OFFICE OF SUPERINTENDENT OF INSURANCE

PATIENT'S COMPENSATION FUND ADVISORY BOARD MEETING

October 20, 2023
9:08 a.m.
7471 Pan American West Freeway, Northeast
Albuquerque, New Mexico

BOARD CHAIR: WILLIAM RITCHIE, M.D.

REPORTED BY: SUSAN M. HILTON, RMR, CRR, NM CCR 108
Bean & Associates, Inc.
Professional Court Reporting Service
201 Third Street, Northwest, Suite 1630
Albuquerque, New Mexico 87102

(8330N) SMH

APPEARANCES

BOARD CHAIR

DR. WILLIAM RITCHIE
2100 Louisiana Boulevard, Northeast, Suite 410
Albuquerque, New Mexico 87110
505-681-6780
ritchiewl@nmortho.com

BOARD MEMBERS

TRIAL LAWYER REPRESENTATIVES

MR. RAY M. VARGAS, II (VIA ZOOM)
The Vargas Law Firm LLC
807 Silver Avenue, Southwest
Albuquerque, New Mexico 87102-3020
505-242-1670
ray@vargaslawfirmabq.com

MS. KATHLEEN J. LOVE (VIA ZOOM)
McGinn, Montoya, Love & Curry, PC
201 Broadway, Southeast
Albuquerque, New Mexico 87110-3424
505-843-6161
kathy@mcguinnlaw.com

HOSPITAL REPRESENTATIVE

MR. TROY CLARK
NMHA President & CEO
505-343-0110 Office
505-235-9844
tclark@nmhsc.com

PATIENT'S OR PATIENT ADVOCATE

MS. ELLEN STEVENS (VIA ZOOM)
elenarita76@gmail.com

MR. ERZA SPITZER (VIA ZOOM)
224 14th Street, Northwest
Albuquerque, New Mexico 87114
505-463-0660
erza.spitzer@gmail.com
erza.spitzer@nmcan.org

CERTIFIED NURSE PRACTITIONER REPRESENTATIVE

MR. ALFONSO B. MARTINEZ, JR., MSN, FNP-BC
Pediatric Hospitalist
Presbyterian Rust Medical Center
7105 Hensch Avenue, Northeast
Albuquerque, New Mexico 87109
C-505-610-3453
alfonsomrtnz25@gmail.com

PCF ATTORNEY

MR. VINCE WARD
505-270-1609
vincent@wardlawnm.com

PHYSCIAN REPRESENTATIVES

MR. NICK AUTIO, JD
New Mexico Medical Society
505-263-8234
nautio@nmms.org

OSI ATTORNEY

MS. ANITA TELLEZ

ALSO PRESENT

MS. DEBBIE LUERA, Integrion Administrator
debbiel@integriongroup.com

MR. ROBERT J. WALLING (VIA ZOOM)
Pinnacle Actuarial Resources
rwalling@pinnacleactuaries.com
MR. DANIEL LINTON (VIA ZOOM)
Pinnacle Actuarial Resources
dlinton@pinnacleactuaries

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CHAIR RITCHIE: We will call the meeting for the Compensation Fund Advisory Board. Let's start with a roll call, please. And let's post the agenda. Put the agenda up, please.

MS. LUERA: I will do my very best.

CHAIR RITCHIE: Okay.

MS. LUERA: Chairman Ritchie.

CHAIR RITCHIE: Here.

MS. LUERA: Vice Chair Love.

MS. LOVE: Present.

MS. LUERA: Mr. Clark.

MR. CLARK: Here.

MS. LUERA: Mr. Dekleva.

Mr. Vargas.

MR. VARGAS: Here.

MS. LUERA: Mr. Autio.

MR. AUTIO: Here.

MS. LUERA: Mr. Spitzer.

MS. LOVE: Mr. Spitzer has informed me that he will be signing on a few minutes late.

MS. LUERA: Thank you.

Ms. Stevens.

MS. STEVENS: Here.

MS. LUERA: And Mr. Martinez.

MR. MARTINEZ: Here.

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CHAIR RITCHIE: Okay. Do we have capability of showing the agenda?
MS. LUERA: Oh, yes. Give me one second, and I'll get that.
CHAIR RITCHIE: Okay. And while we're doing that, did all the Board members receive their copy -- the preliminary copy of the report for the Superintendent? Did anyone not get it?
MR. CLARK: Mr. Chair, this is Troy Clark. Just to clarify.
CHAIR RITCHIE: Yes.
MR. CLARK: The copy that we are referring to is that referenced to be the copy sent out by Mr. Ward this morning for our review --
CHAIR RITCHIE: Thank you.
MR. CLARK: -- to make sure we're using the same version.
CHAIR RITCHIE: So thank you for clarification. There was a copy you should have received this morning right before the meeting from Mr. Ward.
MS. LUERA: I'm getting close.
CHAIR RITCHIE: We can do without that, if we need to.
MS. LUERA: Normally, I can go through the

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OSI website, but that's not in the cards yet, so, so sorry for the delay.
CHAIR RITCHIE: There it is. Is that the current one or is that the last one?
MS. LUERA: This is for October 20, today.
CHAIR RITCHIE: Okay. Excellent. Thank you.
So then we have had a roll call. I believe everyone knows each other. I want to try to speed through this, so I don't know if we need any introductions necessarily.
MS. LUERA: Well, we should introduce Ms. Tellez from OSI.
CHAIR RITCHIE: Yes, except for the people who are not on the Board. So, please, who is present. Yes, go ahead.
MS. LUERA: So it looks like just Board Members on the Zoom call. Here in the room, we have Anita Tellez. She is an attorney for OSI. She will be here for the continuation of the surcharge rate hearing and to enter anything into evidence that is necessary.
CHAIR RITCHIE: Okay. And any other official guests?
MS. LUERA: I don't see any.

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Oh, I'm so sorry. Daniel Linton from Pinnacle Actuarial Resources. He's a colleague of Rob Walling, and so he's here to answer any questions on the actuarial study or the addendum that the Board might have. And it looks like Carrie Robin Brunder from New Mexico Society is also on the call.
CHAIR RITCHIE: Okay. So we do. So we have two members, one from the -- an attorney from the OSI, and then someone representing the actuary, so excellent.
So next order of business, Approval of the Agenda. Do I hear a second, or do we need a second to approve it?
MR. CLARK: I'll make a motion.
MR. AUTIO: I'll make a second.
CHAIR RITCHIE: Hearing no dissension, the agenda is approved.
Meeting Minutes from Last Meeting, is there any -- is there a motion to approve these?
MR. AUTIO: So moved.
CHAIR RITCHIE: Second?
MR. CLARK: Second.
CHAIR RITCHIE: Any discussion?
Hearing none, we'll approve the Minutes from the Last Meeting.

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(Exhibit A marked.)
CHAIR RITCHIE: Item No. 2, "Continuation of Surcharge Rate Hearing to Consider Additional Evidence (If Deemed Necessary by the Board.)" We have had a chance to look over the preliminary report, and there are comments on that with regards to other information that we had discussed at our last meeting. And so we had some questions, I know, of both the actuary and possibly of the OSI.
And so I will at this time open the floor to Members of the Board who had the specific comments or questions either on -- either as entered with the preliminary report or as brought up at the last meeting. And so who would like to go first on that?
MR. VARGAS: Mr. Chair, this is Ray Vargas. You'll note here on the draft report we have essentially a blank section with regard to independent outpatient healthcare facilities. And as I understood it, we were going to get some additional data and information today on independent outpatient healthcare facilities. And I was hoping we could start with that.
CHAIR RITCHIE: Absolutely. I believe -- I think, that may have been where Mr. Clark was going, but let's definitely go to that, so we did as noted.

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In the minutes, we did have questions as we really had very little to go on in the OSI's report or comments on the actuary study.

