NEW MEXICO

OFFICE OF SUPERINTENDENT OF INSURANCE

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In the Matter of Meeting of the Patients' Compensation Fund Advisory Board

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AUGUST 2, 2024
1:00 p.m.
6200 Uptown Boulevard Northeast,
Fourth Floor
Albuquerque, New Mexico 87110

REPORTED BY: JULIANNE L. BEATTY
CCR 201
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A P P E A R A N C E S

(Appearing In Person:)

William Ritchie, MD
Annie Jung
Nick Autio
Ray Vargas
Barry Berenberg
Stephen Thies
Colin Baillio
Debbie Luera (Integrion)
Jennifer Fetherolf (Integrion)
Carmela Starace
Alfonso Martinez
Troy Clark
Vince Ward

(Appearing by Zoom:)

Ellen Stevens
Robert Underwood
Sofia Cerna
Timothy Vigil
Kathy Love
Placido Gonzales
Adam Douma
Michael Dekleva
Todd Williams
Stephanie Maez
Devin O'Brien
Chris Dewald
James Willett
Robert Walling

ALSO PRESENT:
Jenn Romero

(Open Meeting, 1:05 p.m.)

DR. RITCHIE: Let's call this meeting to order. Thank you everyone for coming on a Friday afternoon. We'll make it effectively short and sweet, hopefully. So let's start with roll call, please.

MS. LUERA: Dr. Ritchie?

DR. RITCHIE: Present.

MS. LUERA: Vice-chair Love?

MS. LOVE: Present.

MS. LUERA: Mr. Autio?

MR. AUTIO: Present.

MS. LUERA: Mr. Vargas?

MR. VARGAS: Present.

MS. LUERA: Mr. Martinez?

MR. MARTINEZ: Present.

MS. LUERA: Mr. Clark?

MR. CLARK: Here.

MS. LUERA: Ms. Starace?

MS. STARACE: Present.

MS. LUERA: Ms. Stevens?

MS. STEVENS: Present.

DR. RITCHIE: Okay. Great. Thank you very much.

MR. DEKLEVA: I didn't hear my name.

DR. RITCHIE: Mr. Dekleva?

MR. DEKLEVA: Yeah, I'm here.

MS. LUERA: Oh, hi, Mike. Sorry.

DR. RITCHIE: You just come under a phone number. Sorry.

MR. CLARK: He's been reduced to a phone number.

DR. RITCHIE: Yes. Okay. So next order of business, approval of agenda. Does anyone have any additions, subtractions, comments on the agenda?

Well, I do. We've been asked to possibly let Mr. Walling go a little earlier since it sounds like he's way out of the country and many time zones ahead of us and can actually go ahead with the Pinnacle study from the start. Does anyone have any objection to that? Okay.

Mr. Walling, are you okay with that too?

MR. DEKLEVA: (Indicating thumbs-up.)

DR. RITCHIE: All right.

MR. THIES: Mr. Chair?

DR. RITCHIE: Yes.

MR. CLARK: One quick question. I don't know if it falls under No. 5 or if there needs to be an adjustment to the agenda. There was a notice of a rule change, a proposed rule change by OSI regarding the PCF board. Is that to be included in what is No. 5 or is that going to be discussed today?

MR. THIES: We can discuss the subject as long as it doesn't change the process. Right now I think the

current rule doesn't mirror what the OSI do to adopt rules, and what we're doing is we're modifying the OSI process procedure for adopting rules, and then we're going to adopt the same thing for the PCF.

MR. VARGAS: I think we need to have it on the agenda as public notice if we're going to discuss this. It sounds like a bigger thing.

MR. BERENBERG: And there's a separate hearing on that through OSI, if I'm not mistaken. Right?

MR. THIES: Yes. Right now there's a separate -- well, you still have the same hearing where you adopt those recommended surcharges, but we've got September, November. The change for other type of rules, it is going to mirror what we adopted with the OSI.

COURT REPORTER: Could I ask you to speak up, please. I'm having a hard time hearing you.

MR. WARD: Do you think it's relevant the recommendations?

MR. CLARK: I don't. I read the emergency rule. I really couldn't tell what it was doing and so I was hoping it was being addressed today since it effects the PCF board. I don't know if it's immaterial or not. So, Mr. Chair, if that's what we're hearing is, it's matching the procedure with policy, I think I'm okay, if the other board members are okay, to hear about it at our next meeting. But I think

we do need to hear about it.

MR. VARGAS: When is that hearing?

MS. ROMERO: That hearing is scheduled for August 16th.

DR. RITCHIE: Two weeks.

MR. VARGAS: Yeah.

DR. RITCHIE: So when is that other hearing?

MR. CLARK: Actually, Mr. Chair, if I could ask our counsel if this is merely an update to us, would that violate anything -- the public notice if we were to ask for a simple update today or an explanation of what it was to happen today?

MR. WARD: Probably --

MR. CLARK: Since it's not something we're not voting on.

MR. WARD: I'm uncomfortable that it's not on an agenda, let's put it that way.

MR. VARGAS: Sounds like we need to go to that hearing.

MS. ROMERO: If the Board requests, I can send you a copy of all the proposed rule changes after the meeting.

MR. CLARK: I think maybe I'm not the smartest one on the Board.

MS. LOVE: So this is Kathy Love on Zoom. I'm real sorry, but it's nearly impossible to hear what's going

on in at that room. I would have liked to be there in person, but I'm out of state, so I apologize.

MR. CLARK: Kathy, can you hear me?

MS. LOVE: I sure can now, Troy, when you lean in.

MR. CLARK: The question was whether we needed to add an item to the agenda because there has been -- we have found notice of a proposed emergency rule by OSI that has some involvement with the PCF hearing process. I asked if that was to be a part of what was listed under the agenda today. It is not. And our counsel has said he's uncomfortable for us to add it to the agenda without the public notice hearing.

And then we had a discussion that the actual hearing for that rule, I think, was said to be August 16th.

Anything else I need to summarize for Ms. Love?

So we're trying to figure out whether we need -- what we need to do from here so we at least have an idea of what that rule includes.

MS. LOVE: Thanks, Troy. I did see that proposed amendment come through, and I didn't have any issues with it. It didn't really strike me as anything that was particularly concerning for the Board in terms of our oversight, but certainly if others want to have some kind of a report on it, you know, I don't have a problem with that.

DR. RITCHIE: I think there's a hearing to go to.

MR. CLARK: You-all heard it. We each individually can go to the hearing if we want to have interest in it.

DR. RITCHIE: I think that's -- are you comfortable with that, Kathy?

MS. LOVE: Yeah, I think that's totally appropriate. I don't really have any issue with the proposed changes anyway.

DR. RITCHIE: Okay.

MR. CLARK: I don't have any issues on proposing changes to the agenda. Thank you.

DR. RITCHIE: Okay. So then approval of minutes. Anyone have any additions, subtractions to the minutes, comments?

MR. CLARK: Motion to approve the transcript as submitted.

