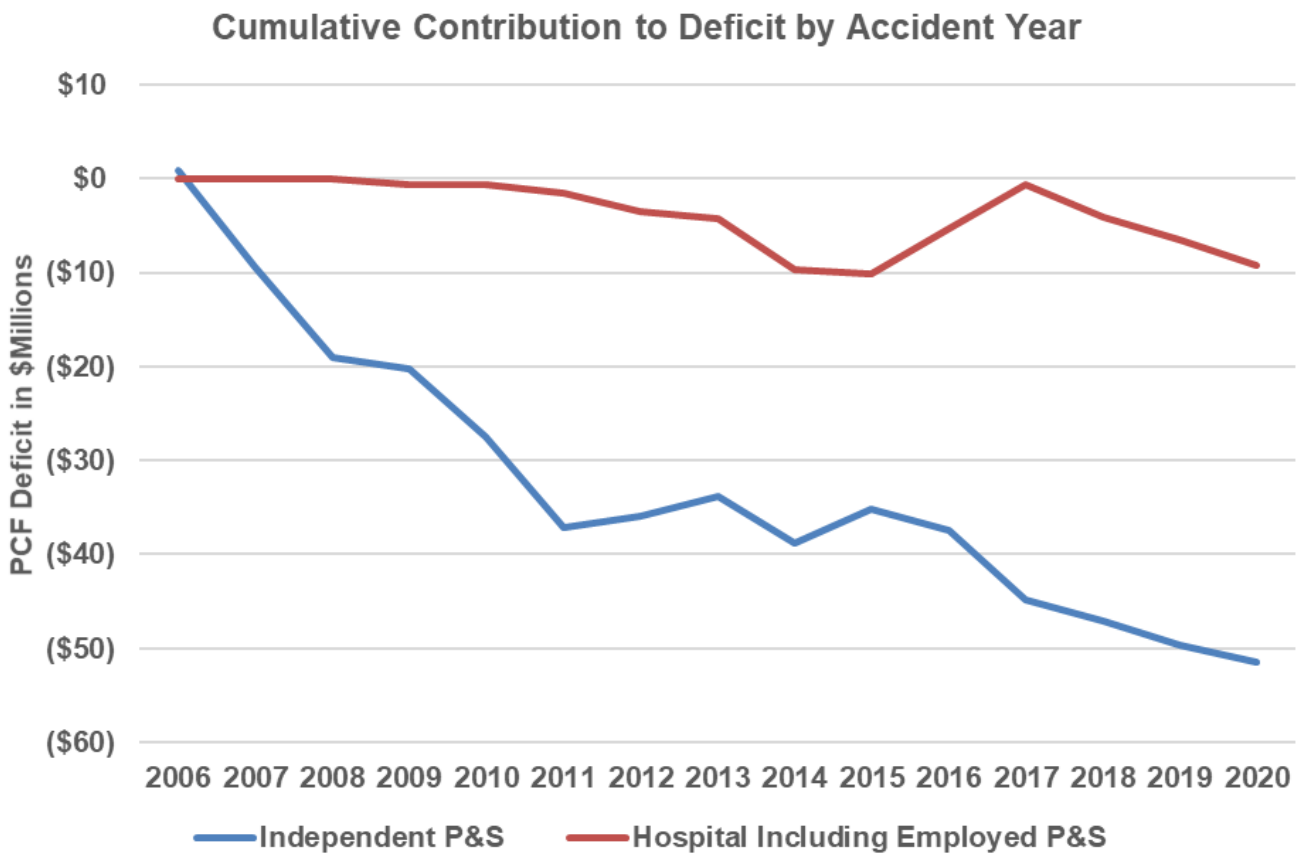
Analysis Details

PCF Fund Deficit by AY between Independent P&S and Hospitals (in $Millions)

	(1)	(2)	(3) (2) - (1)	(4) (3) + (4) prior	(5)	(6)	(7) (6) - (5)	(8) (7) + (8) prior	(9) (4) + (8)
	Independent Physicians & Surgeons (Inc Batch Claims)				Hospitals (Inc Employed P&S)				Combined
Accident Year	Selected Ultimate Loss	PCF Surcharge	Incremental Deficit	Cumulative Deficit	Selected Ultimate Loss	PCF Surcharge	Incremental Deficit	Cumulative Deficit	Cumulative Deficit
Prior	NA	NA	0.0	0.0	NA	NA	0.0	0.0	0.0
2006	8.1	9.1	0.9	0.9	0.0	0.0	0.0	0.0	0.9
2007	19.1	8.8	(10.3)	(9.3)	0.0	0.0	0.0	0.0	(9.3)
2008	19.5	9.7	(9.8)	(19.1)	0.0	0.0	0.0	0.0	(19.1)
2009	11.7	10.5	(1.2)	(20.3)	2.3	1.7	(0.6)	(0.6)	(20.9)
2010	18.0	10.7	(7.2)	(27.5)	1.7	1.7	(0.0)	(0.6)	(28.2)
2011	19.8	10.2	(9.6)	(37.1)	2.6	1.8	(0.9)	(1.5)	(38.6)
2012	8.8	9.9	1.2	(36.0)	3.6	1.6	(1.9)	(3.5)	(39.4)
2013	7.5	9.7	2.2	(33.8)	2.7	1.9	(0.9)	(4.3)	(38.1)
2014	15.2	10.2	(5.1)	(38.8)	7.4	2.0	(5.4)	(9.7)	(48.6)
2015	6.3	9.9	3.6	(35.2)	2.4	2.0	(0.4)	(10.1)	(45.3)
2016	12.0	9.9	(2.2)	(37.4)	6.6	11.3	4.7	(5.3)	(42.8)
2017	17.9	10.5	(7.4)	(44.8)	23.2	27.9	4.6	(0.7)	(45.5)
2018	13.7	11.4	(2.4)	(47.1)	35.0	31.6	(3.4)	(4.1)	(51.3)
2019	14.1	11.7	(2.5)	(49.6)	32.9	30.4	(2.5)	(6.6)	(56.2)
2020	13.9	12.1	(1.9)	(51.5)	31.9	29.3	(2.7)	(9.3)	(60.7)
Total	205.7	154.3	(51.5)	(51.5)	152.4	143.2	(9.3)	(9.3)	(60.7)

