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

DOCKET NO: 2023-0018-PCF

IN THE MATTER OF DETERMINING PATIENT'S COMPENSATION FUND SURCHARGE RATES FOR CALENDAR YEAR 2024

September 22, 2023
9:00 a.m.
MICROSOFT TEAMS VIDEOCONFERENCING

BEFORE: William Ritchie, Chairman
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EXHIBITS

(Note: In session at 9:00.)

CHAIRMAN RITCHIE: Good morning, everyone. I'll call the meeting to order. I'm Bill Ritchie, Chair of the PCF Patient's Compensation Fund Advisory Board, and this is the hearing to discuss the recommendations and the actuarial analysis report. We have one intervenor before we get to the report, because of time constraints and being sensitive to her schedule. So we are actually going to start with that. However, first let's call the roll for the Board, since we're acting as the hearing officers. So let's have a roll call, please.

MS. ROMERO: Chairman Ritchie?

CHAIRMAN RITCHIE: Here.

MS. ROMERO: Vice Chair Love?

MS. LOVE: Here.

MS. ROMERO: Mr. Clark?

MR. CLARK: Here.

MS. ROMERO: Mr. Dekleva?

MR. DEKLEVA: Here.

MS. ROMERO: Mr. Vargas?

MR. VARGAS: Here.

MS. ROMERO: Mr. Autio?

MR. AUTIO: Here.

MS. ROMERO: Mr. Spitzer?

MS. LOVE: He'll be joining us at 9:30.

MS. ROMERO: Thank you. Ms. Steven?

MS. STEVEN: Here.

MS. ROMERO: Mr. Martinez?

MR. MARTINEZ: Here.

CHAIRMAN RITCHIE: Okay. It sounds like we have a quorum here and so we would like to start, just get right away into it. We only have two hours this morning and we will continue tomorrow, if necessary. So we start with the single entity that asks to intervene and we much appreciate that. So we will start with that and then go on to the actual report.

DR. ADAMS: Good morning, Chairman, Committee members. My name is Dr. Gabrielle Adams. Thank you for the opportunity to intervene and share with you how increases in the Patient's Compensation Fund surcharge rates will negatively impact my practice in particular and further reduce access to health care in New Mexico.

I'm the managing partner of Southwest Gastroenterology. We are an independent medical practice and have been serving New Mexico for over 40 years. Our practice has participated in the

Patient's Compensation Fund for over 40 years, and I have participated myself since 1997.

New Mexico has long been medically underserved, which is in part not unique to New Mexico. However, the health care shortage has reached a crisis level, which further burdens the existing system and the physicians who remain. Every day I hear of physicians leaving the state and all of our health care systems in New Mexico are having difficulty recruiting and obtaining physicians.

Let me tell you, there are many reasons that New Mexico is a difficult place to practice. One of them is Keiser medical liability premiums compared to other states. Please refer to the first page in your packet. It's a table that compares medical liability insurance premiums in New Mexico compared to the neighboring states. I would like you to, in particular, look at general surgery and OB/GYN. The top table has the rates for New Mexico. The bottom table has rates for our neighboring states.

So within the Patient's Compensation Fund in New Mexico, premiums for general surgery are 81 to 94,000 a year. OB/GYN is 93 to 105,000 per year

in New Mexico. If you compare that on the bottom table, general surgery in Arizona, 39,000 a year. Texas, 43; Colorado, 60; Utah, 59. OB/GYN, 50,000 compared to 105 in New Mexico; 47 in Texas; 54 in Colorado; 83 in Utah.

The next paper you see in your packet is a graph of the rate increases that my practice has seen over the past couple of years. The premium increase that I mentioned are 53.57 percent compared to 2020, and our surcharge increase has increased by 109 percent.

I understand that you guys would be reviewing the latest actuarial analysis that was published in December of 2022 and that you're tasked with making recommendations regarding rate increases for next year. And in my review of this, I'm not an actuary, but my understanding is that it looks like the amounts that might be represented are as high as 57 to 81 percent for independent physicians and surgeons in order to eliminate the deficit as required by House Bill Senate 5. Independent medical communities simply cannot absorb these kinds of rate hikes, unnecessary rate hikes.

As you are all likely aware, I will explain that physicians who accept Medicare and

Medicaid cannot increase their fees to reflect the increased cost. Reimbursement is determined by a federal fee schedule that varies from state to state. Commercial insurance reimbursement requests Medicare rates which are federally set. In New Mexico we are extra challenged because reimbursements....

(Note: Audio lost.)

THE COURT REPORTER: I am not able to hear well enough to take the record.

UNIDENTIFIED SPEAKER: We just lost audio.

CHAIRMAN RITCHIE: For some reason we keep getting muted. Is there somebody who muted all when someone logged in? If we get muted again and you can't hear, just interrupt us again, please.

MS. LOVE: I apologize. Court reporter, I don't know what your name is, but would you let us know if you're able to pick up everything Dr. Adams is saying?

THE COURT REPORTER: Hi. I'm Jan Gibson. I think I'm hearing what you're hearing, but it sounds like there's not a microphone near her. So me, not being familiar with what you're talking about, it's hard to distinguish all the words. If she can give me what she's reading from later, we

can figure it out.

DR. ADAMS: Is this better?

THE COURT REPORTER: Yes, thank you.

DR. ADAMS: So as I was saying, although rates in New Mexico based on federal fee schedules are often lower in New Mexico compared with other states, health care delivery here can cost more than it does in other states for various reasons, you know, such as gross receipts tax that New Mexico has to pay and higher medical liability insurance premiums.

So you all might be asking yourself, why is she saying this? Physicians are highly compensated so why is a rate hike so critical to delivery of health care here in New Mexico? The problem is that we are competing with other states. Compensation is significantly higher where the ease of practice and professional satisfaction are much greater.

What I'm sharing with you shouldn't be new information or surprising. The prior superintendent of insurance, Mr. Toal, sounded the alarm in October of 2022. That document that I'm referring to is in your packet. It's the third -- it's actually the last item in the packet and it's the

recommendations. The top page says "Recommendation Changes to Medical Malpractice Act." In particular, I would like to refer you to Paragraph 3, which is the third page. And it reads, "The custodian finds that: While hospitals and outpatient health care facilities may be able to withstand or pass on fee for cost increases, independent providers likely find the cost of participation in the PCF as recommended by the actuary and the PCF advisory board to be prohibitive, and leave the PCF, or worse, leave the state. This would increase the cost of reducing the deficit to the remaining qualified health providers in the PCF, potentially leading to a cascade of participants leaving the PCF."

Also in that document, Exhibit A, which is the first page, the superintendent of insurance recommended changes to the Medical Malpractice Act.

So for the health of the medical community, and more importantly, for the health and welfare of all New Mexicans, we need comprehensive tort reform. And in the short-term we need to keep medical liability insurance affordable. Thank you for your consideration.

UNIDENTIFIED SPEAKER: Mr. Chairman, I

just wanted to point out that I don't believe that the final exhibit that you referred to, that is the final order for last year, was submitted as an exhibit when you filed your exhibits, was it? Because we're not seeing that.

DR. ADAMS: Yes. Yes, the documents I have in my hand are the documents --

MR. WARD: We were just looking through them and were not able. In any event, because it's a final order, my point is because it's an order from last year, I don't think it's really relevant if it didn't happen to get filed and that the committee can take notice of this anyway. I just wanted to make it clear for the record.

THE COURT REPORTER: May I know who was speaking?

MR. WARD: This is counsel for the PCF, Vincent Ward.

THE COURT REPORTER: Thank you.

MS. ROMERO: For the board members appearing virtually, all of the documents are on the OSI E-docket for your review. I will send out a link to all the board members after the meeting just so everybody knows exactly where to find the documents.

CHAIRMAN RITCHIE: Do any board members have any questions of Dr. Adams?

MS. LOVE: This is Kathy Love. I only have one. Good morning, Dr. Adams. Dr. Adams, how long has Southwest Gastroenterology Associates been a member of the Patient's Compensation Fund?

THE WITNESS: Over 40 years.

MS. LOVE: Thank you.

CHAIRMAN RITCHIE: Anyone else have any questions of Dr. Adams? Okay. Thank you very much. We're still with the task of getting through the intervening process. Now we have a presentation by --

UNIDENTIFIED SPEAKER: Can I ask a quick question?

DR. ADAMS: Yes.

UNIDENTIFIED SPEAKER: Those rates you're pulling for other states, I assume those are coming from Medical Liability Monitor; is that correct?

DR. ADAMS: Yes. This is public record information that was submitted actually by --

UNIDENTIFIED SPEAKER: Not what I asked. Is it from the medical liability Monitor?

DR. ADAMS: I can't answer that. I don't know.

