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NEW MEXICO OFFICE OF THE  
SUPERINTENDENT OF INSURANCE  
Friday, September 16, 2022  
1:02 p.m.

IN RE: DETERMINING NEW MEXICO PATIENT'S COMPENSATION  
FUND SURCHARGE RATES

A P P E A R A N C E S

- WILLIAM RITCHIE, M.D., Chair
- RAY VARGAS, II
- MS. KATHY LOVE
- MR. TROY CLARK
- MR. MICHAEL DEKLEVA
- KAREN CARSON, M.D.
- MS. ELLEN STEVENS
- MR. EZRA SPITZER
- MR. ALBEN MARTINEZ
- MR. VINCE WARD

TRANSCRIBED BY:

PAUL BACA PROFESSIONAL COURT REPORTERS  
500 4th Street, Northwest, Suite 105  
Albuquerque, New Mexico 87102

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TRANSCRIPT OF PROCEEDINGS

DR. RITCHIE: (Off audio) the roll call.

MS. LUERA: Of course.

Mr. Vargas.

MR. VARGAS: Yes. Good afternoon.

MS. LUERA: Ms. Love.

MS. LOVE: I am present.

MS. LUERA: Mr. Clark.

MR. CLARK: Present.

MS. LUERA: Mr. Dekleva.

MR. DEKLEVA: I'm here.

MS. LUERA: Dr. Carson.

DR. CARSON: Here.

MS. LUERA: Dr. Ritchie.

DR. RITCHIE: Present.

MS. LUERA: Ms. Stevens.

MS. STEVENS: Present.

MS. LUERA: Mr. Spitzer.

MR. SPITZER: Present. Thank you.

MS. LUERA: And Mr. Martinez.

MR. MARTINEZ: I am present.

MS. LUERA: And also Mr. Ward. I see him on there. He's on mute.

DR. RITCHIE: Must be muted.

MS. LUERA: Looks like everybody's here.

1 MR. WARD: I'm sorry. I'm talking. I'm  
2 talking and nobody can hear me. I'm here. Thank  
3 you.

4 MS. LUERA: Okay. Thank you.

5 DR. RITCHIE: Okay, great. So I think as  
6 Ms. Love was just discussing, I think that's right,  
7 there's no agenda because it's a hearing, not a  
8 meeting, correct?

9 And so then we will open this hearing  
10 and the -- the committee is the hearing officer, and  
11 so each member of the committee will have an  
12 opportunity to ask questions.

13 We have been asked to -- perhaps that  
14 the -- the presentation will be broken up into  
15 sections, and asked to wait for questions until the  
16 end of a section so we can stay a little better  
17 organized. And I think that's probably true. But we  
18 can definitely get off on tangents easily when we  
19 start getting into the minutia of all this data.

20 So then -- then the presentation  
21 (inaudible) to start, and that is from -- who is --  
22 are you going to do that, Mr. Berenberg?

23 MR. BERENBERG: Yes, I will be examining  
24 Mr. Walling. And I don't see him in the participant  
25 list yet. His plane landed about five to ten minutes

1 ago in Atlanta, and he said he would get on as  
2 quickly as he could.

3 I have a -- I can do a few introductory  
4 remarks, but then we'll need to wait for him.

5 DR. RITCHIE: It sounds like that could  
6 be -- could be quite a wait.

7 MR. BERENBERG: He said that he would be on  
8 within a few minutes of landing. I assume that he is  
9 going to one of the lounges.

10 DR. RITCHIE: Right. Well, then definitely  
11 we appreciate some remarks from you on the data  
12 that's been presented from the actuarial analysis,  
13 and then -- but the OSI is (inaudible).

14 MR. BERENBERG: Okay. I don't know how much  
15 I can talk about the data, but I'll start with the  
16 introduction.

17 For those of you who don't know me, my  
18 name is Barry Berenberg. I am counsel for  
19 Superintendent Toal in his capacity as custodian for  
20 the Patient's Compensation Fund. I'm in that  
21 capacity as counsel under Integrion's contract with  
22 the PCF as third-party administrator. That contract  
23 requires Integrion to provide legal services to the  
24 PCF and to the custodian. So that's how I am  
25 involved.

1                   And we heard from Mr. Walling a couple  
2 of weeks ago at the earlier hearing. He went through  
3 his report at that time. The board had a number of  
4 questions for him, and he's taken those into  
5 consideration. There was a revised report. He  
6 included, I believe, some answers to some of those  
7 questions. And that was circulated -- I think it was  
8 circulated to the board. And Mr. Walling will be  
9 going through the report in detail.

10                   The way those will work is pretty much  
11 the same as last year. I'll be examining Mr. Walling  
12 in order to establish an evidentiary foundation for  
13 the recommended surcharge rates heading for this  
14 year.

15                   And I see Mr. Walling is on the line  
16 now.

17                   MR. WALLING: He is. Good afternoon.

18                   MR. BERENBERG: So I have just done an  
19 introduction, and I'm going to -- I believe I've  
20 joined -- there's a participant Barry exhibits, and  
21 I'm going to share that screen now so I can start  
22 showing some exhibits.

23                   And the -- I need to have access to  
24 screen-sharing. It's been disabled. Let me know  
25 when that is ready.

1           So what I was going to show initially is  
2 just the top-level outline of the presentation to  
3 give the board an idea of where we'll be going.

4           So we will start by going through  
5 Mr. Walling's CV just very briefly, to establish him  
6 as an expert. We'll do an introduction to the  
7 report, entering it as an exhibit. And then we'll go  
8 through the major topics: Indicate the loss reserves  
9 for physicians; followed by hospitals and employed  
10 physicians; then the indicated deficit and  
11 allocation; the indicated surcharges. First for  
12 physicians, and then specialty class change and  
13 overall physician surcharges indications; finally,  
14 indicated surcharges for the hospitals.

15           And then we'll finish with a round of  
16 questions. There are a few portions of the  
17 examination that I have for Mr. Walling that didn't  
18 really fit under those main topics. And, of course,  
19 if the board has any questions.

20           And as Dr. Ritchie said, it would help  
21 the flow if you could hold questions to the  
22 transitions between the major topics. I will let you  
23 know when we're at those transitions. But of course  
24 if you have a question that you feel should be  
25 answered during the middle of the presentation,

1 please go ahead and ask that. We're not trying to  
2 limit the questions. We're just trying to make sure  
3 that things continue flowing.

4 MS. LUERA: And screen-sharing is available.

5 MR. BERENBERG: Thank you.

6 And -- all right. The screen-sharing  
7 that I tested multiple times before the hearing is,  
8 of course, not working. So give me just a moment to  
9 switch to my backup plan.

10 MS. LOVE: That's how it always goes. We  
11 understand.

12 MR. BERENBERG: Yes.

13 MS. LOVE: We understand.

14 DR. RITCHIE: Absolutely.

15 MR. BERENBERG: I had presentation software  
16 that would allow me to do callouts and things like  
17 that. That is not working, so I'm just going to  
18 share a PDF Viewer.

19 Okay. You should now see the title page  
20 of the report. Does everybody see that?

21 MS. LUERA: Yes.

22 MR. BERENBERG: Okay. All right. So I  
23 actually don't have the top-level outline on this PDF  
24 Viewer, so I -- I did the -- I reviewed that. And  
25 actually, I'm sorry, I need to find Mr. Walling's CV.

1 If you'll give me just a moment, I...

2 DR. RITCHIE: We appreciate that. And  
3 everyone has -- I have these problems all the time.  
4 So we can understand that.

5 So I appreciate everyone being here on  
6 Friday afternoon. We started earlier than I kind of  
7 wanted, so I had to rush, rush. So I apologize for  
8 being here late. But I didn't want to be here late  
9 on a Friday afternoon. So I appreciate everyone  
10 taking time on their Friday afternoon.

11 Okay. Looks like his CV is now on the  
12 screen. So --

13 MR. WALLING: (Inaudible).

14 ROBERT WALLING,  
15 was questioned, and responded as follows,  
16 BY MR. BERENBERG:

17 Q. Mr. Walling, would you please spell your  
18 first and last name for the record.

19 A. Sure. My name is Robert Walling,  
20 R-o-b-e-r-t, W-a-l-l-i-n-g.

21 Q. All right. I put a document up on the  
22 screen. Do you recognize it?

23 A. Yes. That's my curriculum vitae.

24 Q. Does this accurately show your education and  
25 experience?



1 A. It does.

2 Q. What did you do for a living?

3 A. I am a consulting actuary.

4 Q. And what does a consulting actuary do?

5 A. Consulting actuaries, at least within our  
6 firm, provide property casualty actuarial consulting  
7 services to traditional insurance companies,  
8 reinsurers, government insurance programs, public  
9 entity self-insurance programs insurance departments,  
10 and a variety of other stakeholders.

11 Q. And would the New Mexico Patient's  
12 Compensation Fund fall under the list that you gave?

13 A. Absolutely.

14 Q. And your CV also mentions that you're a loss  
15 reserve specialist. What do you do in that roll?

16 A. So in Bermuda, a loss reserve specialist  
17 provides estimates of unpaid claims liabilities for  
18 Bermuda insurance companies. The U.S. equivalent of  
19 that would be an appointed actuary for an admitted  
20 insurance company or a captive insurance company.

21 Q. And sort of briefly, can you tell us what  
22 your educational background is relevant to what you'll  
23 be talking about today?

24 A. Sure. After completing a bachelor's in high  
25 school math education, I completed the syllabus of

1 examinations and -- to achieve the fellow of the  
2 Casualty Actuarial Society, or FCAS designation.

3 I also completed the additional  
4 requirements to be a member of the American --  
5 American Academy of Actuaries, the AAA.

6 And then later in my career, completed  
7 the requirements for the CERA, which is either  
8 Chartered Enterprise Risk Actuary or Chartered  
9 Enterprise Risk Analyst, depending on which domicile  
10 in the world you're practicing in.

11 Q. Is there anything else on your CV you'd like  
12 to point out to the board today?

13 A. Probably worth pointing out, that I did  
14 serve on the Casualty Actuarial Society Board of  
15 Directors, which governs the strategic direction for  
16 actuaries in the United States.

17 I am currently serving on the casualty  
18 practice council of the actuarial standards board,  
19 which sets actuarial standards for actuaries  
20 practicing in the U.S.

21 And you can see in the thought  
22 leadership, it's -- I apologize, it's exhaustive. But  
23 a number of my articles are related to medical  
24 professional liability generally, and patient  
25 compensation funds and birth injury funds

1 specifically.

2 Q. And what were you asked to do for the  
3 New Mexico Patient's Compensation Fund?

4 A. The scope of our assignment is similar to  
5 the work that I've done for the New Mexico PCF for  
6 most of the last 20 years. It revolves around  
7 estimating the current unpaid claims liabilities for  
8 the fund, and from -- based on that estimate, to  
9 estimate what the current fund balance is; to allocate  
10 that deficit between the hospital and W-2 employed  
11 physician part of the program and the independent  
12 physician and surgeon part of the program; to develop  
13 rate -- or surcharge level indications for how those  
14 surcharges should change based on historical  
15 experience; and to look at the indicated coverage  
16 level for nonmedical benefits in the coming year based  
17 on the cost-of-living adjustment that is part of the  
18 current law; and to identify any physician specialty  
19 classes that indicate a change based on the available  
20 information. So those are the elements within the  
21 scope of our study.

22 Q. And I believe you might have answered this  
23 already, but what areas of your background qualify you  
24 to conduct this analysis for the PCF?

25 A. Well, first of all, I'm currently a -- an

1 actuary that meets the continuing education  
2 requirements in the United States to perform those  
3 services. But beyond that, I've worked with  
4 New Mexico PCF for 20 years. I've worked with the  
5 Wisconsin PCF for almost that long, the New York  
6 Medical Indemnity Fund since before its formation, and  
7 a the Virginia Birth-Related Neurological Injury  
8 Compensation Program for about 20 years, as well.

9 So beyond meeting the general  
10 qualifications to do this type of reserving and  
11 rate-making work, I've got very specific not just  
12 experience, but expertise in working with similar  
13 programs.

14 Q. You mentioned that you have worked with the  
15 PCF for 20 years?

16 A. Mm-hmm.

17 Q. What -- what is that experience you have  
18 with the PCF?

19 A. Very similar scope. I think the first year  
20 I did an analysis for the PCF was 2003. So Alan Seely  
21 and I have worked together on that program, may he  
22 rest in peace, until his death a few years ago.

23 So I've been steadily involved doing the  
24 rate-making and reserving and studies for the fund for  
25 most of the last 20 years.

1 Q. Roughly, what proportion of your work is on  
2 the New Mexico PCF and similar programs in other  
3 states?

4 A. Probably 5 to 10 percent. Candidly, there  
5 aren't that many medical professional liability  
6 government insurance programs. If you expand it to  
7 other medical professional liability programs for  
8 physicians and hospitals and physician extenders and  
9 senior care facilities, it's probably more like 15 to  
10 20 percent of my overall practice.

11 MR. BERENBERG: And at this time, I'd like  
12 to move Mr. Walling's CV into evidence as Exhibit A.

13 MS. LOVE: No objection. I think it's clear  
14 that Mr. Walling is an expert actuary. This is Kathy  
15 Love.

16 MR. BERENBERG: Thank you.

17 BY MR. BERENBERG:

18 Q. I'm going to now skip over to the report.  
19 And, Mr. Walling, do you recognize this?

20 A. Yes. That's the -- I believe it's the final  
21 addition of our report for the New Mexico PCF.

22 Q. And I'll represent that this is the copy  
23 that I received by e-mail that was labeled as the  
24 final version.

25 A. Yep.

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

3 A. I'm the primary author. Fundamentally, even  
4 if I've got support staff working on elements of the  
5 analysis, ultimately, it's my work product and it's  
6 got my name on it.

7 Q. I'm going to skip to Page 4 of this report.  
8 Sorry, this is where not having my other -- I'm trying  
9 to get to Page 4 of the report rather PDF, Page 7 of  
10 the PDF.

11 And there's a bulleted list down here.  
12 When I asked you earlier what you did for the PCF this  
13 year, is this essentially what you were -- the list  
14 that you were --

15 A. Yes. Yes.

16 Q. And the main purpose of this report, is it  
17 correct that it's to determine the surcharges for the  
18 next calendar year?

19 A. I would say there's really two main  
20 purposes. One is to estimate the remaining unpaid  
21 claims obligations for the claims that have already  
22 occurred and are covered, ultimately going to be  
23 covered by the PCF. And the other, as you've said, is  
24 exactly that. Based on that information, develop an  
25 estimate of what we think the indicated surcharges

1 level ought to be for the hospitals and for the  
2 physicians and surgeons.

