

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

3 DOCKET NO: 2023-0018-PCF
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6 IN THE MATTER OF DETERMINING PATIENT'S COMPENSATION
7 FUND SURCHARGE RATES FOR CALENDAR YEAR 2024
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11
12
13 September 22, 2023

14 9:00 a.m.

15 MICROSOFT TEAMS VIDEOCONFERENCING
16
17

18 BEFORE: William Ritchie, Chairman
19 Office of the Superintendent of Insurance
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1 (Note: In session at 9:00.)

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

14 MS. ROMERO: Chairman Ritchie?

15 CHAIRMAN RITCHIE: Here.

16 MS. ROMERO: Vice Chair Love?

17 MS. LOVE: Here.

18 MS. ROMERO: Mr. Clark?

19 MR. CLARK: Here.

20 MS. ROMERO: Mr. Dekleva?

21 MR. DEKLEVA: Here.

22 MS. ROMERO: Mr. Vargas?

23 MR. VARGAS: Here.

24 MS. ROMERO: Mr. Autio?

25 MR. AUTIO: Here.

1 MS. ROMERO: Mr. Spitzer?

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

3 MS. ROMERO: Thank you. Ms. Steven?

4 MS. STEVEN: Here.

5 MS. ROMERO: Mr. Martinez?

6 MR. MARTINEZ: Here.

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

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

22 I'm the managing partner of Southwest
23 Gastroenterology. We are an independent medical
24 practice and have been serving New Mexico for over
25 40 years. Our practice has participated in the

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

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

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

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

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

6 The next paper you see in your packet is a
7 graph of the rate increases that my practice has
8 seen over the past couple of years. The premium
9 increase that I mentioned are 53.57 percent compared
10 to 2020, and our surcharge increase has increased by
11 109 percent.

12 I understand that you guys would be
13 reviewing the latest actuarial analysis that was
14 published in December of 2022 and that you're tasked
15 with making recommendations regarding rate increases
16 for next year. And in my review of this, I'm not an
17 actuary, but my understanding is that it looks like
18 the amounts that might be represented are as high as
19 57 to 81 percent for independent physicians and
20 surgeons in order to eliminate the deficit as
21 required by House Bill Senate 5. Independent
22 medical communities simply cannot absorb these kinds
23 of rate hikes, unnecessary rate hikes.

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

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

8 (Note: Audio lost.)

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

11 UNIDENTIFIED SPEAKER: We just lost audio.

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

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

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

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1 can figure it out.

2 DR. ADAMS: Is this better?

3 THE COURT REPORTER: Yes, thank you.

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

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

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

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

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

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

25 UNIDENTIFIED SPEAKER: Mr. Chairman, I

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

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

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

15 THE COURT REPORTER: May I know who was
16 speaking?

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

19 THE COURT REPORTER: Thank you.

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

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

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

7 THE WITNESS: Over 40 years.

8 MS. LOVE: Thank you.

9 CHAIRMAN RITCHIE: Anyone else have any
10 questions of Dr. Adams? Okay. Thank you very much.
11 We're still with the task of getting through the
12 intervening process. Now we have a presentation by
13 --

14 UNIDENTIFIED SPEAKER: Can I ask a quick
15 question?

16 DR. ADAMS: Yes.

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

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

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

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

1 UNIDENTIFIED SPEAKER: Thank you.

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

6 CHAIRMAN RITCHIE: Please give your
7 presentation.

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

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

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

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

11 EXAMINATION OF ROBERT WALLING

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

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

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

20 THE WITNESS: I do.

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

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

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

4 THE WITNESS: It is.

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

7 THE WITNESS: It does.

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

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

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

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

23 UNIDENTIFIED SPEAKER: I'll second it.

24 (Note: Exhibit A admitted.)

25 MR. BARENBERG: So that will save us on

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

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

7 THE WITNESS: I do.

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

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

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

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

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

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

1 MR. BARENBERG: I'm going to turn to Page
2 9 of the report, which is Page 12 of the PDF and
3 there's a bullet list in the middle of the page.
4 Tell me when you're at that page or if you can see
5 it on the screen. What does that list show?

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

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

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

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

23 THE WITNESS: Yes.

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

1 THE WITNESS: It does.

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

5 CHAIRMAN RITCHIE: Any objections? So
6 moved.

7 (Note: Exhibit B admitted.)

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

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

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1 MR. BARENBERG: Is that related to loss
2 reserves?

3 THE WITNESS: Yes.

4 MR. BARENBERG: What are loss reserves?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 to select the ultimate loss in Column 8?

