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

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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.

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

MS. LUERA: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. WALLING: He is. Good afternoon.

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

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

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

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

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

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

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

MS. LUERA: And screen-sharing is available.

MR. BERENBERG: Thank you.

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

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

MR. BERENBERG: Yes.

MS. LOVE: We understand.

DR. RITCHIE: Absolutely.

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

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

MS. LUERA: Yes.

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

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

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

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

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

MR. WALLING: (Inaudible).

ROBERT WALLING,

was questioned, and responded as follows,

BY MR. BERENBERG:

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

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

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

A. Yes. That's my curriculum vitae.

Q. Does this accurately show your education and experience?

A. It does.

Q. What did you do for a living?

A. I am a consulting actuary.

Q. And what does a consulting actuary do?

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

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

A. Absolutely.

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

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

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

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

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

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

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

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

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

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

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

specifically.

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

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

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

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

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

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

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

A. Mm-hmm.

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

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

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

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

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

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

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

MR. BERENBERG: Thank you.

BY MR. BERENBERG:

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

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

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

A. Yep.

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

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

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

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

A. Yes. Yes.

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

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

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

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

A. I did.

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

A. It does.

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

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

MR. BERENBERG: So --

MS. LOVE: We accept him as an expert.

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

MR. CLARK: No objection. This is Troy.

BY MR. BERENBERG:

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

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

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

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

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

A. Mm-hmm.

Q. Is this component related to indicated loss reserves?

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

Q. It is the same thing?

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

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

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

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

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

MS. LOVE: Yeah, this is Kathy Love.

May I just ask, with regard to the loss

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

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

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

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

MS. LOVE: Thank you.

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

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

MR. WALLING: That's true.

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

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

MR. WALLING: Mm-hmm.

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

at this point?

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. LOVE: Yes, it is. Yes.

(Inaudible crosstalk.)

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

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

MS. LOVE: Oh, no problem.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. WALLING: There had not been substantial change.

MR. VARGAS: Okay.

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

MR. VARGAS: Okay. Thank you.

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

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

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

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

MR. WALLING: Yeah.

MS. LOVE: Is that right?

MR. WALLING: Mm-hmm.

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

MR. WALLING: Yes.

MS. LOVE: Thank you.

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

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

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

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

BY MR. BERENBERG:

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

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

A. Yes, it is.

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

A. I believe so, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Is breaking this down by accident year important?

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

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

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

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

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

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

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

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

Q. So is it ultimate loss divided by the

surcharge?

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

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

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

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

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

A. We do.

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

A. I believe that's correct, yes.

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

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

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

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

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

So the net result of that 13 .3 million

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

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

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

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

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

income, then I ought to recognize that fact.

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

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

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

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

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

What can you tell us about the changes from 2021?

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

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

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

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

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

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

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

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

BY MR. BERENBERG:

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

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

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

A. Yes, it is.

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

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

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

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

The 2016 year, the ultimate losses

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

A. We do.

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

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

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

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

Page 2, maybe; 2 or 3.

Q. Here's Page 1.

A. This will work.

Q. Okay.

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

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

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

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

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

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

A. Yes. That's what we did.

Q. You did do it that way?

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

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

A. Correct.

Q. Okay. Can you consider them separately?

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

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

Q. And why does it make more sense?

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

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

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

DR. RITCHIE: Go ahead, Mr. Clark.

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

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

been able to have been made.

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

MR. WALLING: It does.

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

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

MR. CLARK: No further questions.

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

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

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

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

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

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

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

own connection in my head.

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

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

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

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

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

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

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

MR. WALLING: Correct. And to your --

MR. CLARK: And to allocation by year?

MR. WALLING: You're especially going to see

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

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

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

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

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

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

MR. WALLING: Correct.

MR. CLARK: Thank you. No further questions.

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

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

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

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

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

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

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

DR. RITCHIE: Okay. Okay.

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

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

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

DR. RITCHIE: I don't --

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

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

BY MR. BERENBERG:

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

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

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

BY MR. BERENBERG:

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

A. Correct.

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

A. Correct.

Q. What do you estimate that balance to be?

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

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

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

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

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

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

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

Q. Go ahead.

A. No.

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

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

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

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

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

Q. Yes.

A. No.

Q. One more?

A. Sorry, the other way. Other direction.

Q. Here?

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

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

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

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

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

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

largest component of the deficit.

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

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

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

A. Mm-hmm.

Q. What is that?

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

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

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

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

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

A. That's correct.

Q. Were you able to --

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

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

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

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

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

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

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

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

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

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

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

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

MR. WALLING: Honestly --

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

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

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

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

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

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

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

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

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

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

MR. CLARK: Thank you.