MR. VARGAS: Second.

DR. RITCHIE: Thank you. Any dissension? Okay. Then that -- they are so approved.

Then we will skip down to No. 4, and hear straightaway from Mr. Walling and the Pinnacle study to help make it more efficient for him.

So, please, Mr. Walling.

MR. WALLING: I greatly appreciate the consideration. Just as a point of clarification, has our

draft report been distributed to the committee?

DR. RITCHIE: Yes.

MR. WALLING: Okay. What I'd like to do is break our discussion into several bite-sized pieces to deal with this element. Let's start, if you don't mind, with the physician reserve level. And, in particular, where I'd like to go is to Exhibit 1, page 4 of the supporting exhibits to the report.

What's contained in this exhibit is a comparison of the paid losses as of year-end 22 versus year-end '23. Also a comparison of our selected ultimate losses by absent year -- between the year-end '22 analysis and year-end '23 analysis, and then the implied discounted reserves between the two studies. What you will see -- and I'm going to focus on the right-hand side of this exhibit for our discussion this evening -- is that --

MR. CLARK: Mr. Walling, if you could hold on. I don't know if you could share screen to help direct us or give us a moment so we can all figure out what schedule you're on.

DR. RITCHIE: This is what it looks like. It's towards the back. It's 36 of 85.

MR. WALLING: Okay. So what you'll see as the kind of first important number here is that the independent physicians and surgeons' claims that were closed during 2023

paid out an incremental paid loss amount of 12-and-a-half million dollars. So that's in the Difference part of the tab, right-hand side, and it's the paid -- the "NMPCF Paid Losses" column. Does everyone see the 12-and-a-half million?

DR. RITCHIE: Yes.

MR. CLARK: Yes.

MR. WALLING: Okay. In relation to that, there were changes in our selection of ultimate losses by year. So, for example, you'll see our estimate for -- what is that? -- 2017 dropped by a little bit more than a million dollars, and the 2018 number actually increased by almost 1.2 million. Again, that's in the Difference right-hand side of the table under the "Ultimate Lost" column.

And you'll see that for all of the prior years, so not including 2023, the total change in ultimate losses for the physicians and surgeons was a decrease in ultimate losses of about $300,000. That's favorable development. And you might ask yourself, Well, Rob, if we had 12-and-a-half million dollars of payments, why didn't we see a bigger decrease in the ultimates? And the answer, quite simply, is, we're seeing some mixed signals in the data. The incremental payments were quite good. However, we also saw a total of 50 claims closed during the year. That could be interpreted a couple different ways. It can be interpreted

that claims are getting closed faster, and that's a positive. It could also be interpreted as we're seeing more claims than we would have anticipated.

And so there's a little bit of mixed signal in the 2023 claims data. The 12-and-a-half million dollars of payments are real positive. The 50 closed claims still remains to be seen exactly what that is, whether that's deteriorating frequency or actually an acceleration in payments. But it's something we're closely monitoring as we see the claims now pretty much in the late teens and early 20s starting to get paid.

Most of that incremental shift is in the preCOVID years. So it's 2017, '18, and '19 that we're seeing a lot of claims settlement activity on the physicians. But the fact remains that our ultimate losses for the physicians side of the house decreased by about $300,000. That's a slightly positive favorable development. We have new ultimate losses for the 2023 year of just shy of $20 million. The net effect of that is the ultimate losses go up by 19-and-a-half million dollars, and the reserves go up on an undiscounted basis by about $7 million; on a discounted basis by about $7.8 million.

So the reserves keep increasing, and then part of the reason for that, quite candidly, is inflation. Part of it is the nature of the act that as claims cost increase, but

also as the limits of coverages for the PCF continually get that cost of living on an annual basis, there's going to be an incremental increase in the reserves. And so all of this is pretty much in line with expectations and in line with the study we did last year. Okay.

Let me pause there and ask if there are any questions about the physician side of the house, just when it comes to reserves. I promise I'll get back to the raise.

DR. RITCHIE: So with that cost of living adjustor that is compounded every year, that's requiring higher and higher reserves to cover that, resulting in higher and higher reserves.

MR. WALLING: Yep. And we see that impacting the assessment levels. We see that -- and we'll get back to that when we get to -- when we get back to the rate side for the physicians, because, basically, on an annual basis, continually increasing the coverage limit for the PCF requires about a two-and-a-half percent rate change or assessment change before you look at the experience. So think of that cost of living adjustment as just simply a constant drag of about a two-and-a-half percent inflationary increase in the assessment levels, all other things being equal, if there's no indicative rate in the experience. Does that help?

DR. RITCHIE: Okay. So no matter what we do

practically, it will always go up at least two-and-a-half percent a year?

MR. WALLING: Unless there's better than expected experience. I would say if -- if we get to next year and those 50 closed claims were really in acceleration in payments and not an increase in frequency, you could have an indicated rate decrease. But it's always going to be offset by that two-and-a-half percent inflationary push.

DR. RITCHIE: Okay.

MR. CLARK: Mr. Chair, this is Troy Clark. Question: As you look on that schedule in the first column, the ultimate losses for 2023 at 19 -- almost 19.9 million, how many providers? Did we have an increase in providers? A decrease in providers? Because I think that's the second highest number or the second highest calculated loss reserve amount. And, obviously, dependent upon if that's a greater number of providers, a less number of providers, could be even a better signal or a worse signal of trend, right? And I believe I heard that we lost 4- or 500 providers last meeting.

MR. WALLING: You gotta remember the amount of rate increase that has passed through the program in the last three years. So I agree that the number of insured providers drives that surcharge number, but recognize that even with a decrease in number of covered providers, we're

seeing a steady increase in the collected surcharges largely as a function of the rate increases. The total surcharges collected on the independent physicians and surgeons last year was 16.9 million, which is the highest level of surcharge collections in the history of the program.

MR. CLARK: Maybe let me ask the question a different way. I think you answered down a different path. The $19.9 million in ultimate reserves must reflect an increase in the expected ultimate losses for the group of providers for 2023, since you have the second highest ultimate loss reserve with a lower number of providers. Is that correct?

MR. WALLING: Let me repeat what I just said. It's the highest level of practitioner surcharges in the history of the program. So even if the number of covered providers is dropping, the indicated losses per covered provider continues to increase. So what's driving this isn't the shared number of practitioners; it's the expected losses associated or the surcharges associated with those practitioners.

MR. CLARK: So is that because of the four different options of methodologies you used, the most current is based off of collected surcharges?

MR. WALLING: No. That -- surcharges is the best measure of exposure that we have. It's -- it better

reflects the combination of the number of practitioners and the expected losses per practitioner.

DR. RITCHIE: And have you looked at -- I'm sure it can be looked at -- if those are due to a frequency of losses or the size magnitude of the losses?

MR. WALLING: In the appendices you will find a detailed analysis of both frequency and severity for the -- in the physicians and surgeons. Contained in the appendices 1 through 6. There's a detailed analysis of both the claims frequency and the claims severity.