UNIDENTIFIED SPEAKER: Thank you.

THE COURT REPORTER: Excuse me, I just want to remind people, I'm not able to see all of you and I need you to identify yourselves before you speak. I'm sorry, I know it's tedious.

CHAIRMAN RITCHIE: Please give your presentation.

MR. BARENBERG: So I am Barry Barenberg. I am counsel for Alice T. Kane, who is the superintendent of insurance. And my role as counsel is to advise her in her role as the custodian for the Patient's Compensation Fund. We heard from Mr. Mr. Walling a few weeks ago when he introduced an actuary report. I will be examining him today to establish the evidentiary foundation for his rate recommendation. I'm going to try to share my screen.

This is similar to last year. We have a top level outline of what we'll be covering. We'll start with Mr. Walling's CV, qualifications and experience. There will be an introduction to his report and then the topics listed below that with final questions from the Board.

The way we ran this last year was that I would announce at the end of each of these topics

when we do switch to the next topic, and the Board, for the most part, held their questions until that transition and that helped things run a little more smoothly. So if we can follow that as much as possible again this year, that will help us get through it. So with that in mind, I am now moving on to the first topic, which is Mr. Walling's CV. I don't think there will be any questions at this point, but if there are, I will pause for just a moment.

EXAMINATION OF ROBERT WALLING

MR. BARENBERG: Mr. Walling, just so the court reporter has it, can you tell us your first and last name and spell it, please.

THE WITNESS: Sure. My name is Robert Walling, W-A-L-L-I-N-G.

MR. BARENBERG: All right. And I just put up on the display your CV, and do you recognize that?

THE WITNESS: I do.

MR. BARENBERG: And can you tell us what it is?

THE WITNESS: It's essentially my curriculum -- it's the first page of my curriculum vitae.

MR. BARENBERG: You can see there are additional pages here. Is this the full document that you provided to me earlier?

THE WITNESS: It is.

MR. BARENBERG: And does this accurately show your education and experience?

THE WITNESS: It does.

MR. BARENBERG: Are there any significant changes in this from last year?

THE WITNESS: Nothing really significant. Just some changes in the articles I've written and some of the statements of actuarial opinion that I signed, but nothing material.

MR. BARENBERG: So to kind of speed things up, since there are no significant changes from last year, and the Board had accepted Mr. Walling as an expert, unless the Board wants me to go through the details again, I would move that CV be admitted into evidence as Exhibit A and that Mr. Walling be recognized again as an expert.

CHAIRMAN RITCHIE: Any objections to that? No objections. Make a motion.

UNIDENTIFIED SPEAKER: I'll second it.

(Note: Exhibit A admitted.)

MR. BARENBERG: So that will save us on

the first topic. Since I am now going into the report, are there any questions from the Board for Mr. Walling about the background?

MR. BARENBERG: So Mr. Walling, I have put up on the screen the first page of the report. Do you recognize that?

THE WITNESS: I do.

MR. BARENBERG: Can you briefly describe what it is?

THE WITNESS: This is the cover page of the actuarial analysis that we performed relative to the New Mexico Patient's Compensation Fund as of December 31, 2022.

MR. BARENBERG: When you say "we performed," who was that?

THE WITNESS: Pinnacle Actuarial Resources. So I serve as the account exec and the author of the report, but then I have support staff to help me with the technical elements of the analysis.

MR. BARENBERG: And what was your goal in the preparation of the report?

THE WITNESS: Selection of all of the meaningful selections in the analysis, oversight of the data methods and assumptions being used.

MR. BARENBERG: I'm going to turn to Page 9 of the report, which is Page 12 of the PDF and there's a bullet list in the middle of the page. Tell me when you're at that page or if you can see it on the screen. What does that list show?

THE WITNESS: It shows essentially the scope of the analysis, which is to estimate the ultimate benefits liabilities of the fund as of December 31, 2022, to recommend actuarially sound assessment surcharges for the fund, recommend deficit surcharge levels for the fund to eliminate the deficit by 2029, to discuss the notion of illusory coverage and to evaluate the independent positions classification plan.

MR. BARENBERG: And is it fair to say the main purpose of your report is to determine the surcharges for the next calendar year?

THE WITNESS: I guess I would view it as estimating the unpaid claims benefits and the surcharge levels as Priority 1A and 1B.

MR. BARENBERG: Did you perform the work concerning these items?

THE WITNESS: Yes.

MR. BARENBERG: Does your training and experience enable you to do each of those items?

THE WITNESS: It does.

MR. BARENBERG: So now we would like to go through the report, so I move that report be admitted into evidence as Exhibit B.

CHAIRMAN RITCHIE: Any objections? So moved.

(Note: Exhibit B admitted.)

MR. BARENBERG: So going back to the top level outline, we'll do a quick introduction to the report, and in that first bullet back on Page 12 you have the estimated liabilities and loss improved by the PCF as of December 31, 2022. What does that mean?

THE WITNESS: Basically, the coverage that has been provided by the Patient's Compensation Fund includes all claim events that have occurred as of December 31, 2022. Some of those claims we don't know about. Some of those claims we know about but they haven't reached their ultimate settlement value. And so my job is to try to take the available data and extrapolate all of those claim events, known and unknown, to their ultimate settlement basis and essentially estimate how much money is going to be needed to get all of those claims to the ultimate settlement.

MR. BARENBERG: Is that related to loss reserves?

THE WITNESS: Yes.

MR. BARENBERG: What are loss reserves?

THE WITNESS: Loss reserves is a shorthand way of describing the loss and loss adjustment expenses that are still unpaid.

MR. BARENBERG: All right. Now, that was just a quick introduction, and so we are going to go to the next bullet, which is the indicated loss reserves for physicians.

Are there any questions for Mr. Walling before we go on? No? Okay.

One of the key areas of your analysis was estimating the unpaid claims liabilities for the loss reserves for the independent physicians, so we'll go ahead and start there. I'm going to go to Exhibit 2 of the report, which is on Page 40 of the PDF. I put that up on the screen.

THE WITNESS: It's probably worth noting to the Board, the organization of the exhibits has been changed a little bit this year to try and take kind of the detailed work product and shift it to the appendix. You're going to find there are fewer exhibits this year. Hopefully, that allows you to

get what you need out of the report, and the exhibits are kind of the major exhibits supporting the report.

MR. BARENBERG: So I put up on the screen Exhibit 2 from the report, Page 40. And can you explain that exhibit to us?

THE WITNESS: Sure. So we break our analysis between the surgeons and the hospitals for the purpose of evaluating both the loss reserves and the prospective surcharge levels. This particular exhibit looks just at the independent physicians and surgeons. And what it summarizes is the historical surcharge levels for the physicians and surgeons going all the way back to 2000. The losses that have been paid to date in Column 3 are through December 31st of last year.

Then it shows the four different projection methods we use. So it's actuarially appropriate to use multiple different methods to estimate ultimate losses. Some are very responsive, some are very stable. They each have strengths and weaknesses, but this gives us four different perspectives on the ultimate loss values.

What you'll see in Column 8 is we select an ultimate loss estimate for each of the accident

years in this exhibit from 2000 through 2022, and you will see the total value there is $286 million and change. That compares to $234.75 million in surcharges that have been collected during that period. And you can see that that $286 million estimate kind of sits right in the middle of the four different methods if you go across that total.

But what it also shows is that the ultimate loss estimate is about 121.9 percent of the total surcharges collected, so there's a fundamental difference between the surcharges, or you can think of them as premiums collected, and the ultimate losses that we believe are going to be paid out over time.

MR. BARENBERG: So the ultimate losses have not been paid yet?

THE WITNESS: Correct. And actually, if you compare the pay losses in Column 3 to the ultimate losses in Column 8 there's a difference of about 71 1/2, 72 million. That difference is exactly the loss reserve of the unpaid claim liability that we are talking about for the physicians.

MR. BARENBERG: Did you always use the same method from Columns 4 through 7 for each year

to select the ultimate loss in Column 8?

THE WITNESS: No. As more and more of the claims are settled and paid, it makes more sense to shift to methods that are more responsive. So what you will see is for the more mature years, the older years, I'm going much more on the fee development method. Whereas, for the recent years, where literally we haven't paid a dollar for the last three accident years, we need something that's more stable and well behaved, and we're going to rely more on the expected loss method and the frequency and severity method.

MR. BARENBERG: And this data was current as of December 31, 2022?

THE WITNESS: Correct.

MR. BARENBERG: So you went over the total ultimate loss was $286 million, all rounded numbers, with a loss ratio of 121.9 percent. What do these numbers tell us about expected future payments?