Analysis Details

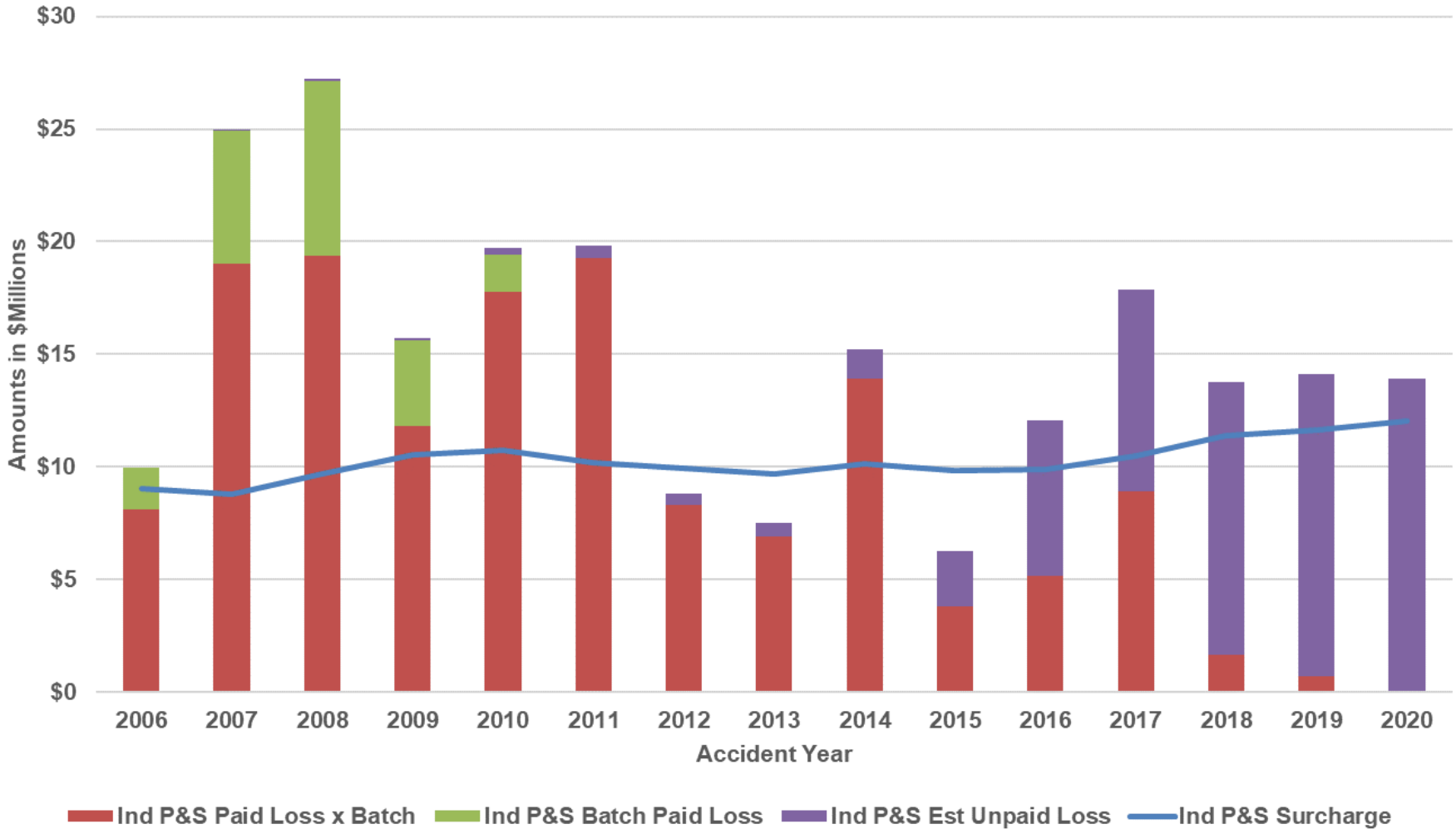
PCF Deficit cumulative contribution by accident year by group (In $Millions)



- Approximately $40M of PCF deficit for Ind P&S due to AYs 2007-2011. Over half of this deficit can be attributed to “batch” claims. The majority of this deficit wasn’t “realized” until the end of 2015.
- Hospital results are “immature” because majority of exposures joined in 2017. Significant differences between estimates may occur for hospitals. However, the difference will insignificantly impact Ind P&S contribution to the deficit.