3 Q. Did you, yourself, perform the work  
4 concerning these items?

5 A. I did.

6 Q. And does your training and experience enable  
7 you to do each of those items?

8 A. It does.

9 MR. BERENBERG: So earlier I offered  
10 Mr. Walling's CV into evidence. At this time, I'd  
11 like to offer Mr. Walling as a qualified actuarial  
12 expert on the subjects of the report, and to offer  
13 expert testimony concerning those subjects.

14 MS. LOVE: This is Kathy Love. I don't have  
15 any objections.

16 MR. BERENBERG: So --

17 MS. LOVE: We accept him as an expert.

18 MR. BERENBERG: And then I'd also move,  
19 then, to enter the report into evidence as Exhibit B.

20 MR. CLARK: No objection. This is Troy.

21 BY MR. BERENBERG:

22 Q. So, Mr. Walling, the first bullet on this  
23 list says that the estimated ultimate liabilities for  
24 losses incurred by the PCF as of December 31, 2021.  
25 What does that mean?

1           A. So that'd be policy form that the PCF  
2 utilizes provides coverage on an occurrence basis.  
3 And the idea here is that the obligation for that  
4 claim triggers when the claim, itself, occurs, when  
5 the negative patient outcome occurs.

6           And so a claim that occurred in July of  
7 2021, because of that occurrence date, is -- is  
8 covered by the PCF as of December 31st of '21, but it  
9 may take six, seven, eight years for that claim to be  
10 resolved. It may take two or three years for that  
11 claim to be recorded. In some cases, we've seen those  
12 claims take 15 or 20 years to be resolved to a full  
13 and final settlement.

14           And so our charge, or challenge, is to  
15 take the historical claims data for the PCF and  
16 augment that with some industry benchmark data to try  
17 an estimate what the future claims payments are going  
18 to be for claims that have already occurred but have  
19 not been settled.

20           Q. And the first major topic that you gave me  
21 in the list of items, looking it over, are -- is  
22 indicated loss reserves.

23           A. Mm-hmm.

24           Q. Is this component related to indicated loss  
25 reserves?



1 A. This is that. So -- so --

2 Q. It is the same thing?

3 A. Yes. The ultimate claims liabilities is  
4 synonymous with the idea of unpaid claims liabilities.

5 Q. And you divide the loss reserves into two  
6 categories, first, physicians; second, hospitals and  
7 employee physicians. Why do you divide them like  
8 that?

9 A. It's easiest to organize both the surcharge  
10 data and the historical claims data into those two  
11 categories. So from the perspective of trying to  
12 estimate the performance of the two programs, the  
13 hospitals and their employed physicians and surgeons  
14 kind of go into one category, and the independent  
15 physicians go into the second category for our  
16 analysis.

17 MR. BERENBERG: So I'm now going to  
18 transition into the first major topic you had in your  
19 list, which is indicated loss reserves for  
20 physicians. So we do questions at the transition  
21 point.

22 So before we get into that, does anybody  
23 have questions for Mr. Walling?

24 MS. LOVE: Yeah, this is Kathy Love.

25 May I just ask, with regard to the loss

1 reserves and the apportioning of the hospitals and  
2 employee physicians and what we've been calling one  
3 bucket, and independent physicians into a different  
4 bucket, are you saying that that is being done  
5 prospectively based on past analyses of employed  
6 physician payouts as well as hospital payouts?

7 MR. WALLING: The reserve analysis is all  
8 related to claims that have already occurred. So it  
9 really isn't prospective, per se.

10 We have made the overarching assumption  
11 that all of these claims that have already occurred  
12 are going to manifest, they're going to be recorded,  
13 they're going to be settled, they're going to be paid  
14 in roughly the same manner, regardless of whether  
15 they're independent physicians or hospitals and  
16 related employees.

17 So because the PCF historical data has  
18 to few claims in it, the breaking down of those loss  
19 development triangles into separate categories would  
20 create more volatility and less predictability. It  
21 would, candidly, create more noise and less signal.  
22 So we're using the same composite data for the  
23 historical PCF performance, regardless of which of  
24 the two segments we're looking at for the reserve  
25 study.

1 MS. LOVE: Thank you.

2 DR. RITCHIE: Mr. Walling, before we get  
3 more down into the weeds, I had a question based a  
4 lot on what we heard about your -- your background  
5 and everything from your CV.

6 So you've been involved for the last 20  
7 years in the rate-making, et cetera, for the  
8 New Mexico PCF, correct?

9 MR. WALLING: That's true.

10 DR. RITCHIE: You know, obviously, part of  
11 our -- part of why this committee exists is that  
12 there's a very a large deficit that's built up over  
13 that time, and then questions on how that's been  
14 affected by the addition of hospitals.

15 And so you -- you have the background  
16 (inaudible) and then -- then the superintendent of  
17 insurance, who we've had several in that time period.

18 MR. WALLING: Mm-hmm.

19 DR. RITCHIE: What do you attribute this --  
20 this -- you know, this really escalating deficit and  
21 how the actuarial studies perhaps, you know, have  
22 been involved in that and contributed to that or not?  
23 You know, should we be doing something different?  
24 You know, what has been kind of the actuarial input  
25 into this -- this deficit that is so overwhelmingly

1 at this point?

2 MR. WALLING: Great question. I would  
3 broadly attribute the disconnect between the  
4 surcharges and the estimated claims really  
5 fundamentally to maybe three things.

6 The first is the batch plans. We had a  
7 couple of systemic patterns of behavior that created  
8 a large volume of claims from a single practitioner  
9 doing the same thing over and over and over again.  
10 Both of those batch claims had a very, very large  
11 value, and both of them had the effect of depleting  
12 the fund balance significantly.

13 The second is, for the last 20 years, if  
14 you go back and look at the surcharge history, it has  
15 largely been the behavior of the PCF to take  
16 surcharge increases that have been less than the  
17 actuaries have indicated in the spirit of trying to  
18 keep stability in the surcharge levels. But the vast  
19 majority of my analyses have indicated larger  
20 increases than were ultimately adopted.

21 And third, I would suggest to you that  
22 social inflation has a nontrivial role to play in  
23 this, I think a number of different aspects, whether  
24 that's litigation financing, whether that's societal  
25 attitudes. We see the inflationary effects on

1 medical professional liabilities claims essentially  
2 in the excess layers, like -- like the layer where  
3 the PCF plays, being susceptible to significant  
4 inflationary pressures. And whether you label that  
5 social inflation or economic inflation, from -- from  
6 an actuarial perspective, it doesn't really matter.

7           What matters is that we could see the  
8 claims severities increase, and we do see some  
9 underlying changes in the claims to the PCF that we  
10 would broadly categorize as inflation.

11           DR. RITCHIE: So as a follow-on to that,  
12 then, then, really, to have kept us from entering  
13 this huge deficit, besides the batch claims, would  
14 have required really increasing surcharges through  
15 the years, and our surcharges would now be higher  
16 than they have been and perhaps be up to where we're  
17 proposing them go to?

18           MR. WALLING: If what I'm hearing you ask  
19 is, would higher surcharges have been a good -- a  
20 possible solution to eliminating the deficit,  
21 absolutely, they would have been. I mean, that  
22 goes -- I mean, that's kind of algebra 101, that if  
23 you've got more surcharges, then, you know, if the  
24 claims aren't any different, then you would have a  
25 smaller deficit.

1           But obviously there are other ways to  
2     remedy that. We've seen legislative changes, as  
3     well, to the PCF over the years that have certainly  
4     had an effect. We saw the introduction of batch  
5     reinsurance to address the potential threat created  
6     by the batch plan. So certainly raising surcharges  
7     is one approach to reducing a deficit, but not the  
8     only -- not the only approach.

9           DR. RITCHIE: And I believe that's where I  
10    was going exactly. That just addressing surcharges,  
11    you know, and that side of it is not going to help  
12    it. There needs to be changes again in the  
13    malpractice act, with legislation, et cetera, to keep  
14    the cost of malpractice lower in the state in order  
15    to prevent these -- the surcharge getting larger  
16    again with the current climate. There's no other way  
17    around it. Otherwise, it will not change, correct?

18          MR. WALLING: I would say that legislative  
19    change and surcharge increases can both be solutions  
20    to address the current problem.

21          DR. RITCHIE: Right. But the surcharge  
22    claims -- the surcharge increase is apt to be borne  
23    by the practices in the state. And the question is,  
24    are they already getting so high that the physicians  
25    will not be able to bear those surcharges and not be

1 able to pay their overhead and keep their businesses  
2 open? That's rhetorical.

3 MS. LOVE: Yes, it is. Yes.

4 (Inaudible crosstalk.)

5 MS. LOVE: This is Kathy Love. I'm sorry,  
6 is somebody not on mute?

7 MR. WALLING: I'm afraid it's background  
8 noise. I'm sitting in the Sky Club. Sorry.

9 MS. LOVE: Oh, no problem.

10 MR. WALLING: For anybody that doesn't know,  
11 I'm -- I'm flying home from Bermuda, so you've caught  
12 me in the Atlanta Sky Club. I'll try and mute as  
13 much as I can.

14 MS. LOVE: No problem. Mr. Walling, I think  
15 that you noted in your report that you are not a  
16 lawyer and you are not one who is here to testify  
17 about the statute or interpretations of the statute  
18 or interpretations of the case law around medical  
19 malpractice.

20 And I'm going to object, Chairman, to  
21 you inserting into this rate-setting hearing a  
22 political issue.

23 DR. RITCHIE: I -- I apologize. I was  
24 speaking more from a -- more the other side of the --  
25 of the -- of it, the -- the setting of rates and

1 costs and overhead. And so not -- not necessarily  
2 the political side of the legislation. But I  
3 apologize if that was taken that way.

4 But it does sound like that it would  
5 take more than just raising surcharges to solve the  
6 PCF's -- PCF deficit, unless the surcharge were  
7 raised very high. Would you agree with that,  
8 Mr. Walling?

9 MR. WALLING: I guess, first of all, to  
10 address Ms. Love's comments, I do have significant  
11 experience as an actuary pricing legislative changes,  
12 and so I'm going to limit my commentary to the role I  
13 play estimating the potential impact of legislative  
14 changes.

15 And I will say that rate increases,  
16 legislative changes, you know, are -- are a couple of  
17 several potential tools that can be used to address a  
18 shortfall in a government insurance program.

19 MR. VARGAS: And I just have a follow-up  
20 question for Mr. Walling. This is Ray Vargas.

21 Mr. Walling, given that you worked with  
22 this PCF for approximately 20 years, isn't it fair to  
23 say that a deficit occurred during a period when the  
24 legislation remained static? For example, the caps  
25 on medical malpractice awards did not change in that



1 time period, yet this deficit occurred and surcharges  
2 were not properly assessed in that time period?

3 MR. WALLING: I would suggest to you that  
4 there are some subtle changes in the law during that  
5 period. And maybe not so much in the law, but simply  
6 the -- the batch claims, I think, were startling in  
7 their impact on the fund. And so from a risk  
8 management prospective, not so much a legislative  
9 perspective, the need to address the impact of those  
10 claims was certainly significant.

11 I think it's -- it's maybe an  
12 oversimplification to say nothing was changing. The  
13 fund was dramatically changing as data-gathering  
14 process. Literally, when I started doing this work,  
15 the only data we had available was from the primary  
16 carriers. And we would get loss runs from AIG and  
17 Medical Protective. So I think it's probably a  
18 little oversimplifying to suggest that nothing was  
19 changing during that period.

20 MR. VARGAS: Well, and my question  
21 specifically was, nothing with the legislation itself  
22 had changed in that time period?

23 MR. WALLING: There had not been substantial  
24 change.

25 MR. VARGAS: Okay.

1 MR. WALLING: I think that's fair -- that's  
2 fairly accurate.

3 MR. VARGAS: Okay. Thank you.

4 MS. LOVE: And may I ask one follow-up  
5 question? This is Kathy Love.

6 Mr. Walling, my understanding is the  
7 batch claims, while they certainly were a hit for the  
8 patient compensation fund, they were -- they account  
9 for a total of 10,182,000. Is that -- am I reading  
10 your report correctly?

11 MR. WALLING: I would have to go back and  
12 look at that. I don't have the number handy.

13 MS. LOVE: I'm looking on Page 7 of your  
14 report. It says -- it refers to -- actually, it  
15 looks like there was one set of batch claims for 11.7  
16 million, and a second set of batch claims that was --  
17 amounted to 10,182,000 on Page 7 of your --

18 MR. WALLING: Yeah.

19 MS. LOVE: Is that right?

20 MR. WALLING: Mm-hmm.

21 MS. LOVE: Okay. That doesn't account --  
22 that accounts for about a third of the deficit; is  
23 that right?

24 MR. WALLING: Yes.

25 MS. LOVE: Thank you.

1 DR. RITCHIE: As a follow-up for the  
2 follow-up, Mr. Walling, then how do you perceive the  
3 changes in the caps, and, you know, the increase in  
4 caps, in exposure to the PCF? How do you think that  
5 will impact the deficit going forward?

6 MR. WALLING: I'm actually -- I know I  
7 volunteered to answer the questions as they came up,  
8 but there's a better place during this discussion to  
9 answer that question.

10 DR. RITCHIE: That's fine. I can see that.

11 MR. BERENBERG: Are we ready to go on now?

12 BY MR. BERENBERG:

13 Q. All right. So we had left off looking at  
14 the major task for a report, and particularly the  
15 first one, the estimated ultimate liabilities, which  
16 you identified as a loss reserves.

17 So it sounds to me like one of the  
18 theories of your analysis is estimating the unpaid  
19 claims liabilities or loss reserves for the  
20 independent physicians. Is that a correct  
21 characterization?

22 A. Yes, it is.

23 Q. All right. And you summarized that data on  
24 Exhibit 2; is that correct?

25 A. I believe so, yes.

1 Q. So I'm going to go to Exhibit 2 of the  
2 report, which is on Page 34. And if you remember, I  
3 introduced the exhibits for this hearing with letters,  
4 and that was intentional, since the exhibits in the  
5 reports are numbers. So when I refer to a numbered  
6 exhibit, it's the exhibit in the report. So that's on  
7 Page 34.

8 And can you walk us through that  
9 exhibit. And let me know if I can just zoom in on any  
10 portion of it?

11 A. I'm okay with those, because I'm not going  
12 to cite specific numbers. There's certainly not very  
13 many of them.

