Patient's Compensation Fund
Advisory Board Meeting

Moderated by William Ritchie, M.D., FAAOS

Wednesday, September 11, 2024

2:05 p.m.

Office of Superintendent of Insurance

6200 Uptown Boulevard, Northeast, Suite 400

Albuquerque, NM 87110

Reported by: James Cogswell

JOB NO: 6871967

A P P E A R A N C E S

List of Attendees:

William Ritchie, M.D., FAAOS, Board Chair

Kathleen J. Love, Board Vice Chair

Ray M. Vargas, II, Board Member (by videoconference)

Ellen Stevens, Board Member (by videoconference)

Carmela Starace, Board Member (by videoconference)

Alfonso B. Martinez, Jr., MSN, FNP-BC, Board Member (by videoconference)

Mike Dekleva, Board Member (by videoconference)

Troy Clark, Board Member

Vincent Ward, PCF Attorney (by videoconference)

Nick Autio, JD, Board Member

Stephen Thies, OSI Attorney (by videoconference)

Jennifer Fetherolf, Integrion

Chris DeWald, Integrion (by videoconference)

Placido Gonzales, OSI (by videoconference)

James Willett (by videoconference)

Sarah Koob (by videoconference)

Devin O'Brien (by videoconference)

Jennifer Romero, OSI

Debbie Luera, Integrion

Julianna Koob

Annie Jung, New Mexico Medical Society

P R O C E E D I N G S

DR. RITCHIE: So we'll call the meeting to order of the PCF Advisory Board. The agenda is here. Let's start with roll call before approving it.

MS. ROMERO: Chairman Richie?

DR. RITCHIE: Here.

MS. ROMERO: Vice Chair Love?

MS. LOVE: Present.

MS. ROMERO: Mr. Clark? Mr. Autio?

MR. AUTIO: Here.

MS. ROMERO: Mr. Dekleva?

MR. DEKLEVA: Here.

MS. ROMERO: Mr. Martinez?

MR. MARTINEZ: Here.

MS. ROMERO: Ms. Stevens?

MS. STEVENS: Here.

MS. ROMERO: Mr. Vargas?

MR. VARGAS: Here.

MS. ROMERO: Ms. Starace?

MS. LOVE: You know, I see that she is there under unverified. And I think because she hasn't been invited to the meetings officially she's not listed as a participant, so that needs to be switched over. Does that make any sense?

MS. ROMERO: Well, it has her on there

and there's others that are unverified --

MS. LOVE: Oh, okay.

MS. ROMERO: -- that were on there.

MS. LOVE: Okay. So maybe she just didn't -- thank you.

MS. ROMERO: She is online.

MS. LOVE: Okay, perfect.

DR. RITCHIE: Okay. And Mr. Clark now is present. He's joined us. So if you'll add him to the -- to the roll call, please.

MR. CLARK: Not so fashionably late. I apologize.

DR. RITCHIE: Okay. Next item on the agenda is approval of the agenda.

MS. STARACE: I'm sorry. I'm sorry. I didn't hear that you said my name. This is Carmela Starace, the patient representative.

DR. RITCHIE: Thank you very much. We saw you there, but didn't wait for your response. Appreciate it.

So next item, approval of agenda. Is there any discussion or changes to the agenda?

MS. LOVE: It's pretty straightforward. Move to approve.

DR. RITCHIE: Okay. Second?

MR. VARGAS: Second.

DR. RITCHIE: All right. Any objections? Okay. The agenda's approved. Next, approval of the minutes. Any additions, subtractions, discussion on the minutes from the last meeting?

MR. AUTIO: Move to approve.

MR. VARGAS: I'll second it.

DR. RITCHIE: All right. Any objections? Okay. It is approved. Onto the next item. Discussion regarding testimony and evidence presented during this surcharge rate hearing that was done just a couple weeks ago.

So we've done this a couple times in the past. Everyone should have gotten a copy of the minutes, the discussion, and already have had a copy of the analysis done. And so I will open it up to the board. As far as to start off, any questions or comments on what was presented at the hearing?

MR. AUTIO: Mr. Chairman, this is Nick Autio. I guess I'll -- I'll kick it off. I'm still -- and I went back and looked through the transcript of the surcharge rate hearing, and I'm still a bit confused on what the actuary is suggesting for a surcharge increase or decrease for the independent outpatient healthcare facilities.

I don't know if other board members have clarification on what the specific recommendation is. When I look at page 7 of 85, which is what Mr. Walling referred to in his testimony, there's, you know, the reference to an adjustment of 5.62 percent, but that's the inflationary adjustment that's required by statute.

And I -- you know, and then in the chart below on page 7 of 85, there are the series of numbers that are listed in column 3, but I'm still not entirely clear on what the recommendation was. And I don't know if you have any clarification either, Ms. Luera?

MS. LUERA: Sure. I went back and did a little bit of research on the matter. And when I looked at the 2023 study, there were no per visit per receipts per exposure surcharge rates presented in the actuarial study.

And so they -- the only thing that was calculated by Pinnacle last year was the providers that would be employed by those independent outpatient healthcare facilities, because they had different limits than everybody else. So there was a column on most of the rate sheets that said 500 X of 500. That was for the independent outpatient healthcare

facilities.

So then, when the Advisory Board had to make their recommendation, and we talked -- Ms. Love helped clarify this at the rate hearing last week -- the recommendation was 10 percent of the surcharge for each covered provider practicing in that facility.

And then the quote said, "The PCF should compile data on a per procedure basis as it does for hospitals for use in determining the most appropriate method for assessing surcharges."

So when we kicked off the actuarial study for this year, Integrion/OSI asked Pinnacle to develop these per procedure per exposure rates because that is the industry standard for rating these types of facilities.

So Pinnacle received New Mexico specific data, they looked at rate filings for carriers providing that base underlying layer, and came up with rates.

And so to the best of my understanding, those rates plus the 5.62 percent, which is just the adjustment to the limits based on CPI, which is written into the statute. That's what you're seeing here in the third column.

So we don't have these rates, for lack

of a better term, like, codified into acceptance from last year, because it wasn't something that was asked for or written into the study. I think they may have calculated them, but they were never entered into evidence. They weren't -- you know, it was never -- there was never a formal approval process for that.

And so based on the two applications that the PCF received this year for entry into the PCF, neither of those entities had employed physicians, and so there was no way to rate, if you will, the surcharge.

And so the underlying carrier actually used the per 100 visits calculation that was created for hospitals. Right. Because the hospitals fill out a spreadsheet every year with, you know, number of procedures, number of beds, number of births. All that good stuff.

And so there is a per procedure surcharge rate calculation in that table. So that's what they submitted. And we believe that they overpaid because those surcharge calculations include the deficit repayment.

And so we wanted to have clarification -- we wanted to have clarity on, you know, if we're -- if the -- if nobody has to pay back

the deficit reduction surcharge, then what would those rates look like for these independent outpatient healthcare facilities based on that and based on the fact that they're 500 X of 500 rather than 500 X of 250. So it's a different rating factor, if you will.

