1 BEFORE THE NEW MEXICO SUPERINTENDENT OF INSURANCE
AS CUSTODIAN OF THE PATIENT'S COMPENSATION FUND

2

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IN THE MATTER OF DETERMINING)
4 PATIENT'S COMPENSATION FUND)Docket No.
SURCHARGE RAGES FOR CALENDAR)2023-0018-CF
5 YEAR 2024)

6

7 HEARING/EXAMINATION OF ROBERT WALLING
9:06 a.m.
8 September 22, 2023
New Mexico Hospital Association
9 7471 Pan American Freeway, NE
Albuquerque, New Mexico

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REPORTED BY: BERNADETTE C. PEREA CCR#123
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1 I N D E X

2 WITNESS: PAGE:

3 ROBERT WALLING

4 Continued Examination by Mr. Barenberg 5:17

5 Certificate of Completion of Deposition 98:1

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7 EXHIBITS

8 Exhibit C NMPCF Spreadsheet 69:8

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1 (In session at 9:06 a.m.)
2 CHAIRMAN RITCHIE: This is William
3 Ritchie calling to order the continuation of
4 hearing on the New Mexico Compensation Fund
5 Advisory Board. This is the second day. We are a
6 good way through the presentation, and so
7 hopefully we can do this in a timely fashion today
8 and finish up everything for sure.
9 So, let's have a role, please of the
10 members of the Board and then we'll begin.
11 MS. LUERA: Chairman Ritchie.
12 CHAIRMAN RITCHIE: Here.
13 MS. LUERA: Vice-Chair Love.
14 MS. LOVE: Here. Good morning:
15 MS. LUERA: Good morning. Mr. Clark.
16 MR. CLARK: Here.
17 MS. LUERA: Mr. Dekleva.
18 MR. DEKLEVA: Here.
19 MS. LUERA: Mr. Vargas.
20 MR. VARGAS: Here.
21 MS. LUERA: Mr. Autio.
22 MR. AUTIO: Here.
23 MS. LUERA: Mr. Spitzer.
24 (No response.)
25 MS. LUERA: Ms. Steven.

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1 MS. STEVEN: Here.
2 MS. LUERA: And Mr. Martinez.
3 MR. MARTINEZ: Here.
4 CHAIRMAN RITCHIE: Thank you.
5 Okay. So please, Mr. King [sic],
6 continue where you left off.
7 MR. BARENBERG: I'm Mr. Barenberg. I
8 represent --
9 CHAIRMAN RITCHIE: I'm sorry. I'm
10 trying to keep things simple.
11 MR. BARENBERG: So I'm going to call up
12 the report that we had been looking at yesterday.
13 ROBERT WALLING
14 was called as a witness and, having been
previously duly sworn, was examined and testified
15 as follows:
16
17 CONTINUED EXAMINATION
18 BY MR. BARENBERG:
19 Q. Mr. Walling, there were a couple of
20 follow-up issues from yesterday that I wanted to
21 go over before we get on to the main topic.
22 So there was a question about what was
23 included in the surcharges, and are you able to
24 clarify that now?
25 A. Yes. I've been able to confirm with my

1 staff that the hospital surcharges and independent
2 physician surcharges in the analysis exclude the
3 deficit surcharges. So as we discussed yesterday,
4 the deficit surcharges really don't bring with
5 them new loss exposure, so it wouldn't be
6 appropriate to use that in the reserve analysis or
7 the rate indications and so they are not in.
8 Q. Do you need to show in any of the
9 exhibits where that comes in?
10 A. No. I think we've documented that
11 yesterday.
12 Q. And then there was a discrepancies in
13 one of the hospital numbers that was brought up
14 yesterday; were you able to resolve that?
15 A. Yes. So, in exhibit -- in Funding
16 Summary, Page 3, which is Page 34 of the report,
17 we show analysis that allocates the current
18 hospital fund reserves to eight different
19 hospitals. And we had a discrepancy of just shy
20 of $2 million in the Ultimate Losses in Column 4.
21 What we identified is that at the time of this
22 analysis, one of the hospital systems and --
23 THE WITNESS: Debbie, do you know who it
24 is?
25 MS. LUERA: Otero County.

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1 A. Yeah, but they're in here. There's a
2 hospital system that is not in this analysis
3 because they've left the fund, so the discrepancy
4 we have is that the surcharge dollars for that
5 system, the paid losses for that system, and the
6 reserves associated with that system, are all --
7 have all been removed from this analysis to the
8 extent that that system came back into the Fund,
9 then obviously we'd update the analysis. But
10 that's the discrepancy, is that there's a system
11 that was participating in the Fund that is not, as
12 of the time of this study.
13 Q. (By Mr. Barenberg) So yesterday we
14 had -- actually, let me ask, are there any further
15 follow-up questions on those two topics?
16 (No response.)
17 MR. BARENBERG: Yesterday we had
18 finished with the topic Indicated Deficits and
19 Allocations, and some Board members had asked some
20 questions. Before we go on to the next topic, are
21 there any questions on the indicated deficit and
22 allocations?
23 MR. CLARK: This is Troy Clark. Just
24 one quick question. If I understand the first
25 response, that was that the excess deficit

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1 repaying surcharges were not included in the
2 analysis.
3 THE WITNESS: Correct.
4 MR. CLARK: Are they included to the
5 fund balance provisions?
6 THE WITNESS: They are. So the fund
7 balance that we're showing in Fund Summary Page 1
8 and I think 2, is actually from the published
9 financial statements of the Fund and so they do
10 reflect the income associated with the 2022
11 deficit surcharges.
12 MR. BARENBERG: Any other questions?
13 Q (By Mr. Barenberg) Okay, so our next
14 topic is the indicated surcharges for physicians.
15 So, Mr. Walling, the purpose of this
16 hearing is to set surcharges for the upcoming
17 year; is that your understanding?
18 A. Correct.
19 Q. And the loss reserve and deficit
20 analyses that you went over yesterday, those
21 support the surcharge calculations?
22 A. They do.
23 Q. I want to turn to Exhibit 4 on Page 44.
24 And does this exhibit show the overall indicated
25 surcharge?

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1 A. The overall base surcharge changed, yes.
2 Q. Okay. And what was it that I said
3 incorrectly?
4 A. There's couple of other proposed changes
5 that aren't reflected in this exhibit that are
6 reflected on Page 43 instead of Page 44.
7 Q. Do you need to go to Page 43 right now?
8 A. No. I actually want to start with 44
9 right now.
10 Q. Okay. So could you describe the methods
11 of the functions that underline this date.
12 A. Sure. This is an actual methodology
13 called a loss ratio rate indication. The idea is
14 that we take historical loss ratios and make some
15 adjustments for coverage differences, inflationary
16 differences to estimate what we think the loss
17 ratio for the program is going to be in the coming
18 year, compare that to a break-even loss ratio to
19 compute the indicated rate redundancy or rate
20 need.
21 And so what you'll see is that we look
22 back ten years, we, as we discussed yesterday,
23 bring all those surcharges on level; we take the
24 ultimate losses from the reserve study; we make an
25 adjustment for the cost of living adjustment in

