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3 PATIENT'S COMPENSATION FUND

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13 BOARD MEETING

July 31, 2023

14 9:00 a.m.

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REPORTED BY: Barbara Jean Morgenweck, RPR, CCR

22 NCRA, RPR

New Mexico CCR #526

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1 APPEARANCES:
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3
4
Debbie Luera
5 Alice Kane
Jeff Haisley
6 Jenn
Kathy Love
7 Mike Dekleva
R. Alfred Walker
8 Trish Farulla
Victor Poulos
9 Vincent Ward
James Willett
10 Cameron Ritchie
Nick Autio
11 Mr. Vargas
Troy Clark
12 Mr. Martinez
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14
15
16 *The phone numbers were people on the conference call
but didn't give their names.
17 * This is not a complete list of attendance as others
were joining as the meeting progressed.
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19
20
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1 MS. LUERA: Cameron Richie.
2 DR. RITCHIE: I'm here.
3 MS. LUERA: Vice-Chair Love? Sorry
4 about that, Vice-Chair Love. I can see you.
5 Could you respond you're here.
6 VICE-CHAIR LOVE: Yes, I am here. Can
7 you hear me?
8 MS. LUERA: We cannot hear you.
9 UNIDENTIFIED SPEAKER: Kathy, I can hear
10 you. It may be a problem on Debbie's end.
11 (Discussion held off the record.)
12 MS. LUERA: Cameron Richie?
13 DR. RITCHIE: Here.
14 MS. LUERA: Vice-Chair Love.
15 VICE-CHAIR LOVE: Here.
16 MS. LUERA: Mr. Clark.
17 MR. CLARK: Here.
18 MS. LUERA: Mr. Autio.
19 MR. Autio: Here.
20 MS. LUERA: Mr. Dekleva.
21 MR. DEKLEVA: Here.
22 MS. LUERA: Mr. Martinez.
23 MR. MARTINEZ: I am here. I am walking
24 in.
25 MS. LUERA: Great. Mr. Spencer,

1 Ms. Stevens. Mr. Vargas.
2 MR. VARGAS: Here.
3 MS. LUERA: Just noting for the record,
4 we have a change in membership on the PCF
5 advisory board. We welcome Nick Autio to the
6 board. Nick replaced Dr. Carson, and we also
7 have our new superintendant of insurance,
8 Superintendant Kane on the call. Good morning,
9 Superintendant.
10 MS. KANE: Good morning.
11 MS. LUERA: Okay. All present except
12 Mr. Spencer.
13 DR. RITCHIE: Thank you very much.
14 First item on the agenda is the report on PCF
15 status. We will get right to the meat of the
16 issue.
17 Everyone had a chance to look at this
18 for a whole 48 hours or so, and so I know there
19 is going to be a lot of questions, but let's
20 have the presentation.
21 I know the OSI had an opportunity to
22 spend the last whatever, two weeks,
23 week-and-a-half to go over it and ask for some
24 clarifications, et cetera, and so let's hear
25 that right now, please.

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1 MS. LUERA: This is Debbie Luera with
2 Integrion. I have a brief PowerPoint updating
3 on PCF status. I will go through it very
4 quickly because I know the heart of the agenda
5 is to review the actuarial study.
6 Okay. So the date I am reporting on is
7 2023 data through the end of June. Our PCF
8 participants include 15 hospitals, 361 group
9 entities and 4,369 individual providers.
10 So probably one of the most important
11 pieces of information that folks would want to
12 know is that year-to-date we selected
13 $72,128,899 in surcharges. That is a big
14 difference compared to 2022 when we collected
15 54,800,000 and change.
16 You can see on the two pie charts the
17 breakdown of hospital versus --
18 (An alarm is going off.)
19 MS. LUERA: Could everybody mute unless
20 you are scheduled to speak. Thank you. And
21 then also the chart on the right shows the break
22 down of --
23 (An alarm is going off.)
24 (There was a brief discussion off the
25 record.)

1 MS. LUERA: I think I have muted
2 everyone on the call except those of us here in
3 person. Going back to the breakdown of
4 individual providers, you can see that
5 independent positions make up just shy of 16
6 million in the surcharges collected and agents
7 or employees, positions of a hospital make up 20
8 million and change.
9 So it is important to note who are the
10 main contributors based on surcharge to the PCF.
11 Okay. This next slide shows all of the
12 individual providers and a breakdown of each so
13 we have got 4,369 MDs and DOs.
14 We have got approximately 833 PAs, 1,284
15 nurse practitioners, 410 CRNAs and 83 midwives.
16 The chart on the right shows the top physician
17 specialties by provider count. No surprise
18 there, the highest count is family medicine with
19 442 enrolled providers.
20 Moving on to finances and balance
21 sheets, so this report here shows data as of
22 12/31/2022. It has not been updated based on
23 the numbers provided in the actuarial study so
24 we have not adjusted these numbers here for the
25 change in the deficit of the PCF.

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1 You can see assets 94 million in cash,
2 39-and-a-half million in investments and
3 2.4 million in other, and then liabilities, we
4 have total liabilities of $207 million so
5 obviously the largest liability is long-term
6 claims liabilities; and again, this is not
7 adjusted for the changes surcharged based on the
8 most recent actuarial.
9 So the deficit at 12/31/22 is reported
10 as just shy of 71 million. We will update this
11 once the report has been finalized.
12 DR. RITCHIE: Does this reflect the 30
13 million infusion from the legislature?
14 MS. LUERA: Yes, it does reflect the 30
15 million but not the second infusion.
16 MR. CLARK: This is Troy. The 30
17 million from last year not the 32-and-a-half
18 from this year?
19 MS. LUERA: Correct. So here is just a
20 very brief summary of revenue and expenses.
21 Again as of 12/31/22 for the year ending, we
22 paid 36.3 million in claims. We did have other
23 expenses. We have the actuarial adjustment from
24 last year's actuarial study which does get
25 reported as an expense.