14 So this is the exhibit where we document  
15 the four different estimates methods we use. These  
16 are shown in columns 4 through 7. An actuary, as I  
17 was saying before, uses those historical claim payment  
18 patterns as a means of estimating what the future  
19 behavior is going to be like.

20 For the independent physicians and  
21 surgeons, we use four methods. We use, in column 6,  
22 the paid development method. This is like estimating  
23 the size of an iceberg. You take the part you can see  
24 as a paid losses, and you use that to extrapolate the  
25 part that you can't see, the unpaid portion.

1           The expected loss ratio method takes the  
2 historical practitioner surcharges, applies an  
3 expected loss ratio to each and every year, regardless  
4 of the claims emergence, which is a very stable,  
5 well-behaved pattern.

6           The B-F method in column 4 is a hybrid.  
7 It allows the paid loss data to date, showing in  
8 column 3, but then uses the expected loss ratio method  
9 to estimate the portion as yet unpaid. So it strikes  
10 a balance between the paid development method and the  
11 expected loss ratio method.

12           And the fourth method is a frequency and  
13 severity method. Claim counseling frequencies tend to  
14 be stable and predictable. And so one of the methods  
15 we used for the physicians was to estimate the  
16 expected number of claims with payment, and then an  
17 expected severity for each of those claims as a fourth  
18 methodology.

19           The selected ultimate losses then are a  
20 selection that I make based on those four methods,  
21 based on the facts and circumstances of each of the  
22 accident years.

23           And then the loss ratio is simply the  
24 ultimate losses that I've selected, divided by the  
25 surcharges. It's a measure of the relationship

1 between what I think the selected ultimate losses are  
2 going to be and the surcharges that were collected in  
3 each of these years.

4 And you can see for the most recent  
5 years, starting in about 2013, you know, the batch  
6 plans manifest back in '07 and '08, and you'll see  
7 they're very large numbers, as Ms. Love presented,  
8 about 10, \$11 million for each of those two batch  
9 claims. And the loss ratio was more than 200 percent,  
10 or the ultimate losses were more than twice the  
11 surcharges that were collected.

12 After some transitional periods, by  
13 about the time we get to 2013, the surcharges were to  
14 a level that we were actually below 100 percent in  
15 that ultimate loss ratio. But we've seen those  
16 numbers bounce back up somewhat, starting in 2017 and  
17 as you can see, the years since then are still very,  
18 very green, they're very immature, because of how long  
19 it takes for PCF claims to be -- to reach an ultimate  
20 settlement value. But it looks like we've settled on  
21 a loss ratio somewhere in the order of about 115  
22 percent of surcharges.

23 Q. How do you select the number in column 8?

24 A. Typically, the older the year, the more I'm  
25 going to rely on the frequency and severity and the

1 paid development methods, because those are very  
2 mature years. There's not a lot of development left  
3 in them.

4 The more recent the year, the more I'm  
5 going to rely on the B-F method and the expected loss  
6 ratio method, because such a small percentage of the  
7 ultimate claims values had been paid at that point.  
8 So we need something that's more stable and less  
9 responsive.

10 You can see the 2017 year, for example,  
11 the paid development method is perusing at an  
12 estimated ultimate loss of 33 million dollars. And  
13 that's influenced by one very large claim payment.

14 What we've chosen to do instead is to  
15 rely on that B-F method as a more stable predictor of  
16 the ultimate losses for that year. So it's -- it's an  
17 informed judgment based on 35 years of doing this kind  
18 of work.

19 Q. Is breaking this down by accident year  
20 important?

21 A. It is. It's an appropriate way to organize  
22 the data. It's important from an actuary's  
23 perspective that you match the surcharges to the  
24 losses that correspond to that. So it allows us to  
25 get a sense of trends over time. It gets us a chance

1 to see how claims that occurred during a given year  
2 are emerging over time. And that really forms the  
3 basis for all four of these methods.

4 Q. So I'm looking down at the bottom of  
5 column 8. You have as a total selected ultimate loss  
6 for the independent physicians approximately 252.5  
7 million. Am I reading that correctly?

8 A. Correct. And that compares to paid losses  
9 to date of 205 million over in column 3. So the way  
10 to think about those unpaid claims liabilities is the  
11 difference between the ultimate losses in column 8 and  
12 the paid losses in column 3.

13 Q. And what does this tell us about expected  
14 future payments?

15 A. Given those two numbers, we would anticipate  
16 that there's something on the order of about \$57  
17 million of additional claims payments for claims that  
18 have occurred as of December 21st of 2021.

19 Q. Now, earlier, you talked a little bit about  
20 column 9, the loss ratio. What is the loss ratio?

21 A. It's just a relationship between my  
22 estimated ultimate losses and the practitioner  
23 surcharges that were collected for those accident  
24 years.

25 Q. So is it ultimate loss divided by the



1 surcharge?

2 A. Yes. And you can see that footnoted down  
3 below that table.

4 Q. I missed that. Why is loss ratio important?

5 A. Simply put, it's a measure of underwriting  
6 income. So if that loss ratio is 100 percent or  
7 lower, then you're paying out less in losses than  
8 you're collecting in -- I'll use premium as shorthand  
9 for surcharges.

10 If it's above 100, then you're going to  
11 pay out more ultimately in claims than you collected  
12 in surcharges. And so the inference would be that  
13 maybe through investment income, while you hold the  
14 money prior to payment, you are able to generate  
15 enough investment income to offset that underwriting  
16 loss.

17 Q. Do you have an estimate of the indicated  
18 unpaid claims liabilities or loss reserves for the  
19 independent physicians and surgeons?

20 A. We do.

21 Q. Is that, if I have it correct, Exhibit 1,  
22 Page 4?

23 A. I believe that's correct, yes.

24 Q. All right. Let me go back to that on Page  
25 32. Is that the proper exhibit?

1           A. Yes, it is. The other thing -- if you'll  
2           indulge me, the other thing that's important about  
3           this exhibit is that one way that we monitor the  
4           reasonableness of what we're doing is to compare it to  
5           the prior analysis.

6                        And so you'll see in this exhibit that  
7           we've included ultimate loss estimates from Milliman  
8           study as of year end 2020, the paid losses as of year  
9           end 2020. And therefore, the computed reserve  
10          estimates from Milliman.

11                      What this allows us to see is that, in  
12          the middle of the page, where you've got that section  
13          of the table a little difference, you can see that the  
14          independent physicians paid out \$13.35 million. And I  
15          apologize, I don't know why there aren't column  
16          numbers on this. But that 13.5 is the incremental  
17          claims payments on all prior accident years.

18                      Similarly, you'll see that our estimated  
19          ultimates, excluding the 2021 year, actually decreased  
20          by about \$3.6 million. So we were able to take those  
21          ultimate loss estimates on prior years and bring them  
22          down, actually, you can see in some cases, pretty  
23          significantly, except for that 2017 year, where we did  
24          have that one large payment.

25                      So the net result of that 13 .3 million

1 dollars of paid losses and updating the analysis was  
2 that we actually reduced the ultimate loss estimates  
3 for 2020 and prior relevant to Milliman's estimates.  
4 And you'll see the impact that then has on the  
5 indicated reserves further to the right of that table.

6 Q. Is there anything else you need to tell us  
7 about how you derived the indicated loss reserves?

8 A. One other thing that's worth noting is the  
9 discounted reserves. You'll see in the Milliman  
10 analysis the difference between their undiscounted  
11 reserves and their discounted reserves is -- it looks  
12 like it's about \$5 million. You'll notice our  
13 analysis, the impact of discounting is less than that.

14 And the issue, candidly, has to do with  
15 the fund deficit. One of the principles of  
16 discounting is you're trying to incorporate the time  
17 value of money in your discounted reserve estimate.  
18 But actuarial standards, specifically Actuarial  
19 Standard of Practice Number 20, provides guidance that  
20 says you ought to consider whether they're invested  
21 assets supporting those claims obligations.

22 So if -- if I've got \$200 million -- or  
23 sorry, \$60 million worth of claims that are going to  
24 be paid in the future, and I've only got 30,000 -- or  
25 \$30 million of invested assets generating investment

1 income, then I ought to recognize that fact.

2 So there is one methodological  
3 difference of note between Milliman and Pinnacle this  
4 year. Pinnacle discounted the full value of the  
5 reserves. We weren't comfortable doing that because  
6 only about half of the assets in the fund right now  
7 are actually invested in that amount. That half of  
8 the fund balance is substantially smaller than the  
9 indicated reserve. So we did make a change in the  
10 discount method.

11 Q. So you're mentioning discounting, discount  
12 methodology. What does that mean? What is  
13 discounting?

14 A. Oh, it's just the idea of if I'm going to  
15 pay off a loan that I took out five years from now,  
16 and the loan was \$100, I don't need \$100 today to pay  
17 it off. I need, you know, whatever the discounted  
18 value of that hundred dollars is based on how much  
19 investment income I can generate on those funds today.

20 So the idea of discounting is to  
21 estimate the timing of those claims payments and then  
22 discount for the time value of money back to a present  
23 value.

24 Q. Then earlier you mentioned that this exhibit  
25 is a comparison between the 2020 and 2021 analyses.

1 What can you tell us about the changes from 2021?

2 A. The -- the, kind of, final answer is in the  
3 bottom right-hand corner. What it says under the  
4 column entitled "New Mexico PCF Undiscounted Reserves  
5 Difference," is that to the undiscounted reserves for  
6 the physicians and surgeons program actually indicate  
7 a decrease of about, if I'm reading the tiny little  
8 number, \$3.6 million. So we're actually bringing that  
9 unpaid claims liability down a little bit based  
10 relative to last year's estimate.

11 Now, it's not as big a reduction on the  
12 discounted. And that's really where you see the  
13 impact of the change in the discount methodology.  
14 We're not giving as much credit for the time value of  
15 money as Milliman does, largely, because there aren't  
16 as many invested assets.

17 Q. And I think finally on this exhibit, down on  
18 this bottom left corner, it talks about  
19 reconciliation. Can you explain that calculation?

20 A. Sure. This is really the idea of kind of  
21 putting the pieces together and saying, as of year end  
22 2020, Milliman said that the physician reserves needed  
23 to be \$62 million and change. You add on the  
24 estimated ultimates for the 2021 year. You subtract  
25 off the payments that have actually been made. And

1 then you subtract off the change in the ultimate  
2 losses for those years to get to the current reserve  
3 estimate.

4 So that (inaudible) that we're getting  
5 from the 62 million in the undiscounted reserves for  
6 the Milliman report that you can see right above that  
7 little inset table to the 57 million that's in the  
8 table above as of 2021. So it's just trying to  
9 identify how you put the pieces together.

10 MR. BERENBERG: That is all the questions I  
11 had on the loss reserves for physicians. We're going  
12 to go into hospital and employed physicians next.  
13 But this is a good point for additional questions  
14 from the board.

15 If there's no questions, then, we'll go  
16 on to indicated loss reserves for the hospital and  
17 employed physicians.

18 BY MR. BERENBERG:

19 Q. So you also did a similar analysis as you  
20 did for the independent physicians?

21 A. We did. We (inaudible), yes.

22 Q. And I believe that is Exhibit 11. Let me  
23 pull that up for you. Is that the correct exhibit?

24 A. Yes, it is.

25 Q. All right. Can you walk us through that?

1           A. Sure. Probably the first thing that jumps  
2 out of the page at me when I look at this is the  
3 surcharges really ramping up from 2015, 2016, 2017.  
4 That's really when the two largest hospital networks  
5 joined the PCF. Prior to that, it was smaller insured  
6 generating lots of surcharge revenue.

7           And so when we think about that,  
8 remember, we talked about these claims taking a lot of  
9 years to get a full and final settlement. So the  
10 vast, vast majority, what, about 148 million of the  
11 168 million, has all been paid in the last five years.  
12 So there's still a tremendous amount of uncertainty  
13 about how these last five years, with these much, much  
14 larger surcharge volumes, are going to perform  
15 relative to the prior years.

16           The other thing that's worth noting here  
17 is there are only three methods. We chose not to do a  
18 frequency and severity method for the hospitals. It's  
19 largely a function of just the credibility of the  
20 data, especially for 2016 and prior. So we're relying  
21 on three methods. You can see some of the volatility  
22 from the years prior to the big -- the big hospitals  
23 joining the 2014 year in retrospect was a real  
24 stinker.

25           The 2016 year, the ultimate losses

1 looked like they were going come in substantially less  
2 than the surcharge income that was collected. So a  
3 fair amount of volatility.

4 The five more recent years, we're still  
5 relying a lot on those B-F methods and expected loss  
6 ratio methods because for portfolios of claims that  
7 are that young, the paid development method is  
8 producing a lot of uncertainty.

9 Now, you can see the 2019 paid  
10 development method is much lower than the other two  
11 methods, whereas in 2018, it's much higher. And so  
12 we're really concerned about the paid development  
13 method overreacting to the presence or absence of  
14 claims early on. So we're really still relying at  
15 this point on the expected loss ratio method and the  
16 B-F method.

17 Other than that, 119 percent loss ratio  
18 is relatively similar to what we saw in the  
19 physicians.

20 Q. And the total selected ultimate losses you  
21 have is about 201 million?

22 A. Correct. And that's relative to paid losses  
23 of about 54 million.

24 Q. Do you have an estimate of the indicated  
25 unpaid claims liabilities for the hospitals?



1           A. We do. And it's going to be up in a similar  
2 part of Exhibit 1 to what we were just looking at.

3           Q. And let me know if I get to the right page.  
4 Exhibit 1, Page 5; is that correct?

5           A. Yes.

6           Q. Okay. And can you explain this to us.

7           A. Same kind of thing going on here, where  
8 we're comparing our analysis to Milliman's. The  
9 number from my perspective that jumps out of the page  
10 is the change in the paid losses.

11                    You'll recall that the independent  
12 physician payments were about 13 million during '21.  
13 The payments for the hospitals were 23.4 million.  
14 That's just to the right of the center of the page.

15                    As a result of that, you'll recall the  
16 physicians brought down some of those ultimate loss  
17 estimates for the hospitals, especially for the more  
18 recent years, what, 2015 and then 2017 through 2020.  
19 Our estimates of the ultimate losses, right smack dab  
20 in the middle of the page, all increased our  
21 estimate -- estimated ultimate loss estimates from  
22 Milliman's, largely because of the volume of the paid  
23 loss activity.

24                    Paid loss activity of that magnitude is  
25 going to typically cause the ultimate losses to move,

1 as well. And you'll see that it did.

2 So similar issue with -- with the other  
3 piece of the analysis. And you'll see that our  
4 estimated undiscounted reserves, over on the far left,  
5 are about 100 and I think that's 40 million. Sorry.  
6 It must be 146, and then the discounted must be 141.