THE WITNESS: They tell us that there is currently a mismatch between the surcharges we're collecting and the estimates of ultimate claims. So if you look at the most recent three, four, five years, the surcharges collected have been on the order of 10 to $15 million. The ultimate loss

estimates run from a low of just under $12 million to a high of about $22 million. There's a deficit position between the surcharges we're collecting and the ultimate losses that we're estimating what we paid out over time.

MR. BARENBERG: Now, is there somewhere that we can see the estimate of the unpaid claims, liabilities or loss reserves for independent physicians and surgeons?

THE WITNESS: Sure. That's going to be --

MR. BARENBERG: Is that Exhibit 1, Page 4?

THE WITNESS: That's a good place to look at it, yeah. Thank you.

MR. BARENBERG: That's Page 38 of the PDF?

THE WITNESS: I have to apologize up front for the size of the font. But Exhibit 1, Page 4, takes that information that we are just talking about in Exhibit 2 and compares our analysis from last year to this year.

So you will see in the first table the ultimate losses and the reserves that we just talked about from Exhibit 2. The next table, as we move to the right, is the same data from last year. So you will see, for example, that the paid losses as of Year-end 21 were $205 million and change. That is

increased to $214 million.

Similarly, the ultimate losses through Year-end 21 were $262 million. That ultimate loss estimate has increased slightly to $268 million. But what we're seeing is actually favorable development, so that the undiscounted reserves for the prior years had dropped from $55.4 million to 53.9, $54 million, so we're seeing a bit of a reduction in the prior years. But then we need to add on the reserves for the current year.

So if you look kind of bottom right in this table, you will see that the total undiscounted reserves for the physicians and surgeons increased by a total of about $14.3 million year over year. So that's the increase from $57.258 million in the second table to $71.553 million in the first table. So that's the summary.

MR. BARENBERG: And at the bottom of this exhibit there is reconciliation calculation. Can you explain that?

THE WITNESS: Sure. This is just showing the components of how we get from the $57.3 million last year to the $71.5 million this year. You add in the losses for the current year, the 17.597. You take the paid losses and actually remove those, but

you add in the change in the ultimate losses that the -- the 6068 that's shown in change of ultimate losses on basically the smack dab middle of the table. The idea is you can actually see the individual components that gets you from last year's undiscounted reserve estimate to this year's.

MR. BARENBERG: The exhibit also mentions discounting. Can you describe how discounting works?

THE WITNESS: The idea of discounting is if you are going to pay out a thousand dollars a year from now, you don't need a thousand dollars now. You need enough money that if you put it into some type of investment vehicle, you would have a thousand dollars by the time the payment is due.

The same thing happens here. We are not paying all of the unpaid claims liabilities today. We are not ripping a check for all of the claims. And, in fact, there's actually a fairly long time that these claims are going to be paid out. So there's an opportunity to generate investment income on the assets supporting those reserves.

And so the idea is that you lay out essentially a cash flow model that says, when do we expect these claims to be paid and how much

investment income can we generate between now and the time those payments are due?

There's one caveat there, though. You need to have assets generating investment income for this accounting to work. And so in our calculations for the Patient's Compensation Fund, that investment income is limited by the actual invested assets of the fund. We don't have invested assets to support every dollar of loss reserves, and so essentially our calculation of the discounted reserves only gives investment income credit or time value of money credit for reserves that are supported by investment acts.

You can see, if you look at the left-hand table, that takes the 71.553 million of invested assets and reduces it on a discounted basis by about $1.7 million to $69.835 million. If the fund balance had invested assets supporting all of the loss reserves, that impacted discounting would be more pronounced.

MR. BARENBERG: All right. That ends the questions I had for indicated loss reserves for physicians, so before going to the next topic, are there any questions for Mr. Walling?

So the invested assets you are using to

calculate the discount on is what we actually have in the fund now?

THE WITNESS: It's what the fund had on the balance sheet as of December 31, 2022.

MR. BARENBERG: The date of investment?

THE WITNESS: Correct. So actuaries at times think like accountants, and in this case that means we're looking at the losses of value as of December 31, 2022 but we're also using an accounting date as of December 31, 2022, which affects things like the invested assets in the fund balance. Because we're looking at those items as of December 31, 2022.

MR. BARENBERG: Now, when you calculate that, you're calculating that as if the payout is in a lump sum?

THE WITNESS: We're actually not looking at that payout on a claim-by-claim basis. We're looking at it in aggregate.

(Note: Audio interference.)

CHAIRMAN RITCHIE: Please mute your microphones.

THE WITNESS: Maybe the easiest way to see that is Exhibit 1, Page 2. Exhibit 1, Page 2 actually shows the total indicated reserves by

accident year. And you can see that the years 2000 through 2010, I believe, are all of the claims that have occurred during those accident years are fully and finally settled. We don't expect any additional unpaid claims.

What we do then is take the $93,000 that we still expect in 2011 and cash flow, kind of, when we expect those to be paid out, and so the percentages that you are seeing over here kind of show the timing of when we expect those payments. So you can see that we're spreading out claims payments eleven years.

So in the case of, say, the 2022 accident year, there's a fairly decent hold time between closing the reserves as of right now and when we can anticipate actually making this claim. That's a good question.

MR. BARENBERG: Thank you.

CHAIRMAN RITCHIE: Go ahead.

MR. CLARK: Mr. Chair, this is Troy Clark for the court reporter.

Mr. Walling, a question. Back on Exhibit 1, Page 4, there's three sections of the table, if I'm looking at the right place.

THE WITNESS: Yes.

MR. CLARK: That far right section, the difference between the years, the most left column of that shows the difference on the ultimate losses between the two years.

A couple sequential questions here. It looks as though, if I read this correctly, your estimate of what the ultimate losses are for years 2011 through roughly 2016 have decreased from prior years, and yet the estimates for 2018 to 2019 have increased from where you were last year.

THE WITNESS: Yes.

MR. CLARK: To what level of granularity do you look for those assessments? Are you looking at the number of outstanding claims that are still open in making those assessments? So can we, as a board, infer that the reduced ultimate losses in the years that dropped, there's a correlation to what that exposure is, based on the open claims? Or is it that claims actually settled for less, or a combination of both?

THE WITNESS: Long story short, we're looking at reported claims and seeing, are there new claims being reported. We're looking at claim closure rates to see if claims are closing as quickly as they have historically closed to see if

there's a change in those settlement rates. We're also looking at changes in paid losses.

You will notice that for the years you've identified where I've actually brought the ultimate loss estimates down, there were also no incremental paid losses. And so to the extent that there are no paid losses -- now, in the last year there was $910,000 of incremental paid loss which was actually less than we projected. And so that actually -- despite the fact that there was a $910,000 payout, the ultimate loss estimate actually came down by almost half a million dollars because it was less than expected.

Conversely, for the two years '18 and '19, the $5.3 million and the $3.1 million were both substantially more than we expected. We also saw some changes in some of the reported claim counts and closed claim counts that resulted in us taking our ultimate loss estimates for those two years.

So great question. And if you dive into the appendices, what you're going to find is that we're looking at, as I said, the reported claim count activity, the closed claim count activity, the paid loss activity, and all three of those things influence our selected ultimate. Great question.

MR. CLARK: Thank you for that, and that leads to the final question in the sequence. For the most current years, 2021 and '22, I'm guessing on the three where you can tell where your cutoff is, obviously, there's an open end where claim count is not yet established for incidents that happen. Do you look at reported incidents or is there any information that you are utilizing towards that, whether it's the volumes, the patient or physicians assets, open claims cannot be --

THE WITNESS: Yes unfortunately, we don't get incident reports like some traditional insurance companies might get, so we don't really get incident reports. What we do instead is we look at the historical reported claims as a percentage of the surcharge dollars. So essentially, there is an expected number of reported counts per dollars of surcharge. And so we're really starting with a jumping off point of X million dollars of surcharge revenue produced Y reported claims, and that's our first estimate of what we think the reported claims activity is going to be.

MR. CLARK: Since you do that, are you doing that based off of the base surcharge or the total surcharge, the one in the last few years, and

then it may apply when we go to the hospital side where there's an additional recovery to fill in the deficit?

THE WITNESS: Right.

MR. CLARK: Total surcharge, is that within corresponding --

THE WITNESS: Well, here's what we're doing. Because, as we've identified, there has been a change in surcharge levels over the last so many years, we take the base surcharge levels but we adjust all the historical surcharge dollars to the current surcharge schedule. That way we get a consistent level of reported claims to currently valued dollars.

MR. CLARK: You keep the ratio consistent?

THE WITNESS: The actuarial phrase is called "bringing the premiums on level." But the idea is we're going to try to state everything in current dollars.

MR. CLARK: Thank you. No further questions.

UNIDENTIFIED SPEAKER: Let me ask the court reporter, did you get the full question?