So long story long, I guess, it's my understanding that Pinnacle took the rates that they would have recommended for last year, and then added the 5.62 percent, because the limit is increasing this year based on the three-year average of CPI. So that's what we're seeing on page 7. And really we're only going to use one of these rates because --

MR. AUTIO: For surgery centers?

MS. LUERA: Yeah. The only -- the only type of independent outpatient healthcare facility that is qualifiable under PCF is an outpatient ambulatory surgery center. So we're not going to use cardiac rehab or dialysis or MediSpa or any of these. We're really just looking at the surgery center rate. That's really the only one we need for purposes of PCF.

MR. AUTIO: So does this rate here on page 7 still include monies to pay off deficit?

MS. LUERA: No.

MR. AUTIO: No. Does not absolutely.

MS. LUERA: No, it does not.

MR. AUTIO: Okay. And then, per 100 visits is obviously retrospective. It's based on the number of visits from last year.

MS. LUERA: It's an estimate.

MR. AUTIO: Estimate for this year based on last year.

MS. LUERA: It's an estimate for the coming year --

MR. AUTIO: Right.

MS. LUERA: -- based on, you know --

MR. AUTIO: Data.

MS. LUERA: Yeah.

DR. RITCHIE: Mr. Clark?

MR. CLARK: Thank you, Mr. Chair. This is Troy Clark for the record. So is it fair to say that if -- if what we're saying is 41.03 per a hundred visits on the surgery center line -- I'm sorry -- 152.25, wrong line -- if we divide that by 1.056239 percent -- if I can do that right.

MS. LUERA: It's, like, 140-something.

MR. CLARK: That's what the rate would have been last year had we used it.

MS. LUERA: It would have been last year.

MR. CLARK: And you mentioned the concern that we overcharged last year because it would have included the deficit. Do we know for certain that when we did the calculation last year it was off the total and not the total before the deficit add-on?

MS. LUERA: Yes. Because I went back, and I looked at the two facilities that are currently participating. One had 10,000 visits and the surcharge calculated was 60,972. If I take this 152.25 divided by 1.0562, I get 144.15.

MR. CLARK: Yep.

MS. LUERA: So they should have actually only paid 14,415.

DR. RITCHIE: What did they actually pay?

MS. LUERA: 60,000. Almost 61,000. Because it was the hospital rate plus the deficit repayment.

DR. RITCHIE: Plus the deficit repayment?

MS. LUERA: Yeah. So we would -- we're working with OSI, we're working with Pinnacle. We would like to go back and make that right based on these per procedure rates that we now have. But we need approval before we can go ahead and do that.

MR. CLARK: One more follow-up question. We may need Ms. Love on this one. Are we going to be capturing the data so we can calculate the performance of the outpatient healthcare centers as a separate unit --

MS. LUERA: For losses?

MR. CLARK: -- like we do for the independents and the hospitals going forward?

MS. LUERA: Yes. Yes. Correct. We have it as a different classification. So we have -- we have agent, we have independent, we have HOSP, which is hospital, and now we're going to have OHCF. So that we can capture the data, and then when we're also entering in the losses. We're entering in that rate category as well. So yes, we will be able to track it.

MR. CLARK: Excellent.

MS. LOVE: And do we have a court reporter?

MS. LUERA: Yes.

MS. LOVE: Okay. I was just wanting to make sure that -- okay. So this is Kathy Love for the record. And so what data will you be collecting from outpatient healthcare facilities in order to do this in the future?

MS. LUERA: So basically, you know, so far we have two participants. We have another one who's applied. That's not really a great universe of data, right? It's not a statistically accurate sample.

So we will be collecting their exposure data, we will be collecting the surcharges, and we will be tracking the losses. Very similar to what we do. And then initially, the actuary's responsibility is to go through any rate filings that are filed with the State of New Mexico, and if they need more data they can look, you know, in neighboring states or whatever they need to do.

So they will be looking at what the underlying carriers are charging. If they're seeing losses. If they're seeing, you know, the need to increase rates for these types of facilities. And that would be reflected going forward in the rates that they're going to propose to the PCF.

MR. CLARK: Mr. Chair, if I could follow-up on Ms. Love's comment. This is Troy Clark again. I assume we'll also be capturing their actual visit numbers since we're going off projected right now. That there's some accounting that somebody doesn't say. I have 10,000 visits, and they did

20,000 or 10,000. I did 5,000. There's some material to check?

MS. LUERA: There's not a mechanism right now to do audits for these facilities, just like there isn't a mechanism to audit the hospitals. But that's something we could certainly discuss with the powers that be at OSI.

MR. CLARK: So, Mr. Chair, I guess my initial reaction is with the -- given the low number of centers -- it's great that we are referring back -- I believe Mr. Walling said that we're using the commercial carriers from inside New Mexico Square, New Mexico specific, and a larger group.

But I think with two there, there ought to be some report that's required each year when they reapply for it of what their actual volumes were the previous year just so we have some sense of are we too high or too low. And that's an easy number to --

DR. RITCHIE: -- they give us a volume that they say. Now, they need to certify as an actual volume is what you're asking for.

MR. CLARK: Yeah.

MS. LUERA: You're asking for, like, an audit; right?

MR. CLARK: Whether it's an audit or

just a, you know -- a certified statement that says --

DR. RITCHIE: Yeah. They certify.

MR. CLARK: -- we did -- we did 11,000 visits last -- 11,222 and a signature. Then if we question it, I guess then we come back and audit.

MS. LUERA: So then, based on that, would they need to true up and pay additional surcharge?

DR. RITCHIE: Well --

MS. LUERA: If they were -- if they were estimating 10,000 and they did 12,000, then do we go back and --

MR. CLARK: I guess the answer depends on what the actuaries are doing with it. Are they taking last year's number and projecting a growth on it, then, we know it's an estimate on an estimate, and how close are they looking?

But if it's last year's number, and that's what we're applying to -- assuming it's the same for this year, and it trues itself up each year. And it really just depends on how the actuary's accounting for that volume.

MS. LUERA: Okay.

DR. RITCHIE: I think with more experience with actual data, then their estimates will

become more and more accurate.

MR. CLARK: Yeah.

DR. RITCHIE: And if we want to invite the centers to give us their estimate, then we can compare against the actuary's estimate. That might make it even more accurate, so to speak. But I think we would base it off the actuary's estimate.

MS. LUERA: Well, so each facility -- so basically everybody's on a common renewal of one, one now, because of the way HB75 was written. So they're estimating for the coming year. Right. The actuary's not estimating anything other than what the surcharges should be.

So the volume is being estimated by the owners of that facility. They report that both to their underlying carrier, and then the carrier reports it to us. So it is an estimate for the coming year.

And then the next year, based on what their actual was for the prior year, they're going to make another new estimate of what their volume's going to be. So we can certainly ask them to provide that data just to see how accurate they were.

DR. RITCHIE: That's what I was about to say. Then, we just need to make sure we're following that, and tracking that, and see how

accurate their estimates are.

MR. CLARK: Mr. Chair, I would propose -- 20-some years ago I ran surgery centers and you would -- we may be getting hung up on the word estimate -- that those policies that we had in place, and I realize things can change and carriers can change, but you would report your volume for, in this case, 2023, and your premiums for 2024 were based off of that. So it wasn't an estimate. You based on what your actual was.