So then, please, we would like to hear from the OSI the recommendations for the independent -- the actuary's report, their recommendations, and the OSI's response to that for the independent healthcare entities and their physicians.

MS. TELLEZ: Those are the ones that are recommended in the actuarial report?

CHAIR RITCHIE: Correct. They were the ones that were not a hospital, but not independent physicians, but initially, they were lumped under independent physicians, and initially -- I'm sorry. They were lumped under the hospitals as far as rate setting, and then the most recent Legislature carved them out as a separate category.

And so any comments on the rate setting for those entities?

MS. LUERA: Well, I'm just filling in for Mr. Barringberg today.

CHAIR RITCHIE: Right, I understand.

MS. LUERA: I'm just letting you know that, and so I was prepared to examine Mr. Linton on the addendum. If you think my examination of him on the

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addendum, if that would give further information on that point, I can proceed to do that. I have not heard from OSI any objection within the actuary report as to those rates.

CHAIR RITCHIE: Okay. Then let's actually start with the addendum.

MS. LUERA: So the addendum doesn't relate --

CHAIR RITCHIE: It doesn't relate?

MS. LUERA: -- to independent outpatient healthcare facilities. Mr. Linton is prepared to discuss their methodology and how they came up with those rates. And the question I posed to him after the last meeting saying we think we might need like a per-visit or a per-procedure rate, there were some questions about tying those facility rates back to the employed doctors because, as most of us know, there are no -- it's not always employed doctors working at those facilities. So I believe Mr. Linton is prepared to talk about how that was calculated.

CHAIR RITCHIE: Okay.

MR. WARD: And this is Vince Ward. Just as a point of procedure, I think it's perfectly acceptable for Board Members to ask the questions to lead that discussion with the witness.

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MR. CLARK: Mr. Chair, this is Troy Clark. I was going to ask that. When you say ask the questions, directly to Pinnacle?

MR. WARD: Yes.

MR. CLARK: So maybe we can just do that.

Mr. Vargas, we are both concerned about the same issue. Are you okay with us just starting to ask -- and I don't care if you go first or I can ask the questions -- but I think what we need is that, as a Board what we are asking for is for Pinnacle to help us understand, what did you do in this realm, and how does it apply to areas that we had concerns about?

MR. VARGAS: No. I agree completely. And go ahead, Mr. Clark.

MR. CLARK: Yes. So, Mr. Chair, this is Mr. Clark. For the record, I would ask a representative from Pinnacle, I believe his name was Danny, but I'll just refer to Mr. Pinnacle.

When you prepared the report and calculated the increased rate for outpatient healthcare facilities, can you give us a summary of the process you went through, and how that would apply to -- well, I guess let's just go first -- the process of the assessing a value to the outpatient healthcare

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facilities?

MR. LINTON: Yes. Good morning. Absolutely. So when we look at the lost data, there was nothing to tell us what would be an outpatient healthcare facility claim. So when we elected, our assumption was to assume that the exposures for outpatient healthcare facilities were not unlike the exposures for the hospitals of the independent docs. And if you'll give me a second to share my screen, I can show you to what I'm referring.

So this is an exhibit outlining all of the rates by class, and so we have the current independent provider, and as you see, the lumped together are the hospitals and outpatient healthcare facility rates here. When we discussed the scope with Debbie, she indicated, hey, can we have some additional rates for outpatient healthcare facilities in the layer 500,000, excess of $500,000? What we did we kept is we kept our same approach of previous analyses where we calculated the indicated rate change for the independent providers and for the hospitals, and then --

MR. CLARK: Danny, if you could give us all a reference to what page number of the report you're on so we can follow along, that will be helpful.

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MR. LINTON: Oh, absolutely. So I'm on Page 41 of 91 of the full actuarial report.

MR. CLARK: Thank you. Sorry to interrupt.

MR. LINTON: No. Thank you.

So we calculated Column 3, 4, 5, and 6 in a similar manner to what we had done in previous years. So we on-leveled all the surcharges to 2024 levels, and then trended and developed all of the historical claims to come up with an indicated rate change and then applied that indicated rate change across all of our classes.

Because the independent outpatient healthcare facilities are going to have a different layer, so 500 -- excess of $500,000, we then created new rates with benchmark adjusted factors to account for what the exposure in that layer is by class.

So, you know, Debbie had indicated calculating a rate per procedure. That's going to take a more involved approach with OSI because we're going to need to understand the amount of procedures or the number of procedures that are taking place and apply them to these rates. So when I think of number of procedures, I anticipate we'll need to have a proration factor to these rates to make that adjustment to say we're having more or less exposure

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in these 500 excess $500,000 layers. But these are calculated as if they're a full annual exposure as of this time. And if we calculate that the number of procedures represents 25 percent of an annual exposure, we would adjust these rates by 25 percent.

MR. CLARK: So, Danny, if on Page 41 on the exhibit, if you were to have an outpatient healthcare facility that either directly employed or had a closely-affiliated organization -- you know, maybe two separate legal entities, but the same structure -- and you're assessing a surcharge to that entity, it would be based upon the number of providers in each class and their rate under Column 7 for the outpatient healthcare facility's portion; is that correct?

MR. LINTON: That is absolutely correct, yes.

MR. CLARK: Would you -- would that be a charge for the outpatient healthcare facility in addition to a charge to their professional practice coming from Column 3 where they were practicing in a clinic or in an -- outside of that outpatient healthcare facility, or would the entire charge be moved and no longer be charged separately as independent physician, that they would now be as an

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independent healthcare facility?

MR. LINTON: My understanding it would be in addition to. And so this goes back to Debbie's point of the per-procedure charge. So, it states, A Class 1 doc would be charged $5,145, but then if there's -- 25 percent of their time is spent in the outpatient healthcare facility, they would be assessed 25 percent of this 3,139 as well, in addition to.

MR. CLARK: So let's create a new scenario. For a outpatient healthcare facility that does not have any employed providers, an ambulatory surgery center where there are multiple partners who are all in separate practices, would that create a zero surcharge on that outpatient healthcare facility because there's no providers that are employed to assess that based upon, or how does your model account for assessing a surcharge to that type of outpatient healthcare facility?

MR. LINTON: That's an interesting question, and I don't quite know the answer to that. Would there ever be exposure to a claim against that outpatient healthcare facility for the actions of those ambulatory services?

MR. CLARK: I believe the answer is yes.

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And I don't know that this exists, but clearly the potential would exist that you could have a provider who is not covered by the PCF in their professional practice practicing at one of those outpatient healthcare facilities that is part of the patient compensation plan.

MR. LINTON: Correct.

MR. CLARK: So I think that's why we were getting confused looking and having a hard time understanding how to make a recommendation to assess a facility-based surcharge to an outpatient healthcare facility when it could be owned by its employees, it could be owned by a separate entity and have no employed facilities. And I don't believe we believe the correct answer is to assess a zero charge because there's no employees because there is still risk and exposure there.

MR. LINTON: That's a very good question. And I don't know the answer to how to assess that risk unless we go back to the point of per event, per procedure, you know, per whatever service is being rendered, if we can apply that on a pro rata basis; right? So we could say 20 percent of their time has been spent with the outpatient healthcare facility, then they would get 20 percent of the surcharge.