THE COURT REPORTER: Yes, I did get that.

MR. DEKLEVA: This is Mike Dekleva. I

have a few questions before we move on to the next topic.

CHAIRMAN RITCHIE: Mike, before we go on, I just want to remind everybody, Mr. Walling, let the question finish so the court reporter can get it down, so try not to speak over each other. Go ahead, Mike.

MR. DEKLEVA: Thank you. Mr. Walling, this is Mike Dekleva. Can you hear me okay?

THE WITNESS: Yes.

MR. DEKLAVA: Okay. I just had a couple questions about -- I'm referring to Page 40, the table on Page 40, which is the independent physicians and surgeons data that we talked about a few minutes ago. Do you have that in front of you?

THE WITNESS: I do.

MR. DEKLAVA: Okay. It's up on the screen as well. If you look at the Practitioner's Surcharges column, Column 2, and the Paid Losses, Column 3, there is a significant difference in years 2007 and 2008 and then again in 2010/2011 where the paid losses are significantly higher than the surcharges collected.

Is that the batch claims that we have talked about periodically in these meetings? Is

that why there's that difference of paid losses above surcharges?

THE WITNESS: In some of those years, I forget, and I apologize. We used to have an asterisk marking which years were the batch claims, and at least some of those years the reason they are high is the batch claims. But I don't think 2014 or 2017 are batch claim years.

MR. DEKLAVA: Okay. And I was going to ask you about that, too. There's a higher paid loss in 2014 and 2017 over the practitioner's surcharges. My question was, do we know why for those two years?

THE WITNESS: I would have to look, but my -- I'm not recalling that it's a frequency issue, so my gut is, it's a severity issue.

MR. DEKLAVA: Okay.

THE WITNESS: Let me look.

MR. DEKLAVA: Sure.

THE WITNESS: This is what I get for moving all this stuff to the appendices. If you go back to Appendix 5.

CHAIRMAN RITCHIE: Which page is that?

THE WITNESS: Page 60. What you will see is the claims closed with payment.

MR. DEKLAVA: Okay.

THE WITNESS: In Column 2. And you will see 07 and 08 are pretty obviously batch claims. 59 and 74 closed claims is extraordinary for this program. You will actually see 14 does have a fairly heavy number of claims. I wouldn't describe the 25 claims in 2017 as particularly heavy.

If you flip forward to Page 56 -- actually, 57 -- you will see a comparable exhibit looking at claim severity. This is just looking at closed claim severity. So closed -- paid dollars versus closed counts, and you will see that 2011 in particular, the average paid claim severity is almost double what had happened before that. 2017 is the same way.

So 2011 and 2017 I would describe as severity issues, not frequency issues. 07/08 and 10 are pretty clearly frequency issues/batch claim issues.

MR. DEKLAVA: Thank you. That's helpful. I appreciate it. I don't have any other questions for you at the moment.

MR. AUTIO: This is Nick Autio. I have a question. Given the statements made on Page 7 in the context of expected deficit surcharges, it indicates a better-than-expected claim experience

with Calendar Year 2022 for physicians and surgeons. When I look at the chart on Page 40, Exhibit 2 regarding loss ratios, it looks like the loss ratio is 115 percent. Can you help us understand how that better-than-expected claim experience impacted your estimate of loss ratio moving forward?

THE WITNESS: I think if you're being objective about that 115 selected loss ratio for the years where we haven't seen any claims yet, I think you've got to objectively look five years prior where the current projected loss ratios are 159, 173, 175, 161 and 142. So I think what you'll find, and this actually goes back to the prior question a little bit, is we're trying to strike a balance between the 2017 year where the loss ratio was quite high, the 2018 year where we're projecting a very high loss ratio, and some of those years where we had very favorable results in 12 and 13 and 15.

So the one -- 115 percent selected loss ratio for the three most recent years, I think, is as straight down the middle of a compromise as I can get, based on what we're seeing in the prior years' data.

MR. AUTIO: Mr. Walling, I want to turn your attention back to Exhibit 1, Page 4 of the

report in, I guess, what would be the table on the far left to discuss the undiscounted reserves and discounted reserves when you were talking about the power of investing the reserves invested. And there's a difference there in terms of discount. When it's undiscounted it's 71.5 and when it's discounted it's 69.8. If we had more of the reserves effectively what type of change could you expect to see there? Is that something you can talk about?

THE WITNESS: Probably the easiest -- sorry, I'm trying to find where I have the total invested assets in the discount population. Certainly more. If you look on Page 36, which is entitled Exhibit 1 Page 2, which is where we do the discount factor, there's a little inset box at the bottom, and what we show is three different discount rates. There's a 3 1/2, a 4 1/2 and a 5 1/2 discount rate, and the first set of discount rates you see are the discount rates that would occur if you had assets supporting all of the liability.

So, for example, in the 3 1/2 percent scenario we would be discounting it just more than 9 percent of the total reserves. We're only, because of the limitations on the invested assets,

discounting 2 1/2 percent, so we're taking those undiscounted reserves and discounting them with a factor of .975.

If there were assets supporting all the liabilities of the fund, then that discount rate would be literally more than three times that. Not quite four times that. So pretty substantial. And if you look at other patient's compensation funds like in Indiana or Wisconsin that do have assets supporting all of their loss reserves, the Virginia Birth Injury Fund, it puts them in a very different position in terms of the investment income they are realizing on the fund.

MR. AUTIO: They obviously have an impact on the amount of surcharge needed to fund the fund, right?

THE WITNESS: Correct.

MR. AUTIO: Those are my questions. Thank you.

CHAIRMAN RITCHIE: As a follow-up to that, so the major charge of the Patient's Compensation Fund is on future medical expenses, so that would presumably be paid out over time. Future medical would be future, and not as a lump sum but it would be future over years, perhaps even decades. But if

it is paid out on a lump sum, then do you take that into account in your calculations? Or how would that change if there were not lump sum payments, if it was paid out just, you know, as a cap and for future medical expenses?

THE WITNESS: So let me try and paraphrase your question. If we shifted away from lump sum payments to more periodic payments over time?

CHAIRMAN RITCHIE: Right.

THE WITNESS: That would stretch out the payment patterns, and to the extent that we were able to generate investment income on those funds would actually reduce it. So all things being equal, it would have the effect of reducing surcharges as well.

CHAIRMAN RITCHIE: Do you have any way to estimate the magnitude of that?

THE WITNESS: Not without coming up with how we expected that to change the timing of payments. Certainly there's something we could do, but we will need to come up with a reasonable payment pattern under that alternate claims scenario.

CHAIRMAN RITCHIE: Last question. Are you given that data at all?

THE WITNESS: What data?

CHAIRMAN RITCHIE: As far as payment patterns on non-lump sum. Are you provided that at all?

THE WITNESS: We don't have it broken out. What we do have is indices -- basically all of Appendix 9 is all of our paid loss data. It's in aggregate by accident year. So to the extent that those behaviors are changing, it will show up in those losses.

MS. LOVE: This is Kathy Love. May I ask a follow-up question to that?

CHAIRMAN RITCHIE: Please.

MS. LOVE: When lump sum payments are made as part of a settlement, those are done based on present value; is that right?

THE WITNESS: That's beyond my expertise. I don't know.

MS. LOVE: Okay. Well, so if future medicals were paid out over a period of time, are you able to estimate, to a reasonable degree of actuarial certainty, what the increased cost of medical care will be in the future?

THE WITNESS: We can certainly project what we think medical inflationary trends will be

and then sensitivity-test that assumption. We do that for birth injury funds where we're trying to model the lifetime of a child. So that is certainly something we have expertise doing.

MS. LOVE: So payments made throughout the future indefinitely for a patient are made based on the cost of the care at the time that they are paid out as opposed to the current value of the money, which is how they would be paid out in a lump sum; is that right?

THE WITNESS: I don't know how lump sums are done with the fund.

MS. LOVE: Okay.

CHAIRMAN RITCHIE: Do we have any knowledge of that, how lump sums are done?

MS. LOVE: It's based on current value of the money as opposed to future medical care being done based on what the cost is at the time it is paid out.

CHAIRMAN RITCHIE: Does it involve life care plans, though, that look at that for future value? Most life care plans I've seen do calculate as future costs.

THE WITNESS: In other programs I've worked with, you have a life care plan that

estimates what the modified life expectancy is, does a present value calculation, assuming there's investment income. It doesn't decide whether there are assets or not, but it also makes medical inflation consideration in those future plans.

CHAIRMAN RITCHIE: So it doesn't include medical inflation?

THE WITNESS: Correct.

THE COURT REPORTER: Excuse me, who is talking, please?

CHAIRMAN RITCHIE: This is Dr. Ritchie, Chairman.