1 the damage cap for the Fund; we also make an
2 adjustment for inflationary trends.
3 So what you see in Column 6 is the
4 trended ultimate loss ratio after adjusting for
5 historical rate changes, after adjusting for the
6 current coverage limits, and after adjusting for
7 inflation. And you'll see those loss ratios vary
8 from a low of 54 percent in 2015, to a high of
9 155 percent in 2018.
10 We compute four different averages,
11 looking at all years, and then different subsets.
12 You'll notice all these of the subsets ignore the
13 two most recent years, it's because the loss
14 experience for the two most recent years is so
15 green, that we know very, very little about what
16 the ultimate claims are going to look like for
17 those two years.
18 Based on those four averages, we select
19 a loss ratio for the coming year of 119 percent.
20 We then look at the expense expectation for
21 losses, which is 8.3 percent of surcharges and
22 also the nonloss expenses, which are 2.1 percent
23 of surcharges, to compute what the indicated --
24 you also notice we talked yesterday a lot about
25 discounting, and you'll see that .835 is

1 essentially giving full discounting credit, we're
2 not adjusting the discounting for the prospective
3 funding for the supporting assets. The logic
4 there is, if we're really looking at the
5 prospective year, it kind of stands on its own and
6 so there isn't any need for the funding analysis
7 to adjust or modify that discount assumption. So
8 we're actually giving full credit for the time
9 value of money in the rate indication.
10 After all of these adjustments, Row 13
11 says that to cover all of the expenses, to pay all
12 of your losses, there's an income need of
13 19.6 percent. The current projected surcharges,
14 excluding deficit surcharges, is 17.8 million and,
15 therefore, just taking the ratio of those two, the
16 indicated need is 10 percent.
17 So it's a long-winded way of saying,
18 after adjusting for inflation, changes in the
19 damage cap, inflationary trends and the funds,
20 loss related and nonloss related expenses, the
21 indicated surcharge need for the Fund for the
22 independent physician/surgeon is 10 percent.
23 Q. And by "10 percent," do you mean a
24 10 percent increase over last year?
25 A. Correct.

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1 Q. And when you refer to Line 13, you said
2 19.6 percent; did you mean 19.6 million --
3 A. 19.6 million. Sorry.
4 Q. I'm going to jump for a moment to Page
5 19 of the report, that should be Page 21 of the
6 PDF, and there's a table here. Can you walk us
7 through what this shows.
8 A. So this is the consumer price index from
9 the Bureau of Labor and Statistics.
10 Q. Looking at -- let's see, the
11 "relativity"?
12 A. Oh, I'm sorry. Sorry, sorry. Did I get
13 the right --
14 Q. You got it right, I got it wrong. I was
15 one page off. So Page 22 of the report, numbered
16 Page 22 of 91.
17 A. Now I have it in the correct place.
18 Q. So what is this showing, this table?
19 A. So one of the things we're tasked with
20 is to look at by physician specialty to identify
21 any class assignments that would suggest an
22 adjustment up or down, based on the individual
23 risk characteristics of a specific specialty.
24 The way we do that is we pull the
25 relativities for the Indiana and Wisconsin Patient

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1 Comp Fund to give us a sense of what other patient
2 comp funds are doing. We also pull publicly
3 available rate filings of the leading medical
4 professional liability writers in New Mexico to
5 give us a sense of what the rate relativities for
6 the primary layer, that first-dollar later looked
7 like.
8 Based on that competitive analysis,
9 looking at other PCFs and leading New Mexico
10 writers, we've actually proposed a number of
11 changes, generally decreases, interestingly. And
12 so what you'll see is, for example, radiology
13 diagnostic without surgery, we're proposing to
14 move from Class 2 to Class 3, that would be an
15 increase of 20 percent.
16 Conversely, oncology minor surgery we're
17 proposing a move from Class 5 to Class 5A, which
18 is actually a decrease of 18 percent. Because
19 there are generally more decreases here than
20 increases, the overall impact of this will be to
21 reduce -- if this change was approved, the overall
22 impact of this change would be to reduce overall
23 surcharge income by almost a quarter of a million
24 dollars.
25 Q. And is that change after the 10 percent

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1 increase?

2 A. It's actually -- it's multiplication so

3 it doesn't really matter whether it's after or

4 before, but it is separate and distinct from the

5 base rate change.

6 Q. All right. I'm going to go back to

7 Exhibit 4, Page 2 on Page 44 that we've been

8 looking at before. Does the change in 10 percent

9 in Line 14 contemplate the cost of living increase

10 for nonmedical coverage limits?

11 A. If does not.

12 So it adjusts to the current level but

13 not to the prospective level.

14 Q. So the amount that the physicians -- so

15 the cost of living increase, that applies only to

16 the cap for nonmedical damage; is that correct?

17 A. Correct.

18 Q. And the amount that the physician pays,

19 that does not increase with the cost of living; is

20 that correct? So the total cap goes up but the

21 amount the physicians are responsible remains

22 constant; is that from the statute?

23 A. Right.

24 Q. And so, over time, the PCF is an

25 increasing percentage of nonmedical damages and

1 the physicians pay a decreasing percentage; is
2 that correct?
3 A. As a percentage, yes.
4 Q. Okay. And did you take into -- did you
5 consider what effect that might have on the PCF?
6 A. Yes, but not on Page 44.
7 Q. Okay. Is there a page we want to look
8 at?
9 A. Yes. Go back to Page 43. And so what
10 Mr. Barenberg has been identifying is there are
11 really three components to the proposed rate
12 change. The first is the base rate change, the 10
13 percent. You can see that in Column 1, that the
14 indication, based on the data as of 12/31/22, is
15 that overall surcharges need to go up by 10
16 percent.
17 However, if that class plan change is
18 adopted, that reduces surcharge income by about a
19 quarter of a million dollars and to get back to an
20 actuarially reasonable level of surcharges, you
21 need to essentially off balance that. And so if
22 you implement the class change, then, to offset
23 that, the base surcharges need to increase by
24 2.3 percent, basically to offset.
25 Finally, because the nonmedical damage

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1 cap is increasing, per statute, there needs to be
2 an increase of about 5.7 percent, just to keep up
3 with the increase in the -- in the nonmedical
4 damage cap.
5 So the cumulative effect, the
6 multiplicative effect of a 10 percent base change,
7 plus a 2.3 percent offset for a class plan change,
8 plus or times the 5.7 percent increase for the
9 nonmedical damage cap increase is a total
10 indicated rate change of 18.9 percent. And you
11 can see that in Column 4.
12 Q. And either on this page or on Page 44,
13 what was the level of statistical confidence that
14 you use?
15 A. Those are expected levels. So as we
16 discussed yesterday, expected for an actuary
17 usually, about a 55 percent level of statistical
18 confidence. And as we discussed yesterday, we
19 also wanted to show a 75 percent confidence level
20 scenario, that's detailed on Page 45 and
21 summarized in the second row of Page 43.
22 The only difference there is, instead of
23 a 10 percent increase to fund at a 75 percent
24 confidence level, requires an 18.9 percent base
25 rate change instead of a 10 percent.