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

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

15 THE WITNESS: Correct.

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

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

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

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

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

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

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

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

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

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

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1 increased to \$214 million.

2 Similarly, the ultimate losses through
3 Year-end 21 were \$262 million. That ultimate loss
4 estimate has increased slightly to \$268 million.

5 But what we're seeing is actually favorable
6 development, so that the undiscounted reserves for
7 the prior years had dropped from \$55.4 million to
8 53.9, \$54 million, so we're seeing a bit of a
9 reduction in the prior years. But then we need to
10 add on the reserves for the current year.

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

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

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

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

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

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

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

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

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

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

14 You can see, if you look at the left-hand
15 table, that takes the 71.553 million of invested
16 assets and reduces it on a discounted basis by about
17 \$1.7 million to \$69.835 million. If the fund
18 balance had invested assets supporting all of the
19 loss reserves, that impacted discounting would be
20 more pronounced.

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

25 So the invested assets you are using to

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

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

5 MR. BARENBERG: The date of investment?

6 THE WITNESS: Correct. So actuaries at
7 times think like accountants, and in this case that
8 means we're looking at the losses of value as of
9 December 31, 2022 but we're also using an accounting
10 date as of December 31, 2022, which affects things
11 like the invested assets in the fund balance.
12 Because we're looking at those items as of December
13 31, 2022.

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

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

20 (Note: Audio interference.)

21 CHAIRMAN RITCHIE: Please mute your
22 microphones.

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

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

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

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

18 MR. BARENBERG: Thank you.

19 CHAIRMAN RITCHIE: Go ahead.

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

22 Mr. Walling, a question. Back on Exhibit
23 1, Page 4, there's three sections of the table, if
24 I'm looking at the right place.

25 THE WITNESS: Yes.

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

5 A couple sequential questions here. It
6 looks as though, if I read this correctly, your
7 estimate of what the ultimate losses are for years
8 2011 through roughly 2016 have decreased from prior
9 years, and yet the estimates for 2018 to 2019 have
10 increased from where you were last year.

11 THE WITNESS: Yes.

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

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

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

3 You will notice that for the years you've
4 identified where I've actually brought the ultimate
5 loss estimates down, there were also no incremental
6 paid losses. And so to the extent that there are no
7 paid losses -- now, in the last year there was
8 \$910,000 of incremental paid loss which was actually
9 less than we projected. And so that actually --
10 despite the fact that there was a \$910,000 payout,
11 the ultimate loss estimate actually came down by
12 almost half a million dollars because it was less
13 than expected.

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

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

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

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

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

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

4 THE WITNESS: Right.

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

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

15 MR. CLARK: You keep the ratio consistent?

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

20 MR. CLARK: Thank you. No further
21 questions.

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

24 THE COURT REPORTER: Yes, I did get that.

25 MR. DEKLEVA: This is Mike Dekleva. I

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

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

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

10 THE WITNESS: Yes.

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

16 THE WITNESS: I do.

17 MR. DEKLAVA: Okay. It's up on the screen
18 as well. If you look at the Practitioner's
19 Surcharges column, Column 2, and the Paid Losses,
20 Column 3, there is a significant difference in years
21 2007 and 2008 and then again in 2010/2011 where the
22 paid losses are significantly higher than the
23 surcharges collected.

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

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

3 THE WITNESS: In some of those years, I
4 forget, and I apologize. We used to have an
5 asterisk marking which years were the batch claims,
6 and at least some of those years the reason they are
7 high is the batch claims. But I don't think 2014 or
8 2017 are batch claim years.

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

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

16 MR. DEKLAVA: Okay.

17 THE WITNESS: Let me look.

18 MR. DEKLAVA: Sure.

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

22 CHAIRMAN RITCHIE: Which page is that?

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

25 MR. DEKLAVA: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 THE WITNESS: Correct.

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

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

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

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

9 CHAIRMAN RITCHIE: Right.

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

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

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

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

1 THE WITNESS: What data?

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

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

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

13 CHAIRMAN RITCHIE: Please.

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

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

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

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

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

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

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

13 MS. LOVE: Okay.

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

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

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

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

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

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

8 THE WITNESS: Correct.

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

11 CHAIRMAN RITCHIE: This is Dr. Ritchie,
12 Chairman.

13 THE COURT REPORTER: Thank you.

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

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

22 THE WITNESS: That's correct.

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

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

12 Now, I will qualify that. Some of those
13 older years, the surcharge volume was very low
14 because there were only one or two systems, but you
15 will see the surcharge dollars ramp up in 2016 and
16 '17 and '18. You will see the paid losses. The
17 ultimate loss estimate here is 276 million and the
18 ultimate loss ratio for the program to date is about
19 133 percent.