THE COURT REPORTER: Thank you.

CHAIRMAN RITCHIE: I don't think there are any more.

MR. BARENBERG: All right. We'll go on to the next topic, which is indicated loss reserves for hospitals and employee physicians. So this was a similar analysis to what we were talking about in the previous topic, but for hospitals and other health care facilities. Is that --

THE WITNESS: That's correct.

MR. BARENBERG: So I'm going to direct you to Exhibit 5, which is on Page 46. Will you walk us through that?

THE WITNESS: Sure. Very similar exhibit in the sense that we have historical surcharges, we have the historical paid losses. Instead of four methods we only do three, so we don't do a frequency and severity method for the hospitals. And the selected ultimate losses are just as before. You will see that -- we were just talking about those loss ratios and why did 115 make sense for the physicians in the more recent years. You will see some eye-popping numbers for the hospitals in the older years that are relatively subtle.

Now, I will qualify that. Some of those older years, the surcharge volume was very low because there were only one or two systems, but you will see the surcharge dollars ramp up in 2016 and '17 and '18. You will see the paid losses. The ultimate loss estimate here is 276 million and the ultimate loss ratio for the program to date is about 133 percent.

MR. BARENBERG: Why did you leave out the frequency severity method for the hospitals?

THE WITNESS: I forget. And I think it has to do with the claim counts. Yeah, I know there's a reason, but as I sit here, I'm embarrassed to say I forget. I think it has to do with claim

count data.

MR. BARENBERG: So in Column 7 at the bottom, you have a total estimated ultimate loss for the hospitals as $276.3 million? Am I reading that correctly?

THE WITNESS: Correct.

MR. BARENBERG: And then overall loss ratio of 133.1 percent?

THE WITNESS: Yes.

MR. BARENBERG: Do you have an estimate for the indicated unpaid claims liability and loss reserves for hospitals?

THE WITNESS: Yes. So there's an exhibit just like the one we were just looking at. So Page 39, which is labeled Exhibit 1 Page 5, same format, same layout, same everything as the comparison exhibit we were just looking at for the independent physicians and surgeons. It pulls all the same data in.

Here the number that kind of jumps out of the page is about two-thirds of the way over from the left. The difference in paid losses. We identified when we were looking at the docs all those years that had no paid losses. Here there's a lot more paid loss activity. In my bound 7 I've got

Page 38 and 39. You can almost compare two of them. You will see the difference in paid losses for the physician is $9.3 million. The difference in paid losses for the hospital is $26.4 million.

So during Calendar Year 2022, the way to interpret those two numbers is that of the 35, almost $36 million that the PCF paid out, 26 million and change of that was related to hospital claims. Only 9.37 million of the paid losses during Calendar Year 22 were associated with the independent physician.

MR. BARENBERG: And in this exhibit you also have a reconciliation table similar to the --

THE WITNESS: Yes.

MR. BARENBERG: Can you explain that, please?

THE WITNESS: Sure. Same thing. We start with 146 million of reserves at Year-end 21. We add in the ultimate losses for Year 22 of 50 million. We subtract out the 26 million paid. We add in the $25 million of changes in my estimate of ultimate losses, and that gets you to the 195.28 million of undiscounted reserves related to the hospital cost.

MR. BARENBERG: Somewhere have you compared the individual physician and hospital

results?

THE WITNESS: Well, I have a summary exhibit that combines those two on Page 37 that gives you a chance to see how the total PCF moves for both of those. But then there's a summary on Page 35, which is Exhibit 1, Page 1, that just simply shows from 2020 through Year-end 22 the ultimate losses, the paid losses and the undiscounted reserves. We then combine those in Column 8 to see the total undiscounted reserves for the fund, the discount factor and then the discounted reserves. We also have historically shown the reserves at a 75 percent confidence level. That adds in $21 million of additional reserves.

MR. BARENBERG: Take the time to explain confidence levels.

THE WITNESS: Sure. Actuaries are like weathermen. They go in every day knowing they are going to be wrong. The question is how wrong. Typically when an actuary is making a central estimate, it's about a 55 percent confidence level. We're a relatively conservative bunch. But through a number of different actuarial methodologies -- simulation, some bias loss estimate techniques, we have ways of estimating what the reserves would be

to be enough 75 percent of the time or 90 percent of the time. And some of our clients ask us to develop those reserve estimates at higher levels of confidence.

The idea of a 75 percent confidence level is that $281 million would be enough to pay all the claims obligations to the fund three times out of four, 75 times out of 100.

MR. BARENBERG: Did you account for recent shift in physicians from independent practices to hospitals?

THE WITNESS: To the extent that that's reflected in the surcharge table, yes.

MR. BARENBERG: How did you do that?

THE WITNESS: The surcharge data fundamentally reflects kind of the current status quo. So when we're making those adjustments to state the surcharges at current level, that adjustment is trying to bring historical surcharge data to where things are right now.

MR. BARENBERG: I'm going to direct you to Page 10, Page 7 of the report. And you've got an additional analysis of loss experienced by hospital.

THE WITNESS: Yes.

MR. BARENBERG: Can you walk us through

that?

THE WITNESS: Sure. This was a request for kind of an informational item. It doesn't really affect the analysis, but we were provided additional data that broke out the surcharges and the paid losses by hospital, and we were asked to come up with a reasonable estimate of how the total $274 million of ultimate loss could reasonably and actuarially soundly be allocated to the hospitals.

Methodologically, for the current years where there's no data, there's no paid losses, we're going to allocate that to hospital entirely based on their surcharges as a percentage of the total surcharges for that year. As the year gets more mature, we're going to base more and more of that allocation based on the actual claims experience.

So if you go back to those old years where I'm saying there's very little additional loss reserve, that little bit of loss reserve is going to be allocated much more based on each individual hospital's paid loss activity for that year. So the allocation methodology changes as more of the paid losses have emerged. And you will see beyond the undiscounted reserves of 195 million are a big part of that. They are almost triple the paid losses.

It takes a long time for these claims to be reported and to be settled, and we're still very much in early days as it relates to the hospital's claims.

MR. BARENBERG: That was all the questions I have on this topic.

MR. AUTIO: Mr. Walling, this is Nick Autio. When we were talking about physicians, on Page 6E you talked to payments and I looked at that chart for physicians. Is there a comparable table for hospitals? I see Page 62. Is there anything that lays out claims closed and payments for hospitals?

THE WITNESS: I believe the answer is no, and I think that's why I don't have a averages method.

MR. BARENBERG: Is there a reason why you don't have those numbers for claims closed?

THE WITNESS: Again, I know there is. I can't remember what it is. It could just be the scarcity of the data. One of the things that we've done with this analysis is we don't bury the loss triangles between the physicians, the independent physicians and the hospitals. And so we're assuming that the hospital claims are going to settle at the same rate as the independent physician claims. We

have done some independent testing of that, and so far there's no compelling difference between the claim reporting rate for the hospitals and the claim settlement or claim payment rate for the hospitals relative to the independent physicians.

So I know that we have the hospital data, and I apologize, I can't honestly tell you why it's not in the exhibit.

MR. AUTIO: Does that have any impact on the numbers? I mean --

THE WITNESS: I don't think so. You're dealing with generally a -- yeah, I don't think so.

MR. AUTIO: My next question, when you go to Exhibit 5, Page 46 of the report, when you look at hospital surcharges, in 2017 you see a drastic increase. From 2016 it's 6.3 million, 2017 it jumps to 21.5 million. Is it safe to assume that's because more hospitals entered the fund at that point?

THE WITNESS: Yeah, that was actually -- there was a point in time where -- I'm trying to think. It was Gerald Champion and St. Vincent were the first two in, and then we saw a fairly large group of hospitals all come in together, so that was just a ramp-up of those new facilities coming on

line.

MR. AUTIO: And when I look at Exhibit 5 on Page 46, you know, it appears that the loss ratios for 2017 on are relatively stable, especially compared to the loss ratio that existed before 2017. But you had mentioned that's basically the time it takes for these claims to mature. Do you, as an actuary, have difficulty identifying an accurate loss ratio based on the lack of data and the time it takes for these claims to mature in the fund?

THE WITNESS: If you're asking me is there more flexibility in the hospital loss ratio than the physicians, yes. And part of that has to do with we're talking about claims that take a long time to get recorded and a longer time to settle, and the vast majority of our exposure are surcharges. Data is from the last six years.

MR. AUTIO: And it's my understanding under the Medical Malpractice Act that the independent physicians are limited to three occurrences. I know there can be some variance based on the definition of occurrence, but hospitals have unlimited claims. How did that impact your assessment in determining what the loss ratios are going to look like in the future?

THE WITNESS: It adds to the volatility.