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

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

MS. LOVE: Thank you.

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

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

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

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

MR. WALLING: Great. Thank you.

BY MR. BERENBERG:

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

A. That is.

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

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

Q. And the results of those calculations,

they're shown in Exhibit 10, Page 2?

A. That sounds about right.

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

A. Perfect.

Q. Is that correct?

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

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

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

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

nothing changes.

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

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

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

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

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

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

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

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

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

So the combined effect of the indicated

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

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

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

Q. -- (inaudible)?

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

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

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

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

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

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

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

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

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

A. That's correct.

Q. And is there anything else you wanted to

discuss on these charts?

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

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

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

A. It does not.

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

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

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

the current value?

A. Without any additional legislative infusions, yes.

Q. Anything else on this chart?

A. No.

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

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

I've got a question, Mr. Chair.

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

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

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

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

BY MR. BERENBERG:

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

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

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

A. Perfect.

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

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

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

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

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

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

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

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

surcharge revenue would be.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Page 2 or Page 1?

Q. Page 2, which was the calculation of

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

A. On -- on Page 1.

Q. Page 1? Okay.

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

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

A. Mm-hmm.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. RITCHIE: Yeah, Mr. Walling.

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

MS. LOVE: Okay. Thanks.

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

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

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

MS. LOVE: Okay.

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

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

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

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

So if we look at class 1, the current

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

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

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

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

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

Now, recognize, the difference in the

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

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

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

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

So looking at those relationships that

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

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

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

MS. LOVE: Thank you.

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

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

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

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

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

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

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

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

MR. WALLING: Mm-hmm. Every year.

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

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

MR. WALLING: Mm-hmm.

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

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

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

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

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

DR. RITCHIE: Okay. It changes the underwriting.

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

DR. RITCHIE: Okay.

MR. WALLING: But that's all.

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

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

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

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

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

DR. RITCHIE: Yeah.

MR. WALLING: Just...

DR. RITCHIE: Okay. Other questions?

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

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

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

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

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

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

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

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

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

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

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

levels, 25.5, with the risk margin.

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

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

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

A. That's exactly right.

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

A. They are.

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

A. I did. Milliman last year, and I think maybe Merlinos the year before that, or Risk & Regulatory Consulting the year before that, both made a recommendation to discontinue the use of experience rating.

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

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

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

A. Correct.

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

A. Other health care facilities.

Q. Other health care facility?

A. Right.

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

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

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

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

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

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

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

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

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

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

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

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

BY MR. BERENBERG:

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

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

And so the indicated rate-level changes

will produce an actuarially reasonable surcharge level for 2023.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Correct.

Q. -- without the deficit surcharge? That

would be what would be needed?

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

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

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

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

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

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

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

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

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

A. Yep.

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

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

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

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

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

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

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

DR. RITCHIE: No questions.

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

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

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

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

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

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

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

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

MR. BERENBERG: Any other questions on this chart?

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

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

MS. LOVE: Yes, please.

DR. RITCHIE: Yes, please.

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

MS. LOVE: I accept it as is.

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

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

MR. BERENBERG: That's correct. It was

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

MS. LOVE: No, thank you.

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

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

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

MR. BERENBERG: I believe that's correct.

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

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

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

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

DR. RITCHIE: And I appreciate everyone

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

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

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

DR. RITCHIE: Okay.

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

DR. RITCHIE: And --

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

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

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

MR. WARD: No, I don't believe so. (Inaudible) the additional exhibit from Mr. Berenberg when it's sent to me.

DR. RITCHIE: Okay. Thank you very much.

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

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

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

DR. RITCHIE: That is Thursday the 22nd?

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

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

I just want to make sure, has the notice

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

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

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

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

DR. RITCHIE: Well put.

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

DR. RITCHIE: I totally concur.

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

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

Do you have a conflict, Ms. Stevens?

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

MS. LOVE: Yeah.

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

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

DR. RITCHIE: Understood.

MS. STEVENS: Yeah.

DR. RITCHIE: Dr. Carson?

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

DR. RITCHIE: Thank you.

DR. CARSON: Yeah.

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

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

MR. CLARK: No objection.

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

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

MS. LOVE: Last question. Is there any

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

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

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

MS. LUERA: Of course.

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

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

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

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

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

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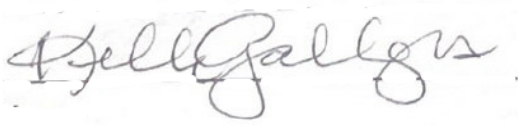

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Article 5, Rule 1-030

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