The role of the PCF in claims handling.

- If a medical malpractice claim involves an admitted PCF healthcare provider, the insurance carrier or healthcare provider notifies the PCF.
- The PCF adjuster monitors the claim and requests billing and medical documentation from the defense counsel. The PCF requests additional information obtained during the investigation, but it is up to the healthcare providers as to what is provided.
- If requested by the parties, the PCF will participate in the mediation. The PCF attends the mediation with the intention of settlement. Based on the circumstances of the case, the PCF will negotiate to pay past medicals pursuant to documentation, up to the statutory limits on compensatory damage, and future medicals as incurred.
- When the case is settled or a judgement is entered, the PCF is notified. The PCF informs the OSI of the terms of the settlement or judgement and requests payment from the state.

1) What changes and trends are we seeing since 2021 – what's going on with medmal insurance for doctors and patient compensation fund payouts. How many cases per year since 2021? How many of those paid caps? How many went to trial?

- The TPA tracks aggregated claim counts and dollars. An overwhelming majority of the claims involve a lawsuit.

	HOSPITAL CLAIMS			PHYSICIAN CLAIMS		
Year	Claims by Settlement Year	Total Settlement Year Paid	Average Claim by Settlement Year	Claims by Settlement Year	Total by Settlement Year	Average Claim by Settlement Year
2017	8	3,095,368	386,921	22	10,730,000	487,727
2018	8	5,895,408	736,926	22	10,005,000	454,773
2019	15	9,915,089	661,006	21	13,278,676	632,318
2020	16	10,499,179	656,199	20	13,743,523	687,176
2021	35	24,937,775	712,508	23	13,771,471	598,760
2022	39	19,406,192	497,595	20	12,749,031	637,452
2023	63	29,369,554	466,183	22	14,701,836	668,265
2024	66	33,444,828	506,740	35	33,646,779	961,337
2025	69	41,200,174	597,104	22	23,514,266	1,068,830

2) How many cases actually include an award of punitive damages and of those how often is that punitive award actually paid.

The PCF is not subject to punitive damage claims and therefore it is not tracked by the TPA.

3) The rule change we discussed about claims made v occurrence based policies – why aren't independent docs allowed to access cheaper claims-made policies but hospitals and out-patient facilities are?

By statute, the PCF operates as an occurrence-based policy. The underlying $250,000 limit purchased from primary carriers is required to be an occurrence-based policy. The Medical Malpractice Act was amended to define occurrence and therefore the PCF operates as an occurrence-based program.

Claims made policies are cheaper in the early years of a career and require a tail coverage policy at retirement. Claims made is not cheaper than occurrence over the life of a career. Here is an example for an Anesthesiologist with TDC.

Premium Calculation

Maturity Year	Occurrence	Claims Made
Year 1	$ 31,035	$ 11,946
Year 2	$ 31,035	$ 20,478
Year 3	$ 31,035	$ 27,304
Year 4	$ 31,035	$ 31,400
Year 5	$ 31,035	$ 34,130
Year 6	$ 31,035	$ 34,130
Year 7	$ 31,035	$ 34,130
Year 8	$ 31,035	$ 34,130
Year 9	$ 31,035	$ 34,130
Year 10	$ 31,035	$ 34,130
Tail	$ -	$ 64,847
Lifetime Total	$ 310,346	$ 360,754

4) Why are defense costs are so high in New Mexico (and concerns about the state and Integrion interfering with or preventing settlements and an impression that that is drawing cases out and increasing defense costs).

The PCF plays no part in driving up defense costs. The TPA is only called upon when there is mediation or a final settlement or judgment. OSI only becomes involved in the litigation when there is an issue that impacts the sustainability of the fund.

5) Problems with Integrion generally.

The OSI was aware of issues surrounding legal representation by the TPA and has taken action to address concerns.

6) Why OSI is allowing folks (like Presbyterian) to use fronting policies to qualify as QHP's, and average premiums charged for those fronting policies.

It is our understanding that Presbyterian has a valid certificate of insurance from a surplus lines carrier. The OSI does not regulate surplus lines. The statute provides that the healthcare provider may provide proof of financial responsibility using any form of malpractice insurance.

7) Average premiums being charged for different entities and providers and what goes into the calculation of the premiums.

There is a rating algorithm for both providers and hospitals and the premium charged varies based on the following rating variables.

- The rate for providers is calculated based on specialty, hospital employee status, and loss history submitted by underlying carrier
- The rate for hospitals is calculated based on the number of occupied beds and the number of procedures performed.

8) Whether individualized risk assessments are being done yet.

A risk assessment is required when the hospital first seeks admission to the Fund. The Superintendent may consider the risk assessment done by the medical malpractice insurance carrier. Risk assessments are not done after the hospital has joined the PCF.

9) What data points should the legislature be requiring insurers to give you so that you are able to give us a full understanding of how the PCF is functioning and what issues are driving premium increases (for example, I know you don't track punis, but if the claim is that punis awards are increasing premiums then don't we need to know what insurers are actually paying for punis to know if that's true?).

We do not believe the medical malpractice carriers have any information on how the PCF is functioning. The actuarial report provides insight into the financial condition of the PCF. The Deloitte report also provides information on the TPA. As noted in the presentation, OSI recommendation would be to restructure the PCF along the lines of a traditional insurance company.

10) Whether OSI collects surcharges directly from providers, or it relies on insurers to collect the surcharge. If it's the latter (which I've been told it is) what oversight if any does the PCF exercise over insurers to ensure they are not collecting a larger surcharge than what was assessed by the PCF? How do providers know if the surcharge amount their insurer collects is actually the surcharge amount OSI set?

Insurers collect the surcharge. The surcharge is calculated by the portal when the batch is submitted to the TPA.

11) Surcharges are calculated using the worksheet that the insurer fills in with information like the number of beds, etc. What oversight if any does the PCF exercise over insurers to ensure that the information they put into that worksheet is accurate? (in one of our cases, the number of beds

Gerald Champion represented having to OSI on that worksheet was significantly less than the number of beds they told the department of health they had, which means they were charged a lower surcharge than they should have been).

All of this data is submitted by the carrier. We rely on the carriers to validate the information needed to calculate their premiums.

12) Has the PCF determined how much it will cost to pay future medicals for the 56 patients who depend on them?

No. The impact of these claims on the overall liability is currently immaterial. The OSI and Pinnacle are monitoring these claims and exploring methods to address these claims as they continue to grow.

13) What is the OSI doing to ensure the money will be there

As we get more data, we will adjust operations to address these claims.

14) What is the OSI doing to help cases resolve faster, given that we have longer timelines on cases than other states and higher defense costs?

Neither the OSI nor the PCF are parties to the litigation so therefore do not control the litigation or the timeline.