DR. RITCHIE: Okay. In those appendices, do you refer to -- or do you have data on the number of providers, covered providers?

MR. WALLING: Nope.

DR. RITCHIE: So how do you figure the number of cases -- so you can't figure the number of cases per provider.

MR. WALLING: Because we have the collected surcharges.

DR. RITCHIE: Okay. All right. Any other questions?

MR. CLARK: Can I try one more?

DR. RITCHIE: Yes. Go ahead.

MR. CLARK: Mr. Walling, if I can go to Exhibit -- I don't know which order it is. It's titled Exhibit 2,

independent physicians surcharges including back claim selected losses. This is the schedule that has the four different methodologies, the B-F Method, the Expected Loss Ration Method, Paid Development Method and Frequently/Severity Method. And then, ultimately, you have the Selected Ultimate Losses. For those in the room, it's page 38 of 85, I think.

DR. RITCHIE: Yes.

MR. CLARK: Under the Expected Loss Ratio Method, which is, I believe, from previous presentations you have had, we see under 2023 the 19.89 million, and we see that under, also, column 8, is the Selected -- we see that same selected -- column Selected in the Ultimate Selected Losses for the past three years, which I believe is based on the ratio of surcharges that you were saying. And then prior to that, some of the other methods become more accurate, I guess, or more acceptable in your actuarial estimate. That's why you see under column 8 different rates used. Is that correct that the most current three years is based off of that expected loss ratio method?

MR. WALLING: And the reasoning, quite simply, is that for the '21, '22, and '23 year, a sum total of two claims have been closed. So as a result, none of the other member -- none of the other methodologies have any predicted accuracy for the most recent three years.

MR. CLARK: I follow that and I agree. Since you have no experience going through on those, the best estimate is your surcharges, and I think your previous answer to my question was, your best estimate of the future, the reason that number is high is because the surcharges are high, and that's the methodology that's most accurate for the first --

MR. WALLING: I don't agree with your characterization that it's high. For example, if you look at appendix 1, page 2, you will see that I'm basing those three most recent years on an expected loss ratio of 117.5 percent.

As has been identified, that method carries the water for the three most recent years. It is also substantially lower than the loss ratio for the 2017, '18 and '19 years. Now, obviously, and we've talked about this in the past, there's a lot of fluctuation in these loss ratios over time. There's a certain amount of cyclicality to the PCF loss ratios as well. But, no, I don't agree with the characterization that they're necessarily high.

MR. CLARK: No further questions.

DR. RITCHIE: Okay. All right. Thank you.

Mr. Walling.

MR. WALLING: Okay. If we go back to that Exhibit 1, page forward, where we're looking at the comparison between the '22 and '23 analyses for the

physicians and surgeons. And go forward a single page. This is the same exhibit, Exhibit 1, page 3. It's the same layout. It's the same format. But -- oh, sorry. Sorry, sorry, sorry. I apologize. I need you to go back a page to Exhibit 1, page 5.

Okay. Exhibit 1, page 5 is an identical analysis of the hospital program. The hospital program, again, if you go over to the incremental Paid Losses, you'll see that incremental payments on the hospitals were 28.4 million. That's noteworthy to me, because if you look over at the far left-hand side, the ultimate losses for the hospitals, we're talking about numbers in the low 40 million-dollar range. And so the fact that we saw paid losses for the hospitals of $28 million and change relative to kind of a current run rate of 40, is a really positive sign.

And, in fact, you'll see that the ultimate losses prior to the 2023 year, actually, it came down by $12.9 million. I don't have a lot of good kind of underlying cause on this, but it's certainly a positive sign. The fact that we're seeing some favorable developments of the estimated ultimate losses for the hospitals, I view as a real positive. It's something that is certainly a positive for the financial health of the fund. It's certainly positive news for the runout of the hospital program as well. So, candidly, pretty good darn

news as it relates to the hospitals, just looking at the incremental changes that we saw during 2023.

That Exhibit 1, page 3 that I errantly guided you to is the combination of those two. You'll see that ultimate losses came down by about $13 million, which is a positive, and that the total reserves in the bottom right-hand corner increased by about 26 million on an undiscounted basis, 28.8 million on a discounted basis.

If we go forward to -- let's go up to about six pages forward, the very first exhibit; so it is called "Fund Summary," page 1. This is a composite summary of all of the stuff that we've just looked at in terms of the estimated reserves for the two programs are shown in column one. The ultimate physicians reserves are $78 million and change. The hospital reserves are 214 million. When you discount those for the time, that value of money, you bring each of them down a little bit to reflect the investment being generated by the funds.

When you compare it to the fund balance, as we've looked at in the past, you'll see that there's still, I don't know, depending on how you look at it, undiscounted or discounted in columns 5, 6 and 7, something on the order of 17-and-a-half to 18-and-a-half million dollar deficit for the independent physicians and surgeons and still something in the low $50 million range on the hospitals.

This exhibit also reflects the $35.9 million legislative infusion. You'll see that that actually eliminates the independent physicians deficit. We're actually showing a negative deficit, which I know is a weird way of showing it, but, essentially, if you think about the independent physicians and the hospitals is kind of two separate accounts, the independent physicians is actually showing, essentially, a positive balance, and the hospitals are still showing a 52 to $55 million deficit.

As a result of that, you'll see that down below the deficit surcharge for the hospitals is shown, but you'll also see that that's on the order of between 26 and, say, 23.7 percent of the otherwise indicated surcharges, which actually reflect the favorable improvement in the hospital reserve. So we are seeing the benefit of that $13 million takedown in the indicated reserves.

Let me pause there and see if there are questions.

Okay. Let me change gears a little bit and let's go over to the raise. The raise -- and I'll do physicians again -- are found on Exhibit 4. And for our purposes, I'll go to Exhibit 4, page 2. What you'll see --

DR. RITCHIE: Page 42.

MR. WALLING: Thank you. It's entitled "Indicated Rate Change Effective 1/1/25 through 1/1/26 Using Expected Value Losses Independent Physicians and Surgeons." For the

purpose of projecting forward-looking surcharges, we take the historical surcharges and adjust them for all the previous rate changes that have been implemented. We also take our selected ultimates and adjust them for next year's limits of coverage, which is shown in column 4, and you'll kind of see that upward sticking in the cost of living index. And you'll see that you end up with trended loss ratios over in column 6 that range from a low of 56.6 percent back in 2015 to a high of 179 percent in 2018, with a blended average that looks like something on the order of 120 percent.

If you select that 120 percent -- or that 120.6 percent as what you think next year's loss ratio is going to look like prior to any rate changes, that produces undiscounted losses in row 9 of 23-and-a-half million dollars. If you compare that to -- well, if you adjust that for loss expenses for the time value of money and overhead charges, you need to generate $21.68 million in income or in surcharges. So if we're at 19.5 and we need to get to 21.6, the difference there is an increase in assessment levels of 11.1 percent.

