

factors made by primary insurers adjusted to the excess coverage limits. In reviewing both recent primary insurer classification changes and classification changes for excess programs in Indiana and Wisconsin, as well as MPLI commercial carriers in New Mexico, there are a limited number of classes we would recommend that the Underwriting Committee consider for movement to a higher or lower class group.

Surcharges for Hospitals and Outpatient Facilities

In previous work for the OSI, Pinnacle recommended that the Division of Insurance should require the completion of an application for coverage as part of the process of hospitals seeking admission to the PCF. After a review of the application currently used by the PCF, we do not believe the application needs any material changes.

The final element of the approach recommended to OSI for hospitals and related facilities was a large risk rating approach. Insureds that apply for coverage are required to complete an actuarial study (including both an analysis and an actuarial report), evaluating the indicated annual assessment required to adequately fund the PCF layer of coverage for their medical professional liability exposures in New Mexico. The first hospital to become eligible for PCF coverage has completed this process. Pinnacle is currently in the process of reviewing the materials for the update to this study and a new application as well. The results of these analyses will be provided under separate covers.

On a more general note, it would appear that the approach proposed by Pinnacle for risks large enough to warrant a heavily experience rated large risk rating options appears to provide adequate regulatory controls that protect the overall solvency of the PCF as well as the interests of the healthcare providers currently insured by the PCF. The implementation of this approach by OSI also appears to be reasonable and appropriate.

Impact of Potential Coverage Changes

Two different proposed changes are evaluated in this analysis. First, the analysis examines the impact of increasing the caps on non-medical damages from the current \$600,000 level to up to \$2,000,000. This analysis will look at limits of \$1,000,000, \$1,500,000, and \$2,000,000. Second, we examine an explicit assumption that overall MPLI claims frequency will increase if the cap on non-medical damages is increased significantly. These proposals have markedly different impacts on primary and PCF premium costs depending on the cap and frequency assumptions selected. It should be understood that increasing the damage caps will increase overall losses and therefore increase health care provider costs.

In order to estimate the impact of the revised cap on non-medical damages, Pinnacle's analysis started by trending the closed claims in the Florida, Michigan, Texas and Virginia closed claims data sets by an annual rate of 5.0% for indemnity payments and ALAE payments. This trend factor is consistent with current MPLI industry trends and was selected after a review of recent insurer rate filings and industry trend analyses. Losses were trended assuming that the non-economic damage caps would begin to apply on July 1, 2016. The resulting trended losses were then organized by total size of loss and the impact of the proposed change in the cap was computed for each size of loss range separately. Exhibit 14 summarizes the results of this analysis.

In many cases, medical malpractice closed claim data does not contain a split between economic and non-economic damages. We reviewed the closed claim information that is publicly available from Texas, Florida and Michigan which does contain the split between economic and non-economic as well as a split in economic damages between medical and other economic damages. Based on this data approximately 55% of total claim amounts are due to non-economic damages. For economic damages, data from Florida suggests that approximately 95% are medical. This suggests that medical costs are approximately 43% of total indemnity payments.

If the non-medical damage cap were increased to \$1,000,000, PCF layer losses are estimated to increase by between 8.9% and 14.9%. Similarly, overall losses in all of the states except Michigan increase between 5.5% and 9.0%. The effect is more pronounced as the non-medical damage cap is increased to \$2 million. These results are largely in line with previous estimates.

The assumptions regarding increased claims frequency in the event of an increase in non-medical damage caps in New Mexico have the expected impacts of 1) increasing primary insurer claims costs, 2) amplifying any impacts on PCF claims costs and 3) driving up overall MPLI system costs in New Mexico.

The fundamental choice health care providers face when choosing to participate in a voluntary patients compensation fund is an economic one. In essence, "am I saving money by participating in the PCF or is something about the coverage worth the additional cost?" Even with a higher damage cap, the PCF would maintain two key coverage advantages over the rest of the insurance market: the availability of occurrence form coverage (as compared to a claims-made policy) and greater limits of protection. Currently, a significant number of physicians find these features attractive. However, increasing the cap on non-medical damages would result in an even larger gap between the coverage typically provided in the non-participating insurance market, e.g. \$1 million per occurrence and \$3 million aggregate limits on a claims-made form for physicians, and the greater coverage of the PCF. At some point, the increases in overall insurance costs, particularly in PCF assessments, suggested in our

analysis increase the insurance cost of PCF participation to the point that it would be less attractive to participating physicians. Given that a number of carriers and healthcare providers already choose not to participate, any additional departures from the PCF, especially from Medical Protective and/or The Doctors Company could materially impair the viability of the PCF and the benefit it provides to the New Mexico medical professional liability insurance market.