And the next year when you reported 2024, that set your premium for 2025. So your volume was, in essence, in arrears. But they also adjusted for that when they would account for your deficit, as the terminology we would use, that you'd get a higher rate to catch it up if for some reason you underestimated in the previous. So it caught up.

So it's my recommendation that maybe it's language that we don't ask them to report what their estimate for the upcoming year is, but what was your actual for last year, and base the premium rate that we're using on that actual report for the upcoming year.

DR. RITCHIE: So I think we'd have to decide as a board if that would be the recommendation

that we made to the superintendent to do it that way. Is there any more discussion on that topic? Anyone online?

MR. MARTINEZ: Yes. I also have one -- this is Alfonso Martinez. I think additional -- additionally through that, there's a bit of accountability aspect. You know, that they are reporting exactly what they're doing so that they're not shading numbers or anything like that in order to get a lower rate.

DR. RITCHIE: And I think that Integrion could track that and just compare what their actual was. Can you track that?

MS. LUERA: Sure.

DR. RITCHIE: Yeah. Okay. So then I think we can probably do this. I don't know that we have to take a roll call vote. But does anyone object to making that recommendation from the board on our report that the OSI consider basing their facility rates and exposure on the actual rates reported by the centers for the previous year?

MR. CLARK: Mr. Chair, if I could amend that one slight bit just to complete it to say, per the proposed rate -- the rate per 100 visits proposed by Pinnacle. I'd add that last piece to it. That way

you got the volume and the rate for the total amount. Yeah. And I would make that motion.

DR. RITCHIE: Thank you. Okay. Is there any --

MR. VARGAS: I'll second -- I'll second that motion.

DR. RITCHIE: Seconded. Thank you, Mr. Vargas.

Any further discussion on it? Okay. Seeing and hearing none, then, I don't feel there's any -- is there any objection then to doing that? Okay. Seeing and hearing none, then, that will be part of our report.

Okay. So then, next topic that anyone wants to bring up on our discussion of the rates?

MS. LOVE: Well -- this is Kathy Love. So does that beg the question then, so what are we going to recommend for this year? I mean we now have a plan for what should be done next year, but maybe we should go ahead and finish the conversation about the outpatient healthcare facilities and what the recommendation should be this year. And I understand you have some thoughts about what OSI wants to do. So do you want to start?

DR. RITCHIE: Well, do we have the data

to do that? Do we have the data on the visits for next year -- or from last year to use for next year?

MS. LUERA: Yes.

DR. RITCHIE: So we actually have the data to use I guess?

MS. LOVE: So we're not going to recommend an actual rate? We're just going to say figure it out? You know what I'm saying? Do we have an actual rate that we're recommending?

MR. AUTIO: And that's -- that's my question. Like, the bottom-line question is -- because when I look at the actuarial report, I don't see that and I don't -- when I read the transcript, I did not see Mr. Walling actually giving us a number that we could accept or reject or modify, unless I'm missing something.

MR. CLARK: So, Mr. Chair, this is Troy Clark again. My understanding -- and I was of the same point -- is that when he's recommending -- because you have two different entities with different volumes -- that if those volumes were to shift disproportionately between the two, to do an overall rate wouldn't work, as including the increase of 5.62 that what we would be setting is the 152.25, for instance.

Actually, I think what he's saying is we would do all of these, but that's the only one that applies. And then if the superintendent accepted that, they would be telling Integrion, now you go back to the data that they submitted for the volume piece of that and do the math to come up with what the total is.

Because an even percentage across both may not be the right number if one's volume changed versus in comparison to the other over -- saying an X percent over prior year may treat both equally on the percentage increase, but that may not be appropriate if one had a big volume increase or decrease, if that makes sense.

MS. LOVE: Okay. Mr. Chair, this is Kathy Love. I think I follow you, Mr. Accountant. However, can you dumb that down for us a little bit in terms of, like, what is the sentence that we're going to write to the OSI? And I also have a follow-up question to that.

MR. CLARK: I believe -- I won't take offense at being an informed accountant -- we'll go for that -- that what we would be recommending to the superintendent is acceptance of the rate schedule proposed on page 7. For the superintendent to then

apply those rates times the submitted volumes by the applicants.

DR. RITCHIE: Because right now, we do not recommend individual rates per hospital. In fact, we just talk about the increase in rates overall, percentage increase. So with the surgery centers, we're starting out, and so we're just -- we're trying to set, and it will be still individual.

So we're going to recommend that -- there is that built-in adjustment that's already there and then the -- we're probably going to continue recommending that it's, you know, per the 100 visits, and then that rate is pretty much going to be set, but with the modification of the experience.

MR. CLARK: And the inflation factor year over year.

DR. RITCHIE: Right. And the inflation factor.

MR. CLARK: The 152 would go up by that. I think the experience would make the adjustment, are we in a deficit position, or are we in a surplus offset, by whatever inflation is.

MS. LOVE: Okay. So that -- this is Kathy Love. That leads into my next question, which is -- and maybe somebody picked up on this during Mr.

Walling's testimony, and I just didn't.

But is Mr. Walling assuming the maximum payout for all potential losses? In other words, the cap plus the COLA. Since we don't have a claims experience, and we don't know how many cases -- again, outpatient healthcare facilities are paid out at lower than the cap.

Therefore, we also don't know how many would be paid out at the cap plus the COLA. Is he assuming the full amount, and therefore, overestimating what the losses are going to be?

MR. AUTIO: Yeah. And that was, I thought, a good question you asked during the hearing, because it almost -- I mean if he's recommending -- because it is -- the three-year average would be 5.6 percent in terms of the inflationary adjuster.

But that would -- I mean if we're saying we need an increase of 5.6 percent, it seems like that assumption would be made that the entire cap amount plus three-year average CPI would be paid out for any claim paid, which we all know is not going to happen.

MS. LOVE: Never happens.

MR. AUTIO: And it also begs --

MS. LOVE: It will -- it never happens

that there's a year when there's all the -- all the claims are full cap.

MR. AUTIO: And it also begs the question -- like, on page 6 of 85 in the report, you know, Mr. Walling discussed, you know -- you know, CPI as applied to physicians, which is not on a three-year rolling average.

And he determined that the adjustment factor would be 3.32 percent. But then, you know, the increase limits factor in the table below is 2.4 percent. So, I mean, it's not -- that's not consistent, in my mind, you know, in terms of the methodology he's using.

I agree more with this, that the increase factor should not just be whatever CPI was. That makes sense. But I'm still confused about the 5.6, to Kathy's point.

MS. LOVE: For outpatient healthcare facilities?

MR. AUTIO: For outpatient healthcare. Yeah.

MS. LOVE: Right.

MR. CLARK: Mr. Chair, if I could add one comment. I don't know that -- I mean, well, I know I cannot say what's in Mr. Walling's head. What

his answer was was that he used the commercial rate for policies inside the state of New Mexico.

So with that, if he's using the going rate, it would include the historical -- is where -- now I'm having to suppose what data he's got -- that would include the run rate. So it's not all at the cap. It's not anything to do with any one individual.