1 Q. And then going back to 43, you had
2 some -- Columns 11 and 12 give some different
3 numbers for the surcharges?
4 A. Right. If you recall yesterday, we, in
5 the -- on Pages 31 of 91 and 32 of 91, we were
6 asked to provide two different scenarios for
7 allocating the funds allocated by the Legislature
8 for 2023, one was a 75/25 allocation between the
9 physicians and the hospitals; the other was a
10 50/50 allocation. That results in two different
11 levels of deficit surcharges. And so what you're
12 seeing in Columns 5 and Column 11, are simply the
13 difference between the two different allocations
14 of the Legislatve allocation of funds.
15 Q. So what is your recommended rate change
16 for the Superintendent?
17 A. The recommended rate change is the -- is
18 to adopt the physician specialty changes, along
19 with a base surcharge increase of 18.9 percent,
20 and the deficit surcharge then would be
21 32.7 percent of the nondeficit surcharges. So,
22 essentially, the deficit surcharge would be an
23 additional percentage of the nondeficit surcharge
24 dollars.
25 MR. BARENBERG: Are there there any

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1 questions for Mr. Walling before going on to the
2 next topic?
3 MR. CLARK: Troy Clark, I've got one
4 question: Are you thereby making the
5 recommendation to OSI that they adopt a 75/25
6 split of the allocation --
7 THE WITNESS: No -- so I'll let you
8 finish.
9 MR. CLARK: Do you use that 32.7 as the
10 hypothetical between the two?
11 THE WITNESS: For the purpose of
12 providing a couple of illustrations to the Fund, I
13 was asked to present two different hypothetical
14 allocations of those funds. I'm not expressing an
15 opinion on how those funds ought to be allocated,
16 so, basically I was asked to provide two
17 illustrative examples, obviously if the Board
18 chooses to -- or the Commissioner -- I guess if
19 the Commissioner would choose to do something
20 different with that, then we'd need to update the
21 analysis for a different allocation.
22 MR. CLARK: So to be clear, your
23 recommendation is the 18.9 percent, which is the,
24 we use the word "average" there, 55 percent level
25 of certainty and then adding to that upon the

1 Superintendent's decision between the allocation,
2 32.741 or some other number.
3 THE WITNESS: That's accurate.
4 MR. CLARK: No further questions.
5 CHAIRMAN RITCHIE: Any questions --
6 MS. LOVE: This is --
7 CHAIRMAN RITCHIE: Go ahead, Kathy.
8 MS. LOVE: This is Kathy Love. My first
9 question is, is there anyplace where you have a
10 chart that shows by provider specialty -- well,
11 actually, let me back up. Is the surcharge for
12 the deficit the same across the board, regardless
13 of specialty?
14 THE WITNESS: It the same percentage --
15 MS. LOVE: Or is it -- go ahead.
16 THE WITNESS: Sorry. It's the same
17 percentage of their otherwise applicable
18 surcharges, so it's a percentage add-on, not a
19 dollar add-on.
20 MS. LOVE: Got it. Got it.
21 Would we be able to see -- probably if I
22 was good at math, I could probably figure this out
23 myself, but would we be able to see a breakdown by
24 the class specialty, this is the surcharge that
25 you're recommending and then this is what they

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1 would have to pay as a percentage for the deficit?
2 THE WITNESS: I think we produced it,
3 I've just got to figure out where the heck it is.
4 Mr. Barry -- Mr. Barenberg, can you
5 please go to Page 42 of my report.
6 MR. BARENBERG: Okay.
7 THE WITNESS: Actually, 40 -- let's go
8 to 41.
9 MR. BARENBERG: We're there.
10 THE WITNESS: So Page 41 of 91 labeled
11 Exhibit 3, Page 1, shows the independent -- so, in
12 Column 3 shows the expected value of the indicated
13 surcharges by class, you'll see that varies from
14 Class 1 at $5,145, to Class 10 at 44,585. You can
15 also see in Column 2A what the current surcharges
16 are. And then you can see in Column 11B as in
17 "boy," what the expected value of the deficit
18 surcharges are. Now, this is assuming -- as was
19 pointed out, this is assuming that the 75/25
20 allocation was implemented.
21 And so for a Class 1 physician, which is
22 typically nonsurgical internal medicine type,
23 ENTs, stuff like that, the surcharge would be
24 $5,145, the deficit surcharge would be an
25 additional 1,680.

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1 Conversely, for the high-risk surgical
2 classes, the Class 10, the surcharge would be
3 44,585, and the deficit surcharge would be an
4 additional 14,558.
5 MS. LOVE: Thank you. One more
6 question, which is, in order to do a fair
7 determination as to how the split of the recent
8 Legislative infusion should be accomplished, would
9 it be helpful for you to look at the data that I
10 was asking about yesterday, which is specifically
11 the historical data of how much was recommended in
12 increased surcharges and how much was actually
13 increased in the surcharges so that we can see how
14 much has not been paid in increases over the
15 years?
16 A. I don't know how useful that would be,
17 from -- purely from an actuarial perspective,
18 ultimately the call on that allocation is not
19 mine, commissioners.
20 MS. LOVE: Okay.
21 And we only have data going back to
22 2022, in terms of the split in payouts between
23 hospitals and independent physicians; is that
24 right?
25 THE WITNESS: I'm sorry, repeat the

1 question.
2 MS. LOVE: Yeah, it was a bad question.
3 The data that we have on settlement,
4 until 2022, did not give us an accurate picture of
5 how the deficit should be split between
6 independent physicians and hospitals, it's only
7 starting in 2022 that we started having that data;
8 is that right?
9 THE WITNESS: It's only been provided in
10 the analysis. As we identified yesterday, the
11 number of years that the majority of the hospitals
12 have been in the Fund is, what, six years. And,
13 so as you're rolling additional full years with
14 $30 million of hospital surcharges on, that's
15 inherently going to be a moving target, just as
16 the relationship between the surcharge revenue
17 from the independent physicians and the hospitals
18 changes.
19 So, if you get my point, you know, five
20 years ago, almost a hundred percent the surcharge
21 revenue, historically, would have been associated
22 with the independent physicians; today, it's a
23 much different mix of loss exposure. So, I don't
24 think it's really as compelling or useful to go
25 backwards as you might think, simply because every

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1 year you go back, you're taking $30 million worth
2 of hospital surcharges kind of out of the
3 conversation.
4 So I think the shifting and the
5 accumulated exposure is more important than kind
6 of casting back to what things look like in 2020.
7 CHAIRMAN RITCHIE: Okay. I had a
8 question. The -- in table -- the table on Page
9 43, deficit surcharge and the percentage of
10 surcharge, so what that's saying is that the
11 percentage we're paying out of your total
12 surcharge, that goes towards the deficit that's
13 that number.
14 THE WITNESS: It's in addition to. So
15 if you look at immediately -- well, two pages
16 previously, that 32.7 percent is a charge in
17 addition to the underlying surcharge. So the
18 Class 1 pays 5,000 in nondeficit related surcharge
19 and then the 32.7 percent is in addition to that.
20 CHAIRMAN RITCHIE: Okay. Thank you.
21 Q (By Mr. Barenberg) And the 32.7
22 percent, that's 32.7 percent of the base
23 surcharge?
24 A. Of the appropriate base surcharge for
25 that specialty.