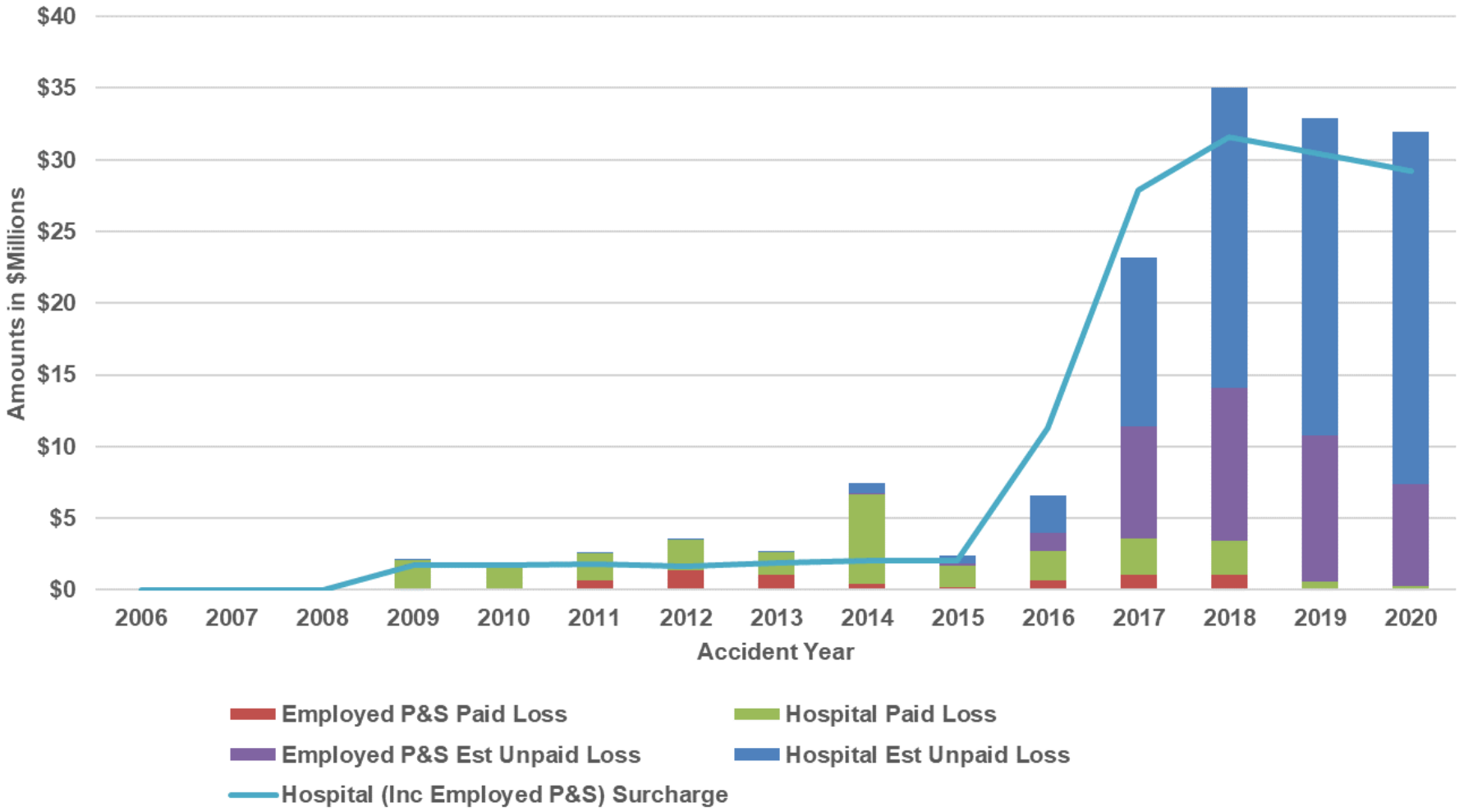
Analysis Details

Independent P&S Ultimate Loss Breakout (In $Millions)



Analysis Details

Hospitals Including Employed P&S Ultimate Loss Breakout (In $Millions)



Estimation of Deficit Assessment

Estimation of deficit assessment

- Calculate difference between ultimate loss and surcharge ($60.7M) and deficit ($66.8M)
  - Allocate this amount ($6M) between Independent P&S and Hospitals (Including Employed P&S) based on deficit contribution
- Calculate assessment for five years that will erase the deficit between Independent P&S and Hospitals (Including Employed P&S):
  - Assessment as a percentage of indicated surcharges as of January 1, 2022
  - Assume 4% increase in surcharges each year for claim inflation
  - Assume consistent exposure base (no change in PCF membership)
  - Include a credit for anticipated investment income earned on collected assessments
- **Important to note that this calculation assumes consistent membership in the PCF over the next five years. Since the combined surcharge and assessment will increase the costs significantly for Independent P&S, there is a possibility that PCF membership will decrease and the assessments will not be sufficient to eliminate the deficit.**

Other Considerations

Other Considerations

- Oral Discussion
  - This document is not complete without the accompanying oral discussion and explanation of the underlying projections, results and variability.
- Uncertainty
  - Any study of unpaid claim liabilities and future funding levels involves estimates of future contingencies. While our projections represent our best professional judgment, arrived at after careful analysis of the available data, it is important to note that a significant degree of variation from our projected results is not only possible, but in fact, probable. While the degree of such variation cannot be quantified, it could be in either direction from our estimates.
- Data Reliance
  - We have relied upon data and other background information prepared by NMPCF without audit or independent verification. We have performed a limited review of the data for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or relationships that are materially inconsistent. Such a review was beyond the scope of our analysis.
- Summary of Report
  - This presentation is a summary of Milliman's analysis of the New Mexico Patient's Compensation Fund evaluated as of December 31, 2020. Details of the following estimates and rates are documented in our report issued September 21st, 2021.
- Use of Name
  - Any reader of this presentation agrees that they shall not use Milliman's name, trademarks or service marks, or refer to Milliman directly or indirectly in any third party communication without Milliman's prior written consent for each such use or release, which consent shall be given in Milliman's sole discretion.

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Physicians and Surgeons Mixture

The data provided by the PCF includes the PCF surcharges paid by Physicians and Surgeons (P&S). This data is combined for independent P&S and employed (by a hospital) P&S. The PCF was not able to identify whether a P&S was independent or employed. In order to split the data between independent and employed providers we estimated an additional 50% of a hospitals' premium was for employed P&S. This was based on a review of the surcharge increase for P&S when a large number of hospitals entered the PCF in 2016/17. Using these amounts, we subtracted the estimated employed physician surcharge from the total in accident year 2015. Using this amount, we estimated the 2016-2020 independent P&S by applying the rate changes in these years and assumed a steady exposure base. The employed P&S surcharges were estimated by subtracting the independent P&S surcharge from the total. This is shown on Exhibit 3.

The loss data provided by the PCF included both independent P&S and employed P&S. These could be split out when an occurrence also listed a hospital as a defendant. The calculation for the total P&S ultimate losses were performed on a combined independent and employed basis. In order to allocate the loss estimates between these groups, we first calculated the unpaid by subtracting the paid losses from the ultimate. We then allocated the unpaid amounts pro-rata (proportionately) based on the surcharge premium for each group. We then added the paid amounts to calculate the estimated ultimate loss for each group. This is shown on Exhibit 4.