He's looking at the book of business for surgery centers, urgent care centers inside the state of New Mexico, and saying they all have their history that builds into what their rates are in the commercial market. So that's what builds into this. Then, if we say our two surgery centers in this case happened to be the norm of those, this is what the rate would be.

What we don't know is do they have a better or worse experience rating than the norm in New Mexico. We have no way to account for that that's in there. We also don't have any way to know, without asking him, did he adjust for anything for the change in what the cap is?

Because if he's calculating on the norm for the commercial rate, we have a new cap for outpatient healthcare facilities that was effective January 1st of 2024, I believe. And so are his

calculations based off a proceeding timeframe where the cap was at 600,000 or 750,000 or whatever -- at the 7.50 rate? Well, for one year before that and proceeding that.

I don't know what the history of his data is that he's pulling from the commercial market. Or we don't, not only me. But I don't think we know. That's where I think the risk is in this number. It it's definitely not on the cap, because not everybody pays out every claim at the max amount every year. Does that make sense?

MS. LUERA: I think what he always tells us too is that, you know, last year is sort of irrelevant because the losses are only this much developed in terms of what the ultimate losses are going to be.

So I know that he based it on the 500,000 excess of 5,000, and then applied the 5.62. That's about as much as I want to say about -- or can say about how he calculated the numbers. But -- and he's our expert, so.

MR. AUTIO: When you actually look at, you know, his reference to 5.62, I mean it is in the context of discussing the overall, you know, increase of the cap to 556,000. So I don't know if he's even

necessarily saying that that's a -- you know, should be a proposed increase to the surcharges they're paying in.

That's also not clear to me, because it is -- in that sentence, it's in the context of discussing just the increase of the cap. So not that that answers any questions, but --

DR. RITCHIE: It seems like he's simplifying the -- for want of lack of data. We don't have much information on the true experience in the past. So he's basing the exposure just on the number of visits as --

MS. LUERA: Based on the -- yeah. Based on the rate filings of --

DR. RITCHIE: Right.

MS. LUERA: -- the carriers who write this type of business.

DR. RITCHIE: Right. And so until there's more data, you know --

MS. LUERA: That's the --

DR. RITCHIE: -- going to have to do it that way.

MS. LUERA: That's the best.

DR. RITCHIE: Right. And I guess we just need to decide for now we agree with that until

there's more data that -- whether it supports that or not.

MS. LOVE: So -- this is Kathy love. So in other words, he is not saying, okay, we are bumping up what the outpatient healthcare facilities have to pay by 5.2 -- 5.62 percent across the board because of inflation and the COLA; correct?

MR. CLARK: I think you're correct. I think he's saying just the rate component, and then you differentiate it by facility based on their volume.

DR. RITCHIE: Based on volume.

MS. LOVE: Okay.

MR. CLARK: That's how I would explain it.

DR. RITCHIE: Okay.

MS. LOVE: We just don't want the outpatient healthcare facilities freaking out thinking that what's happening is that they're getting a 5.62 percent bump across the board every single year, because there is an inflationary increase built into the act. I just want to make sure that that's clear, and everybody agrees with that.

MR. AUTIO: Yeah. This is Nick Autio. Agreed. I mean would the board members be

comfortable -- and I think this is what Mr. Clark recommended earlier -- but accepting the independent outpatient healthcare facility rates as proposed in the table on page 7 of 85.

MS. LOVE: Yes.

MR. CLARK: Yeah. That is what --

MR. DEKLEVA: Yeah. This is Mike Dekleva. I'm fine with that.

DR. RITCHIE: Mr. Martinez, you have your hand up.

MR. MARTINEZ: Yeah. So that was actually my entire question is that we're going to look at this table in an entirety, and kind of accept these values kind of just as they are, based on the type of facilities they are and accept that; correct?

MR. CLARK: That was the motion. Yes. This is Mr. Clark. And I think it's imperative that we do it, because while we are talking about the two surgery centers, if a dialysis center comes in during the year, then you have an approved rate that you already know if they come in with an application submitted.

MR. MARTINEZ: Excellent. Thank you.

MR. AUTIO: This is Nick Autio. Do you want to restate your motion, and then we can move on

it, Troy?

MR. CLARK: So I will make the motion that we accept the recommendation from the report on page 7 of 85 in the table for our outpatient healthcare facilities to have applied the rates -- I'm sorry.

We're making this recommendation to the superintendent that she institute the rates applied in this table that would then be applied to the volumes of any respective applicant.

MR. AUTIO: I second the motion. This is Nick Autio.

DR. RITCHIE: Any discussion? All right. Hearing and seeing none, then, that will be approved. That will go into our report then. Okay.

MS. LOVE: And I have a question.

DR. RITCHIE: Yes.

MS. LOVE: Debbie, do you need anything more to go into this with regard to dealing with what you were explaining earlier as the overpayment based on the deficit?

MS. LUERA: I don't think so. I think because it relates to 2024, it's something that can be resolved between OSI and Integrion.

MS. LOVE: Okay.

DR. RITCHIE: Okay. Great. Good question.

MS. LOVE: Thanks.

DR. RITCHIE: Okay.

MR. CLARK: I would just add to this. I don't -- we just talked about the rates, but I think Ms. Love brings up a good point, and it's what came to mind when I asked in the board meeting last time of what did they pay last time?

And if I heard earlier correct, they paid $60,000 last time, and it's going to come up around 15,000.

MS. LUERA: Yes.

MR. CLARK: Something on those numbers. So if I'm an outpatient healthcare facility, I'm going to see a $45,000 reduction. I'm probably going to be happy about it. Right. But I think there needs to be some comment in the notice to them, in the invoice to them, or at least in our recommendation to the superintendent about how new this data is, and that can vary.

Because if next year we come back and the dollars come in, and say they need -- I'll make up a number -- 40,000, then they're going to go, wait a minute, why are you going from 15 to 40? They're

going to really quickly forget about the 60. But when you only have two entities, you could see a lot of variation in the early years.

DR. RITCHIE: True.

MR. CLARK: And we've seen that on the hospital side. Right. We thought they were way overpaid and way -- or way underfunded and then way overfunded, and dollars moving back and forth. And there's a lot more of them. A lot more dollars than $60,000. So I think there needs to be an additional comment about the variability -- the variability of the rates moving forward.

DR. RITCHIE: And that would go into the comments into the -- the text to the report, which is what we're working on here is the recommendations to the subcommittee. They'll come up in the report.

MS. LOVE: This is Kathy Love. What I have never quite understood -- and we went around and around about this -- about the -- with the hospitals when we first convened as a board and, sort of, it applies to the outpatient healthcare facilities.

I'm sure these facilities all know exactly what their payouts and losses have been over the last 10 to 20 years. I'm sure there is someone who knows exactly what they have paid out, how many

times they've been sued, what kinds of cases. And why can't we get that -- why can't we require that information as part of this analysis?

MS. LUERA: The requirement for application to the PCF is you meet the qualifications under the rules, you submit evidence of your underlying coverage, and you submit the basic data. So unless there's a change to that, you know, none of that data is required.

MS. LOVE: So -- so --

MS. LUERA: And it's up to the actuary to have that historical data based on what he sees in the rate filings that he looks at as part of doing the actuarial study.

