2022 ANNUAL REPORT OF THE
PATIENT COMPENSATION FUND ADVISORY BOARD
TO THE NEW MEXICO LEGISLATURE

To: Members of the New Mexico Legislature
From: Patient Compensation Fund Advisory Board
Date: January 18, 2022
Re: Operations and financial condition of the Patient's Compensation Fund

The Medical Malpractice Act enacted in 1976 was comprehensively revised for the first time, after 45 years, in the 2021 Legislative Session. Among the amendments to the act was the creation of a Patient Compensation Fund (PCF) Advisory Board whose purpose is to advise the Superintendent of Insurance and a newly contracted Third-Party Administrator of the fund. The Board is comprised of nine representatives of the primary stakeholders around medical malpractice laws in New Mexico: patient advocates, New Mexico Medical Society, New Mexico Hospital Association, New Mexico Trial Lawyers Association, and nurse practitioners. It was created in July 2021 and a quorum of the Board met in compliance with the Open Meetings Act on July 21, 2021, September 9, 2021, October 8, 2021, October 20, 2021, October 25, 2021, October 26, 2021, December 17, 2021, and January 6, 2022. Pursuant to NMSA 41-5-25.1 (E) (4), the PCF Advisory Board hereby submits its first "annual report to the legislature on the operations and financial condition of the fund."

Operations of the Fund

As required by the new law, the Office of the Superintendent of Insurance published an RFP for companies interested in serving as Third Party Administrator to operate and administer the PCF. Two companies filed an intent to offer, but only one company – Integrion Group, Inc. – submitted an offer to provide services. Integrion Group, Inc. presented its proposal to the OSI and the PCF Advisory Board. After negotiations between Integrion and OSI, Integrion has been retained at an annual cost of $1,277,330 and began work as the operator and administrator of the fund on January 1, 2022.

Financial Condition of the Fund

On January 1, 2020, Russell Toal became New Mexico's Superintendent of Insurance. Within a month, as Custodian of the PCF, Superintendent Toal ordered a "second look" actuarial study to evaluate surcharges that were to take effect March 1, 2020. The "second look" study identified a large deficit in the fund's budget and concerns that the deficit would continue to grow in the future. Many of the changes to the Medical Malpractice Act were designed to address this issue. One such change is the removal of hospitals and outpatient health care facilities from eligibility for participation in the PCF beginning January 1, 2027, leaving the fund to pay settlements for malpractice claims on behalf of independent providers and their practice groups only.

Another change to the act that was intended to address the deficit was the requirement that participating hospitals and outpatient health care facilities cure any fund deficit attributable to them by December 31, 2026. Furthermore, surcharges for all remaining providers were to be set with the intention of bringing the fund to solvency. As part of the 2022 surcharge rate proceedings, it was therefore imperative to accurately assess the projected fund deficit and identify the causes of the deficit so that future risk and past underpayment could be accurately apportioned among the participants in the fund.

To expedite investigation of these issues and comply with the act's October 31, 2021, surcharge rate setting deadline, in addition to its duties set forth under NMSA 41-5-25.1, the PCF Advisory Board served as Hearing Examiner in the Matter of Determining Patient's Compensation Fund Surcharge Rates. The task of the Hearing Examiner was to recommend to the Superintendent of Insurance 2022 surcharge rates for individual providers, entities organized by one or more individual providers, hospitals and outpatient health care facilities based on the actuary's assessment of the risk of future claims, and to apportion responsibility for the PCF deficit. The board held a public evidentiary hearing on October 20, 2021, during which it considered evidence presented by counsel for the Office of the Superintendent, including the actuarial report and testimony of Carl X. Ashenbrenner, Principal and Consulting Actuary from Milliman, an actuarial consulting firm. All members of the nine-member board had the opportunity to ask questions of Mr. Ashenbrenner and OSI staff and to study the evidence.

On October 26, 2021, the Advisory Board acting as Hearing Examiner issued its Proposed Findings, Conclusions and Recommendations to the New Mexico Superintendent of Insurance. (See Ex. A). **The nine-member board of individuals representing all interests around medical malpractice laws in New Mexico made the following important, unanimous findings:**

1) **The estimated PCF fund deficit as of December 31, 2020, is $66.8 million.**
2) **The fund has suffered from a long history of mismanagement during prior administrations of the Office of the Superintendent of Insurance.**
3) **The Milliman report identified three causes of the deficit[1]:**

    a. **$36,500,000 – failure to raise surcharges on independent physicians despite actuarial recommendations;**
    b. **$20,100,000 – settlement payouts on behalf of two doctors, one who implanted unnecessary pacemakers into more than 25 patients' chests and another who inserted an experimental plastic spacer into more than 60 patients' backs (the so-called "batch claims," defined as multiple claims against one physician that arise out of a similar scheme or type of procedure), and;**
    c. **$10,200,000 – failure to impose adequate surcharges on hospitals.**