Exhibit 8 displays a reconciliation of the claim data provided by the PCF for accident year 2011. The employed P&S were allocated 50% of any PCF loss when a hospital is also listed.

Hospital Claim Data

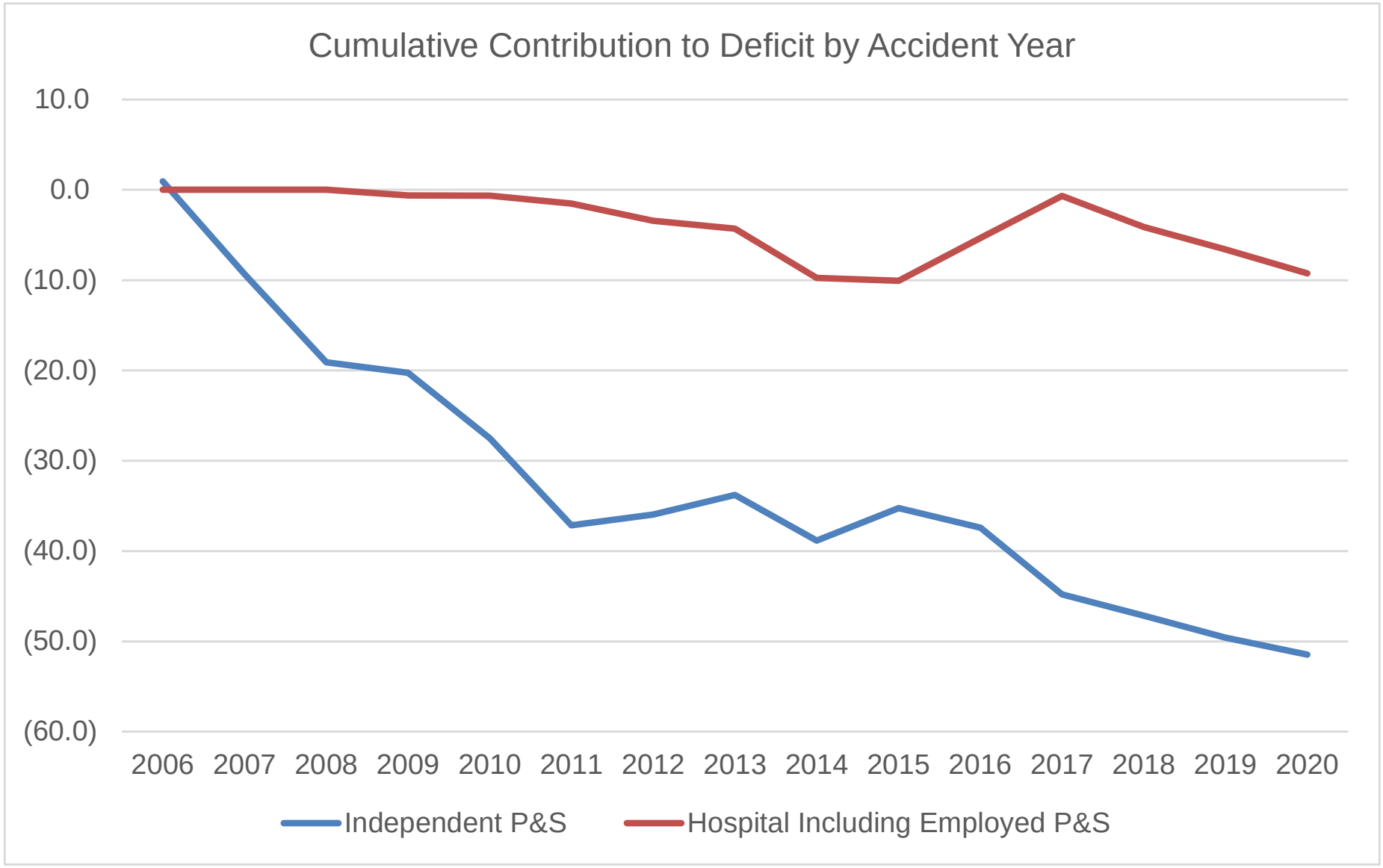
The PCF provided a claim listing from hospitals within the PCF that listed all the claims for several years. We were unable to use this data for the following reasons:

1. The claim data did not split out claims between medical and non-medical damages. It is our understanding most claims are settled and the split between these damage amounts are not known. Without this information we could not directly calculate the amounts that would be paid by the PCF.
2. We attempted to match the claim data to the PCF data by accident year and by claim and were unable to do so.

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate - Amounts in $ Millions

PCF Fund Deficit by Accident Year by LOB

	(1)	(2)	(3) (2) - (1) + (3) prior	(4)	(5)	(6) (5) - (4) + (6) prior	(7) (3) + (6)
	Independent Physicians & Surgeons (Inc Batch Claims)			Hospitals (Inc Employed P&S)			Combined
Accident Year	Selected Ultimate	PCF Surcharge	Cumulative Deficit	Selected Ultimate	PCF Surcharge	Cumulative Deficit	Cumulative Deficit
Prior	NA	NA	0.0	NA	NA	0.0	0.0
2006	8.1	9.1	0.9	0.0	0.0	0.0	0.9
2007	19.1	8.8	(9.3)	0.0	0.0	0.0	(9.3)
2008	19.5	9.7	(19.1)	0.0	0.0	0.0	(19.1)
2009	11.7	10.5	(20.3)	2.3	1.7	(0.6)	(20.9)
2010	18.0	10.7	(27.5)	1.7	1.7	(0.6)	(28.2)
2011	19.8	10.2	(37.1)	2.6	1.8	(1.5)	(38.6)
2012	8.8	9.9	(36.0)	3.6	1.6	(3.5)	(39.4)
2013	7.5	9.7	(33.8)	2.7	1.9	(4.3)	(38.1)
2014	15.2	10.2	(38.8)	7.4	2.0	(9.7)	(48.6)
2015	6.3	9.9	(35.2)	2.4	2.0	(10.1)	(45.3)
2016	12.0	9.9	(37.4)	6.6	11.3	(5.3)	(42.8)
2017	17.9	10.5	(44.8)	23.2	27.9	(0.7)	(45.5)
2018	13.7	11.4	(47.1)	35.0	31.6	(4.1)	(51.3)
2019	14.1	11.7	(49.6)	32.9	30.4	(6.6)	(56.2)
2020	13.9	12.1	(51.5)	31.9	29.3	(9.3)	(60.7)
Total	205.7	154.3	(51.5)	152.4	143.2	(9.3)	(60.7)