1 Then the other large expenses we had the
2 batch claims reinsurance, the contract to
3 provide third party administration services and
4 the medical/legal issue panel as well as some
5 interagency expenses within OSI.
6 As far as revenue, you can see the
7 54.8 million in surcharge revenue, 872,000 in
8 interest income, the 30 million appropriations
9 and then we had some unrealized investment
10 losses which will be trued up.
11 So the total revenue 79.3 million, total
12 expenses 45.9 million. So again, this will all
13 be adjusted once -- the OSI only adjusts the
14 deficit once a year when the actuarial study
15 comes out.
16 So that is what I have on revenue and
17 expenses. If there aren't any questions, I will
18 move on to the report on tracking allocation of
19 settlements.
20 As you know, once Integrion was awarded
21 the third party administration contract, we did
22 begin tracking the claims and who the payments
23 were allocated to.
24 So again, this data here is through
25 June 30th of 2023. We have had 37 settlements

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1 or 37 claims resolved whether it was mediation,
2 trial, anything like that.
3 So we paid a total in the first half of
4 the year of 23.2 million, and you can see here
5 the breakdown of payments on behalf of
6 providers. 15.1 million in payments on behalf
7 of hospitals; 3.7 million on behalf of entities,
8 that would be group entities; 3.8 million on
9 behalf of independent positions; and 593,000 on
10 behalf of hospital employed positions.
11 We will obviously keep tracking this
12 data and update at future meetings as well but
13 this is how things are looking so far for 2023.
14 Are there any questions for me?
15 DR. RITCHIE: Did you ever have a
16 comparison or can you make one, a graph, showing
17 the comparison of, for instance, the surcharge
18 in 2023, the independent physicians was
19 essentially higher than -- the collections for
20 independent was essentially higher than for
21 hospitals, correct? A couple slides before.
22 MS. LUERA: Oh.
23 DR. RITCHIE: I wanted to compare that
24 area. Have you compared that? There is the
25 surcharge. So higher for individuals than for

1 hospitals, right, that surcharge collected?
2 MS. LUERA: Yes.
3 DR. RITCHIE: Then if we go forward to
4 that last slide, how are -- the payouts were
5 very much flipped in the other direction.
6 MS. LUERA: Yes. However, -- sorry,
7 this is my last slide here -- when we look at
8 the payout, this chart here shows the accident
9 year that the payout is attributable to. So
10 the surcharges collected for 2023 are meant to
11 pay all claims for occurrences happening in
12 2023.
13 You can see we do have quite a bit of
14 lag in terms of getting things settled, yes. So
15 you can see here the bulk of the claims here
16 that has been paid this year go back to accident
17 years 2018 and 2019.
18 MS. KANE: This is Alice Kane. It looks
19 like the entity surcharge is much lower than the
20 claim.
21 MS. LUERA: Yes, that is true. We did
22 have -- I believe there was one claim against an
23 entity that is really driving those results.
24 I'd have to go back and look at the spreadsheet,
25 but sometimes the entity wants to take

1 responsibility for the claim so that it is not
2 recorded against the physician. I can't tell
3 you for certain that is what happened in this
4 case, but there was one claim where the entity
5 was the one allocated when the settlement took
6 place if that makes sense.
7 Any additional questions on that data?
8 I did not send out the PowerPoint. I will be
9 sure to get it posted to the PCF website right
10 after the meeting today. If anyone has
11 questions, please feel free to email me.
12 I don't have the agenda up, but the next
13 item on the agenda is the report on the
14 actuarial study.
15 If everyone will hold on for a minute, I
16 have an email from Rob Walling, the actuary. He
17 is having trouble getting in.
18 DR. RITCHIE: Does anyone have a
19 question real quickly on what we saw so far?
20 All right. So hopefully for the meeting coming
21 up there will be more people be able to attend
22 in person the meeting in September so that we
23 don't have to mess with the technology quite as
24 much. We can do this in a much clearer
25 efficient manner.

1 So everyone had an opportunity to look
2 at this but Mr. Walling is going to present
3 presumably the summary and the data and then we
4 will have an opportunity to ask questions after
5 that. Were you able to get hold of him?
6 MS. LUERA: I apologize. I am waiting
7 to hear back from him.
8 DR. RITCHIE: Canada is a big place.
9 Sometimes it takes awhile to get messages up
10 there. Absent -- if we don't have someone that
11 can present from the actuarial side, then I
12 guess we would have to skip to OSI and their
13 shake on it and their basically response or
14 evaluation of the study.
15 MS. KANE: Ann, I assume you're going to
16 respond.
17 UNIDENTIFIED SPEAKER: Debbie, is Rob
18 not able to get on? I am not sure what I can
19 talk about here. The study is what it is. We
20 don't have much of an opinion on it.
21 DR. RITCHIE: Thank you.
22 MS. KANE: I have a question though.
23 The goal is to have a competitive market to
24 attract new positions, and frankly, we are
25 having a problem with coverage and even keeping

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1 physicians.
2 DR. RITCHIE: That is absolutely
3 correct. The data shows that.
4 MS. KANE: Any thought on any actions we
5 might take?
6 UNIDENTIFIED SPEAKER: That's an item
7 for a different meeting. It is not on today's
8 agenda. Today we are going through the
9 actuarial report.
10 DR. RITCHIE: Yes, and I think that is
11 why it is a two-day meeting for the next one to
12 address that because we felt like we didn't have
13 enough time last year to really explore that. I
14 think --
15 MS. KANE: When is the next meeting?
16 THE WITNESS: Hold on a second. It's
17 September 21 and 22.
18 MS. KANE: Thank you.
19 (There was a brief discussion off the
20 record.)
21 DR. RITCHIE: So Rob is on his way in.
22 We will go to the meat of this meeting which is
23 presentation by the actuaries on their study and
24 us having an opportunity to question them and
25 ask perhaps for any clarifications or additional

1 information, and then that is what we have a
2 chance to look at prior to the two-day meeting
3 in September.
4 MS. LUERA: I am going to stop sharing
5 so Rob can share. He is on on the call now.
6 MR. WALLING: Sorry everybody. There
7 was a Teams meeting and a Zoom meeting, modern
8 conference calls.
9 So let me start by, first of all, thanks
10 everybody for taking the time. My name is rob
11 Walling. I am a principal and consulting
12 actuary with Pinnacle Actuarial Resources. For
13 more than 20 years I was in Bloomington,
14 Illinois. For the last three years, I have been
15 in Asheville, North Carolina. I have worked for
16 the New Mexico PCF since 2005. So let's jump
17 in.
18 We have tried to make some changes to
19 our report to make it kind of more accessible to
20 the non-technical reader. We have tried to pull
21 a lot more information into the executive
22 summary so that in a lot of respects the
23 executive summary stands more on its own.
24 Hopefully that will allow readers to
25 interact with the report a little bit better.

1 We organized the executive summary into a group
2 of findings that are consistent with the scope
3 of services that are requested. Is there a
4 question?
5 MS. LUERA: We are just trying to get
6 our conference room's screen to be able to view
7 your screen. Again, challenges of the virtual
8 world.
9 UNIDENTIFIED SPEAKER: Can those on the
10 virtual side can they all see his screen?
11 MS. LUERA: Yes.
12 UNIDENTIFIED SPEAKER: Thank you.
13 MS. LUERA: Sorry. Go ahead.
14 MR. WALLING: So the first finding on
15 the first group of discussion points relate to
16 the unpaid claims liability.
17 The idea here is because the coverage is
18 provided on the current form, there are claims
19 that have occurred -- negative patient outcomes
20 that have occurred that are going to result in
21 claim payments in benefits payments, but they
22 either haven't been reported or they haven't
23 been paid and so they're unpaid, and those are
24 essentially liabilities on the balance sheet of
25 the PCF.