Regarding independent providers (physicians, certified nurse practitioners and their independently owned practice groups), the Advisory Board recommended that the Superintendent of Insurance adopt the rate plan proposed by the actuary but defer to a later date the deficit reduction plan for the portions attributable to the past failures to raise surcharges on independent physicians. The Board's concern was that adding $36.5 million of underpaid surcharges to the current surcharges on independent providers would create a disincentive to practice in New Mexico, and a reduction in availability of quality healthcare for patients. The Board also recommended that a separate plan be considered for extinguishing the deficit attributable to settlement payouts on behalf of the two multiple claim doctors (batch claims). Regarding hospitals' surcharge rates and their portion of the deficit, the Board adopted the recommendation of the actuary.

[1] The Advisory Board had concerns about the lack of data to identify the portions of settlement payouts that should be attributed to independent physicians versus hospital employed physicians. It attempted to collect additional data, but that data is unavailable as it was not collected at the time of settlement.

The Advisory Board recognizes that the PCF risks collapse if it continues to function at such a large deficit. It recommended that the Superintendent of Insurance and its newly contracted Third-Party Administrator study the ways in which risk is evaluated for future surcharge rate setting. For hospitals, the Experience Rating Plan, a system of anticipating losses based on past losses, has been used. However, because the PCF has not historically maintained data on how settlement payouts are allocated (as between hospital employed physicians and independent physicians), it is unclear in some cases how settlements were allocated between the parties. There is no way to reconstruct that data to determine whether any of the deficit attributed to independent physicians should instead be attributed to hospitals. The Board also recommended that the Superintendent of Insurance and its Third-Party Administrator collect and keep additional data about claims handling so that accurate assessments of risk can be done for future rate setting proceedings.

The Superintendent of Insurance accepted some of the Board's recommendations but did not raise the surcharge rates as high as recommended. (See Final Order, Ex. B).

Conclusion and Request of the New Mexico Legislature

The Patient's Compensation Fund has been mismanaged for many years. It has collected inadequate surcharges, performed improper risk assessments, and failed to collect and analyze appropriate risk data. Hospitals have committed to paying their portion of the deficit as required by the amendments to the Medical Malpractice Act. However, a deficit of $56.6 million due to physician surcharge underpayment and batch claim payouts on behalf of two doctors will remain unpaid barring another solution. The Superintendent of Insurance has requested funding from the legislature to bring the PCF to solvency. The Advisory Board supports that request and implores the legislature to grant it. The Board sees no other solution that does not risk compromising patients' access to quality health care or accountability and fair compensation in the case of malpractice.

RESPECTFULLY SUBMITTED BY:

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EXHIBIT A

FILED
October 26, 2021 at 4:31 P.M.
by FKT
Patient's Compensation Fund

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

IN THE MATTER OF DETERMINING	)	
PATIENT'S COMPENSATION FUND	)	
SURCHARGE RATES	)	**Docket No. 21-0004-PCF**
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PROPOSED FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

FINDINGS OF FACT:

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

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

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

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

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

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

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

cure any fund deficit attributable to hospitals and outpatient health care facilities" by December 31, 2026.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ex. B, p. 68.

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

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

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

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

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

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

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

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

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

25. Although it was recommended that the ERP should be eliminated, the Committee found that not enough information about the ERP and how it functioned was presented. The decision of whether to eliminate the ERP should be made after further study by the OSI and the qualified Third Party Administrator that is to be retained.

26. If 2021 surcharge rates for hospital QHPs are carried forward to 2022, hospital QHP participation levels remain constant, the PCF will collect $26,960,759 in surcharges in 2022, which will result in an underfunding of projected losses by $1,395,167. Ex. C, p. 24. To eliminate the projected underfunding, at the central confidence level, hospital QHP surcharge rates would need to increase by 3.6 percent for the 2022 PCF plan year (which becomes 18.1% based on the ERP). *Id.* Applying a 3.6 percent surcharge increase to the 2021 hospital rating plan exposure factors yields the rates per-exposure reflected in the column headed "2022 PCF Rates" on page 26 of Exhibit C which will need to be recalculated based on the ERP.