Cumulative Contribution to Deficit by Accident Year
10.0
0.0
(10.0)
(20.0)
(30.0)
(40.0)
(50.0)
(60.0)
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
Independent P&S
Hospital Including Employed P&S

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Surcharge
Amounts in $ Millions

Allocation of Surcharge between Independent Providers and Employed

Accident Year	(1) P&S PCF Surcharge	(2) Hospital PCF Surcharge	(3) Estimated Employed P&S PCF Surcharge	(4) Estimated Independent P&S PCF Surcharge	(5) Factor to Current Rate Level	(6) Estimated Independent P&S PCF Surcharge	(7) Estimated Independent P&S PCF Surcharge	(8) Estimated Employed P&S PCF Surcharge	(9) Hospital Plus Employed P&S PCF Surcharge
Prior	NA	NA		NA					NA
2006	9.1	0.0		9.1	1.703		9.1	0.0	0.0
2007	8.8	0.0		8.8	1.683		8.8	0.0	0.0
2008	9.7	0.0		9.7	1.572		9.7	0.0	0.0
2009	11.1	1.1	0.6	10.5	1.547		10.5	0.6	1.7
2010	11.3	1.1	0.6	10.7	1.448		10.7	0.6	1.7
2011	10.8	1.2	0.6	10.2	1.421		10.2	0.6	1.8
2012	10.5	1.1	0.5	9.9	1.421		9.9	0.5	1.6
2013	10.3	1.3	0.6	9.7	1.421		9.7	0.6	1.9
2014	10.8	1.4	0.7	10.2	1.421		10.2	0.7	2.0
2015	10.5	1.4	0.7	9.9	1.421		9.9	0.7	2.0
2016	11.7	9.5			1.417	9.9	9.9	1.8	11.3
2017	19.7	18.6			1.333	10.5	10.5	9.2	27.9
2018	21.4	21.6			1.230	11.4	11.4	10.0	31.6
2019	20.5	21.5			1.202	11.7	11.7	8.9	30.4
2020	18.2	23.1			1.162	12.1	12.1	6.1	29.3
Total	194.6	102.8	4.2	98.7		55.5	154.3	40.3	143.2

(1), (2) Provided by the PCF
(3) = 50% of (2)
(4) = (1) - (2)
(5) Provided by the PCF
(6) For 2016, (4) 2015 x (5) Prior / (5) Current; For other years (6) x (5) Prior / (5) Current
(7) = (4) + (6)
(8) = (1) - (7)
(9) = (2) - (8)