Another potential effect of an increase in damage caps as significant as those that have been proposed in New Mexico is an increase in the number of medical professional liability lawsuits. This should not be surprising as a material increase in the caps on non-economic damages would offer the potential for larger overall awards and therefore attorney contingency fees. With this greater potential for larger awards, attorneys would be more likely to make the initial investment in discovery and expert witnesses needed to pursue these claims, even if the likelihood of success were relatively small and highly uncertain.

This phenomenon has been seen in numerous other states immediately before and after material changes in damage caps. In Ohio, there was a significant increase in reported incidents immediately prior to the enactment of Senate Bill 281 and a significant reduction in reported claims occurred subsequent to the enactment of this legislation. This has been attributed to attorneys seeking to have as many incidents governed by the pre-S.B. 281 tort law (i.e. excluding damage caps) as possible. A similar surge in reported claims was seen in Wisconsin when the extremely successful damage cap in that state was ruled unconstitutional in 2005. Finally, Texas has seen double-digit reductions in claims since tort reform measures were enacted in 2003. Incidentally, these reforms have also led to significant decreases in medical professional liability insurance premiums for health care providers. Furthermore, access to care has been dramatically improved in Texas due to an increase in the number of new physicians entering the state. At some points in time, the state has had trouble keeping up with the timely review of licensing applications.

It is important to recognize that these changes in expected losses might not have an immediate, dollar for dollar impact on premiums. Often times, the initial estimates of the “anticipated impact” of legislation take a conservative and somewhat skeptical view of legislative changes until the actual impact can be seen more clearly in the insurer’s own experience. The uncertainty associated with legislative changes, their judicial interpretation, and the difficulty in recognizing changes in medical professional liability incentives all make estimation of impacts difficult and contribute to the conservative approach and the implementation lag.

For most medical professional liability insurance products, underwriting expenses such as commissions, other acquisition expenses, premium taxes and general underwriting expenses are

treated as variable, that is they vary with the level of expected losses and therefore with premiums. Because of this treatment, the expected percentage change in losses and loss adjustment expenses due to a legislative or judicial change should eventually result in a comparable percentage change in rate levels. What is less certain is the timing of these rates changes.

Beyond the initial conservatism and “trust but verify” attitude of insurers when evaluating the impact of legislative reforms, competitive forces play a significant role in the responsiveness of insurers’ rate actions following a legislative change. In insurance markets where a legislative reform appears to be material, but little competitive pressure is being exerted, an insurer may be much slower to reflect the impact of legislative changes than in a state with higher levels of competition. In the more competitive state, the insurer runs a greater risk of losing market share to more responsive insurers. This contributes to states that create an environment of higher levels of competition tend having less extreme cycles in coverage availability and rate affordability.

Glossary of Terms & Abbreviations

The definitions included in this glossary are intended to be practical definitions to assist non-technical readers in understanding the key technical contents of this report.

Accident Year – A method of organizing insurance loss and loss adjustment expense data according to the year in which the accident or event occurred.

Annual Statement – A detailed financial report of an insurance company, required to be filed with state insurance regulators in a specified format using insurance-specific accounting rules.

Calendar Year – A method of organizing insurance loss and loss adjustment expense data according to the year in which the financial transaction (e.g., a loss payment or reserve increase) occurred.

Case Reserves – A financial provision for the potential liability associated with known, unpaid claims.

Claims-Made Coverage – An insurance coverage form that provides reimbursement for claims reported during the coverage period.

Damage Cap – An amount imposed as a limit on claim damages. In New Mexico, this cap applies only to non-medical indemnity payments.

DCC – Defense and Cost Containment, loss adjustment expenses specifically attributable to the defense of a claim or cost containment procedures. Also called DCCE.