MR. AUTIO: What do you do as an actuary to account for that volatility?

THE WITNESS: You'll see it affect things like the risk margin. You'll also see, I don't want to say, more conservatism, but when you're dealing with that potential for a larger number of claims, you've got to be a little cautious. It shows up in a number of different ways, all of them implicit to the analysis. There is no explicit adjustment for it.

MR. AUTIO: I guess to wrap things up, that's why it seems it would be helpful to know the claims paid so we can try to track more of what's happening with the hospitals, especially accounting for the fact that they're going to be leaving the fund at the end of 2046 and physicians will, frankly, be left holding the bag. So just a statement, not a question. I don't have any other questions, Mr. Walling. Thank you.

MR. CLARK: This is Troy Clark for the court reporter. Mr. Walling, I think my questions might follow along the path of Mr. Autio's. On Page 10, the chart that you are referring to on the breakout, the ultimate losses by hospital. First

question, Column 4 shows ultimate losses of 274 and some change.

THE WITNESS: Yes.

MR. CLARK: Go back to Exhibit 5 on Page 46, we have selected ultimate losses of 276 million. Can you help me understand the difference between those?

THE WITNESS: I don't know why those don't reconcile. I'm gathering it's a version control issue.

THE COURT REPORTER: Excuse me, I didn't hear you, Mr. Witness.

MS. LOVE: I think he said it was a version control issue.

THE WITNESS: And I don't know why. Oh, there's a change in paid losses. If you compare Page 46, we're showing hospital paid losses of $81 million, and when we roll up to Page 34, paid losses are different by $1.4 million.

MR. CLARK: So is it safe to say those two numbers should reconcile?

THE WITNESS: They absolutely should reconcile, and my guess is something changed in Exhibit 5 and didn't flow up to the summary in Page 3. That's -- something changed late in the analysis

in Exhibit 5 and it obviously hasn't flowed up.

MR. CLARK: So under the assumption, let's assume that gets resolved, but for the purposes of my question, back on Page 10 on the Valle facility allocation and I'll ask this in a way that hopefully -- if this discloses private information to a facility please don't answer, but I think I can ask in a way it doesn't.

As I look at this chart, there are three of those hospitals broken out, Community Health Systems, Quorum, which may be a factor of small numbers, and Presbyterian, which have a difference between their paid losses and estimated ultimate losses of nearly ten times, nine to ten times. Their calendars are three to four times.

Can you help me understand what the difference is? Does it go back to the claim counts, the open counts that are still open on those facilities or why is there such a great difference when the others seem to be in a ratio of -- some are less than two times the difference on the ultimate?

THE WITNESS: It all starts with paid losses, right? If we're looking at Quorum, Quorum has $400,000 of paid loss, and so yes, for the most recent years they're going to take an allocation

based on their surcharges for the most recent two or three years. But for any year older than that, their allocation of the ultimate is going to be related to that very low paid loss activity. And so as you shift further and further back in time, more of the ultimate loss allocation is associated with the paid losses.

So essentially, you can think of the older-year allocation as kind of an experience-based allocation where for a given year we might allocate 50 percent of the reserves based on surcharges and 50 percent based on the paid losses.

MR. CLARK: Let me step back the question because maybe I'm making the wrong assumption. Is it safe to say that the difference between Column 3 and Column 4 is the amount that you are projecting actuarially that will still be paid?

THE WITNESS: Which is what is in Column 5, yes.

MR. CLARK: Which is what's in Column 5. I guess my question is -- and let's use Presbyterian because it's driving the difference, but so is Community Health. If they have a very low paid number compared to their surcharges, 12 million compared to 93, the multiple to get up to the

ultimate losses is much greater on Presbyterian than if you go up to Christus St. Vincent's where it's less than 1 additional difference. What's driving that difference?

Are you saying they have a lot more claims outstanding that are not settled yet? Or that Christus' settled quicker? Or what would be driving that? Christus obviously plays into a long tale of history, because they've been in the funds since 2009 where -- I don't know what year Presbyterian got in, but I would guess 2016/17 when the surcharges increased, and the same thing with Community Health Systems. I guess I'm just trying to figure out why the difference that is not a set multiple between the two, because you look at LifePoint, for instance, 16 million surcharges paid, 5 million already paid out in losses, but only an expectation of 22 million total, so there's roughly another 16.6 to be paid. That's a little difference than Presbyterian where they paid in 93, only paid out 12 so far, but we think there's 91, almost 92 million more to be paid.

What's driving that big expectation of something so far out for these three line items, Community, Quorum and Presbyterian?

THE WITNESS: Let me try one more time. For the current year, for the 22 year, the allocation of the reserves -- remember, there's zero dollars paid. We know nothing about the 22 year yet. That allocation of reserves is based purely on the surcharges for each hospital for that year. There's no way to experience allocate the 22 year.

If we go back to 2018, the allocation is a weighted allocation between the surcharges and the actual paid losses by hospital for that year. So the further back you go in time, the more the allocation of the reserves is based on the paid losses that that hospital had in that year.

I also want to caution you, from an actuarial standpoint, I'm not sure you are looking at the right number. For me, the number that matters here is actually the ultimate loss ratio in Column 8. The ultimate loss ratio is simply the relationship between the allocated ultimate losses and the historical surcharges.

Presbyterian, yes, they're having a lot of reserves allocated to them because they have been in for a while and they have fairly high surcharge amounts. But their loss ratio at 111 percent is one of the lowest we're indicating here. Their ultimate

losses relative to their surcharges are pretty darn close to a break-even level.

So if I'm looking at Community Health Systems with a loss ratio of 115 percent, they're benefiting from their favorable paid loss experience; whereas, say St. Vincent's with a loss ratio of 151 percent has a higher loss ratio than the overall average for the hospital program and therefore is getting -- is indicating kind of worse loss experience relative to the surcharges they paid.

I think that, to me, is the more -- the more compelling statistic here. Lovelace has paid out $17.9 million in paid losses. As a result, their loss ratio of 196 percent of their paid surcharges is one of the higher in the bunch. So to me, if I'm interpreting this exhibit and trying to kind of draw learnings from it, that's what I'm looking at.

MR. CLARK: Mr. Walling, I agree with you. I'm actually not trying to look at who is performing better or worse. I'm trying to understand the question that I asked on the physician component and I'm going to ask it again. If we go back to Page 46, I want to understand all of that to lead up to

this. If you see the increase in Exhibit 5 in total hospital surcharges from 32.6 million to 39.5 million, we have an increase of about $7 million. That is -- I don't have the exact figures in front of me, obviously, but we know we assessed a deficit recovery amount in surcharge against the hospitals. That increase is not because we have more hospitals. We increased the base rate but we also recovered part of the whole, if you want to call it that, to fill in on the deficit.

So my question is actually going back to, you responded on the physicians of the normalizing. Did we normalize out those dollars that were collected for the deficit reduction? Because if not, in the current year where you don't have claims experience, you base predominantly upon the amount of surcharges collected. Inherently when you collect those additional dollars you're going to calculate and say the hole is deeper when what you were doing is collecting more to fill in the hole.

Now, over time I get that it will resolve, but I'm curious as to what the impact is, from your perspective as an actuary, when we actually recover more dollars in using those dollars to calculate future expectations. Are we saying the future is

going to be worse only in a few years when we get claim experience to come back because we are including that deficit reduction allocation in the estimate of the future losses?

THE WITNESS: To the extent that the deficit surcharges are in here, that should have the effect of bringing the expected loss ratio down. As I sit here, I don't honestly remember whether that 39 million is just the rate change that we have put through or whether it also includes the deficit surcharge. I don't believe it does.

MR. CLARK: And I guess I asked that question because I feel like our job as a board is to make a recommendation to the superintendent on what those future charges should be, which is going to be based on the expected losses. And if those expected losses are overstated because we're assessing an additional expectation based on that recovery amount, it would sure be nice for us as the board to understand if those get isolated out and that the calculation of the expected is, and then applied back in for what the current deficit is for the reserves.

THE WITNESS: Correct. The deficit surcharges by definition are a retrospective charge,

not a prospective charge.

MR. CLARK: Correct. That's a better way of saying what I'm saying. We need to make sure we're not overestimating what we need to pay in, because yeah, we're filling in all the hypotheticals. We're filling in four scoops of the shovel but we're adding one more to it because we added four in and saying it's bigger when it really shouldn't be. So we brought it down three shovelfuls that we put in.

THE WITNESS: I agree with your statement.

MS. LOVE: May I ask a follow-up?

CHAIRMAN RITCHIE: Go ahead, Kathy.

MS. LOVE: This is Kathy Love. Mr. Walling, along those lines then, when you're looking at the surcharges to evaluate expected losses, are you looking at the actual surcharges that were assessed by the superintendent of insurance? Or are you looking at the recommended increased surcharges that the actuaries did?