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate - Amounts in $ Millions

Allocation of P&S between Independent Providers and Employed

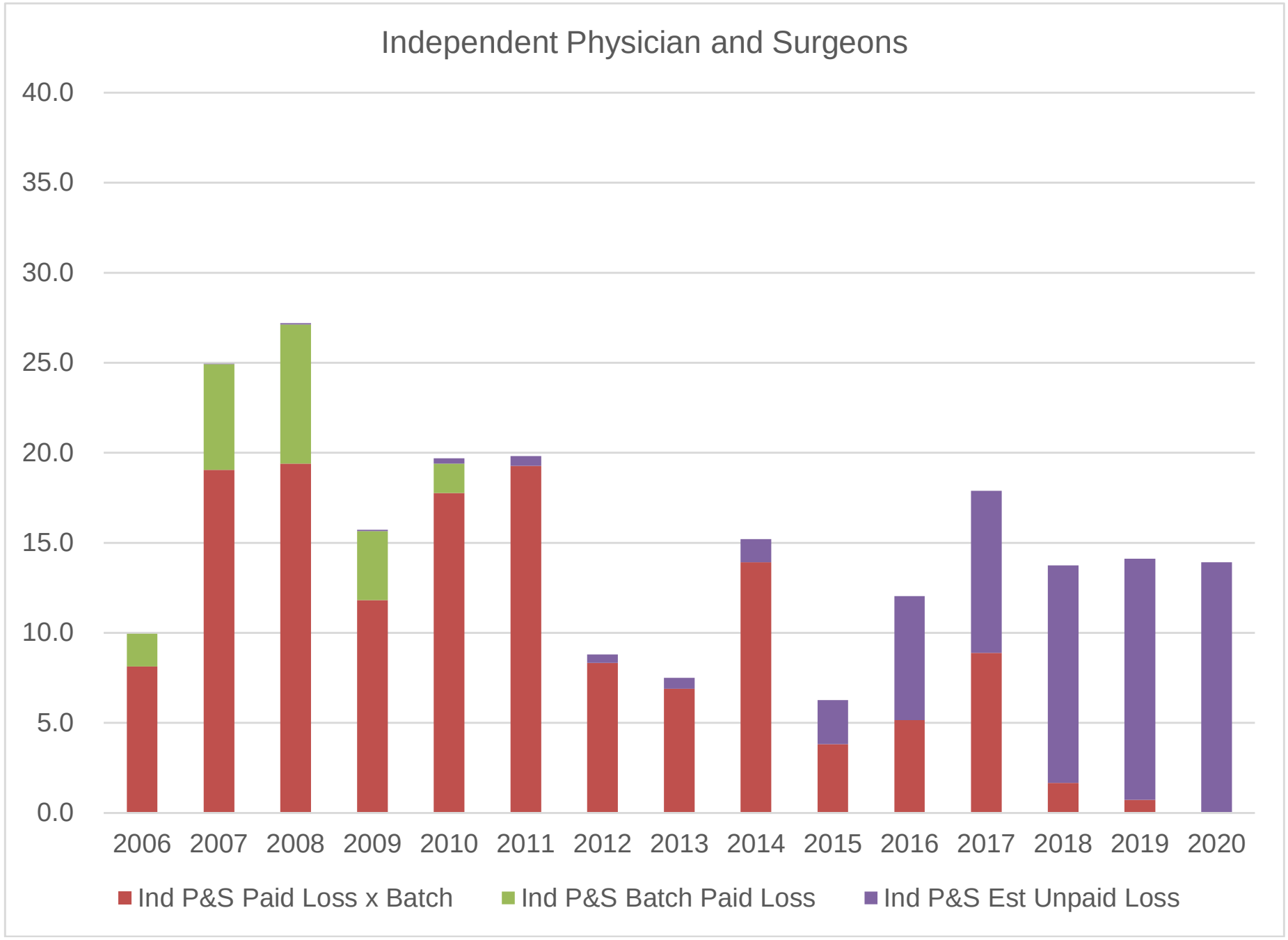
	(1)	(2)	(3)	(4)	(5)	(6) [(1) - (3) - (4)] x [(5) / (2)]	(7) (3) + (6)	(8) (2) - (5)	(9) (1) - (7)
	Physicians & Surgeons (Including Batch Claims)				Estimated Independent Provider P&S			Estimated Employed P&S	
Accident Year	Selected Ultimate	PCF Surcharge	Independent Paid Loss	Employed Paid Loss	PCF Surcharge	Allocated Unpaid Loss	Selected Ultimate	PCF Surcharge	Selected Ultimate
Prior	NA	NA	0	0	NA	0	NA	NA	0
2006	8.1	9.1	8.1	0.0	9.1	0.0	8.1	0.0	0.0
2007	19.1	8.8	19.0	0.0	8.8	0.0	19.1	0.0	0.0
2008	19.5	9.7	19.4	0.0	9.7	0.1	19.5	0.0	0.0
2009	11.9	11.1	11.8	0.0	10.5	0.1	11.9	0.6	0.0
2010	18.2	11.3	17.8	0.1	10.7	0.3	18.1	0.6	0.2
2011	20.5	10.8	19.3	0.6	10.2	0.6	19.8	0.6	0.7
2012	10.2	10.5	8.3	1.4	9.9	0.5	8.8	0.5	1.4
2013	8.6	10.3	6.9	1.1	9.7	0.6	7.5	0.6	1.1
2014	15.7	10.8	13.9	0.4	10.2	1.3	15.2	0.7	0.5
2015	6.7	10.5	3.8	0.2	9.9	2.5	6.3	0.7	0.4
2016	14.0	11.7	5.2	0.7	9.9	6.9	12.0	1.8	1.9
2017	26.8	19.7	8.9	1.1	10.5	9.0	17.9	9.2	8.9
2018	25.4	21.4	1.7	1.1	11.4	12.1	13.7	10.0	11.7
2019	24.3	20.5	0.7	0.0	11.7	13.4	14.1	8.9	10.2
2020 [1]	21.0	18.2	0.0	0.0	12.1	13.9	13.9	6.1	7.1
Total	250.1	194.6	144.9	6.7	154.3	61.1	206.0	40.3	44.1

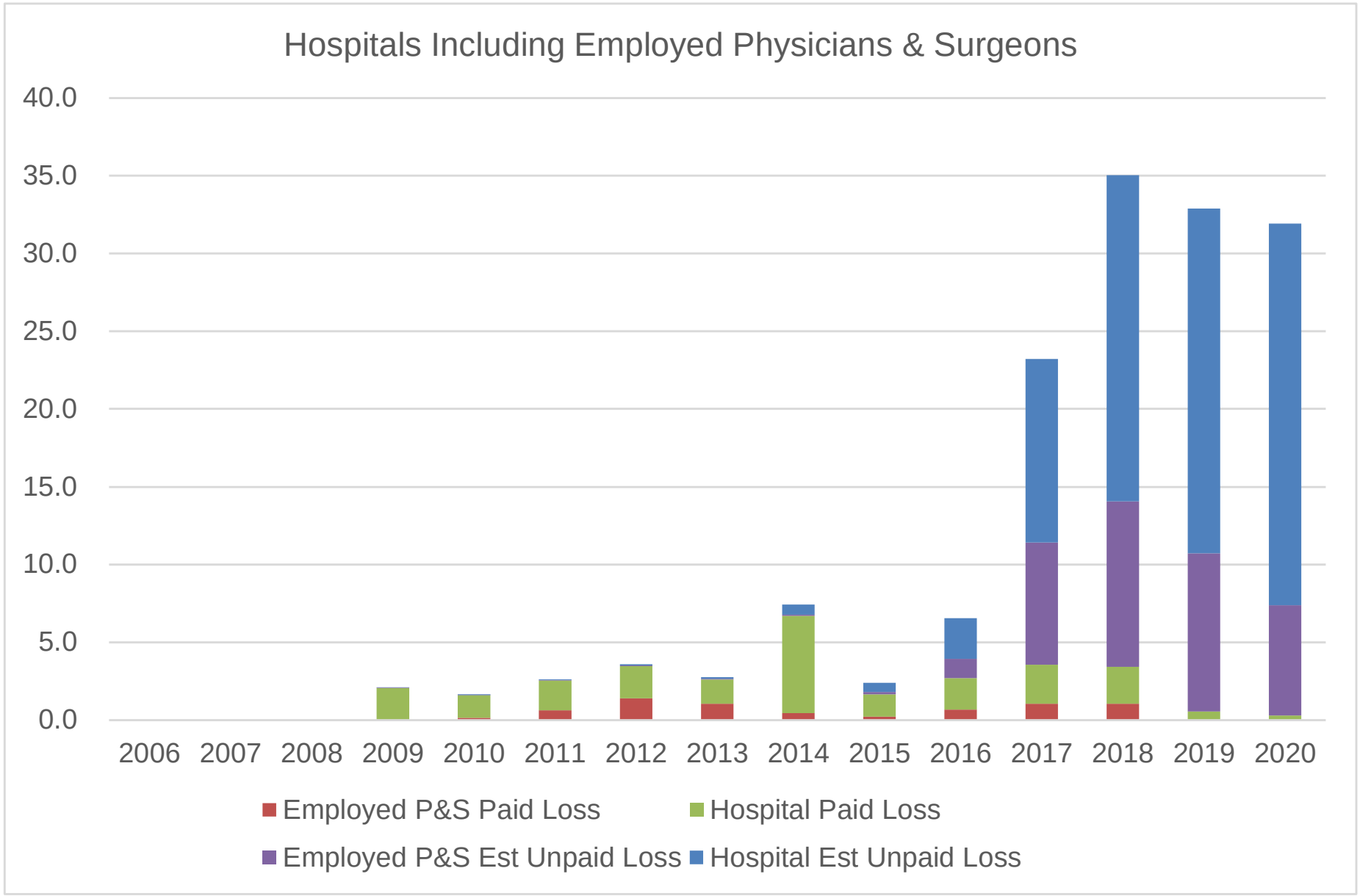
[1] Reflects a full year of earned exposure
(3), (4) Provided by the PCF
(5), (8) Estimated Surcharge Premium for 2009-2015 estimated as 50% of Hospital surcharge
(5), (8) Estimated Surcharge Premium for 2016-2020 uses 2015 as a base (all independent P&S) and is adjusted for future rate changes