27. With respect to casualty loss rate setting, the term "confidence level" refers to the probability that rates will generate sufficient income to cover projected losses. Changing the Confidence Level, the increase in the Base Coverage level, the PCF exposure, and addressing the deficit all in the same year pose a significant threat to the goal of maintaining a stable number of participants in the PCF. Therefore, the PCF Advisory Board does not recommend implementing the recommended change to the confidence level this year but does encourage that recommendation to be considered in future years.

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

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

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

31. Historically, hospital QHPs paid surcharges on behalf of their employed providers. Because the PCF did not separately log employed provider surcharge amounts, total hospital surcharge payments were estimated to be 50 percent of total hospital surcharge remissions. Ex. D, p. 1. This allocation was based on anecdotal evidence that was not by testimony or documents at the hearing. In the future, the PCF should attribute loss payments for employed physicians

directly to the hospitals. Further, if a non-employed physician and a hospital are both the subject of a claim, the PCF should endeavor to allocate loss payments made on behalf of the hospital and the non-employed provider based upon a reasonable estimate of comparative fault.

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

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

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

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

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

A. The PCF should further study, in conjunction with the OSI and the Third Party Administrator to be retained whether to eliminate the ERP; the ERP should not be eliminated this year;

B. PCF surcharges should be assessed at the central confidence level for all QHPs, resulting in a 19.7 percent increase in surcharges for individual providers and provider owned entities, and a 18.1 percent increase for hospitals and outpatient facilities;

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

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

F. $20.1 million of the individual QHP's deficit due to so-called "batch claims" should be placed in a separate category of deficit and a separate plan to extinguish that deficit should be studied.

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

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

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

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

DATED this 26th day of October, 2021

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

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing *Proposed Findings, Conclusions, and Recommendations* was sent by email to the following individuals, as indicated below, on this 26th day of October, 2021.

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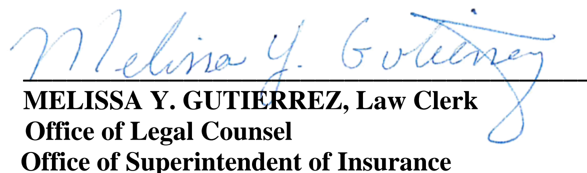

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EXHIBIT B

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

FILED

October 30, 2021 at 10:45 P.M.

Patient's Compensation Fund

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

FINAL ORDER

THIS MATTER comes before the New Mexico Superintendent of Insurance as Custodian of the Patient's Compensation Fund (hereinafter referred to as the "Custodian") upon his receipt of the Patient's Compensation Fund ("PCF") Advisory Board's Proposed Findings, Conclusions and Recommendations filed October 26, 2021 after the PCF Advisory Board conducted a properly noticed public hearing on PCF surcharge rates on October 20, 2021. The Proposed findings, Conclusions and Recommendations of the PCF Advisory Board are incorporated into this Order by reference. The Custodian, having reviewed the PCF Advisory Board's Proposed Findings, Conclusions and Recommendations, having reviewed the evidence from the hearing, and being otherwise fully advised in the premises, **HEREBY FINDS AND CONCLUDES:**

1. The findings made by the PCF Advisory Board are accepted by the Custodian as his own except the statement in finding no. 34 wherein the PCF Advisory Board finds that "Section 41-5-25(E) does not require independent provider QHPs to extinguish their proportionate share of the deficit in any particular time period and are therefore not required to extinguish their share of the deficit in five years."

2. Instead, the Custodian finds that Section 41-5-25(F) provides that "Beginning in 2021, the surcharges shall be set with the intention of bringing the fund to solvency with no projected deficit by December 31, 2026" and the Custodian concludes that Section 41-5-25(F) requires all independent providers to extinguish, by December 31, 2026, the share of the deficit not allocated to hospitals and outpatient health care facilities.

3. Additionally, the Custodian finds that the ERP should be eliminated this year for the reasons found on page 23 of Exhibit B.

4. House Bill 75 from the 2021 Regular Session of the New Mexico Legislature, entitled *Clarifying and Modernizing the Medical Malpractice Act* ("HB 75"), increases costs for all Qualified Health Care Providers ("QHPs"). Most significantly, HB 75 requires QHPs to eliminate the PCF deficit within five years. Because hospitals have not participated in the fund for as long as independent providers, hospitals are responsible for less than twenty percent of the deficit. To extinguish the remainder of the deficit within five years requires imposing an annual deficit reduction surcharge, in addition to the base surcharge, that will increase annual surcharge obligations more than fifty percent on independent providers. HB 75 also increases the future claim funding obligations of the PCF. It is estimated that the increased damages caps require increasing base surcharges on all QHPs by at least eight percent. Finally, HB 75 requires the PCF to engage the services of an independent administrator, and to conduct an annual actuarial study. The expenses associated with these requirements will increase base surcharges annually by 2.5 percent. While hospitals and outpatient health care facilities may be able to withstand (or pass on) steep cost increases, independent providers would likely find the cost of participation in the PCF as recommended by the actuary and the PCF Advisory Board to be prohibitive and leave the PCF, or worse, leave the state. This would increase the cost of reducing the deficit to the remaining QHPs in the PCF, potentially leading to a cascade of participants leaving the PCF.