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1 Q. It's not an additional 32.7 percent
2 increase.
3 A. Correct -- well -- correct.
4 MR. AUTIO: This is Nick Autio. First,
5 correct me if I'm wrong, but when you were
6 discussing the proposed class changes --
7 THE WITNESS: Yes.
8 MR. AUTIO -- you're looking at data from
9 Indiana, Wisconsin and also from large
10 professional liability writers in New Mexico, do
11 you consider actual data from the PCF from claims
12 paid from the PCF when you're looking at those
13 class changes that have been proposed?
14 A. We have in the past and, candidly, from
15 an actuarial perspective, there just aren't enough
16 claims to be statistically credible. If you're
17 looking at the claims frequency by individual
18 specialty, you chop that loaf of claims data into
19 crumbs pretty quickly, and it's just from an
20 actuarial standpoint, it's not statistically
21 credible for the purpose of settings those
22 relativities.
23 As an informational item, if you want to
24 see the more detailed analysis by specialty, it's
25 Appendix 11, and it will give you a really nice

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1 sense of the data we're starting from TDC and Med
2 Pro and the other two patient comp funds and kind
3 of our thought process when it comes to making
4 those specialty changes.
5 Q. And on Page 22 of your report, which
6 goes back, there's a proposed 5.9 percent increase
7 general and family practitioners, in the third
8 column there, it states exposure, does that
9 represent the fact that there were nonpaid claims
10 to a --
11 THE WITNESS: Exposure. So it's
12 full-time equivalent physician counts.
13 MR. AUTIO: Okay.
14 THE WITNESS: So this particular -- this
15 is not the main family practice specialty, this is
16 a nonmajor surgical class for GPs, so there are
17 literally, statewide, only nine practitioners in
18 the Fund that are in this specific classification.
19 So, for example, you can see there's 144
20 radiologists, 108 general surgeons. So the intent
21 was to try and provide some information about how
22 many healthcare providers would be impacted by
23 these changes.
24 MR. AUTIO: Okay. Correct me if I'm
25 wrong, but I believe if those class changes were

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1 adopted by the Superintendent, that would tack on
2 additional 2.3 percent to the overall surcharge?
3 THE WITNESS: Correct. So one way of
4 thing about it is on oncology minor surgery would
5 go down 18.2 percent based on the class change,
6 but there would actually be a 2.3 percent offset
7 to oncology and all other specialties to offset
8 the reduction that oncology got.
9 MR. AUTIO: And can you help those of
10 the Board and the Superintendent understand, if
11 she chose not to adopt those class changes, what
12 impact do you foresee that having in The Fund?
13 THE WITNESS: It's a question of does
14 making these class changes create a more fair and
15 equitable or in actuary speak, the actuarial
16 terminology is the rate can't be excessive, they
17 can't be inadequate and they can't be unfairly
18 discriminatory. And the question here is, does
19 making these changes get each individual
20 specialty's surcharges closer to the actual best
21 estimate, if you want to think of it that way.
22 So in terms of overall actuarial
23 soundness, the payment after surcharges,
24 implementing the 10 percent increase, not
25 implementing this, is equivalent to taking the 10

1 percent plus the 2.3 and implementing this, they
2 both get you the same total surcharge revenue, so
3 yeah.
4 MR. AUTIO: Understood.
5 The last area I wanted to address with
6 you is -- so on Page 44 of your report of Exhibit
7 4, Page 2, you have "Projected Ultimate Losses" in
8 2022 as 17.5 million, correct?
9 THE WITNESS: Yeah.
10 MR. AUTIO: And when I looked at Exhibit
11 2, Page 40 of your report, looking back,
12 historically, in terms of paid losses, and I
13 recognize that claims in recent years have not
14 matured and those numbers are going to go up but
15 we haven't seen anything -- well, anything within
16 $2 million, 17.5 million, since 2011; is that
17 correct?
18 THE WITNESS: I'm going to quibble with
19 you making a comparison between ultimate losses
20 and paid losses.
21 MR. AUTIO: Okay.
22 THE WITNESS: Because I would suggest to
23 you that the 2018 year, because it's already shown
24 us eight-and-a-half million dollars of paid -- I'd
25 have every reason to believe, based on the

1 historical payment of claims, that it's going to
2 come in at more than 17 million of ultimate
3 losses. So I'm -- it's a little apples and
4 oranges, comparing my selected ultimates to the
5 paid losses.
6 MR. AUTIO: I understand what you're
7 saying. And at Page 60 of your report, Appendix
8 5, goes along with what you just stated, that when
9 you look at claims for payment, for example, take
10 this 2018 year we're at 21 claims; as of 2022,
11 that number will go up, correct?
12 THE WITNESS: Absolutely.
13 MR. AUTIO: Okay. So that's what's
14 really driving your projected loss of 17.5, are
15 the anticipated increase in claims and also
16 claims, throughout, from say 2018 on.
17 THE WITNESS: Well, what we've done
18 is -- one of our methodologies is estimate the
19 claims frequency relative to the surcharge
20 resident. And so despite the fact that in 2018
21 and 2019, we're already seeing two-and-a-half
22 claims per million and 3.25 claims per million,
23 we're actually selecting that 1.75 claims per
24 million of surcharge revenue, based on the longer
25 term averages. But that's only one of the

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1 methodologies we're using to come up with those
2 ultimate losses.
3 MR. AUTIO: And in terms of -- I think
4 my last question on this issue is, when you're
5 talking about the increase in claims frequencies,
6 are you able to attribute that to something? Is
7 it because there are additional independent
8 providers in the Fund or, you know, what do you
9 attribute that increase to, if you can.
10 THE WITNESS: Well, I guess I would
11 point you to Page 58 of the report, which is
12 actually where we bring all of our claims and
13 analyses together. We do three different
14 methodologies. And you'll see that our selected
15 claim counts are there in Column 6.
16 What's interesting, actually, is the
17 claim counts themselves are relatively stable, and
18 so my observation would be, other than the batch
19 claim years, the number of ultimate closed claims
20 for the Fund are actually pretty darned stable and
21 well behaved. And so what you're really seeing
22 when you're comparing years, are differences in
23 severity. And you can see that actually on the
24 previous page on 57. The severity especially once
25 you adjust it for trend, varies pretty wildly,

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1 meeting just the close claim severity in Column 4.
2 Before you get all the claims that
3 aren't reported yet or aren't settled yet, you see
4 a couple of those years Claim 17-2011, show a
5 pretty significant balance in severity.
6 If you look at the longer term trend, I
7 think you also see an upward trend in severity,
8 which isn't really that surprising.
9 MR. AUTIO: So that's actually quite
10 helpful from my understanding. So Page 58 when we
11 look at this as a Board, you know, outside of the
12 batch claims, there does appear to be some
13 stability in terms of the number of claims paid.
14 But when we turn to Page 57 and look at severity,
15 those numbers obviously increased, so that just
16 indicates that it's really the value of claims
17 paid out, which is increasing out the number of
18 the claims derived eventually --
19 THE WITNESS: That's correct.
20 MR. AUTIO: I think that was my final
21 question. Thank you.
22 MR. BARENBERG: Any other questions on
23 that topic?
24 (No response.)
25 Q (By Mr. Barenberg) We will go on to

1 the indicated surcharges for the hospital and
2 we'll start with Exhibit 6 on Page 47 to 49, and
3 that shows the hospital rate level indications; is
4 that correct?
5 A. That is correct.
6 Q. Can you walk us through that exhibit,
7 and I think focus on Page 2 of it.
8 A. So let's start on Page 48. We run
9 through that same rate level indication process,
10 where we bring the surcharges on level; we bring
11 the losses in from the reserve analysis; we adjust
12 for historical differences in the coverage limits;
13 we then make a trended or inflational adjustment
14 and, you know, see the trended ultimate loss
15 ratios in Column 6.
16 We run the same subtotals and, based on
17 that information -- and you'll notice, we give a
18 fair amount of credence here to the more recent
19 years, which is where all the surcharges dollars
20 are. We select an undiscounted loss ratio of 121
21 percent; same adjustments for loss adjustment
22 expenses; same adjustment for discount, which is a
23 16.5 percent discount of the expected losses; same
24 overhead charge of 2.1 percent.
25 So the projected income need for the