1 We estimate that the current value of
2 all of those unpaid claims that already occurred
3 is about $266.8 million on a nominal basis so
4 those are the actual dollars we expect to be
5 paid out over the next 15, 20, 30 years.
6 If we discount that to a present value
7 using a 3-and-a-half percent discount rate,
8 reduces that value to just over $260 million.
9 You might say to yourself, Rob, this
10 seems really weird that we have got this big
11 future cash flow that is spread out over a lot
12 of years and we are only getting 6-and-a-half
13 million dollars worth of time value of money.
14 The reason is: Based on actuarial
15 standards, it's prudent to only take the value
16 for the time value of money for the future
17 claims payments that are supported by invested
18 assets. In other words, that are generating the
19 investment income for the discount, and so
20 because of there isn't $266 million invested
21 right now to support the fund, we don't get the
22 full discount for all $266 million but that's
23 kind of an expected value.
24 There are certainly scenarios where the
25 claims can be a lot more than that. Certainly

1 scenarios where the claims can be a lot less
2 than that so we want to increase the statistical
3 likelihood that the reserves that are held are
4 in, say, to a 75 percent confidence level, that
5 three times out of four the value is going to be
6 enough.
7 Then we would suggest increasing the
8 reserves to $281.3 million to increase that to a
9 75 percent confidence level.
10 This compares to the values you see down
11 at the bottom of the screen. 203.7 million on a
12 nominal basis last year; 196.8 on a discounted
13 basis and 213.3 million so a significant
14 increase in the unpaid claims liabilities.
15 We will get more into where that is
16 coming from and why that is coming from in a
17 second.
18 MS. KANE: A quick question. So far as
19 invested assets, should we be discussing whether
20 more of these assets should be invested? I
21 think I met with I am guessing for --
22 MR. WALLING: There is always a
23 challenge with programs like this one in terms
24 of having claims paying ability, having
25 liquidity versus having more invested assets.

1 MS. KANE: But it seems to just be
2 sitting in cash and letting interest bearing
3 account -- where -- it will just be interesting
4 to look at this later on.
5 MR. WALLING: I would suggest to you if
6 you look at, like, the Virginia birth fund that
7 generates typically a 6, 6-and-a-half, 7 percent
8 return on their investments because they are
9 holding funds for 25, 30 years or you look at
10 the Wisconsin compensation fund where they are
11 part of the Wisconsin State investment fund and
12 are throwing off 3, 4, 5 percent returns pretty
13 much every year.
14 There's obviously a lot of, a lot of
15 investment income that can be generated by
16 taking a more aggressive investment philosophy.
17 MS. KANE: -- to the level of
18 aggression.
19 MR. WALLING: Non zero.
20 MS. KANE: Is that going to say to
21 investment people when we dealt with
22 (inaudible)-- I do imagine we bring this back to
23 the board.
24 MR. WALLING: And I would go so far as
25 to say in Wisconsin they have gotten to the

1 point now -- I wouldn't necessarily recommend
2 building up a surplus the size of Wisconsin's,
3 but they are throwing off so much investment
4 income that it's largely reducing the need to
5 assess physicians so that source of a second
6 revenue stream to subsidize the healthcare
7 provider's surcharges is something we see in a
8 lot of these funds.
9 In Virginia, there is a one-quarter of
10 one percent premium tax on all liability
11 insurance in the state as a way to partially
12 fund the birth injury fund.
13 So there are a number of other
14 techniques including investment income that can
15 certainly provide revenue.
16 MS. KANE: So we will come back and look
17 at that. Thank you.
18 MR. WALLING: Uh-huh. So here is a
19 comparison of the ultimate loss estimates
20 comparing the independent physicians and
21 surgeons to the hospitals. You will see that
22 last year in the middle of the page the
23 independent physicians were about 57 million.
24 That estimate has increased to 71 million.
25 Recognize, that is rolling on an additional

1 birth -- or an additional year of claims.
2 So the ultimate loss is all of the
3 things being considered would be expected to
4 increase.
5 Similarly, the hospitalist is going from
6 146 million to 195 million in the second row
7 which is obviously a more material increase, and
8 you will see that that plays through in the
9 reserve numbers as well, that the increase in
10 the physicians' and surgeons' claims has not
11 been nearly as significant as the increase in
12 the hospitals and other healthcare facilities.
13 We will get into more of that as we move
14 on through this. Okay. The second set of
15 findings relate to the debt surplus or deficit.
16 The current PCF fund balance, in other words,
17 kind of all of the held assets is $135.9 million
18 as of year end '22.
19 When you compare that to our nominal
20 reserves of 266 suggesting a deficit position of
21 about $130 million. You reduce that to 98
22 million and change after the reflection of the
23 $32-and-a-half million legislative infusion in
24 2023. We will talk some more about that as we
25 go.

1 That means the deficit is about
2 58 percent of the current fund balance. This
3 reflects an increase of about $19.8 million or
4 about 12 percent prior to our analysis last
5 year.
6 You can do the same thing on a present
7 value basis and look at the discounted funding.
8 That fund deficit on a discounted basis is
9 91.9 million. That is actually an increase from
10 71.8 million last year.
11 You can see all of this summarized in
12 the table below. Again, this is kind of part of
13 our effort to try and incorporate more of the
14 information at a very high level directly into
15 the executive summary. Okay.
16 DR. RITCHIE: Mr. Walling, can I briefly
17 interrupt? I don't really want to very often.
18 You did say the 32.5 million legislative fund
19 infusion '23, but it was $30 million 2023, and
20 looking forward, it should be 32.5 for the next
21 fiscal year. First infusion was 30 million.
22 MR. CLARK: This is Troy. I think
23 Dr. Richie has got a point that may be referring
24 to the differences between the year in which it
25 was past and the fiscal year State fiscal year

1 which it is allocated to. So the 30 million was
2 passed in 2022 for State fiscal year 2023. The
3 32-and-a-half million was past this year in 2023
4 for State fiscal year 2024.
5 MR. WALLING: I believe what you will
6 find is the fund balance -- I will have to
7 double check on this, but I believe the fund
8 balance as of year end '22 actually reflects the
9 30 million. It doesn't reflect the 32.5. I will
10 double check.
11 UNIDENTIFIED SPEAKER: Thank you.
12 MR. WALLING: Very valuable observation,
13 thank you. The third area of findings relate to
14 surcharge levels. Basically the approach we
15 take is called a rate level indication. It's a
16 way of looking at historical claims experience
17 relative to historical surcharges and projecting
18 how much surcharge levels need to change to
19 achieve a break even loss ratio.
20 Our analysis for the physicians and
21 surgeons suggest a ten percent increase would
22 achieve a break even loss ratio going forward.
23 If we increase that to a 75 percent level of
24 confidence, the indicated rate jumps to
25 18.9 percent.