MS. LOVE: Is that -- go ahead.

DR. RITCHIE: Mr. Vargas?

MS. LOVE: Yeah, please.

DR. RITCHIE: Mr. Vargas?

MR. VARGAS: Yeah, I just -- I just had a question. Why couldn't that be considered part of the basic information that's requested? And as we've done in the past, we have specifically instructed the actuary to look at certain things, or we've instructed Integrion to compile certain data. Can't we as a board do that again?

MR. AUTIO: Well -- and this is Nick Autio. To Mr. Vargas' point, I mean that's what we did in 41.5.25 and HB75. I mean it very explicitly calls for, you know, hospitals and outpatient healthcare facilities to provide claims and paid loss detail for the past eight years. I mean, that's black letter law.

So I think we could certainly, you know, include that recommendation. Again, if that's not being done. I don't know if that's -- I mean I would hope that's being done, but --

MS. LUERA: Upon initial application, yes, but not every year. That requirement is only for initial applications. And if superintendent wants to request it or require it at another time --

MR. AUTIO: Well, I --

MS. LOVE: Well, you would -- once they're in, you would know.

MR. CLARK: Yeah. You wouldn't -- you only need it --

MS. LOVE: You would have that.

MR. CLARK: You only need the history on the initial application, because then you have everything going forward that you add to it.

MS. LUERA: Right. But that's -- I

mean, that -- I think what I'm understanding is perhaps there's a mechanism that if your losses are trending worse, you pay more in surcharge. And that's the experience rating plan that we've been talking about the past few years.

And the decision was that since hospitals are only in the fund for two more years after this year, it doesn't make sense to develop an experience rating plan just for that short period of time. If that's something to consider for the outpatient facilities --

MS. LOVE: The outpatient healthcare facilities is my point on this one. I was sort of using the hospitals as an analogy. But it seems to me that before they are allowed in it, we should have eight years of pretty robust data about their loss experience upon which to base the surcharges. And it sounds like we don't have that. Is that your understanding?

MS. LUERA: It's my -- that's my understanding.

MR. CLARK: So is the issue here -- this is Troy Clark again. Is the issue the fact that they were part of the PCF before, but commingled and we've just broken them into their own category now,

and so it's not their initial application year?

DR. RITCHIE: Probably so.

MR. CLARK: But at some point we would have -- I mean we had that data -- whenever they initially came in, we should have that data as far back as they've been part of the PCF.

MS. LUERA: Not if they came in as a -- as an entity. Just an --

MS. LOVE: Ah.

MR. AUTIO: That was the problem is -- remember we -- there was that two-year stop gap where we -- when -- with the cap increase, and we basically redefined independently owned outpatient healthcare facilities as independent providers. So maybe that's where the gap is.

But I agree, I mean -- and it's what we've always talked about with the hospitals is, you know, we should be as accurate as possible in our risk assessment and surcharge assessment. And loss history would be a pretty good way to do that.

MR. CLARK: Mr. Autio, you quoted 41.25 [sic]. Does that only address hospitals? It doesn't address outpatient healthcare facilities? The hospitals -- I remember when I came into this, we had to go back and get the data to fill in the gaps for

hospitals that weren't part of -- like, Christus, they already had it all, because they'd been -- they're the ones that had been in since, I think, 2009. But the others had to fill in the gap to get to that level.

MR. AUTIO: So it's interesting. So --

MR. DEKLEVA: Hey, folks. This is -- this is Mike Dekleva.

DR. RITCHIE: Yeah, Mike.

MR. DEKLEVA: I have a question. May I have -- may I have a question -- ask a question and ask for clarification from Debbie?

DR. RITCHIE: Yes. Go ahead.

MR. DEKLEVA: Yeah. Debbie, I think you said -- and I'm not going to probably articulate this as well as you did, but the surcharges to the hospitals are a function of their losses for the previous year. That's actually part of the calculation; is that correct?

MS. LUERA: By the actuary, yes. But --

MR. DEKLEVA: Because --

MS. LUERA: -- there's no experience rating being done of the hospitals right now. So the actuary looks at the losses, proposes a percent increase, and then that gets applied across the board

to the factors that are used in determining what the surcharge should be for the hospitals. So number of births, number of beds, number of surgeries, all of those factors.

So whatever the superintendent -- whatever percentage the superintendent makes on her final order gets applied across the board to all of those factors.

MR. DEKLEVA: Okay. Thank you.

DR. RITCHIE: Okay. Mike. Thank you, Mike.

MR. AUTIO: I -- just, you know, for the board's consideration, it's interesting because the -- and it could have been an oversight in our most recent amendments to the act, but in 41.5.25, it references hospitals and outpatient healthcare facilities. And we changed those definitions; right?

So arguably, independent outpatient healthcare facilities, which got a new definition under the most recent amendment, was not, you know, included in 41.5.25.

But I do -- and stand by what we've always tried to do here, and that is having the most accurate data we can to assess surcharges. Which, in my mind, should include loss history, whether it's

good or bad, so --

MS. LOVE: And the outpatient healthcare facilities have always represented that they have very low loss rates. My guess is that they would be delighted to provide that information because it would protect their surcharge rates.

So I wonder if that's something that we can recommend that be done going forward so that we can get more accurate information on their loss experiences.

DR. RITCHIE: I think it's important. We certainly can do that.

MS. LOVE: I can't imagine that they would refuse to produce it.

MR. CLARK: I agree. I would agree. I think it's -- I would even say if there was a hesitancy to do it, then we need to go back and change the language of 41.5.25 just to match, because that's how we got the data accurate for the hospitals to calculate things and to track it going forward.

MR. AUTIO: This is Nick Autio. I don't -- I don't have any issue with that. I think, you know, that's what we as the board should be doing in making accurate data-driven decisions, so.

DR. RITCHIE: Is there any discussion

from anyone online?

MR. MARTINEZ: This is Mr. Martinez. I think my only concern is that, you know, as we know, claims data lags; right? You could have a five-, six-year lagging data from claims that have not even been filed yet.

So even if you have a facility that's kind of going down the tubes or something like that, we're not going to be able to capture that. But I think I overall agree.

DR. RITCHIE: Okay. And definitely there will be obviously constraints to what we get, but I think we need to start it off on the right foot. So then barring any objection, that will also be a recommendation to the subcommittee to put into our recommendations. Okay.

Then, hearing no other discussion on that topic, next topic for anyone to bring up on the results of the hearing. In the past, we went through it item-by-item, but we kind of let it skip around to what was important, because that took a long time last time.

MR. CLARK: Mr. Chair, this is Troy. I'll go ahead with the hospital.

DR. RITCHIE: Yeah, please.

MR. CLARK: I'd make a recommendation. I can't find it in what we have in the printed packet here. This looks to still have the draft bottom mark. So I don't know that it has Mr. Walling's revised numbers for removing the batch claims.

MS. LOVE: Yeah. That's in your packet as a separate --

MS. LUERA: He didn't add that into the actual report. He provided it as an addendum.

MR. CLARK: There we go.

DR. RITCHIE: No batch provision down here below.