THE WITNESS: We're actually looking at the collective surcharge dollars.

MS. LOVE: Okay. Because in past years there have been recommended increases that were not followed by the Superintendent of Insurance; is that

right?

THE WITNESS: Correct.

MS. LOVE: Okay.

THE WITNESS: Yeah. In fact, for the majority of the years I have worked on the PCF, what has been adopted has been different -- not necessarily better or worse -- just different from the actuarial recommendation.

MR. AUTIO: This is Nick Autio. Mr. Walling, I just want to be very clear on the question. When we look on Page 46, Exhibit 5, the hospital surcharges, those numbers, are those just including the surcharges hospitals paid to participate in the fund or does that number also include the amount that was paid to use the surcharge?

THE WITNESS: I need to doublecheck, but it should only include the surcharges paid in, not the custom surcharge.

MR. AUTIO: Thank you. If you can communicate that to someone --

THE WITNESS: Yeah.

MR. AUTIO: Thank you.

CHAIRMAN RITCHIE: This is Dr. Ritchie. Is there a way -- or do any of these tables really

split that out? Are all of these exhibits we're looking at, we're looking at the rate setting because that's traditionally what we have talked about that's the core of this, but then we had to add in now the reduction. So are those split out anywhere within your report?

THE WITNESS: We don't summarize that data that way. I mean, I guess we certainly could, but no, we don't show the surcharge dollars separately.

CHAIRMAN RITCHIE: So would that be an actuarial study to do, to look at, where we are with the deficit reduction, what it would take actuarially to bring it to zero, looking at the difference between -- you know, there's this cutoff when hospitals come out of the fund, but will there be future losses after that that are accounted for or not? And do we need to account for that?

A. Two parts. One, the surcharges do change the fund balance. So last year's deficit surcharges do actually contribute to the fund balance. Two, we haven't gotten to it yet on the agenda, but yes, we do that.

CHAIRMAN RITCHIE: No questions on this section.

MR. BARENBERG: I will move on to the next

section, which is the indicated deficit and allocation. So you've given us the loss reserve estimates. Using those, are you able to estimate the fund balance as of December 31, 2022?

THE WITNESS: Yes.

MR. BARENBERG: I'm going to take this to the fund summary on Pages 1 and 2, which is Pages 31 to 33. So what do you estimate the balance to be?

THE WITNESS: So let's just start on Page 31. The estimate of ultimate reserves are shown as $266.8 million. The fund balance is shown as of Year-end 22 to be $135.9 million. Therefore, the deficit on the undiscounted basis, just subtraction, is $130.9 million.

MR. BARENBERG: And just to make it clear, the fund balance was Column 4 and the undiscounted is Column 5?

THE WITNESS: The undiscounted deficit is Column 5. So basically, if you take -- you can take Column 1 minus Column 4 you get Column 5.

MR. BARENBERG: Does that answer how you came up with that number?

THE WITNESS: Yes.

MR. BARENBERG: Let's take a look at Page 33. That's Page 2 in the Fund Summary. Does that

give some more detail of how you came up with the number?

THE WITNESS: It does. So ultimately, you've got to allocate that deficit, or we have been asked to allocate that deficit between the independent physicians and the hospitals. And so what we do is take that fund balance of $135,000. It's really the total deficit of $130.9 million, so the total number from Column 5 -- and we allocate that back to the two cohorts. The way we do that is what's shown on Page 33.

And essentially, what we do is calculate the gain and loss, the relationship between the surcharges and the ultimate losses. And as we have identified, some years the physicians actually outperform the surcharges. In especially the batch years, they were much, much worse, but over the last 23 years they have produced a deficit of $51.3 million. The hospitals have produced a net loss of $68.7 million.

If you just calculate those two deficits as a percentage of the total, you end up allocating 42.8 percent to the physicians and 57.2 to the docs. You will see I have the prior numbers in there. There's been a fairly fundamental shift. And I

mentioned it earlier, of the 36 million that was paid out last year by the fund, 26 million and change of it was associated with the hospitals. We're seeing a pretty fundamental shift in the performance of the hospitals' claims relative to the surcharges.

As a result, we're suggesting that we shift the allocation of that deficit so that 42.8 percent of it -- if you go back to Page 31 -- 42.8 percent of $130.9 million is $56 million. So we've allocated the undiscounted deficit based on that ratio of 42.8 percent to the physicians and 57.2 to the hospitals.

MR. BARENBERG: Why do you allocate between those two groups?

THE WITNESS: Primarily for the purpose of determining deficit surcharges going forward to try and retire those deficits. And so to start the calculation of what the deficit surcharges are for the physicians and for the hospitals separately, you've got to start from an allocation of that deficit.

MR. BARENBERG: And we're on Page 31, so 31 and 32 show the schedule of deficit surcharges. What does that mean?

THE WITNESS: We were asked to present two different scenarios for the consideration of the commissioner. Basically, the only difference between 1A and 1B is that 1A takes the $32.5 million of funds allocated during 2023 by the legislature and allocates 75 percent of that to the physicians and 25 percent of it to the hospitals.

And then you'll see that has the effect of reducing the independent physicians' deficit to about $31.6 million and reducing the hospital deficit to $66.7 million. If you look at a 50/50 allocation of those funds, obviously, it doesn't reduce the physicians as much but it reduces the hospital's a little bit more, and the two sets of deficit surcharge schedules then are based on those deficit positions after the allocation of those funds under those two scenarios.

MR. BARENBERG: On that topic, those are all the questions I had.

CHAIRMAN RITCHIE: This is Chair Ritchie. I have a question on this. It's the first page that we refer to. It's the first page we went to.

UNIDENTIFIED SPEAKER: That was Page 31, I believe of Fund Summary 1A. Is that what it's referring to?

CHAIRMAN RITCHIE: There was a trend looking at the -- where it changed, where you compare --

UNIDENTIFIED SPEAKER: That's Page 33, sorry. It's a trend, right? Have you modeled that or looked at that trend from the back going forward? Have you looked at does that factor into your calculations?

THE WITNESS: My current estimate is by definition I look forward. I have not gone back and looked at this for Year-end 2020. And I think there's a lot of -- well, that comparison where less than $10 million of claims were paid related to claims for the independent physicians and $26 million and change were paid relative to the hospitals is markedly different than what we would have expected. It's, I think, really early days and maybe too early to tell whether that's a systemic issue, whether it's a limited number of claims that are creating that, whether the hospitals are trying really hard to get the claims reported given the sunset time. I don't know, and candidly, there's not -- there's not a wealth of data to identify whether the paid claims activity in 22 is noise or signal, so we're trying to be fairly balanced in how

we respond to it, trying not to overreact but also trying not to underreact, too.

CHAIRMAN RITCHIE: Okay. Because certainly the number of occurrences, unlimited versus three, things like that, seems like that might have a real effect on that data. I was wondering if you're seeing that or if you've tried to look into that? Obviously, you looked into it some, but are you looking into that?

THE WITNESS: Obviously, monitoring exactly what I answered before. The reported claims activity, the closed claims activity, those are the three data points that I have.

MR. CLARK: I have one further question. This is Troy Clark. Back on 31, could you walk me through the middle section of this report where the figures come from for this amortization of the deficit surcharge?

THE WITNESS: Sure. So basically what we're doing is trying to take -- let's start at Column 9. The independent physicians undiscounted deficit is $31.645 million. That comes down to Row 13. Essentially what we're doing then is amortizing that undiscounted value. So if you add up the 6.7, 6.5, 6.3, 6.1, 5.9 million, that is essentially

amortizing that value. And then in Column 12, basically we're building an inflationary impact on that.

MR. CLARK: This is Row 12?

THE WITNESS: I'm sorry, Row 12. So the idea is to get to the undiscounted reserve of 31.65 million, you actually need to fund about 35.6 million on a present value basis to equal the 31.64 reserve. Same thing with the hospitals, but unfortunately, it's a shorter time horizon. But it's basically just an amortization of those reserves over a five-year window or a three-year window for the hospitals.

MR. CLARK: So thank you for that. It seems to me then Row 13, whether it's physicians, hospitals or combined, is tied to what the deficit undiscounted amount is?

THE WITNESS: Correct.

MR. CLARK: Row 12 above it has the inflationary or makes the future value comparison. Row 14 is simply bringing in the actual surcharge amount to calculate the percent beneath it, which is then Row 13 or Row 12 as a percentage of 15.

THE WITNESS: Right. So 15 is actually based on 13 and 14.

MR. CLARK: 13? Okay. 13 is a percentage?

THE WITNESS: Correct.

CHAIRMAN RITCHIE: Any more questions from the board?