1 Furthermore, there are a few class
2 changes that are proposed. These are largely
3 rate reductions for individual classes. As a
4 point of background, part of what we do is we
5 look at patient comp funds in Indiana and
6 Wisconsin that publish their rates by physician
7 specialty.
8 We also look at rate filings for the
9 doctor's company and I believe MedPro and
10 medical protective in New Mexico to try and give
11 us two different perspectives on how different
12 physician specialties should be priced by the
13 New Mexico PCF.
14 There are a few proposed decreases but
15 if you're going to decrease a limited number of
16 classes to keep the overall surcharge level, you
17 need to have an offset and that offset is about
18 2.3 percent.
19 We also looked at how the consumer
20 pricing index affects the PCF coverage limits.
21 Basically, that change would suggest an increase
22 in the first dollar per occurrence limit from
23 $803,000 to 854, almost $855,000. That would
24 actually increase the PCF exposure layer for
25 claims subject to the cap to 600, almost

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1 $605,000 as a result.
2 MR. VARGAS: I have a question about
3 that. Is that taking into account the latest
4 change to the act where we agreed to basically
5 average the CPI over three years and use that
6 average for the increase.
7 MR. WALLING: The acts, if you read it
8 closely, actually has two different applications
9 of CPI: One using three-year average and one
10 not which is unfortunate and really ought to be
11 cleaned up.
12 We believe what we have done with the
13 damage cap is accurate to the current act but
14 great question. Thank you.
15 So the problem with increasing that
16 damage cap is it has an impact on the indicator
17 rate because you now need to fund that
18 additional limit of coverage and so there is an
19 additional 5.7 percent rate need just to keep up
20 with the change in the damage cap.
21 That is one of the interesting nuances
22 of dealing with cost of living adjustments in
23 birth injury funds and patient compensation
24 funds is that it creates a constant upward
25 pressure on surcharges. All of the things being

1 equal; no change in claims experience; no change
2 in anything; just the change in the coverage
3 limits is going to indicate a rate surcharge
4 increase.
5 So we summarize that -- all this
6 information for the physicians, surgeons in this
7 table. So if you're just looking at the
8 historical losses, it's plus ten. If you're
9 going to offset the class plan changes, it is
10 another two. The cost of living adjustment in
11 the coverage limits is another 5.7. In total
12 the indicated rate change increase is
13 18.9 percent.
14 For the hospitals, the rate level
15 indication suggested is 11.8 percent. There
16 isn't an adjustment for the class plan and so
17 it's simply at 11.8 percent increase or if you
18 increase the level of fiscal confidence
19 20.9 percent.
20 A bullet point here at the end of this
21 page that is worth noting because the PCF is no
22 longer purchasing reinsurance for batch claims
23 -- for the folks that aren't familiar with the
24 term, a batch claim is a sustained pattern of
25 behavior.

1 In New Mexico, we had a surgeon doing
2 spinal fusions with a consistently bad
3 procedure. In Indiana, they had a guy doing
4 nose jobs; but when you have a sustained bad
5 pattern of behavior, sometimes they are treated
6 as a single claim, almost like a pollution claim
7 or an employment practices liability claim;
8 whereas, a single sustained pattern of behavior.
9 Because of those spinal fusion claims and one
10 other claim, the PCF for a time purchased
11 reinsurance to protect against that kind of
12 contagion risk.
13 That coverage has since been allowed to
14 lapse and is not currently being purchased so we
15 actually put a provision back into the rate
16 indication because the history -- the historical
17 data we looked at had those claims reinsured so
18 there needed to be a provision put into the rate
19 making analysis to address the issue of the
20 batch claims.
21 MR. AUTIO: This is Nick Autio. I had a
22 couple questions on that as far as your report.
23 Can you help us understand why when the
24 independent physicians are limited to three
25 occurrences under the law why they need coverage

1 for batch claims?
2 MR. WALLING: Batch claims was
3 specifically addressing, honestly, the spinal
4 fusion claim and I forget the other claim.
5 There was another very large batch claim 12,
6 13 years ago, and from a risk management
7 perspective given the batch claims in New Mexico
8 but also the batch claims that we saw in some
9 other states, the PCF made the risk management
10 decision to purchase the reinsurance.
11 They also have since made the decision
12 to let that coverage lapse so I think given the
13 propensity for batch claims that we see these
14 days, it is not a bad decision to purchase the
15 reinsurance, but I also understand the
16 motivations to let it lapse and maybe it is that
17 limitation of three claims that would -- the
18 problem is the definition of a claim if a
19 sustained pattern of behavior can be one claim
20 then it -- a batch claim is still a very real
21 possibility even with that three claim limit.
22 MR. AUTIO: Thanks for that. This is
23 Nick Autio again. In terms of the indicator
24 assessment level change for the independent
25 physicians, is there a breakout of what percent

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1 is going towards that provision for batch
2 claims.
3 MR. WALLING: Sure. Back in the
4 exhibits -- I am going to make your eyes swim
5 for a minute. I apologize.
6 Back in the physician exhibits in
7 Exhibit 7, page 1 which you're going to find is
8 the historical batch claim expected losses based
9 on the reinsurance pricing so there is a
10 4.9 percent of loss provision that is being
11 loaded into the rate level indications and only
12 the rate level indications. It is not affecting
13 the reserves at this point so there's just shy
14 of a five percent load going into the overall
15 grade level indications for that issue of the
16 batch claim reinsurance.
17 MR. AUTIO: This is Nick Autio again.
18 Correct me if I am wrong. Taking that ten
19 percent figure in terms of the figure without
20 the risk margin, five percent -- am I
21 understanding it correctly that five percent of
22 that ten percent is devoted toward the batch
23 claims provision.
24 MR. WALLING: Not quite but it would
25 reduce the indication if you took that provision

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1 for batch claims out that will reduce it.
2 MR. AUTIO: Thanks for that
3 clarification.
4 MR. WALLING: I guess, I would hesitate
5 to take that interpretation given that we're
6 seeing the definition of an occurrence very much
7 under attack.
8 I have got every reason to believe that
9 batch claims are still a potential issue for
10 patient compensation fund.
11 MR. AUTIO: Understood. Thank you.
12 MR. CLARK: I know you have already
13 slipped back from your exhibits, but is that
14 five percent number consistent for the
15 hospital's portion as well? Is there any
16 different percentage?
17 MR. WALLING: Should be the same.
18 MR. CLARK: Thank you.
19 MR. WALLING: I'd have to go look but
20 I'm pretty sure it's the same. Okay. But it is
21 important to remember when we are talking about
22 these -- indications, we are only talking about
23 getting the surcharges to an adequate rate level
24 in an ongoing forward basis that doesn't do
25 anything to reduce the deficit on going forward