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

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

1 count data.

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

6 THE WITNESS: Correct.

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

9 THE WITNESS: Yes.

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

13 THE WITNESS: Yes. So there's an exhibit
14 just like the one we were just looking at. So Page
15 39, which is labeled Exhibit 1 Page 5, same format,
16 same layout, same everything as the comparison
17 exhibit we were just looking at for the independent
18 physicians and surgeons. It pulls all the same data
19 in.

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

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

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

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

14 THE WITNESS: Yes.

15 MR. BARENBERG: Can you explain that,
16 please?

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

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

1 results?

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

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

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

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

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

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

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

14 MR. BARENBERG: How did you do that?

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

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

24 THE WITNESS: Yes.

25 MR. BARENBERG: Can you walk us through

1 that?

2 THE WITNESS: Sure. This was a request
3 for kind of an informational item. It doesn't
4 really affect the analysis, but we were provided
5 additional data that broke out the surcharges and
6 the paid losses by hospital, and we were asked to
7 come up with a reasonable estimate of how the total
8 \$274 million of ultimate loss could reasonably and
9 actuarially soundly be allocated to the hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 line.

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

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

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

1 THE WITNESS: It adds to the volatility.

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

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

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

21 MR. CLARK: This is Troy Clark for the
22 court reporter. Mr. Walling, I think my questions
23 might follow along the path of Mr. Autio's. On Page
24 10, the chart that you are referring to on the
25 breakout, the ultimate losses by hospital. First

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

3 THE WITNESS: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

8 So essentially, you can think of the
9 older-year allocation as kind of an experience-based
10 allocation where for a given year we might allocate
11 50 percent of the reserves based on surcharges and
12 50 percent based on the paid losses.

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

18 THE WITNESS: Which is what is in Column
19 5, yes.

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

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

5 Are you saying they have a lot more claims
6 outstanding that are not settled yet? Or that
7 Christus' settled quicker? Or what would be driving
8 that? Christus obviously plays into a long tale of
9 history, because they've been in the funds since
10 2009 where -- I don't know what year Presbyterian
11 got in, but I would guess 2016/17 when the
12 surcharges increased, and the same thing with
13 Community Health Systems. I guess I'm just trying
14 to figure out why the difference that is not a set
15 multiple between the two, because you look at
16 LifePoint, for instance, 16 million surcharges paid,
17 5 million already paid out in losses, but only an
18 expectation of 22 million total, so there's roughly
19 another 16.6 to be paid. That's a little difference
20 than Presbyterian where they paid in 93, only paid
21 out 12 so far, but we think there's 91, almost 92
22 million more to be paid.

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

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

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

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

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

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

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

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

20 MR. CLARK: Mr. Walling, I agree with you.
21 I'm actually not trying to look at who is performing
22 better or worse. I'm trying to understand the
23 question that I asked on the physician component and
24 I'm going to ask it again. If we go back to Page
25 46, I want to understand all of that to lead up to

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

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

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

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

5 THE WITNESS: To the extent that the
6 deficit surcharges are in here, that should have the
7 effect of bringing the expected loss ratio down. As
8 I sit here, I don't honestly remember whether that
9 39 million is just the rate change that we have put
10 through or whether it also includes the deficit
11 surcharge. I don't believe it does.

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

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

1 not a prospective charge.

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

11 THE WITNESS: I agree with your statement.

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

13 CHAIRMAN RITCHIE: Go ahead, Kathy.

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

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

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

1 right?

2 THE WITNESS: Correct.

3 MS. LOVE: Okay.

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

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

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

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

22 THE WITNESS: Yeah.

23 MR. AUTIO: Thank you.

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

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

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

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

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

23 CHAIRMAN RITCHIE: No questions on this
24 section.

25 MR. BARENBERG: I will move on to the next

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

5 THE WITNESS: Yes.

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

9 THE WITNESS: So let's just start on Page
10 31. The estimate of ultimate reserves are shown as
11 \$266.8 million. The fund balance is shown as of
12 Year-end 22 to be \$135.9 million. Therefore, the
13 deficit on the undiscounted basis, just subtraction,
14 is \$130.9 million.

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

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

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

23 THE WITNESS: Yes.

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

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

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

12 And essentially, what we do is calculate
13 the gain and loss, the relationship between the
14 surcharges and the ultimate losses. And as we have
15 identified, some years the physicians actually
16 outperform the surcharges. In especially the batch
17 years, they were much, much worse, but over the last
18 23 years they have produced a deficit of \$51.3
19 million. The hospitals have produced a net loss of
20 \$68.7 million.