MS. LOVE: Sorry, this is Kathy. I had a couple questions.

CHAIRMAN RITCHIE: Please.

MS. LOVE: You know, in recent years when we were debating the question of whether it was proper for the hospitals to be participating in the Patient's Compensation Fund, one of the questions that was burning on the minds, I think, of legislators and all of us was what caused this big deficit, and I think it's an important question because it informs us about how the fund can move forward and informs the yearly setting of the surcharges.

So I have a few really general questions, Mr. Walling. So obviously, the PCF acts in many ways like an insurance company, but the goal is not to make money. The goal is to bring in enough in surcharges to cover what it's going to have to pay out. Is that generally correct?

THE WITNESS: I'm going to modify your

statement a little bit. The purpose of the fund is to have enough funds available to pay their claims obligations.

MS. LOVE: Okay. So that can be done by collecting surcharges and also investing; is that right?

THE WITNESS: Correct.

MS. LOVE: And your goal as the actuary is to attempt to predict how much will likely have to be paid out in the future obviously, correct?

THE WITNESS: Correct.

MS. LOVE: And you can't have enough to pay out if you don't collect or turn over enough investments to meet what has to be paid out. So how long, how many years has Pinnacle been acting as the actuary for the PCF?

THE WITNESS: Twenty.

MS. LOVE: So your involvement goes back even earlier than 2012. Other than the couple years that I think Milliman did the studies; is that right?

THE WITNESS: Milliman did a study and I think another firm, Taylor Walker or somebody like that did a study.

MS. LOVE: And I also understand that

there were a number of -- I have data going back to 2012 for the years that there were actuarial reports, and what the recommendations of Pinnacle and Milliman were in terms of the raises. Do you have that data as well?

THE WITNESS: Probably going back to '03.

MS. LOVE: To '03? Okay.

THE WITNESS: Yes.

MS. LOVE: So would it be possible for us to have a chart that shows, by year, what the actuary recommended in terms of the surcharge increases versus what was actually implemented by the Superintendent of Insurance?

THE WITNESS: I think that can be -- some combination of me and OCI can probably construct that.

MS. LOVE: Okay. The reason I'm asking is I think it would be instructive to see what the difference is by year in terms of how much it was recommended by the actuary, by Pinnacle, that be collected in surcharges versus what was actually collected in surcharges. Because, for example, I know that in -- I'll pick a random year. In 2019 I understand that it was recommended that the surcharge rate be raised by 13.8 percent in order to

have sufficient funds in the patient's compensation fund, and there was an actual zero increase.

And so if you just do the math and you look at Page 31, which sets forth all of the surcharges that were collected from the hospitals for 2019, 31,872,000 was collected. There was a 13.8 percent recommended increase, but a zero actual increase.

So if we just multiply that recommended increase by the 31 million that was collected, essentially we have 4.3 million that was not collected, but presumably, according to the actuarial analysis, should have been. Is that a fair way of looking at this?

THE WITNESS: I think it's a broad generalization, but as such, I don't think it's inaccurate. Typically, the surcharge change that's been implemented broadly has been lower than the actuary's indication.

MS. LOVE: Okay. And so like I said, I don't have all the data, but the data that I do have, just going back to 2012, which does not include -- I mean, several years there was no actuarial analysis done, and then in several years there were either no increases or reduced increases

from what the actuary recommended. But by my calculations, just for the hospitals there was almost 20 million from 2012 to 2022 that was not collected. There's a $20 million difference between what the actuary recommended be collected and what was actually collected.

So I would like to see that data. I would like to see the data by year, what was recommended be collected and -- or the percentage increase that was recommended, the actual increase that was implemented and the difference in what would have been collected versus what actually was as a surcharge because I think that informs why we are continuing to have the snowball effect of this increased deficit.

So first of all, I want to confirm that I'm looking at this right, because I don't have an accountant's eye like Troy does; and second of all, ask that information be compiled for us.

THE WITNESS: I can certainly give you the rate history.

MR. DEKLEVA: This is Mike Dekleva. Kathy, just to be clear, are you asking for that data both with regard to the hospitals and independent physicians and surgeons?

MS. LOVE: Yes, absolutely. Because if you look -- based on the data that I have, that I have been able to collect, based on old actuarial reports and orders from the superintendent, we have the same issue, although not to quite the extent, but with independent providers it looks like we have under-collected, according to what was recommended by the actuaries, around $9 million. And that's without all of the data. And so, you know, this is a real problem because it answers what legislators want to know, which is why, when we have just given $62.5 million to help pay off the deficit, why does the deficit continue to grow.

And I assume, Mr. Walling, it is not because Pinnacle hasn't done an appropriate actuarial study each year, but that is a combination of OSI not raising the rates as recommended and a lack of data, particularly -- well, maybe solely, you can tell me, but with regard to the hospitals. Because only last year did we start to collect and have Integrion distinguish between the two buckets of doctors so that we know what the hospital risk is versus what the provider risk is.

So correct me on any of that that I have wrong, Mr. Walling.

THE WITNESS: I would suggest to you there are several other variables going on here. Just because there's -- well, the first point I would make, and I actually point back to the earlier presentation, taking more rate at a prior point in time, I would observe, would exacerbate the economics of independent physicians earlier. So there is no guarantee they would have stayed in the PCF. There's no guarantee they would have stayed in New Mexico.

I would also suggest the legislative change putting the cost of living escalator into the Medical Malpractice Act may be having an effect on claims. But certainly the rate issue and just the sheer data issue with the hospital certainly contributed.

MS. LOVE: Well, and Mr. Walling, the cost of living increase hasn't been an issue that you have had to analyze in these actuarial reports until last year; is that right?

THE WITNESS: I believe that's correct.

MR. AUTIO: This is Nick Autio. Are you done, Kathy? I don't want to interrupt you.

MS. LOVE: Yeah, thanks.

MR. AUTIO: To follow up on your comments,

Mr. Walling, if surcharges are put in place at a level that is cost prohibitive for physician participation, or they choose not to participate, what does that do to the fund's ability to pay its liabilities?

THE WITNESS: Interesting question. To the extent that loss reserves relate, they're kind of retrospective. They look back, right? You're comparing the prior surcharge collections to the prior claims activity. So if somebody chooses to leave, that simply changes, kind of, the base of people in the program that can bear part of the burden of the deficit.

Conversely, there are PCFs that are mandatory in other states that have a different effect. So I don't know whether that's what you're looking for, but it does affect the membership in the PCF.

MR. AUTIO: And in terms of bearing the burden, if there are fewer physicians to bear that burden, the cost of bearing the burden will be higher, correct?

THE WITNESS: For the folks remaining in the program, yes.

MR. AUTIO: Thank you.

UNIDENTIFIED SPEAKER: One quick follow-up question. I think Ms. Love's request for looking at this is right on track and it would be helpful for us. However, one point of clarification. I don't believe we can go back and look at the difference of each year's recommended amount in the OSI superintendent's actual implementation cumulative; is that correct? Because each year would have taken into account so you couldn't calculate each year.

THE WITNESS: No, it's that you can't multiply one plus each of the indicated and compare it to one plus the implemented. But you can get a sense of did implementing zero when the indication was -- sorry, I forget the number -- did it have an effect the following year? And I will tell you, by and large it did.

UNIDENTIFIED SPEAKER: I think that's why I said, because I wanted to make sure that I was correct in my thinking that it's not cumulative. We can't add up each individual year because each year builds upon the following year's estimates, correct?

THE WITNESS: Yes.

UNIDENTIFIED SPEAKER: No further questions.

CHAIRMAN RITCHIE: So we are just past the

11:00 that we are supposed to finish for today. How much is left? We have two significant topics, the indicated surcharges for physicians and for hospitals and then a short topic on the coverage analysis. So we predicted a continuation for tomorrow morning at 9:00 a.m. so we will suspend this hearing, I think is the term, not being a lawyer, until tomorrow morning and continue. Thank you. So we are continued until tomorrow morning at 9:00 a.m. Thank you very much.

(Note: The hearing was adjourned at 11:04.)

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

DOCKET NO: 2023-0018-PCF

IN THE MATTER OF DETERMINING PATIENT'S COMPENSATION FUN SURCHARGE RATES FOR CALENDAR YEAR 2024

REPORTER'S CERTIFICATE

I, Jan Gibson, New Mexico Certified Court Reporter, do hereby certify that I reported the foregoing proceedings in stenographic shorthand and a transcript of those proceedings was reduced to printed form under my direct supervision.

I FURTHER CERTIFY that I am neither employed by nor related to any of the parties or attorneys in this case and that I have no interest in the final disposition of this case.

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New Mexico Rules of Civil Procedure for the

District Courts

Article 5, Rule 1-030

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