1 basis. So we have got kind of two issues here:
2 One is getting the ship righted in terms of next
3 year's surcharges; one is trying to start
4 filling in this hole on the deficit.
5 So as with last year, we went through
6 the process of trying to allocate the deficit
7 between the physicians and the surgeons and the
8 hospitals.
9 This year we have allocated 42.8 percent
10 to the physicians. That is a reduction from
11 last year where it was 56.4 percent.
12 We then adjusted by allocating -- we
13 actually showed two snares: One is a 50/50
14 split of the 32-and-a-half million; the other
15 was a 75/25 split with 75 percent allocated to
16 the physicians.
17 Basically what this says is: There
18 would need to be a 32.7 percent load on top of
19 the 2024 surcharges for the independent
20 physicians to retire the surcharge deficit for
21 the physicians within five years.
22 We also looked at longer timetables too
23 to basically eliminate the deficit, and those
24 are included in the full report.
25 Conversely, for the hospitals, we

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1 allocated 57.2 percent of the deficit. That is
2 an increase from 43.6 so that everything sums to
3 a hundred percent.
4 And I am going to -- give me a second.
5 Part of what you need to recognize about this
6 allocation is what we're doing is we're
7 allocating -- Zoom in just a touch.
8 So here is the situation as it stands.
9 We're looking at the difference between --
10 sorry, that is not the right table.
11 We're looking at the surcharges
12 collected versus the ultimate losses from our
13 analysis for physicians and surgeons versus the
14 hospitals.
15 What we're seeing is that since 2000, so
16 for the last 23 years, the practitioner's have
17 contributed surcharges on the order of $234.75
18 million, and we estimate the ultimate losses to
19 be 51.38 million so it is a deficit of about
20 21.9 percent of a shortfall of 52 or
21 $51-and-a-half million.
22 Conversely, if we're looking at the
23 hospitals, we are looking at a shorter
24 timeframe. I will be the first to admit there
25 is more uncertainty because PCF claims take a

1 long time to emerge and a long time to settle,
2 but based on our best most recent analysis, the
3 hospitals over the last 14 years have
4 contributed $207.6 million in surcharges. We
5 estimate their ultimate losses are going to be
6 on the order of 276.3 million, a shortfall of
7 $68.7 million just looking at surcharges versus
8 ultimate losses.
9 So thinking of this very much like an
10 insurance company where it -- the first test is
11 how do your losses compare to your premiums; and
12 simply saying if we assume the expenses are
13 approximately equal, then this is a reasonable
14 way to allocate the surcharge.
15 And what you'll see is that the hospital
16 surcharge increases significantly. It is not so
17 much the physicians are decreasing. The
18 physician seems to have settled into a
19 relatively stable environment at the moment.
20 The problem is really the hospitals, and
21 that goes to this table in the previous page.
22 In the last 12 months and during the
23 2022-calendar year, the physicians only had
24 $9.4 million of paid claims. That is much lower
25 than historical averages. It is actually a

1 pretty solid result for the docs.
2 The hospitals on the other hand had
3 $26.4 million of paid claims, and so it's really
4 the change in the allocation isn't so much to do
5 with the docs improving; although, there was
6 some favorable experience you can see in those
7 losses for the years 2017 and prior for the docs
8 in column four. The experience for the
9 hospitals is really what is driving these
10 changes.
11 So we summarized then the allocation of
12 the deficit and then we provide schedules for
13 how it could be retired over of longer term.
14 MR. CLARK: This is Troy Clark with
15 questions. I guess, I am curious you mention in
16 your executive summary a allocation between the
17 physicians and the hospitals of the
18 32-and-a-half million, a 75/25 split.
19 Later you do a 50/50 split. You just
20 explained -- I don't know what the exact
21 percentage is but a 58 million, a 51 million
22 ratio. Are there basis -- I mean, obviously the
23 last one you gave us was what the basis was on
24 the net shortfall projected. Is there any other
25 basis behind your 75/25 or your 50/50 split that

1 is in there other than arbitrary and have you
2 looked at it on number of physicians -- I think
3 as we had talked about it before, not that
4 anybody had agreed to it, but I had proposed
5 looking at it on just number of doctors, not
6 knowing what that number is. I know roughly
7 what the employed versus unemployed are in the
8 state but not in the PCF.
9 I am looking for some rationale behind
10 what you're looking for so that we as a board
11 can recognize what that is and if there is a
12 recommendation for a difference there, get to
13 what that recommended allocation of that first
14 32-and-a-half million would be.
15 MR. WALLING: I was not given the prior
16 conversation at the board level about that
17 allocation of the infusion. Largely -- and I
18 was told that the legislation itself does not
19 describe how it ought to be allocated so
20 basically what I have done is try to provide a
21 couple of different scenarios.
22 One is a 50/50 split and one is a 75/25
23 split, but certainly I would be responsive to
24 any direction from the board about doing a
25 different allocation.

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1 I guess I had been led -- I don't know
2 whose call that is, but I will leave that to
3 whoever has got the authority to make that
4 decision, but what I was trying to do is provide
5 some information about how a 75/25 versus a
6 50/50 split would impact things. In this tape
7 --
8 UNIDENTIFIED SPEAKER: Mr. Chair, on
9 that, Nick, you may remember. I do believe that
10 the -- my recollection is the legislation that
11 was passed does designate for physician's, not
12 for hospitals, not for independent physicians.
13 That is why I made the recommendation on
14 number of physicians. I am not sure that the
15 discussion -- if that is the case, Nick, I don't
16 know if you remember the exact words of the
17 statute but I thought it said four physicians.
18 -- language got changed. I can't remember what
19 was in there firmly, but I do believe that if
20 that is the case that we would need to make some
21 recommendation based upon physicians whether
22 they're employed or independently an allocation
23 not on an overall deficit of hospitals because
24 you're going to have the hospital part and the
25 employed physician part blending in there, and I

1 think that would blur it. I just want to be
2 upfront.
3 MR. WALLING: That gets really tricky
4 and maybe we can have a conversation outside of
5 this one because the allocation based on
6 surcharges versus physician counts versus claims
7 aren't necessarily all the same allocation, but
8 I am certainly happy to have that conversation.
9 DR. RITCHIE: That is a question I have
10 later as well in a little different way. The
11 one comment I have or question of you and then I
12 won't interrupt you anymore for this is: For
13 that table for the historic underwriting
14 performance, is there -- can you provide that
15 like in a graph form to show us for those of us
16 who are more visual than number oriented how
17 those surcharges and losses are going over this
18 last 22 years or certainly, say, over the last
19 ten years? And also, have you figured out just
20 for a running average or rolling average of
21 what's happening year over year that the trend
22 because it seems like that needs to be taken
23 into account when looking at this actuarially.
24 MR. WALLING: I guess, I would caution
25 you against looking too hard at trends, and part