So if you go forward a page to Exhibit 4, page 1. You'll see that same 11.1 percent as the indicated assessment level surcharge for 1/1 of '25. You'll see an offset due to changes in class plan. Every year we get

through the process of evaluating how the class -- the physicians specialty rating factors for each of the specialties compares to patient compounds but also compares to the class plans of the leading carriers in the state.

We use that, then, to look at what we identify as potential dislocations. It gives us the ability to propose some suggested changes based on what we've seen. Sorry, I'm having a little technical difficulty. We proposed a few small changes in individual class assignments. Okay. We proposed, looks like about a dozen, potential changes in classes. In total, there were four classes that were going to experience premium decreases. The largest of those was pediatrics without surgery, who were going to go from class 3 to class 2, a decrease of about 16 percent.

Same thing for pulmonary diseases without surgery, a decrease of 20 percent. And dermatology going from class 2 to class 1, a 25 percent decrease. Offsetting that, hospitalists, we're looking at an increase from class 2 to class 3. And that's really -- and the other cla- -- the three neurology classes that are nonsurgical classes for neurology are all moving up from class 2 to class 3. So they're all seeing an increase. But the net effect of that -- and that's on page 18 of the report if you want to see the detail -- but the net effect of that is that you don't need as much base rate increase.

And so as you can see on that Exhibit 4, page 1, what actually you -- putting an offset in the decrease of .7 percent. There's that 2.4 percent in column 3 that relates to the increase in coverage limits for the PCF. And so the product of columns 1, 2 and 3, the 11 percent minus the .7 percent in the positive 2.4 percent, is an indicated rate change, a rate increase of 13 percent for the physicians.

The second row there is simply stating that same indication at a higher level of the physical confidence as stated at a 75 percent confidence level. And you'll see that pushes the indicated rate change to 20.5 percent, and the indicated rate change after the class plan change and the increased limits change to 22.6 percent.

So any questions about the indicated physicians change?

Okay. If you, again, go back a few pages to Exhibit 6. And, again, I'll point you to Exhibit 6, page 2. Same exhibit, same format, same issue. What you will see is that the loss ratio, once you adjust the hospitals to the current surcharge levels, actually is producing loss ratios that are a bit lower; so at 106.5 percent.

After some hiccups in the early years when there were only a couple of hospitals, the loss experience relative to the surcharges, at current surcharge levels, and I want to

make that really, really clear. If you look at the loss ratios at the prior surcharge level, the loss ratios aren't this good, aren't this low, but we've taken several significant rate actions to the hospitals.

So relative to the current hospital surcharge level, we're actually indicating a decrease of 1.9 percent. Now, remember that that decrease is prior to any issues related to the deficit surcharges. If you look at the next page, again, we stated at a 75 percent confidence level and it suggests a 6.5 percent increase. If you go back to Exhibit 6, page 1, you'll see that there's no class claim change, there's no increase limits change. And so the minus 1.9 percent without the risk margin and the plus 6.5 with the risk margin is what it is. And the deficit surcharge that's shown in column 4 comes from that deficit surcharge calculation up in the summary; so all of that.

I'll pause again and see if there are any questions about the hospital assessment change.

MR. CLARK: Mr. Chair, one question on the hospital assessment changing. In the executive summary you note -- I don't know if you want to cover this elsewhere, but it affects the rate -- the implication of amounts for batch claims since it's not covered separately. Can you guide us to how much of that 1.9 -- negative 1.9 percent was attributable to an inference of batch claims, I guess you

would say?

MR. WALLING: Well, the analysis that we do of the indicated rate change -- you asked me the same question last year, and I don't remember the answer.

MR. CLARK: I didn't like the answer last year, so I'm hoping for a better answer.

MR. WALLING: Yeah.

MR. AUTIO: Just keep asking.

MR. CLARK: Maybe while you look for it, let me ask the question that you're looking for the exact number. If we're estimating future losses based off the hospitals' experience and run rate and collection of all the hospitals' -- that's hospitals with extra apostrophe at the end -- experience and rates, that would include all future claims. So why would we be adding an extra increment of batch claims when we're already estimating the total exposure?

MR. WALLING: We're not double counting. And the issue is, is that we -- for the purpose of -- the only place we use the -- that we cull out the batch claims is actually in the rate level indications. And the rate level indications are pulling data -- I need to double-check this, but I believe the answer I came to last year is that the projected ultimate losses exclude the batch claims in the indications, and in the indications only. So in Exhibit 4

and Exhibit 6 only.

And as a result of that, we have brought the batch claims in as an expense load. I'm going to ask your deference, because I'm in Copenhagen and I need to confirm that that's true. But I know we had a question about the batch claims versus treating them as a reinsurance cost, and I know I got an answer that I was satisfied with last year. So I'm going to ask your indulgence and give me a chance to double-check that that's correct, rather than me trying to do it in realtime while the Board stares at me.

MR. CLARK: Not a problem. And it was included last year in the rate -- the buildup of the rate of charge. I guess the follow-up to that might be -- and maybe it's a question to you, maybe it's to Integrion -- what exactly would we be defining a batch claim for a hospital as? Because a batch claim makes sense to what it would apply to the physicians as where they have a limit of three claims per year, but due to circumstances that are not allowed in the, We only pay the first three, but we decided to pay these batch claims. I don't know what the definition of a batch claim would be on a hospital, because there is no such limit. And that's why I still have this feeling that it is being double counted, because if you removed it, what did you remove. And if we added it back in, what are we adding back in. Because there's really nothing that definitionally

defines what a batch claim would be on a hospital.

MR. WALLING: Got it. I appreciate that as a takeaway, and I will get back to everybody as quickly as practicable on that.

MR. CLARK: Thank you.

MR. WALLING: And that is the end of my prepared comments.

DR. RITCHIE: Okay. Any other questions of Mr. Walling right now? Everyone's digesting. It's a lot to digest.

Okay. Mr. Walling, thank you very much.

MR. WALLING: I really appreciate the consideration. I'm sorry I ended up so far out of position, but here we are.

DR. RITCHIE: It's rough being in Denmark, I know.

MR. WALLING: Somebody's got to do it.

MS. LOVE: Enjoy your time there. Thank you.

DR. RITCHIE: Exactly. Thank you.

MR. MARTINEZ: I move that we all meet him in person.

DR. RITCHIE: Okay. Thank you very much. All right. So we'll go back, then, to item 2 and go to Integrion OSI for a report on the PCF status, please.

MS. LUERA: I think I'll move down here by the microphone just so everyone can hear me who's online.

Thanks for not making me stand.

MS. ROMERO: Is everyone able to see?

MR. BERENBERG: Why don't you put it in slideshow.

MS. LUERA: Jenn, if you wouldn't mind fast forwarding to page 4 for me.

Okay. So I'm going to start with presenting some data through the first half of 2024. The first slide I have for you is the carrier surcharges. We still have 11 participating carriers. There's been no change from 2023. All the same carriers.