7 Q. Do you want me to zoom in on that portion?

8 A. No. And then you'll see the reconciliation  
9 below, where you take last year's reserves, you add in  
10 the new accident year ultimate to subtract off the  
11 payments. And ultimately, there's a \$7.8 million  
12 increase in the prior reserve estimates to get you to  
13 the current -- the current unpaid claims liability for  
14 the hospitals.

15 Q. This exhibit was similar to the exhibit for  
16 the physicians, so I just want to make sure we cover  
17 the same topics.

18 A. Yes.

19 Q. Again, this one was a comparison between  
20 2020 and 2021. So what can we tell about the changes  
21 from 2021?

22 A. Again, the change here is, instead of having  
23 less payment activity than we would have anticipated,  
24 like we saw in the independent physicians and  
25 surgeons, here, we saw substantially more payment

1 activity than we would have anticipated. And that  
2 resulted in our ultimate loss estimate increasing for  
3 a number of the historical accident years. And  
4 that -- that action of increase in the ultimates  
5 corresponds to an increase in the indicated loss  
6 reserves, or the undiscounted reserves that we're  
7 showing here.

8 Q. Were you able to account for a recent shift  
9 of physicians from independent practices to hospitals?

10 A. The data is really well organized in that  
11 respect. And so remember, we're looking at the claim  
12 situation as it existed for claims that occurred in  
13 2018, 2019, 2012. And so we're comfortable that the  
14 data is organized well for the purpose of setting the  
15 reserves.

16 Q. Do you have an exhibit that combines the  
17 individual physician and hospital results?

18 A. We do.

19 Q. And what's that going to show us?

20 A. You're going to see the improvement in the  
21 physicians offset by the deterioration in the  
22 hospitals.

23 Q. And I believe that's the beginning of  
24 Exhibit 1?

25 A. Correct. Actually, it's like Exhibit 1,

1 Page 2, maybe; 2 or 3.

2 Q. Here's Page 1.

3 A. This will work.

4 Q. Okay.

5 A. This doesn't have the comparison. But what  
6 it does show is the selected ultimate reserves of 57  
7 million for the independent physicians and surgeons,  
8 the selected ultimate reserves of 146 million for the  
9 hospitals and employed physicians and surgeons.

10 So you see then the combined effect of  
11 those are an estimated discounted reserve of  
12 196 million and discounted reserves at a 75 percent  
13 confidence level. So increasing a margin for loss  
14 volatility to basically being enough, three times out  
15 of four, increase in those reserves up to 213 million  
16 and change.

17 If you go to the next page -- no, one  
18 more. This is actually the combined effect of both  
19 the physicians and the hospitals. So you can see that  
20 the combined paid loss activity is 36 million, in the  
21 middle of the page. And you can see that, actually,  
22 on a combined basis, we only increased our estimates  
23 for the prior years by -- it looks like it's about  
24 \$2.4 million in that little inset at the bottom of the  
25 page.

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1           So largely, the increases in the  
2 hospitals due to the increased paid activity, and the  
3 improvement in the physicians analysis due to the less  
4 than expected paid activity, were largely offsetting  
5 to the total reserves.

6           Q. So in past years, all of the doctors were  
7 evaluated under a single bucket, the term that's been  
8 used, and hospitals under another bucket. Now it's  
9 hospitals and employed doctors are lumped together.

10           Can you consider separately the risk  
11 data or hospitals and for hospital-employed  
12 physicians?

13           A. Yes. That's what we did.

14           Q. You did do it that way?

15           A. Correct. So the hospitals and the  
16 W-2-employed physicians are -- all that claims data,  
17 all that surcharge data is in that portion of the  
18 analysis.

19           Q. Okay. I guess maybe I didn't phrase the  
20 question well. So you considered the hospitals and  
21 employed doctors together?

22           A. Correct.

23           Q. Okay. Can you consider them separately?

24           A. Not easily. And part of that has to do with  
25 some of the data capture. And candidly, it makes more

1 sense to look at them on a combined basis, especially  
2 given the changes in the medical malpractice law.

3 Q. And why does it make more sense?

4 A. Because fundamentally, the coverage goes  
5 together. The coordination of the claims settlement  
6 is on a coordinated basis. From an actuarial  
7 perspective, it doesn't make an awful lot of sense to  
8 try and bifurcate the employed physicians from the  
9 hospital.

10 MR. BERENBERG: I believe that's all the  
11 questions I have on loss reserves. We're going to  
12 transition now to indicated deficit and allocations.  
13 So this, again, would be a good place for questions  
14 from the board.

15 MR. CLARK: Mr. Chair, this is Troy. I've  
16 got a question for Mr. Walling.

17 DR. RITCHIE: Go ahead, Mr. Clark.

18 MR. CLARK: I'm trying to keep track on my  
19 copy, as well. I believe it was on Exhibit 11. But  
20 just a fundamental question.

21 On your calculation of the selected  
22 ultimate losses for hospitals, you mentioned, and I  
23 understand why, the reliance on the expected loss  
24 ratio method in the current year because claims  
25 haven't been filed, or if they have, payment hasn't

1       been able to have been made.

2                       In your report, that leads you to the  
3       expected loss ratio and the B-F method.  As I read  
4       through those in your report, it appears to me that  
5       the expected loss ratio method and the B-F method  
6       rely heavily upon a multiplication factor of your  
7       surcharges times an amount, we'll use 114 percent, to  
8       calculate what that expected loss ratio would be.  Is  
9       that correct?

10                   MR. WALLING:  It does.

11                   MR. CLARK:  So is it fair, then, to say that  
12       as surcharges increase, if they were increased to  
13       reduce a deficit, you're actually increasing the  
14       amount of the projected deficit because you're above  
15       100 percent?  So even though you're paying more in,  
16       you're saying your expected payout is also  
17       increasing, so you're actually exacerbating the  
18       problem for that one current year?

19                   MR. WALLING:  That's an oversimplification.  
20       And that's actually -- yeah, that's an  
21       oversimplification about how this works.

22                   MR. CLARK:  No further questions.

23                   MS. LOVE:  Can you expand on that,  
24       Mr. Walling, about why that's an oversimplification?

25                   MR. WALLING:  Sure.  Part of what's going

1 into this analysis is trying to look back at those  
2 historical payment patterns, but also those  
3 historical loss ratios to try and inform what we  
4 think the current years are doing.

5 If -- I would be more concerned about  
6 this if -- I'm trying -- probably the easiest way to  
7 think about this is, if I felt like different  
8 accident years had dramatically different expected  
9 loss ratios, then it would have been reasonable for  
10 me to select different expected loss ratios by year  
11 to address the concern Mr. Clark just brought up.

12 I don't have compelling evidence to tell  
13 me that that's the case for the four or five most  
14 recent years. And so because of that, we've made  
15 the -- the assumption that the expected loss ratio  
16 for the five or so most recent years are of a kind.

17 And you can see that the surcharges  
18 revenue, especially in the four most recent years,  
19 has actually been relatively stable. So I -- there  
20 wasn't, in my opinion, a compelling reason to use  
21 different expected loss ratios by years for the B-F  
22 method or the expected loss ratio method. And so  
23 that's as simple an answer as I can give.

24 MR. CLARK: Mr. Chair, maybe I can clarify.  
25 I'll ask the second question that I think I made my



1 own connection in my head.

2 Mr. Walling, I was trying to figure out  
3 the difference between your first draft report and  
4 second draft report when I called out that there were  
5 missing surcharges that were not included. I was  
6 trying to understand how the gap got wider.

7 And I believe the answer is, and you  
8 just gave me what I asked, is because we don't have  
9 paid -- I'm not questioning your choice in those. I  
10 mean, it's the most current year. You don't have  
11 paid loss history.

12 But I'm trying to boil it down to the  
13 fact that the deficit appears larger for the  
14 hospitals between your draft report and this report  
15 not because of any change in any underlying  
16 fundamentals, but because you included missing  
17 hospital surcharges that were out there. And by  
18 those numbers going up, when you correspondingly have  
19 an expected loss ratio go up by 114 percent of  
20 whatever that number is, the deficit is going to  
21 grow. And that's what the cause in that growth was.

22 MR. WALLING: No. But close. The -- the  
23 primary change in this exhibit was actually a better  
24 alignment of the hospital surcharges to the accident  
25 year they belong in. The first draft that you saw

1 had that weird surcharge number for 2021. And  
2 ultimately, the change was to take the historical  
3 surcharges by their effective date and allocate them  
4 more accurately to the accident year they belong in.

5 So the reallocation oftentimes shifted,  
6 and you can see that between this version and the  
7 draft, shifted some of the surcharges to a more  
8 recent year. And the shift to a more recent year,  
9 subjected that the claims maturities were less  
10 mature, the average accident date was less, it was  
11 more recent. And so the adjustment we made to  
12 address the hospital surcharge issue did shift some  
13 of the surcharge dollars incrementally forward a year  
14 to better match it to the accident year in which the  
15 claims happened. But that's really what caused the  
16 shift that you're noticing.

17 MR. CLARK: So I appreciate that answer.  
18 Just to clarify for me, because I only looked at the  
19 change in the numbers for 2021, if I was to go back  
20 and compare this report to the draft, you're telling  
21 me that the prior years 'numbers would have also  
22 changed?

23 MR. WALLING: Correct. And to your --

24 MR. CLARK: And to allocation by year?

25 MR. WALLING: You're especially going to see

1 the surcharges in '15, '16 and '17 decrease because  
2 of the way we've, I think, better assigned the  
3 surcharge data to the correct accident year to  
4 address the issue we identified with the draft.

5 MR. CLARK: So could you clarify, then, your  
6 new definition of which -- did you allocate the  
7 surcharges in this final report based upon the year  
8 that they were invoiced for, billed for, attributed  
9 to, whatever word you want to use, as opposed to the  
10 date they were collected?

11 MR. WALLING: The date it's collected is  
12 incorrect. The date it was invoiced is also  
13 incorrect.

14 The correct way, from both an accounting  
15 perspective and an actuarial perspective, to organize  
16 this data is the year in which the surcharges or  
17 premium are earned. So, for example, if a policy was  
18 effective on July 1st, then half of that premium  
19 would be earned in the year in which the policy was  
20 effective, and the other half would be earned in the  
21 next year, because it's intended to match up with  
22 claims that occur that way, right? So half the  
23 claims on that July 1 policy would presumably occur  
24 during the first year, and half those claims would  
25 occur during the second year.

1           So this approach to earning the premium  
2 evenly over the policy term is accounting best  
3 practices, and it's also actuarial best practices.

4           MR. CLARK: Okay. So it's an accrual-based  
5 presentation.

6           MR. WALLING: Correct.

7           MR. CLARK: Thank you. No further  
8 questions.

9           MR. WALLING: And in insurance speak, it's  
10 calendar accident year.

11          DR. RITCHIE: Mr. Walling, just a broad  
12 overview for us. What were -- what do you think the  
13 effect will be with the increases and the caps that  
14 we're seeing because of inflation and the  
15 recommendations here on hospitals and physicians?  
16 What is that going to do to these numbers?

17          MR. WALLING: I'm not understanding the  
18 question.

19          DR. RITCHIE: Well, I mean, the caps take a  
20 huge jump. All this is based on caps and surcharges  
21 based on, you know, the 200,000, 600,000 cap and  
22 keeping surcharges low.

23                 Now, going forward, and starting last  
24 year, all of a sudden, the caps have gone to, you  
25 know, 4 million for hospitals and their agent, and --

1 and the surcharges are being ramped up, plus there's  
2 this inflation increase in the caps. (Inaudible) --

3 MR. WALLING: (Inaudible) keep asking the  
4 same question, and I'm going to ask you to wait  
5 again.

6 DR. RITCHIE: Okay. Okay.

7 MR. WALLING: When we organize the data by  
8 accident year, the cap that applies is the cap that  
9 was in place when the claim occurred. So what you're  
10 really talking about is a prospective surcharge  
11 issue. We're talking about the retrospective  
12 estimates of the claims that have already occurred.

13 DR. RITCHIE: I understand. And I'm sorry  
14 I'm getting ahead of myself, but that is the charge  
15 of this committee, of our committee, is --

16 MR. WALLING: It's a surcharge issue, it's  
17 not a reserve issue.

18 DR. RITCHIE: I don't --

19 MR. WALLING: I promise I'll get to it. But  
20 it's not a reserve issue.

21 DR. RITCHIE: Okay. Okay. That's fine.  
22 I'm just over anxious.

23

24

25

1 BY MR. BERENBERG:

2 Q. So if I understand correctly, Mr. Walling,  
3 what we've been going over so far is what has happened  
4 to the fund in the past. And what we're going to be  
5 getting into is how do we use that past data to see  
6 what's going to happen in the future?

7 A. We have one bit of the past left, and that's  
8 the current estimate of the deficit.

9 MR. BERENBERG: If there's no more  
10 questions, then, we can get into the deficit and the  
11 allocation.

12 BY MR. BERENBERG:

13 Q. So you use then the loss reserves estimates  
14 to estimate the fund balance?

15 A. Correct.

16 Q. And you did an estimate of the fund balance  
17 as of December 31, 2021?

18 A. Correct.

19 Q. What do you estimate that balance to be?

20 A. I'm going to need you to go to that summary  
21 exhibit.

22 Q. And I'm going to Page 26; is that correct?

23 A. Perfect. So what I'm going to focus people  
24 on is the top part of this exhibit. And I'm actually  
25 going to ask people for the moment to humor me for a

1 minute, and let's just focus on the total row.

2 That \$203.7 million is my current  
3 estimate of the undiscounted reserves. The discounted  
4 reserve estimate next to it, then, is the 196.7  
5 million. And the discounted reserve estimate then is  
6 the 213 million next to it in column 3.

7 The fund balance as of year end in  
8 column 4 is the 95 million shown. If my reserves in  
9 column 1 are 203 million and my fund balance is 95  
10 million, then my end discounted deficit in column 5  
11 would be 108.7 million. Just straight subtraction.  
12 All the footnotes are shown down below.

13 So the undiscounted balance, if this was  
14 an admitted insurance company, if this was State Farm,  
15 the number they'd be booking for their reserves would  
16 be the undiscounted number of 108.7 million in column  
17 5. If the number being booked was to reflect a risk  
18 margin -- or a time value of money discounting, you  
19 could reduce that liability to 101.7. If you wanted  
20 to increase the level of fiscal confidence of that  
21 reserve number, you could take it up to 180.25.