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1 of the reason I say that is there is so much
2 volatility here year over year and so few claims
3 in each and every year that I think it is hard
4 to get a decent statistical fit to any kind of a
5 trend line.
6 We certainly do that as part of our
7 analysis. Typically the fit is so poor that I
8 think it is hard to come to any conclusive
9 finding about the trends, but I will point you
10 back in the exhibits. Sorry. I am making you
11 blur again, but if you go back to the rate level
12 indications where we estimate --
13 DR. RITCHIE: I think that is where a
14 graph would help us.
15 MR. WALLING: I completely agree. Here
16 is a look at the -- essentially the loss ratios,
17 the same data for the physicians, and you will
18 see that, you know, in 2014 there's a
19 132 percent loss ratio but the following year it
20 is 54.
21 2017 and '18, both seem to running a bit
22 of a temperature, but 2020 obviously COVID year
23 and there is going to be an asterisk around that
24 forever, but there is so much volatility here
25 that I think -- now, I can certainly turn this

1 into a graph. That is easy enough, but there is
2 so much volatility here that I think it makes it
3 hard to come to any conclusive decisions about,
4 you know, is there a trend here or not.
5 Same thing for the hospitals. Probably
6 the hospitals is: When the hospitals are bad,
7 they're really bad. And what we're starting to
8 see -- let me go back to the indication.
9 (Talking over one another)
10 Exactly. I completely agree. Part of
11 what we're dealing with is we're starting to see
12 -- we have got really really new years here.
13 The jump in the hospitals doesn't occur until
14 2017, and there is still a lot of uncertainty
15 about how the ultimate claims values on even
16 2017, the oldest of kind of the full
17 participation years, are going to perform.
18 So there is still a tremendous amount of
19 uncertainty here. Let me go back again. I want
20 to point out one other thing. We went through
21 the exercise as an informational item of trying
22 to do a first approximation of how the hospital
23 experience would allocate to the different
24 systems, and I want to spend a second here
25 because it highlights exactly how much

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1 uncertainty, how much in actual -- insurance or
2 actuarial -- there is on these claims.
3 The hospitals paid in $207.6 million.
4 We have already discussed that. So far 79.6
5 million have been paid out, and my estimate of
6 ultimate liabilities is almost $200 million
7 higher.
8 So there is still literally 75 percent
9 of these ultimate claims obligations that are
10 still subject to a significant amount of
11 uncertainty.
12 That is the nature of medical
13 professional liability especially in excess
14 layers.
15 We deal with the same issue in Wisconsin
16 where we do the work for the patient comp claim.
17 Same issue with the medical indemnity funds in
18 Florida and Virginia and New York.
19 So when you deal with excess medical
20 professional liability, it has just got a really
21 long tail and that is what you're seeing here
22 with the hospitals.
23 So what we have tried to do is take that
24 ultimate loss of $275 million and allocate it to
25 hospital network to get a feel for whose

1 performing better than average, whose performing
2 worse than average, recognizing that it's still
3 subject to a tremendous amount of uncertainty.
4 There is nothing in this analysis that
5 says that quorum health isn't going to have a
6 bunch of late claims emerge, and there is
7 nothing to say that Christus Saint Vincent
8 having a lot of paid losses early on is going to
9 continue to see that behavior except that
10 typically when you see claims emerge, it's
11 early. It portends additional claims emerging.
12 So we have tried to do a reasonable
13 allocation of those ultimate losses just -- and
14 let's start with something as simple as: Let's
15 look at St. Vincent. They have paid in about
16 $34.5 million of surcharges and they have
17 already paid out $32.7 million in claims.
18 Sorry. The PCF has already paid out
19 $32.7 million of claims on behalf of St.
20 Vincent.
21 Conversely, Presbyterian has paid in
22 $93.75 million of surcharges and has only paid
23 out $12 million through the PCF in claims.
24 So even at these early days if we look
25 at Lovelace at 23 million of surcharges and

1 already 17.9 million of PCF paid claims. They
2 have already -- if you think of it as kind of a
3 loss fund kind of thing, I am not trying to draw
4 that parallel here that Lovelace has already
5 essentially blown through all but $5 million and
6 change of the surcharges they have paid in.
7 That is not how the PCF works, but I wanted to
8 try and start providing some information to
9 Integrion and the commissioner and staff about
10 the relative performance of the different
11 healthcare facilities. This is a first attempt
12 to do that.
13 You will see that there are some -- so
14 far, so far based on the early claims emergence
15 some facilities that are performing better than
16 others, still very much in the early days for
17 the hospital program.
18 MR. AUTIO: Mr. Walling, I have a
19 question. I saw Vice-Chair Love unmuted. I
20 don't know if you have a question, Ms. Love.
21 VICE-CHAIR LOVE: I do but I can wait.
22 MR. AUTIO: No, go ahead.
23 VICE-CHAIR LOVE: Could you tell us is
24 this chart that you have created is this for all
25 years for these hospitals?

1 MR. WALLING: Yes.
2 VICE-CHAIR LOVE: Okay. Thank you.
3 MR. WALLING: Yep. And just to add
4 clarification, what we have done is taken the
5 surcharges and the losses from each year and
6 allocated the combined experience of all the
7 hospitals to all the hospitals that pay
8 surcharges kind of by year and then rolled it up
9 to this table.
10 VICE-CHAIR LOVE: Thank you.
11 MR. AUTIO: When -- I guess, it gives me
12 heartburn looking at these loss ratios that
13 we're discussing, and, you know, I think we all
14 as a board need to keep in mind that the
15 hospitals after they leave the fund in 2026, I
16 don't know of a way to, you know, basically claw
17 back money if they haven't paid the sufficient
18 surcharges.
19 So these loss ratios certainly give me
20 some heartburn and the volatilely you're talking
21 about. When you're looking at and proposing
22 these different surcharge rates, are you
23 considering the fact that the hospitals will no
24 longer be participating after 2026? Is that
25 accounted for? Is there a way to account for

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1 that?

2 MR. WALLING: We do those amortizations

3 schedules for the physicians, but we recognize

4 that there is not a possibility of a 15-year

5 amortization of the deficit for the hospitals.

6 It would be very difficult to recoup the

7 hospital deficit over a longer horizon once the

8 hospitals are out of the fund. Long way of

9 saying, yes.

10 DR. RITCHIE: In other words, you

11 already alluded to the fact there is a very long

12 tail for these claims typically at the hospital.

13 So after '06, what happens to the fund for those

14 payments need to be made on behalf of the

15 hospitals.

16 MR. WALLING: Very interesting question.

17 You know, it is funny. We were talking about

18 the batch reinsurance a little bit ago, and

19 honestly, if I am putting my kind of risk

20 management hat on -- one of my credentials after

21 my name is actually certified enterprise risk

22 analyst or actuary; and from an enterprise risk

23 perspective, I might consider finding a

24 reinsured to buy the runoff of the hospital

25 claims.