Between January 1 and June 30th, we collected total surcharges of 115,616,972. If we compare that to last year, 2023 surcharges were 74.7 million. So we've seen an increase in 584.8 -- of 54.8 percent year over year. That is mostly due to the hospitals' deficit repayment schedule. And so -- but it's great to see, you know, more money coming in to the PCF to just boost its stability.

Okay. Moving on to the next slide, please. Okay. So this is, again, through June 30th of this year. Our participants are 16 hospitals and outpatient healthcare facilities, 338 group entities and just shy of 5300 individual providers. The pie chart on your left shows the surcharge by provider type. So we've got 54.1 million in hospital surcharge, 58.8 million in individual surcharge, and 2.6 million in entity surcharge.

Now, that 58.8 million is broken out in the pie chart to the right; so you can see 43-and-a-half million of that is agent surcharges, and 15.3 is independent physician. So we've seen a really -- last year it was closer to, like, 55/45. It was really close between the agents and the independents. This year, because of that deficit repayment surcharge that the hospital providers are paying, it's more like 75/25. So, again, that's the surcharge collection amounts, not the number of providers.

So you can also see here, if we take the 54.1 million and the 43.5 million, 97.6 million-ish is coming from the hospitals. So a very large chunk of the surcharge revenue coming in is coming from the hospitals. So I just wanted to point that out just because, you know, in two years when the hospitals go away, we're going to see a very large reduction in the surcharges coming in.

MR. CLARK: Quick question. You've got it labeled on the legend as "Agent." Is that only hospital-employed or could that be employed by large groups like QHPs or anybody else?

MS. LUERA: Agent is employed by hospital.

MR. CLARK: It's all hospital?

MS. LUERA: Yes, it's all hospital.

MR. AUTIO: Would you repeat the total surcharge from hospitals?

MR. CLARK: 97.6 million.

DR. RITCHIE: So that's hospital here, plus agents, hospitals?

MS. LUERA: Yes.

MR. CLARK: And the deficit is split into both categories or is it all part of the 54, the deficit recovery?

MS. LUERA: The deficit recovery is both.

MR. CLARK: There is some of it in both?

MS. LUERA: Yes, there's some in both. And it's about 40 percent this year. So on top of what they're paying for the exposure, they're paging an additional 40 percent-ish to account to cover that deficit.

Okay. We can move ahead.

So this is actually the same data I showed you back at our last meeting. There haven't been any changes, really, because all of the hospitals renewed again on January 1st. Now, everybody renewed. New Mexico Heart actually renewed as a group entity versus a hospital. That's why their surcharge amount is not included on this hospital surcharge table here. So this -- again, this is just breaking it out by hospital. You can see a big jump for everybody. Most everybody. Again, mostly due to the deficit repayment surcharge. Otero County Hospital Association, they were in for a partial year last year, so that's why you see a really

big jump in their number.

Okay. I'll jump ahead. So we do have 338 entities paying surcharges into the PCF. So that -- you take the providers, you calculate ten percent of the providers employed by that entity, so that's what this amount comes up to. So we've got 2.6 million. Again, we saw a big jump. And I have a trend chart in a little bit, but we see a pretty good jump in entity surcharges this year. A good bit of that is New Mexico Heart Institute moving from paying hospital surcharge to paying the independent group surcharge. So, again, these are just the largest groups based on that ten percent surcharge portion.

Okay. So here's our count by provider type. So we have 3,591, MDs and DOs, 989 nurse practitioners, 290 CRNAs and 592 PAs.

And, Alfonso, I was looking at your question from last time, which I apologize, I should have followed up sooner. I was way off. I thought most of them would have shown as hospital-employed NPs, but it's actually almost an even split 50/50.

MR. MARTINEZ: Okay. That's interesting.

MS. LUERA: Unfortunately, I don't have the data on, you know, like, independently practicing NPs, you know, sort of practicing on their own, but -- so a lot of these would be, obviously, NPs employed by --

MR. MARTINEZ: So when you look at the 490 independent NPs, those are mostly entity employed?

MS. LUERA: Yes.

MR. MARTINEZ: Gotcha.

MS. LUERA: Yes.

MR. CLARK: Do you have the same numbers for 6/30/23?

MS. LUERA: I have year-end.

MR. CLARK: Year-end. Are we up or down or am I jumping ahead?

MS. LUERA: You're jumping ahead. Don't spoil my fun.

Okay. So I think we can move on to the next slide. So the next one is a trend of surcharges by provider type. I just wanted to be able to provide some context. You know, it's great to see the numbers for one year, but how are they trending. So I only went back as far as Integrion becoming the TPA for the PCF. So we're starting January 1, 2022.

So I took the full year for 2022 and 2023, and the half year for 2024. Although, that's going to encompass most of it, right, because everybody has a January 1 renewal. So what we're going to see between now and the end of the year is, you know, the adds, the cancels, the deletes, anybody moving, you know, from full time to part-time. So this does incorporate the bulk of the

surcharge that we're going to see. Obviously, we'll re-run it at year-end.

So you can see the entity trend. You can see the good jump in 2024 collecting that 10 percent in surcharge. Hospital surcharge increased dramatically. Again, as a result of the deficit repayment. You can see a very similar trend if you look at the hospital trend and the agent provider trend, because they're subject to those same increases and surcharge deficit repayment.

And then the independent providers are a little bit up and down, but fairly steady, right. We went from 15.3 to 16.9, and now we're back down to 15.3. So fairly steady. I do -- let's jump ahead to the next slide because I do have a trending account.

DR. RITCHIE: That doesn't take into account the number of providers, though, just the total amount?

MS. LUERA: Right. Surcharge amount.

DR. RITCHIE: So per provider, surcharge amount for that category?

MS. LUERA: Yes.

DR. RITCHIE: So per individual one, it certainly could have gone up if the numbers have gone down?

MS. LUERA: Right. So this is the trend in the counts of the independent -- so I didn't include hospitals because they've been relatively stable. Entities, same

thing, relatively stable in the counts. So here's what we see for the independent providers. We -- 2022 was about 3200. Then we jumped to 3500 in '23. And now we're down to 3,000 and change for 2024.

That is a little bit offset by the hospital-employed providers, right. We had 2,125 in 2022. We saw a decrease of about 130 in 2023. And now we're back up to 2,225. So over that time period we have a net gain of 100 hospital-employed physicians, and we have a net decrease of about 120 independent providers.

Okay. I think that -- so that is my summary on counts and surcharges. If anybody would like me to dig a little deeper in anything, just let me know and I'm happy to kind of take a deeper dive with the data if you'd like me to. And so the next report I have is the Financial - Balance Sheet.

DR. RITCHIE: Questions. Okay.

MR. MARTINEZ: I have one question. Not to beat a dead horse, but the NPs, finding out how many of the self-employed NPs are actually participating.

MS. LUERA: Uh-huh.

MR. MARTINEZ: Because with my group, that's where we have the big question mark, right.