5. The Custodian adopts the PCF Advisory Board's Recommendations except Recommendations B, E, F and G.

IT IS THEREFORE ORDERED:

A. The PCF shall not implement the ERP for 2022 rates. The Office of Superintendent of Insurance ("OSI") and the PCF third-party administrator shall study the ERP and determine whether to eliminate it in future years.

B. The PCF shall not adopt the PCF Advisory Board's recommendation that base surcharge increases for independent providers be set in a manner which would result in a 19.7 percent increase over 2021 surcharge assessments. The Custodian takes administrative notice that adopting this recommendation would likely result in decreased provider participation in the PCF and, potentially, a decrease in the number of providers who deliver services to New Mexicans. Such an outcome would be an unintended and unacceptable consequence of HB 75.

C. The Custodian has reason to believe that the Legislature, in an effort to reduce provider costs, reduce the PCF deficit, and retain independent providers in the state, will appropriate in the upcoming legislative session approximately $30 million to eliminate the deficit costs associated with the PCF Advisory Board's finding no.12. Accordingly, any appropriation to the PCF shall be used to reduce the deficit and adjust independent provider base surcharges.

D. Based on the anticipated Legislative appropriation, the Custodian orders that the 2022 base surcharge increases for independent providers be set at a 12.2 percent increase over 2021 surcharge assessments. PCF surcharges for entities owned by independent providers shall be assessed at 10 percent of the cumulative individual independent provider surcharges for all providers who practice within the entity.

E. Base PCF surcharges for hospitals and outpatient health care facilities shall be assessed at the central confidence level resulting in a 3.6 percent increase for hospitals and outpatient health care facilities. Because HB 75 eventually eliminates hospital and outpatient health care facility participation in the PCF and requires all qualified hospitals and outpatient care facilities to cure any fund deficit attributable to hospitals and outpatient health care facilities by December 31, 2026, the assigned confidence level and associated percentage increases shall be reevaluated for PCF 2023 rates.

F. The risk classifications set out on pages 17 through 20 of Exhibit C shall be adopted for use by the PCF.

G. For hospitals and outpatient health care facilities, the PCF shall adopt the proposed deficit reduction plan and apply the deficit reduction assessments recommended on page 26 of Exhibit C.

H. Hospital and outpatient health care facility surcharges shall be assessed according to the rating plan that appears on page 26 of Exhibit C, plus the surcharge and deficit reduction amounts for employed providers as specified in page 16 of Exhibit C, plus the entity surcharge for each contracted agent entity.

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

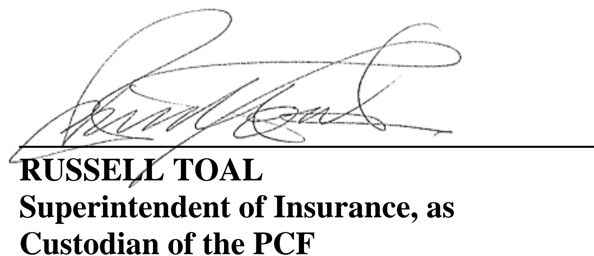
J. The Custodian expresses his appreciation to the Governor and the Legislature for their assistance in reducing the deficit amounts that were not the fault of currently enrolled QHP providers.

K. The Custodian recommends that all parties address all the unintended consequences of HB 75 in the next full legislative session in early 2023.

L. A copy of this Final Order shall be sent to all persons as indicated on the attached Certificate of Service and distributed through the PCF Newsletter.

M. This docket is now closed.

DONE AND ORDERED at Santa Fe, New Mexico, this 30th day of October, 2021.



RUSSELL TOAL
Superintendent of Insurance, as
Custodian of the PCF

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing *Final Order* was sent by email to the following individuals, as indicated below, on this 30th day of October, 2021.

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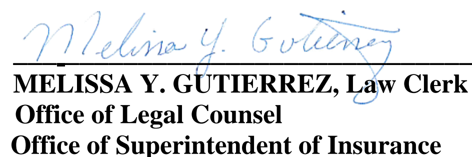

MELISSA Y. GUTIERREZ, Law Clerk
Office of Legal Counsel
Office of Superintendent of Insurance