22 Q. Go ahead.

23 A. No.

24 Q. I was going to ask you how you come up with  
25 those numbers.

1           A. That's just simply the difference between  
2 the liabilities on the balance sheet and the fund  
3 balance assets on the balance sheet. So it's  
4 literally subtraction.

5           Q. And these exhibits show the overall fund  
6 balance and the allocation in the independent  
7 physicians and then the surgeons and hospitals?

8           A. Correct. So the process used to allocate  
9 the deficit was to look at the historical performance  
10 of the independent physician program and the hospital  
11 and employed physician and surgeon program separately  
12 to see the relative contributions to the -- sorry, the  
13 historical relationship between the surcharges and the  
14 losses for the two programs.

15                       So if you'll do me a favor and go back  
16 one more page.

17           Q. Yes.

18           A. No.

19           Q. One more?

20           A. Sorry, the other way. Other direction.

21           Q. Here?

22           A. The allocation process was simply this, to  
23 kind of keep a score card of all the surcharges that  
24 have been collected for the two programs, the current  
25 ultimate loss estimates for the two programs, and



1 estimate the difference, you know, how much  
2 underwriting gain or loss was derived from each of  
3 these accident years from the two programs.

4 You'll see that the physicians program  
5 over the last 22 years has generated what I would  
6 describe as an underwriting loss of about \$42 million.  
7 That's about 19 percent of the total surcharges that  
8 have been collected over that time.

9 Similarly, the hospitals have generated  
10 \$32.9 million in losses over the last 13 years that  
11 that program's been in existence. Again, about 19  
12 percent of the collected surcharges.

13 If you compare the \$42 million shortfall  
14 for the physicians to the \$32.9 million shortfall for  
15 the hospitals, you end up with an allocation of that  
16 underwriting loss of about 15 -- 56 percent and change  
17 to the independent physicians at about 43.6 percent to  
18 the hospitals and employed physicians and surgeons.

19 So the idea, simply put, is that the  
20 deficit on the balance sheet of the PCF is in many  
21 ways comparable to the underwriting gain or loss that  
22 I'm showing here. And our assumption is that the  
23 historical gain or loss for the two segments is a  
24 reasonable means for allocating the deficit. So these  
25 underwriting gains or losses essentially are the

1 largest component of the deficit.

2 So you take that 56 percent and that 43  
3 percent back up to -- go up two pages to -- on summary  
4 1-A, we've taken those deficits in columns 5, 6 and 7,  
5 and simply allocated them to the hospitals and  
6 employed physicians and surgeons and that independent  
7 physicians and surgeons, using those percentages. So  
8 those numbers are how we've estimated the allocation  
9 of the deficit.

10 The recent change to the legislation has  
11 a \$30 million contribution to the funds that intended  
12 to reduce the deficit for the independent physicians  
13 and surgeons, and so you can see the impact that has  
14 over in columns 9, 10 and 11. It simply reduces those  
15 three estimates and the deficit for the independent  
16 physicians and surgeons.

17 Q. Below the portion you've been talking about,  
18 with the 11 columns, there's a deficit surcharge  
19 amortization.

20 A. Mm-hmm.

21 Q. What is that?

22 A. The idea here was simply to try and create a  
23 mechanism to allocate -- one of the charges within the  
24 scope of our services was to try and create a  
25 four-year timetable to eliminate the deficit. And the

1 specific charge to do that in such a way that the  
2 independent physicians would attempt to eliminate  
3 their portion of the deficit, and the hospitals and  
4 employed physicians and surgeons would eliminate  
5 theirs.

6 And so we started with the undiscounted  
7 deficit in column 9, so the 31.2 million and the 47.4  
8 million, and essentially set up an amortization  
9 schedule, my choice of words, as a means of how much  
10 money would you need to collect over the next four  
11 years to eliminate the current deficit. If -- if  
12 everything played out the way we thought it was going  
13 to play out and the new accident years didn't create  
14 any new deficit, then this payment schedule would  
15 actually result. And so an additional collection of  
16 \$8.659 million from the independent physicians, and an  
17 additional \$12.6 million for each of the next four  
18 years from the hospital and their employed physicians  
19 and surgeons would be sufficient to pay off that  
20 deficit.

21 So that's all this schedule is, is just  
22 trying -- meeting -- one of the requirements of the  
23 RFP that we responded to for the study was to try and  
24 come up with a cash-flow analysis, if you would, to  
25 eliminate the deficits by the end of 2026.

1 Q. So is this a surcharge that's needed to pay  
2 the deficit without paying any new claims?

3 A. That's correct.

4 Q. Were you able to --

5 A. The sole purpose of these funds is to reduce  
6 the current deficit. This isn't intended to address  
7 in any way new claims that occur in 2023 through '26.

8 Q. And you're saying new claims that occur in  
9 those years. That includes claims for injuries that  
10 were from previous years?

11 A. No. Those are already in -- that's actually  
12 in here. That's in the reserve analysis. So there's  
13 kind of a bright line between everything that is  
14 December 31st of 2021 and prior, that's the reserves,  
15 versus everything that happens 1/1/22 and forward,  
16 which is the surcharge study.

17 Q. We've been looking at Page 1-A, and as we  
18 skipped past it quickly, there's a Page 1-B, which  
19 looked very similar. What's the difference between  
20 these two pages?

21 A. The only difference here is that we were  
22 asked to provide a scenario in which an additional  
23 \$30 million of funding was provided. This is purely a  
24 hypothetical. Conceptually, all that really changes  
25 is column 8. You'll see that the number allocated by

1 the legislature jumps from 30 million to 60 million,  
2 and an additional \$30 million has the effect of  
3 largely eliminating the deficit for the independent  
4 physicians and surgeons.

5 And then that flows through into the  
6 schedule below, and there's a di minimus amortization  
7 of the little bit of deficit that's left for the  
8 physicians.

9 Q. So then using this information, you were  
10 able to then calculate surcharges?

11 A. This is an element of the surcharges, yes.

12 MR. BERENBERG: So I think we're going to go  
13 on next to surcharges. That's another transition  
14 point, so we'll take questions again from the board.

15 MR. CLARK: Mr. Chair, this is Troy. I've  
16 got another question.

17 In your previous analysis, Mr. Walling,  
18 you did a comparison, a roll forward, if you want to  
19 call it, from Milliman's report. Is there any  
20 comparison here as, a year ago, the hospital portion  
21 was reflected at just over 15 percent of the deficit  
22 and now showing 43 percent of the deficit of what --

23 MR. WALLING: Honestly --

24 MR. CLARK: -- (inaudible) of that is?

25 MR. WALLING: Sure. It's -- honestly, it's

1 the same comparison exhibit that I just showed. If  
2 you look at Exhibit 1, Page 3 and Page 5, the  
3 physician ultimate loss estimates went down because  
4 claims were better than expected.

5 So you -- I mean, the ultimate losses  
6 for the years that Milliman evaluated, we brought the  
7 ultimate losses down pretty significantly.

8 Actually, go -- go one more for the  
9 physicians. So we brought those ultimate loss  
10 estimates for the physicians down \$3.6 million. We  
11 brought the reserves for the physicians down by 16  
12 million and change. So that brought the physician  
13 share of the deficit down.

14 Similarly, if you go to the next page,  
15 the hospitals had \$23.4 million of payment. That was  
16 more than was anticipated. The ultimate loss  
17 estimates went up not as much. I mean, you won't see  
18 a dollar for dollar there. So if you look at the --  
19 what year? -- the 2017 year, there was \$10.9 million  
20 of paid losses and we took the ultimates up by about  
21 5.

22 So it's not a dollar-for-dollar type  
23 thing here, but the best available data from the  
24 hospitals changed for the worse. The best available  
25 data, based on the latest information for the

1 independent physicians, then improved. So between  
2 those two kind of causal factors in the reserve  
3 analysis, the allocation of the deficit changed.

4 MR. CLARK: So stated in that way,  
5 simplistically for me, just to make sure I  
6 understand, the -- the results in the current years  
7 changed the projections from the prior years. So it  
8 wasn't just the current year impact only, but the  
9 results from current year -- or prior years'  
10 estimates, as well?

11 MR. WALLING: I think that's fair. Yeah, I  
12 think that's a fair characterization.

13 MR. CLARK: Thank you.

14 MS. LOVE: This is Kathy Love.  
15 Mr. Berenberg or Mr. Walling, just so the record is  
16 clear from that last explanation, could you read off  
17 what exhibit and page numbers you were just talking  
18 about.

19 MR. WALLING: Exhibit 1, Page 4 for the  
20 physicians, and Exhibit 1, Page 5 for the hospitals.

21 MS. LOVE: Thank you.

22 MR. BERENBERG: All right. If there aren't  
23 any more questions, we'll go on to indicated  
24 surcharges for the physicians.

25 MR. WALLING: And, Mr. Berenberg, I just

1 want to be -- I want to do a bit of a time check. So  
2 I have a flight leaving in -- I need to be probably  
3 off this, if at all possible, in an hour. But every  
4 minute past an hour from now is going to threaten me  
5 getting home tonight. So I just want to come out --  
6 put that out there and beg a little -- a little  
7 sympathy.

8 MR. BERENBERG: Okay. We'll get through it  
9 as quickly as we can.

10 MR. WALLING: Great. Thank you.

11 BY MR. BERENBERG:

12 Q. All right. So, like I said, the purpose of  
13 this hearing is, the title of the hearing is to set  
14 the surcharges for the upcoming year. And I believe  
15 we used the loss reserve and debit analyses to support  
16 your surcharge calculations; is that correct?

17 A. That is.

18 Q. And you used four methods for calculating  
19 physician surcharges, or physician loss reserves.  
20 Which do you use to determine the physician  
21 surcharges?

22 A. Really, the selected ultimate. So the -- so  
23 the selections that I made based on those four  
24 methods.

25 Q. And the results of those calculations,



1 they're shown in Exhibit 10, Page 2?

2 A. That sounds about right.

3 Q. Let me get to that. Here we are.

4 A. Perfect.

5 Q. Is that correct?

6 A. So one of the most commonly used methods for  
7 estimating the indicated rate need for an insurance  
8 program is called a lose ratio indication. The idea  
9 is to take a historical period, in this case, the last  
10 decade, restate the surcharges at current surcharge  
11 levels. So you're trying to restate everything as of  
12 the accounting date; in this case, December 31st.

13 You take those same projected ultimate  
14 losses from the reserve analysis and trend them  
15 forward for inflation to come up with a trended  
16 ultimate loss ratio. That's shown over the column 5.

17 We then look at a number of different  
18 kind of cross-sections of that decade to give us an  
19 informed judgment about what we think the expected  
20 loss ratio for next year is.

21 We chose a selected ultimate loss ratio  
22 of 120.4 percent. So we think for every dollar of  
23 surcharges that are collected without modification  
24 that we're ultimately going to pay out a buck 20 in  
25 losses for every dollar of surcharge collected if

1 nothing changes.

2 So, Dr. Ritchie, this gets to your point  
3 of what do I think about things prospectively. Well,  
4 adjusting to claims conditions that I think are going  
5 to exist next year, I think that if nothing changes,  
6 our loss ratio is going to be about 120 percent on the  
7 physicians program.

8 Now, if we take that and look at the  
9 impact of increase in the limits, you'll see in row 7  
10 that we believe the increase in the coverage limits is  
11 about a seven-tenths of 1 percent increase in the  
12 required surcharges.

13 We also estimate that loss adjustment  
14 expenses are going to be about 3 and a half percent of  
15 surcharges. You can see that in row 10. We've  
16 actually discounted for the time value of money at  
17 3 and a half percent. And for the surcharges, we've  
18 continued the practice of discounting all of the  
19 funding for the time value of money. So you'll see a  
20 much larger discount value.

21 The idea here is that the surcharge, the  
22 additional surcharges revenue that comes in should  
23 actually predominantly be invested, and so we're  
24 giving more credit on the surcharges than we are on  
25 the reserves right now.

1           The overhead for the program has been  
2 one-half of 1 percent for a long time. The cost of  
3 the batch reinsurance in row 13 is about 5 and a half  
4 percent of surcharge revenue.

5           So all of that taken into consideration  
6 suggests that we need about \$13.74 million of  
7 surcharge revenue. We're only expecting 12.37 up in  
8 row 8. So if nothing else changed, we could estimate  
9 a rate need of about 11.1 percent increase in  
10 surcharges.

11           Q. And is that the value that you are  
12 recommending?

13           A. In part. I'll ask you to go to the  
14 immediately preceding page, so Exhibit 10, Page 1.  
15 There are a couple of additional elements that needed  
16 to be built into this. One is the offset for proposed  
17 changes in the class plan. I'll stick a plan in that  
18 for a minute.

19           Another is the cost-of-living increase  
20 that's mandated in the law. We estimate, based on the  
21 most recent CPI numbers, that that ought to increase  
22 the cap on nonmedical damages to 553,224 excess of a  
23 quarter of a million. That is going to have the  
24 impact of increase in surcharges by almost 5 percent.

25           So the combined effect of the indicated

1 rate change and the class plan change and the change  
2 in coverage limits is an increase of 19 percent over  
3 current surcharge levels.

4 Q. And then I'll ask the question again, is  
5 that the number that you are recommending --

6 A. That's the number I'm --

7 Q. -- (inaudible)?

8 A. -- recommending. If -- if we're trying to  
9 accomplish all of those things, reflecting the new  
10 limits required by law, making the proposed changes in  
11 individual physician specialties and recognizing the  
12 indicated rate being the historical experience, the  
13 recommendation would be to increase surcharges by 19  
14 percent.

15 Q. And that is in a row that is labeled  
16 "Without Risk Margin." Below that, you have "With  
17 Risk Margin" being 29 percent. What is the difference  
18 between those two rows?

19 A. So the without risk margin is stated on an  
20 expected basis. On a -- not a quite a coin-flip  
21 basis, because actuaries aren't coin-flip kind of  
22 people, but probably a 55 to 60 percent level of  
23 statistical confidence.

24 We generated risk margins at a higher  
25 levels of statistical confidence, in this particular

1 case, a 75 percent confidence level, to give the board  
2 a chance to consider funding at a -- you know, a 75  
3 percent level of fiscal confidence rather than an  
4 expected level.

5 Q. What criteria should the board use if it's  
6 trying to choose between the 50 percent roughly and 75  
7 percent confidence levels?

8 A. Typically, if I'm advising a client on what  
9 level of fiscal confidence to reserve at or to fund  
10 at, I think about things like access to additional  
11 capital, or in this case, additional legislative  
12 funds, the current fund balance, economic conditions.