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MR. VARGAS: This is Ray Vargas.
MR. LINTON: Excuse me. Mr. Clark, I'm sorry to interrupt.
MR. CLARK: No. Go ahead.
MR. LINTON: I think we're kind of limiting our view of outpatient healthcare facilities to physicians. And I'll just give you guys an example that I'm dealing with right now. I have a case where (inaudible) physician performed a surgery at an ambulatory surgical center, and both the physician as well as an employed nurse with that facility were negligent. And there are cases where it's a combination of employed -- employees and non-employees in these outpatient healthcare facilities that are creating risk. Is there any way to account for that or deal with that in the surcharges for the facility itself?
MR. CLARK: And this is Mr. Clark. I would add to that that I don't know of your example, Mr. Vargas. But if that position, that surgeon was not a participant in the PCF, there would not be a column that we could refer to on the report to even assess a pro rata portion or an adjustment to because they're not a surgeon, whether it's in reality of that situation or hypothetically, wouldn't have a

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surcharge to gross up or prorate between their practice and the facility.
MR. LINTON: Correct.
CHAIR RITCHIE: This is the Chair. I mean, it sounds like what we need to -- it's about the fees for the center and not the -- and their employees, and not the physicians. And they are two separate entities. Even if the physicians own the center, either directly or indirectly, it's still a separate -- the center is separately liable for their employees that fall directly under the center, and the physicians generally have their own insurance.
MR. LINTON: Then they should still have the ability to be assessed in the same manner that the hospitals are assessed. Because the way I see it, there are three buckets; right? You have hospital surcharges, then you have employee agent surcharges, and then you have independent agent surcharges. Can these outpatient healthcare facilities be assessed in the same manner that the hospital surcharges are?
MR. CLARK: Mr. Chair, this is Troy Clark. I would say in structure, but you've got different threshold levels with the 500/500 versus the 250/750, so there's some nuanced differences. But I think

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that is a proposal that would sound more consistent with what we would have expected to understand.
Mr. Chair, if I could ask a question to Ms. Luera. This past year, we've had outpatient healthcare facilities. How did we assess surcharges in the past? I mean -- and I'm concerned that while Danny is trying to come up with what is a possibility, he's not going to be able to do it on the fly. I don't know if one can be done before we can revert back and make a recommendation. Can we at least explore what's been currently done, or whether we're comfortable with that, or that plus some inflationary measure?
I mean, I feel very uncomfortable with what we currently have in Exhibit -- on Page 41 to make anything of that. I think that's not even apples and oranges. We are talking apples and steak, total different food groups here. So could we find out how did we make an assessment in this current calendar year to outpatient healthcare facilities?
MS. LUERA: So if the outpatient healthcare facility was part of the hospital, they were included in the hospital rates. And we do have those per visit, per admission, per birth, what have you, we have those rates for hospitals. And so that's how

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the hospital surcharge has always been calculated. And then -- so, generally, there's a line item that's submitted for the hospitals, they fill out what we call a facility rating spreadsheet, and then the rest of the surcharge calculation is based on the employed providers who are eligible for coverage in the PCF. With an independent outpatient healthcare facility, it's generally just like an additional insured, and so they're paying a 10 percent entity surcharge.
CHAIR RITCHIE: 10 percent of what?
MS. LUERA: 10 percent of -- so the organization that owns the entity. Well, I think what we have always seen is that it's a 10 percent surcharge based on the physicians who are also associated or employed by that entity. We're not really -- right now, those independent facilities are sort of lumped in with the independent physicians. You can add an entity, you can name as many entities as you need, and as long as that 10 percent entity surcharge is paid, then they are a Qualified Healthcare Provider provided they meet all the other requirements under the statute.
And so we haven't -- and I think there may be some other independently-owned healthcare facilities who aren't participating in the PCF. So

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they have other coverage to carry that -- to cover that outpatient healthcare exposure. So I would -- and I hope I'm correct. I may not be 100 percent correct. But I think the independent outpatient healthcare facilities that are covered under the PCF currently are all part of another entity that's also covered, so it is just that 10 percent entity surcharge. There's no per patient visit, per procedure. There's none of those rates contemplated at all right now. But because the limits are going to be different, we have to figure out a way to charge them for the risk that is going to be, you know, covered by the PCF now.

MR. CLARK: So, Ms. Luera, this is Mr. Clark again. If I understand you correctly, we don't have currently any independent outpatient healthcare facilities that have applied for or are being covered under the PCF that are not closely affiliated with a physician practice who is also a participant in the PCF?

MS. LUERA: We have a rehab facility, but it's rated as a hospital. So they're paying.

MR. CLARK: And that would not make them, Ms. Luera, an outpatient healthcare facility?

MS. LUERA: And that would not make them an

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outpatient healthcare facility, right.

MR. CLARK: So the example that Mr. Vargas had or that I am bringing up -- because I believe there are some of these in the state, but I didn't know if they're members of the PCF or not -- the independent ambulatory surgery center that's owned by several desperate entities is not in the portfolio of what we have in the PCF today?

MS. LUERA: Unless it's named. So because all the limits are the same, whether it's based on the type of provider, we don't break that out. So there may be a facility that's covered with another entity, but it has to be tied to physicians. So like an ambulatory surgery center, I don't think we have any of those. But we haven't really done the research because we haven't needed to up until now. I don't think they're in, though. I don't think they're in there.

MR. CLARK: So let me go back to an example that I believe that we do have, and I'll be a little generic in the terms. We have a gastroenterology center that is covered by the PCF that is closely aligned with a gastroenterology group. If I understand you that when I ask how the current fees or surcharges -- I'm sorry -- are applied to that,

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the PCF is looking at the professional practice, what class they're in, how many physicians go into the rate, and multiplying "X" number of providers in that class times the rate, and then for the closely-affiliated center where they do the procedures, there's a 10 percent add-on to what the sum total of the practice is?

MS. LUERA: Correct. So there's a 10 percent surcharge for each entity that's named. So we're checking the certificates of insurance when we receive a batch submission from an underlying carrier. So we are checking the Certificate of Insurance. And if there are two entities named on the Certificate of Insurance, what we would expect to see charged is 10 percent of the sum total of all the physicians and -- or I shouldn't just say physicians, but all the eligible providers for each entity. So if we have -- let's say we have a group with 10 physicians, and each one of them -- each one of their surcharge is $10,000. So we have $100,000 for the 10 providers.

Then for entity No. 1, we would see a 10 percent entity surcharge for that entity to be named under the Patient Compensation Fund as a QHP under the Patient Compensation Fund -- sorry, Qualified

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Healthcare Provider -- and then if there's a second entity on that Certificate as well, we would expect to see another 10 percent entity surcharge.

MR. CLARK: So, Ms. Luera, bear with me.

MS. LUERA: Sure.

MR. CLARK: I think I need to go through a couple steps here. I'm not questioning you, so --

MS. LUERA: Sure.

MR. CLARK: -- don't take this personally, but just to understand where we're at.

I believe the history of the 10 percent surcharge on the Patient Compensation Fund was to cover if there were either physicians who are all jointly in a practice and covering their legal entity that combined them, or hospitals that have multiple hospitals and are a corporate entity, that that 10 percent would apply to the corporate entity for coverage as well; is that correct?

MS. LUERA: Correct. It's what we call vicarious liability.

MR. CLARK: So with that, the vicarious liability would not expose the Patient Compensation Fund to additional payout or outflows -- let me say that again. The Patient Compensation Fund would not be exposed to additional occurrences because of the

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entity, just the number of the entities that may be named in a claim?

MS. LUERA: Well, that's all interpreted by the courts. That's the intent, though.

MR. CLARK: Okay. Whereas with an independent outpatient healthcare facility, you have the potential of a claim being generated in the practice, but then also a claim being generated on a procedure that happened within the outpatient healthcare facility, which means there could be additional exposure to the PCF fund; is that correct?

MS. LUERA: That's correct. And because -- so if it's a non-employed physician, but somebody who is participating in the Patient Compensation Fund, that physician's limit underlying would be that 250,000, and then the Patient Compensation Fund layer kicks in, but for the facility, that the Patient Compensation Fund does not begin to participate until the $500,000 underlying is met. So because there are different limits, there may be additional exposure.