21 If you just calculate those two deficits
22 as a percentage of the total, you end up allocating
23 42.8 percent to the physicians and 57.2 to the docs.
24 You will see I have the prior numbers in there.
25 There's been a fairly fundamental shift. And I

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

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

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

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

23 MR. BARENBERG: And we're on Page 31, so
24 31 and 32 show the schedule of deficit surcharges.
25 What does that mean?

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

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

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

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

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

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

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

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

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

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

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

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

19 THE WITNESS: Sure. So basically what
20 we're doing is trying to take -- let's start at
21 Column 9. The independent physicians undiscounted
22 deficit is \$31.645 million. That comes down to Row
23 13. Essentially what we're doing then is amortizing
24 that undiscounted value. So if you add up the 6.7,
25 6.5, 6.3, 6.1, 5.9 million, that is essentially

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

4 MR. CLARK: This is Row 12?

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

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

18 THE WITNESS: Correct.

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

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

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

3 THE WITNESS: Correct.

4 CHAIRMAN RITCHIE: Any more questions from
5 the board?

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

8 CHAIRMAN RITCHIE: Please.

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

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

25 THE WITNESS: I'm going to modify your

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

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

7 THE WITNESS: Correct.

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

11 THE WITNESS: Correct.

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

17 THE WITNESS: Twenty.

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

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

25 MS. LOVE: And I also understand that

1 there were a number of -- I have data going back to
2 2012 for the years that there were actuarial
3 reports, and what the recommendations of Pinnacle
4 and Milliman were in terms of the raises. Do you
5 have that data as well?

6 THE WITNESS: Probably going back to '03.

7 MS. LOVE: To '03? Okay.

8 THE WITNESS: Yes.

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

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

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

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

3 And so if you just do the math and you
4 look at Page 31, which sets forth all of the
5 surcharges that were collected from the hospitals
6 for 2019, 31,872,000 was collected. There was a
7 13.8 percent recommended increase, but a zero actual
8 increase.

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

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

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

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

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

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

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

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

1 MS. LOVE: Yes, absolutely. Because if
2 you look -- based on the data that I have, that I
3 have been able to collect, based on old actuarial
4 reports and orders from the superintendent, we have
5 the same issue, although not to quite the extent,
6 but with independent providers it looks like we have
7 under-collected, according to what was recommended
8 by the actuaries, around \$9 million. And that's
9 without all of the data. And so, you know, this is
10 a real problem because it answers what legislators
11 want to know, which is why, when we have just given
12 \$62.5 million to help pay off the deficit, why does
13 the deficit continue to grow.

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

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

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

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

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

21 THE WITNESS: I believe that's correct.

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

24 MS. LOVE: Yeah, thanks.

25 MR. AUTIO: To follow up on your comments,

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

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

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

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

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

25 MR. AUTIO: Thank you.

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

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

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

22 THE WITNESS: Yes.

23 UNIDENTIFIED SPEAKER: No further
24 questions.

25 CHAIRMAN RITCHIE: So we are just past the

1 11:00 that we are supposed to finish for today. How
2 much is left? We have two significant topics, the
3 indicated surcharges for physicians and for
4 hospitals and then a short topic on the coverage
5 analysis. So we predicted a continuation for
6 tomorrow morning at 9:00 a.m. so we will suspend
7 this hearing, I think is the term, not being a
8 lawyer, until tomorrow morning and continue. Thank
9 you. So we are continued until tomorrow morning at
10 9:00 a.m. Thank you very much.

11 (Note: The hearing was adjourned at
12 11:04.)

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

3 DOCKET NO: 2023-0018-PCF
4
5

6 IN THE MATTER OF DETERMINING PATIENT'S COMPENSATION
7 FUN SURCHARGE RATES FOR CALENDAR YEAR 2024
8

9 REPORTER'S CERTIFICATE

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

15 I FURTHER CERTIFY that I am neither employed by
16 nor related to any of the parties or attorneys in
17 this case and that I have no interest in the final
18 disposition of this case.
19

20 
21

22 JAN GIBSON, CCR, RPR, CRR

CCR No. 194

23 License Expires: 12/31/23
24
25

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[clear - contribute]

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New Mexico Rules of Civil Procedure for the
District Courts

Article 5, Rule 1-030

(e) Review by Witness; Changes; Signing.

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

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THE ABOVE RULES ARE CURRENT AS OF APRIL 1,
2019. PLEASE REFER TO THE APPLICABLE STATE RULES
OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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