13 All of those things would be -- you  
14 know, if this program -- the Wisconsin Patient Comp  
15 Fund at one point had a surplus of over a billion  
16 dollars. It's very easy to fund at an expected level  
17 when -- when you're -- when you're flushed with cash  
18 of heavily capitalized. So those are the kinds of  
19 factors that would certainly influence this.

20 Q. So just to make it clear, your  
21 recommendation is without the risk margin, for a 19  
22 percent rate change, but with a risk margin, for 29  
23 percent rate change?

24 A. That's correct.

25 Q. And is there anything else you wanted to

1 discuss on these charts?

2 A. I have brought forward or, I guess,  
3 backward, the accrual numbers for disposing of the  
4 current deficit in column 5 and column 11. Those are  
5 just simply the numbers of what kind of an add-on,  
6 tack-on would you have to put on to the existing  
7 surcharges to kind of amortize, in the terminology  
8 that I was using, the current deficit.

9 So those -- those schedules to eliminate  
10 the deficit in the top table reflect just the first  
11 \$30 million infusion. The second table reflects if  
12 the board wanted to recoup from the physician some  
13 portion of the currently indicated physician deficit.

14 Q. So the upper portion of the chart, which  
15 does not reflect a second \$30 million legislative  
16 infusion, if the board chooses the 19 percent or 29  
17 percent, does that eliminate the deficit?

18 A. It does not.

19 Q. So you would then have to go to the amount  
20 of column 6 in order to eliminate the deficit?

21 A. If the decision was to go with that  
22 four-year kind of repayment schedule, it would require  
23 the change in surcharges indicated in column 6.

24 Q. So we're looking at very roughly, in order  
25 to eliminate the deficit, doubling the surcharge over

1 the current value?

2 A. Without any additional legislative  
3 infusions, yes.

4 Q. Anything else on this chart?

5 A. No.

6 MR. BERENBERG: So we'll be going on to the  
7 specialty class changes which you mentioned. So,  
8 again, this is a good point for questions from the  
9 board.

10 MR. CLARK: Thank you, Barry, for pausing  
11 there again.

12 I've got a question, Mr. Chair.

13 Just to be clear, Mr. Walling, when you  
14 talk about the difference between with the risk  
15 margin and without, is it safe to say that if you  
16 were to use the 75th percent confidence level, that  
17 does not mean that 75 percent chance that you will be  
18 correct? That means that if you ran a hundred  
19 different scenarios, in 75 of those scenarios you  
20 would at least have an adequate amount of funding or  
21 over-funding, and an in 25 of those potential  
22 scenarios, you would be underfunded?

23 MR. WALLING: That's accurate, yes. And  
24 it's worth pointing out for the benefit of the group,  
25 an admitted insurance company, that had an adequate

1 capital in the surplus account, would typically fund  
2 at the level without a risk margin. But that's not  
3 currently the case for the fund.

4 MR. BERENBERG: If that's all the questions,  
5 we'll then go on to the indicated physician specialty  
6 class changes and overall physicians surcharge  
7 indications.

8 BY MR. BERENBERG:

9 Q. And I believe you showed that in Exhibit 18  
10 through 21, beginning on Page 63. Is that correct?

11 A. It is. And you better zoom that in.

12 Q. Well, I'm going to ask you, you had a  
13 summary of that at the beginning of the report. It  
14 was report Page 14. And let me just show that to  
15 see --

16 A. Perfect.

17 Q. -- (inaudible) there on this chart. Does  
18 that make it easier?

19 A. Sure. To give a little background  
20 microscopic exhibit we were just looking at was an  
21 analysis looking at the current class groupings for  
22 all of the physician specialties, physician and  
23 surgeon specialties into groups.

24 The idea here is to organize each of the  
25 specialties into groups with similar exposure to loss,



1 and in doing so, simplify the rating plan and kind of  
2 expedite the pricing process.

3 PCF has a number of classes, so you'll  
4 see specialties in class 1, 2, 3, 4, 5, 6, 4-A, for  
5 some magical reason that even I don't remember, and  
6 7-A.

7 What we did is we looked at the current  
8 groupings and compared them to the groupings and  
9 pricing relativities used by the patient compensation  
10 funds in Indiana and Wisconsin, I found them to be  
11 good proxies for New Mexico, as well as the underlying  
12 first-dollar class relativities for the two largest  
13 carriers in the State of New Mexico for medical  
14 professional liability.

15 The idea here is to use the two best  
16 proxies I have within New Mexico, and then the two  
17 best proxies nationally providing similar excess  
18 coverage.

19 Based on those four competitive analyses  
20 or competitive benchmarks, we've proposed the changes  
21 summarized here. We've also shown the number of  
22 full-time equivalent physicians in each of these  
23 groups, how the change would increase or decrease the  
24 surcharges generated by those specialties, to try and  
25 come up with what the overall impact on total

1 surcharge revenue would be.

2 The first several are increases to a  
3 higher severity class. So acupuncture moving from the  
4 class 1 to class 2 would increase from \$3900 a year to  
5 \$5200 a year per physician.

6 You'll see anesthesiology -- pain  
7 management has 30 full-time equivalent docs, and so  
8 on. So we're talking, other than pediatrics, about a  
9 relatively small count in terms of the number of  
10 insured physicians.

11 The last class here, the pediatrics no  
12 surgery, last year, Milliman made a change or  
13 recommended a change, I guess the board made the  
14 change, to the pediatrics minor surgery class and  
15 moved it into a lower specialty group. And we  
16 actually had a situation for one year where pediatrics  
17 minor surgery were paying a lower surcharge than  
18 pediatrics with no surgery, which doesn't make  
19 intuitive sense.

20 So that last change I feel particularly  
21 strongly about moving pediatrics no surgery from  
22 class 4-A to class 3 is actually the best way to  
23 correct a current inversion, if you will, between the  
24 pediatrics no surgery and the pediatrics minor surgery  
25 classes.

1           But these changes, especially the  
2 neonatal and the pediatrics actually are going to  
3 reduce the anticipated surcharge. So if we adopt  
4 these changes, we would actually need to increase the  
5 percentage increase in the surcharges across the board  
6 to offset this decrease in surcharge revenue.

7           So if you think -- we were talking about  
8 a 19 percent increase. So what would happen to the --  
9 pediatrics would be -- surcharges would go up by the  
10 19 percent, if that's what's adopted. But then it  
11 would go down by the change reflected here in going  
12 from the class 4-A to class 3. So the pediatrics no  
13 surgery would actually see, I think actually, just  
14 a -- a small decrease overall between the base rate  
15 change and then the class change.

16           So this 2 percent and change that was in  
17 the summary pricing exhibit is basically the increase  
18 you need to make across the board to offset the  
19 surcharge revenue loss if these changes in specialty  
20 class assignment were topped.

21           Q. If the board were to recommend the -- or  
22 adopt the 19 percent overall change and these  
23 recommendations on the changes in classes, that's all  
24 accounted for in your final numbers and then  
25 correctly --

1           A. So the offsets for this reduction is  
2 actually contemplated in the 19 percent.

3           Q. So if the board were to, say, not take the  
4 recommendation for changes in classes, the 19 percent  
5 would be adjusted in some way?

6           A. Correct. So the 2.4, whatever the  
7 percentage was, would go away that there would  
8 actually be a lower surcharge. I would just -- a  
9 couple of things about the kind of decision rules we  
10 were using here. We didn't propose a change unless  
11 the competitive intelligence really made a compelling  
12 argument that the specialty was misclassified. And we  
13 only moved up or down one class.

14                   So it may have been that, I don't know,  
15 urology maybe should have gone from class 3 to class  
16 5. But we chose to cap the changes going up or down  
17 one class from the current class.

18                   And I'll just reiterate that the current  
19 reversal where the pediatrics minor surgery are paying  
20 a lower surcharge than pediatric no surgery I feel  
21 like really needs to be addressed.

22           Q. I want to skip back to Exhibit 10, Page 2,  
23 which is Page 47 of the report.

24           A. Page 2 or Page 1?

25           Q. Page 2, which was the calculation of

1 physician surcharges based on expected loss values.  
2 Now, somewhere do you combine all the factors  
3 impacting the surcharges for independent physicians?

4 A. On -- on Page 1.

5 Q. Page 1? Okay.

6 A. So you'll see that offset in column 2 and  
7 column 8. So to offset the quarter of a million  
8 dollars in surcharge loses by making these class  
9 changes, you would need to make that up by increasing  
10 the surcharges across the board by 2.1 percent. So  
11 that the quarter of a million dollars of reduced  
12 surcharges that we just saw is actually reflected  
13 here, that you would actually need to increase  
14 surcharges across the board to offset or off balance  
15 those class changes that were just presented.

16 Q. And in columns 3 and 9, you've got the  
17 increase limits to factor for the 553,000 in excess of  
18 250?

19 A. Mm-hmm.

20 Q. Is that from the cost-of-living increase?

21 A. That's the results of the cost-of-living  
22 increase. We used data from insurance services  
23 office, and a couple of the medical professional  
24 liability insurers in New Mexico and the PCF claims  
25 data to develop a size of loss curve to estimate the

1 impact of changing the nonmedical cap from the current  
2 level to the level after the cost-of-living change.

3 So it's based on all the data that's  
4 available to figure out the best estimate of what the  
5 change due to CPI is going to have on overall  
6 surcharges. And it's about 5 percent.

7 Q. So the cost-of-living increase applies to  
8 the total nonmedical cap, but it doesn't apply to the  
9 amount that -- of insurance, the underlying insurance  
10 that needs to be carried. So over time, the PCF share  
11 of the nonmedical cap is going to grow, and it's going  
12 to stay the same for the underlying insurance. Is  
13 that going to cause any issues in the future?

14 A. You will see an adjustment like this every  
15 year. The one challenge is when you see spikes in  
16 CPI. So the latest CPI data that was used in our  
17 estimate had a fairly significant spike in it, as you  
18 can see. And so especially during periods of higher  
19 inflation, that nonmedical cap layer is going to  
20 increase significantly, and the surcharges will need  
21 to -- will need to increase in sympathy with the  
22 change in the nonmedical damage cap.

23 Q. And I was trying to be a little more  
24 specific. Is there any issue with the cost-of-living  
25 increase applying only to the PCF share of the

1 payments versus the underlying insurers' share of  
2 (inaudible)?

3 A. Actuarially, the idea is that if you keep  
4 the primary layer static and increase the excess  
5 layer, over time what will happen is a loss that three  
6 years ago might have been a \$225,000 claim, after  
7 adjusting that for inflation, will actually blow into  
8 the PCF layer.

9 And so the idea here is -- the actual  
10 terminology is "excess trend." But conceptually, the  
11 idea is that if you keep that primary layer fixed,  
12 claims that didn't used to breach the PCF layer will  
13 start breaching the PCF layer over time.

14 Q. What do the indicated rate changes on  
15 columns 6 and 12 mean?

16 A. 6 and 12 are basically kind of the all-in  
17 estimates. So it's adjusting for historical  
18 experience, adjusting for the class plan changes,  
19 adjusting for the cost-of-living, CPI, increase in the  
20 nonmedical coverage limit, and amortizing the deficit  
21 based on the deficit allocation that was shown before.  
22 So 6 and 12 are reflecting all of the factors that  
23 could impact surcharges.

24 Q. But, again, your recommendations were for  
25 columns 4 and 10; is that correct?

1           A. Yeah, my -- I'm -- I think me recommending  
2 how to eliminate the deficit is beyond the scope of  
3 what I've really been asked to do.

4           In terms of providing information, the  
5 information in 6 and 10 is what I said it was. It's  
6 that the increase in surcharges that would be required  
7 to -- to fund all of the changes that are affecting  
8 the fund right now, whether that's the current  
9 deficit, whether that's the change in cost of living  
10 for the nonmedical damage cap, whether that's just the  
11 underlying loss experience, not -- you know,  
12 surcharges not keeping up with losses, or that's the  
13 to the changes to the class plan.

14           Q. And are these changes -- do they apply  
15 equally to all physicians?

16           A. Subject to the changes that are proposed for  
17 individual specialties, yes.

18           MR. BERENBERG: All right. I believe that's  
19 all the questions I have on the specialty class  
20 changes and the overall surcharges indication. So  
21 before going on to the hospitals, does the board have  
22 any questions?

23           DR. RITCHIE: Yeah, Mr. Walling.

24           Oh, go ahead, Kathy. I'll let you go.

25           MS. LOVE: Okay. Thanks.



1           Mr. Walling, I'm going to ask you to  
2 call on your -- your college degree in high school  
3 math and help me. I'm going to ask you -- what I  
4 want you to do for me is, if you could point out, and  
5 maybe Exhibit 19 is the best one to look at, but tell  
6 me if I'm right, I want to just understand what the  
7 real numbers are that we're talking about.

8           We're talking about percentage  
9 increases, but what actual real numbers are we  
10 talking about that doctors have to pay every year in  
11 order to participate and have the \$750,000 coverage  
12 for claims against then?

13           MR. WALLING: Actually, yeah, I think if you  
14 go maybe one more exhibit to Exhibit 2.

15           MS. LOVE: Okay.

16           MR. WALLING: I think it might be -- oh, one  
17 more. No. Okay. Sorry, go -- yeah, go back to 19.

18           Yeah, your point is well taken. So --  
19 sorry, go back to the tiny little numbers.

20           MS. LOVE: And I think it was Page 14 that  
21 you were looking at that was a summary.

22           MR. WALLING: Yeah. If you'll indulge me.  
23 Let me stick here for a minute and try and answer  
24 your question.

25           So if we look at class 1, the current

1 surcharge is 300 -- is \$3,935. And so if the plus  
2 19 -- and you can see the specialties here. These  
3 are nonsurgical; they're mostly noninvasive. It's,  
4 you know, psych and hypnosis and geriatrics, the GPs  
5 are in here, the family practice docs are in here.  
6 And we're talking about \$3900.

7           And so that 19 percent increase would be  
8 an increase of, what, \$780. So you're talking about  
9 \$4700. So each full-time doctor in these  
10 nonsurgical, noninvasive classes, you're talking  
11 about a \$800 increase per doctor, if you -- if you  
12 accept that 19 percent indicated surcharge change.

13           If you're going to the 100 percent  
14 change that includes everything, including amortizing  
15 the deficit, you're talking about \$8,000, you know,  
16 instead of 4,000.

17           Would you do me a favor and go maybe to  
18 the top of the next page. Actually, go to the bottom  
19 of this page. I think it'll -- I think I know where  
20 Ms. Love is headed.

21           For the invasive, the really risky  
22 surgical class, the gastro guys, the cardiovascular  
23 guys, the neurosurgery guys, they're paying \$34,000 a  
24 year for their coverage right now.