MR. CLARK: And so for my question this leads up to, are we using a 10 percent figure that was meant for an umbrella entity arbitrarily to an entity that now could actually create more risk events, which my concern, is there a correlation

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there? We could be overcharging or undercharging. I understand that we don't have the data. And maybe the question back to Pinnacle is, how do we get something more closely aligned to get a comfort level that says the outpatient care facility is receiving or being assessed surcharges commensurate with the risk they're bringing to the PCF, much like the data we have for independent physicians and for hospitals. Sorry I grabbed the wrong report because it has many, many hundred more pages. So it is pretty intensive that gives us the comfort to say there's a method to getting to these rates. I'm not sure that I feel comfortable that the 10 percent for a corporate legal entity is the right rate to be applying to a additional facility. And I don't know if that's too high or too low.

CHAIR RITCHIE: Danny, you look like you have something.

MR. LINTON: That's why I was thinking of the pro rata adjustment. So you have a physician group, and they do 1,000 procedures a year, and this other entity that does 200 procedures a year, you would take these rates and multiply them by 20 percent because of the number of procedures that they provide in the application of the healthcare facility

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of 20 percent of the number of procedures that they provide in their main facility.

So that's my initial reaction to how to properly charge for that. You can still use these 500 excess of 500,000 rates, but they would just be adjusted depending on how many procedures are going in to that facility relative to the average number of procedures in a typical independent provider facility.

MR. VARGAS: And this is Ray Vargas. I have a question about that, though, because the risks to me seem different. And I'll use Southwest Gastroenterology and Southwest Endoscopy as an example, and that is, Southwest Gastroenterology is a physician practice, but then when procedures are done, they're done in a separate outpatient healthcare facility, which is the Endoscopy Center.

And the risk is different from seeing the patient in the office and examining them and prescribing medicine than it is for doing a colonoscopy and potentially perforating the colon. Is that being taken into account, or are you simply adjusting the physician number by number of procedures and higher limits?

MR. LINTON: Well, it's not like I think

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it's being taken into account because it's being covered at these rates, and that we're just trying to account for additional exposure. But I do understand that you have heightened risk in any outpatient healthcare facility, or is this just examining someone and prescribing meds. But when I look at these rates, I think that risk is already accounted for in these rates.

So if we were, for example, just to charge them $5,450 for a (inaudible) physician, and they charge an additional $3,139, I think we're double-dipping. So I think most of the risks that you're describing is still in this rate because this rate accounts for all of the claims that we observed just looking through the claims (inaudible) that provides the style of facts.

So I just want to be careful that we're not double-counting the amount of risks from this rate to this rate. I don't know how to quantify that.

MR. VARGAS: Okay. And then an additional concern that I have is the example that Mr. Clark's used, which is if the physician is not an employee of the Outpatient Healthcare Facility -- and I can envision a case where the plaintiff only sues the facility and did not sue the physician -- how do we

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deal with that particular risk if we're just charging a 10 percent for the facility?

MR. CLARK: This is Mr. Clark again. I'll add to that, or if the claim is against an employee of the facility and not the physician, again, that would be against the facility only because the employee is part of that facility. But I think that's the one that rung out to me as Mr. Vargas shared his earlier example.

MR. LINTON: That's why I had the thought of maybe the facilities should be assessed in the same manner that the hospitals are.

MS. LUERA: I agree, Danny, if I may just sort of use my experience and what we've seen before.

You know, when the carriers are submitting this information to Integrion for us to process the batches and receive the payments, we're going to look at who the physician is employed by. So if they're employed by that facility, then they're subject to the 500,000 excess of 500,000, so we're going to apply that surcharge. If they're employed -- and let's use Mr. Vargas' example -- Southwest Gastro versus Southwest Endoscopy.

So if they're employed by Southwest Gastro, they are going to pay the independent provider rate.

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If they're employed by Southwest Endoscopy, then we would charge the 500 X of 500 rate, which is a little lower because it's based on the attachment point of the PCF.

But we still -- the part that I still question -- and I agree 100 percent with you, Danny -- when you said I think the facilities need to be -- you know, for the entity that is the ambulatory surgery center or other type of Outpatient Healthcare Facility, we need to calculate their exposure on like a per visitor or a per procedure or, you know, whatever it is that they're doing, that needs to be sort of the underwriting or the rating mechanism for those independent outpatient healthcare facilities.

MR. AUTIO: Mr. Chair, this is Nick Autio. I mean, that approach seems to make a good amount of sense. I mean, once again, hitting on the Southwest Endoscopy versus Southwest Gastro. If you've got all of the -- everyone is employed by Southwest Gastro, they're assessed a surcharge and independent provider, but they're acting as agents and performing colonoscopies in the endoscopy center. That 10 percent surcharge, you know, probably it doesn't seem like that would necessarily be sufficient. We don't know. So that other approach of actually doing this

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on a procedure base like you do the hospitals would hopefully more accurately capture the actual risk that's posed and avoid double-dipping at the same time. We obviously want to avoid that and not overcharge, but we need to capture the actual risk that exists. And it seems like that would be the best way to do that.

Debbie, is that something that you would have the ability to do moving forward if that were a recommendation?

MR. CLARK: Mr. Chair, that might be an appropriate and possibly the most appropriate method until such time as we have the data to see whether that -- I mean, Mr. Autio is correct. 10 percent may be too much if it's only covering the claims against the facility or the facility is the one being named by itself or its employees versus the surgeon. And if all the surgeons are or physicians are already covered, and the claim is against them, 10 percent may be too much. It also may be too little. I think this is the more appropriate route to go until sufficient time carries on that we would have the data to look to see the balance between how those claims are arising.

MS. LUERA: Also, selfishly speaking, it

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would be a lot easier for us to process that, and I think for the underlying carriers as well because they're not having to look at each physician and try to quantify what percent of their time are they with the group and what percent of the time are they with the independent outpatient healthcare facility. It would just be, I think, a much cleaner approach as well.

MR. AUTIO: And, Mr. Chair, this is Nick Autio. I feel like heading down that road could lead to a lot of problems trying to basically speculate as to how much time they will be spending in an NAFC. I mean, it seems like that could be very difficult. And if, in the unfortunate event, litigation arises, that could also lead to some problems if they've underestimated. You know, it just seems like it would be very difficult to go down that route personally.

CHAIR RITCHIE: I think we have found our way to the most logical, and I can give a good example. In our surgery center, or in general, to my knowledge, in surgery centers, surgery centers don't employ physicians. Physicians own surgery centers or work in surgery centers they don't own. But surgery centers don't employ physicians. And so, you know,

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working at it from that angle is probably not appropriate.

So I think the discussion has worked that out well. And so it's figuring out what the exposure is for the surgery center itself and their employees, which are nurses and techs and things like that, and the physicians are separate. And whether they're surgeons, whether they're endoscopists, they will have different ratings. They won't be in Category 1, a pediatrician. They don't go to surgery centers. I mean, so it's a very much more limited category.

In, for instance, surgery centers owned by multiple entities like ours, it would be a nightmare if we chose to try to be represented under the fund because I don't know how you would figure that 10 percent surcharge on what entity, which of the three entities that owns it. And so I think that that surcharge truly is, as Mr. Clark said, for the administrative part for the practice which -- with much lower exposure of different -- whether it's the administration or techs that work there or whatever, but it doesn't represent liability of physicians. And that's why it's a flat low 10 percent. Does that make sense to everyone?

MR. MARTINEZ: This is Mr. Martinez.

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Because with that, I think you have to also consider some of these outpatient healthcare facilities are going to have higher risks than other ones. You know, you're going to end up be doing more riskier procedures in some places than others. You know, if you have like a bone/splint clinic versus doing endoscopies, you know, the risk in a bone splinting clinic is very low versus doing colonoscopies. So having that ability to kind of vet that out and put them in proper perspective is going to be very important.

CHAIR RITCHIE: The one caveat -- and this has been brought up because we have been speaking of more procedural things like endoscopy, maybe orthopedics, things like that -- is if you speak of coverage like at a dialysis center. In a dialysis center, I can envision maybe does employ a physician to be the direct medical director or something like that.