1 There are a lot of companies out there.
2 Warren Buffet has made a killing out of buying
3 portfolios of long-tailed claims and then
4 investing those funds while the claims are still
5 outstanding and making money on the float.
6 It is a very kind of unformed idea but
7 doing some kind of reinsurance transaction to
8 get those off the funds books I think would be
9 something to at least strongly consider just to
10 take the uncertainty out of the funds out of the
11 funds balance sheet.
12 DR. RITCHIE: So would you say that
13 essentially the hospital's purchasing a tail
14 coverage for the PCF.
15 MR. WALLING: I think all of that is
16 negotiable. I don't know -- I couldn't be
17 positive who would pay for it or how it would be
18 financed or any of that, but as a concept, a
19 reinsurance transaction to do a loss portfolio
20 transfer I think would be a very neat and tidy
21 solution for all parties.
22 MR. AUTIO: Hopefully my last question.
23 There was also this last legislative session
24 there was in the junior bill money there was an
25 appropriation of just over $15 million to

1 address medical malpractice insurance subsidy
2 cost for individual providers and independent
3 group practices. Were you aware of that
4 $15 million allocation or was that accounted for
5 at all in your report?
6 MR. WALLING: To the best of my
7 knowledge, it is not and that is news to me.
8 UNIDENTIFIED SPEAKER: Is that for '24
9 or '23?
10 MR. AUTIO: That would be for fiscal
11 year 2024. I wanted to start the discussion.
12 UNIDENTIFIED SPEAKER: Is that going to
13 the PCF or is that subsidized?
14 MR. AUTIO: Unfortunately, there is no
15 clarity there.
16 MR. WALLING: Hard to take on when I
17 don't know it is earmarked for the PCF.
18 VICE-CHAIR LOVE: Along those lines,
19 this is Kathy Love, I just wanted to point out
20 that I pulled up House Bill Two. There was a
21 question about the appropriation and what the
22 language says about how it's supposed to be
23 attributed, and the language is this: It is to
24 the office of the superintendant of insurance
25 32,500,000 for the elimination of the existing

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1 deficit in the patient's compensation fund and
2 to reduce the rate impact of non-deficient
3 related rate increases. So there is no
4 specificity. I think it is up to the
5 superintendant.
6 MR. WALLING: Okay. There is one last
7 bit of commentary here, and apparently, there is
8 some judicial activity alleging that the
9 hospital underlying coverage, not the PCF
10 coverage, but the underlying insurance coverage
11 is illusory; and I wanted to make essentially
12 two key points here.
13 I can't fathom a scenario where a
14 hospital in the United States let alone in New
15 Mexico would truly be self-insured.
16 There is a marked difference between
17 having a large deductible or self-insured
18 retention and being truly self-insured. It has
19 been awhile since I looked at the policies of
20 the hospital and networks in New Mexico, but it
21 is -- I am 99 percent sure all of them are
22 purchasing either large deductible or
23 self-insurance policies from nationally rated
24 carriers.
25 Often times they are taking that

1 deductible or self-insured retention layer and
2 actually funding that through a captive
3 insurance company.
4 So I just wanted to make sure I make it
5 really really clear that having a large
6 deductible is not self-insurance. I think it is
7 self-evident but I will say it anyway.
8 The logistics of unwinding the hospitals
9 after all of the surcharges have been collected,
10 after all of the claims have already been paid
11 as a sheer practical matter, first of all, it is
12 not illusory. Second of all, if it were found
13 to be illusory, as a practical matter, trying to
14 unwind all of that would be a nightmare that
15 would have extraordinary costs and candidly
16 little or no benefit so for what that's worth.
17 That is the end of my prepared comments.
18 I am happy to answer any questions.
19 MR. CLARK: One comment here. I know in
20 the previous two years has been an allocation of
21 additional surcharges to bring down the deficit
22 for the hospital that has been included in the
23 rate increases, and what we see with data today
24 is continued increases in the deficit amount.
25 Does that correlate over to what --

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1 would the answer to that be that that is due to
2 the increase in risk exceeding what we have
3 covered before. So while we think we are
4 filling in the hole, we are just not digging it
5 as fast?
6 MR. WALLING: I would suggest that our
7 previous analyses would not have expected to see
8 $26 million of payments this year for the
9 hospital, and so my observation would be that
10 we're seeing more claims emergence than we would
11 have anticipated, and that is resulting in
12 increases in our ultimate loss estimates.
13 And again, some of that comes down to
14 2017 being the first year that the hospitals
15 really had a high level of exposure in the PCF
16 and a high level of surcharges. So for better
17 or for worse, what we're -- actually, here is a
18 good example: If we just look at the 2018 year
19 here, we saw $9.7 million of incremental paid
20 losses on claims that occurred in 2018 this year
21 -- 2022. That increased our ultimate loss
22 estimate by 5.3 million so it is not a dollar
23 for dollar swap, but the fact we saw 9.7 million
24 of paid losses during this one 12-month period
25 caused us to increase our ultimate loss

1 estimates by $5 million.
2 Part of what we're seeing is almost a
3 leading indicator when we see that $9.7 million
4 worth of claims payments in 2018, it also gives
5 us pause when we're looking at 2019, 2021 where
6 we're just now seeing the first claims emerge.
7 So it's really driven by the claims emergence
8 that we're seeing in 2016, to a lessor extent
9 '17. '17 actually ultimate losses came down a
10 bit but 2018 -- 2016 and 2018 are influencing
11 how we view the subsequent years.
12 DR. RITCHIE: Are you aware -- so the
13 indicated rate changes for independent
14 physicians, the lowest, the nominal one is
15 18.9 percent in total sum and for hospitals
16 11.8 percent, and are you aware -- and I think
17 this may have come from the OSI -- what the end
18 rate change was for last year?
19 I think it was around 14.7 percent, but
20 I know it was double digit so we're looking at
21 year after year double digit increases.
22 MR. WALLING: Let's be clear, since
23 2005, pretty much every year my indication has
24 been double digit and most of those years we've
25 ended up taking 9.9 percent. So there is

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1 nothing really new to that finding.
2 DR. RITCHIE: So in your experience with
3 other states which I think is terrific, I can't
4 imagine other states are experiencing that same
5 increase. I mean, it is not sustainable, and so
6 it sounds like one way to mitigate it was better
7 employment of their funds in earning money
8 themselves.
9 Are you aware of any other practices
10 that would help offset and prevent these year
11 after year double digit increases?
12 MR. WALLING: Well, if I look at
13 Wisconsin, the two biggest differences between
14 New Mexico and Wisconsin is that Wisconsin has a
15 larger fund balance. They also have a hard cap
16 on non-economic damages that isn't subject to
17 cost of living adjustments.
18 I think there is also some thought that
19 ought to be given to making the PCF mandatory
20 for all healthcare providers. The mandatory
21 PCF, if you look at the universe of PCFs, I
22 would suggest to you that the mandatory ones
23 tend to outperform the voluntary ones, and there
24 is a lot to un-peel in that.
25 I actually did a study for the State of

1 Ohio when they were considering forming a PCF
2 and did a pretty exhaustive breakdown of all of
3 the patient compensation funds and birth injury
4 funds.
5 There is a lot more to this than just
6 that limited handful of things, but certainly
7 when you have got a fund balance that is capable
8 of throwing off investment income, it takes some
9 of the pressure off the docs, but recognize when
10 you're talking excess medical professional
11 liability, inflation is a very real issue and
12 you need some means to try and keep pace with
13 that inflation; and if you're going to try to do
14 it without increasing surcharges, then you
15 better be generating investment income as a
16 hedge against the inflation.
17 DR. RITCHIE: That makes sense. My last
18 question --
19 MS. KANE: Sir, we have access to that
20 Ohio study?
21 MR. WALLING: It is a bit dated, but I
22 have got at least pieces of it updated for you
23 that I will be happy to share.
24 MS. KANE: But the leverage must be the
25 same I would assume?