1 hospital program is 46.9 million; the projected
2 surcharge revenue, prior to, a -- you know, what
3 currently is 41.945 million, so the overall
4 indicated base surcharge change is 11.8 percent.
5 Q. And where there any deficit surcharges
6 contemplated in that change?
7 A. In that change, no.
8 Q. Is there one in another change?
9 A. Yup. So if you go forward a page to
10 Page 47, you'll see an exhibit very similar to the
11 one we just looked at for the independent
12 physicians. Fundamental difference, there's no
13 change in the damage caps for the hospitals;
14 there's no class factor change. And so the only
15 rate change is the rate level indications of 11.8
16 percent. Alternately, the 76 percent confidence
17 level, there's an indicated change of
18 20.9 percent. And then those same amortization
19 schedules from the Funding summary are pulled
20 through here again, as we've identified in prior Q
21 and A, those are two illustrative examples,
22 ultimately the allocation of that $32.5 million is
23 at the discretion of the commissioner. So the
24 recommendation is that the base surcharges
25 increase by 11.8 percent and the deficit

1 surcharges be finalized once the disposition of
2 the 32.25 million is made.
3 Q. So just to be clear, then, your
4 recommendation to the Superintendent is that the
5 surcharges for hospitals be increased by 11.8
6 percent?
7 A. Correct.
8 Q. All right.
9 MR. BARENBERG: Any questions on the
10 hospital surcharges?
11 MR. CLARK: This is Troy Clark.
12 Question: I'd like to direct you -- I'll just go
13 in order here, start on Page 48.
14 THE WITNESS: Yup.
15 MR. CLARK: You've got nine Number 10s.
16 THE WITNESS: Correct.
17 MR. CLARK: "Projected loss adjustment
18 expense and percentage of losses of 8.3 percent."
19 THE WITNESS: Yes.
20 MR. CLARK: Exhibit 7, Page 1 on Page 50
21 I believe; is that correct?
22 THE WITNESS: Correct.
23 MR. CLARK: Could you walk us through
24 the makeup of this calculation?
25 THE WITNESS: Sure. So the expense

1 categories that have been identified as being
2 related to losses are the medical panels, the
3 directors for the period of 2020 and 2021, the
4 contracts and consultants and the batch claim
5 reinsurance, which was actually diverted to an
6 expected loss amount. Recall that basically
7 what -- we're no longer purchasing that batch
8 claim reinsurance, and none of the years in the
9 rate level indications, includes any of the batch
10 claims, so this is a way that we've actually built
11 a provision for batch claims into the rates in
12 lieu of the reinsurance.
13 If you compare those four expense
14 categories to the paid losses for the last five
15 years on a calendar year basis, what you'll see is
16 that averages about 7 percent. There are some
17 changes in the underlying expenses for the Fund,
18 particularly the contracts and consultant so you
19 can see that jumps from half a million to about
20 1.1 million in '22. And so the selection of 8.3,
21 is primarily really driven by that change in the
22 contracts and consultants charge.
23 MR. CLARK: So the shift from the 7 to
24 the 8.3 is a professional judgment assessment and
25 based upon what you see as the increased rate for

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1 2022, yet, if we were to add up the individual
2 components of 2022, the .8 percent, 3.2 to 4.1,
3 would you end up with 8.1 percent, so you're going
4 beyond the averages?
5 THE WITNESS: I'm going above the
6 averages for 2022.
7 MR. CLARK: And then one last question
8 on this. Is it fair to say that that 4.1 percent
9 in 2022, or the 4 percent, overall, let's go to
10 that, go to the batch claim expected loss that we
11 are assessing a charge and expect a charge to the
12 Fund, historically, I understand the report's just
13 a policy for reinsurance no longer due, however,
14 that would only occur if there was a decision to
15 go outside of the parameters that the current PCF
16 regulations call for, are only a limit on three,
17 up to three claims by any one provider. So this
18 is building in an expense that says we're going to
19 violate the current regulation.
20 THE WITNESS: That's not how I interpret
21 it. To me, a batch claim is a sustained pattern
22 of behavior that is treated as a single claim.
23 It's not multiple claims. A batch claim, by
24 definition, is a sustained pattern of behavior
25 that is treated as a single claim.

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1 And so that's what this is protecting
2 against, is an interpretation that a sustained
3 pattern of behavior by a physician, by a hospital,
4 is treated as a single claim and doesn't run into
5 that protection in the Act. But claims of that
6 type are not reflected in the ten years of
7 experience that I'm using in the rate indication,
8 so I want to be really clear what that is.
9 MR. CLARK: So make to certain I'm clear
10 on that, I'm going to ask a follow-up question:
11 Are you saying that this batch claim estimate is
12 if there is a legal decision over the definition
13 of occurrence that happens to a single patient,
14 multiple defined occurrences, thereby, it's not
15 limited to the three incidences that are out
16 there, but it could have a stacked or a two,
17 three, four times payout that exceeds the limits.
18 THE WITNESS: Correct. A batch claim
19 inherently, because of the way -- stepping aside
20 from the PCF for a minute -- the whole challenge
21 created by a batch claim is it's treated as one
22 occurrence and as a result, it doesn't expose
23 multiple policies, it doesn't create multiple
24 claims, it creates a single claim at the beginning
25 of that pattern and behavior that tends to have

1 the effect of being a single claim with much, much
2 higher severity. In that scenario, it would
3 certainly provide more exposure to the PCF than if
4 each of those individual events was created as a
5 separate claim and a separate occurrence.
6 MR. CLARK: But it could involve
7 multiple patients; in other words a class
8 action --
9 THE WITNESS: That's an interesting
10 question. I can certainly see a couple of
11 different scenarios where a sustained pattern of
12 behavior related to the same patient or a
13 sustained pattern of behavior related to multiple
14 patients.
15 CHAIRMAN RITCHIE: As a follow-up to
16 that, so we still have these caps, you're saying
17 that there would be this batch claim, but it would
18 still not exceed the cap because it was a single
19 claim, so whatever happens --
20 THE WITNESS: Which cap are you
21 referring to?
22 CHAIRMAN RITCHIE: The applicable cap,
23 the hospital cap, the independent physician cap.
24 THE WITNESS: Are you talking about the
25 nonmedical damage cap, or are you talking about

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1 the number of claims cap?
2 CHAIRMAN RITCHIE: The nonmedical damage
3 cap.
4 THE WITNESS: So the nonmedical damage
5 cap would still apply --
6 CHAIRMAN RITCHIE: Right.
7 THE WITNESS: -- to that batch claim.
8 CHAIRMAN RITCHIE: Right. So that way
9 it's not triggering an increase in number of suits
10 and liability from that aspect, but it is
11 triggering increase of severity.
12 THE WITNESS: Of medical severity, yes.
13 Specifically, yes --
14 CHAIRMAN RITCHIE: Right.
15 THE WITNESS: Just to close the thread
16 the following page, 51, shows the same analysis
17 for the expense categories of the Fund that are
18 viewed as not related to the losses, so you'll see
19 IT, employee services rent and so on, the shift to
20 Integrion is kind of cooked into this and
21 certainly affects my selections. The expense
22 structure for the PCF in 2018 was fundamentally
23 different. And so you'll see, again, that based
24 on everything we're seeing going on here, our
25 professional judgment in conversation with

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1 Integrion and with the Insurance Department, was a
2 provision of 2.1 percent.
3 MR. AUTIO: This is Nick Autio. I had I
4 guess one area of questions and, really, this is
5 probably just me being horrible at math, but when
6 I compare the table that's in Exhibit 4 at Page 2,
7 which is on Page 44 of your report, with the
8 similar table Exhibit 6, Page 2 of Page 40 of your
9 report, looking at Column 16 both of those have
10 loss ratios, on Page 44 addresses physicians and
11 surgeons, when I look at those loss ratios and see
12 that there were four years where it was well under
13 or at least a hundred percent loss ratio and
14 nothing over 155 percent, when I compare that to
15 the trended out loss ratios for hospitals and see
16 that, you know, there's no year that's been under
17 110 percent and there was some years more than 200
18 and 300 percent, my range is, I can't wrap it
19 around that when we get to the projected
20 discounted loss ratio for physicians that are
21 119 percent, and 121 percent for hospitals, how do
22 those numbers work? Can you help me understand
23 why there's just two percentage points difference
24 in those numbers when the loss ratios historically
25 are so different?