And so I think we need information, we need exposure information data before we can really opine on that, to be honest, because I don't know how we said otherwise. I don't know that. Maybe Pinnacle has experience there or something, but I don't know if any of those are even represented under our PCF at this point.

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MS. LUERA: Sure. We have to look at the definition of what qualifies as an independent outpatient healthcare facility. That's a lot of words. And so one of the things that I spoke with OSI's actuary about was, you know, maybe we can sort of -- this is the first year. So let's set surcharges that we believe are reasonable and cover the rest, and then we're not going to know what types of facilities are going to apply for this coverage until they're actually, you know, applying for admittance to the fund.

So maybe at the end of next year, as we start to prepare for the actuarial study that's coming next year, we will have some data. We probably won't have good data for a couple years. I mean, I don't think we're going to have lost data, but we'll, at least, have a better understanding of the types of facilities that are going to be classified into this independent outpatient healthcare facility structure.

CHAIR RITCHIE: Okay. So for purposes of our report to the Superintendent, I'll put this out to the subcommittee who wrote this or who came up with the first draft, how do we want to change it?

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Do we need to add anything to this? How will it change our wording?

MR. CLARK: Mr. Chair, this is Troy Clark. I believe currently, it's a blank.

CHAIR RITCHIE: I know. That's the problem.

MR. CLARK: So we need to change something.

CHAIR RITCHIE: What do we add to it? What do we put in there? So we're going to find this Section 29, is that correct, or Paragraph 29?

MR. CLARK: Mr. Chair, I don't know if the Board needs to have some discussion. Obviously, we don't have the data like we do from the other two categories.

CHAIR RITCHIE: Right.

MR. CLARK: I think from my perspective what's been described by Danny from Pinnacle, and furthermore, by Ms. Luera's comment that currently, we don't have any participants in the PCF that don't have a physician or are closely tied to a physician group, the risk is probably much less.

Danny has reiterated that if they looked at the different classes of physicians that are included, i.e., would take on the -- adjust for the risk that Mr. Martinez was suggesting. So if it was

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an endoscopy center versus a splinting clinic versus a procedure room, a fusion center, it should be matched to the risk level that's out there gives me more comfort to continue with the 10 percent, but I can't tell you that I'm totally comfortable.

I think part of our recommendation that I feel more comfortable is what we've discussed about for how we track this for future years. I still don't know that I can represent that there's a number that I'm comfortable with. I would be interested to hear from other Board Members what your consensus is, if you gained more comfort, and we recommend continuing on with the 10 percent add-on due to lack of any additional information to go another direction, I don't know.

MR. VARGAS: This is Ray Vargas. I have a similar concern. I think given the lack of any data, there's not a whole lot we can do right now other than the 10 percent. But I think we can say going forward, you know, we need to start tracking it on a proved procedure basis like with the hospitals and examine whether, in subsequent years, we need to assess rates based upon that specific data.

MS. LOVE: This is Kathy Love. I agree with all of that, and I also wonder, I don't know of

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anything that prevents the OSI for requesting past data on outpatient healthcare facilities even for time periods when they were not participating in the fund. Certainly, a private insurance company would do that. So I don't know why we couldn't come up with whatever additional data it is that the actuaries would find helpful in terms of coming up with what the risk is and requesting that at this (inaudible).

MR. CLARK: Mr. Chair, I might even add -- and this is Troy Clark again -- I might add that our actuaries, I would assume, have access to data from other states so a much broader area to identify the ratio of occurrences to claims. I don't know that their -- other states' legal structures are like our PCF with the base layers and amounts and the range of coverage, but I would hope that we can include in our recommendation at least a suggestion to look to other states' experience of events to -- volumes within a facility as a leading indicator of what a potential claim ratio could be until we have sufficient data within our own state. Well, actually, not within our own state, within our own PCF applicant pool.

MR. AUTIO: This is Nick Autio. It doesn't seem a whole lot different than what we've done with

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the hospitals. I mean, we wanted to gather as much good data as we can to assess the risk they pose, and we should treat outpatient the same way in my book to make sure we're having actual accurate assessments in terms of surcharges.

I agree at this point, it seems difficult to really nail this down. And if we do recommend the 10 percent approach with the intention of gathering better data for future years, maybe we get numbers and the 10 percent is working. But if it's not, you know, then we'll have that data to change the assessment approach and really dial it in as much as we can.

MR. CLARK: Mr. Chair, one --

CHAIR RITCHIE: Yes.

MR. CLARK: -- more comment, I think. If we were to go down that approach as I process this, all the work that's been done on the hospitals and independent physicians shows a need for an increase. Inherently, if you have a 10 percent add-on, that would take on that additional increase that's already based upon physician experience.

So that gives me a little more comfort that it doesn't need to be something greater from an arbitrary standpoint lacking data that some of that

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additional exposure that has been identified from the actuarial work that is based upon data already includes that. So you would be adding on upon something that already has an add-on and not double-dipping.

MR. MARTINEZ: And this is Mr. Martinez. I think, also, reaching out to those other states with patient compensation plans and seeing how they handle it, and having a -- kind of a deeper analysis of those other funds, and how they are parsing these things out would also be very helpful.

CHAIR RITCHIE: That's certainly a recommendation to Integrion.

Are there any other comments on this subject? I think we had a great discussion on it. And I mean, it's just like we've been working on these last three years. We're always needing new data. This is still a fresh process, so to speak, and so we're still gathering data.

Any comment from Danny from Pinnacle?

MR. LINTON: No. I think that's a reasonable approach. And you know, even the 10 percent, it does take into account the additional rate increase, so there is additional funding going into the PCF. We do work with other PCFs. We work

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with Wisconsin. We work with the Virginia Birth Fund. We work for the Birth Fund. I haven't seen them tracking differently from an actuarial perspective, but it's worthwhile reaching out to other PCFs and seeing what -- if they are doing something different.

But to my own knowledge, that hasn't come across my desk. But right now, I think it's prudent to continue with the 10 percent, but to begin tracking data to Debbie's point to say, okay, what facilities are going to begin to participate and what type of exposure are we going to get into the PCF with this new approach.

MR. VARGAS: I would like to make a motion that a recommendation for this year be that we continue with the 10 percent facility surcharge, but also direct the PCF to start accumulating data to the extent these facilities are entering based on our per-procedure basis, like maybe to the hospital, so that we have an alternative basis to assess surcharges in the future.

MR. CLARK: This is Mr. Clark. I would second that motion.

CHAIR RITCHIE: We have certainly had a lot of discussion on that. There's not any last second

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discussion? Is there any dissenters to that?

Excellent. So moved, and that then we need to make sure we include it to the final report.

MR. CLARK: Mr. Chair --

CHAIR RITCHIE: Yes.

MR. CLARK: -- if I could just ask Mr. Vargas, since you made the motion, are you comfortable that you've got the language you need to add that into the section of the report?

MR. VARGAS: I believe so. I'll give it my best try, and then I'll rely on you and the other members of the subcommittee to do a check on me.

MR. WARD: This is Vince Ward, Board Counsel. Are we then planning on having that additional board meeting for the final report that's currently scheduled for next week?

MR. CLARK: I think we have to at least -- even if it was a quick dial-in or everybody say you've had a chance to -- assuming that the report will be modified based on today's discussion on this and further discussion, and then send out -- I think that's why we put that on the agenda so that everybody could say, yes, I'm okay, and be done, oh and it could be that quick.

CHAIR RITCHIE: I believe that's what we

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did last year, as I recall. We got a final report sent out to everyone, and then we met to fulfill our State obligations to make it legal, so yes.

Let's go back to the agenda. Let's see where we are at here. So that's the independent entities, the independent outpatient centers.