1 MR. WALLING: Absolutely.
2 DR. RITCHIE: I guess my last question
3 real quick, see if anyone else has any. The
4 effects of the utilizing the consumer price
5 index and the way that is compound interest on
6 these rates. Not only does it raise the cap
7 each year which I think was the intention but it
8 is also though substantially raising the rates
9 each year and that is compounded. You know,
10 every year it is higher. It is not based on a
11 beginning basement that doesn't change. It is
12 based on the increase that has gone into effect
13 the last year.
14 How much do you feel like this is
15 affecting it and how much in the future is this
16 going to affect it, say, even five years from
17 now? What could we be looking at in increase in
18 the rates just from utilizing the CPI?
19 MR. WALLING: Great question. Is
20 everybody still hearing me? I froze up for a
21 second. Here is the thing about an excess level
22 of insurance: Inflation always has the tendency
23 to take claims that used to be below the
24 attachment point and inflation drives them into
25 the excess layer so a claim that five years ago

1 was worth $175 million at a 3 to 5 percent
2 inflation is suddenly worth $210 million -- or
3 thousand dollars now and maybe is into the PCF
4 layer.
5 But so you always got claims kind of
6 creeping into the bottom of the PCF layer and so
7 that is a separate type of inflation for an
8 excess program; but now with the cost of living
9 adjustment at the top, you also have inflation
10 on the top of the PCF coverage.
11 So you have claims coming into the
12 bottom of the layer and now you have got the
13 top, the ceiling of the PCF increasing so you
14 really have inflation affecting the PCF both
15 from the bottom and at the top so it does tend
16 to make inflation worse.
17 DR. RITCHIE: Any other questions?
18 UNIDENTIFIED SPEAKER: Mr. Walling, just
19 to be clear for our future meetings, the first
20 table on page 6 of your report regarding
21 independent physician and surgeons rate changes,
22 the 18.9 percent would be, you know, based on
23 expected value, right? So just based on your
24 actuary analysis what those claims are worth
25 with no risk margin, right?

1 MR. WALLING: Correct. So that 18.9 is
2 to get going forward rates to an actuarially
3 sound pace to adjust for the class plan changes
4 we proposed and to accommodate the cost of
5 living adjustment to the PCF coverage limit.
6 That is it. There is no additional risk margin
7 in that.
8 UNIDENTIFIED SPEAKER: Then the 28.5,
9 would be at that 75 percent confidence level?
10 MR. WALLING: Exactly. You said page 6,
11 page 6 of the PDF; page 3 of the report just to
12 be clear.
13 DR. RITCHIE: Any other questions? Have
14 the agenda up, look at the agenda for the next.
15 Thank you very much.
16 MR. WALLING: Have a great meeting.
17 DR. RITCHIE: Have a great time in
18 Canada.
19 MR. WALLING: Thank you so much. Take
20 care.
21 DR. RITCHIE: We really appreciate
22 everyone that is attending virtually. We
23 wouldn't have been able to fit you all in here
24 anyway so that is a good thing, I guess, but
25 hopefully the next one in September will be

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1 basically hopefully like 90 percent or a hundred
2 percent in person at least for the board
3 members.
4 So here is the important dates we had:
5 The rate hearings the next meeting in
6 September 21 and 22 beginning 9:00 a.m. each
7 day. Second day is if needed but experience
8 last year indicated that there is a good chance
9 it will be needed at least for a short while on
10 that Friday morning and then again the deadlines
11 that are on the superintendant.
12 So what else is on the agenda? So we
13 can open it briefly for public comment. Is
14 there any public comment at this point? Okay.
15 Hearing none, seeing none online, then that --
16 we have put forth the schedule.
17 We now have quite a bit of time so I
18 suggest this amongst everyone. We will be in
19 discussion with Mr. Ward about what we can and
20 can't do and keep ourselves from getting in
21 trouble with the State and thank you.
22 MR. WARD: You guys are doing an A plus
23 job, good job.
24 DR. RITCHIE: Okay. Thank you.
25 MR. WARD: Virtual attendance is fine.

1 I just wanted to send it as a reminder there is
2 that provision in the AG's guide so if you have
3 any questions about your virtual attendance, I
4 know we are starting to have everybody there. I
5 couldn't be there today, but just always feel
6 free to reach out to me. I can help you think
7 through that. I don't think it is a big deal.
8 Just want everybody to know the standard there.
9 DR. RITCHIE: Well, we really appreciate
10 that. Thank you. I thank everyone for being
11 here particularly Superintendant Kane and other
12 members of the OSI, and we are looking forward
13 to the next discussion. We will have a lot more
14 time before then to go over these results.
15 Superintendant, do you have any comment
16 at all at the end here.
17 MS. KANE: No but we're going to be
18 having a health summit meeting at the governor's
19 mansion I think the 15th. I think obviously
20 this PCF will come up. I do think we should
21 look at the things that were raised.
22 I did talk to the state investment
23 advisors and let's see if we think we can do
24 some more with the funds that are just sitting
25 there totally in cash and also mandatory

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1 participation by the doctors.
2 DR. RITCHIE: Great. Thank you very
3 much, and thank you again. Welcome also -- sort
4 of remiss in not welcoming the first meeting
5 first time really appreciate that and I
6 appreciate your openness to listen to what goes
7 on.
8 So everything being said, again, thank
9 everyone for their work on this, particularly,
10 the OSI and actuary and for attending this
11 morning and I believe we can adjourn about
12 22 minutes early. Thank you.
13 (At 10:35 a.m. the matter was completed)
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3 CERTIFICATE
4
I, Barbara Morgenweck, Registered
5 Professional Reporter, and Certified Court
Reporter, do hereby certify that the foregoing
6 is a verbatim transcript of the meeting as taken
stenographically by me at the time, place and on
7 the date hereinbefore set forth, to the best of
my ability.
8 I DO FURTHER CERTIFY that I am neither a
relative nor employee nor attorney nor counsel
9 of any of the parties to this action, and that I
am neither a relative nor employee of such
10 attorney or counsel, and that I am not
financially interested in the action.
11 Dated: 8/6/23
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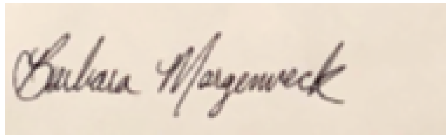

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