25           Now, recognize, the difference in the

1 surcharges are actually pretty highly correlated to  
2 the difference in their underlying premiums. So, you  
3 know, the underlying premiums for a GP is going to be  
4 commensurately lower than the PCF surcharge for a  
5 neurosurgeon. But that 19 percent recommendation for  
6 a neurosurgeon, you're now talking about a \$7,000  
7 increase, and you're talking about going from \$34,000  
8 in surcharges to 41,000.

9 So if I'm getting the gist of where  
10 you're going, the percentages are lovely, but when  
11 you get it down to each physician, you're talking  
12 about \$7,000 for every neurosurgeon.

13 MS. LOVE: Okay. Thank you. And just to  
14 clarify one thing, when you said that this is  
15 directly based on the underlying premiums, this is --  
16 these differences are based on the underlying  
17 premiums, which are based on the risk posed by these  
18 categories of specialties?

19 MR. WALLING: Correct. And part of the  
20 reason I rely on the leading writers is they've  
21 simply got more data. The data they've got for  
22 first-dollar coverage has more claims in it, it's  
23 more credible from an actuarial perspective, which  
24 means it's got more predictive accuracy.

25 So looking at those relationships that

1 TDC and MedPro use for the underlying premiums gives  
2 me some information to make good decisions here in  
3 the excess layer.

4 MS. LOVE: Okay. So if you were to -- so  
5 would you say that Exhibit 19 is what we should be  
6 looking at in terms of what the real-world dollar  
7 amount in increases are for these surcharges  
8 increases?

9 MR. WALLING: It's a good reference point,  
10 because it gives you, I think, a bridge from that 19  
11 percent number to what does it really mean in  
12 dollars, you know, for a podiatrist that does  
13 surgeries. You know, you can get down to there are  
14 30 of -- there are 30 urological surgeons in town, or  
15 in the state, and they're paying \$18,000 in surcharge  
16 right now, and if it goes up 20 percent, you're  
17 talking about \$3600, and they're going to be paying  
18 more. So I think that's -- it's a good reference  
19 point in terms of converting those percentages into  
20 dollars.

21 MS. LOVE: Thank you.

22 DR. RITCHIE: Mr. Walling, to follow real  
23 briefly on that point, these are just the -- the  
24 premiums for the surcharges for the PCF. So  
25 obviously the physicians on these pages are also

1 going to be paying for the base insurance, for that  
2 first \$250,000, as well.

3 MR. WALLING: And in the current market  
4 conditions, MedPro and TDC are also facing  
5 underwriting losses and they're also, in a lot of  
6 states, increasing rates. So oftentimes, when you  
7 see PCF surcharges go up, you'll also see the  
8 underlying premiums go up.

9 DR. RITCHIE: All right. Obviously that's  
10 outside, you know, our -- our committee charges,  
11 except that it is a factor.

12 MR. WALLING: It's a market phenomenon  
13 that -- you know, the PCF doesn't operate in a  
14 vacuum.

15 DR. RITCHIE: Right. And the cost-of-living  
16 increase that -- that you saw built in and raises  
17 that difference of cap from 500,000 -- 550,000,  
18 between 250 and -- 500,000, between 250 and 750,  
19 that's gone up by the 7 percent or whatever, that's  
20 compounded, so --

21 MR. WALLING: It's going to be compounded  
22 over time, yes.

23 DR. RITCHIE: Right. Over time, that's  
24 compounded.

25 MR. WALLING: Mm-hmm. Every year.

1 DR. RITCHIE: So each year, that starts at a  
2 higher level and adds, just like compound interest in  
3 your savings account.

4 One other quick question, and you may  
5 not know the answer to this. You had in there that  
6 the -- that there was the cost for the reinsurance  
7 for batch claims.

8 MR. WALLING: Mm-hmm.

9 DR. RITCHIE: Now, was that past, or --  
10 there's been some question over whether we're going  
11 to continue that or not. And if we did not continue  
12 that, it's because those batch claims have been  
13 accounted for because --

14 MR. WALLING: How -- how are next year's  
15 batch plans accounted for? You just made a jump in  
16 logic that I'm not agreeing with.

17 DR. RITCHIE: Okay. No, no, that's why I  
18 need help on that. Okay. So if --

19 MR. WALLING: If you don't buy the batch  
20 insurance, then the expense line item for buying the  
21 batch reinsurance would actually be replaced by an  
22 increase in the expected losses that indicates the  
23 potential for a batch plan next year. So it's got to  
24 be one or the other. Either there's got to be a  
25 recognition in the losses for the potential for batch

1 claims each and every year, or there's got to be an  
2 expense line item to be the reinsurance. It's got to  
3 be funded one way or the other. So removing the  
4 batch reinsurance wouldn't materially affect the  
5 analysis.

6 DR. RITCHIE: Okay. It changes the  
7 underwriting.

8 MR. WALLING: It changes the bucket it's in  
9 from being an expense bucket right now to being a  
10 loss bucket if it was removed.

11 DR. RITCHIE: Okay.

12 MR. WALLING: But that's all.

13 MR. CLARK: Mr. Walling, that's making the  
14 assumption that all batch claims would be paid out,  
15 even though the current policy says that there's only  
16 three -- a limit of up to three per provider per  
17 year?

18 MR. WALLING: It would -- I'd have to look a  
19 little bit more closely at that aspect it. But from  
20 where I'm sitting right now, my -- my best estimate  
21 is that removing the batch reinsurance would be  
22 replaced by an increase in the expected losses at  
23 least equal to the batch reinsurance.

24 DR. RITCHIE: And to Mr. Clark's point,  
25 exactly, according to the regulations, there should

1 be no batch claims. There should be a three-claim  
2 limit per physician per year.

3 MR. WALLING: That's what -- that's what  
4 Indiana thought before about a third of their surplus  
5 disappeared.

6 DR. RITCHIE: Yeah.

7 MR. WALLING: Just...

8 DR. RITCHIE: Okay. Other questions?

9 DR. RITCHIE: We can go on to the last major  
10 topic, which is the indicated surcharges for the  
11 hospitals. And if I have it correct, that's  
12 Exhibit 14, which begins on Page 53 of the report.  
13 Is that correct, Mr. Walling?

14 A. One more page, please. There we go.  
15 Actually, I'd like to expand it out like that.

16 Q. All right. It was cutting off the bottom a  
17 little bit.

18 A. It's okay. The footnotes are useful, but so  
19 are legible numbers.

20 Q. All right. Can you then explain this  
21 exhibit.

22 A. So same analysis. Take the historical  
23 surcharges and state them at today's surcharges  
24 levels. Take the projected ultimates from the reserve  
25 analysis and trend them to current cost levels. Look



1 at what the indicated loss ratios are. Select based  
2 on the available information what we think a  
3 reasonable projected loss ratio is.

4 In this case, we've tried to strike a  
5 balance. The older years, obviously, run really high  
6 loss ratios, but it's on a very small number of  
7 smaller insureds. So we've tried to lean more heavily  
8 on the more recent experience and selected 120.3  
9 percent. Same adjustment for increased limits. Same  
10 adjustment for loss adjustment expenses and discount.  
11 Same expense loads for the batch reinsurance and the  
12 office expenses of the PCF.

13 In this case, we go from anticipated  
14 surcharge revenue of almost 35 million to a indicated  
15 need of 38.8 to cover all expenses, all claims  
16 activity, which indicates an increase of 11 percent.

17 So now, if you'll go back to Exhibit 14,  
18 Page 1, you'll see that this looks exactly like the  
19 physicians exhibit, except there's no second table for  
20 an additional infusion of funds. There's also no  
21 reflection of the class plan change. So that's not  
22 reflected in this analysis.

23 So you've only got the indicated plus  
24 11, the increased limits change of plus 4.3, resulting  
25 in an indicated change of 15 percent at expected

1 levels, 25.5, with the risk margin.

2 The deficit recoupment from the balance  
3 sheet summary as before says that if you're going to  
4 do the four-year amortization to deficit, surcharges  
5 need to increase 38.6 percent on an expected level,  
6 50 percent at a 75 percent confidence level.

7 For the benefit of the board members  
8 that haven't been around the last 20 years, we used to  
9 state that with risk margin at 90 percent, and that  
10 has not historically had a lot of influence on the  
11 decision of the board, just to try and provide a  
12 little historical perspective.

13 Q. So this exhibit, similar to the physician,  
14 so it's your recommendations for rate changes without  
15 the deficit, you would recommend 15.8 percent without  
16 a risk margin, or 25.5 percent at 75 percent risk  
17 margin. And then column 5, to account for the  
18 deficit, would be 38.6 percent, without risk margin,  
19 and 50.3 percent with a risk margin?

20 A. That's exactly right.

21 Q. And so those are your recommendations to the  
22 board and the superintendent?

23 A. They are.

24 Q. And did you make a recommendation regarding  
25 experience rating for the larger hospitals?

1           A. I did. Milliman last year, and I think  
2 maybe Merlino's the year before that, or Risk &  
3 Regulatory Consulting the year before that, both made  
4 a recommendation to discontinue the use of experience  
5 rating.

6           For a number of years, the hospital  
7 groups that met the eligibility size requirements  
8 were -- based on fund -- goodness -- funded based on  
9 an experienced rating methodology based on historical  
10 claims experience. The recommendation from the last  
11 two years has been to eliminate that practice.

12           We found some of that -- those arguments  
13 persuasive. We feel like the rate-level indications  
14 are doing a good job of reflecting the experience of  
15 the hospitals, which are predominantly the large  
16 experience-rated hospitals. So we feel like there are  
17 enough other levers going on in the fund right now to  
18 reflect the experience of the large hospital groups  
19 that the experience-rating methodology within the  
20 funding for the hospitals isn't necessary at this  
21 point.

22           Q. So just to make it concise, you are not  
23 recommending experience rating for the larger  
24 hospitals?

25           A. Correct.

1 Q. And I want to skip real quickly to Page 13  
2 of the report, which is 16 of the PCF. And there's a  
3 discussion on the last paragraph about hospital OHCF  
4 rating plan. OHCF is outpatient health care facility?

5 A. Other health care facilities.

6 Q. Other health care facility?

7 A. Right.

8 Q. And I wanted to look at the sentence, the  
9 second sentence: We find that the rate-level  
10 indications derived for all hospital participants  
11 produce reasonable indicated rate changes for the  
12 hospitals in total. Is that related to what we were  
13 just talking about?

14 A. It's essentially what I just said, that  
15 because the large hospital groups that we saw, you  
16 know, dramatically increase the surcharge revenue, are  
17 the majority of the surcharge revenue, and so  
18 therefore, when you do a rate-level indication for all  
19 the hospitals, most of the experience that you're  
20 basing that on is the large hospital.

21 So it doesn't -- it feels like you're --  
22 you're doing experience rating on top of experience  
23 rating to experience rate the two large hospital  
24 groups and then do the experience-based indication.  
25 So the recommendation was basically consistent with

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1 the two previous recommendations, to discontinue the  
2 experience rating for the hospitals.

3 MR. BERENBERG: That was all the questions I  
4 had on the surcharges for the hospitals. I have a  
5 few questions that didn't really fit under the other  
6 topics, and I think at that point then I was going to  
7 suggest to the board to finish up their questions.  
8 The questions I have might answer what the board's  
9 questions are. So unless there's questions specific  
10 to the hospital surcharges, I'll go into those.

11 DR. RITCHIE: I do have one. It's the  
12 difference -- so there's the excess insurance for  
13 batch claims that's carried and, in fact, to be  
14 either in the underwriting or by purchasing excess  
15 coverage, and that's based on over and above three  
16 claims per physician per year. The hospitals have  
17 unlimited claims per year.

18 How does this -- how does that affect  
19 the numbers? Because I'm sure you take that into  
20 effect. So I'm just kind of curious how -- how that  
21 changes the actual numbers.

22 MR. WALLING: We reflect both of those  
23 treatment -- you know, differences in treatments of  
24 the coverage. They're also reflected in the  
25 historical claims experience. So I think what we're

1 doing in terms of reflecting it in the historical  
2 surcharges and the historical claims experiences is  
3 reasonable and appropriate.

4 DR. RITCHIE: But when -- how short of a  
5 time period do you have on historical claim? Do you  
6 feel like that that really is sufficient going  
7 forward?

8 MR. WALLING: Am I going to know more  
9 accurately in five years? Yes. Are we -- are we  
10 making appropriate data methods and assumptions for  
11 those differences based on the information we have  
12 right now? Yes.

13 MR. BERENBERG: Okay. I have a few general  
14 questions, and then we'll finish up with board  
15 questions.

16 BY MR. BERENBERG:

17 Q. So will the proposed rates adequately fund  
18 claims in the future?

19 A. The rate-making, by its nature, is for a  
20 prospective period. Some of our analysis is for the  
21 2023 surcharge year. So the whole reason to go  
22 through this process is the claims experience changes,  
23 the inflationary trends change, the invest yield  
24 change, the fund balance changes.

25 And so the indicated rate-level changes

1 will produce an actuarially reasonable surcharge level  
2 for 2023.

3 Q. But it's not guaranteed to fund the claims?  
4 It's the best estimate you can make?

5 A. It's -- it's -- the standard that an actuary  
6 is held to, whether it's State Farm's pricing actuary  
7 or the PCF, is reasonable. And the indicated rate  
8 changes are reasonable from an actuarial perspective.

9 Q. Is the sharing of the risk between the  
10 independent providers and the hospitals fair?

11 A. The data organization, I believe, is  
12 producing a fair and equitable distribution of the  
13 deficit, and it's also resulting in adequate  
14 rate-level indications for both programs.

15 Q. The PCF always seem to be operating at the  
16 limit of its available cash. And I think you've  
17 touched on this earlier in your presentation. Would  
18 you all recommend creation of a reserve or a surplus  
19 fund to tap into if needed?

20 A. That's actually what the fund balance is.  
21 So that \$95 million fund balance, which is about half  
22 of the indicated reserves, is about half invested  
23 assets, about half not. So there -- this is not a pay  
24 as you go. This isn't Social Security. There is a  
25 fund balance of assets in the fund right now. It's

1 just not sufficient to pay all these -- all the claims  
2 that have already occurred.

3 Q. So would you recommend going beyond the fund  
4 balance, creating some additional surplus account?

5 A. Yeah, that's what -- that's what the whole  
6 deficit calculation is. In my mind, the first step is  
7 to get it back to no fund deficit. Then you could  
8 have a discussion about whether you would want a  
9 positive fund balance or just a zero fund balance.