Let's go back to -- I don't believe that the OSI had any more questions necessarily of Pinnacle or Danny, as I understand it. You don't have any other --

MS. LUERA: We -- oh, sorry.

CHAIR RITCHIE: Go ahead.

MS. LUERA: So Mr. Linton prepared the addendum based on the request at the last board meeting.

CHAIR RITCHIE: Right.

MS. LUERA: So I think it makes sense for Ms. Tellez to enter that into evidence and have Mr. Linton walk through how he calculated --

CHAIR RITCHIE: Excellent.

MS. LUERA: -- and what he did.

CHAIR RITCHIE: Okay. So let's go to that then. I keep losing the agenda.

MS. LUERA: I have lost the agenda. I'm sorry.

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CHAIR RITCHIE: Danny, if you will, just walk us through real quick the addendum. And I'm sorry. You can certainly question about it.

MS. TELLEZ: Sure. I was going to actually just do a little bit of foundation testimony for Mr. Linton to start off with.

CHAIR RITCHIE: Okay.

MS. TELLEZ: He jumped in, and I just didn't have a chance. I think maybe now it's appropriate to do that.

CHAIR RITCHIE: Thank you.

MS. TELLEZ: Mr. Linton, would you please spell your first and last name for the record?

MR. LINTON: Yes. My name is Danny Linton. D-a-n-n-y, L-i-n-t-o-n.

MS. TELLEZ: And could we pull up his CV?

MS. LUERA: I'm working on it. You wanted his CV?

MS. TELLEZ: His CV, yes.

MS. LUERA: Danny, do you have your CV handy that you could pull up?

MR. LINTON: I do.

MS. LUERA: That would be wonderful. We're having a little bit of technical difficulties here, and it's all on me.

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MR. LINTON: What would you like me to do?
MS. TELLEZ: I'll just ask you a couple questions, Danny.
Does the CV accurately show your education and experience?
MR. LINTON: Yes, it does.
MS. TELLEZ: Okay. And could you please describe for the board what you do for a living?
A. Yes. So I'm a property and casualty consulting actuary. I've been in the profession for 18 years working with all forms of alternative risk transfers, casualty insurance companies, self-insureds, government entities and pools, and government insurance programs of the New Mexico PCF.
Specific to this assignment, I have experience with the Wisconsin PCF, the Florida and Virginia Birth Related Neurological Injury Compensation Fund, and the New York Medical Indemnity Fund. So I do have experience with government insurance programs similar to the New Mexico CSF.
MS. TELLEZ: Okay. And can you describe what a consulting actuary does?
MR. LINTON: Sure. So we advise clients on quantifying the impassive risk. So we have some very simple assignments where we will quantify load layers

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of risk for workers' compensation, general liability, auto liability. And we also work with more complex programs, most specifically the medical professional liability, quantify the amount of risk retained by our clients. And if I do them on a corporate courses of acts to whether it is to take on more risk, deploy capital, and other elements of risk retention.
MS. TELLEZ: And can you tell us about your educational background relevant to your testimony today?
MR. LINTON: Yes. So I got an undergraduate degree, a bachelor's of science degree, at the University of Notre Dame in mathematics. I also got a master's of education degree in education also from Notre Dame, which I got my passion for educating and consulting.
I am a fellow of the Academy of the Actuarial Society. So I have passed nine rigorous examinations over the course of seven to 10 years to maintain those credentials, and I am also a member of the American Academy of Actuaries.
MS. TELLEZ: Thank you.
At this time, I would just like to move Mr. Linton's CV into evidence as the next exhibit. I don't know if we're at Exhibit C.

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CHAIR RITCHIE: That's accepted.
MS. TELLEZ: Okay.
(Exhibit C marked.)
MS. LUERA: Mr. Linton, would you mind pulling up the addendum that you created for us and sent to me yesterday?
MR. LINTON: Of course.
MS. LUERA: Thank you so much.
MR. LINTON: So this addendum consists of two pages, one showing what we just were looking at indicating the current rates, and also what the load for the deficit surcharge percentage of the current surcharge. I'm referring to Column 11a here. This is the focus of the addendum, what is the additional load so that the hospitals can pay down their portion of the deficit by the end of 2026, which is my understanding of when the hospitals will no longer be participating in the PCF.
MS. TELLEZ: What was your role in the preparation of the addendum, Mr. Linton?
MR. LINTON: I had an active role in the preparation of the addendum. The change to the addendum from the actuarial report, the actuarial report considered two different options for the $32.5 million that was allocated by the New Mexico

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Legislature. In our report, we considered two scenarios. One was a 75 percent, 25 percent split; 75 percent going to the independent doctors, and 25 percent going to the hospitals, and we also showed a 50/50 split.
More recently, Debbie had sent some information regarding an updated split, which was going to be a 62 percent allocation of that $32.5 million to the independent physicians, and 38 percent to the hospitals. And that split was derived based on the distribution of physicians between the two entities.
So the top of the page shows that about -- of the doctors participating in the PCF, 62 percent are independent, and 38 percent are employed by the physicians. So this was an equitable approach to allocating the $32.5 million capital infusion approved by the New Mexico Legislature.
MS. TELLEZ: And so you did say that this split will take into account the need to eradicate the hospitals' share of the deficit given the fact --
MR. LINTON: Right. So --
MS. TELLEZ: -- they were departing from the PCF in the future?
MR. LINTON: Yes.

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MS. TELLEZ: Okay.
MR. LINTON: So the 62/38 split, what that does is it takes 62 percent of the 32 and a half million and applied to bring down the independent physicians' portion of the deficit, and 38 percent of that 32.5 million goes to the hospitals. And based on that allocation, we're recommending that for the hospitals, there's an additional load of 46.0 percent built into their surcharge. And that estimate is designed to pay down the hospitals' portion of their deficit by the end of 2026.
MS. TELLEZ: Okay. Could you -- I don't know if you have already answered this, but why is it 46 percent?
MR. LINTON: It's 46 percent because we've amortized paying out the deficit over a three-year period, so from 2024, 2025, and 2026. And to bring down the deficit to zero, our model says that 46 percent for 2024 would get to that level getting the deficit down to zero by the end of 2026.
MS. TELLEZ: Okay. Is there any reason to believe this load is excessive, inadequate, or unfairly discriminatory in your opinion?
MR. LINTON: Not at this time. It is based on the current rating structure, which is also a

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reasonable set of rates. We don't believe that this is -- these rates are inadequate, this load is excessive, or it's unfairly penalizing the hospitals.
MS. TELLEZ: Okay. So is it possible that the load should be higher than 46 percent?
MR. LINTON: You know, that's a very good question. So this load assumes that there's not any favorable or adverse development on all claims that have been incurred by the PCF. So if there's additional adverse development on the claims that we have included in our analysis, and for that provision for IBNR incurred, but not reported, it's likely that this load could be increased next year. But it's also likely that if the hospitals had paid for the claim development over the next 12 months, that this load wouldn't decrease. But this load is meant to reflect an expected value, so accounting for those adverse and favorable outcomes.
MS. TELLEZ: I see. Those are all the questions I have.
Any questions from the board?
MS. LOVE: This is Kathy Love. I have a question for you. You said that this is based on the deficit being amortized over three years, and it's based on your current recommended surcharge increase.