Earned Premium – The portion of an insurance policy's premium for which the coverage has been provided.

Experience Rating – A method of adjusting insured premium derived from manual rates for insured historical loss experience to the extent that it is predictive of future loss results.

Frequency – The number of claims per unit of exposure, such as physicians or beds.

Incurred but not Reported (IBNR) reserves – A provision for unpaid claims liabilities intended to provide a provision for both unknown/unreported claims events and additional development on known claims.

Incurred Loss – Paid losses plus Case Reserves.

Indemnity – The sum paid by the insurer to the insured by way of compensation for a particular loss suffered by the insured.

LAE – Loss Adjustment Expenses, insurance company expenses associated with settling claims. LAE includes both unallocated loss adjustment expenses (ULAE, which is similar to Adjusting and Other Expense, AOE) and allocated loss adjustment expenses (ALAE, which is similar to DCC).

Limit – The most the insurer is obligated to pay for loss in any one occurrence.

Loss Cost – The ratio of actual losses to a company's subject matter exposure for the same period.

Loss Ratio – The ratio of some measure of losses (typically paid or incurred) to some measure of premium.

Patient Compensation Fund (PCF) - a medical malpractice insurance mechanism, created by state law, designed to increase professional liability coverage availability and/or affordability primarily by providing coverage for a specific type of injury or an excess layer of coverage.

Primary Carrier – The insurance company issuing the insurance policy to the insured and typically providing the lowest or primary layer of coverage. This is compared to a reinsurer or excess carrier providing coverage to the primary insurer for higher loss limits.

Pure Premium – The provision in the rate per exposure unit to pay losses.

Rate – The price per exposure unit for insurance coverage.

Reinsurance – A mechanism by which an insurance company can transfer some of their insurance risk to another insurer.

Report Year – A method of organizing insurance loss and loss adjustment expense data according to the year in which the accident or event was reported to the insurer, regardless of when it occurred.

Risk Margin – A factor added to indicated ultimate losses, loss reserves or funding estimates to increase statistical confidence to a higher level.

Severity – The average cost or payment amount of a claim.

Surcharges – For the PCF, assessments paid by insureds to fund benefits payments. Akin to premiums, these surcharges are added to the premiums charge by primary insurers so insureds can make a single payment for both primary and PCF coverage.

Territory – The geographic area within which a carrier provides coverage.

Trend – The direction in and amount that rates, premium, or losses tend to move over time.

Written Premium – The entire amount of premium on a policy contract.

Legal Disclosures

Distribution and Use

This report is being provided to the New Mexico Division of Insurance solely for their internal use. It is understood that this report may also be distributed to representatives of the New Mexico Medical Society, New Mexico Bar Association, as well as other makers of public policy and various stakeholders in the healthcare industry in the State of New Mexico. Distribution to these parties is granted on the conditions that the entire report be distributed rather than any excerpts and that all recipients be made aware that Pinnacle is available to answer any questions regarding the report.

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Any reference to Pinnacle in relation to this report in any reports, accounts, or other published documents or any verbal reference issued by PCF is not authorized without prior written consent and then only if the complete report is provided.

Reliances and Limitations

Judgments as to conclusions, recommendations, methods and data contained in this report should be made only after studying the report in its entirety. It should be understood that the exhibits, graphs and figures are integral elements of the report. These sections have been prepared so that our actuarial assumptions and judgments are documented. Pinnacle is available to answer any questions that may arise regarding this report. We assume that the user of this report will seek such explanation on any matter in question.

We have relied upon a great deal of publicly available and proprietary data, without audit or verification. Pinnacle reviewed as many elements of this data and information as practical for reasonableness and consistency with our knowledge of the insurance industry. It is possible that the historical data used to make our estimates may not be predictive of future experience in New Mexico.

We have not anticipated any extraordinary changes to the legal, social or economic environment which might affect the size or frequency of medical malpractice claims beyond those contemplated in the proposed legislative changes.