10 Different funds have different answers.  
11 Virginia seems to try and get to exactly a zero fund  
12 balance. Wisconsin, as I said, has hundreds of  
13 millions of dollars in their fund balance. So there  
14 are choices.

15 Q. In last year's meeting, like this one, there  
16 were a number of questions about the number of  
17 occurrences per claim. Did you look at the past, I  
18 guess, practices as far as the number of occurrences  
19 per claim, how that affects the fund, and did you --  
20 how did that affect your analysis going forward?

21 A. We did get data on the number of claimants  
22 per claim and looked at how that data was allocated.  
23 I think it helped us understand the interactions  
24 particularly between the employed physicians and the  
25 hospitals.



1           So I was -- and, candidly, I've got to  
2 say it's probably the biggest improvement in the fund  
3 over the last 20 years, is the data is simply much  
4 better.

5           Q. Have you looked at any trends as far as a  
6 number of occurrences per claim that are being made?

7           A. We looked at that, especially on the  
8 independent physician side. We also looked at  
9 differences in settlement lags between the hospital  
10 segment and the independent physician segment and the  
11 data so far in terms of, you know, are the hospital  
12 claims bigger or smaller, do they settle faster or  
13 slower. At this point, it's inconclusive. But we did  
14 actually do more testing of those types of differences  
15 and trends than we've done in 20 years.

16          Q. So take hypothetically that the PCF deficit  
17 is immediately eliminated, so as of this year, no  
18 deficit. What would the fund need in order to operate  
19 without incurring a future deficit?

20          A. Take the -- take the recommended surcharges  
21 changes for both pieces of the program.

22          Q. So it was a roughly 19 percent at the  
23 50 percent confidence level --

24          A. Correct.

25          Q. -- without the deficit surcharge? That

1 would be what would be needed?

2 A. Yeah, exactly. And if you keep up with that  
3 and if you take that change instead of capping it 9.9  
4 percent every year, then conceptually, you should be  
5 able to keep your fund balance equivalent -- you know,  
6 so you keep a zero deficit position.

7 Q. And at this point, would you be able to do  
8 an analysis of what level the surcharges would have to  
9 be after 2023?

10 A. Sure. You would trend forward the expected  
11 losses. You would trend forward the increases in the  
12 damage cap. That's based on the best available --  
13 based on the best available information on CPI trends  
14 and loss trends. And you could certainly project that  
15 forward. Now, obviously, there's more uncertainty the  
16 more years you go out.

17 Q. What data for risk assessments would be  
18 needed for the remaining years that the hospitals and  
19 outpatient health care facilities are in the fund?

20 A. Basically, just that modeling the claims  
21 severities and modeling the changes in CPI would be  
22 the two major factors.

23 Q. Would it be possible to subdivide the fund  
24 into separately operating funds, one for independent  
25 providers and one for hospitals and OHCFs?

1           A. Is it possible? Yes. You're exposing both  
2 silos to more claim volatility than the fund -- than a  
3 combined fund, because each one is smaller, each one  
4 has more claim volatility in their silos than they  
5 do -- there's a risk diversification or a risk  
6 distribution effect by combining of the two in a  
7 single fund. But yes, you would create two separate  
8 funds, two separate silos.

9           Q. And I want to show you -- all right. This  
10 is an additional table. And I think I sent this to  
11 you by e-mail, and if you'll give me just a second,  
12 there's one that I had in my other prepared package.  
13 And of course it's not working.

14                   I sent you a table that showed  
15 surcharges collected and losses paid by year for the  
16 different hospitals. Do you remember seeing that?

17           A. Yep.

18           Q. Okay. Let me see if I can try one other  
19 thing.

20           A. If you'll indulge me while you're doing  
21 that.

22                   MS. LOVE: You could stop sharing your  
23 screen and then share again.

24                   MR. BERENBERG: Okay. I'm trying to let --  
25 the screen is showing -- I'll stop the share.

1           So while I'm trying to do this, maybe if  
2 the board has other questions, go ahead and do that  
3 and I will work on this exhibit. So we'll open it up  
4 for other questions, final questions.

5           DR. RITCHIE: Anyone else on the board have  
6 any questions?

7           MR. CLARK: I have no further questions,  
8 Mr. Chair. I asked mine during the presentation.

9           DR. RITCHIE: No questions.

10          DR. WALLING: So while Barry is pulling up  
11 THE exhibit, basically what it's showing is  
12 surcharges by hospital group and the claims  
13 experience to date for the hospital group. And it's  
14 nice data as far as it goes, but it has very little  
15 usefulness yet because it is so immature.

16                 When you're talking about, you know, the  
17 2019, 2018 year, there's such a small percentage of  
18 the claims that are even reported, let alone settled,  
19 that there's just too much of the iceberg that is  
20 unseen at this point to use it to come to, really,  
21 any meaningful categorical conclusions about the  
22 relative experience of the different hospital groups.  
23 The data is just too green.

24           MS. LOVE: So if that is the case -- this is  
25 Kathy Love. So if that is the case, then tell us how

1 we rely on the claims -- the risk analysis for the  
2 surcharge rating setting for hospitals?

3 MR. WALLING: There are a number of aspects  
4 of -- yeah, so you can see Lovelace in 2017 had a big  
5 claim. But there's absolutely nothing in this data  
6 that tells us that Carlsbad Medical Center isn't  
7 going to have a claim blow into the PCF layer that we  
8 don't know about yet. And that, to me, is the --  
9 that -- that's the issue we're dealing with.

10 Now, maybe, maybe if we look at Lovelace  
11 across all of the years and it's consistently bad  
12 already, then maybe you can make some inference about  
13 it by combining all of the years.

14 But to your original question, actuarial  
15 methods have within them ways to accommodate data  
16 that is very immature, data that still has a lot of  
17 loss development tail to it. And by combining all  
18 the hospitals, instead of looking at them one at a  
19 time, we increase the predictive accuracy of the  
20 data.

21 So largely, it has to do with how we  
22 organize the data, the methods we use, and getting  
23 more predictive accuracy out of the hospitals as a  
24 group, rather than looking at them hospital by  
25 hospital.

1 MR. BERENBERG: Any other questions on this  
2 chart?

3 MR. CLARK: Mr. Berenberg, I'm not certain  
4 if I was the only one, but if you would make  
5 certain -- if you're going to introduce this chart,  
6 that you certainly send that out to all board  
7 members.

8 MR. BERENBERG: Actually, that was going to  
9 be my next question. Does the board want me to  
10 introduce this chart as an exhibit?

11 MS. LOVE: Yes, please.

12 DR. RITCHIE: Yes, please.

13 MR. BERENBERG: All right. And do you want  
14 me to lay a formal foundation for this, or is  
15 introducing it as-is okay?

16 MS. LOVE: I accept it as is.

17 MR. BERENBERG: Okay. This will then be, if  
18 I am correct, Exhibit C, and I will send it around.  
19 I'll get it into a better looking format, something  
20 that I can easily mail.

21 MS. LOVE: And, Mr. Berenberg, this is Kathy  
22 Love again. For the record, I accept it as-is based  
23 on my understanding that this is data that was  
24 compiled by the -- your office; is that right?

25 MR. BERENBERG: That's correct. It was

1 compiled by Debbie Luera from data that the PCF has.  
2 And she's available if you want an explanation of how  
3 it was compiled.

4 MS. LOVE: No, thank you.

5 MR. CLARK: I appreciate that. I was just  
6 going to ask for the source of the data and so we  
7 understand if it's been verified.

8 MR. BERENBERG: If -- it's been verified to  
9 the extent that it's data that the PCF has received  
10 and has in its various records.

11 MR. WALLING: And my understanding is it's  
12 from the same claims database that I use, from the  
13 same source data.

14 MR. BERENBERG: I believe that's correct.

15 So I will get that -- I'll send that to  
16 Mr. Ward, so that he can send that to you. It will  
17 be Exhibit C. And at that point -- or at this point,  
18 I don't have any further questions for the witness.

19 DR. RITCHIE: I don't believe anyone on the  
20 committee has any further questions, either.

21 So being no more, I believe we can get  
22 Mr. Walling to his flight on time.

23 MR. WALLING: Which means Mrs. Walling is  
24 going to be very happy.

25 DR. RITCHIE: And I appreciate everyone

1 being here on a Friday afternoon. The committee will  
2 have a lot of data here to go through to submit a  
3 recommendation. And certainly, Ms. Luera and  
4 Mr. Walling and Mr. Berenberg, we may have further  
5 questions to ask of you, clarifications, et cetera.

6 Mr. Toal, Superintendent Toal, do you  
7 have any comments or input.

8 SUPERINTENDENT TOAL: No, thank you,  
9 Mr. Chairman. I look forward to getting the  
10 committee's recommendation.

11 DR. RITCHIE: Okay.

12 SUPERINTENDENT TOAL: The board's  
13 recommendation, excuse me.

14 DR. RITCHIE: And --

15 SUPERINTENDENT TOAL: I express my thanks to  
16 both Barry and to Rob.

17 DR. RITCHIE: And certainly we echo that  
18 thanks several more times.

19 And, Mr. Ward, do you have anything to  
20 keep the board on the straight and narrow as far as  
21 what we need to do going forward?

22 MR. WARD: No, I don't believe so.

23 (Inaudible) the additional exhibit from Mr. Berenberg  
24 when it's sent to me.

25 DR. RITCHIE: Okay. Thank you very much.



1           Being a non-attorney, I appreciate all  
2 the help I can get trying to stay out of trouble.

3           And from the standpoint of the hearing  
4 officer and the board, I would thank everyone for  
5 their commitment here and to the end and appearing.  
6 And I wish you all a very good weekend.

7           MR. DEKLEVA: Mr. Chairman, I did have one  
8 housekeeping matter. I apologize. And that is, I've  
9 got an issue with the starting time of our next  
10 meeting. I think it's scheduled from 2:00 to 4:00,  
11 and I wanted to see if we could reset that from -- it  
12 would be ideal from 3:00 to 5:00, but I don't want to  
13 inconvenience everybody. So even if I could -- we  
14 could start it at 2:30, I might still be a couple  
15 minutes late, but I could make the majority of the  
16 meeting.

17           DR. RITCHIE: That is Thursday the 22nd?

18           MR. DEKLEVA: Yeah, next Thursday's meeting.  
19 Ideally, if we could start it at 3:00, but if  
20 that's -- again, I'm cognizant of everyone having  
21 their own schedule and so if we could start it at  
22 least at 2:30, that would be of great help.

23           MR. WARD: Mr. Chair, this is -- this is  
24 Vince Ward.

25           I just want to make sure, has the notice

1 gone out yet for that meeting, Debbie? I don't  
2 believe it has.

3 DR. RITCHIE: It was included in the notice  
4 with this -- for this meeting.

5 MR. WARD: It was included in the notice.  
6 So I think that if we're going to change the time --  
7 I think we're fine on the amount of time for the  
8 notice. I think we would just want to put a  
9 supplementary notice for the time change.

10 MR. CLARK: Mr. Chair, I'd be open to a  
11 later start time and keep the end time the same.

12 DR. RITCHIE: Well put.

13 MR. CLARK: Just a representation to be more  
14 efficient.

15 DR. RITCHIE: I totally concur.

16 So, Ms. Love, do you have any input?

17 MS. LOVE: I don't have a conflict. But I'm  
18 curious about Ms. Stevens.

19 Do you have a conflict, Ms. Stevens?

20 MS. STEVENS: That will be difficult for me.  
21 I can make it work, but it'll be hard for me to stay  
22 until the end. Because I had to work to make the  
23 2:00 to 4:00 work.

24 MS. LOVE: Yeah.

25 MS. STEVENS: So if we can do 2:30. 3:00

1 would be real hard. But 2:30, I can maybe make that  
2 work.

3 DR. RITCHIE: Understood.

4 MS. STEVENS: Yeah.

5 DR. RITCHIE: Dr. Carson?

6 DR. CARSON: I'm the chair of the medical  
7 board and we're meeting that afternoon, so I will not  
8 make the meeting. And that was scheduled a year ago,  
9 so...

10 DR. RITCHIE: Thank you.

11 DR. CARSON: Yeah.

12 DR. RITCHIE: I do remember that now. I --  
13 we apologize. We are sorry you're so busy.

14 And then I believe it sounds like 2:30  
15 would be the most agreeable to the majority of the  
16 committee. Are there any objections to that?

17 MR. CLARK: No objection.

18 MR. DEKLEVA: Thank you. Thank you,  
19 Mr. Chairman, and thank you to everyone on the  
20 committee. That will help me out.

21 DR. RITCHIE: Right. Well, again, thank you  
22 everyone for all your participation today. And that  
23 will be the next meeting of the board. And we will  
24 meet at -- to go out right away, that announcement.

25 MS. LOVE: Last question. Is there any

1 chance of having the minutes of this hearing before  
2 our meeting next week? I know it's a big ask, but --

3 MS. LUERA: I don't think so. The standard  
4 turnaround is ten days. If -- I suppose we could ask  
5 and certainly pay rush charges, if you feel that's  
6 really important. But I just know from last time  
7 that the standard turnaround is ten days.

8 MS. LOVE: Okay. Debbie, would you mind  
9 finding out what the rush charges would be and let me  
10 know --

11 MS. LUERA: Of course.

12 MS. LOVE: -- and then we could maybe talk  
13 about that. Thank you.

14 DR. RITCHIE: I think it would be nice to  
15 have the minutes. I agree. I concur.

16 Okay. Then hearing no more questions,  
17 then we'll stand adjourned. Thank you everyone.

18 (Proceedings adjourned  
19 at 2:26 p.m.)

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1 IN RE: DETERMINING NEW MEXICO PATIENT'S COMPENSATION  
FUND SURCHARGE RATES

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NEW MEXICO

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[250,000 - accident]

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[accident - analysis]

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[compelling - curious]

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[equitable - extrapolate]

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[ezra - funds]

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[funds - happens]

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[intuitive - level]

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[m.d. - minor]

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[sole - surcharge]

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[surcharge - think]

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[think - ultimate]

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New Mexico Rules of Civil Procedure for the  
District Courts

Article 5, Rule 1-030

(e) Review by Witness; Changes; Signing.

If requested by the deponent or a party before completion of the deposition, the deponent shall have thirty (30) days after being notified by the officer that the transcript or recording is available in which to review the transcript or recording and, if there are changes in form or substance, to sign a statement reciting such changes and the reasons given by the deponent for making them. The officer shall indicate in the certificate prescribed by Subparagraph (1) of Paragraph F of this rule whether any review was requested and, if so, shall append any changes made by the deponent during the period allowed.

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2019. PLEASE REFER TO THE APPLICABLE STATE RULES  
OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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