MR. CLARK: Thank you. Make sure I reference the right one. Then, for the hospitals -- I would make a recommendation that for the hospitals we apply the 19.7 percent recommended increase from Mr. Walling, which is at the expected level, excluding any additional for batch claim reserves or whatever he wants to term it as.

I don't think that reality exists there. So without batch -- no batch provision is the way he references it on Exhibit 6, page 1, which would be in line with his recommendation. So 19.7 percent for the hospitals, which includes the deficit surcharge.

DR. RITCHIE: And it was -- what I got out of the discussion was that the batch should be already built into the hospital surcharges since -- basically baked into it because there is no limits. So there is no such thing as a batch claim really at the hospital. They have unlimited claims. So is that the way we --

MR. CLARK: Correct. Yeah. It's unlimited in -- I'm trying to describe a negative, I guess. In a hospital, a batch claim, a physician may -- if we go back to the example he used where I think he used the spine example, where we were putting a man in the same spine. A hospital is a large number of providers.

It's not going to be the same person doing the same procedure six or eight times before it's identified that it's an issue. Generally, in a hospital, the cases are more against process than individual.

On the provider side is where you get to the individual who would do that over and over. So -- and there's not that limit of the three to create a batch. It's whatever the claims are. If there were four or five, they're already in the history of the run rate, so.

DR. RITCHIE: Yes, Ms. Love.

MS. LOVE: This is Kathy Love. I don't have a problem with basing our recommendation on the no batch provision chart from Mr. Walling. But I'm a little worried about -- okay. So let me see if I can frame this properly.

This total that you've recommended of 19.7 in your motion based on Mr. Walling's recommendation is basically the deficit surcharge minus his negative indicated assessment for future claims for next year; right?

And so my worry is that after he acknowledged pretty strongly that we have some concerns about the data, about whether or not we have sufficient data upon which we can make expectations regarding losses. I'm a little bit worried about going down to a negative number, because we might be surprised.

And I'm wondering if the hospitals would rather pay a little more now, and then have over the next couple of years less to pay back in the deficit if their claims experience continues to look good. But if the claims experience doesn't continue to look good, then we have collected enough to pay the claims.

MR. CLARK: So, Mr. Chair, and Ms. Love, I guess my reaction to that would be that at the expected level, as Mr. Walling has described, he's about the 55th to 60th percent.

Meaning that of all the possible outcomes, 55 to 60 percent of those outcomes will be a lower number than the dollars he's projecting. And 35 to -- or 40 to 45 percent would be a higher number. That's already in there on how -- it's not that the possible outcomes have any change. They're already in there. It's just where in that range that we would be putting the numbers.

And if you look, I guess my -- or my comfort level on the opposite is I continue to ask the question of him. As you look at the detail -- I can't find these. Let me try. Give me a second to see if I can find the exact page. If you look at the experience on the hospitals, yes, part of it is because it's new, but there are -- we are now many hospitals into this.

If you start from 2017 until now, we're seven years into this, and we still have a preponderance of the fund is all on projected estimate as opposed to payout. Very small, especially -- oh, I know where I can get one of the numbers.

If you go to the chart that shows all of the hospitals. So beyond page 10 of 85, for instance, when he allocates and he said, you know, I allocate the total amongst the hospitals in this chart, but if you look at Presbyterian, who I believe has been in since 2017, there's $115 million. I'm sorry, 10 of 85.

There's $115 million of estimated surcharges, 120 million of total estimated losses, and there's only 20 million paid out. That's one-sixth or, you know, roughly what, 13 percent has been paid out. So the rest is all falling into this category of an estimate of what could happen. Which would make a lot of sense if it was only the past three years that you have that much or four years.

But when you've got a number of these claims that go back into '17, '18, and '19 that have had time to go through that process, I would argue and say I'd expect that $20 million paid loss number to be a lot higher than our outstanding exposure that he is still holding onto for '17, '18, and '19.

I'd say -- and this is where I asked him, do you go back and look at the number of claims for those hospitals and what the status is of those claims? Or are we looking at a $50,000 payout or are

we looking at a cap level payout on these? And he says, no, I look at them in total over time.

And furthermore, on the current years, the first two years he uses -- if you remember, there are three options on the model. There's four on the physicians, three on the hospitals. And the model that -- or the -- I shouldn't call it the model -- the equation that is used for the first two years is based on a percentage of the -- predominantly based on the percentage of the amount paid.

So as we raise surcharges, you're going to naturally raise the estimate. It's a percentage math. In fact, it's 117 percent, if I remember the right number for this year. So the more we raise, the more we say we're going to expect to pay out for the first two years until there's some experience to apply to it. And I think that's what's driving a big chunk of the difference.

So I think going back to my comfort level is if he says we are at a 55 to 60 percent expected level, that means there's 55 to 60 percent of the potential outcomes actually say we are over-reserving and only 40 to 45 that we're under-reserving on those.

So we're already in a condition of the

predominance of them, and there's only one more year on the surcharge to allocate across. So that's why I think you're going to have that drop off for all the facilities as long as legislation continues. If the hospitals are removed from the PCF, there won't be the third, fourth, and fifth year for spreading it across, if that was your suggestion.

You know, not taking a big dip now and a recovery in years three, four, and five when there wouldn't be a 3.5. That's why the deficit number of 26.8 percent is there, which really amounts to about half of what is outstanding on the deficit. So it's paid off this year and the following year.

DR. RITCHIE: I'm always jealous of Mr. Clark's math abilities.

MS. LOVE: I know. I know.

DR. RITCHIE: Can he walk and chew gum?

Mr. Martinez, did you have a comment?

MR. MARTINEZ: Oh, no. I was just saying I concur.

DR. RITCHIE: Any comments from online or questions? Okay. So then, I think if there's no more discussion, then what's been proposed by Mr. Clark probably requires a second, and the board needs to vote on if that's going to be in our final

recommendations. So is there a second on that recommendation?

MR. AUTIO: I'll second.

MR. MARTINEZ: I do have one question. I'm sorry.

DR. RITCHIE: Yes.

MR. MARTINEZ: One question I have, we are looking at the revised -- page 45 of 85; is that correct? Exhibit 6, page 1?

DR. RITCHIE: Exhibit 4, page 1. Revised with no batch provision.

MR. MARTINEZ: Okay.

DR. RITCHIE: I'm sorry. It's Exhibit 6, page 1, revised note. You're right. The hospital. Sorry.

MR. MARTINEZ: So Exhibit 6, page 1, I have without the risk margin that's 50 to 65 or 55 to 65; 23.4 recommendation.

DR. RITCHIE: That's the old order.

MS. LOVE: Are are you looking at the separate document that was sent? There was -- the last thing we got was a copy of the full report and the second document had two pages.

MR. MARTINEZ: I opened this from the email I received today. So I have both.

MS. LOVE: Okay.

MR. VARGAS: Does it say no batch provision at the bottom?

MR. MARTINEZ: Correct.

MR. CLARK: That is the updated version of the 23.4 percent that you were referring to, Alfonso.

MR. VARGAS: Right. I'm asking if Alfonso's copy has that.

MR. MARTINEZ: I have not seen that on my copy. No.