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1 THE WITNESS: I think you've got to only
2 assign as much credibility to the oldest hospital
3 years as the surcharge volume suggests. The worst
4 hospital years were during periods of time when
5 only one or two hospitals systems were in the
6 Fund. I think if you focus on the 2017 through
7 '22 years, the hospital loss rate years are
8 relatively stable, however, I think you've also
9 got to keep in mind how much uncertainty still
10 exists in those ultimate losses for the hospital.
11 So if you flip back a couple of pages to
12 Page 46, we're still talking about an environment
13 where we've got $81 million of paid losses and
14 almost $200 million more in ultimate losses.
15 There's still a tremendous amount of uncertainty
16 in how the hospital program ultimate losses are
17 going to play out, simply because of the nature of
18 how long it takes for those claims to get reported
19 and how long for these claims to get closed.
20 Having said that, if I focus my
21 attention on that 2016 to 2020 period, where at
22 least I know some leading indicators based on
23 number of reported claims and paid claims to date,
24 I think the 121 is a pretty reasonable expectation
25 for what we think the hospital loss ratio is going

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1 to be next year.
2 For the docs, yes, there's more
3 uncertainty, positive and negative. And we've
4 tried to strike a balance -- it's part of the
5 reason we show those different subtotals on Page
6 44. We want to illustrate that, yeah, there's a
7 couple of pretty poor years in the middle of that
8 ten-year period, but there's some good years
9 before and after, and so we think that 119 is a
10 pretty reasonable expectation, taking the
11 experience of this ten-year period in its
12 totality.
13 MR. AUTIO: And the changes that were
14 made in 2021 to the Medical Malpractice Act, as
15 you're aware, the cap on independent physician,
16 went up slightly, but it's still under a million
17 dollars cap on hospitals is north of 4 million, I
18 think, just from a common sense standpoint, that
19 could result in the frequency of claims against
20 hospitals, they're simply more valuable claims, if
21 I'm a Plaintiff's attorney and I have a choice
22 between suing independent physicians or a
23 hospital, I might sue the hospital because there's
24 a higher cap, it could lead to a greater frequency
25 in claims against hospitals. Is that accounted

1 for at all in your analysis?
2 THE WITNESS: To the extent we're
3 keeping an eye on those claim counts, yes. But,
4 candidly, as I just said that the reporting lags
5 on those claims, we literally don't have any paid
6 dollars for the hospitals for the last two years.
7 And so, if you're telling me if I'm monitoring the
8 claim frequency since the reform, sure, the
9 hospital frequency since the reform is zero so
10 far, so it's just too early, even from my first
11 leading indicators, which would be a reported
12 claim, to see if the reforms are having any
13 material impact on frequency. It's just too early
14 to tell.
15 MR. AUTIO: That makes sense. And as we
16 talked about and we were discussing the proposed
17 surcharges for physicians, even looking back for
18 physicians to 2018, there is still tons of
19 outstanding claims, potentially, and we want to
20 know what those numbers actually look like for
21 years to come; is that correct?
22 THE WITNESS: With certainty.
23 MR. AUTIO: Okay. And so we have no
24 claims to come through for hospitals over the last
25 two years --

1 THE WITNESS: For the last two accident
2 years, just to be clear.
3 MR. AUTIO: Okay. For the last two
4 accident years, okay. All right. So we really
5 have no good data, it's just simply speculation to
6 try and determine what impact those changes would
7 have on frequency?
8 THE WITNESS: I think it's still very
9 early days.
10 MR. AUTIO: Thank you.
11 CHAIRMAN RITCHIE: Any other questions?
12 MR. DEKLEVA: This is Mike Dekleva,
13 Mr. Walling, can you hear me?
14 THE WITNESS: Yes.
15 MR. DEKLEVA: I just have some questions
16 for you about the hospital surcharge rates and how
17 they're calculated, and I'm looking at Page 47,
18 Exhibit 6, and if I'm understanding correctly, the
19 information that you provided us with regard to
20 the indicated assessment percentages rate changes,
21 would be essentially aggregated rate level changes
22 for all of the hospital, as I'm understanding it,
23 and please correct me if I'm incorrect about that,
24 but my question is, when the surcharges are set
25 for each individual hospital, is there a modifier

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1 that applies, based on each hospital's experience?
2 THE WITNESS: At this point in time, I
3 don't know there is. There was historically
4 essentially an experience rating modification, but
5 I don't believe that's in place at this time.
6 MR. DEKLEVA: Okay.
7 So, in other words, what you understand
8 to be happening is that the aggregated percentage
9 increases are applied across the board and my
10 question is, would it be appropriate to include a
11 modifier to set surcharge levels for individual
12 hospitals, for example, based on the modifier or
13 the ultimate loss ratio contained in the table on
14 Page 23.
15 THE WITNESS: I would not recommend
16 using the data on Page 23, as the basis. If the
17 broader question is, "Would it make sense to have
18 some kind of experience modification?" It's hard
19 to tell. But, I think that a justification could
20 be made for some limited experience modification
21 factor.
22 MR. DEKLEVA: And what would that
23 normally be based on, in your experience? Would
24 it be number of claims to hit the primary layer
25 for example, or number of closed claims or dollars

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1 that have actually been paid out on those claims
2 or some other information that could be used to
3 form that experience modifier?
4 A. Historically what we did is we ignored
5 the two most recent years, because the data is so
6 green, and I think we looked at the previous five
7 or six years. We focused on actually the
8 underlying claims data, both frequency and
9 incurred loss dollars, as a way of saying, "More
10 claims in the primary layer are indicative of more
11 potential for losses in the PCF layer."
12 There isn't any specific prescribed
13 methodology for doing the kind of experienced
14 modification that you're looking at, there are
15 some general rules of thumb that apply, but the
16 challenge here quite candidly is exactly how long
17 it takes for claims in the PCF layer to be
18 reported and settled and that report lag and that
19 settlement lag, just simply make doing
20 modifications very difficult.
21 MR. DEKLEVA: Do you see these types of
22 modifiers being used in some of the other states
23 where you fulfill a similar role to what you're
24 doing here in New Mexico, for example, in Kansas
25 or Indiana, or is it more that those states also