MS. LUERA: Okay.

MR. MARTINEZ: Because it seems like that's the

most difficult area for us to grow due to the difficulties with getting that underwriting for that initial --

MS. LUERA: The underlying coverage?

MR. MARTINEZ: Yeah, the underlying coverage. And it still seems that's quite the challenge.

MS. LUERA: Okay. So I can look at the independent NPs, and I can kind of do an analysis of, like, what's the group size associated with that NP and see if I can get some better data for you on that.

MR. MARTINEZ: Okay. Perfect. Thank you.

MS. LUERA: Sure. Okay. So what I have is a financial report based on June 30, 2024, numbers. Now, I want to point out this data right now is a little bit misleading simply because the fiscal year ended on June 30th. It hasn't closed yet, so we don't have all the numbers plugged into this data.

But a couple things to point out. So you can see the first red circle, the long-term claims liability has not been updated. You'll see it's the same number as 6/30 of 2023. And then the deferred revenue, which is -- so we split -- when somebody renews 1/1, because the State's on a fiscal year, we have to defer half of that surcharge revenue to fiscal year '25 because it's covering that whole year. So that adjustment hasn't been made yet. That will -- both of those numbers will absolutely make a difference on these.

So I'm not going to spend a lot of time here, just 'cause it's so incomplete, and I'll just -- I'll happily update this just as soon as, you know, the year's closed for OSI. I do think the net position should be better than last year; again, based on the legislative infusion, based on the report we just saw from Rob. So, again, really incomplete data, but I think things are gonna show a little bit of improvement year after year.

Okay. And then the second slide on the financials is the expenses. Again, several fiscal year-end numbers are still being finalized, so I'll be happy to report on that. There -- the one thing I did want to point out is down at the bottom there we're seeing a slight upward trend in claims paid just -- again, and this is based on fiscal year, not calendar year. So Integrion generally reports our claims data calendar year, but -- so this is fiscal year.

And then so slight upward trend there. The actuarial adjustment, again, is not there yet for 2024, but, again, we did have that big adjustment for fiscal year 2023. And then we also see a big jump in all other expenses there. You can see, if you look on the contractual line, we've gone from 415 to 926 to 1.3 up to 17. So I will guarantee all of you that is not Integrion. So that would be a question to ask OSI's finance team what that money is being allocated for. I don't have that information. We don't keep those books.

MR. AUTIO: Just to be clear. There's an increase from '23 from 1.3 to 17.1. I mean, and that's just contractual expenses related to the PCF that OSI is paying out?

MS. LUERA: Yeah. So we don't actually keep the books for OSI. We get a trial balance from them that lists out the expenses by month, but we don't have the detail. We just have the amounts. So...

MR. AUTIO: But we're reading that accurate? I mean --

MS. LUERA: Yes.

MR. AUTIO: Okay. Something to follow up on.

MR. CLARK: Do we have anyone from OSI that can explain that, Colin?

MR. BAILLIO: I would have to check with our budget team. What it looks like, to me, is they have counted the subsidy we're providing for medical malpractice private payments to independent providers in that number, 'cause it's pretty close year to year from that. So let me check with our finance team and I'll see what that's -- what that's reading as. And did you get that from --

MS. LUERA: Yeah, that's from --

MR. BAILLIO: Fran or Molly.

MS. LUERA: Molly. It's from Molly.

MR. CLARK: Those should have offset revenue

dollars coming from the legislature, right. So it doesn't impact -- otherwise, you're charging, that's going to hurt the deficit.

MR. BAILLIO: That shouldn't -- yeah, that will not affect --

MS. LOVE: Sorry. This is Kathy Love. I'm so sorry, I did not hear that discussion, and I don't expect anybody to repeat it, but who was speaking and what was the upshot?

MS. LUERA: I can summarize it. If that's okay?

MS. LOVE: Thank you.

MS. LUERA: Yeah. So the large increase on the contractual line item, Colin spoke and he believes that the 15 million in surcharge relief for the independent providers is hitting that line, and that's why it's showing such an increase. But he's going to follow up and confirm.

MS. LOVE: Thanks.

MS. LUERA: Yep. Okay. So that's it on the finances. Is everyone okay if I move ahead to the claims information?

DR. RITCHIE: I think so. Yep.

MS. LUERA: Okay. Great. So as you know, since we were awarded the contract, we've been tracking and allocating settlements among the QHPs to include the independent providers, which is the hospital-employed

providers. So here's the first half of the year data. We've settled 46 claims for a total payout of 28.4 million. 16.2 million of that is paid on behalf of individual providers. Just shy of 14 million of that is independent, and 2.2 million is hospital-employed provider. We've got 10.7 million paid out on behalf of hospitals and 1.5 million on behalf of entities.

So that independent provider number looks really big. Two cases make up about half of that. We've had a couple significant claims. One claim was about one-and-a-half million, and then the most significant one was about 5.6 million. It was a very unfortunate case where there were a lot of past medicals that needed to be accounted for, so that one, unfortunately, hit the books for PCF. And so, again, the almost 14 million, that's just about half of it there is two claims.

Okay. So this is data through first half of 2024. I'm going to jump ahead and show you -- so this is just a summary of that 28.4, what accident years they hit. So you can see a big chunk there hit for the 2018 and 2019 accident years, which really tracks with what Rob was saying in his actuarial study.

So then I went and tracked the data since January 1 of 2022, just so we can look overall picture with what 30 months' worth of data, which is just a larger data set. So

195 claims closed with payment. Total paid 107.1 million. So we've got 38.5 million on behalf of individual providers. 10 million of that is hospital employed, and 28 million of that is independent. We've paid 61.3 million on behalf of hospitals and 7.3 million on behalf of entities. So then to the right is just the pie chart breaking it all out.

MR. CLARK: Question on that: If I'm right, 1/1 of '22 to 6/30 is two-and-a-half years?

MS. LUERA: Yes.

MR. CLARK: Rob seemed to be focused that 46 claims paid seemed to be an inordinately high number. But if you take 195 claims over two-and-a-half years, that's 70 to 80 claims per year, which means 46, that's a low number.

MS. LUERA: True. Good one to follow up on.

MR. VARGAS: He did talk about paying out more in '18 and '19 and the number of claims decreased over time.

MR. CLARK: Okay.

MS. LUERA: So the next slide I have shows the 30 months of data which accident years these hit. So, again, we're seeing 2018 and 2019 with the largest share there. And, of course, the more recent years are going to have a smaller amount because they haven't matured quite yet.

MR. CLARK: Is it possible for us in the future, I think what might be helpful, to see the number of claims paid out over half a million to see how that number

fluctuates?

MS. LUERA: Yep, absolutely. Actually, I did have some data on that. So I started at two million. So we've only had five settlements over two million. One was right at two million, two paid around 2.7 million, and we've had two claims, including the one we recently paid, that were five million dollars plus.

But, yeah, we can -- we do track that. So I can definitely track that in increments for you. I can provide that as a follow-up. Any questions on that?