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But if the surcharge levels aren't raised to the recommended rate, then the deficit will continue to grow, and so this will actually not cover the deficit; is that true?
MR. LINTON: That's a very good question. So if the rates are not increased to the recommended level, it's likely that our follow-up study for next year will have a higher than 46 percent load to cash up for that portion that was not accounted for in this study if those rates are increased to our recommended level, that's correct.
MR. CLARK: Mr. Chair, this is Troy Clark.
CHAIR RITCHIE: Yes.
MR. CLARK: I guess to make sure we have both sides of that equation, on the other side of that, if the outflows of the fund or the experience improves, the 46 percent next year would actually be a lower number we would be overcollecting from this. So there's the potential of it going both directions; is that correct?
MR. LINTON: That is absolutely correct. So if there's favorable claim development next year, effectively what you would see is you've overcollected in this first year in 2024. And so for 2025 and 2026, that load will be much lower because

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more than enough funds were collected for that 2024 year, absolutely.
CHAIR RITCHIE: And let me ask, and so if -- because there's also the opportunity for investment income into the fund, that if this also was greater than the expected amount -- I think you've been using 3.5 percent as an expected value there -- if that was greater than that, it would also help decrease the deficit more than anticipated here, or if it was less than that, then it would add to requiring more surcharges in the future; correct?
MR. LINTON: You make a very good point. So we do account for invested income when calculating this load, and certainly our investment assumptions are three and a half percent. But given the rising interest rate environment, there is a possibility that investment income could exceed our expectations, and that would have an impact on the load going forward.
CHAIR RITCHIE: Are there any other questions based on the addendum? Anything further?
MS. TELLEZ: Nothing further.
CHAIR RITCHIE: Okay. Thank you very much, Mr. Linton, for that addendum. I believe you answered all our questions.

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MS. TELLEZ: I'm sorry. Did we move that into evidence?
CHAIR RITCHIE: Yes, you did move it into evidence.
MS. TELLEZ: Okay. That was the CV, but not the addendum.
CHAIR RITCHIE: But not the addendum?
MS. TELLEZ: Yes. I would also like to enter the addendum into evidence as the next exhibit. Thank you.
CHAIR RITCHIE: Thank you.
After that discussion, any further discussion or objection to that? Then that's so moved.
(Exhibit B marked.)
CHAIR RITCHIE: So thank you very much, Mr. Linton. As I was saying, I appreciate the hard work.
MR. LINTON: Thank you. I'm happy to be a part of this.
CHAIR RITCHIE: And so I believe then we need to go back to the body of what's been presented to discuss anything more that needs to be discussed in these comments, et cetera, before a final draft is established by the subcommittee. And then we will

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probably have to meet very briefly to approve that draft to make this official. And that board meeting is already set up.
So there are comments on here from Mr. Dekleva, who is not present, Mr. Clark, Mr. Vargas.
Mr. Clark, do you want to go first? Do you have any on your comments so far, and have we really reached all those?
MR. CLARK: Thank you, Mr. Chair. This is Mr. Clark for the record.
On Item No. 24, I believe it's Page 4 of the report, the paragraph starts, "Should the New Mexico Legislature allocate the 32 and a half million dollar infusion 50/50 to the hospitals," this is reiterating, I guess, the facts that come out of the report earlier. We just had a discussion about the addendum of how it will be allocated. But I don't believe the New Mexico Legislature is who would allocate it, that that authority sits with the Superintendent, and that's the recommendation that we made.
So my comment was, I believe this should read, "Should the Superintendent allocate," not "Should the New Mexico Legislature." The New Mexico

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Legislature provided funds with no reference to any form of allocation. So it's my recommendation that it should read, "Should the Superintendent who would make that allocation of the funds that she received."
CHAIR RITCHIE: I believe that accurately represents the current, although certainly the Legislature could earmark them differently if there are further infusions in the future.
MR. CLARK: Mr. Chair, that's correct if there were in the future. But I believe line item or -- right, No. 24 is specifically relating to the 32 and a half million which was granted and funded in the past legislative sessions, and that's already been done. Therefore, it's in the hands of the Superintendent to determine the allocation of that 32 and a half million.
CHAIR RITCHIE: Does anyone understand that differently or have another comment? I think everyone agrees with that, that that's a simple change or clarification.
Did you have another comment on here?
MR. CLARK: I believe the only other comment I had on the draft -- we made it to Item No. 30. I'm sorry. After Item No. 30, it would be Subsection A of the actual recommendation, which I

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think is a point of discussion from this group, I believe. My recollection is we had multiple discussions about not the first part of the paragraph where we say that the PCF charges for independent providers should be increased by 14.4 percent, and how we get there be it the 18.9 less the batch claim. I don't think that's under discussion.
I think what was under discussion amongst this Board last time we met was the additional language saying that we recommend that the Superintendent take into consideration. I think we settled on both sides of the tension; both that higher rates may cause additional departures from the fund, but also that undercharging or underassessing of a surcharge may cause further underfunding. But those were the two tensions that were out there.
There were discussions along the way about a specific number and only the first part. I thought we came to an agreement at the end in the meeting, and I think the minutes reflect that the agreement was to include both sides of the tension without a specific number. That number historically being presented was 10 percent.
MR. MARTINEZ: This is Mr. Martinez. I agree.

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MR. AUTIO: Sorry, Kathy, or whoever that was.
MS. LOVE: Go ahead.
MR. AUTIO: This is Nick Autio. I think, you know, I added some of this language. I know Mr. Vargas has an issue, I believe, with the last sentence, which really, you know, what I think needs to be made clear -- and I'm happy to discuss and work out the language -- but I do think we need to make it clear that we are not -- for the Superintendent's purposes that we are not offering a recommendation that we levy a deficit surcharge on the independent providers. I don't want to leave that blank.
I think because we are advising the Superintendent on the surcharges, we need to include that, and I think it's helpful in our role as advisors to provide her with a basis for that. That evidence specifically came out through Dr. Adams that can be seen at Page 6 and Page 9 of the first transcript which includes a reference she actually read former Superintendent Cole's prior order on this issue into the record. I'm happy to discuss that, and we can revise it, as needed, to satisfy everyone.
MR. VARGAS: This is Ray Vargas. I guess my concern with adding that, and particularly the

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last phrase, is that the purpose of this was to lay out the competing tensions, and I think that last phrase leaves out the competing tension of risking failure of the fund and leaving patients without compensation when they've been injured. So if we're going to put that last one in, I think we need to be consistent and put the competing tension of risking the fund's stability and ability to be there to answer for claims on behalf of patients.
MR. AUTIO: This is Nick Autio. Mr. Vargas, I don't disagree that the agreement was to highlight that tension. We can, you know, try and you know, put in some language there, or we could simply -- you know, if the Board thinks it would be appropriate, we could simply clarify that a deficit surcharge is not being assessed against independent -- or we are not recommending an excessive surcharge be assessed against independent providers and leave it at that. I'm happy to work on that language with you, though, Mr. Vargas.
MR. VARGAS: I think that would satisfy the concern if we just put a period after the words "independent providers" and leave out the phrase because of the additional surcharge.
MR. AUTIO: Yeah, that's -- I mean, I

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wouldn't object to that. You know, I think that the tension is captured in the sentence before that which tracks the agreement we had. So I think if we put that period after "independent providers," it could revise this issue -- or resolve this issue.
MR. CLARK: Mr. Chair, this is Mr. Clark. Can I make a suggestion that I think is consistent with what we all intend, and if we're going to do that, that we make it say something to the effect of a deficit surcharge is not recommended to be assessed against independent providers this year? I don't think any of us have made any discussion that we don't think it ever ought to be. I think our discussion is around this year. So I would propose that maybe we add those two words before we put the period after the word "provider."
MR. VARGAS: This is Ray Vargas. I think that's appropriate.
MR. AUTIO: No objection.
CHAIR RITCHIE: I don't hear any objection to that.
Ms. Love, did you have a comment?
MS. LOVE: It's all been captured. Thank you.
CHAIR RITCHIE: Great.