MS. LOVE: Yeah. It's a --

MR. VARGAS: I think you're looking at the old one.

MR. MARTINEZ: Okay.

DR. RITCHIE: It is -- under the no batch provision without risk margin, the indicated rate change would be minus 5.7 percent. And then when you include the deficit surcharge as a percent of surcharge the indicated rate change with deficit surcharge would be 19.7 percent, and with the risk margin it would be 29.8 percent.

MR. MARTINEZ: In that case, I will second.

DR. RITCHIE: Okay. Is there any

further discussion? Let's have a vote, please.

MS. ROMERO: Dr. Richie?

DR. RITCHIE: Agree.

MS. ROMERO: Vice Chair Love?

MS. LOVE: No objection.

MS. ROMERO: Mr. Clark?

MR. CLARK: Yes.

MS. ROMERO: Mr. Autio?

MR. AUTIO: Yes.

MS. ROMERO: Mr. Dekleva?

MR. DEKLEVA: Agree.

MS. ROMERO: Mr. Martinez?

MR. MARTINEZ: Yes.

MS. ROMERO: Ms. Stevens?

MS. STEVENS: Yes.

MS. ROMERO: Mr. Vargas?

MR. VARGAS: Yes.

MS. ROMERO: Ms. Starace?

MS. STARACE: Yes.

DR. RITCHIE: Okay. Thank you very much. So that will go forth to the subcommittee.

MR. AUTIO: Well, should we do physicians?

DR. RITCHIE: Yes.

MR. AUTIO: Okay.

DR. RITCHIE: Yeah. Yeah. That's the hospitals. Now, we need to discuss the physicians. That would be in order.

MR. AUTIO: Okay. Happy to discuss it. You know, I think, you know, having listened to Mr. Walling, and I wish we -- I asked the question about possibly, you know -- you know, using some of the surplus for physicians to reduce surcharges. You know, he provided a good explanation as to why that wouldn't be wise.

Although it would provide some temporary relief for the long-term health of the fund and for -- potentially for, you know, independent practitioner of surcharges, that does not seem to be the right move.

So I'm ready to make a motion to accept the 8.6 percent increase recommended by the actuary, which is the indicated rate change without deficit surcharge since the independent practitioner's surcharge has been paid off -- or deficit, I mean. But open to discussion on that.

MS. LUERA: And that's -- just for clarification, that's the number with no batch provision?

MR. AUTIO: Yes.

MR. CLARK: This is Mr. Clark. I'll second it so we can have discussion.

DR. RITCHIE: Thank you.

MR. CLARK: Which I'd like to have discussion.

DR. RITCHIE: Mr. Clark, lead it off.

MR. CLARK: Mr. Autio, does that assume -- so part of that calculation assumes the changes in class plans as part of your motion then -- that we are accepting the proposed changes in class plans. I'm sorry. I don't have where that is. Wherever it is in Mr. Walling's report.

MR. AUTIO: Yes. It would include those.

MR. CLARK: Probably need to find that to reference it. Let's see.

DR. RITCHIE: Otherwise that does change that number.

MR. CLARK: Correct.

DR. RITCHIE: Unless we want to get really into the weeds. And I think we've done that in the past, haven't we? Haven't we accepted the --

MR. CLARK: We've always accepted the change of class plans.

DR. RITCHIE: Class plans, yes.

MS. LUERA: Page 21 of 85.

DR. RITCHIE: Thank you. Otherwise, I don't even know if you could do that. Okay. So, Mr. Autio, then that is with the provision that we're accepting the changes in the class plans?

MR. AUTIO: Yeah. So the motion to accept the 8.6 percent indicated rate change would include the class -- the class plan changes that are set forth on page 21 of 85 of the actuarial report.

MR. CLARK: Okay. Thank you. I would propose that as a friendly amendment just for clarification for the drafting team, because I do think we need to -- I think as we have done that in the past, we've also called that out in our recommendation to the superintendent.

MR. AUTIO: No objection to that amendment.

DR. RITCHIE: Yeah. That needs to be in the report. All right. Any discussion online? Start there.

Okay. All right. Here in person. Any discussion. Ms. Love? No. Any -- no. Well, that's pretty straightforward. Okay.

Then, with that little discussion, if there are no objections, we'll just accept that by

acclamation and not do a full vote. Okay.

So that covers the hospital and independent physician surcharges. Then -- so we've covered all three of the categories. Then, really now we need to discuss any other points that people would want to bring up in the report, questions to bring up, or things that we want to add to the report that we send to the superintendent.

Does anyone want to lead off on that? Does anyone have anything else that they think we should add to the report? We certainly have had things in the past.

MR. CLARK: Mr. Chair, this is Mr. Clark. A question, I guess.

Ms. Luera, in the past we've talked about the amounts being invested, and as I recall from last year's conversation, there were a lower amount of the dollars being invested, and we were making the recommendation to get more of those dollars invested to earn returns. Did that happen or is that something that we should be recommending again to the superintendent this year?

MS. LUERA: I don't know that that happened. That's all done with OSI, and Integrion is not involved in that piece of it at all.

MR. CLARK: So it's not that -- you know, that it didn't; you don't know if it did or not?

MS. LUERA: I don't know if it did. Correct.

MR. CLARK: So, Mr. Chair, I think absent that, if we can't get an answer, it might be worth making that recommendation again, that we feel like we ought to be getting the fund to generate as much possible investment income return.

And I don't remember the exact numbers, but I remember it was we were keeping in cash much, much more than we historically had paid out, and we were limiting our investment returns. And so absent knowing whether that's happened or not, I would recommend that we -- if the board's comfortable with that we make that recommendation again.

DR. RITCHIE: Is there any discussion? I think just making that recommendation, certainly the superintendent would have a discussion in the office as far as how much -- you know, what percentage is appropriate.

But I definitely think increasing it or doing whatever's felt to be safe, but that would increase the solvency of the fund would be appropriate. Okay.

Mr. Autio?

MR. AUTIO: And this would really go under item 4, other matters of the board. I don't know if it's appropriate now, Mr. Chair.

DR. RITCHIE: Well, we're sort of --

MR. AUTIO: Unless we're there. I'm happy to --

DR. RITCHIE: We are blending into the best discussion of the process. So this would be -- we're still just kind of -- any other things to add to the report, and then we can discuss the process of it.

You know, we have definitely spoken in the past of requesting possibly more funding from the legislature, which did happen and has now put the independent physicians into a positive territory rather than negative. So I think the discussion or the mention in the report will be to thank the legislation for that.

And then, is there any other points to be made as far as we discussed all this is the funding of the PCF. We have made points or it has been brought up even by Mr. Walling about the outflow from the PCF as far as helping its solvency by decreasing the amount -- the other side of the balance sheet.

Is there any discussion of that? Any

questions to be brought up or points to be made there that haven't been made in the past?

MR. AUTIO: Mr. Chair, probably not at this stage for the surcharge rate hearing and what's relevant to the surcharge rates. I mean, I think down the road, you know, in terms of our report to the legislature, we could have those discussions, but I certainly don't have anything else that's relevant to the surcharge rate hearing.