So this last one here is just showing you how many claims closed and opened by accident year. So this is only the data for claims that have been assigned to Integrion since 2020. So these are just all the claims in our system. It doesn't factor any that were closed before Integrion started adjusting claims.

So on top of this 1,050, we have 35 claims open for future medical treatments. So we -- since 2020, because if you remember, before we were the TPA, we were the claims adjusting firm, if you will, for about a year and a half. So in this -- in the full time since about, I think we started in September of 2020, we have closed 430 claims. We have 620 claims still open, and you can see the breakdown by accident year there, for total claims in our system of 1,050. So I can tell you when we took on the claims

adjusting in 2020, we got just over 300 claims. So the volume has really, really grown since then.

MR. CLARK: Would you help correlate that 430 total closed claims with the 195 that you presented on this page before?

MS. LUERA: Yeah. So the 195 is closed with payment, and then the balance of that; so 235 is closed without payment.

DR. RITCHIE: Do you have -- I'm sure it's coming up -- an average for the closed claims payouts?

MS. LUERA: I don't have it in this presentation, but I have it.

DR. RITCHIE: Okay. I think that would be nice to track as well. Since we're looking at numbers and amounts going up, we need to look at the average and the over a certain amount.

MS. LUERA: Okay. Yep. I can certainly provide that.

MS. LOVE: And it might also be interesting to see, like, a median as well, because you're bigger ones that you were recently just talking about are going to throw off that average.

DR. RITCHIE: True.

MS. LUERA: Yes, I can do that as well.

MR. CLARK: Great point, Kathy. In fact, that's

why I asked to see the number of claims below a threshold of 500,000. If we see that number being steady, then the outliers of the big claims can really throw off the averages.

MS. LUERA: Yep. Absolutely.

DR. RITCHIE: That's what I was getting at. Kathy said it better.

MS. LUERA: Okay. That's actually my full report on everything you asked me to speak on.

DR. RITCHIE: Thank you.

MS. LOVE: I have a question.

MS. LUERA: Of course.

MS. LOVE: With regard to future medicals, at the last meeting I raised the question of whether anything is being done to set aside whatever amounts are expected to be needed to pay out for future medicals for those patients who are participating in the future meds as incurred plan. Has anything been done on that?

MS. LUERA: I honestly will have to follow up with you on that. Let me check with OSI. We don't necessarily set a reserve in our system for what we expect to pay out, so I'm not sure if it's being tracked anywhere else. I know you're speaking specifically of the settlement that you were involved in. Let me follow up with that, and I'll absolutely let you know.

MS. LOVE: Well, and just to be clear. That was an example, and I think that's -- it's the only one I know of where there was an amount that was ordered set aside by the courts. But I would assume that the fund or the OSI have some kind of a fiduciary duty to make sure that that money is going to be taken care of for those people who are expecting their future meds to be paid.

So I was assuming there was some kind of a system where they would do an estimate of the future meds and have that money sort of secured and set aside and invested for those patients, and I'm just curious if that is true and if not, why not.

MS. LUERA: Well, I do think -- I am not, obviously, involved in every single settlement. I do think -- I actually went back and asked my team, and they can't think of any other settlements where there was a specific amount ordered. So that might be a very unique situation. But I can certainly talk to OSI, and, like I said, if there's not a procedure, we can set one up.

But there is a load in the actuarial study that, you know, part of the future or the ultimate expected losses is a load for future medical payments.

MS. LOVE: Sure, sure. But once there's a settlement and there's an obligation to pay on behalf of that person for whatever number of years they're going to

need the future meds, regardless whether or not there's a court order, it seems, to me, that money has to be estimated and set aside or accounted for. It's not all money that's available for future payouts; it is money that has to be available just for those patients who the funds settled with.

MS. LUERA: Sure.

DR. RITCHIE: That's normal insurance practice; you set aside money specifically.

MS. LUERA: Yeah, and that's -- yeah.

DR. RITCHIE: Okay. All right. Anything else? Any other questions? Mike Dekleva, do you have anything? You're being really quiet up there.

MR. DEKLEVA: No, I don't. I'm doing fine. Thank you. I'm following everything. I just don't have any questions.

DR. RITCHIE: Okay. All right. Then we'll discuss schedules and procedures, how we go forward from here. And I think that's OSI talking about that; correct?

MR. BAILLIO: The rate hearing schedule and procedures?

DR. RITCHIE: Correct.

MR. BAILLIO: Do we have it on the screen, Jenn?

MS. LUERA: I think it's the next-to-last slide on the PowerPoint.

MR. BAILLIO: All right. So September 5th of 2024, and I believe that is a Friday.

MR. MARTINEZ: Thursday.

MR. BAILLIO: Scheduled at 1:00 p.m., parties must file for intervenor status by August 5th. Superintendent has to promulgate the rates by October 31st. And I think we wanted to have that discussion about when we need the recommendation, and then that the rates will take effect on January 1st.

And, Superintendent, are you still on the phone with us?

SUPERINTENDANT: Yes, I am.

MR. BAILLIO: 'Cause I think we wanted to open up that dialogue about how far in advance we would like the PCF Board's recommendations to be able to set that rate by October 31st.

SUPERINTENDANT: I'm getting a little bit of what you're saying, but you want to change the schedule?

DR. RITCHIE: No.

MR. CLARK: I'll try -- this is Troy. I'll try and restate what he said. He said that you have an obligation to promulgate the rates for 2025 by October 31st. And I think he was looking for you to give us an indication of how far ahead of that October 31st date you would need the recommendation to be received from the PCF Advisory

Board.

SUPERINTENDANT: I'm thinking. When did we get it last year?

DR. RITCHIE: I think we tried for about three weeks ahead. Two to three weeks ahead.

SUPERINTENDANT: Does that work for you? I mean, I didn't have a problem with it. Does that work for you?

MR. VARGAS: It gives us enough time to decide and write it up.

DR. RITCHIE: That gives us a month to -- after the rate hearing, so...

SUPERINTENDANT: Is that -- I had no problem with the timing last year, so I defer to what you need to do and how much time you need.

MR. CLARK: Mr. Chair, could I make a proposal of October 11th, which is a Friday?

SUPERINTENDANT: Is that a question?

DR. RITCHIE: No, no, I -- well, I think it's a question to the Board --

MR. VARGAS: That makes sense.

DR. RITCHIE: -- if everyone can make or thinks that that's reasonable to do, Friday, October 11th. And canvassing the Board members here and online, do I hear any dissents, any people with a problem with that? So that would be Friday, October 11th, to have it finalized to send

to you, to the Superintendent, to then have -- you have plenty of time to review it.

Okay. I do not hear any objections to that, so that gives us plenty of time to set up some meetings and stay -- and keep running afoul of the Open Meetings Act.

MR. MARTINEZ: Troy, do you think we might want Pinnacle available for that meeting on October 11th, or do you think we'll have all our questions answered by then?