Our analysis is based on closed and open claims information provided by OSI in prior analyses as well as aggregate calendar year loss payments for 2014 and 2015. In the data provided for prior analyses, there were a small number of claims that did not contain accurate loss dates. In addition, there were a small number of claims handled in 2000-2001 by a secondary third party administrator (TPA) that were not contained in the data we were provided. The inability to accurately determine the accident year of calendar years 2014 and 2015 loss payments is a significant shortcoming in the data provided, and introduces additional uncertainty into the analysis. However, we believe the methods and assumptions incorporated into our analysis effectively recognize these shortcomings in the data. If it is subsequently discovered that the underlying data or information provided to us is materially in error, the calculations and conclusions herein will not be correct and will need to be revised. We expect OSI to notify us promptly if any such data issues are subsequently discovered.

The payment pattern used in our analysis for deriving PCF's present value factor and estimated unpaid losses is based on the somewhat limited data available from PCF claims payments for most claims since 2000 through 2013. We also reviewed a variety of external databases for other PCFs and MPLI reinsurance to validate the reasonableness of the payment pattern for the PCF excess layer. The volatility of the payment patterns for this layer of coverage on a relatively small portfolio of claims introduces additional risk into the estimation process.

Many actuarial estimates, including loss and loss adjustment expense reserves, future premium level estimates and potential legislative impacts, are subject to potential errors of estimation due to the fact that the ultimate liability for claims is subject to the outcome of events yet to occur, e.g., jury decisions, judicial interpretations of statutory changes and attitudes of claimants with respect to settlements. Pinnacle has employed techniques and assumptions that we believe are appropriate, and we believe the conclusions presented herein are reasonable, given the information currently available. It should be recognized that future loss emergence will likely deviate, perhaps substantially, from our estimates.

A source of variation is introduced in estimating outstanding liabilities on a discounted basis. That is, besides the risk of underestimating or overestimating the overall amount of nominal loss liabilities, there is the additional risk that the future yield on the underlying assets will differ from our assumed discount rate. Actual loss payments could occur materially more rapidly or more slowly than projected, due to random variations and the timing of large claim payments. The yield on assets

supporting the liabilities may be affected by capital gains or losses, or significant changes in economic conditions.

The mathematical techniques underlying our estimate of the risk margin are intended to provide an approximation of the potential variation in loss costs. It should be noted that this estimate reflects only the potential “process” variation (i.e., the random variation inherent in the claim process) based on the assumed loss distributions and the selected parameters. Additional “parameter” variation exists due to the risk that the selected theoretical loss distributions and their parameters will not be predictive of the actual loss distributions. Of particular concern is the potential for unexpected increases in the inflation of the losses.

A simulation model of this type cannot possibly capture all or completely describe any of the dynamic forces that impact medical professional liability losses. Such a model, however, can provide considerable insight into the range of potential fluctuation of losses.

Pinnacle is not qualified to provide formal legal interpretations of state legislation. The elements of this report that require legal interpretation should be recognized as reasonable interpretations of the available statutes, regulations, and administrative rules. State governments and courts are also constantly in the process of changing and reinterpreting these statutes.

Exhibits and Appendices

Estimated Unpaid Claims Liabilities

- Exhibit 1. Reserve Summary
- Exhibit 2. Selected Ultimate Losses
- Exhibit 3. B-F and Expected Loss Methods
- Exhibit 4. Paid Loss Development Method
- Exhibit 5. Frequency and Severity Method
- Exhibit 6. Paid Claim Projection Based on B-F Method
- Exhibit 7. Paid Claim Projection Based on Frequency Method
- Exhibit 8. Paid Claim Development Method
- Exhibit 9. Historical Loss Experience
- Exhibit 10. Historical Claim Experience

Expected Surcharge Levels

- Exhibit 11. Development of Surcharge Estimates
- Exhibit 12. Indicated Rate Change
- Exhibit 13. Expense Analysis

Impact of Potential Coverage Changes

- Exhibit 14. Impact of Damage Cap and Primary Limit Changes on PCF

Analysis of Current Class Factors

- Exhibit 15. Impact of Damage Cap and Primary Limit Changes on PCF

Appendices

- Appendix 1. Development of Estimated Incremental Diagonals
- Appendix 2. Development of Calendar Year Loss Allocation Percentages