1 set the hospital rates on an aggregated basis?
2 THE WITNESS: I don't work on Kansas or
3 Indiana, I've looked at the Indiana, but not in a
4 long time.
5 MR. DEKLEVA: Okay, I misspoke, I guess
6 maybe it was Wisconsin that you said that you --
7 THE WITNESS: Yeah, Wisconsin, I don't
8 know the hospitals are in. I'd have go back.
9 MR. DEKLEVA: Okay.
10 THE WITNESS: But like the Virginia
11 Birch Funds (phonetic), for example, or the New
12 York Medical Indemnity Fund, or the Florida
13 Neurological Injury Compensation Association,
14 don't have experience based adjustments to their
15 fees.
16 MR. DEKLEVA: Okay. Let me ask you a
17 question about Table 23.
18 If I understand your testimony
19 yesterday -- sorry, not Table 23, but the table on
20 Page 23.
21 THE WITNESS: Yup.
22 MR. DEKLEVA: -- I'm trying to flip
23 there so I can accurately -- it's the allocation
24 of outstanding losses by hospital. If I
25 understood your testimony, you were asked to put

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1 this table together, but it's not really forming
2 your opinions, per se, in terms of your ultimate
3 conclusions and how the rate should be set for the
4 hospitals; is that a fair way of saying it?
5 THE WITNESS: It is an informational
6 item. It doesn't affect my primary charge, which
7 is to estimate the current fund deficit and to
8 provide an actuarial estimate of indicated
9 surcharge levels for next year.
10 MR. DEKLEVA: Okay.
11 THE WITNESS: So it doesn't -- it
12 doesn't inform either of those two areas of scope.
13 Also, just for your benefit and maybe for others'
14 benefit, the allocation -- I described the
15 allocation yesterday, but if you look back at
16 Appendix 19 which starts on Page 83, it actually
17 has the details by facility of how the surcharges
18 were allocated by hospital system by year, so you
19 can kind of see in gory detail.
20 So if you're interested in actually
21 seeing what our methodology was, you can certainly
22 take a look at that. And that's the work paper
23 that supports the table on Page 29.
24 MR. DEKLEVA: Okay. Thank you. A
25 couple of other questions.

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1 With regard to the physician surcharge
2 rates that are assessed against the hospital, I
3 mean, you're aware that the hospitals pay a
4 surcharge for the facilities and then they pay a
5 separate surcharge for the employee providers; is
6 that right?
7 THE WITNESS: Yes.
8 MR. DEKLEVA: First of all, do you know
9 whether the employed physician claims are backed
10 out of the analysis on the hospital surcharges
11 side?
12 THE WITNESS: Um, actually, if you dig
13 into the claims, I'd have to go back and
14 double-check, but the last I looked, there were
15 either no claims assigned to the W2 physicians, or
16 only one or two. The losses have all been
17 allocated to the hospital side of the house, which
18 I found really interesting. So --
19 MR. DEKLEVA: Okay.
20 THE WITNESS: It was something --
21 MR. DEKLEVA: Who is doing the
22 allocation, if you know?
23 THE WITNESS: I don't know.
24 MR. DEKLEVA: Okay. Let me ask you a
25 couple of questions --

1 THE WITNESS: I think there might be
2 some reasons outside the scope of this discussion
3 why the claims are being allocated to the
4 hospitals.
5 MR. DEKLEVA: Okay. Let me ask you some
6 questions.
7 I'm going ask to you turn to Page 9 to
8 zero of your report.
9 THE WITNESS: Yup.
10 Can I ask a kindness, can we take a
11 two-minute necessary break?
12 MR. DEKLEVA: Of course. I'm fine with
13 that, yeah.
14 CHAIRMAN RITCHIE: Yes.
15 (Recess taken from 10:13 to 10:17.)
16 CHAIRMAN RITCHIE: Let's return to the
17 hearing, please.
18 Please repeat again what page we're
19 going to in the question.
20 MR. BARENBERG: We were on Page 90.
21 CHAIRMAN RITCHIE: Ninety, okay. I
22 don't see Mike back yet.
23 MR. DEKLEVA: Are we back on the record?
24 This is Mike Dekleva.
25 CHAIRMAN RITCHIE: Yes.

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1 MR. DEKLEVA: Okay.
2 So, Mr. Walling, do you have Page 20 in
3 the packet of materials in front of you?
4 THE WITNESS: Yes.
5 MR. DEKLEVA: Okay. And so, my question
6 is, if you look at Column 3 -- and just for the
7 record, this is the allocation of the ultimate and
8 outstanding losses by hospitals, and I'm looking
9 at Column 3, which is the load for employer
10 provider surcharges, can you explain what that
11 column meaning is, or what the load for employer
12 surcharges is.
13 THE WITNESS: Sure. What's in Column 2
14 is purely the hospital surcharges and doesn't
15 reflect the W2 employed physician surcharges, and
16 there were some limitations in the data that was
17 available to us, so what we ended up having to do
18 is use the data from I think it was 2021, where we
19 did have the hospital surcharges and the employed
20 physician and surgeon surcharges, we used that
21 ratio from 2021 to allocate back to the prior
22 year.
23 So what you'll see is we have data for
24 '22, we have data for '21, all of the prior years
25 are the same relationship between the employed

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1 physicians and the hospitals, so it's simply a way
2 for us to estimate as best we can, what the
3 related physician surcharges are as a percentage
4 of the hospital surcharges.
5 MR. DEKLEVA: Okay. So you kind of read
6 my mind on where I was going with that. My
7 question -- you probably answered it, but I'll
8 just ask it in this way: In looking at that load
9 for employer provider surcharges, it stayed
10 constant at .816 from 2009 to 2021 and then for
11 2022, it increased to 1.034. And if I'm
12 understanding -- well, rather than me trying to
13 recite back what my understanding is, which will
14 probably be incorrect, can you just explain,
15 again, what that increase is based on.
16 THE WITNESS: Is the actual surcharge
17 revenue for the physicians in '22 relative to the
18 actual hospital surcharges in '22.
19 MR. DEKLEVA: Okay.
20 THE WITNESS: So the two years that we
21 have data for are 2021 and 2022. The assumption
22 in this allocation is that the prior years will
23 all look like 2021.
24 MR. DEKLEVA: Okay. Let me ask you a
25 question about physician surcharge rates, and I'm

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1 going to pull up to Page 41 of your report, just
2 let me know when you get there.
3 THE WITNESS: I'm there.
4 MR. DEKLEVA: You have that in front of
5 you?
6 THE WITNESS: I do.
7 MR. DEKLEVA: Okay. And my question is,
8 if you look at Columns 2A and 2B, the hospital and
9 outpatient healthcare facility employed provider
10 rates are quite a bit higher for class than those
11 rates for the independent providers, and I'm just
12 wondering why that is or what that's based on.
13 THE WITNESS: My recollection -- and I'd
14 have to do a little research on this -- was, the
15 divergence is that the employed providers
16 surcharges followed the hospital surcharge change,
17 rather than the independent provider change. So I
18 think that's actually the history, is that the
19 hospital employed providers surcharge changes over
20 the last, I forget how many years, have actually
21 followed the hospitals rather than following the
22 independent providers. They used to be the same,
23 but I believe the divergent was that the W2
24 employed providers started following the
25 independent change -- not actually the independent

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1 change, but the implemented hospital change. And
2 I wish I could tell you when that started, but I
3 don't recall.
4 MR. DEKLEVA: Do you know why that is?
5 Because let me just give -- kind of give you a
6 hypothetical that will sort of maybe help you
7 understand kind of what I'm thinking is, I --
8 well, let me ask it this way: Is there any
9 information or data that you've seen that would
10 indicate that, for example, an obstetrician
11 practicing as an employed W2 physician in a
12 hospital, has -- presents greater risk to the Fund
13 than an independent obstetrician? Do you see my
14 point?
15 THE WITNESS: I do. I guess my
16 observation would be, because of the way that the
17 hospital claims data for the PCF is allocated
18 between the hospitals and the physicians, it's
19 candidly impossible for me to come to any
20 conclusion about how the W2 employed physicians
21 experience compares to the independents.
22 MR. DEKLEVA: Okay.
23 And so, your -- if I'm understanding
24 what you told us earlier, it's just simply follow
25 the rate for the hospital employed providers is