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Mr. Clark.
MR. CLARK: Mr. Chair, that's the end of my comments.
CHAIR RITCHIE: Okay.
Mr. Vargas, did you have something additional?
MR. VARGAS: Not at this time. I just -- well, basically, all I would add is that, obviously, we would need to have a recommendation for "d," which we agreed to by motion today, so I will work on that and circulate it over the weekend so that everyone has it well in advance of the next meeting.
And let me take a look at my notes and make sure we don't need to add. We might need to ask something in the numbered paragraphs based upon the addendum information that was provided to us today. And so if everyone is agreeable to that, I will attempt to do that as well.
MR. CLARK: Mr. Chair, this is Mr. Clark. I'm in agreement with that and might suggest again where I made comment earlier before either as part of No. 24 or as a 24 and a half, 24a, the concept that should the -- because, ultimately, the Superintendent will make this allocation and the decision on it. But given that we have got the presentation of the

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addendum that we as a board are referring on recommending, that may be the appropriate place either within that paragraph or a new paragraph to make reference to that addendum.

MR. VARGAS: This is Ray Vargas. I agree.

CHAIR RITCHIE: Okay. So I believe that's everyone that put in comments out of the committee.

Then does anyone from the Board have any comments on this initial draft? Any other comments from anyone on this draft, because that's what we're here for is pushing this draft forward until we get a final draft?

MR. MARTINEZ: Mr. Chair, this is Mr. Martinez. I know you were talking offline just before the meeting had started about probably like a comment in either including that in with this draft or with our report to the Legislature. Do we want to formally talk about that?

CHAIR RITCHIE: We're going to have to have another meeting to finalize that report to the Legislature. That's what we did last year.

MR. MARTINEZ: Great.

CHAIR RITCHIE: We typically have it after the Superintendent's final decision because that, obviously, is part of that draft.

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MR. MARTINEZ: I'm sorry. This is Mr. Martinez again. Do you want to make any of those comments to be included in our recommendations to the supervisor -- or Superintendent? Sorry.

CHAIR RITCHIE: I don't think -- I think that our advising of the supervisor -- now you got me doing that.

MR. MARTINEZ: That's my fault.

CHAIR RITCHIE: I think our charge in advising the Superintendent of Insurance really is addressing what we have addressed so far. And perhaps the only additional I think we covered somewhat is that if there is more opportunity for more investment, because that was brought up by the actuary even, that that may be a way to help mitigate some of these future increases or to try to mitigate the deficit.

I think that that's in the record, although, you know, the committee can discuss whether we want to put anything in there or not. But it's certainly in the record already. I think that other comments or other advising or, you know, further discussion might be in what we present to the Legislature.

MR. MARTINEZ: Okay. Thank you.

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CHAIR RITCHIE: Any further comments? So we have pretty much gone through 2, 3, 4. The committee is coming up with the final recommendations.

Regarding the actuarial analysis, I think we have heard a lot that we have given to Mr. Linton and to Integrion about further data we want that we feel like we really need to do a better job of this in the future and become more accurate. Are there any comments on other ways that we can make it more accurate in the future or easier to accomplish what we are set up to do?

MR. AUTIO: Mr. Chair, I would appreciate it if the actuary next year could devote some time to looking at, you know, what we could do with investment income, if the funds were invested, whether that's looking at different percentages, different amounts invested, and analyzing what would be an appropriate amount to invest, and looking at some of the returns we could get on that, and then also looking at the impact that could have on surcharges. I think that would be helpful for us and the Superintendent.

CHAIR RITCHIE: I would add to that the experience from other states because we did hear some

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testimony how it's being done in other states and the investment income, et cetera, from other states and the impact. So that is the record, but I would like to see that more formally done. I agree.

MR. CLARK: Mr. Chair.

CHAIR RITCHIE: Yes.

MR. CLARK: This is Troy Clark. Just to get it in all one place, we had significant discussion. But the collapse, I think, in the Board's discussion about more focused efforts on the outpatient healthcare facility and pulling that data both from other states and from our own participants in the fund.

CHAIR RITCHIE: Does anyone else have any more comments, feedback regarding the actuarial analysis?

MR. AUTIO: Mr. Chair, if they could put it in English next time, it would be helpful.

MR. CLARK: And larger font.

CHAIR RITCHIE: Mr. Linton.

MR. LINTON: This is Danny. So in regard to the investment income, we do provide sensitivity analysis to what impact the returns would have on the PCF in terms of commenting how much, how much to invest, or how much capital to deploy, that's part of

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the Board's decision. But we can provide guidance to the sensitivity to returns on the study, which we do include in the report. I just want to make sure that we're on the same page of what is expected from us and what we can provide to the PCF.

CHAIR RITCHIE: And I think, yeah, if you have more information like you say you have experience from other states and other funds, if you have data on, you know, how much of their fund they have invested, what percentage they have invested, the impact it has on the fund, I think that that's part of what we're looking for.

MR. LINTON: Okay. So it sounds like you want more benchmarking against what other funds are doing?

CHAIR RITCHIE: I'm sorry. What was that? Go ahead.

MR. LINTON: Just to confirm, it sounds like you're looking for more benchmarks and what the other funds are doing?

CHAIR RITCHIE: Correct. And if they have an investment policy or, you know, how they handle that, and what their benchmarks are, precisely.

MR. LINTON: All right.

CHAIR RITCHIE: Okay. Any other comments?

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MR. CLARK: Mr. Chair, I think one final comment from me, and I would hope the Board would concur with this, but a big thanks to Mr. Vargas for taking the time to be the main drafter on this recommendation that's already been done ahead of time. Somebody has to step up and be the initial shot at it, and he's done a great job.

MR. MARTINEZ: I very much concur.

CHAIR RITCHIE: Yes. I think that's unanimous, Mr. Vargas. Thank you.

MR. VARGAS: Thank you-all.

MR. CLARK: For several years in a row now.

CHAIR RITCHIE: Exactly. This is not the first year.

Mr. Ward.

MR. WARD: Are we done with taking evidence with respect to the next hearing?

CHAIR RITCHIE: Yes.

MR. WARD: Meeting?

CHAIR RITCHIE: Hearing no objection to that, yes, we are done with that.

MR. WARD: There won't be on the agenda a line item for taking any additional evidence?

CHAIR RITCHIE: Correct, for the next agenda, yes. For the next board meeting, I don't

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believe anybody needs more evidence. It is strictly to discuss and confirm or vote on the submission to the Superintendent.

MR. WARD: Great.

CHAIR RITCHIE: That's the only item on the next agenda.

MR. CLARK: Mr. Chair, just to reiterate that. I think Mr. Vargas has our input of what changes to make?

CHAIR RITCHIE: Right.

MR. CLARK: The next meeting's agenda is simply to confirm that how he put those into English in larger font is consistent with what we directed him to do so today?

CHAIR RITCHIE: Correct. And the other agenda item would be setting the date for the meeting after that to compose the report to the Legislature.

MR. WARD: We'll have a next meeting date agenda item?

CHAIR RITCHIE: Correct.

I want to thank everyone's participation in that, not just Mr. Vargas, but Mr. Vargas deserves special mention for, you know, appearing at this even virtually, everyone's hard work on it. We are done a little bit earlier than I anticipated, which is

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always awesome. I'm sorry you have to put up with a surgeon chair that's always pushing things to go faster, and we will all meet again.

The date and time, please, Debbie?

MS. LUERA: October 26 at 1:00; is that right?

CHAIR RITCHIE: Yes. So the next meeting is October 26 at 1:00 p.m. for everyone to hear it again. Obviously, e-mails will be sent out.

So then we will adjourn the meeting. Thank you, everyone.

(The meeting adjourned at 10:36 a.m.)

STATE OF NEW MEXICO)
) ss
COUNTY OF BERNALILLO)

REPORTER'S CERTIFICATE

I, Susan M. Hilton, New Mexico Certified Shorthand Reporter, DO HEREBY CERTIFY that I did report in stenographic shorthand the testimony set forth herein, and the foregoing is a true and correct transcription of the proceeding had upon the taking of this hearing.

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 whatsoever in the final disposition of this case in any court.

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PATIENT'S COMPENSATION FUND ADVISORY BOARD MEETING
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ATTORNEY: MS. DEBBIE LUERAS
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