MR. VARGAS: That's usually when we have it written up.

DR. RITCHIE: This is the submission date.

MR. CLARK: I think we -- to follow up with what you were saying, Ray, and help me, I believe that after the rate hearing we asked them to make it available to us one day before we started drafting, and then we actually would have to have a meeting before this to review the draft of this Board for that to be the final submission.

So if we're looking to schedule dates, we have to schedule a hearing with this group sometime before the 11th. If I remember how we did it.

MR. VARGAS: We did it kind of right in the middle so it gave us time to deliberate and come up with a decision, asked Pinnacle a couple of questions, and then we wrote it up.

MR. CLARK: I was going to say, and I think,

Vince, you encouraged us to pick that date far enough in advance of the Open Meetings Act notice that we could hold that meeting, and if something happened at that meeting and we had to meet again, we could still hold it by the 11th. Is that 72 hours?

MR. WARD: Well, we can -- that's the agenda.

MR. CLARK: So if we pick a meeting date at least before October the 8th or earlier, then should something come up that we had to meet again on, we would have time to notice it.

MR. VARGAS: Yeah.

MR. AUTIO: That would be a squeaky wheel. But my only concern is the August 5th date for intervenors. I mean, that seems like a pretty -- being that the report just came out last night, the draft report, that seems like a very quick turnaround. I'm looking -- Vince or Barry and Mike know better than I do. I'm looking at the reg, and I don't see a 30-day requirement, but even pushing that out a week might make some sense to allow people to actually consider if they want to intervene, and so we don't have people intervening just for the sake of intervening. You know, so they can take a look at the report and see if they want to intervene. But I don't know, there could be something in the reg of a 30-day requirement. I didn't see it.

MR. WARD: I'd have to look at the reg. I don't remember off the top of my head. You know, last year we only had one intervenor, so it wasn't unmanageable.

MR. AUTIO: And I don't think -- I mean, we have sole discretion as the Board whether we allow them to intervene. I think we have sufficient time, even if we push that back a week, you know. I don't see a whole tidal wave of intervenors. Who knows, though.

MR. CLARK: I agree. I'd rather push -- if we have the ability to push it back a week and not have a 30-day notice, then that might reduce the number of people inclined to hold a spot as the intervenor while they review it and get those who really just want to intervene so it's more of an efficient process.

MS. LUERA: There was a comment last year to -- at the process to file for intervenor status was quite onerous, so that might -- they might need an extra day or so --

DR. RITCHIE: I did hear that.

MS. LUERA: -- to figure out that process too.

MR. BERENBERG: There doesn't appear to be a 30-day deadline.

MR. WARD: I'm just going back and I'm trying to look at our process last year. Just give me a sec.

MR. VARGAS: Why don't we just add a week and make it the 12th?

MR. AUTIO: I think that's sufficient time. I mean, you know, that gives everyone a full week to decide whether they want to intervene and get it submitted.

MR. VARGAS: Yeah.

MR. WARD: So we were definitely within the 30-day window when we were going through all that. I didn't see a problem, so...

MR. VARGAS: Want to make a motion?

MR. CLARK: I'll second that motion.

MR. AUTIO: August 12th for intervenor status.

DR. RITCHIE: August 12, intervenor status.

MR. CLARK: Everyone okay with that, Colin or Superintendent?

MR. BAILLIO: I don't have any concerns. But, Superintendent, does that work for you?

SUPERINTENDANT: Yes, I think so.

DR. RITCHIE: Okay. Now, September gets really tight for me because I'm going to be out of the country for the last half of September. So could we --

MR. CLARK: Where are you going to be that we're going to hold this meeting?

DR. RITCHIE: Exactly. Let's see, the Italian Alps.

MR. VARGAS: Perfect. I can book my flight now.

MR. BAILLIO: That's what that extra contract

money is --

DR. RITCHIE: That's it.

MR. AUTIO: Tack on another three, and we'll have a really good time.

DR. RITCHIE: It will be a lot nicer trip on that budget.

MR. VARGAS: That means we have to have another meeting the week of September 9.

DR. RITCHIE: Yes. If possible, yeah, the 12th, 13th. And handle the rest by email.

MR. VARGAS: Could we do it the 11th?

DR. RITCHIE: 11th, Wednesday.

MR. AUTIO: 11th works for me.

MR. MARTINEZ: 11th works for me.

DR. RITCHIE: Wednesday, we could -- either afternoon or, like, first thing in the morning?

SUPERINTENDANT: I can only do afternoon.

MR. CLARK: I can do afternoon after two o'clock, from 2:00 on, on September 11.

DR. RITCHIE: Something, like, 2:00 p.m. September 11, 9/11?

MR. VARGAS: Perfect.

MR. CLARK: That will work. We will make that available by Zoom, right?

MR. WARD: Yeah, there's a Zoom option.

DR. RITCHIE: And that will gives us a lot of time to work on the actual submissions as well.

MR. CLARK: 2:00 on the 11th.

DR. RITCHIE: Okay. Any other comments by anyone? Questions? Okay. That's from the Board here.

Any public comments? We'll entertain any public comments.

MR. CLARK: Do we need to type it in the chat?

DR. RITCHIE: Yeah. So anyone online, any public comments? You can raise your hand, put it in the chat.

MR. BAILLIO: Mr. Chair, if there aren't any public comments, I just wanted to -- because we kind of breezed through it in that report, just briefly celebrate that we paid down the deficit on the independent providers. So, yeah, I mean, I think that provides some relief to providers, and I want to thank the Superintendent for advocating for getting those funds from the LFC, 'cause that took a little bit of actual work this year, but I think it was worth it.

MR. CLARK: Hear, hear.

DR. RITCHIE: That's a perfect lead-in to closing remarks. I must second that very much so, that we really appreciate that from the Superintendent, from the legislature, from the Governor, everyone's efforts to do that. You can see what we're up against with everyone's

overhead, and increasing every year, and so we really appreciate that very much.

So I appreciate everyone's efforts on this and coming to these talks -- these talks -- these meetings, and being so flexible on setting up future meetings, et cetera. So I cannot thank everyone enough, and I think it's time to adjourn and start the weekend, hopefully. Thank you.

(Meeting concluded at 2:34 p.m.)

STATE OF NEW MEXICO)
)
COUNTY OF BERNALILLO)

REPORTER'S CERTIFICATE

BE IT KNOWN that the foregoing transcript of proceedings was taken by me; that I was then and there a Certified Court Reporter and Notary Public in and for the County of Bernalillo, State of New Mexico, and by virtue thereof, authorized to administer an oath; that the witness before testifying was duly sworn by me; that the foregoing pages contain a true and accurate transcript of the proceedings, all to the best of my skill and ability.

I FURTHER CERTIFY that I am not related to nor employed by any of the parties hereto, and have no interest in the outcome hereof.

DATED at Albuquerque, New Mexico this August 15, 2024.

Julianne L. Beatty
License Expires: 12/31/2024
RPR-CRR

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