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2015
Reserve Summary

Exhibit 1
Page 1

Accident Year	Selected Ultimate Losses	Paid Losses	Selected Ultimate Reserves	Discount Factor	Estimated Discounted Reserves	Indicated Risk Margin @ 90%	Estimated Discounted Reserves @ 90%
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1998			2,735	0.983	2,688	1.224	3,290
1999			7,070	0.970	6,857	1.224	8,393
2000	6,573,059	6,560,000	13,059	0.959	12,526	1.224	15,332
2001	9,289,582	9,261,652	27,930	0.951	26,552	1.224	32,500
2002	9,550,000	9,509,500	40,500	0.944	38,232	1.224	46,796
2003	6,664,558	6,596,189	68,369	0.939	64,188	1.224	78,566
2004	5,732,668	5,634,529	98,138	0.935	91,751	1.224	112,303
2005	9,500,000	9,215,150	284,850	0.932	265,462	1.224	324,925
2006	8,500,000	8,060,950	439,050	0.930	408,167	1.224	499,596
2007	18,250,000	17,641,872	608,128	0.928	564,265	1.224	690,661
2008	17,250,000	16,173,454	1,076,546	0.928	998,873	1.224	1,222,621
2009	15,500,000	13,497,133	2,002,867	0.939	1,879,851	1.224	2,300,938
2010	16,500,000	13,926,436	2,573,564	0.948	2,438,972	1.224	2,985,302
2011	16,830,782	11,794,679	5,036,103	0.945	4,761,318	1.224	5,827,853
2012	16,500,000	8,217,168	8,282,832	0.934	7,737,091	1.224	9,470,200
2013	16,374,925	3,122,188	13,252,737	0.920	12,188,143	1.224	14,918,287
2014	20,000,000	972,480	19,027,520	0.897	17,069,133	1.224	20,892,619
2015	20,800,000	302,565	20,497,435	0.870	17,829,871	1.224	21,823,762
Total	213,815,574	140,485,944	73,339,435		66,383,943		81,253,946
(9)	Estimated 12/31/2015 Fund Balance		\$36,573,346		\$36,573,346		36,573,346
(10)	Difference		-\$36,766,089		-\$29,810,597		-\$44,680,600

Column/Row	Note
(2)	Exhibit 2, Col (8)
(3)	Exhibit 2, Col (3)
(4)	Col (2) - Col (3); Exhibit 3, Page 1, Col (7) for years 1999 and prior
(5)	Exhibit 1, Page 2
(6)	Col (4) x Col (5)
(7)	Based on simulation analysis of future closed claims
(8)	Col (6) x Col (7)
(9)	Provided by client
(10)	Row (9) - Column totals

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2015
Compare

Exhibit 1
Page 3

Accident Year	as of 12/31/15		as of 12/31/13		Difference			
	NMPCF Ultimate Excess Losses	NMPCF Discounted Reserves	NMPCF Ultimate Excess Losses	NMPCF Discounted Reserves	NMPCF Ultimate Excess Losses		NMPCF Discounted Reserves	
1976		0		0			0	
1977		0		0			0	
1978		0		0			0	
1979		0		0			0	
1980		0		0			0	
1981		0		18			-18	-100%
1982		0		43			-43	-100%
1983		0		78			-78	-100%
1984		0		128			-128	-100%
1985		0		198			-198	-100%
1986		0		296			-296	-100%
1987		0		434			-434	-100%
1988		0		627			-627	-100%
1989		0		897			-897	-100%
1990		0		1,276			-1,276	-100%
1991		0		1,807			-1,807	-100%
1992		0		2,551			-2,551	-100%
1993		0		3,592			-3,592	-100%
1994		0		5,050			-5,050	-100%
1995		0		7,091			-7,091	-100%
1996		0		9,948			-9,948	-100%
1997		0		14,220			-14,220	-100%
1998		2,688		18,751			-16,063	-86%
1999		6,857		28,066			-21,209	-76%
2000	6,573,059	12,526	7,200,000	583,240	-626,941	-9%	-570,713	-98%
2001	9,289,582	26,552	9,298,537	33,740	-8,955	0%	-7,187	-21%
2002	9,550,000	38,232	9,567,008	52,757	-17,008	0%	-14,525	-28%
2003	6,664,558	64,188	6,657,142	56,037	7,416	0%	8,151	15%
2004	5,732,668	91,751	5,560,312	71,641	172,355	3%	20,110	28%
2005	9,500,000	265,462	10,250,000	1,344,280	-750,000	-7%	-1,078,818	-80%
2006	8,500,000	408,167	8,500,000	1,035,470	0	0%	-627,304	-61%
2007	18,250,000	564,265	18,000,000	1,657,014	250,000	1%	-1,092,748	-66%
2008	17,250,000	998,873	16,000,000	3,075,384	1,250,000	8%	-2,076,511	-68%
2009	15,500,000	1,879,851	13,250,000	5,900,051	2,250,000	17%	-4,020,199	-68%
2010	16,500,000	2,438,972	15,000,000	9,222,210	1,500,000	10%	-6,783,237	-74%
2011	16,830,782	4,761,318	15,000,000	11,573,475	1,830,782	12%	-6,812,157	-59%
2012	16,500,000	7,737,091	15,000,000	12,513,466	1,500,000	10%	-4,776,374	-38%
2013	<u>16,374,925</u>	<u>12,188,143</u>	<u>15,500,000</u>	<u>13,532,239</u>	874,925	6%	-1,344,096	-10%
Subtotal	173,015,574	31,484,939	164,783,000	60,746,074	8,232,574	5%	-29,261,136	-48%
2014-15	<u>40,800,000</u>	<u>34,899,004</u>						
Total	213,815,574	66,383,943						