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Actuarial Central Estimate - Amounts in $ Millions

Summary of Paid and Unpaid Loss between Independent P&S and Hospitals

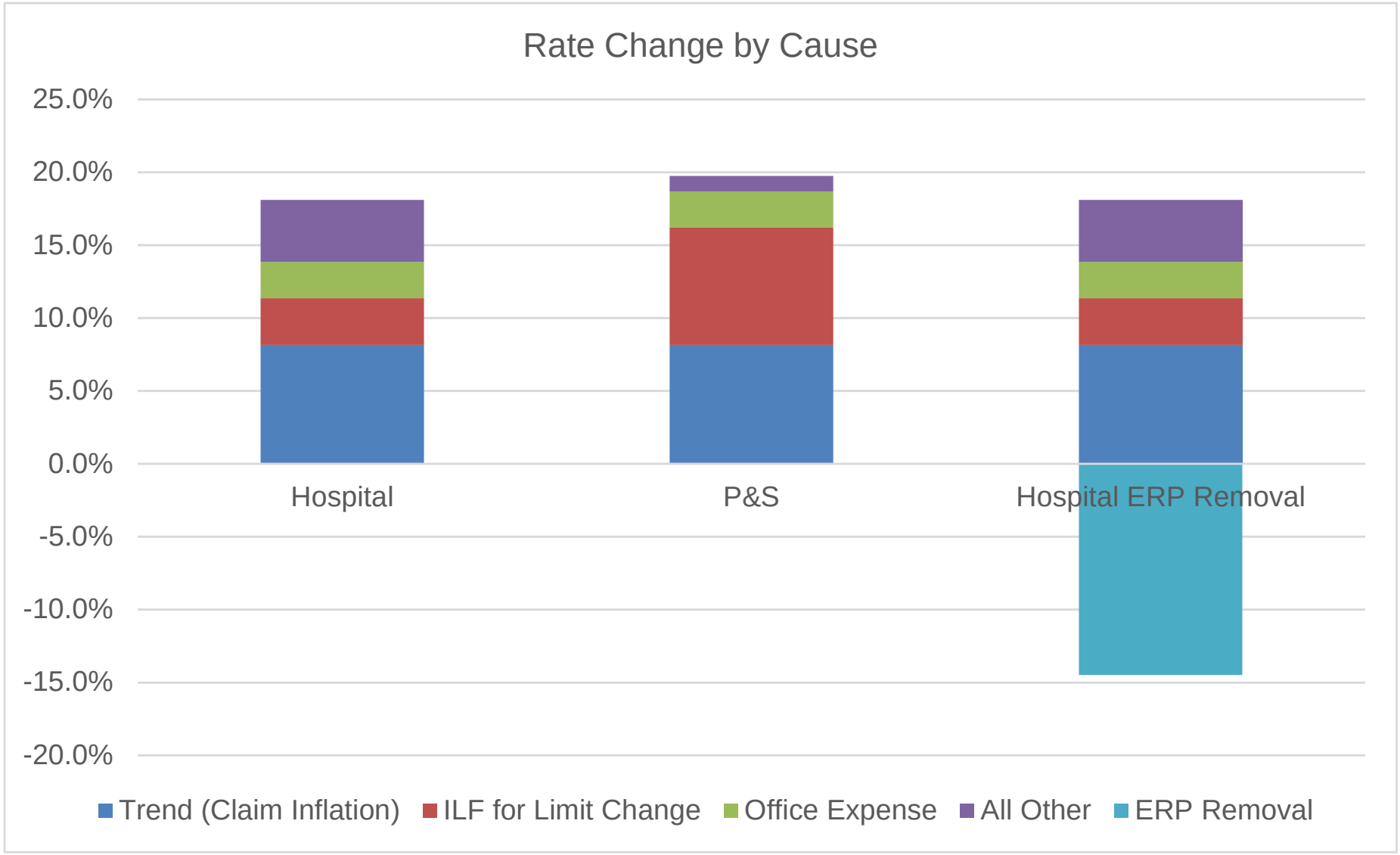
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Independent Physicians & Surgeons			Hospitals + Estimated Employed P&S			
Accident Year	Ind P&S Paid Loss x Batch	Ind P&S Batch Paid Loss	Ind P&S Est Unpaid Loss	Employed P&S Paid Loss	Hospital Paid Loss	Employed P&S Est Unpaid Loss	Hospital Est Unpaid Loss
2006	8.1	1.8	0.0	0.0	0.0	0.0	0.0
2007	19.0	5.9	0.0	0.0	0.0	0.0	0.0
2008	19.4	7.7	0.1	0.0	0.0	0.0	0.0
2009	11.8	3.8	0.1	0.0	2.1	0.0	0.0
2010	17.8	1.6	0.3	0.1	1.5	0.0	0.0
2011	19.3	0.0	0.6	0.6	1.9	0.0	0.1
2012	8.3	0.0	0.5	1.4	2.1	0.0	0.1
2013	6.9	0.0	0.6	1.1	1.5	0.0	0.1
2014	13.9	0.0	1.3	0.4	6.2	0.1	0.7
2015	3.8	0.0	2.5	0.2	1.4	0.2	0.6
2016	5.2	0.0	6.9	0.7	2.0	1.3	2.6
2017	8.9	0.0	9.0	1.1	2.5	7.9	11.8
2018	1.7	0.0	12.1	1.1	2.4	10.6	21.0
2019	0.7	0.0	13.4	0.0	0.6	10.2	22.1
2020	0.0	0.0	13.9	0.0	0.3	7.1	24.5
Total	144.9	20.9	61.1	6.7	24.5	37.4	83.6