1 simply following the assessed rate for the
2 hospitals themselves; is that correct?
3 THE WITNESS: The approved percent
4 change in surcharge levels, yes.
5 MR. DEKLEVA: Okay. Do you know, in
6 your experience in working in other states on
7 similar funds, whether that -- this is universally
8 true, or have you seen it where either these
9 employed provider rates and independent provider
10 rates are either the same or even inverse to what
11 we see here, where the hospital employee providers
12 actually have a lower surcharge than the
13 independent providers?
14 THE WITNESS: As I sit here, I don't
15 remember any situations where they're different at
16 all.
17 MR. DEKLEVA: Okay. So they're normally
18 the same?
19 THE WITNESS: Yeah, that's my
20 recollection.
21 MR. DEKLEVA: Okay. And why is that, if
22 you know?
23 THE WITNESS: I think you run into the
24 problem of simply not having enough claims data to
25 differentiate.

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1 MR. DEKLEVA: Okay. I think that's it
2 for now. Thank you, Mr. Walling.
3 THE WITNESS: Um-hum.
4 CHAIRMAN RITCHIE: Question to follow-up
5 on that. Is it your understanding that the cap
6 for independent physicians is the same as the cap
7 for W2 physicians?
8 THE WITNESS: Requires a legal
9 interpretation and I'm not an actuary -- I'm an
10 actuary.
11 I will say this, we organized the data
12 with the independent physicians and surgeons,
13 separate and distinct from the hospital and their
14 W2 employed physicians, and that's how we've
15 chosen to organize the data. And, candidly, it
16 has to do with that issue of trying to unravel how
17 you would allocate each of those hospital claims
18 between the employed physician and the hospital.
19 It's a data challenge.
20 CHAIRMAN RITCHIE: Okay. Any other
21 questions on the hospital surcharges?
22 MR. BARENBERG: Those were the main
23 subjects. There was one additional topic that was
24 new to the report this year which was labeled
25 "Illusory Coverage," that was covered on Pages 10

1 and 23, I believe they were identical, so I'll
2 show 23 on the screen. What was the concern that
3 you addressed with this issue?
4 THE WITNESS: It was communicated to me
5 that there's some allegation that the underlying
6 coverage for some of the hospitals was being
7 alleged to be illusory and that creates all sorts
8 of issues downstream, but it felt important to me
9 clarify that, just because a hospital chooses to
10 purchase a large deductible policy or chooses to
11 use a captive insurance company for some layer of
12 their insurance funding, doesn't in any way make
13 that coverage illusory, it's simply a different
14 risk financing mechanism than using a traditional
15 insurance company. There are still valid
16 insurance policies being issued, there are still
17 substantial regulatory oversight, and so I find it
18 pretty hard to -- hard to agree with the idea that
19 using a different insurance mechanism than a
20 first-dollar guaranteed cost insurance policy,
21 somehow makes the coverage illusory.
22 MR. BARENBERG: How is a large
23 deductible policy different than self-insurance?
24 THE WITNESS: On a large deductible
25 policy, there is still a first-dollar policy

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1 issued and then the insurance carrier recovers the
2 deductibles from the insured. So in the case of a
3 default of an insured on a large deductible
4 policy, literally the carrier would be required to
5 drop down and provide first-dollar coverage.
6 MR. BARENBERG: And for the PCFs
7 purposes, what is the difference between a large
8 deductible policy and a regular insurance policy?
9 THE WITNESS: There's -- it's just like
10 your personal auto or your homeowners' policy
11 that, you've got an obligation to pay the first
12 thousand dollars for every collision claim that
13 you have with your car and on a large deductible
14 policy for a hospital they might be responsible
15 for the first hundred thousand dollars,
16 quarter-of-a-million dollars for each and every
17 claim beyond the premium they've paid for the
18 policy itself. So there's an additional financial
19 obligation to fund the deductible for the claims.
20 Q. And what if the deductible is equal to
21 the coverage?
22 A. That's typically known as a fronted
23 policy, where the company issuing the policy is
24 not in a risk-bearing position. Still insurance
25 still regulated as insurance, it's simply a fully

1 reinsured transaction, but if it's a large
2 deductible policy, that front-end carrier still
3 has a the financial obligation in event of the
4 insolvency of the insured, and because of that,
5 would actually typically require a pretty
6 substantial amount of collateral to support that
7 large deductible.
8 MR. BARENBERG: What would the practical
9 indications be of retroactively disqualifying
10 healthcare providers on -- based on what's been
11 called illusory coverage?
12 THE WITNESS: It would be a logistical
13 nightmare. Trying to figure out how to unravel
14 the surcharges that have been paid, the claims
15 that have been paid, verdicts and settlements that
16 have been arrived at, the frictional cost of
17 trying to come to some satisfactory resolution of
18 all those issues, not to mention the ones that
19 come up in the future, would be a logistical
20 nightmare that would have massive, massive
21 frictional expenses associated with it.
22 MR. BARENBERG: That is my questions on
23 that topic. Are there any questions of
24 Mr. Walling.
25 CHAIRMAN RITCHIE: I think, yeah we'll

1 open it up to allover questions --
2 MR. BARENBERG: Well, we have a couple
3 of the other topics that were added.
4 So a question came in last night or
5 yesterday afternoon, and this refers to one of the
6 documents in Southwest Gastroenterology
7 Associates' intervention packet where it compared
8 other patient compensation funds. And let me know
9 if you need to see specific portions of the
10 documents, but there is the table --
11 THE WITNESS: Can I grab a copy of the
12 hard copy? Got it.
13 MR. BARENBERG: So, beginning on the --
14 this was the -- I have it up on the screen where
15 it talks about other states and then at the bottom
16 of the first page there's a comparison of other
17 patient compensation funds and that table
18 continues. And so the question that came in is,
19 "In your opinion, what are the contributing
20 factors with these other funds that make them more
21 robust and more sound than New Mexico's fund?"
22 THE WITNESS: First and foremost, I
23 would observe that in both Indiana and Wisconsin,
24 there's pretty substantial tort reform in place.
25 The mandatory nature of the Wisconsin fund is

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1 certainly an appeal. But the one number that
2 really needs to be on here and isn't, is the
3 current surplus, the current fund balance of these
4 funds and the current invested assets.
5 Last I checked, Wisconsin has over a
6 billion dollars of invested assets that are a
7 segregated account in the Wisconsin State
8 Investment Fund, so they have investment managers
9 working very hard to generate really pretty
10 excellent returns on those invested assets and it
11 throws off a significant amount of investment
12 income every year, which is used to subsidize the
13 otherwise indicated surcharges in Wisconsin.
14 Same thing with Indiana, they are in a
15 surplus -- a positive surplus position or a
16 positive equity position, if you want to think of
17 it that way, that allows them to accomplish some
18 pretty positive things.
19 M-Care is a challenge. M-Care has gone
20 through struggles not dissimilar from New Mexico's
21 and there's a myriad of issues that have
22 contributed to their deficit and also results in
23 M-Care being phased out. Their deficit position,
24 their unfunded liability is just over a billion
25 dollars, as you see in the handout. M-Care has