DR. RITCHIE: And I don't see anyone else wanting to speak up to it. And I think it is only -- it's applicable only in discussing what -- how that would affect the change in the surplus or change in the rates. And so we -- there was very little commentary on the rates and where they're going. So that sounds very appropriate.

Then, hearing no objections or additions, let's go on to the next part of the agenda. And that would be the discussion of process to prepare the written recommendations. We had process before of a subcommittee of writing the recommendations and presenting it to the full committee.

And do I hear any volunteers to man that subcommittee again? Or sorry. That may be a sexist way to put that. Sorry. I apologize. Be a

member of that subcommittee?

MR. AUTIO: Mr. Chair, this is Nick --

MR. VARGAS: I'm happy to help again. Yeah.

MR. AUTIO: Sorry.

DR. RITCHIE: Is that Mr. Vargas?

MR. VARGAS: Yeah. I'm happy to help again this year.

MR. AUTIO: And this is Nick Autio. I'm happy to assist also.

DR. RITCHIE: I believe that is experienced people.

MR. CLARK: Mr. Chair, I'm happy to accept the willingness of both those capable volunteers who've done such a good job. And I believe the only one missing from that would be Mr. Dekleva, so I might voluntold his name as a nominee to continue on that committee and add the same great work.

MS. LOVE: The good news is, I think it's going to be the easiest one yet.

MR. DEKLEVA: I can't do the drafting, but I'm happy to serve on the committee and review and revise. So yeah, I can -- I can -- this is Mike Dekleva, by the way. So I can serve on the committee.

MR. VARGAS: And I'm happy to take a

first stab at the first draft, so if Mike and Mr. Autio just want to do revisions, that would be great.

MR. DEKLEVA: That's great. Thanks, Ray.

MR. VARGAS: My pleasure.

DR. RITCHIE: Okay. Sounds like that we have three people on the committee, Mr. Vargas, Mr. Autio, and Mr. Dekleva.

MR. CLARK: Mr. Vargas, we challenge you to get the draft down to one page. It's so simple this year. Let's see if we can do that. Just because you like challenges.

MR. VARGAS: Get it down to two lines and a lot of footnotes.

DR. RITCHIE: Okay. Boy, that went easy. All right, then, going -- moving on to the next portion of the agenda. Other matters of the board. Does anyone have other matters? Mr. Autio, you sounded like you had something.

MR. AUTIO: I just wanted to follow-up before it kind of left -- went off the board's radar. But during -- and I forget when, Ms. Luera -- but I think it was during your most recent presentation, we had discussed -- I think it was the amount related to, you know, contract amounts, you know, with Integrion

or something along those lines.

And it had jumped from a million something to 13 or 15 million. Did we ever figure out was that jump because of the premium assistance that was sent out to providers?

MS. LUERA: Yes.

MR. AUTIO: Okay.

MS. LUERA: We confirmed with OSI and that was the case. Yes.

MR. AUTIO: Okay. Good. I just -- I was thinking about that the other day and didn't want it to fall off our radar. So with that clarification, that's all I had.

DR. RITCHIE: So the new car you're driving had nothing --

MS. LUERA: My 2016 Nissan that I just paid off. Thank you very much.

DR. RITCHIE: And I believe there will be opportunity in our final report to the legislature to thank them for multiple helps they have contributed to the independent physicians, et cetera, for making the fund more solvent, and make it easier to keep your overhead down in New Mexico.

So hearing no other matters of the board, next meeting date we already have set; do we

not?

MS. LUERA: I don't think so.

DR. RITCHIE: I thought we did for -- or we talked about it. The superintendent has to -- submitted October 31 to legislature. Is that where it goes?

MS. LUERA: So --

DR. RITCHIE: Or just publishes it on 31 October.

MS. LUERA: Yes. She --

DR. RITCHIE: Publishes it on 31 October.

MS. LUERA: October. Propagate is the word. But yes, that just means her final recommendation is made public.

DR. RITCHIE: And so we wanted to give her at least a couple weeks before that.

MS. ROMERO: That's correct. I have in my notes that you decided that the deadline would be October 11th to get her the recommendation.

DR. RITCHIE: I thought we had discussed the deadline. Does that still work for everyone?

MR. CLARK: In which case we would need to set a meeting far enough before that for us to

review the draft. And then have the potential for another meeting in case there were edits to approve a final.

MR. AUTIO: I think with the simplicity of the

MS. LOVE: I agree. I --

MR. AUTIO: I think it's going to be --

MS. LOVE: We're going to sail through this.

DR. RITCHIE: Yeah.

MS. LOVE: Yeah.

DR. RITCHIE: So I don't --

MS. LOVE: For the first time ever. Yeah.

DR. RITCHIE: We're getting -- we're getting better at it. We're getting experienced.

MS. LOVE: Yeah.

DR. RITCHIE: So yeah. I can't do it before the eighth. So it -- time gets tight. I believe we had -- no. Can't do the 10th. I thought we had spoken, I guess, of possibly the 11th. That's during Balloon Fiesta. Or maybe the start of that next weekend, the 14th, because that is a full two weeks still ahead of time.

So a Tuesday afternoon, the 15th,

Friday afternoon, the 11th, for a probably pretty short meeting within the --

MR. VARGAS: I can do Friday the 11th.

DR. RITCHIE: Friday the 11th.

MR. VARGAS: This is Ray Vargas.

MR. CLARK: I prefer Friday the 11th.

DR. RITCHIE: Okay.

MR. AUTIO: That works for me also.

DR. RITCHIE: And then with the goal of the subcommittee getting the draft to the rest of the committee the beginning of that week, seven, eight.

MR. VARGAS: We can -- yeah. We can do that.

MR. CLARK: What time on the 11th? Do you want to do one or two?

DR. RITCHIE: So how about two o'clock on Friday the 11th? Well, hearing no objections, it sounds like that's what we will set. Two o'clock, Friday the 11th. With the intention of that being the final meeting for this portion of the board's business.

MS. LOVE: I set it for an hour.

DR. RITCHIE: Set it for an hour. Ms. Love, yes. Okay. I like the challenge. Yes. Challenge accepted.

All right, then. Any other comments from anyone? All right, then. Three-twenty. Kept this well under two hours, so that's a good sign.

So then we will adjourn this meeting and meet again on that date in October. Thank you everyone for contributing and coming.

(Whereupon, the meeting concluded at 3:21 p.m.)

CERTIFICATE

I, JAMES COGSWELL, the officer before whom the foregoing proceedings were taken, do hereby certify that any witness(es) in the foregoing proceedings, prior to testifying, were duly sworn; that the proceedings were recorded by me and thereafter reduced to typewriting by a qualified transcriptionist; that said digital audio recording of said proceedings are a true and accurate record to the best of my knowledge, skills, and ability; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

JAMES COGSWELL
Notary Public in and for the
State of New Mexico

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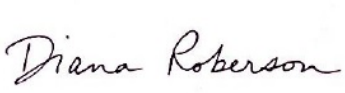
I, DIANA ROBERSON, do hereby certify that this transcript was prepared from the digital audio recording of the foregoing proceeding, that said transcript is a true and accurate record of the proceedings to the best of my knowledge, skills, and ability; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.



DIANA ROBERSON