Independent Physician and Surgeons
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
Ind P&S Paid Loss x Batch
Ind P&S Batch Paid Loss
Ind P&S Est Unpaid Loss


Hospitals Including Employed Physicians & Surgeons
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
Employed P&S Paid Loss
Hospital Paid Loss
Employed P&S Est Unpaid Loss
Hospital Est Unpaid Loss

New Mexico Patient's Compensation Fund
Medical Professional Liability
Occurrence Coverage Evaluated as of December 31, 2020
PCF Loss
Claim Reconciliation of Data

Claim #	Sub-claim	Incident Date	Settlement Date	Payment Date	PCF	Provider Type
22	0	2/28/2011	11/2/2012	11/2/2012	1,325,000	Ind P&S
35	0	1/4/2011	5/10/2013	5/10/2013	400,000	Ind P&S
39	0	2/16/2011	7/22/2013	7/22/2013	125,000	Ind P&S
47	0	2/9/2011	11/4/2013	11/4/2013	75,000	Ind P&S
54	0	7/20/2011	1/28/2014	1/28/2014	1,530,000	Ind P&S
65	0	2/17/2011	4/24/2014	4/24/2014	123,000	Ind P&S
69	0	6/27/2011	6/30/2014	6/30/2014	400,000	Ind P&S
71	0	8/8/2011	8/12/2014	8/12/2014	50,000	HOSP
75	1	7/1/2011	9/12/2014	9/12/2014	262,500	HOSP
75	2	7/1/2011	9/12/2014	9/12/2014	262,500	Emp P&S
76	0	10/13/2011	9/12/2014	9/12/2014	200,000	Ind P&S
89	0	3/24/2011	3/5/2015	3/5/2015	85,000	Ind P&S
91	0	5/27/2011	4/15/2015	4/15/2015	325,000	Ind P&S
92	0	1/10/2011	4/27/2015	4/27/2015	275,000	Ind P&S
94	1	7/25/2011	6/8/2015	6/8/2015	295,000	HOSP
94	2	7/25/2011	6/8/2015	6/8/2015	295,000	Emp P&S
96	0	1/21/2011	6/11/2015	6/11/2015	400,000	Ind P&S
97	0	1/28/2011	6/11/2015	6/11/2015	195,000	Ind P&S
99	0	10/2/2011	8/4/2015	8/4/2015	1,400,000	Ind P&S
100	0	7/21/2011	8/5/2015	8/5/2015	507,312	Ind P&S
101	0	2/7/2011	8/8/2015	8/8/2015	120,000	Ind P&S
102	0	6/27/2011	8/19/2015	8/19/2015	1,300,000	Ind P&S
119	0	7/12/2011	2/8/2016	2/8/2016	395,000	Ind P&S
120	1	12/23/2011	2/8/2016	2/8/2016	75,000	HOSP
120	2	12/23/2011	2/8/2016	2/8/2016	75,000	Emp P&S
122	0	2/23/2011	3/10/2016	3/10/2016	4,600,000	Ind P&S
125	0	5/31/2011	5/18/2016	5/18/2016	345,000	Ind P&S
130	0	2/11/2011	7/19/2016	7/19/2016	1,335,916	Ind P&S
132	0	6/17/2011	9/1/2016	9/1/2016	100,000	Ind P&S
136	0	8/4/2011	11/7/2016	11/7/2016	150,000	Ind P&S
138	0	11/17/2011	12/28/2016	12/28/2016	200,000	HOSP
139	0	8/19/2011	1/18/2017	1/18/2017	325,000	HOSP
145	0	12/2/2011	3/16/2017	3/27/2017	1,050,000	Ind P&S
146	0	7/16/2011	4/21/2017	5/9/2017	320,000	HOSP
147	1	8/11/2011	4/28/2017	5/25/2017	-	Ind P&S
147	2	8/11/2011	4/28/2017	5/25/2017	162,500	Ind P&S
147	3	8/11/2011	4/28/2017	5/25/2017	162,500	Ind P&S
159	0	12/18/2011	10/27/2017	10/27/2017	112,500	HOSP
174	0	7/18/2011	4/2/2018	4/2/2018	400,000	Ind P&S
178	0	7/21/2011	5/16/2018	5/16/2018	550,000	Ind P&S
180	0	9/7/2011	5/17/2018	5/17/2018	275,000	HOSP
185	0	8/30/2011	8/3/2018	8/3/2018	390,000	Ind P&S
232	0	12/29/2011	12/18/2019	1/9/2020	853,241	Ind P&S
				Total	19,279,469	Ind P&S
				Total	632,500	Emp P&S
				Total	1,915,000	HOSP


Rate Change by Cause
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
-5.0%
-10.0%
-15.0%
-20.0%
Hospital
P&S
Hospital ERP Removal
Trend (Claim Inflation)
ILF for Limit Change
Office Expense
All Other
ERP Removal