New Mexico Patients' Compensation Fund
Reserves as of 12/31/2015
Selected Ultimate Losses

Exhibit 2

Accident Year	Participant Surcharges	Paid Losses	Indicated Ultimate Losses				Selected Ultimate Losses	Loss Ratio
			B-F Method	Expected Loss Ratio Method	Paid Development Method	Frequency/Severity Method		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
2000	8,238,309	6,560,000	6,576,188	10,709,802	6,569,931	5,289,955	6,573,059	79.8%
2001	9,181,946	9,261,652	9,293,070	11,936,530	9,286,094	9,354,869	9,289,582	101.2%
2002	9,421,675	9,509,500	9,562,823	12,248,177	9,551,081	8,287,829	9,550,000	101.4%
2003	9,924,688	6,596,189	6,686,454	12,902,094	6,642,662	8,405,056	6,664,558	67.2%
2004	9,283,270	5,634,529	5,767,860	12,068,251	5,697,475	7,846,039	5,732,668	61.8%
2005	9,151,210	9,215,150	9,420,360	11,896,573	9,376,896	11,370,901	9,500,000	103.8%
2006	9,067,465	8,060,950	8,375,850	11,787,705	8,282,203	8,208,369	8,500,000	93.7%
2007	8,810,595	17,641,872	18,112,597	11,453,774	18,397,989	13,319,945	18,250,000	207.1%
2008	9,696,249	16,173,454	16,986,304	12,605,124	17,288,301	13,985,942	17,250,000	177.9%
2009	12,243,554	13,497,133	15,497,654	15,916,620	15,437,425	13,821,402	15,500,000	126.6%
2010	12,423,496	13,926,436	18,309,795	16,150,545	19,114,131	18,140,590	16,500,000	132.8%
2011	11,974,097	11,794,679	19,374,014	15,566,326	22,987,358	18,095,238	16,830,782	140.6%
2012	11,598,412	8,217,168	18,662,528	15,077,936	26,744,935	18,000,000	16,500,000	142.3%
2013	12,119,526	3,122,188	16,994,466	15,755,384	26,122,411	19,950,000	16,374,925	135.1%
2014	15,208,274	972,480	20,104,579	19,770,756	30,104,854	26,286,120	20,000,000	131.5%
2015	15,959,367	302,565	20,933,186	20,747,177	53,857,051	29,519,438	20,800,000	130.3%
Total	174,302,134	140,485,944	220,657,728	226,592,774	285,460,797	229,881,691	213,815,574	122.7%

Column	Note
(2)	Exhibit 3, Page 2, Col (2)
(3)	Exhibit 9
(4)	Exhibit 3, Page 1, Col (6)
(5)	Exhibit 3, Page 2, Col (6)
(6)	Exhibit 4, Col (5)
(7)	Exhibit 5, Page 1, Col (4)
(8)	Judgmental selection based on Cols (4) - (7)
(9)	Col (8) / Col (2)